# California's Methamphetamine Crisis:
## Examining Strategies for Prevention, Treatment, and Law Enforcement

*Briefing Paper*

**January 18, 2006**

**Purpose of the Hearing**

Methamphetamine is California's primary drug problem. Endemic in this state for years and now spreading East, it was recently called the leading drug-related local law enforcement problem in the country by the National Association of Counties.

The purpose of this hearing is to determine the extent of the methamphetamine problem in California, including rates of use, production, and distribution; to examine what the state government is currently doing to address methamphetamine; and to highlight model programs in meth prevention, treatment, and law enforcement.

## I. Public Health Impact

*Key Public Health Questions*

- How addictive is methamphetamine?

- What effect do short-term and long-term use of methamphetamine have on the body and the brain?

- What is known about meth's impact on prenatal health and childhood development?

- What are meth's environmental impacts?

Measured by its effect on the central nervous system, methamphetamine is among the most powerful of the amphetamine group of drugs.[1] A Schedule II controlled substance, it is available only by prescription and has a strong potential for abuse. Legal, medical uses of the drug (trade name Desoxyn) include treatment of narcolepsy and attention deficit hyperactivity disorder. Small amounts of meth can increase alertness and suppress the appetite.[2]

Meth creates a feeling of euphoria in users by releasing dopamine in the part of the brain that controls feelings of pleasure.[3] Meth and other amphetamines release up to 3 times the amount of dopamine triggered by cocaine use.[4]

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[1] "Methamphetamine: A Growing Threat to California." California State Department of Alcohol and Drug Programs, March 2002.
[2] Testimony of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse, "Methamphetamine Abuse – Testimony before the Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies – Committee on Appropriations." April 21, 2005.
[3] David J. Jefferson, "America's Most Dangerous Drug." Newsweek. August 8, 2005.

Meth also metabolizes more slowly than cocaine, and its stimulant effect lasts much longer. According to experts, the high from methamphetamine can last up to 12 hours, versus a high of about one hour for cocaine.

Meth can be smoked, snorted, orally ingested, or injected. The effect of the drug depends in part on how it is administered: if smoked or injected, meth creates a "flash" or rush that lasts minutes; if snorted or eaten, the drug produces a less sudden, less intense high.[5]

"Crystal meth" is a form of the drug that is often smoked. According to the US Department of Justice, crystal methamphetamine "typically resembles small fragments of glass or shiny blue-white 'rocks' of various sizes…, typically has a higher purity level and may produce even longer-lasting and more intense physiological effects than the powdered form of the drug."[6]

Long-term, frequent use of meth can have the following health consequences: addiction; violent behavior; anxiety; depression; confusion; insomnia; psychotic features including paranoia, auditory hallucinations and delusions; rapid heart rate; irregular heartbeat; increased blood pressure; irreversible stroke-producing damage to small blood vessels in the brain; and death from overdoses.[7]

The drug can also cause brain damage. According to federal NIDA, studies of methamphetamine-abusers' brains show that meth can cause changes usually associated with lower motor speed and "impaired verbal learning." Studies have shown that chronic meth users' brains show deficits in areas that control depression, anxiety, and memory. Meth's effect on the brain can last for at least 2 years after a person stops using the drug.[8]

There are only limited studies in the area of meth's impact on child development. NIDA testified before Congress in April 2005 that it recently started the first large-scale study of meth's developmental consequences. The few studies that do exist are often qualified by small sample size or the presence of more than one drug in the study subjects. However, these studies show increased rates of premature delivery; a slowing of fetal growth; and smaller brain volumes.[9]

The American Dental Association has also linked meth with poor oral health. "Meth mouth" is the term used to describe the extensive tooth decay that is often attributed to a combination of meth's side effects: lack of bacteria-fighting saliva; extended periods of poor oral hygiene; and craving for carbonated, sugary drinks.

