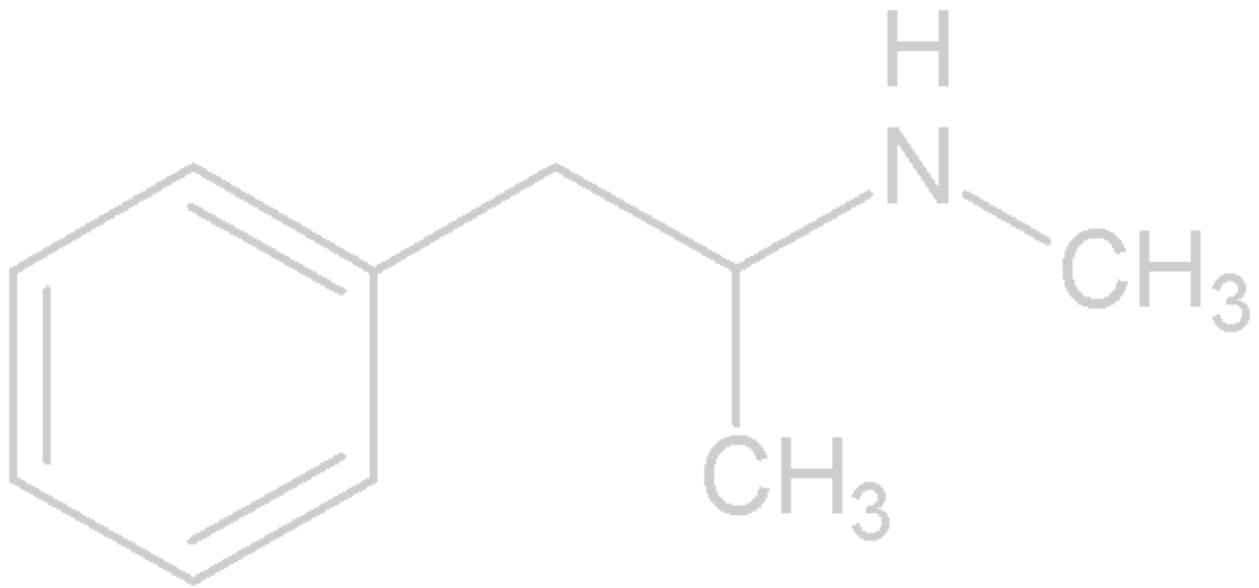


The Impact of Methamphetamine on Georgia



Submitted to: The Governor's Criminal Justice Coordinating Council,
Statistical Analysis Center Committee

September 5, 2006



Applied Research Services, Inc.

"turning data into decisions"

We would like to thank all of the Georgia state agencies that provided data to help make this analysis possible: Georgia Bureau of Investigation's Georgia Crime Information Center, Georgia Department of Human Resources, Georgia Department of Corrections, Georgia Board of Pardons and Paroles, Georgia Department of Juvenile Justice. We also extend thanks to the Georgia Alliance for Drug Endangered Children who helped facilitate the procurement of data and provided input into the design of survey questions to assess the impact of meth on Georgia's children and families. Lastly, we would like to thank all of the criminal justice, first responder, and social service professionals across the state who took the time to complete and return our statewide meth survey which provided a crucial link to our understanding of the impact of meth in Georgia.

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Applied Research Services, Inc.

Tammy Meredith, Ph.D.
John Speir, Ph.D.
Sharon Johnson
Heather Hull
Jake Bucher
Aishia Rogers

Georgia Statistical Analysis Center

LaSonja Fillingame, Statistical Analysis Center Director

Georgia Statistical Analysis Center Committee

Mr. Brian DiNapoli, Georgia Department of Community Affairs (Chair)

Ms. Donna Burns, Georgia Office of Homeland Security/Georgia Emergency Management Agency (Past Chair)

Ms. Judy Hadley, Office of Planning and Budget

Dr. William L. Megathlin, Armstrong Atlantic State University

Mr. John Prevost, State Board of Pardons and Paroles

Mr. Rob Rosenbloom, Georgia Department of Juvenile Justice

The Impact of Methamphetamine on Georgia

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Executive Summary

Methamphetamine, commonly referred to as *meth*, is a central nervous system stimulant that produces an unparalleled sense of euphoria. It appears to be the recently popular drug of choice, so much that the word *meth* is used often in conjunction with the word *epidemic*. But is there a *meth epidemic* in Georgia? How can this be defined and what information is available to evaluate it? To what extent should the state's justice, health, and economic systems be challenged for it to become a priority? Since there are no scientific rules for applying the word *epidemic*, how many persons must be arrested for meth-related crimes or enter treatment facilities for meth addiction before meth reaches epidemic proportions?

The goal of this report is to replace conjecture with facts derived from quantifiable data. While there is no denying that the abuse, production, and trafficking of meth has become a major concern to both criminal justice and public health professionals in Georgia and nationwide, some of the recent epidemic mentality cannot be substantiated with data.

Some significant responses to meth have occurred already. Penalties for meth crimes were increased in 2003. Governor Sonny Perdue's 2004 *Methamphetamine Summit* led to 25 specific recommendations to combat the meth problem. Restrictions were placed on the availability of medications with the key ingredients to produce meth in 2005. To support ongoing, evidence based decisions, this study was conducted on behalf of the Governor's Criminal Justice Coordinating Council, Statistical Analysis Center. Its purpose is to inform policymakers so they may effectively allocate resources

to address the impact of meth on Georgia's criminal justice and public health systems.

Meth Crime and Addiction on the Rise

The baseline data presented in this report paints a troubling portrait of meth in Georgia. According to the U.S. Drug Enforcement Administration (DEA) and the Georgia Bureau of Investigation (GBI), despite a decline in the number of domestic meth producers, the supply of meth remains high. Although 30% fewer meth labs were found in 2005 compared to 2004, the DEA seized twice as much meth in Georgia in 2005 as in 2002. Atlanta is considered a major distribution hub for Mexican ice (the crystal rock form of meth), with an estimated 95% of the meth available in Georgia coming from Mexico. In August 2006, the U.S. Attorney for the Northern District of Georgia announced that two of the largest federal seizures of crystal meth on the eastern coast were right here in Georgia – 174 and 341 pounds. That represents 234 kilos of meth seized in 2006 in just two drug busts, compared to the 282 total kilos seized last year in Georgia.

According to the U.S. Department of Health and Human Services Drug and Alcohol Services Information System (DASIS) report, Georgia has seen a large jump in combined meth- and amphetamine treatment admissions. Their report shows that only 3 in 100,000 treatment admissions (for ages 12 and older) to a publicly-funded facility in Georgia were for amphetamine abuse in 1993. By 2003, the rate had jumped to 39 in 100,000.

In late 2005, the National Association of Counties conducted a survey to understand the impact of meth on the nation's county

hospital system. Meth was characterized by responding hospital administrators as presenting increasing challenges due to the number and uninsured status of patients. However, the impact of meth on Georgia emergency rooms remains unclear since only 3% of survey respondents originated in-state.

Grabbing the attention of criminal justice professionals is the increase in the sheer volume of people arrested for meth crimes. Since 1990, drug-related arrests increased 41% in Georgia, while meth-related drug arrests increased more than seven-fold. In the past five years alone, meth-related arrests increased 132% and meth-related prison commitments doubled. In 2005, Georgia prisons admitted 2,224 people convicted of at least one meth offense.

However, while meth arrests and prison commitments have been steadily rising, they are still well below both cocaine and marijuana. In 2005, the 7,200 meth-related arrests accounted for 11% of all drug arrests in Georgia. In that same year, 23,000 drug arrests (36%) involved cocaine, and nearly 39,000 (60%) involved marijuana. Cocaine is the most pervasive drug offense in our prison system, with cocaine-related offenders out-numbering meth offenders by more than 3 to 1. Prisoners with a meth offense account for 7% of the 2005 prison admissions; prisoners with a cocaine or marijuana offense account for 29% and 9% of admissions respectively.

The reader is cautioned that the impact of meth is not uniform across the state. Northern Georgia has been most adversely affected by meth-related arrests, incarcerations, and drug treatment admissions. But the problem is no longer

isolated to that part of the state. Many counties, even in the southern regions of Georgia, have been impacted. While thus far rural jurisdictions have been most affected, the Atlanta High Intensity Drug Traffic Area (Atlanta HIDTA) now identifies meth as the primary threat to suburban communities.

The Voice of Professionals on the Front Line

Despite the fact that meth is not *yet* the primary drug of choice among criminal offenders, the disturbing question for policymakers is whether the radical increases in recent years are indicators of a looming disaster. To get a realistic glimpse of the future, we turned to a wide variety of professionals dealing with meth on the front lines. As part of this study, a statewide survey of law enforcement officers, first responders (fire and EMS), prosecutors, drug court personnel, drug treatment providers, DFCS caseworkers, and domestic violence shelter administrators was conducted. Nearly one thousand respondents collectively forecast that meth will become a formidable problem.

While the volume of meth offenders does not yet rival other drug offenders, the nature of their behavior presents special challenges. Law enforcement officers, sheriffs, and first responders confirm what scientists warn about the *tweaking* phase of a meth binge (see Chapter 2). This is a highly dangerous phase especially for first responders, since meth users may appear normal but are irritable, paranoid, and often violent. First responders describe their primary concern as the level of violence and hostility exhibited by meth users – unique problems not seen with other drug users. Most reported little or no cooperation from meth users when

responding to calls. Over half of sheriffs (58%) also reported that meth users create unique problems in their jails – including uncooperative and unpredictable behavior, violence, and multiple medical problems.

Responding to meth calls often includes the added medical concerns associated with entering a meth lab. Eight percent of law enforcement and 18% of sheriffs reported that officers had been injured in the course of responding to a site. The most frequent medical issues cited were breathing problems, burning eyes, and chemical burns on the skin. Police, first responders, and DFCS caseworkers estimate that one in ten of their professional group requires medical attention after responding to a meth lab call.

To deal with the growing volume of meth arrests, two out of three prosecutors reported a need to have a special unit or attorney specifically trained to handle meth cases; 41% actually have a person on staff (most often a drug prosecutor who was not limited to handling meth cases only). Prosecutors cited challenges unique to meth cases, including the valid household use of chemicals involved and the *enclave* mentality of the meth community, where persons tend to be armed and work together to protect the lab and drug supply. Thus, meth cases are often handled more as a gang-related case than standard drug case.

First responders are not the only professionals to describe problems unique to meth. Drug treatment providers also face new dilemmas – including the lack of effective treatment protocols, the severity of the cognitive impairment seen with meth abusers, a higher relapse rate, and the severe deterioration of the body. Sixty-one percent said that they had seen evidence of drug

users *switching* to meth because of the lower cost, longer high, and easier access. They report that the majority of meth users have been using the drug for less than two years when they enter treatment, and approximately two-thirds seeking treatment spend 3-6 months in their facility – similar to a person seeking treatment for crack/cocaine addiction. Unfortunately, both drug treatment providers and drug court personnel indicated they could accommodate less than one quarter of all persons in their community abusing meth that need treatment.

The Devastating Impact on Children and Families

Over half of the domestic violence shelters surveyed reported increases in meth-related cases, and one third reported that meth was involved in half of their recent year's caseload. Half of the shelters reported that injury levels are higher when the batterer is a meth user. Many expressed concerns about the erratic and paranoid behavior of meth users, which escalates the level of violence in the household. Shelters are also seeing more female meth users staying in abusive relationships longer because their spouse/partner is their drug source.

Collaborating in this study, the Georgia Alliance for Drug Endangered Children assessed the impact of parental meth use on children. The surveys showed great concern across all professionals about the ability of meth addicted persons to parent their children. The perceived consequences to children of meth abusing parents include child neglect, mental/emotional abuse, behavioral problems, and distress from seeing parents arrested and/or going into foster care.

Meth use clearly impacts a parent's ability to maintain child custody. The surveys show that one in five parents entering a publicly-funded drug treatment center or a drug court has lost permanent custody of their children. The rate of parents losing custody of their children is higher among meth abusers than other drug addicts. DFCS caseworkers confirm the connection between meth use and child custody. They estimated that over half of meth users lose permanent custody of their children, compared to 38% of those using other drugs.

Finally, meth has a substantial impact on child deprivation investigations statewide. DFCS workers reported an average of 42% of their child deprivation caseload involves

parents using meth. Wide variation across the state exists, from 19% in DFCS Region 12 (coastal Georgia) to 71% in DFCS Region 2 (northeast Georgia).

Recommendations for Filling Gaps in the Data

The lack of essential data greatly impacts our ability to assess entirely the impact of meth on Georgia. A second component of this study was to identify gaps between our critical questions and the data available to answer them. The following list points out additional information of value to future studies of meth. Recommendations for retrieving the information are provided in Chapter 5.

Additional Data Required to Fill in the Gaps:

- Detailed information on substance abuse involved in child deprivation cases.
- Data on the prevalence of meth-related criminal activity.
- The impact of meth on emergency rooms and the impact of uninsured meth-abusing patients on state and local resources.
- Comparisons of the number of meth-related offenders receiving treatment between counties with and without drug courts and offenders receiving treatment prior to the drug court.
- Availability and capacity of meth treatment in all Georgia counties.
- Prevalence of meth use in community corrections populations.
- Consistent data on all juvenile drug offenders, whether they are processed by the Department of Juvenile Justice or one of Georgia's independent juvenile courts.
- Detailed information on the type of drug involved in school campus drug offenses.
- Exploration of why persons first begin to use meth and why certain communities are disproportionately impacted.
- Future arrest data captured with specific GCIC meth offense codes.

Chapter 1: Establishing Baseline Information on Meth in Georgia

Methamphetamine, commonly referred to as *meth*, is a powerfully addictive central nervous system stimulant that produces an unparalleled sense of euphoria. The abuse, production, and trafficking of meth has become a major concern to both criminal justice and public health professionals nationwide. In Georgia, penalties for meth crimes were increased in 2003 and restrictions were placed on the availability of medications with the key ingredients to produce meth in 2005. Governor Sonny Perdue's 2004 *Methamphetamine Summit* lead to 25 specific recommendations, all requiring information to combat the meth problem. This study was conducted on behalf of the Governor's Criminal Justice Coordinating Council, Statistical Analysis Center, to establish baseline information on meth in Georgia. Its purpose is to support evidence based decision making among Georgia policymakers and quantify the impact of meth on Georgia's criminal justice and public health systems.

Often the word meth is used in conjunction with the word *epidemic*. Is there a meth epidemic in Georgia? While documented use of the word epidemic dates back some 2,500 years, the extension of the meaning to noninfectious causes is a late 20th century development – referring to something that affects a large number of people, with a recent and substantial increase.¹ Since there

are no scientific rules for applying the word epidemic, how many persons must be arrested for meth-related crimes or enter treatment facilities for meth addiction before meth reaches epidemic proportions? Given the subjective nature of the word, and the panic it can conjure, this report will stop short of drawing such conclusions. This study instead relies on a multitude of data to illuminate the current state of meth in Georgia.

This study answers many questions about the impact of meth on Georgia, including:

- How many persons are arrested for meth-related offenses in Georgia?
- How do meth arrests compare to arrests for other drugs?
- How many persons are incarcerated for meth-related offenses?
- Do meth prisoners look like other prisoners?
- How many juvenile offenders report using meth?
- How many people enter publicly-funded drug treatment centers for a meth addiction?
- How many meth labs have been seized in Georgia and where are they?
- Are certain regions of the state disproportionately impacted by meth?
- What do various professionals suggest we do to combat meth?
- What questions are we unable to answer because data is not available?

Anecdotal evidence suggests that meth has a large stronghold in Georgia. This study examines quantifiable data from a variety of sources, including: the Georgia Bureau of Investigation's Georgia Crime Information Center (GCIC), Georgia Department of Corrections, Georgia Board of Pardons and Paroles, HODAC's Helpline Georgia, Georgia Department of Juvenile

Justice, and the Georgia Department of Human Resources (DHR). In addition, findings from statewide surveys conducted with law enforcement officers, sheriffs, first responders (fire and EMS), prosecutors, drug court personnel, drug treatment providers, DHR's Division of Family and Children Services (DFCS) caseworkers, and domestic violence shelter administrators are presented. Data was also obtained through interviews with key informants with expertise and firsthand experience in dealing with meth across our state. Together these data will form a baseline understanding of the impact of meth in Georgia.

Chapter 2: The Impact of Meth on a Nation

What Is Meth?

Methamphetamine is a powerfully addictive central nervous system stimulant. Meth is a synthetic drug that was developed as a derivative of amphetamine for use in nasal decongestants, bronchial inhalers, and has limited medical application for the treatment of narcolepsy and obesity.¹ By the 1970s the drug was deemed to have little medical use and a high potential for abuse and was defined as a schedule II drug. Meth interferes with neurotransmission of the brain and spinal cord and impacts release of the neurotransmitter dopamine which is part of our brain's natural reward system.² Meth ranges in color from white to yellow and darker colors such as red or brown. It can either be in a granulated powder form, in a clear crystal rock form known as *ice*, or less commonly in small colored tablets.³ The powder form can be snorted, smoked, eaten, dissolved in a drink and ingested, or heated and injected.⁴ Ice, purer than the powder form of meth, is usually smoked or injected.⁵

Meth is a stimulant that increases the energy level, alertness, and sense of well-being of users. People who smoke or inject meth report an intense rush typically within five minutes.⁶ People who ingest meth orally or through snorting do not report the rush effect, but instead report a longer lasting high.⁷ The effects of meth are felt in about 20 minutes after oral ingestion.⁸ The meth *high* results from the brain's release of excessive amounts of dopamine (the neurotransmitter that controls pleasure) and the effects are felt for an average of six to twelve hours.⁹



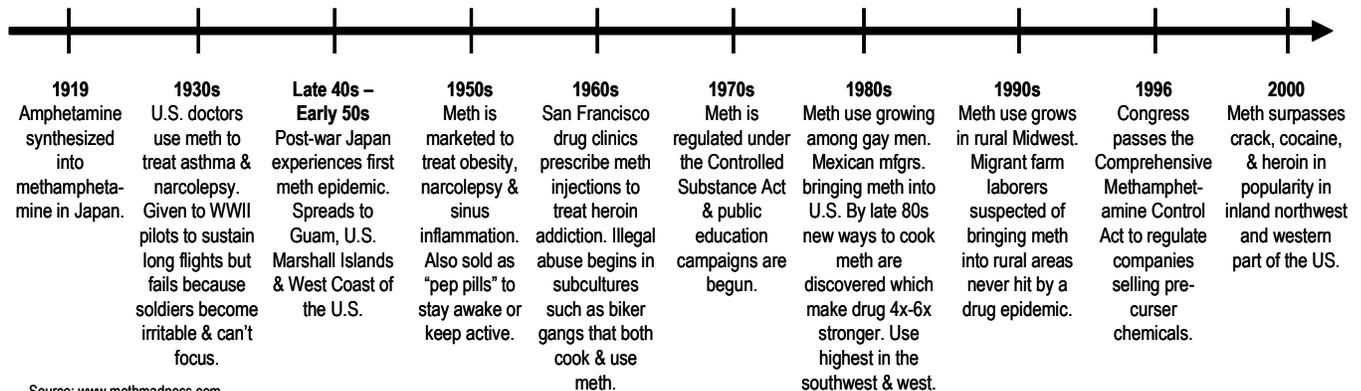
Source: www.drugs-info.co.uk

Methamphetamine "Ice"



Source: www.methmadness.com

Meth Timeline



Source: www.methmadness.com

Meth Street Names & Price

Meth is known by hundreds of street names which vary by geographic location. A sampling of some of the more common names are listed in the table below. Meth users themselves also have a variety of nicknames based on their mode of ingestion. Smokers of meth are frequently called *bulbers* or *hitters*.¹⁰ Meth snorters can be called *geeters* or *tweakers*, and injectors are often known as *bangers* or *slammers*.¹¹

Street Names of Meth

Bag Chasers	Hydro
Batu	Ice
Billy	Jetfuel
Candy	Redneck Cocaine
Chalk	Rock
Crank	Speed
Crypto	Tina
Crystal	Tweak
Crystal Meth	Yaba
Glass	Yellow Bam
Go Fast	Zip

Source: www.nida.nih.gov/infofacts/methamphetamine
www.whitehousedrugpolicy.gov/streetterms/bytype.asp?inttypeid=14
www.stopmethaddiction.com/meth-slang
www.gdcada.org/statistics/meth
www.wikipedia.org/wiki/list_of_street_names_of_drugs#methamphetamine

The price of meth is volatile and prices vary by geographic region of the country, purity, and governmental regulations on meth ingredients such as ephedrine and pseudoephedrine. Meth is typically comparable in price to cocaine and heroin. One hit (one quarter gram) is approximately \$25.¹² Research by the Office of National Drug Control Policy (ONDCP) in 2002 showed that the price varies widely – from \$60 per gram in Seattle to \$330 in Chicago.¹³

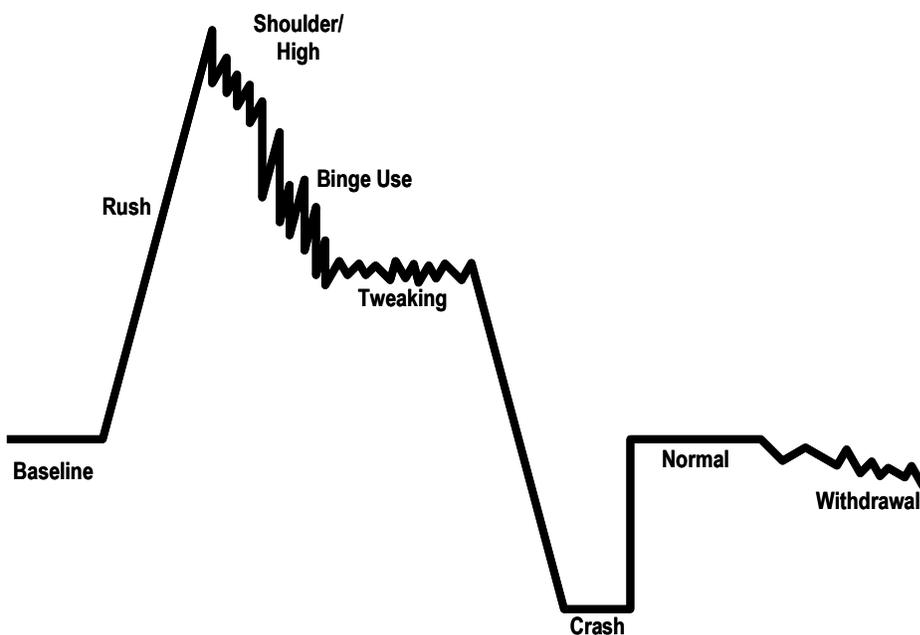
Meth Abuse

There are three patterns of meth abuse: low-intensity, binge, and high-intensity.¹⁴ Low-intensity abusers usually snort or swallow the drug and use it either for extra stimulation or for weight loss. These persons typically hold jobs and function normally, but are in danger of becoming binge users. If they switch to smoking or injecting meth, which provides a euphoric rush not found in oral or nasal ingestion, they can quickly transition into binge use.

