PERCEPTIONS OF METHAMPHETAMINE USE IN THREE WESTERN TRIBAL COMMUNITIES: IMPLICATIONS FOR CHILD ABUSE IN INDIAN COUNTRY

Tribal Law and Policy Institute

January 2007

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The authors give special thanks and recognition to the Tribal Law and Policy Institute for their leadership in the fight against child abuse and methamphetamine use in tribal communities. We would also like to acknowledge each of the tribal leaders and professionals from across the three Western tribal communities that participated in this telephone survey. The ongoing commitment and work of tribal leaders, child welfare workers, law enforcement, community members, and advocates to protect tribal children and their families is critical to combat the methamphetamine epidemic that has spread to non-Native and Native communities throughout the country.

Introduction

In 2004, tribal service providers and law enforcement (LE) agencies began reporting that parents were selling their furniture, personal belongings, family heirlooms and regalia, cars, homes, and in some instances prostituting their children in order to obtain cash to continue their addiction to methamphetamines (meth). Criminal Justice Act grantees also were reporting dramatic increases in interpersonal violence, crime, and death, in which meth was a contributing factor (D. Payne, personal communication, April 10, 2006). However, Indian country lacks both a macro and micro study of child abuse and meth use. Furthermore, a systematic examination into the impact of the meth crisis on emergency services, social services, law enforcement, and schools has not taken place on a tribal basis, much less on a pan-tribal level. Only now are news stories about the invasion of meth into tribal communities emerging on websites, journals, newspapers, senate testimony, and agency reports. The majority of these accounts are focused on individual cases of child abuse at the hands of drug addicted friends or family, or examples of children suffering from pre-natal methamphetamine exposure.

In an attempt to explore the increasing concerns raised by this emerging meth epidemic in Indian country, professionals from three Western tribal communities were asked to complete a survey about their perceptions of meth use and the implications for child abuse in the communities in which they work. Specifically, the purpose was to assess community perceptions and awareness of meth use and the resultant implications for child maltreatment, permanency outcomes, and agency workloads.

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Executive Summary

Originating as a drug problem in the early 1990s in the rural west, the methamphetamine (meth) epidemic is now sweeping the entire United States and continues to impact small, rural, urban, suburban, and tribal communities. Although federal precursor legislation was passed in 2006 to curtail access to pseudoephedrine, much remains to be done to impact the prevalence of meth addiction and the growing need for treatment of methamphetamine users. While manufacturing and production via clandestine labs has arguably been reduced due to increased law enforcement efforts, the availability of higher quality meth imported from Mexico has become more widely available throughout rural and tribal communities. Methamphetamine use remains highest in per capita usage for non-metropolitan areas of the country. Counties across America have been struggling with meth, especially since law enforcement, treatment, and child welfare services are sparser in rural and reservation areas than in urban areas.

In July of 2003, the U.S. Commission on Civil Rights released a report entitled, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country,* which outlined the unmet funding needs in health and human services, housing, education, and within the justice system response. As we consider the present impact of methamphetamines in tribal communities the issues identified in, *A Quiet Crisis* pertaining to policing, justice, corrections, and health provision are particularly relevant as tribal governments initiate efforts to respond to the increased presence of methamphetamines in their communities. Policing, justice, corrections, and health and human service provision were all identified as substandard by the U.S. Commission on Civil Rights when compared to the rest of the nation. Tribal communities continue to be particularly vulnerable to crime given the serious lack of federal funding for an adequate criminal justice presence. With critical challenges already present in health care provision, the absence of treatment options for meth users and children exposed to meth presents a serious threat in an already compromised system of health care in rural and reservation areas.

According to tribal leaders, tribes are inadequately funded and ill equipped to deal with the meth epidemic present in many communities. As a result, they have not been able to coordinate a multi-jurisdictional approach that includes counties, states, and federal law enforcement agencies and resources. Although some tribal communities are developing interagency law enforcement partnerships to combat meth use, distribution, and production, other tribes lack the personnel and infrastructure to do so effectively.

For this study, tribal professionals working in the areas of law enforcement, social services, tribal courts, probation, domestic violence, services for children, Head Start, mental health, prosecution, juvenile justice, housing, addictions, and tribal committees offered their perceptions on the use of methamphetamines and the implications for children in their communities.

The data suggest that there is a significant problem with meth use in Indian country with serious implications for children, women, families, and systems. Professionals working in these tribal communities report increases in the incidence of child abuse and neglect, domestic violence, and sexual assault as a result of meth. They also expressed an awareness of increases in child abuse allegations and out-of-home placements that involved a meth-related investigation. Furthermore, these professionals believe that meth involvement increases the difficulty of family reunification. In addition, there are serious concerns regarding the impact of methamphetamines on children, including attempted or completed suicides, meth-impacted births, and exposure to chemicals within the home environment. Many of the perceptions provided by tribal professionals in this survey are supported by recent data gathered by the Bureau of Indian Affairs and Office of Justice Services from 96 Indian country law enforcement agencies that suggests meth is the greatest threat in their communities. These law enforcement agencies also identified increases in domestic violence, assaults, burglaries, and child abuse and neglect cases with the increased use of meth.

The lack of accessible treatment services for users is a serious barrier in addressing meth addiction in tribal communities. By most accounts, resources available to children exposed to meth presents a critical health challenge for tribal children. Current research efforts suggest the treatment of

meth addiction can be effective when local initiatives include users with the same addictions, and in particular for women who are able to bring their children with them while in recovery.

Tribal professionals were aware of an increase in the workload of law enforcement, social services, child protection, and other tribal agencies as a result of meth. Specialized training, services, funding, and a concerted effort to collaborate with tribal, state, and federal agencies were identified as critical needs in combating meth use. Professionals were most concerned with the overall long-term impact that meth will have in their communities and on tribal children.

Clearly methamphetamines present serious challenges for tribal communities, as it has for many communities in the U.S. The epidemic of meth in Indian country is in many ways much like what other rural communities are experiencing throughout the west. What separates tribal communities from other rural communities is that most do not have the resources, personnel, or the infrastructure present to address meth use within a more complex jurisdictional environment. Yet it is also important to consider that tribes have a long history of resistance and resilience and have withstood many historical and social challenges. Tribal communities are situated in a unique legal environment where tribal leaders and tribal courts can play a potentially powerful role in combating meth use, especially in communities where tribal drug courts are already in place. Additionally, some tribal, state, and federal law enforcement agencies have begun to work in a coordinated multi-jurisdictional manner to combat meth use and trafficking.

Tribal communities continue to rely on cultural histories, community networking, and practices to address health and healing. Most model programs in Indian country are built on a philosophy of reinforcing tribal community, cultural pride, and identity. Thus, tribal communities have the potential to develop culturally relevant treatment strategies that promote community detection and responsibility given the level of awareness and dynamics present in close social tribal networks. The value of supporting and promoting cultural identity may present another opportunity in creating prevention programming for meth use in children and adolescents. Lastly, successful child welfare programs should incorporate Native providers, family restoration, kinship care, and culturally relevant approaches for children in the child welfare system as a result of meth abuse.

Literature Review

The following literature review provides a historical perspective and current context on methamphetamines and presents research on meth addiction and the impact of meth on children, and child abuse and neglect in Indian Country. In addition, the literature review details barriers to community, tribal, and federal response to the meth epidemic, along with promising solutions for the meth war.

Historical Perspective

In the 1930s, amphetamines emerged as a medical treatment for allergy relief, and were used by the military during World War II, first in the Pacific theater by the Japanese and later by other countries, because of the drug's ability to induce prolonged periods of wakefulness (U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies [LHHSE], 2005). According to *Methamphetamine in Missouri*, a brief written by the Division of Alcohol & Drug Abuse of Missouri, the abuse of methamphetamines did not emerge until the 1960s (LHHSE, 2005).

