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Taking Control of Methamphetamine in Our Communities: An Opportunity of Necessity

H. Westley Clark, MD, JD, MPH, CAS, FASAM, Director, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, Rockville, Maryland

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes that the production and consumption of methamphetamine takes a severe toll on all Americans. However, the affect on American Indians and Alaska Natives (AI/AN) is particularly severe. Thus, it is essential that we continue our partnership with AI/AN communities in an effort to contain and neutralize the impact that methamphetamine use has in Indian Country.

In our effort to address methamphetamine use in Indian Country, SAMHSA partners with Indian Health Service (IHS) as well as other Agencies and Departments within the Federal government. We are an active member of the Office of National Drug Control Policy's Executive Tribal Law Enforcement Workgroup, which includes representatives from the IHS, Department of Justice, Department of Interior, Environmental Protection Agency, Federal Bureau of Investigation, Tribal Law Enforcement, and the Drug Enforcement Agency. The goal of this work group is to address methamphetamine use and production in Indian Country and to help educate AI/AN communities about methamphetamine. We also partner with the National Institute on Drug Abuse in an effort to foster appropriate treatment strategies, and with the Centers for Disease Control and Prevention to address the infectious disease aspects of methamphetamine use and abuse.

Methamphetamine use and abuse has created an opportunity of necessity. Small laboratories are on the decline in many areas, but they still remain a problem. In addition to laboratories, law enforcement agents recognize the need to address the problem of across-the-border smuggling and drug dealing.

While there are no magic solutions to the problem of methamphetamine use and abuse, there is the realization that the health of the AI/AN communities rests on the wisdom of those communities to work together within and outside of Indian Country with people of good will committed to the well-being of these communities. With this partnership, progress can be made and will be made.

Methamphetamine Abuse in Indian Country

Lori De Ravello, MPH, CDC Assignee to the National STD Program, volunteered to coordinate two special issues of *The IHS Provider* dedicated to the problem of methamphetamine abuse in Indian Country. The first issue, a series of articles *defining the problem, appeared in the December 2006 issue*. This issue is devoted to *working together on solutions*. Due to the enthusiastic response of the many authors who volunteered for this project, we have several additional articles that will be published this spring. We wish to recognize Ms. De Ravello's initiative and hard work that made this project possible.

In this Issue…

Strength Through Unity: The IHS/SAMHSA Methamphetamine Initiative

Wilbur Woodis, Division of Behavioral Health, Indian Health Service, Rockville, Maryland

In spring 2005, IHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) formed the IHS/SAMHSA Methamphetamine Initiative Workgroup. The goal of the workgroup is to help coordinate, collect, analyze, and report information concerning methamphetamine use in Indian Country to a variety of interested parties, including legislators, policy makers, program managers, and persons active in prevention and treatment.

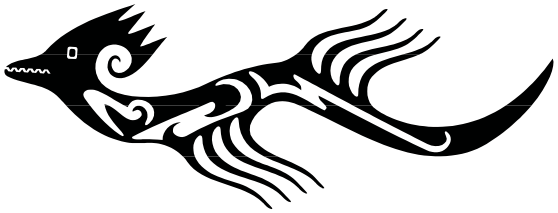
The workgroup has monthly information-sharing calls hosted by the IHS Division of Behavioral Health. Some early methamphetamine-related efforts recognized by the workgroup include:

- SAMHSA Center for Substance Abuse Prevention (CSAP) supported the Pascua Yaqui Tribe to collaborate with the University of Arizona to address substance abuse prevention, focusing on inhalants, methamphetamine, and alcohol abuse.
- The Cherokee Nation formed a Multi-Disciplinary Task Force to address methamphetamine prevention as well as rehabilitation and education.
- SAMHSA made a three-year Target Capacity Expansion grant to the Choctaw Nation to treat methamphetamine-using women with children.
- The SAMHSA-funded Methamphetamine Treatment Project has provided the Billings Area with technical assistance since 1998, when methamphetamine first became a crisis on some of the Area reservations.
- The Matrix Institute trained I/T/U providers on the Ft. Peck and Blackfeet reservations and in Great Falls and Billings in the Matrix model of cognitive behavioral treatment for stimulant use disorders.
- The Phoenix Area developed an Intensive Outpatient Alcohol and Drug Treatment Manual that provides a step-by-step treatment curriculum for methamphetamine addicts with an accompanying Clinician's Guide to Methamphetamine.
- The Phoenix Area is conducting assessments to determine community-level stage of readiness to deal with methamphetamines and to develop strategic plans to address the problem.
- The Navajo Area produced the film, Methamphetamine on the Navajo Reservation "G" and recently the Navajo Nation Council passed legislation prohibiting the manufacturing, distribution, sales, possession, and use of methamphetamines.

Another activity of the workgroup was to develop a plan to address problems caused by methamphetamine abuse, including aspects related to primary care, mental health, emergency departments, addictions treatment, environmental health, health education, and law enforcement. Some components are underway, while others currently lack resources to implement. As the workgroup continued to meet via conference calls, it began to identify local, regional, and national experts who could provide technical assistance at meetings, conferences, and summits. The workgroup assisted the National Native American Law Enforcement Association (NNALEA) to coordinate the methamphetamine training track at its annual conference in November 2006 and is assisting with the planning of an Aberdeen Area Methamphetamine Summit, scheduled to take place in Fargo, North Dakota in spring 2007.

The workgroup supports the ideals of the HHS "Indian Country Methamphetamine Initiative," many of which were identified through a series of tribal roundtables in 2006. One outcome of the tribal roundtables was a comprehensive plan to address methamphetamine abuse issues across Indian Country. Tribal officials identified many areas of need and concern, including domestic violence, the environmental impact of manufacturing methamphetamine, suicide, increased risk for sexually transmitted diseases, the burden on law enforcement and courts, and drug endangered children.

For information on the IHS/SAMHSA Methamphetamine Initiative Workgroup, visit our website at: *http://www.ihs.gov/MedicalPrograms/Behavioral/index.cfm?module=BH&option=Meth*.



Using the "5 A's" to Address Methamphetamine Use in the Primary Care Setting

Kathleen Masis MD, CAPT, USPHS (ret), Billings, Montana

Methamphetamine (meth) abuse and dependence, and related behaviors (e.g., injection drug use, interpersonal violence, child abuse and neglect, self-destructive behaviors) in our service populations are creating a public health dilemma for many Indian Health Service/Tribal/Urban primary care clinics. What are evidence-based strategies to address prevention and intervention in our practices?

Other articles in this series on methamphetamine have demonstrated the prevalence of problems from its use among American Indians and Alaska Natives. This article will present a rationale and method for delivering preventive services to a targeted population at risk.

The U.S. Preventive Services Task Force and the American Academy of Family Physicians have issued evidence-based recommendations on the level of intervention indicated for risk behaviors, including tobacco abuse, sedentary lifestyle, unhealthy diet, and alcohol abuse. There is insufficient evidence to recommend for or against screening for illicit drug use, other than alcohol and tobacco, among adolescent patients.[1] The same holds for "screening" adults.

Longitudinal studies have shown that substance abuse treatment results in reduced use of drugs and costs to society.[2] As primary care providers, our role is to assist our patients to move towards positive behavior change. Unfortunately, methamphetamine users often demonstrate "more than the usual denial."[3]

A model recommended for intervention with tobacco users who are willing to quit is the "5 A's."[4] The "5 A's," which are applied in order, are Ask, Advise, Assess, Assist, and Arrange. Appropriate types of visits to initiate the Five A's for methamphetamine use might be Prenatal, Well Woman, New Patient, Adolescent, Behavioral Health (anxiety, depression, insomnia, chronic pain,) STD testing and treatment, Dental, and visits by incarcerated patients.

Ask: Ask If The Patient Is Using

The task is to identify patients currently using methamphetamine.

> *Provider:* "I can see that your rash is bothering you a lot. In order to help you, I need to ask some other questions about your health. (Do a targeted ROS.) Are you taking any medications? When was your last alcohol use? Methamphetamine, "crystal" or (local terminology)? How do you use it, smoking, or injecting?"

We are familiar with the distinctive and/or common indicators of chronic methamphetamine use: missing teeth, dermatitis around the mouth; muscle cramping with dehydration and abnormal electrolytes, rhabdomyolysis; anorexia and extreme weight loss; pulmonary, cardiovascular, and cerebrovascular disorders, including cognitive deficits; hypertensive crisis; choreoathetosis; and psychiatric and behavioral disorders such as insomnia, paranoia, anxiety, perceptual disturbances (such as bugs under the skin,) delusions and hallucinations, depression, and risk of suicide.[5]

Primary care practicioners are starting to recognize that many methamphetamine users are seen in primary care settings at an earlier stage before these manifestations are apparent. Brief interventions may be more effective at this stage.

Strategies include the following:

- The manner and attitude of the professional doing the asking is as important (even more important) than the specific question(s) or "tool" that is used. A non-judgmental attitude is crucial.
- For patients who are at risk, but deny the behavior, the least intrusive intervention would be indicated; that is general information that targets all community members. The objective is not to "close the door" between the health care provider and the patient.

> *Example:* If the patient denies meth use: "A lot of our patients are using meth. I've seen lots of health problems such as itching and rashes, caused by meth, and so I tell all my patients about quitting meth."

Advise: Give Clear, Strong, and Personalized Behavior Change Advice, Including Information about Personal Health Harms of Meth and Benefits to Quitting

It is important to personalize your advice by including specifics of the patient's health concerns, including past experiences, family, or social situations. "Education is often the first phase of treatment."[3] Provide feedback to the patient on the information you collected in the first step. For example:

> *Provider:* "You told me that you have used meth for a year, and injected meth only one time, which was last week. You have never shared needles with anyone else . . .. You

have symptoms of anxiety and depression, which are affecting your work and family life . . ..

"I am concerned about your risks for STD, HIV, and worsening mental state if you continue to use . . ..

"As your health care provider, I can tell you that the most important thing you can do for your mental and physical health is to stop using meth and to stop using it now . . ..

"Because a lack of awareness or even memory of what a person does while they are high on meth is common, and they end up sharing a dirty needle or having unprotected sex . . .

"Our clinic is interested in helping people get off meth. We have several ways to help."

Often even a positive drug screen result does not result in admission of use by the patient. Nevertheless, the core message to convey to the patient is: meth is dangerous to your health, it is possible to stop, and your family doctor can help. In fact, "he or she can be your biggest ally."[6]

Assess: Determine Willingness to Make a Quit Attempt

For example:

Provider: "Are you interested in quitting meth?"

Patient: "I've been depressed for as long as I can remember. When I tried meth, I felt normal for the first time. But I have to have clean urines to get custody of my kids back."