Binge abusers smoke or inject meth and experience what is called the binge use cycle.¹⁵ The figure on the next page outlines the seven stages of the binging cycle. The first is called the *rush* which typically lasts for 5-30 minutes. During this phase the user's heartbeat races, blood pressure and pulse soar, and intense feelings of pleasure are experienced. During the rush, the user may experience the pleasure equivalent of ten orgasms.

The second phase is called either the *shoulder* or the *high* and lasts for approximately 4-16 hours. The user often feels aggressively smarter and becomes argumentative. This phase is followed by the *binge* phase in which the abuser tries to maintain the high by smoking or injecting more meth. The rush from each subsequent ingestion of meth gets smaller until there is no rush or high. The binge can last 3-15 days and during this time the user is mentally and physically hyperactive.

The Seven Cycles of Binge Methamphetamine Use



Source: Bill O'Dell, Community Prevention Specialist, West Virginia Prevention Resource Center, "What's Up With Meth" Powerpoint, 2004

The fourth phase of the cycle is called *tweaking*. At this point the user has likely not slept at all during his binge phase (3-15 days) and he is very irritable, paranoid, and uncomfortable. The user craves meth, but use of the drug in this phase will not bring the desired euphoric high. This can lead to uncontrollable frustration, unpredictable behavior, and the possibility of violence. Often persons in the tweaking phase take a depressant such as alcohol, marijuana or heroin to ease their discomfort. This tends to intensify the user's negative feelings and lower inhibitions, which makes reasoning with the user even more difficult. This is the most dangerous phase in the cycle because of the user's unpredictability and the potential for violence. Provocation is not needed for a person tweaking to become violent, but confrontations increase the likelihood of violence. Anything can serve

as a trigger for a tweaker because they are in their own world of hallucinations that cannot be perceived by the outside world. Case histories show that tweakers tend to act negatively to police uniforms which often results in verbal and physical assaults on police officers.¹⁶ Persons tweaking are often involved in domestic disputes, motor vehicle accidents, and may participate in impulsive crimes such as purse snatchings, assaults with a weapon, strong-arm robberies, burglaries, and motor vehicle thefts in order to support their habit.¹⁷

Tweaking is followed by the *crash* phase, which primarily involves sleeping. Even violent abusers become lethargic and require much sleep as their body replenishes its supply of epinephrine. This phase can last from 1-3 days. The crash is followed by what is known as the *normal* phase where the

user returns to a slightly deteriorated state of normalcy. This stage lasts from 2-14 days. As a person binges more often, the normal phase shortens.

The final phase of the cycle is *withdrawal*, which can last 30-90 days. There are no immediate signs of physical distress with meth withdrawal, and often without realizing it the user finds he has become lethargic, depressed, lost the ability to experience pleasure, and begins to crave meth. Users often become suicidal in this phase. If the user gives in to the cravings and ingests more meth, the binge cycle begins all over.

The final pattern of meth abuse is known as *high intensity* abuse. At this point the addict has become what is often referred to as a *speed freak* and their existence revolves around preventing the meth crash phase. The user needs increasing amounts of meth to get high, and the highs experienced are less euphoric.

Long-Term Effects Of Meth Abuse

Long-term meth use has many damaging effects on the body. Chronic users may exhibit violent behavior, anxiety, confusion, insomnia, paranoia, hallucinations, mood disturbances, delusions, homicidal or suicidal thoughts, psychotic behavior, and out-of-control

rages.¹⁸ Other effects on the body include rapid heart rate, irregular heartbeat, damage to small blood vessels in the brain, inflammation of the heart lining, damaged blood vessels, skin abscesses, paranoia, and violent behavior. Psychotic symptoms can continue well after meth usage has ceased. Overdoses can lead to elevated body temperature and convulsions which, if not treated immediately, can lead to death.¹⁹

Meth use also changes the chemistry of the brain, destroying the brain's pleasure centers which make it difficult for the user to experience pleasure.²⁰ The tissues can repair themselves over time, but may never completely recover. A study found that after more than a year of sobriety from meth, former users still showed impaired memory, judgment, and motor coordination.²¹ There is also research to suggest that while some brain tissue damaged by meth may repair



Source: www.justthinktwice.com/gotmeth

itself over time, other damage may be permanent.^{22 23}

One of the most dramatic visible effects of meth on the body is the change in physical appearance. Meth binges lead to increases in physical energy and a suppressed appetite which, over time, leads to drastic weight loss. Binging and tweaking are also frequently accompanied by tooth-grinding and bad hygiene which causes users to not only look gaunt, but to have broken and rotting teeth (often called *meth mouth*).²⁴

Heavy meth use also damages or destroys blood vessels, which impairs the bodies ability to repair itself. Skin lesions take longer to heal, and the skin loses its luster. Chronic users also frequently have sores all over their bodies which are the result of a disorder known as formication (often called *crank bugs*) where the user believes there are bugs crawling under their skin and they obsessively pick, dig, and scratch the skin. The physical changes are so dramatic that many anti-meth campaigns use *before and after* photos to highlight the drastic bodily changes in meth users.

Before & After Meth Use



Source: Multnomah County Oregon Sheriff's Department

Meth used during pregnancy can also adversely affect a fetus. It can cross the placenta and result in premature birth, growth retardation, cause infants to sleep for unusually long periods, cause irritability and feeding problems, as well as lead to aversions to being touched on the hands or feet.²⁵ A Swedish study that followed children prenatally exposed to amphetamines for 16 years found that while the children had normal IQ scores, they

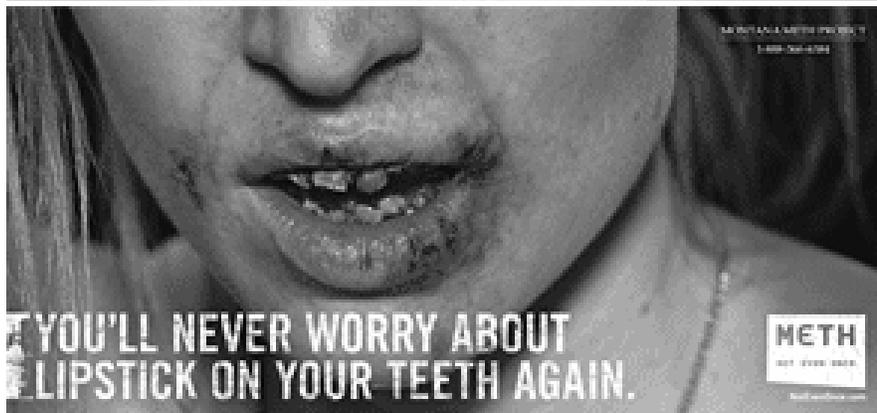
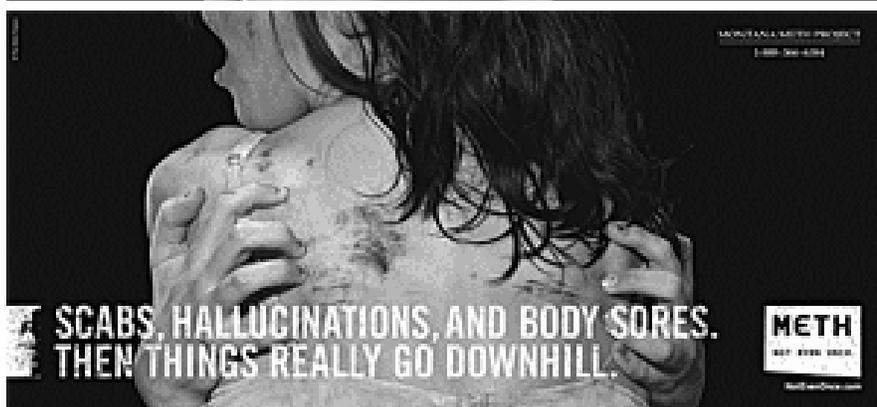
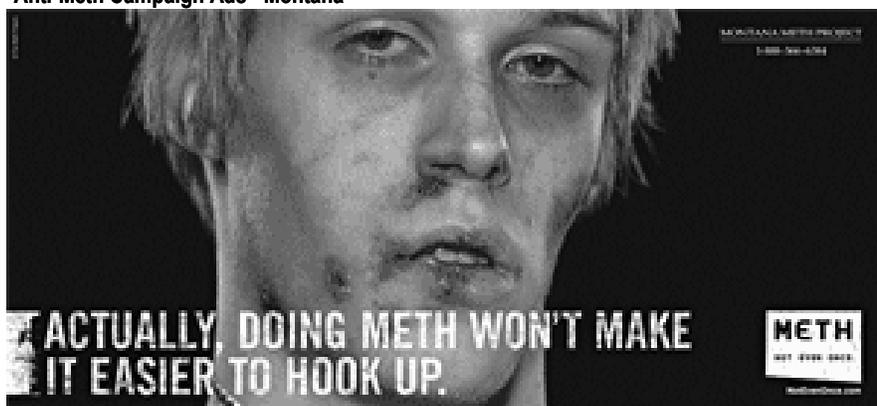
exhibited higher levels of aggressive behavior, had difficulty adjusting to new environments, and had higher rates of failure at school.²⁶

Meth vs. Cocaine Abuse

How does meth abuse compare to cocaine abuse? While meth and cocaine are both stimulants, there are differences between the two drugs in their composition and how they

impact the body. First, meth is a man-made substance while cocaine is a plant-derived substance.²⁷ Meth is made from lethal ingredients, such as battery acid and drain cleaner, which increases the user's risk of heart attack, stroke, or brain damage.²⁸ Meth has also been shown to produce a stronger and more extended high. Studies in animals have shown that cocaine releases 350 units of dopamine, while meth releases 1,200 units.²⁹ *That is twelve times the level of dopamine one would get from normal pleasurable activities.*³⁰ In addition, the meth high lasts 6-24 hours, compared to only 20-30 minutes with cocaine.³¹ The body can remove about 50% of ingested cocaine in only an hour, compared to 12 hours with meth – which leads to its prolonged stimulant effect.³² Finally, scientists believe that meth has more long-term serious effects on the brain than cocaine.³³

Anti-Meth Campaign Ads - Montana



Source: Montana Meth Project

Treatment for Meth Addiction

The meth treatment model recommended by the Center for Substance Abuse Treatment (CSAT), a division of SAMHSA, is the *Matrix Model* which is an outpatient treatment model that includes cognitive behavioral therapy.³⁴ This model of treatment includes 12-step counseling techniques, relapse prevention education, individual counseling, family and group sessions, and urine/breath testing.³⁵ Cognitive interventions that modify the addict's thinking, expectations, behavior, and increase coping skills are the most effective.³⁶ Research also suggests that treatment outcomes may improve if health problems commonly found in meth addicts are addressed during treatment, such as depression and anxiety.³⁷

Experts used to believe that meth addiction was insurmountable. While reliable treatment data on meth addiction is sparse, available data suggests that recovery is indeed possible. The Methamphetamine Treatment Project is a multi-site initiative between the UCLA Integrated Substance Abuse Program and the Matrix Institute on Addictions, funded by CSAT, to study meth treatment protocols.³⁸ Treatment experts anxiously await the findings of this comprehensive project, but in the meantime, available research shows that treatment outcomes for meth addicts are similar to those of users of other drugs.³⁹

Research shows that treatment success with meth appears to be similar to cocaine, with 50%-60% of treatment participants being drug-free at the end of one year.⁴⁰ Evidence suggests that cocaine and meth users respond similarly to cognitive-behavioral strategies.⁴¹ A California study of meth relapse found that over 60% of meth addicts had used meth more than five times in the 12-month period after treatment.⁴² This relapse rate was similar to concurrent users of heroin and cocaine, and users of crack cocaine (55% relapse). Relapse was found to be lower among cocaine users (37% relapse), and higher among marijuana (71% relapse) and heroin abusers (80% relapse). In terms of completing treatment, meth users appear to experience somewhat more difficulty and are marginally more likely to leave treatment prior to completion than users of other drugs.⁴³ Retention rates may be negatively impacted by the cognitive impairments and mental health issues commonly found in meth addicts.

Meth Labs

Clandestine meth labs are a dangerous piece of the methamphetamine equation. While many illicit drugs can be manufactured (such as MDMA, PCP, and LSD), methamphetamine accounts for 80%-90% of all drug lab productions, making

Mobile Meth Lab In A Car



Source: www.methmadness.com

Meth Lab Set Up In A Bedroom



Source: www.methlabvictims.com/methlabvictims.htm

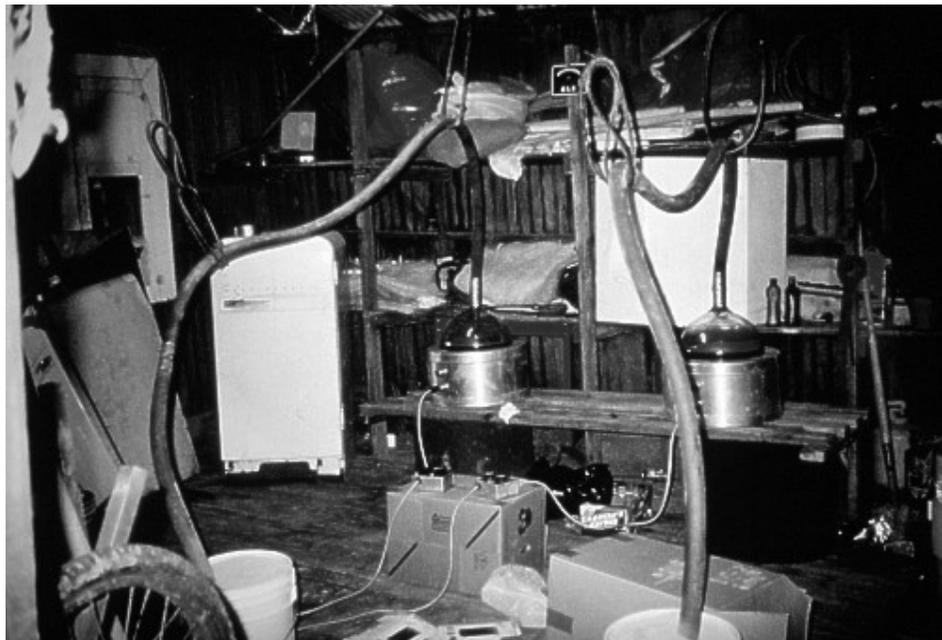
it the most prevalent synthetic drug produced in the U.S.^{44 45}

There are two types of clandestine meth labs. The first is the super-lab, which is a lab capable of producing 10 pounds or more of methamphetamine per production cycle. It is estimated that super-labs account for about 80% of all meth production.⁴⁶ Most

super-labs are found in southern California and Mexico. The second type of meth lab is much smaller and is called a *mom and pop lab* or a *small toxic lab* (STL). These operations typically just produce enough of the drug for the producer and close associates, typically one to four ounces at a time. While these labs do not produce nearly as much meth as the super-labs, they are responsible for many more explosions, fires, uncontrolled hazardous waste dumping, and child endangerment.⁴⁷

Mom and pop labs operate because meth is relatively easy to produce, instructions for cooking meth are available online, and new manufacturing methods have allowed drug production from everyday household items.⁴⁸ Labs have been seized by law enforcement in all 50 states, and have been found in a vast array of settings from rural farms and wooded areas to rental property, apartments, hotels, self-storage units, and

Home Meth Lab -- Basement



Source: www.methmadness.com

even vehicles.⁴⁹ While labs have been found in both urban and suburban locations, rural locations seem to be preferred because they offer more privacy and reduce the odds of detection by law enforcement.⁵⁰ Remote locations provide cover for the storage and disposal of pre-cursor chemicals, and reduce the risk of detection of the strong odors from the chemicals and the production process.

Next to marijuana, meth is one of the most profitable drugs to produce. An investment of \$1,400 to \$1,600 in raw ingredients yields enough meth to bring in anywhere from \$10,000 to \$20,000.⁵¹ It is estimated that 100 pounds of cooked meth could bring in as much as \$4 million dollars when sold on the street.⁵²

There are three main methods for cooking or producing meth.⁵³ The first is *phenyl-2-propanone* which is the least common because the main ingredient, phenyl acetic acid, is highly regulated and hard to obtain. Most meth cooked today is done using the red phosphorous or *Nazi dope* method. These methods both rely on ephedrine or pseudophedrine, which is commonly found in cold and allergy medicine. The red phosphorus method also uses iodine, and the Nazi dope method uses lithium or sodium metal strips as well as anhydrous ammonia (an agricultural fertilizer). It is estimated that 34 chemicals can be used in meth production.⁵⁴ The table to the right provides some of the common chemicals and household items used in a meth lab.

Risks Of Meth Labs

Meth labs are dangerous and can pose three main types of harm.⁵⁵ The first is the risk of physical injury from explosions, fires, chemical burns and toxic fumes. This risk impacts the whole community. When people cook meth they not only expose themselves to toxic chemicals, but neighbors, first responders, hazardous material clean-up crews, and future property inhabitants all suffer from the risks of chemical exposure. It is estimated that one out of every five or six meth labs is discovered because of an explosion or fire.⁵⁶ In addition, first responders face the additional threat of booby traps and armed lab operators which further intensify the risk of responding to calls involving meth labs.^{57 58}

Equipment & Chemicals Commonly Used For Methamphetamine Cooking

Household Equipment

Tempered glass baking dishes
Glass pie dishes
Glass or plastic jugs
Bottles
Measuring cups
Turkey baster
Glass jars
Funnels
Coffee filters
Blender
Rubber tubing
Paper towels
Rubber gloves
Gasoline can
Plastic tote box
Tape
Clamps
Hotplate
Strainer
Aluminum foil
Propane cylinder (20 lb.)

Chemicals (Source)

Ephedrine (cold & allergy medicine)
Pseudoephedrine (cold and allergy medicine)
Alcohol (rubbing/gasoline additive)
Toluene (brake cleaner)
Ether (engine starter)
Sulfuric acid (drain cleaner)
Methanol (gasoline additive)
Lithium (camera batteries)
Trichloroethane (gun scrubber)
Anhydrous ammonia (farm fertilizer)
Sodium hydroxide (lye)
Red phosphorous (matches)
Iodine (veterinarian products)
Sodium metal (made from lye)
MSM (animal food supplement)
Table salt/rock salt
Kerosene
Gasoline
Muratic acid
Campfire fuel
Paint thinner
Acetone

Source: McEwen et. al. (August 2003). *Combating Methamphetamine Laboratories and Abuse: Strategies For Success*. U.S. Department of Justice, Office of Community Oriented Policing Services. Washington DC.

