Indian Health Service
Head Start Program

Health Bulletin

April 18, 2008

Inside this issue:

Acknowlegement:
The materials for this bulletin were provided by Diane Payne, Children's Justice Specialist, for the Tribal Law and Policy Institute, All articles except the Navajo Times news article were written by Diane Payne.

IHS/HS BRIEFING SHEET:
METHAMPHETAMINES AND NATIVE AMERICAN CHILDREN

Compiled by Diane Payne, Children's Justice Specialist, Tribal Law & Policy Institute, diane@tlpi.org, www.tlpi.org

Background Information - Impact of Methamphetamines on Native Children

Almost 1 million of the Native people in the United States are under the age of 18. Twenty percent (20%) or 200,000 of the children under 18 are at risk of abuse and 40,000 suffer substantiated abuse and neglect based on 2004 Child Welfare League of America data. Of these abused/ neglected children, 65% – 85% are thought to be substance abuse related. Native children who are impacted by abuse, neglect and abandonment by their parents suffer loss of family, community and often of identity – all of which contribute to emotional difficulties later in life. The already tragically high percentage of substance abuse related child abuse and neglect has reached unprecedented levels since methamphetamines arrived in Tribal communities. Tightened state laws, successful law enforcement campaigns and prosecution of methamphetamine cooks and dealers in urban areas has pushed the drugs deeper into tribal communities where there are fewer law enforcement officers, vast areas of unsupervised land, jurisdictional loopholes and a generally isolated and vulnerable population. National, the two major methamphetamine groups involved in trafficking methamphetamines are Mexico based and California based Mexican traffickers who often bring the drugs in through areas near one of the 61 reservations located within 50 miles of the US-Canada or the US-Mexico borders.

There is increasing concern across the west that the experience of an Indian woman in Washington State is not unusual. Law enforcement officers have frequently found that members of Mexican drug cartels set up their drug trafficking operations by having members move into Tribal communities and become involved with single Indian women. In a Seattle newspaper report, a Makah woman told how she was romanced on her remote Pacific Northwest reservation by a Mexican drug dealer who fed her methamphetamine addiction and then peddled dope to her tribe. She spoke to news reporters in the fall of 2007 and had been clean and sober since December 2006. She warns other Tribal members about meth……. "They are told in Mexico, even before they come here, to find an Indian woman and marry her," she said of the dealers. "You will get a free home, a free clinic. And they basically do it and set up shop." Ms. Pendleton knows. Her former lover made her home on the reservation his personal drug den. He's gone now, but she's fighting to regain custody of their meth-affected little boy.

While actual statistical data specific to methamphetamine impacts in Indian country is limited, some of the facts and information below should compel us to focus more deliberately on educating ourselves and seeking new approaches to addressing the endangerment of Native children who are exposed to illegal drugs, especially methamphetamines.

Tribal Law and Policy Institute research, 2006 – *Perceptions on Three Western Reservations Regarding Impacts of Methamphetamine on Child Safety* (available at www.tlpi.org)
Findings include:

- 91.9% increase in Social Services workload from meth use
- 88.9% increase in child protection workload
- 78,4% increase in IHS workload
- 77.8% increase in prosecutor workload
- 62.2% increase in victim advocate workload
- 91.9% increase in law enforcement workload
- 83.8 increase in Tribal court workload
- 81.1% increase in DV workload

BIA Law Enforcement Survey 2006, selected Findings:

- 35% of high school seniors at Navajo Nation reported trying meth at least once in 2006 compared to 6.2% among seniors in 2004 (OJJDP)
- 74% of Tribal police rank meth as greatest drug threat
- 40% of violent crime attributed to meth
- 64% of Tribal police report increased domestic violence and assault/battery
- 80-85% of Indian families involved with tribal or state child welfare systems have drug and/or alcohol abuse issues
- 45% of Tribal police report increase in child abuse/neglect due to increases in meth use

Heath and Treatment Studies, selected Findings:

- Nationally Native Americans have the highest rates of meth abuse (1.7% for AI/ AN & 2.2% Native Hawaiians
- Other ethnicities: whites: 0.7%; Hispanics: 0.5%; Asians: 0.2% and African -Americans: 0.1% - data from NSDUH, SAMHSA (9/05)
- In 2004 data from LA County, methamphetamine addiction replaced alcohol as the most commonly reported drug problem in admissions for treatment among Native Americans/ Alaska Natives.
- 2005 LA County data shows that of Native Americans in treatment with methamphetamine as their primary drug, 43.7% were male and 56.3% were female.

