



METHAMPHETAMINE USE IN INDIANA

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EXECUTIVE SUMMARY

Methamphetamine (meth) is a powerful, highly addictive drug that is easily made with over-the-counter ingredients. Meth's relative ease of manufacture and addictive properties are thought to contribute to its prevalence. This report provides an overview of meth consumption patterns among adults and young people at the national level and in Indiana. Analysis and discussion of the criminal, health-related, and social impacts of meth use also are included. In addition, trend analyses of available data illustrate the change over time in meth consumption and consequences of its use.

According to recent survey results, approximately 4.3 percent of the American population aged 12 and older has tried meth at least once during their lifetime. Survey results regarding prevalence of use among the general population tend to show a slightly higher rate of meth use by males than females. However, substance abuse treatment statistics suggest a typical meth user would likely be a white female between 25 and 34 years of age. In Indiana, an estimated 4.5 percent of the population used meth at least once in their life and less than 1 percent in the past year or month. Both at the national and state level, rates of past year meth use tend to be highest among young adults aged 18 to 25. Among most high school students in grades 9 through 12, reported lifetime meth use has declined in recent years. Nonetheless, perhaps 1.5 percent of Indiana high school seniors reported being current meth users (the past month) in 2006, and about one out of 11 high school seniors reported using meth at least once—compared to one of 16 in the United States overall. Meth use also tends to be more prevalent among white students than black students. With regard to consumption patterns associated with substance abuse treatment, the rate of treatment admissions reporting meth use in Indiana more than doubled over a six-year period. Meth use is also associated with age and is more common among younger adults and those in their mid 30s and 40s than other age groups.

With regard to the criminal impacts of meth use and manufacture, Indiana has ranked in the top 10 states in the number of clandestine meth labs seized over the past five years. Between 2002 and 2006, 35 Indiana counties had an average of more than 10 labs seized and seven had over 40 disassemblies. However, more recently, and specifically between 2004 and 2006, 45 Indiana counties have seen a decline in lab seizures. Additionally, while the greatest activity has been in the southwestern portion of the state, counties in other regions have recently experienced an increase in lab seizures. UCR arrest data show that from 2002, when Indiana was approximately at the U.S. rate, to 2005, Indiana has grown to twice the U.S. rate of arrests per 1,000 people for possession of synthetic drugs. Indiana rates for synthetic drug sale/manufacture steadily increased from 1999 to 2004 and have recently shown a decline, while national arrest rates have remained relatively stable. More generally, Indiana is arresting more persons for possession, but fewer synthetic drugs are being manufactured in Indiana. Between 2002 and 2005, nearly 90 percent of Indiana counties experienced an increase in arrest rates for possession, and rates of arrest associated with synthetic drug sale/manufacture rose in 68 counties.



INTRODUCTION

Meth is a powerful, highly addictive stimulant that affects the central nervous system. Meth is similar to amphetamine, yet has a more pronounced effect. The drug is easily made in clandestine laboratories with over-the-counter ingredients. Meth's relative ease of manufacture and highly addictive potential are thought to contribute to its use across the nation. This report provides an overview of meth consumption patterns among adults (age 18 and over) and youth (under age 18) at the national level and in Indiana, when currently available data permit. Analysis and discussion of the criminal, health-related, and social consequences of meth use also are included.

CONSUMPTION PATTERNS

Overall Consumption Patterns

According to the 2005 National Survey on Drug Use and Health (NSDUH)¹, approximately 4.3 percent of the American population aged 12 and older has tried meth at least once during their lifetime (Substance Abuse and Mental Health Services Administration (SAMHSA), 2007). While self-reported lifetime meth use has been on the rise, its prevalence remains substantially lower than marijuana (40.1 percent) and cocaine (13.8 percent). NSDUH results demonstrate that lifetime use has risen from 2 percent among the adult population in 1994 to 4.3 percent in 2005. Self-reported current (past month) meth use has remained steady at either 0.2 percent or 0.3 percent between 1999 and 2005. However, meth use in the past year among the population aged 12 years or older has increased between 2002 and 2005, from 0.2 percent to 0.5 percent. In Indiana, according to annual averages of 2002 to 2004 data, an estimated 4.5 percent of the population (225,000 residents) used meth in at least once in their life, 0.8 percent (40,000) in the past year, and 0.2 percent (10,000) in the past month.

Adult Consumption Patterns

Results from the 2005 NSDUH indicate that the rate of past year meth use was highest for young adults age 18 to 25 (U.S.: 1.5 percent; Indiana: 1.9 percent). By comparison, among adults age 26 or older, the national rate was 0.3 percent. Past year meth use was slightly higher among adult males (0.6 percent) than females (0.3 percent). Among 18- to 25-year olds, self-reported rates of lifetime use, past year use, and current usage remained constant between 2002 and 2005. Among adults aged 26 or older, reported lifetime use has declined—2002: 5.7 percent; 2003: 5.7 percent; 2004: 5.3 percent; 2005: 4.5 percent.² Self-reported current, monthly use has remained relatively stable among this age group. The average age of first meth use was consistently between 18 and 20 years of age. (SAMHSA, 2007).

Youth Consumption Patterns

According to NSDUH results, reported rates of meth use among 12- to 17-year-olds across the nation remained constant or declined slightly between 2002 and 2005. Self-reported lifetime use was 1.5 percent in 2002 and fell to 1.2 percent in 2005. Past year use among 12- to 17-year-olds also fell between 2002 (0.9 percent) and 2005 (0.7 percent), while past month use remained steady at about 0.3 percent during the time period.

¹ The NSDUH is national survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) designed to measure substance abuse patterns among the general population. The survey is administered on an annual basis.

² The difference between the 2004 and 2005 estimates is statistically significant at the 0.01 level.



According to the 2005 Youth Risk Behavior Surveillance System (YRBSS)³, among students in the 9th through the 12th grades, 7.0 percent in Indiana reported having used meth once or more in their lifetime, compared with a national rate of 6.2 percent.⁴ Rates of use declined slightly from 2003 levels, when 8.2 percent of Indiana students and 7.6 percent of U.S. students indicated lifetime use. Reported lifetime meth use among students in the 9th through 12th grades declined between 2003 and 2005 at the national and state level, with the exception of Indiana 10th graders (Centers for Disease Control and Prevention, 2005) (see Table 1). In addition, there is a clear difference in racial usage patterns for meth: in both Indiana and the United States, white students are much more likely to have reported meth use than black students. Lifetime meth use among Indiana high school students parallels U.S. rates (see Figure 1).

Table 1: Percentage of High School Students (9th–12th Grade) Reporting Lifetime Methamphetamine Use, by Grade, Gender, and Race, Indiana and United States, 2003 and 2005 (Youth Risk Behavior Surveillance System, 2003 and 2005)

Grade	Year	Indiana (%)	U.S. (%)
9th	2003	7.0	6.7
	2005	5.7	5.7
10th	2003	6.6	7.5
	2005	6.9	5.9
11th	2003	8.0	8.0
	2005	7.0	6.7
12th	2003	12.0	8.0
	2005	9.0	6.4
Gender	Year	Indiana	U.S.
Male students	2003	9.4	8.3
	2005	7.9	6.3
Female students	2003	7.0	6.8
	2005	6.1	6.0
Race	Year	Indiana	U.S.
Black students	2003	2.7	3.1
	2005	3.7	1.7
White students	2003	8.6	8.1
	2005	7.7	6.5
Other	2003	12.8	10.4
	2005	4.6	6.4
Total	Year	Indiana	U.S.
	2003	8.2	7.6
	2005	7.0	6.2