Assist: Assist the Patient in Quitting

The assistance we provide should be tailored to the patient's perceived needs. Returning to our patient example, above (a composite of actual patient visits):

Provider: "You want to get your depression under control, and to get custody of your kids . . . I am willing to work with you on both depression and meth issues. I suggest we start by assessing both problems and coming up with a plan for each."

The health care provider may be more helpful and credible if he/she can describe the common course of withdrawal from meth, (See Table 1) and provide the patient with strategies to deal with them in health-promoting ways (See Table 2). Medical detoxification is seldom needed; but monitoring by a supportive friend, family member, or non-medical detox program is warranted: suicide is the most lethal complication.

It is important to have direct knowledge of community resources when making a referral. Encourage the patient to enlist support from non-using family and friends. No

Table 1. Course of Methamphetamine Withdrawal

1, 2, and 3 are common	
1. Early crash	Dysphoria, agitation, craving. Onset 12-24 hrs after last use. "Tweaking" can appear now and/or later, and includes irritability, jittery state, quivery speech, brisk, jerky movements. Thinking seems scattered, subject to paranoid delusions, aggression.
2. Middle crash	Protracted sleep, 24-36 hrs. Fatigue, depression, anhedonia Decreased mental and physical activity. Desire for sleep, with insomnia (users commonly take alcohol, benzos, opiates to deal with these symptoms).
3. Late crash	Awake and hungry
4. Protracted Fatigue *less common*	Symptoms opposite to meth intoxication. Withdrawal, loss of physical and mental energy. Depression, anhedonia, limited interest in surroundings. May increase in intensity over 12-96 hours following crash, or wax and wane over several weeks. Severe, persistent depression can result in suicidal behavior. Anhedonia and dysphoria last 6-18 weeks. Periods of intense drug craving, "triggers."

Source: CSAT, 1999 TIP #33

Table 2. Strategies for Quitting Methamphetamines

Some problems to expect:	**What to do about it:**
1. Mood is low; depression	Exercise Cultural/spiritual activities Fun (clean and sober friendships) Good nutrition Counseling Mental health assessment
In case of suicidal thoughts/acts	*911; emergency room if needed*
2. Memory loss	Reminders of appointments Visual (signs) or picture reminders
3. Poor judgment	Addictions treatment AA/NA
4. Drug craving	Learn how to avoid triggers Stay away from drug-using friends Schedule clean and sober activities

medication has been developed to block the effects of methamphetamine. However, there are options to consider at different stages of treatment. Antipsychotics are used for hallucinations in the immediate withdrawal period, and when they persist. Antidepressants have not been shown to be useful during withdrawal, but may reduce prolonged depression.[3]

Insomnia, anxiety, and pruritis can be treated symptomatically. Drug diversion is an issue that limits the choices and amounts of outpatient pharmacotherapy. Immunizations should be offered/updated.

Arrange: Arrange Follow-up

A follow-up visit was arranged for one week later.

Patient: "I had an assessment over at (Substance Abuse Program.) I was supposed to start IOP (Intensive

Outpatient Treatment) but I kept missing my appointments…."

Provider: "It sounds like you've already taken some steps in the right direction. So, when was your last use . . . ?"

Follow up visits address patient success, identify problems encountered, and offer encouragement. Consider referral to more intensive treatment if needed. The primary care provider can offer continuity of care. Many methamphetamine users have unrecognized health problems. Depression, STDs, Hepatitis C, and HIV should be considered.

Drug addiction is a chronic condition, with similar relapse rates as type 2 diabetes, hypertension, and asthma.[7] As in tobacco cessation, knowledge of what to expect and methods to address the relapse factors aid the former user in recovery.

For patients unwilling to quit, and for those who relapse, motivational interventions are indicated. The provider should remain empathic, avoid arguing, and promote patient autonomy and self-efficacy.[4]

This description of the use of clinical intervention strategies with the methamphetamine user in a primary care setting should not minimize the difficulties involved in addressing this destructive addiction. The objective is for primary care providers to realize that we can apply the tools we already use for other risk behaviors, knowing that there is evidence for the benefit of brief interventions. One primary care medicine author stated, "Until we know more about which brief interventions are effective in patients with drug use problems, extrapolating findings from studies of brief interventions with problem drinkers is reasonable."[8]

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Online Methamphetamine Resources

Lori de Ravello, MPH, CDC Assignee to the IHS National STD Program, Albuquerque, New Mexico

Prevention Programs

Project Venture; National Indian Youth Leadership Project: *http://niylp.org/programs/project_venture*

Environmental Health Issues

Drug Lab Clean Up Program: *http://www.oregon.gov/DHS/ph/druglab/index.shtml*

MN DOH Meth Lab Clean Up: *http://www.health.state.mn.us/divs/eh/meth/lab/labcleanup.html*

OK Guidelines for Cleaning Up Former Meth Labs: *http://www.deq.state.ok.us/LPDnew/MethLabs/meth.htm*

WA State Dept of Health Clandestine Drug Lab Program: *http://www.doh.wa.gov/ehp/ts/CDL/default.htm*

WY DOH Cleaning Up Hazardous Chemicals at Meth Labs: *http://wdh.state.wy.us/epiid/methcleanup.asp*

Campaigns

End Meth Campaign — Partnership for a Drug Free America: *http://www.drugfree.org/endmeth*

Just Think Twice/Got Meth Campaign — Drug Enforcement Agency: *http://www.justthinktwice.com/gotmeth/home.html*

Meth Awareness Project: *http://www.methawarenessproject.org/*

Mothers Against Methamphetamine: *http://www.mamasite.net/*

Local Meth Efforts

Drug Free Northwest Arkansas: *http://www.drugfreenwa.com/*

Methamphetamine Awareness Project — Community Partnership of the Ozarks, Springfield, MO: *http://www.nometh.org/*

Meth Awareness and Prevention Project of South Dakota: *http://www.mappsd.org/*

Meth Education and Drug Awareness — Wright Co., MN: *http://www.meada.org/*

Meth Free Montana: *http://www.methfreemt.org/*

Methamphetamine Strike Force — County of San Diego: *http://www.no2meth.org/*

Rural Meth Education Project — Minot State University, Minot, ND: *http://www.minotstateu.edu/rcjc/project_rmep.shtml*

Stop Drugs — California Attorney General's Office: *http://www.stopdrugs.org/*

Drug Courts

Defining Drug Courts — Bureau of Justice Assistance: *http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf*

Tribal Wellness to Healing Courts – Bureau of Justice Assistance: *http://www.ncjrs.gov/pdffiles1/bja/188154.pdf*

Substance Abuse Treatment

Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders – SAMHSA: *https://store.health.org/catalog/productDetails.aspx?ProductID=17441*

The Matrix Institute on Addictions: *http://www.matrixinstitute.org/index.html*

The Methamphetamine Treatment Project - UCLA - Integrated Substance Abuse Programs (ISAP) and The Matrix Institute: *http://www.methamphetamine.org/*

Treatment for Stimulant Use Disorders – SAMHSA: *http://ncadi.samhsa.gov/govpubs/bkd289/*

Other Resources

Community Crisis: Public Health's Role in the Methamphetamine Epidemic "Partnering to Confront the Issue" (archived webcast): *http://www.mchcom.com/archivedWebcastDetailNewInterface.asp?aeid=400*

Meth on the Rez – NDN News: *http://www.ndnnews.com/Meth%20on%20the%20Rez.htm*

Methamphetamine Tools and Resources – Tribal Resource Center: *http://www.tribalresourcecenter.org/legal/details.asp?83*

National Congress of American Indians Meth Initiative: *http://www.ncai.org/Meth_in_Indian_Country_Initiat.192.0.html*

Healing to Wellness Courts: Best Practice for Indian Country

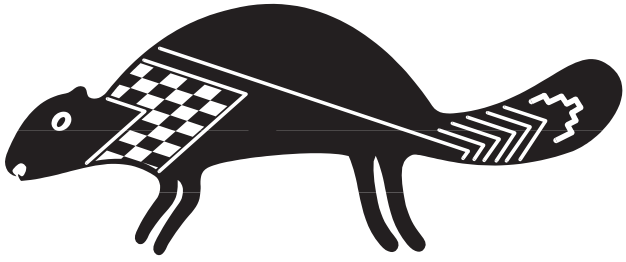
Honorable Amy Lovell, Pueblo of Zia Chief Judge; President and CEO, Lovell, Perales and Associates, Inc., Albuquerque, New Mexico

Healing to Wellness Courts evolved out of the Drug Court Movement from the 1980s, which was a response to the judicial and treatment systems' failure to effectively address substance abuse and its related activity. It was realized that the only way to combat the overwhelming issues of drug abuse, dependency, and addiction would be to create a marriage between the two systems intertwined with support from ancillary entities. States call their efforts Drug Courts, whereas tribes prefer Healing to Wellness Courts. Just as the name implies, a Healing to Wellness Court focuses on wellness through healing: healing of individuals, healing of families, healing of communities.

By combining indigenous forms of knowledge with modern techniques and evidence-based practices, Healing to Wellness Court teams have successfully paved pathways to recovery for substance abusing offenders and their families while also improving service delivery and achieving maximum use of limited resources. Criminal justice systems have not been effective in their punitive approaches, and most treatment systems have not been successful in keeping clients engaged long enough to effectively treat what ails them. Healing to Wellness Courts require a seamless integration between judicial and treatment systems, providing the necessary legal pressure on offenders to keep them in treatment for an adequate period of time. Results have been rather successful in holding substance abusing offenders accountable, providing them with a support network that encourages recovery through appropriate incentives and sanctions, and giving them the tools to recognize their own strengths, including resiliency to make better decisions providing for rehabilitation and reducing recidivism. In short, a Healing to Wellness Court that is effectively planned and implemented mandates culturally competent policies, procedures, and processes that make the most of traditional, holistic approaches to promote restorative justice practices resulting in healthier members, stronger families, and wealthier communities.

As tribes exercise their sovereignty, they increasingly utilize their own respective traditions, culture, and customs to do so. While their efforts to heal their communities may vary accordingly, they are becoming successful beyond measure. Similarly, no two Healing to Wellness Courts look alike, nor should they be expected to. Each community is afforded the opportunity to empower their service providers and those served through traditional means such as talking circles, peace keeping courts, and other holistic approaches that nurture and heal the spirit, body, and mind, with the focus of each court varying as well. Originally, target populations for Healing to Wellness Courts were adult offenders, juvenile offenders, or family dependency and permanency planning. Today, they have evolved as special problem solving courts for identified challenges like methamphetamine courts, DUI courts, domestic violence courts, and grade courts to name a few. This concept works well for indigenous communities, regardless of the type of court system — tribal, contemporary, or combination — because it provides for integrated treatment systems of care that address substance abuse, mental health, medical screenings and treatment, employment, housing, academics, and other family issues such as child care and transportation. Most of our clients present with a multitude of problems that only a team approach can address with the participant and his/her family or significant others without overwhelming them. Team members vary according to tribal infrastructure and resources.