Rise in Methamphetamine Use Among American Indians in LA County, 2007

August 2007. Justice Department data show a 27 percent decline in FBI investigative activity on Indian lands since 2001. Officially, the FBI maintains that the number of agents assigned to Indian County has increased by 7 percent, and that the number of indictments handed down has remained steady. But special agents in the field, former FBI administrators and federal prosecutors say the real picture is bleak. They say agents who would normally respond to reservation crimes aren't doing it as much because of a domino effect of the FBI being saddled with homeland security matters; they say federal investigations on most reservations have failed to keep pace with burgeoning crime.
http://seattlepi.nwsource.com/national/328272_fbinative20.html

EFFECTS OF METHAMPHETAMINES ON CHILD DEVELOPMENT

When the illegal drug, methamphetamine, is used by adult caregivers, children experience a number of disruptions in their daily lives. These disruptions may occur in escalating patterns over a period of days and weeks, or may be present immediately when the methamphetamine use begins. Methamphetamine addicts in recovery have reported that the drug becomes the most important focus in their lives and their children become unimportant, and sometimes even "in the way". Keeping in mind that most methamphetamine use in Tribal communities co-occurs with alcohol and other drugs, such as marijuana, the following indicators relating to drug use by caregivers can indicate probable neglect and high potential for other forms of child abuse as well:

- Inconsistent parenting, chaotic home
- Poor supervision, nutrition
- Exposure to interpersonal violence
- Exposure to second-hand smoke, toxic chemicals, chemical burns
- Exposure to pornography, sexual violence toward adults and child sexual abuse
- HIV exposure from needle use by parent, needles and other paraphernalia within reach of child
- Normalized criminal behavior, presence of convicted felons, drug dealers and other criminals in the child's environment

Impacts of methamphetamine exposure may be identified differently depending on the age of the child. Children area always vulnerable to abuse when drugs and alcohol are being used by caregivers, but recognition of specific effects of methamphetamine should take into consideration the level of physical activity and the independence of the child on others.

A. Methamphetamine use during pregnancy may result in neonatal death (because methamphetamine is a neurotoxin) on the fetal development, neurological system and vital organs. The infant may have a smaller head circumference and suffer from any number of anomalies including blindness, spinal cord deformities, brain, kidney and heart disorders, or cerebral hemorrhage and/or systolic murmur. These infants tend to be smaller babies and may also have limb deformities and vascular restriction. As infants, babies exposed prenatally to methamphetamine may also exhibit the following challenges:

- Sleep disturbances (may sleep so deeply that they do not eat well)
- Sensory problems: light, noise, touch (may resist being touched, especially on head & feet)
- Tremors & coordination problems
- Suck, swallow difficulties
- Lack of expression – (does not cry over discomfort, sleepiness, wet diaper, illness, hunger, etc.) OR
- Very difficult to comfort, extended periods of agitation, hypervigilent

B. Methamphetamine Exposure: Mobile Infants ("crawlers") and Toddlers

While the methamphetamine addict is focused on drug use, infants and toddlers are at high risk of exposure to direct as well as indirect effects of this drug. These children are becoming physically active yet do not have the judgment to distinguish between what is dangerous and what is safe in their environments. These children are more tactile and sensory – putting things in their mouth; tasting and touching is normal at this age. They are dependent on the adult caregivers to be vigilant and the "child's world" must be safe because of the experimental nature of this stage of development. Where significant drug and alcohol use is present, these children may also be restricted in their movement (kept in a playpen or crib), and thus fail to develop motor skills normally. At a minimum, these crawling infants and walking toddlers are endangered by the following:

- Chemical spills on floor
- Drug paraphernalia within reach
- Smoke residue on floor & surfaces
- Putting everything they can grasp in their hand into their mouths
- Small lung capacity – susceptible to respiratory problems
- Infections – combined affects of having untreated wounds, playing on floors, tables and other surfaces where chemicals have been spilled as well as generally unclean, filthy floors and poor nutrition
- Poor hygiene – lack of bathing and hair washing; still in diapers – infrequent diaper changes, inattention to rashes, etc.
- Poor sleeping & eating habits due to chaos and lack of consistent schedule
- Dependent on others for nutrition, bathing, supervision, medical attention

Methamphetamine Exposure: Pre-adolescent "Walkers and Runners"

