



Testimony
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Comprehensively Combating
Methamphetamines: Impacts on Health
and the Environment

Statement of
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Chairman Deal, Chairman Gillmor, and Members of both the Subcommittee on Health and the Subcommittee on Environment and Hazardous Materials, I am Stephenie Colston, Senior Advisor to Charles G. Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). I am pleased to present SAMHSA's substance abuse prevention and treatment response to methamphetamine abuse. Many of our most pressing public health, public safety, and human services needs have a direct link to substance use disorders. This link is why the Administration places such a great importance on increasing the Nation's public health approach to prevention and to increasing the Nation's substance abuse treatment capacity.

SAMHSA is working to do just that. Our everyday work at SAMHSA is structured around our vision of "a life in the community for everyone" and our mission "to build resilience and facilitate recovery." Our collaborative efforts with our Federal partners, States and local communities, and faith-based organizations, consumers, families, and providers are central to achieving both our vision and mission. Together, we are working to ensure that the 23.5 million Americans with a serious substance abuse problem have the opportunity to live, work, learn, and enjoy healthy lifestyles in communities across the country.

Equipping communities with substance abuse treatment capacity is a clear priority for President Bush, HHS Secretary Leavitt, and Office of National Drug Control Policy (ONDCP) Director Walters. The Administration has embarked on a strategy that has two basic elements: discouraging drug use and reducing addiction; and disrupting the market for illegal drugs.

The strategy is backed by a \$12.4 billion Federal anti-drug budget proposed for FY 2006. SAMHSA has a lead role to play in the demand reduction side of the equation; naturally, we defer to our law enforcement partner agencies, such as the Drug Enforcement Administration (DEA), which is also testifying today, to address issues concerning the supply side of the equation. SAMHSA helps stop drug use through education and community action before it starts, and we heal America's drug users by getting treatment resources where they are needed.

I am pleased to report that our strategy is working. By focusing our attention, energy, and resources, we as a nation have made real progress. The most recent data from the 2004 Monitoring the Future Survey, funded by the National Institute on Drug Abuse (NIDA), confirms that we are steadily accomplishing the President's goal to reduce teen drug use by 25 percent in five years. The President set this goal with a two-year benchmark reduction of 10 percent. Last year we met and exceeded that goal. Now at the three-year mark, we have seen a 17 percent reduction, and there are now 600,000 fewer teens using drugs than there were in 2001.

Additionally, the most recent findings from SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH) clearly confirm that more American youth are getting the message that drugs are illegal, dangerous, and wrong. For example, 35 percent of youth surveyed in 2004 perceived that smoking marijuana once a month was a great risk, as opposed to 32.4 percent of youth in 2002. This is an indication that our partnerships and the work of prevention professionals, schools, parents, teachers, law enforcement, religious leaders, and local community anti-drug coalitions are paying off.

We know that when we push against the drug problem, it recedes, and fortunately, today we know more about what works in prevention, education, and treatment than ever before. We also know our work is far from over. In particular, we continue to be very concerned about abuse of prescription drugs and methamphetamine. The use of methamphetamine continues its assault as an extremely serious and growing problem.

THE SPREAD OF METHAMPHETAMINE USE

Methamphetamine use was initially identified in SAMHSA's Drug Abuse Warning Network (DAWN). DAWN is a public health surveillance system that monitors drug-related visits to hospital emergency departments and drug-related deaths that are investigated and reported by medical examiners and coroners across the country. In the early- to mid-1990's, DAWN data served as an early warning about the rise of methamphetamine use.

Almost immediately, this early alert from DAWN was confirmed through another SAMHSA data reporting and analysis system, the Treatment Episode Data Set (TEDS). TEDS provides information on the demographic and substance abuse characteristics of the 1.9 million annual admissions to facilities that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services. As early as 1992, TEDS data had indicated that methamphetamine treatment admissions were accounting for about 1 percent of all admissions. Within a decade, methamphetamine admissions grew at a rapid rate. Our most current 2003 TEDS data indicates treatment admission of persons with primary methamphetamine use problems increased from 21,000 in 1993 to 117,000 in 2003. Over half (55 percent) of these admissions were male. Of those admitted in 2003 for the treatment of methamphetamine use, almost three-quarters (73 percent) were white, followed by 16 percent who were Hispanic and 3 percent each who were Black and Asian/Pacific Islander.