It is important that identification of all stakeholders, community strengths, assets, and resources occur. Inevitably, as tribal teams begin the planning stages, one of the first challenges noted is lack of funding. This is nothing new. Historically, tribal communities have been under-funded in every social discipline, including behavioral health, law enforcement, and judicial services among others.[1] By uniting all stakeholders, a shared vision and mission can be created and a plan of how each stakeholder can contribute and what role he/she will have in moving towards attainment of the goals and objectives defined by the vision and mission statements can be



executed. In doing so, existing funding streams are examined, restructured, and re-deployed, ensuring that those resources are maximized and gaps in service minimized. Planning and implementing in this manner provides a greater opportunity for sustainability of the Healing to Wellness Court program.

Historically, each system within tribal communities has operated autonomously. In doing so, we have often delegated the responsibility of healing to any one person or agency, and more often than not, *outside* of our communities. This activity has proven, time and time again, to be one of the most costly and detrimental acts that we have done as indigenous people, and social ills have continuously escalated over the past three decades and claimed so many lives of our relatives. Yet, we continue to do things in the same manner over and over, expecting different results. Healing to Wellness Courts mandate a team approach that requires training across disciplines. This breaks down barriers, such as lack of communication, territorialism, and professional jealousy, and promotes nothing short of professional respect and courtesy.

Healing is a journey, and participants are made aware that the team is not going to "heal" them, but rather assist them to become directors of their own healing. Because the journey is long, it is traveled in phases. Phase one usually focuses on detoxing, while phases two through four are stabilization, maintenance, and relapse prevention, respectively. Each phase brings about more responsibility for healing on the participant and his/her family, with decreasing need for judicial supervision. Treatment embodies the following principles, as identified by the National Institute of Drug Addiction:

1. No single treatment is appropriate for all.
2. Treatment needs to be readily available.
3. Effective treatment attends to the multiple needs of the individual.
4. Treatment plans must be assessed and modified continually to meet changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling and other behavioral therapies are critical components of effective treatment.
7. Medications are an important element of treatment for many patients.
8. Co-existing disorders should be treated in an integrated way.
9. Medical detox is only the first stage of treatment.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should assess for STDs, HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and help clients modify at-risk behaviors.
13. Recovery can be a long-term process and frequently requires multiple episodes of treatment.

Teams are required to continuously monitor, update, and implement individualized treatment plans that are relevant to clients and their needs. Completion of Healing to Wellness Court programs creates productive and healthy individuals who demonstrate good citizenry. And, since the wealth of a community should be calculated by the health of its members, the concept of healing needs to continue to be in the forefront of our financial portfolios.

As Indian people, we proudly boast that we have preserved our culture, our tradition, and our customs, and that we have survived acts of genocide aimed to desecrate the Indian race. Healing to Wellness Courts provide a road that is paved with indigenous forms of knowledge, guided by compassionate people, to be traversed by our relatives who are seeking a better way of life: a road that detours each of us from suffering silently with a feeling of despair and helplessness knowing that higher rates of alcoholism, addiction, and suicide plague our people and a road that has a light of hope shining brightly at the end of the tunnel. It suffices to say that Healing to Wellness Courts have evolved to become a mainstay for many tribal justice systems and a best practice for Indian Country.

Reference

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Healing from Methamphetamine: Community Efforts, Recovery, and Healing in American Indian and Alaska Native Communities

Don Coyhis, President and Founder, White Bison, Inc., and Richard Simonelli, Communication and Media Specialist, White Bison, Inc., Colorado Springs, Colorado

White Bison, Inc. convened a conference in Denver, Colorado in April 2006 to gather people working to stop the destructive effects of methamphetamine in American Indian and Alaska Native communities nationwide.[1] Participants were those in substance abuse/misuse recovery leadership positions, as well as grassroots community members from across the country. The Wellbriety Council of Elders was also present to share their wisdom and the unique perspectives that elders bring to any gathering. Entitled *Taking a Stand Against Meth: Recovery is Possible,* the goal of the conference was to provide hope and solutions for dealing with methamphetamine in Indian Country.

The Wellbriety Movement understands that prevention, treatment, intervention, and recovery are four interconnected aspects of substance abuse healing efforts in Indian Country. It's not possible or advisable to separate them, as might be done in some non-Native substance abuse recovery efforts. They are unified by the healing journey that arises when all four are acting in concert. Consequently, keynote addresses, workshops, and the grassroots Discovery Circles[2] that took place in Denver often connected these four directions of addictions recovery. The conference teaching and learning experience focused itself naturally into four primary areas: 1) knowledge about the drug methamphetamine; 2) what's working in Native American communities; 3) personal healing and recovery success stories; and 4) vision.

Knowledge about Methamphetamine

The methamphetamine epidemic is at the phase where education about its effects is vital. To drive this point home, Sissy Falcon said in a workshop entitled *Rez Watch*, "We need to become educated, educated, educated, educated, educated. Knowledge gained by feeding your spirit, knowledge about meth, changes the attitude in our hearts. We need this kind of learning for community change. We need our people educated and then we are going to see behavior change in our community." Wellbriety elder Theda Newbreast said in a workshop entitled *Women and Meth*, "We need to know meth. Know your language, know your culture, know your ceremony, and know the facts about how the drug methamphetamine works." Then, to emphasize the need for education, she quipped, "We need to have a tee shirt that says, 'Just say 'Know' to Meth!'"

Presenters emphasized that the effects of methamphetamine are different from those of alcohol and other drugs that most recovery programs are familiar with.[1,3] Because methamphetamine addicts a person so quickly, attacking centers in the brain, many of the cognitive-based treatment approaches that work for alcohol need to be modified for methamphetamine addicts. Group meetings based on reasoning, intuition, and the thought process, as well as methods such as reading, watching films, and other logical approaches probably won't work well for the methamphetamine sufferer. The 28-day treatment approach for alcoholics needs to be increased in duration and changed in curriculum for methamphetamine addicts.

What's Working?

Rez Watch is one of the most hopeful new approaches to deal with methamphetamine in reservation communities. Modeled after Meth Watch, which originated with non-Native communities in Kansas, Rez Watch empowers residents to take their communities back from methamphetamine dealers, users, and the houses where the drug is manufactured. It's called Rez Watch because reservations have their own cultural and logistical needs that might not be satisfied by the mainstream Neighborhood Watch or Meth Watch models. Rez Watch utilizes the anonymous reporting of possible meth-related activity through the *neighborhood activity log,* which can be collected at stores and tribal buildings on the reservation. "We need to stand for our people and we need to take back our reservations," said Sissy Falcon in the Rez Watch workshop. "They do not belong to the drug dealers."

What's also working is the integration of culture-specific healing programs into the non-Native approaches that some treatment centers are utilizing across the nation. For example, the Kokopelli Treatment Center, in Silver City, New Mexico, has had great success with the Matrix Model, created by the Matrix Institute of Los Angeles. The Matrix Model emphasizes personal structure and scheduling as well as a visual and repetitive approach for methamphetamine users. A primary component of the Matrix program at the Kokopelli

Center is recovery information tailored to those recovering from methamphetamine and addressing the fact that their cognitive ability is often impacted in early recovery.

The original Matrix program lacks a Native cultural approach, which can be added by using some of the White Bison Wellbriety movement resources. "The White Bison Firestarters Wellbriety Circle can be integrated into a Matrix approach to introduce Native culture and spirituality," says Sue Lyons of the Kokopelli treatment Center. "The Matrix model has recognized that they were missing a Native American component," she says. "Because of the damage to the left brain and analytical thinking in meth users, what we are finding is that there is tremendous success if we access the right brain with storytelling, drumming, prayer and ceremonies."

Personal Recovery Stories

David Parnell stunned the conference with his own personal methamphetamine abuse recovery story. Not a word was heard as he presented slides and comments covering his own descent into meth, a suicide attempt, and then — through the Creator's pity — his subsequent recovery. His presentation, which he makes available to communities everywhere, is exactly the prevention education package that some might need to realize what a bad choice methamphetamine use is.[3] Wellbriety elder Ozzie Williamson said during a follow-up elders panel, "The session we've just heard is probably one of the best I have ever seen in the thirty-some years that I've spent in this field. The message I would have is we need to get more people like David Parnell into our communities to get our young people to understand that this can happen and will happen to them if they try using or continue to use methamphetamine or other drugs. I think it was really a blessing to have him here with us this morning."

Four former methamphetamine users now associated with the Native American Rehabilitation Association (NARA), based in Portland, Oregon, also shared their recovery stories from methamphetamine, demonstrating the fact that people can and do recover. Each emphasized that re-embracing their own cultural traditions and ways was and is an essential part of healing from methamphetamine. One said, "I went to NARA for 3 months. There I found my self-identity, who I was, and the opportunity to teach the culture and tradition that was taught to me." Another revealed, "I went to NARA and met the NARA family. It really helped me in my recovery. Now we're building a traditional canoe with others in recovery. That's part of the healing process. We got together with social services and the drug and alcohol department we have in Nisqually to back our traditional canoes in our area. I brought back the White Bison talking circle way to Nisqually, as well as other things I learned at NARA. Now White Bison is on Nisqually and it's taking off over there like a wildfire."

Vision

Many visionary teachings were shared during the conference in Denver. Don Coyhis, Founder and President of White Bison, Inc., encouraged participants to think in terms of healing from methamphetamine, not waging war, as is often promoted by some mainstream efforts.[4] Healing, not war, is more in line with the Indian way of thinking.

Dr. Eduardo Duran, a psychologist, author, and drug and alcohol therapist with the Miwok/Maidu community in northern California, revealed that he sometimes asks his clients in recovery what they think the spirit of methamphetamine is trying to tell them. He asks them why they think it has come to them and what its unique message might be for them. This question often awakens the visionary response, to which many clients will respond positively.

Don McCloud, a grassroots participant from the Northwest, shared a vision that emphasizes a return to tradition and culture in healing from alcohol and drug problems. "We're the survivors," he says, "Its about our culture and our spirituality. If we don't find our way we're just going to be like the dominant society. If we don't find our spirituality we will become the dominant society." The Wellbriety Movement teaches that the community is the treatment center. It is also the best place for prevention, intervention, recovery, and healing to begin and to flourish.

