This Toolkit is an early intervention and prevention strategy for Maine communities. While methamphetamine has not been a significant drug threat in Maine, there has been an increase in the number of meth labs in Maine. Other states have reported that widespread use and production of methamphetamine developed overnight. The Toolkit is designed to raise awareness about methamphetamine production and use, and to provide prevention, intervention and public safety resources.

The Maine Methamphetamine Prevention Toolkit was originally made possible by a grant from the Maine Department of Public Safety, Maine Drug Enforcement Agency through the U.S. Department of Justice Community Oriented Policing Services, Grant #2008-CK-WX-0500. The toolkit has been updated in November 2017 to reflect trends in Methamphetamine use.

The opinions contained herein are those of the author(s) and do not necessarily represent the official position of the U.S. Department of Justice. References to specific companies, products, or services should not be considered an endorsement of them by the author(s) or the U.S. Department of Justice. Rather, the references are illustrations to supplement discussion of the issues.

For questions and information about the Toolkit, contact the Maine Methamphetamine Prevention Project at 207-287-8901.
MAINE METHAMPHETAMINE TOOLKIT

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Section 1: Contact Information

If you suspect methamphetamine related activity, always put your own safety first. Leave the scene immediately and contact your local police, sheriff, or state police for assistance.

Maine Drug Enforcement Agency

To report suspected methamphetamine use, meth lab or other illicit drug activity: you can provide confidential drug tip information by calling the Drug Tip Hotline at 800-452-6457, or by providing information at: http://www.maine.gov/dps/mdea/drugtip.html

To contact your local Maine DEA district Task Force for general information: http://www.maine.gov/dps/mdea/districttaskforces.html

Substance Abuse Prevention, Treatment and Recovery

The Maine Office of Substance Abuse and Mental Health Services (SAMHS) provides leadership in substance abuse prevention, intervention, treatment and recovery. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency. For more information visit: http://www.maine.gov/dhhs/samhs/

The Maine Center for Disease Control and Prevention’s (ME CDC) mission is to provide the leadership, expertise, information and tools to assure conditions in which all Maine people can be healthy. The ME CDC’s Substance Abuse Prevention Services’ mission is to prevent and reduce substance abuse and related problems by providing leadership, education and support to communities and institutions throughout Maine. For more information visit: http://www.maine.gov/dhhs/mecd/ and www.preventionforme.org/
Maine Drug Enforcement Agency
Roy E. McKinney, Director
45 Commerce Drive, Suite 1
Augusta, ME 04330 (626-3850)

Statewide Tip Line – 1-800-452-6457
www.maine.gov/dps/mdea

**Division I** – Commander Scott Pelletier (822-0371)

District 1 – York DTF (York County)
Supervisor Peter Mador – 459-1332

District 2 - Cumberland DTF (Cumberland County)
Supervisor Jeffrey Calloway – 822-0373

District 3 – Western Maine DTF (Franklin, Oxford and Androscoggin Counties)
Supervisor Matthew Cashman – 783-5334

District 6 – Mid Coast DTF (Waldo, Knox, Lincoln and Sagadahoc Counties)
Supervisor James Pease – 594-6182

**Division II** – Commander Peter Arno (941-4732)

District 4 – South Central DTF (Kennebec and Somerset Counties)
Supervisor Lowell “Chip” Woodman – 624-8983

District 5 – North Central DTF (Piscataquis and Penobscot Counties)
Supervisor Brandon Vafiades – 941-4738

District 7 – Down East DTF (Hancock and Washington Counties)
Supervisor Christopher Thornton – 664-2443

District 8 - Aroostook DTF (Aroostook County)
Supervisor Craig Holder – 532-5171

*Updated: November 2017*
Section 2: Methamphetamine in Maine

[http://muskie.usm.maine.edu/justiceresearch/Publications/Adult/Methamphetamine_Threat_in_Maine.pdf](http://muskie.usm.maine.edu/justiceresearch/Publications/Adult/Methamphetamine_Threat_in_Maine.pdf)

**Help Prevent Methamphetamine Use and Manufacturing in Maine** Maine Methamphetamine Prevention Project: [www.methwatchme.org](http://www.methwatchme.org)

**Methamphetamine in our backyard**, Lewiston Sun Journal (Perspective), February 14, 2010: [www.sunjournal.com/node/788963](http://www.sunjournal.com/node/788963)

**2013 Trends in Maine: Maine Methamphetamine Prevention Project**  

**2017 State Epidemiological Profile**  
[http://maineseow.com](http://maineseow.com)

*This information was accessed in 2011 from [www.nationalmethcenter.org](http://www.nationalmethcenter.org)* a website that is now disabled.

**Methamphetamine History**

**1887-1893** Amphetamine and methamphetamine were first formulated in Germany and Japan respectively at the close of the 1800s. A Japanese scientist was the first to create crystal methamphetamine in 1919.

**1930s-40s** Germany and Japan both dispensed methamphetamine to their troops in battle. The Germans mixed the drug with chocolate and handed it out to increase soldiers’ stamina in the field. Armies used Meth to push soldiers in WWII.

**1950s** Japan had large stockpiles of the drug at the end of World War II and it was made available shortly after the war. In 1951, however, the health ministry banned the substance and for the first time, methamphetamine went underground as an illegal drug distributed by the notorious Yakuza. In the United States, methamphetamine was available by prescription for a wide variety of ailments including alcoholism, narcolepsy, depression and obesity.

**1960s** A desire to experience methamphetamine’s incredible “high” begat an increased demand for recreational use of the drug. Small labs began showing up, particularly on the West Coast, as “cookers” manufactured meth for their own use. Some larger-scale “super labs” increased production and the supply on the street.

**1970s-80s** Recreational use of methamphetamine climbed quietly but steadily until the mid-1980s when federal authorities in both the U.S. and Canada outlawed possession of some
chemicals and equipment used to make methamphetamine. Instead of curbing methamphetamine use, the new rules drove labs further underground and the drug’s use actually spread from the West to the Midwest and South.

1990s As methamphetamine use continued to grow, state and federal lawmakers passed several laws to slow its manufacture in the U.S. Progress against meth cooking was slow and spotty and its use went on largely unabated.

2000s The biggest advance against methamphetamine manufacture came in 2005 with the federal Combat Methamphetamine Epidemic Act of 2005. Under the law’s terms, severe limits were placed on the purchase of the drug’s main ingredients—ephedrine and pseudoephedrine as used in cold capsules such as Sudafed. In addition, all drugs containing these key ingredients were placed behind pharmacy counters to avoid theft.

