

COMMUNITY CRISIS:
Public Health's Role in the Methamphetamine Epidemic
"Partnering to Confront the Issue"

September 26, 2006

STEPHANIE BRYN: Welcome to the webcast. We have assembled a great webcast for you today. And thank you to our featured speakers whom you'll meet in a few minutes. Special thanks to the production team at CADE at the University of Illinois in Chicago and a special appreciation to our HRSA representative, Rebecca, who led the production activities. Now some information for you about the webcast.

Slides will appear at the central window and should advance automatically. The slide changes are synchronized with the speakers' presentations. You do not need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speakers questions at the end of the broadcast. Simply type your question in the white message window on the right of the interface, and select question for speaker. You may do that during the broadcast. Select the dropdown menu and press send. Please include your state or your organization in your message so that we'll know where you are. The questions will be relayed onto the speakers periodically throughout the broadcast. If we don't have the opportunity to respond to your question

during this broadcast, we will respond by email after the broadcast. And again, we encourage you to submit your questions at any time during the broadcast.

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Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you will have the opportunity to fill out an online evaluation.

Please take a couple of minutes to do so because your responses are important and it will help us improve our broadcasts and our technical support. Persons who are listening by telephone will be able to ask questions during the question and answer period.

May I have the first slide, please. Today's webcast's goals are four. We want to help raise awareness about the methamphetamine epidemic and help to describe the role of public health and safety professionals on how they can be involved at the local and state levels. We also will be showcasing highly functioning coalitions and networks that are addressing the methamphetamine epidemic. And we want to point out to you resources for additional education, training and programming. And you'll see on the mchcom.com the Meth 101 resources for your use.

Next slide, please. We see that Scott Burns, the deputy director said it well. This epidemic is a community crisis and we all should be involved. Next slide, please. We will feature public service announcements from the Montana Meth Project during this webcast. The

Montana Meth Project and the not even once campaign were funded by a grant from the Thomas and Stacy Siebel Foundation. We obtained permission to air three of their PSAs during this webcast. To learn more about their project and campaign, go to mchcom.com and follow the link to the Montana Meth Project website. After the PSA we'll hear from our first speaker, Deborah Durkin. She's an environmental scientist in the Division of environmental health at the Minnesota Department of Health. She's coordinator of the Minnesota Department of Health Meth lab program. And co-founder of the Minnesota multi-agency meth lab task force. And now, The Montana Meth Project PSA just once.

>> I'm going to try meth just once.

>> I'm going to try it just once.

>> I'm going to steal just once.

>> I'm going to sleep with him for meth just once.

>> I'm going to try meth just once.

DEBORAH DURKIN: This is Deborah Durkin. My job is to provide an overview of the drug methamphetamine and its impact on our lives and communities. If you've downloaded the Power Point handout for this talk note that seven slides in the handout will not be seen on the screen.

Next slide, please. Part one, the drug, next slide, please. The reason we're here is not that meth is used by more people than alcohol or other drugs, but because of its impacts on those who use it, and those who are impacted by its use. In other words, all of us. Those impacts are greater because meth lasts in the body and in the brain longer and at higher levels than do other drugs. For example, smoke crack cocaine and you get several seconds of intense rush and 5 to 20 minutes of high. Smoke meth 20 minute rush and a high that can last for many hours. Up to 24 hours for new users with good methamphetamine. And the half-life makes a difference, two. Half of cocaine is gone from the body in an hour or two. Half of methamphetamine is still there 10 to 12 hours after use.

Next slide. We all know that cocaine become a more serious problem when the use of the high intensity coke, crack cocaine, increased. The meth that's on the street today is a high >>intensity version of the methamphetamine abused in the past. Versions of the drug abused in the past, l-meth and d-meth are different than the dope today. It is a different isomer of the drug, more potent, more rapidly addictive and it has much better access to the brain than earlier versions. Next slide. The purity and the potency of the drug, the dose and the delivery system smoke, inject, snort, ingest all effect the outcome including intensity, length of the high and the amount that is delivered to the brain. Next slide. Although we often think of injecting as the scariest, most dangerous form of use, smoking, in fact, delivers the best rush, the longest high and the greatest amount of chemical to the mouth and throat as well as lasting longer in the brain. However, injecting, which is a close second, has its own dangers, including dirty needles and transmission of disease. Users

who snort or ingest meth are lower intensity users and they may not require the same treatment and care as high intensity smokers and injectors.

Next slide. Reflecting the availability of that better smokeable meth numbers of meth smokers -- smokers have increased dramatically over the past decade while use by other methods has declined or leveled off. Although smoking may be best, injectors among men who have sex with men as well as in the broader community tend to have more social health and psychological problems as demonstrated in this study among H.I.V. positive men who have sex with men. Meth is a drug of isolation. Injecting is an even more isolating practice. Next slide, please. Part two, trends.

Next slide. Call it what you will, epidemic, crisis, or social phenomenon, we have experienced whatever it is twice since 1965. This slide says that we are in the midst of our second epidemic crisis or whatever you wish to call it. The slide shows meth initiation or new users through 2004.

Next slide. Here is what this data tell us. If you look at those who say meth is their number one drug. We've gone from 13 out of 100,000 population to 56 per 100,000 in the decade 1993 to 2003. In 2004 if you look at meth is my first, second or third favorite, the numbers nationwide were 85 per 100,000 persons.

Next slide. The national household survey tells us that the number of lifetime users leveled off from 2002 to 2004 and in the data which were released this for 2005 we saw significant

decline from 2004 to 2005. So we see a big increase from 2000 to 2002 and then a slight decline in lifetime users.

Next slide. However, that promising headline from a year ago had this sub text. Although past month's use was level, the number of people who satisfied the criteria for addiction or dependence both for meth and for all dependents doubled in that last two-year period, although the number of past month's users was relatively stable. That increased number of people satisfying the criteria for dependence and abuse are the people who are so challenging our ability to provide service.