A document summarizing results from the five grassroots Discovery Circles that took place at the conference is available on the White Bison, Inc. website.[2] White Bison, Inc. is making available the DVDs and audio CDs of many of the keynote addresses, workshop sessions, and grassroots Discovery Circles from the April, 2006 conference, at cost, to readers of this IHS journal article. Contact White Bison, Inc. at (877) 871-1495, or e-mail *info@whitebison.org* to receive a set.

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Editor's Note: The following is a digest of the monthly Obstetrics and Gynecology Clinical Consultant's Newsletter (Volume 4, No. 12, December 2006) available on the Internet at http://www.ihs.gov/MedicalPrograms/MCH/M/OBGYN01.cfm. *We wanted to make our readers aware of this resource, and encourage those who are interested to use it on a regular basis. You may also subscribe to a listserv to receive reminders about this service. If you have any questions, please contact Dr. Neil Murphy, Chief Clinical Consultant in Obstetrics and Gynecology, at* nmurphy@scf.cc.

OB/GYN Chief Clinical Consultant's Corner Digest

Abstract of the Month
Organizational silence threatens patient safety

Organizational silence refers to the tendency for people to do or say very little when confronted with significant problems or issues in their organization or industry. This paper focuses on some of the less obvious factors contributing to organizational silence that can serve as threats to patient safety. Converging areas of research from the cognitive, social, and organizational sciences and the study of socio-technical systems help to identify some of the underlying factors that serve to shape and sustain organizational silence. These factors have been organized under three levels of analysis:

1. individual factors, including the availability heuristic, self-serving bias, and the status quo trap;
2. social factors, including conformity, diffusion of responsibility, and microclimates of distrust;
3. organizational factors, including unchallenged beliefs, the good provider fallacy, and neglect of the interdependencies.

Finally, a new role for health care leaders and managers is envisioned. It is one that places high value on understanding system complexity and does not take comfort in organizational silence.

Henriksen K, Dayton E. Organizational silence and hidden threats to patient safety. *Health Serv Res*. 2006 Aug;41(4 Pt 2):1539-54. Reprints (AHRQ Publication No. 06-R060) are available from the AHRQ Publications Clearinghouse, *http://www.ahrq.gov/research/order.htm#clear*

OB/GYN CCC Editorial comment:
Value dissent and multiple perspectives as signs of organizational health

Henriksen and Dayton, of the Agency for Healthcare Research and Quality (AHRQ), describe the individual, social, and organizational factors that contribute to organizational silence and can threaten patient safety. They cite several individual factors that contribute to clinician silence. For example, the availability heuristic suggests that if relatively infrequent events that harm patients go unreported and are not openly discussed, clinicians don't believe these events are a problem at their hospital. A second factor is self-serving bias. People tend to view themselves as "above average" in their chosen field of work and so "why do things differently?" Successes are attributable to their own abilities but failures are blamed on situational factors. Finally, members of all organizations display a strong tendency to perpetuate the status quo and not speak up or rock the boat.

Several social factors also underlie clinician silence. There is great pressure to conform in order to gain acceptance and work harmoniously with coworkers. Diffusion of responsibility is also a problem. In clinical settings, individual roles and responsibilities are often assumed rather than clearly spelled out. Under these conditions of diffused responsibility, components of care that should be attended to are often missed. Also, managers who seek blame and attribute error to the individual failings of careless or incompetent staff create a microclimate of distrust. Finally, three areas of organizational vulnerability that warrant closer attention are unchallenged beliefs, the perceived qualities of the good worker who "works around" problems rather than focusing on the contributory factors to the problem, and lack of understanding of the interdependence of complex clinical systems.

The authors recommend that health care leaders and managers value dissent and multiple perspectives as signs of organizational health, and question agreement, consensus, and unity when they are too readily achieved.

Another successful example is the 100,000 Lives Campaign, which is an initiative to engage US hospitals in a commitment to implement changes in care proven to improve patient care and prevent avoidable deaths. The Institute for Healthcare Improvement estimates that the lives saved as of June 14, 2006 was 122,300.

To that end, the National Indian Health MCH and Women's Health meeting, August 15 - 17, 2007 in Albuquerque will highlight speakers from the Institute for Healthcare Improvement and others who have evaluated and treated various health care systems. The meeting has individual facility program review as well as many hours of CME/CEUs. Your facility should send a team of staff to this meeting; you and 2 - 3 colleagues from different disciplines should start planning now. For more information, go to *http://www.ihs.gov/MedicalPrograms/MCH/F/CN01.cfm#Aug07*.

From Your Colleagues
Judy Thierry, HQE
Menstruation in girls and adolescents: using the menstrual cycle as a vital sign

Evaluation of the menstrual cycle is a viable tool to assess

healthy development of teen girls' menstrual patterns. Young patients and their parents often are unsure about what represents normal menstrual patterns, and clinicians also may be unsure about normal ranges for menstrual cycle length and amount and duration of flow through adolescence. "It is important to be able to educate young patients and their parents regarding what to expect of a first period and about the range for normal cycle length of subsequent menses," the authors point out. "It is equally important for clinicians to have an understanding of bleeding patterns in girls and adolescents, the ability to differentiate between normal and abnormal menstruation, and the skill to know how to evaluate young patients' conditions appropriately."

American Academy of Pediatrics Committee on Adolescence; American College of Obstetricians and Gynecologists Committee on Adolescent Health Care; Diaz A, Laufer MR, Breech LL. Menstruation in girls and adolescents: using the menstrual cycle as a vital sign *Pediatrics*. 2006 Nov;118(5):2245-50.

Obstetrics

Shoulder dystocia: Only 43% participants could achieve delivery before training

Conclusion: This study verifies the need for shoulder dystocia training; before training only 43% participants could achieve delivery. All training with mannequins improved the management of simulated shoulder dystocia. Training on a high-fidelity mannequin, including force perception teaching, offered additional training benefits. LEVEL OF EVIDENCE: I

Crofts JF, et al Training for Shoulder Dystocia: A Trial of Simulation Using Low-Fidelity and High-Fidelity Mannequins. *Obstet Gynecol*. 2006 Dec;108(6):1477-1485.

OB/GYN CCC Editorial Comment
Regular simulation practice: win x3

The Crofts JF, et al randomized trial confirms previous recommendations that regular drills should be part of ongoing health care expectations. Regular drills and medical emergency preparedness improve patient care, as well as satisfy JCAHO evaluations. In addition, this process is endorsed in this month's ACOG Committee Opinion (see below).

The National Indian Health MCH and Women's Health meeting, August 15 - 17, 2007 in Albuquerque will highlight speakers from the Institute for Healthcare Improvement and others who have developed simulation processes. Phoenix Indian Medical Center offers a best practice example of a successful model in Indian Country. Contact Judy Whitecrane for more information *Judy.Whitecrane@ihs.gov*. The Advanced Life Support in Obstetrics Course is another great resource. Go to *http://www.aafp.org/online/en/home/cme/aafpcourses/clinicalcourses/also.html*

Medical emergency preparedness, ACOG Committee

Abstract: Patient care emergencies may occur at any time in a hospital or an outpatient setting. To respond to these emergencies, it is important that obstetrician/gynecologists prepare themselves by assessing potential emergencies that might occur, creating plans that include establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify what went well and what are opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.

Medical emergency preparedness. ACOG Committee Opinion No. 353. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2006;108:1597–99.

Majority of women with GDM are not tested for glucose intolerance after delivery

Conclusion: Although persistent abnormal glucose tolerance was common in our cohort, less than half of the women were tested for it. Our data suggest that to increase rates of postpartum glucose testing, improved attendance at the postpartum visit with greater attention to testing and better continuity between antenatal and postpartum care are required. LEVEL OF EVIDENCE: II-2.

Russell MA, et al. Rates of postpartum glucose testing after gestational diabetes mellitus. *Obstet Gynecol*. 2006 Dec;108(6):1456-62.

OB/GYN CCC Editorial Comment
GDM women are not tested for glucose intolerance after delivery

Although Russell et al are not from Indian Country, the same result would be found here, despite our enormous burden of diabetes related disease. Our Indian health GDM guidelines recommend a 2-hour oral glucose tolerance test at six weeks post partum and a fasting blood glucose every three years thereafter. How many of your GDM patients actually get that follow-up? Go to *http://www.ihs.gov/MedicalPrograms/MCH/w/Documents/DMPreg102504_000.doc*

Gynecology

HPV vaccine is effective: Why do we not provide it to most AI/AN?

Conclusion: Based on the data obtained in this study, widely-implemented prophylactic HPV vaccination could make an important contribution to the reduction of the risk for cervical cancer and could also prevent about half the vulvar carcinomas in younger women and about two thirds of the intraepithelial lesions in the lower genital tract. LEVEL OF EVIDENCE: II-3.

Hampl M, et al. Effect of human papillomavirus vaccines on vulvar, vaginal, and anal intraepithelial lesions and vulvar cancer. *Obstet Gynecol*. 2006 Dec;108(6):1361-1368.

OB/GYN CCC Editorial comment:
Honestly, are you actively giving out HPV to all your female patients between 9 - 26 years old?

I bet you are not, but you should be. Hampl M, et al is additional evidence that the HPV vaccine is clearly beneficial.

Yet HPV vaccine is not widely available to most AI/AN women 9 - 26 years old. How can this disparity be resolved? On November 1, 2006, the Centers for Disease Control and Prevention added the new human papillomavirus (HPV) vaccine to the federal Vaccines for Children program, which provides free vaccines to children from families with low incomes or who are uninsured. The articles in the Winter 2006 issue of the Guttmacher Policy Review discuss related policy issues. In "Achieving Universal Vaccination Against Cervical Cancer in The United States," the authors discuss the case for universal vaccination, the role of school-entry requirements, financing challenges, the potential role of family planning clinics in an HPV vaccine campaign, and solutions to various challenges presented by the HPV vaccine.

Child Health

Why do disparities in infant mortality continue to persist between AI/AN and white infants?

Objectives: To describe changes in infant mortality rates, including birthweight-specific rates and rates by age at death and cause.

Methods: We analyzed US linked birth/infant-death data for 1989 - 1991 and 1998 - 2000 for American Indians/Alaska Native (AI/AN) and White singleton infants at > or = 20 weeks' gestation born to US residents. We calculated birthweight-specific infant mortality rates (deaths in each birthweight category per 1000 live births in that category), and overall and cause-specific infant mortality rates (deaths per 100,000 live births) in infancy (0 - 364 days) and in the neonatal (0 - 27 days) and postneonatal (28 - 364 days) periods.

Results: Birthweight-specific infant mortality rates declined among AI/AN and White infants across all birthweight categories, but AI/AN infants generally had higher birthweight-specific infant mortality rates. Infant mortality rates declined for both groups, yet in 1998 - 2000, AI/AN infants were still 1.7 times more likely to die than White infants. Most of the disparity was because of elevated post-neonatal mortality, especially from sudden infant death syndrome, accidents, and pneumonia and influenza.

