Department of Health and Human Services
Division of Mental Health and Developmental Services
Substance Abuse Prevention and Treatment Agency (SAPTA)[1]
Methamphetamine Prevention Overview

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In order to understand how to prevent the first use of methamphetamines and its long term impact it is imperative to understand basic substance abuse prevention theory and research. Prevention is defined as "a proactive process of helping individuals, families, and communities to develop the resources needed to develop and maintain healthy lifestyles."[2] Prevention is broad-based in the sense that it is intended to alleviate a wide range of behaviors that put individuals and communities at risk.

According to reports from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies (2005), the average age of first use of methamphetamine was 22.1 years old. In addition, the Office of National Drug Control Policy (2005) reports methamphetamine use is greatest among those ages 19-40 years old. Therefore it is important for the prevention of methamphetamine use to focus on programs and strategies that address youth prior to first use.

While the findings of this report provide important information to use in the prevention of methamphetamine abuse it is also essential to remember that the use of any drug, particularly the gateway drugs of alcohol and marijuana by youth, significantly increase the risk of later use of methamphetamines. In a Washoe County School District, Youth Risk Behavior Survey (2005) report it was found that the age of first use of marijuana and alcohol had a significant impact on later drug use. The following tables are a summary of those findings:

Table 1: Methamphetamine Use and Age of First Use of Alcohol Comparison

Age of First Use of Alcohol	<8	9-10	11-12	13-14	15-16	17+	Never
Tried Methamphetamine	31.6%	21.1%	14.1%	11.7%	4.3%	4.8%	1.9%

Table 2: Methamphetamine Use and Age of First Use of Marijuana Comparison

Age of First Use of Marijuana	<8	9-10	11-12	13-14	15-16	17+	Never
Tried Methamphetamine	62.9%	38.1%	33.0%	18.1%	9.8%	8.8%	1.2%

[1] The Division of Mental Health and Developmental Services (MHDS), Substance Abuse Prevention and Treatment Agency (SAPTA), was previously known as the Health Division, Bureau of Alcohol and Drug Abuse (BADA).
[2] International Certification and Reciprocity Consortium; IC&RC.

It is easy to see from these tables that in order to truly prevention methamphetamine abuse and its negative consequences it is imperative to include the prevention of alcohol and marijuana use as well.

In a recent report in the *American Journal of Psychiatry* (December, 2005) researchers studied the "gateway" theory of drug abuse, which theorizes that a child will use legal drugs first (alcohol and tobacco) and then proceed to softer drugs like marijuana, prior to moving onto harder drugs like methamphetamines, heroin, or cocaine. Instead however, they supported the "common liability" model, which hypothesizes that behavioral deviancy and genetic risk have the greatest influences on whether an individual will use illegal (or legal) drugs. As a result, the researchers recommend early intervention for children and youth with conduct problems, writing "in effect the greater the deviancy, the more likely an individual is to use an illegal drug." These findings underscore the need to prevent conduct problems in early childhood to diminish the risk of later illicit drug use.

To reduce the incidence of methamphetamine use, abuse, addiction, and related community problems there must be a broad based approach that focuses on multiple strategies across multiple sectors. Any single focus approach to methamphetamine prevention will result in either a decreased impact across the board or no impact at all. Often methamphetamine prevention has focused on creating laws and policies to regulate precursor drugs that are used in the manufacture of methamphetamine, the investigation and removal of methamphetamine production labs, and enforcement issues. While all of these strategies are critical, there must also be a balance of early primary prevention and intervention to stop the progression of addiction in all populations before it starts.

Substance abuse prevention has a long standing history of research that has documented what is effective and what does not work to prevent addiction. The Northwest Regional Educational Laboratory's *Effective Comprehensive Prevention Programs: A Planning Guide* (1996) is a guidance document that summarized prevention research to that point and is a foundation for what we know today about what is effective substance abuse prevention. That document reports that prevention must be part of a larger effort. Prevention programs that are add-ons, tacked onto one corner of a curriculum or aimed at one segment of the population, are unlikely to succeed. The guide which is a compilation of reports and articles, states that prevention programs must be folded into the mainstream. "We cannot afford the luxury of fragmented, categorical, or territorial approaches any longer, for our children are paying the price of our lack of unity," the authors write. Prevention efforts must touch not only the individual but the whole community, the planning guide maintains. In short, programs must be comprehensive. They must cut across disciplines and across categories of kids. They must extend into the homes, neighborhoods, businesses, agencies, churches, recreational programs, and service organizations that make up the surrounding community. Skimming the surface with one-time assemblies or other piecemeal approaches won't work, the authors say. In fact, they warn, some prevention efforts can backfire, actually encouraging kids to experiment with drugs. "Comprehensive prevention programs must address basic human needs and developmental issues," the authors note. "Not only must individuals be provided opportunities to develop those attributes and skills necessary for their individual health, but we must create environments that sustain and promote health." The guide goes on to outline those activities that have repeatedly been shown not to work including

information only programs and scare tactics. It must be kept in mind that a change in knowledge does not necessarily result in a change in behavior. (For a complete copy of this guide go to (http://eric.ed.gov). This guide is one of many historical publications, studies, and articles that outline effective approaches to prevention that are the foundation of evidence based substance abuse prevention today.

Evidence based substance abuse prevention can be broken into three basic categories of focus; universal, selective, and indicated, as defined by the Institute of Medicine.

