

Maine,

# Methamphetamine,

and National Patterns of Use



April 2021

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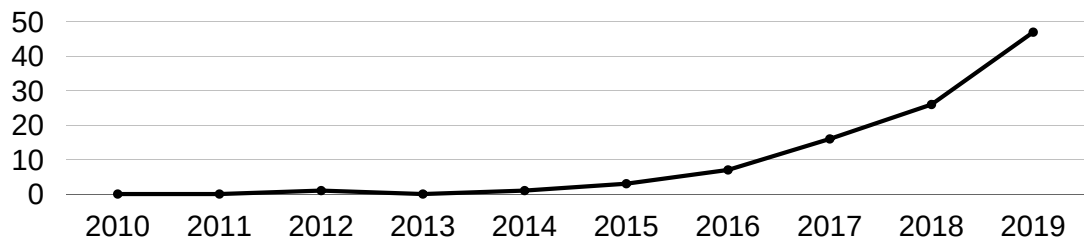
MAINE  
PREVENTION  
SERVICES

Maine Center for Disease Control & Prevention  
Department of Health and Human Services

# Maine Factsheet, 2013 - Q3 2020

**Methamphetamine (aka meth) use is an emerging concern in Maine.**

Maine deaths involving methamphetamine began rising in 2016.<sup>1</sup>



2017 - 2019, methamphetamine manufacturing investigations decreased 39% while methamphetamine sale investigations increased 63%.<sup>2</sup>

**53** 2018  
**38** 2019

Meth manufacturing investigations

**63%**

2019 increase in meth sale investigations

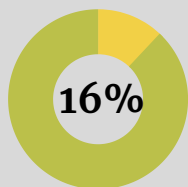
**35**

Methamphetamine labs/dumpsites discovered in Maine, 2019

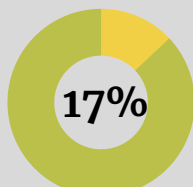
## DEATHS & CO-INTOXICANTS<sup>1</sup>

Deaths involving methamphetamine totaled **47** in 2019, marking an 81% increase from **26** in 2018. In the *first quarter* of 2020, Maine experienced **34** methamphetamine involved drug deaths.

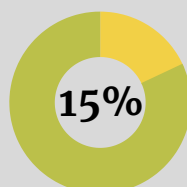
In 2020, methamphetamine accounted for 16% of drug deaths in Maine. Meth was also listed as a co-intoxicant in forty one fentanyl related deaths (17%) and 15% of pharmaceutical opioid deaths.



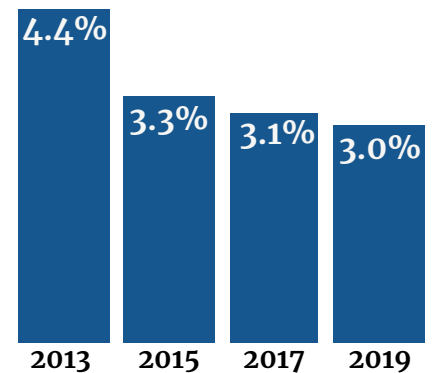
All deaths



Fentanyl



Pharm Opioids



From 2013-2019, the rate of high school students reporting methamphetamine use in their lifetime decreased by one percent (1%).<sup>2</sup>

## IMPACT ON THE BEHAVIORAL HEALTHCARE SYSTEM<sup>2</sup>

In 2018, methamphetamine was listed as the primary reason for 2% (119) of substance use treatment admissions and secondary reason for 3% (140) of admissions.

# National Usage Characteristics 2015-2019

Methamphetamine was one of the drugs most frequently involved in overdoses.<sup>4</sup> While the rate of methamphetamine use remained relatively low and stable between 2015-2019 compared to other substances (0.5% - 0.7%)<sup>3</sup>

# 4th

In 2017, meth ranked fourth in the nation for drugs most frequently involved in overdose deaths.<sup>5</sup>

# 53%

Approximately one half (52.9%) of adults who reported past year meth use met the diagnostic criteria for methamphetamine use disorder.

## Usage trends & characteristics<sup>5</sup>

### Men used at higher rates than women

Estimated rates of past-year use were 8.7 for men and 4.7 for women (per 1,000).

### Men who identified as a sexual minority were disproportionately affected

The usage rate among men was 2-4 times higher in those who self-identified as homosexual or bisexual.

