Methamphetamine Environmental Scan Summit

November 28, 2002
Delta Airport Hotel
Richmond, British Columbia

Canadian Community Epidemiology
Network on Drug Use – Vancouver Site

and

Addictive Drug Information Council (ADIC)

Final Report
January 2003

Contents

Executive Summary

This report was developed following the *Methamphetamine Environmental Scan Summit* hosted by the Canadian Community Epidemiology Network on Drug Use (Vancouver site) on November 28, 2002 in Richmond, British Columbia. It highlights what is known about methamphetamine use in British Columbia, describes key issues related to methamphetamine use, and concludes with a summary of areas of action and specific recommendations to address methamphetamine use.

Methamphetamine (MA) is a synthetic central nervous system stimulant also known as crystal, meth, ice, jib, and speed. Although there is no collection of information or reporting system that would allow for the accurate estimation of patterns of MA use, treatment, and production in BC, delegates at the summit described MA as a drug that has moved beyond rave culture and into mainstream society. Summit participants described the diverse populations and contexts in which they saw MA use occurring. These included recreational use, unintentional poly-drug use (ecstasy is often adulterated with MA), street use, and workplace use. Summit participants reported methamphetamine use to be of particular concern for youth.
In a treatment setting, participants reported an increase in youth who are using or have tried MA. Although reasons for use vary, summit participants described some of the factors they felt were driving the increased use of MA. These factors include easy availability, low cost, lack of stigma associated with use, and the specific effects of the drug (i.e., long high, increased energy, improved body image). This report also outlines the short- and long-term effects of MA for the user and the potential consequences of MA use for the user, the family and friends of the user, and for communities and society at large.

The primary goals of the summit were to quantify the MA problem in BC and to develop a strategy to address methamphetamine use. Recommendations proposed by summit participants focused both on better utilization of available resources and development of new strategies. The summit resulted in the formation of a coordinating body, the Methamphetamine Response Committee (MARC), and the development of working groups to move these recommendations forward.

Acknowledgements

Appreciation goes to the Summit Organizing Committee: Jane Buxton, Ian Martin, Betsy MacKenzie, and Scott Rintoul. Special thanks to our morning speakers: Tom Hetherington, Ian Martin, Theo Rosenfeld, Wayne K. Jeffery, and the King County Meth Action Team.

The *Methamphetamine Environmental Scan Summit* would not have been possible without the assistance and contribution of the following organizations:

Addictive Drug Information Council (ADIC)
Canadian Community Epidemiology Network on Drug Use (CCENDU)
City of Vancouver
Health Canada
RCMP Drug Awareness Service (Vancouver)
Vancouver Coastal Health Authority

Report prepared by Tasnim Nathoo. Additional copies of this report can be downloaded from the Canadian Centre on Substance Abuse web site at http://www.ccsa.ca.

Lastly, we would like to thank all of the summit participants who generously donated their time, energy, and ideas.

Introduction

This document was developed following the *Methamphetamine Environmental Scan Summit* hosted by the Canadian Community Epidemiology Network on Drug Use (Vancouver site) on November 28, 2002 in Richmond, British Columbia. This document highlights what is known about methamphetamine use in British Columbia, describes key issues related to methamphetamine use, and concludes with a discussion of priorities and areas of action to address methamphetamine use. It also is intended to be a resource for individuals working in areas related to methamphetamine use and includes a list of summit participants to facilitate the networking and discussion that began at the summit.

The need for a summit on methamphetamine use became apparent earlier this year at the Vancouver CCENDU meeting in September. It was noted by a physician at the Three Bridges Community Health Centre that he and his colleagues were seeing an increasing number of patients with methamphetamine-related problems. In addition, a member of the Vancouver RCMP Drug Awareness Service mentioned that the RCMP had seen an increase in the presence of methamphetamines in the analysis of drugs confiscated by the RCMP at raves, in clubs, and on the street. An attempt to quantify the extent of the problem by contacting emergency rooms, ambulance control, and laboratories performing drug screens found that, in most instances, the information was either not recorded or coded, had to be extracted manually in text format, or were no longer part of the standard drug screen. Although anecdotal evidence suggested that methamphetamine use was a growing concern, it soon became clear that no one had a clear grasp of the size of the methamphetamine problem in the Lower Mainland and surrounding areas.

The *Methamphetamine Environmental Scan Summit* brought together over 120 individuals from a range of backgrounds. Delegates at the summit included physicians, nurses, youth workers, counselors, advocates, social workers, first responders, local politicians and representatives from the RCMP, school boards, public health, non-profit groups, and provincial and federal governments.

Drawing upon the experience and knowledge of the delegates, the primary objectives of the summit were to collectively define and answer the following questions:

- *What is the extent of the methamphetamine problem in British Columbia?*
- *What is driving methamphetamine use and what are the consequences of methamphetamine use?*
- *What should we, and what can we, do about the problem? And how do we do it?*

The format of the summit involved opening presentations by Dr. Ian Martin of the Three Bridges Community Health Centre, Wayne K. Jeffery from the RCMP Forensic Laboratory, Tom Hetherington of Pacific Community Resources Society, Theo Rosenfeld of Pala Community Development and a video presentation describing the King County Meth Action Team (the full agenda can be found in Appendix B). These opening

presentations were followed by morning and afternoon breakout sessions and group discussions in the following areas:

- current trends in the use of methamphetamines
- the direct and indirect costs associated with methamphetamine use and production
- the supports, resources, and strategies currently available to address methamphetamine use
- the types of actions that could be undertaken, both collectively and individually at each delegate's respective organizations, to address concerns and issues related to methamphetamine use and production

Through this process participants identified a range of key issues related to methamphetamine use and collectively identified priority areas comprised of key recommendations (see Appendix A).

In this document, we draw upon available statistics, research on methamphetamine use, and the insights and experience of the summit delegates to highlight what is known about methamphetamine use and production in the British Columbian context. We describe the areas of priority identified by the delegates and the recommendations and ideas generated throughout the summit. The summit also resulted in the development of several working groups (see Appendix F), consisting of individuals who have volunteered to be involved in moving these recommendations forward. This document is intended to be a resource for individuals working to address issues related to methamphetamine use at their respective organizations and also provides a foundation from which the working groups can move forward.

