MCFARLAND RADAR (Relevant Alcohol & Drug Awareness Resources) COALITION

AODA PREVENTION NEWSLETTER

September 2023

Methamphetamine

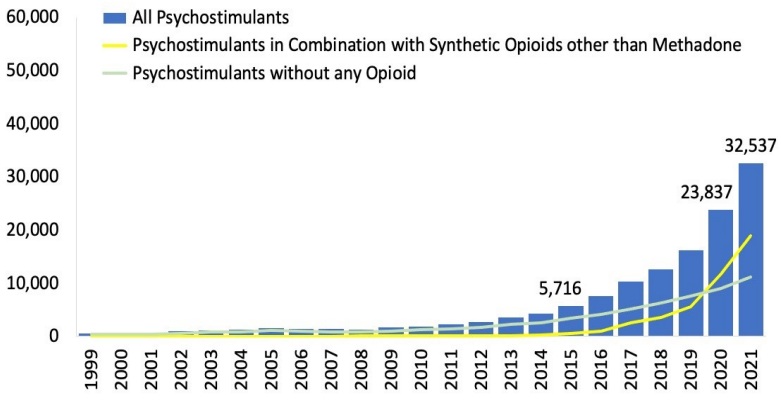
Methamphetamine (also known as Meth) is a laboratory made, white, bitter-tasting powder. It can sometimes be made into a white pill, or a shiny, white or clear rock called crystal. Meth is made in the United States and often in Mexico "superlabs" which are big, illegal laboratories that make the drug in large quantities.

Meth was first synthesized from ephedrine by a Japanese scientist Nagai Nagayoshi in 1893. But it wasn't until 1919 that another Japanese scientist, Akira Ogata, managed to synthesize it in the crystalline form in which it is most commonly known today.

During World War 2, methamphetamine was used by Germany and Japan soldiers to give greater stamina and tolerance to the psychological trauma of warfare. During the Korean War, US troops were also given methamphetamines.

In the 1960s, as more and more substances were restricted in the US, production of methamphetamine began to go underground, and was increasingly used recreationally as 'crystal meth.' This trend quickly spread to the UK and Europe, and smoking it became popular in the 1980s, although incidence of injecting had also increased due to the faster acting and more intense effects.

Figure 7. National Overdose Deaths Involving Psychostimulants with Abuse Potential (Primarily Methamphetamine)*, by Opioid Involvement, Number Among All Ages, 1999-2021



*Among deaths with drug overdose as the underlying cause, the psychostimulants with abuse potential (primarily methamphetamine) category was determined by the T43.6 ICD-10 multiple cause-of-death code. Abbreviated to *psychostimulants* in the bar chart above. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

Although methamphetamine was originally scheduled as a Class B substance under the Misuse of Drugs Act 1971, due to a recommendation to the Home Secretary by the Advisory Council on the Misuse of Drugs in May 2006, methamphetamine was raised to Class A substance in 2007.

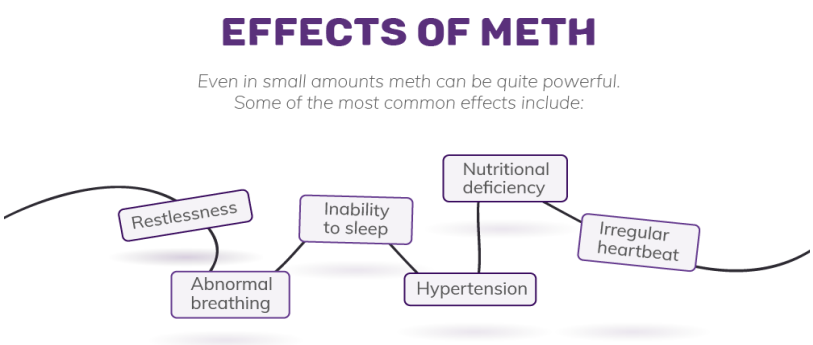
Wisconsin and Meth

Northwest Wisconsin experienced a surge in methamphetamine use in the late 1990s and early 2000s. State laws enacted in the mid-2000s restricted access to substances used to produce methamphetamine in home labs. Yet, in recent years, Wisconsin has seen a new surge in methamphetamine use, which has spread across the state. Methamphetamine is less expensive and it has a longer euphoric effect than other illegal stimulants. Today, the majority of the methamphetamine available in Wisconsin is produced in Mexico and transported here by drug-trafficking organizations.

Effects of Methamphetamine

Meth, when it is snorted, injected, smoked or ingested orally can produce a euphoric rush but poses many short and long term risks.

