A Four-Pillars Approach to Methamphetamine

Policies for Effective Drug Prevention, Treatment, Policing and Harm Reduction

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“Being addicted is being addicted. Meth wasn’t my problem. Addiction is my problem. But [with treatment], I’ve been sober for three years.”

Cynthia, Escondido, CA

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It has been more than 40 years since the first illegal methamphetamine laboratory was discovered in the United States. The national strategy for dealing with abuse of this powerful stimulant is the same now as it was then: incarcerate as many methamphetamine law violators as possible and hope for the best. This punitive strategy has devastated families and public health while failing to make the country safer. There are clear steps, however, that can be taken to reduce methamphetamine abuse and protect public safety, and places like California, New Mexico, Utah, and Vancouver, Canada are leading the way.

This report lays out the fundamentals of an effective national strategy for reducing the problems associated with both methamphetamine misuse and misguided U.S. methamphetamine policies. It presents policymakers with a diverse range of evidence-based policy proposals that seek to save lives, reduce wasteful government spending, and empower communities. The “four pillars” of an effective national methamphetamine strategy are prevention, treatment, policing and harm reduction.

Prevention

Encouraging people to make healthy choices and providing alternatives to drug use is crucial to reducing substance abuse problems. Scare tactics and zero tolerance policies, however, often impede prevention efforts. Policymakers can prevent youth methamphetamine abuse by increasing funding for after-school programs and supporting the development of a better drug education paradigm that fosters trust and emphasizes factual information over failed scare tactics. Adult methamphetamine abuse can be reduced by increasing employment and educational opportunities, strengthening families, and promoting economic growth. Cutting funding to ineffective programs, such as Drug Abuse Resistance Education (D.A.R.E.), the National Youth Anti-Drug Media Campaign, and random student drug testing, would produce tremendous savings.

Treatment

The quickest, cheapest and most effective way to undermine drug markets and reduce drug abuse is to make quality substance abuse treatment more widely available through public spending, tax credits and other measures. Policymakers should expand access to treatment and mental health services, divert methamphetamine offenders to treatment instead of jail, and promote family unity. More funding should be provided for longer, more intensive methamphetamine treatment, especially in rural areas, with a focus on reducing the significant barriers to treatment that exist for women and gay men. There should also be a greater investment in pharmacotherapy research, including replacement therapy. Policymakers should take every step possible to advance the development of a substitution treatment for methamphetamine abuse, akin to methadone and buprenorphine for opioid addiction.

Policing

Strategic policing is critical to protecting public safety. Law enforcement agencies should concentrate on what only they can do, disrupting and dismantling crime syndicates, apprehending violent criminals and keeping neighborhoods safe. This requires prioritization in the war on drugs, which means focusing on violent offenders instead of nonviolent drug law violators and on the most problematic drugs instead of the least problematic drugs. Congress should set clear statutory goals for the disruption of major methamphetamine operations, and federal agencies should be required to report on their progress toward these goals, including resources wasted on arresting and prosecuting low-level nonviolent offenders.
Harm Reduction

Investing in harm reduction programs will minimize the public health threats associated with methamphetamine abuse and reduce healthcare expenditures. Methamphetamine use is closely associated with high-risk sexual behavior, which can contribute to the spread of HIV/AIDS and other sexually transmitted diseases. The sharing of syringes among people who use methamphetamine intravenously is also a factor in the spread of HIV/AIDS, as well as hepatitis C and other infectious diseases. Policymakers should ensure that free condoms and sterile syringes are widely available and increase funding for safe-injection and safe-sex education programs. The federal government should repeal the ban on using federal HIV/AIDS prevention money on syringe exchange programs.

While the U.S. government has failed to develop an effective methamphetamine strategy, other governments have implemented successful policies at the state and city level:

California

Although not methamphetamine-specific, California’s Substance Abuse and Crime Prevention Act of 2000 (Proposition 36) has proven to be the nation’s most systematic public health response to methamphetamine to date. This landmark measure, approved by 61 percent of voters, diverts approximately 35,000 persons from jail to drug treatment every year – over half of whom identify methamphetamine as their primary illegal drug. No other statewide program in the nation has offered treatment to or graduated more methamphetamine users than Proposition 36. In the process, California taxpayers have saved more than $1.5 billion over the program’s first seven years.

New Mexico

New Mexico is the only state to have developed a statewide methamphetamine strategy that combines prevention, treatment, policing and harm reduction. This strategy could become a model for bringing together key stakeholders, fostering interagency collaboration, and implementing a coordinated methamphetamine strategy. In addition, Drug Policy Alliance New Mexico is working with state agencies and the private sector to implement a youth methamphetamine education program funded by federal grant money. This campaign will serve as a pragmatic alternative to the failed scare tactics of, most notably, D.A.R.E., the National Youth Anti-Drug Media Campaign, and random student drug testing.

Utah

Utah recently enacted an innovative program that provides substance abuse screening and assessment to anyone convicted of a felony offense (drug- and non-drug-related). The results of these screenings and assessments are provided to the court before sentencing, allowing judges to divert certain offenders to treatment instead of jail. This program, the Drug Offender Reform Act (DORA), is based on a pilot program that has diverted more than 200 offenders in Salt Lake County to treatment instead of jail, many of whom have methamphetamine-related problems. The state is also in the process of expanding access to treatment for pregnant and parenting women struggling with methamphetamine. The Utah Methamphetamine Joint Task Force recently rejected calls to develop scare-based TV ads in favor of developing a more realistic and uplifting prevention campaign.

Vancouver

Vancouver, Canada, leads the world in innovative solutions to the problems posed by methamphetamine production and abuse. Not only does the city have a well-developed, integrated four-pillars approach to methamphetamine misuse, it is developing a replacement therapy program to treat methamphetamine users with legal alternative stimulants such as methylphenidate (Ritalin) and dextroamphetamine. This program, based on research trials from around the world, could serve as a model for how to apply successful replacement strategies found effective in treating heroin and nicotine addiction to methamphetamine and other stimulants.

Past experience with the cyclical nature of drug abuse outbreaks, as well as an analysis of U.S. and international drug policies, make it clear that local, state and federal governments and the Native American nations should embrace a strong public health response to methamphetamine abuse centered on prevention and treatment. Law enforcement agencies have a very important role to play in this response. Locking up tens of thousands of our fellow citizens, however, is a sign of a failed policy, not a successful one. The problems associated with methamphetamine are manageable, but only if policymakers take a balanced approach.
Four-Pillars Policy Checklist
For a More Effective Methamphetamine Policy

Prevention Checklist

☐ Eliminate wasteful and counterproductive government prevention programs that rely on scare tactics, such as D.A.R.E., the National Youth Anti-Drug Media Campaign and random student drug testing.
☐ Increase funding for after-school programs and substance abuse treatment.
☐ Develop better prevention campaigns based on peer-reviewed research.
☐ Support reality-based drug education programs in schools.
☐ Eliminate failed zero-tolerance programs in schools and focus scarce resources on professional counseling, intervention and therapy.
☐ Increase employment and educational opportunities, strengthen families and promote economic growth.

Treatment Checklist

Make substance abuse treatment more widely available:
☐ Divert people convicted of simple methamphetamine possession to drug treatment.
☐ Ensure treatment programs are meeting the needs of populations who have faced unique obstacles to effective treatment in the past, such as women, people of color, at-risk youth, lesbian, gay, bisexual and transgendered individuals, and rural populations.
☐ Increase funding for replacement therapy research.
☐ Make treatment available to all who need it as often as they need it.
☐ Allow individuals to deduct the costs associated with substance abuse treatment from their taxes.
☐ Eliminate zoning and other regulatory obstacles to opening new treatment centers.
Keep families together:
- Increase funding for family treatment programs.
- Increase funding for treatment programs designed for pregnant and parenting women.
- Establish programs that will pay for child care in areas where no treatment programs exist that provide child care services.
- Enact treatment immunity policies that shield parents who seek drug treatment from having their children taken away.
- Evaluate state and federal prisons on their ability to transport incarcerated parents to custody hearings.
- Find ways to increase the ease and quality of family members’ visits to prison; make family caseworkers available in prison.
- Expand re-entry services to help parents returning from prison more quickly get their children back into their lives, including expanding housing, employment, education and substance abuse treatment services.
- Eliminate barriers that prevent people from getting their lives back together, such as laws that prohibit drug offenders from accessing school loans and public assistance.
- Eliminate programs that stigmatize former offenders, such as public databases of drug offenders.

