PHOENIX AREA INDIAN HEALTH SERVICE
ALCOHOLISM/SUBSTANCE ABUSE PROGRAM
WHISPERING WIND

Volume 1, Issue 3 October 2000

Special points of interest:

- More than 40 counselors and prevention specialists attended the North American Congress 2000. Many interests were captured by the Drug Court Track and new technologies such as the Harm Reduction methodology, in the field.
- The new CEO of Southern Indian Health Council Incorporated, accompanied by the Program Director and Intake Coordinator gave a presentation on their RTC located in Boulevard, California to everyone who attended the post conference meeting sponsored by the PHXAO–A/SAP. Ms. Paula Colpa is the Intake Coordinator and can be reached at (619) 478-2269 extension 206.

Inside this issue:

NEXT ISSUE

DATE: JANUARY 2001

- **ADHD PART-II COMPLEMENTARY APPROACH**
- **I AM LISTENING!**
- **CDMIS**

Attention Deficit Hyperactivity Disorder (ADHD)-Part I

By: B. Nayeri, ND

This article examines the prevalence of ADHD and behaviors that cause significant impairment in a child's daily functioning. The differential diagnoses, including organic medical conditions that mimic ADHD are mentioned. The part-I of this article begins to convey therapeutic considerations, including suggestions for teaching parents to support these children more effectively.

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder characterized by a persistent pattern of inattention and/or hyperactivity/impulsivity that occurs in academic, occupational (when applicable), or social settings. Problems with attention include carelessness, inability to complete tasks (jumping from one task to another), disorganization and difficulty keeping track of things, becoming easily distracted, etc.

Problems with hyperactivity can include being excessively fidgety and squirmy a great deal, running or climbing when it is not appropriate, running into the street without paying attention to the traffic, excessive talking, and being constantly on the go acting as if "driven by a motor." Impulsivity can show up as impatience, difficulty awaiting one's turn, blurting out answers, and frequent interrupting.

Although many individuals with ADHD display both inattentive and hyperactive/impulsive symptoms, some individuals show symptoms from one group but not the other. Of course, many of the behaviors described above are typical of normal children. When they occur only occasionally and do not impair daily functioning, they are most likely...

(Continued on Page two)

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Managing Editor: Babak Nayeri, ND, MS

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Publication of Articles

Articles, comments, requests, and letters to B. Nayeri are welcomed. Articles submitted for publication should be no longer than 3000 words in length, typed, double-spaced, and conform to publication standards. Additional guidelines can be obtained from the publisher at office of A/SAP

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(Continued from Page 1)

reflective of normal childhood behavior. However, in a child with ADHD these behaviors, which are observed often, can cause significant impairment in daily functioning.

Epidemiology:

There is a 1-20% prevalence of ADHD in childhood. The gender ratio of ADHD is 3 boys to 1 girl. Nationally, it is estimated that 85% of the special education budget is spent on education for children with this condition. Furthermore, 10-60% of childhood symptoms of this disorder persists into adulthood. [Barkley 1990, 1994]

Differential Diagnosis:

It is possible that an individual's functioning may be impaired by ***pervasive developmental disorder***, ***schizophrenia***, or some other ***thought disorders, mental retardation, hyperthyroidism*** (endocronoligcal), ***post-traumatic encephelopathy***, ***stress effects on the frontal lobe***, ***neurological disorder***, ***neurotransmitter imbalances***, and therefore unrelated to ADHD. In diagnosing ADHD, it is necessary to confirm that it is not one of these other disorders that is responsible for the symptoms. The severity of such disorders should be clearly differentiated. Differential diagnoses such as ***anxiety disorder***, ***conduct disorder***, and ***alcohol/drug abuse*** are most likely to be the cause of ADHD-like symptoms when the symptoms emerge after age 7, and there is no indication of ADHD symptoms at an earlier age.

Differential Diagnostic Evaluation is necessary for appropriate treatment.

In a child with ADHD, the symptoms are present in *two* or *more* settings (e.g., at school [or work] and at home). Therefore, in assessing a child for ADHD it is necessary to corroborate with parents *and* teachers. This is usually accomplished through a series of questionnaires. If a child's parents and teacher report that s/he displays more problems with attention and hyperactivity than a majority of children his/her age, then this is a good indicator for a comprehensive evaluation, usually conducted by a child psychologist.

Therapeutic Considerations

It is important for counselors to instruct parents and educators on effective behavioral management techniques.

PEARL

Nintendo and T.V. are more interesting than school because it provides immediate reinforcement, it is rapidly changing and exciting.

The Friends and Foes: Applying prolonged time-outs and taking away the Nintendo privileges as a consequence is considered ineffective in dealing with a child who is suffering from inattention and/or hyperactivity. Instead, the consideration ought to be for *behavior-specific*, *time-appropriate* and *outcome-desired* consequences.