Overview of Methamphetamine Use in British Columbia

History and Background

Methamphetamine (MA), also known as meth, crystal, ice, jib, and speed, is a derivative of amphetamine. Although first synthesized in the late 1880s, MA was not extensively studied until the 1930s and did not become widely used until the 1940s. During World War II, Japan, Germany, and the United States provided the drug to military personnel to increase endurance and performance. It was later prescribed to treat depression, obesity, and as a treatment for heroin addiction. During the 1960s, illicit MA laboratories emerged in the San Francisco area and the use of MA spread up and down the Pacific Coast of the United States (Anglin, Burke et al. 2000).

In the 1980s, a new and simpler method of MA production was developed and a different and more potent form of MA, d-methamphetamine hydrochloride (crystal meth, or "ice," is a crystallized, smokeable form of MA), became available. In the United States, the MA problem is no longer limited to the West Coast and its user population has broadened to include people from all walks of society. Worldwide, the World Health Organization estimates that there are more than 35 million users of amphetamine and

methamphetamine, making amphetamine and MA the most widely used illicit drugs in the world after cannabis (World Health Organization 1997). The UN Office for Drug Control and Prevention (United Nations Office for Drug Control and Crime Prevention 2000) estimates that there are more users of amphetamine/MA worldwide than users of heroin and cocaine combined.

Although there are numerous studies describing the use, prevalence and spread of MA in the United States, there is much less information available on MA use in Canada. In this document we begin by presenting an overview of the trends and patterns of MA use and production in BC. Currently, there is no information, collection and reporting system that would allow for the accurate estimation of patterns of MA use, treatment, and production in BC and these data limitations make it impossible to provide a comprehensive overview of MA use. This documents draws upon the insights and experiences of the delegates at the *Methamphetamine Environmental Scan Summit* as well as available published data and statistics generously provided by summit delegates from their respective organizations to provide an overview of the issues related to MA use.

Trends in MA Use

Participants at the summit described MA as a drug that has moved beyond rave culture and into mainstream society. Participants reported that while MA remains a popular recreational drug, users of MA have expanded to include a wide range of groups, including high school students, street youth, professionals, the gay/bisexual/lesbian/transgendered (GLBT) population, and young mothers.

Although MA use is a problem that faces people from all walks of life, summit participants saw MA use (and the greatest possibilities for abuse) as an issue facing youth in particular. Summit participants working with youth described MA as being the "drug of choice" for many youth.

Survey data in Canadian settings indicate that drug use in general (including MA), is increasing among

What is Methamphetamine (MA)?

- Methamphetamine (MA) is also called crystal, meth, jib, speed, teck, glass, ice, peanut butter, and shards
- MA is a synthetic central nervous stimulant that produces intoxication through increased stimulation of dopamine, serotonin, and norepinephrine receptors in the brain
- MA can be swallowed, smoked, injected or snorted and its effects can last anywhere from 2 to 16 hours depending on the purity and form of use
- MA provides similar feelings as cocaine, but it is metabolized at a slower rate and its effects can last for days
- MA provides a sense of alertness, euphoria, and a feeling of endless energy
- MA is found in different forms, i.e., off-white transparent powder, brown granules, or crystals
- MA is usually sold in paper flaps, plastic baggies, tablets or capsule form

youth. The Ontario Student Drug Use Survey (1999) found that 5.3% of grade 7-13 students admitted using MA in the last year. The highest MA use was by students in grades 11-13 where just over 8% had used MA in the last year (Centre for Addiction and Mental Health 1999). The 1998 McCreary Adolescent Health Survey (The McCreary Centre Society 1998) in British Columbia reports similar numbers, with reported lifetime amphetamine (including MA and ecstasy) usage of 5% high school students. A recent survey on youth drug use conducted by Pacific Community Resources (PCR) (Pacific Community Resources 2002) in the summer of 2002, interviewed a convenience sample of 1,936 youth aged 12-24 in six Lower Mainland communities. This survey found a 19% lifetime usage rate for MA and a 30-day usage rate between 7% and 8%. The survey also found that the average age of first use of MA was 14.5 years and that 45% of youth reported being able to obtain MA within a 24-hour period. Consistent with the McCreary and Ontario Drug Use survey, the PCR survey found that MA use is slightly higher in males than females at 8% versus 6% (30 day use).

In a treatment setting, participants also reported an increase in youth who are using or have tried MA. The Victoria Specialized Youth Detox Program reported a substantial increase in the number of youth who are referred to the program where crystal methamphetamine is their drug of choice and a decrease in the number of heroin referrals. Between 2000/2001 and 2001/2002, the number of crystal methamphetamine referrals rose from 11% to 36% while heroin referrals decreased from 41% to 31%.

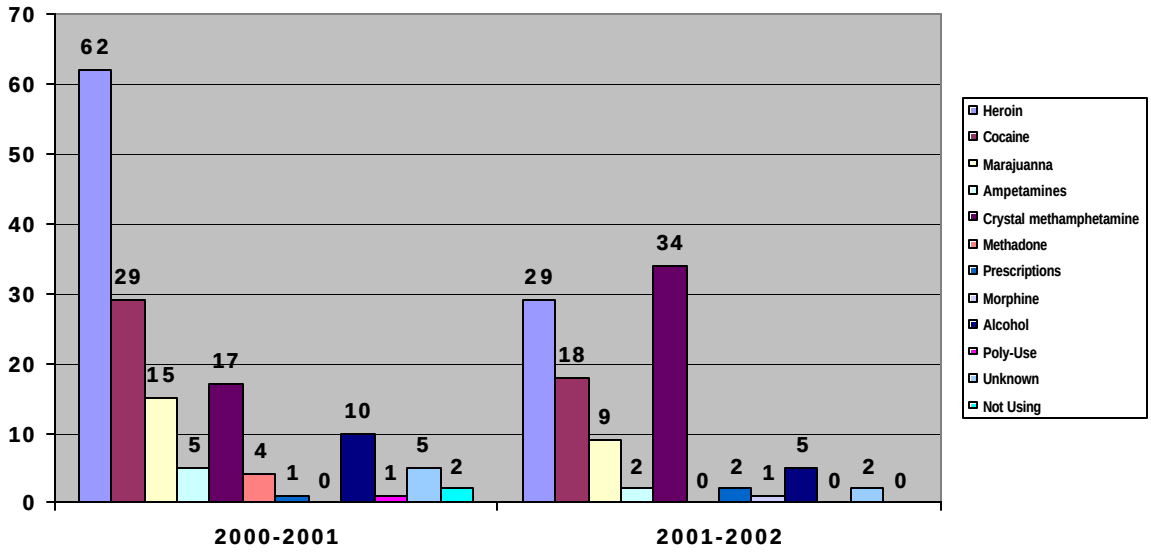

Figure 1: **Referrals By Drug of Choice 2000/01 & 2001/02**, Victoria Specialized Youth Detox, Annual Report 2001-2002. **(**It should be noted that 2001-2002 data is for a 10-month period as compared to 2000 – 2001 which was 12 months).

