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Public Health

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April 10, 2007

TO: Each Supervisor

FROM: Jonathan E. Fielding, M.D., M.P.H.
Director and Health Officer

SUBJECT: **METHAMPHETAMINE USE, PREVENTION, AND INTERVENTION IN LOS ANGELES COUNTY**

On September 19, 2006, in response to a petition presented by the Act Now Against Meth Coalition, your Board instructed the Department of Public Health's (DPH) Alcohol and Drug Program Administration (ADPA) and Office of AIDS Programs and Policy, and the Department of Mental Health (DMH) to report back on a comprehensive strategy for methamphetamine use, prevention, and intervention, to include an overview of methamphetamine use in Los Angeles County and best practices for prevention and treatment. You also asked us to identify specific goals, objectives, and outcome measures for dealing with the epidemic that includes specific recommendations for better data collection, information exchange, and coordination across County agencies and with community groups and service providers. Finally, you asked that DPH's Methamphetamine Work Group be expanded to include community service agencies serving at-risk populations and communities of color.

At the same time, the Board also instructed the Chief Administrative Office (CAO) to work with DPH, DMH, Department of Public Social Services, Sheriff's Department, and other County agencies, as appropriate, to assess all existing County contracts, services, and resources dedicated to addressing the County's methamphetamine epidemic. Additionally, your Board asked County advocates to identify and support legislation that will fund and expand the County's research, prevention, and treatment efforts on methamphetamine addiction.

On December 20, 2006, I provided you a status report about actions taken in response to your motion. This is to provide a full response to your September 19, 2006 motion. This response includes comments from the CAO and DMH.

Comprehensive Strategy

Attachment 1 is a report on methamphetamine use in Los Angeles County. Available data suggest that methamphetamine has become a substantial public health problem in Los Angeles County, especially

among women, adolescents, and men who have sex with men. The use of sound prevention strategies targeting these high-risk groups is needed. Treatment for methamphetamine dependent individuals is effective, and can be made more effective through use of empirically supported treatment methods. The report includes best practices for prevention and treatment, particularly within the targeted populations.

Goals and Objectives

Attachment 2 is a set of goals, objectives, and measurable outcomes developed to address the methamphetamine problem in Los Angeles County. It reflects work that will be done using existing resources. DPH plans to ask the Methamphetamine Work Group, of which DMH is a member, to assist us in meeting these goals. This will ensure the active participation of community advocates, service agencies, communities of color, and affected County departments in addressing the methamphetamine problem in Los Angeles County. One of the goals addresses data collection, information exchange, and coordination across County agencies and service providers. We will provide you a quarterly outcome report beginning July 2007.

If additional funding is identified, additional services can be made available to specific populations. Based upon this strategy, we would propose to fund additional treatment services for methamphetamine-injecting users and MSMs, and outreach services in order to bring difficult to reach persons into treatment.

Outreach programs to engage in early intervention or treatment persons from populations that may be difficult to reach or those who are underserved would cost approximately $1.6 million. An effective outreach program would increase the number of persons from specific populations receiving intervention and treatment services. If funding were to become available, DPH-ADPA will issue a Request for Proposals to select contractors that will provide outreach services in each of the Service Planning Area. These will target young adults (especially MSM, Hispanic/Latino, homeless, drug offenders, and casual drug users) and pregnant and/or sexually active drug using women ages 18 to 40, including those who are homeless, drug offenders, spouses of drug users, spouses of drug offenders, and drug using Asian women and Latinas.

We could also offer additional services to methamphetamine-injecting individuals and MSMs if additional funds become available. We could fund additional residential resources for individuals who inject methamphetamine, who require a period of time in a restricted setting to successfully discontinue methamphetamine use. The cost of providing a six-month residential program to approximately 720 methamphetamine-injecting users per year is $11 million.

We could also increase the amount and diversity of treatment services of all intensities (low threshold, outpatient, and residential services) specifically designed for MSM if additional funds were to become available. These individuals may be placed in a low threshold outpatient, intensive outpatient, or residential program. The annual cost of providing these services to approximately 600 MSM is $6 million.

Expansion of Methamphetamine Work Group

As reported to you on December 12, 2006, we have expanded the Methamphetamine Work Group to include additional advocates against methamphetamine use, including community service agencies serving at-risk populations, members of the Act Now Against Meth Coalition, and additional representatives from DMH and the Office of Education.

Chief Administrative Office's Actions

The CAO has directed its legislative advocate to identify and support legislation that will fund and expand the County's research, prevention, and treatment efforts on methamphetamine addiction. The CAO also developed information about the County's existing resources available to address methamphetamine use. This information was provided to you on December 12, 2006. A revised list is included with this memo that includes the Sheriff Department's resources (Attachment 3).

Other Activities

In an effort to assure availability of methamphetamine prevention and treatment services, OAPP funded three new HIV programs to provide services specifically targeting MSM who use methamphetamine. Funding has also been increased to expand the services of two HIV and crystal methamphetamine prevention programs that have been successful.

In addition, Los Angeles County was one of four recipients nationwide to receive funding from the Centers for Disease Control and Prevention (CDC) for a research intervention targeting out-of-treatment methamphetamine-using MSM. The grant is a collaboration between Van Ness Prevention Division, UCLA and OAPP.

We are also continuing to work with the Act Now Against Meth Coalition to discuss opportunities for continued collaboration. Public Health staff and I have met with Coalition members several times over the last few months, and we will continue to seek their assistance, particularly in our work to meet the goals set forth in Attachment 2.

If you have questions or need additional information, please let me know.

JEF:dhd
PH:609:010

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
Director of Mental Health
Director of Children and Family Services
Director of Public Social Services
Sheriff

Methamphetamine in Los Angeles County

Overview and Best Practices

INTRODUCTION

Methamphetamine (MA) abuse is not a *new* problem in the United States, but the current version of the problem is more widespread and presents with more pernicious consequences than past epidemics. Methamphetamine, frequently called "speed," "crystal," "crank," "ice," or "tina," is a potent psycho-stimulant that can be swallowed in pill form or delivered via intranasal, injection, through rectal insertion or smoking routes of administration. MA use can rapidly lead to abuse and dependence. Serious medical and psychiatric symptoms are associated with chronic MA use. Epidemiologic data on the extent and consequences of MA abuse among increasingly involved user populations—women, adolescents, men who have sex with men—indicate a need for additional efforts to effectively treat and prevent MA abuse and related problems.

