

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT
OF
ROBERT McSWAIN
DEPUTY DIRECTOR
INDIAN HEALTH SERVICE
BEFORE THE
SENATE COMMITTEE ON INDIAN AFFAIRS
OVERSIGHT HEARING ON THE PROBLEM OF METHAMPHETAMINE IN
INDIAN COUNTRY
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Mr. Chairman and Members of the Committee:

Good morning, I am Robert McSwain, Deputy Director of the Indian Health Service (IHS). Today, I am accompanied by Dr. Jon Perez, Director, Division of Behavioral Health, IHS and Dr. Anthony Dekker, Associate Director, Clinical Services, IHS Phoenix Indian Medical Center. We are pleased to have this opportunity to testify on behalf of Secretary Leavitt on the problem of Methamphetamine use in Indian Country.

The IHS has the responsibility for the delivery of health services to more than 1.8 million Federally-recognized American Indians and Alaska Natives through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians/Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to promote healthy American Indian/Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Secretary Leavitt has also been proactive in raising the awareness of tribal issues within the Department by contributing to our capacity to speak with one voice, as One Department, on behalf of tribes. As such, he recognizes the authority provided in the Native American Programs Act of 1974 and utilizes the Intradepartmental Council for Native American Affairs to consider cross cutting issues and seeks opportunities for collaboration and coordination among Department programs serving Native Americans. The Council serves as an advisory body to the Secretary and has responsibility to assure that Native American policy is implemented across all Divisions in the Department including both health and human services programs. As Vice-Chair of the Secretary's Council, the IHS Director facilitates advocacy within the Department, promotes consultation, reports directly to the Secretary, collaborates directly with the Assistant Secretary for Health, advises the heads of all the Department's divisions and coordinates activities of the Department on Native American health and human services issues.

We are here today to discuss methamphetamine use in Indian Country, and the situation can be described in a single word: crisis. It is a crisis for individuals, families, communities, agencies, and governments across the country. It is also not specific to Indian Country, but affects the entire nation and scores of communities, especially in the Upper Plains and West, and particularly in rural areas, all of which are places where many tribal communities are also located. The latest national information from the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), published in September of 2005, indicates that in 2004, an estimated 1.4 million persons aged 12 or older (0.6

percent of the population) had used methamphetamine in the past year, and 600,000 (0.2 percent) had used it in the past month. The number of past month methamphetamine users who met criteria for illicit drug dependence or abuse in the past 12 months increased from 164,000 (27.5 percent of past month methamphetamine users) in 2002 to 346,000 (59.3 percent) in 2004. The highest rates of past year methamphetamine use were found among Native Hawaiians or other Pacific Islanders at 2.2 percent of the population, and persons reporting two or more races at 1.9 percent. American Indians or Alaska Natives were third at 1.7 percent. By contrast, past year methamphetamine use among whites was 0.7 percent; 0.5 percent for Hispanics; 0.2 percent for Asians; and 0.1 percent for blacks.

There are manifold aspects to this situation and many windows through which to view the crisis including clinical effects, familial and social effects, and legal and economic impacts. We will focus primarily on IHS and tribal clinical information first, then describe the intervention, training, and community mobilization programming in which we are engaged with tribal communities and public and private partners to address the situation.

Beginning in approximately 2000, marked increases were noted in patients presenting for amphetamine related problems, and that trend continues through today. The number of patient services provided related to amphetamine abuse went from approximately 3,000 contacts in 2000 to 7,004 contacts in 2005, an increase of almost 2 ½ times over five years, and congruent with the overall increases noted by the NSDUH data . The number of individual patients seeking treatment rose similarly, and in 2005, numbered 2,124.

The ages of those most affected by amphetamine abuse span mid-adolescence through adults in their forties, with a sizable minority found even into their early fifties. The ages of highest usage are found from age 15 through 44, with the highest usage ages being 25 to 34 years of age. Finally, males and females are affected essentially equally regardless of age.

