Indian Health Service
and
Substance Abuse and Mental Health Services Administration
National Conference

"Building Partnerships to Better Serve
American Indian and Alaska Native Communities"
June 25-26, 2003
San Diego, California

Keynote Address

"Ensuring the Health and Well-being of our People"

by

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Interim Director, Indian Health Service

June 25, 2003

Good morning. Welcome to the third national conference on the challenges facing all of us as we work toward eliminating the scourge of substance abuse in our communities, and its devastating effects on the lives of American Indian and Alaska Native people.

We know there is a problem and what the problem is. Substance abuse is an insidious addiction that in many cases robs an individual of free will. Compulsive drug seeking and using . . . changes the brain's structure and function. But it can be treated. There is no single cause and there is no single cure. I view that as an indication that there are numerous opportunities to intervene to prevent substance abuse, and there are numerous treatment options that can return an individual to a productive and drug-free life.

What are those opportunities and options? Let me say again, welcome to this national conference of learning and sharing – answers to that question began to be formed with the first of these conferences and I propose as an agenda item for the next conference that we include reports on partnerships and collaborations that result from this conference. By working together, I believe new strategies and partnerships will emerge that will strengthen best practices, enhance effective research into substance abuse and Indian communities, and coordinate approaches to address all the factors that may play a role in substance abuse. By being here today, you are showing that you are willing to take up the challenge of doing more than just talk about the problem, but are willing to work towards integrating our approaches toward the same goal – removing substance abuse as a coping mechanism. This meeting is not the end of a process but the beginning of one. Let's make a difference together.

Some say that substance abuse is a problem of geography – that it is a rural problem. It is estimated that 43% of all American Indians and Alaska Natives live in nonmetropolitan (rural) areas of the United States. This makes the Indian population the most rural population in the United States. Yet other studies indicate that substance abuse is no different among residents of large cities than among mid-size cities or rural areas. Unfortunately, what I

The text is the basis of Dr. Grim's oral remarks at the IHS-SAMHSA National Conference on substance abuse prevention and treatment in San Diego, California, on Wednesday, June 25, 2003.. It should be used with the understanding that some material may have been added or omitted during presentation.

believe this indicates is that, over time, rural substance abuse rates have caught up with the urban abuse rates. I also conclude that even though the current rates may be the same, for rural America and particularly for American Indian and Alaska Native communities, the problem is more serious because the infrastructure to respond to substance abuse needs of individuals and communities is not as evolved as it is in urban areas, which have been dealing with the problem for longer periods of time.

Some say that substance abuse is a problem of poverty and unemployment – and certainly studies have shown correlations that support that belief. And the valid anti-drug message is repeated across the country that drug abuse knows no economic or social boundaries. That is true, but it is also true that that there is an overrepresentation of drug abuse among the poor and unemployed. Using drugs provides a means to escape the worry and despair, and dealing drugs can be an alternative source of income. When poverty and lack of opportunity are a daily constant, many people feel they have little to lose if they get involved in drugs. The stress of economic hardship can also affect the relationship of parents and their children, who may perceive they are part of the problem or are not wanted. The children can then be at risk for depression, behavioral, physical health, and substance abuse problems.

Some say that substance abuse is a problem for Indian people who have to live in two worlds, that of their Tribe and that of mainstream society – leading to dealing with feelings of inadequacy and stress by abusing alcohol, tobacco, and drugs. And inter-generational conflicts between extended family members and children adopting western values also increases the risk for substance abuse. Interestingly, similar cultural alienation and transition stress factors have been shown to lead to substance abuse problems in those who have recently immigrated to the United States and are attempting assimilation, and this is even more of a factor than poverty.

Yet, it is a fact that some Tribes have fewer substance abusers relative to the U.S. population, whereas other Tribes have more. And it is a fact that not everyone who lives in poverty resorts to substance abuse. Rural Americans are not universally substance abusers the same as all urban dwellers are not involved in gang activity. Being Indian and living in a rural area are only two possible factors that can lead to substance abuse. As shown in the above example, there are many possible contributory and interrelated issues that can lead to substance abuse, such as preexisting psychological problems, lack of supportive social and family ties, learning or physical disabilities, individual personality traits, history of abuse, and perhaps even gender or genetic factors. Certainly, all these factors must be taken in account when considering how to address substance abuse in Indian communities.