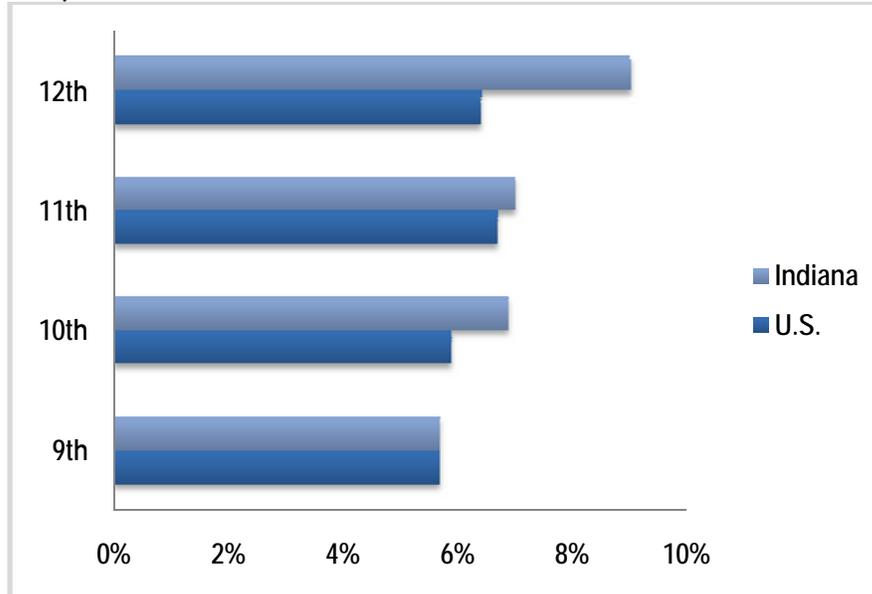
Source: Centers for Disease Control and Prevention, 2005

³ The YRBSS is a national survey sponsored by the Centers for Disease Control (CDC) and local state health departments every two years that monitors the health risks and behaviors among youth in 9th through 12th grades.

⁴ While Indiana rates of meth use in all grades are slightly higher than the nation's, these differences are not statistically significant.



Figure 1: Percentage of Indiana and U.S. High School Students (9th–12th Grade) Reporting Lifetime Methamphetamine Use, by Grade, 2005 (Youth Risk Behavior Surveillance System, 2005)



Source: Centers for Disease Control and Prevention, 2005

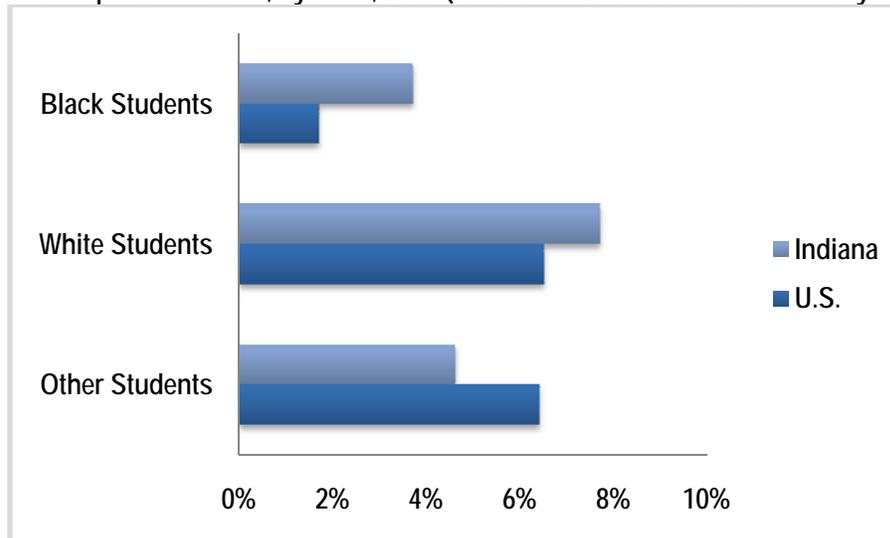
Male students, both nationally and in Indiana, are more likely to report lifetime meth use than their female counterparts (see Table 1).⁵ In Indiana, reported rates of lifetime meth use fell between 2003 and 2005 among both male and female students. Similar declines in reported use are evident at the national level (see Table 1). Differences between Indiana and U.S. rates are not statistically significant.

White students are more likely than black students to report meth use. In 2005, 6.5 percent of white students nationally indicated lifetime meth use, compared with 1.7 percent of black students. Similarly, in Indiana, 7.7 percent of white students reported use, while only 3.7 percent of black students indicated they had ever used meth (see Table 1 and Figure 2). While rates of use among black and white students in Indiana exceed U.S. rates and are lower among *other* minority Indiana students, these differences are not statistically significant. As shown in Table 1, lifetime use fell among all groups, both at the state and national level, with the exception of black students in Indiana, which rose from 2.7 percent in 2003 to 3.7 percent in 2005.

⁵ While Indiana usage rates among both male and female students exceed U.S. rates among the same groups, these differences are not statistically significant.



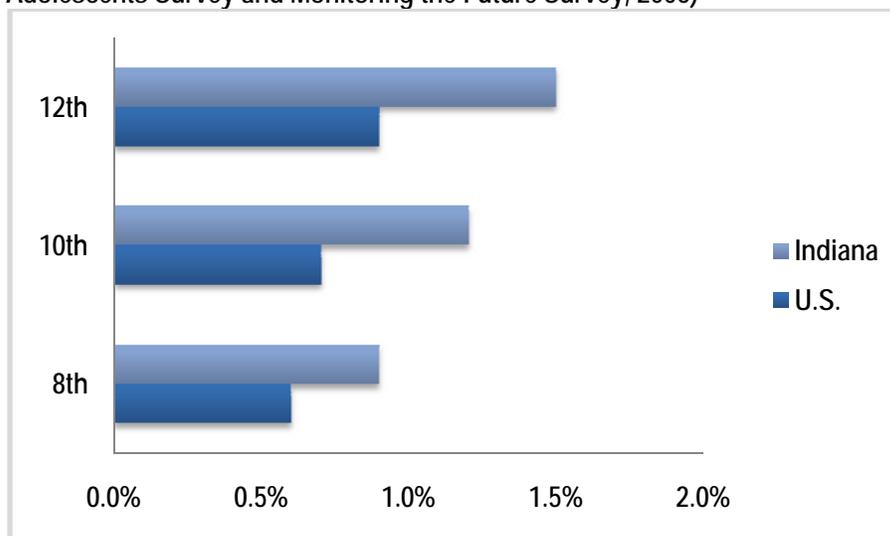
Figure 2: Percentage of Indiana and U.S. High School Students (9th–12th Grade) Reporting Lifetime Methamphetamine Use, by Race, 2005 (Youth Risk Behavior Surveillance System, 2005)



Sources: Indiana Prevention Resource Center, 2006; National Institute on Drug Abuse, 2006

Two surveys of young people that include questions about lifetime, annual, and current (past 30 days) meth use are the Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents Survey (ATOD)⁶ and Monitoring the Future Survey (MTF).⁷ Comparable results for 2006 are shown in Figure 3. In all grades, reported rates of current meth use among Indiana students surpass U.S. rates.

Figure 3: Percentage of Indiana and U.S. 8th, 10th, and 12th Grade Students Reporting Current (Past Month) Meth Use, by Grade, 2006 (Alcohol, Tobacco, and Other Drug Use by Indiana Children and Adolescents Survey and Monitoring the Future Survey, 2006)



Sources: Indiana Prevention Resource Center, 2006; National Institute on Drug Abuse, 2006

⁶ The ATOD is a survey conducted annually by the Indiana Prevention Resource Center (IPRC) regarding alcohol, tobacco, and other drug use among Indiana middle and high school students—6th through 12th grades. Caution should be exercised when interpreting the survey results, as these are based on a non-randomized sample of respondents.

