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

MOVING PAST THE ERA OF GOOD INTENTIONS: METHAMPHETAMINE TREATMENT STUDY

EXECUTIVE SUMMARY AND INTRODUCTION

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Executive Summary

In the crush of anticipation surrounding the release of the *Initial Report* in December, 2005, much attention was focused on specific recommendations for policy makers to consider during Nebraska's 99th Legislature. The Final Report retains recommendations for adjusting Nebraska's substance abuse treatment system, however, it is hoped that with the urgency of the legislative session relieved, more consideration will be given to the specific research findings reported here.

The first irony of any research project is that good reports provide a foundation of information from which more questions are generated. That was certainly the case with the *Initial Report*. In response to the Community Corrections Councils' close scrutiny and analysis, the research team was challenged to use the *Final Report* to: 1) re-emphasize the nature of the methamphetamine ("MA") problem in Nebraska, 2) extend the original findings to reflect comments and concerns raised about the *Initial Report,* and 3) establish a base-line from which future program design, policy debates, and scholarly research could proceed without having to start from scratch.

The second irony of this type of project is that comprehensive research prompts collateral inquiries into topics which were not expected to fall within the original scope of the research effort. The research team could not have anticipated how much work remains to be done before the MA problem can be fully understood. For example, it has only been in the last month and a half that we began to comprehend the global dynamics of large-scale MA production. Although tentative findings are reported in this *Final Report,* a supplemental report is being prepared to detail what many will consider the most exciting discovery of the entire project: the potential eradication of MA.

Finally, this report provides the research team with the opportunity to clarify issues and make corrections resulting from the *Initial Report.* The body of the *Final Report* addresses the bulk of these, but we would like to immediately clarify a use of terms which may have caused some confusion in the *Initial Report.* When the reports refer to Nebraska's "substance abuse treatment system" without capitalization, they refer to the State's entire, general substance abuse treatment system, not, the Department of Health and Human Services System. The Behavioral Health Services (BHS) division has a strong record of innovation, advocacy, and leadership in the areas of substance abuse treatment and mental health. Criticisms, observations, and recommendations for Nebraska's "substance abuse treatment system" are not aimed at BHS specifically, but are addressed, instead, to that web of providers, agencies and administrative systems which make up the whole integrated complex.

Methamphetamine Only Treatment

The MA problem is often discussed in ways which imply that a substantial number of addicts are singularly dependent on methamphetamine. In truth, such persons occur so rarely, that focusing on this archetype can lead policy makers to mistakenly conclude that methamphetamine-specific responses will produce meaningful results.

Instead of this clear-cut, narrowly targeted population, the State must develop treatment response strategies for a more difficult, insidious pattern of addiction. The majority of methamphetamine users can be best classified as general substance abusers. While the debilitating physical and psychological consequences of their methamphetamine use are

frequently the extreme symptoms which draw the attention of social service and justice professionals, these addicts are equally dependent on other drugs. Misuse of alcohol and other drugs almost inevitably precedes the experimentation which produced the addict's eventual dependency on methamphetamine. As the highs and cravings of the methamphetamine habit gradually monopolize the user's attention and resources, the desire for some drugs may diminish, but the pharmacological effects of others, especially alcohol, simply complement the experience. Studies show that as addicts receive treatment for their "primary" dependency on methamphetamine, many compensate by increasing their use of alcohol and marijuana. If treatment services fail to address the methamphetamine addict's struggle to abstain from all legal and illegal alternatives, then the user has been set up to simply swap one substance for another. Worse, in an inadequate system of recovery and relapse prevention services, it places the user at risk of gravitating back to methamphetamine when alternative drug use eventually proves unsatisfying.

From a clinical treatment perspective, methamphetamine use clearly indicates a need for a specialized case-plan which accounts for how methamphetamine factors into the overall constellation of an addict's recovery. From the standpoint of justice and social service systems, however, the broad array of chemical dependency services required to promote long-term abstinence do not support the creation of a unique treatment infrastructure particularized for methamphetamine. In other words, the most effective treatment model for alcoholism may differ substantially from the most effective treatment model for methamphetamine, but both require the same types of treatment services.