Pre-school children are active physically and most are also curious, adventurous and busy exploring the world around them. As these children grow and become more independent, they also become more vulnerable to some of the toxins in the air and on surfaces where methamphetamines are smoked, injected, inhaled and where the drug is being cooked. While pre-school and elementary age children may demonstrate some competence in dressing themselves, independent toileting and bathing, and other aspects of self-care, they should be able to rely on adults for guidance, prompting and selecting proper clothing for the weather, proper nutrition, and appropriate sleep and play schedules. Where methamphetamine is being used the adults are commonly disconnected from the needs of these children. In addition, the curiosity and adventurousness of these children puts them at risk with weapons, chemicals, needles and other hazards within reach in drug environments. These children are also extremely vulnerable to sexual abuse by drug users whose sexual libido is greatly increased by methamphetamine use. At a minimum, the following risks are present for these active children:

- Chemical & smoke exposure enhanced by physical activity level
- Increased respiratory illness
- Behavioral challenges
- Vulnerability to sexual abuse increased
- Personal hygiene left to child
- Weapons and exposure to violence

Children in these situations are also exposed to people with criminal backgrounds, including drug dealers and perpetrators of assault, burglary and other crimes. Children may begin to normalize the attitudes and actions of the adults in their environment and eventual model the criminal behavior. Adolescents may also be coerced or forced to "run" the drugs (become involved in the delivery of drugs to others), further normalizing the drug-use behavior and environments.

WHAT TO EXPECT: EFFECTS OF METHAMPHETAMINES ON PARENTING

Adult Behaviors/Symptoms

- Increased heart rate, shortness of breath
- Moodiness, outbursts of anger
- Aggressive & violent behavior
- Paranoia ("someone is following them")
- Hallucinations
- Uncontrollable movements, twitching
- Convulsions, seizures, strokes
- Sleep problems – awake for days, then sleeping for days to recover
- Excessive talking, grinding teeth
- Sexually transmitted diseases
- Inevitable (but not irreversible) brain damage

Impacts on Child

- Physical Abuse: parent is easily agitated; increased likelihood of violence toward child and others in the home
- Neglect: parent is focused on own needs, ignores child's needs; lack of supervision, child's basic needs ignored, not taking child to school, medical and dental neglect;
- Emotional/physical: child may be locked in room or restrained so caretaker isn't interrupted or bothered by child's demands
- Sexual abuse: libido of meth user is increased, risk of sexual abuse of children and sexual assault of adults is high; caretaker is often unaware of who has access to children; may leave kids with unsafe people; may "sell" child to drug dealers or prostitute children

MANDATORY REPORTERS OF CHILD ABUSE

Any of the symptoms or conditions listed below should be reported by teachers, day care workers and others who care for children. You must report to your local child protection and law enforcement[1] agency so an investigation can be done to determine if the child is in danger or in need of intervention. In addition, if you have concerns based on the other descriptions of affects of exposure (such as skin infections, lesions/burns, poor nutrition and hygiene) discussed in this document, be sure to report those situations as well.

Signs of Meth Exposure in Children

Watery eyes
Eye pain, burning
Sneezing, coughing
Chest pain
Abdominal pain
Moderate to severe headache
Dark colored urine
Decrease in mental status
Hallucinations
Difficult & labored breathing
Discharge from eyes
Skin irritation, redness
Congestion of the voice box
Nausea & vomiting
Diarrhea
Rapid heart rate
Fever
Yellow jaundice
Extreme irritability, severe neglect

Important Safety Considerations For Those Who Do Home Visits When Working With Children & Families

- Do not enter a home if you suspect drug activity & contact law enforcement immediately
- Only contact children AFTER contact with officers, and approval
- Use protective gloves and footwear if entering the environment
- Always have covers for vehicles when transporting children from meth use or manufacturing homes
- DO NOT take children's personal clothing or toys
- Facilitate getting children to medical personnel for a drug-exposed child's medical evaluation

[1]PL 101-630, Indian Child Protection and Family Violence Prevention Act, requires all those who have "legal or other responsibility for an Indian child's welfare" to report concerns, including suspicions that the child may be in a situation that could result in abuse, to local child protection and local law enforcement authorities. Reports made in good faith protect the reporter from liability; failure to report may result in federal charges for any mandatory reporter and/or supervisors of mandatory reporters. For a full list of reporters, see 25 U.S.C., Chapter 34 and 18 U.S.C. 1169.