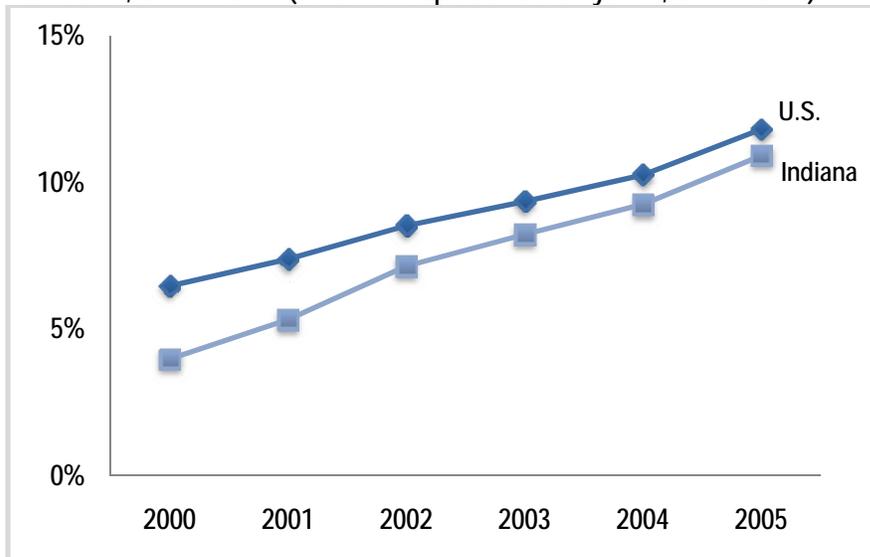
⁷ Monitoring the Future is a national survey conducted annually by the National Institute on Drug and Alcohol (NIDA) that tracks drug consumption among students in 8th, 10th, and 12th grades.



Consumption Patterns Associated with Treatment

The SAMHSA Treatment Episode Data System (TEDS) includes information gathered from patients at admission for each episode of substance abuse treatment.⁸ TEDS data from 2000 through 2005 show a steady increase, both nationally and in Indiana, in the reported rate of meth use at admission (see Figure 4). However, Indiana treatment admissions are significantly less likely to report current meth use at admission than patients in the United States.⁹ From 2000 to 2005, the rate of treatment admissions reporting meth use in Indiana more than doubled from 4.0 percent to 10.9 percent.

Figure 4: Percentage of Indiana and U.S. Treatment Admissions Reporting Methamphetamine Use at Admission, 2000 to 2005 (Treatment Episode Data System, 2000 – 2005)



Source: Substance Abuse and Mental Health Data Archive

Meth use is also associated with age. As shown in Figure 5, self-reported meth use is significantly higher among those in their mid 20s and 30s (25–34 years old), young adults (18–24 years old), and adults in their mid 30s and 40s (35–44 years old) than other age categories.¹⁰ In addition, reported rates of meth use among 18- to 24-year-olds and 25- to 34-year-olds, in particular, steadily increased between 2000 and 2005.

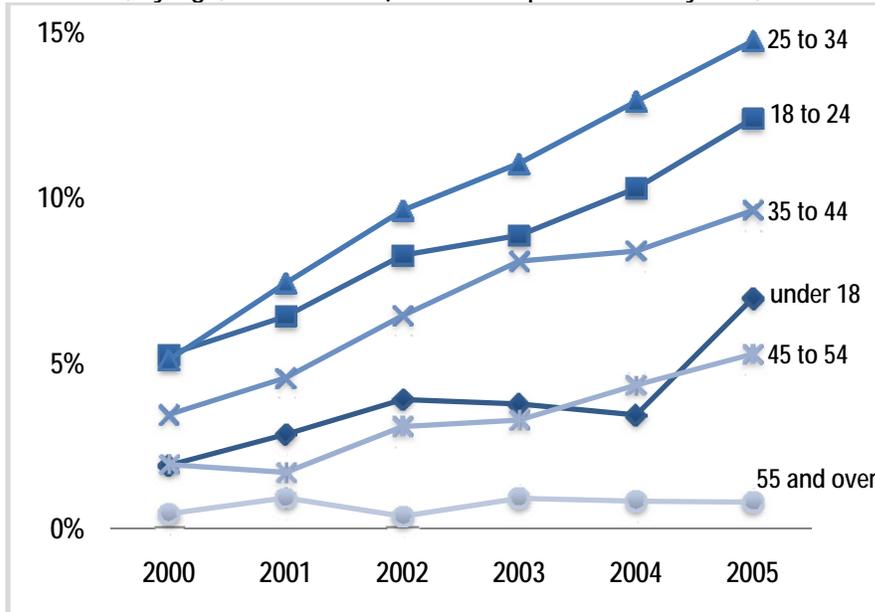
⁸ SAMHSA maintains the national TEDS database and collects demographic and substance abuse information for annual admissions to treatment facilities. State health departments submit data to the TEDS on an annual basis. While the TEDS provides information on substance use and abuse patterns nationally and at the state level, the data are not considered representative of all individuals who received drug and alcohol treatment. In Indiana, only individuals who are 200 percent below the poverty level are eligible for treatment at state-registered facilities.

⁹ The chi-square test can be used to assess whether the difference in current meth use between Indiana and U.S. respondents is random or due to some other underlying difference between the two populations. It is also known as a 'goodness of fit' test. In this case, the Indiana respondents are significantly different each year from the U.S. respondents, shown by year as: 2000: Pearson chi-square = 387.14, $p < .001$; 2001: Pearson chi-square = 174.62, $p < .001$; 2002: Pearson chi-square = 73.35, $p < .001$; 2003: Pearson chi-square = 46.52, $p < .001$; 2004: Pearson chi-square = 40.60, $p < .001$; 2005: Pearson chi-square = 29.11, $p < .001$.

¹⁰ The goodness of fit statistics are as follows: 2000: Pearson chi-square = 185.01, $p < .001$; 2001: Pearson chi-square = 226.17, $p < .001$; 2002: Pearson chi-square = 265.49, $p < .001$; 2003: Pearson chi-square = 313.88, $p < .001$; 2004: Pearson chi-square = 489.75, $p < .001$; 2005: Pearson chi-square = 509.95, $p < .001$.



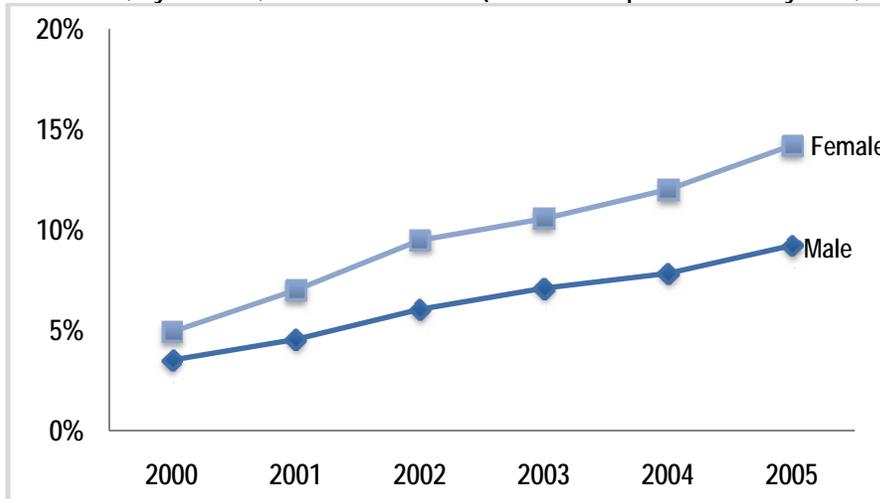
Figure 5: Percentage of Indiana Treatment Admissions Reporting Methamphetamine Use at Admission, by Age, 2000 to 2005 (Treatment Episode Data System, 2000 – 2005)



