

# Transcript of an Educational Teleconference on the Methamphetamine Crisis

Monday, May 10, 2004  
1:00-3:00 pm, CDT

Co-sponsored by  
the Public Health Law Association  
and  
the Public Health Law Program,  
Centers for Disease Control and Prevention

## Moderator:

Anne M. Murphy, JD, Chief Counsel, Illinois Department of Public Health

## Faculty:

- Fay Boozman, MD, MPH, Director, Arkansas Department of Health
- Steve Mange, Senior Policy Advisor for Illinois Attorney General Lisa Madigan
- Richard Rawson, PhD, Associate Director, Integrated Substance Abuse Programs, University of California at Los Angeles
- Blake Harrison, MS, JD, Senior Policy Specialist, Criminal Justice, National Conference of State Legislatures

## Disclaimer:

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BACKGROUND:

On May 10, 2004, the Public Health Law Association and the Public Health Law Program of the CDC, launched the 2004 Public Health Law Educational Teleconference Series with a teleconference providing an overview of the methamphetamine crisis. Methamphetamine is a potent, Schedule II psycho-stimulant that dramatically affects the central nervous system, and is easily made in clandestine laboratories with relatively inexpensive, over-the-counter ingredients. These factors, coupled with a high rate of addiction and high profit potential, make methamphetamine a drug readily abused.

Initially concentrated among white males and most prevalent on the West coast, methamphetamine is rapidly becoming a national problem. Its broad public health and social impacts call for inter-agency cooperation and the active involvement of many different partners— law enforcement personnel, clinicians, substance abuse treatment providers, the public health community, the child welfare community, corrections officers and professionals, and others.

This 2-hour teleconference attracted an estimated 300 listeners from across the nation representing a wide spectrum of disciplines. Questions and comments made by listeners—including an environmental epidemiologist in Kentucky concerned with assessing the health risks of clandestine methamphetamine labs, and a practitioner who works in the Texas Department of Family and Protective Children Services looking for information on the use of cognitive behavioral therapy as a method for treating methamphetamine addiction— demonstrated just how widespread the methamphetamine crisis has become and how timely the need for such a forum.

A. Murphy

I would like to welcome everyone to this educational teleconference on the methamphetamine crisis. This teleconference is co-sponsored by the Public Health Law Association and the Public Health Law Program at the Centers for Disease Control and Prevention. My name is Anne Murphy, and I'm the Chief Counsel for the Illinois Department of Public Health. I'm also a member of the Board of Directors for the Public Health Law Association.

I'm going to cover a few general informational items and some housekeeping matters as quickly as I can so that we can get on with the substance of this teleconference.

For those who don't know, the Public Health Law Association is a national membership association for those who have an interest in public health legal interest issues. It was formed about a year ago, and has generated significant national interest and support.

It's designed to bring benefits to attorneys, policy makers, practitioners and scientists in an interdisciplinary way, and is specifically intended to be a benefit not only to attorneys, but others with an interest in public health

legal issues. If you have an interest in learning more about the Public Health Law Association, I would encourage you to go to our website at [www.phla.info](http://www.phla.info).

Today's teleconference is the first in a series of teleconferences that will be offered by the Public Health Law Association. Our next teleconference will be in about a month, and it will be on trends in medical errors reporting and healthcare quality measurement initiatives. In particular, trends in that area that are sponsored by state and federal governmental entities.

I would also be remiss if I didn't point out that for those of you with an interest in public health legal issues, we would like to commend your attention to the Third Annual Public Health Law Conference that is co-sponsored by the CDC and the American Society of Law, Medicine and Ethics. This conference is being held in Atlanta from June 14<sup>th</sup> to 16<sup>th</sup>, and will cover a diverse array of public health legal topics, including without limitation, a session on the methamphetamine crisis with Dr. Boozman and others. If you have an interest in that conference, please go to the American Society of Law, Medicine Ethics website at [www.aslme.org](http://www.aslme.org).

Let me turn to a few more particular housekeeping issues for purposes of this teleconference. Note that this conference is open to a wide array of members of the public and has received wide distribution. Therefore, particularly for the speakers, but also for those who might be asking questions, note that there are a number of listeners on the call from a wide variety of perspectives, and also note that the media may be on the call. We are going to make a transcript of this call publicly available as well.

Each speaker is going to present for approximately 20 minutes, and we will then have time for questions and answers. If you have a question during the course of the presentations, I'm going to give you an e-mail address, and I would ask you to e-mail your questions to that e-mail address. Those questions will then be sorted and forwarded on to me, and when we're done with the presentations, I will present questions to the several speakers. That e-mail address for questions is [kwilliams@phla.info](mailto:kwilliams@phla.info).

As I indicated a few moments ago, we will post a transcript of this teleconference both on the PHLA website at [www.phla.info](http://www.phla.info) and on the CDC website at [www.phppo.cdc.gov/od/phlp](http://www.phppo.cdc.gov/od/phlp).

Turning to today's event, I'm going to spend the minimum amount of time setting up the substantive portion of this call because I think all of you are here to hear the experts, as am I. It is clear that methamphetamine use is

increasing nationally, and can be described as an epidemic. It's having a significant societal impact, necessitating involvement by law enforcement, clinicians and substance abuse treatment providers, the public health community, policy makers, the child welfare community, corrections professionals and others.

It is also clear that effective approaches to this problem must be interdisciplinary. Thus, the purpose of today's call is to provide an overview of this topic from several different perspectives in an effort to perpetuate that interdisciplinary approach. I'm going to briefly introduce the speakers and the perspective they represent, and then I'm going to turn it over to our first speaker, Dr. Boozman.

From a public health perspective, we are fortunate to have Dr. Fay Boozman, who is the Director of the Arkansas Department of Public Health. From a clinical perspective, we have Dr. Richard Rawson, who is recognized as one of the leading thinkers in terms of methamphetamine addiction treatment in this country. He is the Associate Director for the UCLA Integrated Substance Abuse Programs.

From a legislative perspective, at the policy level, we have Blake Harrison, who is a senior policy specialist in the criminal justice arena for the National Conference of State Legislatures, and last, but certainly not least, both from a policy and from a law enforcement perspective, we have Steve Mange, who is the senior policy advisor for Illinois Attorney General, Lisa Madigan, and who has spent a tremendous amount of time in Illinois, looking at the methamphetamine crisis. Without further adieu, I turn the platform over to Dr. Boozman.

F. Boozman

Well, good afternoon. It's a great honor to have the opportunity to visit with you. My role as a state health officer is just to set the stage about the methamphetamine epidemic and the amount of problems that we're having to face, and then, like the rest of you, I anxiously want to sit back and listen to the real experts on the rest of this panel talk to us.

To put it in perspective for Arkansas, we have 2.7 million people, 51.2% of those are female and about a half a million are school age. Eighty-percent of our population is white and 4% is Hispanic. These numbers are important since studies show that whites and Hispanics are more likely than any others to abuse methamphetamine, and females are using the drug at an increased rate to help lose weight or increase energy.

In Arkansas, methamphetamine is scheduled as a Schedule II drug, which means that it has a high potential for abuse. It has limited accepted medical uses, and these are quite restricted, and that abuse might lead to severe psychic or physical dependence. Arkansas is currently considering

making pseudoephedrine a Schedule V drug, just like its sister drug, ephedrine. A Schedule V drug requires proof of identity at the time of purchase, and purchase can only be made at a pharmacy.

9.6 million Americans have tried meth at least once. A batch of meth costs about \$100 to make, and can be sold for about \$1,000 on the street. Federal lab seizures rose from 327 in 1995 to more than 13,000 in 2001. In 2002, more than 2,000 children were present at the time of a DEA lab seizure. Twenty-six of those children were injured and two were killed.

Here in Arkansas, we've had 76 children that were at the site of a meth lab seizure in 2002. Just yesterday, here in Pulaski County in Arkansas, four were arrested for cooking meth in a trailer house and two children were onsite at the time - a 13 year old and a two year old.

Many terms are used for meth. The slang terms are speed, crank, chalk, zip, crisy, ice, crystal and quartz. It comes in many forms. It can come as a pill, a powder, a capsule, or in chunks. It can be snorted, smoked, ingested or used intravenously. The ingredients used to make meth are very common ingredients. The cold and asthma medications, ephedrine and pseudoephedrine, are used, red phosphorus, hypochlorotic acid, drain cleaner, battery acid, lye, lantern fuel, antifreeze and fertilizers.

Meth can be made in makeshift labs, which could actually fit into a suitcase, and therefore are very mobile. The average person that cooks meth on an annual basis will teach ten other people how to manufacture meth. Meth use among high school seniors has more than doubled in the last six years.

According to the Youth Risk Behavioral Survey for 2001, approximately 10% of students had used meth during their lifetime, with white and Hispanic students, 11% and 9% respectively, more likely than black students - only 2% - to have used meth. Twelfth grade use of meth was approximately 13% compared to ninth grade use of 8%.

Methamphetamine abuse among adolescent populations in Arkansas is higher than the national average. For grades nine through 12 in Arkansas, we're at about 12%, and nationally it's only 2%.