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[4] Volkow Testimony.
[5] Volkow Testimony.
[6] "Crystal Methamphetamine Fast Facts." National Drug Intelligence Center, U.S. Department of Justice. http://www.usdoj.gov/ndic/pubs5/5049/#What.
[7] Volkow Testimony.
[8] Volkow Testimony.
[9] Volkow Testimony.

While users are high they may also grind or clench their teeth, which can also be harmful.[10]

Unlike cocaine and heroin, both of which are organic drugs, meth is synthetic and often made from chemicals found in everyday household products. One common method of producing, or "cooking," meth centers around pseudoephedrine, the active ingredient in over-the-counter cold and allergy medications such as Sudafed and Claratin-D. In the "cook cycle," pseudoephedrine is mixed with acid, red phosphorus, caustic soda, freon, and hydrogen chloride.[11]

These and other chemicals used to produce meth can be highly toxic and damaging to those who come in contact with them, including the manufacturers themselves and any law enforcement or health officials investigating a lab site. Meth is frequently made in kitchens and other parts of a house, exposing any children present to risk of injury or death from fire or explosion, risk of acute health problems such as upper respiratory symptoms, headaches, or chemical burns; and risk of long-term problems such as asthma or cancers.[12]

For every pound of methamphetamine produced in a clandestine lab, 5 to 6 pounds of waste are produced as well.[13] This waste is typically dumped into the environment and left until accidentally found. Bulk chemicals and apparatus that are left behind in a clandestine lab seized by law enforcement are removed by the state Department of Toxic Substances Control at substantial state cost. (DTSC does not remediate buildings back to their uncontaminated state; this cost is borne by property owners themselves).

According to the Department of Justice, costs for DTSC meth-lab clean-up are as follows:[14]

| CY 2002 | CY 2003 | CY 2004 |
| --- | --- | --- |
| $4,974,517 | $4,432,718 | $2,108,490 |

[10] "Methamphetamine Use and Oral Health (Meth Mouth)." American Dental Association. www.ada.org/public/topics/methmouth.asp.
[11] Steve Cowden and Steve Suo, "Meth Superlab." (Infographic) The Oregonian. http://www.oregonlive.com/special/oregonian/meth/pdfs/1003meth_superlab.pdf
[12] "2004 Pseudoephedrine OTCs and Methamphetamine Related Issues: A Briefing Report," Bureau of Narcotic Enforcement, California Department of Justice, 2004.
[13] AB 1078 (Keene, 2005) Senate Bill Analysis: http://info.sen.ca.gov/pub/bill/asm/ab_1051-1100/ab_1078_cfa_20050628_100246_sen_comm.html
[14] "2004 Pseudoephedrine OTCs and Methamphetamine Related Issues: A Briefing Report," Bureau of Narcotic Enforcement, California Department of Justice, 2004.

**A Brief History of Meth**

1887 – Amphetamine is first synthesized in Germany.

1919 – Methamphetamine is first synthesized in Japan.

1930s – "Amphetamines are sold under the name Benzedrine to treat narcolepsy, depression, attention deficit disorder, Parkinson's disease and alcoholism."[15]

1938 – First published report of amphetamine addiction.[16]

1940s – Amphetamines including methamphetamine reportedly given to U.S. WWII soldiers and pilots to fight fatigue and depression.

1950s – "Legally manufactured methamphetamine tablets were used nonmedically by college students, truck drivers, and athletes, who usually did not become addicted."[17]

1960s – Outlaw motorcycle gangs begin producing and distributing methamphetamine; meth becomes part of the "1960s drug culture."[18]

1960s-early 1970s – Amphetamines used medically as appetite suppressants. "At one time, there were 31 million active prescriptions approved, meaning that approximately 6-8 percent of the American population was legally exposed to amphetamines."[19]

1970 – Meth becomes regulated under the federal Controlled Substances Act.