The first step to resolving the methamphetamine problem demands that policy makers and government officials understand this critical distinction. Methamphetamine use determines the *individualized treatment* plan of an addict, but bears little on *society's response* to methamphetamine addiction. The crisis of methamphetamine abuse certainly signals a shortage of effective methamphetamine treatment, but it also reveals the inadequacies of Nebraska's overall substance abuse system. The methamphetamine treatment needs of the criminal justice and health and human services systems cannot be distinguished from the alcohol, cocaine, marijuana, or other drug abuse treatment needs of those systems: they are one and the same.

The Continuum of Assessment, Treatment and Recovery

The recipe for recovery from methamphetamine addiction does not require Nebraska to develop innovative strategies. Put plainly, the continuum of successful drug and alcohol treatment services is as follows:

1. A standardized, validated assessment of the nature and severity of a person's chemical dependency;
2. The design of a case-plan which accounts for the person's substance abuse factors within the context of their individual lives and legal constraints;
3. The provision of treatment services matching the person's short-term, individualized treatment needs; and,
4. The provision of recovery and relapse prevention services which support the person's life-long effort to remain clean and sober.

The challenge facing Nebraska lies not in the complexity of the response needed to combat methamphetamine addiction, but in manifesting the will to establish a complete continuum of assessment, treatment and recovery. Alcoholics are taught that recovery is a life-long process. As a state, however, Nebraska has been slow to accept that not only is it a long-

term process for the individual, it also demands a long-term commitment from society. Once the sobriety of an addict has been stabilized through initial treatment, their continued abstinence will always depend on the accessibility of recovery support and relapse prevention services.

Nebraska's Existing Capacity

Ultimately, the recommendations for the State turn not on the prevalence of methamphetamine users in any given justice or social service system, but on the State's ability to establish the continuum of assessment, treatment and recovery as needed beneath all substance abusers. Perhaps one of the most surprising findings from the research reveal that Nebraska cannot buy its way out the biggest obstacle to substance abuse reform, at least not very quickly. Nebraska presently faces such a severe shortage of substance abuse clinicians and treatment professionals that every level of service within the continuum of care has a waiting list. Justice and treatment professionals from all over Nebraska report that regardless of an individual's personal financial resources, obtaining even the initial assessment on which so many critical legal and treatment decisions depend can be delayed for weeks. Similarly, once an assessment has been obtained, the addict faces more delay as they wait for admission to the most appropriate level of treatment, if it exists at all.

The ramifications of this shortage are fairly obvious in terms of treatment for methamphetamine abuse. The impact on the justice and social service process is equally profound, though more subtle. The primary mission for justice and social services is to hold substance abusing offenders accountable for their crimes and/or the family crises they have caused as a result of abuse or neglect. When criminal rehabilitation and the restoration of parental responsibility turn on the elimination of a person's substance abuse problem, these waiting lists and gaps in the continuum of assessment, treatment and recovery become part of the transactional calculus offenders and neglectful parents use to avoid the compelled surrender of addiction. Addicts play justice professionals, social service workers, and treatment providers against each other by exploiting these gaps and shortages as excuses for their lack of recovery progress.

It would seem that the solution to this dilemma turns on the State's ability to quickly develop a cadre of clinicians and treatment specialists to fill these gaps. Increasing reimbursement levels might motivate more people to complete the rigorous education and training requirements to become treatment professionals and possibly improve Nebraska's ability to recruit and retain them from other states. As other Nebraska studies have shown, however, this strategy provides only a partial remedy. While the State must seriously consider the incentives it can create to grow the number of treatment specialists, the payoffs from this effort are likely to be years in the making.