As domestic labs were shut down, demand was met by offshore operations, largely in Mexico. U.S. Customs and Border Patrol methamphetamine seizures at just two major U.S.-Mexico border stations soared from 811 pounds in 2004 to 2,960 two years later.

Source: This information was accessed in 2011 from www.nationalmethcenter.org, a website that is now disabled.
Section 3: Facts about Methamphetamine

Signs and Symptoms, Biology and Awareness

Basic Facts about Methamphetamine, Source: https://www.whitehouse.gov/ondcp/key-issues/methamphetamine

Signs and Symptoms of Methamphetamine, Source: This information was accessed from National Institute on Drug Abuse which is available at https://www.drugabuse.gov/publications/drugfacts/methamphetamine

Anatomy of a Meth User, http://www.kci.org


Methamphetamine and Teens, Source: This information was accessed in 2011 from www.theantidrug.com which now redirects to www.drugfree.org.

Biology, Behavior and the Brain: Methamphetamine Addiction, Source: This information was accessed in 2011 from www.nationalmethcenter.org

Links:


NIDA Drug Facts - Methamphetamine: www.drugabuse.gov/drugs-abuse/methamphetamine


Source: National Institute on Drug Abuse (NIDA)


Basic Facts about Methamphetamine

**Methamphetamine** is an addictive stimulant drug that strongly activates certain systems in the brain. Methamphetamine is closely related chemically to amphetamine, but the central nervous system effects of methamphetamine are greater. Both drugs have some medical uses, primarily in the treatment of obesity, but their therapeutic use is extremely limited.

The chemicals or ingredients needed to manufacture methamphetamine are often illegally diverted from legitimate sources. Some of these precursor chemicals include pseudoephedrine (contained in over-the-counter cold medicines), anhydrous ammonia (used primarily as an agricultural fertilizer and industrial refrigerant), and red phosphorus (used in matches).

**Methamphetamine comes in more than one form** – it can be smoked, snorted, injected, or orally ingested, though smoking has become more common recently. Smoking leads to very fast intake into the brain, which multiplies the user’s potential for addiction and health implications.

Street methamphetamine is referred to by many names, such as “speed,” “meth,” and “chalk.” Methamphetamine hydrochloride, clear chunky crystals resembling ice, which can be inhaled by smoking, is referred to as “ice,” “crank,” “crystal,” “tina,” and “glass.”

Sources: This information was accessed in 2011 from [http://www.methresources.gov](http://www.methresources.gov) which now redirects to the ONDCP website (2012).
Signs & Symptoms of Methamphetamine

There are certain signs associated with meth use that can be noticeable from the first time someone tries the drug. Not every user will display every one of these symptoms; other illicit drugs may also cause similar signs.

**Signs of early meth use include:**
- Euphoric "high" state (excessively happy)
- Decreased appetite
- Increased physical activity
- Anxiety, shaking hands, nervousness
- Incessant talking
- Rapid eye movement
- Increased body temperature (can rise as high as 108 degrees and cause death)
- Dilated pupils
- Sweating not related to physical activity

**If you suspect someone might be using meth, symptoms can include:**
- Paranoia
- Sleeplessness and severe depression
- Nausea, vomiting, diarrhea
- Extreme irritability and anxiety
- Seizures
- Teeth grinding, bad teeth, and body odor
- Skin ulceration and infections, the result of picking at the skin or imaginary bugs
- Auditory and visual hallucinations
- Violent and erratic behavior
- Nervousness
- Anhedonia - loss of pleasure
- Dryness of mucous membranes
- Burnt or blistered lips and/or fingertips from holding hot "Ice Pipes"

*Source: This information was accessed in 2011 from NIDA InfoFacts: Methamphetamine.*
ANATOMY OF A METH USER

- Extreme loss of appetite
- Malnutrition
- Anorexia

- Extreme rise in body temperature, which can cause brain damage
- Loss of vision
- Tooth decay
- Dry mouth
- Permanent nerve damage

- Self-inflicted wounds from removing hallucinatory 'crank bugs' / 'meth bites'
- Sores take longer to heal

- Breakdown of muscle tissue which may lead to kidney failure
- Putrid body odor

- Bone loss from mineral and vitamin deficiencies
- Hair loss

- Respiratory failure
- Toxic vapors scorch or burn the esophagus and lungs
- Crystals form in lungs
- Chest pain
- High blood pressure
- Build-up of fluid in the lungs and brain
- Liver damage
- Kidney and lung disorders

Meth Respects No One!

Meth is different; it isn’t going away. Once it gets into your community, it stays.

Source: http://www.kci.org
Meth and Teens

(Source: Parents: The Anti-Drug)

Methamphetamine is an addictive stimulant drug that strongly activates certain systems in the brain. Methamphetamine is closely related chemically to amphetamine, but the central nervous system effects of methamphetamine are greater. Both drugs have some medical uses, primarily in the treatment of obesity, but their therapeutic use is limited.

Street methamphetamine is referred to by many names, such as "speed," "meth," and "chalk." Methamphetamine hydrochloride, clear chunky crystals resembling ice, which can be inhaled by smoking, is referred to as "ice," "crystal," and "glass."

Health Hazards

Neurological hazards. Methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, enhancing mood and body movement. It also appears to have a neurotoxic effect, damaging brain cells that contain dopamine and serotonin, another neurotransmitter. Over time, methamphetamine appears to cause reduced levels of dopamine, which can result in symptoms like those of Parkinson's disease, a severe movement disorder.

Addiction. Methamphetamine is taken orally or intranasally (snorting the powder), by intravenous injection, and by smoking. Immediately after smoking or intravenous injection, the methamphetamine user experiences an intense sensation, called a "rush" or "flash," that lasts only a few minutes and is described as extremely pleasurable. Oral or intranasal use produces euphoria - a high, but not a rush. Users may become addicted quickly, and use it with increasing frequency and in increasing doses.

Short-term effects. The central nervous system (CNS) actions that result from taking even small amounts of methamphetamine include increased wakefulness, increased physical activity, decreased appetite, increased respiration, hyperthermia, and euphoria. Other CNS effects include irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, and aggressiveness. Hyperthermia and convulsions can result in death.

Long-term effects. Methamphetamine causes increased heart rate and blood pressure and can cause irreversible damage to blood vessels in the brain, producing strokes. Other effects of methamphetamine include respiratory problems, irregular heartbeat, and extreme anorexia. Its use can result in cardiovascular collapse and death.

How Dangerous Is It to Teens?

While meth use in the U.S. has been declining, widespread media coverage about the drug often raises many questions and causes parents to worry about whether their children are exposed to or using this dangerous substance. Meth is a stimulant drug used for the euphoria it produces and for weight loss and increased libido. The down side of the high is addiction and a variety of
toxic short- and long-term effects. One of the most serious and unpleasant side effects is "meth mouth," where the users' teeth rot from the inside out.