With the recent release of SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH), a comparison study of data was completed which demonstrates the prevalence of methamphetamine use was unchanged in 2002, 2003, and 2004. In 2004, 1.4 million persons aged 12 or older had used methamphetamine in the past year and 600,000 had used it in the past month.

SAMHSA's 2004 NSDUH continues to demonstrate that a much younger population has grown vulnerable to methamphetamine's grip. The NSDUH now reports that young adults aged 18-25 had the highest rate of methamphetamine use among the 12 million Americans over the age of 12 who have used this illicit drug. Fortunately, the rates of past-year methamphetamine use among youths age 12-17 declined from 0.9 percent in 2002 to 0.7 percent in 2003, and has dropped again to 0.6 percent in 2004.

DAWN and TEDS data documented the proliferation of methamphetamine use over time, and a geographic pattern of methamphetamine use among the U.S. population emerged as well. Initially a problem in a few urban areas in the Southwest, methamphetamine use spread to several major Western cities and then east from the Pacific States into the Midwest, and now through the South and Southeast. For the United States as a whole, the methamphetamine/amphetamine admission rate increased by 420 percent between 1992 and 2002. Once thought of as a metropolitan drug problem, methamphetamine, or "meth," has now spread to rural America and is the fastest-growing drug threat in the Nation.

The alarming growth of methamphetamine use over the last ten years and, in part, its popularity can be explained by the drug's wide availability, ease of production, low cost, and its highly addictive nature. It is a popular drug because it is a synthetic drug that is easy to make. It is often produced in small, makeshift "laboratories," using equipment and ingredients that are – for the most part – readily available at local drug, hardware, and farm supply stores. The instructions for making methamphetamines are easily found on the Internet, and the equipment needed is as simple as coffee filters, mason jars, and plastic soda or water bottles. Making it even more inexpensive and easy to produce is the essential ingredient, ephedrine or pseudoephedrine. As you know, these substances are commonly found in over-the-counter allergy and cold medicines. Producing an entire batch of methamphetamine can take less than four hours from start to finish, making it more readily available than other illicit drugs.

Complicating the efforts to stop methamphetamine's growth is its highly addictive nature. Immediately, methamphetamine use produces a brief but intense "rush," followed by a long-lasting sense of euphoria that is caused by the release of high levels of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure. Eventually, methamphetamine leads to addiction by altering the brain and causing the user to seek out and use more methamphetamine in a compulsive manner. Chronic use leads to increased tolerance of the drug and damages the ability of the brain to produce and release dopamine. As a result, the user must take higher or more frequent doses in order to experience the pleasurable effects or even just to maintain feelings of normalcy.

Methamphetamine users and their families who are searching for treatment options, in addition to drug treatment programs, often rely on emergency rooms, the primary health care system, the mental health care system, child and family services, and the criminal justice system. As a result, addressing methamphetamine use often requires collaboration among law enforcement officers, prosecutors, judges, probation officers, treatment providers, prevention specialists, child welfare workers, legislators, business people, educators, retailers, and a number of other individuals, agencies, and organizations who all have critical roles in the prevention and treatment process.

SAMHSA'S ROLE IN PREVENTION

SAMHSA's earlier efforts in preventing methamphetamine abuse were channeled through its Center for Substance Abuse Prevention's (CSAP) Methamphetamine and Inhalant Prevention Initiative. This initiative funded grantees that were battling methamphetamine's spread to communities across the country. For example, in Oregon, health officials were reporting an increase in the number of youth who were seeking treatment for addiction to methamphetamine. In 2002, the "Oregon Partnership Methamphetamine Awareness Project" was awarded a SAMHSA grant that targets 9th and 10th grade students over a three-year period to prevent substance abuse among young people in school and community settings in rural Oregon. CSAP's Methamphetamine and Inhalant Prevention Initiative was designed to conduct targeted capacity expansion of methamphetamine and inhalant prevention programs and/or infrastructure development at both State and community levels.

