



# FACT SHEET

## METHAMPHETAMINE USERS IN TREATMENT

The treatment data in this fact sheet are based on admissions and discharges from publicly funded/or monitored treatment services in California during State Fiscal Year (SFY) 2009/10 as reported in the California Outcome Measurement System-Treatment (CalOMS-Tx) unless otherwise noted. For additional information on CalOMS-Tx data collection, refer to the CalOMS-Tx Data Collection Guide or the CalOMS-Tx Data Dictionary, available on the CalOMS-Tx web page: <http://www.adp.ca.gov/CalOMS/CalOMSmmain.shtml>.

*This fact sheet provides information about methamphetamine users who received treatment in California.*

### Background<sup>1</sup>

- Methamphetamine is a highly addictive central nervous system stimulant. The drug produces a state of increased energy, suppresses appetite, and elevates mood. Negative short-term effects include rapid/irregular heartbeat and elevated body temperature.
- Methamphetamine is classified as a Schedule II stimulant which means it has a high potential for addiction and is available only through a prescription. However, the drug is easily made in clandestine laboratories using inexpensive over-the-counter ingredients such as ephedrine or pseudoephedrine.
- Methamphetamine is a white, odorless, bitter-tasting crystalline powder that is easily dissolved in water or alcohol. It comes in pill form, capsules, powder, and chunks. Some street names for

methamphetamine are “speed”, “meth”, and “chalk”. “Ice” refers to the crystallized chunk form.

- The drug can be smoked, snorted, injected or taken orally. Smoking methamphetamine leads to very fast uptake of the drug in the brain. The effects are stronger and longer lasting compared to the other methods.
- Prolonged use of methamphetamine can lead to addiction, psychosis (e.g., paranoia, hallucinations, and delusions), as well as changes in the structure and functioning of the brain. Also, the increased risk of stroke from methamphetamine abuse can lead to irreversible damage to the brain.

### Treatment Data Collection

The data used for this fact sheet are based on client admissions and discharges, not unique client counts. A client may receive treatment for several service types or receive treatment for one particular service type multiple times. A client is counted each time he/she is admitted to or

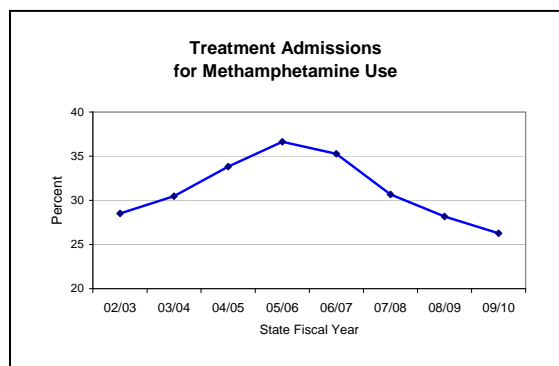
discharged from a treatment service during the reporting period.

Admissions/discharges are for outpatient, residential and detoxification services.

Detoxification by itself does not constitute complete substance abuse treatment. This service type is considered a precursor to treatment for the physiological effects of stopping alcohol or other drug use. It is short term (usually less than a week) and is often repeated numerous times. Including detoxification services in treatment data could bias the client characteristics and other treatment statistics if a large percentage of clients receive these services. However in SFY 2009/10, only 8% of clients received detoxification services for methamphetamine use. Therefore detoxification services are included in the admission and discharge data presented in this fact sheet.

### Trends in Methamphetamine Treatment

The chart below shows the trend in annual methamphetamine admissions over the past eight years. Data from the California Alcohol and Drug Data System (CADDSS) were used from SFY 2002/03 through SFY 2005/06 until CalOMS-Tx was implemented in SFY 2006/07. Methamphetamine admissions peaked in SFY 2005/06 and in SFY 2009/10 they declined to the lowest level in eight years.



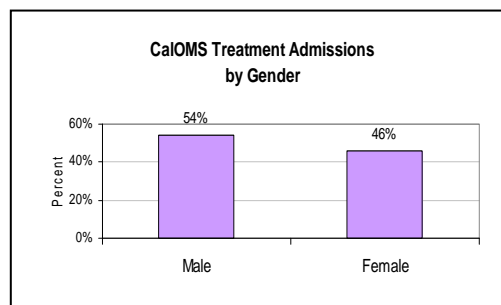
Despite the decrease in the percentage of methamphetamine admissions over the past four years, it is still the most commonly reported primary drug in publicly funded/and or monitored treatment programs in California. Admissions with methamphetamine as the primary drug make up 26% of the total 187,526 admissions in SFY 2009/10.