Parents need to talk to their kids about meth and the reality of what it does to the body. Parents also need to know when their teen might be using meth. Some of the most common signs and symptoms are extremely dilated pupils, dry or bleeding nose and lips, chronic nasal or sinus problems and bad breath. Because meth is a stimulant, users also experience hyperactivity and irritability. This includes a lack of interest in sleep and food, leading to drastic weight loss or anorexia. It may also cause users to be aggressive, nervous, and engage in disconnected chatter.

Some short-term effects are irritability, anxiety, insomnia, Parkinson-like tremors, convulsions and paranoia. Longer-term effects can include increased heart rate and blood pressure, damage to blood vessels in the brain, stroke and even death. Psychotic symptoms can sometimes persist for months or years even after the user has stopped taking the drug.

**Meth use is declining among youth.** The Monitoring the Future study shows that among 8th, 10th, and 12th graders, meth use has declined by 28, 47, and 51 percent respectively in the past three years.

It is important to note that marijuana is still the single largest drug of abuse in this country — 15 million current or past month users compared to one million meth current or past month users. **Meth is often in the news because of its dramatic effects and consequences.** Illegal meth labs often explode, creating danger to communities through fires. Meth labs on public lands create dangers to hikers and tourists, and children of meth users are often abandoned or neglected and are flooding the social services systems in many areas. Meth is easily made with common ingredients and readily available household equipment, making it widely and inexpensively available.

Adult methamphetamine addicts often become so obsessed with the drug that they neglect their children. Twenty percent of the meth labs raided in 2002 had children present. In addition to general neglect, children living in meth labs face a variety of dangers including the usual meth lab hazards — fires, explosions and exposure to extremely toxic chemicals. Chronic exposure to meth lab chemicals can damage the brain, liver, kidneys and spleen and can also cause cancer.

**If you suspect a teen in your life is using meth or is exposed to meth, the time for a courageous conversation is now.** Discuss the risks and effects of using this substance. Even without addiction, experimentation is too great a gamble. If something interrupts your conversation, pick it up the next chance you get.

*Source: This information was accessed in 2011 from www.theantidrug.com which now redirects to http://www.drugfree.org.*
Biology, Behavior, and the Brain: Methamphetamine Addiction

Methamphetamine is a powerful drug, roaring through our reservations at an alarming rate of "speed." Maybe you’ve seen a movie that depicts some of the paranoid behaviors of a meth addict, or maybe there’s someone from your own life experience who has used crystal meth. I know that has been true in my life. Though we may have seen the outward effects of crank use, most of us have no idea how this deadly, persuasive menace affects us at a biochemical level.

Classified by the scientific community as a psychomotor stimulant, methamphetamine acts as a chemical messenger in the sympathetic nervous system. This is the system responsible for “fight or flight” and other similar behaviors. For this reason, scientists call methamphetamines, cocaine, and other central stimulants sympathomimetics, meaning they act upon the sympathetic nervous system.

Chemical Characteristics of Methamphetamines

Chemical messengers, or neurotransmitters, communicate information at specific receptor sites. Methamphetamine is a compound that mimics a neurotransmitter at serotonin (5-HT) and dopamine (DA) receptor sites, which means that it relays information as though it were that specific neurotransmitter. The relationship between receptor and receptor site is similar to that of a lock and its key; the receptor site (lock) is prepared to receive only information that the specific neurotransmitter (key) recognizes as its chemical counterpart.

Methamphetamine increases the release and blocks the uptake of dopamine. These monoamines, along with norepinephrine, (NE), and epinephrine (E), play a critical role in understanding the way in which methamphetamines act upon neurotransmitters in the sympathetic nervous system and act on the behavior of the organism.

Behavioral Effects of Methamphetamine

The dopamine and serotonin systems influence aggressive, defensive, social and sexual behaviors. Users of methamphetamines exhibit exaggerations in these behaviors. Bipolar (manic-depressive) people might also behave this way. People using speed also exhibit behaviors similar to a schizophrenic.

In animal studies, methamphetamine consumption stimulates locomotor activity, and produces stereotypic behaviors. These have been related to the norepinephrine, dopamine and serotonin systems.

*Drug-related stereotypy* is a term referring to repetitive behaviors. In rats, stereotypic behaviors may include head sways, hyperactivity, avoidance behaviors, and automutilation (self-mutilation).

E. Rylander, a researcher in the 1960’s, studied several Danish methamphetamine users. He was the first to note a behavior known as *Punding*. Punding is performing a useless task compulsively again and again. This seems to be the human equivalent of drug-related stereotypy.
Interestingly, these Danish users reported being aware of their Punding behavior, but were unable to cease performing it. The behavior could be assembling, disassembling, and reassembling an apparatus after a compulsive fashion. Punding is known colloquially as “tweaker habits,” and could include coloring, writing, playing cards, or taking apart items in a prolonged and bizarre manner.

Amphetamine psychosis is another prominent aspect of methamphetamine use, and is nearly identical to full-blown schizophrenia. There is a direct relationship between this psychosis and the alterations in the DA system. Other similarities include hallucinations, aggression, and increased excitability.

**Biology, Behavior, and the Brain**

Animal studies have cast a fascinating light into drug studies at a cellular level. The basic assumption behind all drug use is that it does not take place repeatedly in the absence of some kind of reinforcement or reward. One contemporary model used as a framework for the biological basis of addiction is called the "Brain Reward System." This model studies the psychological and chemical aspects of drug addiction, proposing that an organism engages in a drug-seeking behavior because it is somehow rewarding for them to do so. Experiments show that an animal will work to obtain electrical stimulation to the lateral hypothalamic brain region. Drugs such as methamphetamine lower the threshold for this rewarding brain stimulation.

For psychologists, these are important activities to investigate, because it is essential to understand what the "hook" is for people who get "hooked." (The trouble with drugs is that people who use 'em just keep on using!) The answer to the question, "WHY " is a bit involved, however.

**Biopsychology and Addiction**

Biopsychology is the study of behavior from a biological perspective. Researchers have established that central stimulants, including methamphetamine, have very specific actions on certain brain structures. These structures, including the brain's pleasure centers, are stimulated, which creates a pleasurable effect on the organism. Studies also show that when an animal receives a stimulant, its reward threshold (minimum level at which an organism becomes sensitive to a pleasurable stimulus) is reduced, an immediate response to a small amount of drug. This electrochemical stimulation is what produces sensations of euphoria.