Among other things, meth produces hallucinations. It's one of the hardest drug abuses to treat. A meth lab cleanup usually will cost from anywhere from \$2,000 to \$10,000, but can be as expensive as \$150,000. Meth use also increases risk of child abuse and neglect, and domestic violence. Unlike methadone and other new drugs to treat heroine addiction, there's really no good drug treatment for meth abuse.

Every pound of methamphetamine produced leaves behind five to six

pounds of toxic waste. It kills by causing heart failure, brain damage and stroke. It can induce paranoia, and this has led to numerous murders and suicides. As I mentioned a moment ago, but I want to reemphasize, other problems associated with meth use include domestic abuse, child abuse and child neglect, elder abuse and elder neglect, disabled abuse, rape and sexual assault.

Now if we look at the incidence and prevalence of methamphetamine use in our country, it peaked in 1975 in terms of new users. We had 400,000 new users in 1975. In 1990, we had 164,000 new users and in 2000, 344,000. Something that's very disturbing to me as a public health official is that in the last ten years we've seen the average age of the first-time user move down. In the early 1990s, it was around 22 years of age, and now it's about 18 years of age.

Now the largest group using, about 35% of users, are in the 18 to 23 year age group. But as I said, I'm extremely concerned that we're seeing that initial use of the drug, the age group is moving down.

Now if we look at approaches to this problem from a public health standpoint, according to the Council of State Governments, there are really about four things that we need to be doing: limiting access to the ingredients, training law enforcement officers, raising public awareness and targeting youth and drug-prevention programs. Most of these also fall into the public health arena.

If we look at limiting access to ingredients and the laws associated with the use of amphetamines in Arkansas, we've passed laws which require people convicted of possessing the ingredients for methamphetamine, with an intent to manufacture, to serve 70% of their sentence before becoming eligible for parole. We've also passed laws that limit the amount of cold medicine or ephedrine or pseudoephedrine that an individual can buy.

We have enhanced criminal sentences for ten extra years for manufacturing or possessing methamphetamine in the presence of a minor. It's a felony to possess the ingredients of meth with the intent to manufacture, and it's a misdemeanor to possess anhydrous ammonia in any container that does not comply with federal regulations.

Many additional resources have been appropriated to help train law enforcement officers, and also to train individuals who can go out into the community and help to teach individuals about things to look for. That site I mentioned here in Pulaski County, it was actually found because the neighbors in the community were smelling an unusual odor and that led to the police investigating the situation.

Of course, a huge public health endeavor is to raise public awareness, both at the local and the state levels. Much effort in Arkansas is going on to educate citizens about meth abuse, the hazards of its production, and, as I said just a moment ago, we're also helping citizens to be able to be informed to such an extent that they could actually tell if things are going on in their community. Our environmental health specialists are working here in the department daily. They work with law enforcement to help them try and locate these laboratories.

Certainly we have to target youth in drug-prevention programs. Research has shown that if a person can make it to age 21 without ever using drugs, it's very likely that they never will use drugs. We know that effective programs for children give accurate information about drug abuse, while teaching them how to recognize and withstand the social pressures of drug use. Many students lack the abilities that can help them stay away from drugs and alcohol. Successful programs teach these little ones the skills such as effective problem solving, basic social skills, how to improve their self-esteem and how to be assertive.

In conclusion, public health interventions can reduce meth abuse, but they have to be addressed at a local level. They have to be evidenced-based and certainly the speakers that are going to follow me will give us much authoritative information about these issues. We also need to target our approaches. We are in a time when resources, certainly for state agencies, are extremely limited. We've just got to do an excellent job of focusing where we put our resources. I'm very pleased as I see more and more literature coming out helping us target those.

I was just recently made aware of an excellent article on methamphetamine use, behaviors and gender differences in the *Addictive Behaviors Journal* in January. There, it looked at the different things, how do people start using the drug, and it showed that males, basically, get into methamphetamine use through friends, as opposed to women who get into it through their spouses or a boyfriend.

Men basically get into methamphetamine abuse just for the high. Women, as I mentioned earlier, typically seem to be more interested in getting more energy and in weight loss. The different ways that it's used: males tends to inject; women tend to snort. For men, methamphetamine abuse leads them to problems at work. For women, it leads to unsightly skin lesions and problems with dental issues.

All of that helps us focus and helps us develop better interventions and ways to more effectively use the few resources that we have. With that, Anne, I'll turn this over to you.

A. Murphy

Thank you, Dr. Boozman, and let me remind the listeners, as questions occur to you, please e-mail those questions to [kwilliams@phla.info](mailto:kwilliams@phla.info). I'm going to turn the podium, as it were, over to Dr. Rawson, who is going to discuss the clinical aspects of methamphetamine abuse.

R. Rawson

Thank you. It's a real honor and pleasure to participate in this. I've never been in a forum quite like this. Although, I have to say, over the last 15 years, I've spent the better part of my time talking to groups on methamphetamine, from Bangkok to Eastern Europe to California and Hawaii to the Midwest. It's unfortunate that those of you east of the Mississippi are now becoming interested in this problem. We were hoping that the Mississippi River would somehow magically prevent the methamphetamine epidemic from getting east, but obviously it didn't work.

This week, I'm going to Des Moines. Next week, I'm going to Missouri. I've spent a good deal of time in the Midwest over the last decade, since they have a very severe meth problem.

I'm a research psychologist at UCLA. I've been doing addiction work for 30 years. I've been doing meth work almost exclusively now for about 15 years. We've seen, here in California, here in our treatment centers in Los Angeles, about 9,000 methamphetamine users over the last 15 years or so. In California, just for some perspective, in our treatment system, over 60% of the people admitted under our new Proposition 36 were meth users and meth was their primary drug of use.

California is still awash in methamphetamine, which is a bad sign because California had the earliest signs of methamphetamine - California and Hawaii. It's not as though this is a temporary epidemic. It doesn't come and then go. It comes and it stays, unfortunately. So we've seen a lot of meth users and have had a lot of experiences with them.

The realities of methamphetamine, the previous speaker talked about some of how meth works and what it is made out of and how people make it. It's easy and cheap to make here in California. We have multiple lab busts, literally 15 or so a day, here in Los Angeles County and in the greater Southern California area. It's a mess.

Meth use does some things that people like. That's why they start taking it. Again, as mentioned previously, people take it often not to party, although they can, but it's a drug that actually extends work performance. You can work longer hours. If you're a woman, you can lose weight and you can deal with being a working mother, a mother, a wife and all of the other roles they have to play. This is the only drug we've ever seen, drug epidemic we've ever seen, where over half of the users are women in

some places. It is a drug where women's treatment has to be prioritized because there is a large female population.

Some of the things people like methamphetamine are that when they start taking it, it improves energy. It reduces shyness. It can allow people, obviously, to reduce their appetites, and probably a main thing is that it reduces fatigue. You're able to work long hours. You're able to stay up and party. You're able to drink lots of beer. You're able to do lots of things under the influence of methamphetamine. It makes you feel energetic. It makes you feel powerful. It makes you feel extremely confident and clear thinking, and your mood is elevated.

If you take it via smoking or injecting, you get a powerful rush of euphoria, which makes the addiction very strong later on when we start dealing with trying to help people with their recoveries.

Physiologically, methamphetamine increases heart rate, increases blood pressure, pupil size, increases energy, and it decreases a need for sleep and fatigue. Now that's what you find attractive about it when you start in.

Unfortunately, over time, the drug affects the brain. Methamphetamine is probably the best example of substance disorders as true brain diseases because methamphetamine changes the brain. It changes it profoundly, rapidly and the user doesn't really understand what's going on. We have a tremendous amount of research on how the drug affects the brain through PET scan research where we can actually take pictures of the brain and actually see what damage has been done and what the recovery process looks like.

Dopamine is the main neurotransmitter affected, although the other ones, serotonin and norepinephrine, are also affected. But dopamine is where it has its main action. We know methamphetamine, unlike drugs like cocaine and heroine and marijuana, methamphetamine destroys neural tissue. It actually doesn't destroy neurons, but it destroys their extensions. They're called axons. These extensions are destroyed as a result of methamphetamine, but they grow back over time. One of the things that we've seen now with PET scan data is that it takes a brain anywhere from four to 12 months to start to show significant recovery after a period of chronic meth use.

Now, while you're going through that four- to six-month period or four- to 12-month period of time when your brain isn't wired properly, you feel different. You think different. You have experience of depression, inability to concentrate. You're not able to think clearly. You're often fatigued.

Actually, depression isn't quite the right word. The right word is anhedonia, the inability to experience pleasure. Nothing feels good. You've actually damaged the reward centers of your brain so that you're not able to truly experience the good feeling that comes with natural rewards, and so you often hear meth users saying things like, "If this is the way it feels to be sober for the rest of my life, I can't do this." Part of what treatment involves is educating them about the timetable and the fact that they, in general, do get better.

Now, when methamphetamine starts to have its chronic effects, you go from these initial, what appear to be, beneficial effects to things like having symptoms that are almost a mirror image of the acute effects. The chronic effects are memory loss, extreme difficulty concentrating, people having hallucinations, paranoia being the major symptom with meth use.