METHAMPHETAMINE USE IN LOS ANGELES COUNTY

Since 2000, MA use has increased dramatically among persons seeking treatment for drug problems in Los Angeles County (Crevecoeur, Snow, & Rawson, 2006; EPIC, 2006). Compared to other Southern California counties, including San Diego, San Bernardino and Riverside, where MA was a substantial problem throughout the decade of the 1990s, Los Angeles County has more recently experienced a notable increase in the number of primary MA users (Rutkowski, 2006). However, because the availability of County funded treatment services is reliant upon Federal and State categorical funding streams, it is difficult to determine the extent to which this trend reflects an overall increase in the number of new drug users who choose MA as their

primary drug or rather a higher proportion of existing users who replaced their previous primary drug with MA instead.

According to the National Survey on Drug Use and Health (NSDUH) 7.3% of individuals aged 12 and older in California used MA at some point in their life; 1.2% used MA sometime during the last year; and 0.6% reported MA use at least once in the last 30 days (NSDUH, 2005). Nationally the rates were between 30% and 50% of California rates with 4.9% reporting lifetime use, 0.6% reporting use during the previous year, and 0.2% reporting use in the prior 30 days (NSDUH, 2006).

Furthermore, the Community Epidemiological Work Group (CEWG) noted in its most recent report (includes information through December 2004) that in San Diego County, MA abuse indicators remain high compared to indicators for other drugs; in the San Francisco Bay Area, MA use is high compared with other metropolitan areas in the United States; and in Los Angeles County, the report suggests increasing patterns of MA use (National Institute of Drug Abuse, Community Epidemiology Workgroup, 2005).

Among treatment admissions to Los Angeles County funded providers during the 2000-01 fiscal year, the most frequently reported drug of primary use was heroin. By the 2004-05 fiscal year, MA became the most commonly reported primary drug among people seeking county funded treatment in almost all Californian counties, including Los Angeles County (Carr, 2006). At the same time primary MA admissions were on the rise, the number of primary cocaine admissions had leveled off and the number of primary heroin admissions had decreased (CDADP, 2005).

In a recent analysis of the 80,000 people admitted to publicly funded treatment in Los Angeles County from 2001 to 2005, MA was the most commonly reported primary drug of use (Snow, Crevecoeur, Rutkowski, & Rawson, 2006). Data were collected by the Los Angeles County Evaluation System (LACES) via the Los Angeles County Participant Reporting System (LACPRS) admission and discharge questions developed and implemented by the Los Angeles County Alcohol and Drug Program Administration

(ADPA). Data from 64 geographically dispersed Los Angeles County funded outpatient counseling, residential treatment, and daycare habilitative programs that participate in LACES show that primary MA-using treatment admissions for participants between the ages of 18 and 79 increased from 19% in 2001 to 36.4% in 2005 (Snow et al., 2006).

Female treatment admissions were more likely to be for primary MA use relative to other drug use than were male treatment admissions over this 5-year span, increasing from 23.1% to 40.8% for females and from 16.3% to 34.2% for males. Primary MA-using treatment admissions for younger participants were higher than they were for older participants, but the number of primary MA-using treatment admissions for participants of all ages increased from 2001 through 2005. The treatment admission percentages of Asians, Latinos, Native Americans, and Whites entering county-funded treatment for primary MA use was high, with an overall increase from 29.3% in 2001 to 49.0% in 2005. (See Table 1.)

Table 1: Admissions for Primary MA use and all other Primary Drugs by Year

Year	Primary MA (N)	Primary MA (%)	Other Primary (N)	Other Primary (%)
2001	5237	15.6%	28,371	84.4%
2002	5129	18.9%	22,043	81.1%
2003	4273	20.7%	16,370	79.3%
2004	4406	28%	11,337	72%
2005	8207	29.2%	19,903	70.8%

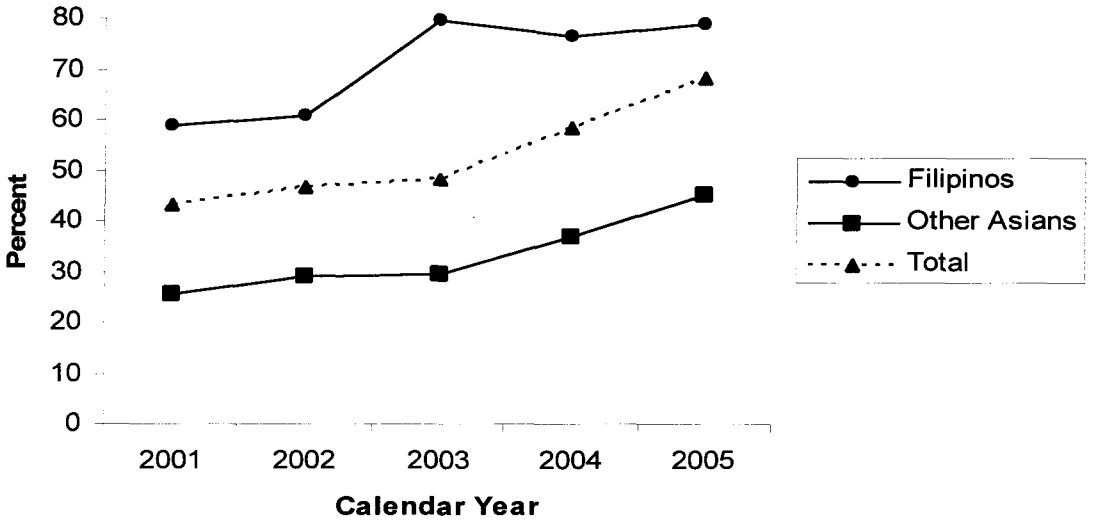
However, during this time period, an average of 3.3% of African-American treatment admissions were for primary MA use. Two subgroups that experienced the most dramatic increase in admissions for primary MA use from 2001 through 2005 were

Filipinos (male and female) and young (18-25 years) Latinas. Nearly 70% of all Filipino treatment admissions from 2001 through 2005 were primary MA users and the primary MA-using treatment admissions for young Latinas increased from 46.2% in 2001 to 76.8% in 2005 (Snow et al., 2006). (See Table 2 and Figures 1 and 2.) It must be noted that the average delay in seeking treatment is approximately five to seven years. As such, the noted increase in treatment admissions for MA may be due to increased numbers of users who began using the drug years ago.