Policing Checklist
- Provide law enforcement officers with better training on arresting individuals when children are present to reduce the emotional damage to children and help parents understand their rights.
- Focus local and state drug law enforcement on arresting and prosecuting offenders who commit crimes against people or property by shifting focus away from nonviolent offenders.
- Re-prioritize federal anti-methamphetamine law enforcement resources toward drug cartels, and leave low- and medium-level offenders to states.
- Set clear statutory goals for the disruption of major methamphetamine operations and require agencies to report on them.

Harm Reduction Checklist
- Make free condoms more available and increase funding to safe-sex education for high-risk groups.
- Make sterile syringes more available and increase funding for safer-injection prevention programs.
- Deregulate the sale of syringes through pharmacies.
- Decriminalize the possession of syringes.
- Establish and fund syringe exchange programs.
- Deregulate the sale of syringes through pharmacies.
- Deregulate the sale of syringes through pharmacies.
- Repeal the federal ban on using HIV/AIDS prevention money on syringe exchange.
- Increase public funding to help clean up clandestine methamphetamine lab sites.
- Train first responders on how to reduce the harms associated with exposure to methamphetamine operations.
Introduction

A Brief History of Methamphetamine in Society

The history of the use of methamphetamine is intertwined with the history of its chemical cousin amphetamine. Their chemical structures are similar but the effect of methamphetamine on the central nervous system is more pronounced. Like amphetamine, methamphetamine increases activity, decreases appetite and causes a general sense of well-being. The initial effects can last up to eight hours, after which there is typically a period of high agitation. Consequences of long-term methamphetamine abuse can include psychosis, malnutrition, severe depression and loss of control.\(^1\)

Amphetamine was first synthesized in Germany in 1887.\(^2\) Methamphetamine was discovered in Japan in 1919.\(^3\) By 1943, both drugs were widely available to treat a range of disorders, including narcolepsy, depression, obesity, alcoholism and the behavioral syndrome called minimal brain dysfunction (MBD), known today as attention deficit hyperactivity disorder (ADHD).\(^4\) Following World War II, during which amphetamine was widely used to keep combat duty soldiers alert, both amphetamine (Adderall, Benzedrine, Dexidrine) and methamphetamine (Methedrine, Desoxyn) became more available to the public. Amphetamine was used for weight control, for athletic performance and endurance, for treating mild depression, and to help truckers complete their long hauls without falling asleep. Methamphetamine was widely marketed to women for weight loss and to treat depression.\(^5\)

In 1971, Congress passed the Comprehensive Drug Abuse Prevention and Control Act, which among other things classified amphetamine and methamphetamine as Schedule II drugs, the most restricted category for legal drugs. As a result, it became much more difficult to legally obtain either drug to stay awake, increase productivity, boost stamina, feel better or anything else deemed recreational and not medical. In response to an ever-increasing demand for black market stimulants, their illegal production, especially that of methamphetamine, increased dramatically.\(^7\)

Pharmaceutical methamphetamine is still available legally under the brand name Desoxyn, but only infrequently prescribed to treat severe obesity, narcolepsy and ADHD. Pharmaceutical amphetamine is available by prescription under a number of brand names (most notably Adderall) and is commonly prescribed to treat narcolepsy, ADHD, fatigue and (to a much lesser extent) depression.\(^8\) Although ostensibly not available to enhance productivity or wakefulness, amphetamine is commonly used that way.\(^9\) This has created a divide between those with health insurance who are able to obtain stimulants through legal means and those who seek out black-market stimulants and face arrest.
Moving Beyond a ‘Drug War’ Approach

While in some ways methamphetamine abuse seems to present new and unique challenges, there are important lessons to be learned from failed efforts to address the abuse of other drugs, such as cocaine and heroin. The bulk of federal efforts to control illegal drugs is comprised of costly – and largely unsuccessful – programs to reduce the availability of drugs by attempting to halt their production abroad, interdict them at the border, and incarcerate as many (mostly nonviolent) drug law violators as possible. And yet, despite spending hundreds of billions of dollars and incarcerating millions of Americans, experts acknowledge that illicit drugs remain cheap, potent and widely available in every community.

Meanwhile, the harms associated with drug abuse – addiction, overdose and the spread of HIV/AIDS and hepatitis – continue to mount, while entire communities are devastated by astronomical incarceration rates. To this record of failure, add the extensive collateral damage of drug prohibition and the drug war: broken families, racial inequities, billions of wasted tax dollars, and the erosion of hard-fought civil liberties. Punitive drug war policies are no more likely to succeed in addressing methamphetamine abuse.

While federal, state and local officials have grappled with the issue for more than 40 years, methamphetamine abuse continues to present serious and complex threats to health and public safety. In rural areas, for example, the wide availability of methamphetamine has exacerbated significant shortages of resources for drug treatment and infectious disease prevention, creating new public health challenges. As a consequence, the problems typically associated with methamphetamine – crime, environmental contamination, risky sexual behavior and the spread of HIV/AIDS – have jumped to the forefront of national concern.

Facts about Methamphetamine Use

The number of Americans who report binge drinking in the last month – an indicator heavily associated with crime, violence and family dissolution – is more than 90 times the number who report using methamphetamine in the same period. The following official estimates, though not exact, provide a sense of the relative popularity of various drugs and a realistic snapshot of current methamphetamine use rates in the U.S.*

- 10.3 million Americans have tried methamphetamine at least once – far fewer than those who have tried inhalants (23 million), hallucinogens (34 million), cocaine (34 million), or marijuana (97 million).
- Of those 10.3 million, only 1.3 million used methamphetamine in the last year; and only 512,000 used it within the last 30 days.
- The estimated number of semi-regular methamphetamine users in the U.S. (those who use once a month or more) equals less than one quarter of one percent of the population (0.2 percent).
- There is no indication that meth use is increasing. The proportion of Americans who use methamphetamine on a monthly basis has hovered in the range of 0.2 percent to 0.3 percent since 1999.


Crafting an intelligent national methamphetamine response offers the opportunity to make a clean break with the mistakes of the past and embrace a new policy framework based on reason, compassion and equal justice under the law. Numerous cost-effective policy options, many developed at the state and municipal levels, are already working to reduce rates of addiction, protect public safety and save countless lives. An effective national methamphetamine strategy will depend on strong leadership, a determination to abandon old falsehoods about methamphetamine, and the courage to work with treatment professionals, community leaders and parents to implement evidence-based policies. It is time for a new bottom line for U.S. drug policy, one that focuses on reducing both sets of problems: those associated with drug misuse and those stemming from the destructive war on drugs.
Perpetuating Old Myths
Only Makes Matters Worse

Discussions about methamphetamine and related policy in the U.S. are often reminiscent of discussions about crack-cocaine and related policy in the 1980s. Many of the assertions made about crack then – “it’s instantly addictive,” “once you try it you’re hooked for life” – are sometimes made about methamphetamine today. Copious amounts of scientific evidence, however, and numerous studies, including a recent analysis by the U.S. Sentencing Commission, show that many of the assertions that elected officials and the media made about crack in the 1980s were not supported by sound data and were exaggerated or outright false. Unfortunately, the punitive crack policies created during this hysteria (most notably the 100-to-1 crack/powder cocaine sentencing disparity) are still in place.

Like crack cocaine, methamphetamine poses some serious public health and law enforcement challenges, but hysteria and media hype will once again serve only to impede our efforts to address the problem. A culture that perpetuates myths about methamphetamine, its use and misuse presents a formidable obstacle to progress by biasing the national discussion and lowering expectations.

Judging by today’s newspaper headlines, the clandestine manufacture, trade and misuse of methamphetamine appears intractable. Reports abound of a national “methidemic.” But methamphetamine is among the most infrequently used illegal drugs, with its use declining among youth, stabilizing among adults, and demonstrating small decreases in first-time users. Only two tenths of one percent of Americans regularly use methamphetamine. Four times as many Americans use cocaine on a regular basis and 30 times as many use marijuana. The federal government’s own statistics show a clear stabilization of methamphetamine use since 1998, and even declines in recent years.