Intersecting Treatment Needs with Justice/Social Service Process

When one considers the specific missions, separate budgets and differing philosophies of Nebraska's social service and justice systems, it is easy to see how these agencies are viewed as silos of command rather than an integrated network. At the same time, the State's response to the methamphetamine and substance abuse problem requires it to recognize that all of these agencies are actually points within the flow of the justice and legal process. Viewed as a stream of decisions and response, rather than administrative units, one sees the vast potential of this stream to quickly and dramatically alter the course of substance abuse for individual offenders/parents and the State as a whole. When earlier stages of the justice and social service

process successfully intervene in the offender/parent's substance abuse problem, more expensive, intensive levels of supervision or incarceration are avoided.

The trick, of course, is to develop levels of service and treatment beneath all points of the HHSS and justice systems which are appropriate to their statutory authority and inherent structure. These strategies must seal the gaps, shorten the delays, and remove the explicit barriers to recovery now found in Nebraska's present substance abuse system. To reduce methamphetamine abuse, an infrastructure must be laid which enforces a state-wide response to the problem and channels addicts into a fast-flowing stream of recovery in which it is easier to succumb than escape.

The main recommendations for changing or expanding the infrastructure for Nebraska's methamphetamine response system include:

- ***Developing more substance abuse treatment professionals state-wide;***
- ***Increasing awareness of methamphetamine-specific treatment models among professionals throughout the state;***
- ***Incentives for treatment providers to expand and develop localized methamphetamine abuse treatment programs;***
- ***Funding and legislative action to establish and staff day/night reporting centers across Nebraska in support of Probation, Parole, drug courts, and diversion programs;***
- ***An increased utilization of the WEC as a methamphetamine treatment facility for those offenders whose crimes and risk to others do not warrant incarceration by DCS;***
- ***A centralized substance abuse treatment facility for offenders sentenced to prison;***
- ***Expanding the use of ASI/CASI evaluations and the standardized reporting format throughout all of justice and HHSS;***
- ***A centralized database where substance abuse evaluation results and treatment summaries are kept and accessed by social service, justice, and treatment providers;***
- ***Ongoing research to drive targeted capacity expansion for treatment and recovery services;***
- ***Ongoing research to monitor the effectiveness of treatment programs; and***
- ***Creating an office which can coordinate the implementation of any recommendations which may be adopted and report to the Governor, Legislature, and Supreme Court on the progress being made.***

Of these recommendations, the proposal from the *Initial Report* which caused the most controversy was the call for a centralized substance abuse facility for offenders sentenced to prison. Setting aside disagreements to the facility being developed in Norfolk, the main objection to the facility related to a misunderstanding about the population it is intended to serve. Following the press reports about the *Initial Report*, the public response revealed that the research team had failed to adequately explain the reasoning and goal of this recommendation.

Nebraska's justice and social service agencies must address the MA and substance abuse treatment needs of two distinct groups. The first group includes approximately 8,000 offenders a year who will be processed within the criminal justice system, but who will not be sentenced to prison. In general, the offenders in this group will enter diversion programs, drug courts, and sentenced to Probation. With appropriate community-based, out-patient treatment and recovery support services, *these offenders will not require treatment at a centralized facility.* To effectively treat this group, Nebraska must develop a state-wide network of localized services

which enables these offenders to beat back their addiction in their home communities. Many of these services will overlap with the community-based mental health programs being developed as a result of mental health reform. This recommendation is in absolute agreement with the State's philosophy of moving away from centralized treatment facilities for mental health.