At a needle exchange site in Victoria, it was reported approximately 70% of the 194 registered clients aged between 20 and 29 have tried or are using crystal meth while approximately 10% of the 339 registered clients >29 years have tried or are using crystal meth. Anecdotal data from an outreach program for youth in Vancouver suggests that

approximately 35-50 of the 65-70 youth they see each night are using crystal meth. In November 2002, St. Paul's Hospital in Vancouver received 215 psychiatric visits; 44 of these visits were for substance abuse and approximately 60% of these 44 were for crystal meth. One summit participant from Adult Addictions in Vancouver reported no significant increase in crystal meth use between October 2001 and October 2002. Family Services of Greater Vancouver, which provides detox services for youth in Vancouver, report 14-34 youth seeking detox for crystal meth in a six-month period in 2001. In the same six-month period in 2002, they saw 32-59 youth seeking detox for crystal meth. At present, it appears that the numbers of youth seeking treatment for heroin and/or cocaine remain stable.

Information supplied by addiction service providers of Fraser Health Authority, (with the exception of Delta), report an increase in the percentage of clients seen who are MA users. However, despite the consistent trend in most regions the numbers are small and the time frame short and must be treated with caution. Surveys administered in two schools in the Health Authority had differing results. One community saw an increase from 3 to 5.5% of 400+ students who reported ever using MA from 1999 to 2000. A persistently higher (though fairly constant) rate, ranging between 11% and 13%, of ever users was found in the 1995, 97, 99 and 2000 surveys in the second community. Survey results and anecdotal evidence suggests that with time, the age of onset is getting younger and those who do use may be doing so more frequently.

Although numbers are not available to quantify many of the patterns and trends in MA use, summit participants provided anecdotal evidence describing the diverse populations and contexts in which they saw MA use occurring. These included:

- *Recreational use*: many youth, often of a higher socio-economic background, use MA via the party scene at raves and in clubs. Summit participants report MA being especially popular with groups within the GLBT population. These recreational users do not appear to be using MA between raves or parties.
- *Unintentional poly-drug use*: many ecstasy users are unaware of the purity of their ecstasy and are using MA without knowing it. Analyses by the RCMP (Vancouver) Drug Awareness Service have found that ecstasy is often adulterated with MA or MA is being sold as ecstasy (>58% of ecstasy-like pills contained MA)
- *Youth who did not complete high school or who became parents at an early age:* in certain areas, MA use is popular with individuals who did not complete high school and/or young parents (e.g., 19-28 years old). Several summit participants commented that MA use is occurring in the children of parents who use MA.
- *Street Use*: Some users of MA use other street drugs concurrently and may use MA to stay awake or work the street. MA is not as common as other street drugs but may be used when a drug of choice is not available, e.g., cocaine user may use MA and vice versa.
- *Gamers*: One participant reported MA to be popular with "tech heads" or gamers (role playing games)

- *Younger age of use:* In discussion, summit participants commented that youth are using MA regardless of their socio-economic background, race, gender and academic ability. Participants also stated that they were seeing an increase in the numbers of youth using MA at a younger age.
- *Improved Body Image:* MA is reported to be used by young people in high school because it suppresses the appetite, assists with weight loss and contributes to a desired body image
- *Workplace Use:* MA is used by people in a range of workplace settings to improve performance. Often, they will use smaller amounts of MA over an extended periods of time.

Why methamphetamine?

Summit participants provided numerous insights into the factors driving the increased use of MA. Although reasons for use vary depending on the context and individual, these are some of the reasons summit participants believe MA use is increasing:

- Lack of stigma associated with MA use and greater peer acceptance, particularly when compared with other street drugs – MA is more acceptable and believed to be more "natural"
- Cheap
- Easily available
- High is longer than with other drugs and MA use can be sustained for longer periods
- Immediate high
- Provides increased energy and productivity and may improve performance
- Don't feel as out of control as on other drugs
- Enhanced sexual performance
- Provides an alternative family support structure via a new peer group
- May be used as an unconscious treatment of ADD/ADHD as it helps to "normalize" thinking
- Many youth have no reason not to use drugs
- For street youth, MA is one way to "deal" with the problems of staying awake, coping with lack of shelter and food
- Easily concealed and use can be hidden easily
- Can assist with weight loss and improve body image
- Numerous routes of delivery
- Effect of MA use is a desire to continue use

Poly-drug Use

Many participants reported that MA is often used in conjunction with other drugs such as marijuana, ecstasy, heroin, alcohol, and ketamine and that the particular combination of drugs will depend on reasons for use. Marijuana appears to be extremely popular in counteracting effects of MA. Some may use alcohol to help maintain normal sleep patterns to keep up other parts of life while other users may avoid alcohol because it exacerbates the after-effects of MA. Others may mix MA with prescription drugs such as

antidepressants, Ritalin, and Dexedrin, use MA to keep their energy up while using ecstasy, or use other hallucinogens to lengthen the high.

Availability and Production

Participants at the summit emphasized how cheap and how easy MA is to obtain. The reported cost of MA ranged from $10-20 for 0.10 g. The cost of MA could vary depending on where one purchased it—a point (0.10 g) could cost more at a club scene while a gram could be obtained for $60 in Vancouver. Participants also reported that it could cost less than $5/day to maintain the habit.