The sensation of euphoria encourages the organism to repeat the pleasure-producing behavior, but a tricky thing happens after the user experiences the initial enjoyment: It quits being as enjoyable. The reward threshold increases again, meaning that while these drugs may be pleasurable at first, the sensitivity to the drug quickly goes down, and the drug fails to yield the same euphoric results.

This phenomenon is called "Chasing the Ghost" by drug users. There could be an internal mechanism that serves to protect the system from toxification (poisoning), yet the insanity of addiction drives the creature to pursue the pleasurable sensation again and again.
The destructive action of this drug is compelling and profound. Though it is unlikely that drugs will affect every being identically, this overview of the biopsychology of methamphetamine use paints a dark image for anyone who considers using meth.

One might wonder how an understanding of neurotransmitters and Brain Reward Systems can have any impact on the monstrous problem of drug addiction. Some argue that it is a problem only experienced by people of weak moral constitutions or defective characters. In reality, methamphetamine abuse and addiction is an affliction of many people in many cultures. "Fathers, soldiers, sons," anyone can join the ranks of methamphetamine addicts. It remains a leveling influence, a great "respecer of no one."

**Source:** This information was accessed in 2011 from www.nationalmethcenter.org, a website which is now disabled.
Section 4: Types of Methamphetamine, Manufacture and Labs


Diversion – Methamphetamine: This information was accessed in 2011 at www.methresources.gov which now redirects to the ONDCP website (2012).

Signs You May Be Near A Meth Lab: http://www.kci.org

Meth Production and Trafficking: This information was accessed in 2011 at www.methresources.gov which now redirects to the ONDCP website (2012).

Tips for property owners and landlords: Link to 1 pager

Links:

The Truth about Pseudoephedrine


Clandestine Labs Classifications and Hazards http://www.forensic-applications.com/meth/meth.html

Methamphetamine Laboratory Identification and Hazards Fast Facts
DRUG GUIDE

What is Methamphetamine?
Methamphetamine (Meth) is an addictive stimulant that strongly activates certain systems in the brain. Federal classification: Schedule II

What are the street names/slang terms? Chalk, Crank, Croak, Crypto, Crystal, Fire, Glass, Meth, Tweek, White Cross

What does it look like? Methamphetamine is a crystal-like powdered substance that sometimes comes in large rock-like chunks. When the powder flakes off the rock, the shards look like glass, which is another nickname for meth. Meth is usually white or slightly yellow, depending on the purity.

How is it used? Methamphetamine can be taken orally, injected, snorted, or smoked.

What are Methamphetamine Pills?
Meth pills are a combination of the stimulants methamphetamine and caffeine. It is produced in Burma by groups such as the United Way State Army and marketed predominantly in Thailand. Methamphetamine is an addictive stimulant drug that strongly activates certain systems in the brain. Federal classification: Schedule II

What are the street names/slang terms? Yaba

What do they look like? A tablet, commonly reddish-orange or green, that fits inside the end of a drinking straw with a variety of logos — “WY” being the most common.

How are they used? Normally is it ingested orally.

What are their short-term effects of methamphetamine and methamphetamine pills? Immediately after smoking or intravenous injection, the methamphetamine user experiences an intense sensation, called a “rush” or “flash,” that lasts only a few minutes and is described as extremely pleasurable. Oral or intranasal use produces euphoria — a high, but not a rush. Other effects include irritability/aggression, anxiety, nervousness, convulsions, and insomnia.

What are their long-term effects of methamphetamine and methamphetamine pills? Meth is addictive, and users can develop a tolerance quickly, needing higher amount to get high, and going on longer binges. Some users avoid sleep for 3 to 15 days while binging. Psychological symptoms of prolonged meth use are characterized by paranoia, hallucinations, repetitive behavior patterns, and delusions of parasites or insects under the skin. Users often obsessively scratch their skin to get rid of these imagined insects. Long-term use, high dosages, or both can bring on full-blown toxic psychosis (often exhibited as violent, aggressive behavior). This violent, aggressive behavior is usually coupled with extreme paranoia. New research shows that those who use methamphetamine risk long-term damage to their brain cells similar to that caused by strokes or Alzheimer’s disease.
What is Crystal Meth?

Crystal Meth is a very pure, smokable form of methamphetamine. It is a powerful and extremely addictive man-made stimulant. Its use can lead to severe physiological and psychological dependence. Federal classification: Schedule II

What are the street names/slang terms? Ice

What does it look like? Clear crystal chunks, similar in appearance to actual ice or glass, odorless and colorless.

How is it used? Crystal Meth is usually smoked, but is sometimes snorted or injected. The drug is abused because of its euphoric effects.

What are its short-term effects? The drug’s effects are similar to those of cocaine but longer lasting. Crystal Meth can cause erratic, violent behavior among its users. Effects include suppressed appetite, interference with sleeping behavior, mood swings and unpredictability, tremors and convulsions, increased blood pressure, irregular heart rate. Users may also experience homicidal or suicidal thoughts, prolonged anxiety, paranoia and insomnia. Crystal meth use by pregnant women can lead to premature birth or birth defects (heart defects and cleft palate).

What are its long-term effects? Long-term effects can include brain damage (similar to the effects of Parkinson's disease or Alzheimer's disease), coma, stroke or death. Signs of chronic use include weight loss, tooth decay and cracked teeth (“Meth Mouth”), psychosis and hallucinations, sores on the body from picking at skin, and formication (an abnormal skin sensation akin to “bugs crawling on skin”).

What is Methcathinone?

Methcathinone is a stimulant that is a structural analogue of methamphetamine and cathinone. It is clandestinely manufactured from readily available chemicals. Federal classification: Schedule I

What are the street names/slang terms? Cat

What does it look like? A white or off-white crystalline powder. Almost exclusively sold in the stable and highly water soluble hydrochloride salt form.

How is it used? It is most commonly snorted, although it can be taken orally by mixing it with a beverage or diluted in water and it can be injected intravenously.

What are its short-term effects? Methcathinone produces amphetamine-like activity.

What are its long-term effects? Little scientific research is available on the long-term effects of methcathinone.

Source: www.drugfree.org/drug-guide/
Diversion- Methamphetamine

Methamphetamine is often produced using chemicals and other products that are illegally diverted from legitimate sources. Some of the precursor chemicals needed to manufacture meth include pseudoephedrine (contained in over the counter cold medicines), anhydrous ammonia (used primarily as an agricultural fertilizer and industrial refrigerant), and red phosphorus (used in matches).