To more effectively and efficiently align and focus our prevention resources, SAMHSA has launched the Strategic Prevention Framework. SAMHSA has awarded 26 Strategic Prevention Framework grants to States and territories to advance community-based programs for substance abuse prevention,

mental health promotion, and mental illness prevention. We expect to continue these grants and fund seven new grants in FY 2006 for a total of \$93 million in funding so far. These grants are working with our five regional Centers for the Application of Prevention Technology that provide technical assistance to States and communities to systematically implement a risk and protective factor approach to prevention across the Nation. Whether we speak about abstinence or rejecting drugs, tobacco, and alcohol; or whether we are promoting exercise and a healthy diet, preventing violence, or promoting mental health, we really are all working towards the same objective – reducing risk factors and promoting protective factors.

The success of the framework rests in large part on the tremendous work that comes from grass-roots community anti-drug coalitions. That is why we are so pleased to be working with the ONDCP to administer the Drug-Free Communities Program. This program supports approximately 775 community coalitions across the country. Consistent with the Strategic Prevention Framework and the Drug Free Communities grant programs, we are transitioning our drug-specific programs to a community-wide risk and protective factor assessment approach to prevention. This approach also provides States and communities with the flexibility to target their dollars in the areas of greatest need.

SAMHSA'S ROLE IN TREATMENT

While the number of individuals who have used methamphetamine in their lifetimes, in the past year, or in the past month has not grown in the past few years, the level of dependence on the drug has. In 2002, 27.5% of those who said they used meth in the past month met the definition of being dependent. In 2004 the percentage was 59.3%. You should also know that the average person presenting themselves for treatment today for methamphetamine addiction has been using methamphetamine for over 7 years. The level of dependence and the length of use present challenges to treatment providers, and yet we know that treatment works.

SAMHSA supports treatment primarily through the Substance Abuse Prevention and Treatment Block Grant. Appropriated at nearly \$1.8 billion in FY 2005, these funds are distributed to States using a formula dictated in statute. States have considerable flexibility in their use of the funds. States, if they want to, could use most if not all of the funds to address methamphetamine abuse. These funds, however, are used more often to maintain the current treatment system.

We also support treatment through competitive grants whereby public and non-profit private entities apply directly to SAMHSA for funds in areas chosen by the agency after consultation with stakeholders. Applications are reviewed and scored by experts from outside Federal government, and SAMHSA funds those applications with the best scores.

One such competitive program is our Targeted Capacity Expansion (TCE) program under which SAMHSA continues to help States identify and address new and emerging trends in substance abuse treatment needs. In FY 2004, SAMHSA awarded funds to programs in California, Texas, Oregon, and Washington to provide treatment for persons addicted to methamphetamine. Three other grants focused on methamphetamine were awarded to Hawaii and Iowa for a total of \$3.8million. In FY 2005, SAMHSA awarded an additional 12 grants in New Mexico, Georgia, Tennessee, Oregon, Texas, Montana, South Dakota, and California.

In his 2003 State of the Union Address, President Bush resolved to help people with a drug problem who sought treatment but could not find it. He proposed Access to Recovery (ATR), a new consumer-driven approach for obtaining treatment and sustaining recovery through a State-run voucher program. State interest in ATR was overwhelming. Sixty-six States, territories, and Tribal organizations applied and competed for \$99 million in grants in FY 2004. We funded grants to 14 States and one Tribal organization in August 2004. Because the need for treatment is great - as methamphetamine abuse rates alone have demonstrated - President Bush has proposed to increase funding for ATR to \$150 million in FY 2006.

Of the States that are now implementing ATR, Tennessee and Wyoming have a particular focus on methamphetamine. The State of Tennessee is using ATR-funded vouchers to expand treatment services and recovery support services in the Appalachians and other rural areas of Tennessee for individuals who abuse or are addicted primarily to methamphetamine. The Wyoming ATR program is also addressing the methamphetamine problem, focusing its efforts on Natrona County. This county has the second-highest treatment need in the State and is considered to be at the center of the current methamphetamine epidemic in Wyoming.

Wyoming and Tennessee are just two examples of ATR's potential. ATR's use of vouchers, coupled with State flexibility and executive discretion, offer an unparalleled opportunity to create profound positive change in substance abuse treatment financing and service delivery across the Nation. And, although it is reassuring to focus on treatment initiatives and the progress being made, we can and must do more to prevent drug use before it begins.