In the following decades, the meth epidemic has continued to spread into rural, urban, suburban, and tribal communities. In 2004, the National Drug Intelligence Center reported that 31% of state and local law enforcement agencies believe that meth is the primary drug threat with 58% indicating a medium to high availability in their communities (Kraman, 2004). In 2005, the National Association of Counties (NAC) conducted a survey in the U.S., which found that 87% of the 500 law enforcement groups surveyed reported an increase in meth related arrests in comparison to three years ago (Kyle & Hansell, 2005). There also was a fourfold increase in meth-related treatment admissions from 1992 to 1997 (Pach & Gorman, 2002). In addition, the 2002 National Survey on Drug Use and Health concluded that meth abuse among youth ages 12 and older from rural areas was equal to the levels of meth abuse in adolescents from urban areas (Kraman, 2004).

As for the impact of meth on children, the 1999 survey conducted by the National Center on Addiction and Substance Abuse (NCASA), found that 76% of social welfare professionals cited substance abuse as one of the top three causes for the rise of child abuse and neglect since 1986. NCASA's *No Safe*

Haven study also reported an increase of children under the age of five living in substance-abusing homes, with 81% of these parents using both alcohol and an illegal drug (14.2% using meth in 1999).

Results from the National Association of Counties Survey

In 2005, the NAC conducted two surveys of 500 counties in 45 states, which sought to understand the impact meth was having on crime and children. Meth was found to be a problem nationally with 87% of the county law enforcement agencies reporting increases in meth-related arrests that required incarceration. The report also noted that other crimes were increasing as a result of meth use in their communities (Kyle & Hansell, 2005). Meth was associated with child abuse and neglect, as 40% of officials surveyed reported increases in out-of-home placements due to meth use within the past year. For example, respondents from Colorado and California reported that 70% and 71% of out-of-home placements resulted from a parents meth use, respectively. Overall, 59% of officials believe that a meth-addicted parent greatly increases the difficulty of family reunification (Kyle & Hansell, 2005).

A follow up to the NAC survey was conducted in 2006 and meth continues to be identified as the number one drug problem in the U.S. For example, 73% of the counties reported that their overall workload has increased, while 63% of counties are experiencing increases in overtime for sheriff's departments due to meth-related crime (Hansell, 2006a). Precursor legislation (i.e., controlling the availability of pseudoephedrine) has passed in 90% of the counties surveyed, and busts of clandestine labs were reported as a result of the legislation. Meth has increased the workload of the counties and crimes related to meth use continue to grow, as 48% of the counties reported increases in robberies, burglaries, and domestic violence. Law enforcement agencies report that the majority of meth today is being imported into the U.S. primarily from Mexico (Hansell, 2006a).

Meth Addiction

Methamphetamine is a schedule II narcotic under the Controlled Substances Act (Kraman, 2004), and is a highly physically and psychologically addictive and neurotoxic drug (Haight et al., 2005; Itzhak & Ali, 2002). A neurotoxin is a substance that can damage the nervous system and the brain. Dopamine is a chemical that is naturally released in the body, functions as a neurotransmitter, and serves a number of

functions within the brain. The dopamine release triggered by the ingestion of meth results in an extended high that can last between 8 and 24 hours.

Extended meth abuse can result in dental problems, weight loss, or skin conditions resulting from repetitive physical behaviors and the drug's physiological effects on the brain (Haight et al., 2005). Additional physiological consequences include an increase in body temperature, heart rate, blood pressure, and possible death from cardiac arrest or stroke (Kraman, 2004; McMahon, Andersen, Feldman & Schanberg, 1971). As a result of meth's impact on brain chemistry, abusers generally suffer from drug craving, paranoia and other psychiatric disorders long after they have stopped taking the drug (Itzhak & Ali, 2002; National Drug Institute on Drug Abuse [NDIDA], 1998; Xiaoxi et al., 2001). Treatment for meth addiction is somewhat different than treatment for other drugs, as it is often more intensive and may require different protocols than other drugs (Hansell, 2006b).

Meth in Indian Country

In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that methamphetamine use had grown to 1.7 percent in the Native population in comparison to just 0.7 among American Caucasians (McSwain, 2006). According to *Trends in Indian Health*, produced by the Indian Health Service in 2000-2001, American Indian and Alaska Native populations have seen a 164% increase in the number of drug-related deaths from 3.9% in 1979-1981 to 10.3% 1998. The North Dakota Drug Threat Assessment of 2002 concluded that meth use and distribution was a problem in all reservations within the state, including Turtle Mountain, Standing Rock Nation, Fort Berthold, Spirit Lake Nation, and Lake Traverse (U.S. National Drug Intelligence Center [NDIC], 2002). It is believed that most of these reservations have been targeted by Mexican drug traffickers who bring the drugs in wholesale from California or Mexico and then use Native distributors for both on and off reservation trafficking (NDIC, 2002).

According to Gerard (2005), fully 20% of all Native American youth had used an illicit drug in 2002. In an earlier study, Wallace and Bachman (1991) found that almost half of Native American youth under the age of 17 drank alcohol or smoked marijuana, with a higher substance abuse rate for boys than

for girls. Furthermore, the 2002 National Survey on Drug Use and Health (NSDUH) reported that adolescents whose median family income fell below $20,000 were more likely to drink, abuse prescription medication, or use illicit drugs than adolescents whose median family income exceeded $75,000. Beauvais maintains that in general, Native youth use drugs and alcohol at somewhat higher levels than non-Native youth, although the trends in use over time are similar for both groups (F. Beauvais, personal communication, October 10, 2005). This similarity is an indication that Native and non-Native youth are responding in the same ways to the social forces that shape adolescent drug use (F. Beauvais, personal communication, October 10, 2005).

According to newspaper accounts, U.S. and tribal law enforcement agencies have witnessed a large increase in violent crimes stemming from meth use. Furthermore, there have been reports of tribal elders and family members being involved with meth distribution. As a result, some tribal communities have enacted tribal legislation to stem the flow of meth by banning the sale and distribution of chemical variants and precursors.

According to media reports coming out of the Wind River reservation in Wyoming, the tribal community had been targeted by Mexican drug cartels in an attempt to create a market for meth that dwarfs the demand for alcohol and marijuana. As a result, drug rehabilitation facilities in the community have reported a substantial increase in treatment for meth users, while social services agencies have seen a large increase in child neglect cases. The addition of meth-exposed children to an already strained network of social services in tribal communities almost guarantees additional complications in educational, social, and medical services on the reservation.

Requests through the Indian Health Service (IHS) for drug rehabilitation services for meth addicts increased from 137 in 1997 to 4,946 in 2004. However, the average healthcare provided by IHS or through contracted services only meets about ten percent of the need. To illustrate this point, Julia Doney, the president of the Fort Belknap Tribal Council, testified that her nephew, who was incarcerated for shooting a police office while in a drug-induced stupor, receives better health care in prison than the rest

of the family experiences on the reservation (Doney, 2006; U.S. Commission on Civil Rights [USCCR], 2003).

Children at Risk from Meth

Based on the available scientific data, prenatal exposure to methamphetamine has a damaging neurological and physiological effect on exposed children. Recent studies have found that meth addicted mothers give birth to children that suffer a higher number of birth defects, while experiencing a greater incidence of miscarriages and Sudden Infant Death Syndrome than do children whose mothers are not addicted to meth. Furthermore, infants exposed to meth are more likely to be preterm, have lower birth weight, and smaller head circumference than are infants not exposed to meth (Wouldes et al., 2004). In a recent study, Smith et al. (2006) found the strongest evidence to date for the effect of meth on prenatal development. Specifically, pregnant women using meth were three and one-half times more likely than non-using mothers to give birth to smaller babies.

As for the long-term effects for meth-exposed children, the outcome is best if use is reduced during pregnancy. According to Billing, Eriksson, Jonsson, Steneroth and Zetterström (1994), there is a strong correlation between levels of exposure in gestation versus levels of aggressiveness towards peers and the development of social networks.