- Universal Prevention: Those programs, strategies, and practices that are designed to reach entire populations (e.g. all students in a school, mass media campaigns, all families, etc.). This method of prevention has the widest impact and has activities designed to change the overall norms and behaviors of an entire population. This is the least expensive method of prevention.
- Selective Prevention: Those programs, strategies, and practices that are designed to target populations or groups that are at risk (e.g. children of alcoholics or drug addicts, poor school achievers, etc.). This method of prevention focuses on a smaller part of the population, those groups that are at a higher risk by virtue of belonging to that group.
- Indicated Prevention: Those programs, strategies, and practices that are designed to identify individuals that exhibit high risk behaviors (e.g. initial use of alcohol, tobacco, or other drugs, delinquency, school failure or drop out, etc.) are considered indicated. Indicated prevention is for those individuals who have shown signs of developing a problem with substance abuse (e.g. school failure, beginning to use, delinquency, etc.). While this method of prevention has the smallest scope of impact and is the most expensive to implement due to focusing on a single individual it is often the easiest because it is about one person and changing their behavior.

Within each of those categories are a set of evidence based strategies that can be used to implement activities within each of the categories. Those strategies on the approved SAMHSA list are; information dissemination, prevention education, community based processes, environmental strategies, alternative activities, and early identification and referral. It is therefore critical to employ an approach to methamphetamine prevention that is inclusive of all populations and strategies that research has shown to reduce illegal drug use.

SAMHSA currently maintains a list of best practice and model programs that are designed to reduce the use of alcohol and other illegal drug use that focus on children and underage youth and research has shown to be effective. Currently the SAMHSA website lists 28 best practice programs for the prevention of illegal drug use that if implemented in communities will help to reduce the number of new methamphetamine users in the future. A partial list and description of some of these evidence based model programs are listed below (for a complete list go to http://modelprograms.samhsa.gov).

- **All Stars™** is a school or community-based program designed to delay and prevent high-risk behaviors with middle school-age adolescents (11 to 14 years old), including substance use, violence, and premature sexual activity, by fostering development of

positive personal characteristics. A highly interactive program, All Stars involves 13 lessons during its first year and 9 booster lessons in its second year.

- **CASASTART:** (Striving Together to Achieve Rewarding Tomorrows) is a community-based, school-centered program designed to keep high-risk preadolescents (8 to 13 years old) free of drug and crime involvement. The central notion underlying the program is that while rates of experimentation with drugs and alcohol are similar for preadolescents from all backgrounds, those who lack effective human and social support are at higher risk of continuing and intensifying substance abuse.
- **Creating Lasting Family Connections (CLFC):** CLFC is a comprehensive family strengthening, substance abuse, and violence prevention curriculum that has scientifically demonstrated that youth and families in high-risk environments can be assisted to become strong, healthy and supportive people. Program results, documented with children 11 to 15 years, have shown significant increases in children's resistance to the onset of substance use and reduction in use of alcohol and other drugs. CLFC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth.
- **The Leadership and Resiliency Program (LRP)**: LRP is a school and community-based program for high school students (14 to 17 years of age), that works to enhance youths' internal strengths and resiliency, while preventing involvement in substance use and violence.
- **Positive Action (PA):** PA is an integrated, comprehensive, and coherent program that has been shown to improve academic achievement and behaviors of children and adolescents (5 to 18 years old) in multiple domains. It is intensive, with lessons at each grade level (from kindergarten to 12th) that are reinforced all day, school wide, at home, and in the community. It includes school, family, and community components that work together or can stand alone.
- **Too Good For Drugs (TGFD):** TGFD is a school-based prevention program designed to reduce the intention to use alcohol, tobacco, and illegal drugs in middle and high school students.

In Nevada, community substance abuse prevention coalitions are an integral part of prevention efforts. Community coalitions are responsible for implementing a diverse continuum of prevention activities in multiple venues. They follow the research recommendations of implementing a comprehensive approach to substance abuse prevention in general and methamphetamine prevention specifically. SAPTA conducted a survey of Nevada's thirteen substance abuse prevention coalitions to determine their scope of activities on methamphetamine prevention. The following summarizes findings of the survey:

- Twelve of the thirteen coalitions are actively involved in methamphetamine prevention activities. One of the newest coalitions, which serve White Pine, Eureka, and Lincoln counties, is not yet involved in methamphetamine prevention because it is in the process of building infrastructure and overall organizational readiness.
- All coalitions take part in the Statewide Coalition Partnership, an organization comprised of Nevada's substance abuse coalitions. Through the Partnership the coalitions share

information on methamphetamine issues and plan methamphetamine prevention activities.

- All coalitions actively involved in methamphetamine prevention develop and disseminate information on the issue to educate and increase awareness in their communities.
- A number of coalitions are collecting data on the issue to develop plans and logic models on combating the problem.
- The coalitions have formed partnerships with key stakeholders including law enforcement, business leaders, school districts, and organizations such as The Partnership for a Drug Free America.
- A number of coalitions have distributed public service announcements (PSAs) through local television, radio, and print media.
- Seven coalitions have held town hall meetings and/or developed task forces to discuss and plan methamphetamine prevention.

In addition to using evidence based programs, strategies, and practices it is also important to employ patience. To see the reduction of any drug use in the general population there must be enough time allocated to allow the change to occur. It is not uncommon for prevention to take five years to show the impact of a program or strategy in the overall population. Many of the above listed programs began to be implemented in Nevada over the last three years with funding from the original State Incentive Grant (SIG).