Including the TCE and ATR competitive grant programs, the total amount of competitive grant funding specifically for methamphetamine in FY 2005 is \$16,756,642.

SCIENCE TO SERVICE

To help better serve people with substance use disorders, a true partnership has emerged between SAMHSA and the National Institutes of Health (NIH). Our common goal is to more rapidly deliver research-based practices to the communities that provide services. SAMHSA is partnering with the pertinent NIH research Institutes - NIDA, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health - to advance a "Science to Service" cycle. Working both independently and collaboratively, we are committed to establishing pathways to rapidly move research findings into community-based practice and to reducing the gap between the initial development and widespread implementation of new and effective treatments and services.

As an example, SAMHSA began working on the problems resulting from methamphetamine in 1998 with a competitive grant program designed to expand on work done at NIDA on effective treatment for stimulants. SAMHSA's Center for Substance Abuse Treatment (CSAT) Methamphetamine Treatment Project (MTP) was the largest randomized clinical trial of treatments for methamphetamine dependence to date. Eight grants were funded in California, Hawaii, and Montana. This effort helped identify proven ways of treating those dependent on methamphetamine.

The clinical trials were used to evaluate and expand on the Matrix Model, which was developed in 1986 by the Matrix Institute with support from NIDA as an outpatient treatment model that was

responsive to the needs of stimulant-abusing patients. CSAT compared the Matrix Model to other cognitive behavioral therapies. The result was the development and release of a scientific intensive outpatient curriculum for the treatment of methamphetamine addiction that maximizes recovery-based outcomes. It is through this evaluation and our experience with behavioral cognitive therapies that we know that treatment works. Information on the Matrix model and other cognitive behavioral approaches are available in a set of two DVD's produced by our Pacific Southwest Addiction Technology Transfer Center and our Treatment Improvement Protocol (TIP) #33 - Treatment for Stimulant Use Disorders. These are available through the National Clearinghouse for Alcohol and Drug Information (<http://www.ncadi.samhsa.gov>).

Treatment Improvement Protocols are best practice guidelines for the treatment of substance use disorders and are part of the SAMHSA's effort in conjunction with the National Institute of Health to bring science to service. TIPs draw on the experience and knowledge of clinicians, researchers, and administrative experts. They are distributed to a growing number of facilities and individuals across the country. TIP #33 describes basic knowledge about the nature and treatment of stimulant use disorders. More specifically, it reviews what is currently known about treating the medical, psychiatric, and substance abuse/dependence problems associated with the use of methamphetamine and cocaine. SAMHSA has also published a Quick Guide for Clinicians as well as Knowledge Application Program (KAP) Keys that are also based on TIP #33

Education and dissemination of knowledge are key to combating methamphetamine use. SAMHSA's Addiction Technology Transfer Centers (ATTCs) are providing training, workshops, and conferences to the field regarding methamphetamine. The Pacific Southwest ATTC has developed two digital Training Modules on Methamphetamine. Additionally, SAMHSA has collaborated with ONDCP, the National Guard Bureau's Counter Drug Office, NIDA, and the Community Anti-Drug Coalitions of America (CADCA) on a booklet, video tape, and PowerPoint presentation entitled, "Meth: What's Cooking in Your Neighborhood?" This package of products provides useful information on what methamphetamine is, what it does, why it seems appealing, and what the dangers of its use are.

Additionally, SAMHSA has been working in partnership with the DEA to provide funding to support a series of Governors' Summits on Methamphetamine. These summits provide communities with opportunities for strategic planning and collaboration building to combat methamphetamine problems faced in their own communities. Summits have been held in 15 States.

In conclusion, if we continue to foster these initiatives and further our goals of expanding substance abuse treatment capacity and recovery support services and of implementing the strategic prevention framework, we will simultaneously better serve people in the criminal and juvenile justice systems, those with or at risk of HIV/AIDS and hepatitis, our homeless, our older adults, and our children and families. We are doing our part at SAMHSA. We have been building systemic change so that no matter what drug trend emerges in the future, States and communities will be equipped to address it immediately and effectively before it reaches a crisis level.

Chairman Deal, Chairman Gillmor, and Members of the Subcommittees, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.