The prevalence of methamphetamine use is higher in selected areas, however. Nationwide, just five percent of adult male arrestees tested positive for methamphetamine, compared with 30 percent who test positive for cocaine and 44 percent who test positive for marijuana. But in some cities (Los Angeles, San Diego and San Jose, California, and Portland, Oregon) arrestees tested positive for methamphetamine at a rate of 25-37 percent. The Sentencing Project found that in those cities the overall rate of drug use did not rise between 1998 and 2003, suggesting that an increased use of methamphetamine replaced the use of other drugs, particularly cocaine.

Any discussion of a truly effective strategy to confront the misuse of methamphetamine requires an honest and straightforward discussion of facts:

“Methamphetamine is not instantly addictive for most people who use it; and most people who use methamphetamine are never hooked for life; Far from untreatable, treatment for methamphetamine addiction is similar to that for cocaine and other stimulants and just as likely to succeed; The effects of prenatal exposure to methamphetamine are still not fully known, but there is no peer-reviewed research that demonstrates that prenatal exposure to methamphetamine harms infants; Methamphetamine abuse is neither on the rise nor out of control on a national scale, though there are, of course, regional differences.”

Bill, Los Angeles, CA
Supply-side Strategies: Wasteful and Misguided

Drug control strategies that seek to interrupt the supply at its source have failed over and over again for cocaine, heroin, marijuana and virtually every drug to which they have been applied – including alcohol during alcohol Prohibition. Fundamental economic principles demonstrate why: as long as a strong demand for a drug exists, a supply will be made available at some price to meet it. Worse than simply being ineffective, supply-side strategies drive immutable market forces to expand cultivation and trafficking, generate unintended consequences and, in many instances, ultimately worsen the problem.

Methamphetamine is no exception, and an effective national methamphetamine strategy must therefore depart from past approaches to drug control. Previous attempts to curtail access to methamphetamine have mostly failed; in some cases, they even backfired. Legislation designed to restrict the availability of legally produced amphetamine and methamphetamine, introduced in the 1950s and 60s, had the unintended, though perhaps predictable consequence of driving the manufacture of methamphetamine to clandestine labs. The subsequent proliferation of illegal methamphetamine labs – which employ highly volatile and toxic chemicals in an unregulated setting – created unique environmental dangers, special job-related hazards for law enforcement, and new, complex threats to public health and community well being.

As state and federal enforcement agencies in the 1970s, 80s and 90s implemented precursor restrictions designed to curb access to the chemicals needed to manufacture methamphetamine, traffickers exploited loopholes, switched to new ingredients, bought ingredients in smaller amounts and set up many more – though smaller – illegal labs.

More recent precursor controls, such as requiring Americans to produce identification and sign a government-mandated register before purchasing cold and allergy medicines containing pseudoephedrine, may have played a significant role in reducing the number of domestic methamphetamine labs and their associated environmental dangers. But while much of the media surrounding methamphetamine focuses on “home cooks” and the need to restrict public access to pseudoephedrine, approximately 80 percent of the methamphetamine consumed in the United States is actually made beyond our borders. Most methamphetamine is smuggled into the U.S. by organized groups of Mexican producers who obtain pseudoephedrine in bulk and mass produce methamphetamine in “super labs.”

The shrinking number of domestic clandestine labs could be attributed to Mexican drug cartels working with major domestic traffickers to manufacture and import higher potency methamphetamine. As Florida Attorney General Bill McCollum noted in 2007, “The volume [of methamphetamine] is increasing, it appears to us, and meth in its crystal form is still very readily available, maybe even more available in our state today than through the homegrown labs.” Should authorities successfully crack down on Mexican drug cartels, other distribution channels are likely to emerge to meet the demand. For example, a recent Drug Enforcement Administration (DEA) report cites the importation of methamphetamine tablets from Southeast Asia through the mail.
Treatment, Not Incarceration, Can Keep Families Together

In all their deliberations on our national strategy for methamphetamine, and other drugs, policymakers should avoid enacting policies that do more harm than good. A policy of simply incarcerating low-level drug users, for example, may create more problems than it solves. Former drug law violators face countless challenges after completing a jail or prison sentence (the majority of which are for simple possession), including ineligibility to receive public assistance benefits like federal housing, food stamps and student loans, as well as tremendous difficulty finding employment. Punitive drug policies that rely on incarceration also result in tearing apart families, children being placed into foster care, and the steady erosion of entire communities. Moreover, incarceration is incredibly expensive, certainly far more so than drug treatment with few long-term societal benefits.

Alternative approaches abound, with California, New Mexico, and several other states leading the way. California’s hugely successful drug demand reduction program, the Substance Abuse and Crime Prevention Act (Proposition 36), allows first- and second-time nonviolent, simple drug possession offenders the opportunity to receive community-based substance abuse treatment instead of incarceration. Approved by 61 percent of California voters in 2000, Proposition 36 has helped tens of thousands of people improve their lives while increasing public safety and saving taxpayers more than one billion dollars through reduced criminal justice expenses. It has also proved to be the nation’s most comprehensive public health response to methamphetamine abuse to date. Since its inception, 150,000 people have entered drug treatment through Proposition 36, half of whom used methamphetamine as their primary drug. Many of those entering treatment have long histories (10 or more years) of drug abuse and Proposition 36 provided them with their first opportunity at medically supervised treatment. Proposition 36 data also demonstrate that methamphetamine abuse is a treatable medical condition, with third-year completion rates for methamphetamine (35 percent) comparable to those for cocaine (32 percent) and heroin (29 percent).

New Mexico, which has long been at the forefront of effective public policy on drug-related problems, has crafted a statewide methamphetamine strategy based on the four pillars approach that links prevention, treatment, policing and harm reduction. It is a winning model for how policymakers can bring key stakeholders together, foster interagency collaboration and implement a truly effective methamphetamine strategy. New Mexico’s approach includes leveraging research grants to help fund treatment with both traditional and alternative modalities, increasing access to syringe exchange and infectious disease testing, reducing criminal activity by increasing funding for drug treatment, and ensuring that standardized reporting and evaluation tools are used by all prevention agencies to enhance evaluation efforts.

In formulating a national methamphetamine strategy, policymakers have an historic opportunity to correct what has been missing from our national approach to drug policy for the last 40 years: a commitment to substance abuse treatment for all who need or seek it. Indeed, better access to treatment options for more Americans may well have prevented the problems associated with methamphetamine abuse currently plaguing many American communities. In lieu of funding for new prisons, a rational methamphetamine strategy would fund treatment services critical to reducing methamphetamine-related problems at their source. The death, disease and disability related to drug abuse can be prevented through closer partnerships between public health and public safety with the larger investment of resources going toward prevention and treatment rather than incarceration.
Among the world's most effective drug policies is the four-pillars approach pioneered in Switzerland and Germany in the 1990s. A four-pillars drug strategy is a coordinated, comprehensive approach that balances public order and public health in order to create safer, healthier communities. In Geneva, Zurich, Frankfurt, Sydney and other cities, most notably Vancouver, British Columbia, the four-pillars approach has resulted in a dramatic reduction in the number of users consuming drugs on the street, a significant drop in overdose deaths, and a reduction in the infection rates for HIV/AIDS and hepatitis.32

A new national strategy on methamphetamine must be as comprehensive and address the four-pillars of any effective drug policy: prevention, treatment, policing and harm reduction.