Clandestine labs producing MA require little space or specialized equipment and MA can be produced virtually anywhere. Summit participants reported MA being produced in a range of settings, including storage sheds, houses, high rises, basements, and apartments. Participants commented that MA production seems to be a greater problem in more rural areas and areas outside of Vancouver such as Chilliwack and Abbotsford. Participants also described the differences between smaller, "mom and pop" labs and larger, more organized "superlabs" that produce more than 10 pounds of MA. Although more organized labs produced more MA, there are a greater number of smaller labs. In B.C., in 1998, the RCMP dismantled eight meth labs. In 1999, 19 labs were discovered and, in 2000, 30 labs were uncovered (Ko January 6, 2003). Participants report that the majority of labs uncovered in the last year by the RCMP were "mom and pop" laboratories. The trend is similar to the USA where "superlabs" are the exception rather than the norm. However, 60% of the labs in B.C. last year were producing both ecstasy and MA in the same lab, a trend not seen in the USA. Several participants expressed a concern that B.C. may see a rapid increase in the numbers of labs producing MA as seen in Washington State. In 1990, 38 labs were uncovered in Washington State; in 2001, 1,886 were located (Ko January 6, 2003).

Participants highlighted the ease with which MA could be produced. The production of MA uses relatively inexpensive over-the-counter ingredients and requires little specialized knowledge or equipment. The chemical precursors to MA, ephedrine and pseudoephedrine, are a common ingredient in many over-the-counter cold remedies and can be easily obtained. Other products used in creating methamphetamines can be obtained from hardware stores, pharmacies and retail stores. It is estimated that there are over 300 ways to manufacture MA and "recipes" can be easily downloaded from the Internet.

Participants also described the dangers that clandestine labs producing MA pose to producers, the friends, families, and children of producers, and the police officers involved in clan lab investigations. Many of the chemicals used to produce MA are ignitable, corrosive, and toxic and can cause fires, produce toxic vapors and damage to the environment. Laboratory explosions and fires are a hazard and threat to neighbors and the communities where MA is produced. Meth labs are not easily detected by the same signs that are characteristic of other clandestine labs (e.g., meth labs can be identified by

a strong smell of cat urine). One summit participant commented that every pound of MA produced results in 5-6 lbs of toxic waste.

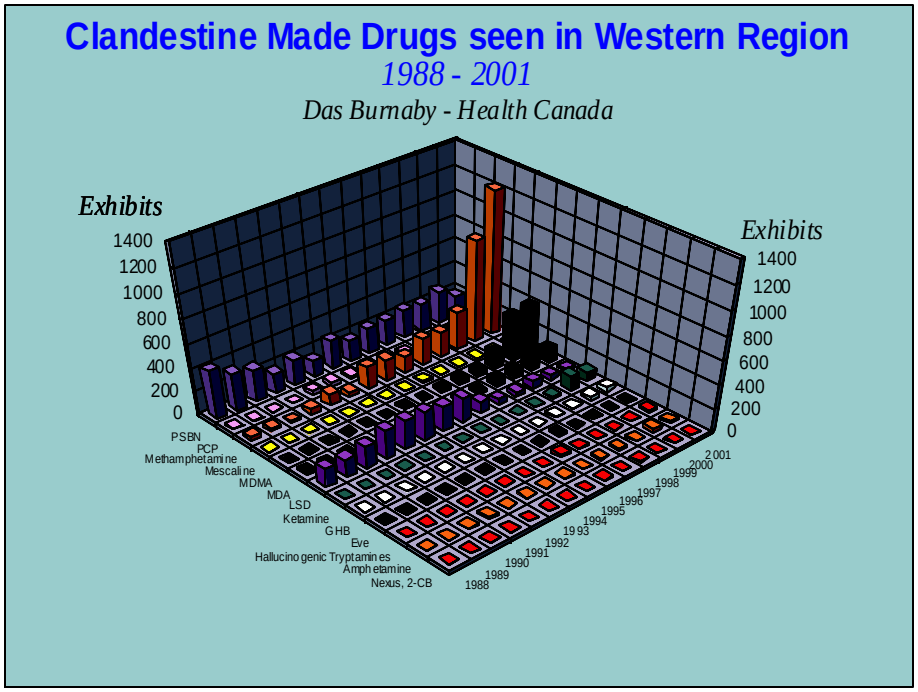

Figure 2: **Clandestine Made Drugs seen in Western Region, 1988-2001**. Drug Analysis Service (Burnaby), Health Canada

Consequences of MA Use

Summit participants discussed the short- and long-term effects of MA for the user and the potential consequences of MA use for the user, the family and friends of the user, and for communities and society at large. These included:

Short-term Effects of Use: MA creates a feeling of endless energy and provides an initial euphoric rush and elevated motor activity. Different modes of administration can result in varying sensations, e.g., inhaling provides a greater rush than intravenous use. Other effects of MA include increased wakefulness, increased physical activity, decreased appetite, and increased respiration. After the effects wear off, users will experience anxiety, depression, mental confusion, fatigue, and headaches. With large enough dosages, visual and auditory hallucinations may occur; as MA is very addictive, using more will increase the after-effects of use.

Long-term Effects of Use: Prolonged use of MA may result in tolerance to the desired effects of MA and the user is required to use MA at higher doses. Many users will go on binges lasting for days at a time. Withdrawal symptoms include extreme irritability, loss of energy, depression, fearfulness, excessive drowsiness or difficulty sleeping, shaking,

nausea, palpitations, sweating, hyperventilation, and increased appetite. Long-term health effects include structural changes to the brain, memory loss and difficulty completing complex tasks. Long-term users may also develop movement disorders and may be at risk of developing permanent psychotic symptoms. Summit delegates also described the paranoia that some users develop, particularly after binging for several days. Several participants commented on the high rates of violence in MA users, even in youth with no previous history of violence.

Other Consequences of Use for the Individual: Summit participants described how users may be at increased risk of violence and sexual assault. In some populations, MA is used to enhance sexual performance and users may be at increased risk of acquiring HIV and other STIs. In addition to physical health effects, participants also highlighted the long-term mental health effects of use. Users may have a loss of self-esteem and define themselves as an "addict;" they may turn to stealing, dealing or the sex trade. They may have to deal with the consequences of a criminal record, the breakdown of important relationships, and have a loss of spirituality/self.