1980s – "Drug treatment counselors see increased abuse among gay men. Mexican drug manufacturers begin bringing meth north of the border."[20]

1990s – "Methamphetamine abuse, as measured by the number of people entering rehab centers, spread eastward…while intensifying in the West."[21]

1994 – Mexican drug-trafficking organizations with 'super labs' in California and Mexico begin to take control of U.S. meth production and distribution."[22]

2000 – Federal Methamphetamine Anti-Proliferation Act passes – limits over-the-counter purchase of pseudoephedrine-containing drugs.[23]

2004 – Oklahoma legislation places more stringent controls on pseudoephedrine sales: limits consumers to 9 grams (3 boxes) per month; restricts sales to pharmacies only; requires customers to show ID and sign a log book at purchase.

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[15] Pamela M. Prah, "Methamphetamine: Are tougher anti-meth laws needed?" CQ Researcher, Volume 15, Number 25. July 15, 2005.
[16] Patricia Case, Sc.D., "A History of Methamphetamine: An Epidemic in Context." (PowerPoint Presentation).
[17] "Methamphetamine: A Growing Threat to California."
[18] CQ Researcher
[19] "Methamphetamine: A Growing Threat to California."
[20] The Spokesman Review.com, "A History of Meth." http://www.spokesmanreview.com/library/meth/methstory.asp?ID=s811271
[21] Derrik Quenzer and Steve Suo, "The Spread of Meth" (Infographic). The Oregonian.
[22] CQ Researcher
[23] Ibid.

## II. How bad is the problem?

*Key Epidemiological Questions*

- Is the use of meth at epidemic proportions in California?
- Is the use of meth growing in California?
- Will widespread meth use "cycle out" and be replaced by use of other drugs?
- Is the use of meth by adolescents decreasing?
- What populations are using meth more than others, and why?

*How prevalent is meth use in California, and is the problem growing worse?*
This question is answered by looking at a number of different indicators. Some studies, especially those using state-specific data, suggest that meth has been a serious problem in California for several years and that its popularity may be rising. Some national surveys, on the other hand, show that meth use is declining across the general U.S. population.

*California Leads Nation in Meth Output Capacity*

To describe the magnitude of meth production and distribution in California, law enforcement officials say that "California is to methamphetamine as Columbia is to cocaine."

Although California ranked only 6th in the nation for the number of methamphetamine-producing labs seized in 2005, the total potential meth output from labs in this state (661.5 lbs.) far outstripped the potential output of the next most productive state (275.8 lbs.). California has the capacity to produce more meth than any other state in the nation; 28% of the country's meth capacity is found in this state alone.[24]

This capacity comes in the form of "super labs" – manufacturing sites capable of producing 10 lbs. or more in a single batch. In 2005, California officials seized 25 of the country's 31 super labs for a total of 500 lbs. of potential meth output.

While other states may have more total meth labs, the majority of these are "small toxic laboratories" that are not capable of the sort of output seen in super labs.

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[24] Figures compiled by California Department of Justice, Bureau of Narcotic Enforcement, and emailed to committee staff, December 12, 2005.

Total lab seizures, however, have declined over the past 6 years. This trend is discussed in greater detail below, under the Law Enforcement section.

*Treatment Admissions Up*

State data show that meth is most often the drug of choice among people entering drug treatment centers in California. In 2003-04, approximately 31% of people in county drug treatment centers reported meth as their number one drug compared to 22% for alcohol and 16.5% for heroin.[25]

Treatment admission rates suggest that the use of meth has risen consistently since at least the early 1990s. Treatment admissions for meth addiction increased 226% from 1992 to 1998.[26] Admissions for treatment of meth increased from 13.21% of all admissions in 1995-96 to about 31% in 2003-04.[27]

Over the past five years, methamphetamine was increasingly the primary drug of choice by those entering treatment, while cocaine's popularity remained steady and heroin's decreased.[28]

In March 2005, the Department of Corrections and Rehabilitation conducted a voluntary survey of the roughly 9,000 inmates in the state's in-prison Substance Abuse Programs and received responses from about 70%.

The results: 44% of women and 34% of men identified meth as their primary drug of choice. These rates were higher than for any other drug.