Table 2: Number and Percent of Primary MA Admissions by Race and Year.

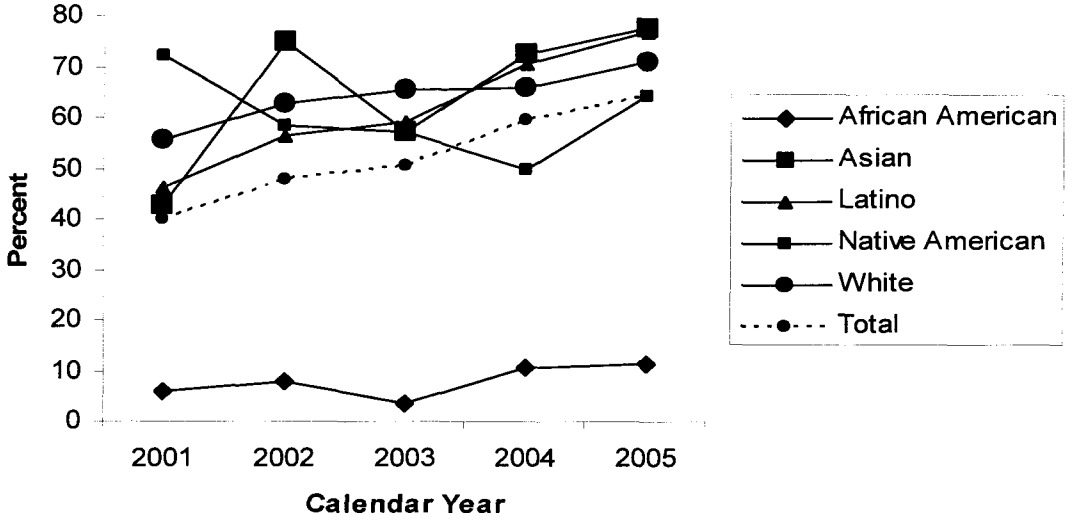
Race	Year	N	% of Total Admitted that Year
White	2001	2754	26.2%
	2002	2491	29.7%
	2003	1970	31.2%
	2004	1887	36.2%
	2005	3011	39.4%
Black/African American	2001	186	1.8%
	2002	218	2.7%
	2003	144	2.6%
	2004	179	4%
	2005	276	4.1%
Asian/Pacific Islander	2001	172	29.9%
	2002	167	36.4%
	2003	116	30.9%
	2004	134	45.9%
	2005	229	46.7%
Native American	2001	82	24.6%
	2002	63	22.2%
	2003	56	26.5%
	2004	45	31.5%
	2005	75	29.1
Latino	2001	1917	16.9%
	2002	2044	22.4%
	2003	1846	24.2%
	2004	2063	38.8%
	2005	3341	36.4%

Figure 1. Treatment admissions in Los Angeles County: Percentages of Filipinos and other Asians admitted for primary methamphetamine use from 2001 through 2005.



Filipinos: N = 286
Other Asians: N = 399
Total: N = 685

Figure 2. Treatment admissions in Los Angeles County: Percentages of racial/ ethnic groups (females: 18- to 25-years-old) admitted for primary methamphetamine use from 2001 through 2005.



African American: N = 99
Asian: N = 97
Latino: N = 1,846
Native American: N = 41
White: N = 1,331
Total: N = 3,414

Other indicators further demonstrate the increasing problem with methamphetamine abuse in Los Angeles County. Rutkowski (2007, CEWG) reported that the California Poison Control System hit a 5-year high in methamphetamine/ amphetamine-related exposure calls for Los Angeles County. During the first 6 months of 2005, methamphetamine arrests made within the City of Los Angeles increased 67% from 221 arrests in 2004 to 369 arrests in 2005. Law enforcement seizures in the City of Los Angeles for possession of methamphetamine also showed an increase of 8% (Rutowski, 2007).

METHAMPHETAMINE: ACUTE AND CHRONIC EFFECTS

Immediate physiological changes associated with MA use are similar to those produced by the fight-or-flight response: increased blood pressure, body temperature, heart rate, and breathing. Even small doses can increase wakefulness, attention, and physical activity and decrease fatigue and appetite. Negative physical effects typically include hypertension, tachycardia, headaches, cardiac arrhythmia, and nausea; whereas the psychological impact is manifested by increased anxiety, insomnia, aggression, and violent tendencies, paranoia, and visual and auditory hallucinations. High doses can elevate body temperature to dangerous, sometimes lethal levels, causing convulsions, coma, stroke and vegetative states, and even death.

Prolonged use of MA frequently creates tolerance for the drug and escalating dosage levels creates dependence. Chronic MA abusers exhibit violent behavior, anxiety, confusion, and insomnia resulting from the direct drug effects plus the consequences associated with sleep deprivation, as abusers will often report days and even weeks of sleeplessness. When in a state of prolonged MA use and sleep deprivation, users commonly experience a number of psychotic symptoms, including

paranoia, auditory hallucinations, mood disturbances, and delusions. The paranoia can result in homicidal and suicidal thoughts and behavior.

Table 3. Adverse Effects of Methamphetamine Abuse

Cardiac Effect	*Psychiatric Effects*	*Neurologic Effect*
–Myocardial Infarction	– Paranoia	–Headache
–Cardiomyopathy	– Psychosis	–Seizures
–Myocarditis	– Depression	–Cerebral infarcts/stroke
–Hypertension	– Anxiety	–Cerebral vasculitis
–Tachycardia	– Suicidality	–Cerebral edema
–Arrhythmia and Palpitations	– Delirium and hallucinations	–Mydriasis
–Inflammation of the heart lining	– Aggression and violence	–Cerebral hemorrhage
–Stroke-related damage		–Choreoathetoid movements.