Effects of Use on Community and Society: Summit participants discussed the wide range of effects of MA use on communities and society in general. At the level of the family, children of MA users are at higher risk of neglect and MA use by pregnant women can result in growth retardation, premature birth, and developmental disorders in newborns. In addition, parents who are using cannot be a resource for their children and MA use can lead to family breakdown. Participants described how MA use by students places a drain on teacher/counselor resources, and leads to environmental disruption and increased bullying. Participants expressed concern over the potential increase in violence and psychotic behaviour, involvement in organized crime, and criminalization due to MA use. They also described the impact of increased criminal activity and violence on society and the effects of crime on individuals. Increasing MA use was seen as a drain on prevention resources and resulting in increased demand for services, increased use of health resources and increased stress on social services. In addition, summit participants commented on how MA use resulted in the loss of potential for the individual and for society.

Current Resources to Address MA Use

All summit participants agreed that there are very few resources available to address MA use and not enough is being done to prevent and address MA use. In Vancouver, there are 10 beds allocated to youth detox services and the number of youth admitted to youth detox represents a small fraction (approximately 10-20%) of the actual need. Summit participants commented that crystal meth requires a longer withdrawal period than other drugs and requires a longer period in treatment. Models of treatment for MA users are still being developed and there are currently no medications available specifically for treating MA. Anti-psychotics and anti-depressants are often used in therapy to reduce symptoms associated with withdrawal, although there is limited evidence supporting their use. Summit participants commented that there is a general lack of awareness around MA use. They also commented on how MA use presents challenges for the system, e.g.,

mental health may be unwilling or not have the resources to treat MA users with psychosis. Several outreach programs are restructuring their programs and mode of service delivery to better reach youth and are trying to adjust to the high levels of MA use they are now seeing (For example, one of the effects of MA use is decreased appetite. One program has stopped serving dinner as the majority of their clients are using MA and do not eat the meal provided). Appendix E contains a list of some of the resources available to address MA use.

Recommendations

One of the primary goals of the summit was to develop a strategy to address methamphetamine use. Participants worked in small interprofessional, cross-sectoral groups to generate recommendations based on the morning's presentations and breakout group discussion. Some of these recommendations focused on better utilizing available resources while others were more focused on developing new strategies to address MA and other drug use. In this section we present a summary of the areas of action and the specific recommendations that emerged.

Prevention, Education, and Awareness

Overall, participants at the summit identified the need for broad-based education initiatives on methamphetamine targeted at the general public, high-risk groups, parents, and professionals. Participants emphasized the importance of raising awareness in the general public regarding MA use, the manufacture of MA, consequences for individuals, families, and communities (e g., environmental damage) and the need to counter misperceptions regarding safety of MA. Participants recommended a variety of strategies for increasing awareness of MA, including effective utilization of the media, building on current public awareness campaigns, the formation of a coalition on drug prevention, developing newspaper inserts specific to stimulants, and the production and distribution of videos on stimulant use and the dangers of clandestine labs to television and individual groups. Several participants also stressed the importance of portraying substance abuse as a social issue.

In discussions at the summit, participants emphasized the need for a full and realistic drug strategy targeted at youth. Participants described ways of increasing the credibility of information given to youth such as involving users in education strategies and using peer-based education models. The importance of educating parents also was described, including the need to provide parents with adequate information and the tools to discuss drugs with their children. The recent survey conducted by Pacific Community Resources (Pacific Community Resources 2002) found that parents (61%) were the most trusted source of drug information for youth followed by school (58%) although parents were the fifth (22%) actual source of alcohol and drug information.

Another issue raised regarding education for youth was the need to begin drug education at a much earlier age, e.g., grades 3 and 4, and to develop age-appropriate education. Early education and prevention strategies should focus on developing skills, self-

confidence, and resilience. As well, youth need to be provided with recreational activities and other opportunities and easy access to people they trust for information and support. The importance of keeping kids in school and developing strategies other than expulsion to deal with addiction issues was also discussed. Participants also valued having a provincial or federal mandate through the Ministries of Health and Education to ensure drug education in schools.

Participants also described a need for education initiatives on MA for professionals. Increasing general awareness of MA among health professionals, judges, police officers and social worker and others was discussed. For professionals more directly involved in the area of substance use, participants suggested developing a professional hotline on MA as a resource for police and fire departments as well as health professionals, social workers and frontline workers. Several frontline workers suggested offering an MA specific information session while other professionals recommended developing crisis intervention training.

In all areas of education, prevention, and awareness, participants stressed the importance of increased consideration for diversity, including culture, gender and sexuality. As well, many people recognized that many traditional education and prevention strategies are not effective and valued being open to innovative thinking. Although there is not very much evidence of what *does* work, there is ample evidence of what *doesn't* work. One participant advocated for the development of a "Promising Practices" approach rather than a "Best Practices" approach. In general, participants believed that new approaches should be encouraged.

Treatment

Summit participants stressed the severe shortage of treatment capacity and options (e.g., self-help, family treatment, all detox, long-term follow-up) that currently exists. In addition to the need to allocate more resources to treatment, improving access to treatment was also discussed. Participants noted numerous barriers to treatment, including waiting periods, discrimination, lack of attention to issues of culture, problematic location of treatment centers (e.g., provide choice of location and/or locate centers away from high use areas), and the need to allocate more beds to specific populations (e.g., GBLT). Participants also discussed issues related to mandatory treatment and treatment availability for those who seek it on their own versus those who are placed in treatment.

Participants described a need for increased emphasis on the causes and roots of addiction and the need to address these in treatment and follow-up programs. They discussed the need for more employment and low-income housing and increased follow-up to support integration into the community. The importance of developing consistent medical protocols for the treatment of patients with methamphetamine-related problems was also discussed.

Participants discussed the importance of exploring and developing alternate models of care and the incorporation of alternative therapies such as acupuncture into treatment. Areas for further investigation included developing longer-term treatment (e.g., 2 years versus 4 months), involving former users in the treatment process, family treatment and outreach, and different detox models (e.g., residential, mobile, home, secure treatment such as the Adolescent Recovery Centre in Alberta). Also, the provision of services specific to the needs of MA users, e.g., twelve step crystal meth programmes, additional Crystal Meth Anonymous groups, and discussion groups for active users and former users, were discussed.