Elements of More Effective Prevention

The single most effective way for policymakers to prevent drug abuse among youth is to increase funding for after-school programs. Research shows that most dangerous adolescent behavior (including drug use) occurs during the unsupervised hours between the end of the school day and parents’ return home in the evening.33 Increasing funding for after-school programs is especially critical to preventing youth methamphetamine abuse in rural areas, where methamphetamine is heavily concentrated and often where fewer activities are available. Research shows that students who participate in extracurricular activities are:

• less likely to develop substance abuse problems;
• less likely to engage in other dangerous behavior such as violent crime; and
• more likely to stay in school, earn higher grades and set and achieve more ambitious educational goals.34

Unfortunately, the federal government continues to waste hundreds of millions of dollars every year on three failed prevention programs: D.A.R.E., the National Youth Anti-Drug Media Campaign and student drug testing. Ineffective at best and counterproductive at worst, lawmakers should discontinue all three programs,35 and shift existing funding to after-school programs and substance abuse treatment. Ineffective drug prevention messages are a big part of why prevention efforts are losing ground:

• Despite D.A.R.E.’s special status as the most widespread school-based prevention program in the country, 20 years of studies, including a 2003 U.S. General Accounting Office evaluation, have consistently concluded that D.A.R.E. has no significant impact on student drug use.36 Moreover, some studies conclude that the program may actually be backfiring, with students becoming even more likely to use drugs the longer they are in the program.37

• Both U.S. and European studies show that scare tactics, the over-use of authority figures, speaking condescendingly to young people, and conveying messages or ideas that are misleading, extremist or do not conform with young people’s own perceptions and experiences – also known as “manipulative advertising” – are ineffective and may have a counterproductive effect on the target audience.38 Yet, an enormous amount of federal prevention dollars targeting America’s youth are devoted to just such media advertisements, though with little progress to show for it. The federal government’s premier youth prevention program, the National Youth Anti-Drug Media Campaign, seeks to reduce youth drug use through television, radio and print ads. Unfortunately, after spending more than $1.5 billion over the last nine years, eight separate government evaluations have concluded that the ads have had no measurable impact on drug use among youth.39 Two of these studies found the ads might make some teenagers more likely to start using drugs.40 Additionally, a recent study by researchers at Texas State University at San Marcos found that 18- to 19-year-old college students who viewed the program’s anti-marijuana TV ads developed even more positive attitudes toward marijuana than those who did not.41

• Student drug testing is the latest costly, scientifically unproven prevention program to gain the federal government’s favor. According to experts in the fields of medicine, adolescent development, education and substance abuse treatment, random, suspicionless drug testing undermines the trust between teenagers and adults and deters students who have substance abuse problems from participating in extracurricular activities – the very intervention shown to prevent drug use.32,43 The only national, federally funded, peer-reviewed study to date compared 94,000 students in almost 900 American schools with and without a drug testing program, and found virtually no difference in illegal drug use.44

The looming public health and safety threats posed by methamphetamine abuse should spur governments at all levels to implement better prevention programs, especially as they pertain to youth (where most prevention resources are already focused). Three key areas for reform stand out.
Providing Real Drug Education

Policymakers should support the development of an education paradigm for older adolescents, who have matured beyond the scare tactics intended to inoculate adolescents against drug use without critical thinking. For older adolescents, an emphasis on factual information and interactive discussions among peers and credible adults is essential. Research shows that when teens hear what they perceive as lies or half-truths from an authority figure they are much less likely to believe that source in the future. Federal programs that attempt to convince adolescents that marijuana is as dangerous for them as cocaine or methamphetamine, for example, are discrediting themselves and their messages with high school and college-age persons.

Young people need and deserve verifiable information about drugs, drug chemistry, drug effects, and the relative risks of different drugs, both legal and illegal. Honest information de-mythologizes drug use and the romance of transgression against authority. A good example of an innovative, reality-based drug education and support program for high schools is the UpFront program operating in Oakland, CA (see www.upfrontprograms.org and www.safety1st.org). Although not limited to methamphetamine, UpFront stands in sharp contrast to D.A.R.E. and other failed, scare-based school prevention programs in its ability to create the kind of trusting relationships that will keep teens safe.

Moving Beyond Zero Tolerance

Most American high schools fail to offer either effective drug education or appropriate interventions that would assist students struggling with abuse of alcohol or other drugs. Instead, school-based prevention efforts overly rely upon the threat of the “big four” consequences – exclusion from extracurricular activities, transfer to another school, suspension and expulsion – which proponents believe serve as deterrents. Extensive research has shown, however, that these punishments are not likely to change students’ behavior, can potentially compound the harms associated with drug abuse by isolating students, and that the only factors likely to have a positive impact on adolescent health-risk behavior are school and family “connectedness.” “Zero-tolerance” drug policies that punish students who have problems with drugs instead of helping them should be eliminated by schools and replaced with a restorative process, in which offenders identify harms they caused and make amends (for more information, see www.safety1st.org). A far better prevention strategy than suspending students with methamphetamine-related problems or otherwise excluding them from an education would be helping them get access to treatment.

Rejecting Scare Tactics

The Office of National Drug Control Policy (ONDCP) has focused only a small part of the National Youth Anti-Drug Media Campaign on methamphetamine prevention (most of the campaign has been focused on marijuana). Some policymakers have urged ONDCP to run more methamphetamine-related TV ads. But as long as the agency remains wedded to the same outmoded scare-based campaign that has been failing for years, any new methamphetamine ads would likely be just as ineffective, and possibly could do more harm than good.

Consistent with the federal government’s usual approach to drug education, a private venture in Montana has been running scare-based anti-methamphetamine TV ads since 2005. The preliminary results are discouraging. While policymakers around the country are understandably anxious to implement media campaigns in their own states, they should be cautious. Most importantly they should invest...
in research and evaluation and ensure that they are implementing science-based campaigns. If they are interested in innovative approaches that reject scare tactics, they should look at New Mexico and Utah.

In 2006, the Drug Policy Alliance New Mexico (DPANM) was awarded a grant through the U.S. Department of Justice to create a statewide methamphetamine prevention and education project directed at high-school-age youth. Working with a statewide advisory committee comprised of representatives from state health agencies, local prevention programs and community-based coalitions, DPANM is focusing on promoting science-based information and youth engagement, rather than simplistic “Just Say No” messages. The grant funded a two-day statewide conference entitled Building Positive Communities: A Public Health Approach to Teen Methamphetamine Prevention in October 2007, which was attended by more than 300 teachers, counselors, prevention specialists, parents and youth. The conference featured nationally recognized keynote speakers and interactive breakout sessions that provided current data on methamphetamine use, prevention, treatment, and reality-based approaches to drug education and student assistance programs. The grant is also being used to fund a social marketing campaign created by and for youth, including a prevention video and discussion guide that is currently in production. The final phase of the grant will fund training and technical assistance to communities statewide to build prevention capacity and enhance effective substance abuse prevention and education programs for our youth.

In Utah, the Utah Methamphetamine Joint Task Force rejected a proposed Montana-like scare-based media campaign in favor of a more realistic and nuanced one. Instead of commercials featuring “ghoulish faces that demonize meth users,” the Utah media campaign will emphasize that recovery is possible and that people have it in them to improve their lives.51
At least 20 recent studies show the efficacy of methamphetamine treatment, despite the persistence of myths to the contrary. A 2003 survey of various treatment approaches published in the *Journal of Substance Abuse Treatment* concluded, “Clients who report methamphetamine abuse respond favorably to existing treatment.” A Washington State study found “there were no statistically significant differences across a series of outcomes between clients using methamphetamine and those using other substances.” Treatment success rates and relapse rates for methamphetamine are similar to those for other drugs, with no documented differences among male and female users.

In 2005, an open letter to the media signed by 92 prominent physicians, treatment specialists and researchers warned, “Claims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research,” and noted that such erroneous claims were causing great harm. The open letter continues, “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.”

Moreover, dozens of scientific studies to date have shown that increased funding for treatment is absolutely the most cost-effective way to undermine drug markets and reduce drug abuse. The evidence of the effectiveness of treatment is overwhelming:

- **RAND Corporation study** for the U.S. Army and the Drug Czar’s office found treatment to be 10 times more effective at reducing drug abuse than drug interdiction, 15 times more effective than domestic law enforcement, and 23 times more effective than trying to eradicate drugs at their source. It concluded that for every dollar invested in drug treatment taxpayers save an estimated $7.46 in social costs. In contrast, taxpayers lose 85 cents for every dollar spent on source-country control, 68 cents for every dollar spent on interdiction, and 48 cents for every dollar spent on domestic law enforcement.

- **California’s CALDATA study** found that every dollar invested in alcohol and drug treatment saved taxpayers more than seven dollars, due to reductions in crime and healthcare costs.

- **Oregon estimates** its return on every dollar invested in treatment to be $5.62, primarily in the areas of corrections, health and welfare spending.

- **A Substance Abuse and Mental Health Services Administration (SAMHSA) study** found that treatment reduces drug selling by 78 percent, shoplifting by almost 82 percent and assaults by 78 percent. Treatment decreases arrests for any crime by 64 percent. After only one year, use of welfare declined by 10.7 percent, while employment increased by 18.7 percent. Medical visits related to substance abuse decreased by more than half following treatment, while in-patient mental health visits decreased by more than 25 percent.