Next slide. This slide is here to remind us that meth exists in a broader context of abuse. I've started thinking of meth as an opportunity, a crisis that has created wonderful local and national coalitions, collaborations and actions that will benefit us far beyond the world of meth response. That's what we're all doing is responding not only to the abuse of this drug, but the broader context of substance abuse.

Next slide. When we look at who is using, we know that the numbers say this is drug use predominantly by Caucasians but when we look at the per capita rate and we -- and at our communities we know the most intense impacts are being felt in Hawaii among native communities and in Indian country on the main land.

Next slide. The number of Indian health service meth coded visits have continued to increase since 1997 and the graph shows steady increase and it's alarming. But it doesn't tell the whole story.

Next slide. Those numbers may not come close to reflecting the actual toll. There are many reasons for this including privacy issues, issues about resources, coding and payment problems. In short, the computer doesn't know what is really happening in IAH clinics and elsewhere and we need to pay attention to what we see and hear and feel is going on.

Next slide. Quantifying this meth use, the use of the drug and the impacts in a way that will generate needed resources has been a problem from the beginning. For example, we quantify our drug abuse problems in this country largely based on numbers collected in large metro areas. And that's not how this drug works. A meth treatment guru says public health indicators that should indicate the meth problem lag five to seven years behind the emergence of the drug. If people in the gay community where you live, if there are even a small number of meth labs where you live, then you've got a meth problem regardless of what the numbers say.

Next slide. Another data collection problem occurs in the area of age. We know that the majority of users are less than 25 years old, which is tragic in itself because meth and other dangerous chemicals are impacting so many young and unformed brains. But the

household survey doesn't collect numbers on the under 12 and we know that we have children 9, 10 and 11 using this drug.

. Monitoring the future does look at meth use in grades 8, 10 and 12. The 2005 data showed a continued decline since 1999 in grades 10 and 12 and a small increase among 8th graders. The problem with those data is that you have to be in school to be counted. And monitoring the future P.I. did put out a press release recently saying maybe that's not why we're capturing the users.

Next slide. Another way meth has challenged the status quo and our resources is by its broad use by women. Typically an average for most drugs is 70% male users, 30% female. With methamphetamine we're seeing one man to one woman ratio.

Women use this drug -- oops, next slide, please. Women use this drug for a variety of reasons. Many of them related to demands we and others make on ourselves in this busy world. Be skinny, be sexy, do more than is humanly possible, methamphetamine.

Next slide. Just remember when you look at the data that they do not always reflect the community view. The local view. From 1998 to true 2 more than 90% of users lived west of the Mississippi but we looked at national data to describe the problem. There are still many communities east of the Mississippi where the social workers, health workers, police officers and nurses don't automatically suspect meth when they learn of a house fire, a suicide or a crime of violence.

Next slide. Chicago, please move quickly through these. The darker the state, the more people admitted to treatment for meth. 1992.

Next slide. 1997. Next slide. And 2003. We are here, I think, today because we do not intend that the whole map will be black before we respond in a meaningful way. Next slide. In 2002 for the first time more police officers nationwide called meth the greatest threat to their communities than any other drug. They did not -- methamphetamine is by far not the most available but is the greatest threat to communities where it is broadly used. They did so again in 2005 and 2006.

Next slide. And these are some of the reasons that this crisis epidemic is different this time around. Different than it was in the 1970s. In fact, different than it was in the 1940s. One reason is the Internet. The fact that meth can be made in one's community. The fact that this is becoming a national outbreak. We are seeing more and varied user groups. We're seeing this association with this high intensity meth with violent crime, with domestic abuse. We have more smoking of a better drug and then we're seeing this link with STDs, hepatitis and other communicable disease. Part three public health concerns.

Next slide. We've come to associate meth use with great harm to the user and everything and everyone around them. Abuse and neglect, interpersonal violence, the significant use of other drugs with methamphetamine and rapid physical and psychological disability.

Next slide. It's almost impossible to come up with a comprehensive list of all the aspects of life in public health that are affected. I've chosen to speak briefly about these few.

Infectious disease, treatment, environmental health, community health and maternal child health issues. In the area of infectious disease, that meth and sex connection has raised huge concerns about increased rates of STIs, hepatitis, TB and other diseases. The bulletin, this bulletin that you're seeing on the slide came from DHHS in August. Noting, among other things, that there have been two TB outbreaks among users since 2005. Several months ago my health department issued a press release warning that syphilis cases in Minnesota had increased three-fold in one year and the CDC told us in 2000 that syphilis would be eradicated in this country by 2005. Methamphetamine.

Next slide, please. In New York, Toronto, L.A. and other cities meth-related syphilis has risen sharply with rates almost five times higher among meth users. Next slide. And some of the best prevention work, some of the best programs I have seen in this country are being done by HIV/AIDS prevention groups. I asked somebody from Toronto, why is it that you jumped on this so soon and so hard and so openly? And he stopped, he paused and he looked at me and he said denial, been there, done that.

Next slide. In the area of substance abuse treatment, one of many challenges is that meth is almost always used except among about 30% of users in really end-stage disease with large amounts of marijuana, alcohol, often together and other drugs. This makes diagnosis, assessment and treatment more complicated and it's obviously very bad news for the bodies and brains of the users.

Next slide. One of my meth heroes says why do we think meth treatment doesn't work? Because many of the places that have been hit hard by meth abuse simply don't have extensive treatment for severe drug dependence. We're not only trying to deal with people's substance abuse treatment, but medical and psychiatric aspects of meth dependence exceed program capabilities. I've got a lung full of respiratory infection, episodic psychosis, a mouthful of bad teeth and I can't remember my name I'm just not a good candidate to go to treatment tomorrow. Add to that the high rate of women, the needs of their children, and staff in many, many agencies feeling overwhelmed and unprepared and we have a real problem.