Another risk of meth labs is the impact on the environment. It is estimated that five to six pounds of hazardous waste are produced for every pound of manufactured meth. These toxic wastes are often dumped into the ground, sewers, streams, and rivers. Further, the chemical vapors that are produced during manufacture can permeate the walls and carpets of homes, offices, and buildings rendering them uninhabitable. It

costs an average of \$2,000 to \$4,000 to clean up a meth lab site.⁵⁹

The third harm caused by meth labs is child endangerment. Children exposed to meth labs often have traces of meth in their systems, and they may suffer chemical burns to their lungs and skin. Some children have even died in explosions and fires at meth lab sites. Child protection services in some areas are inundated with cases of child neglect and children being removed from homes where they were endangered by toxic fumes.⁶⁰

Signs Of A Meth Lab

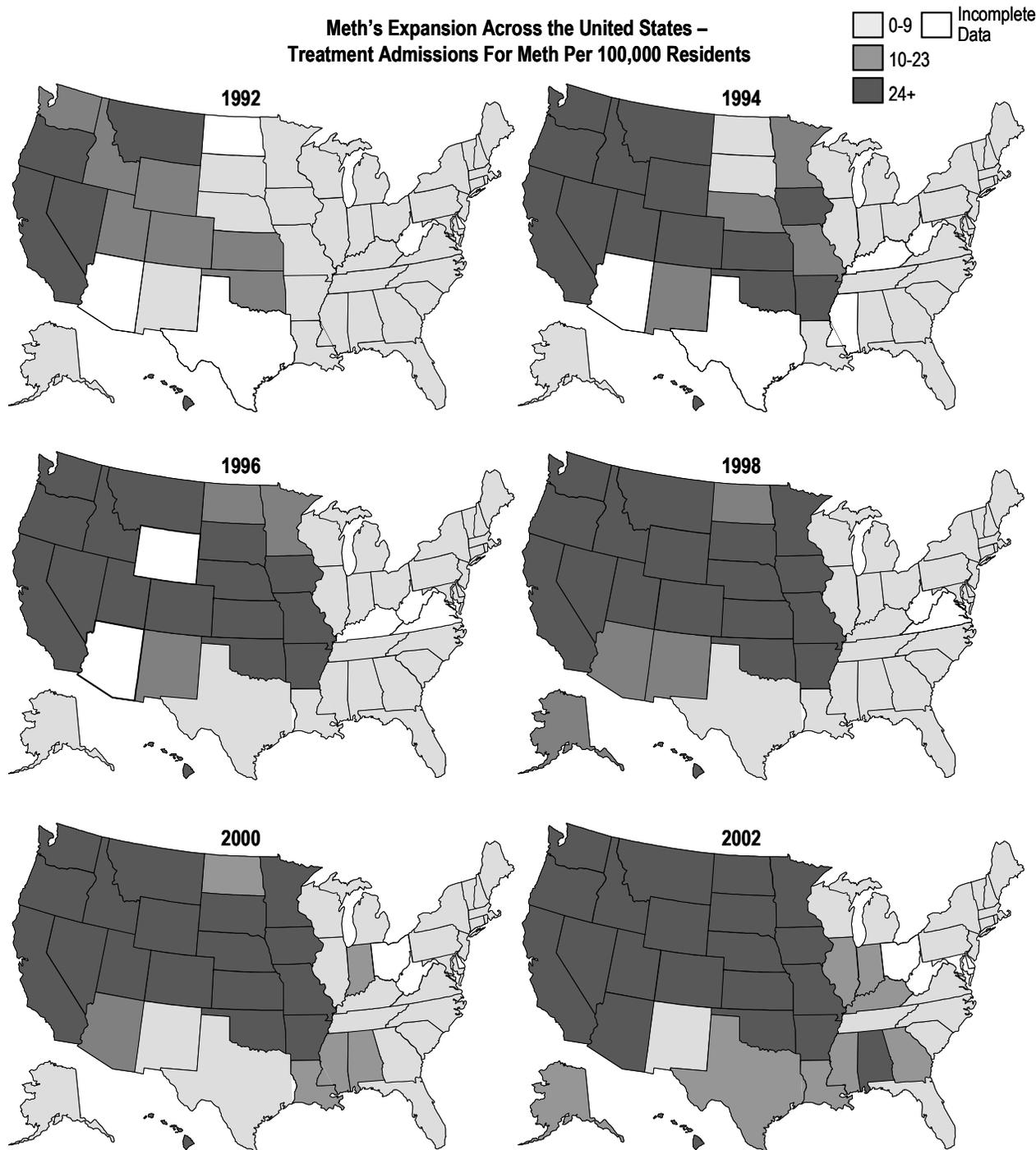
- Unusual strong chemical odors such as ether, ammonia (smells similar to cat urine) and acetone (smells similar to fingernail polish)
- Excess amounts of cold medicines containing ephedrine or pseudoephedrine
- Empty pill bottles or blister packs
- Propane/freon tanks with blue corrosion on fittings, or spray-painted or burned, with bent or tampered valves
- Starting fluid cans opened from the bottom
- Heating sources such as hotplates/torches
- Excess coffee filters, baggies, matches, and/or lithium batteries
- Cookware (Corning type) with white residue
- Glassware, mason jars or other glass containers
- Plastic tubing
- Funnels
- Hoses leading to outside for ventilation
- Soft drink bottles with hoses running from them
- Drain cleaner, paint thinner, toluene, denatured alcohol, ammonia, acid, starter fluid, antifreeze, hydrogen peroxide, rock salt/iodine
- Lantern or camp stove fuel
- Iodine- or chemical-stained bathrooms or kitchen fixtures
- Evidence of chemical waste or dumping
- Excessive amounts of trash, particularly chemical containers, coffee filters with red stains, duct tape rolls, empty cans of paint thinner or pieces of red-stained cloth around the property
- Secretive or unfriendly occupants
- Extensive security measures or attempts to ensure privacy such as "No Trespassing" or "Beware of Dog" signs, fences, or large trees or shrubs
- Curtains always drawn or windows blackened or covered with aluminum foil on residences, garages, sheds, or other structures
- Increased activity, especially at night
- Frequent visitors, particularly at unusual times
- Renters who pay their landlords in cash

If you suspect a dwelling or property may be an illegal lab, contact your local police or sheriff's department. If it's an emergency, call 911. Do not enter a site that you think may have been used for cooking meth. Meth labs present extreme dangers from explosions and exposure to hazardous chemicals.

Source: *Facts About Meth – Meth Fact Sheet*. The Partnership for a Drug-Free America.

Meth Trends In The United States

Perhaps one of the best ways to illustrate the spread of meth across the U.S. is by examining meth treatment trends. The maps on the next page show the number of people admitted to publicly-funded treatment per 100,000 state residents. In 1992, the problem was primarily centered on the west coast. By 1996, most of the west and mid-western U.S. were showing sharp increases in meth treatment admissions. In 2002 it was clear that the southeastern part of the country was impacted and that meth was progressing eastward. Interesting to note is that as meth moves east, the states that were impacted early on still have high treatment admissions. Despite prevention efforts in the states most adversely impacted in the early 1990s, it appears that meth continues to be a daunting problem in those locales.

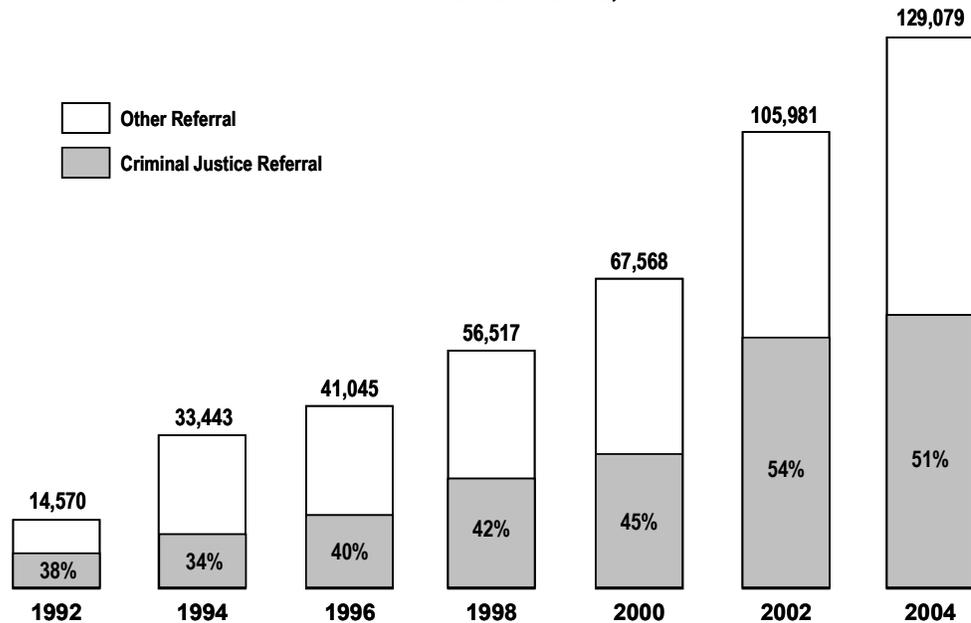


Source: Office of Applied Studies, Substance Abuse & Mental Health Services Administration, Treatment Episode Data Set (TEDS) – 3/1/04

While the maps on meth treatment show the spread of meth use across the country, caution should be exercised in using this data as an indicator of nationwide meth use and dependence. As the chart on the following page shows, there has been a large increase in the number of persons entering meth treatment as a referral from

the criminal justice system. In 1992, 38% of persons entered meth treatment as a criminal justice referral, compared to 51% in 2004.⁶¹ Treatment admissions may be impacted by changes in sentencing practices, growth of drug courts, or legislative changes which divert meth offenders into treatment.

Number of Primary Methamphetamine Treatment Admissions & Percentage That Were Criminal Justice Referrals, 1992-2004



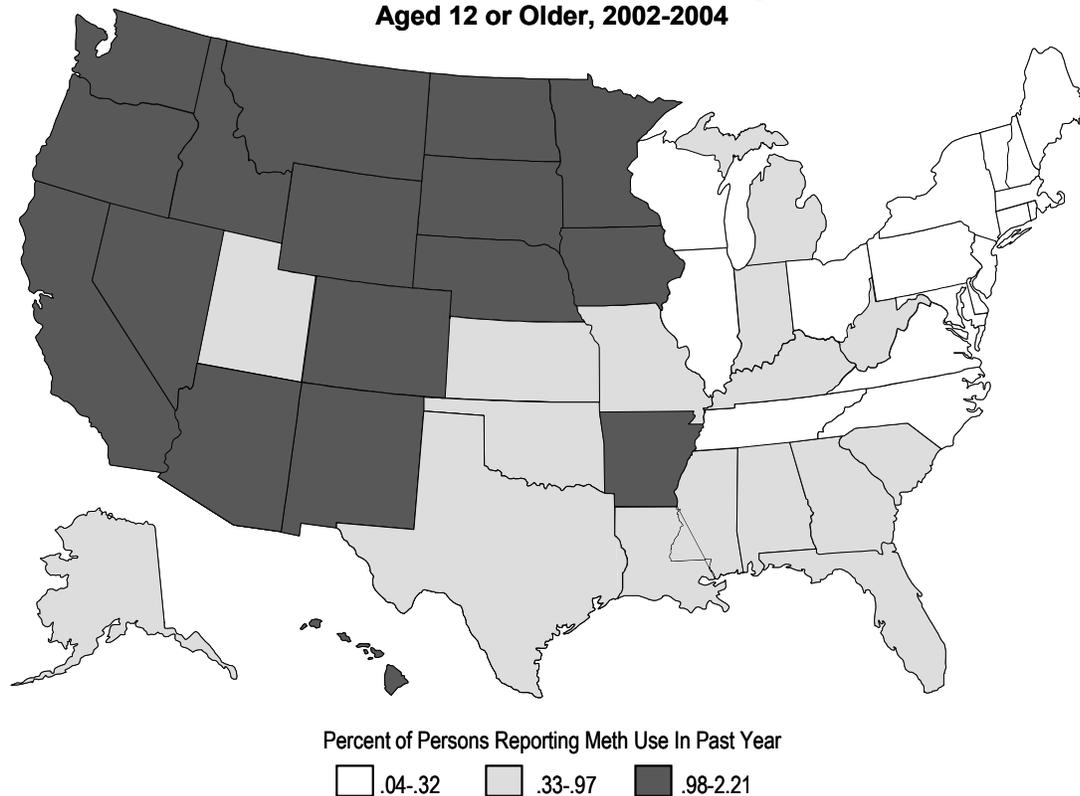
Source: Adapted by CESAR from Substance Abuse and Mental Health Data Archive, online analysis of the concatenated 1992-2002 TEDS data set, conducted 6/2/06. The SAMHDA is available online at www.icpsr.umich.edu/SAMHDA.

The National Survey on Drug Use and Health (NSDUH) conducted by the Office of Applied Studies, Substance Abuse and Mental Health Service Administration (SAMHSA) reports on drug usage among Americans. In 2004, an estimated 12 million persons (non-institutional civilians) aged 12 or older (4.9% of the population) had used meth at least once in their lifetime.⁶² An estimated 318,000 had used meth for the first time in the 12-months prior to the survey, indicating that they were new to the drug.⁶³ While casual meth use appears to have remained stable since 2002, there is concern that the number of persons classified as abusers or dependent on meth has risen. In 2002, 164,000 persons met the criteria to be classified as an abuser or drug dependent, but in 2004 the number jumped to 346,000.⁶⁴ There is also concern that chronic meth use is not likely to decline in the near future due

to the highly addictive nature of the drug and high relapse rates among those seeking treatment.⁶⁵ Meth use in the past year was found to be highest in counties not located in metropolitan areas, and in small metropolitan counties.⁶⁶

According to the National Clandestine Laboratory Database, there has been a decline in meth labs discovered across the country in recent years, with decreases in both the numbers of mom and pop labs and super-labs seized by law enforcement.⁶⁷ These reductions are attributed to law enforcement efforts, greater public awareness, and governmental regulations on the sale of pre-cursor chemicals, namely pseudophedrine. However, despite decreases in domestic meth labs, the availability of meth in America has remained stable.⁶⁸

Methamphetamine Use In Past Year Among Persons Aged 12 or Older, 2002-2004



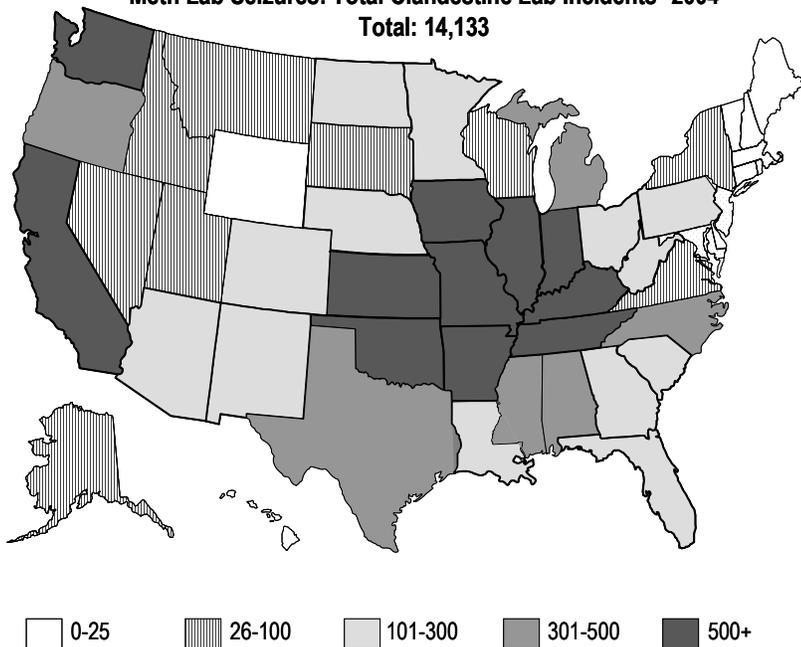
Source: The National Survey On Drug Use & Health Report, 9/2005

While there is no data system to track the availability of meth, anecdotal law enforcement reporting indicates stable supplies in established markets, as well as increasing availability in the Great Lakes, northeast, and southeast parts of the country.⁶⁹ National-level purity data also show an overall increase in the purity of meth available (likely because of increased amounts of ice which have higher purity levels than powdered meth). It is believed that the production and distribution of meth from Mexico has increased so as to both make up for the decreases in domestic production, and facilitate the spread of meth eastward across the country.

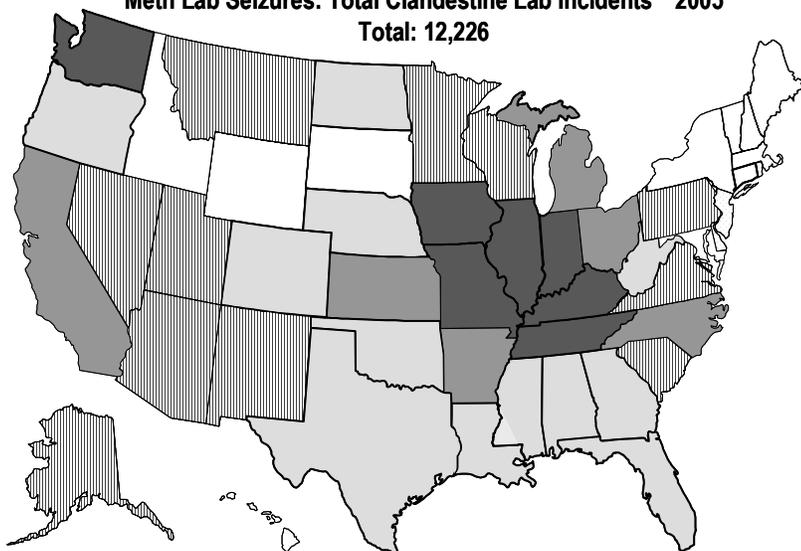
The Drug Abuse Warning Network (DAWN) is a public health surveillance system

designed to monitor emergency department (ED) visits. DAWN includes 22 geographic units to determine national trends (the system underwent major changes in 2003, so data is not comparable to previous reports). For the third and fourth quarters of 2003, DAWN reports that 25,039 meth-related visits were made to emergency rooms across the country, which equates to 4% of all ED visits precipitated by an illicit drug or alcohol use. In comparison, one in five ED visits for illicit drugs/alcohol were cocaine-related, 13% were marijuana-related, and 8% were heroin-related.⁷⁰ When ED visits are considered in relation to population (number of visits per 100,000), meth-related visits account for 9 visits per 100,000 persons compared to 44 visits for cocaine, 28 for marijuana, and 16 for heroin.⁷¹ So, while meth

Meth Lab Seizures: Total Clandestine Lab Incidents* 2004
Total: 14,133



Meth Lab Seizures: Total Clandestine Lab Incidents 2005**
Total: 12,226



*Includes labs, dumpsites, chemical/glass/equipment reported & entered into the CLSS as of 2/15/05.
 **Includes labs, dumpsites, chemical/glass/equipment reported & entered into the CLSS as of 2/15/06.
 Source: National Clandestine Laboratory Database

Monitoring program (ADAM). ADAM operated at 39 sites (the program is no longer active) and included interviews with arrestees about their frequency of illicit drug use and method of drug acquisition. Respondents were also asked to provide a urine sample for drug testing. An average of 5% of male arrestees tested positive for meth across all sites in 2003.⁷² However, the rate varied widely from a low of 0% at some sites to a high of 40%. The female arrestees showed similar patterns, with an average of 9% testing positive for meth across all sites (with a range from 0% to 57% across sites). While the positive test rate for meth seems relatively low, the variation between the geographic sites illuminates the regional nature of the meth problem. Places like Albany and New York City in New York had no positive meth tests for both women and men, but over a third of arrestees tested positive for meth in cities such as Honolulu, Phoenix, San Diego, and San Jose. Keep in mind that the NSDUH survey found that meth use is highest in small metropolitan and non-metropolitan counties, while all of the 39 ADAM testing sites are located in metropolitan areas.

accounts for a formidable number of ED visits, it is far exceeded in volume by cocaine.