Implementing prohibitionist policies without providing and funding treatment options poses its own special problems. A three-state, $6.1 million study conducted in counties in Arkansas, Kentucky and Ohio raises concerns that laws intended to drive down the manufacture and use of methamphetamine in rural areas may actually be causing unwanted side effects by driving up the use of cocaine. The two-year study, funded by the National Institute on Drug Abuse and published in a 2008 issue of the journal *Addiction*, noted a statistically significant increase in cocaine use of nine percent associated with the implementation of laws designed to reduce methamphetamine use although, due to the study’s observational design, the authors caution against making definitive conclusions.

This and studies like it underscore the importance of making a broad spectrum of treatment services available to the public. Simply instituting restrictions on precursor ingredients, such as over-the-counter cold medicines, will not decrease overall substance abuse. Treatment on demand – not incarceration – is the surest way to ensure that well-intended policy measures do not merely exchange one set of societal problems for another.
Increasing Access to Treatment for All Americans

Policymakers at all levels of government should ensure that substance abuse treatment is available to all who need it, whenever they need it, and as often as they need it. Unfortunately, as many as ten million Americans each year do not receive the substance abuse treatment for alcohol and other drugs that they need.*

Of the ways to expand access to treatment, four stand out:

1) Increase federal, state and local funding to provide treatment for more people. Treatment should include mental health services, as well as sexual abuse, domestic abuse and child abuse services to deal with the root causes of addictive behavior. Treatment options should strive for inclusion and offer both abstinence-based and non-abstinence-based treatment. Policymakers should also ensure that treatment programs are meeting the needs of populations that have faced unique hurdles to accessing substance abuse treatment in the past, such as women, people of color, youth, lesbian, gay, bisexual and transgendered individuals, and rural populations.

2) Provide people in need of treatment with vouchers redeemable for treatment services through the program of their choice. The Bush administration has already established a model program, Access to Recovery, which provides block grants to states for distributing treatment vouchers to those who need it. Congress should fully fund this program, and states should take advantage of it and supplement it with their own funds where needed. The City of Milwaukee has operated its own treatment voucher program for a decade and could serve as a model.

3) Increase the number of people who can access substance abuse treatment through their health insurance. This would require expanding access to health insurance in general, encouraging more companies to include substance abuse and mental health treatment in the insurance policies they offer their employees, and requiring insurance companies to reimburse their customers for treatment expenses at the same level as other medical expenses (known as “parity”).

4) Provide tax credits to people who pay for substance abuse treatment for themselves or others.

Treatment is the Answer

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Treatment Works:
California’s Proposition 36

California is leading the way in providing comprehensive treatment to reduce methamphetamine abuse and its associated problems. The Substance Abuse and Crime Prevention Act of 2000 – also known as Proposition 36 – sponsored by a Drug Policy Alliance affiliate and approved by California voters, requires the state to provide drug treatment, rather than jail time, for nonviolent drug possession offenders. While not specific to methamphetamine offenders, more than 19,000 methamphetamine users enter treatment annually under this program, and no other program in the nation has offered treatment to or graduated more methamphetamine users.

A recent evaluation by the University of California Los Angeles (UCLA) found that California taxpayers saved nearly $2.50 for every dollar invested in the program. Of people who successfully completed their drug treatment, California taxpayers saved nearly $4 for each dollar spent. In all, Proposition 36 is estimated to have saved state and local government more than $1.3 billion over its first six years.61

Other states to implement treatment-instead-of-incarceration programs in recent years include Maryland, Texas and Utah, although none as comprehensive as California’s Proposition 36.

While Proposition 36 is unquestionably a model for how to effectively address the methamphetamine problem, it does not go far enough. People with substance abuse problems should not have to get arrested to receive effective drug treatment. It is both cheaper for taxpayers and better for public safety to provide quality treatment to those who need it before they encounter the criminal justice system. An estimated 300,000 Americans who sought treatment in 2005 for the abuse of alcohol or other drugs did not receive it. The most commonly cited reason for failure to obtain treatment was cost.62

Women and Methamphetamine Policy

It is especially important that policymakers devote more resources to tailored treatment services for women, especially pregnant and parenting women. In contrast to other illicit drugs, rates of admission to treatment for methamphetamine are roughly equal for women (47 percent) and men (53 percent).63,64 Women also face unique obstacles to recovery, ranging from being the primary caretaker of their children to having been physically, emotionally or sexually abused. Yet, a 2004 U.S. government study found that only 32 percent of treatment facilities in the U.S. have unique programs for women, while only 14 percent have special programs for pregnant or postpartum women.65

While no national data are currently available on child welfare cases specifically attributed to methamphetamine, some state and county agencies have reported increases in the number of children separated from their families because of parental use of methamphetamine.66 Unfortunately, less than eight percent of all U.S. treatment programs provide childcare, and only five percent provide residential beds for children.67 Yet almost two thirds of all individuals seeking treatment for methamphetamine are believed to have minor children.68

Women with children cannot enroll in in-house treatment programs unless accommodations exist for their dependent children. Mothers needing outpatient treatment services may have difficulty being on time or making every meeting – problems arise with their children and they need to balance work and family with treatment.

In a 2005 survey of 13 states, 40 percent of child welfare officials reported an increase in out-of-home placements in the last year due to methamphetamine use.69 While it may be warranted to remove children from a parent who is violent, dysfunctional or clearly unable to fulfill their parental responsibilities, the removal of a child, placement in foster care and adoption all have significant drawbacks as well. Too often children are removed based solely upon a parent’s drug use. Policymakers should strive to preserve family unity to the extent possible.
Women who use methamphetamine and bear children have increasingly become the targets of state prosecutors seeking to prosecute them for “fetal” abuse and delivery of drugs through the umbilical cord. Advocates for women and children universally agree that women should engage in behaviors that promote the birth of healthy children. However, they also recognize the complex factors inherent to substance abuse must be met with constructive responses.

According to the American Medical Association, “Pregnant women will be likely to avoid seeking prenatal or other medical care for fear that their physician’s knowledge of substance abuse … could result in a jail sentence rather than proper treatment.” The effects of prenatal exposure to methamphetamine are still unknown. “In utero physiologic dependence on opiates (not addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosable and treatable, but no such symptoms have been found to occur following prenatal cocaine or methamphetamine exposure.”

Drug use during pregnancy is a health issue that requires appropriate care from qualified health professionals, not destructive interventions by law enforcement. Every major medical and public health organization in the country opposes the arrest and jailing of pregnant women for the use of alcohol, methamphetamine or other drugs. Policymakers should stress treatment over incarceration when it comes to women who use methamphetamine or other drugs during pregnancy.

Supporting Women in Recovery:

- Nearly 15 percent of women who use methamphetamine are single parents, more than four times the percentage of men.

- More than 40 percent of women who use methamphetamine are unemployed compared to about 10 percent of men.

- Women who seek treatment for methamphetamine on average use methamphetamine with greater frequency than men.

- Women in treatment for methamphetamine have higher instances of psychological trauma, physical trauma, and both long and short-term sexual abuse. Women are more than four times as likely to have been sexually abused in the 30 days immediately prior to entering treatment.

- Approximately 37 percent of women who use methamphetamine in California say that they use the drug to lose weight, compared to nine percent of men; an equal number of men and women use it to relieve depression.

- Young girls represent almost 70 percent of treatment admissions for methamphetamine among 12- to 14-year-olds, and more than half of treatment admissions for 15- to 17-year-olds.

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i The CSAT Methamphetamine Treatment Project: A Comparison of Characteristics of Men and Women Participants at Baseline, slide 6.

ii Ibid (slide 7).

iii Ibid (slide 9).


v Ibid (table 3, page 82).

vi Ibid (page 2).
Gay Men and Methamphetamine

Gay men also face a shortage of prevention and treatment programs tailored to their needs. A November 2006 report by the Gay and Lesbian Medical Association (GLMA), “Breaking the Grip: Treating Crystal Methamphetamine Addiction Among Gay and Bisexual Men,” draws upon several studies to estimate that 10-20 percent of gay men in major cities have used methamphetamine in the past six months. The report notes that, “Psychosocial pressures – including homophobia, discrimination, fear, loss and stigma resulting from HIV/AIDS, and a public discourse which denigrates the ‘lifestyle choices’ of [lesbian, gay, bisexual and transgendered] persons, same-sex marriage, and equal rights – often result in internalized homophobia, feelings of low self worth and depression, and these conditions increase susceptibility to drug addiction in some individuals. Gay men frequently use methamphetamine to cope with anxiety, depression, loneliness and fears about being physically unattractive due to aging.”