Need for an Integrated and Coordinated Response

Summit participants agreed that an integrated and coordinated response to address MA use is needed. Participants suggested formalizing the networking process to increase information sharing. While better communication between service providers was seen as an important step in decreasing the fragmentation and lack of coordination between existing services, strategies are needed to address issues of confidentiality. Participants also discussed the need for a provincial approach to creating a continuum of services and decreasing the service gaps between various geographic regions. Participants suggested meeting the needs of specific populations and providing a better continuum of care through liaison with other service providers and referrals to other services. Participants discussed providing opportunities for inter-professional training (e.g., medical teams with clandestine lab teams) and increasing communication between professional groups. Participants also valued utilizing a holistic approach to address MA use, e.g., address MA use within larger addictions framework, consider mental health and addictions concurrently, etc.

Resource Allocation

Issues related to resources and funding were highlighted at the summit. Many participants described the challenges of trying to do more to address MA and other drug issues with fewer resources. Summit participants suggested ways of securing funding such as re-allocating proceeds of crime and drug seizures or securing federal funding for addictions. Participants discussed sharing resources and accountability and the importance of ensuring equitable funding between stakeholders.

Law Enforcement and Justice

Participants stressed the importance of decreasing access to MA as an important strategy to reduce MA use. Participants supported the identification and dismantling of clandestine labs and advocated for changes in precursor legislation to decrease access to MA precursors. (Regulations developed by the federal government were passed in October 2002 and implemented in January 2003, requiring individuals who produce, import and export ephedrine and pseudoephedrine to have licenses and permits. These regulations will expand to include domestic sales (December 3, 2002)). Participants also discussed the development of effective penalties and deterrents to reduce MA use.

Discussion covered a wide range of areas, including changing the criminal code to reflect the harm of MA use on the community, developing consequences to breeching conditions regarding treatment/abstinence, developing alternative measures for lesser offences in order to prevent multiple court appearances, the need for realistic dealer sentencing, harder penalties and financial consequences for organized crime, and developing diversion programs. Participants also described the importance of finding a balance between medicalization of the issues and still holding users accountable for criminal actions. Participants expressed a need for protocol concerning children in drug endangered environments (i.e., children of MA users/producers) in order to better liaise and share information between appropriate agencies (e.g., police, social workers, health care providers).

Research and Monitoring

Participants highlighted the importance of research in all areas of MA use. Participants discussed developing mechanisms for quantifying the issue and identifying trends in MA use at an early stage. Participants talked about establishing mechanisms for ongoing data collection in individual communities and later amalgamation by a central group. It was noted by several participants that testing for MA is no longer included in routine drug screens and is not covered by MSP. As MA is only tested when there is some suspicion of MA use, this has meant that recent drug screens indicate a higher percentage of positive tests for MA. In order to obtain an accurate picture of the number of individuals testing positive for MA, MA would need to be included in standard drug screens. There also is a need for research to evaluate the efficacy of different treatment models, the effectiveness of prevention and education strategies, and the effects of drug use on brain and fetal development. Participants also valued involving users in the research process and viewed the USA and Europe as case studies to demonstrate the effectiveness of various interventions.

Moving Forward

Participants at the *Methamphetamine Environmental Scan Summit* emphasized the importance of developing a group that will move the above recommendations forward. Participants also suggested several activities that should be undertaken. These include:

- Hold a 2-day summit in June 2003 with increased representation, especially from users, youth, Aboriginal groups, seniors, and the GBLT population
- Hold a Meth Info Day for professionals and develop a forum for parent discussion

Several of the activities suggested by the participants have already been initiated. These include:

- The Methamphetamine Response Committee (MARC) has been organized to act as a coordinating body to move the recommendations forward. MARC also will work to incorporate methamphetamine into overall drug approaches, including making links with *The Vancouver Agreement*
- Working groups in the areas of Professional Education, Prevention/Treatment, and First Responders and Justice have been organized (contact information for the MARC Working Groups can be found in Appendix F). Presentations for professionals have been organized and an information pamphlet on methamphetamine issues has been developed.
- A media release designed to increase awareness of methamphetamine issues has been released in conjunction with the posting of this report on the Canadian Centre on Substance Abuse web site (http://www.ccsa.ca)

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Appendices

Appendix A: Methamphetamine Priority Planning

During the morning breakout session, participants identified methamphetamine use to be a growing problem and described numerous trends in the use of methamphetamines. One of the primary goals of the summit was to develop a list of priority areas and actions to address methamphetamine use. Participants worked in small interprofessional, cross-sectoral groups to generate recommendations based on the morning's presentations and breakout group discussion. This section summarizes the areas of priority (in no particular order) identified by the participants and an overview of the recommendations that emerged.

Priority Area: Resource Allocation

- Develop strategies to secure funding such as re-allocating proceeds of crime and drug seizures or securing federal funding for addictions
- Ensure equitable funding between stakeholders

Priority Area: Education and Prevention

- Develop broad-based education initiatives targeted at the general public, high-risk groups, parents, and professionals
- Utilize education strategies that are peer-based, involve users and make effective use of media such as TV and CD-Rom
- Strategies targeted at youth must begin at an early age, provide information from a credible source and be age-appropriate
- Raise awareness in general public regarding methamphetamine use, the manufacture of methamphetamine, consequences for individuals, families, and communities (e.g., environmental damage) and counter misperceptions regarding safety of methamphetamine
- Develop skills, build resilience, capacity, and reasons NOT to use, e.g., through the provision of opportunities and recreational activities to youth

Priority Area: Treatment

- Allocate more resources to treatment in order to address shortage of detox and treatment beds
- Improve access to treatment (e.g., quicker and easier access, fewer barriers)
- Increased emphasis on the causes and roots of addiction and address these in treatment and follow-up programs
- Develop consistent medical protocols for the treatment of patients with methamphetamine-related problems

- Explore and develop alternate models of care and the incorporation of alternative therapies (e.g., longer term treatment, acupuncture, services specific to methamphetamine users)

Priority Area: Law Enforcement

- Monitor effectiveness of new precursor legislation designed to decrease access to meth precursors
- Allocate more resources to the identification and dismantling of clandestine labs
- Develop effective penalties and deterrents

Priority Area: Greater Integration and Co-ordination

- Formalize networking process to increase information sharing
- Decrease fragmentation and lack of coordination between existing services through better communication among service providers while still respecting and addressing issues of confidentiality
- Share resources and accountability
- Create a continuum of services and decrease service gaps between various geographic regions and subgroups
- Provide opportunities for inter-professional training (e.g., medical teams with clandestine lab teams) and increase communication between professional groups
- Utilize a holistic approach to address methamphetamine use, e.g., address methamphetamine use within larger addictions framework, consider mental health and addictions concurrently, etc.