*Emergency Room Visits Up*

In addition to drug treatment admissions, emergency room data indicate that use of meth may be rising. In the three California regions surveyed in a national study, the total meth mentions in emergency rooms increased 43.1% from 1998 to 2002.[29]

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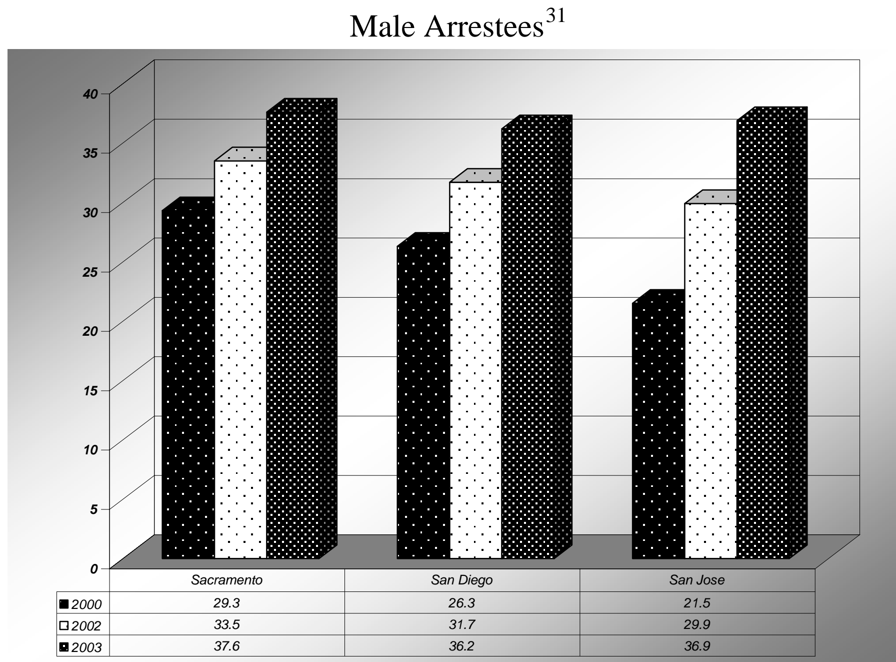
[25] "Info For Haight Ashbury Clinic Talk.doc." Document emailed to committee staff from Department of Alcohol and Drug Programs September 29, 2005.
[26] (The NIDA Methamphetamine Clinical Trials Group (MCTG): Taking research into the field. 2001 UCLA Report; R. A. Rawson, 2001)
[27] Update of Tables from Report "Methamphetamine: A Growing Treat to California, March 2002." Produced by California Department of Alcohol and Drug Programs Office of Applied Research and Analysis. November 4, 2005.
[28] Ibid.
[29] "Facts and Figures on Methamphetamine" California Department of Alcohol and Drug Programs, Office of Applied Research and Analysis. July 2005.

*Arrests Up*

California adults in 3 major cities who were arrested and processed in local detention facilities increasingly tested positive for meth use between 2000 and 2003.

In San Jose, the percentage of male arrestees testing positive for meth went from 21.5% to 36.9 percent; and the percentage of female arrestees testing positive for meth went from 40% to 45.3%. Similar increases took place in Sacramento and San Diego.[30]

Male Arrestees[31]




*Some National Surveys Show Declining Use of Meth in U.S. Population*

According to one national study, lifetime use of meth among people 12 years or older has decreased since 2002. Approximately 12.4 million people had used meth in their lifetime in 2002. This figure fell to 12.3 million the next year and fell again to 11.7 million in 2004 (about 4.9 percent of the population).[32]

This survey showed fewer people reporting meth use than marijuana (96.8 million), cocaine (34.2 million), and nonmedical use of psychotherapeutics (48 million people).