Yet, effective treatment programs for gay men are severely lacking:

Even in major urban areas with large gay populations and established general healthcare programs serving them, there is still a significant lack of culturally appropriate substance abuse programs for gay men. Substance abuse treatment professionals in other cities and rural areas, have little understanding of the clinical needs of gay men or knowledge of resources to provide treatment. When dealing with methamphetamine dependence among gay men, it is important that healthcare providers are able to discuss frankly with their patients and clients the situations and motivations surrounding their methamphetamine use. In many, if not most instances, these situations and motivations will include past and/or present sexual activity. Focus group members provided numerous anecdotes about patients who reported previous experiences in addiction treatment programs where staff [was] unwilling to discuss such issues, and core triggers in their addictions were never addressed during the treatment. This suboptimal treatment results in poor clinical outcomes, alienates patients who feel that their needs are not being met, and wastes financial resources of government and private insurance funds that pay for treatment that demonstrates poor efficacy.

The GLMA recommends increasing the cultural competency of substance abuse clinicians, conducting more research on the social and sexual context of methamphetamine use, and developing more effective treatment programs (including pharmacological approaches).

Special Mental Health Issues

Additional funding for research that examines the root causes of methamphetamine abuse, including whether methamphetamine offenders are self-medicating for depression, Attention Deficit Disorder or other disorders would help lay a foundation for new treatment modalities. A key component of such studies should be what role the lack of access to healthcare generally, and prescription drugs specifically, plays in perpetuating methamphetamine abuse.

In general, policymakers should facilitate better collaboration between mental health programs and substance abuse programs. Although 80-90 percent of mental disorders are treatable using medication and other therapies, only 50 percent of adults who need help receive it. In many cases, mental health agencies will not treat someone who is abusing drugs, while substance abuse agencies cannot treat the person until their mental health issues are resolved. This bureaucratic Catch-22 situation prevents many drug offenders from getting the help they need. Lack of health insurance or inadequate coverage may drive some people to treat medical conditions with black market drugs.

After receiving treatment through a prison diversion program, Mary Pruitt went back to school in the field of recovery, received her certification and has been working in a women’s recovery house in Sacramento since 2003.
Replacement Therapy

Like alcohol and other drugs, it is important for policymakers to invest in research for viable replacement therapy options for methamphetamine abuse. Under replacement therapy, doctors prescribe one or more pharmaceutical drugs to people with substance abuse problems to eliminate or reduce their use of problematic drugs and improve their mental and physical well-being. The exact therapy differs from drug to drug and patient to patient. In some cases, the therapy is direct, such as prescribing medications that block or limit the effects of the drug the patient is abusing (e.g., Naltrexone for opiates). In other cases, the therapy is indirect, such as prescribing medication to treat problems that might be driving their drug use (treating depression with Prozac or Attention Deficit Disorder with Ritalin). Sometimes doctors prescribe patients an alternative to the drug they are abusing that is longer lasting but less euphoric (such as methadone and buprenorphine for heroin users). And sometimes doctors prescribe an alternative form of the drug a patient is abusing that is safer and less problematic (the “patch” for cigarette smokers and pharmaceutical-grade heroin for heroin users).

Research into pharmacotherapies for the treatment of stimulants has fallen into two areas: antagonists that block the abused drugs’ effects thus precluding or reducing use; and agonists that partially replace effects of the abused drug, thereby stabilizing the patient. Because stimulants affect multiple neurotransmitter systems, both antagonists and agonists must interfere with the action of a number of systems to be effective, making the development of an effective medication challenging. So far, no medication has been approved as uniquely effective for the treatment of methamphetamine abuse or dependence in the United States.

Antagonist strategies have traditionally not shown much success in treating stimulant abuse.81 The use of agonists, however, to treat stimulant abuse (including methamphetamine) has shown promise. Currently, there are two stimulant drugs that are praised globally in research for replacement therapy for stimulant abuse: dextroamphetamine82 and modafinil.83 A 2004 comprehensive review of the available research on stimulant replacement therapies concluded that oral dextroamphetamine may help stabilize illicit amphetamine users’ dependency and provide some reduction in the use of other drugs, injection behavior and criminal activity.84

In 1998, Australian and New Zealand researchers found positive results in the use of dextroamphetamine to treat intravenous amphetamine users. Seventy percent of the patients who were prescribed dextroamphetamine in pill form decreased their intravenous use of illegal street amphetamine.85 In contrast, 67 percent of intravenous heroin users who were prescribed methadone decreased their heroin use.86 Similarly, researchers in the United Kingdom are extremely confident in the use of dextroamphetamine to treat stimulant abuse. In a 2001 study, researchers found that prescribing dextroamphetamine decreased their clients’ consumption of street methamphetamine and amphetamine and reduced the frequency of intravenous drug use.87 Other studies have reached similar conclusions.88

The United Kingdom’s Department of Health recommends the limited prescription of dextroamphetamine to patients who use street amphetamine in order to reduce craving, minimize withdrawal, and stabilize them as part of drug treatment.89 It is not uncommon for British doctors to prescribe dextroamphetamine to amphetamine abusers on an ongoing basis to reduce criminality and legal problems, discourage injection drug use and improve the health of their patients.90

Unfortunately, many studies on the use of dextroamphetamine to treat stimulant abuse have been limited by their small sample sizes and lack of controlled randomization. More studies are needed, especially in the United States.

A federally-funded report prepared for the National Institute of Justice, a division of the U.S. Justice Department, concluded:

Poor results with [antagonist] drugs have encouraged a further look at the use of replacement or agonist therapies in the treatment of amphetamine/methamphetamine abuse, much like the approach used with methadone in the treatment of opioid abuse. As with methadone, the approach relies in part on a harm reduction model in that it replaces the illicit drug, methamphetamine, with a legal, controlled dose of a stimulant or replacement drug provided, however, in a therapeutic setting together with supportive services can be supplied. The replacement of, for example, dextroamphetamine for methamphetamine would ideally reduce problems related to crime, injection practices, family and economic issues, and health problems related to escalating illegal use. Grabowski and colleagues (2003) have reviewed the available and somewhat limited research on using replacement (agonist) therapies in the

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treatment of methamphetamine or amphetamine abuse. These studies are often small and involve self selected samples and self reporting of behavior changes. However, many indicate that using oral dextroamphetamine to stabilize illicit amphetamine users’ dependency can provide some reduction in the use of other drugs, injection behavior and criminal activity.91

Modafinil (marketed under the name “Provigil”) is a mild non-amphetamine stimulant originally approved as a medication for narcolepsy. It is increasingly used to ward off fatigue and increase concentration and alertness in both the military and the private sector. Numerous studies have confirmed that its use does not cause elation or euphoria like amphetamine and methamphetamine, making it an unlikely drug to be abused.92 In fact, the DEA has classified it as a Schedule IV drug because it has a “low potential for abuse.” Early studies suggest that it is helpful in the management of psychostimulant withdrawal symptoms such as hypersomnia, poor concentration and low mood. Case reports point to positive responses in both cocaine- and amphetamine-dependent patients with no apparent over-stimulation or abuse.93

Although the use of modafinil in treating methamphetamine abuse is still in the early stages of research, Nora Volkow, M.D., the director of the National Institute on Drug Abuse notes that, “Because modafinil has shown early efficacy in cocaine treatment and may have positive effects on executive function and impulsivity, it is being tested as a potential treatment in methamphetamine addiction.”94

The city of Vancouver, Canada, is working to implement the first stimulant replacement program in North America. Under the plan, called Chronic Addiction Substitution Treatment (CAST), up to 700 chronic cocaine and methamphetamine users would be provided with replacement medication, such as Ritalin or dextroamphetamine. The program, which would need an exemption from Canada’s drug laws from the federal government, is part of an ambitious city program to cut homelessness, panhandling and drug dealing in half by 2010.95

The United States lags behind Canada and Europe in allowing doctors to prescribe medication to treat substance abuse problems. U.S. policymakers should increase funding for the study of both agonists and antagonists to treat methamphetamine abuse. Doctors should be able to use dextroamphetamine, modafinil and other medications to treat stimulant addiction as part of counseling and drug treatment, if it is deemed medically warranted, in the same way that methadone and buprenorphine are used to treat opiate addiction. People struggling with substance abuse problems should have a diverse array of treatment options.