Methamphetamine, when taken over time, produces an interesting paradox effect. Some of the effects in the brain get worse. For example, the paranoia gets worse and your brain gets sensitized to methamphetamine. Other effects, like the energy and euphoria, develop tolerance and so you need more and more to get the feeling you're looking for. So at the same time your brain starts to react more psychotically quickly, but at the same time, you're trying to take more drug to feel better. So it really is the worst of both worlds.

Panic reactions often occur, irritability, confusion and these hallucinations that are experienced by roughly 60% of meth users generally are paranoid in nature. They often involve people believing that someone is watching them, or someone is having an affair with a spouse. That kind of thinking can often lead to violence, and can often lead people to act out in ways because they really believe that these bad things are going on.

Now there are also effects on other body systems - obviously, as was mentioned, the heart, kidneys. You can die of a methamphetamine overdose. The skin is affected. The users will start to pick at their skin and often come into treatment with scabs on their arms and face where they've been digging themselves. Because methamphetamine retards the flow of saliva in the mouth, dental problems are common, as people just aren't able to take care of their teeth.

For those of us in the treatment field, who have treated heroine users and cocaine addicts over the last 30 years, methamphetamine users have the delightful characteristic of generally having very poor hygiene. They smell bad. They often come in with head lice, and they're not exactly a popular group of people to see in a treatment center.

The routes of administration have changed. What was mentioned before

has been pretty much true historically, but in the last ten years the route of administration for methamphetamine in most parts of the country is smoking. It's smoked as either powder or in crystallized form, through glass pipes or through other mechanisms of smoking. There are tremendous geographic differences in this.

In Hawaii, for example, people only smoke methamphetamine. They don't take it any other way. In California, it's about 70% that smoke it, about 10% that snort it and 15% or so that inject it. In the northwest, over half of the people inject it. I'm not sure what's going on so much in Arkansas or Illinois or in places like that, but I know in Missouri and Iowa smoking is the major route of administration. This also produces lung damage. It produces damage that's similar to asbestos disease. You often see meth users coming in with really severe lung problems, and things that need treatment.

Now meth has the effect - we don't know exactly what methamphetamine does when taken by a pregnant woman, but it doesn't appear to be a good thing, as you might expect. Animal data suggests that methamphetamine given to pregnant animals causes a retardation of brain development, lower birth weights, more spontaneous abortions and a variety of other problems.

In the human data so far, there's a big study currently underway looking at prenatal meth effects with women delivering babies. Right now, we know that babies are born lighter. There's a higher spontaneous abortion rate. We've done testing here in southern California with three to five year olds who were exposed to meth. Although much of their development appears to be relatively normal, they have striking deficits in their verbal learning ability, and we're not sure exactly what that is. It appears that meth affects that particular part of the brain development.

There's a national system of people working on the problem of kids in meth labs. In meth labs, when children are taken out of them, about a third to a half of them will test positive for methamphetamine, although they haven't taken it meaningfully, they've absorbed it either through the vapor of cooking methamphetamine or through the powder that they come in contact with, or because somebody put liquid meth in the refrigerator and it looked like apple juice and somebody drank it. That's happened and killed quite a number of children here. Kids and meth are a bigger problem than we've seen with other drugs. Often because so many women are involved, you tend to see more children involved or affected by it.

You can die of methamphetamine overdoses. Basically what it does is to increase your heart rate and your body temperature to a point where you

can get hyperpyrexia; you can have a heart attack. Hyperpyrexia is a high fever of 106 to 107 degrees and you actually die of overheating. So often treatment involves putting people on an ice bed and cooling them down because they come in revved up and certainly heart attack is another main thing.

Methamphetamine psychosis, which is more than just the hallucinations - the hallucinations occur to 60% of the users. Methamphetamine psychosis is experienced by a somewhat smaller number. This is a persistent psychosis that lasts well after people are under the influence of the drug. It will often, in early treatment, make engaging patients in treatment more difficult because the patients are so weary and suspicious and paranoid, and it will often go for several weeks after their use has stopped. Again, it's paranoia. It tends to be manifested as one who is paranoid.

The withdrawal from methamphetamine is uncomfortable, although not physically dangerous. The withdrawal effects are typically described in psychological terms; that is anhedonia, irritability, difficulty concentrating, having low energy, although often having sleep problems, low sex drive and all of those things. Those symptoms, you go through an initial week to two-week severe period of those. However, then, because of this brain effect, often those symptoms will persist for four to six months in this protracted withdrawal that is uncomfortable and often isn't understood by either the addict or the treatment program as still being a part of the physiological effects of the dependence.

The high-risk groups are obviously, as mentioned, women who require specialized treatment in a lot of cases. Often these women have been abused because they're in situations where violence has occurred. Methamphetamine and sexual behavior is a particularly important clinical issue because both men and women will find the drug enhances sexual activity. You'll often see all kinds of extreme sexual behavior, and often the people who go in and take down labs find extensive pornography and other kinds of sexual things, which, again, makes this population somewhat less appealing to both the criminal justice people and the treatment people.

Gay men are particularly affected by methamphetamine. In the gay community, methamphetamine is and has been the major drug of choice now for about 15 years. That's moved into New York, and we're starting to see more reports.

In our treatment centers here in California, last year at UCLA we treated 300 adolescents for methamphetamine dependence. Because the drug is so available and so cheap, and is considered to be a useful thing to do for studying or for sports performance or for losing weight, it is appealing to

young people.

Now the only thing I'm going to disagree with the previous speaker on is the issue of treatment. We've done about four very large studies out here in California, comparing methamphetamine treatment outcome between different kinds of disorders. Methamphetamine is almost identical to the treatment outcome and the treatment methods for treating cocaine abuse. Now that's not a good thing because we're not thrilled with our treatment outcome with cocaine abusers, but methamphetamine is no better or no worse than treating people for cocaine disorders.

Somehow, in the last year, there has been some information circulated in the southeastern United States by somebody - and I don't know how that happened - that methamphetamine users are untreatable. That's not true. They respond reasonably well to treatment. However, the treatment providers need to know what to do. This is not like treating an alcoholic. It requires special training. It requires special materials, and it often requires fairly extensive new training because much of the treatment is done on an outpatient basis.

The treatment, as was mentioned, though, there are no medications. We're currently running some large trials, looking at a variety of medications. We have a big project for the National Institute on Drug Abuse, but we currently don't have anything that works. There is a paper coming out in June in *Journal Addiction*, which has the first large-scale clinical trial for a behavioral treatment for methamphetamine and that I was a senior author on. That article shows relatively good treatment response and quite good treatment outcome at one year post-treatment.

So if you use the proper tools, these folks are treatable, but if your only tool is the big book of AA, it's not going to work. You need that tool. It's an important tool, but you need other things as well. Cognitive behavioral therapy is useful. Something called "contingency management," which is a reward paradigm, as well as something called "motivational interviewing," which is a new strategy for engaging and retaining people in treatment.

The basic message for methamphetamine treatment is, if you can keep them coming in, they get better. Retention is the ballgame. If you can get them in the door, and you can hold onto them, in outpatient treatment or in residential treatment - it doesn't matter - if you can retain them in treatment, they do well. If you don't retain them, they don't do well. That often takes training treatment centers to focus on retention and not focus on some of their typical goals of getting people to do certain AA activities or steps, or surrendering to -- Retention is the ballgame with this group.

The training for law enforcement has been much more extensive than the training for people trying to treat these people. That's part of the reason why there's this rumor that methamphetamine users are untreatable. We do a lot of training now, but it's still a drop in the bucket. There are treatment manuals. There is something called the matrix approach, which is something I developed. It's the subject of that paper I just mentioned. The Center for Substance Abuse Treatment has a document called, "Tip 33," which has a lot of good information on treating people for methamphetamine disorders.

All states have, within their state or within the nearby state, something called the Addiction Technology Transfer Centers (ATTC). There are 17 of these in the United States. Their job is to train clinicians in new treatment requirements, but that doesn't happen unless somebody asks them to do it. So you should find out who your ATTC is in your geographic area and ask them for methamphetamine training, and that will help bring clinicians up to speed on that.

In addition, states have technical assistance grants that they can apply to the Substance Abuse and Mental Health Services Administration (SAMHSA) to get assistance with treatment. That's what I'm doing in Iowa and Missouri in the next week, in order to provide technical assistance visits. There are people who have done a lot of this. I don't think it's necessary to invent the wheel all over the country. Laura Birkmeyer, who is an Executive Assistant U.S. attorney in San Diego and the chairman of the Methamphetamine Precursor Chemical Task Force, is a wonderful expert on law enforcement and the Drug Endangered Program, and is somebody that has spent about 15 years on the criminal justice side working on this.

So there are resources. This is not a problem that has not been dealt with. The problems that it brings to communities that were mentioned before are pretty much common, whether we're talking about Bangkok or Des Moines or Cedar Rapids or Sacramento. A lot of that has already been looked at and task forces have been set up. Attorney General Reno had a task force that I was on from 1996 to 2000 that developed some good materials for methamphetamine that are still available through the National Institute on Justice. So there is material available. People just need to know how to access it.

I'll stop there, and turn this over to the next speaker.