Other Effects	*Respiratory Effects*	*Social Effects*
– Skin ulcers and dermatological infections	– Pulmonary hypertension	–Environmental and health dangers of MA manufacture
–Bruxism, broken teeth	– Dyspnea	–Violence
–Inflamed gums	– Bronchitis	–Risky sexual behavior
–Extensive tooth decay	– Pulmonary edema	–Criminal activity
– Blackened, stained, rotting, or crumbling teeth.	– Pulmonary granuloma	–Negative effects on children
–Obstetric complications, low birth weight	– Pleuritic chest pain	–Financial problems
–Ulcers	– Asthma exacerbation	–Employment problems
– Anorexia		–Family problems
– Hyperpyrexia		–

SPECIAL GROUPS IMPACTED BY METHAMPHETAMINE

Women and Methamphetamine Use

Women are more likely to become involved with MA than with cocaine and heroin. While the male to female ratio of heroin users is 3:1 and for cocaine is 2:1, among samples of MA users, the ratio approaches 1:1. (Brecht, O'Brien, Mayrhauser, & Anglin, 2004; National Institute of Justice, 1999; Rawson, 2006). Surveys have indicated women are more likely attracted to MA because it can aid in weight loss and alleviating depression-a condition more common among women (Rawson, 2006). MA addiction takes a toll on the health of women. It causes dramatic weight loss to the point of emaciation, and it produces severe damage to the teeth. The skin of MA addicts is frequently badly scarred from compulsive scratching and trauma. Insomnia and other sleep disturbances are common. Long-term MA addiction causes psychosis and almost universal feelings of anxiety, paranoia, depression, and hopelessness. Due to the high rate of sexual behavior associated with MA (mostly unprotected) there is a high risk of sexually transmitted diseases (STDs), including HIV infection, and, among women, pregnancy. One study found that MA using women averaged 70.3 unprotected sex acts and 8.8 protected sex acts over a two month period (Semple, Grant, Patterson, 2004). In addition, 56% of all vaginal sex acts were unprotected, 83% of all anal sex acts were unprotected, and 98% of all oral sex acts were unprotected (Semple, et al., 2004).

There is particular concern regarding MA addiction among pregnant women because MA use during pregnancy can cause premature birth, growth problems in newborns, and developmental disorders among children.[4] Recent data suggest that among pregnant women entering drug treatment in California, MA is the most commonly used drug (Carr, 2006).

Adolescents and Methamphetamine Use

In Los Angeles County, there has been a very dramatic upward trend in the percentage of adolescents admitted with MA as their primary drug since 2000 [e.g., 2000-01 (8%), 2001-02 (9%), 2002-03 (15%), 2003-04 (25%), and 2004-05 (31%)]. Most of the participants were enrolled in outpatient treatment (81.8%) compared to residential treatment (18.2%) throughout Los Angeles County. There is a higher prevalence of MA use relative to other drug use among girls than boys. A longitudinal study found that girls and young women reported greater MA use than boys, develop a dependency on the drug at a quicker rate, and experience the negative effects of MA use earlier than boys and young men (National Center on Addiction and Substance Abuse at Columbia University [CASA], 2003). Results from Rawson et al. (2005) found that female adolescent MA users experienced more severe psychological distress in terms of depression and suicidality than MA-using males (5).

Men Who Have Sex with Men and Methamphetamine Use

The term "men who have sex with men" (MSM) refers to men who identify as gay or bisexual as well as heterosexually identified men who have sexual encounters with men. Recent data indicate that approximately 1 out of every 10 MSM in Los Angeles County reports MA use within the past 6 months, a frequency 20 times greater than the reported MA use among the general population (Shoptaw et al., 2005). Reback (1997) found that MA use was common in gay venues/settings such as gay bars, sex clubs, and bathhouses. MA is frequently used in combination with sexual activities, enabling increased duration of sexual activities and, often sexual encounters with multiple partners (Larkins, Reback, & Shoptaw, 2005). MSM who reported recent MA use were predominately Caucasian/White (62%) and were more likely to engage in high-risk sexual activities, such as unprotected sex, sex work, and sex with injection drug users than were substance users who were not MA users. MA users were also more likely

than non-MA substance users to report both using a variety of drugs and injection as a route of administration in the previous 30 days.

The relationship between MA use and HIV infection among MSM has been repeatedly demonstrated in the research and is likely a consequence of MA's effect of reducing inhibitions and, thereby, increasing high-risk sexual activities (Colfax & Shoptaw, 2005; Larkins et al., 2005; Mansergh et al., 2006; Rawson et al., 2002; Reback, Larkins, & Shoptaw, 2004; Shoptaw et al., 2005) while placing them at risk for HIV and STD infection. Specifically, MSM who reported MA use also reported a high number of sexual partners (Shoptaw et al., 2005; Reback & Grella, 1999); decreased condom use (Semple et al., 2002); and an increase in the use of sildenafil (Viagra) (Mansergh et al, 2006). MA use among MSM has been associated with impaired judgment/decision making due to the impact of MA on the prefrontal cortex and a reported increase in the pursuit of more "novel" sexual experiences due to the impact of MA on the limbic system. Research examining the 25% of MSM in the pacific region (CA, OR, WA, HI, AK and Guam) reporting recent MA use, those who also reported unprotected anal intercourse were 4 times more likely to have used MA before or during sex than those reporting no unprotected anal intercourse.

A relationship between MA use and syphilis among MSM has been found. Among 167 MA-using MSM diagnosed with early syphilis in Los Angeles County between 2001 and 2004, MA use was significantly associated with having multiple sex partners, not using condoms, being recently incarcerated and meeting sex partners at bathhouses (Taylor MM, Aynalem G, Smith LV, Kerndt P. Methamphetamine use and sexual risk behaviors among men who have sex with men diagnosed with early syphilis in Los Angeles County. International Journal of STD & AIDS 2007; 18: 93–97).

MA use also interferes with medication-taking behavior among HIV-positive individuals. In a recent study, all of the HIV-positive participants who were prescribed

HIV medication reported that MA use had a detrimental impact on their schedule of taking HIV medicine (Reback, Larkins, & Shoptaw, 2003). Some clients intended to disrupt their schedule for taking HIV medicine, while others did not. Nearly 50% of the sample discussed their practice of combining MA use with sexual activities, and reported that these activities were often the impetus for intentional HIV medication disruption. They described that MA made them feel temporally healthy, whereas taking HIV medication served as a reminder that they were ill. However, decreased medication adherence may contribute to the development of medication-resistant strains of HIV (Solomon et al., 2000; Ahmad, 2002; Simon et al., 2002).