The second group is made up of approximately 530 MA users per year who will be committed to the custody of the Department of Correction Services or, in other words, 530 men and women sentenced to prison. Since these offenders will be forcibly removed from their home communities and incarcerated in DCS correctional facilities, it will be impossible for them to access the community-based treatment network. Research shows that the most effective way to treat the substance abuse problems of prisoners is to separate them from the general population of a correctional facility in what is generally referred to as a "therapeutic community". This allows treatment staff and prisoners to focus on recovery away from the distraction of the typical issues surrounding prison life. There are basically two ways that therapeutic communities can be arranged: 1) separate wings or living units within a larger prison which are restricted to inmates undergoing treatment, or 2) an entirely separate facility populated only by inmates who are undergoing treatment. Over the years, Nebraska has used both methods, but at the present time, DCS does not have a correctional facility which operates solely as a treatment facility. *The recommendation for a centralized MA and substance abuse treatment facility was strictly for the treatment of prison inmates*. The Legislature has charged the Community Corrections Council with the task of reducing the State's reliance on incarceration as a response to criminal offending. There are two ways in which the State can attempt to reduce its reliance on incarceration for offenders who use MA or other substance abuse problems. First, it can develop effective community-based treatment services for offenders who have not yet earned a prison sentence. This was the basis for recommending that localized recovery services be developed for the 8,000+ offenders each year who have not yet earned a prison sentence. Hopefully, offenders who succeed in community-based substance abuse services will not recidivate and thereby avoid an eventual prison sentence.

The second way the State can reduce its reliance on prisons is to expand effective treatment programs for inmates. In Nebraska's present system, many inmates are denied parole each year because they have not completed substance abuse treatment. This leads the State's prison population to be artificially inflated because inmates who would otherwise be paroled and out of prison cannot be released because they have not completed substance abuse treatment. After considering the long-term expense, and comparing the relative benefits of building a separate treatment facility versus expanding treatment capacity within Nebraska's existing correctional facilities, the MTS research team recommended that the State build a separate, centralized treatment facility dedicated solely to the MA and substance abuse treatment needs of the 530 offenders sentenced to prison each year.

Contrary to some people's impression following the *Initial Report,* the MTS research team has repeatedly, consistently, rejected the idea that Nebraska should develop a centralized treatment facility for the typical MA user.

Conclusion

There used to be a public service announcement which ended with "No one wants to be a drug addict when they grow up." If that is true, then it is only natural that we wonder, "why do people become drug addicts?"

Researchers have published libraries full of journal articles arguing over the causes of drug addiction. Those leaning toward individual choice contend that the use of drugs and alcohol reflect a life-time of deliberate decisions some people make in search of excitement or in rebellion against authority. At the other extreme, social theorists argue that the lingering effects of trauma from divorce, parental neglect, parental example, low achievement in school, inequities in economic opportunity, social ostracism, or peer pressure lay a foundation of pain and discontent which drives people to find some escape or relief through the use of drugs and alcohol.

Ideally, research into the causes of addiction could lead the State to develop iron-clad prevention programs which keep every juvenile and adult from using MA or any other drug or alcohol. For the time being, however, it appears researchers are no closer to identifying the "cause(s)" of addiction than they were fifty years ago. This is not to imply that prevention programs are wholly ineffective, but they provide no help in addressing the pressing needs of the tens of thousands of substance abusers with which Nebraska's justice and social service systems must immediately contend.

In his keynote address to the Nebraska Juvenile Justice Association's Annual Conference in May 2006, psychologist Stanton Samenow said that researchers and treatment providers cannot help a person surrender a substance abuse problem by worrying over the root causes of their addiction. Instead, he urged conference attendees to think of a substance abuse problem like a scratch on a table. The measures required to fix the table depend on the properties of the table and finish, not the way in which the table was damaged. Many may disagree with Samenow's particular strategy for treating addiction (in fact, much of the research related to the effectiveness of coerced treatment directly contradicts his therapeutic philosophy), but his metaphor of the scratched table holds a great deal of merit.

The strategies contained in the *Initial* and *Final Reports of the Methamphetamine Treatment Study* reflect the prevailing best practices for MA and substance abuse treatment. The recommendations include all the tools needed to provide MA users with effective treatment programs and recovery support services. By adopting systematic, standardized assessments and relying on those treatment techniques for which positive outcome results can be proven, Nebraska will greatly increase its success in this battle—no matter what propelled a particular user down the road of addiction.