Next slide. And then if meth is -- how is meth addiction similar and dissimilar. A doctor testified in North Dakota last summer that meth abuse is like other drug abuse in many ways including the fact that it's a progressive, relapsing and often fatal disease and that treatment absolutely does work. The ways that meth is different are frightening and challenging. It's a better, longer, cheaper highing it can transform behavior and do terrible damage. Some of which may be permanent.

Next slide. Finally, the doctor testified that the most scary difference is that matter of dose duration and effect. She says that we should be very concerned because methamphetamine packs a powerful punch. When we hit young brains that hard that often and with such a potent neurotoxin our children may not move past the experience intact.

Next slide. In the area of environmental health I'll just say briefly meth cooking and smoking are harmful in many ways. We need to clean up after labs. We need to clean up homes where smoking has occurred. The national Jewish research center folks told us in small labs with few chemicals meth was found at levels 10,000 times the cleanup level and far away in the home from where cooking happens. Levels in larger, long term labs can be much higher. Implications? Children and others can be harmed forever by high exposures to cooking.

Next slide. Levels of meth and other chemicals are not as high when meth is smoked but meth smoke is also dangerous to children who are exposed and smoking can also contaminate a structure and remain behind when the smokers are gone. Next slide. No one has great stats and they vary from place to place but we all know that many children are being impacted by meth cooking and smoking.

Next slide. In the area of community health, all I can say is methamphetamine is an octopus of harm reaching into every corner of our lives.

Time is short so we'll go on to the next slide. We also know that meth may impact pregnancy, labor and delivery, the survival of the fetus, the survival or well-being of the infant and the continuity of family life. Next slide. We don't have enough research but we do have some. The national drug intelligence center tells us that about 4% of pregnant women and 8.5% of new mothers report using illegal drugs in the past month. Add alcohol and tobacco and we have so many endangered pregnancies. Next slide. IDEAL. The first

major study of meth in pregnancy found in L.A. Des Moines, Tulsa and Honolulu. 5% reported meth use during their pregnancy. In pediatrics this month the IDEAL study that meth exposed infants are 3.5 times more likely to have low birth weight is a predictor of infant mortality and other poor outcomes.

When meth and other substances are part of the in utero exposure the list of possible but not proven birth outcomes includes cardiac anomalies and other birth and developmental outcomes. We're waiting for the jury on that. We may not know how many pregnancies end in miscarriage or spontaneous abortion but experts think the numbers are high. This warning from an early DEC advisor and proper parent and a judge in California. Judges and all of us should always think when we have an individual before them who is an abuser of alcohol or drugs, is there a child who depends on this person? Next and last slide. Now I would like to introduce Holly Hopper, child advocate, project coordinator for Kentucky's drug endangered training network and chair of the Kentucky alliance for drug-endangered children. But before we hear from Holly, we'll see another one of the Montana PSAs. Thank you very much.

>> Come on.

>> Wish I had taken the shortcut through that empty parking lot. Wish I had gotten jumped. I wish they had broken my ribs. Put me in the hospital. I didn't get jumped. I went to that party. I did meth for the first time. Now all I do is meth. All I do is meth.

HOLLY HOPPER: Hello from Holly Hopper in Kentucky. I'll be speaking about creating a public health response to drug-endangered children.

Next slide. What is DEC? DEC is a national and statewide movement that was begun in 1998 in California by a woman named Sue Webber Brown. Sue met and began to work with Laura, who was mentioned previously by Deborah Durkin. Laura at the time was an assistant U.S. attorney in the San Diego U.S. attorney's office. The national alliance for drug endangered children was formed and housed there in response to some of the very, very horrific cases that were meth-involved and caused the deaths of a number of children. In addition to the number of children that were seen by narcotics officers and didn't receive a response because it was considered a drug crime area rather than a child protection issue. In 2006 when funding allowed the national resource center has been established in Denver, Colorado. DEC as a term can be used to describe a subset of our nations abused and neglected children and for additional information you can view the website that is on the slide [national DEC.org](http://nationalDEC.org).

The next slide. There are a number of states with DEC programs. The states in red have statewide alliances. The states in a dark yellow have DEC alliances that are in progress, and the lighter yellow states have no statewide efforts to date.

Next slide, please. The Kentucky alliance for drug endangered children began August of 2004. In Kentucky we had experienced a number of fairly high profile cases and we realized very quickly that we were experiencing the same effects of methamphetamine

that the western part of the nation had experienced in the ten years prior. Our mission statement began to be developed based on the needs that we identified. At the top of that list really was a competent workforce and a consistent response like many states, we experienced hysteria and didn't know where to go to get accurate information so that we could protect not only children, but the workers who were responsible for responding. We did learn about the national alliance for drug endangered children and were fortunate enough to have them come to our state and providing training and foresight in our state. We required at that time an action plan. And development of DEC teams in every county in our state. Currently willingness to act is mandatory to qualify for training that is provided at no cost. Prior to that we did one year of awareness training.

Next slide, please. The DEC crisis response team is the group of individuals typically thought of when you -- when people think of a DEC response. That involves child protection, law enforcement, emergency medical service, mental health and prosecutors. And those individuals are required or expected to work together to respond to the immediate crisis needs of the child that typically happen or need to occur within the first 72 hours of identification of a meth lab scene.

Next slide, please. What is a drug endangered child? Endangerment is a little more broad by definition than would be identified by the methamphetamine cooking crisis.

Endangerment can be direct or indirect exposure to drug production, sale or use. 88% of child abuse of children under the age of four years involves substance abuse and that's substances in addition to methamphetamine, although methamphetamine certainly has

been responsible for the increased rates of child abuse cases identified and the increased need of foster care homes in our state. Awareness we believe is credited to meth.