### Education, income, and insurance

Controlling for other factors, lower educational attainment, an annual household income of <\$50,000, and having Medicaid or no insurance are all variables associated with increased risk of past-year use.

### Adults age 26-34 were most at-risk

The highest estimated rates of use were among adults age 26-34 (11.0) 18-25 (9.3), and 35-49 (8.3) and among non-Hispanic whites (7.5) Hispanics (6.7), and non-Hispanic other races (5.6) per 1,000.

### Past-year treatment

Fewer than 1/3 of adults with methamphetamine use disorder received treatment.

### Rates of use increased in rural areas

Methamphetamine use disproportionately affected residents in small metro and nonmetro counties.

### Overlap with mental health

57.7% of adults who used methamphetamine in the past year reported any mental illness; 25% reported serious mental illness during the past year.

### Misuse of other substances was common

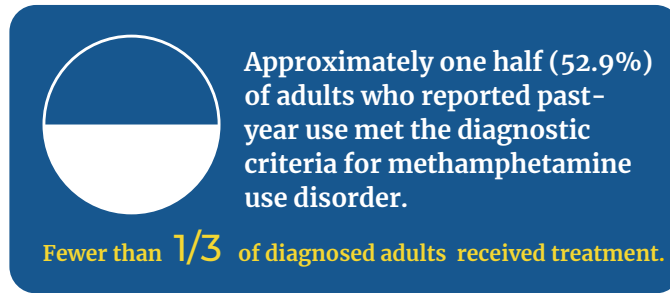
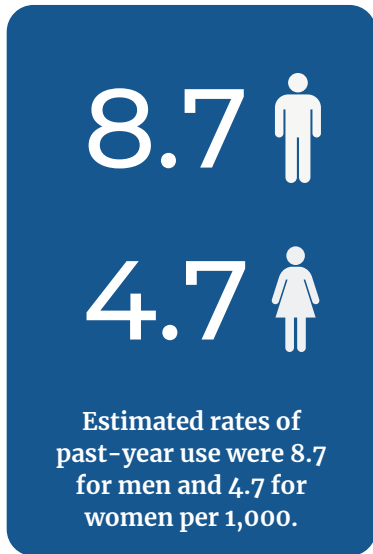
Estimated prevalences of past-year use or misuse of other substances included cannabis use (68.7%), prescription opioid misuse (40.4%), cocaine use (30.4%), prescription sedative or tranquilizer misuse (29.1%), prescription stimulant misuse (21.6%), and heroin use (16.9%).

### Among adults reporting past year use, 27.3% reported using ≥200 days

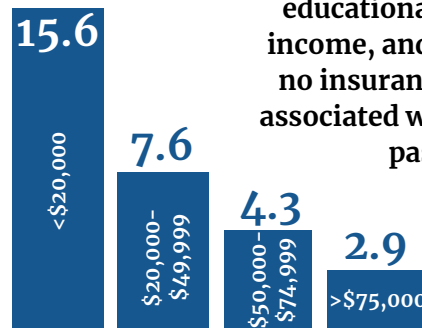
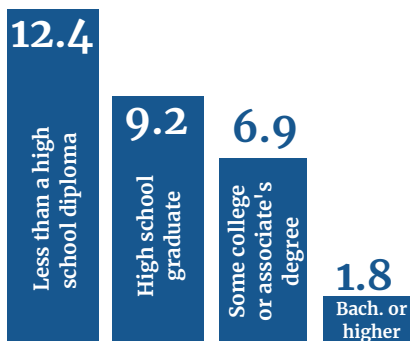
An estimated 36.2% of meth users reported using 1-29 days; 19.2% reported using 30-99 days; 17.2% reported using 100-99 days and 27.3% reported >200 days.