Some of the common ways used to divert products containing pseudoephedrine include:
- “Smurfing” – making multiple purchases at different locations
- Shelf-Sweeping – the theft of all shelf stock
- Shoplifting
- Theft from wholesalers

Illegal drug makers often steal anhydrous ammonia from areas where it is stored and used, such as farms. Attempted thefts have also occurred at such places as refrigeration systems holding ammonia, underground pipelines carrying ammonia, and rail cars transporting anhydrous ammonia. Often thefts are aborted when thieves are injured or overcome by the toxic gas.

Preventing the theft and diversion of precursor chemicals involves the coordination and cooperation of law enforcement, retailers, farmers, and others who may sell or work with these products. Some methods for preventing retail diversion include setting and enforcing thresholds on the amount of products that can be purchased by customers, storing products behind the retail counter, and establishing education programs for employees.

Source: This information was accessed in 2011 at www.methresources.gov which now redirects to the ONDCP website (2012).
Signs you may be near a meth lab

Many people may be unaware that they're living near a meth lab. Meth labs turn up in houses, barns, apartments, trailers, campers, cabins and motel rooms – even the backs of pickups. The equipment for a meth lab can be as small as to fit in a duffel bag, a cardboard box or the trunk of a car.

Here are some things to look for in identifying a meth lab:

- Unusual, strong odors (like cat urine, ether, ammonia, acetone or other chemicals).
- Residences with windows blacked out.
- Renters who pay their landlords in cash. (Most drug dealers trade exclusively in cash.)
- Lots of traffic - people coming and going at unusual times. There may be little traffic during the day, but at night the activity increases dramatically.
- Excessive trash including large amounts of items such as: antifreeze containers, lantern fuel cans, red chemically stained coffee filters, drain cleaner and duct tape.
- Unusual amounts of clear glass containers being brought into the home.
- Windows blacked out or covered by aluminum foil, plywood, sheets, blankets, etc.
- Secretive / protective area surrounding the residence (like video cameras, alarm systems, guard dogs, reinforced doors, electrified fencing).
- Persons exiting the structure to smoke
- Little traffic during the day, but high traffic at late hours; including different vehicles arriving and staying for short periods of time.
- Little or no mail, furniture, visible trash and no newspaper delivery.

Presence of the multiple items from this list could indicate the existence of a meth lab:

<table>
<thead>
<tr>
<th>White Gasoline</th>
<th>Batteries/Lithium</th>
<th>Alcohol</th>
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<td>Phenyl-2-Propane</td>
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<td>Ether</td>
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<tr>
<td>Phenylacetone</td>
<td>Wooden Matches</td>
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<td>Phenylpropanolamine</td>
<td>Propane Cylinders</td>
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<td>Iodine Crystals</td>
<td>Hot Plates</td>
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<td>Red Phosphorous</td>
<td>Ephedrine (over-the-counter)</td>
<td>Acetone</td>
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<tr>
<td>Black Iodine</td>
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<td>Lye (Red Devil Lye)</td>
<td>Bronchodilators</td>
<td>Camp Stove Fuel/Coleman</td>
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<td>Drano</td>
<td>Energy Boosters</td>
<td>Starting Fluid</td>
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<tr>
<td>Muriatic/Hydrochloric Acid</td>
<td>Rock Salt</td>
<td>Anhydrous Ammonia</td>
</tr>
<tr>
<td>Battery Acid/Sulfuric Acid</td>
<td>Diet Aids</td>
<td>&quot;Heet&quot;</td>
</tr>
</tbody>
</table>

Source: www.kci.org
Meth Production & Trafficking

Meth is produced in clandestine meth labs, which can be found in a variety of locations, including rural rentals with absentee landlords, urban home or apartment rentals, trailers, motel rooms, houseboats, and mini-storage units.

The number of reported meth lab seizures in the U.S. has steadily decreased each year from a peak in 2004. From there, production levels went down nationwide.

Preliminary 2008 data also indicate an increase in the flow of meth into the United States from Mexico – most likely attributable to the efforts of methamphetamine producers in both countries to reestablish the meth supply chain in the face of disruptions and shortages that began occurring in early 2007 and continued into 2008 as the result of Mexico’s enactment of import and sales restrictions on pseudoephedrine.

Mexican drug trafficking organizations have further adapted their operating procedures in several ways – including smuggling restricted precursor chemicals through new routes, importing non-restricted chemicals instead of traditionally used precursor chemicals, and using alternative production methods.
Preliminary data show fairly consistent levels of meth seizure amounts, as there were 6,335.66 kilograms of methamphetamine seized in the U.S. from January to November 14, 2008.

Section 5: Methamphetamine Prevention, Intervention and Treatment

Early Intervention, Source: This information was accessed in 2011 at http://www.methresources.gov which now redirects to the ONDCP website (2012).

Methamphetamine Prevention, Source: This information was accessed in 2011 at http://www.methresources.gov which now redirects to the ONDCP website (2012).

Holding Meth At Bay Is Difficult Process, Source: This information was accessed in 2011 from http://www.nationalmethcenter.org, a website which is now disabled.

Intervention Strategies, Source: This information was accessed in 2011 at http://www.methresources.gov which now redirects to the ONDCP website (2012).

Links:

Treatment: Dial 2-1-1 or text your zipcode to 898-211 or visit http://www.211maine.org

You are Prevention: https://www.youareprevention.org/


Early Intervention

Recognizing early signs and symptoms of meth use is a first step in early intervention. There are certain signs associated with meth use that can be noticeable the first time someone tries the drug. Not every user will display all of these symptoms; other illicit drugs may also cause similar signs. Signs of early meth use include: euphoric high state (excessively happy), decreased appetite, increased physical activity, anxiety, shaking hands, nervousness, incessant talking, rapid eye movement, increased body temperature (can rise as high as 108 degrees and cause death), dilated pupils, and sweating not related to physical activity.

Intervention and treatment works differently for each person. A licensed practitioner can help to guide individualized assessments and treatment plans, including a range of services from support groups to psychiatric care, until an effective plan is determined. However, if you recognize these signs or symptoms in friends or family members, there are a few steps to keep in mind and prepare for before discussing the issue with them:

Be safe – Never confront a person who is high on meth. Methamphetamine users frequently become psychotic (i.e., gross mental impairment characterized by delusions, hallucinations, incoherent speech, agitated behavior, loss of touch with reality) from using meth, and their behavior could pose real danger to you. Talk at a time and in a place that feels safe. If the person becomes angry or violent, leave and bring up the subject later when everyone is calm.
**Plan what to say** – Tell them that you’re worried and that is why you want to talk. Be specific about how you know that they are using and why you are concerned. You may want to have a hotline number or some facts on hand about real examples of people who have sought treatment and have overcome their meth addiction.