Priority Area: Research and Monitoring

- Develop mechanisms for quantifying the issue and identifying trends at an early stage
- Research and evaluate the efficacy of different treatment models, the effectiveness of prevention and education strategies, and the effects of drug use on brain and fetal development
- Establish mechanisms for ongoing data collection in individual communities and amalgamation by a central group

Priority Area: Harm Reduction

- Reduce risk and improve safety by increasing acceptance and tolerance
- Develop strategies to reduce harm such as providing information on safer using, risks of different methods of administering, risks of mixing methamphetamine with other drugs (including prescription drugs)

Appendix B: Agenda

NOVEMBER 28, 2002: METHAMPHETAMINE SUMMIT	
8:30 –8:40	*Welcome and Introduction* Jane Buxton, MBBS FRCPC Vancouver Coastal Health Authority
8:40 – 9:30	*Medical Aspects of Crystal Methamphetamine: An Overview* Ian Martin, MD, CCFP Three Bridges Community Health Centre
9:30-9:45	*A User's Perspective on Crystal Meth* Theo Rosenfeld, Pala Community Development
9:50-10:10	*Report on RCMP Clan Lab Investigations and Drug Analysis* Wayne K Jeffery I/C Toxicology Section Royal Canadian Mounted Police Forensic laboratory Vancouver B.C.
10:15-10:30	*Results of the 2002 Lower Mainland Youth Drug Use Survey* Tom Hetherington, Pacific Community Resources Society
10:30-10:45	*Video Presentation*: King County Meth Action Team
	BREAK
10:45-12:00	Morning Breakout Groups
12:00-1:00	Lunch; Reporters from each group meet to discuss priorities
1:00-1:15	*Survey Proposal and Video Project* Dr. Doug McGhee
1:15-1:45	Report from Morning Breakout Groups
1:45-2:45	Afternoon Breakout Groups
2:45-3:00	*BREAK*
3:00-3:30	Report from Afternoon Breakout Groups
3:30-4:00	Developing an action plan and working groups

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YEE Colleen, Det/Cst.	Vancouver Police Department	colleen_yee@city.vancouver.bc.ca
VIRK, Jim	Ministry For Children & Family Development #102-4430 Halifax St., Burnaby, BC	Phone 604-660-0602 Fax 604-660-0605 jim.virk@gems.gov.bc.ca

Appendix D: Breakout Group Questions

This purpose of this workshop is to develop a better understanding of the trends, issues and health risks associated with the use of Crystal Methamphetamine (CM) and to collectively develop an action plan to address these concerns and issues.

Morning Breakout Groups

Drawing upon the knowledge, experience and diverse fields of expertise of the delegates, the objective of the morning breakout session is to increase our understanding of the scope of the CM problem in the GVRD. Each group will address one of two questions. The questions will (A) identify current trends in the use of CM and (B) identify the direct and indirect costs associated with CM use and describe the supports, resources, and strategies currently available to address CM use.

Each breakout group will be asked to address one question only. Odd numbered tables will address question A, even tables will address question B

GROUP A

Objective: Identify current trends from the perspective of the CM user/consumer.

Question: Based on your knowledge and experience address the objective using the following questions as a guide:

Who is using CM?
What are users using in addition to CM?
Where is CM being produce? Where is CM available?
When are they using CM and in what context?
Why is it being used at all?
Why are users choosing CM over other drugs?
How much CM is being used?
How much does CM cost?

GROUP B

Objectives: (1) Identify the direct and indirect costs and risks associated to the CM user/consumer, their friends, their family, their workplace, their school and their community. (2) Describe the supports, resources, and strategies currently available to address CM use.

Question: Based on your knowledge and experience address the objectives using the following questions as a guide:

What are the direct and indirect costs of CM use to the user/consumer, their friends, family, school/work place and community (e.g., mortality, effects on physical, mental and emotional health, impact on family, etc.)?
What are we doing to prevent CM abuse (street/home/school/workplace)?
How do people stop (detox/treatment)?
What are we doing to help users (harm reduction/abstinence)?

Afternoon Breakout Groups

Objective: It is evident from the morning session that CM use is a concern facing all community service providers throughout the Greater Vancouver Regional District. In order to address these concerns and prevent future problems, the purpose of the afternoon session is to discuss the types of actions we can undertake, both collectively and individually at our respective organizations, to address concerns and issues related to CM use.

Question: Where do we go from here?

Discuss and describe proactive responses we can do (respecting the needs of your organization/agency and the collective needs of your breakout group) to counteract the CM problem in the GVRD. To assist you in addressing this question you may want to consider using a framework that looks at Prevention, Treatment, Harm Reduction and Law Enforcement Initiatives.

Examples of possible initiatives:

- Setting up a monitoring program to identify and collect pertinent data (from current Prevention, Treatment, Harm Reduction and Law Enforcement Initiatives) so we can accurately measure, assess and evaluate our proactive initiatives.

- Design and deliver Awareness/Education seminars to all Community Service Providers (private, public, City/Municipal, Provincial, and Federal).

- Design and deliver Awareness/Education workshops to all youth regardless of whether they are high school, alternative lifestyles, community youth, or homeless youth and parents/families.

- Prepare a media package including backgrounders for all media outlets with respect to CM.

- Form a GVRD CM Action Response Team

Initiatives may also be integrated into existing programs or systems, so please identify these.

Appendix E: List of Resources on Methamphetamine

Information Resources

Print Materials

ADIC and RCMP Drug Awareness Service. (2001). *Designer Drugs and Raves, 2nd edition*. Addictive Drug Information Council: British Columbia, Canada.

ADIC and RCMP Drug Awareness Service. (2001). *Dancing with Death: Club & Rave Drugs*. (Brochure available through local RCMP Drug Awareness Coordinator)

Oishi, S.M., West, K., and Stuntz, S. (2000) *Drug Endangered Children Health and Safety Manual*. The Drug Endangered Children Resource Center. http://www.cdcadd.org/dec.