LIFE AFTER METH
FORMER DEALER, ADDICT FINDS PEACE IN MAKING AMENDS

WINDOW ROCK , Sept. 20, 2007

By Marley Shebala
Reprinted with permission from the Navajo Times

When Jerald Kee woke up in a ditch in Tuba City with nothing but the clothes on his back, he finally started asking himself why he was using methamphetamine. That was three years ago. Kee was 33 years old.

Today, Kee, 35, is director of the Native American Family Center outpatient program and manager of the Four Winds Sobriety House in Long Beach, Calif., where he is also studying substance abuse counseling and human services. The family center is a 15-bed facility that works with people who have rid themselves of alcohol and drugs for at least 30 days.

Kee, in a telephone interview from Long Beach, said he decided to tell his story after reading about the arrest of a former client accused of stabbing his common-law wife.

He said he was Eric Bert's meth dealer before Bert, 25, of Hard Rock, Ariz., was arrested in 2005. Bert was eventually sent to prison and then to a halfway house for one year, where he started his recovery from meth, alcohol, and domestic violence. Bert's story appeared in the Navajo Times ("After the fall: Meth addict travels long road home," July 5, 2007) after he spoke at a June 20 workshop in Pi–on, Ariz.

"I'm very thankful that Eric Burt made a change and is helping his relatives," Kee said. "My heart is full of joy." He noted that unlike Burt, he had no family support when he began his recovery because his meth addiction had driven away his wife, three children and other relatives.

Crooked path

Kee was raised in a traditional family at Dennebito, Ariz., and grew up speaking Navajo, helping out with the animals and with traditional ceremonies. His road to meth began when an uncle and other relatives gave him a taste of alcohol and marijuana when he was a fifth-grader. He remembered thinking that if he didn't do as they did, they wouldn't want him around.

"They didn't say that to me but I thought if I didn't smoke with them I wouldn't be cool," Kee said. "I wanted to be accepted, to be one of the guys." Members of the N‡t'oh Dine'é (Tobacco People Clan), they corrupted it by calling themselves the Marijuana Clan, he recalled.

"It was a joke but it was really disrespecting our clan, relatives and our tribe," Kee said. By 16, he had graduated to dealing marijuana and cocaine while attending Tuba City High School.

"I thought I was popular because people were around me," Kee remembered. Though a good student, he said, he started ditching school and dropped out during his freshman year. He continued to support himself as a drug dealer throughout his teens and early twenties, buying a house in Tuba City and starting a family.

He also remembers his first taste of meth.

"Like any addict, I ran out of marijuana and I was looking for something to get me high," Kee said. "There was this guy who brought a lot of meth onto the rez. I thought it wouldn't be any different than marijuana but when I tried it, it totally got hold of me. I got addicted."

His meth addiction made him forget his promise to himself - that he would never sell or use drugs in front of his wife and three kids, ages 1, 4 and 6 at the time. "I started smoking when they were around," Kee said. "I chose the drugs over my family. That's how addictive the meth became. Marijuana would just burn me out, make me lazy."

But the meth made him "all hyper, do things real fast," and think he could fix anything.

"It got me so hyper, I would be awake for days while my wife and kids slept," Kee said. "It was like I was married to it. I had to have it. I started taking things from my house to get it."

He and his wife had been together for nine years, but she never used, he emphasized.

"I was basically hiding everything," he said. "She knew I smoked marijuana but she never knew about the meth. She found out after I started staying up all night, not eating, losing weight, slurring my speech, sleeping for a couple of days. When I didn't have it, I was angry, grouchy. So it was getting really obvious."

Continued on page 4

LIFE AFTER METH: FORMER DEALER, ADDICT FINDS PEACE IN MAKING AMENDS cont.

Losing everything

Kee's growing meth use gobbled up his income, which had been in the range of a couple of thousands dollars a month. He started losing everything - their cars, their house, "anything a dad or husband would want. But at the time I didn't really care because that meth had a grip on me.

The meth came ready to sell from Phoenix, from people he thought were his friends. "But they were just making money," he said matter-of-factly.

The suppliers included a Hopi and some Navajos. They'd arrive at his house every Monday, where they'd split the meth for distribution across the Navajo and Hopi reservations.

One day, his family had enough and he found himself alone. "My wife and kids didn't want to be around me," Kee remembered. "I started to be verbally abusive."

"I kept using, using," Kee said. "I basically hit rock bottom. I lost all respect from my own relatives for cheating and lying. And I started stealing from people to get my drugs."