Introduction

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

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

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

Fact or Myth: The accuracy of common ideas about methamphetamine

"Anyone can make MA" or "Meth is easy to make"

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

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

Given a supply of pseudoephedrine or its related cold-medicines, however, MA can be made produced using common household items such as battery acid, iodine, anhydrous ammonia, lye, lantern fuel, and anti-freeze. At one time, recipes for cooking MA could be found on the internet, but much of this is being gradually eliminated. When ingredients and instructions were easily obtainable, people throughout the county cobbled together kitchen and container labs and brewed up batches of MA. The production of MA requires no particular expertise, just access to the precursor chemicals and the ability to follow instructions.

Over the past two years, state and local governments, enacted legislation regulating the sale of over-the-counter medications containing pseudoephedrine. As a result, law enforcement

reports a dramatic decline in the number of clandestine MA labs being discovered or seized. These recent successes, and some historical instances in which the illegal supply of pseudoephedrine was greatly reduced, show that restricting access to these necessary precursor chemicals directly reduces MA production.

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

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

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

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

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

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

"MA creates environmental hazards."

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

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

Individuals who come in contact with a clandestine lab or dump site should not touch anything. If you enter a building that you suspect has been used as a MA lab, you should leave

the building immediately. Report any clandestine labs or dump sites to local law enforcement officers who are trained how to safely deal with the situation. When cleaning up a lab or dump site, law enforcement officers wear protective clothing to prevent contact with the hazardous materials or ingestion of methamphetamine. A modest MA lab or dump-site costs thousands of dollars to close and clean up. State and county budgets are strained to pay for the necessary clean up associated with these sites. Professionals at the Western Nebraska roundtable discussion expressed concerns about the clean-up expenses associated with buildings that have been used as methamphetamine labs.

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

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

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

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

Taken together, these findings suggest that some people become addicted to MA faster than others. While the neuro-chemical reaction to MA is extreme, researchers cannot say that a single use causes irreversible, life-long damage to the brain. Like any other extreme metabolic event, different people possess different capacities for recovery. In terms of physiological dependency, it is unlikely that most people are damned to a life-long need for MA after only one use. On the other hand, the extraordinary euphoria associated with MA use presents an extraordinary temptation that few users appear capable of resisting. There is no research available which says how many people become addicted to MA after only one use. The only users science knows anything about are those users who developed serious or fatal addictions to the drug.

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

That said, it must also be made clear to anyone who has ever experimented with MA that the hellish descent into MA addiction is not inevitable. The quicker someone seeks help with their drug and alcohol problems, the easier it will be to fight back an addiction to MA or any other drug. For someone who has used MA a few times, it may take awhile to forget the lure

of the MA high, but the brain and organ damage associated with prolonged use and binging may be avoided altogether. More importantly, the personal degradation and loss of family, friends, and careers can be prevented. Experimenting with MA may not fit the clinical definition for "addiction", but it reflects such a profound disregard for risk and personal well-being that anyone who has tried MA even once would be well-advised to seek counseling help. Securing early help may be all that stands between a long, normal life and one beset by one of the most vicious addictions that exist.

"There is no effective recovery strategy for MA addiction."

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

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

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

MA users require an array of support services to successfully complete treatment. Research has found that structure is vital to a MA addict's recovery. Recovery from MA requires long-term support services. A MA addict cannot be discharged from his treatment program and left to fend for himself. The addict must have access to a network of support services specifically designed to support him in his continued recovery.

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

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

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

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

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

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

"MA causes medical and dental problems."

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

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

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

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

"More women use MA."

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

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

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

"MA is a white person's drug."

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

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

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

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

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

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

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

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

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

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

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

In addition to strong recovery results, research also shows that coerced treatment can have a positive effect on criminal recidivism. The *Iowa Adult Methamphetamine Treatment Project – Final Report, 2003* indicated that 90.4% of MA clients had not been arrested 6 months after treatment and 95.7% of MA clients interviewed one year after treatment had not been

arrested during the previous 6 months (Roth 2003). The Year Six Report of the *Iowa Project Outcomes Monitoring System* 2004 recidivism numbers indicated no arrests in the six months after treatment for 86% of MA users; 90.7% of alcohol users; 79.2% of cocaine users; and 86.8% of marijuana users. These rates are compared to 30.9% of clients who had not been arrested in the 12 months prior to treatment. (Johnson A 2004)

"MA use increases sexual activity."