Another source of data to help understand the prevalence of methamphetamine use in the U.S. is the Arrestee Drug Abuse

The National Forensic Laboratory Information System (NFLIS) is a program sponsored by the U.S. Drug Enforcement Administration (DEA) that collects toxicological analysis results from state and local forensic laboratories. They have found consistent increases in meth. In 1997 less than 4% of substances seized by law enforcement and analyzed at forensic labs

were found to be meth.⁷³ By 2000 the number had jumped to nearly 10%, and by the first half of 2005 it was nearly 14%.⁷⁴ Western states accounted for the highest percentage of meth (39%), followed by the midwest (9%), the south (8%), and the northeast (<1%).⁷⁶

The Monitoring The Future survey, conducted by the University of Michigan and supported by the National Institute on Drug Abuse (NIDA), provides information on drug use among youths nationwide since 1975. The most recent survey conducted in 2005 included 50,000 students in grades 8, 10 and 12 at 400 secondary schools nationwide to assess drug use patterns and trends. The 2005 report indicates the use of crystal meth has remained relatively constant since 1997, with 2%-3% of students reporting having used the drug in the preceding 12 months.⁷⁷ When students were asked if they had used *any* type of methamphetamine in the past 12 months, results have shown a steady decline between 1999 and 2005. In 2005, 1.8% of 8th graders, 2.9% of 10th graders, and 2.5% of 12th graders report using meth. Those figures compare to 3.2% of 8th graders, 4.6% of 10th graders, and 4.7% of 12th graders in 1999.⁷⁸

The National Association of Counties conducted a nationwide survey of law enforcement agencies to better understand the impact of meth. Their survey included 500 law enforcement agencies in 45 states.⁷⁹ Over half of responding agencies reported that one in five arrests in their county during

the past five years was meth-related. Seventeen percent reported that more than half of their arrests are meth-related. Over half of respondents (58%) reported that meth was their number one drug problem, compared to 19% citing cocaine, and 17% citing marijuana as their primary drug problem. When examining this question from a regional perspective, meth is shown to have a regionally disproportionate impact. Seventy-six percent of counties in the southwest, and 75% in the northwest ranked meth as their number one drug problem, as did 67% in the upper midwest, and 57% in the lower midwest. Only 26% of respondents from the southeast and 4% in the northeast ranked meth number one.

Summary

The data on meth in the United States paints a somewhat confusing picture. Casual meth use by adults appears to be stable, but decreasing among high schoolers. While *causal* adult use is stable, there are more adults meeting the criteria of meth *abuser*. Substantial decreases in the number of meth labs seized have been seen across the country, but meth continues to be available on our streets because of increases in imported meth from Mexico. While meth appears to be spreading across the nation, the west and midwest continue to be the most adversely impacted with the highest number of drug treatment admissions for meth, positive arrestee drug tests for meth, meth-related forensic evidence seizures, and law enforcement professionals indicating

that meth is their primary drug problem. Survey data also indicates that meth is the least prevalent in large metropolitan areas, making rural and suburban locales the most adversely impacted. Now that an understanding of the history of meth and its impact on the nation has been established, attention will turn to specifically examining the impact of meth in Georgia.

Summary of Meth in the U.S.

- Casual adult meth use stable, but more adults meet criteria for meth abusers/drug dependence
- Meth use among high school students declining
- Reductions in meth lab seizures, but increase in imported meth from Mexico
- The west and mid-west most adversely impacted by meth
- Small metropolitan and non-metro counties more adversely impacted by meth

Chapter 3: Meth in Georgia

This chapter focuses exclusively on the impact of meth on Georgia. Data from state agencies is used to explore the prevalence of meth in our state and its impact on our criminal justice system, publicly-funded drug treatment centers, and social services. When possible, county-level data is provided so that geographic trends within the state can be examined.

The agencies supplying data include the Georgia Crime Information Center of the Georgia Bureau of Investigation, Georgia Department of Corrections, HODAC Helpline Georgia, Georgia Department of Juvenile Justice, and the Georgia Department of Human Resources. Federal agency data for Georgia has also been obtained from the U.S. Drug Enforcement Administration, and the El Paso Intelligence Center.

Meth Arrests In Georgia

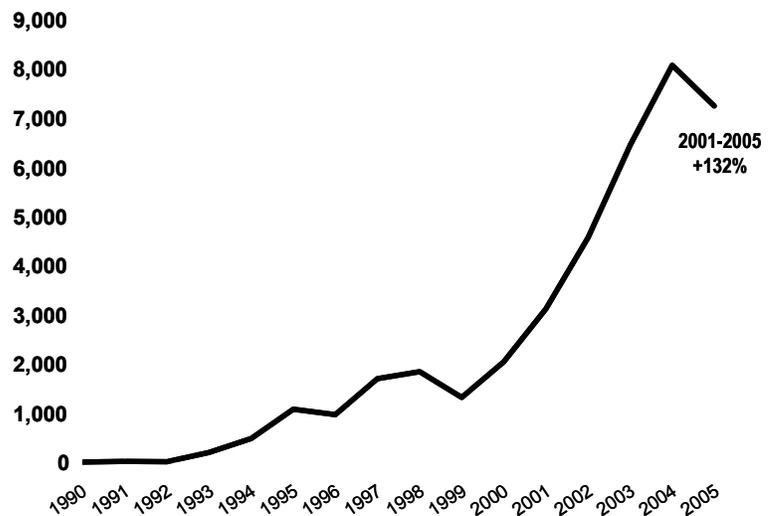
Assessing the number of meth-related arrests in Georgia is challenging because the automated arrest data of the Georgia Crime Information Center (GCIC) does not have a data entry code specific for meth offenses. Meth crimes are classified as drug possession, drug sale, drug manufacturing, or as general drug code violations. To determine if historical arrest episodes included a charge for a meth crime, data mining techniques were applied to the free-text narrative field entered by law

enforcement agencies into the GCIC system.

This narrative field provides details of the offense, including the drug that precipitated the arrest. While the data mining techniques utilized are highly sophisticated and resulted in the identification of thousands of meth arrests, the reader is cautioned that if an arresting agency failed to identify the specific substance involved in a drug arrest, meth-related arrests will be under-counted.

The analysis of GCIC arrest data reveals that meth arrests have increased 132% in the last five years. The decline in 2005 coincides with a drop in all drug arrests, and all arrests. Since GCIC data available for this report only included only adults (and juveniles processed as adults), the Department of Juvenile Justice (DJJ) data was examined to ascertain meth-related arrest trends for juveniles. Unfortunately, DJJ data only indicates whether an offense is for drug sale or possession – it does not include data about the particular drug involved.

Number of Meth-Related Arrests In Georgia, 1990-2005

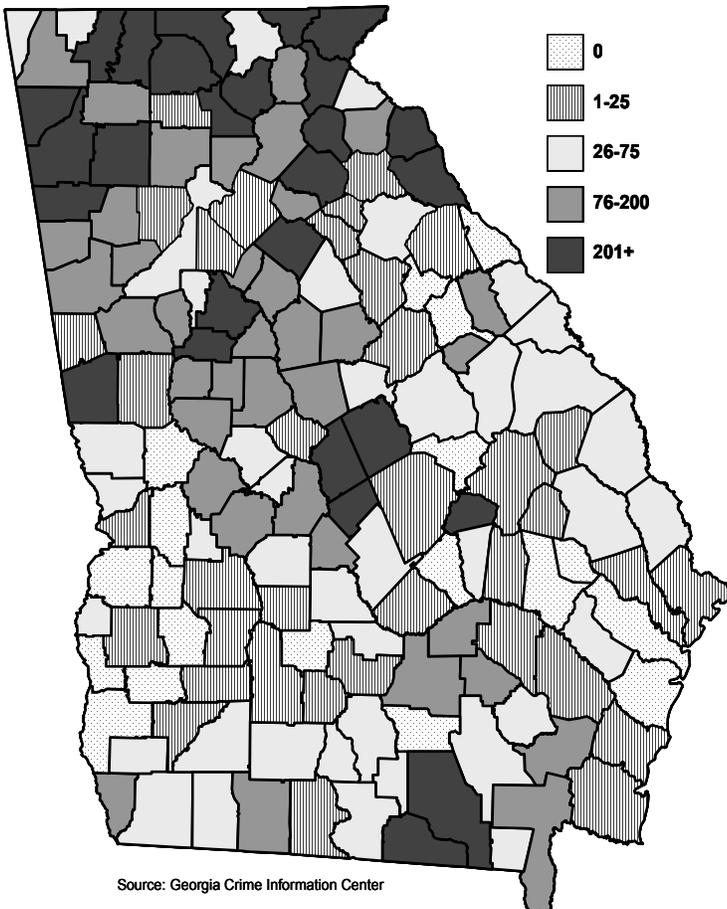


Source: Georgia Crime Information Center

The map below compares the rate of meth arrests per 100,000 residents across Georgia counties in 2005. The northern part of the state has the highest arrest rate, but the problem is not isolated in that region. Meth arrests are also high in parts of south and central Georgia, as well as several metro-Atlanta counties. Fewer than 20 counties in the state have a meth arrest rate of zero. While meth has impacted some counties more than others, the drug has touched most parts of the state.

Another county-level indicator of Georgia’s meth problem is the number of meth items reported by the Georgia Crime Lab. Meth items include all drug evidence secured in law enforcement operations that test positive for meth at the Crime Lab. While the number of items per county residents coincides with the arrest rate map to some extent, there are some surprises. For example, Irwin and Brooks counties in south Georgia had relatively low meth arrest rates, but were among the counties with the highest number of meth items turned over to the Georgia Crime Lab. The reasons for this are not clear. It is possible that substances are described initially as other than meth then later identified as meth by the Crime Lab. Another plausible explanation is that agencies are not properly using the narrative field in GCIC to identify the drug involved in the arrest, which is causing an under-count of meth arrests in some jurisdictions. Regardless of the reasons for the disparity, the map further shows that while the northern portion of the state is sending a large volume of seized meth items to the Georgia Crime Lab, a sizeable quantity of meth items are also coming from south metro-Atlanta counties, central Georgia, and south Georgia.

Georgia County Arrest Rates for Meth-Related Offenses, 2005
(Arrests per 100,000 county residents)



Source: Georgia Crime Information Center

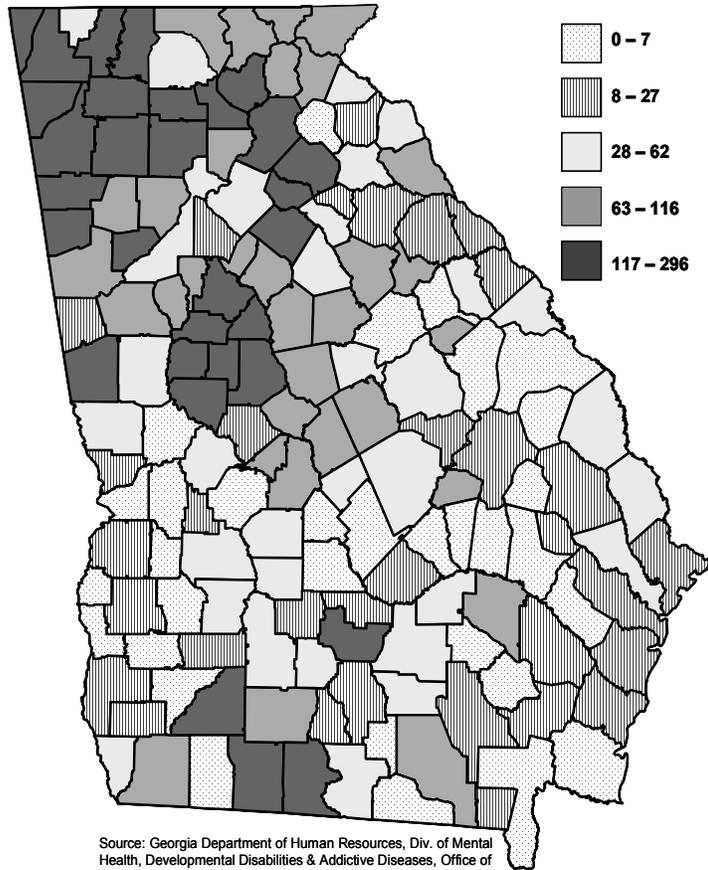
In addition to increases in meth-related arrests, there have also been increases in meth seizures by law enforcement. In 2005, the DEA seized 282 kilos of meth in Georgia, over double what had been seized in the state in 2004.

Kilos of Meth Seized By The DEA, 2002 – 2005*

2002	253 kilos
2003	151 kilos
2004	96.7 kilos
2005	282 kilos

* Fiscal Year
Source: US Drug Enforcement Administration

Number of Meth Items Reported by Georgia Crime Lab Per 100,000 County Residents, 2002-2004

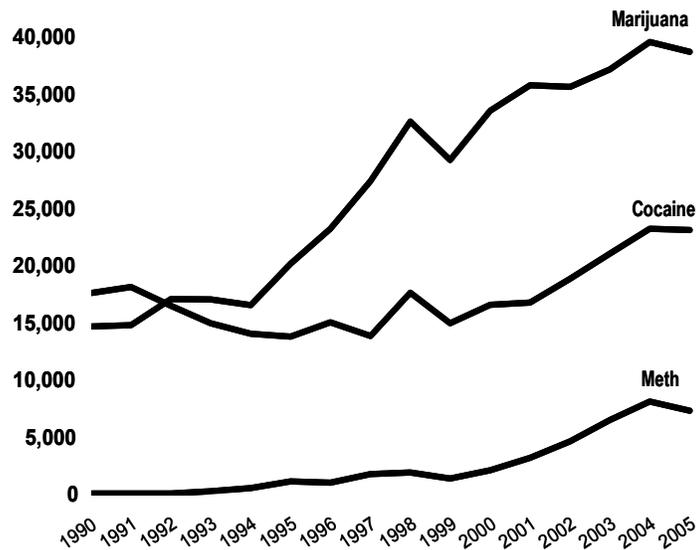


Source: Georgia Department of Human Resources, Div. of Mental Health, Developmental Disabilities & Addictive Diseases, Office of Prevention Services & Programs, Social Indicator Study to Assess Substance Use and Prevention Needs at the State & County Levels in Georgia, March 2006

Comparing Meth Arrests to Cocaine & Marijuana

To fully assess the recent *meth epidemic* discussion, it is important to compare the volume of meth-related arrests to arrests for other drugs. In 2005, there were over 7,200 meth-related arrests in Georgia, which accounted for 11% of all drug arrests. However, in that same year, over one-third of all drug arrests involved cocaine (36%), and 60% involved marijuana (persons can be arrested for multiple drugs, so the percentages do not equal 100%). While meth arrests have been steadily rising in Georgia, the volume of meth-related arrests is still well below both cocaine and marijuana.

Number of Drug Arrests in Georgia By Type, 1990-2005



Source: Georgia Crime Information Center

Clandestine Meth Labs

According to the U.S. Drug Enforcement Administration (DEA), there were 328 meth labs found in Georgia in 2005.⁸¹ This represents a nearly one-third drop in meth labs in the past year.

Clandestine Meth Labs Seized In Georgia 2002-2005*

2002	395
2003	462
2004	485
2005	328

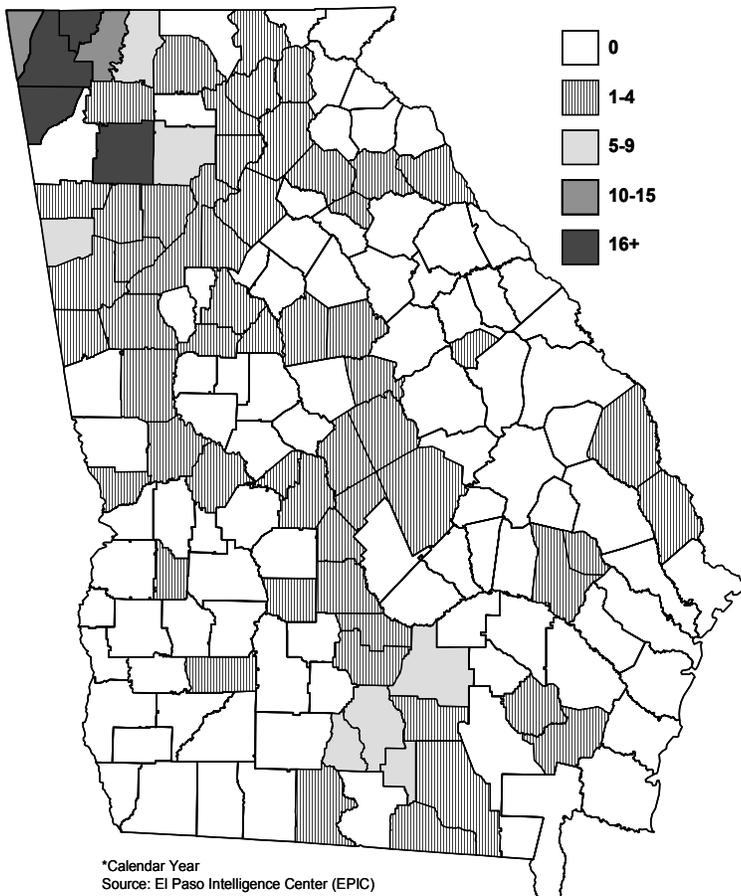
*Calendar Year
Source: US Drug Enforcement Agency, Clandestine Lab Division

Over half of Georgia counties had no meth lab seizures in 2004 (90 counties), including several counties located in the northern part of the state. While the counties most adversely impacted by meth were located in the northern part of the state, the map shows that all regions of the state were at least minimally impacted by meth lab seizures.

The map below provides information on meth lab seizures by county, collected by the El Paso Intelligence Center (EPIC).⁸² The counties with the highest number of meth lab seizures in 2004 were all located in the northwest corner of the state: Bartow, Chatooga, Catoosa, and Walker counties.

As the number of meth lab seizures has decreased, so has the number of children found at seized meth lab sites. In 2004, 69 children were found at meth labs, a one-third drop from 2003. The counties with the highest number of children found at meth labs were Walker, Barrow, Lanier, Haralson, Dade, and Catoosa (see Appendix B).

Number of Meth Labs Seized in Georgia Counties, 2004*



Children Found At Seized Clandestine Meth Labs In Georgia, 2001 2004*

2001	25
2002	59
2003	105
2004	69

* Calendar Year
Source: EPIC NCLSS Total Children Affected (Present, Residing, Exposed to Toxic Chemicals, Killed)

Representatives from the Georgia Bureau of Investigations (GBI) report that the majority of meth available in Georgia is imported from Mexico. Legislation making it increasingly difficult to buy the necessary ingredients for meth, such as ephedrine and psuedoephedrine, has made it hard for many mom and pop labs to continue production. While it is believed the number of domestic producers has declined, the supply of meth

available in the state remains high due to imports from Mexico. The DEA reports that Atlanta is a major distribution hub for Mexican ice for the entire eastern seaboard, and GBI representatives estimate that 95% of the meth available in Georgia is from Mexico.

Several respondents to the statewide meth survey (discussed in detail in the next chapter) expressed concern that their jurisdictions have low levels of meth arrests and lab seizures simply because of manpower problems. Some law enforcement professionals are not convinced that their county has *escaped the meth problem*, and instead believe their figures reflect a lack of law enforcement manpower to search rural areas for meth labs and to conduct sting operations with persons suspected in meth-related activity. Some believe that if their county was part of a drug taskforce, more meth would be uncovered in their jurisdiction.