Source: Substance Abuse and Mental Health Data Archive

Meth seems to appeal to both men and women (as a percentage of all white women admitted for substance abuse treatment) but perhaps more so to women. TEDS data from 2000 through 2005 tend to bear this out (see Figure 6). A significant gender effect is observed with meth use among individuals entering substance abuse treatment in Indiana. Across all data points, female clients were significantly more likely to report meth use at admission than males.¹¹

Figure 6: Percentage of Indiana Treatment Admissions Reporting Methamphetamine Use at Admission, by Gender, from 2000 to 2005 (Treatment Episode Data System, 2000 – 2005)



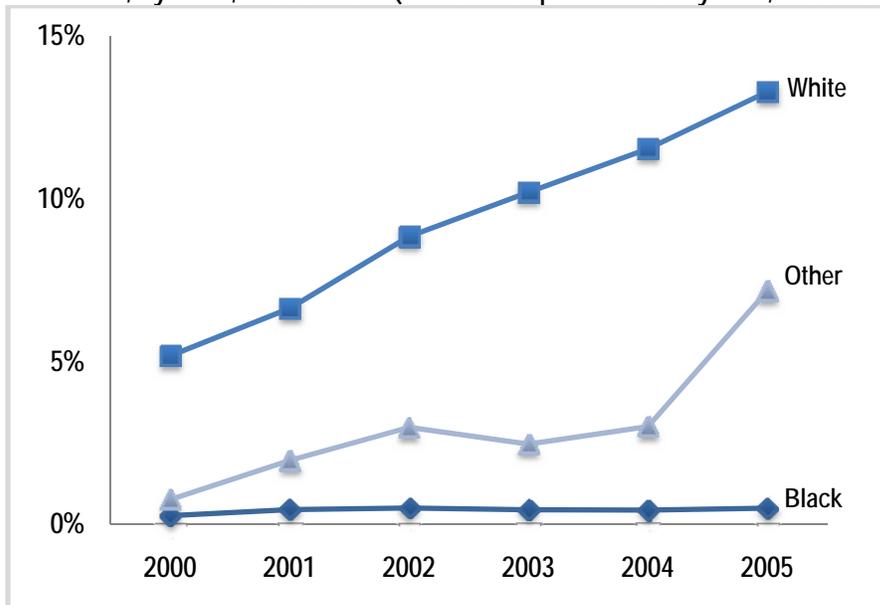
Source: Substance Abuse and Mental Health Data Archive

¹¹ Goodness of fit statistics are as follows: 2000: Pearson chi-square = 43.01, $p < .001$; 2001: Pearson chi-square = 72.97, $p < .001$; 2002: Pearson chi-square = 117.99, $p < .001$; 2003: Pearson chi-square = 109.79, $p < .001$; 2004: Pearson chi-square = 175.13, $p < .001$; 2005: Pearson chi-square = 213.87, $p < .001$.



A statistically significant race effect also is observed with meth use among individuals entering substance abuse treatment (see Figure 7). White persons were significantly more likely than black or other minority individuals to report meth use at admission.¹² While rates of use among white patients at treatment admission increased between 2000 and 2005, from 5.2 percent to 13.3 percent, respectively, reported meth use by black individuals in treatment has remained steady at 0.5 percent or less.

Figure 7: Percentage of Indiana Treatment Admissions Reporting Methamphetamine Use at Admission, by Race, 2000 to 2005 (Treatment Episode Data System, 2000–2005)



Source: Substance Abuse and Mental Health Data Archive

CONSEQUENCES

Criminal Consequences

According to the U.S. Drug Enforcement Agency (DEA), Indiana has become an area of high drug trafficking and distribution. Meth manufactured in Mexico and the southwestern states is increasingly transported into Indiana. The DEA notes that meth labs in Indiana produce higher purity (30 to 40 percent) meth, but do not generate large quantities for distribution. Over the last five years, Indiana has ranked in the top 10 states in the number of clandestine meth labs seized. In 2005, Indiana ranked third and remained in that position in 2006 (U.S. DEA, 2006).

The DEA El Paso Intelligence Center (EPIC) National Clandestine Laboratory Seizure System houses the central repository for data pertaining to clandestine labs seized in the United States by local, state, and federal law enforcement agencies. The National Clandestine Laboratory Seizure report includes types, numbers, and locations of labs seized; precursor and chemical sources; and number of children and law enforcement officers affected. The Indiana State Police (ISP) and a number of local law enforcement agencies report clandestine meth lab seizures directly to EPIC. These data describe seizures of drug labs within the state and lab-related arrest rates. ISP made 507 drug lab arrests in 2006; down from 885 in 2004

¹²Goodness of fit statistics are as follows: 2000: Pearson chi-square = 429.28, $p < .001$; 2001: Pearson chi-square = 345.09, $p < .001$; 2002: Pearson chi-square = 491.19, $p < .001$; 2003: Pearson chi-square = 616.48, $p < .001$; 2004: Pearson chi-square = 858.46, $p < .001$; 2005: Pearson chi-square = 653.74, $p < .001$.



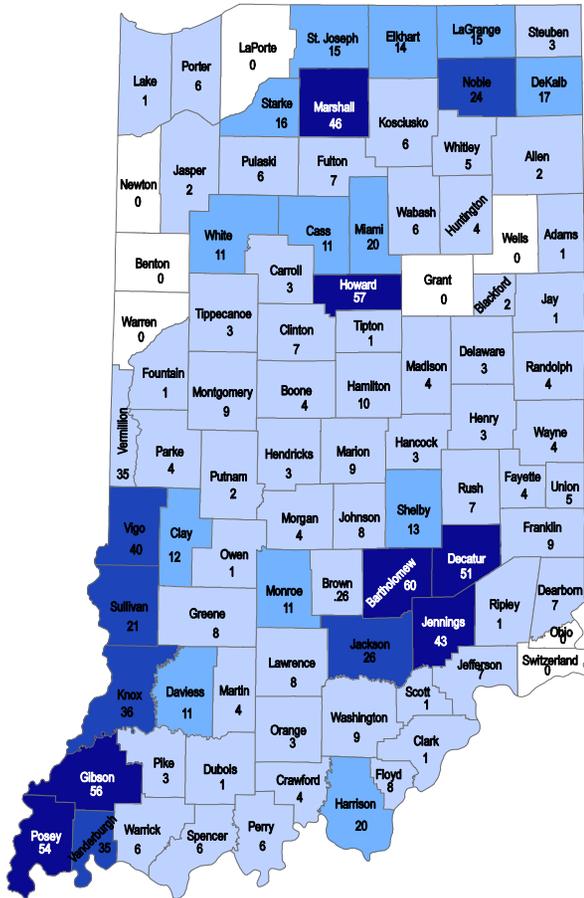
and 650 in 2005. In 2006, Indiana law enforcement agencies responded to 993 labs in 2005, down from a record high of 1,549 clandestine labs in 2004.

The 2006 statistics for lab disassemblies per Indiana county are shown in Map 1. The average number of labs seized in 2006 was 11. Overall, 26 counties had 11 or more labs seized and seven counties had over 40 seizures. The majority (58) of Indiana counties had between 1 and 10 lab disassemblies. Eight counties had no activity. Map 2 displays the average number of meth labs seized by county between 2002 and 2006. Over the five-year period, 35 counties had an average of more than 10 labs seized; 9 counties experienced between 20 and 40 seizures, and 7 counties had over 40 disassemblies. Six of these seven counties are located in the southwestern portion of the state bordering Illinois. Map 3 presents the change from 2004 (record number of seizures) to 2006 in the number of meth labs seized. Forty-five counties experienced a decline in lab seizures.¹³ Five of these counties—Vigo, Sullivan, Knox, Posey, and Vanderburgh—are among the six with the highest average number of labs seized between 2002 and 2006. Only Gibson County shows an increase of 35 events. Ten counties remained stable and 37 showed an increase in activity, with 8 of those 11 or more. While over time (2002 to 2006), the greatest activity has been in the southwestern portion of the state (Map 2), lab seizures have shifted recently (Maps 1 and 3). With the exception of Gibson County, seven counties around the state have experienced an increase in reported lab seizures.