### Admission Statistics

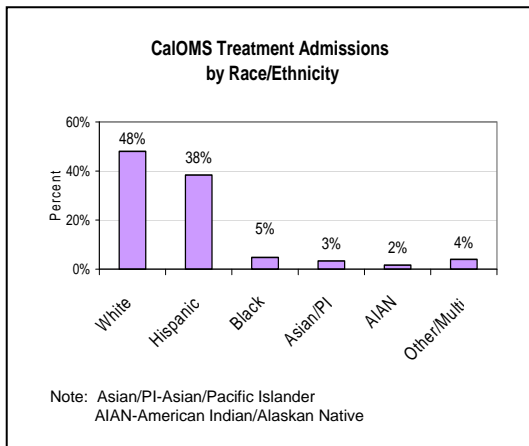
The following information displays data about the 49,268 admissions for clients that entered treatment during SFY 2009/10 for methamphetamine use. Only treatment admissions where the primary drug was methamphetamine are included in this analysis. Percentages may not add to 100% due to rounding.

### Demographic and Other Client Characteristics

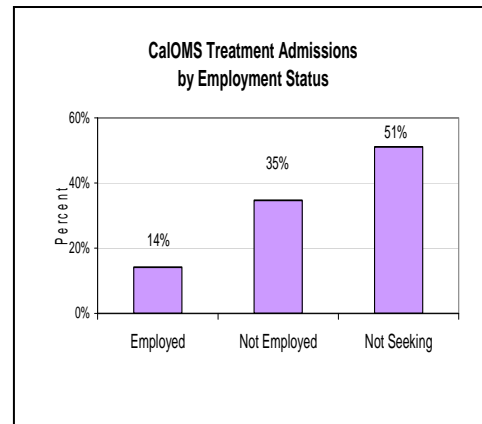
- As shown in the chart below, more males (54%) received treatment services than females (46%). Clients who identified their gender as "other" are not included in this chart.



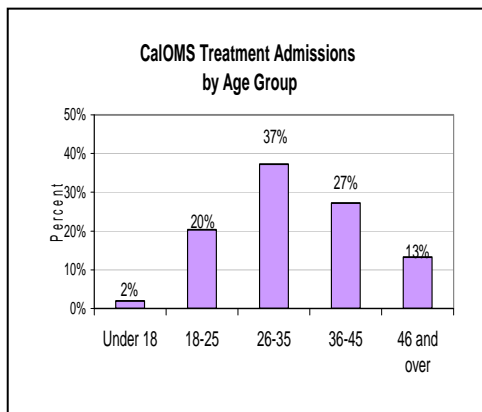
- Whites (48%) made up the largest proportion of clients admitted into treatment followed by Hispanics (38%). Admissions for all other races and multiple races made up the remaining 14%.



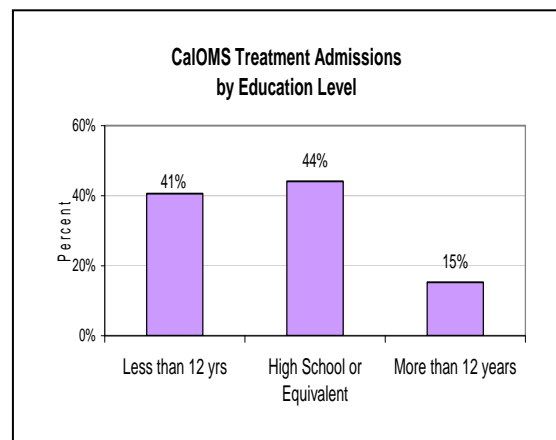
- The majority of clients were not seeking employment (51%). This includes persons not currently employed who retired, were disabled or were never in the labor force. Thirty-five percent of the clients were unemployed but looking for work. Only 14% were employed full-or part-time.



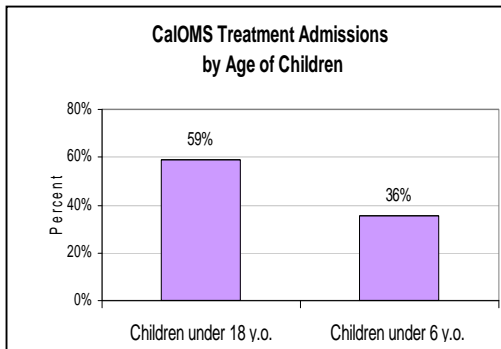
- Clients between 26 to 35 years of age made up the largest proportion (37%) of treatment admissions. Those between 36 to 45 years of age made up the second largest group (27%), followed by 18-25 year olds (20%).



- 44% of the clients admitted into treatment completed high school or an equivalent. Another 41% had less than 12 years of education.