PREVENTION OF METHAMPHETAMINE USE

There is limited research on approaches or techniques that specifically reduce methamphetamine use. However, it is believed that established principles of substance abuse prevention are clearly important to MA prevention efforts.

According to the National Institute on Drug Abuse (NIDA), there are a number of prevention strategies that can be used to decrease methamphetamine use. These include:

- Using prevention programs that enhance protective factors (i.e., education) and reverse or reduce risk factors;
- Developing programs that address the type of drug abuse problem in the local community, target risk factors, and strengthen the protective factors;
- Tailoring prevention programs to address risks specific to population (age, gender, and ethnicity);
- Implementing community prevention programs that combine two or more effective programs, such as family-based and school-based programs;

- Creating community prevention programs that reach populations in multiple settings (schools, clubs, faith-based organizations, and the media);
- Ensuring that programs are developed that can be maintained in the long term and repeated to reinforce the original prevention goals Without repetition, prevention programs are less effective; and
- Developing programs that are research-based as they can be cost-effective.

TREATMENT OF METHAMPHETAMINE USERS

Treatment of MA Withdrawal

MA withdrawal within 2 weeks after last use includes psychiatric and physical symptoms that are unique to this drug (McGregor et al., 2005). Anhedonia (inability to experience pleasure) is a key symptom of acute withdrawal (Newton et al, 2005). Rest, exercise, and a healthy diet may be the appropriate recommended "therapy" (Rawson, Gonzales & Ling, 2006). No medications are available yet to address severe craving and the high risk of relapse.

Treatment of MA Psychosis

Strategies for acute intoxication are applicable to acute MA-induced psychosis. However, appropriate duration of antipsychotic medication for acute psychosis remains an issue. Low-dose antipsychotic medication between psychotic episodes may have some merit, but is still being researched. (Curran, Bryappa, & McBride, 2004). With increasing numbers of younger users and the increasing appearance of psychosis in adolescents (>500% increase in the decade from 1993-2002; Cooper et al., 2006), where the use of MA appears to be causal, exposure to antipsychotics may have long term consequences in the maturing brain. Empirical support for use of these antipsychotics for the treatment of acute or chronic MA-induced psychosis among youth is lacking.

Treatments for Methamphetamine Abuse and Dependence

Research demonstrates treatment for MA-related drug disorders is effective and produces measurable and desirable reductions in drug use as well as increases in pro-social behaviors compared to no treatment. A recent outcome evaluation conducted from multi-county longitudinal data examined treatment patterns and outcomes among a large group of primary-dependent MA abusers (n = 1,073) in California receiving standard-based treatment models of differing modalities (Hser, Evans, & Huang, 2005). Results revealed that treatment participation was associated with positive retention, reductions in MA use, and substantial improvements in overall psychosocial functioning after treatment. In another large study comparing treatment results of adult and adolescent MA patients with users of other hard drugs in Washington State, few differences were found in treatment completion or readmission, employment, and criminal justice involvement (Luchansky, Krupski, & Stark, 2007).

Cocaine vs. Methamphetamine Outcomes.

Despite the growing body of treatment outcome studies specific to MA-related drug disorders, the majority of studies investigating the effectiveness of treatment for stimulant addiction have focused on cocaine abuse and dependence. Several studies have demonstrated that treatment outcomes for MA and cocaine users are comparable. It is likely therefore that the array of treatments with demonstrated efficacy for cocaine dependence can be applied to MA-dependent users with an expectation of comparable outcomes. For a review of stimulant-based treatments, see Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) No. 33, "Treatment for Stimulant Use Disorders (CSAT, 1999a).

Key Treatment Concepts for stimulants users include:

Improve motivation for recovery. Many MA users are ambivalent about stopping their drug use. *Motivational Interviewing or Motivational Enhancement Therapy* are

techniques that help addicted individuals recognize the damage that drug/alcohol use is doing to their lives, encourages them to stop drug/alcohol use and supports positive steps toward recovery.

Teach skills for stopping MA use and avoiding relapse. Once a person becomes dependent upon MA, they truly don't know how to stop their use and avoid relapse. Cognitive Behavioral Therapy (sometimes called Relapse Prevention) techniques teach critical recovery information and essential recovery skills. Patients learn why they crave MA and how to cope with craving; how to avoid situations that increase their risk of using MA, how to cope with difficult feelings that can trigger relapse to drugs/alcohol, and how to prevent a minor slip or "lapse" from becoming a major relapse or return to re-addiction.

Use positive incentives to encourage treatment participation and reward progress. Recovery from MA dependence takes time. Longer stays in treatment produce greater success. Changing friends, habits, and lifestyle is difficult. Positive reinforcement or incentives following successful accomplishments in treatment (e.g., 30 days of consecutive abstinence from MA or perfect attendance at treatment sessions) can help encourage and reward these difficult changes. These incentives, such as movie tickets, gift certificates, restaurant coupons, can promote behavior changes and provide positive reinforcement for treatment progress.

Involve family members in treatment activities. Family members who are well informed about addiction and who participate in treatment activities can greatly improve the success of treatment for the addicted individual. Family therapy and couples therapy provide appropriate help and support for involving family members in the recovery process.

Encourage participation in recovery support groups. Alcoholics Anonymous (AA) and other 12-step self-help groups (Narcotics Anonymous, Cocaine Anonymous, etc.) are extremely valuable support systems for recovering individuals.

Several behavioral treatments, including the following, have been evaluated for MA dependence in multi-site controlled, randomized clinical trials and have shown evidence of efficacy:

The Matrix Model is a structured behavioral therapy for MA dependence that has been proven effective in a large randomized clinical trial (Rawson et al., 2004). The Matrix Model incorporates principles of social learning, cognitive behavioral therapy (CBT), family education, motivational interviewing, and 12-step program involvement. The Model has been adapted and evaluated for subgroups of MA abusers, gay and bisexual men (Shoptaw et al., 2005); and Native Americans, (Obert et al., 2006).