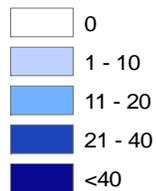
¹³ It is thought that the decline in clandestine meth lab activity is attributed to relatively recent meth-specific legislation. Senate Enrollment Act (SEA) 444 (also known as the “Methamphetamine Protection Act”), became effective July 1, 2005, and regulates the sale and display of products containing ephedrine and pseudoephedrine. The law requires retailers to track purchasers’ information and maintain log books including such information for monitoring by law enforcement. The law also mandates regulation of laboratory cleanup and handling of cases involving children.



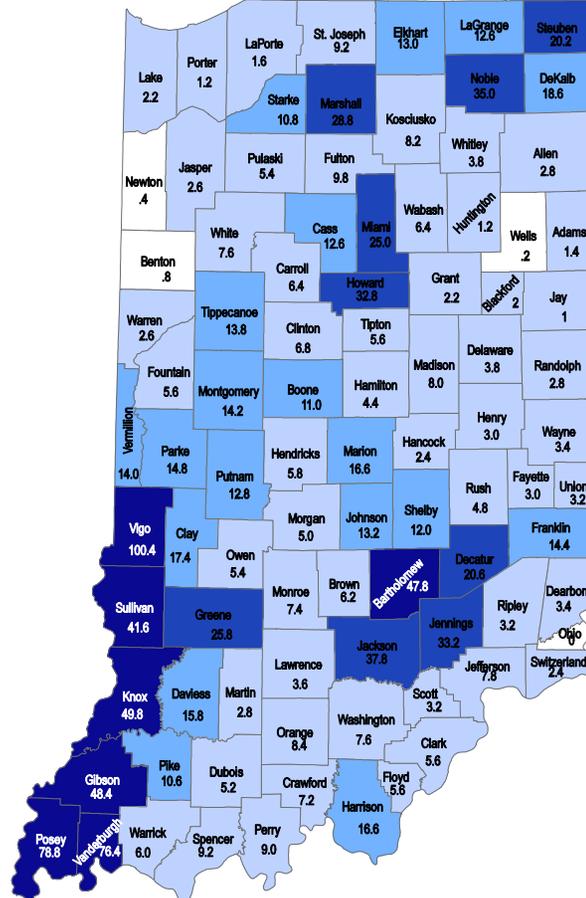
Map 1: Number of Clandestine Meth Labs Seized in Indiana, by County, 2006 (Mean=11)



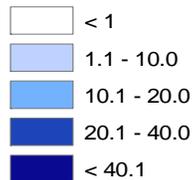
Number of labs



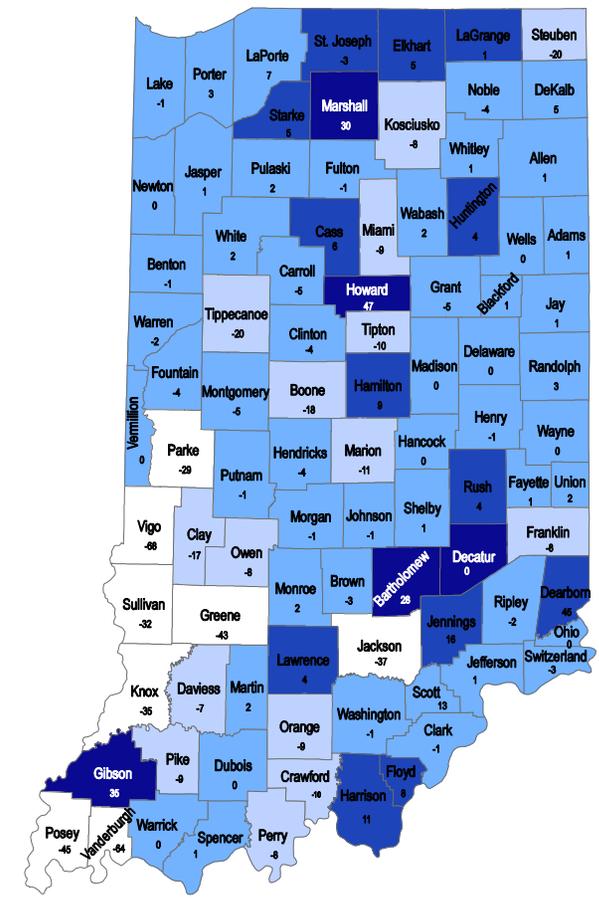
Map 2: Average Number of Meth Labs Seized in Indiana, by County, from 2002 to 2006



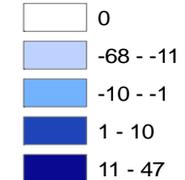
Average Number of labs



Map 3: Change in Number of Meth Labs Seized in Indiana, by County, from 2004 to 2006



Change in number of labs

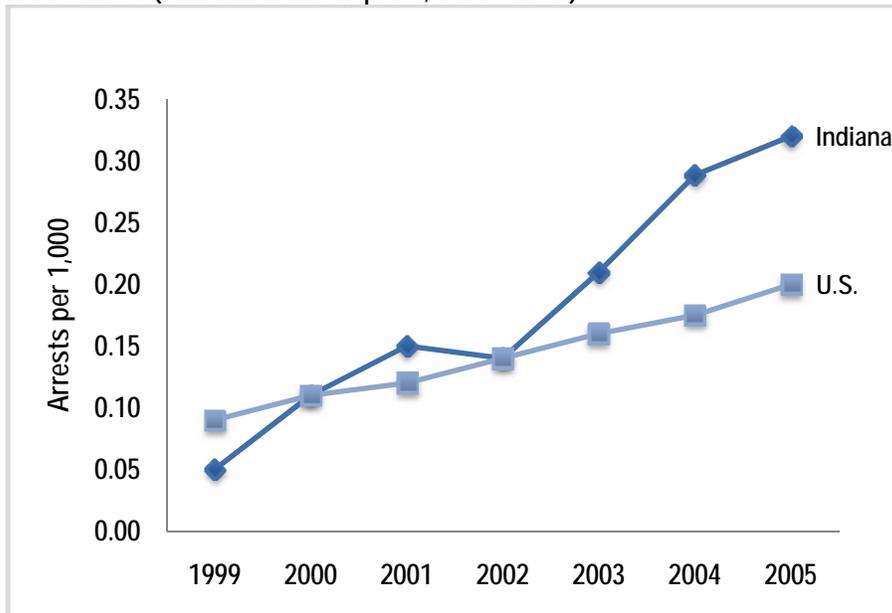


Source: U.S. Drug Enforcement Agency El Paso Intelligence Center and Indiana State Police, 2007



Meth is considered a synthetic stimulant. The FBI Uniform Crime Reporting (UCR) Program database includes information on synthetic drug possession and manufacturing arrests. Substances defined as “synthetic” include a number of drugs in addition to meth, such as Demerol and methadone. According to UCR data, arrest rates for synthetic drug possession rose between 1999 and 2005 for both Indiana and the United States, with Indiana’s rates exceeding the nation’s in every year since 2001, except 2002 (see Figure 8). While U.S. arrest rates for synthetic drug sale/manufacture remained relatively stable between 1999 and 2005, Indiana rates were more erratic, climbing from 0.01 in 1999 to 0.10 in 2002 and 0.12 in 2004 and dropping to 0.09 in 2005 (see Figure 9).