# National Trends and Usage Characteristics<sup>5</sup>

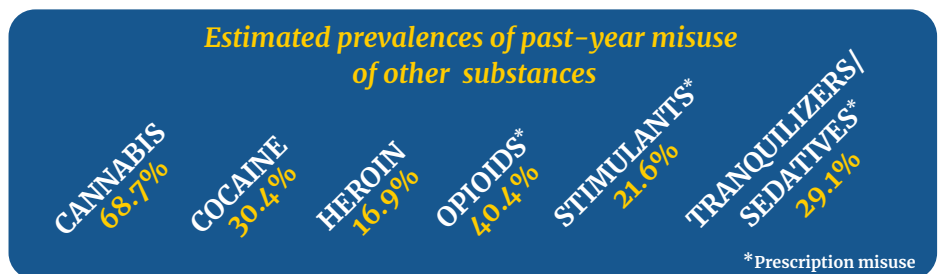
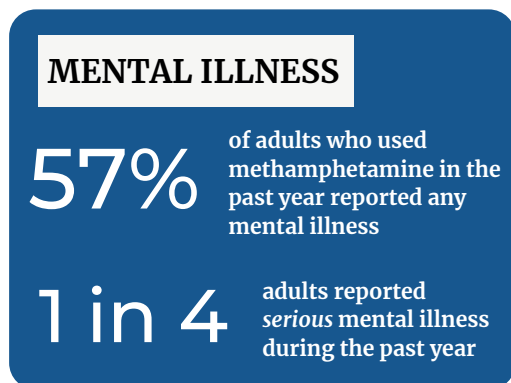
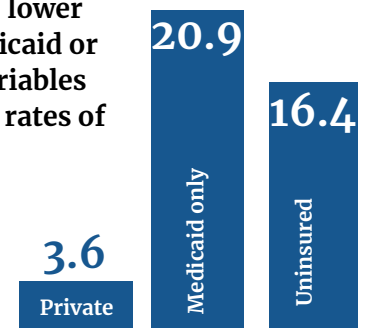
## 2015 - 2019 Visual Factsheet



### EDUCATION, INCOME, AND INSURANCE...



Controlling for other factors, lower educational attainment, lower income, and having Medicaid or no insurance were all variables associated with increased rates of past-year use.



**26-34**

Adults age 26-34 were most at risk of past-year use



Usage Disparity Spotlight

# Methamphetamine Use Among Men Who Have Sex with Men (MSM)



"MSM" is a broad umbrella term and behavioral category representing **many** diverse identities, practices, and sexualities.<sup>6</sup>

Men who have sex with men are **2 TO 4 TIMES MORE LIKELY** to use methamphetamine<sup>5</sup>

The prevalence of methamphetamine use is higher among men who have sex with men than in the general population.<sup>7</sup> Methamphetamine use among MSM is closely connected to sexual identity and expression<sup>5,7</sup> with links between using methamphetamine and increasing sexual risk behaviors.<sup>8,9</sup>



Methamphetamine is structurally similar to the neurotransmitter dopamine, a brain chemical associated with feelings of pleasure and reinforcement of rewarding behaviors.<sup>10</sup> The positive emotional flood users experience contributes to increases in sexual risks (for example, number of sex partners, lowered inhibitions, increase sex drive) and decreases in protection, including condom use.<sup>5,8,9</sup>

This euphoric state also helps users escape negative feelings of internalized homophobia, guilt, shame and social stigmas associated with sexual and gender minorities.<sup>7</sup>



Persistent methamphetamine use is one of the biggest risk factors for HIV infection among men who have sex with men<sup>11</sup> and the risky sexual behaviors linked to methamphetamine use puts users at significantly greater risk of transmission and/or infection with many other STI's.<sup>8</sup>

For individuals who are HIV positive, methamphetamine use is associated with higher viral loads, delayed diagnosis/initiation of therapy, immune dysfunction, and decreased medication adherence, antiretroviral resistance, and added challenges to already immune-compromised individuals.<sup>11</sup>



Since HIV continues to be the major contributing factor to premature death rates among MSM in the U.S.,<sup>12</sup> exploring unique considerations associated with methamphetamine use among men who have sex with men is essential for preventing disease, improving health outcomes, and meeting the needs of a historically stigmatized and underserved population.