“I started using alcohol and drugs when I was 12. I had been in and out of state and federal prison throughout my life for nonviolent drug offenses and was never before offered treatment. In prison there were more drugs in a smaller area. I was worn out and struggling with crank when I entered Proposition 36. I switched to a more intensive residential treatment program and felt like I was finally offered the tools I needed to make a change.”

Scott, Sacramento, CA
Law enforcement agencies have been required to play an unrealistic role in our nation’s drug policies for far too long, and have been unfairly blamed for their failure to grapple with social problems largely beyond their control. For instance, because treatment, prevention and other public health strategies have not received adequate funding, the brunt of addressing methamphetamine and its associated harms has fallen on the shoulders of state and local law enforcement. Instead of being the last line of defense, law enforcement has become the first – and in some cases only – response to methamphetamine-related problems. This has strained policing budgets and put law enforcement officers in perpetual danger.

Ultimately, policymakers must begin to treat drug abuse as a healthcare issue that has an important criminal justice component. Implementing a comprehensive approach to methamphetamine provides a good opportunity to do so. An effective policing strategy for methamphetamine and other illegal drugs would:

• Concentrate law enforcement resources on drug law offenders who threaten public safety – people who commit violence, steal to support their habit, or drive while impaired. People who are not harming others should be left to private and public health agencies to deal with. Since many drug law violators cause no harm to others, law enforcement could easily improve public safety with existing resources by shifting the public health burden to appropriate public health agencies.

• Refrain from doing anything that exacerbates the harms associated with drug abuse, such as arresting people enrolled in syringe exchange programs – especially those that local authorities have legalized and encouraged96,97 – or arresting drug users who call 911 when a companion is overdosing. One study of nearly 400 current or former drug users in Baltimore, Maryland, who reported having witnessed a drug overdose, found that just 23 percent of the participants reported calling an ambulance to report the overdose.98 To the greatest extent possible, law enforcement should build partnerships with the public, helping drug users find public health services and seeking their help in protecting public safety.99

• Re-prioritize scarce law enforcement resources. This means refocusing enforcement on those who pose the greatest threat to others and on the most dangerous drugs. Violent methamphetamine sellers should take enforcement priority over nonviolent marijuana sellers. Shutting down major methamphetamine crime syndicates should take precedence over incarcerating people simply for methamphetamine use.

A recent publication by the American Enterprise Institute summarizes this last point succinctly:

[It is hard to find evidence that the sharp ratcheting-up of [drug arrests] since the late 1980s has done much to reduce availability or increase price. At the same time, however, there has been some good news about enforcement, which is that carefully crafted policing strategies can materially reduce drug-related crime and violence and the blight of open drug markets.]

Clearly, retail-level drug enforcement should focus on what it can accomplish (reducing the negative side effects of illicit markets) and not on what it can’t achieve (substantially raising drug prices). Thus, instead of aiming to arrest drug dealers and seize drugs – the mechanisms by which enforcement seeks to raise prices – retail drug enforcement should target individual dealers and organizations that engage in flagrant dealing, violence, and the recruitment of juveniles. Arrests and seizures should not be operational goals, but rather tools employed, with restraint, in the service of public safety.100

Local and state anti-methamphetamine law enforcement resources should focus on apprehending violent methamphetamine sellers or users who commit crimes against people or property, and disrupting criminal networks. Federal anti-methamphetamine resources should focus on large cases that cross international and state boundaries, with a priority on disrupting Mexican drug cartels and major domestic crime syndicates. Low- and medium-level offenses should be left to state criminal justice systems. Congress should set clear statutory goals for the disruption of major methamphetamine operations, and federal agencies should be required to report on their progress toward these goals, including resources wasted on low-level drug offenses.
Harm reduction (sometimes called risk minimization) is a public health strategy designed to reduce the harms of activities that cannot be completely eliminated. It is often used as a fall-back strategy when prevention efforts fail. For example, one of the best known examples of a drug-related harm reduction strategy is when parents instruct their teenagers to call home if they are ever intoxicated or stranded and need a ride home, no questions asked. Other examples include providing cigarette smokers with safer nicotine delivery devices (such as nicotine patches) or making sterile syringes available to injection drug users to reduce the spread of HIV/AIDS and other infectious diseases. Harm reduction strategies in other areas include safe sex education, seat belt laws and amnesty laws that encourage desperate mothers to drop their babies off at hospitals and churches rather than abandoning them.

While there are many harm reduction strategies that could mitigate problems associated with methamphetamine abuse, the most urgent need is to address related public health threats. As noted above, methamphetamine use is of particular concern among the gay male community. Among gay men methamphetamine is closely associated with high-risk sexual behavior, which can spread HIV/AIDS and other sexually transmitted diseases. For instance, a 2003 study of gay and bisexual men who used methamphetamine, found that more than half had engaged in high risk sexual behaviors such as unprotected sex, or having sex with someone who had HIV or later developed HIV. While little research has been devoted to studying the association between methamphetamine use and sexual risk among heterosexuals, what research has been conducted suggests prolonged use of the drug significantly increases high-risk sexual behavior. In addition to culturally appropriate drug and safe-sex education, the widespread availability of free condoms is essential to prevent HIV infections and reduce government healthcare expenditures.

Sharing of syringes among people who use methamphetamine intravenously is also a factor in the spread of HIV/AIDS, as well as hepatitis C and other infectious diseases. Policymakers at all levels should make sterile syringes widely available, and increase funding for safe-injection education programs. The federal government should repeal the ban on using federal HIV/AIDS prevention money on syringe exchange programs.

Increasing the availability of sterile syringes through syringe exchange programs, pharmacies and other outlets reduces unsafe injection practices such as syringe sharing, curtails transmission of HIV/AIDS and hepatitis, increases safe disposal of used syringes, and helps intravenous drug users obtain drug education and treatment. Every established medical and scientific body that studied the issue concurs on the efficacy of improved access to sterile syringes toward reducing the spread of infectious diseases, including:

- National Academy of Sciences;
- American Medical Association;
- American Public Health Association; and
- Centers for Disease Control and Prevention.

Seven government reports conclude access to sterile syringes does not increase drug use. No report yet exists that contradicts this basic finding.

The consequences of failing to make sterile syringes more widely available are dire. According to the U.S. Centers for Disease Control and Prevention (CDC), of the 415,193 persons reported to be living with AIDS in the U.S. at the end of 2004, at least 30 percent of cases were related to injection drug use. About 12,000 Americans contract HIV/AIDS directly or indirectly from the sharing of dirty syringes each year. About 17,000 contract hepatitis C. An estimated one in seven stimulant users (amphetamine and methamphetamine) report injection drug use in their lifetime. A recent study found that rural methamphetamine users are more likely to inject the drug than urban users. The strong presence of methamphetamine in rural areas, combined with the significant shortage of both drug treatment and HIV/AIDS prevention resources in those areas, make the sharing of dirty needles a serious threat to public health. The lifetime cost of treating just one person with HIV can be as high as $600,000.

Finally, policymakers should continue to adopt measures to reduce the harms associated with the illegal production of methamphetamine. Recent precursor controls may have reduced some of the public health threats posed by domestic methamphetamine labs (although as previously noted, with some negative consequences); but more should be done. In particular, the federal government should increase funding to states for the safe clean-up of methamphetamine lab sites. Local and state governments should provide better training to law enforcement officers, first responders, child service workers and anyone else who could become exposed to dangerous methamphetamine precursors through the course of their work.
Optimal Syringe Law Reform

Depending on existing law in a particular state, optimal syringe law reform may require one or more of the following:

- Deregulate the sale of sterile syringes, so that pharmacies can sell them to customers without a prescription. Pharmacy sale is standard throughout most U.S. states, Western Europe, much of Central and Eastern Europe, and Oceania.