**Listen** – After you finish talking, ask what they think – and listen. It’s critical that you hear what they’re saying so you can offer to help. But you shouldn’t feel like you have to personally solve this problem – there are counselors and other professionals who are specially trained to help at times like this.

**Keep at it** – Getting someone to seek treatment might be a continuous process – not a one-time event. In highly structured interventions, led by professionals, the discussions are planned to guide the person from one step to the next in gaining sobriety and entering treatment, increasing the likelihood of success.

Once your friend or loved one commits to entering treatment, the first task for a practitioner is to determine the severity of drug use and the level of “life functioning” in legal, family, medical and psychiatric arenas. Feel free to view the meth-related interventions from A&E’s *Intervention* show. ONDCP is not responsible for the content contained in the A&E programming. The stories, however, are real and may assist the friends and family members of meth abusers to better understand meth addiction and to provide hope for the treatment/recovery process.

### Methamphetamine Prevention

At the present time, research about prevention programs specifically focused on meth is limited. At least one research project points to the success of a comprehensive approach to meth prevention for a youth audience. In this report, the combination of a school-based prevention program, plus a family-focused intervention, shows promise in reducing adolescent meth use. Currently, more research must be conducted to determine the effectiveness of prevention programs focused on meth use in the young adult population, particularly since meth usage typically starts in the late-teen years or early twenties – a time when young adults are less likely to be involved in school, family or community prevention programs.

Although meth-specific prevention research is limited, the National Institute on Drug Abuse has developed “Prevention Principles” to serve as the foundation of effective substance abuse prevention programs to combat general drug abuse; these principles are grounded in research about effective drug abuse prevention programs.

According to these principles, drug prevention programs should be comprehensive, and they are most effective when they address individual risks for abusing drugs; include family, school, and community prevention efforts; and are consistent with an overall campaign message and delivery. As such, drug prevention programs should be comprehensive and inclusive, aiming to prevent all illicit drug use, often by preventing use of those drugs considered the drugs of first use.

**Addressing Risk and Protective Factors** – Many factors can contribute to a person’s risk for drug abuse, from aggressive behavior and exposure to substance abuse to poverty and peer pressure. Protective factors, including strong family bonds and academic success, can help to counter those risk factors. Prevention programs should work to strengthen those protective factors while addressing all forms of drug abuse – whether taken alone or in combination with other drugs. Education about drug abuse should address illegal and legal drugs, including prescription and over-the-counter medications. All programs should be tailored to address risks specific to the local community and audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.
Prevention Planning – Family, school, and community programs should all be incorporated to maximize prevention campaign effectiveness. Family-based prevention programs should strive to enhance family bonding and relationships. Parental monitoring and supervision are critical for drug abuse prevention. Prevention programs in the school setting can be designed to address a wide range of school-aged students, from elementary school-aged children to high school-aged teens, depending on the substance and nature of the drug-related topics. Programs aimed at key transition points, such as the transition to middle and high school, have proven effective, even among high-risk families and children. Reaching people in various settings – school, clubs, faith-based organizations, through the media, etc. – can help to validate and maximize prevention efforts.

Message Delivery – When communities adapt programs to match their needs, they should retain core elements of the original research-based prevention program. All programs should include guidelines for teacher training, interactivity (role-playing, peer discussion groups, etc.), and long-term planning.

Prevention

The concept of drug abuse prevention sounds pretty simple on the surface: (1) Identify populations that are vulnerable to the temptations of drug use, and (2) give them information they can use to make the choice not to get involved. Easily stated, not as easily completed.

Some of the potential problems: lack of funding for materials and trainers; some governments not receptive to anti-drug programs; difficulty getting communities into motion. To put the difficulty into perspective, look at some basic groups that need large doses of prevention:

The individual child: The big risks are those with drug-abusing friends, children with lots of free time on their hands or so-called "latchkey" kids who have three to five unsupervised hours to spend alone every day after school. To keep this group on the straight and narrow requires lots of information, mentoring and supervision -- none of which are cheap or easy to provide.

Families: One of our greatest challenges is identifying and assisting families who need help with preventing their children from becoming involved with drugs. Methamphetamine has a real attraction for youth because of its seeming power to give them more energy. Young women also find the appetite-suppressing nature of the drug appealing because it helps them lose weight. Parenting and anti-drug programs are essential in helping families understand the environment in which their children are living, the indicators of drug usage, and how parents can educate and interact with their children to prevent drug abuse and addiction.

Schools: Critical elements of in-school anti-drug work are teaching teachers the basics of drug-abuse prevention and providing it on a steady basis. Many schools are now overwhelmed with demands for good test scores and limited budgets. As a result, students may not be exposed to drug education on more than a hit-and-miss basis. Some prevention experts think only consistent K-12 drug education will keep the vulnerable students from using drugs.

Communities: As risks for drug epidemics in neighborhoods become apparent, members must step up and endorse a variety of processes -- from placing billboards and passing out literature to building coalitions of individuals or neighborhoods and organizing meth action teams. Once more, good prevention programs grow not only from good training and training materials but from inspiration from within the communities themselves.
### Treatment

**Screening, Brief Intervention, Referral and Treatment (SBIRT)**

The majority of people who require treatment for illicit drug or alcohol use are either unaware that they need help or choose not to seek it. To combat this public health challenge, SBIRT was created to encourage health care providers to help diagnose, intervene in, and treat drug abuse before it becomes a more serious problem. Federally-funded SBIRT programs are already established in 17 states and territories.

Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users. In these settings, medical professionals screen for drug using behavior and provide brief substance abuse intervention, if necessary.

The main components of SBIRT include:

- **Screening** – To quickly assess the severity of substance use and identify the appropriate level of treatment.
- **Brief intervention** – To increase insight and awareness regarding substance use and motivate patients to change their behaviors.
- **Referral to treatment** – To provide those identified as needing more extensive treatment with access to specialty care.

### Drug Courts

A drug court can be defined as a special court given the responsibility to handle cases involving substance-abusing offenders through comprehensive supervision, drug testing, treatment services, and immediate sanctions and incentives. Drug courts can be used as a tool in the fight against meth as they combine intensive rehabilitation services for addicts with legal requirements to complete treatment. They offer longer treatment periods, an emphasis on addressing co-occurring mental health disorders, and intensive community supervision and monitoring.

For more than a decade, a number of drug courts have been extremely effective in stemming the tide of meth-affected areas of the nation. Federally-funded drug courts in California, Oregon, Hawaii, Nevada, Oklahoma, and Kentucky have been using the drug court model to successfully intervene and manage the methamphetamine-addicted offender. Drug courts in these states have used the coercive power of the justice system with effective treatment strategies to successfully intervene and manage the meth-addicted offender.