Next slide, please. The roll of public health in the DEC effort involves a number of groups including Maternal and Child Health, oral health programs, early start programs, environmental divisions which involve the program we developed for landowners. So much cleanup in production is actually produced on landowner's property without their knowledge. San tears, community health centers, folks who give immunizations, it's important to recognize that. Home visitor programs. We have a safety program, a photo identification guide with emergency response directives and phone numbers for truancy officers and health department home visitors. Child centers, WIC programs, health access nurturing development services for parents of children 0 to 2. We realized also that each community needed to have a DEC education team or a group of local experts to which people could turn when they had questions or needed services for children. The DEC response team may be involved in the education team but we realized that it is critical that accurate, consistent messages are given within the community. There is nothing more dangerous with regard to this effort than to have hysteria and a lack of accurate information. Partnering with drug courts, drug treatment programs and the faith community we've found also to be very helpful and team volunteer groups to have a lot to contribute as well.

Next slide, please. We were fortunate in 2005 to have a grant awarded by the Appalachian regional commission to fund the drug endangered child network. The college

of public health, college of dentistry and social work at the University of Kentucky. We have a regional advisory board that's a multidisciplinary team that includes representatives, professionals, from the Appalachian region in the eastern part of Kentucky. Next slide, please. The DEC Training Network goals include building local capacity and sharing resources. Our primary starting point involves the implementation of the national medical protocol for drug endangered children in all health facilities within the region. One goal also is to survey the incidence and care of children. That's in progress. That involves reviewing case records, reviewing medical records and assuring that children have all of their health, mental health and safety needs taken care of. Once they are identified. Another critical piece is the development of community-based response and education teams to assure that children have the best response available.

Next slide, please. Where are we now? In the state over 4,600 professionals have been trained since the initial national DEC training. We've trained professionals in 116 counties in the state. No training is granted at this time without commitment to form and maintain an operational DEC team. Sessions have been made available on the Kentucky online public health training system that is available at the website listed on there. Follow-up and tracking of all counties is in process so that we can provide technical assistance as needed. Next slide, please. This is an example -- the national medical protocol for medical evaluation of children found in drug labs, the authors of this are Dr. Wendy Wright and Dr. penny Grant part of the national alliance for drug endangered children.

Additional information is available at the national DEC website. Children will test positive from exposure to cooking of meth as passive ventilation and dermal absorption in contaminated homes. The tracking for children which are critical are interagency agreements. Everybody has a role and the roles work better when the responsibility is shared. Medical examinations, donations of toothbrushes and things that certain groups have more readily available than others, increasing care for children. I mentioned the national medical protocol for drug endangered children and an additional benefit we have is 24-hour medical consultation is available through the University of Kentucky pediatrician is available for 24 hours if there are physicians in the field that have questions. The post 72 hour response is in process for children that I would describe. Next slide, please. The reason that additional protocols are in process and we are continuing to monitor is because we discovered not all are babies and that many of the DEC children that we see are actually sexually abused children as well. Oral neglect issues are common. Many are dehydrated and malnourished. The first once is to have training to meet those needs and make sure that the information we're providing is actually the best practice available. Additionally not everyone is ready to actually become involved and that's okay. So we apply and consider – next slide, please.

These are photographs of actual crime scenes from our state. We use these for training and also awareness because so many people may be in homes and may not recognize what they're looking at if they aren't taught or trained to associate this with methamphetamine production. And the photo that you're viewing now you see drugs on that dresser, there was also -- there was a meth lab in the crib. This photograph is an

example of a dump site that you can also see has been used as a playground. Clearly that is not a safe situation and the problem is if children are not home those are children that may not be identified as drug-endangered. Part of the role for a drug-endangered child teams in communities will be to determine what is acceptable for children. In that photograph you can see there is a meth lab on the left in that circle and on the right that is a child's play area. But those things look very similar. It is important for community members and individuals who work with children to monitor play and know how to identify red flags so that additional questions can be answered and children -- asked and answered and children can be protected. Next slide, please. This is another example of the home on the right, this is the same home. Those photographs there on the left that is where the parents who are cooking meth put the child in the cage outside while they cooked methamphetamine inside. It happened to be 42 degrees that day. So again, it requires advocacy and identification to prove that that decision was not made for the safety of the child.

Next slide, please. Children's advocacy centers can play a very important role if states are fortunate enough to have them as a resource. Children's advocacy centers tend to be child friendly. The individuals who work there are quite used to working with children who have experienced trauma. And many of the sexual abuse victims may be drug endangered but identified as sexually abused first and alternatively many drug endangered children may be also identified as sexual abuse victims through proper examination. We believe that everyone who works with children can help to improve services and to provide for the overall health and physical and mental health of the child.

Next slide, please. I would ask you now to consider alternate points of entry. And to ask yourself how many of these cases may present to a local health department, yet not necessarily be related to a traumatic event? Part of what we have operated on in the past is that when you find a meth lab that is how you know you have a drug-endangered child. That may not necessarily be the case. I'll talk about several cases that I think illustrate that fairly well. A 13-year-old with a history of previous miscarriage presented with a ration the body, not the face. They have worn rest praitors to protect that part of the body. A little more to that story. A nurse did a very good job to identify that case. The mother had been a meth cook when the lab was discovered at that home approximately three months prior. The daughter, the 13-year-old girl went out the door with an adult male meth cook. She moved in with him and she reported in the emergency room that she -- they were cooking meth to save money because she wanted to be a stay-at-home mom and her goal was to be a wife and mom. So that was how that child was identified.

The next case a 3-year-old brought into the emergency room for a respiratory problem was found to have head lice and the child had 38 human bites on his body and evidence of penetrated sexual abuse. This mother had traded this child out in addition to an older female sibling and younger twin sibling. So they were all staying with different individuals and this woman's repeatedly abused. And he was -- it ended up being a meth-related case. The next one I'll discuss is a 5-month-old that had recurrent ear infections and an unusual rash after a weekend visit with a father who had not previously been a meth user. The mother did not know. They had separated. His behavior had changed but she didn't

identify that. It was discovered through urine screen. No meth lab was found in that case, either. A 5-year-old presented to the E.R. for seizures with an elevated temp. This child was actually playing in a neighborhood, a nice neighborhood, the family was not related or involved with the meth lab that had been discovered the night prior. But he and a couple of friends were playing in a dump site he apparently put his mouth on a gas generator that is basically a 20 ounce coke bottle with a tube. That's how he was injured and did have a serious seizure. These are children that come into the system in an alternate manner and that may be seen in a public health department or present with those symptoms at a school.