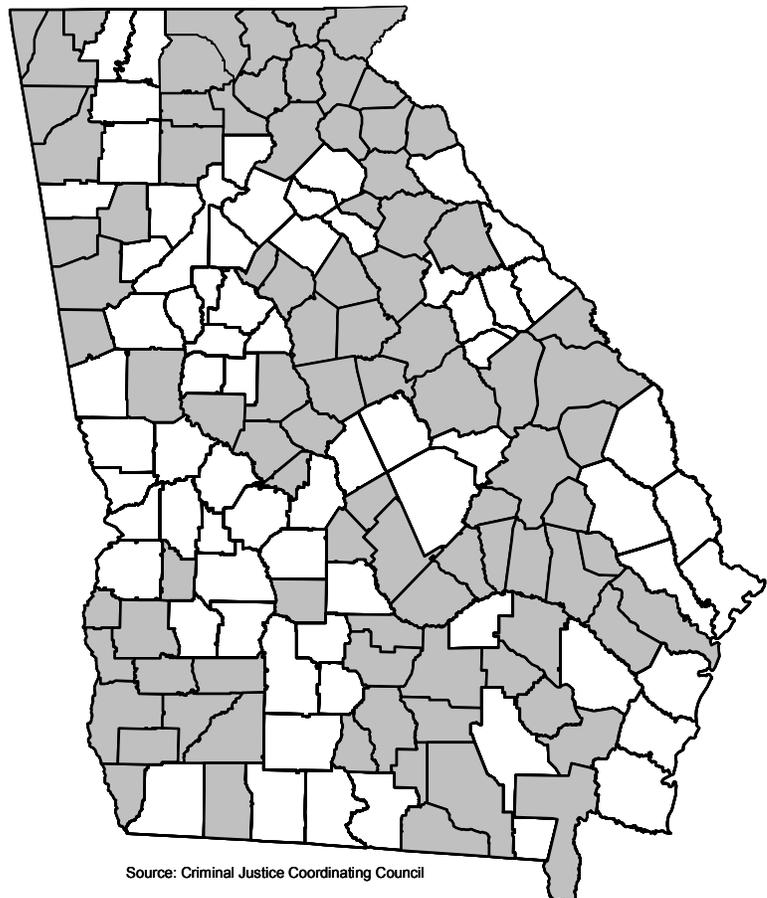
To examine this issue, all counties with a drug taskforce funded by CJCC were mapped. Of the nineteen Georgia counties with a meth arrest rate of 0%, over half (10) are not part of a drug taskforce. Of the 90 counties that had no meth lab seizures in 2004, 35 counties (39%) were not part of a drug taskforce. Historically, multi-jurisdictional grant-funded taskforces in Georgia have been funded based on criteria other than volume of drug activity, principally upon evidence-based practice of sharing and economic resources. While this data

does not illustrate a clear connection between the presence of a county drug taskforce and meth-related arrests/seizures, it does suggest the possibility that law enforcement resources may influence the volume of drug arrests and seizures.

Incarcerations for Meth-Related Offenses

As meth arrests in Georgia are on the rise, and the volume of drugs seized by the DEA increases, it is not surprising that the number of offenders entering prison for meth is also on the rise. Commitments to Georgia prisons for meth-related offenses have been steadily climbing over the past twenty years. In the last five years alone, the number of persons

Georgia Counties That Are Part of a CJCC-Funded Drug Taskforce (Shaded County = Drug Taskforce)



Source: Criminal Justice Coordinating Council

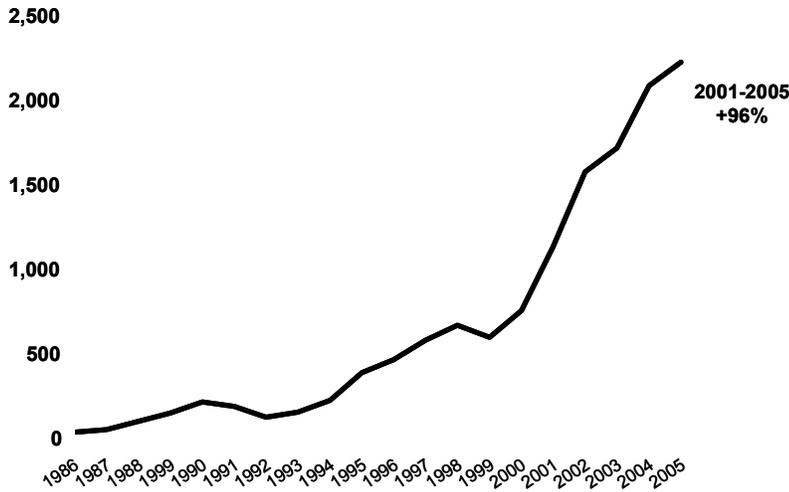
entering prison for a meth-related offense has doubled. In 2005, Georgia prisons admitted 2,224 offenders who had at least one meth offense (prisoners can enter with multiple conviction offenses).

The map to the left displays county-level meth-related prison commitment rates. The majority of meth offenders enter prison from Georgia's northern counties. Interestingly, 49 counties had no meth-related incarcerations in 2005. Very few counties in southwest Georgia are sending meth offenders to prison.

While the data supports the rise in meth arrests and prison commitments, it remains important to compare meth offenders to other drug offenders in prison. The table on the next page compares meth, cocaine, and marijuana offenders entering the Georgia prison system in 2005. Cocaine is the most pervasive drug offense in our prison system, with cocaine-related offenders outnumbering meth offenders by more than 3 to 1. Prisoners with a meth offense account for 7% of the 2005 prison commitments, compared to 29% for cocaine and 9% for marijuana.

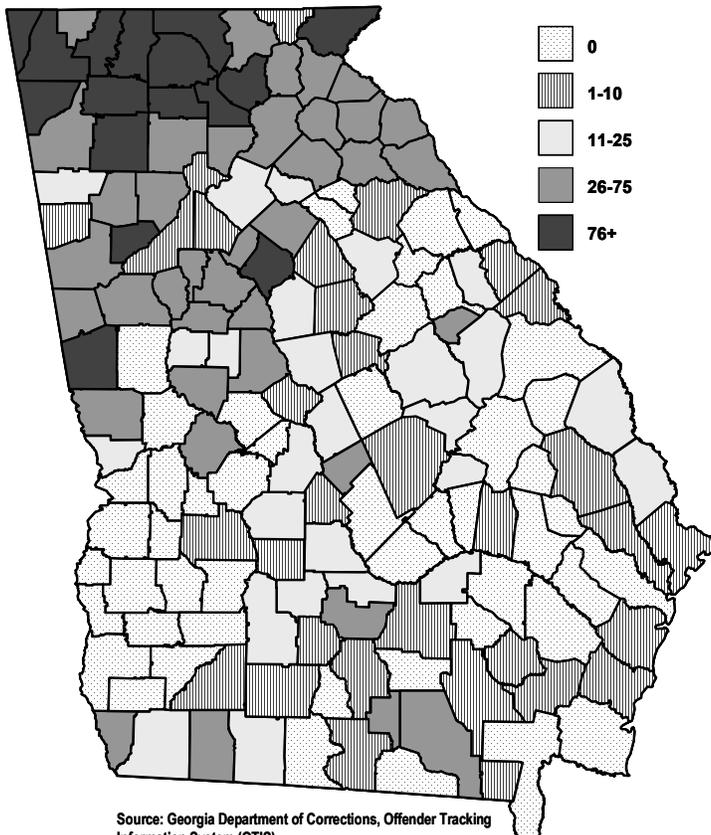
The table also provides a comparison between meth, cocaine, and marijuana offenders entering prison in terms of demographic and personal data. All three types of drug offenders are similar in many respects, with the exception of race. Only 6% of meth offenders are non-white, compared to 84% of cocaine, and 73% of marijuana offenders entering prison. Meth offenders are also more likely to be both employed and married at the time of their arrest.

Number of Meth-Related Prison Commitments in Georgia, 1986-2005



Source: Georgia Department of Corrections, Offender Tracking Information System (OTIS)

Georgia County Prison Commitment Rate for Meth-Related Offenses, 2005 (Prisoners Per 100,000 Residents)



Source: Georgia Department of Corrections, Offender Tracking Information System (OTIS)

Drug-Related* Prison Admissions in Georgia, 2005

	Prisoners With Meth-Related Offense	Prisoners With Cocaine-Related Offense	Prisoners With Marijuana-Related Offense
Number of prison admissions in 2005	1,423	5,593	1,674
% of all prison admissions in 2005	7%	29%	9%
Male	87%	91%	95%
Non-white	6%	84%	73%
Unemployed at time of arrest	20%	26%	26%
On welfare at time of arrest	4%	9%	8%
Grew up with parents (or step)	89%	85%	87%
Married at time of arrest	17%	11%	11%
High school graduate (including GED)	29%	29%	28%
History of mental health treatment	19%	16%	11%
Mental health treatment in prison	13%	12%	8%
Classified as drug abuser/addict	70%	54%	48%
Classified as alcoholic/abuser	32%	33%	30%
Classified as both drug addict & alcoholic	27%	24%	20%
Reading equivalency (grade)	9.7	8.1	8.8
Has children	66%	69%	65%
If children, avg. number per prisoner	1.32	1.62	1.47
Total number of children for all prisoners	1,809	8,820	2,405
Most serious offense is drug possession	45%	39%	43%
At least one offense at conviction is violent	5%	8%	8%
Has prior conviction for violence	8%	14%	10%
Has a prison disciplinary report for violence	4%	10%	9%
Has prior conviction to prison	20%	38%	28%
Has a prior conviction to probation	62%	71%	63%
Mean prison sentence in months	66	76	55
Median prison sentence in months	48	36	36

Source: Georgia Department of Corrections Offender Tracking Information System (OTIS) Inmate Research File 4/7/2006.
*Offender groups defined by specific drug crime codes for meth, cocaine, marijuana in any of the 10 offenses captured in OTIS.

Since many sources describe meth offenders as more violent than other drug offenders, we examined both violent offenses and violent criminal histories of drug prisoners. Compared to other drug offenders, meth offenders are more likely to be imprisoned for drug possession, and less likely to have

a current or prior conviction for a violent offense. However, after completing the prison classification process, meth offenders are more likely to be classified by the Department of Corrections as drug abusers/addicts, and have co-occurring drug and alcohol addictions.

Prison data also reveals that two-thirds of meth-related prisoners have children, and that over 1,800 children had a parent incarcerated for meth in Georgia in 2005. Children of meth-abusing parents are faced with many negative consequences, especially children living in a home used as a clandestine meth lab. It is estimated that nationally 30-35% of seized meth labs are in homes where children live.⁸³ The hazards to these children include exposure to toxic chemicals and toxic fumes, contact with chemicals or chemical wastes, the potential for fire and/or explosions, exposure to drug users/dealers, accessible drugs and/or drug paraphernalia, and weapons or booby traps to protect the meth lab from law enforcement.

Meth use also has negative consequences for a person's ability to parent. During the *binge* phase of a meth high, the user may become agitated, exhibit violent behavior, experience increased libido, and become intensely self-centered. These behaviors increase the likelihood of child physical abuse, sexual abuse, and neglect. During the *crash* phase of a meth high, the user may experience insomnia or intense sleep, intense hunger, depression, and they may be easily agitated or violent. This phase also increases the likelihood of physical abuse, sexual abuse (unable to protect child from the actions of others), and neglect stemming from not providing supervision and not providing for the child's basic needs. The consequences for the children of meth-addicted parents include: abuse, anger

issues, neglect, loneliness, school absenteeism, delinquency, depression, school problems, shame, injury, poverty, addiction, illness, attachment disorder, chaotic lifestyle, and homelessness.⁸⁴ While the children of parents abusing any drug are at risk, meth experts point to the increased dangers faced by children of meth-abusing parents because of the extended length of time the parent is impacted by the stimulant effect of the drug (a 20 minute high from smoking crack cocaine vs. a 12 hour high from meth).

There is very little data available on meth use among Georgia's probationer and parolee populations. The DOC probation automated case management system, SCRIBE, does not contain information on the types of substances found in positive drug tests. This data would need to be garnered from each probation office's paper records of drug test results. The Board of Pardons and Paroles Field Log of Interaction Data (FLOID) automated case management system does contain positive drug test information, but very few positive meth tests are reflected in the data. The standard drug test given to parolees at most state parole offices is a urine stick that tests only for cocaine and marijuana (THC). Parole officers use a special test to detect meth, which is typically only used if the officer has reason to suspect that this person is a meth user.

While data is not available on the number of juveniles arrested for meth-related

offenses, a Critical Review of Needs (CRN) assessment is completed for all youthful offenders adjudicated and sentenced to probation or committed to a juvenile lock-up facility (youthful offenders that enter the DJJ system via one of Georgia's 16 independent juvenile courts do not receive a CRN). The CRN assessment contains self-reported data and includes detailed information about the use of illicit substances. The results of the CRN provide information on the number of juvenile offenders who admit to using meth.

Between 2002 and 2005, 11% of all arrested youths completing the CRN assessment admitted to using meth. This was higher than reported cocaine use (8%), LSD (3%), or heroin (2%), but lower than reported marijuana use (60%). Of those admitting to meth use, 76% reported that they used meth *sometimes*, 11% reported *weekly* usage, and 13% said they used it *all the time*. Meth usage was highest among youths whose most serious offense was drug possession (18%), probation violations (17%), drug sales (13%), and status offenses (12%).

While there are many risks to children using meth (addiction, lowered inhibitions, risky sexual behavior, violence), one typically over-looked is the impact on the brain. The human brain does not fully mature until approximately 25 years of age. Children who use substances such as meth, which impact the brain's serotonin, dopamine, and endorphin networks, risk damaging systems not yet fully developed. Meth experts warn

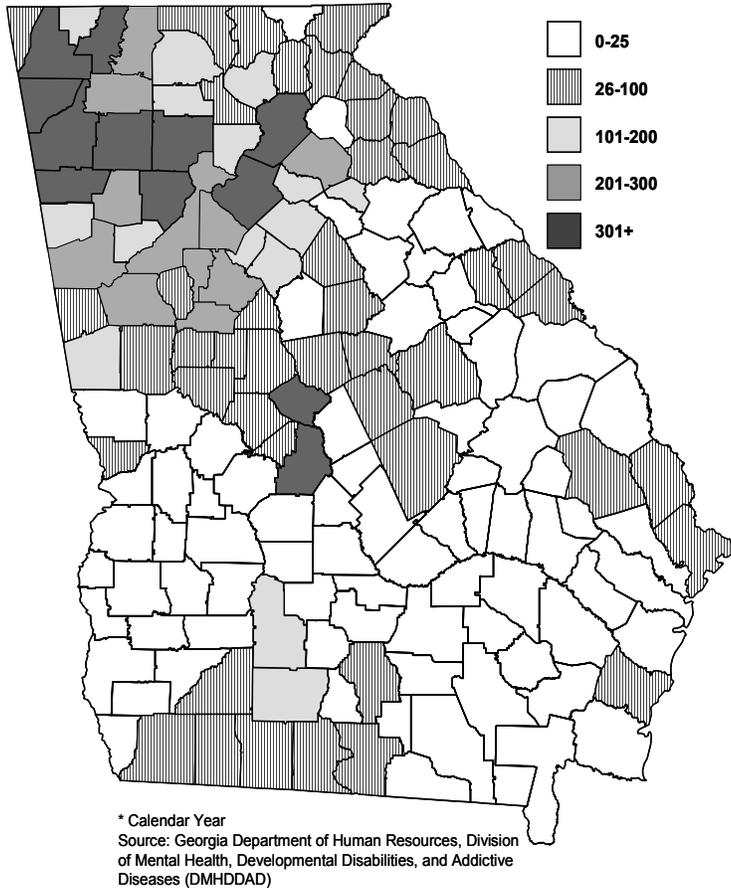
that neurogenesis from meth damage in adults can take as many as seven years, and the brain still never fully returns to normal (the state prior to meth use). Neurogenesis is much different for a user whose brain never fully developed, or reached *normal* before it was damaged by meth.

Meth Treatment In Georgia

As more people in Georgia are arrested and imprisoned for meth offenses, more people are also receiving treatment for meth addiction. This is especially critical as prison data indicates higher levels of drug addiction among meth offenders than other types of drug offenders.

According to the U.S. Department of Health and Human Services Drug and Alcohol Services Information System (DASIS) report, Georgia has seen a large jump in amphetamine treatment admissions (due to different state reporting practices, the amphetamine category includes both methamphetamine and amphetamines). Their report shows that only 3 in 100,000 treatment admissions (for ages 12 and older) to a publicly-funded facility in Georgia were for amphetamine abuse in 1993. By 2003, the rate had jumped to 39 in 100,000.⁸⁵ While Georgia is still below the national average (56 admissions per 100,000) for amphetamine abuse, the data reflect an admission rate thirteen times higher at the end of the ten year span.⁸⁶

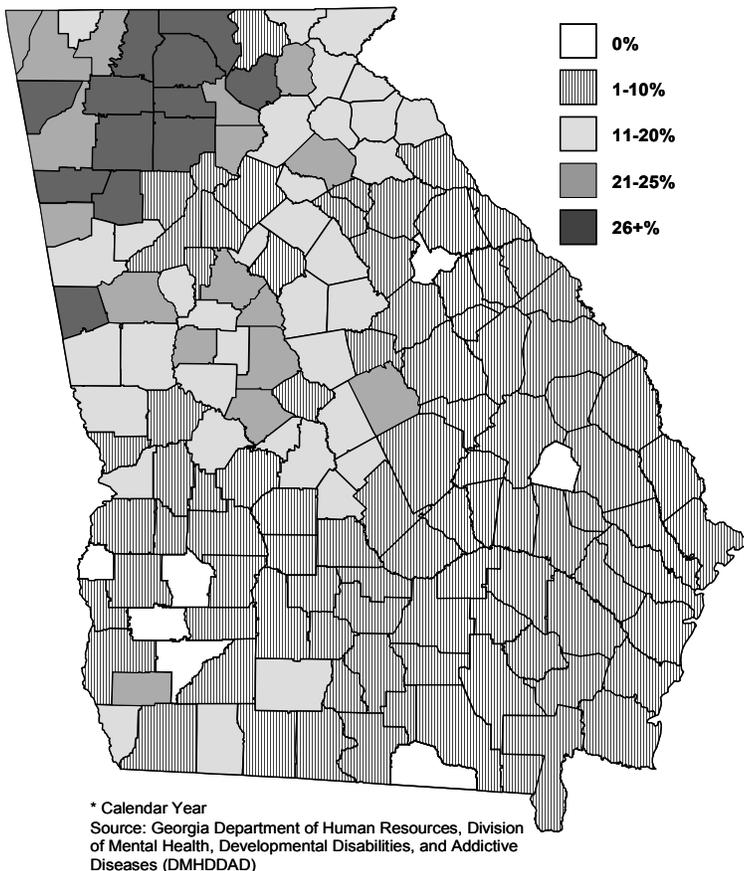
Persons Admitted to DMHDDAD Substance Abuse Services with Primary, Secondary, or Tertiary Drug Problem of Meth 2001-2005*



The map to the left shows the number of persons admitted to publicly-funded drug treatment facilities in Georgia with a methamphetamine problem. Counties with the highest volume of persons seeking meth treatment were located in the northern part of the state. The vast majority (96%) of persons seeking treatment were white.

The raw number of meth treatment admissions can be somewhat misleading due to differences in county populations and numbers of persons seeking drug treatment. The map on the bottom left shows the percentage of drug treatment admissions that were meth-related for each county. This shows a somewhat different picture of meth treatment in Georgia. For example, counties like Miller, Heard, Fannin, Gilmer, Pickens, and Lumpkin all showed relatively low raw numbers of persons admitted for meth treatment; however, meth admissions accounted for over a quarter of all drug treatment admissions in these counties. Conversely, Fulton County showed a relatively large number of meth admissions, but meth comprised only 2% of drug treatment admissions in the county.

Percentage of All Persons Admitted to DMHDDAD Substance Abuse Services With Primary, Secondary, or Tertiary Drug Problem of Meth 2001-2005*



Attempting to depict a connection between treatment admissions for meth and operational drug courts results in an uncertain link. The map on the next page indicates which Georgia counties have drug courts and does not indicate a similar pattern between drug court locations and high meth treatment admissions. This may be caused by many reasons, including a low number of

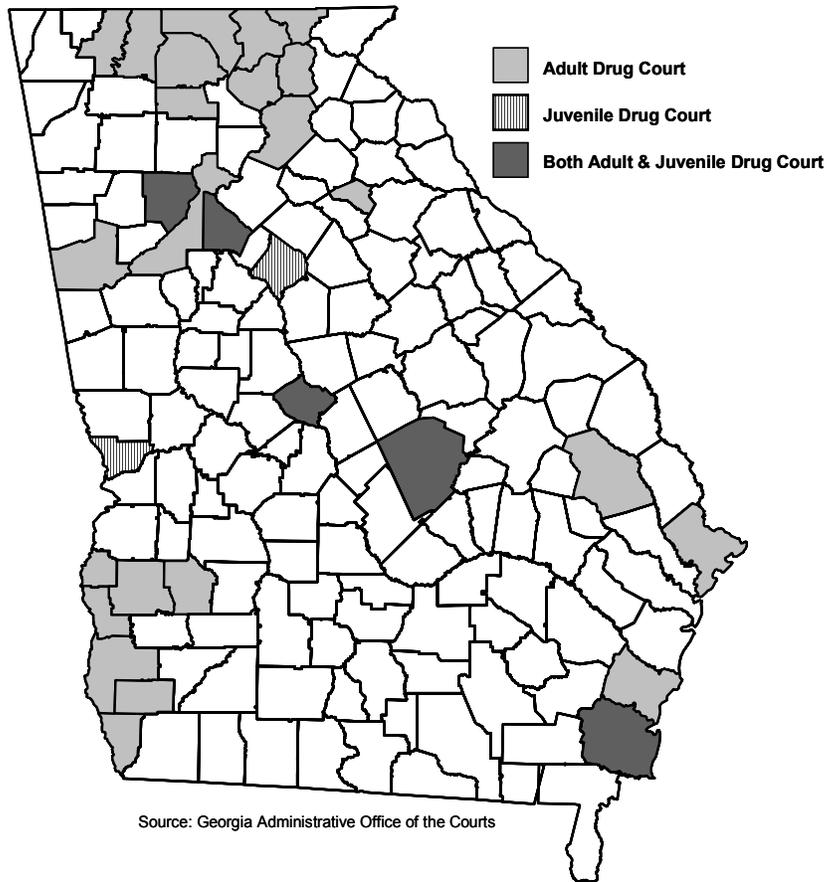
meth cases in counties with drug courts (although not true in the north Georgia counties), meth offenders may enter the court system with other serious offenses which prevent their case from being referred to a drug court, offender refusal to participate in drug court proceedings, a lack of community resources to treat meth users, or drug court reliance on private treatment providers.