As a percentage of overall services provided within the IHS and tribal systems of care, these data indicate that, while increasing sharply, they still represent only a small fraction of the overall services provided. In 2005, there were over 12.5 million clinical services provided in the combined systems, and those directly related to amphetamine abuse amounted to less than .01% of them.

The drug is insidious in its power and effects on the body. It has equally powerful effects on families and communities. In response to the problem, IHS, with federal partners and tribal communities across the country, established ongoing partnerships and formulated long term strategic approaches to intervene in the crisis. These strategic approaches include several components, the primary focus was and continues to be the provision of ongoing clinical services within our system and to support tribal communities to provide those services where they are delivering them. Second, we established collaborative programming with other governmental organizations and agencies, from tribal to federal, to coordinate medical, social, educational, and legal efforts. Finally, we are supporting communities to mobilize against the threat by providing them program models, training, tools, networks, and ongoing consultation, so

they can formulate and deliver their own programs. Most all of the direct service and community mobilization efforts occur at the tribal community level, which is to be expected given the nature of funding and service delivery in Indian Country, where tribes increasingly are the ones who are managing all of their behavioral health programs. As such, most of the efforts are directed in support of those Tribes. Much of the programming is locally directed, but connected nationally by the networks, training, and educational services being provided by the collaboration.

Direct Clinical Services

Direct clinical services include medical, psychological, psychosocial, and recovery services. As noted above, the number of services continues to rise across clinical settings. There are various intervention models being used including pharmacological; cognitive behavioral treatments; traditional medicines and traditional treatments; twelve-step; and psychosocial recovery models. The overwhelming majority of direct services are provided in outpatient settings, but the eleven Youth Regional Treatment Centers provide residential treatment, and many tribal and urban programs provide similar residential services across the country.

IHS National Methamphetamine Initiative and Programming:

In 2004 a national workgroup was formed including IHS, SAMHSA, the Bureau of Indian Affairs, the Department of Justice (DOJ), several tribal behavioral health programs, and several private sector groups to coordinate national, area, and local efforts to address methamphetamine abuse issues. The national interagency workgroup agreed that this effort was to be a community driven, but a nationally coordinated effort for both clinical and community mobilization development models. It was clearly evident that this intense substance of abuse was impacting all systems in the community, tribe, state, regional and national environments. Therefore, the initiative seeks and incorporates federal, state, and local funders of health, law enforcement, courts, environment protection, social services, and behavioral health, to share information, resources, and coordinate mutual efforts.

Collaborative Training and Programming

Collaborative programming with other governmental and private organizations are critical to develop and coordinate medical, social, educational, and legal efforts. Most recently, in 2005, there were five national level meetings and summits on methamphetamine held specifically for tribes and tribal programs, sixteen regional level conferences and trainings, and scores of local community conferences and programs. Based on registrations for the national and regional programs, alone, over 2,000 people attended.

Among the highlights of these:

- The Phoenix Area Health Summit, *Reaching for a New High, Uniting For Methamphetamine-Free Communities*, provided clinical tools, training, and

community mobilization models for tribal communities, with over 450 in attendance.

June, 14-16, 2005: Phoenix, Az

- The Billings Area “*Know Meth*” Summit, *Call to Action on Methamphetamine Treatment*, offered clinical skill-building to deal with this epidemic and strategic plans and tools for communities to use in coordinating responses, with over 240 in attendance.
November 16-17, 2005: Billings, MT
- *The National Clinical Update on Substance Abuse and Dependence Training* (Formerly known as the “Primary Care Provider Course on Alcoholism and Substance Abuse”) is a three-day intensive clinical training for physicians, physician assistants, nurses, and advanced practice nurses, held twice per year. They are designed to increase the skill level and knowledge base of healthcare providers in substance abuse evaluation and treatment. The programs are limited to 30 providers per training, and the curriculum is updated annually with the most current nursing, addiction medicine (including methamphetamine), and prevention information. This training is available to all providers in Indian health settings: federal, tribal, urban and private. In 2005, the programs were held in Bemidji, MN, and Phoenix, AZ.
- The *IHS/SAMHSA National Behavioral Health Conference* is the single most significant annual gathering of behavioral health professionals and programs nationally. In addition to its presentation programming, it also convenes several national task forces, workgroups, and interest areas over the entire week of programming. Among the significant tracks in 2005 were methamphetamine clinical and community trainings and programs, with over 600 people in attendance.