A. Murphy

Dr. Rawson, if you could indulge me and perhaps spend a couple of minutes talking in a little bit more depth about the matrix approach. I know a number of people on this call have heard of it. I suspect that many of them, like me, would like to have a little bit of an overview as to that

approach.

R. Rawson

Okay. The matrix approach is something we put together in the mid-1980s. I'm a researcher, and we went to the literature, the research literature, and pulled out all of the various treatment strategies that we could find that had scientific support for their use. We packaged them into a manual that is designed to be delivered over four to six months in an intensive outpatient treatment model.

It includes 12-step activities. It includes cognitive behavioral therapy. It includes family involvement and education. It includes both group and individual work. It's structured into a protocol that is outlined in the manual. It's not as though you do whatever feels -- one of the things that we found in trying to work on this is that substance abuse treatment in many places, particularly outpatient substance abuse treatment, kind of is based on whatever the counselor feels like they want to talk about that day. That doesn't work with methamphetamine.

Counselors have to function like coaches. They have to teach people. They have to reward them for going in the right direction and correct them for going in the wrong direction. The therapist in a treatment program has to be a very active teacher and coach to both the patient and their family members. Family involvement will improve outcomes by about 100%. If you have the family to come in and participate and learn about addiction, that's important.

The matrix model, we've evolved it over time as new data has come in. There's a lot of educational information, and it's not education in that you're simply telling people drugs are bad. What you're educating them about is how the drug affects their brains, why they do the things they do, and how they can stop them. There are some specific things that they can be taught.

**The Center for Substance Abuse Treatment** has taken the manual that we've developed and should have it out available for free within the next several months, although they've been saying that for quite a while, but they say now they're getting it ready.

In the meantime, here at UCLA, we can make the manual available to people if they're interested, but this addiction article that will be out next month in the **Journal Addiction** outlines what's in the manual. We've published a lot of stuff on it. We've published ten or 15 research articles already and evaluated it with a variety of populations, and we're certainly not satisfied with the outcomes. Nobody is satisfied with the outcomes yet, but it is a place to start. It is a set of materials that counselors can be trained to use, that give them tools that they can use to work with their

patients.

A. Murphy

Thank you. I appreciate the amplification. Now, I'm turning it over to Blake Harrison, who will provide an overview from a policymaking and legislative perspective.

B. Harrison

Thank you, Anne. Lots of good information so far - let's see if I can add something to that. My name is Blake Harrison. I track crime legislation for the National Conference of State Legislators. As we've heard from the other speakers today, meth is a big problem. It's a growing problem, and it certainly has the attention of state legislators.

They've had to attack this problem from a number of different fronts, and I wanted to just give brief overview of the types of legislation that has been passed in recent years in a few key areas. First of all, with regards to sentencing, I'm going to go over some of the different approaches to incarceration and some of the alternatives to incarceration.

Next, I'm going to address the issue of precursor substances. It's been touched on briefly, but go into a little bit more depth of how states are trying to restrict and track the sale of those precursor substances. Then I'll briefly touch on the environmental impacts and clean up of drug labs, and approaches to alleviating some of those problems. Finally, I will touch on some of the statutory approaches to protecting children.

Under sentencing, most states treat methamphetamine as a Class II controlled substance, but the penalties for possession and sale of methamphetamine vary very widely from state to state. For example, the penalty for a first offense for the sale of ten grams of methamphetamine is punishable by a prison sentence of five years or fewer in about ten states, and in five states, those states can impose a sentence of up to life in prison for the sale of that same amount.

In 2003, Illinois eliminated probation for repeat offenders caught with materials used to make the drug. The measure was enacted in part because methamphetamine dealers were coming to Illinois because it has less strict laws than bordering states. So states are looking at what others are doing, what their neighbors are doing, and are trying to close the differences between them and make it so no one is encouraged to move to one state or another to commit these crimes.

Some states have also provided alternatives to incarceration by emphasizing treatment for those who only use the drug. A good example of this is an innovative approach used in Colorado. Colorado passed a law last year that reduces the penalty for the possession of small amounts of Schedule I and Schedule II drugs. They used the money that they saved

from those reduced penalties, because people are incarcerated for a shorter period of time, they used the money saved from those funds and they've created a fund that provides resources for the treatment of drugs. It's just one of the innovative approaches to put more of an emphasis on treatment instead of incarceration.

Drug courts are also a very popular approach to help people recover from addiction, and some states are fine-tuning their statutes to see what is the most effective way to address the drug problem. As you know, drug courts put a lot of discretion into the judges' hands to use the power of the courts to mandate that they get some treatment, that they meet certain benchmarks. They need to get tested. They need to meet certain conditions and, in exchange, in many cases, they do not have to serve prison time.

For example, last year Iowa gave courts the discretion to impose community-based treatment under a drug court program, but it also provides mandatory minimum sentences to apply for subsequent offenses. In essence, it's giving the first offender the chance to rehabilitate, and then on the backend has mandatory sentences if they're not able to comply.

The next issue I wanted to address was the one about precursors, which is where states have been putting most of their efforts in recent years. As we've heard from Fay at the beginning, the reason we need to control - the states want to control precursors is because that's how they're made.

They're made from very easily attainable components - drain cleaner, matchsticks, lighter fluid and the like. But the main component that's gotten the attention is cold medicines that contain ephedrine or pseudoephedrine. They make up the main component in methamphetamine, and states have been attempting to control the distribution of these legal drugs in a number of ways.

Our latest analysis shows that at least 21 states have made it illegal to possess these precursor drugs, if it can be established that the possessor intends to use this legal drug to manufacture methamphetamine. At least six states have set maximum amounts that can be legally possessed. Now these restrictions usually translate to - well, they range from nine to 24 grams, meaning maybe three packages of cold medicine to five packages. Again, those vary from state-to-state, but the amounts tend to reflect, for example, the maximum dosage that a family could safely take in a reasonable amount of time.

So, say, the maximum recommended dosage would be three tablets for every four hours, multiplied by however many days and they come up with the maximum amounts for possession. But this has met with some

resistance politically because there are circumstances where people could possess more than that amount for a legitimate purpose, such as if they live in a rural area and they usually buy in bulk, they can't make it to town very often.

Nevertheless, it seems that states are moving toward tighter restrictions on the possession and the sale of these precursor substances. The way these statutes are usually written, they make the certain amount, like, say, the possession of nine grams, of one of these precursor substances a rebuttable presumption that the substance is going to be used for the manufacture of methamphetamine. This then puts the burden of proof on the defendant to prove that they had a legitimate reason for possessing that amount of the drug.

At any rate, states are moving towards restricting the amount that people can have and the amount that wholesales, or that retailers can sell. Thirteen states make it illegal for a retailer to sell precursors if they know or they have reason to know that the product will be used for illegal manufacture. Now that's a little difficult. How does a retailer know or have reason to know if the person buying the asthma medicine or the cold medicine is going to make methamphetamine?

Well, a number of states have tried to strengthen these remedies by instituting education programs that help retailers recognize a suspicious customer. So for example, if somebody buys five boxes of matches, lighter fluid, drain cleaner and three boxes of Sudafed, that makes that customer pretty suspicious for being a manufacturer. Law enforcement has told us that these educational programs have been pretty successful in catching drug manufacturers and in slowing the production rates, and not much material is out there about the deterrence of this, but it is definitely catching some people and it's making more people aware of how the drug is made and how people can manufacture with such ease.

States have also combined this with statutory schemes that provide civil immunity for retailers who make a good faith effort to report such sales. I wanted to mention Oklahoma briefly with this precursor issue. They require manufacturers and wholesale distributors to keep records of who purchases precursor substances for three years, and also, this year, they became the first state to require a pharmacist to sell ephedrine-based products. It's required to be behind the counter, and they need to make a photocopy of the customer's driver license.

So there are lots of efforts. It's hard to say that there are trends, but it seems that there is an effort in a number of states to restrict the sales, or at least educate people and to restrict and make it more difficult for people to get these precursor substances.

Next on the topic is the area of cleanup of clandestine labs. As Dr. Boozman mentioned, for every pound of methamphetamine produced, about six pounds of toxic waste are left behind. This poses significant health and environmental hazards. Small-scale clandestine labs are typically located on residential properties or in mobile units, which make cleanup very important and sometimes difficult.

So what states have done: Michigan, Missouri and Wisconsin make it a felony to illegally dispose of methamphetamine waste, making stiff penalties for somebody who takes the toxic waste and just dumps it on the side of the road, or even pours it down the drain, which can be environmentally hazardous. Oregon and Washington have had pretty comprehensive drug cleanup laws for more than a decade. The laws require, really, a coordinated effort, a cooperative effort among government agencies to manage the cleanup and requires owners of houses to make residue levels that are sufficiently low.

Property owners are required, in at least four states, to tell potential buyers and disclose if that site had previously been a meth lab. There are a lot of environmental hazards to people, just from the chemicals that are leftover on the walls and in the carpet of these houses. Six states make the offender liable for cleanup costs associated with the manufacture of methamphetamine. Some of the problem with that is, obviously, many of these people don't have any money. Still, they are being somewhat effective in helping to offset the cost of these cleanups, which can be pretty significant.