- Eliminate criminal penalties for possession of syringes, so that people who use drugs intravenously can carry sterile syringes and properly dispose of used ones. (After Connecticut changed its paraphernalia and prescription laws in 1992 to allow for possession and sale of up to ten syringes, needle sharing dropped 40 percent and needle stick injuries to police decreased 66 percent.)

- Remove all legal barriers to syringe exchange programs and increase public funding to such programs. A worldwide survey found that HIV seroprevalence among intravenous drug users decreased 5.8 percent per year in cities with needle exchange programs, and increased 5.9 percent per year in cities without syringe exchange programs.

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iii Hurley SF. Effectiveness of needle-exchange programmes for prevention of HIV infection. Lancet 1997;349:1797. Survey included primarily U.S. cities and found that cities with syringe exchange programs had an 11 percent lower rate of increase in seroprevalence each year.
While methamphetamine abuse and the proliferation of illegal methamphetamine labs have recently become subjects of heightened national concern, state and federal policymakers have been grappling with both problems for more than 40 years. During this time, policymakers have enacted one ineffective policy after another. This is one reason why the problems associated with methamphetamine – crime, addiction, child neglect, the spread of HIV/AIDS – continue to mount. An effective national strategy for addressing methamphetamine abuse is possible but it will take real leadership to pass and enact.

Policymakers must take the lead in stopping the perpetuation of myths. Methamphetamine is not instantly addictive. People who use it are not hooked for life. Methamphetamine addiction is never untreatable. These and other myths permeate the national methamphetamine discussion and give rise to both defeatism and hysteria. The problems associated with methamphetamine abuse are serious, but they are manageable. Policymakers should also learn from the mistakes of the past: Our country cannot incarcerate its way out of the methamphetamine problem. Punitive policies have been exhaustively tried and they have failed, not just with methamphetamine, but also with cocaine, heroin, marijuana and numerous other drugs (including alcohol). Despite spending hundreds of billions of dollars and incarcerating millions of Americans, illegal drugs remain cheap, potent and widely available in every community.

• Many drug policies do more harm than good. Breaking up families perpetuates drug abuse, poverty and crime. Prohibiting former drug offenders from receiving public assistance, housing, school loans and other benefits makes it even harder for them to put their lives back together. Aggressively arresting and incarcerating people who use drugs increases drug-related deaths because people are afraid to call 911 when their friends are overdosing. Using scare tactics and over-the-top messages in prevention campaigns can cause people to rebel against prevention messages, undermining prevention efforts.

• Severe consequences can result from ignoring public health and human rights concerns. If policymakers had prioritized making drug treatment available to all who needed it in the 1980s, instead of arresting millions of Americans for what they put into their own bodies, they may very well have prevented many of the methamphetamine-related problems that plague our country now. Additionally, making sterile syringes widely available would have saved tens of thousands of American lives.

Implementing an effective national methamphetamine strategy would provide policymakers with an opportunity to break from the mistakes of the past. They could adopt a new drug policy framework based on treatment instead of jail, strategic policing and harm reduction. Ideally, and obviously, this new framework should apply to all illegal drugs, not just methamphetamine. Its essential policies should include:

• providing treatment to all who need it, whenever they need it, and as often as they need it;
• developing reality-based prevention programs that foster trust and emphasize factual information;
• investing in pharmacotherapy, including replacement therapy, and expanding treatment options;
• making sterile syringes more widely available to reduce the spread of HIV/AIDS and other infectious disease;
• prioritizing family unity; and
• shifting enforcement resources away from incarcerating low-level nonviolent drug law violators toward disrupting and dismantling violent crime networks.

Methamphetamine poses many challenges to policymakers, but there is no need for panic. There are clear steps elected officials can take to reduce methamphetamine abuse, protect public safety, eliminate government waste and save lives. These steps – some small, some large – would improve the lives of hundreds of thousands of Americans, and states like California and New Mexico are already leading the way.
Endnotes


3 Ibid.


7 Ibid.


Endnotes

continued from page 25

35 While funding for D.A.R.E. and student drug testing has remained relatively stable over the last few years, Congress has significantly cut funding to the National Youth Anti-Drug Media Campaign, cutting it from $100 million in FY2007 to $60 million in FY2008.
46 Through a series of dialogue-driven, interactive workshops, combined with group and individual work, UpFront provides a forum for discussion while conveying age-appropriate prevention messages. Created primarily based on students’ feedback, this multi-tiered program can be tailored to the specific needs of both students and the school.
50 An initial evaluation of the Montana media campaign found that the percentage of young people viewing methamphetamine use as risky behavior actually declined during the campaign. A subsequent evaluation found that teen methamphetamine use remained relatively stable during the ad campaign, suggesting it had little to no impact on methamphetamine use rates. More recently, the Montana Meth Project has claimed that their media campaign has led to a decrease in the number of first-time methamphetamine users in Montana. This claim, however, is based on an independent survey that did not measure the effectiveness of their ad campaign; thus it is impossible to determine what impact, if any the media campaign had on this statewide trend. The survey also only looked at first-time meth use and not regular use. Additionally, while the survey found that first-time methamphetamine use rates were declining among Montana high school students, it found that first-time methamphetamine use rates were increasing among middle school students. In any event, first-time methamphetamine use rates among both groups were declining in the years preceding the launch of the advertising campaign. See: Montana Meth Project, “Montana Meth: Use and Attitudes Survey,” Apr. 2006, Montana Meth Project, 28 Sep. 2007 <http://www.montanameth.org/documents/ MMP_Survey_April_2006.pdf>; Montana Office of Public Instruction, 2007 Montana Youth Risk Behavior Survey, Sep. 2007 <http://www.opi.mt.gov/ yrhs/>; and Fenske, Sarah. “For $5 million Arizona can grow its population of meth users – just like Montana.” Phoenix New Times, April 26, 2006.
51 Brenton, Ana. “TV spots offer meth addicts hope: New approach differs from ‘ghoulish’ spots that demonized users, which were rejected.” The Salt Lake Tribune, 15 May 2007.
54 Luchansky, B. “Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug.” Olympia, WA: Looking Glass Analytics, 2003.


67 Ibid.

68 Ibid.


76 Ibid: 1.


81 Ibid.


86 Ibid.


Endnotes

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98 In 2006, Drug Policy Alliance New Mexico wrote and backed a “911 Good Samaritan” bill, which Gov. Richardson signed into law in April 2007, the first such law in the country. This unique law will save thousands of lives by protecting people from arrest when they call 911 in response to a drug overdose. The chance of surviving an overdose, like that of surviving a heart attack, depends greatly on how fast one receives medical assistance. No one thinks twice about calling 911 when they witness a heart attack, but people who witness an overdose often hesitate to call lest they be arrested on drug law violations or other charges.


108 Ibid. A recent Nebraska-funded study found that rural addicts began using meth at a younger age, were more likely to use the drug intravenously and to be dependent on alcohol or cigarettes. They also exhibited more signs of psychosis than urban addicts, 45 percent vs. 29 percent, according to the study.

The Drug Policy Alliance (DPA) is the nation’s leading organization promoting alternatives to the drug war that are grounded in science, compassion, health and human rights. It is headquartered in New York and has offices in California, New Jersey, New Mexico and Washington, D.C.

DPA Network (our partner organization) was responsible for drafting and building broad public support for California’s Substance Abuse and Crime Prevention Act of 2000 (Proposition 36), which has become the nation’s most systematic public health response to methamphetamine abuse to date. In 2005, the Drug Policy Alliance’s New Mexico office assembled stakeholders from around the state to form the New Mexico Methamphetamine Working Group, co-chaired by the governor’s drug czar and the director of DPA New Mexico. In 2007, DPA New Mexico received a grant from the U.S. Justice Department to create a statewide methamphetamine education and prevention program directed at New Mexico high school students. DPA’s Washington, D.C. office has helped shape numerous methamphetamine-related federal laws.

**About the Author**

Bill Piper is director of national affairs for the Drug Policy Alliance, where he lobbies Congress in support of a “new bottom line” for U.S. drug policy; one that seeks to reduce the negative consequences associated with both drugs and the war on drugs. He has more than 12 years of Washington, D.C. political experience and writes and speaks often on methamphetamine-related issues.

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