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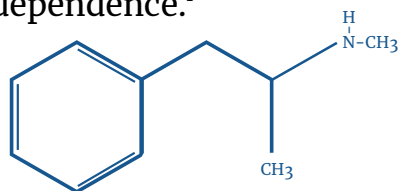
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# Context & Common Terms

## Methamphetamine

Methamphetamine is a highly addictive stimulant that affects the brain's central nervous system (CNS). Methamphetamine is classified as a Schedule 2 (II) drug with a limited medical use and high potential for abuse, potentially leading to severe psychological or physical dependence.<sup>1</sup>



The man-made methamphetamine molecule is structurally similar to amphetamine and to dopamine, a neurotransmitter chemical in the brain that is responsible for mood, memory, alertness, learning, and reward-motivated behavior.<sup>2</sup>

Medically, methamphetamine (brand name: Desoxyn) is available in pill form and used to treat attention deficit hyperactivity disorder (ADHD) and narcolepsy, a sleep disorder. Illicit methamphetamine comes in many different forms that vary in potency and method of use.<sup>3</sup>

## Common street names<sup>4</sup>

- Blue
- Chalk
- Chicken feed
- Cinnamon
- Crank
- Crissy
- Crystal
- Crystal meth
- Geep
- Glass
- Granulated orange
- Hillbilly crack
- Hot ice
- Ice
- L.A. glass
- Lemon drop
- Meth
- OZs
- Peanut butter
- Sketch
- Speed
- Stove top
- Super ice
- Tick tick
- Tina
- Wash
- Yaba
- Yellow powder

## Context in the stimulant family

Methamphetamine is part of a class of drugs called stimulants. Stimulants speed up the body's systems and come in the form of pills, powder, rocks, and injectable liquids. Stimulants include prescription drugs, such as amphetamines like Adderall and Dexedrine, as well as illicitly used drugs such as methamphetamine and cocaine.<sup>5</sup>

While stimulants such as cocaine have similar behavioral and physiological effects on the body, there are some major differences. Methamphetamine has a longer duration and remains in brain significantly longer than cocaine, which is quickly metabolized and removed from the body.

In addition to blocking dopamine re-uptake like cocaine, methamphetamine also increases dopamine release, leading to higher concentrations that can be toxic to nerve terminals.<sup>6</sup>



**Methamphetamine**  
50% of the drug is removed from the body in **12 hours**

**Cocaine**  
50% of the drug is removed from the body in **1 hour**<sup>2</sup>


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Federal &amp; State (Maine)

# Methamphetamine Policy & Legislation


## 1990s–2004

Illicit use and production of synthetic drugs started rising during the early 1990s, with methamphetamine use gradually spreading eastward across the U.S. to Maine.<sup>1</sup> 

Between 1992 and 2002, the treatment admission rate for methamphetamine/amphetamine increased over 500%, and between 2000 and 2004, the positive drug-testing rates among the general U.S. workforce increased more than 200%. Additionally, methamphetamine production in clandestine home labs skyrocketed, with approximately 17,750 methamphetamine lab seizures by law enforcement in the U.S.<sup>1</sup>

In response to the rise of illicit use of synthetic drugs in the U.S., the Bush Administration released the National Synthetic Drugs Action Plan in October 2004 with more than 40 recommendations for federal, state, and local action.<sup>2</sup>


## 2005–2015

The reduction in home methamphetamine production began with the passage of various state laws in 2004, restricting retail sales of certain products (mostly ephedrine and pseudoephedrine) that can be used to make methamphetamine.<sup>3</sup> 

Oklahoma was the first state to pass restrictive transaction laws, with more than 40 states implementing some new type of restriction by early 2006.<sup>4</sup> Maine's methamphetamine precursor law<sup>5</sup> went into effect on April 6, 2006, and it is stricter than the federal Combat Methamphetamine Act of 2005 (CMEA) in several respects.<sup>6</sup>

In September 2006, the CMEA went fully into effect, setting a national baseline standard for legally selling key ingredients used to make methamphetamine. State laws, which vary widely, are concurrently in effect. As a result, domestic production of methamphetamine is at its lowest point since 2000.

## 2016–2020

Nearly all the methamphetamine trafficked in the U.S. is now produced by transnational criminal organizations (TCO) in Mexico. TCO-produced methamphetamine is highly potent, pure, and low in price.<sup>1</sup> 

The 2019 National Drug Threat Assessment<sup>1</sup> highlights the shifting landscape with a 246% increase from 2013 to 2018 in methamphetamine seizures along the southwest border (SWB). Total nationwide seizures increased 37%. Goal 9 of the 2020 National Drug Control Strategy<sup>7</sup> is focused on reducing the supply by increasing prices and disrupting distribution hubs.

While production by TCOs remains high, home labs continue in prevalence in areas farther away from the SWB, particularly in the upper Midwest and Northeast—including Maine.<sup>1</sup>

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