Contingency management (CM) entails provision of reinforcements/rewards for desired behaviors or performance (e.g., a drug-free urine test). Roll et al., 2006, have recently conducted a multi-site clinical trial in which a CM protocol was evaluated when added to an outpatient MA treatment program. Participants in the CM group demonstrated a superior clinical performance on multiple outcome measures (number of MA-negative urine samples, number of consecutive weeks of abstinence, percent who completed the trial with continual abstinence).

Medications for MA Abuse and Dependence

Efforts to develop and evaluate medications that may be useful in recovery from MA dependence have been underway for a decade. At present, bupropion (Wellbutrin®) and modafinil (Provigil®) have exhibited some potential as adjuncts to behavioral therapy in treating MA dependence. Other medications (e.g., gabapentin, lobeline, vigabatrin, ondansetron) are under consideration, but evidence for efficacy is lacking.

SPECIAL POPULATION TREATMENT CONSIDERATIONS

Women and Treatment for Methamphetamine

Due to the extensive MA use among women, treatment tailored to the specific needs of women is highly warranted. The following issues are important to consider when treating methamphetamine-addicted women:

- History of sexual abuse, physical abuse, and trauma;
- Mental health issues (e.g., depression, anxiety, paranoia, emotional disassociation, verbal communication difficulty, and hyper-sexuality);
- Relationship issues (e.g., risky sexual behaviors, domestic violence);
- Pregnancy and parenting problems; contact with child welfare system;
- Medical issues (e.g., dental problems, weight loss, skin problems).

Treatment programming for female MA users should incorporate therapy and information that can effectively assist with this array of clinical issues.

Adolescents and Treatment for Methamphetamine

It is important to note that adolescent MA users had significantly higher levels of psychosocial dysfunction, such as depression, auditory hallucinations, suicidal ideation, problems in school, criminal activity, and greater exposure to violent and abusive behavior as opposed to adolescents not using MA. At present there is not enough research to make empirically based recommendations about the unique treatment needs of MA using adolescents. However, principles of effective adolescent treatment (SAMHSA-CSAT TIP No. 32, "Treatment of Adolescents with Substance Abuse Disorders," CSAT, 1999) provides the current best guide for the treatment of MA-using adolescents.

Treating Methamphetamine Users Within the MSM Population

Higher levels of MA use are associated with higher incidents of HIV infection among the MSM population. When considering the best practices for treating MA users within the MSM population, it is important to assess at what point to intervene (i.e., occasional users vs. recreational users vs. dependent users) as well as the intensity of the intervention (i.e., social marketing vs. health education/risk reduction, outpatient treatment vs. residential treatment). Research suggests that infrequent users of MA may respond to lower cost interventions such as social marketing or street outreach, while MA-dependent MSM may require higher cost interventions such as outpatient or residential treatment. Low intensity programs that target occasional and recreational MA users, typically offer brief HIV and substance abuse interventions and referrals to needed medical, psychiatric, and social services. More intensive interventions employ contingency management for increasing pro-social and healthy behavior and reducing substance abuse among non-treatment seeking MSM substance users. LA Behavioral Men's Survey data indicated MA use was associated with new HIV infections among Latinos regardless of level of MA use. MSM, in general, have high exposure to HIV infection as compared to the overall population. This is an important thing to note because when an MSM does MA and engages in high risk sexual activity the risk of contracting HIV is much higher than among the general population.

The intervention level of intensity increases for MSM who are seeking outpatient treatment for their MA use. Shoptaw et al. (2005) found that CM and CM in combination with CBT are more effective in increasing retention rates and decreasing MA use (as evidenced by urinalysis) among MSM than CBT alone. CBT fosters the development of skills that decrease the likelihood of relapse. Additionally, a culturally relevant, gay-specific HIV risk reduction intervention that incorporated principles of CBT for reducing MA use and high-risk sexual behaviors (i.e. gay-specific cognitive behavioral therapy

[GCBT]), was significantly more effective at reducing HIV sexual risks, specifically unprotected receptive anal intercourse, compared to a standard CBT condition (Shoptaw et al., 2005).

Some issues to keep in mind when treating the methamphetamine-addicted MSM population are:

- Interventions and treatment techniques should use gay referents to make concepts more culturally relevant;
- The strong link between sex and MA use will require addressing both issues – MA use and sex (particularly high risk for HIV/STDs sexual behaviors);
- Triggers may include many of the triggers reported by others who use MA (e.g., presence of MA) as well as other triggers such as holidays (e.g., Halloween,) and cultural events (e.g., Gay Pride Day, circuit parties);
- When discussing sexual behaviors and ways to decrease/cease unsafe behaviors, references to sexual behaviors engaged in when on MA and when sober should be discussed;
- The recognition that revealing a drug problem is similar to the coming–out process (Shoptaw et al., 2005).

Finally, for MA-using MSM who require a higher level of treatment than outpatient services, a residential treatment may be required. Together, the programs/ studies provide a continuum of interventions from street-based outreach programs to venue-based risk reduction/ health education to outpatient drug treatment to inpatient drug treatment. Additionally, based on Semple et al.'s (2006) research, identifying certain personality characteristics such as high sexual compulsivity among MSM could help to target that particular population with therapeutic approaches that couple CM and CBT with techniques for treating sexual compulsivity.

LIMITATIONS OF THE REPORT

The primary data sources for the data in this report were from treatment admission data provided by the Los Angeles County Department of Alcohol and Drug Programs. Additional data were provided from a number of surveys conducted by other LA County Health Department groups, by researchers in specific research reports, the LA County Sherriff's office and the Office of Alcohol and Drug Programs for the State of California. These data provide an incomplete picture of the impact of MA on LA County. The existing, accessible data suggest that MA is a substantial public health problem in LA County. However, due to data limitations, the full impact of this problem cannot be completely assessed.

SUMMARY

Methamphetamine has become a substantial public health problem and has created tremendous strain on the criminal justice and social service systems in Los Angeles County. There are particular groups (women, adolescents, MSM) that have been severely impacted by these problems. Prevention activities need to target these high risk groups using sound prevention strategies. Treatment for MA dependent individuals is effective and can be made more effective through use of empirically supported treatment methods.