Short Term Effects can include:



- Increased attention and decreased fatigue
- Increased activity and wakefulness
- Decreased Appetite
- Euphoria and Rush
- Increased Respiration
- Rapid/irregular heartbeat
- Hyperthermia

The long-term physical effects of meth are likewise considerable and include the following:

- Severe dental damage and gum disease: Meth is acidic, meaning it can damage teeth simply through oral contact. Moreover, because users experience paranoia and aggression, they often grind their teeth to the point of extreme wear or cracking.
- Damage to brain tissue and function: Meth is poisonous to the central nervous system. It sabotages the natural circuitry of dopamine, a mood-regulating chemical, destroys brain tissue, and raises the risk of stroke, coma, and even death.
- Heart disease and cardiovascular damage: Even with limited usage, meth dangerously raises the heart rate. Over time, its effects are even more severe. Blood vessels can become permanently constricted; heart tissue may be inflamed and weakened; and cardiovascular disease and heart attack are significantly more common.
- Parkinson's Disease: Meth deteriorates the brain's substantia nigra area, which can cause physical rigidity and other movement challenges, elevating the risk of developing Parkinson's Disease.

Rural Life and AODA Prevention

Rural is defined as areas that are far away from urbanized cities, often characterized by low population density and limited access to resources. These regions are generally sparsely populated, with a higher percentage of people spread more widely apart than in cities or suburban areas. Most rural populations live in the countryside, small towns, or villages, with few businesses and services.

Rural and Urban Substance Use Rates

(ages 12 and older, unless noted)

	Non-metro	Small metro	Large metro
Alcohol use by youths aged 12-20	29.8%	28.5%	28.1%
Binge alcohol use by youths aged 12 to 20 (in the past month)	7.7%	9.1%	8.0%
Cigarette smoking	26.7%	20.0%	15.8%
Smokeless tobacco use	7.1%	4.1%	2.2%
Marijuana	15.7%	19.4%	19.2%
Illicit drug use	18.4%	22.4%	22.5%
Misuse of Opioids	3.2%	3.6%	3.2%
Cocaine	1.2%	1.7%	1.9%
Hallucinogens	2.3%	2.3%	2.9%
Methamphetamine	1.5%	0.9%	0.8%

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Results from the 2021 National Survey on Drug Use and Health: Detailed Tables.

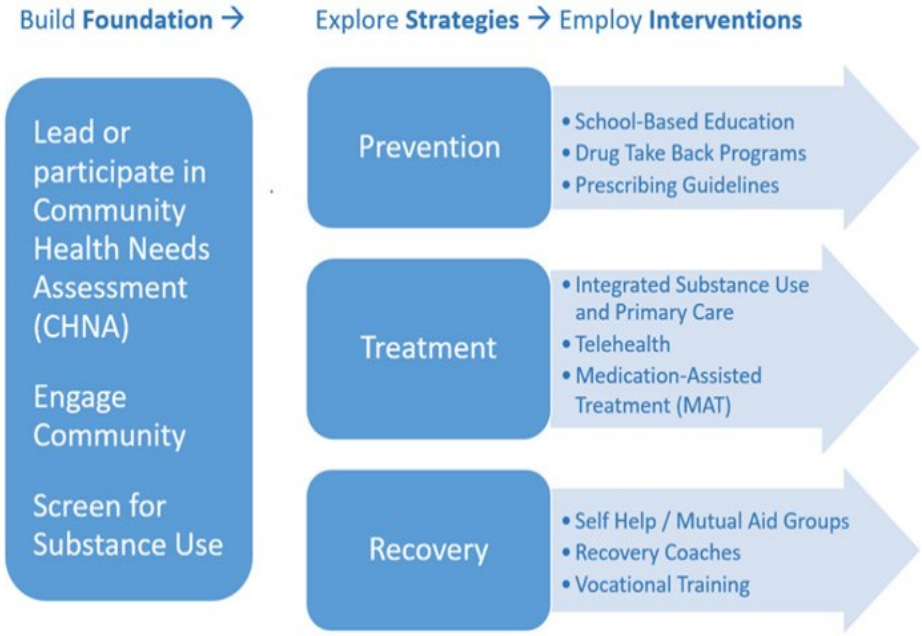
Rural areas typically have a higher poverty rate than urban and suburban regions, leading to an increased risk for substance use. This is compounded by the lack of access to healthcare, a lack of mental health treatment and drug abuse prevention services, and the inability to afford addiction treatment. Sadly, these disparities mean that rural communities are more likely to suffer from substance use issues than their urban peers.