We must keep in mind that the goal of behavior therapy is to increase the frequency of desirable behavior by increasing the child's interest in pleasing parents and teachers and by providing positive consequences when the child behaves. Inappropriate behavior is reduced by consistently providing negative consequences when such behavior occurs. The goal of this therapy is to build up good feelings between you and your child so that your child will become more invested in wanting to please you. When this occurs, discipline and limit setting generally proceed more smoothly.

When parents first try this approach, they are often surprised at the results. The child gets chores, homework, or errands done. It is however, important to consistently follow through with spending the extra time which will be required to implement such a behavioral program. The absence of this special time with the child can be a real loss for both parents and children, and working to make it part of your routine can yield substantial benefits in the parents' relationship with their children.

1. Onset is before 7 years of age.
2. Potential for Alcohol/Drug Abuse (80% of adolescents in C.D. treatment are ADHD). [Barkley 1990, 1994]
3. Sleep Problems.
4. Poor social relationships.
5. Inattentive.
6. Accidental injuries.
7. Restless.
8. Fearless.
9. Overreacts.
10. Aggressive Behavior.
11. Noisy & interruptive.
12. Learning problems & Academic Failure.
13. Problems with Executive Functions such as: Language, Thinking, Memory, Factual & Emotional processing, and Decision making.
14. Delinquency.

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(Continued from page two)

Teach the parents to:

Be very clear about what behavior is expected of their child in order to earn the reward and make sure the child understands this.

1. Make sure that the expectation they have for their child is reasonable - parent (s) not set themselves and the child up for failure by having expectations that are not appropriate for the child's age.
2. Try not to work on too many different things at one time.
3. Let their child participate in choosing the types of rewards he or she can earn.
4. Design the program so their child has a good chance to experience some initial success.
5. Be sure to provide lots of social rewards (e.g., praise) in addition to the more tangible rewards that can be earned.
6. Be consistent. Try and make school and home more "Nintendo-like."

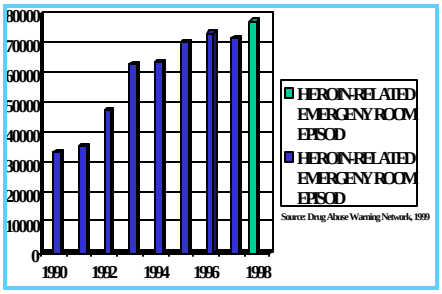
SUMMARY

As is hopefully clear from the above, the diagnosis of ADHD is not a simple matter. It requires that careful attention be given to a number of specific symptoms; that information about a child's functioning be collected from different sources (i.e. at least parent and teacher); that there be clear indication of impaired functioning in important life areas; that appropriate psychological testing battery be done and that other possible explanations for a child's symptoms are ruled out. When these detailed criteria are applied, you can be confident that the diagnostic judgment is more likely to be accurate. Then it is vital to assist the parents and teachers to utilize behavioral, parenting and teaching techniques to bring about greater academic and social success and increased self-esteem for the child, as well as an acceptable and satisfying classroom and home environment for all concerned.

(Natural Alternative Considerations in the **Next Issue of Whispering Wind…)**

Heroin-A Deadly Drug

Heroin is a narcotic derivative of the opium poppy plant chemically known as diacetylmorphine. It is an alkaloid



prepared from morphine by acetylation. In other words, it is morphine with at least twice the potency, or "morphine with an attitude." Pure heroin is a white powder with a bitter taste. Most illicit heroin is distributed in powder form and may vary in color from white to dark brown. The variation in color is caused by impurities left from the manufacturing process or the presence of additives in most street heroin, when it is "cut" with other drugs or with substances such as sugar, starch, powdered milk, or quinine. Street heroin can also be cut with strychnine or other poisons. The purity of street heroin ranges from one to ten percent; more recently, the purity of heroin, especially that from South America, has skyrocketed to rates as high as 98 percent, with the national purity average at 41 percent. Heroin is most often injected; however, high-purity heroin may also be snorted or smoked. Another form of heroin known as "black tar" is available in the western United States. Black tar heroin, which is produced only in Mexico, may be sticky like roofing tar or hard like coal, and its color may vary from dark brown to black. The color and consistency of black tar heroin result from the crude processing methods used to illicitly manufacture heroin in Mexico. Black tar heroin is often sold on the street in its tar-like state at purities ranging from 20 to 80 percent. It is most frequently dissolved, diluted, and injected. The effects that heroin may have on users include euphoria, drowsiness, respiratory depression, constricted pupils, and nausea. Due to severity of the abstinence syndrome and protracted abstinence, the abuser deals with a drug "panic," and through a vicious cycle continues to use in order to

State of New Mexico

YEARS	HEROIN-RELATED DEATHS
1995-1997	274
1992-1994	209
1989-1991	131

Source: New Mexico Office of the Medical Investigator

avoid the unpleasant symptoms of the abstinence syndrome (withdrawal). Withdrawal syndrome usually occurs about **4** to **8** hours after the last dose, and can reach its *peak* at **36** to **72** hours. The disturbances could subside in 5 to 10 days. Symptoms of heroin overdose include slow and shallow breathing, clammy skin, convulsions, coma, and because heroin abusers do not know the actual strength of the drug or its true contents, they are at constant risk of overdose or possible ***death***. Heroin also poses special problems because of the transmission of HIV, Hepatitis, Septicemia, Acute Endocarditis, and other diseases that can occur from sharing needles or other injection equipment.