Less than a year had elapsed between the time he first used meth, and the day he woke up in the ditch. Kee remembers sitting there and praying for answers to his questions about why and how he had sunk so low.

He also thought about his older brother Harold, who had died the day before in San Carlos, Ariz. "I don't know what happened to him to this day," he said. He learned about Alcoholics Anonymous after picking himself up out of the ditch and going to the local Department of Behavioral Health Services office for help.

Long way back

Kee was referred to Community Behavioral Health Services in Page, where he spent five days in the detoxification center.

When he returned, the Tuba City counselors told him about American Indian Changing Spirits, a six-month alcohol and drug abuse treatment program in Long Beach.

His treatment was funded by DBHS, but he had to make the commitment to stay through the full six months, and to stay clean while on the waiting list to get in. He went home to Dennebito, where his grandmother took him in and drove him to outpatient treatment appointments.

After a two-month wait, a spot opened up and Kee caught a bus from Flagstaff two days before Thanksgiving 2005. "I was still hesitant to go but deep inside I knew I had to go because I knew I didn't want drugs to take my life," Kee said. "So I stood strong and got on the bus."

Kee said the AICS treatment program helped him find and love himself again. He also learned how to let go of "all my egos" and open his mind to many teachings, which helped him to slowly admit that he was an addict.

And with those realizations, he knew he had to temporarily sever his ties to home, even the phone calls, in order to focus on his treatment and what he needed to do.

But it was his connection to his children that sustained him.

"I missed my kids every day and that's what pulled me through," Kee said. "I asked myself, 'How can I help them, do something better for them?' My wife had moved on but I wanted my kids in my life because I love them."

He graduated from the AICS program in May 2006, which included earning his GED. A couple of weeks later, as part of his exit plan, he enrolled in Long Beach City College to become substance abuse counselor.

As Kee attended school, he volunteered at the Native American Family Center outpatient program. And after a couple of months, he was asked to conduct talking circles by Matt Jimenez, the NAFC executive director and co-founder. Jimenez, in a separate interview, said he's known Kee for a year and met him when he finished the Changing Spirits program.

He recalled Kee telling him that coming to the Native center was a "spiritual journey" and that the talking circles were a "sacred space."

"He is doing very good," Jimenez said. "As far as being a leader, he's developing. He is utilizing skills, such as people skills. I emphasize to all the workers that it's important to have positive communication and he does. He's understanding and he's patient with clients and at the same time he can be more direct."

He noted that Kee's experiences with meth, marijuana, cocaine and alcohol actually have helped him be more effective now as a counselor. "He helps (people with addictions) identify the traps they can fall into and how to avoid those traps," Jimenez said. "He knows how to guide them to safe zones.

"It's really been a blessing to know Jerald because our paths crossed at a time when he needed our help. But soon we found out he became an integral part of what we were doing. It was very timely," he said.

What the future holds

Kee makes periodic visits home and plans to eventually return to the reservation to help his people as a behavioral health administrator and spiritual person.

"When he came, he was very tender, and I think things bothered him more," Jimenez said. "But through every experience, I've seen him get stronger.

"At our staff meeting yesterday, I could see he's become more objective and he's not affected by other people like when he got here," Jimenez said. "It's all a process. And the process is time.
And time will let everybody know surrounding that one person whether the changes are permanent and real and lasting."

Kee said that when he went home, his relatives didn't want anything to do with him because of the reputation he had made for himself.

His former buyers wanted to know if he had something to sell.

"It hurt for someone to ask me for drugs," Kee said. "But it was my own doing for people to see me like that. There are a lot of people that don't know that I'm doing this (alcohol and drug abuse counseling)."

He said that when he was first asked for drugs, he didn't tell the individuals that he had become an alcohol and substance abuse counselor.

"Part of me wanted to tell them that I was a counselor and a part of me didn't," Kee recalled. "I didn't want to tell them at the beginning because I was kind of ashamed. I had introduced them to the drug and it hurt to see them like that."

But then he thought about how his lifestyle change could help them.

Kee said, "I wanted them to know and start thinking, 'If that guy, who was really bad, can change, then I can too.'"

And so he gave his alcohol and substance abuse counseling business card to the next person who asked him if he had any drugs to sell.

"Some didn't believe," Kee remembered. "And even my own dad didn't believe what I was doing, even when I gave him my own card."

But he said his family is "full of joyful tears to see me like this.
There is life without substance abuse.