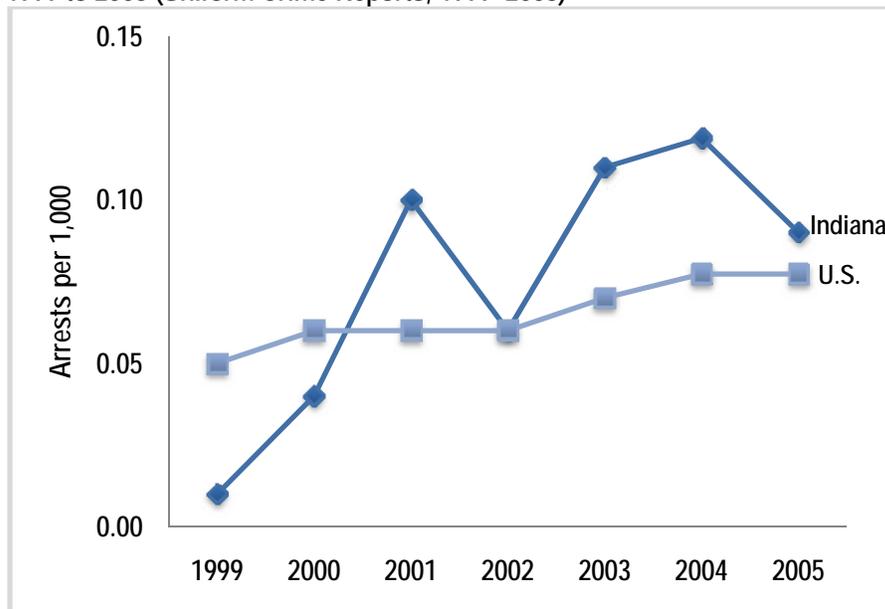
Figure 8: Indiana and U.S. Arrest Rates, per 1,000 Population, for Synthetic Drug Possession, from 1999 to 2005 (Uniform Crime Reports, 1999 – 2005)



Source: Federal Bureau of Investigation; U.S. Census Bureau



Figure 9: Indiana and U.S. Arrest Rates for Synthetic Drug Sale/Manufacture, per 1,000 Population, 1999 to 2005 (Uniform Crime Reports, 1999–2005)



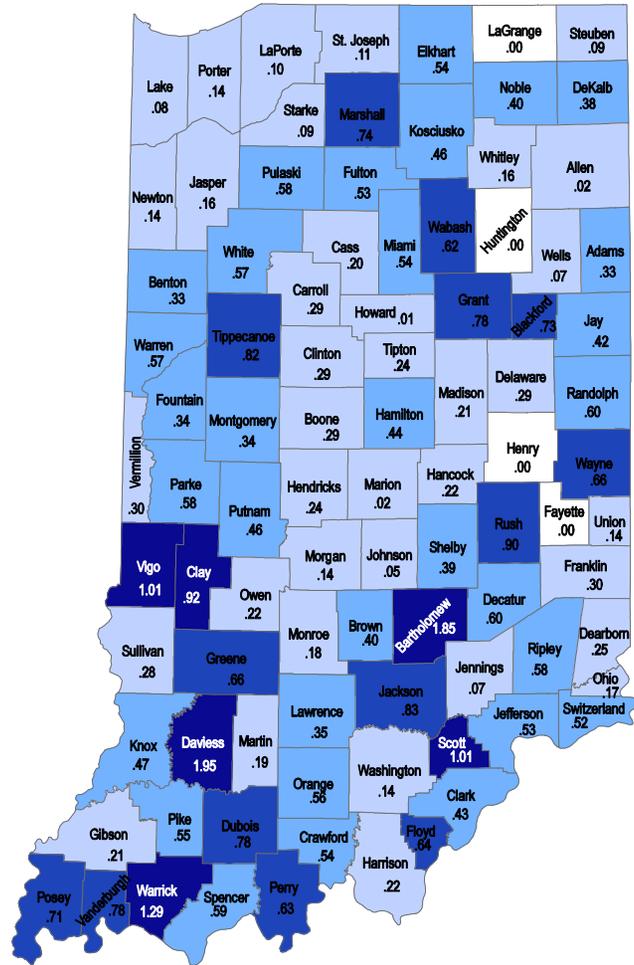
Source: Federal Bureau of Investigation; U.S. Census Bureau

Maps 4 and 5 shows the distribution, by county, of arrest rates per 1,000 population for synthetic drug possession and dealing (sale/manufacture).¹⁴ While Map 4 illustrates that rates of arrest for possession are dispersed throughout the state, a number of southwestern Indiana counties have higher rates of arrest for possession (over .90). By comparison, only one county had an arrest rate for sale/manufacture over .61. The change in arrest rates for possession and dealing between 2002 and 2005 are shown in Maps 6 and 7. These exhibits illustrate that, when compared with reported lab seizures, arrests for synthetic drug activity do not appear to be concentrated in any region. Between 2002 and 2005, 80 counties experienced an increase in arrest rates for possession, and rates of arrest associated with synthetic drug sale/manufacture rose in 68 counties.

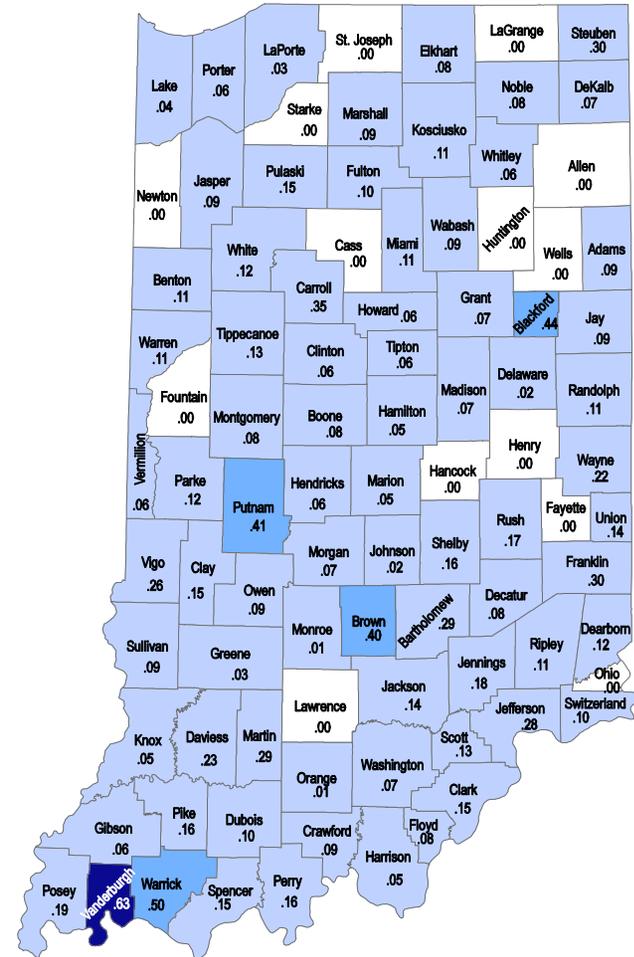
¹⁴ Due to variations in reporting procedures and a lack of data to identify meth-specific arrests, caution should be exercised when interpreting these data. In Indiana, reporting by county and local law enforcement jurisdictions is sometimes incomplete, and therefore, a portion of these data are based on estimates. (Further details and analysis regarding UCR reporting coverage in Indiana can be found in the Center for Urban Policy and the Environment report, *Timely and Accurate Data Reporting Is Important for Fighting Crime* (2007) at http://www.urbancenter.iupui.edu/PubResources/pdf/236_07_C10UCR.pdf. The UCR-specific analysis addresses the rate at which Indiana jurisdictions report crime information to the FBI through the UCR.)