Tribal Leaders Roundtable on Community Approaches for Addressing Alcohol and Substance Abuse

Interagency Task Force

- The Interagency task force will consult with tribal leaders on funding and resources and operate within a Government-to-Government relationship
- The Interagency Task Force shall strive to meet the goal of the President's Executive Order on Consultation
- Develop coordination of funding, programmatic, and technical assistance among federal agencies
- Increase coordination within federal agencies, bureaus and offices e.g., Office of Justice Programs, U.S. DOJ

Interagency Task Force

The primary responsibilities of the task force shall be the following:

- Coordination of federal policies that affect American Indian and Alaska Native actions to address alcohol and substance abuse among federally recognized tribes or actions by any agency or agencies of the federal government, which may significantly impact tribal alcohol or substance abuse efforts.
- To assure that each federal agency develops a policy on consultation with American Indian and Alaska Native on alcohol and substance abuse efforts.
- To assure adequate permanent funding to provide for a comprehensive tribal response to alcohol and substance abuse

Interagency Task Force

The task force shall be comprised of representatives from: each federal agency that establishes or implements policies that affect federally recognized tribes in their effort to address alcohol and substance abuse and violence, including the Departments of:

- Interior, Justice, Health and Human Services, Housing and Urban Development, Transportation, Commerce, and Education, and
- The Executive Office of the President- Office of National Drug Control Policy

Funding Issues Addressing Alcohol and Substance Abuse

- Increase Funding for Prevention
- Create permanent and direct funding for tribes
- Support family preservation programs
- Support regional treatment
- Increased funding for Head Start
- Support increased funding for Safe Futures for Indian Nations
- Increase support for shelter programs for women
- Support $2 billion special initiative to enhance healthy nations, for facilities and programs to be added to base funding for tribes
- Comprehensive funding for continuum of care prevention, intervention, and treatment by federal agencies

Post Summit Activities

- Immediate creation of the Interagency Task Force
- Prepare briefing papers on alcohol and substance abuse, and violence in Indian country for the next Administration
- Immediate publication and dissemination of the Summit Proceedings to tribal leaders.

Policy

- Create non-competitive, permanent funding for programs addressing alcohol, substance abuse, and violence
- Fund tribes directly
- Develop funding guidelines supporting programs based on tribal culture and beliefs
- Support Indian preference for federal agencies administering Indian programs
- Support tribal consortiums
- Move Indian Health Service budget to Health and Human Services appropriations from Interior appropriations
- Support certification for Indian counselors
- Increase state mandates for Temporary Assistance for Needy Families (TANF) including administrative cost
- Develop tribal programs based on traditional beliefs, e.g. Native arts, peacemaking and healing, etc.
- Training federal administrators to work effectively with Indian Nations
- Inhalant abuse treatment and education on cocaine, crank, etc.
- Suicide prevention
- Family mentorships and parent strengthening
- Gang prevention, intervention, & suppression
- Support for welfare moms
- Support for domestic violence shelter programs for women and children
- Tribal treatment facility

Intergovernmental Issues

- Regular consultation on current and future programming, funding and policy addressing alcohol and substance abuse
- Federal funding guidelines based on government-to-government relations
- Adherence to the Executive Order with a clear plan for consultation by each federal agency
- Continue forums for dialogue, e.g., summits

SPECIAL EMPHASIS AREAS

- Support strategies for unique issues of California and Alaska tribes and for other tribes
- Recruit and retain Native American counselors

Tribal Leaders Alcohol and Substance Abuse Issues
Tribal Leaders roundtable on Community Approaches for Addressing Alcohol and Substance Abuse

- Training for federal practitioners of Indian programs, e.g., FBI, USA, BIA criminal investigators, federal probation officers, IHS health professionals, DOT, HHS, HUD, etc.
- Develop youth involvement in planning i.e. Youth council
- Economic development for Indian nation communities
- Support socially responsible drinking and sobriety
- Provide leadership in modeling implementation of drug testing, policies and sobriety
- Develop mission statement
- Strengthen local and national tribal consortiums
- Strengthen tribal partnerships
- Develop tribal guidelines for drug testing and other policies
- Support certification for Indian counselors
- Support training for administrators and practitioners to work effectively with Indian Nations