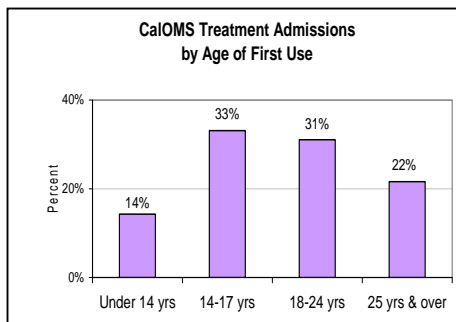


- Almost 60% of the clients admitted into treatment had children under 18 years of age. These children may or may not have lived with the client. About 36% of the clients had children who were younger than 6 years of age.

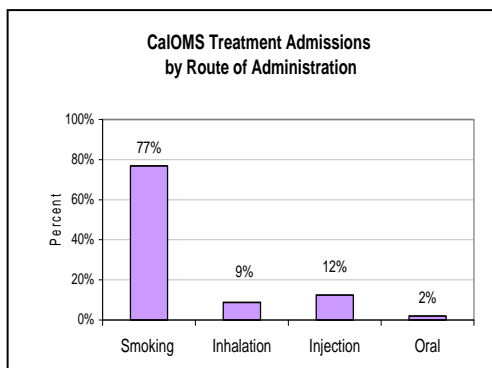


**Substance Use and Treatment Characteristics**

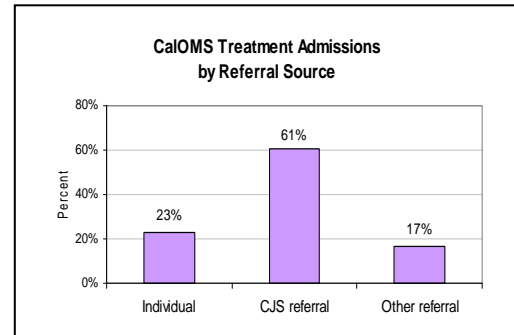
47% of the clients admitted into treatment used methamphetamine for the first time before the age of 18.



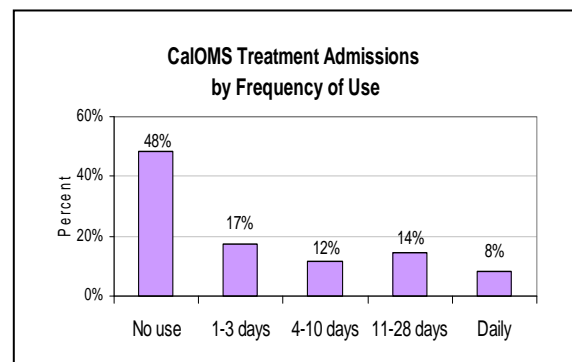
- More than three-fourths of the clients (77%) admitted into treatment smoked methamphetamine.



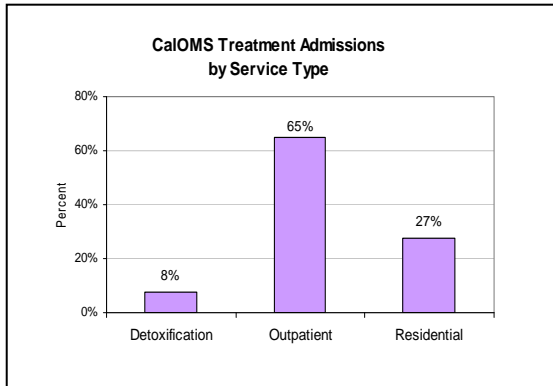
- The majority of clients (61%) admitted into treatment for methamphetamine use were referred by the criminal justice system, either by a court order or as a condition of parole.



Most of the clients (48%) admitted into treatment reported no use of methamphetamine in the 30 days prior to admission. This is reasonable as most admissions were referred by the criminal justice system where clients were in a controlled environment (e.g. jail, prison) where drugs are not allowed.



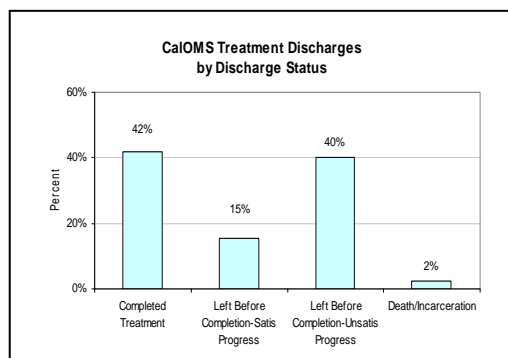
- Nearly two-thirds of the clients (65%) received outpatient services while 27% received residential services for methamphetamine treatment.