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

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

The medical treatment consequences of MA use include a full range of disease and disorders resulting from risk sexual activity. The disinhibitory affects of MA (and Ice in particular) have been strongly associated with sexual behaviors that put men at high risk of sexually transmitted and blood-borne disease, including HIV infection (Maxwell 2005) (Kurtz S 2003). Studies have confirmed some of the medical complications arising from MA abuse. In HIV-infected patients complications include hypertension, hyperthermia, rhabdoymyolysis, stroke, and some researchers believe that dopaminergic systems are vulnerable to the combined neurotoxity of HIV infection and methamphetamine (Maxwell 2005) (Urbina 2004).

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

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

"MA affects your mental health" or "MA makes users psychotic"

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

Psychiatric disorders arising from MA abuse were confirmed in a study of 405 methamphetamine users in Taipei. MA users with pre-morbid schizoid/schizotypical personality were found to be predisposed to developing psychoses (Maxwell 2005) (C. Chen 2003). A study among MA psychotic patients in a multi-country study involving Australia, Japan, the Philippines and Thailand indicated that persecutory delusion was the most common lifetime

psychotic symptom, followed by auditory hallucinations, strange or unusual beliefs, and fear of thought reading (Maxwell 2005) (M. Srisurapanont 2003).

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

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

"MA eventually leads to Alzheimer's Disease in recovered addicts."

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

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

"MA is Nebraska's biggest substance abuse problem"

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

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

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

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

"MA is mainly a problem for people older than 18."

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

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

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

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

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

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

For Nebraska to appreciably reduce the number of crimes related to MA use, it must commit to long-term strategies aimed at addressing the substance abuse treatment needs of all offenders no matter how their crime is classified. A solid step in the right direction can be seen in the Unicameral's recent appropriation of 4.3 million dollars to fund testing, treatment and increased justice capacity for all offenders (LB1060). Through these funds, the Community Corrections Council has resources with which it can pro-actively encourage all offenders to discard their substance abuse problems. While sobriety offers no guarantee that a person will cease offending, an addicts' recovery increases his or her chances of maintaining a job, family and the normal responsibilities and benefits which insulate all of us from committing crimes.

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

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

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

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

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

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

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

they are at in their cycle of drug use. Parents can exhibit psychotic paranoia or sleep for days at a time.

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

Eliminating clandestine MA labs reduces only one of the dangers children face as a result of MA. Over the past two years, there has been a crackdown on MA labs in southwest Iowa. In spite of this effort by law enforcement, the percentage of child neglect cases involving MA using parents has remained at approximately 49%. Children in MA affected homes continue to suffer from abuse and neglect as a result of their parents drug use.

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

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

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

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

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

If the child welfare system delivers prompt treatment planning and the comprehensive array of services on which MA recovery depends, parents who continue to choose addiction have

discarded their children as clearly as they have rejected recovery. At that point, the State can only be faulted for the delay in which it acts to restore a child's sense of permanency.

Recovery may be a life-long process for addicted parents, but childhood, adolescence, and the transition into young adulthood are not. The developmental needs of children cannot be subordinated to the pace of a parent's recovery. Failure to prioritize the child's long-term well-being over a parent's addiction risks surrendering two victims to MA: the parent and the child.

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

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

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

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

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

"Methamphetamine detoxification requires residential treatment in a drug rehab center."

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

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

The key to MA detoxification is ensuring that an addict does not use during the 45-60 day detoxification period. In most cases, research consistently shows that residential treatment is not required to prevent use. For example, day reporting centers can be designed to deliver the supervision and structure that MA users need to maintain sobriety. These resources include daily, personal contact with case-workers, frequent drug screens and individual and group therapy.

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

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

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

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

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

Except nicotine. And, except caffeine.

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

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

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

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

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

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