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METHAMPHETAMINE USE, PREVENTION, AND INTERVENTION

GOALS AND OBJECTIVES

Goal 1: Strengthen the DPH response to the methamphetamine epidemic.

Objective: Expand and enhance collaborative efforts to reduce the consequences of methamphetamine abuse.

Action Steps	Responsible Office	Scheduled Completion Date
Expand Meth Work Group to include additional representatives from community advocates such as Act Now Against Methamphetamine; other County offices, including the Department of Mental Health and Office of Education; and County-contracted service providers serving at-risk populations such as women, adolescents, and Men who have Sex with Men (MSM).	DPH-ADPA	12/19/2006 (Completed)
Provide recommendation to the California Department of Alcohol and Drug Programs urging the State to include specific messages targeting at-risk populations such as women, adolescents, and MSM in its social marketing campaign.	DPH-ADPA	06/30/07
Work with medical associations to inform their members about issues related to methamphetamine use and abuse, including patient screening, assessment, and referral services. Activities should include: - Identifying medical associations that will be included in this effort; - Providing methamphetamine-specific information to members through mailers. - Arranging to present methamphetamine-specific information during associations' membership meetings.	DPH Meth Work Group	09/30/07

METHAMPHETAMINE USE, PREVENTION, AND INTERVENTION

GOALS AND OBJECTIVES

Goal 2: Prevent or decrease methamphetamine use among specific populations.

Objective: Develop and implement prevention and treatment strategies aimed at enhancing services for methamphetamine-using specific populations.

Action Steps	Responsible Office	Scheduled Completion Date
Require contracted community-based agencies to implement strategies aimed at enhancing prevention and treatment activities for at-risk populations such as women, adolescents, and MSM.	DPH-ADPA	06/30/07
Meet with Director of the Department of Health Services (DHS) to submit a proposal for DPH to provide methamphetamine-specific information to physicians at County hospitals and clinics. The information will assist the physicians in recognizing the signs and symptoms of methamphetamine use, and determining the level of risk for sexual trauma, HIV, and other STDs for those patients accessing County medical services.	DPH/DMH/DHS	06/30/07
Provide training to selected DPH-ADPA contracted substance abuse treatment providers on:	DPH-ADPA	09/30/07
- "Best practices" treatment approaches including motivational interviewing, contingency management, and cognitive behavioral therapy; and the application of strategies to enhance treatment engagement and retention		02/08/07 02/15/07 02/22/07 03/07/07
- Trauma-informed treatment approaches for women.		09/30/07
- Adolescent protocols developed by the Substance Abuse and Mental Health Services Administration (e.g., Motivational Enhancement Therapy – Cognitive Behavioral Therapy [MET-CBT]). These protocols, and accurate MA information should be integrated into adolescent treatment programs.		09/2006 (Additional training to be provided)
- Emphasis on methamphetamine use and related sexual behavior and injection drug use for men who have sex with men.		09/30/07

METHAMPHETAMINE USE, PREVENTION, AND INTERVENTION

GOALS AND OBJECTIVES

Work with the County Board of Education in developing a plan for obtaining agreement from school districts to promote and support methamphetamine education for teachers, parents, and students.	DPH Meth Work Group	12/31/07

Goal 3: Enhance data collection processes to capture methamphetamine abuse prevalence and incidence rates, monitor trends in at-risk populations, and use these data to develop an appropriate public health response.

Objective: Improve data collection and distribution methods/instruments across participating County offices and community service providers in order to have appropriate and accurate methamphetamine prevalence and incident rates for individuals receiving County funded services, to monitor trends in at-risk populations, and to use data to best align services.

Action Steps	Responsible Office	Scheduled Completion Date
Identify data to be collected to ensure the following information about methamphetamine use is captured among at-risk populations: - Women: History of sexual abuse, physical abuse, and trauma; mental health issues; medical issues (dental problems, weight loss, skin problems) - MSM: Sexual behaviors; mental health issues; medical issues. Provide recommendations to DPH.	DPH Meth Work Group	09/3/07
Revise data collection instruments and coordinate data collection procedures to facilitate analysis of data for at-risk populations.	DPH-ADPA, OAPP, STD DMH	09/30/07
Analyze methamphetamine prevalence rates, incidence rates, and trends in at-risk populations and use information to develop appropriate public health response.	DPH-ADPA, OAPP, STD DMH	12/31/07
Develop recommendations for collecting data about the extent at which MSMs are accessing County-funded treatment services from DPH-ADPA, OAPP, STD and DMH. Recommendations should include use of data to evaluate the need for additional outreach and service development.	DPH Meth Work Group	12/31/07

METHAMPHETAMINE USE, PREVENTION, AND INTERVENTION

GOALS AND OBJECTIVES

Goal 4: Improve access to services for at-risk populations.

Objective: Strengthen linkages between mental health, substance abuse, social services, and the criminal justice system that provide services to populations at risk for methamphetamine use, and integrate services where possible.

Action Steps	Responsible Office	Scheduled Completion Date
Identify existing resources and funding for services to people suffering from mental health and substance abuse problems (also called co-occurring disorders).	DPH-ADPA, OAPP, STD DMH	06/30/07
Review and revise screening and intake procedures to better identify people with co-occurring disorders.	DPH-ADPA, OAPP, STD	09/30/07
Review and revise screening and intake procedures to better identify people who may be engaging in high-risk sexual behavior.	DPH-ADPA, OAPP, STD	09/30/07
Train staff at DPH contracted screening and referral locations for recognition of at-risk behavior and referral to DPH-contracted agencies serving the specific population.	DPH-ADPA, OAPP, STD	09/30/07

Goal 5: Secure funding for prevention/education, treatment, and research.

Objective: Increase efforts to secure additional funding for education, treatment, and research in addressing the methamphetamine problem.