If you compare the map of Georgia drug court locations to the map of incarceration rates for meth, we see that many of the counties with a drug court have relatively low incarceration rates. However, this is not true of the north Georgia counties with drug courts or Cobb, Carroll, or Seminole counties, all of which have rather high meth-related incarceration rates. Unfortunately, the data available does not provide a clear picture of the link between drug courts and increases in meth treatment and decreases in meth-related incarcerations. An analysis of meth cases on a county level would be required to assess the impact of a drug court on improved treatment opportunities for meth users entering the criminal justice system.

Meth in Georgia's Hospitals & Emergency Rooms

In late 2005, the National Association of Counties conducted a survey to understand the impact of meth on the nation's county hospital system. Forty-seven percent of the responding hospital administrators said that

Georgia Drug Court Locations



methamphetamine is the top illegal drug involved in emergency room visits.⁸⁷ Nearly three-fourths said that they had seen an increase in the number of meth-related emergency room visits in the past five years. Eighty-three percent of hospitals also reported that persons entering county hospitals for meth-related emergencies are often uninsured. These surveys mostly represent the midwestern United States, so the impact on Georgia emergency rooms is not clear. Only 3% of survey respondents were from Georgia, and only 8% from the southeastern United States.

Another measure of the impact of meth on emergency rooms is the Drug Abuse Warning Network (DAWN), which monitors

emergency department visits in large metropolitan cities across the country. It does not include data from hospitals in rural counties (which data shows are most adversely impacted by meth in Georgia), and also does not currently include any sites in Georgia. Due to a lack of available data, we are unable to assess the impact of meth on Georgia’s hospitals and emergency rooms. Research targeting a representative sample of hospitals across the state to review emergency room visits is needed to garner this information.

represents a 2.5% increase in meth-related calls from the year prior. Over one-third of the calls came from DHR Region 1, which encompasses the northern portion of the state (see Appendix C). The second highest number of calls came from Region 2 which includes the metro-Atlanta area, followed by Region 3 which includes the western part of the state. When examining meth-related calls on the county-level, Fulton had the highest volume of calls (9.7%), followed by Cobb (7.9%), and Houston County (5.5%).

Helpline Georgia

Helpline Georgia is a multi-crisis line that serves Georgians. Operators respond to a variety of inquiry topics including: medical/health issues, abuse/neglect, criminal/legal reporting, mental health, and substance abuse/addiction. Between July 1, 2004 and June 30, 2005, the Helpline received 13,555 calls.⁸⁸ Thirteen percent of those calls involved meth-related inquiries. This

Meth In the Atlanta Metropolitan Area

As the largest city in Georgia, Atlanta may not be representative of the rest of the state in terms of meth trends, but there are several sources of meth data specific to the Atlanta area. The Atlanta High Intensity Drug Traffic Area (Atlanta HIDTA) identifies cocaine as the most significant drug threat to the Atlanta metropolitan area, but reports that meth has emerged as the primary threat to suburban

Call Volume By DHR Region			Call Volume By County Top 10	
	2004	2005		
1	39%	36%	Fulton	9.7%
2	23%	20%	Cobb	7.8%
3	20%	18%	Houston	5.5%
4	7%	11%	Gwinnett	5.4%
5	5%	8%	Henry	3.5%
6	3%	2%	Douglas	3.2%
7	3%	5%	Hall	3.2%
			Coweta	2.9%
			Bartow	2.6%
			Bibb	2.6%

Source: HODAC FY05 Helpline Report

communities neighboring Fulton and DeKalb counties.⁸⁹ They report that both powdered meth and ice are readily available in the suburbs and that they are an increasing threat due to the price and potency of the drug.⁹⁰ According to Atlanta HIDTA, meth crosses socioeconomic lines in urban, suburban and rural communities, and they report 50% of meth cases are closely associated with violent crimes.⁹¹ Atlanta HIDTA also reports a recent increase in crystal methamphetamine (ice) seizures.⁹²

Between 1995 and 2002, Atlanta served as a DAWN data collection site and emergency department (ED) admissions for drugs were monitored by DAWN researchers. The DAWN program was drastically re-designed in 2003 and Atlanta was no longer selected to serve as a data collection site. The data between 1995 and 2002 show that meth ED admissions increased 67% over the seven year period.⁹³ However, the number of person entering EDs for meth-related issues was very small compared to admissions for cocaine or marijuana.

Atlanta serves as a data collection site for the Arrestee Drug Abuse Monitoring

program (ADAM). The purpose of ADAM is to measure drug and alcohol use in persons who have been arrested and booked in city and county detention facilities. There are three booking facilities in Fulton and DeKalb counties and data is collected at two of the three sites. In 2003 (the most recent data available), 8,169 male offenders were processed through these facilities and were included in the ADAM program.⁹⁴ In 2003, 72% of male arrestees tested positive for drugs through urine tests; 2% tested positive for meth, compared to 50% for crack cocaine and powder cocaine, and 42% for marijuana.⁹⁵

The National Institute on Drug Abuse conducts Community Epidemiology Work Groups (CEWG) in 21 cities to inform drug abuse prevention agencies, treatment providers, public health officials, policy-makers, and the general public about emerging drug abuse patterns. The Atlanta CEWG representative is Dr. Brian Dew from Georgia State University. His data collection efforts forecast that meth is an increasing threat in suburban Atlanta because of the low price and availability of the drug.⁹⁶ The DEA and HIDTA report that a gram of meth sold

**Atlanta DAWN Meth, Cocaine, and Marijuana-Related ED Visits Per Year
1995-2002**

	1995	1996	1997	1998	1999	2000	2001	2002	1995-2002 % change
Meth	147	135	214	162	83	109	172	246	67%
Cocaine	6,515	5,434	4,244	5,980	5,236	6,229	8,891	8,947	44%*
Marijuana	1,671	1,547	1,577	2,633	2,515	2,431	3,486	3,602	116%

* Percent change, 2000-2002

Source: Drug Abuse Warning Network, 1995-2002

for approximately \$110 in July of 2004 in the Atlanta market (cocaine sold for approximately \$70-\$100 per gram).⁹⁷ Drug treatment data from the first half of 2004 show that 16% of admissions to publicly-funded drug treatment in areas other than metro-Atlanta were for meth (primary drug of choice). Meth was tagged as the primary drug threat in the suburban communities surrounding Fulton and DeKalb counties.⁹⁸

While cocaine is still the primary drug of choice in metro-Atlanta, accounting for 53% of drug treatment admissions in the first half of 2004 (primary addiction), nearly 11% of admissions were for meth.⁹⁹ Between 2001 and 2004, cocaine treatment admissions dropped almost 15%, while meth admissions increased 8%. The CEWG also cites increases in the number of items analyzed by forensic laboratories (NFLIS) from metro-Atlanta between 2003 and 2004 that tested positive for meth (21% vs. 27%) as evidence that meth is increasing in popularity in the metro area.¹⁰⁰

Summary

The data discussed in this chapter show steady increases in meth arrests, prison admissions, and treatment admissions in Georgia. The northern part of the state has been the most disproportionately impacted by meth arrests and treatment admissions, but most of the state has experienced some impact from meth in their criminal justice and social service systems. Rural counties have been the most adversely impacted thus

far, but there are warnings that the suburbs are at great risk of increases in meth abuse, and that urban areas of the state are not immune.

There have been reductions in meth lab seizures across the state which is good news for first responders who are put at risk by responding to dangerous meth lab calls. However, the DEA and GBI believe that despite the reductions in mom and pop meth labs across the state, the supply of meth on our streets remains high due to increasing imports of meth from Mexico, namely Mexican ice. This increases the likelihood that meth use and meth arrests will continue to rise.

There are also many important pieces of information needed to fully understand the impact of meth on Georgia that are missing. We lack data on juvenile arrests for meth. We also lack public health data from Georgia hospitals about the number of meth-related emergency room admissions and the percentage of meth-related cases that involve uninsured persons. We lack information on the number of persons entering Georgia's jails who test positive for meth use, which hampers our ability to understand how much crime is meth-related. Information is unavailable on the number of meth-related offenses that occur on school property (federal reporting standards only require offenses to be categorized as felony or misdemeanor drug offenses, drug type is not reported). We also lack information on the impact of meth on the social service system

as the Department of Family and Children Services (DFCS) data system only tracks whether an offense was related to substance abuse, but does not log the exact drug involved. So, while there is much data to indicate that meth is a growing problem in Georgia, the missing data prevents us from fully understanding the severity and impact of the drug on state resources and services.

Summary of Meth in Georgia

- Meth arrests have increased 132% between 2001-2005.
- Meth arrests rising, but still greatly outnumbered by marijuana and cocaine arrests.
- Northern Georgia has the highest arrest rate, but most Georgia counties have been impacted by meth to some degree.
- Decreases in meth labs and children found at meth labs.
- Ninety-six percent Increase in meth-related prison admissions between 2001-2005.
- Warnings that meth is the primary threat of suburban counties.

Chapter 4: Statewide Meth Survey Results

To document the impact of meth on both the criminal justice and social service systems in Georgia, a statewide mail survey of law enforcement officers, sheriffs, first responders (fire and EMS), and prosecutors was conducted. Fifteen hundred surveys were mailed to a random sample of Georgia's police departments, sheriff's offices, county prosecutors, and state and federal law enforcement agencies. Each survey respondent received an introductory letter describing the study and requesting participation. A week later respondents were mailed a detailed survey along with a self-addressed, stamped envelope and were given a three week deadline for completion. Reminder cards were mailed prior to the deadline with notice of an extra week for participation.

In addition to the 1,500 mail surveys, 2,167 online surveys were solicited from drug court personnel, drug treatment providers, and DFCS caseworkers. The Administrative Office of the Courts provided e-mail information on drug court personnel and drug treatment providers. DFCS regional directors contacted each county DFCS director requesting that e-mail contact lists of all county caseworkers be forwarded to Applied Research Services. One hundred and thirteen county directors provided contact information for 1,879 caseworkers (see Appendix D). Respondents were e-mailed a letter that introduced the study,

provided a link to the online survey, and were given a three-week deadline for completion. Prior to the deadline, reminder e-mails were sent with another survey link and the deadline for participation was extended by one week.

During the course of the survey project, the research team decided that domestic violence shelters would also be a rich source of information and a telephone survey was designed. A list of 63 publicly-funded domestic violence shelters was obtained from the Governor's Office of Planning and Budget and each shelter administrator was contacted and asked to participate in a brief phone survey about the impact of meth on their clients and their facility.

The table on the next page outlines the number of surveys distributed for each group and the response rate. Short surveys with a narrow focus tend to garner the highest rates of participation, but that type of survey was not appropriate for this project. Exploratory surveys of this nature often result in somewhat low response rates. Because so little was known about meth in the state, it was necessary that the surveys cover a wide array of topics. A copy of each survey instrument is included in the Survey Appendix that accompanies this report.

The surveys covered a wide array of questions pertaining to meth and were custom-designed to each respondent group. While the questions differed across survey types, topics included the prevalence of

"More people are discovering it. Originally it (meth) was a white problem, but it is crossing racial barriers."
Prosecutor

"Meth is a growing problem in rural areas and normally these agencies don't have the manpower or funding to hire officers to combat these problems."
Sheriff

"I only see the problem continuing to grow and getting more out of control. We do not have the resources to handle the meth epidemic."
DFCS Caseworker

"Those who use meth includes doctors to elementary school drop-outs."
First Responder

“Meth is going to cause more problems than crack did before this is all over.”
Law Enforcement Officer

“Meth has definitely taken over as the drug of choice and drug addiction in our area.”
Sheriff

“Meth has evolved into southeast Georgia.”
Law Enforcement Officer

“I work in a community where meth is not the biggest problem right now, but it is growing, and there are other surrounding areas that are experiencing more of it, which still involves us all because we are all linked to this growing addiction.”
DFCS Caseworker

Survey Type	# Surveys	# Returned – no longer w/ agency/bad address	# Surveys Completed	Response Rate
Law Enforcement	591	15	218	38%
Sheriffs	159	1	72	46%
First Responders	375	17	89	25%
Prosecutors	375	37	81	24%
Drug Courts	40	2	20	53%
Drug Treatment Providers	248	10	60	25%
DFCS Caseworkers	1,879	56	390	21%
Domestic Violence Shelters	63	0	50	79%
Total	3,370	138	980	26%

Source: Applied Research Services Statewide Meth Survey, 2006

meth in communities, meth arrests and prosecution, the unique behaviors of meth users, the connection between meth use and crime, the dangers of responding to meth labs, meth addiction and treatment, the impact of meth on families, and suggestions for combating meth in Georgia.

Meth in our Communities

Law enforcement respondents characterized the prevalence of meth use in their community. Since answers varied by geographic location, we compared responses across the 15 Georgia Bureau of Investigations (GBI) regions (see Appendix E). The law enforcement community was most likely to respond that meth is a *major* or *major and growing problem* if they were located in Region 1 and 8 (north Georgia), followed by Regions 6 and 4 (south central Georgia). Law enforcement was most likely to categorize meth as a *small problem* in Region 15 (southwest) and Region 14

(coastal Georgia). Meth was reported to be *not a problem at all* in Regions 10 (metro-Atlanta), 5 and 7 (eastern Georgia). It is interesting to note that 40% - 50% of the counties categorizing meth as *not a problem at all* ranked cocaine as their major drug problem.

When asked to describe the demographics of meth users, both law enforcement officers and sheriffs provided very similar information. Approximately two-thirds of both groups thought that the typical meth user was a male, but a third of each group said that it was an equal distribution between males and females. Almost all users are described as white (98%), and characterizations of the typical meth user were lower to middle class (often described as blue collar). Several respondents said they had arrested persons from *all classes* (very poor to very rich) for meth. Law enforcement respondents were asked the origin, form, and mode of delivery of

the meth they encounter in their jurisdiction. Results about the origin were mixed; one third indicated that most of the meth was imported, another third believed it was a mix of locally made meth and imported meth, and 18% thought it was mostly locally made. Over one half of the meth encountered is ice/crystal (the remainder being a mix of powdered, rock and tablets), and nearly two-thirds said that the meth is smoked (20% is injected).

Meth Arrests and Prosecution

Law enforcement officers and sheriffs were asked to assess trends in drug arrests over time – identifying the top three most frequent drugs involved in adult drug arrests in their community five years ago, two years ago, and today. The trend that clearly emerged from the responses is a decrease in crack/cocaine and an increase in meth arrests. Some survey responses are confirmed by the arrest and incarceration data presented in Chapter 3, which suggest a growing meth problem. However, cocaine arrests still outnumber meth arrests by three to one and are *not* declining over time.

To fill our gap of knowledge on juvenile trends (due to lack of available data on the nature of juvenile arrests), respondents were asked to also rank the top three drugs involved in juvenile drug arrests. While marijuana is the predominant drug of arrest during each of the three time periods, the responses indicate that marijuana has been

Survey Question: Identify The Top 3 Most Frequent Drugs Involved in Adult Drug Arrests In Your Community.

	Crack/ Cocaine is #1	Meth is #1
Law Enforcement Respondents:		
5 Years ago	55%	10%
2 Years ago	54%	23%
Today	44%	45%
Sheriff Respondents:		
5 Years ago	57%	21%
2 Years ago	48%	49%
Today	38%	57%

Source: Applied Research Services Statewide Meth Survey, 2006

decreasing while arrests for meth have been steadily increasing.

To deal with the growing volume of meth arrests, two out of three prosecutors said their agency saw a need to have a special unit or attorney specifically trained to handle meth cases; 41% have a person on staff specifically trained to deal with meth cases (most often it was a drug prosecutor who was not limited to handling meth cases only).

“The courts do not seem to understand the destruction of meth. They tend to treat it the same as crack when it is actually much worse.”
Prosecutor

“Probation is a waste of time. Meth users don’t show up and don’t comply.”
Prosecutor

Survey Question (Law Enforcement Survey Only): Identify The Top 3 Most Frequent Drugs Involved in Juvenile Drug Arrests In Your Community.

	Marijuana is #1	Crack/ Cocaine is #1	Meth is #1
Law Enforcement Respondents:			
5 Years ago	89%	17%	6%
2 Years ago	78%	33%	14%
Today	67%	30%	33%

Source: Applied Research Services Statewide Meth Survey, 2006

“Meth users are more likely to be more violent with law enforcement personnel, to specifically include trying to take officers’ guns.”

Law Enforcement Officer

“Meth users are unpredictable and uncooperative”

Sheriff

“People high on meth that have been on a meth binge for several days present a danger to any public safety personnel.”

First Responder

Over half of prosecutors cited prosecutorial problems unique to meth cases. Challenges to prosecuting meth lab cases include the valid household use of chemicals involved and the *enclave* mentality of the meth community, where persons tend to be armed and work together to protect the lab and drug supply. Thus, meth cases are often handled more as a gang-related case than standard drug case.

Unique Behavior of Meth Users

The surveys examined unique problems associated with the behavior of meth addicts – behavior not seen with other drug addicts. The table below compares the views of many different professionals on the issue of violence and hostility among meth users. Over half of the respondents in every profession except drug court personnel felt that meth users were *more violent* than other

drug users. Very few described meth users as non-violent.

When law enforcement officers, sheriffs, and first responders were asked about the level of cooperation they receive from meth users when responding to calls, most reported little or no cooperation. Over half of sheriffs (58%) also reported that meth users create unique problems in their jails not seen with other drug users. The most common problems described were violence, entering jail with multiple medical problems, and uncooperative and unpredictable behavior.

The Connection Between Meth Use and Crime

Law enforcement officers, sheriffs, and prosecutors were asked for their professional opinions on the criminality of meth users. The vast majority of respondents (95%) said meth users are often involved in

Survey Question: Please Describe Any Unique Problems Associated With Persons Abusing Meth Compared to Persons Abusing Other Drugs In Terms of Violence/Hostility Of Users

Question Response	Law Enforcement	Sheriffs	First Responders	Prosecutors	Drug Court Personnel	Drug Treatment Providers
No difference between meth & other drug users in terms of violence/hostility	7%	6%	7%	30%	20%	20%
More violent	51%	64%	73%	51%	20%	53%
More verbally combative/aggressive	11%	12%	0%	4%	40%	27%
Behavior is unpredictable	5%	2%	13%	4%	20%	0%
Suffer from paranoia	23%	6%	0%	7%	0%	0%
More likely to have weapons	2%	6%	0%	0%	0%	0%
Persons on meth not violent/less violent than other drug users	1%	4%	7%	4%	0%	0%

Source: Applied Research Services Statewide Meth Survey, 2006

Survey Question: Please Describe Any Unique Problems Associated With Persons Abusing Meth Compared To Persons Abusing Other Drugs In Terms of Cooperation With Police/Emergency Personnel

Question Response	Law Enforcement	Sheriffs	First Responders
No difference between meth & other drug users in terms of cooperation	0%	0%	9%
No cooperation	35%	23%	91%
Usually violent/much resistance	8 %	13 %	0 %
Rarely are cooperative	41 %	51 %	0 %
Slow to respond/comprehend situation	1 %	3 %	0 %
Very paranoid/suspicious	15 %	10 %	0 %

Source: Applied Research Services Statewide Meth Survey, 2006

“An abundance of meth in an area causes other crimes, such as theft and burglary, to increase.”

Law Enforcement Officer

criminal activity outside of drug use. When asked about the types of crimes witnessed among meth users, each group of professionals describe property crimes, drug crimes, and acts of family violence.

DFCS caseworkers were also asked about meth use and parental criminality and 91% reported that parents addicted to meth are often involved in criminal activity (outside of drug use). The top three crimes cited, in order, were family violence, property/theft, and drug crimes.