**Source:** This information was accessed in 2011 at www.methresources.gov which now redirects to the ONDCP website (2012).

**For more information about SBIRT:**  

**For more information about Drug Courts:**  
www.nij.gov/topics/courts/drug-courts/welcome.htm
Section 6: Drug Endangered Children

**Methamphetamine: Children at Risk**, Source: Maine Methamphetamine Prevention Project

National Guideline for Medical Evaluation of Children Found in Drug Labs, Source: National Alliance for Drug Endangered Children

**Webinar**: “The national guideline for medical evaluation of children found in drug labs provides instructions for law enforcement and other first responders, child protective services, medical personnel and emergency medical departments for medical evaluation of children found in clandestine labs manufacturing methamphetamine and other illegal drugs, including steps for immediate response and follow up protocols.”

**Presented by**: Dr. John Martyny and Dr. Penny Grant, 2010

**Available at**: [https://vimeo.com/16008916](https://vimeo.com/16008916)

**Links:**

- Methamphetamine and Child Welfare,
METHAMPHETAMINE: CHILDREN AT RISK

Risks to children include:
- Exposure to explosive, flammable, toxic ingredients stored in kitchen cabinets, bathrooms and bedrooms
- Access to methamphetamine and paraphernalia
- Presence of loaded weapons in the home and booby traps (due to paranoia of methamphetamine users)
- Physical and sexual abuse
- Exposure to high risk populations (sexual abusers, violent drug users)
- Neglect including poor nutrition, poor living conditions
- Presence of pornography

If a pregnant woman uses meth, the baby may experience:
- Premature birth
- Growth retardation
- Withdrawal symptoms including abnormal sleep patterns, high pitched cry, poor feeding
- Cerebral injuries
- Limbs
- Apparent depression
- Shaking and tremor
- Irritability
- Fits of rage
- Sensitivity to stimuli including human touch and regular light
- Coordination problems
- Birth defects (6 times more likely) including effects on the central nervous system, heart and kidneys
- Cerebral palsy and paralysis are common

The effects of meth last longer than crack and can lead to more damage. Levels of meth present in breast milk are higher than the level in blood.

Parents who use meth often exhibit:
- Extreme mood fluctuations
- Violent behavior
- Depression
- Poor impulse control
- Strange behaviors
- Lack of attention to hygiene
- Acute psychotic episodes
- Poly-drug use
As meth use continues, the parent is unable to provide basic needs to the child. Due to changes in brain chemistry, the parent loses the capacity to care about anything but meth.

Children whose parents use or manufacture meth may experience:
- Respiratory problems
- Delayed speech and language skills
- Higher risk for kidney problems and leukemia
- Malnourishment
- Poor school performance/attendance problems
- Isolation
- Physical, sexual and emotional abuse
- Poor dental health
- Hyperactivity and attention disorders
- Lice
- Obesity
- Other developmental problems
- Violent behavior
- Drug usage
- Lack of boundaries/easy attachment to strangers

Medical personnel may notice:
Agitation, inconsolability, tachycardia, respiratory problems (often meth kids present with asthma), nausea, protracted vomiting, hyperthermia, ataxia, roving eye movements, seizures, and headaches.

Source: Mesa Center Against Family Violence

If you suspect meth production, leave the area immediately and contact local law enforcement!

For more information, contact the Maine Methamphetamine Prevention Project at (207) 621-8118 or www.methwatchme.org

Adapted from the Kansas Methamphetamine Prevention Project.
National Guideline for Medical Evaluation of Children Found in Drug Labs

**National Guidelines for Medical Evaluation of Children Found in Drug Labs**

**LAB SITE**
- Activate
- If explosion, obvious chemical exposure, active lab, or child appears ill, transport immediately via EMS

**IMMEDIATE STEPS ON-SITE**
- Law Enforcement
- Narcotics
  - 1. Identify chemicals present
  - 2. Clan lab certified & DEC trained personnel to photograph living conditions and collect evidence
  - 3. Submit data to appropriate databases

**ACTIVATE**
- Decontamination per local protocol when medically stable
  - Medical Facility
    - 1. Perform Medical Assessment/Screening
    - 2. Collect Urine via Chain of Custody within 12 hours after removal
  - Placement per local protocol

**PLACEMENT per local protocol**
- Conduct Forensic Interview jointly with CPS
- Developmental & mental health assessment
- Update databases

**EMERGENCY DEPARTMENT**
1. Neurological status
2. Respiratory status:
   - O2 sat
   - CXR
3. Blood:
   - CBC
   - Chemistry panel
   - LFT’s
   - BUN/Cr
4. Urine toxicology via chain of custody

**CHILD PROTECTIVE SERVICES**
1. Identify all siblings and obtain tracking information
2. Gather medical history
3. Medical follow-up: Within 30 days, 6 mos, 1 yr
PERSONNEL DECONTAMINATION
Decontamination of the children should occur prior to transport to the medical facility as medically appropriate. Basic life support takes precedence over decontamination. Removal of clothing, cleansing of the skin and hair and new clothes are the minimum requirements of decontamination.

DO NOT USE WIPES!

LAW ENFORCEMENT
Immediate
1. Document the quantity and types of chemicals present and document how found (e.g. uncapped, in tin cans), so that the exposure of the child can be determined.
2. Document the condition of the home. Document odors and state of lab (actively cooking, decanting stage, drying stage, etc.) Document the people at the scene and those who also reside in the home. Share this information with medical facility.
3. Collect and submit all the required data to appropriate databases.
4. Transport child as per local DEC protocol in conjunction with CPS.

Within 24 to 72 hours
1. Children need to be interviewed by personnel trained in the forensically correct method for children. Coordinate this process with CPS.

Follow-up
1. Update databases as needed.

MEDICAL PERSONNEL
Symptomatic - Immediate
1. Head to toe exam of the children within 2 to 4 hours to ensure medical stability and document any acute findings that might need treatment or change over time. This may occur in an ED, physician’s office or by EMTs on scene. This should include but not be limited to a good pulmonary exam, skin exam, neurologic exam, and affect (scared, happy, detached). May include observations by EMTs, RN on scene, or other personnel to document the affect of the children.
2. Collect urine for toxicology. This should happen as soon as possible but must occur within 12 hours for optimal results. Submit to a lab that screens and reports for the level of detection of the test, not just at NIDA standards. Chain of Evidence forms may be utilized or usual medical protocols for urine toxicology screens may be followed.
3. Blood tests. Can be done acutely or within 24 to 72 hours: a CBC (anemia, cancers, thrombocytopenias), Chemistry Panel to include BUN/Cr and LFT’s (kidney and liver damage, electrolyte imbalances), Hepatitis B and C panels.