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[30] Arrestee Drug Abuse Monitoring Program (ADAM), National Institute of Justice. Data from 2000, 2002, 2003 Annual Reports. http://www.ojp.usdoj.gov/nij/adam/welcome.html.
[31] Chart created by committee staff based on ADAM data.
[32] SAMHSA, Office of Applied Studies, "2004 National Survey on Drug Use and Health." Table H.1.

Another national study, this one specific to adolescent drug use, found that annual use of methamphetamine by 8th, 10th, and 12th graders has generally decreased over the past 6 years. Among high school seniors, for example, the study shows that annual prevalence of methamphetamine use was 3.4 percent in 2004, down from 4.7 percent in 1999.[33]

## III. Law Enforcement

*Key Law Enforcement Questions*

- Is meth the primary drug problem in California?

- What sorts of crime does meth use lead to?

- Is pseudoephedrine control a priority for state law enforcement officials?

- Is meth production shifting to Mexico or has California-based production remained constant?

- Is meth distribution tied to gangs?

- What are the most effective programs targeting meth currently? What is their level of funding?

*California Department of Justice Funding in the 2006-07 Budget*

> Methamphetamine is the leading drug-related law enforcement problem facing California. Distribution networks are growing nationally, and California is no exception. This drug is a threat not only to public safety, but to public health as well. Therefore, the state must enhance efforts of suppressing methamphetamine use, production, and distribution by dedicating additional resources to investigate and eliminate the means by which methamphetamine is produced and distributed. (Governor's Budget Summary 2006-07)

The Governor's Proposed Budget 2006-07 includes an augmentation of $6 million General Fund and 29.6 positions for the California Methamphetamine Strategy (CALMS) Program. The funding is targeted for three new teams focused on less-populated, rural areas of the state "where methamphetamine production has become increasingly difficult to control."

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[33] Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2005). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2004.* (NIH Publication No. 05-5726). Bethesda, MD: National Institute on Drug Abuse. National Institute on Drug Abuse NIH Publication No. 05-5726 Printed April 2005.

According to the Attorney General's office, the CALMS program was developed by the Bureau of Narcotic Enforcement within the Department of Justice in 1996, and was the first comprehensive meth strategy in the country. Through CALMS, BNE directly investigates drug trafficking, trains local law enforcement, regulates the sale of meth-making materials, conducts forensic analysis at crime scenes, and conducts public outreach. BNE conducts these activities from its headquarters in Sacramento and its nine regional offices.

According to the AG's office, in the wake of September 11, 2001, staffing levels and funding for the CALMS program fell as resources were redirected to homeland security (and as California struggled with its fiscal shortfall). Currently, CALMS is staffed with 9 supervisors and 20 agents to address what the AG's office calls "the greatest drug threat in the most populous state in our country."

*Lab Seizures Down in California*

Statistics show that over the past several years the number of meth-making clandestine labs seized by law enforcement has fallen in California. In 1999, the federal DEA reports, law enforcement found 2,090 meth labs in this state. By 2003, that number had fallen to 709 labs.

Meth lab seizures are often seen as a measurement of meth production within a state. However, the AG's office reports that reductions in CALMS program funding – and not a true decrease in the number of labs operating in the state - explains the decrease in labs seized by the department.

*The Mexico Connection*

According to the federal DEA, most of the meth sold in the U.S. comes from Mexican drug traffickers making meth in both California and Mexico. These traffickers control the super labs in both countries, as well as the mid-level and retail meth distribution throughout the Pacific region.

According to recent DEA testimony, "A precise breakdown is not available, but current drug and lab seizure data suggests that roughly two thirds of the methamphetamine used in the United States comes from larger labs, increasingly in Mexico, and that approximately one-third of the methamphetamine consumed in this country comes from the small, toxic laboratories."[34]

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[34] Joseph T. Rannazzisi, Drug Enforcement Administration: "Comprehensively Combating Methamphetamine: Impact on Health and the Environment." Statement before the House Committee on Energy and Commerce, Subcommittee on Health and Subcommittee on Environment and Hazardous Materials. October 20, 2005.