Next slide, please. Summary of points, access to accurate information is critical. Caution is critical but overreaction is absolutely unnecessary. And it's critical to keep in mind that environments are toxic. We should not be afraid to touch, examine or work with these children especially in foster homes. Contamination does not disappear without proper remediation. That's critical and true for smoking as well as cooking. Cross training and collaboration between multidisciplinary groups are keys and can prevent many negative outcomes for children's well-being.

Next slide, please. I just want to announce quickly that the national drug-endangered child conference will be held in Nashville in November. Registration information is available at [national DEC.org](http://nationalDEC.org). I would now like to introduce Terry Beartusk, chairman of the subcommittee of community involvement with the northern Cheyenne war against meth. We'll show another PSA from the Montana meth project.

>> Hey, what about me?

>> What about you?

>> Come on.

>> Give her some. >> Give me some.

>> All right. All right. You want meth, kid, here is your meth and here is your meth dealer and your meth boyfriend. And your meth baby. And don't forget your meth face.

TERRY BEARTUSK: Sunny Montana, want to invite all our viewers to our discussion about what we are doing about our methamphetamine problem on the northern Cheyenne reservation. The problem has been here for some time. Not just with meth. I want to take a few minutes to just paint a little picture for the viewers and listeners. 30 years ago, I left this reservation to pursue a career and at the time that I left, the alcoholism rate on this reservation was approaching 80%. So four out of five individuals in our community on a given day required some type of treatment -- having been gone for 30 years, I imagined that upon my return, because it has always been my intention to return home to bring back my education, my experience to help at the local tribal level. I imagined that when I got back that the situation with alcohol or drugs would be different. To my amazement, the problem is still here and it is still every bit as rampant as it was when I left. The only thing that has really changed is instead of it being just an alcohol problem, it has expanded now

to more of a probably drug use problem with methamphetamine definitely coming in as a strong second to the alcoholism.

So methamphetamine is currently having a tremendously devastating effect on our entire population. And it seems futile to try to figure out approaches to this because obviously we've had this problem for 30 plus years. However, we recognize that Native Americans tend to be action oriented. In our history, we don't have a written language, so we learn through oral presentation, we learn through visual presentation and through tactile types of demonstrations. So as we approached this problem to decide, you know, what and how are we going to deal with this epidemic, we had to keep those three things in mind. So our discussion today is going to talk about what we are doing. And the things that we're doing in this community are all action oriented. They're designed to involve the entire community and so as we begin the slide production here, I just want to invite you to -- you all to look at each photograph as they come up, because each one tells a story that I'm incapable of. And also imagine that we have what -- we have basically a ghetto living situation here in most of our communities. I mean, this is beautiful country.

We live here in Montana. However, we live in basically a Third World situation. Also I want to talk a little bit about the 80% abuse or addiction rate and how that correlates to how people receive help. Because when you're dealing with addictions, it isn't normal for the person who is having problems to check into a treatment center and say, you know, I'm having drug problems, I'm having alcohol problems, I've got a problem with meth. The way they generally present themselves is through their abhorrent behavior or oftentimes

through consequences such as legal consequences or medical consequences. So in order for a person to be deemed to be in need of care their behavior generally has to stand out above the crowd. Now, when you've got a population where 80% of the population is addicted, in order for a person's behavior to stand up above the crowd, they most always are into the chronic stages of the disease before they're recognized as needing help in this situation. So the difficulty that we have as treatment practitioners is by the time we get these people into our centers we're dealing with the chronic of the chronic. So, you know, that's a difficulty that we start with.

Okay. Next slide, please. In January of 2006, our president, Eugene Little Coyote declared war against meth. Previous to that, the Montana/Wyoming tribal leaders association had challenged tribes to develop strategies to reduce the use and abuse of methamphetamine on our reservations. And fortunately for us our tribe took that challenge very seriously. We funded our war through the northern Cheyenne board of health. \$150,000 is a good sum of money here so you have -- we had to fund our war, we formed basically a core committee of tribal leaders, professionals and everyday Joe community members but to get things done, we needed to break that core committee down into subcommittees or action groups. Each with a specific and separate purpose and we had -- we have several committees. Just to mention a few we have a legal committee, a cultural subcommittee, a youth subcommittee, medical and the subcommittee that I'm currently chairing is called the subcommittee for community involvement. And we recognized through past failures, because this tribe has mounted war against alcohol, war against different things over the years and has always failed. So we recognized that in order to be successful, we needed

to not just form a committee of community leaders, we needed to get the population involved. So our task is to get the community involved to bring awareness of the methamphetamine epidemic to the attention of the general populace and to encourage community members to take ownership of the problem. We need to break down walls of mass denial because the whole community, you walk up to anyone on the street and ask them if they know that there is a methamphetamine problem here they'll say yes. But to give you more details about that, even though it is so pandemic, people really can't. They are living in the forest and just, you know, can't see the extent of it for the trees. And lastly we want to encourage and invite and assist community members to participate in the solutions. And so awareness and solutions is our primary goals.

Next slide, please. So we wanted to do two major things this summer. And my partner here, Anita Small, will talk about some other events we did that are more diversionary in their process. But we wanted to make a big noise. We wanted to get the community's attention and a reservation community like this people love a parade. We Marched through

Lame Deer through the front lawn of the capitol building. We had over 1,000 participants. The first speaker was chairman Little Coyote. He's on the bottom holding up a yellow sheet of paper. What that yellow sheet of paper is, is his urinalysis that he had just taken. All new employees on the reservation have to successfully pass a urinalysis test. He was showing the 1,000 participants that he had passed his test just that week.

Next slide, please. The second part of That March was to hold a rally and we invited our community elders, our medicine people, our politicians to address the crowd and to encourage everyone to undertake this war with them because this is a tribal-wide war that we are declaring.