Conclusions: Although birthweight-specific infant mortality rates declined among both AI/AN and White infants, disparities persist. Preventable causes of infant mortality identified in this analysis should be targeted to reduce excess deaths among AIAN communities.

Tomashek KM, et al. Infant mortality trends and differences between American Indian/Alaska Native infants and White infants in the United States, 1989 - 1991 and 1998 – 2000. *American Journal of Public Health*. December 2006,Vol 96, No. 12.

Editorial Comment

Judy Thierry, MCH Coordinator, HQE

Kay Tomashek and her CDC colleagues present AI/AN infant mortality trends and differences emphasizing birthweight-specific infant mortality rates. This national picture uses three year aggregate data drawn from the NCHS Vital Statistics 1989 - 1991 and again 1998 - 2000).[1] Given the contribution of SIDS to elevated post neonatal AI/AN infant mortality, it is important to consider several key studies and national interventions that occurred in the early to mid 1990s between these two data sets. Key contributions include New Zealand and other international studies on SIDS; further study of SIDS in Seattle King County by Spiers and Guntheroth on the supine sleep position[2]; roll out of the AAP and NICHD guidelines on infant sleep position and the "Back to Sleep" campaign; and the prospective case control study conducted by the IHS, NICHD, and CDC (1994 - 1997) entitled the "Aberdeen Area Tribal Chairman's Health Board (AATCHB) Infant Mortality study," "Mi Cinca kin towani ewaktonji kte sni," "I will never forget my child."

The APHA December 2006 publication of the analysis demonstrates downward trends in AI/AN birthweight-specific infant mortality rates (albeit not enough) and helps us to further clarify the populations at risk in this complex issue, one that will require further elaboration using the triple risk factor model.[3] A list of key partners includes tribal epidemiology centers (local surveillance) linked with perinatal infant and child mortality review teams (local review), community health representative and public health nurse outreach (culturally-based outreach); including the Healthy Start Project model of home interventions and case management and other intensive maternal support programs. Tomashek discusses perinatal tobacco exposure. It is cited among the 33 references that are essential reading when discussing AI/AN birth and infant death data. Maternal and family risk factors will be further elucidated with an AI/AN specific point-in-time PRAMS soon to be underway. Funding of comprehensive campaigns to address tobacco exposure such as the AATCHB Smoke Free Homes Campaign should be priority. Timely access to care, quality of care, care of the maternal/fetal unit through a planned and regionalized and risk stratified manner remain fundamental to infant survival and maternal wellbeing.

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3. A triple-risk model for the pathogenesis of SIDS - intersection of three overlapping factors: (1) a vulnerable infant; (2) a critical developmental period in homeostatic control, and (3) an exogenous stressor(s). cited December 4 http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Abstract&list_uids=80

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Chronic disease and Illness
Firearm safety in homes with adolescents

Approximately one-third of US households with children and adolescents contain firearms. Despite recommendations to keep firearms stored unloaded and locked, a significant number of households store them loaded or unlocked, substantially increasing the risk that children or adolescents will accidentally or intentionally use a firearm to cause injury. Parents tend to assume that older children will act more responsibly, and studies have evaluated safe firearm storage according to the age of the children in the home. However, no studies have addressed individually the issues of storing firearms unloaded and of storing them in a locked place. Johnson and associates evaluated these individual safety issues in households with children or adolescents.

The authors conclude that parents of adolescents are less likely to store their firearms safely compared with parents of younger children. They add that these results are worrying because a significant number of firearm injuries occur in the adolescent age group. The authors suggest that firearm prevention programs focus on parents with adolescent children to improve safety practices.

Johnson RM, et al. Are household firearms stored less safely in homes with adolescents? Analysis of a national random sample of parents. *Arch Pediatr Adolesc Med*. August 2006;160:788-92.

Features
ACOG
Treatment with selective serotonin reuptake inhibitors during pregnancy

Abstract: Depression is a common condition among women of reproductive age, and selective serotonin reuptake inhibitors (SSRIs) are frequently used for the treatment of depression. However, recent reports regarding SSRI use during pregnancy have raised concerns about fetal cardiac defects, newborn persistent pulmonary hypertension, and other negative effects. The potential risks associated with SSRI use throughout pregnancy must be considered in the context of the risk of relapse of depression if maintenance treatment is discontinued. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommends that treatment with all SSRIs or selective norepinephrine reuptake inhibitors or both during pregnancy be individualized and paroxetine use among pregnant women or women planning to become pregnant be avoided, if possible.

Treatment with selective serotonin reuptake inhibitors during pregnancy. ACOG Committee Opinion No. 354. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2006;108:1601–3.*Obstet Gynecol*. 2006;108:1597–99.

Breastfeeding
Suzan Murphy, PIMC
Flu season and breastfeeding, CDR Julie Warren, RPh, Pharmacist, PIMC, Chair, IHS MCH Breastfeeding Web Page Medication Section

When a breastfeeding mom gets an upper respiratory infection, there are many medications that can help and are safe to use. General guidelines are as follows:

- ✓ Keep breastfeeding. The baby has already been exposed. A breastfeeding mom's immune system will make antibodies that fight the infection, protecting both the mom and her baby.
- ✓ Take the medicine right after nursing or before baby's longest sleep time.
- ✓ Watch baby for effects from the medicines that you take.
- ✓ Don't choose medicines that have a variety of ingredients.
- ✓ Use "regular strength" instead of "extra strength," "maximum strength," or "long acting."
- ✓ Follow the directions on the label. Don't take more than what is recommended.
- ✓ Take the lowest dose recommended.

If mom has:

A fever, headache, or aches all over, try:
- Acetaminophen (Tylenol® and many other brands)
- Ibuprofen (Advil®, Motrin®, etc.)
- Naproxen (Aleve®, etc.)
- Do not use aspirin.

A stuffy nose, use:
- Best: sodium chloride nasal spray
- Phenylephrine nasal spray (Neo-Synephrine® , etc.)
- Oxymetazoline nasal spray (Afrin® and others)
- Pseudoephedrine oral tablets (Sudafed® and many other brands). Moms may notice a decrease in breast milk production if they take Sudafed for extended periods.

Sneezing, hay fever symptoms, and her allergies are acting up, consider:
- Diphenhydramine (Benadryl® and many other brands)
- Brompheniramine + pseudoephedrine (Bromfed®, Rondec® syrup, etc.)
- Triprolidine + pseudoephedrine (Actifed® and other brands)
- Chlorpheniramine (Coricidin® and many other brands)
- Dexbrompheniramine + pseudoephedrine (Drixoral® and others)
- Loratadine (Claritin®, Alavert®, others)
- Cromolyn sodium nasal spray (Nasalcrom®).

A sore throat, even after a cup of hot tea, use:
- Warm to hot salt water gargles (don't swallow it!)
- Throat sprays (Cepacol® Maximum Strength Sore Throat Spray, others)
- Throat lozenges (Sucrets® Regular Strength, Halls® Mentho-Lyptus Drops)

- Don't use phenol and hexylresorcinol.

A cough, try:

- Guaifenesin with or without Dextromethorphan (Robitussin®, Robitussin DM and other brands with the same ingredients).

For more information, go to *http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT.* The link is also listed on the IHS MCH Breastfeeding web page, in the Medication section. Go to *http://www.ihs.gov/MedicalPrograms/MCH/M/bfMeds.cfm*.

International Health Update
Claire Wendland, Madison, WI
A nurse, a doctor, and an epidemiologist were standing by the river . . ..

Most of us have heard this anecdote: a nurse, a doctor, and an epidemiologist are standing at a river's edge when they notice body after body floating by. The doctor and nurse jump in, fish out everyone they can, and begin resuscitating the victims. The epidemiologist runs upstream instead, hollering over her shoulder, "I'm going to see who's pushing them in!"

In recent years, scholars from public health and related fields have increasingly proposed upstream or "structural" interventions into serious problems of public health, as opposed to the traditional education or behavior change interventions. The word "structural" in this sense refers to the social, political, and economic structures that make individuals more vulnerable to disease and violence. The logic of such proposals is that, for instance, it makes little sense to combat diabetes by teaching individuals about healthy eating in a poor rural community if the only place to buy food for miles around is a gas station convenience store specializing in Cheetos, and subsidized corn syrup production means that soda is cheaper than clean water.

Although much epidemiologic and social science literature explores the structural determinants of poor health, few structural intervention trials have been conducted. In fact, controversy over whether such trials are worthwhile (or ethical) is substantial. A recent trial of microfinance initiatives and their effects on intimate partner violence (IPV) and HIV seroconversion rates provides us a rare opportunity to examine the effects of a structural intervention, although with mixed results.

Paul Pronyk and colleagues from the University of the Witwatersrand noted that poverty, lack of economic opportunities, and gender inequalities combine in rural South Africa to allow high levels of both HIV infection and IPV in women. Projects addressing violence and HIV through education alone have met with little success. Would improved economic opportunities for women do better? Pronyk's team randomized eight villages in Limpopo province to intervention – establishment of a microfinance program combined with a participatory empowerment curriculum – or a comparison group. Over 400 of the poorest women in intervention villages received one or more small loans averaging $165 to support business initiatives; as a loan condition, they also attended training sessions on gender empowerment, relationships, communication, HIV, and domestic violence. The researchers assessed the impact of the intervention not only on the women themselves, but also on young people living in loan recipients' households and on randomly selected villagers. In the intervention villages, reports of intimate partner violence declined dramatically (adjusted RR 0.45, 95% CI 0.23-0.91). Intervention villagers also reported improved household communication, especially on matters of sex and sexuality, and improvement in the total value of household assets – although not food security or other measures of wealth. Several other attitudinal measures of empowerment trended toward positive change, but none met criteria for statistical significance. In addition, young people in intervention villages showed no difference in HIV seroconversion and rates of unprotected sex with someone other than a spouse. (Loan recipients themselves were not asked these questions. At a mean age of 41, the authors imply they were considered too old to discuss such matters!)

Although the study did not demonstrate the effectiveness of microfinance for HIV prevention, it is the first to show that microfinance is effective in reducing intimate partner violence. (Research in South Asia demonstrated initial increases in IPV with the initiation of microfinance, perhaps related to threats to male control of household resources, followed by a later decline.) It also demonstrates that a relatively small structural intervention can have relatively quick effects at the community level.

Pronyk PM, Hargreaves JR, Kim JC et al. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomized trial. *Lancet*. 368:1973-83, 2006.