*Precursor Controls Seen as Vital to Combating Meth Production*

As noted above, the principle ingredient in meth manufacturing is pseudoephedrine (PSE), a close cousin to the stimulant, ephedrine, that is found in over-the-counter and prescription cold medicine. Police and lawmakers across the country have made restricting access to PSE for meth manufacture a priority.

In June, 2005, US Senator Dianne Feinstein sent a letter to Mexican President Vicente Fox urging him to investigate his country's PSE imports.[35] An analysis conducted and reported by the Portland Oregonian had found that Mexico imports almost twice the amount of bulk PSE that it needs to meet its legitimate demand for the ingredient.[36] In November, the Oregonian reported that Mexico plans to cut imports of PSE by 40 percent in 2005, "acknowledging that drug cartels have artificially inflated demand for the key ingredient in methamphetamine."

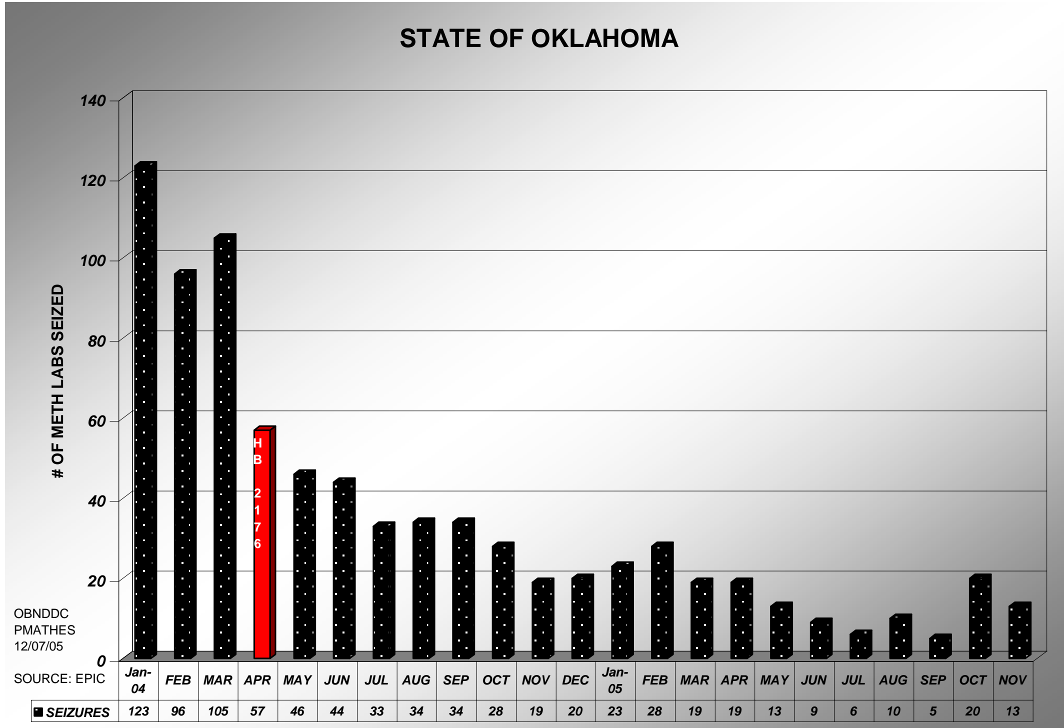
"Smurfing" is the term used to describe the serial purchase of multiple packages of cold and allergy medicine in order to obtain PSE for meth production. In California, it is illegal for retailers to sell more than 3 packages or 9 grams of pseudoephedrine-containing product in any single transaction.[37] Law enforcement officials report that meth manufacturers skirt the California sales restriction by returning to the same store multiple times to purchase at the 3-box limit or by traveling from store to store to do so.