Currently planned meetings for the remainder of 2006 include:

- Fargo, ND, *Methamphetamine Summit*, in association with the Aberdeen Area Tribal Chairman’s Association and SAMHSA.
July 11-12, 2006
- Oklahoma Area Indian Health Service
Cherokee Nation, ‘06 *Meth Summit*
- White Bison
Taking a Stand Against Meth: Recovery is Possible
April 20-23, 2006
Denver, CO

- *National Clinical Update on Substance Abuse and Dependence Training For Medical Providers*
May 9- 11, 2006: Phoenix, AZ
June 20-22, 2006: Bangor, ME
- *IHS/SAMHSA National Behavioral Health Conference*
June 6-8, 2006
San Diego, CA
- National Native American Law Enforcement Association
National Methamphetamine Conference
Albuquerque, NM
November 14-17, 2006

Area Program and Clinical Services Highlights

Aberdeen

The Aberdeen Area is currently budgeting approximately \$150,000 to provide area wide training and interventions to service programs throughout the area, including community awareness and mobilization information; materials and manuals; and a culturally specific methamphetamine awareness campaign. This is in addition to its support of the Fargo, North Dakota, Methamphetamine Summit in July, 2006. Aberdeen began receiving funding in FY 2005 to address methamphetamine abuse and continues to receive funding in FY 2006 to address this problem.

Alaska

Tribal programs in Alaska are working with IHS, DOJ, and state governmental organizations to develop a coordinated strategy to address all realms of meth impacts. Additionally, organizations in Alaska are working nationally to prepare a *What's Happening with Meth Issues in Indian Country* briefing paper for those involved with Department of Justice technical assistance to tribal courts, drug courts, law enforcement, child abuse, juvenile delinquency, domestic violence/sexual assault, and prosecution grantees in Indian Country.

Albuquerque

The Albuquerque Area IHS is working with several area tribal programs to deploy and utilize telehealth equipment for clinical consultations, treatment, and education directly related to methamphetamine treatment. As an example of its applicability, the New Sunrise youth residential treatment program in Acoma is now able to include families and local treatment teams with the New Sunrise staff via telehealth equipment. Treatment team meetings, family sessions, discharge planning, and training are now delivered via televideo hook-up with local community programs that was never possible before.

Billings

The Billings Area, with several area tribes, formulated the *Billings Area Methamphetamine (4 Step) Recovery Model: Get Started, Get Clean, Stay Clean and Stay Healthy* (24 month process of treatment, discharge and ongoing recovery). The Crow Nation has developed a proposal for comprehensive substance abuse services with an emphasis on methamphetamine abuse, and the northern Cheyenne tribe has a methamphetamine task force which meets regularly to coordinate its activities across the reservation.

California

California Area tribes and programs are involved in multiple programs, from telehealth to training and interventions using the Matrix Model. It provides a step-by-step treatment curriculum for methamphetamine addicts with an accompanying “Clinician’s Guide to Methamphetamine.” It is proven effective in the treatment of methamphetamine and used in many settings across the country. Among the programs of national scope and significance is the Friendship House of American Indians, which now offers residential substance abuse and methamphetamine treatment in its new state-of-the-art 80-bed facility in San Francisco, including family residential programming and outpatient care.

Navajo

The Navajo Nation is actively training staff to use the Matrix Model for treatment and recovery in its programs. Chapters continue to form Community Task Forces to intervene locally at the community level. The Navajo Nation Council recently passed legislation prohibiting the manufacturing, distribution, sales, possession, and use of methamphetamines. This allows for enforcement and prosecution by the Nation for methamphetamine use and distribution. IHS also recently opened its Fort Defiance inpatient adolescent facility to provide higher levels of acute care than was ever possible previously. Finally, “G,” a powerful one-hour documentary, was produced in cooperation with Navajo Nation, and examines the effect of methamphetamine use there, revealing the shattered lives of those affected by the drug. The documentary, on DVD, is now being distributed nationally.