The Dangers of Responding To Meth Labs

Several survey questions involved meth labs, and law enforcement officers, first responders, and sheriffs were asked to rate the discovery of meth labs in their jurisdiction between 2004 and 2005. Almost half of each group reported an increase in

meth labs in their jurisdiction, attributable to the rise in popularity and demand for the drug, and the belief that it is relatively easy and cheap to make. Those reporting decreases in meth labs (16% of law enforcement, 8% of first responders, and 21% of sheriffs) attribute it to increases in meth imported from Mexico, the belief that meth can easily be purchased on the streets, and new laws which make it more difficult to purchase meth ingredients.

“Meth abusers have lower inhibitions, leading to more threats and acts of violence.”

Prosecutor

Survey Question: Which Types Of Criminal Activity Are Meth Addicts Most Often Involved?

Question Response	Law Enforcement	Sheriffs	Prosecutors
Property/theft crimes	27%	27%	27%
Violent/personal crimes (not including sex or family violence offenses)	15%	15%	17%
Drug crimes	20 %	19 %	22%
Family violence	20 %	22 %	19 %
Nuisance crimes/city ordinance violations	9%	9%	6%
Sex crimes	8%	6%	7%
Other crimes	2%	2%	2%

Source: Applied Research Services Statewide Meth Survey, 2006

“Officers have been involved with labs -- almost burned or blown up. Meth lab cooks present real danger to officers because of their paranoia.”
 Sheriff

Law enforcement and first responders were asked about the prevalence of finding children at meth lab sites. Both groups reported that children are present at approximately one-third of the meth labs they respond to (this is consistent with national estimates that children are present at 30%-35% of meth lab sites seized). Of the children found at meth labs, they estimate

were breathing problems, burning eyes, and chemical burns on the skin. One respondent reported that an officer has permanent liver damage due to exposure to toxic chemicals at a meth lab site, and another reported that a suspected cause of a chronic illness suffered by a K9 unit animal was exposure to chemicals at multiple meth lab sites. First responders, police officers, and DFCS caseworkers estimate that one in ten of their professional group requires medical attention after responding to a meth lab call.

Survey Question: Please Compare The Rate of Discovery of Meth Labs In Your Jurisdiction Between 2004 & 2005

Question Response	Law Enforcement	Sheriffs	First Responders
Slight increase	22%	31%	32 %
Major increase	20 %	15%	14 %
Slight decrease	10 %	12%	7 %
Major decrease	6 %	9%	1 %
Stayed about the same	20 %	21%	17 %
Don't know	22 %	13%	29 %

Source: Applied Research Services Statewide Meth Survey, 2006

The majority of law enforcement and first responder professionals also believe their staff needs special training to deal with meth lab calls (94% of law enforcement respondents and 88% of sheriffs and first responders). They identified the most pressing need for specialized training in meth lab safety, awareness, and clean-up. Over one-third of DFCS caseworkers (39%) also identified a need for caseworker training in responding to meth lab sites. A wide range of training needs was cited, but the most common responses focused on meth lab recognition, personal safety, and decontamination issues (for children and caseworkers).

“We’re not getting a lot of (meth) labs because a lot of the crystal meth is coming from the Hispanic drug groups in Atlanta.”
 Prosecutor

one in four requires medical attention. When asked if their agency follows the DHR/GBI *Guidelines for Managing Children Found at Clandestine Methamphetamine Laboratory Site* when responding to a meth lab scene, 85% of law enforcement and 57% of first responders said their agency follows the guidelines.

The surveys inquired about officers needing medical treatment as a result of responding to a meth lab site. Eight percent of law enforcement and 18% of sheriff respondents reported that officers had been injured in the course of responding to a lab site. The most frequent medical issues cited

Meth Addiction and Treatment

To learn more about the treatment of meth addicts from the front lines, we asked drug treatment providers if they have seen any evidence of drug users *switching* to meth because of its long high. Sixty-one percent

“These people are more protective of their homes if they cook meth there. They might set booby traps for law enforcement.”
 Law Enforcement Officer

of respondents said that they had seen this happening; and the most common example was crack/cocaine users switching to meth because of the lower cost, longer high, and easier access.

Drug treatment providers report that the majority of meth users have been using the drug for less than two years when they enter treatment, and approximately two-thirds seeking treatment spend 3-6 months in their facility – similar to a person seeking treatment for crack/cocaine addiction. Drug court personnel agreed with the drug treatment providers that treatment was comparable in length to crack/cocaine, and that persons typically enter treatment in the same physical health as crack/cocaine users.

Both drug treatment providers and drug court personnel indicated they could accommodate less than one quarter of all persons abusing meth that need treatment; 42% and 38%, respectively, said they do *not* have the resources to deal with the number of meth users coming to their facility or court room in need of treatment. Half of drug treatment providers reported unique challenges to meth treatment compared to treatment for other drugs – including the lack of effective treatment protocols, the severity of the cognitive impairment seen with meth abusers, a higher relapse rate, and the severe deterioration of the body.

The Impact on Children and Families

The Criminal Justice Coordinating Council worked in close collaboration with the Georgia Alliance for Drug Endangered Children to assess the impact of parental meth use on children. Respondents were asked to describe the impact on the physical well-being of children whose parents manufacture and abuse meth. The question was asked in an open-ended format and data mining techniques were used to group responses into categories.

Generally, respondents believe that children suffer a number of negative impacts on their physical well-being due to parental meth use. Some of the most common answers include: the healthcare needs of the children of meth users are neglected, the children are malnourished/under weight, the children are in generally poor health, and the children are exposed to high risk chemicals.

Respondent also answered open-ended questions about the impact on the emotional and mental well-being of children whose parents manufacture and abuse meth. Some of the perceived consequences of parental meth manufacturing/abuse were: child neglect, mental/emotional abuse, behavioral problems, and distress from seeing parents arrested and/or going into foster care. The responses illustrate the negative impacts on children when their parents manufacture or abuse meth.

“People are going from crack to meth. Particularly see young caucasians and gays switching.”
Drug Treatment Provider

“I have never seen anything like this (meth) epidemic. The children have to suffer for yet another drug, but this is the most addictive one by far.”
DFCS Caseworker

“Children can’t understand why mom is freaking out, not sleeping, losing weight or why dad is agitated and abusive.”
Prosecutor

“Children (of meth users) live in filth, without utilities such as water and electricity, and are often malnourished.”
Sheriff

Survey Question: From Your Experience, Please Describe The Impact (If There Is Any) On The Physical Well-Being Of Children Whose Parents Are Involved In The Manufacture & Abuse of Meth

Question Response	Law Enforcement	Sheriffs	Prosecutors	Drug Court Personnel	Drug Treatment Providers
Impact of Parental Meth Manufacturing:					
The children have poor hygiene	9%	12%	12%	n/a	n/a
The children are malnourished/under weight	15%	10%	12%	n/a	n/a
The children's healthcare needs are neglected	29%	30%	33%	n/a	n/a
The children have respiratory problems	5%	5%	0%	n/a	n/a
The children are in generally poor health	19%	27%	8%	n/a	n/a
The children suffer physical abuse	3%	12%	3%	n/a	n/a
The children are exposed to high risk chemicals	10%	2%	20%	n/a	n/a
The children have unhealthy living conditions	10%	2%	10%	n/a	n/a
The children experience the effects of living in a dysfunctional family	0%	0%	2%	n/a	n/a
Impact of Parental Meth Abuse:					
The children have poor hygiene	13%	23%	11%	0%	0%
The children are malnourished/under weight	22%	18%	20%	25%	6%
The children's healthcare needs are neglected	28%	23%	39%	50%	40%
The children have respiratory problems	2%	0%	0%	0%	0%
The children are in generally poor health	17%	18%	4%	25%	18%
The children suffer physical abuse	8%	13%	7%	0%	12%
The children are exposed to high risk chemicals	4%	5%	6%	0%	18%
The children have unhealthy living conditions	5%	0%	11%	0%	6%
The children experience the effects of living in a dysfunctional family	1%	0%	2%	0%	0%

Source: Applied Research Services Statewide Meth Survey, 2006

“Children lose everything - their homes, toys, clothes, and parents. They get moved around from home to home changing environments, schools, and friends. They have to learn to deal with problems beyond their age and understanding.”
 Sheriff

Drug treatment providers and drug court personnel were also asked specific questions about the children of meth users entering their facilities and courtrooms (where 30%-40% enter as a custodial parent). Meth use clearly impacts a parent’s ability to maintain child custody. The surveys show that one in five parents entering a publicly-funded drug treatment center or a drug court has lost permanent custody of their children. Another 41% of

parents entering drug treatment and 30% of those entering a drug court have lost temporary custody of their children. The rate of parents losing custody of their children is higher among meth abusers than other drug addicts. They report that approximately one-third of those being treated for abuse of drugs other than meth have lost temporary custody of their children, compared to 41% of meth users. Additionally, 16% of other

Survey Question: From Your Experience, Please Describe The Impact (If There Is Any) On The Emotional/Mental Well-Being Of Children Whose Parents Are Involved In The Manufacture & Abuse of Meth

Question Response	Law Enforcement	Sheriffs	Prosecutors	Drug Court Personnel	Drug Treatment Providers
Impact of Parental Meth Manufacturing:					
The children suffer from socialization problems	11%	17%	0%	n/a	n/a
The children have problems at school	12%	22%	4%	n/a	n/a
The children are emotionally disturbed	7%	9%	0%	n/a	n/a
The children are neglected	26%	17%	25%	n/a	n/a
The children are withdrawn	9%	9%	0%	n/a	n/a
The children suffer distress from watching their parents be arrested/entering foster care	9%	9%	20%	n/a	n/a
The children have developmental problems	2%	0%	7%	n/a	n/a
The children have behavioral problems	4%	0%	7%	n/a	n/a
The children have low self-esteem	2%	2%	0%	n/a	n/a
The children suffer negative consequences of their parent's meth-induced paranoia & inability to care about the needs of others	2%	5%	13%	n/a	n/a
The children suffer from mental/emotional abuse	7%	5%	7%	n/a	n/a
The parent's drug problem has a negative impact on the emotional/mental well-being of the children	9%	5%	17%	n/a	n/a
Impact of Parental Meth Abuse:					
The children suffer from socialization problems	10%	7%	0%	14%	0%
The children have problems at school	15%	21%	0%	0%	4%
The children are emotionally disturbed	6%	12%	3%	0%	13%
The children are neglected	29%	22%	14%	14%	8%
The children are withdrawn	9%	12%	0%	14%	0%
The children suffer distress from watching their parents be arrested/entering foster care	3%	2%	11%	0%	4%
The children have developmental problems	0%	0%	3%	0%	0%
The children have behavioral problems	7%	0%	9%	30%	8%
The children have low self-esteem	5%	2%	0%	0%	0%
The children suffer negative consequences of their parent's meth-induced paranoia & inability to care about the needs of others	2%	10%	31%	0%	0%
The children suffer from mental/emotional abuse	8%	2%	9%	14%	8%
The parent's drug problem has a negative impact on the emotional/mental well-being of the children	6%	10%	20%	14%	55%

Source: Applied Research Services Statewide Meth Survey, 2006

drug users have lost permanent custody, compared to 19% of meth users.

DFCS caseworkers confirm what drug treatment and drug court professionals say about the connection between meth use and losing permanent custody of children. DFCS caseworkers estimated that 38% of users of

other drugs lose permanent custody of their children compared to 53% of meth users.

Statewide, meth has a substantial impact on child deprivation investigations. DFCS workers reported an average of 42% of their child deprivation caseload statewide involves parents using meth. The table on the next page shows the wide variation

"Meth users don't care about anything or anyone when on meth."
Prosecutor

“It seems like they never stop using (meth). We are always arresting the same people over and over again.”
Law Enforcement Officer

across the state, from 19% in Region 12 (coastal Georgia) to 71% in Region 2 (northeast corner of Georgia). The DFCS regions are defined in Appendix E.

DFCS caseworkers also expressed serious concerns about the parental abilities of meth-addicted persons. Nearly half of caseworkers said that meth users are unable/unfit to be effective parents. They also had a multitude of other concerns, including worries that meth users only care about themselves, choose the drug over their children, meth impedes their ability to supervise their children, meth contributes to child neglect, and meth increases the level of violence/child abuse in the home.

“This thing (meth) is worse than any of us realize.”
Law Enforcement Officer

DFCS caseworkers were asked to describe any unique problems associated with parents addicted to meth, as compared to other drugs, in terms of physical abuse in

**Survey Question (DFCS Respondents Only):
What Percentage Of Your Child Deprivation Cases Involve Parents Specifically Manufacturing Or Abusing Meth?**
(Average of all responses)

DFCS Region	Proportion of Child Deprivation Cases Involving Meth Parents
1	56%
2	71%
3	43%
4	56%
5	35%
6	22%
7	31%
8	23%
9	31%
10	21%
11	26%
12	19%
Statewide Avg.	42%

Source: Applied Research Services Statewide Meth Survey, 2006

the household. Almost all (92%) reported that households where parents use meth are prone to violence. They reported that children of meth users witness higher levels of domestic violence between parents in the home, and that the children are more likely to be the victims of physical abuse themselves. Most respondents also reported child neglect in households with a meth abusing parent.

In order to further clarify what we learned from the drug treatment providers and DFCS caseworkers, an informal telephone survey was conducted with domestic violence shelter administrators in Georgia. Sixty-three publicly-funded shelters were contacted, and

Survey Question (DFCS Respondents Only): Please Describe Any Unique Problems Associated With Parents Addicted to Meth, As Compared To Parents Addicted To Other Drugs In Terms of Ability To Parent.

Meth users are unable/unfit to be effective parents	46%
Meth users only care about themselves	12%
Meth users choose the drug over their children	10%
Meth impairs ones ability to parent more than other drugs	9%
Meth has some negative impact on ability to parent	7%
Meth users do not properly supervise their children	5%
Meth users neglect their children	4%
Meth users parent the same as users of other drugs	3%
More violence/child abuse in the homes of meth users	2%
There are not parenting inadequacies in meth users	2%

Source: Applied Research Services Statewide Meth Survey, 2006

50 shelters agreed to participate in a short ten minute telephone survey.

According to shelter personnel, domestic violence cases that involve meth are on the rise – over half of the shelters reported an increase in meth-related cases in the past two years. They reported increases in both the number of meth using batterers, and meth using women entering shelters. Shelter personnel were also asked to estimate the overall percentage of women that had entered their shelter in the past year that were abused by a meth-using partner or spouse. Two out of three shelters reported that nearly half of the women had been abused by a meth-using partner or spouse; 12% estimated that over one half of the women entering their shelter fit the criteria.

One half of domestic violence shelters reported that the level of injury was higher when the batterer was a meth user than when he was not. Many expressed concerns about the erratic and paranoid behavior of meth users, which escalates the level of violence in the household. In addition to meth-using batterers, a concern raised by several shelters was that they are seeing more meth-using women staying in abusive relationships longer because their spouse/partner is the source of the drug. These women are so addicted that they choose to stay in abusive relationships for fear of losing their drug supply.

Allocation of Funds To Address Meth In Georgia

Between 95% and 100% of survey respondents across all professions (except the domestic violence shelters, who were not presented with this question), believe that funds should be allocated to address meth in Georgia. In order, the top 10 recommendations for funding are listed below.

Top 10 Funding Recommendations

1. Training on statewide protocol for how to respond when encountering a meth lab
2. Prevention
3. Public awareness
4. Social services for impacted children
5. Healthcare for children exposed to meth labs
6. Treatment for meth abusers
7. Increase street level enforcement efforts
8. Police academy training for dealing with meth-related issues
9. Formation of a meth task force to bring local law enforcement together
10. Expand drug courts in Georgia

Source: Applied Research Services Statewide Meth Survey, 2006

Summary of the Statewide Meth Surveys

The statewide surveys provide a detailed layer of understanding about meth in our state from professionals on the front line. Respondents expressed much concern about

“I am a strong supporter of education. The public must understand the effects that this problem (meth) has on society, and that is done through education and training.”

DFCS Caseworker

“We are a small community with limited resources and need access to a special (meth) unit, but cannot afford our own.”

First Responder

“Not enough drug agents to counteract the (meth) problem.”

Sheriff

“Public awareness would be a great tool. Many people are not aware of the seriousness of this (meth) problem. A task force that included representatives from the GBI, local law enforcement, and prosecutors would help identify and prosecute dealers and other drug offenders.”

Prosecutor

“Meth users tend to have more physical and cognitive issues.”

Drug Court Personnel

“Meth increases all the negative/dangerous aspects of an investigation including weapons, violence, counter surveillance, increased crime, and extreme addiction.”

Sheriff

the level of violence/hostility exhibited by meth users, and the belief that most meth users are involved in criminal activity (outside of drug use). Respondents also expressed concern about the impact of meth-addicted parents on the physical and emotional well-being of children, as well as the ability of meth-addicted persons to parent effectively. Further, DFCS caseworkers report an alarming number of child deprivation cases that involve parents either manufacturing or abusing meth. The statewide average is 42%, but the figure was as high as 71% in the northeast corner of the state. Drug treatment providers and drug court personnel also express concern about a lack of resources to respond to what they perceive as the growing need for meth treatment in their communities. The data collected through the statewide surveys provided a view of meth from those on the front lines, and the outlook provided is worrisome.

Summary of Meth Survey Findings

- Meth arrests increasing for adults and juveniles.
- Most respondents (except drug court personnel) think meth users are more violent than other drug users.
- Law enforcement and first responders report little cooperation from meth users.
- Most respondents think meth users are involved in criminal activity (outside of drug use).
- Treatment providers report they can only service about a quarter of all meth users in the community needing treatment.
- DFCS reports that 42% of deprivation cases involve meth parents.

Chapter 5: Recommendations for Filling Gaps in the Data

Despite the volume of data presented in this report, there are still many questions that cannot be answered because information is unavailable. This greatly limits our ability to completely assess the impact of meth on Georgia. The second component of this study was to identify gaps between our critical questions and the data available to answer them. The following recommendations address the identified gaps in the data and offer suggestions to provide a more complete appraisal of the impact of meth on our state.

Recommendation #1: Update the DFCS case management system to capture information on substance abuse in child deprivation cases. Very little is known on the impact of meth on children and families in Georgia. DFCS does not collect detailed information on the types of drugs involved in child deprivation cases, which makes analysis of meth cases impossible. Our meth survey of DFCS caseworkers showed that 42% of child deprivation cases statewide are meth-related. However, since this information is not tracked in the DFCS case management system, these cases cannot be analyzed via computer to learn more case detail, nor can they be compared to other drug-related cases. Caseworkers expressed concerns about neglect and abuse in the households where a parent abuses and manufactures meth, as well as concerns

about the inability of persons using meth to effectively parent (more so than users of other drugs). These are serious issues that warrant examination, but the current case management system does not allow for such case analysis. We recommend that the DFCS case management system be updated to allow caseworkers to provide detailed information on the type of substance abuse involved in child deprivation cases.

Recommendation #2: Seek funding opportunities to drug test arrestees in jail.

Survey respondents believe that much crime can be attributed to meth users. However, due to a lack of drug testing in Georgia jails, we are unable to validate this assertion with data. Two metro-Atlanta booking facilities are part of the ADAM program, where urine testing and interviews are conducted with incoming male arrestees to gauge the prevalence of drug use. To our knowledge, such testing of arrestees is not routinely conducted elsewhere in the state. In order to explore the meth use/criminal activity connection, a solid measure of meth use among arrestees must be established. We recommend that funding opportunities be sought which would provide drug testing and interviews with arrestees to garner detailed information on the prevalence of meth-related criminal activity. Data indicates that non-metro areas are the most adversely impacted by meth, so such locales should be a priority.

Recommendation #3: Conduct a statewide survey of hospital and emergency rooms.

The impact of meth on Georgia's hospitals and emergency departments is unknown. Atlanta was a DAWN data collection site through 2002, but is no longer a part of the program. Further, there is no data on the impact of meth on suburban or rural hospitals. A survey conducted by the National Association of Counties in 2005 found that three-fourths of county hospitals reported an increase in meth emergency room visits. Their survey further found that 83% of persons entering an emergency room for a meth-related problem were uninsured. We recommend that a statewide survey of hospitals be conducted to assess the impact of meth on emergency rooms and the impact of uninsured meth-related patients on state and local resources. We recommend that this analysis include information on all major drugs of abuse, and also allow for comparisons between counties so that geographic trends can be mapped.

Recommendation #4: Analyze sentencing practices of counties with drug courts.

The Statistical Analysis Center Committee of the Criminal Justice Coordinating Council expressed an interest in understanding how drug courts have influenced treatment admission rates for meth users in the criminal justice system. Such an examination was outside the scope of this report and would require a detailed analysis of each Georgia drug court. We recommend an analysis of sentencing practices in counties with drug

courts be completed to compare the number of meth-related offenders receiving treatment to those in counties without drug courts and offenders receiving treatment prior to the drug court.