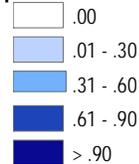
Map 4: Arrest Rates for Synthetic Drug Possession, per 1,000 Population, in Indiana, by County, 2005



Map 5: Arrest Rates for Synthetic Drug Sale/Manufacture Arrest, per 1,000 Population, in Indiana, by County, 2005



Arrests per 1,000 Population

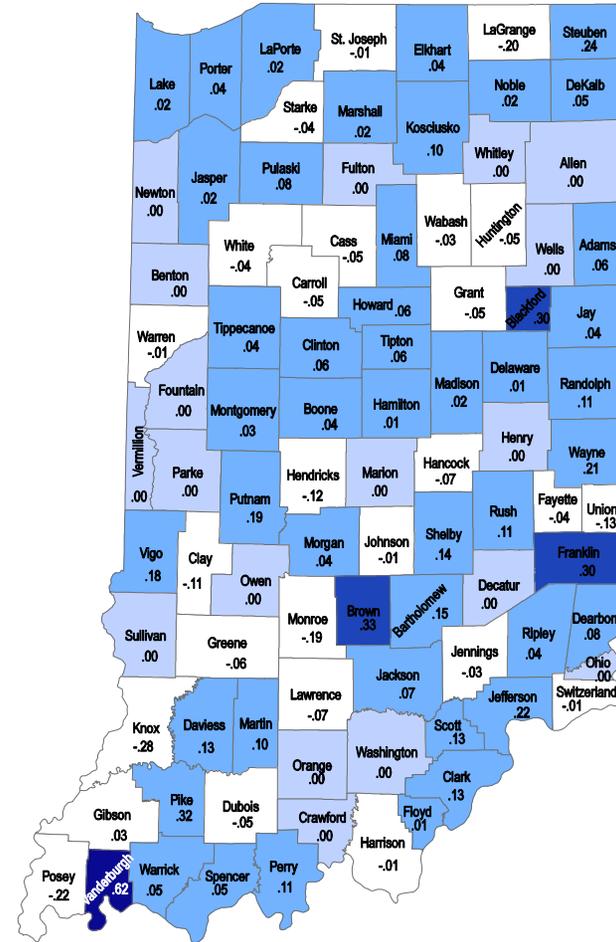
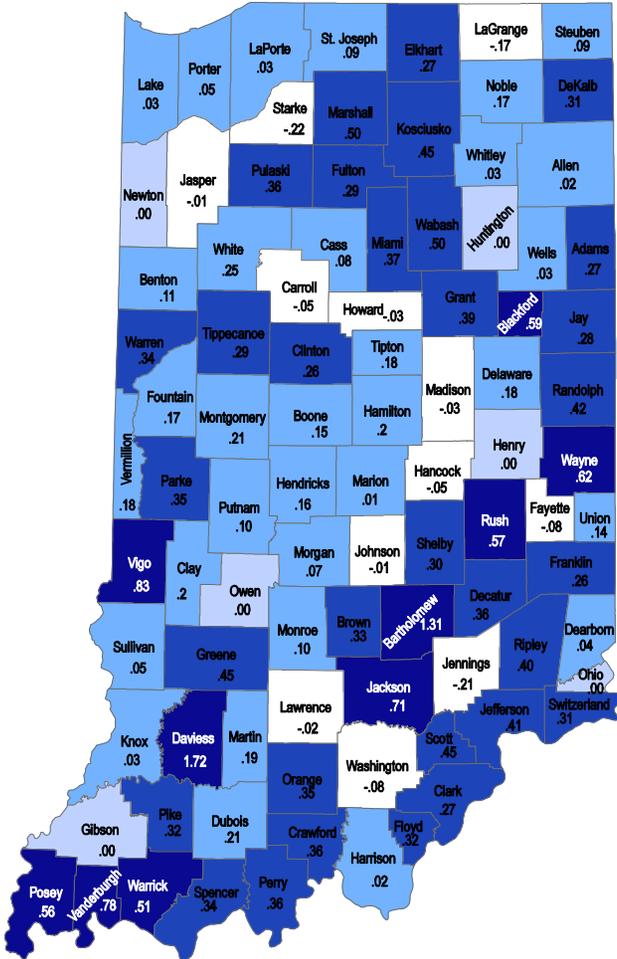


Source: Uniform Crime Reporting Program Data: County-Level Detailed Arrest and Offense Data, 2005, U.S. Department of Justice, Federal Bureau of Investigation. Retrieved from Inter-University Consortium for Political and Social Research; 2005 population estimates retrieved from U.S. Census Bureau.

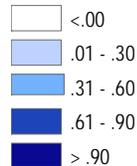


Map 6: Change in Arrest Rates for Synthetic Drug Possession, per 1,000 Population, in Indiana, by County, 2002 to 2005

Map 7: Change in Arrest Rates for Synthetic Drug Sale/Manufacture Arrest, per 1,000 Population, in Indiana, by County, 2005



Change in Arrest Rates (2002 - 2005)



Source: Uniform Crime Reporting Program Data: County-Level Detailed Arrest and Offense Data, 2002 and 2005, U.S. Department of Justice, Federal Bureau of Investigation. Retrieved from Inter-University Consortium for Political and Social Research; 2002 and 2005 population estimates retrieved from U.S. Census Bureau.



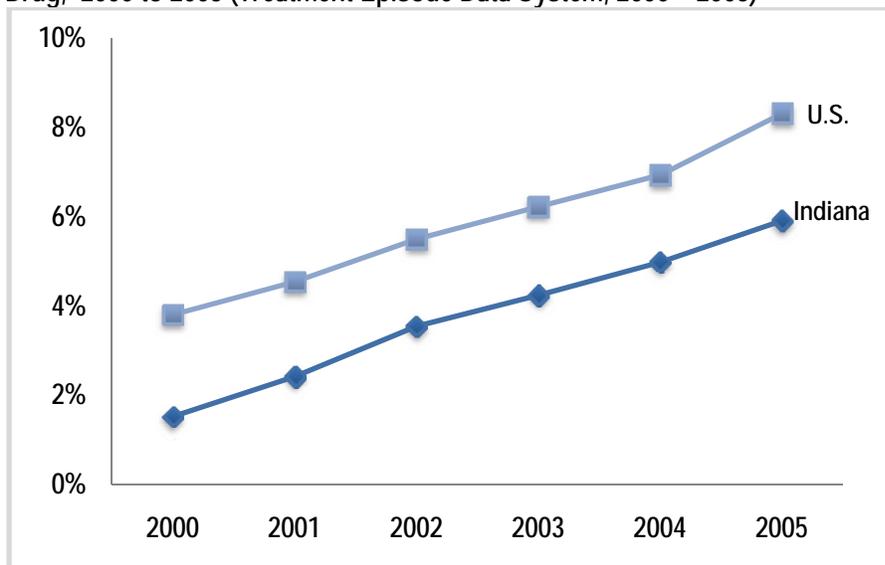
Health-Related Consequences

The health consequences of meth use include both short-term and chronic impacts. Short-term effects include increased wakefulness, increased physical activity, and decreased appetite, as well as cardiac problems, hyperthermia, depression, and confusion. When used chronically, meth causes long-term changes that result in impaired memory, mood alterations, diminished motor coordination, and psychiatric problems. Chronic, long-term use can lead to insomnia, violent behavior, hallucinations, weight loss, and stroke. Other health consequences of prolonged meth use include cardiovascular collapse; brain, liver, and kidney damage; severe tooth decay (or “meth mouth”); hepatitis; extreme weight loss; mental illness; increased risk of unsafe sex and risky sexual behavior; increased risk of STD/HIV transmission; unwanted pregnancy; and death (U.S. Office of National Drug Control Policy, ONDCP, 2005; NIDA, 2002 and 2005). Meth labs and parental addiction pose serious risks to children due to the highly toxic fumes generated during production and because users often sleep for long periods of time, neglecting their children. Children who are present during or after meth production may face severe health and safety risks, including medical neglect, and physical, emotional, and sexual abuse (National Drug Intelligence Center, NDIC, 2002).