Medical Mystery Tour
A boy has been born in Chile with a fetus in his stomach

Santiago, Chile (Nov. 24). A boy has been born with a fetus in his stomach in what doctors said was a rare case of "fetus in fetu" in which one twin becomes trapped inside another during pregnancy and continues to grow inside it. Doctors carried out a scan on the boy's mother shortly before she gave birth on November 15 in the southern city of Temuco and noticed the 4-inch-long fetus inside the boy's abdomen. It had limbs and a partially developed spinal cord but no head and stood no chance of survival, doctors said. After the birth, doctors operated and removed the fetus from the boy's stomach. The boy, who has not been named, was recovering at Temuco's Hernan Henriquez hospital. It's very rare," said Maria Angelica Belmar, head of the hospital's neonatal wing, speaking of fetus in fetu cases. It occurs in only one in every 500,000 live births," she told Reuters, adding that the number of cases recorded worldwide was fewer than 90. Before you explain the embryology of this case to us, please answer this one simple question: Which reputable medical resource was this story taken from? National Enquirer or Reuters?

Stay tuned till next month to find out.

Midwives Corner
Lisa Allee, CNM, Chinle
Start 'em young for future success and maybe no one will be left behind

This month I digress. I have no peer juried article; I don't even have a URL link. This month's topic is in honor of my mom. I visited her for Thanksgiving and we read an article in the Sunday *New York Times Magazine* called "Still Left Behind" about the No Child Left Behind Act. My mom worked for 20+ years as a reading specialist in a junior high school and has continued her work for literacy in retirement. She has always admonished me and my sisters to read to our children every day starting at birth, and for years we had the grandma-books-of-the-month delivery service. She was excited about this article because besides restating the previously known fact that school success is proportional to income, the author presented research delving into why this is. Some researchers have found a link between a child's school success and his/her vocabulary at age three — middle to upper income children often have 1000+ words at that age versus lower income children who have one-half to one-quarter that amount — and that the number of words a child has at age three is directly related to the mother's/parents' vocabulary. Another researcher found that not only did the parents' vocabulary matter, but the way the parents speak to the children plays a very important role. Parents of successful children (mid to upper income generally) used a higher proportion of encouragements, while parents of less successful children (generally lower income) used a much higher proportion of discouragements when speaking to their children. So, I was profoundly struck by the possibility that we as midwives, nurse practitioners, obstetricians, and pediatricians, could have an influence on parents and, thus, their children by pointing out three rules:

1. Follow Grandma Allee's rule of reading to your child every day starting at birth.
2. Improve your vocabulary and use your new words with your child.
3. Make sure at the end of every day you have said more encouraging things to your child than discouraging things.

I did this with a couple expecting their second child the other day. It took about a minute, and they said thank you for the information! It can fit into a busy clinic. If you want to read the article it is "Still Left Behind" in the November 26, 2006 Sunday *New York Times Magazine*.

Navajo News
Tomekia Strickland, Chinle
GYN spotlight: endometrial ablation

Pre-menopausal dysfunctional uterine bleeding unrelated to malignancy continues to be a significant problem for women wrought with social embarrassment, disruption of daily activities, and morbidity associated with anemia. Not only is it a challenging condition for the patient, but dysfunctional uterine bleeding usually requires lengthy and frequent outpatient visits for appropriate evaluation and management. Many times, patients have suffered for years with the condition and often present discouraged after a series of failed hormonal regimens. Hysterectomy, the only procedure that is 100% effective in eliminating abnormal uterine bleeding, is often less acceptable to Native American women than other populations, both for cultural reasons and because of a general reluctance to undergo major surgery. Thus endometrial ablation has risen as an ideal treatment option for women who have completed child bearing, failed conservative management, and desire uterine conservation.

The Department of Gynecology at Chinle Service Unit is now offering endometrial ablation to appropriate candidates, as are some other IHS sites. There are several global endometrial ablation techniques that have become available nationally over the past few years. *Global endometrial ablation* refers to a series of FDA approved newer generation technologies that do not require an operative hysteroscope. These include Thermachoice (hot liquid filled balloon), hydrothermal ablation (circulating hot water), Novasure (bipolar desiccation), Her Option (cryoablation), and microwave ablation. This is in contrast to the *standard technique* which uses monopolar energy via a rollerball, roller barrel, or resectoscope requiring operative hysteroscopy. There is also increased risk of uterine perforation and fluid overload with the standard techniques. We have started using the Novasure system, which is a global ablative technique that utilizes a three dimensional bipolar gold mesh that when inserted conforms to the shape of the uterine cavity. The average ablation time for Novasure® is 90 seconds. It also has the advantage of not requiring hormonal pretreatment to thin the endometrial lining. When used correctly, the global ablative techniques are considered safe, effective, fast, simple to perform, painless, and cost effective to both physician and patient. Many of these procedures can also be performed as office-based procedures.

Like the standard technique, global ablation techniques are considered successful not so much according to amenorrhea rates, but by reduction in menstrual flow. Hypomenorrhea correlates with high rates of subjective patient satisfaction, usually greater than 80 - 90%. The amenorrhea rates for some of the devices are as follows: Thermachoice, 14% at 12 - 24 months; Microwave 38% at 3 years; and Novasure 51% at 1 year.

In conclusion, global endometrial ablation will most likely continue to become an increasingly popular and primary minimally invasive surgical treatment option for women who have completed childbearing and continue to suffer for abnormal uterine bleeding despite medical therapy. Like all medical and surgical interventions, care must be taken to evaluate each patient carefully and individualize their treatment plan accordingly. "Endometrial Ablation" by UpToDate, *www.uptodate.com*, provides a detailed discussion on the indications, contraindications, and safety profiles for each ablative procedure. If you would like more information about our exciting but still new experience with Novasure, please feel free to contact me at *tomekia.strickland@ihs.gov*.

Nurses Corner
Sandra Haldane, HQE
Nurses less satisfied than physicians or nurse managers: perceptions of teamwork on L/D

Caregiver role influences perceptions of teamwork. Overall, physicians and nurse managers were much more satisfied than nurses with the collaboration they experienced. For example, anesthesiologists had higher scale scores than certified registered nurse anesthetists for five of the six teamwork climate items. Most (80 %) L&D staff felt it was easy for personnel in their unit to ask questions. However, only 55 % found it easy to speak up if they perceived a problem with patient care, and only half felt that conflicts were appropriately resolved. The study was supported in part by the Agency for Healthcare Research and Quality (HS11544).

Oklahoma Perspective
Greggory Woitte, Hastings Indian Medical Center
Reduction in teen pregnancies

The preliminary numbers from 2005 from the CDC show a 2 % reduction in teenage pregnancies, down to its lowest recorded level in 65 years. The biggest decline was in the ages 15 - 17 years group. Here in Oklahoma, we were the 8th highest state in the nation for teen births ages 15 - 19 in 2002. Like in all other states, we as women's health providers have to work hard at encouraging young women to delay sexual activity as well as to take steps to prevent becoming pregnant. ACOG recently released a statement that a 13 month supply of OCPs showed a greater likelihood of continuation and use and would be very beneficial in the continued reduction of teen pregnancies. In fact, it is estimated that for every dollar invested in teen pregnancy prevention programs, at least $2.65 was saved in direct medical and social service costs (The National Campaign to Prevent Teen Pregnancy. Not Just Another Single Issue: Teen Pregnancy's Link to Other Social Issues, 2002).

NCHS Health E Stats – Births-Preliminary Data for 2005 *http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimbirths05/prelimbirths05.htm*

ACOG Statement 13 month Supply of OCPS leads to more consistent use *http://www.acog.com/from_home/publications/press_releases/nr11-01-06-2.cfm*

Perinatology Picks
George Gilson, MFM, ANMC
Amniocentesis procedure-related loss risk 1 in 1600, not prior 1 in 200

Results: The spontaneous fetal loss rate less than 24 weeks of gestation in the study group was 1.0% and was not statistically different from the background 0.94% rate seen in the control group (P=.74, 95% confidence interval -0.26%, 0.49%). The procedure-related loss rate after amniocentesis was 0.06% (1.0% minus the background rate of 0.94%). Women undergoing amniocentesis were 1.1 times more likely to have a spontaneous loss (95% confidence interval 0.7-1.5).

Conclusion: The procedure-related fetal loss rate after midtrimester amniocentesis performed on patients in a contemporary prospective clinical trial was 0.06%. There was no significant difference in loss rates between those undergoing amniocentesis and those not undergoing amniocentesis. LEVEL OF EVIDENCE: II-2.

Eddleman KA et al. Pregnancy loss rates after midtrimester amniocentesis. *Obstet Gynecol*. 2006; 108(5):1067-72

STD Corner
Lori de Ravello, National IHS STD Program
Less than half of parents infected with HIV tell their children about the diagnosis

Parents are reluctant to disclose their HIV infection to their children, primarily because they fear the emotional impact. As a result, fewer than half (44 percent) of children are aware of their parent's HIV infection, according to a new study supported in part by the Agency for Healthcare Research and Quality (HS08578 and T32 HS00046). Parents did not disclose their HIV status to their children primarily due to worry about the emotional consequences of disclosure for the child (67 percent), worry that the child would tell other people (36 percent), and not knowing how to tell their child (28 percent). Many parents also feared that their children would reject them or lose respect for them. Certain parents were less likely to disclose their HIV infection than others. These included those who contracted HIV through heterosexual intercourse (rather than homosexual intercourse or intravenous drug use), those with higher CD4 cell counts (indicative of greater disease progression), those who were more socially isolated, and those with younger children. According to the parents, 11 percent of children who were aware of their parent's HIV infection worried they could catch HIV from their parent, 5 percent had experienced other children not wanting to play with them, and 9 percent had been teased or beaten up.

Corona R, et al. Do children know their parent's HIV status? Parental reports of child awareness in a nationally representative sample. *Ambulatory Pediatrics*. May 2006;6(3):138-144.

Barbara Stillwater
Alaska State Diabetes Program
Three years later, participants in the Diabetes Prevention Study still benefiting

Lifestyle intervention has lasting benefits in those at risk of diabetes. The effects of lifestyle intervention on diabetes risk do not disappear after active counseling has stopped, a new follow-up of the Finnish Diabetes Prevention Study shows. Three years after the end of the study, those in the intervention group still had a reduced incidence of type 2 diabetes compared with the control

Interpretation: Lifestyle intervention in people at high risk for type 2 diabetes resulted in sustained lifestyle changes and a reduction in diabetes incidence, which remained after the individual lifestyle counseling was stopped.

Lindstrom J, et al. Sustained reduction in the incidence of type 2 diabetes by lifestyle intervention: follow-up of the Finnish Diabetes Prevention Study. *Lancet*. 2006 Nov 11;368(9548):1673-9.