Next slide, the second major event we undertook was a Rockin' the Rez concert. We wanted to -- in order to encourage maximum participation we wanted to make sure that people were attracted to it to have fun and so -- we also wanted to kind of showcase our local talent. So we invited probably -- had over a dozen separate bands. In order to get native people to come to any event, you must provide food. So the tribe provided us a buffalo. We had a buffalo feast. We had different types of bands. For about 14 hours interspersed with motivational speakers and testimonials from community members. We had traditional drum groups. We had hand drum contestants and we just had a great time. But blended in there was the anti-meth message and again, helping people to be aware that this is our problem. This is a community problem. And we were inviting them to join us in making this a community solution. So I'm going to introduce now Anita Small, who is the public health nurse with the northern Cheyenne public health nursing center and a member of the subcommittee on community involvement. She's one of our partners.

ANITA SMALL: Good afternoon. Thank you all for joining us. My presentation is called, the northern Cheyenne war on meth.

Next slide, please. Our community involvement subcommittee was to raise awareness, like Terry said. Some people make things happen. Some watch while things happen and some wonder what happened. We are movers and shakers and we want to make things happen.

Next slide, please. Our mission statement is to involve the northern Cheyenne community in our war on meth efforts through healthy activities, learning opportunities, other hands-on approaches like increasing the awareness by providing healthy solutions. We can't increase awareness without providing diversional activities and also promoting traditional healing practices. We need to get back to our roots.

Next slide, please. Our goals are to follow our committee's mission statement to really believe in ourselves and this committee, to invest our time and effort to make a difference in our community. We ourselves need to buy in. Most of us live here. We're from here. This is our community. These are our children. These are our relatives. We really need to invest our hearts in all of our time and effort into making this happen and that's what's great about our committee is that we are really in -- we're really into it. Also to collaborate with other programs in the community like Indian Health Service, the law enforcement, the schools. We have a college. All the local businesses. The boys and girls clubs, head start to name a few.

Next slide, please. Some of our results, Terry named a couple. But as far as our activities, we had an event every week which one week we had barrel racing and pole bending. The

next week we had a roping event, the age group was from 3 to 60 plus. We used horses because they had been such a huge part of the culture and we have so many talented riders. When there is an audience and family support it boosts confidence and a self-respect leading to a higher self-esteem which can decrease the chance of one wanting to abuse their bodies by putting a harmful substance in it. If you have a child out there on a horse or even an adult and they do something good and they're with their horse and they've trained that horse, it is just like a team effort out there and you've got their family members or even if they don't have family members in the audience, clapping for them, that does something to their hearts. That makes them feel good about themselves and this whole war is about making them respect their bodies so they don't want to go around with a meth face or no teeth or, you know, hurting their bodies. So that's where we want to help with self-esteem.

Next slide, please. Enjoy the little things. For one day you may look back and discover they were the big things. Take that extra moment to stop and help that child. It really can make a difference. Let them feel good about themselves. Let them know to have self-respect. To not hurt themselves.

Next slide, please. Here at one of our events a tribal member, J.D. Oldmouse delivers an important anti-drug message. The deal, if we were to hand out a bunch of flyers or pamphlets, they would all end up on the dirt, on the floor, on the ground. That's why it is so important while kids or adults are having fun to incorporate our meth message so they can relate the two to having fun, you know, it's not a boring classroom type thing where they

are just being told, they're being lectured to. It is just -- it was really neat having J.D. talk about what drugs do to your life. What -- how bad they can be.

Next slide, please. The goals for our rodeo events. I talked about that in the previous slides. Just to provide a bunch of activities and specialized clinics. The next slide, please. Let's keep our children too active to do drugs. It takes more than a family to raise a child. It really takes a village. It takes the whole community, which is -- some children don't have a mom and a dad. They are being raised by their grandparents so it's really important for us all to step in.

Next slide, please. The messages that we had at our events, we had a sign that said this is a meth-free arena. Speakers delivered messages. And I would literally tell them, if you're using meth you aren't welcome here and we need to set good examples for our community. I didn't say it that nice but I also told them that they needed to leave because it is a meth-free place or activity. We gave out anti-meth wrist bands, bumper stickers, T-shirts. You can see them all over the place.

Next slide, please. We had some specialized clinics. We had a Pareli Clinic. They only have one body and they need to take care of it.

Next slide, please. Tell me and I'll forget. Show me and I may not understand. Involve me and I'll understand. Show me and I may not remember. Involve me and I'll understand. Native American proverb. I go into the jail at least once a week and even though I'm only

5'2" and only weigh 100 some pounds. I'm not saying exactly how much. They do really respect me. I build trust with the inmates. I do hep C testing and also H.I.V. testing. We screen. If I find any problems I refer them, which 90% of them have problems. 99% of them. We refer them to recovery, behavioral health and/or medical doctors. I do take them to the doctor, to the local clinic and I also have a health person come to the jail, behavioral health person. We have a partnership with IHS because we have a dental hygienist that comes with me once a week. There are so many teeth problems and there is usually like 50 people in jail and out of the 50, I would say 90% have oral problems directly linked to meth. I ask them if they use meth and they go from there. Ask them if they want to get help.

Next slide, please. I would now like to introduce Dr. Marcia Brand, associate administrator for rural health policy with the health resources Health Resources and Services Administration. Thank you.

MARCIA BRAND: Good afternoon. My name is Marcia Brand and I'm pleased to highlight for you some of the activities taking place in the Department of Health and Human Services and the hers is a organization that addresses. I direct the rural health policy. Our office seeks to strengthen health services delivery in rural America and have a strong interest to staff and finance mental and substance abuse activities in rural America. I heard a New England lawmaker put it this bluntly. In rural America our jails have become the waiting rooms for our mental health services. Many in the crowd not in agreement but certainly we can improve the situation through collaboration. It is very encouraging for us

here in HHS to know there are somewhere around 500 folks listening to this webcast today. I think it represents a strong commitment across the nation to address this problem.