Protecting children: Methamphetamine is explosive. It's toxic. It's dirty. It poses many serious health risks to children. But probably the biggest health risk is simply being a child in the home of a meth addict. Parental addiction can be devastating to the children that grow up in these homes. A growing number of states have enacted legislation to address this problem.

At least nine states have expanded their child abuse and endangerment statutes to include manufacturing a controlled substance in the presence of a child. Now this can obviously have the immediate effect of criminal sanctions on these people that have child endangerment, but also gives child service programs another tool. When they're making determinations of the best thing to do for a child, they have this, as well, that previously they may not have had the problem of having to deal with, or had the advantage of having somebody who was convicted of child abuse simply because they were operating a meth lab.

Arkansas and Washington established separate criminal sentences for

exposing a child to an illicit chemical substance, and California, last year, made grant funds available to counties to establish multi-agency drug endangered child response teams, making it easier for the locals to address the many problems that confront children that get tied up in the problem of methamphetamine.

Federal action: The U.S. Department of Justice has dedicated \$230 million to combat methamphetamine since 1995. The community-oriented police service funds go directly to state and local law enforcement agencies for community policing activities that address methamphetamine. In 2002, \$70 million was allocated for methamphetamine enforcement. This is federal money going to the states.

So there are lots of efforts out there. State legislatures have had to address this on a number of different fronts. I wasn't able to cover all of them. There are obviously others. For example, increasing penalties for people who steal farm equipment, fertilizer, or propane from ranchers or from people in rural areas, for the purpose of manufacturing methamphetamine. They've increased penalties for that. There are a number of different areas that are happening in this process, but state legislators have been working hard. It's a difficult issue. There are many things to consider.

I also wanted to mention, if anyone on the line is going to be at our annual meeting this year in Salt Lake City July 21<sup>st</sup>, we're going to have a conference entitled, "The Methamphetamine Menace," and we'll have state legislatures and other elected officials to talk about their experiences and help share information from state-to-state to get some of the best ideas to help combat this problem.

Also, if anyone needs, we have a couple of documents that we've written on state policy on methamphetamine. If you'd like a copy of that, you can just e-mail me. My e-mail address is [blake.harrison@ncsl.org](mailto:blake.harrison@ncsl.org). That's all I have, Anne.

A. Murphy

Let me probe a few issues before we turn to Steve. First of all, the Oklahoma legislation restricting sales to behind the counter, that is, as I understand it, considered particularly significant in terms of precursor controls. Is that correct?

B. Harrison

Yes, Oklahoma had a very unfortunate incident in the last year where at least one law enforcement officer was killed in relation to methamphetamine manufacturers. So they've taken a pretty tough line on this.

It's hard to say if this is the strongest approach because everybody is addressing it in a different way, but this is - when we talk about ephedrine

and pseudoephedrine-based products, these are things like Sudafed and drugs that are used for cold suppressants or allergies, and they're very safe products. They just happen to be the drug of choice for manufacturers of methamphetamine.

Oklahoma seems to have taken it a step further in that they require a driver's license from somebody who requests these legal drugs. They have to be sold by a pharmacist, and the pharmacist makes a photocopy of their driver's license. That way, the police have records of people who purchase large amounts of methamphetamine. It gives them one more tool to track who is getting a hold of these precursor substances.

A. Murphy                      And then my follow-up question: Is it the case that many or most states that have addressed methamphetamine abuse problems have done so through discrete pieces of legislation - in other words, a piece of legislation that addresses precursor issue and then maybe another piece of legislation that addresses sentencing - or are there states that can be pointed to that have taken a more integrated and comprehensive approach through a single piece of legislation?

B. Harrison                      The trend is, once a state legislature decides that they really want to tackle the methamphetamine epidemic, that it is better not to address it piecemeal, but rather to do a comprehensive piece of legislation. I'd point you to North Dakota and Washington and Oregon - especially those states, when it comes to cleanup. Oklahoma has had quite a few comprehensive packages that deal with many issues from sentencing and releasing people on bail and keeping track of offenders, to keeping track of people who purchase precursors.

So I would say, in the beginning, it started out with states going piecemeal, addressing one issue at a time. Now it seems quite obvious that the issues are very diverse, and they come from a lot of different areas. So if you're going to jump into it, it's best to try and address as many of these problems as you can: from sentencing to addiction, to cleanup, and to protecting children - all of these issues. It's recommended that once you learn about the issue, there are many, many different aspects to it that should be addressed.

A. Murphy                      Thank you for that clarification. Before turning it over to Steve Mange, our final speaker, let me, once again, and perhaps for the last time, remind you that if you have a question, please e-mail it to [kwilliams@phla.info](mailto:kwilliams@phla.info). I do have a number of questions at this point.

As I just indicated, our final speaker is Steve Mange from the Office of the Illinois Attorney General, Lisa Madigan, who will provide an overview of initiatives by law enforcement and from a policy perspective, with special

emphasis on Illinois initiatives. Steve?

S. Mange

Thank you very much, Anne, and thanks to the Public Health Law Association for initiating this conference call. The theme I would like to emphasize today is that to the extent there is any silver lining at all to this terrible meth crisis, it has been the relationships that have been formed between policy makers and the agencies and community members who are not particularly used to working cooperatively together.

I think that the meth problem has been so frustrating to law enforcement and public health officials and child protection specialists and treatment providers that I think everyone has realized they cannot really make a dent in the problem working in their own little sphere, and have really been forced to reach out and take more of an interagency cooperative type of approach. Perhaps as horrible as the meth crisis is, this can be something that comes out of it and can be applied to other difficult problems that we face.

Methamphetamine has been a top priority of the attorney general in Illinois since she took office a little more than a year ago, and I've been working on it pretty much full time for the last year or so. I come at it, in a certain sense as - or I've become, I guess, to some extent, a Jack-of-all-trades. Although I'm an attorney by training, I don't come from a prosecutorial background. I've had to learn both the law enforcement aspects, as well as the public health aspects, and all of the other aspects to this problem. I guess I'd like to share with those of you who are listening some of the perspectives that I've gained.

I'm going to start by talking a little bit about the perspective of law enforcement agencies and then talk about some strategies that others have already touched on, but that I'd like to emphasize as, I think, hopeful in the struggle against meth.

So starting with the law enforcement perspective, I think if you had to characterize it in a single word, it would be desperation. I think that when you talk to local sheriffs and police chiefs and participants in anti-drug task forces, there is really just an extraordinary sense of desperation. They have, at least in some of the worst-hit areas of Central and Southern Illinois - and I'm sure this is true in many of the other states represented on this call - there are just overwhelming caseloads faced by local sheriffs and police chiefs.

Some will tell you that they spend 70%, 80%, 90%, even 100% of their time on meth cases or meth-related cases because one of the things that we found is that, like other drugs, meth tends to be tied to many other crimes ranging, in the worst case, from murder and acts of violence, all the way

down to robbery, identify theft and other things.

From the perspective of a police chief or a county board member, you're dealing with enormous bills for housing prisoners in county jails. There's a lot of dark humor in this area, and I've heard several stories of people getting un-arrested on meth offenses simply because the offense was minor enough compared to the size of the prospective medical and dental bills that it just was not worth keeping this person in jail.

A lot of the most talented and most highly trained officers in local county and state law enforcement agencies spend their time dismantling meth labs. As many of you know, you have to be what's called clandestine lab certified to be able to bust a meth lab. You typically have to have at least four officers at a time. There's a lot of paperwork, a lot of work at the scene, and that has taken away the ability of law enforcement agencies to do basic investigative work because they spend so much time cleaning up meth labs.

I think, related to all of this, is really the perspective of law enforcement that while you may have law enforcement people saying, "We have to send all of these people to jail," they also recognize that as soon as they get out of jail, typically, many meth users will go back to using meth, sometimes the very day they get out of jail. So I think there's an enormous sense on the local law enforcement level of just desperation and lack of resources.

I think, on the national level, Dr. Rawson has written, I think quite compellingly, that the federal government, both in terms of law enforcement and in terms of treatment and other issues, was very slow to respond to the meth crisis. It really wasn't until Barry McCaffrey, President Clinton's drug czar, took an interest in this problem in the late 1990s that we started to get larger amounts of federal resources devoted to this problem.

I think from the perspective of, for example, the Drug Enforcement Administration, a key issue is controlling meth precursors, because originally meth was made with P2P. There were substantial federal controls imposed and meth makers switched to ephedrine. There were substantial controls over ephedrine, and meth makers have switched to pseudoephedrine. There is some hope that if we can get a handle on the supply of pseudoephedrine available to meth makers that there's some possibility that they may be down to their last readily available precursor.

While it's possible to control some of the other ingredients, like lithium batteries or whatever, the fact is that your best strategy is going to be controlling the precursors; that is, the chemicals that become

methamphetamine.

That is because, first of all, they're essentially the flour for the bread. They are what becomes methamphetamine, and they are required in every single meth recipe, whereas the other ingredients can be varied. For example, even anhydrous ammonia, which is used in the Midwest, you can actually make your own condensed ammonia if you're having trouble stealing anhydrous ammonia from farmers. So I think one thing that I've learned is that a critical approach is, as many states are trying to do, to control pseudoephedrine particularly.