Many mothers, regardless of their addictions, will insist that they are providing adequate physical and emotional care to their children, even in the face of contrary evidence (Baker & Carson, 1999). However, data from the National Center for the Prosecution for Child Abuse (2002) suggest that parents addicted to meth are less likely to have the ability to control their emotions. These findings suggest that meth-addicted parents (fathers more frequently than mothers) are more likely to abuse their children when using the drug, while neglecting them as the high wears off (Hogan, Myers & Elswick, 2006; U.S. Department of Health and Human Services [HHS], 2003). As noted by NCASA (1999), "the powerful lure of this addiction competes with parents' bonds to their children, and can diminish their ability to meet the demands of child welfare officials and to regain their children despite an abiding love for them" (p.11).

Furthermore, the home environment can be a serious hazard for children of meth-addicted parents, as they are exposed to dirty needles, drug paraphernalia, and toxic chemicals (Baker & Carson, 1999; NDIC, 2002). For example, smoked drugs such as crack cocaine or methamphetamine can travel through the air and cause a child to test positive for extended exposure when hair samples are provided (Baker & Carson, 1999). Lastly, these children are at risk of sexual or physical abuse at the hands of an addicted parent or other users at the home site (Haight et al., 2005).

Child Abuse and Neglect from Meth Abuse in Indian Country

According to newspaper reports, child abuse resulting from meth use has had some serious consequences in a number of tribal communities. Anecdotal evidence suggests particularly egregious cases of child abuse by parents addicted to meth. Children in Indian country who are abused or neglected by meth abusing parents face many dangers in regard to out-of-home placement, health care, and education. According to the testimony of Ivan D. Posey, Chairman of the Eastern Shoshone Business Council, Tribal social workers report that parental meth addiction accounts for 65% of all cases involving child neglect and placement of children in foster care (Posey, 2006). The frequent placement of these children with grandparents or other kin may further complicate the relationship with the addicted parents and thus, their protection within the foster care system (Posey, 2006). For example, the danger of molestation from a family friend or relative increases significantly when meth use is involved, as it may increase sexual drive and stamina (NCASA, 1999). In addition, children with addicted parents are more likely to suffer from malnutrition and absenteeism from school (Posey, 2006).

Barriers to Community, Tribal, and Federal Response

The barriers to community, tribal, and federal response to the meth crisis in Indian country are illustrated in the testimony of Jefferson Keel, First Vice President of the National Congress of American Indians. Specifically, Keel (2006) reports that: (1) IHS and tribal health programs are funded at 60% of the level needed to provide adequate health care services; (2) Tribes receive very little federal funding to help design and implement child abuse prevention and foster care programs; (3) Tribal governments are currently not eligible to apply and receive allocations from the Title XX Social Services Block Grant

Program, despite the fact that tribal population numbers are used to determine individual state allocations; (4) Tribes received none of the $16.2 million for meth abuse prevention awarded to 11 rural communities by the U.S. Health and Human Services Department in 2005; and (5) A significant percentage of Tribal TANF funds must be used for substance abuse services, counseling, and drug testing.

In April 2006, the Senate Indian Affairs Committee held its first hearing on the effects of methamphetamines in Indian country. Testimony from Matthew H. Mead, the United States Attorney for the District of Wyoming, highlighted the problems facing federal officials. Mexican and American drug traffickers utilize the largely unpatrolled seventy acres bordering Mexico as a gateway for marijuana and meth. As such, it is largely unsurprising that almost eighty percent of all methamphetamine is produced in "superlabs" along the Mexican border (Mead, 2006). Furthermore, due to funding issues as well as population scattered over large areas of land, tribal law enforcement generally numbers only two officers per one thousand people instead of the standard 3.9 to 6.6 officers per 1000 people on non-tribal lands (USCCR, 2003). In addition, Natives were twice as likely as others to be victims of crime, while LE coverage of tribal lands consists of no more than three law enforcement officers working one at a time to cover a land mass the size of Delaware (USCCR, 2003).

Robert McSwain, Deputy Director of the Indian Health Service, admits that the spread of meth through Indian Country has produced a health crisis of monstrous proportions. For example, mental health programs in Indian Country (e.g., IHS psychiatrists, addiction medicine specialists) are severely under funded and thus, are unable to provide sufficient services to children and families (Kitcheyan, 2006). Furthermore, there is a need for greater resources and personnel for child protective services, so they can better handle the overwhelming case load resulting from meth abuse (Kitcheyan, 2006).

From a grant investigating the impact of drugs and alcohol in Indian country, the United Tribes Multi-Tribal Indian Drug and Alcohol Initiative identified the following key findings for tribal communities in North Dakota: (1) IHS is not tracking meth use, so there is currently no reliable data available; (2) Juveniles are being used as drug dealers and pushers because of lesser sanctions against juveniles; and (3) There are no treatment facilities within the state for juveniles, and the only long term

treatment facility for adults is at the state penitentiary (Azure, 2006). United Tribes further identified a multi-Tribal need for additional funds to construct: (1) Residential treatment centers and half-way houses; (2) Access to resources for use in establishing jobs for recovering addicts; and (3) Access to long-term treatment and payment for that treatment (Azure, 2006).

Posey (2006) identified a lack of local treatment facilities for juveniles and adults, a decrease in juvenile prevention programs, and the absence of long-term treatment facilities in rural areas such as reservations. Finally, Schinke, Tepavac, and Cole (2000) found that a policy focused only on a school-based, "just-say-no" support plan was largely ineffective in the long-term prevention of drug and alcohol abuse, as poverty, combined with unemployment seems to correlate with increased alcohol and drug abuse in tribal communities for both youth and adults.

Promising Solutions in the Meth War

Tribal communities in Indian country are beginning to respond to the multi-generational threat of meth abuse. Many communities have begun their own meth awareness programs, educational rallies, interagency task forces, and sponsor walks that highlight drug awareness campaigns. The National American Indian Housing Council (NAIHC) has devised a creative way of educating Native housing authorities in spite of decreased funding. Specifically, the NAIHC has developed a series of webcasts that deal with the problems that housing officials face when cleaning up a house where meth was either made or used. In addition, a number of tribal leaders are speaking out about the rising epidemic of meth in tribal communities and many tribal leaders testified in the April, 2006 Senate Committee on Indian Affairs Hearings on Methamphetamines in Indian Country.

Northern Arapahoe and Eastern Shoshone Tribes demonstrated that federal and tribal law enforcement can work together to successfully break meth distribution rings on the reservation. For example, 22 of 25 federal defendants, in addition to Mexican nationals at the heart of the distribution and sale of meth at Wind River, have received federal convictions (Mead, 2006). Multiple law enforcement agencies also dismantled a meth ring within the Chickasaw Indian Nation, which resulted in 108 arrests

and the destruction of seven meth and two crack cocaine distribution pyramids along the Oklahoma-Texas border (Mead, 2006).

The Bureau of Indian Affairs (BIA) and the Office of Justice Services (OJS) are currently strategizing to develop interagency partnerships at a national, regional, and local level. These partnerships would increase training, education, and prevention of illegal drugs in tribal communities (Honahni, 2006). To further stem the tide of meth being smuggled from Mexico, a Senate bill has recently been submitted for the Border Technology Grant Program (42 U.S.C. 3797cc § 3825) that would fund "a viable use of technology or aerial surveillance to detect methamphetamine and its precursors on the border of the United States" (Grim, 2006). Although the statute is a promising start, a dramatic increase in funding will be required to really make a difference in border security and control.

To address the medical, psychological, psychosocial, and recovery needs resulting from meth use, IHS has formed various anti-meth summits and provided funding for treatment programs such as the Matrix model and the Billings Area 4-Step Recovery program which is offered in Aberdeen, Alaska, Albuquerque, Billings, California, Navajo Nation, Oklahoma, Portland, and the Phoenix and Tucson areas (McSwain, 2006).

Keel (2006) supports the idea of alternative sentencing and Family Courts where the integration of cultural ideals and healing are used. He also recommends to: (1) Increase funding for tribal Courts; (2) Renew and expand the COPS program for the training, hiring and retention of tribal police officers; (3) Ensure all Department of Justice/office of Justice Programs meth related grants are available to tribes; (4) Maintain National American Indian Housing Council meth funds; (5) Increase funds to the DOJ Indian Alcohol and Substance Abuse Prevention Program and SAMSA grants; (6) Prevent IHS funding from falling further behind, as need is estimated to be $9-$10 billion according to the IHS Budget Formulation Process and Federal Disparities Index Workgroup; and (7) Include tribes in all relevant meth grants.