### Discharge Statistics

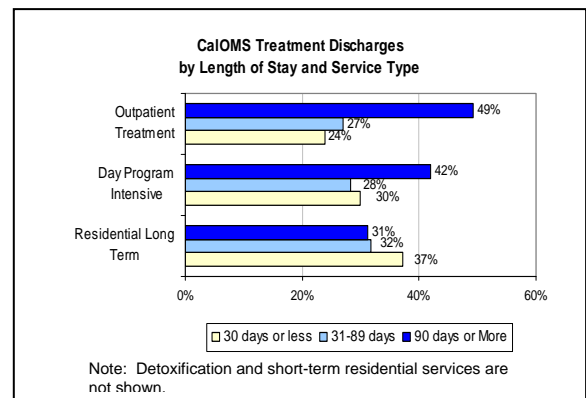
Discharge information is collected at the point when a client leaves the treatment service into which he/she was admitted. As with treatment admissions, clients are counted each time they are discharged from a treatment service during the fiscal year. In SFY 2009/10 there were 48,575 discharges from methamphetamine treatment.

- 42% of the clients who were discharged from treatment completed their treatment/recovery plan. Another 15% left before completing treatment, but made satisfactory progress.



- Research shows that longer treatment stays are associated with positive outcomes. However, time in treatment varies by type of service and client needs and some treatment services have time limitations. For example, Day Program Intensive services are limited to 365 days.

The following chart shows treatment duration for various service types that exceed 30 days. The chart excludes detoxification and short-term residential services where 100% of the stays are for 30 days or less. Clients who received outpatient and day program intensive services had the highest percentage of stays lasting 90 days or more (49% and 42%, respectively). 37% of clients receiving long-term residential services stayed 30 days or less.



Although treatment duration is shown here by service type, it is the total time in treatment that is important. Treatment frequently includes multiple types of treatment services starting with more intensive, costly services and then transferring to less intensive services. For example, clients who satisfactorily complete residential services are often referred to outpatient services. This explains why fewer clients stay in residential treatment services for 90 days or more compared with outpatient treatment services.

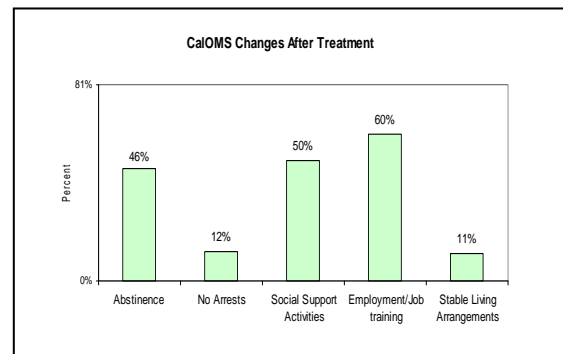
## Changes after Treatment

The outcome information presented in this section show how treatment has affected various aspects of a client's life (e.g., drug use, employment, arrests, etc.). Data on client functioning are collected at admission and discharge. The results of all matched admission-discharge records are then combined and the percentage change in client functioning is calculated. A total of 26,544 records are included in the outcomes analysis.

Detoxification services are excluded from these outcomes analyses as this service type is short-term and considered a precursor to treatment designed to treat the physiological effects of stopping drug use. Also, some clients with a discharge status of "Left before Completion" may not have answered the outcome questions at discharge and are excluded from these outcomes analyses. Finally, outcome data were not collected from clients who were incarcerated or died. The missing data from these clients may result in a bias in the results towards favorable outcomes. ADP is working with stakeholders to increase reporting of the data used for client outcome measurement.

The time span for the questions on frequency of use, arrests, and social support activities is during the past 30 days. The current situation applies to the questions on employment/ job training and living arrangements.

The following chart and bullets highlight changes seen in several areas of clients' lives, their families and communities.



- The largest change (60%) in client functioning is an increase in employment/job training. This includes part- or full-time employment or enrollment in a job training program.
- A positive change (50%) is also seen in the participation in social recovery activities such as 12-step or other self-help programs. Research indicates that these social support groups help to achieve and maintain abstinence and other healthy behaviors during and after treatment.
- There is a 46% increase in abstinence despite a high level of no drug use reported at admission (see 4<sup>th</sup> bullet on page 4). When abstinence levels are reported as high at the start, it is more difficult to effect change.
- Modest positive changes are seen in having no arrests (12%) and living in a stable environment (11%). A stable living environment is where a client lives in a home or apartment, and contributes financially to the cost of their living.

<sup>1</sup> Methamphetamine Abuse and Addiction, National Institute on Drug Abuse Research Report Series, September 2006.