Unique Challenges Prevention Practitioners May Face in Rural Communities:

- **Increased social stigma:** Rural cultural values of sharing and helpfulness make it easy to access alcohol and prescription opioids, but conversely create difficulties in publicly admitting problems related to the misuse of these substances. Rural residents place a higher value on self-sufficiency than urban residents, which complicates social acceptance for treatment and recovery programming for substance use disorders
- **Lower perceived harm of substance misuse:** Parents of rural teens are more likely than urban parents to downplay the harms of alcohol use and to allow teenagers to consume alcohol in their homes, believing that teen drinking is a “rite of passage.” Unsurprisingly, rural teens also perceive alcohol use as not harmful and are more likely than urban teens to begin drinking at earlier ages. Similarly, rural teens and adults perceive less harm from prescription opioid use than their urban counterparts.
- **Fewer first responders trained to reverse opioid overdose:** In contrast to many urban first responders, rural first responders, from police officers to emergency medical service providers, are less likely to carry or be trained to administer the opioid overdose reversal medication naloxone. Rural ambulances are more likely to be staffed by EMTs, who provide basic medical services such as assisting patients with medications they already take or orally task order
- **Decreased access to treatment and recovery programs:** Because people living in rural communities have reduced access to primary care providers, diagnosing substance use disorders is considerably more difficult as a part of routine medical care since changes in patterns of behavior may be harder for physicians to identify.

How Rural Communities Combat Substance Use

Prevention programs can help reduce substance use in rural communities, especially when they are focused on adolescents. Health care professionals, teachers, parents and law enforcement can work together to identify problems and develop prevention strategies to control and limit substance use in rural communities by:



- Holding community or town hall meeting to raise awareness
- Train law enforcement regarding liquor license compliance, underage drinking, and detection of impaired drivers.
- Invite speakers to talk to youth and help them understand the consequences of substance use
- Collaborate with churches, service clubs, and employers to provide a strong support system for individuals who might be in recovery.
- Train volunteers to identify and refer individuals at risk
- Develop formal substance use prevention, treatment, or recovery programs for the community
- Provide emergency departments (EDs), first responders, and the public with training and access to NARCAN.

- Collaborate with human services providers and local service organizations to ensure families affected by substance use disorder have adequate food, housing, and mental health services
- Implementing family-centered prevention programs that can work to improve the knowledge and skills for children and parents as it relates to substance use, as well as communication within the family.
- Implementing safe and supportive school environments, where students feels cares for by teachers and staff.

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ACORN	BOOTS	ECOLOGY	LEAVES	SEPTEMBER
AFTERSUMMER	BRIGHT	FALL	MIGRATE	SHORELINE
APPLES	BROWN	FALLING	ORANGE	SMOKEY
APPLECIDER	CARNIVAL	FISHING	PLANTS	SOYBEANS
AUTUMN	CHANGE	FOOTBALL	PICTURESQUE	SPORTFISHING
BACKTOSCHOOL	CHERRIES	FROST	PUMPKIN	SWEATER
BALD EAGLE	COLORFUL	GOLDEN	PREPARE	SUNFLOWER
BEFORE WINTER	COLORS	HALLOWEEN	RAKE	TOURISM
BLAZING STAR	COOL	HARVEST	RED	WATER
BONFIRE	CORNFIELD	INVASIVE	SEASON	YELLOW

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McFarland is a small community south of Madison in Dane County. In January of 2017, a group of concerned citizens came together to discuss substance abuse problems in the McFarland area. The McFarland RADAR is a result of these meetings

We are comprised of local representatives from schools, businesses, churches, village administration as well as parents, and youth—all working together to promote healthy lifestyles

For more information go to: https://www.radarmc.com/

The McFarland RADAR (RADAR stands for Relevant Alcohol & Drug Awareness Resources) Coalition works to develop, implement and support environmental strategies to reduce substance abuse.

We believe by working together, we can nurture social and environmental changes to make the McFarland area a safer and healthier place, brightening the future of our children, youth and families.

For time, day and place of meetings, please contact Cathy Kalina at CathyK@fsmad.org

McFarland RADAR Mission Statement

"The mission of McFarland's RADAR Coalition is to promote healthy lifestyles in the McFarland area through alcohol and drug abuse prevention and education efforts."

HOW CAN YOU HELP?

We are asking you to give the gift of time. Make a difference in the lives of our youth and our community by

1. Working with us in providing support for planning, project management and awareness campaigns
2. Helping with coalition events, conferences, workshops, and fairs held throughout the year.
3. Being a voice for change in our community, it is time to come together and be that force for change in the McFarland area.