I think that what I'd like to do for the next ten minutes or so is talk about a number of strategies that have been touched on that I think are particularly promising in combination with law enforcement efforts. Here is where I come back to my theme about if there's any silver lining to the meth crisis, it's the different interests that have really been forced, because of meth, to work together in innovative ways.

One thing that has been mentioned, particularly by Blake Harrison, is the drug court model. It seems to me, based on looking at the meth problem, that the drug court model is really ideally suited to methamphetamine and this is for a number of reasons, but particularly because, as Dr. Rawson has said, the key to effective meth treatment is keeping people in treatment.

Drug courts really, by using carrots and sticks, have quite a lot of potential to keep people in treatment and be helpful in actually trying to help solve the meth addiction problem for individuals rather than putting them in jail and then having them come out and use meth again and then go back to jail and this never-ending cycle.

As some of the previous speakers have mentioned, and as you probably know, drug courts essentially provide very carefully monitored drug treatment as an alternative to incarceration. They are supported by the White House. They're supported by Illinois law and a number of laws in other states, and have quite a following among judges, prosecutors, defense attorneys, probation officers, treatment providers, and many other people who have dealt not just with the meth problem, but with other drug problems as well.

Essentially, a drug court is a special program within a criminal court that generally channels non-violent drug-addicted defendants into, as I said, a very highly structured and closely monitored drug treatment program. The participants essentially make the commitment to treatment and counseling, and they agree to abide by very strict rules. If they succeed, if they go through the various stages of the program and graduate from the

program, the benefit to them is that, depending on how the drug court is structured, the charges against them may be dropped, or the sentences may be reduced or eliminated.

There's quite a bit of federal support and funding for drug courts, and I would highly recommend for those areas that are dealing with a serious meth problem that do not have drug courts to take a very serious look. You can find some basic information about drug courts on part of Illinois Attorney General Madigan's website, which we've devoted specifically to the meth problem. Let me provide that internet address. It is [www.illinoisattorneygeneral.gov/methnet](http://www.illinoisattorneygeneral.gov/methnet). That actually brings me to my next subject, which is public education.

One of the things that we have realized is that even in areas that are plagued by meth, there is a great deal of knowledge, a great deal of very basic knowledge about meth that many members of the public do not have. That was really the impetus behind creating this methnet page on the Attorney General's website.

If you go there, you'll see that our first sort of cut at this, which went online about a month ago, contains sections on recognizing meth. For example, how to recognize a meth lab in your neighborhood, how to recognize a meth lab from the inside of a house if you're, say, a babysitter or a child protection worker.

There's a lot of background information about meth. There are different strategies for fighting meth, including drug courts and some of the other strategies I'm going to mention, and a special section on protecting children from meth.

Each of these sections, particularly the strategies for dealing with meth, contains very extensive references to other websites to the key organizations in these different areas. So I would highly recommend you taking a look at it if you have a chance. We're very interested in suggestions for improvements, since this is going to be a work in progress.

The third area that I'd like to mention is prevention in schools. Clearly, the best way to deal with a meth crisis, or any other drug crisis for that matter, is to persuade people not to start using the drug in the first place. Really the evidence on prevention efforts in schools really shows that while programs that might go into the school for a day and talk about drug problems, or drug abuse, or alcoholism or whatever, those can certainly be helpful, but clearly what really works, what there's evidence for, is a more sustained program, starting even in elementary school, that basically focuses on teaching kids to have self-respect and how to make good decisions, developing their intellectual and social skills, creating positive

norms for young people instead of just offering short-term alternatives, and this type of education, which is outlined in a little bit greater detail on the methnet webpage, tends to equip kids to make more positive choices in their lives in general, including making decisions not to use drugs.

The last area that I'd like to touch on is community anti-drug coalitions, or, specifically, community anti-meth coalitions. Again, this is addressed on the attorney general's website as a possible strategy. A community coalition, of course, can take many forms and can be formed around any issue, but I think in the area of preventing drug use, it can be particularly effective.

I think it's very empowering. We've seen, really, that it's very empowering for community members to come together to have an opportunity to identify what they see as the meth problem and how meth affects them, and to begin to identify the resources that actually exist in the community to deal with the problem.

So, to some, I think it gets people out of a victim mentality and into a mentality of actually having some control over the situation. I also think that, on the one hand, it saves people from just kind of complaining that nobody is doing anything, and complaining that there aren't enough resources to do anything. At the same time, when you have a community together on an issue like this, it actually makes it more likely that you can secure outside resources, whether you're talking about federal grants or assistance from state agencies or from private foundations or what have you.

So I guess, summing up, the lesson from my work on the meth crisis in Illinois has been that the more strategies that you can try to employ and the more interest groups you can bring to the table, the more likely you are to succeed. So again, Anne, thanks very much for this opportunity.

A. Murphy

Well, on behalf on Public Health Law Association, it's our pleasure. I do have a number of questions that have come in from across the country, and it's going to be a challenge to endeavor to get through all of these. To the best of my ability, I will distill and consolidate and try to touch upon most, if not all, of these questions over the next half hour or so.

Before I do that, let me give the speakers fair warning. There have been several references throughout this call to resources - websites, articles and the like. I think, before we end this call, I would like to do a few things. I would like to ask each of the speakers to identify any readily available resources of which they are aware, whether they be websites or otherwise, that have not yet been identified so that those who are listening on the call can benefit from that information, and second, I am going to suggest that

the speakers in particular, to the extent that they cannot come up with resources that might be available free of charge spontaneously, e-mail that information to the same e-mail address that we're giving to those who are submitting questions, [kwilliams@phla.info](mailto:kwilliams@phla.info), so that we can post those resources on the PHLA and CDC websites for those who want to access that information after this call. Does that seem like a fair request to the speakers?

Okay. We'll see if we can't give people a couple of additional places to go for information before we close out the call, but we will also make that information available on those websites.

To the questions - and I will try to balance these among the various speakers - the first is directed to Dr. Rawson, but others may have observations as well. It comes from New York City. "Do you have advice for public health officials on the East Coast so they don't, in your words, 'become awash in the meth crisis' as it hits that part of the country?" I suppose, for the other speakers, that would also get to the targeted approaches and targeted interventions in an era of budgetary constraints issues as well. But starting with Dr. Rawson -

R. Rawson

Well, from the point of view from a large-scale public health approach, availability of methamphetamine makes a huge difference in these communities where we're seeing the epidemic and seeing teenagers using it at increasing rates, one of the major drivers is the fact that the drug is everywhere. It's cheap. It's available.

When we've interviewed patients about reasons they seek treatment, they almost never seek treatment because they can't afford to get enough of the drug, because people will give it to them.

Methamphetamine is supplied basically in two ways, either by laboratories that produce it locally in "Mom and Pop" and "Beavis and Butthead" labs, as they're referred to, or via large-scale trafficking generally that comes either from Southern California or from Mexico.

One thing that needs to be done from a public health point of view is, as was said earlier, partnering with the criminal justice system to make sure that every effort that can be done is done to reduce availability of the drug.

One area in New York that's a particular problem is in the gay community where methamphetamine is reversing some of the gains that have been made in HIV prevention. A very aggressive outreach into that community with information about methamphetamine, availability of methamphetamine treatment, is important, because when people are in the middle of a meth run, they don't engage in safe sex. You can teach them

all day long about using condoms and other things, but when they're in a bathhouse using meth, anything goes and the spread of HIV is increased. Getting those people into treatment is an important step. I'm sure there are other things, but I can't think of any off of the top of my head.

A. Murphy                      There was another question that came in on the increasing prevalence of meth abuse among the gay male population. I will summarize the question in a slightly different way than it was presented, which is, "Is there any targeted research that is available at this point that addresses, for that community, how meth makes its way into the community, and how to engage in effective outreach and intervention?"

R. Rawson                      Well, there is material on treating meth users, gay male meth users. The materials have to be different because the ballgame there is meth and sex, meth and bathhouses, meth and gay bars, meth and meeting other men. It gets woven into the fabric. Aggressive street outreach with information, with available treatment and prevention material on what meth does and the damage it can produce.

One of the things that we think is important is that a lot of people won't avoid meth because of addiction, but they will avoid it because it produces a degradation of people. It's a drug that causes them to look bad, to smell bad, to behave in ways that they don't want to behave in. If that information can somehow be conveyed in prevention efforts, within that community, it may be particularly effective.

A. Murphy                      Thank you. The second question is directed to Dr. Boozman, and others, after Dr. Boozman responds, may want to chime in as well. It has to do with the environmental health issues. There are a few questions suggesting that some of the attendees are interested in hearing a little bit more about the precise environmental health risks, particularly risks to children who may be in the presence of those who are creating the drug. That's one question - a little more detail about the environmental health issues.

Then the second part of the question, Dr. Boozman, has to do with the strategies that you and other public health leaders have employed to encourage law enforcement public health interagency cooperation.

F. Boozman                      Of course, the major issues with children really center around the fact that little ones will pick up things that are laying around on the ground and put them in their mouth. So you have the side effects that are the listed side effects of all of these various components - liver toxicities, kidney toxicities, brain toxicities and things such as that.