Recommendation #5: Determine the meth treatment capacity in Georgia counties.

Little is known about the meth treatment capacity statewide or by county. Treatment providers expressed concern over a lack of resources to accommodate those in need of meth treatment, and the growing need they see in their communities. For example, Echols, Clinch and Treutlen counties all have very high arrest rates for meth, but they have very few admissions for meth treatment. Is this due to a lack of available drug treatment in the community? Are other reasons to blame for the low treatment admission rate? Do county drug court practices influence meth treatment admission rates and treatment availability? Does the availability of county drug treatment services influence drug offender sentencing decisions?

The Department of Human Resources conducted a social indicators study which examined each county in terms of risk for alcohol/drug abuse and alcohol, tobacco, and drug availability (including meth).¹⁰¹ However, this study does not include data on the drug treatment capacity of each county. One of the top ten most important funding priorities cited by front-line professionals was ensuring treatment for meth users. We recommend that county-level analysis be conducted to explore the

availability and capacity of meth treatment in the state. Special attention should be given to counties with high arrest rates for meth-related offenses.

Recommendation #6: Expand drug testing for meth among probationers and parolees.

Due to the lack of meth drug testing for probationers and parolees, we do not have information on the prevalence of meth use for these two populations. The Parole case management system indicates very few positive meth tests and the Probation case management system does not include any systematic capture of the drug test results by type of drug. Part of the problem is the use of urine drug tests that primarily check for the presence of cocaine and marijuana. We recommend that drug testing for meth be expanded for probationers and parolees in order to better evaluate the prevalence of meth use in community corrections populations. We also recommend that this data be systematically included in the automated case management systems of each agency to facilitate swift analysis of the data captured.

Recommendation #7: Develop a centralized automated data collection system to be shared between all arms of the juvenile justice system (DJJ and the 16 independent juvenile courts). The only data available on the level of juvenile involvement with meth-related offenses is through our statewide surveys. DJJ does not collect detailed drug offense information

in its automated case management system. It is unknown what type of data is collected at each of the 16 independent juvenile courts, as each has its own case management system. We recommend that a centralized, automated data collection system be developed whereby detailed offense data can be shared between all arms of Georgia's juvenile justice system. Such a system would also enable analysis of trends throughout the state's entire juvenile justice system.

Recommendation #8: Expand the collection of drug offense information captured from schools.

Data is unavailable on the prevalence of meth on school campuses. The Department of Education requires county school systems to report the number of felony and non-felony drug offenses per year, but this published information does not provide details on the type of drugs involved. We recommend that this reporting system be expanded to provide more detailed information on the drug offense. This will enable drug trends in Georgia schools to be tracked.

Recommendation #9: Support prevention efforts with research.

The scope of this study did not allow for any investigation into why persons choose to use meth. Funding for prevention efforts was one of the top allocation priorities of front line professionals, but this report's charge did not include an investigation of the reasons why persons begin using meth. We recommend investigating the reasons why

persons first begin using meth to provide data on why certain communities are disproportionately impacted, as well as to improve prevention strategies.

Recommendation #10: Revise GCIC's coding system to include specific codes to denote each meth-related offense.

Sophisticated data mining techniques were employed to extract the number of meth-related offenses from GCIC data. This analysis was limited by the quality of data entered into a free-text field to identify an arrest as meth-related. Codes that designate arrests as meth-related would help ensure the accuracy of arrest data.

Appendix A

Map of Georgia Counties



Appendix B

Children Found At Seized Clandestine Meth Labs In Georgia By County, 2001-2004*

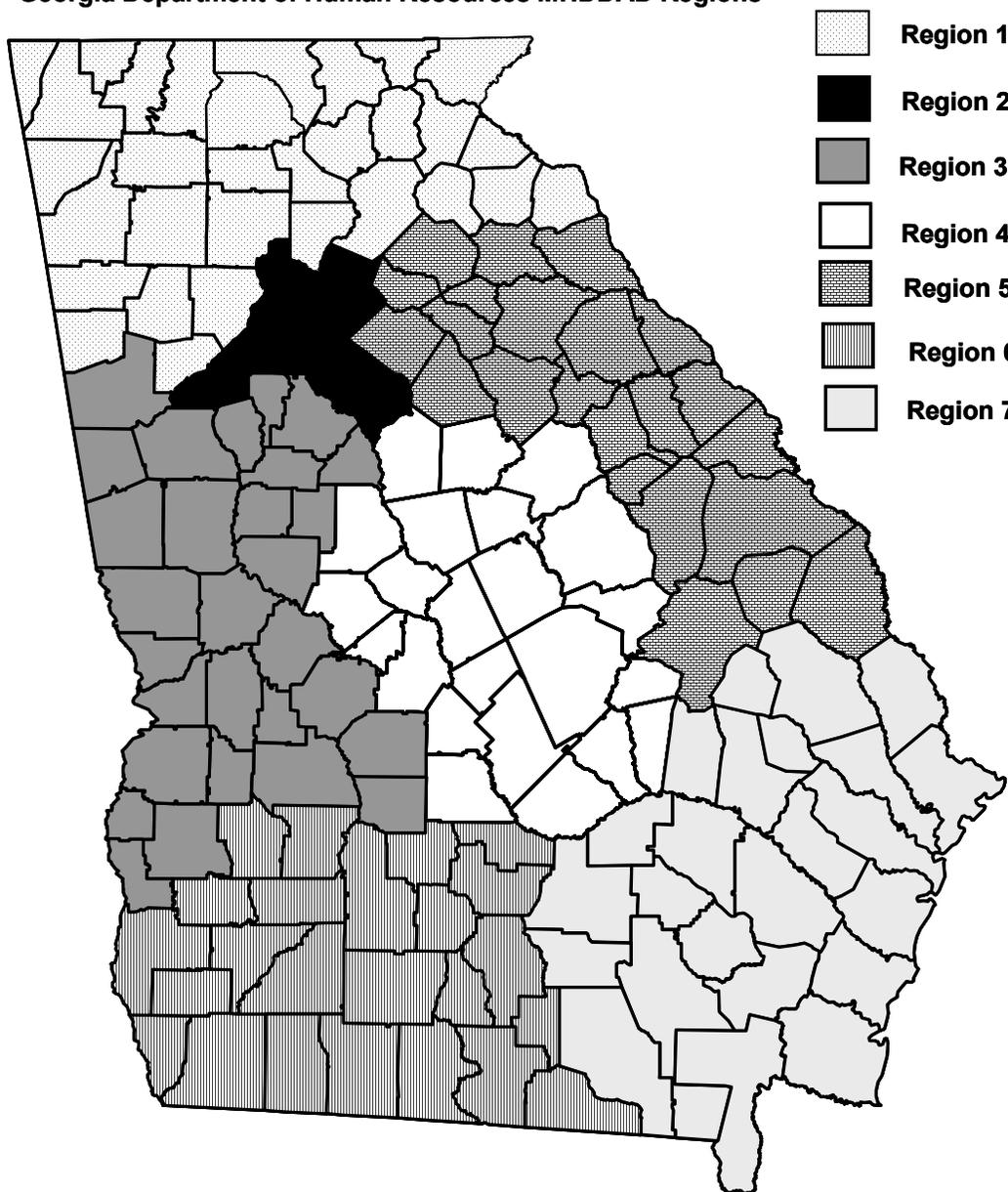
County	2001	2002	2003	2004	County	2001	2002	2003	2004	County	2001	2002	2003	2004
Appling	0	0	0	0	Evans	0	0	0	0	Newton	0	0	0	0
Atkinson	0	0	0	0	Fannin	0	0	0	0	Oconee	0	4	0	0
Bacon	0	0	0	0	Fayette	0	0	0	0	Oglethorpe	0	2	0	0
Baker	0	0	0	0	Floyd	0	0	0	0	Paulding	0	0	5	0
Baldwin	0	0	1	1	Forsyth	0	0	3	0	Peach	0	0	0	0
Banks	0	0	0	0	Franklin	0	0	0	0	Pickens	0	3	0	0
Barrow	0	0	1	0	Fulton	0	0	0	0	Pierce	0	0	0	0
Bartow	0	0	2	8	Gilmer	0	2	4	2	Pike	0	0	0	0
Ben Hill	0	0	4	0	Glascocock	0	0	0	1	Polk	0	1	4	0
Berrien	0	0	1	0	Glynn	0	0	0	0	Pulaski	1	0	0	1
Bibb	0	0	0	0	Gordon	0	0	0	0	Putnam	0	0	0	0
Bleckley	0	0	0	0	Grady	0	0	0	0	Quitman	0	0	0	0
Brantley	0	0	0	0	Greene	0	0	0	0	Rabun	0	3	2	0
Brooks	0	0	2	0	Gwinnett	0	0	0	0	Randolph	0	0	0	0
Bryan	0	0	0	0	Habersham	0	0	0	0	Richmond	0	0	0	0
Bulloch	0	0	0	0	Hall	2	0	2	0	Rockdale	0	0	0	0
Burke	0	0	0	0	Hancock	0	0	0	0	Schley	0	0	0	0
Butts	0	0	0	0	Haralson	0	4	10	5	Screven	0	0	0	0
Calhoun	0	0	0	0	Harris	0	0	0	0	Seminole	0	0	0	0
Camden	0	0	0	0	Hart	0	0	1	0	Spalding	0	0	0	3
Candler	0	1	0	0	Heard	0	5	0	0	Stephens	2	0	0	0
Carroll	0	3	0	1	Henry	0	0	0	0	Stewart	0	0	0	0
Catoosa	0	3	6	5	Houston	0	0	0	0	Sumter	0	0	0	0
Charlton	0	0	0	0	Irwin	0	0	3	1	Talbot	0	0	0	0
Chatham	0	0	0	0	Jackson	0	0	2	0	Taliaferro	0	0	0	0
Chattahoochee	0	0	0	0	Jasper	0	0	0	0	Tattnall	0	0	0	0
Chattooga	8	1	7	3	Jeff Davis	0	0	0	0	Taylor	0	0	0	0
Cherokee	1	7	3	1	Jefferson	0	0	0	0	Telfair	0	0	1	0
Clarke	0	1	0	0	Jenkins	0	0	0	0	Terrell	0	0	0	0
Clay	0	0	0	0	Johnson	0	0	0	0	Thomas	0	0	0	0
Clayton	0	5	0	0	Jones	0	0	0	0	Tift	0	0	0	0
Clinch	0	0	0	0	Lamar	0	0	0	0	Toombs	0	0	0	0
Cobb	2	2	0	0	Lanier	0	0	0	6	Towns	0	0	0	0
Coffee	0	0	0	0	Laurens	0	0	0	2	Treutlen	0	0	0	0
Colquitt	0	0	0	0	Lee	0	0	0	0	Troup	0	0	0	0
Columbia	0	0	0	0	Liberty	0	0	0	0	Turner	0	0	0	0
Cook	0	0	0	0	Lincoln	0	0	0	0	Twiggs	0	0	0	0
Coweta	0	0	0	0	Long	0	0	0	0	Union	0	0	0	0
Crawford	0	0	0	0	Lowndes	0	0	0	0	Upson	0	0	0	0
Crisp	0	0	2	2	Lumpkin	0	2	2	0	Walker	2	0	9	12
Dade	2	1	8	5	Macon	0	0	0	0	Walton	0	0	0	0
Dawson	1	0	0	0	Madison	0	1	0	0	Ware	0	0	0	0
Decatur	4	0	0	0	Marion	0	0	0	0	Warren	0	0	0	0
Dekalb	0	0	0	0	McDuffie	0	0	0	0	Washington	0	0	0	0
Dodge	0	0	0	0	McIntosh	0	0	0	0	Wayne	0	0	0	0
Dooly	0	0	0	0	Meriwether	0	0	0	0	Webster	0	0	0	0
Dougherty	0	0	0	2	Miller	0	0	0	0	Wheeler	0	0	0	0
Douglas	0	0	1	0	Mitchell	0	0	0	0	White	0	1	0	1
Early	0	0	0	0	Monroe	0	0	0	0	Whitfield	0	0	9	0
Echols	0	0	0	0	Montgomery	0	0	0	0	Wilcox	0	0	0	0
Effingham	0	0	3	2	Morgan	0	0	0	0	Wilkes	0	0	0	0
Elbert	0	0	0	3	Murray	0	3	1	1	Wilkinson	0	1	0	1
Emanuel	0	0	0	0	Muscogee	0	3	3	0	Worth	0	0	3	0
										Grand Total	25	59	105	69

* Calendar year.

Source: EPIC NCLSS Total Children Affected (Present, Residing, Exposed to Toxic Chemicals, Killed). Updated 1/27/2006.

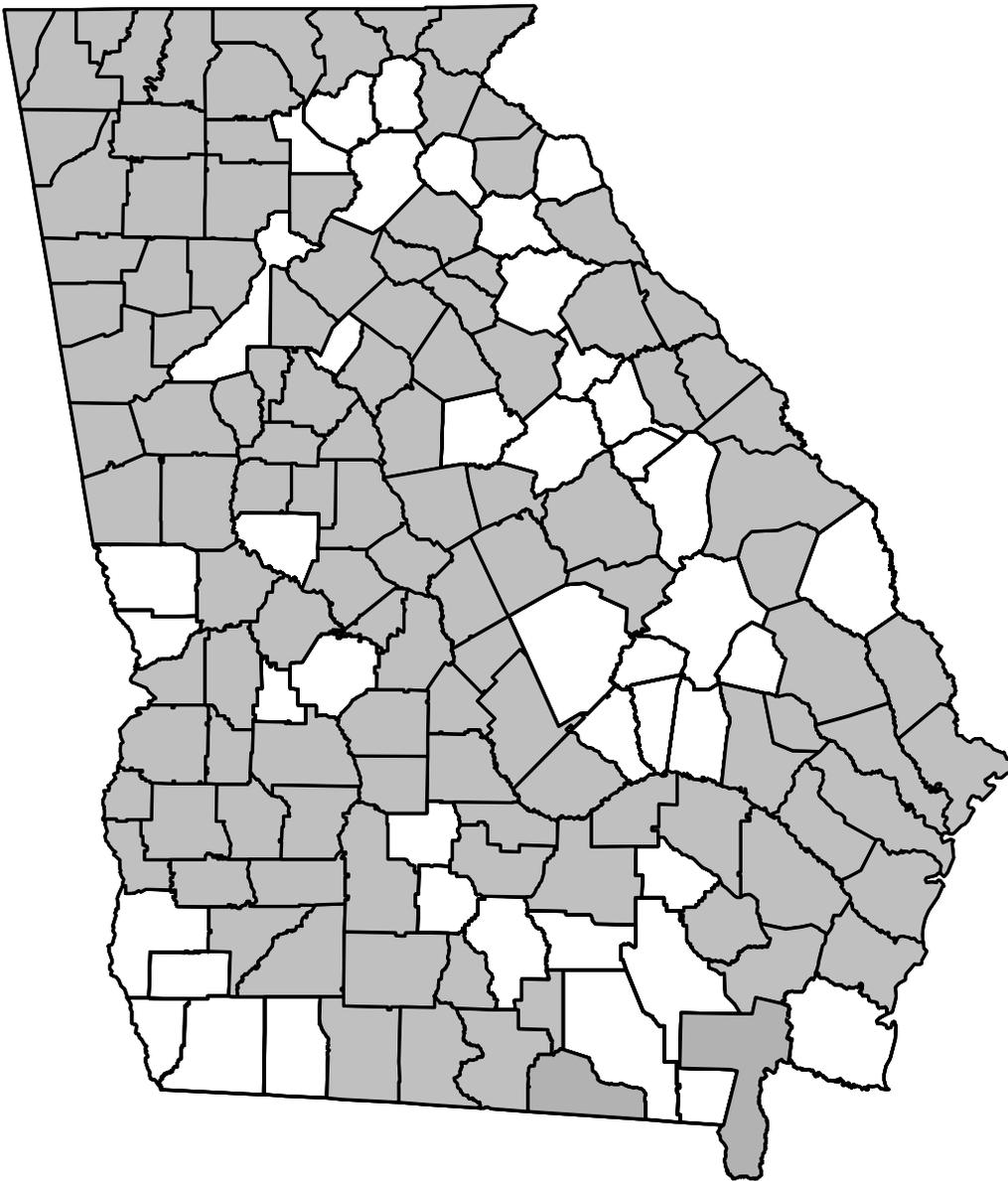
Appendix C

Georgia Department of Human Resources MHDDAD Regions



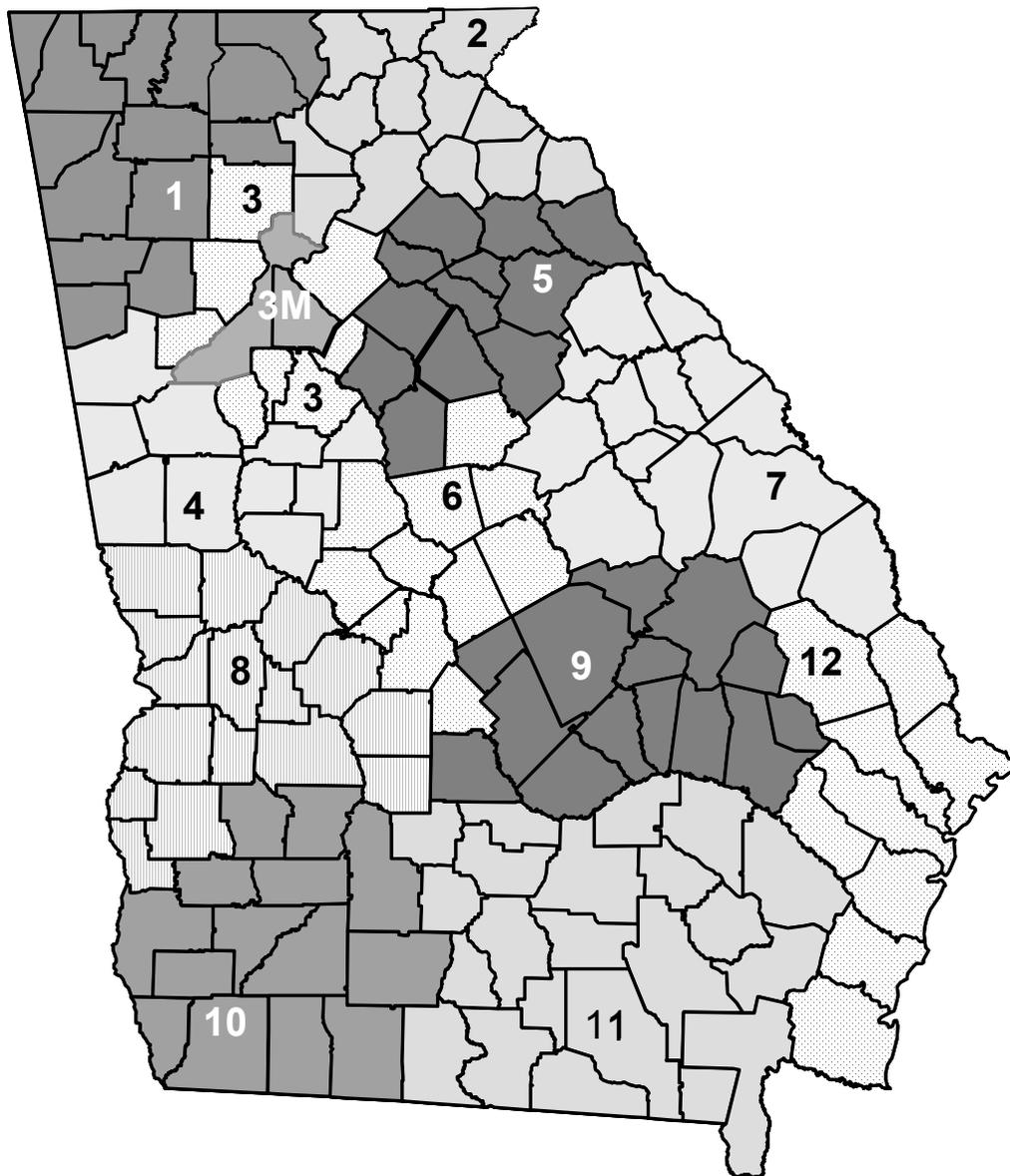
Appendix D

Georgia County DFCS Offices Providing Child Protective Caseworker E-Mail Addresses for Meth Survey; 112 Counties, 1,879 Caseworkers



Appendix E

Georgia Department of Family and Children Services (DFCS) Regions



Footnotes

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