This is a page for sharing "what works" as seen in the published literature, as well as what is being done at sites that care for American Indian/Alaskan Native children. If you have any suggestions, comments, or questions, please contact Steve Holve, MD, Chief Clinical Consultant in Pediatrics at sholve@tcimc.ihs.gov.

IHS Child Health Notes

Quote of the month

"A radical is a man with both feet planted firmly in the air. A conservative is a man with two perfectly good legs, however, who has never learned to walk forward."

Franklin Roosevelt

Article of Interest

Effect of needle size on immunogenicity and reactogenicity of vaccines in infants: randomized controlled trial. *BMJ*. 2006 Sep 16;333(7568):571. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed*

Editorial Comment

A cliché is that sometimes "less is more." In this case the British demonstrate that "more is less" when it comes to needle size and vaccinations. Infants receiving intramuscular vaccinations with a long needle (25mm) had fewer local reactions, and especially had fewer severe local reactions, when compared with infants vaccinated with a short (16mm) needle. The width of the needle did not affect the reactogencity and immune response did not differ between groups. While we often choose the smallest needle in an effort to decrease pain, this study suggests that a longer needle may be the better choice to minimize local reactions after vaccinations.

Infectious Disease Updates.
Rosalyn Singleton, MD, MPH

Introducing the 2007 Child and Adolescent Immunization Schedule. Here's a simplified version of the 2007 Child and Adolescent Immunization Schedule – although there's nothing simple about this schedule! There are some caveats on each vaccine in the footnotes.

	Birth	2m	4m	6m	12m	15m	2yrs	4-6yrs	11-18yrs
Hep B[1]	√	√		√					
DTaP[2]		√	√	√	√			√	√Tdap[10]
IPV[3]		√	√	√				√	
Hib		PedvaxHib ®	PedvaxHib ®		PedvaxHib ®				
PCV7[4]		√	√	√	√				
Rotavirus[5]		√	√	√					
MMR[6]					√			√	
Varicella[6]					√			√	
Hep A[7]					√		√		
Influenza[8]				Yearly, 6-59 month olds----------					
HPV[9]									Gardasil®
MeningCV4[11]									Menactra®

1. **HepB**: First Hep B soon after birth. You may use Pediarix® (DTaP-IPV-HepB) at 2,4, 6 months or Comvax® (HepB-PedvaxHIB) at 2, 4, and 12 months for doses 2, 3, and 4 of Hep B in infants. Final dose must be ≥ 24 weeks of age, at least 8 weeks after dose #2.
2. **DTaP**: min. age 42 days. Pediarix® can be used for doses 1 - 3 of DTaP. Don't use Pediarix® in children ≥ 7 yrs or for DTaP 4 or 5. DTaP 4 can be given at 12 months if 6 months since dose 3. Don't need DTaP5 if DTaP4 given after age 4 yrs.
3. **IPV**: min. 42 days. Pediarix® can be used for doses 1 - 3 of IPV. Single antigen IPV, not Pediarix®, must be used for dose 4. Do not need IPV4 if IPV3 given after age 4.
4. **Pneumo-conj**. (Prevnar®): min. age 42 days. Give at 2, 4, 6 months with booster ≥ 12 months, at least 2 months from previous dose.
5. **Rotavirus** (RotaTeq®): min. 42 days. Give dose 1 at 6 - 12 weeks. Don't start series if ≥ 13 weeks. All doses of RotaTeq® must be given by 32 weeks (8 months) of age.
6. **MMR and Varicella**: 12 months. 2nd MMR and Varicella routine at 4 - 6 yr, but can be given ≥ 4 wks (3 mo for Var – but don't need to repeat if ≥ 4 weeks) after dose 1. Varicella dose 2 can be given to Vaccine for Children eligible children through age 18.
7. **Hep A**: min.12 months. Can be given as early as 12 months, but is forecast at 15 months. Two doses of Hep A vaccine are needed at least 6 calendar months apart.
8. **Influenza:** min. age 6 mos. 2 doses first year, 1 dose every year after for children < 9 years. Routinely immunize 6 - 59 month olds.
9. **HPV** (Gardasil®): min age 9 yrs. Many states are providing for 11 - 12 year old girls. 3 dose series at "0", 1, and 6 months.
10. **Tdap** (Adacel®): min. age 11 yrs. all 11 - 18 year olds ≥ 5 years since last Td/DTaP.
11. **MeningCV4** (Menactra®): 1 dose for 11 - 12 and 15 year olds and college freshmen in dorms as well as rare conditions such as asplenia and terminal complement deficiencies.

Recent Literature on American Indian/Alaskan Native Health

Doug Esposito, MD

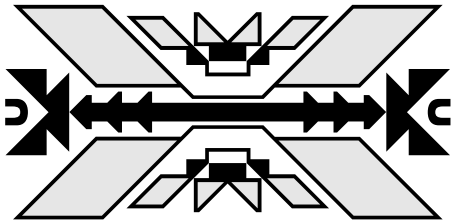
I would like to direct the reader's attention to several excellent articles in the December issue of the *American Journal of Public Health*. This entire issue is devoted to "Embracing a Common Destiny: Health for All." It is impossible not to be consumed by the subjects of health disparities and inequities in access to health care when considering issues facing Native American and First Nations populations in North America. As regular readers of this column know, the thrust of my comments have centered on these topics since I began writing for Dr. Holve nearly one and a half years ago. Imagine my excitement whenever I come across an entire journal issue devoted to Health for All!

Health and health care for the 21st century: for all the people. *Am J Public Health*. 2006 Dec;96(12):2090-2. Epub 2006 Oct 31. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=17077403&query_hl=1&itool=pubmed_docsum*

The December issue of the *American Journal of Public Health* begins with this excellent editorial by the much celebrated former Surgeon General of the United States, Dr. C. Everett Koop. Just to set the tone, here is a wonderful quote by this dedicated and outspoken public health advocate and leader: "Our capability to prevent and treat disease seems to exceed our willingness to apply our interventions." Truer (and sadder) words have not been written on the subject. We certainly have the technological and economic means to advance the health status of every American to a point far beyond the current level. The only thing lacking is the resolve. Dr. Koop further elaborates, "I am concerned, however, that the difference between the "haves" and the "have-nots" will worsen. It is in vogue to blame problems on the victims of disease and disability, on laziness, on immigration, on those who hold opposing political points of view, or even — and perhaps most incredibly in this most wealthy of all nations — on lack of resources. Consider just two telling facts: 80% of people without health insurance are from working families and nearly 20% of them are children. Can we blame their lack of access to health care on them?"

The persistence of American Indian health disparities. *Am J Public Health*. 2006 Dec;96(12):2122-34. Epub 2006 Oct 31. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=17077399&query_hl=1&itool=pubmed_DocSum*

This paper chronicles the 500-year history of health disparities for American Indian populations. It explores the diverse explanations proposed over time that have been used to rationalize, and sometimes address, the presence and persistence of these disparities. Beginning with theories of providence of God and working through to more contemporary ideas emphasizing environment, behavior, biology, and socioeconomics, the author takes the reader on a wonderful post-Columbian journey, presenting a novel, interesting, and important approach to answering some key contemporary questions. "Do American Indians have intrinsic susceptibilities to every disease for which disparities have existed? Or does the history of disparity after disparity suggest that social and



economic conditions have played a more powerful role in generating Indian vulnerability to disease?" Yet again, the issue of biology vs. society rears its ugly head (please see the "Additional Reading" section below).

In reading this article, I wonder how far we really have come since the late 1800s. "Medical campaigns, for example, suffered from inadequate funding. Commissioner of Indian Affairs T. J. Morgan compared the salaries paid to government physicians in the Army, Navy, and IHS and divided these sums by the populations served. He then calculated a crude estimate of how the government valued people: $21.91 per soldier, $48.10 per sailor, and $1.25 per Indian." Now, doesn't this sound frighteningly similar to contemporary estimates of disparities in per capita health expenditures? As reported in a study done by the United States Commission on Civil Rights in April 2004: "HHS estimates the FY 2003 annual per capita health care spending for the general population at $5,065. In contrast, IHS spent $1,914 per eligible user, or 38 percent of that spent by the general population." What rightfully stirs the ire of Native Americans, though, is this: the U.S. spends $3,803 per year per federal prisoner, almost twice as much as it spends for an American Indian or Alaska Native.

I believe it is absolutely critical for our society to acknowledge and come to grips with the true etiology of the health disparities endured by minority populations. Society needs to take responsibility for the existence of these deplorable realities. The fallacy that there exists a real biologic cause, conveniently reflected by skin color and body habitus alone, only serves to divert attention away from the true problem; that being disparities in wealth and power, or more simply, racism and unequal access and opportunity. But please, don't take my word for it, go to the article and deliberate for yourselves . . . then let's all work together as a society on a solution.

Additional Reading

On the issue of genomics, please see the March 2006 issue of the *IHS Child Health Notes* on Race, Genetics, and the Biologic Versus Social Determinants of Health and Health Disparities: *http://www.ihs.gov/MedicalPrograms/MCH/M/documents/ICHN306.doc*

Broken Promises: Evaluating the Native American Health Care System. US Commission on Civil Rights, April 2004. *http://www.usccr.gov/pubs/nahealth/nabroken.pdf*

Infant mortality trends and differences between American Indian/Alaska Native infants and white infants in the United States, 1989-1991 and 1998-2000. *Am J Public Health*. 2006 Dec;96(12):2222-7. Epub 2006 Oct 31.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=17077400&query_hl=1&itool=pubmed_DocSum

In another article highlighting the "Health for All" theme, this study offers a detailed analysis of measurable disparities in infant and neonatal mortality suffered by Native Americans. In the October issue of the *IHS Child Health Notes*, I discussed an *MMWR QuickStats* showing that infant mortality for American Indian/Alaska Native mothers ranks second highest in the US, surpassed only by the rate for non-Hispanic blacks. The paper appearing in the December issue of the *American Journal of Public Health* is a much more detailed and relevant analysis.

The authors analyzed linked birth/infant-death data in order to generate birthweight-specific and cause-specific neonatal and infant mortality rates for white and AI/AN infants born at ≥ 20 weeks' gestation in the U.S. in 1989 - 1991 compared with 1998 - 2000. Although some definite and significant gains have been made over the period, presumably preventable disparities still do exist. Of note is that decreases in disparities between AI/AN and White infants were identified in some measures while increases were found in others.

On a slightly more cheery note, the authors found that AI/AN infant mortality overall was only 1.7 times that of White infants. This compares favorably with historical data. Infant mortality rates once were several-fold higher for Native Americans than for the general US population. However, although real progress has been made, it has been impossibly (and perhaps unforgivably) slow. As a result of the disparity in infant mortality, countless and needless infant deaths have occurred over the centuries, exacting a terrible toll on the well being of the afflicted populations through chronic, unrelenting emotional trauma. This situation will certainly have a lasting negative impact that can be expected to persist perhaps generations beyond the time the disparity is finally eliminated.