So I think a major focus we have to have is on, once we identify a site, is

the cleanup of that site in terms of how safe it's going to be for individuals to return to that site. I know that we, here at our department, have very little resources to be a part of this, and we have set up protocols that are on our website in terms of what a site should be like after the cleanup. We, as an agency, though, have had no resources to do cleanups, and those typically have been done by private contractors.

Of course, we have to, first of all, when you have one of these sites, it's a crime scene. So initially, the law enforcement has to go in and collect the various things they need to collect for the case that they're going to be making against the individuals that perpetrated this, but once that's done, then you have to go in for the secondary cleanup, and that's just simply removing everything that's there, washing all of the surfaces, take samples. Post cleanup, I think the recommendation is 0.5 micrograms of meth residue per square foot of various samples for an acceptable reentry.

In terms of interagency cooperation, I think that the main thing is that, as I alluded to just a moment ago, that law enforcement has to go in first, and they're well trained in terms of having the appropriate protective equipment, and they do the things that they need to do and then, after that point, then we can go in, or individuals can go in, to make sure it's clean.

In the suggestions that we've set up, we have a level one approach where you have them actively cooking, where meth was actively being cooked. We have various teams respond in a certain way to that, and then you have ones where you think meth maybe was cooked, but it's not being actively cooked; it's not highly explosive; and then the final one where we go in and they're actually cleaning up after the evidence has been taken out.

I might say one thing, Anne, on a previous question that I think is extremely important from a public health standpoint. In a time when there are not many resources - and Steve alluded to this very important point - I think communities are the key in getting them engaged on these issues. If you can get a community coalition and folks at the community level enraged about this and concerned about this, it's amazing what these folks can do. There are a lot of resources out there for that kind of activity. Many of the non-profits will support those kinds of efforts, and even the business community, within the community, many times, will step up to the plate.

I've been pleasantly surprised and very pleased as I've seen a community sort of take this bull by the horns and move on. I think those of us in government can offer many resources, many suggestions, on ways to do these things, but at the local level is where it really has to happen.

A. Murphy

Thank you, Dr. Boozman. Do any of the other speakers wish to comment,

either on the environmental issues generally or on interagency cooperation between public health and law enforcement?

R. Rawson

I just have one quick comment to reinforce what everybody else has said about drug courts. Drug courts are uniquely effective with methamphetamine users. In the study that we're publishing in June, one of the sites was a drug court site and the response in that site was about 30% better than in all of the other sites. It was not because we did any particularly better therapy. It was that they were within the context of a drug court. It makes theoretical sense as well as practical sense, and having the partnership with judges and treatment providers is extraordinarily important.

A. Murphy

Thank you. I'm going to move on to the third question, and that is to identify the highest and most cost effective priorities for intervention in this area. As I pick and choose from among the questions, I would emphasize, once again, the reality of governmental budget constraints and also identify, from some of the questioners, interest in how one would best intervene in schools, how one might best educate providers, how one might formulate targeted treatment and intervention programs.

What I think I will do, while I am putting our able speakers on the spot, is ask each speaker to identify one strategy that they think both gets at a high priority and also is cost effective. I know I am putting you on the spot, but in terms of addressing this question, it might be interesting. If you had to choose one thing to identify to the group as being both high priority and cost effective what might it be? I think I will start with Steve.

S. Mange

I don't want to sound like a broken record, but I do think that forming community-based coalitions is both - can be highly cost effective and can be, really, the platform for launching a lot of the other things that we've talked about. If you have a well-educated community, a community that's working together, a community where the members feel that their voices are heard and that they have power to do something, you can do a lot of other things that you didn't think you could do, and you can do them a lot cheaper than you thought you could.

I mean a community coalition can be supportive of every single strategy that's been discussed today. It can be supportive of law enforcement because the community is educated, for example, to recognize the signs of a meth house or a meth addict or a meth-endangered child, and report those things to law enforcement. It can be extremely supportive of drug courts. In fact, if you look at some of the websites, the key websites dealing with drug courts, and, again, those are links available on Illinois Attorney General Madigan's website, a critical component of an effective drug court is involving the community.

It can be a well-organized, well-educated community is critical to successful treatment because they can be supportive of people who are in treatment. They can be supportive of people who come out of treatment, who in a less-educated, less-organized community might be stigmatized, but in a more-educated, more-organized community might be invited back into the community, and have an opportunity to get a job and so forth. The same thing for education efforts and the schools and so forth.

So I think a community coalition can be started at essentially no cost and can be a pillar of support for many of the strategies that are critical for combating the meth problem. It's not easy to get money to support efforts of community coalitions. I think, as they develop, sometimes it becomes apparent that it would be very helpful to have funding to support, say, an administrator or certain costs of maintaining the coalition or particular initiatives of the coalition, but there are national organizations, including the White House Office of National Drug Control Policy (ONDCP), that do provide at least small grants to community coalitions. Again, that information, some of those critical links are on the website and I'll just give that address one more time. It's [www.illinoisattorneygeneral.gov/methnet](http://www.illinoisattorneygeneral.gov/methnet). So those are my two cents on that question.

A. Murphy

Thanks, Steve. If I could go next to Blake.

B. Harrison

Yes. I think something that would be important for people who are listening in on this call is education, and I don't necessarily mean from a structural point of view, but from whatever your organization is, put that information out on the Web. Methamphetamine isn't really a new issue, but there are a lot of smart people out there that are doing a lot of work. Sharing that information with others will be highly productive and shouldn't cost anything, because the hard work has already been done.

But doing my research, it seems difficult sometimes to find a lot of information that's already been done and we don't like to see people reinvent the wheel. If you have something out there that can be shared with people, get it up on the Web and share that information with others.

The other thing I'd mention from a public policy standpoint is to try and make the policy be proactive and not retroactive. If you don't have a problem in your area, or it's not a big problem yet, go ahead and address the tough issues and the tough questions that are inevitable that will definitely come up. So try to get a head start on your planning because it's a lot easier to have structures in place before and do it proactive instead of retroactively.

A. Murphy

Great. Thank you. Dr. Rawson, you next, and while I do that, I'm going to cheat a little bit and embed a related question, which has to do with your statement earlier as to media misinformation about meth addicts being untreatable - a question from a meth addiction counselor in Tennessee who confirms your observation that that misinformation has been circulating in the southeast, particularly in Tennessee, and has an adverse effect on those who might benefit from treatment and their families. So, for you, the question of an intervention you would identify and also perhaps, either in combination with that or separately, any observations you might have about countering that misinformation as to the treatability of addicts.

R. Rawson

Okay. Intervention - two quick things: One is the squeaky wheel principle. I met with a senior official at ONDCP two weeks ago, and her recommendation was people need to communicate to ONDCP about the severity of the meth problem. They're not hearing about it. They actually have a procedure where if they get 15 letters on a topic to Director Walters in a six-week period, it will trigger an inquiry to make a response. I would suggest that communities get some letters into the Office of National Drug Control Policy to ask for resources for training. It's just a matter of redirecting some existing resources.

Also, a cost-effective strategy - you all have treatment programs in your communities. Making those treatment programs more effective with meth user requires some training funds, but not a lot of training funds. You all have ATTCs in your area that pay for training that doesn't come out your pocket, but comes out of SAMHSA's pocket. Those things can all be tapped.

As far as the other question about how do you reeducate a community, it's just getting media attention to the fact that these people are treatable. They do get into recovery. They do respond and they do get back to being productive citizens. It's a matter of just sort of reeducating people. I'm not sure how this occurred in the southeast, but it really is pervasive, that this is a population that you just can't treat - less than one-percent recovery rate. I've done newspaper interviews with probably 30 newspapers in the southeast, asking the same set of questions. So it's a matter of reeducating.

A. Murphy

Thank you.

S. Mange

Dr. Rawson, this is Steve Mange. Is there anywhere on the UCLA website, or the Matrix Institute website, or somewhere where there is some - and maybe we need to wait for your article to come out, but in drafting the section on the attorney general's website about treatment, I kept wanting to try to cite some scholarship that really says, that really

does counter the myth that meth is not treatable. I had a difficult time putting my hands on it. I mean are there some scholarly articles or reviews of the literature on meth treatment that we could cite to people in the media or to law enforcement that says, "Look here. Here are some definitive statements about how meth treatment can actually work."

R. Rawson

Yes. We've actually published some stuff on that in some of the drug abuse journals. UCLA's website is [www.uclaisap.org](http://www.uclaisap.org). The other one is, as you suggested, [www.matrixinstitute.org](http://www.matrixinstitute.org).

Now if you get into there, we have PowerPoint presentations that can be downloaded to use with community or in treatment programs and, in terms of the specific articles, this one in *Addiction* will be a good one, but we have others. We did a review a year ago in the *Journal of Substance Abuse Treatment* on treatment outcome with meth users and a five-year follow-up of meth users. So there are a number of articles, but they're in the drug abuse literature and they're somewhat hard to find, but they can be tracked down through those websites, or you can send me an e-mail directly and my e-mail is [matrixex@ucla.edu](mailto:matrixex@ucla.edu). Any inquiries I get on references that people want, or papers, we turn them around and send them out.

S. Mange

Thanks.

A. Murphy

On this question, if you had to select one intervention - Dr. Boozman?