Meth Dependence

As previously mentioned, meth is considered a highly addictive substance resulting in drug dependence. Data from the TEDS demonstrate that the percent of admissions for which meth is indicated as the primary drug has been significantly lower in Indiana than the rest of the nation.¹⁵ In Indiana, between 2000 and 2005, the percentage of admissions for which meth was reported as the primary substance of use increased from 1.5 percent to 5.9 percent (see Figure 10).

Figure 10: Percentage of Indiana and U.S. Treatment Admissions Reporting Methamphetamine as Primary Drug, 2000 to 2005 (Treatment Episode Data System, 2000 – 2005)



Source: Substance Abuse and Mental Health Data Archive

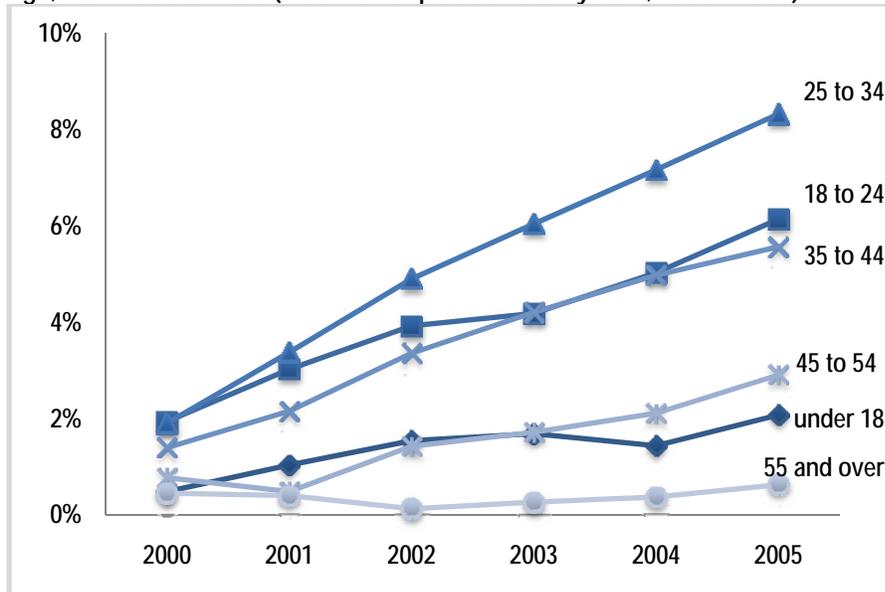
Age, as with meth use, appears to be associated with reporting of meth as primary substance at admission in Indiana. Younger adults are statistically more likely than those under 18 and over 45 to report meth as their primary

¹⁵ The goodness of fit statistics are: 2000: Pearson chi-square = 540.65, $p < .001$; 2001: Pearson chi-square = 294.30, $p < .001$; 2002: Pearson chi-square = 222.21, $p < .001$; 2003: Pearson chi-square = 212.38, $p < .001$; 2004: Pearson chi-square = 219.97, $p < .001$; 2005: Pearson chi-square = 280.89, $p < .001$.



drug.¹⁶ Rates among 18-to 24-year-olds increased between 2000 (1.9 percent) and 2005 (6.1 percent), and similarly among 25- to 34-year-olds and 35 to 44-year-olds (see Figure 11).

Figure 11: Percentage of Indiana Treatment Admissions Reporting Methamphetamine as Primary Drug, by Age, from 2000 to 2005 (Treatment Episode Data System, 2000 – 2005)



Source: Substance Abuse and Mental Health Data Archive

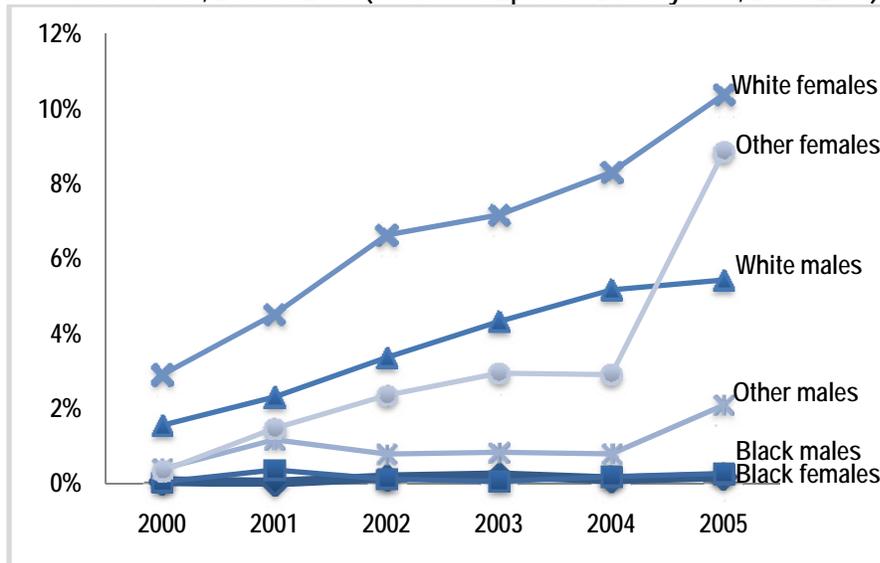
With regard to race and gender, as demonstrated in Figure 12, white women are significantly more likely than white men to report meth as their primary drug of use at admission for substance abuse treatment, with rates for both gender groups showing a steady increase from 2002 to 2005.¹⁷ Rates for black men and black women do not differ, are extremely low compared to other groups, and remained constant during the six-year period (2000-2005).

¹⁶ The goodness of fit statistics are: 2000: Pearson chi-square = 59.43, $p < .001$; 2001: Pearson chi-square = 120.26, $p < .001$; 2002: Pearson chi-square = 141.59, $p < .001$; 2003: Pearson chi-square = 185.58, $p < .001$; 2004: Pearson chi-square = 285.73, $p < .001$; 2005: Pearson chi-square = 296.10, $p < .001$)

¹⁷ The goodness of fit statistics are: (2000: Pearson chi-square = 55.14, $p < .001$; 2001: Pearson chi-square = 80.06, $p < .001$; 2002: Pearson chi-square = 132.13, $p < .001$; 2003: Pearson chi-square = 89.23, $p < .001$; 2004: Pearson chi-square = 111.44, $p < .001$; 2005: Pearson chi-square = 574.85, $p < .001$)



Figure 12: Percentage of Indiana Treatment Admissions Reporting Methamphetamine as Primary Drug, by Race and Gender, 2000 to 2005 (Treatment Episode Data System, 2000–2005)



Source: Substance Abuse and Mental Health Data Archive

Social Consequences

In addition to the consequences discussed above, meth use and abuse can have serious social impacts. Students who use meth are more likely to exhibit lower academic performance, higher rates of absenteeism, and are less likely to graduate from high school. Individuals who use meth are more likely to have problems at work. Meth use also impacts children and families, in ways similar to other forms of substance abuse, by contributing to increased interpersonal conflicts, financial problems, poor parenting, incarceration (of parents), and placement of children in protective custody (NIDA, 2005). According to data from EPIC/ISP, the number of children affected by meth labs in Indiana rose from 182 in 2002 to 217 in 2004, and fell to 144 in 2006.

CONCLUSION

Survey results and the analysis of various available data sources presented in this report do not provide a definitive picture of meth use trends in Indiana. While national survey results show that meth use has either remained stable or declined in recent years, among certain segments of the population, such as those in substance abuse treatment, rates of meth use and dependence continue to rise. In recent years, arrests rates for synthetic drug possession have also risen, both nationally and at the state level, while rates of arrest for the sale or manufacture of meth in Indiana have fallen. In addition, while the overall number of clandestine meth labs in Indiana appears to have recently declined overall and specifically in the southwestern portion of the state, such activity may be shifting to other regions.



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