Next slide, please. I want to highlight just a couple of activities that we're engage in. One is a department-wide methamphetamine workgroup. The department has a budget of more than \$5 million and a staff of 60,000 and 225 programs that serve rural communities. What we try to do is improve the way the department works with rural communities and this particular group is trying to improve coordination across the HHS activities that address methamphetamine. I also want to reference a conference that the Office of Rural Health Policy sponsored with the Appalachian regional commission which used a really innovative community-wide approach to addressing methamphetamine. 21 communities sent cross-sector teams comprised of law enforcement, education, social services and healthcare to develop a community-wide plan to address methamphetamine abuse in their communities.

The philosophy is the problem is the community, so is the solution. We looked forward to seeing what the communities did when they went back and began to implement they Cleveland -- the plans they made. I think the workgroup will continue to meet. I would be very interested to know the suggestions that you on the call today would have for how the department might work more effectively with you and across the department. We are always looking for your good suggestions and I'm certain we'll get some of them in the question and answer period. I'm very pleased to say for the agency, HRSA. Next year substance abuse and mental health will be a priority. We are \$7 million with the safety net

providers and so we hope we can use the resources to work with you going forward. I also want to tell you that each of you has a state Office of rural health. If you don't know those folks, please get to know them. They are interested in serving as your partners in addressing this issue and they will be able to help you by identifying other likely partners in your community. So please seek out your state offices of rural health and the link is there for you. Finally, just a few resources that might be useful to you.

The next slide, please. This is the link to the Office of Rural Health Policy. We have an ongoing mental health activity. We collaborate with our other federal partners. Feel free to contact us. If you get very little from what the woman from the federal government said today get this next link. The rural assistance center and it is one-stop shopping for all things Health and Human Services within the department. You can contact them by telephone or by email and they will respond to your questions. They pride themselves in a 24-hour turnaround. They have an excellent guide on methamphetamine and a list of funding to address the epidemic. They have had more than half a million hits this year. I think that's reflective of how effective they've been. If you're interested in looking at a community-based approach to addressing methamphetamine abuse I encourage you to examine the model for the Appalachian commission meeting and there is the link. We're really excited about this opportunity and it is also my pleasure now to introduce to you Dr. Judith Thierry. The Maternal and Child Health coordinator for the Indian Health Service.

JUDITH THIERRY: Good afternoon. Our closing comments will conclude with connections for action, a second slide on those activities that we would like to have you continue to

look at, followed by some question and answer period. Really honoring the participation that we've had here today. And closing comments.

Next slide, please. As you can see from this list which is not exhaustive, we wanted you to consider the environment, the human resources, the -- all the various entities and institutions that may be available in your communities. We heard the word hysteria. I think there are plenty of people who have a lot of activities that are already going on that they can really focus and our point in the next slide as well, go ahead to the next slide, is the targeting through the coalitions. The coalitions as we heard with the meth epidemic and the DEC had focused missions and issues. The second bullet here is building skills with training and education. We heard this across all four presentations as well. This may look different in a classroom, in a clinic, one-on-one, in a drug treatment center or with any numerous activities.

The third bullet developing and expanding prevention at the populations at risk, again, we will address this with some of the questions that have come up from the participants, how do we determine who is at risk? How do you know somebody who is in a clinic is using meth or how do you approach that? Monitoring the data for trends, several questions came up for that as well. We'll be able to get to some of these, not all of them. Our presenters are ready to address some of these questions about surveillance and the data collection. And lastly is expanding the recognition of emerging issues. We've seen the maps going from west to east. There are questions about, you know, why is it moving from west to east and what are the other emerging issues besides the rural health issues or the

issues in the west or drug trafficking across the borders? And what are maybe the urban issues as well? With that we'll move to some questions and answer period and those questions that we do not get to on this call today we'll respond to. The archives will be archived about five working days or probably next Tuesday after the webcast. Our presenters said that they would be available for questions as well. So as we put together our thoughts post webcast we will be addressing your questions further as well. With that, to our presenters, to Deborah, Holly Terry and Anita I have one question here from Alaska on tracking of child abuse and neglect cases due to meth. Are the DEC's doing that? I would phrase it to Holly, I guess, first. And Holly make sure you're off mute.

>> Can you hear me now?

>> Yes.

>> There is a study that is taking place in Colorado. Kitty fryer is leading that effort. University of New Mexico is also attempting to evaluate what is going on there. And in Kentucky we're attempting to devise a plan with our Department of community-based services to better track the number of children. Because the difficulty is in identifying who they are by drug of choice. We do know that 88% of children under 4 under there because of drug involvement of adults. But as far as breaking out by methamphetamine and making sure that all of those children get services they need, that's in process.

>> This is one of the presenters. Beyond cleanup what should a local public health department do in response to the meth epidemic? Anybody want to take a stab at that? These are tough questions.

>> Deborah?

>> Well, beyond cleanup of meth labs I'm not sure I understand. I'm sorry, I'm not sure I understand the question.

>> I guess beyond the environmental cleanup, what would a coalition want to tackle next?

>> I guess that -- when you hear each one of us say that our greatest triumphs have happened when public health, Human Services, law enforcement, the court folks when everybody sat down at the table public health can be there to offer information to help with those -- with medical protocols, public health can be there because Maternal and Child Health works with women, works with pregnant women and moms. Public health in my mind has a critical function as part of a local collaborative. Public health can be very different from state to state, county to county but we always know that we have important skills to add to whatever -- to whatever effort is underway.

>> One more thing and that is when we're dealing with people who don't just need treatment from those folks who work with treatment, but who may have critical physical or psychological needs, public health input can be really important.

>> Thanks, Deborah. A question about the DEC's role in parent treatment or is it just child focused?

>> It's family focused. Clearly it began as being very child centered but currently in our state we're working closer with drug courts and with treatment facilities. In fact, in a couple of the regions where it's available, regional service areas, DEC teams actually provide treatment vouchers as part of their community coalition effort. They will actually pay for treatment for the adult parent in hopes of reunifying families and providing safety to children at the same time.