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REGIONAL TRAINING SIGN-UP FORM
DSM-IV, ASAM Placement Criteria, and SASSI Training

Name _____

Address _____

_____

_____

_____

Phone _____

Mode of Travel

- ☐ POV
- ☐ GSA
- ☐ Tribal Government Vehicle
- ☐ Commercial Airline
- ☐ POV and Commercial Airline

Tribal/Program Affiliation _____

Sign up for: DSM-IV, ASAM SASSI	Time	DAY(S)
☐ November 14 & 15, 2000 (Salt Lake City)		1 2
☐ November 29 & 30, 2000 (Salt River-Phoenix)		1 2
☐ December 13 &14 (Inter-Tribal Council of Nevada)		1 2
☐ January 10 & 11, 2001 (Las Vegas)		1 2
☐		
☐		

To sign up for the Phoenix Area A/SAP Regional Training, please complete the above form and return it to us by mail.

PHOENIX AREA INDIAN HEALTH SERVICE

Alcoholism/Substance Abuse Program

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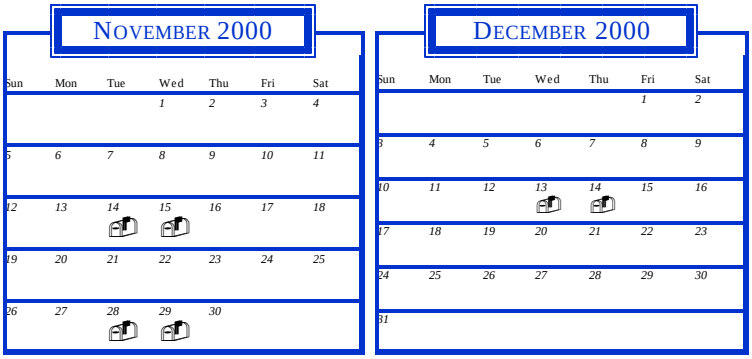
B. Nayeri

We are on the web at:
<http://www.ihs.gov/MedicalPrograms/Alcohol/index.asp>



BULLETIN BOARD

REGIONAL TRAINING SCHEDULE

NOVEMBER 14 & 15 **INDIAN WALK-IN CENTER - SLC**
NOVEMBER 29 & 30 **PAIHS (6TH FLOOR)**
DECEMBER 13 & 14 **ITCN**
JANUARY 10 & 11, 2001 **LAS VEGAS (COLONY)**

All DSM-IV, ASAM and SASSI Trainings are scheduled for two days from 8:30 AM to 4:00 PM
Make Your reservations Now!

Resources

Books...

- Cognitive-Behavioral Therapy With ADHD Children : Child, Family, and School Interventions by Lauren Braswell, Michael Bloomquist.
- Family Therapy for ADHD: Treating Children, Adolescents, and Adults by Craig A. Everett, Sandra Volgy Everett.
- Defiant Teens: A Clinician's Manual for Assessment and Family Intervention by Russell A. Barkley, et al.
- ADHD in the Schools: Assessment and Intervention Strategies (Guilford School Practitioner Series) by George J. Dupaul, Gary Stoner.
- Childhood Psychopathology by Eric J. Mash (Editor), Russell A. Barkley (Editor).
- ADHD and the Nature of Self Control by Russell A. Barkley.
- Attention Deficit Hyperactivity Disorder by Russell A. Barkley, Kevin R. Murphy.
- Defiant Teens by Russell A. Barkley, et al.
- ADHD in Schools by George J. Dupaul, Gary Stoner.
- Family Therapy for ADHD by Craig A. Everett, Sandra Volgy Everett.
- Treatment of Childhood Disorders by Eric J. Mash (Editor), Russell A. Barkley (Editor)
- ADHD Rating Scale-IV by George J. Dupaul (Editor), et al.
- Defiant Children by Russell A. Barkley.

Child Psychopathology by Eric J. Mash (Editor), Russell A. Barkley (Editor).

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RESOURCES

ADHD Resources

CH.A.D.D.
http://www.chadd.org/
800-233-4050
Chapters: *Phoenix* 602-706-5162
Kim Flessor, Coordinator
Tucson 520-744-9493
Nancy Hanley, Coordinator

ADA & Disability Information
Http://www.public.iastate.edu:80/~sbilling/ada.html

Information to assist parents and professionals in understanding ADHD and helping children with ADHD to succeed: ***www.helpforadd.com***

National ADDA
1788 Second Street, Ste 200
Highland Park, IL 60035
E-mail: mail@add.org
Phone: 847-432-ADDA

Centers For Disease Control (CDC)
http://www.cdc.gov/nceh/cddh/ADHD/dadphra.htm