On-line Resources

Addictive Drug Information Council
http://www.adicbc.com/
Provides information on addictive drugs and substances of abuse. Links to research, programs, and treatment.

"The Meth Crisis" http://www.stopdrugs.org/
A web site produced by the California Narcotic Officers' Association and the California Department of Justice. Contains information on "the meth crisis" in USA and describes the effects of meth, prevention efforts, treatment, identification, and enforcement. Links to other resources.

Tweakers.org
http://www.tweaker.org/
Using principles of harm reduction, this web site contains information for gay and bisexual men who use methamphetamines.

Methamphetamine Abuse and Addiction
http://www.nida.nih.gov/ResearchReports/Methamph/Methamph.html
National Institute on Drug Abuse (NIDA) fact sheet describing methamphetamine use.

Crystal Meth Anonymous http://www.crystalmeth.org/aboutCMA.htm
This 12-step program for those in recovery from addiction to crystal meth is modelled on the Alcoholics Anonymous program. A CMA meeting currently runs at the Three Bridges Community Health Centre in Vancouver.

RCMP 'E' Division Drug Awareness Service
http://www.rcmpda.com
The RCMP B.C. Provincial Headquarters site has links to publications, drug information, D.A.R.E., and information on legalization, ADIC, and raves.

Drug Endangered Children Resource Center
http://www.decresourcecenter.org/DECcounty.html
The Alliance for Drug Endangered Children (DEC) Resource Centre web site provides information on developing interdisciplinary collaborative approaches to drug endangered children.

Organizations

Alcohol and Drug Information and Referral Service
1-800-663-1441 or (604) 660-9382 (24 hours/day)

Canadian Centre on Substance Abuse
http://www.ccsa.ca/

Prevention Source BC
www.preventionsource.bc.ca

Poison Control BC (Emergency Help)
(604) 682-5050 (Lower Mainland)
1-800-567-8911 (Province wide)

RCMP 'E' Division (British Columbia) Drug Awareness Service
http://www.rcmp-fairmont.org/da/

Methamphetamine Research

Anglin, M.D., Burke C., Perrochet, B., Stamper, E., and Dawud-Noursi, S. (2000). History of the methamphetamine problem. *Journal of Pscyhoactive Drugs*, 32(2): 137-41.

Gibson, D.R., Leamon, M.H. and Flynn, N. (2002) Epidemiology and public health Consequences of methamphetamine use in California's Central Valley. *Journal of Psychoactive Drugs*, 34(3): 313-319.

Rawson, R.A., Anglin, M.D., and Ling, W. (2002) Will the methamphetamine problem go away? *Journal of Addictive Disorders*, 21(1): 5-19.

Srisurapanont, M., Jarusuraisin, N., and Kittirattanapaiboon, P. (2003). *Treatment for Amphetamine Dependence and Abuse (Cochrane Review)*. Cochrane Drugs and Alcohol Group. http://www.cochrane.org

Srisurapanont, M., Jarusuraisin, N., and Kittirattanapaiboon, P. (2003). *Treatment for Amphetamine Withdrawal (Cochrane Review)*. Cochrane Drugs and Alcohol Group. http://www.cochrane.org

Srisurapanont, M., Kittirattanapaiboon, P., and Jarusuraisin, N. (2003). *Treatment for Amphetamine Psychosis (Cochrane Review).* Cochrane Drugs and Alcohol Group. http://www.cochrane.org

U.S. Department of Health and Human Services. (1999) Treatment for Stimulant Use Disorders. *Treatment Improvement Protocol (TIP)* Series 33. Available for download or order at http://www.samhsa.gov/centers/csat2002/publications.html.

Referrals and Assistance

Alcohol and Drug Information and Referral Service
1-800-663-1441 or (604) 660-9382 (24 hours/day)

In Vancouver:

Three Bridges Community Health Centre
1292 Hornby Street (@ Drake) (604) 736-9844

Watari Youth and Family Alcohol and Drug Service
301-877 East Hastings, (604) 254-6995

Dual Diagnosis Program for Adolescents
300-2250 Commercial Drive, (604) 251-2264

Family Services of Greater Vancouver-Street Youth Detox
202-1193 Kingsway, (604) 872-4349

DEYAS Youth Detox Program
432 E. Hastings Street, (604) 251-7615

Covenant House
575 Drake Street (@Seymour), (604) 685-7474

Crystal Meth Anonymous (CMA)
(604) 633-4242

Broadway Youth Resource Centre
691 E. Broadway, (604) 709-5720

PLEA Detox (Youth)
3894 Commercial Street, (604) 891-1082, (604) 871-0450 (pager)

In Victoria:

Dallas Youth and Family Services
12-1560 Church Avenue, (250) 721-2669

Pacific Centre Family Services Association
3221 Heatherbell Rd., (250) 478-8357

Victoria Alcohol and Drug Services
(250) 387-5077

Narcotics Anonymous
(250) 383-3553

AIDS Vancouver Island
For information (250) 382-2366 or the Needle Exchange and Street Outreach (250) 384-1345

YM/YWCA Youth Counselors
(250) 386-7511 Keith Mowen ext. 829, Kathryn Saunders ext. 820, and Amanda Seymour, the alcohol and drug counselor ext. 865 or cell: 888-4697.

Native Friendship Centre
(250) 384-3211

Appendix F: Summit Organizing Committee and MARC Working Groups

Summit Organizing Committee
Dr. Jane Buxton, Vancouver Coastal Health Authority
Dr. Ian Martin, Three Bridges Community Health Centre, Vancouver
Betsy MacKenzie, Regional Coordinator, Drug Strategy, Health Canada BC/Yukon
Cpl. Scott Rintoul, RCMP Drug Awareness Service, Vancouver

Methamphetamine Response Committee (MARC)
Contact: Jane Buxton, jane_buxton@vrhb.bc.ca

MARC Working Groups

- Professional Education Working Group
  Contact**:** Ian Martin, ian_imartin@hotmail.com

- Prevention/Treatment Working Group
  Contact: Jennifer Vornbrock, jennifer_vornbrock@vrhb.bc.ca

- First Responders and Justice Issues Working Group
  Contact: Scott Rintoul, Scott.Rintoul@rcmp-grc.gc.ca