Asymptomatic - Within 24 to 72 hours
1. A complete medical evaluation.
2. If seen within 12 hours, collect urine for toxicology
3. Blood tests as above
4. Developmental evaluation using an age-appropriate standardized tool.
5. Mental health evaluation.
5. Dental evaluation.

Follow-Up
1. Repeat medical evaluation in 30 days, 6 mos & 1 year
2. Follow up developmental evaluations as needed based on the initial evaluations.
3. Follow up mental health interventions and assessments as needed.

EMERGENCY ACTIVATION
Transport immediately to the ED by emergency personnel if there is an explosion, active chemicals at the scene or the child appears ill i.e. fast breathing, obvious burns, lethargy or somnolence.

CHILD PROTECTIVE SERVICES
Immediate
1. Assist law enforcement in the collection and documentation of the scene from the child’s perspective. Decide who will photograph scene.
2. Transport child as needed to facility as designated in your local DEC protocols.
3. Placement of children in a safe environment as per local protocol.

Within 24 to 72 hours
1. There may have been other children in the family or home who were not present at the time of the seizure. All children who have lived in the home will need to be examined and their information collected for tracking.
2. The medical histories of the children need to be investigated and documented.

Follow-up
1. Input all the gathered information into a database as determined by the local, state and national protocols.

EMERGENCY DEPARTMENT
1. Complete medical evaluation to assess acute medical needs.
2. Specific attention to the pulmonary exam as the chemicals can cause acute respiratory problems. RR, O2 saturation and a CXR in the symptomatic child are the minimum required.
3. Blood tests as needed in addition to a CBC, Chemistry Panel to include BUN/Cr and LFTs.
4. Collect urine for toxicology. This should happen as soon as possible but must occur within 12 hours for optimal results. This should be submitted to a lab that screens and reports for the level of detection of the test, not just at NIDA standards. Chain of Evidence forms may be utilized or usual medical protocols for urine toxicology screens may be followed.
Section 7: Law and Policy

Links:

FEDERAL LAW

Combat Methamphetamine Epidemic Act: Title VII of Public Law 109-177
http://www.deadiversion.usdoj.gov/meth/index.html

Methamphetamine Remediation Research Act of 2007: Public Law No: 110-143
www.govtrack.us/congress/bill.xpd?bill=h110-365

Methamphetamine Production Prevention Act of 2008

MAINE LAW

An Act To Further Restrict the Availability of Methamphetamine and Amphetamine Pills

Maine Meth Watch Program and An Act to Prevent the Manufacturing of Methamphetamine in Maine.
http://www.mainelegislature.org/ros/LOM/LOM122nd/10Pub401-450/Pub401-450-46.htm

An Act To Restrict Further the Amount of Methamphetamine Precursors That May Be Bought or Sold www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC584.pdf
Policy & Legislation

Both federal- and state-level legislation has provided increased funding to train law enforcement personnel in the cleanup of dump sites and the remediation of former meth labs, provided support for meth prevention and treatment programs, limited the quantity of cold medicines containing pseudoephedrine or ephedrine that may be sold over-the-counter, and required proper identification is shown when purchasing products which may be used in the making of meth.

Key pieces of federal meth-related legislation include:

**Combat Methamphetamine Epidemic Act (CMEA) of 2005:** This law regulates retail over-the-counter sales of products containing ephedrine, pseudoephedrine, and phenylpropanolamine. Retail provisions of the CMEA include daily sales limits and 30-day purchase limits, placement of product out of direct customer access, sales logbooks, customer ID verification, employee training, and self-certification of regulated sellers.

**Methamphetamine Remediation Research Act of 2007:** This law establishes a research program to develop guidelines, based on the best currently available scientific knowledge, for the cleanup and remediation of former meth labs, including guidelines regarding preliminary site assessment and the remediation of residual contaminants.

**Methamphetamine Production Prevention Act of 2008:** This law requires retail sellers of legal substances used in the production of methamphetamine to use an electronic logbook or a bound paper book to obtain required information (i.e., name and address of purchaser, date and time of sale, and quantity sold) for sales of listed chemicals (e.g., legal substances used in the production of methamphetamine).

**Source:** This information was accessed from: [https://www.whitehouse.gov/ondcp/key-issues/methamphetamine](https://www.whitehouse.gov/ondcp/key-issues/methamphetamine)
Section 8: Tools and Resources

Links:

**Methpedia**: Includes information, tools and resources for community coalitions, prevention, treatment and law enforcement, [http://sai-dc.com/methpedia/](http://sai-dc.com/methpedia/)

**Methproject.org**: Program of The Partnership for Drug-Free Kids, [www.methproject.org](http://www.methproject.org)


**Rural Law Enforcement Methamphetamine Initiative (RLEMI)**: RLEMI Summit Video Series, [https://www.youtube.com/watch?list=PL7wcQS50CGBiEZotDmDyJXflPfb7hzhua&v=RL3O0iSF DpU](https://www.youtube.com/watch?list=PL7wcQS50CGBiEZotDmDyJXflPfb7hzhua&v=RL3O0iSF DpU)
Section 10: What You Can Do To Help

You are Prevention

Information for all populations about substance use prevention, there is something we can all do to help. [https://www.youareprevention.org/](https://www.youareprevention.org/)

Teens

Learn about the dangers of substance use, what the “normal” really is, how to say no when friends are using and how you can help a friend or family member who is using.

Adults

Learn how you can recognize the signs and symptoms of substance use, how to help a friend or family member who is using, how to support young people to make good choices and recognize those most at risk for substance use, and where to find the most up to date information.

Parents

Learn how you can model good behavior and send messages to your children to prevent substance use, where to find the most up to date information and data, how to talk to your teen and how to recognize the signs and symptoms of substance use and where to turn to for help if you know your teen is using.

Organizations

Recognize the risk factors, signs and symptoms of substance use, find information on policies for workplace substance use, get training for your employees on substance use, and learn how to help a colleague who has a substance use problem.

Partnership for Drug Free Kids

Parents

Talk to your kids early about the dangers of substance use, look for warning signs of substance use, set limits and make them clear to your children, and encourage behavior change. [https://drugfree.org/landing-page/get-help-support/is-there-a-problem/](https://drugfree.org/landing-page/get-help-support/is-there-a-problem/)

Contact local law enforcement

Community members are urged to contact their local law enforcement or closest Sheriff’s office to report any suspicious activity that might indicate a methamphetamine manufacturing lab or a location where methamphetamine is being used or sold.