In April 2004, Oklahoma enacted the strongest retail-level pseudoephedrine control in the country at that time. HR 2176 required that all PSE-containing products be sold only in pharmacies and that customers be limited to 9 grams per month (compared to 9 grams per transaction in California). To monitor purchases over time, HR 2176 required customers to show a photo ID and to sign a log book at the pharmacy. After HR 2176 was passed, Oklahoma saw a dramatic (50-80%) drop in the number of meth labs seized by police, as the chart below illustrates:

[35] "Senator Asks Fox to Intercede on Meth." June 25, 2005 article from The Oregonian found on U.S. Senator Feinstein's webpage: http://feinstein.senate.gov/news-meth062505.html.

[36]Steve Suo, "Mexico's math problem adds up to a U.S. meth problem." The Oregonian. June 5, 2005.
http://www.oregonlive.com/special/oregonian/meth/stories/index.ssf?/oregonian/meth/mexico_math.html.

[37] See Health and Safety Code §11100 et seq.




Since the Oklahoma law took effect, several other states have enacted similar legislation, and Oregon has recently made PSE a prescription drug.

In the 2005 session of the California Legislature, two measures were introduced patterned on the Oklahoma PSE law, SB 152 (Speier) and AB 283 (Koretz). Both measures failed passage in the Senate Business, Professions & Economic Development Committee.

Pending federal legislation sponsored by US Senators Talent and Feinstein would extend provisions similar to the Oklahoma law nationally.

## IV. Treatment of Meth Addiction as Effective as Treatment of Other Addictions

*Key Treatment Questions*

- How well does treatment for meth addiction work?

- What kind of treatment is necessary for people addicted to meth? Is this different from other types of treatment?

- How should different treatment modalities be tailored to specific populations?

Some observers of drug addiction trends have noted that treatment for methamphetamine addiction is often assumed to be less effective than treatment for other drug addictions. A recent UCLA study of California's Proposition 36 (2000) appears to contradict this assumption.

Proposition 36 passed in November 2000 as the Substance Abuse and Crime Prevention Act (SACPA). In general, SACPA allows "adults convicted of nonviolent drug offences to be sentenced to probation with drug treatment instead of either probation without drug treatment or incarceration."[38]

An evaluation of the program published July 2005 by UCLA found that "Methamphetamine users were similar to the overall SACPA population in treatment completion and duration…. Concern has been raised regarding the treatment system's ability to meet the clinical challenges (e.g., poor engagement in treatment, severe paranoia, severe and protracted dysphoria, and high relapse rates) presented by methamphetamine users (Rawson, 2002). Findings suggest that treatment providers in SCAPA have responded to the challenges presented by methamphetamine users."

## V. Meth's Impact on Families

*Key Questions Regarding Meth's Impact on Families*

- How is meth impacting California's child welfare system?

- How have counties developed multi-jurisdictional teams (i.e., involving police, health, and child protective services) to address meth's impact on families?

- Does meth use by parents play a role in use by their children?

[38] Douglas Longshore, Ph.D., et al, "Evaluation of the Substance Abuse and Crime Prevention Act: 2004 Report." Integrated Substance Abuse Programs, University of California Los Angeles. July 22, 2005.

- Why do women use meth at higher rates than they use other drugs?

In July 2005, the National Association of Counties published a survey of 500 counties from 45 states that found meth to be a major cause of child abuse and neglect. Seven out of 10 counties from California responded to the survey.

The findings indicate that meth's impact on child welfare may be higher in California than the national average: "Forty percent of all child welfare officials in the survey report increased out of home placements because of meth in the last year. During the past five years, 71% of the responding counties in California reported an increase in out of home placements because of meth."

Oregon has seen meth have a strong effect on the state's foster care system: a recent study showed that 50% of Oregon's children in foster care entered the child welfare system because a parent or caretaker was using methamphetamine.[39] (Staff of this committee asked for similar information from the state Department of Social Services, but no such information is available.)

In light of these studies, the State Senate Select Committee on Methamphetamine Abuse asked the County Welfare Directors Association to conduct an informal survey of counties to gauge the impact of meth on child welfare in this state.