Oklahoma

The Cherokee Nation and IHS are funding a multidisciplinary task force for community prevention, rehabilitation, and education for Cherokee. They are also planning a methamphetamine conference in the coming year to coordinate efforts across governmental and community programs. SAMHSA recently supported the Choctaw Nation with a Targeted Expansion Grant to treat women with children who use methamphetamine. Oklahoma was originally funded in 1998 by SAMHSA and continues to receive funding from them to address these efforts.

Phoenix Area

In addition to their training and education programs, which have reached over 700 people throughout the Area, the Phoenix Area IHS is using an intensive out-patient alcohol and drug treatment manual based on the Matrix Model for area programs. The Area has also contracted with the University of Colorado for community readiness assessments of eight area programs to determine a community's ability to implement a substance abuse prevention and/or treatment program for methamphetamine. Once the readiness level is determined, the University will provide training on the stages of readiness and assist with the development of a strategic plan to address the methamphetamine problem for each community.

Portland

Portland Area supports the Native American Rehabilitation Association (NARA) range of inpatient and outpatient programs, considered some of the best in the nation for AI/AN individuals and families. NARA is the only inpatient facility of which we are aware treating methamphetamine addiction with western medical, mental health, and traditional care for families. Additionally, the SAMHSA-supported One Sky Center at the Oregon Health and Science University is providing training and technical assistance throughout Indian Country, particularly with Dialectic Behavioral Therapy programming and assistance to create and sustain community mobilization models.

Tucson

SAMHSA is supporting a Pascua Yaqui/University of Arizona inhalant and methamphetamine prevention program and previously supported meetings and prevention programming specific to these.

Promising Programs and Programs Available Nationally

The Matrix Model of stimulant abuse treatment is being supported by SAMHSA, IHS, and scores of tribal programs; staff currently are being trained to use this approach in Aberdeen; California; Navajo; Phoenix; Portland; and Albuquerque Areas. It is evidence-based and showing positive results among many programs and groups nationally.

The Billings Area Methamphetamine 4-Step Recovery Program is also now being offered nationally, and includes traditional medicines and Western psychological/recovery components centered around its 4-step recovery process.

Community Readiness Assessment programs are currently underway in many tribal communities to determine community readiness to implement, and support them in creating community-wide prevention and intervention programs. These programs are currently being used in every IHS Area.

The IHS Addiction Telemedicine Program, centered at Phoenix Indian Medical Center, includes dedicated professional medical, psychiatric, psychological, and advanced practice nursing staff

capable of training medical and other providers in emergency assessments and stabilization (withdrawal), and pediatric/drug endangered children nationally via televideo and telemedicine technologies. Psychiatric specialists are also available nationally by phone and videoconference for real time or other consultation.

The IHS Chief Consultant in Addiction Medicine, Anthony Dekker, DO, is available for site visits; telephone and televideo consultations; clinical program development consultation; and training to IHS and tribal programs nationwide. He also directs the *National Clinical Update on Substance Abuse and Dependence Training for Medical Providers* programs.

Conclusion

As is very clear to everyone involved in the efforts to reduce methamphetamine abuse, and is evidenced by the programs and collaborations I have highlighted, the overarching strategy for addressing this crisis requires coordinated and collaborative responses from federal, tribal, state, and private agencies. The Indian Health Service is so engaged with these partners, and we will continue to provide treatment and prevention services throughout our system and the tribal systems of care. In addition to our current partners, we also welcome and encourage the Committee's continued involvement and support, because the crisis is of such proportions that only combined resources and unified action can be effective.

Mr. Chairman, that concludes my prepared remarks, and I would be pleased to answer any questions you or other members of the Committee may have.