There is also a great need for more research efforts on these possible causative factors and their relative importance in predicting and treating substance abuse in Indian communities. To this end, I find it encouraging that Native American Research Centers for Health (NARCH) have been established through a joint NIH/IHS partnership effort, to address issues such as these in Indian communities. It is important that we continue to direct research efforts toward the causative factors unique to specific Indian communities, since variations among Native American Tribes and communities are as great sometimes as the variations between Indian and non-Indian communities.

In addition to the NARCH grants, The Department of Health and Human Services supports wide-ranging research programs and activities, and the Department established an initiative to develop a research agenda for the entire Department. The Research Coordinating Council sent four recommendations to the Secretary for developing a coordinated research agenda funding request – and one was that all HHS agencies would collaborate and partner with the Indian Health Service on any research activities undertaken by the Department that involve or benefit American Indians or Alaska Natives. Another step is the collaboration with the Agency for Healthcare Research and Quality to conduct surveys of the Indian population, in order to gather the data that we all need to make better decisions regarding programs that will benefit Indian people.

Future research efforts will undoubtedly provide some valuable insights into causation, and therefore, treatment factors. What we do know at this point is that community-based culturally sensitive and family focused prevention programs, carried out by culturally competent staff, offer the greatest hope for prevention and also for recovery. The Indian health network of substance abuse program and staff are an example of this: 90% of IHS substance abuse funds directly support tribally administered programs, and 95% of the 1800 employees in those programs are tribal staff.

In addition to research, there are other programs and activities throughout the Department's operating divisions that can be directed toward the substance abuse issues in Indian country. This conference is one

of them. I am also pleased to announce today, on behalf of SAMHSA Administrator Charles Curie, the awarding of $1.5 million in grants for American Indian and Alaska Native Community Substance Abuse Treatment Plans. The grants are being awarded to 6 rural American Indian and Alaska Native communities in the states of Alaska, California, Ohio, Oklahoma, South Carolina, and Washington.

In addition, last Wednesday, Secretary Thompson announced the awarding of $11 million to 19 communities to extend health care services to low-income and uninsured Americans. These awards are part of President Bush's 5-year health centers initiative to expand health centers in underserved rural and urban communities. There are approximately 40 million Americans without health insurance. This number includes many American Indians and Alaska Natives who live in urban areas and areas outside of the serving areas of IHS and tribal health programs. Since 2002 this initiative, managed by the Health Resources and Services Administration, has brought health care services to some 2 million additional Americans, and these 19 new grants will extend services to an estimated 150,000 more people. Tomorrow I will visit one of the health centers receiving a $650,000 grant, the San Diego Family Care Health Center, and present the grant award to them on behalf of the Secretary.

These new awards, and other programs of the Department, are all available to us to help create partnerships and opportunities to address substance abuse in Indian country, rural America, and with the uninsured.

We cannot afford to not do something. Every $1 that goes toward treatment reduces by $4 to $7 the costs of drug-related crime and its prosecution. And there are estimates that $1 for treatment of substance abuse reduces by $12 the cost of treating health issues related to substance abuse.

While that ratio is encouraging and certainly shows that investing in prevention and treatment programs makes good business, if not humanitarian, sense. The ratio of those needing treatment and the availability of services is almost 5 to 2. And the public response to drug use is incarceration – and even with that captive audience, only 12% of state prisoners and 10% of federal prisoners participated in substance abuse treatment programs.

The American Indian and Alaska Native population has the highest need for substance abuse treatment; more than twice the need of other population groups. Substance abuse accounts for 25 percent of the deaths of American Indian and Alaska Native women, and, overall, the death rate for Indian people is 60% higher than that for the rest of the population.