Action Steps	Responsible Office	Scheduled Completion Date
Continue to work with the State Department of Alcohol and Drug Program and other federal agencies in identifying new funding for prevention/education, treatment, and research.	DPH-ADPA	Ongoing
Disseminate funding opportunities to interested parties via the Meth ListServ and other appropriate forms of communication.	DPH-ADPA	Ongoing

COUNTY OF LOS ANGELES
RESOURCES TO ADDRESS THE METHAMPHETAMINE EPIDEMIC

Attachment 3

Department		Estimate of Funds Spent Annually	Notes	Source of Funds: Feds	State	NCC	Funding Restrictions	Services provided directly or through contracts? How many contractors?	Estimated # of people directly served through this program
DCFS	Treatment	$3,200,000	A	100%			Services are only for families who have a child/children in placement 15 months or less and are not eligible for funding under another source	MOU with DPH	Funding privides for a maximum of 3,869 assessments and approximately 96 residential beds and 99 outpatient slots
DCFS		$1,400,000		Title IV-B 75%	Title IV-B 17.5%	Title IV-B 7.5%	Title IV-B Restrictions	One contracted vendor for D/A Testing	Approximately 1,700 to 2,000 clients testing monthly
MH	10% Prevention/ 90% Intervention	$100,000,000	B	60%	25%	15%	*Funding is restricted to serving those individuals with a primary mental illness. Funding may dictate specific population to be served i.e., Medical, Medicare Calworks, HIV/AIDS etc.	Directly and thru 130 contractors	40% of those persons served within the County mental health system of care are estimated to have COD.
DPSS	Intervention	$7,588,500.00	A,C			X	Existing NCC Expenditure. Restrictions Condition of aid-If the individual declares or is observed a drug or substance abuse related behavior they must be referred to assessment.	DPSS has an MOU with DPH who subcontracts with 62 providers and 88 treatment centers	For FY 05/06--11,370 people were assessed and 8,122 received treatment
DPSS	Intervention	$18,500,000	A,D		X		Funds must be spent during the FY in which they are allocated. Funds come from State Allocation intended for CalWORKs participants to overcome employment barriers.	DPSS has an MOU with DPH. DPH contracts out with various local providers.	Approximatel 450 to 500 participants per month.

COUNTY OF LOS ANGELES
RESOURCES TO ADDRESS THE METHAMPHETAMINE EPIDEMIC

Attachment 3

Department		Estimate of Funds Spent Annually	Notes	Source of Funds: Feds	State	NCC	Funding Restrictions	Services provided directly or through contracts? How many contractors?	Estimated # of people directly served through this program
Sheriff-California Multi-Jurisdictional Methamphetamine Enforcement Team (Cal-NMET)	Enforcement	$1,655,000			x		N/A	0	Countywide (i.e., approximately 10 million people served)
Sheriff-Community Oriented Multi-Agency Narcotics Enforcemtn Team (COMNET)	Enforcement	$1,670,000				x	N/A	0	Countywide (i.e., approximately 10 million people served)
PH	Prevention	$ 3,913,062		x		x	Funding source may dictate specific population, area, or use; e.g., Latinos, media campaign, South Los Angeles, etc.	57	Not available. Prevention programs target communities and do not provide services to individuals.
PH	Intervention/ Treatment	$ 42,502,218		x	x	x	Funding source may dictate specific population to serve, e.g., Drug/Medi-Cal recipients, Proposition 36 clients, General Relief/CalWORKs clients, etc.	196	47,721
PH	Prevention	$205,000	E	X			All funding for OAPP prevention programs must focus on HIV prevention	Through APLA	1. Group Sessions for MSM Crystal Meth Users. 2. Group Sessions for Social Affiliates of Meth Users. 3. Community Level Intervention (forums)

COUNTY OF LOS ANGELES
RESOURCES TO ADDRESS THE METHAMPHETAMINE EPIDEMIC

Attachment 3

Department		Estimate of Funds Spent Annually	Notes	Source of Funds: Feds	Source of Funds: State	Source of Funds: NCC	Funding Restrictions	Services provided directly or through contracts? How many contractors?	Estimated # of people directly served through this program
PH	Intervention	$2,587,900	F	X			All funding for OAPP Care programs must be provided to HIV positive Individuals	Services provided directly through 10 contractors	Annually, 687 Clients receive Substance Abuse Services through Day Treatment, Detoxification, Residential Rehabilitation and Transitional Living Services.
PH	Intervention/ Research	$225,000		X			All funding for OAPP Care programs must be provided to HIV positive Individuals	PI: Van Ness Recovery House Prevention Division. Partners: UCLA/OAPP	One of four national grantees for a research intervention targeting out of treatment, meth using MSM
PH	Prevention	$80,000			X		All funding for OAPP prevention programs must focus on HIV prevention	Through CA Drug Consultants	MSM Crystal Meth Users. Outreach: 61, Services: 20, Group: 40
PH	Prevention	$150,000		X			All funding for OAPP prevention programs must focus on HIV prevention	Through LAGLC	MSM, MSM/W Crystal Meth Users. Outreach: 144, Open Group: 96, Closed Group: 40, ILI: 75
PH	Prevention	$100,000		X			All funding for OAPP prevention programs must focus on HIV prevention	Through CSULB	Project Respect, MSM Crystal Meth Users. Outreach: 300, Services: 96, ILI: 48
PH	Prevention	$220,000		X			All funding for OAPP prevention programs must focus on HIV prevention	Through VNPD	Evidence-based Behavioral Therapy. MSM Meth Users: 48

Total Resources **$151,383,180**

COUNTY OF LOS ANGELES
RESOURCES TO ADDRESS THE METHAMPHETAMINE EPIDEMIC

Attachment 3

Department	Estimate of Funds Spent Annually	Notes	Source of Funds: Feds	State	NCC	Funding Restrictions	Services provided directly or through contracts? How many contractors?	Estimated # of people directly served through this program
A	Not included in the Total Resources shown, because these are Included in PH-ADPA funding. DCFS and DPSS subcontracts with PH-ADPA to provide substance abuse services.							
B	Funds spent annually on primary mental health servises for persons with Co-Occurring Substance abuse (COD)							
C	Funds spent annually on primary mental health servises for persons with Co-Occurring Substance abuse (COD)							
D	MSARP Information applies to all Alcohol/Drug problems and not specifically to Methamphetamine use.							
E	2005-2006 Existing Program: $145,000 Augmentation (pending Board approval) for additional: $60,000							
F	Two funding sources: Ryan White Title I: $2,070,743. CSAT- Center for Substance Abuse Treatment (SAMHSA): $517,157.							