In conclusion, all of the Senate testimonies by tribal officials stressed the need for an increase in the IHS budget, renewed funding for both tribal health and law enforcement personnel, a critical infusion

of funding for children affected by meth, other drugs, and alcohol, and increased medical, psychological, and foster care services for children in tribal communities affected by meth.

Promising Solutions for Child Welfare in the Meth War

The traditional response of child welfare and social services has been to seize the children of meth addicted mothers and place them with either another relative or within the foster care system (Marquez, 2006). Several tribes have resorted to banishment, either temporary or permanent, and even disenrollment for those convicted of dealing meth. The prospect of banishment and disenrollment, even with the opportunity to reapply in five years, is a devastating prospect for drug-addicted parents and their children. Even if the parents manage to succeed in drug rehabilitation, their banishment from the tribe almost certainly ensures that the children within that family will suffer the consequences of exile as well. Tribal members in the Lummi community have used banishment for serious drug offenses, and while some community members support banishment as a traditional form of justice others are split on whether banishment should be an option at all (Ross, 2004).

Libesman (2004) has broken new ground in identifying the factors that provide successful recovery for children in the child welfare system as a result of meth abuse. First, any welfare intervention needs to be community based and sensitive to the cultural and social mores of Indigenous peoples. Second, "meaningful" collaboration between government agencies, tribal governments, and social services is critical in addressing the needs of the child, focusing on family networks rather than individual solutions. Third, staffing of these agencies must include Natives who are sensitive to the needs of the children via a community framework and active participation. Finally, family preservation or family restoration must be part of the goal of rehabilitation and recovery for both the parent(s) and children (Libesman, 2004).

Generations United (2006) has come to the following recommendations regarding the response of child welfare agencies in tribal communities: (1) Create a reliable, flexible child welfare financing structure to provide a wide range of activities, including prevention, treatment, comprehensive services for tribal communities, and cross-system collaborations; (2) Target resources towards those communities,

such as American Indian/Alaska Native Communities, that are disproportionately affected by meth; (3) Expand permanency options for children in foster care to include subsidized guardianship when adoption or reunification is not possible; (4) Establish and expand services and supports for grandfamilies and adoptive families including specialized supports for grandfamilies who step in to care for children living with meth affected parents; and (5) Strengthen dependency courts and broaden the use of family drug court models.

Wilke, Kamata, and Cash (2005) argue that current child welfare policies actually inhibit the rehabilitation of meth addicted mothers and the preservation of the family unit. Recent research by the Harbor-UCLA Medical Center shows that women addicted to meth respond better in a community-based treatment center with women who are not only suffering from the same addiction, but are permitted to bring their children with them while they are in recovery (Marquez, 2006). Ross (2004) is at the forefront of a growing number of sociologists and family social workers that believe that current drug policies harm Native families by removing Native children from the supportive cultural and social framework of their communities. Furthermore, research on Native adolescents emphasizes that the strongest predictors of resilience are enculturation, maternal warmth, and level of community support (LaFromboise, Hoyt, Oliver, & Whitbeck, 2006).

Methods

A total of 37 participants completed this survey either by telephone, or in a few instances returned by mail when respondents could not complete the survey by telephone or had difficulty scheduling a telephone interview. The sample was comprised of professionals representing the following entities: Tribal and Federal Law Enforcement, Tribal and BIA Social Services, Domestic Violence and Children's Advocates, U.S. Attorney's Office, Mental Health Providers, Head Start programs, Community Elders, Private Practice Therapists, Juvenile Justice Services, Tribal Court and Probation Department Personnel, Tribal Transportation Providers, Tribal Housing, Drug/alcohol counselors, and advocates working with people with developmental disabilities.

As displayed in Appendix A, the survey included 20 items, including close-ended yes/no, multiple choice, and open-ended questions to provide additional information regarding the prevalence and impact of methamphetamine use in the three tribal communities. This survey instrument was originally adapted from the National Association of Counties Survey (NAC, 2005) and modified significantly for use in tribal communities. Prior to data analysis, the completed surveys were copied with the unique participant and tribal identifiers removed and then transmitted to the Social Work Research Center at Colorado State University.

The quantitative data were entered into the Statistical Package for Social Sciences (SPSS) and analyzed using descriptive statistical techniques. Specifically, frequency counts and descriptive statistics were generated for the quantitative questions. Responses to the open-ended prompts were analyzed using qualitative methods. First responses were coded by hand and then entered into a Microsoft Word document for formatting and further refining. A constant comparative analysis approach was employed to uncover emergent categories that provided identification of the main themes from the data.

Quantitative Results

The following results are based on the completed surveys from 37 respondents, including 16 from Community #1, 11 from Community #2, and 10 from Community #3.

Awareness of Methamphetamine Use

As displayed in Table 1, there was great awareness of methamphetamine use in these tribal communities. Specifically, 100% of respondents were aware of methamphetamine use and 89% believe that community members were aware of its use.

Table 1 - *Awareness of Methamphetamine Use*

Question	*n*	*%*
Aware of Meth Use		
Yes	37	100.0
No	0	0.0
Not Sure	0	0.0
Community Members Aware of Meth Use		
Yes	33	89.2
No	0	0.0

Awareness of Methamphetamine Manufacturing and Distribution

As displayed in Table 2, respondents reported less awareness of methamphetamine production and distribution in their communities. Specifically, only 24% of respondents were aware of increases in manufacturing arrests while just 54% were aware of increases in distribution arrests. However, only three participants were able to provide an estimate of the increase in methamphetamine production during the past year or three years. As for distribution, 13 participants estimated an average increase of 41-60% during the last year, and 41-60% over the past three years.

Table 2 - Awareness of Methamphetamine Manufacturing and Distribution

Question	*n*	*%*
Aware of Increase in Manufacturing Arrests		
Yes	9	24.3
No	21	56.8
Not Sure	7	18.9
Aware of Increase in Distribution Arrests		
Yes	20	54.1
No	11	29.7
Not Sure	6	16.2

Awareness of Abuse and Neglect from Methamphetamine Use

As displayed in Table 3, participants reported increases in child abuse and neglect and adult criminal behavior because of methamphetamine use in their communities. For example, 87% of respondents were aware of an increase in child neglect, 78% were aware of an increase in child physical abuse, 58% were aware of an increase in child sexual abuse. Furthermore, 95% of respondents were aware of an increase in domestic violence, 81% were aware of an increase in theft, and 66% were aware of an increase in sexual assault due to methamphetamine use in their communities.

Table 3 - *Awareness of Abuse, Neglect, and Violence from Methamphetamine Use*

Question	*n*	*%*
Aware of Increase in Child Physical Abuse		
Yes	29	78.4
No	1	2.7
Not Sure	7	18.9
Aware of Increase in Child Sexual Abuse		
Yes	21	58.3
No	4	11.1
Not Sure	11	30.6
Aware of Increase in Child Neglect		
Yes	32	86.5
No	0	0.0
Not Sure	5	13.5
Aware of Increase in Domestic Violence		
Yes	35	94.6
No	0	0.0
Not Sure	2	5.4
Aware of Increase in Sexual Assault		
Yes	23	65.7
No	2	5.7
Not Sure	10	28.6
Aware of Increase in Homicide		
Yes	6	17.1
No	5	14.3
Not Sure	24	68.6
Aware of Increase in Theft		
Yes	30	81.1
No	0	0.0
Not Sure	7	18.9

Awareness of Child Abuse and Out-of-Home Placements

As displayed in Table 4, respondents reported strong awareness of increases in child abuse allegations and out-of-home placements that involved a methamphetamine investigation. Specifically, 70% of respondents were aware of increases in child abuse allegations and increases in out-of-home placements. In addition, these 17 respondents estimated an increase of 41-60% in out-of-home placements during the past year and 41-60% over the past three years. As for child abuse allegations, 14 participants estimated an average increase of 21-40% during the past year and 41-60% over the past three years.