Is the substance abuse problem one of prevention or one of treatment? Looking at the financial impact, it is neither. It is a problem of consequences to society. A study of the cost to states of substance abuse and addiction showed that for every $1 spent – 96 cents went to deal with the consequences and 4 cents went toward prevention and treatment for substance abuse.

While society would prefer to deal with substance abuse through the criminal system, it is a health problem. Addiction is a disease. And it rarely is seen separate from other health problems. More than 40% of people with drug addictions also have mental health disorders. More than half of the people who became infected with hepatitis-C in 1999 were injection drug users. Most drug-using individuals have interwoven health and behavior problems.

We must do more to bring prevention and treatment into the public health model. We cannot be an effective health system without having substance abuse and treatment programs as part of our other health care services. Many effective programs are individually developed and established by those who have overcome their addiction. Whether an effective program is developed by a medically trained staff or a self-taught recovering addict, we can learn from them. We can develop our own substance abuse treatment and prevention programs to add to, not replace, the options and resources available to those who are dealing with addiction themselves, or the addiction of a family member. As I mentioned earlier, there are not enough treatment programs to meet the need and the last thing we need to do is replace effective programs.

For the Indian health system of IHS, tribal, and urban Indian health programs, we need to tailor best practices to also consider the bicultural challenges faced by many of our patients. And we need to increase understanding whenever possible on both sides – our traditional and tribal cultures and the non-native world in which many of us live. With age and experience come wisdom and balance, and so, for our children, we need to understand that they have a traditional heritage and non-native society to contend with, and sometimes they are in conflict and are out of balance. The 21st century offers some coping mechanisms, such as illegal chemical substances, that our children can select as a way to cope with their conflict and stress rather than selecting their traditional ways. In some cultures the teenage years are a time when they are given greater

freedom to make choices and to learn and to suffer the consequences of their choices – but the teenage years for a 21st century child in America are much different from the world of our ancestors. Even with tribal variations, the majority of Indian youths report experimentation with alcohol and a higher percentage of Indian youth report use of marihuana. Perhaps our families and communities need to hold our children a little closer and a little longer and share with them our knowledge and wisdom to help them as they make their choices. And, conversely, Alcoholic Anonymous and Narcotics Anonymous need to be adjusted by the community so that those programs are culturally sensitive and reflect the values and customs of a tribal community – what works in the Bronx does not necessarily work in Bemidji.

The diversity of organizations represented at this conference offer an opportunity to build partnerships that can make a difference. Rural areas face some additional challenges – fewer resources, dispersed services, and lack of trained counselors. Together with other state and federal programs, we should be able to develop a screening and assessment process that does not burden just one organization or agency with the role of screening and identifying those who may have a substance abuse problem. At many public service and benefit programs – welfare, social security, mental health services, for example, there are opportunities to screen beneficiaries.

In addition to identifying where we can establish partnership programs, we will also need to invest in training staff to identify and assess those who may be in need of treatment. Not just training substance abuse counselors, but also other members of the health team who may not be as proficient in recognizing early signs of substance abuse.

But it is not just substance abuse prevention and treatment programs. It is education level, job opportunities, meaningful employment, community investment, self-esteem, safety, shelter, and nourishing food that also can become factors for improved health.

As I stated before, many interrelated factors must be researched and appropriately addressed in order to end the scourge of substance abuse in our Indian communities. Substance abuse is not just an addictive illness; it is also a symptom and indicator of a community in crisis. The destructive effects of substance abuse extend beyond the abusers themselves to their families, friends, communities, and Tribes, and even to the next generation as the abusers become dysfunctional or neglectful parents. We need to end this cycle, this tangled web of destruction, in order to improve and ensure the health and well-being of our people, for today, for tomorrow, and for all the generations to come.

We can do it. Thank you for attending this important meeting.

Thank you.

The text is the basis of Dr. Grim's oral remarks at the IHS-SAMHSA National Conference on substance abuse prevention and treatment in San Diego, California, on Wednesday, June 25, 2003.. It should be used with the understanding that some material may have been added or omitted during presentation.