The authors offer a very thoughtful analysis of the troubles and the achievements in infant mortality over a ten-year period. This article is well worth a look by any practitioner delivering care to AI/AN infants or by anyone seeking to assist in the reduction and eventual elimination of health disparities for this population.

Additional Reading

October 2006 issue of the *IHS Child Health Notes*: *http://www.ihs.gov/MedicalPrograms/MCH/M/documents/ICHN1006.doc*

Locums Tenens and Job Opportunities

If you have a short or long term opportunity in an IHS, tribal or urban facility that you'd like for us to publicize (i.e., AAP website or complimentary ad on Ped Jobs, the official AAP on-line job board), please forward the information to *indianhealth@aap.org* or complete the on-line locum tenens form at *http://www.aap.org/nach/locumtenens.htm*.

Save the Date

Title: "Making Data Count: Measuring Diabetes and Obesity in Indian Health System
Sponsor: IHS Division of Diabetes Treatment and Prevention
When: July 24-26, 2006
Where: Westin La Paloma Resort
Tucson, Arizona

Who Should Attend:

Anyone who works with data addressing diabetes and obesity in Indian health care systems. The conference will provide plenary sessions and concurrent workshops with both clinical and technical applications. All users, new and experienced, will benefit from this Conference.

Program Overview:

An innovative conference that will provide opportunities for individuals and programs working in Indian health care systems to

- review current and advanced data systems and analysis tools relevant to diabetes and obesity data
- learn the impact of cost and quality issues
- network and share common issues and best practices for capturing, reporting, using, and improving data to help improve the lives of American Indian and Alaska Native people

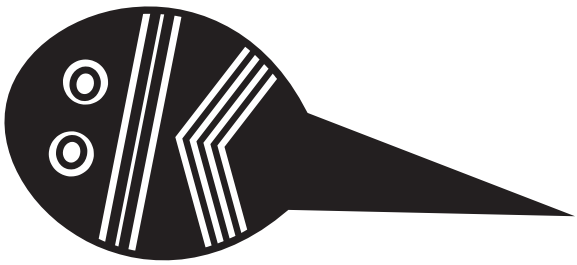
Program Objectives:

- Identify current status of diabetes and obesity data-related issues
- Identify currently available and advanced diabetes and obesity related data systems and analysis tools in IHS, Tribal, and Urban (I/T/U) health care settings
- Discuss data quality issues and the impact on required data reporting, cost accounting and program evaluation
- Network and share ideas on diabetes and obesity related data issues and best practices in unique settings
- Explore opportunities for education, training, and career development in data management and program analysis in I/T/U systems

Registration: coming soon

The 12th Annual Elders Issue

The May 2007 issue of THE IHS PROVIDER, to be published on the occasion of National Older Americans Month, will be the eleventh annual issue dedicated to our elders. Indian Health Service, tribal, and Urban Program professionals are encouraged to submit articles for this issue on elders and their health and health care. We are also interested in articles written by Indian elders themselves giving their perspective on health and health care issues. Inquiries or submissions can be addressed to the attention of the editor at the address on the back page of this issue.



Prevention of Methamphetamine Use in Indian Country: Promising Practices

Craig Love, PhD, Senior Study Director, Westat, Rockville, Maryland; and Maria Barrera, EdD, Division of Systems Development, Center for Substance Abuse Prevention, Rockville, Maryland

Prevention is Prevention is Prevention

Methamphetamine abuse is only one of many issues that American Indians and Alaska Natives (AI/AN) face. The "real" issues associated with methamphetamine abuse are also associated with the abuse of other substances, mental and physical health problems, and other barriers to a generally healthy lifestyle. Thus, it is important to understand the context of the growing methamphetamine problem in Indian Country.

Key Issues in Indian Country

AI/AN communities possess a rich cultural history; the traditional perception is that an individual's identity reflects the collective identity of the community.[1,2] In these communities, when the collective identity feels pain, an individual's sense of personal efficacy, self-esteem, interpersonal satisfaction, and competence also suffers. Many AI/AN have experienced inter-generational and cultural traumas that persist today and are so apparent in the pervasive social problems that affect the lives of its members living in reservation, rural, and urban settings.

The creation of reservations and federal policies that "tried to take the Indian identity out of the Indian" left many AI/AN feeling misplaced.[3] Anger, rage, and resentment are prominent among AI/AN youth.[4] AI/AN inherit community stressors, and their family lives are marked by the effects of poverty, broken homes, lack of supervision, teenage pregnancy, domestic violence, child abuse, and neglect. The result is often reflected in disabilities, incarceration, death, suicide, sexual abuse, rape, unemployment, school failure, and loss of traditional ways.

There are other risk factors that affect AI/AN that require special focus. First, five million Americans have used methamphetamine in the United States, thereby creating a highly profitable enterprise for gangs affecting Indian Country today.[4] Second, the frontier nature of many reservations lends itself to the clandestine labs used to produce methamphetamine.[5] Also, there is insufficient law enforcement coverage in Indian Country to deal with rising gang activity. Third, residues and discharged chemicals from the methamphetamine labs are highly toxic substances that penetrate buildings and the soil, hurting not only our people, but also mother earth.[4] Fourth, youth and adults on reservations credit "boredom" or "nothing for kids to do" as major contributors to their eventual involvement with substances. Fifth, the victims of methamphetamine abuse include family members who are humiliated, traumatized, and physically threatened by their addicted relatives. Finally, elders and tribal officials in many communities cite the lack of education and prevention efforts. They see a need for AI/AN to reconnect to the traditional ways in order to gain the personal tools needed to solve the methamphetamine problem in Indian Country.

Not Much Evidence Yet

In the past few years, SAMHSA has funded several prevention programs that focused on the prevention of methamphetamine use. Most of the methamphetamine intervention programs are still in process and the data are not yet available. Until more evidence is available, promising practices for AI/AN must address some important features of the modern Native community.[6] One of the complicating factors in conducting evaluations and making generalizations in research on AI/AN is the very diversity within our racial group. Over 61% live in urban settings; most, but not all, are very poor; the level of assimilation within and among the various tribes stretches across a broad continuum; and the nature of substance abuse varies between tribes (e.g., males versus females or both; style of abuse, such as binging; etc.). There are many variations among and within AI/AN tribes, including languages, customs, and values; some tribes have no particular problems with substance abuse.[7] One important common feature is the role of the extended family (including elders and clan mothers and fathers), which can provide positive support for healing.

The Importance of Culture

Our understanding and belief is that any prevention intervention in Indian Country needs to be holistic and culturally appropriate. However, achieving cultural appropriateness can be challenging, depending on an individual's level of exposure to traditional ways or ceremonies. For many AI/AN, who are deeply invested in their culture and traditional ways, a traditional approach is an absolute necessity. Other AI/AN may be curious and interested in learning traditional ways, although it may not be a critical need.[8] A further complication in AI/AN prevention programs, especially in urban settings, is that Indians from many different tribal groups may participate in the programs. This mix of AI/AN tribes makes it difficult to provide anything other than generic ceremonies in a pan-Indian approach; the lack of tribal specificity may not be as effective.

Depending on the cultural disposition of the participants, methamphetamine prevention programs for AI/AN need to focus on reconnecting them with their traditional spiritual side and culture. For most AI/AN, culture will provide a sense of place in the world and a positive spiritual perspective. There are a variety of traditional prevention programs being used in Indian Country that may help methamphetamine users change their way of life and gain that spiritual connection.

Model Programs in Indian Country

To-date, the effectiveness of methamphetamine prevention programs for AI/AN have not been rigorously evaluated. The programs discussed below are presented as promising practice.

The Medicine Wheel and other culturally based activities. AI/AN work toward living a healthy life by integrating a well-balanced lifestyle that is physically, emotionally, and spiritually stable. This integrated approach is reflected in the teaching of the Medicine Wheel Model, which has four phases: 1) embracing the individual's balance and wellness; 2) letting the individual know that addiction is an evil spirit in the body and easy to overcome; 3) helping the individual understand the reasons why they have an addiction; and 4) using recovery as a time for healing, in which the addict slowly overcomes the problem by understanding who they are as AI/AN. Other traditional AI/AN approaches include healing sweat lodge ceremonies and the use of talking circles in the course of treatment.

Project Venture and Service Learning. The National Indian Youth Leadership Project (NIYLP) "Project Venture" has been in existence and developing since 1986 and has been designated as a SAMHSA Model program.[9] It is based on traditional pre-Columbian learning methods used across the North American continent. Youth are engaged in various outdoor activities and participate in service learning, which includes search and rescue, survival and teamwork, and other community support activities. Although McClellan Hall developed this program in Gallup, New Mexico with mostly Dine' children, he has subsequently introduced Project Venture to many different communities and helped them adapt the program to their own cultures. According to the NIYLP, there is clear evidence that the program is effective in reducing alcohol use and halting the growth in alcohol and marijuana consumption among the AI/AN youth served in the program. In an evaluation, Project Venture participants had statistically superior outcomes compared to a control group.

Native HOPE. Another promising approach is Native Helping Our People Endure (Native HOPE), a suicide prevention program that incorporates community members, leaders, and medicine men in its implementation. The concept is to provide strong community ties among the providers of prevention service and the youth the programs serve. The project clarifies and strengthens the role of individuals in the community and helps them lead by example. Training manuals are available to help individuals fulfill their roles as facilitators.[10]

Next Steps

Evidence-based practices for the prevention of methamphetamine abuse among AI/AN are not yet available. It is clear that there needs to be a systematic evaluation of currently funded programs to ascertain those that are the most effective on a long-and short-term basis. As the promising practices are empirically established, their application to additional tribes and communities also needs systematic evaluation. Our intent here is to present program strategies that make sense given what we do know about Indian Country.

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Letter to the Editor

To the Editor:

Dr. Steve Holve's paper in the October, 2006 PCP, "Fluoride Varnish Applied at Well Child Care Visits Can Reduce Early Childhood Caries," gave good reasons for the use of fluoride varnish by staff at well child visits. The study documented a decrease in the severity of ECC (Early Childhood Caries). There was not a reduction of ECC itself, which would mean more caries free children. Parents/guardians should be reminded that they are the key person to keep a child caries free. They should brush the child's teeth every day (six years old or younger), preferably before bed. Research has shown that children in this age range do not have the skills or language to wield a toothbrush effectively.

Dr. Andrew Casterline
Salt River Clinic Dental Department
Scottsdale, Arizona

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A journal for health professionals working with American Indians and Alaska Natives

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