Table 4 - *Awareness of Child Abuse and Out-of-Home Placements from Methamphetamine Use*

Question	*n*	*%*
Aware of Increase in Child Abuse Allegations		
Yes	26	70.3
No	5	13.5
Not Sure	6	16.2
Aware of Increase in Out-of-Home Placements		
Yes	26	70.3
No	4	10.8
Not Sure	7	18.9

Awareness of Barriers to Reunification

Overall, almost two-thirds of respondents reported being aware of methamphetamine involvement increasing the difficulty of family reunification. As displayed in Table 5, 75% of these 24 participants believe that the severity of parents' methamphetamine involvement prevents reunification, 71% believe that it takes longer to reunify families, 71% believe that permanent placements are often made with other family members, 63% believe that there are more families that cannot be reunified, 63% believe that the severity of child abuse has prevented reunification, and 54% believe that family reunification does not last when it involves methamphetamine use.

Table 5 - *Awareness of Barriers to Reunification from Methamphetamine Use (N = 24)*

Ouestion	*n*	*%*
More Families cannot be Reunified		
Yes	15	62.5
No	8	33.3
No Estimate	1	4.2
Takes Longer to Reunify Families		
Yes	17	70.8
No	6	25.0
No Estimate	1	4.2
Reunification Does Not Last		
Yes	13	54.2
No	10	41.7
No Estimate	1	4.2
Child Abuse Prevented Reunification		
Yes	15	62.5
No	8	33.3
No Estimate	1	4.2
Permanent Placements Made with Family		
Yes	17	70.8
No	6	25.0
No Estimate	1	4.2
Meth Involvement Prevents Reunification		
Yes	18	75.0
No	5	20.8
No Estimate	1	4.2

Awareness of Workload Increases

As displayed in Table 6, respondents were very aware of increases in the workload of agencies in tribal communities as a result of methamphetamines. For example, over 90% of participants were aware of increased workloads for law enforcement and social services agencies. Furthermore, greater than 80% of respondents were aware of increased workloads for substance abuse programs, child protection agencies, tribal courts, and domestic violence programs.

Table 6 - *Awareness of Workload Increases from Methamphetamine Use*

Question	*n*	%
Increase in Law Enforcement Workload		
Yes	34	91.9
No	1	2.7
Not Sure	2	5.4
Increase in Social Services Workload		
Yes	34	91.9
No	0	0.0
Not Sure	3	8.1
Increase in Indian Health Services Workload		
Yes	29	78.4
No	1	2.7
Not Sure	7	18.9
Increase in Tribal Court Workload		
Yes	31	83.8
No	1	2.7
Not Sure	5	13.5
Increase in HUD Workload		
Yes	25	59.5
No	0	0.0
Not Sure	15	40.5
Increase in Head Start Workload		
Yes	18	50.0
No	1	2.8
Not Sure	17	47.2
Increase in Behavioral Health Workload		
Yes	28	77.8
No	1	2.8
Not Sure	7	19.4
Increase in Substance Abuse Workload		
Yes	33	89.2
No	0	0.0
Not Sure	4	10.8
Increase in Child Protection Workload		
Yes	32	88.9
No	0	0.0
Not Sure	4	11.1
Increase in Tribal Prosecutor Workload		
Yes	28	77.8
No	0	0.0
Not Sure	8	22.2
Increase in Victim Advocates Workload		
Yes	23	62.2
No	0	0.0
Not Sure	14	37.8
Increase in Domestic Violence Workload		
Yes	30	81.1
No	0	0.0
Not Sure	7	18.9

Awareness of Programs, Resources, and Collaborations

As displayed in Table 7, a plurality of respondents were aware of training for child welfare professionals and collaborations between federal, tribal, and state agencies to address methamphetamine use in these tribal communities. However, there was little to no awareness of treatment programs for users in the community or for resources and services available for children exposed to methamphetamines.

Table 7 - *Awareness of Programs, Resources, and Collaborations from Methamphetamine Use*

Question	*n*	*%*
Aware of Training for Child Welfare Professionals		
Yes	13	36.1
No	11	30.6
Not Sure	12	33.3
Aware of Treatment Programs for Meth Users		
Yes	1	2.8
No	30	83.3
Not Sure	5	13.9
Aware of Resources for Children Exposed to Meth		
Yes	2	5.6
No	27	75.0
Not Sure	7	19.4
Aware of Agency Collaboration		
Yes	15	40.5
No	14	37.8
Not Sure	8	21.6
Aware of Jurisdictional Issues		
Yes	9	24.3
No	16	43.2
Not Sure	12	32.4

Qualitative Results

For each open-ended question, the qualitative results are presented in three ways. First, the main themes from the responses are shared. Second, all of the participant answers are displayed (except for those with only one response). Lastly, selected quotes from the participants are presented.

As displayed in Table 8, the main themes, in order of significance, from the question, *how do people learn of the methamphetamine use in your community,* are as follows: 1) Professionals and community members primarily learn about methamphetamine use within their own circle of friends and family; 2) Professionals working in tribal communities also learn about methamphetamine use at work from clients and co-workers; 3) Many people have learned more about methamphetamine use from the interventions from the criminal justice system (e.g., arrests, convictions, incarcerations); and 4) There is a lot of community awareness of methamphetamine use.

Table 8 - *Participant Responses from Question #1a*

Response	*n*	*%*
Community members (word of mouth)	16	43.2
Family	16	43.2
In my job (co-workers/clients)	15	40.5
Law enforcement busts/reports	14	37.8
Meth trainings (local groups)	8	21.6
Meth users	6	16.2
People seeing it sold or used	6	16.2
Friends	4	10.8
Newspaper	4	10.8
Rumor	3	8.1
Parents leaving kids with elders	3	8.1
Small communities everyone knows	3	8.1
Child abuse reports	3	8.1
I've seen it (weight loss)	2	5.4
Employee/Parents drug screens	2	5.4
Legal system (convictions)	2	5.4
Skin problems/bizarre behavior	2	5.4

Selected Quotes

- *"From other kids coming to me, and women through work experience because of the domestic violence involved, and other community members who are telling me."*
- *"Well the truth is my daughter was on it and it has affected her life because I have her children. The people she was hanging around were all meth users and there are a lot of kids using it."*
- *"From reading pre-sentence reports, and prosecutions…seeing the indictments."*

- *"Humungo problem. I see it in my family, friends and my friend's families because we are a small community."*

As displayed in Table 9, the main themes, in order of significance, from the question, *what do you believe are the most common reasons for methamphetamine use in your community*, are as follows: 1) Inexpensive drug and easier to get than alcohol; 2) Poverty related factors (e.g., prevalence of poverty, no jobs and potential for income from selling meth); 3) Presence of prior addictions; 4) Cheap and long lasting high; and 5) Nothing for kids to do, peer pressure, and low surveillance.

Table 9 - *Participant Responses from Question #3*

Response	*n*	*%*
Easy to get (easier than alcohol)	12	32.4
No jobs here/Poverty	11	29.7
Cheap	9	24.3
Something to do	6	17.1
Weight loss	5	16.2
Income from selling	4	10.8
People get hooked from experimenting	4	10.8
A long high/like the high/more energy	4	10.8
Extension of prior alcohol use	4	10.8
Escape or medicate pain/feelings	3	8.1
Young kids experimenting/peers	3	8.1
Depression	2	5.4
Low surveillance on meth	2	5.4
No programs or things for youth here	2	5.4
Low self-esteem	2	5.4

Selected Quotes

- *"Maybe unemployment, no jobs, no money, depression, post trauma behavior, historical chaotic family life, hopelessness and helplessness."*

- *"Cheap high. There are not enough jobs or income here so they use the meth to sell as part of their income."*

- *"It is cheap, addictive and it does wondrous things for women because they want to feel good, lose weight and they don't realize the effects until it's too late."*

- *"These are the poorest areas of the nation. There is nothing to do here. There are no programs for youth."*

As displayed in Table 10, the main themes, in order of significance, from the question, *why do you think that children are being left in homes in which methamphetamines use, manufacturing, and/or distribution is taking place*, are as follows: 1) System challenges (e.g., not enough LE or social workers, large amount of clients, unsubstantiated cases, lack of funds); and 2) Impact of meth on parents.