F. Boozman

Well I think one thing that's very important, in a time when we do have limited resources, that we not look at these things as individual items. Here in Arkansas, we're trying to incorporate our drug prevention and I think the key, in terms of where we have to put a significant amount of our effort, is in prevention. This starts, I think, with the kids in school.

When you look at what happened with seatbelts, children came home from the hospital with seatbelts, and now, kids basically, young kids, don't believe a car will even work without seatbelts. So you have the interesting sight of seeing a teenager driving down the street with a can of beer in one hand and a marijuana cigarette in the other hand, but they have a seatbelt on. I think that we have to, in the prevention world, maximize our resources.

I think the same strategies that we've found to be useful in stopping kids from initiating smoking activity, I think the CDC best practices approach where you have to have a good strong media campaign, we've already talked about the community efforts. In a community, you just create a culture that's one that it's clear that it's not something that the peer pressure would approve of.

Then, within the school, good health programs - the same programs that we need to be focusing on getting kids to be physically active, not to be using tobacco, kids to be eating right. We need that to include the drug message. I think we can do things in the legislative arena to make it difficult so that we affect the access.

I'm not sure that we ought to have the meth program, the smoking program, the obesity program, all of these prevention efforts, really. I think it was mentioned earlier by Blake that we don't have to keep recreating the wheel. The same approaches that are going to work in any one of these, I believe, will work in all of them.

A. Murphy

Thank you. Let me do this. We have three minutes left on this call and there are a couple of critically important things that I'd like to do in that short period of time. First of all, on behalf of both the Public Health Law Association and the CDC Public Health Law Program, we want to thank our speakers, who have done an extraordinary job of summarizing some very complex issues and have been very generous with their time and with their promises of making resources available in terms of websites and the like. So thank you to all of you.

Second, I would like to encourage those who are listening in to do two things. First of all, I would like you to e-mail any requests for information that you have, ideas that you have for future teleconferences, interests that you have in the Public Health Law Association, observations that you have in terms of ways that we can make additional information available with respect to today's topic. We would very much like to hear that information. If you could e-mail that either to [kwilliams@phla.info](mailto:kwilliams@phla.info) or [mrtsick@phla.info](mailto:mrtsick@phla.info) we will be grateful and we will take that information and try to respond to your suggestions and comments.

Third, I would like to encourage you, one more time, for this is very important, if you have an interest in considering joining the Public Health Law Association, please go to our website at [www.phla.info](http://www.phla.info) and we will also post more substantive information on that website in mid-June, including information about methamphetamine intervention and treatment.

Finally, in a minute or less, if we could have the speakers summarize. I'm told we have a little more time. If we could have the speakers identify for everyone on the call those resources that they have not already identified, even if you would like to repeat a few of those. I know there are some that have been repeated several times already, but if you're aware of websites or places to go for information, if we could summarize that for the audience at this point, recognizing that we at the Public Health Law Association will also take that information and make sure that it's posted

on our website and probably the CDC's website. I think that would be of tremendous benefit to those who are trying to access additional information.

So let's try to do this in some sort of order. Dr. Rawson, if we could start with you - resources, places to go, websites or otherwise that you think would be particularly useful for people.

R. Rawson Let's see. I think I've given you my best shot. The SAMHSA website, [www.SAMHSA.gov](http://www.SAMHSA.gov), which is the Substance Abuse and Mental Health Services Administration. On both of those websites, if you search for methamphetamine, they do have information on treatment funding, training possibilities, information on where the ATTCs are. Those are all good.

The National Institute on Drug Abuse, <http://www.nida.nih.gov/>, has a lot of material on methamphetamine, its effects. They have public documents. They have PowerPoint presentations that can be downloaded. There are booklets you can get. All of those things are at no cost and are state of the art and best information.

A. Murphy Great. Blake?

B. Harrison Yes. Just briefly, for state legislative information, our webpage is [www.ncsl.org](http://www.ncsl.org). You can find state legislative summaries on our criminal justice page. There's also information on health and environmental pages. Again, you can e-mail me, [blake.harrison@ncsl.org](mailto:blake.harrison@ncsl.org). I've already answered a couple of people's requests, but I can send you or direct you to more information. Then I think it's been mentioned before - the Office of National Drug Control Policy, ONDCP, has quite a bit of good research information available on their website.

A. Murphy Thank you. Dr. Boozman? You had mentioned your website and some protocols that were on there earlier.

F. Boozman Yes. Healthyarkansas.com has some protocols in the environmental area. Many of the resources we use have already been mentioned. One, I think it maybe has been mentioned, but just to be sure, is the National Drug Intelligence Center at <http://www.usdoj.gov/ndic> is a good website. It has a lot of state-specific information on it. The DEA has a lot of good links on it too at <http://www.usdoj.gov/dea>.

A. Murphy Steve, aside from the methnet website, are there any others that you think are particularly useful?

S. Mange I guess I should say first, anyone is welcome to e-mail me with any

follow-up questions. My e-mail is [smange@atg.state.il.us](mailto:smange@atg.state.il.us). I'd like to agree with Blake about the ONDCP, the Office of National Drug Control Policy website. The actual address is <http://www.whitehousedrugpolicy.gov>. That's it for me.

A. Murphy

I'm hoping and assuming one of the support people on this call is taking down all of these websites and we'll gather these with some additional information and post them. I have received from e-mail a few other websites that I'll mention: one, from Washington State, which has been remediating drug lab sites since 1991, <http://www.doh.wa.gov/ehp/ts/CDL.HTM> another from California, which has fact sheets covering a variety of different pertinent topics - [http://www.oehha.ca.gov/public\\_info/clanlabs.html](http://www.oehha.ca.gov/public_info/clanlabs.html). I'm sure there are others. If people have additional websites and are not speakers, please feel free to make those available to us.

I have a number of additional questions. In recognizing that we had indicated to both the speakers and the attendees that this conference would end at 3:00 Central time, and while I know we have some latitude to go further, I also know that people have busy schedules. I think, given that and given the number of additional questions that I have, it may be appropriate for us to distribute these questions to the speakers and then maybe post some general responses on the website. Did somebody have something they wanted to say? I heard one of the speakers comment.

So unless the speakers object, I think we should proceed at this juncture to wrapping up the call, thanking them, once again, for their thoughtful and attentive participation, reminding folks of the information about the Public Health Law Association and thanking our co-sponsor, the CDC, and then last, but not least, reminding people that there is a comprehensive Public Health Law conference to take place in Atlanta, co-sponsored by the CDC and the American Society of Law Medicine and Ethics.

It is the one conference, educational conference, a year that I feel is an absolute must-attend for me, and certainly is of benefit to attorneys and non-attorneys alike. If you've the desire to secure additional information about that conference, you can go to the website at <http://www.aslme.org> and you will find additional information there.

With that, I am going to wrap it up. Thank you, all, who are listening for attending, and we hope that you have an interest in our future educational teleconferences, that you found this one to be rewarding, and that we hear from you soon. To the speakers, once again, thank you.

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## APPENDIX

### TELECONFERENCE PANELISTS:

#### **Moderator**

Anne M. Murphy, JD, Chief Counsel, Illinois Department of Public Health

#### **Faculty:**

Fay Boozman, MD, MPH, Director  
Arkansas Department of Health

Blake Harrison, MS, JD, Senior Policy Specialist,  
Criminal Justice, National Conference of State Legislatures  
blake.harrison@ncsl.org

Steve Mange, Senior Policy Advisor  
Illinois Attorney General's Office  
smange@atg.state.il.us

Richard Rawson, PhD, Associate Director,  
Integrated Substance Abuse Programs,  
University of California at Los Angeles  
matrixex@ucla.edu

#### **Website References:**

Public Health Law Association  
[www.phla.info](http://www.phla.info)

American Society of Law, Medicine & Ethics  
[www.aslme.org](http://www.aslme.org)

Centers for Disease Control and Prevention  
[www.cdc.gov](http://www.cdc.gov)

Illinois Attorney General Methnet  
[www.illinoisattorneygeneral.gov/methnet](http://www.illinoisattorneygeneral.gov/methnet)

The Matrix Institute  
[www.matrixinstitute.org](http://www.matrixinstitute.org)

National Conference of State Legislatures  
[www.ncsl.org](http://www.ncsl.org)

The National Institute on Drug Abuse, National Institutes of Health  
<http://www.nida.nih.gov/>

State of California Office of Environmental Health Hazard Assessment  
[http://www.oehha.ca.gov/public\\_info/clanlabs.html](http://www.oehha.ca.gov/public_info/clanlabs.html)

Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services  
<http://www.samhsa.gov>

United States Department of Justice, The National Drug Intelligence Center  
[www.usdoj.gov/ndic](http://www.usdoj.gov/ndic)

United States Drug Enforcement Agency  
[www.usdoj.gov/dea](http://www.usdoj.gov/dea)

University of California, Los Angeles, Integrated Substance Abuse Programs  
[www.uclaisap.org](http://www.uclaisap.org)

The White House Office of National Drug Control Policy  
[www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov)

The Washington State Department of Health, Division of Environmental Health, Office of Environmental Health and Safety, Clandestine Drug Lab Program  
<http://www.doh.wa.gov/ehp/ts/CDL.HTM>