Eight counties provided the Select Committee with estimates of the number of child welfare cases where meth is a known factor. (Several counties responded that they did not track particular drugs that may be involved in child protective service cases.) Results are as follows:

| **County** | **Impact of Meth on Child Welfare Services** |
|---|---|
| Butte County | It is believed that 95% of children detained by Child Protective Services are from meth families. |
| Calaveras County | Of the 133 children served by CPS since 1/1/04, 84 of the children (63%) had one or more parents with a history of using meth. |
| Mariposa County | 75% of families on CWS caseloads have used meth to some degree. |
| Merced County | Estimated that 67-75% of current CWS cases are meth related. |
| San Benito County | 36 total active cases: 26 (72%) involve meth; 111 total cases and referrals: 83 (74%) involve meth |
| San Bernadino County | Pulled a sample of 320 Family Maintenance and Family Reunification cases that had a parent ordered to participate in substance abuse services. Parental drug of choice: by far methamphetamine, especially for mothers. Of the 320 cases, meth was the drug of choice for 200 mothers. That is 62.5%. |

[39] Steve Suo, "Meth and the media." The Oregonian. August 11, 2005. http://www.oregonlive.com/weblogs/publiceditor/index.ssf?/mtlogs/olive_publiceditor/archives/2005_08.html

| | |
|---|---|
| San Joaquin County | 25% of all referrals to CPS involves substance abuse. For cases requiring juvenile court intervention, 80% of cases have parents with drug abuse problems. In past 2 years, meth has gone from 50% of cases to 90% |
| Shasta County | Methamphetamine is a significant factor in CPS involvement with 70% to 80% of families in our caseloads. |

*Unique Rates of Use by Women*

According to state data, women and men enter treatment for methamphetamine addiction at relatively similar rates. Men make up 57% of admissions for meth and women 43%.

This is a closer male-female ratio than seen for other drugs. Men in drug treatment identify heroin, cocaine, and alcohol as their primary substance problem at roughly twice the rate that women in treatment do.[40]

Moreover, between the ages of 18 and 30, more women identify meth as their primary drug of choice than men do. According to 2003-04 state treatment data:

- 55% of women in treatment between 18 and 30 indicated meth as their primary drug;
- 40% of men in treatment between 18 and 30 indicated meth as their primary drug.[41]

**VI. HIV Transmission**

*Key HIV Transmission Questions*

- How does meth use fuel the spread of HIV?

- Does meth reduce the effectiveness of anti-HIV drugs?

- Is the HIV-meth connection a problem solely within the gay community?

- What sort of programs have been developed to address the use of meth within populations at risk for HIV transmission?

The link between methamphetamine abuse and the transmission of the Human Immunodeficiency Virus (HIV) has been well established by medical and social research.

[40] "Update of Tables…" (See Note 27).

[41] "Meth Report" PowerPoint Presentation provided to committee by Department of Alcohol and Drug Programs October 4, 2005.

According to federal NIDA, "Meth use increases the risk of contracting HIV not only due to the use of contaminated equipment, but also due to increased risky sexual behaviors as well as physiological changes that may favor HIV transmission."[42]

According to one report, "Methamphetamine is particularly common among men who have sex with men (MSM), with use as much as 10 times higher than in the general population...In a probability-based sample of young MSM in the United States, 20% reported methamphetamine use in the prior 6 months, with 6% reporting at least weekly use."[43]

Some studies suggest that meth may increase the rate at which HIV progresses into AIDS. According to NIDA, "in a study of HIV-positive individuals being treated with highly active anti-retroviral therapy (HAART), current meth users had higher plasma viral loads than those who were not currently using meth….differences could be due to poor medication adherence or to interactions between meth and HIV medications."[44]

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[42] Volkow Testimony.
[43] Grant N. Colfax, M.D., "Methamphetamine: Important Clinical Guidance for Healthcare Providers." Medscape. Posted October 17, 2005. http://www.medscape.com/viewarticle/514193
[44] Volkow Testimony.