Table 10 - *Participant Responses from Question #8b*

Response	*n*	*%*
Limited social services	4	10.8
Cases can't be substantiated	3	8.1
People/parents are hiding it (no place else to go)	3	8.1
Children grow up learning about meth in the home	2	5.4
Parents don't care	2	5.4
Lack of law enforcement & funds	2	5.4

Selected Quotes

- *"Because there are all of 2 social workers here and with the amount of court ordered clients we have and the prevalence of families on the drug kids grow up with it. We have 19-35 year olds young adults that have learned about using in their home."*
- *"Because the increase in meth is in the use not the production. Can't get the materials anymore…they are importing the meth now."*
- *"Lack of funding, shortage of police officers and lack of social workers."*

As displayed in Table 11, the main themes, in order of significance, from the question, *what type of training is being provided for child welfare professionals who work with children exposed to methamphetamine use in your community*, are as follows: 1) Lots of efforts here either locally some federally funded programs or on a state wide basis; and 2) Training is not specialized to methamphetamine use.

Table 11 - *Participant Responses from Question #11a*

Response	*n*	*%*
Some local efforts (domestic violence (DV) programs)	4	10.8
State agencies	4	10.8
Some community wide training	2	5.4
Annual meth conference	2	5.4
Federal meth task force (state, tribal, federal)	2	5.4
Upcoming efforts are planned	2	5.4

Selected Quotes

- *"The state has put on training and the federal meth task force as well."*
- *"We sponsor an annual meth conference."*
- *"Multiple state trainings, tribal program and Criminal Justice Act trainings are all being done."*

As displayed in Table 12, the main themes, in order of significance, from the question, *what type of treatment is being provided for methamphetamine users in your community,* are as follows: 1) Most participants thought there was no effective treatment available locally that is meth specific; 2) Even within the state in which their community resides treatment remained a serious challenge for tribal community members; and 3) Any treatment available locally was outpatient and education vs. treatment oriented.

Table 12 - *Participant Responses from Question #12a*

Response	*n*	*%*
None or not sure	25	67.6
No in-patient nothing local	5	13.5
Here out-patient abuse classes that are educational	5	13.5
In-patient other part of state	3	8.1

Selected Quotes

- *"We don't have one and it's hard to get. The state prison has a program."*
- *"None here, we have a 6 week program in another part of the state & they tell us most of their clients are from our county…otherwise people are going to California."*
- *"Just AA and outpatient stuff."*

As displayed in Table 13, the main themes, in order of significance, from the question, *What type of resources and/or services are available for children who have been living in homes where methamphetamine is being used, sold or manufactured,* are as follows: 1) Almost all of the participants indicated that there were no resources or services available for children in their communities; 2) In one community, there was not a single participant who was able to identify any resources/services for children; and 3) For the few that indicated there were some resources, none of those identified were methamphetamine specific.

Table 13 - *Participant Responses from Question #13a*

Response	*n*	*%*
None or not sure	25	67.6
No in-patient nothing local	5	13.5
Here out-patient abuse classes that are educational	5	13.5
In-patient other part of state	3	8.1

Selected Quotes

- *"Very limited mental health programs here for child abuse or meth. We have kids that have seen suicides or have attempted suicide themselves and they don't have any help and some of these are meth related."*
- *"We have one program that provides services, treatment and cultural healing."*

As displayed in Table 14, the main themes, in order of significance, from the question, what aspects (if any) of the current child protective services system regarding methamphetamine use and child abuse are in need of changes, are as follows: 1) Investigation challenges (e.g., quicker response, meth specific protocols, understaffed, SS/LE coordination, reporting); 2) Methamphetamine specific training needed (e.g., foster families, reporting); 3) Treatment services (e.g., inpatient, meth specific, support for grandparents, halfway houses); and 4) Additional funding (e.g., foster parents, etc.).

Table 14 - *Participant Responses from Question #14*

Response	*n*	*%*
Training (specific to meth)	15	40.5
Funding	11	29.7
Protocols (have LE accompany SWs in meth cases)	11	29.7
We need local inpatient treatment programs	10	27.0
Reporting (education/training)	6	16.2
Increased social workers or advocates	5	13.5
Tribal code changes for meth	5	13.5
Funding, support, and education for foster parents	3	8.1
Coordination with reservation agencies	3	8.1
No halfway houses or transitional programs	2	5.4
More complete & timely investigations	2	5.4

Selected Quotes

- *"More education for resource families who take meth affected children. I took a meth baby and she has lots of skin problems unlike things other people see. She has poor vision, chronic respiratory infections, asthma, and originally had failure to thrive. Social services never told us about the clothing being contaminated so families don't know that."*

- *"I would like to see a better protocol for cleaning up the meth in the home. Parents go to jail and another family moves in with no cleaning they just move in."*

- *"Training and more dedicated people to work with meth kids and meth families with more empathy. The lack of transportation for treatment and evaluation makes it really difficult for meth users and the ones who want to get clean there are no places for them to go and no transitions, no halfway houses."*

As displayed in Table 15, the main themes, in order of significance, from the question, *what aspects (if any) of the current law enforcement system regarding methamphetamine use and child abuse are in need of change (and/or juvenile justice system),* are as follows: 1) Structural challenges related to federal/tribal policies and coordination (Meth specific laws and protocols, contamination clean-up, coordinating LE on tribe/state/federal level); 2) Tribal/federal infrastructure challenges preventing sustainable efforts to address meth (more LE, better trained LE, burnout prevention for LE, overcrowded or lack of jails, inadequate response to juveniles, no emergency shelter for juveniles); 3) Training and funding for meth specific criminal justice response; 4) Drug specific response (Court ordered treatment, jail as a place to "dry out", housing and jobs for users following court ordered treatment; and 5) Need for a juvenile specific criminal justice response.

Table 15 - *Participant Responses from Question #15*

Response	*n*	*%*
More trained and dedicated LE	15	40.5
Tribal code criminal changes	11	29.7
Protocols that are meth specific	6	16.2
Coordinating efforts of LE with state, federal, tribal	6	16.2
Training (include tribal courts, burnout prevention)	6	16.2
Funding	6	16.2
Court ordered treatment (no treatment available)	5	13.5
Inadequate system response for adolescents	5	13.5
Help people get housing, jobs and reentry after treatment	3	8.1
Overcrowded jails	2	5.4
Keep Council members out of LE work	2	5.4

Selected Quotes

- *"We have only one juvenile officer and their workload has more than doubled. There is a need for more juvenile officers. We had a juvenile judge but they got cut. We need a separate system for juveniles."*
- *"More police. The FBI drug task force will not work in our area because we don't have a person to dedicate to the task force."*
- *"An emergency shelter for kids is really needed."*
- *"People need to serve their time and then do treatment, if only because you can guarantee that they've dried out for 30-45 days in jail."*
- *"Tribal code changes for meth impacted babies. We could use a treatment program to court order it."*

As displayed in Table 16, the main themes, in order of significance, from the question, *which federal, tribal, and state agencies are working together to address methamphetamine issues in your community (how they are working together),* are as follows: 1) In two of the three communities surveyed there was a presence of tribal/state/federal agencies that were working together; and 2) In one community, many reported a significant decrease in the tribal/state/federal coordination.