>> Thanks, Holly. We had a question from South Bend school district on what should home visitors look for as they approach a home, go up the driveway, walk into the door? What are some tips that any of you may have for them.

>> Deborah here. We ask people who visit homes to use all of their senses, to look for people who smoke outside the home, who may have extraordinary surveillance measures, who do not wish to let people in, who burn trash in the yard when they should have trash pickup. Inside the home clearly Drano on the kitchen table is not unusual but five cans in the corner of the living room would be unusual. Watch for the chemicals used to make meth. Anyone visiting a home who has burning of the skin, the eyes, the nasal passages,

who feels shortness of breath or any kind of allergy or respiratory symptom should leave that place regardless it's a meth labor some other problem.

>> Thanks, Deborah. Anita, do you have any comments as a public health nurse?

>> Those are very good things to look for. Another thing I would look for is if they are trash is out there and if you see any poppers, like pill -- any battery savings, because they do cut open the batteries and use that, the strip in there. And if you do not feel comfortable, use your inner -- your instincts. You have that 6th sense. If that feel -- if you don't feel right, don't go. That's just bottom line. Go with your sixth sense. If I don't feel comfortable going into a home I take another nurse with me because we do not have cell phone service out here or radio service. So we are really at risk for endangerment going into homes. So I just take another health nurse with me.

>> Thanks, Anita. The same would go for many urban environments also. There was a question about trends in minority and urban environments for minorities. Deborah, Holly, could either of you speak to that?

>> Well, I can start. What we have seen really nationwide is in most states we've seen meth hit rural areas first. And the small number -- the relatively small numbers of Asian and African-American users are predominantly in urban areas. So meth is used by Caucasians and Native Americans in the rural area. When it gets to the city we see a broader representation of ethnic groups. I got up at a conference not long ago and said

well, well really don't see very many black users, very many Asian users and a hand went up. It was a young woman who worked in a local program for pregnant women and she said I have women of all ages, I have women of all ethnic groups using meth in this city. So once it gets to the city, the numbers are quite different than they are in rural areas.

>> And this is Holly. I would just add, too, that we have not seen the bleeding -- we're predominantly Caucasian meth using population here but experiences from other states indicate that it is economically driven as well. So when the cocaine addict or current cocaine users look for a more economic high then that's when other states have experienced the shift into African-American population.

>> Thank you. Behind the counter, pseudoephedrine behind the counter, I would actually like to hear from all four participants or from Lane Deer and Deborah on the legislation activities and has that impacted the communities that you've been working with?

>> This is Terry in Montana. One of the major problems that we face here in the reservation community is lack of legal code, laws to deal with the current epidemic and so, in fact, we don't have legal codes that allow us to do anything about the sale of different drugs or substances that can be used in the manufacture of methamphetamine. That's a major problem we face here on the reservation.

Thanks, Terry. Deb or Holly?

>> Kentucky -- our legislation went into place June of 2005. And we have seen a dramatic decrease in labs. I do want to add that doesn't mean that the risk to children goes away or the risk to anyone goes away. Crystal methamphetamine carries with it its own share of problems.

>> A couple of questions from the participants were around what does a meth addict look like? How would I know if a person just came into a general clinic for another problem that they were using meth?

>> This is Anita. The meth addicts that we see, some people, especially males, you may have an overweight male who has been using meth for years. That's the uncommon. But as far as somebody that I would see that would be high, their jaws move. They get these twitches. They may not be able to sit still. A little irritable. Vital wise blood pressure is high, pulse can go up past 200. Just really kind of standoffish is another -- they're paranoid. They may experience huge paranoia. Think you're after them. Things like that. Thank you.

>> Thanks, Anita. Comments from any other participants? Or the presenters? I'm sorry. If one wanted to start a DEC in their state, what would they -- how would they go about doing this, Holly?

>> In order to start a DEC it would be -- basically I would get together a multidisciplinary group. Gather information from community groups to see what they're saying because this

really, to be effective a grassroots effort is important supported by state policy, procedures and implementation of protocols. Certainly the national alliance for drug endangered children will be a great resource. That website is national DEC.org as I mentioned. In November, November 27-29 in Nashville, Tennessee, the focus of this year's national DEC conference will be the third annual conference will be putting together your state initiative. We also have a website drug endangered child.org where you can find some resources as well. That would be where I would direct people initially.

>> Thank you. That's going to conclude our questions. We have two minutes until we close here. I want to thank all of our presenters and those of you who have been our participants as well. This meeting wouldn't be here without a lot of people's interests long before we even put this together, you heard many names and discussions in the presentations and our feeling was to bring this together in a webcast with one of many ongoing steps to keep methamphetamine and the drug and alcohol and substance abuse issues that communities are dealing with before all of us.

The next slide, please. We really want you to take advantage of the Meth 101 resources that we put together. We think they're fairly comprehensive. They cover the domains of child welfare as well as environmental health and the community responses. There is many public health opportunities and again, targeting where you see your best skills being utilized is probably the key. The power is in the coalition and I think that was reiterated by all of our speakers that this is a community effort, this is not the lone ranger. Developing data for meaningful surveillance, local, county, state, national, these are going to be next

steps that all of us will be dealing with. Reducing the supply of meth. We talked a little bit about behind the counter, some questions on that and we'll fill in some of that further in our post -- in our archives. Improving the meth drug prevention we saw the PSAs today. Food for thought. Very compelling media and our community leaders and our media people clearly have a role to play in our coalitions as well. I would like to again acknowledge Amanda Woodsfield, our summer intern who helped put this together and again Rebecca Sanchez and Christy Martinson who also assisted us greatly in developing this webcast and moving us onto the next step. Thank you all again for joining us. And we look forward to hearing from you in your responses on the evaluation and we'll be probably sending out another evaluation asking more detail questions about methamphetamine and what you would like to see us present next. Thank you very much. Goodbye.