"I spent most of my life spreading the disease of drugs, the addiction," Kee said. "This interview is my way of making amends to my relatives and to help them live a better life. I can't make everybody forgive me. But making amends will make me feel better and that's one step in Alcoholics Anonymous."

Kee will be a guest speaker at the Department of Behavioral Health Services in Tuba City on Monday, Sept. 24.

Information: 928-283-3031/32, or Jerald Kee, 562-495-4534 or 562-208- 8948, or e-mail jeraldkee@yahoo.com.

Indian Health Service
Head Start Program

801 Vassar Dr., NE
Albuquerque, NM 87106

Phone: 505-248-7694
Fax: 505-248-7728
http://www.ihs.gov/NonMedicalPrograms/HeadStart/

The IHS Head Start Program is the provider of preventive health support services for AI/AN Head Start programs funded by the Head Start Bureau - American Indian/Alaska Native Programs Branch (AI/ANPB). The mission of the IHS Head Start Program is to assist AI/ANPB Head Start grantees in the development and enhancement of comprehensive health service programs for children and families by promoting preventive health services and interventions, and by assisting in the development and mobilization of health care systems to ensure ongoing health care. This is accomplished by promoting preventive health services such as nutrition, physical activity, mental health, family wellness, environmental health, oral health care, injury prevention and other health priorities identified by the grantees and assist the grantees in developing health partners at the local, state and federal level.

Selected Child Endangerment and Methamphetamine Resource List

Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims, Swetlow, Karen, OVC Bulletin, U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, June 2003.

Drug Courts: An Effective Strategy for Communities Facing Methamphetamine, Huddleston, C. West, III, Bureau of Justice Assistance Bulletin, U.S. Department of Justice, Office of Justice Programs, May 2006.

Impact of Methamphetamine Abuse on Children and Families, Shaw, Rizwan Z., M.D., FAAP, Blank Hospital for Children, Des Moines, Iowa.

"Methamphetamine abuse among women on Navajo", Kathleen, Horner, Maternal and Child Health, OB/GYN Chief Clinical Coordinator's Corner, parts 1 – 4. All the articles may be found at http://www.ihs.gov/MedicalPrograms/MCH/M/index.cfm.

Meth and Child Welfare: Promising Solutions for Children, Their Parents and Grandparents, Generations United, 2006. www.gu.org.; includes The Impact of Meth on Children and Families: Answers to Commonly Asked Questions.

Methamphetamine Use: Lessons Learned, Hunt, Dana, Ph.D., Sarah Kuck, Linda Truitt, Ph.D., National Institutes of Justice, Office of Justice Programs, 2006.

Substance Use During Pregnancy: Time For Policy To Catch Up With Research, Lester, Barry M., Lynne Andreozzi and Appiah, Lindsey, Harm Reduction Journal 2004, BioMed Central, http://www.harmreductionjournal.com/content/1/1/5

The Meth Epidemic in America, Two Surveys of U.S. Counties: The Criminal Effect of Meth on Communities, the Impact of Meth on Children, Kyle, Angelo D., NACo President and Hansell, Bill, NACo President-Elect., National Association of Counties.

Working With Methamphetamine Abusers: Personal Safety Recommendations And Procedures, Webber, Randall, M.P.H., Chestnut Health Systems Lighthouse Institute, 2006.

Other web sites that may provide valuable references and information on methamphetamines to support increased awareness.

- www.nationaldec.org
- www.methresources.gov
- www.whitehousedrugpolicy.gov
- www.methamphetamine.org/presentations
- www.ncsacw.samhsa.gov/Methamphetaminelist
- www.mappsd.org
- www.oas.samhsa.gov
- www.notevenonce.org

TRIBAL SPECIFIC RESOURCE LINKS:

http://www.tribal-institute.org/lists/pubs.htm - downloadable research article on *Perceptions on Three Western Reservations Regarding Impacts of Methamphetamine on Child Safety* referred to above, and other tribal and child abuse resources
http://www.mappsd.org/Home10.htm - Indian country specific pages
http://www.ihs.gov/medicalprograms/behavioral/index.cfm?module=bh&option=meth – Indian Health Service links Methamphetamine Initiative
http://www.ncai.org/News - Methamphetamine Toolkit and other announcements
http://www.banishmeth.com/ - N. Cheyenne meth information site
http://www.sheepheadfilms.com/ - Navajo video "G" can be ordered here
http://www.tribalresourcecenter.org/resources/other/resourcedetails.asp?83 – links
http://www.atsdr.cdc.gov/tribal/services.html - research reports and other resources