Table 16 - *Participant Responses from Question #16*

Response	*n*	*%*
Tribal LE, sheriff and FBI	6	16.2
Meth conference sponsored by LE or state agencies	3	8.1
MDT (DV program too)	3	8.1
Efforts have decreased with federal and local LE	3	8.1
DC Tribal Summit Meeting	2	5.4

Selected Quotes

- *"Law enforcement is working with other law enforcement agencies state/federal BIA. I know they are surveiling and looking for manufacturers, distributors and who is all behind it."*
- *"Now they are. Finally the U.S. Attorney, FBI & tribal criminal investigators."*
- *"The drug task force was really going strong and then it just lapsed. If there is a drug case. I will call the feds not the local police here."*

As displayed in Table 17, the main themes, in order of significance, from the question, *what are the specific challenges to jurisdictional issues for methamphetamine use and child abuse that currently exist in your community*, are as follows: 1) Many participants indicated they were not aware of any specific jurisdictional challenges; 2) Unenrolled Natives & non-Natives presented the greatest jurisdictional challenges; and 3) Structural gaps (no local jails, problems with highway patrol, offenders who work gaps within the tribal/state/federal system, no meth specific codes or statutes).

Table 17 - *Participant Responses from Question #17a*

Response	*n*	*%*
Unenrolled members	2	8.1
Inmates worked the system given tribal/federal/state laws	2	5.4
Non-Indians committing crimes	2	5.4
Interracial marriages with child abuse cases	2	5.4
Few laws dealing with meth	2	5.4

Selected Quotes

- *"With unenrolled offenders and non-Native offenders that are cooking meth."*
- *"There are very few laws dealing with meth here."*
- *"Big problem when it comes to a non-Indian committing the crime in Indian country."*

As displayed in Table 18, the main themes, in order of significance, from the question, *what is your greatest concern about methamphetamine use in your community,* are as follows: 1) Greatest concern for most participants were the impacts to people (newborns, children, adolescents, elders, and other tribal members); 2) Many participants were troubled by the impact meth was having on moms who were using, their babies and other children; 3) Many participants were deeply troubled by the implications that meth posed for their tribe, their tribes' future and the long term impacts from the drug; 4) Some participants were disturbed by the lack of system response and indicated that their communities needed critical assistance.

Table 18 - *Participant Responses from Question #18*

Response	*n*	*%*
Violence (DV, guns, severity of assaults, gangs)	12	32.4
Impact on children (grandchildren)	9	24.3
Worried about our future/long term damage	6	16.2
It's destroying tribes (affects everyone)	5	13.5
Abuse of children (DEC)	5	13.5
Needs (education, coordination, LE, foster parents, help)	5	13.5
Who will teach our youth their culture and tradition	4	10.8
Impact on families (destroying them)	4	10.8
This is the tip of the meth iceberg (increased use)	2	5.4
Abuse of elders	2	5.4
Trauma and deaths	2	5.4
No matter what we do drugs/sellers just relocate	2	5.4
No treatment no support	2	5.4
Meth impacted babies	2	5.4

Selected Quotes

- *"Those children and the cultural damage. When I work with kids, they don't know our stories, they don't have Indian names, and they don't know their clan. It has wiped out our culture."*
- *"Our people are getting more violent and the community is deteriorating. The kids are at risk trying to make it safe for the younger ones."*

- *"Long term effects on our children, families and the environment. People say there is something in the air, I say that something is meth. It is in our air, water, soil, and in our children. In the fish houses this winter they were cooking meth and dumping it in our water."*

- *"Child abuse and neglect, elderly abuse and neglect."*

- *It has escalated the level of violence and the level of how bad someone is beaten or injured has gone up significantly. Someone on meth just doesn't stop."*

As displayed in Table 19, the main themes, in order of significance, from the question, *are there any other ways in which children and adolescents in your community are being impacted by methamphetamine use that we haven't discussed,* are as follows: 1) Most participants indicated that children were being exposed to increased violence (e.g., child sexual abuse, sexual assault, DV, neglect, deaths, gangs, overdoses); 2) Increases in attempts and completed suicides that participants perceived to be meth related; 3) Methamphetamine impacted births; 4) Exposure to methamphetamines in the home (asthma, DEC); 5) Children being left with grandparents or within the system; and 6) The use of meth by children and adolescents.

Table 19 - *Participant Responses from Question #19*

Response	*n*	*%*
Suicide	10	27.0
Meth impacted births (long term effects)	9	24.3
Exposure to chemicals/DEC	7	18.9
Increased child abuse and neglect cases	5	13.5
Parents are exposing kids to meth	4	10.8
Meth has greater impact on kids than alcohol	3	8.1
Overdose	2	5.4
Sexual assault/child sexual abuse	2	5.4
Kids placed out-of-home or with kin	2	5.4

Selected Quotes

- *"People 15-21 years old are exposed to chemicals and suicide. Meth has impacted suicides and been a factor in suicides here and in sexual assaults because meth lowers the inhibitions of the meth user and they simply take what they want. If the victim and the aggressor do meth together sexual assault happens more."*

- *"Children accepting and living with parents with meth addictions."*

- *"I don't understand how women can't see whatever they ingest is going to the baby. I would rather see these women treatment and not incarcerate them. . . I would figure out a way to help the mother and I don't see anyone doing anything for them."*

As displayed in Table 20, the main themes, in order of significance, from the question, *are there any other comments you would like to make regarding methamphetamine use in your community,* are as follows: 1) Need for local treatment programs for meth users; 2) More education and prevention programs for mothers and adolescents; 3) Better coordination and funding for social services and law enforcement agencies; and 4) Fear that meth abuse will exacerbate existing tribal challenges.

Table 20 - *Participant Responses from Question #20*

Response	*n*	*%*
Need local treatment for meth	6	16.2
More education/prevention for mothers/young people	4	10.8
Fear that meth will magnify challenging tribal issues 3	8.1	
Inadequate LE (no federal coordination)	3	8.1
Long term training (awareness)	3	8.1
Positive family involvement	2	5.4
Funding (beyond government grants)	2	5.4
Coordination with SS & LE	2	5.4
Make Tribal Code changes	2	5.4
Impact on kids is serious (young children especially)	2	5.4
Reservations are targeted for meth use and sales	2	5.4
Drug dogs make a difference	2	5.4
Empower people	2	5.4

Discussion

The following discussion summarizes the findings from the survey while laying the foundation for future theoretical and applied research regarding methamphetamine use and child abuse in tribal communities. The conclusions and implications should be interpreted in light of the methodological limitations of the survey.

Conclusions

Overall, there appears to be a significant problem with meth use in the tribal communities that participated in this study with serious implications for children, women, families, and systems. Specifically, participants reported great awareness of meth use and some awareness of meth production and distribution. Some community members and professionals know of meth use from the involvement of their own family members or friends. These professionals also acknowledged that children have knowledge of the drug from living in homes in which meth is being used, and that elders are aware from taking care of grandchildren as a result of their own children's meth use. In addition, local drug busts and news coverage have informed the general tribal population about this problem. Thus, it appears that many people within tribal communities are talking about the prevalence and impact of meth.

Professionals working in tribal communities believe that meth has become more widespread because it is easy to obtain (easier to get than alcohol) and inexpensive. Furthermore, poverty related factors (unemployment and the potential for income from selling), and prior substance abuse addictions (depression, self medication) were identified as contributing factors to the increase in meth use in the tribal communities involved in this study.

Survey respondents reported increases in the incidence of child abuse and neglect, as well as domestic violence and sexual assault. Furthermore, participants reported strong awareness of increases in child abuse allegations and out-of-home placements that involved a meth investigation. Although the three communities differed slightly on views toward barriers to permanency, respondents were very aware of meth involvement increasing the difficulty of family reunification. Other reported impacts of meth on

tribal children were attempted/completed suicides, birth defects, and exposure to chemicals from home environments.

Additionally, participants reported awareness of increases in the workload of law enforcement, social services, child protection, and other agencies in tribal communities as a result of meth. Specifically, new challenges for social services investigations, training, and funding were identified. As for the law enforcement system, participants identified the need for more training, increased funding, protocol development, tribal code provisions, increased reporting, adequate responses for adolescents, and sufficient infrastructure to sustain an appropriate criminal justice response (e.g., personnel, jails, shelter for children, drug courts).

There was some indication that training is available for child welfare professionals and that agencies are working together to address meth use. However, there was almost no awareness of treatment programs for meth users or for resources and services available to children exposed to meth. If there was local drug treatment, it was most likely an outpatient program with a primarily educational focus. If local treatment programs offer more services for meth users and their children, community members were not aware of those services.

Several participants indicated that there has been some coordination between tribal and federal agencies regarding meth. However, other participants reported that there has actually been a decrease in tribal and federal agencies working together as a result of jurisdictional challenges (involvement of non-Natives) and lack of dedicated law enforcement to investigate meth related cases.

Overall, participants were most concerned with the long term impact that meth might have on their community and particularly on their children. This fear is illustrated by the following survey response: *"On our main street here right here at 8:00 in the morning I see kids under 3 they are out on the street. And when I come home at the end of the day I see those same kids out there with the same clothes on and the same diaper that is now drooping down."* As articulated by the participants, there is a pervasive feeling that tribal communities are overloaded and in need of critical assistance before it is too

late. The traditional tribal kinship system may not be equipped to deal with the challenges that meth has brought, and thus, these communities are sending out an urgent call for help.

Limitations

The qualitative and quantitative results should be interpreted in light of several limitations in the survey methodology. Most notably, this is a small sample size and some participants did not have enough awareness of the meth problem in tribal communities to accurately answer all of the questions. For example, some respondents were unable to provide precise estimates of the prevalence or increases in meth use, production, and distribution. Thus, there was a relatively small sample size for several of the questions that required this information. In addition, not all agency types were represented for each of the tribal communities. Furthermore, there were insufficient numbers of participants from each agency type to allow for subgroup analyses. Lastly, the survey was administered by telephone, but a few participants (although initially contacted via telephone) completed the survey by mail, which might have influenced their response set.

Implications

There are numerous implications from the results of this survey. First, new treatment programs for meth users and additional resources and services for children exposed to meth should be made available in tribal communities. Second, additional funding and personnel support for law enforcement, social services, judicial, and educational agencies is critically needed to allow these agencies to effectively address the meth problem and the resultant increase perceived by participants in violence, drug impacted babies, suicides, domestic violence, and child abuse in tribal communities. Third, barriers to reunification and agency collaboration should be addressed through legislation and implementation of best practices in this area. Finally, additional research on this topic should be conducted to provide a more accurate and detailed picture of the relationship between meth and child abuse in tribal communities.

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Appendix A

Telephone Survey on Methamphetamine Use and the Incidence of Child Abuse in Tribal Communities

Agency: _____

Tribe: _____

1. Are you aware of any methamphetamine use in your community?

Yes _____ No _____ Not Sure _____

1a. If yes, how did you learn of the methamphetamine use in your community?

_____

_____

2. Are other community members aware of any methamphetamine use in your community (e.g., tribal leaders)?

Yes _____ No _____ Not Sure _____

2a. If yes, how do others learn of the methamphetamine use in your community?

_____

_____

3. What do you believe are the most common reasons for methamphetamine use in your community?

_____

_____

4. Are you aware of an increase in the arrests for the manufacturing of methamphetamines in your community?

Yes _____ No _____ Not Sure _____

4a. If yes, can you provide an estimate of this increase during the last year _____ and over the past three years _____ (Select one of the following percentage ranges)

0-20% 21-40% 41-60% 61-80% 81-100%

5. Are you aware of an increase in arrests for the distribution or sale of methamphetamines in your community?

Yes _____ No _____ Not Sure _____

5a. If yes, can you provide an estimate of this increase during the last year _____ and over the past three years _____ (Select one of the following percentage ranges)

0-20% 21-40% 41-60% 61-80% 81-100%

6. Are you aware of an increase in the following crimes because of methamphetamine use in your community?

Child physical abuse	Yes _____	No _____	Not Sure _____
Child sexual abuse	Yes _____	No _____	Not Sure _____
Child neglect	Yes _____	No _____	Not Sure _____
Domestic violence	Yes _____	No _____	Not Sure _____
Sexual assault	Yes _____	No _____	Not Sure _____
Homicide	Yes _____	No _____	Not Sure _____
Theft	Yes _____	No _____	Not Sure _____

7. Are you aware of an increase in child abuse allegations in your community that also have involved a methamphetamine investigation?

Yes _____ No _____ Not Sure _____

7a. If yes, can you provide an estimate of this increase during the last year _____ and over the past three years _____ (Select one of the following percentage ranges)

0-20% 21-40% 41-60% 61-80% 81-100%

8. Are you aware of an increase in out-of-home placements of children due to the use, manufacturing, and/or distribution of methamphetamines?

Yes _____ No _____ Not Sure _____

8a. If yes, can you provide an estimate of this increase during the last year _____ and over the past three years _____ (Select one of the following percentage ranges)

0-20% 21-40% 41-60% 61-80% 81-100%

8b. If no, do you think that children are being left in homes in which methamphetamine use, manufacturing, and/or distribution is taking place? Why?

_____

_____

9. Are you aware of methamphetamine involvement increasing the difficulty of family reunification?

Yes _____ No _____ Not Sure _____

9a. If yes, which of the following are the most likely reasons for this?

____ There are more families that cannot be reunited
____ It takes longer to reunify families
____ Family reunification does not last
____ Severity of child abuse has prevented reunification

____ Permanent placements are often made with other family members
____ Severity of parents' methamphetamine involvement prevents reunification
____ Other: _____

10. Are you aware if the use of methamphetamines in your community has increased the workload of the following entities?

Law Enforcement	Yes _____	No _____	Not Sure _____
Social Services	Yes _____	No _____	Not Sure _____
Indian Health Service	Yes _____	No _____	Not Sure _____
Tribal Court	Yes _____	No _____	Not Sure _____
HUD Housing	Yes _____	No _____	Not Sure _____
Head Start	Yes _____	No _____	Not Sure _____
Behavioral Health	Yes _____	No _____	Not Sure _____
Substance Abuse	Yes _____	No _____	Not Sure _____
Child Protection	Yes _____	No _____	Not Sure _____
Tribal Prosecutor	Yes _____	No _____	Not Sure _____
Victim Advocates	Yes _____	No _____	Not Sure _____
Domestic Violence	Yes _____	No _____	Not Sure _____

11. Are you aware if additional training is being provided for child welfare professionals who work with children exposed to methamphetamine use in your community?

Yes _____ No _____ Not Sure _____

11a. If yes, please indicate what type of training is being provided:

_____

_____

12. Are you aware of any treatment programs for methamphetamine users in your community?

Yes _____ No _____ Not Sure _____

12a. If yes, please indicate what type of treatment is being provided:

_____

_____

13. Are you aware of any resources and/or services available for children who have been living in homes where methamphetamine is being used, manufactured, and or sold?

Yes _____ No _____ Not Sure _____

13a. If yes, please indicate what type of resources and/or services are available:

_____

_____

14. What aspects (if any) of the current child protective services system regarding methamphetamine use and child abuse are in need of change? (Prompt for protocols, reporting, treatment, training, funding etc.)

15. What aspects (if any) of the current law enforcement system and/or juvenile justice system regarding methamphetamine use and child abuse are in need of change? (Prompt protocols, for tribal codes, court ordered treatment etc., coordination with state task forces, training, funding)

16. Are you aware if federal, tribal, and state agencies are working together to address methamphetamine issues in your community?

Yes _____ No _____ Not Sure _____

16a. If yes, please indicate which agencies are collaborating on this issue and how they are working together:

17. Are you aware if any challenges to jurisdictional issues for methamphetamine use and child abuse currently exist in your community?

Yes _____ No _____ Not Sure _____

17a. If yes, please indicate the specific challenges:

18. What is your greatest concern about methamphetamine use in your community?

19. Are there any other ways in which children and adolescents in your community are being impacted by methamphetamine use that we haven't discussed? (Prompt for physical abuse, neglect, child sexual abuse, births, violence, accidental ingestion, exposure to chemicals, overdose, suicide etc.).

20. Are there any other comments you would like to make regarding methamphetamine use and child abuse in your community?

_____

_____

Note: *This survey was adapted from the 2005 National Association of Counties Survey.*

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