

The RURAL MONITOR

A Publication of the Rural Assistance Center

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Meth Abuse a Smoldering Crisis

By Hope Hanson

Methamphetamine abuse in rural America is a burning bush bursting into a raging wildfire.

"Meth abuse is now recognized as the number one drug abuse problem," said Joe Hansen, former emergency medical technician (EMT) and executive director of the Critical Illness and Trauma Foundation in Bozeman, Montana.

Methamphetamine, or meth, is a highly addictive synthetic stimulant easily produced with readily available farm and household chemicals. Users are making their own meth, particularly in rural areas, where pungent production odors remain far from detection. Once considered a victimless crime, meth abuse is infiltrating all corners of society.

Stories abound of emergency room horrors, addicts choosing meth over their children and seized clandestine meth labs rivaling Superfund toxic waste sites. For healthcare and social services providers, meth is straining the system.

"There are so many different groups affected," said Julie Nelson Ingoglia, senior analyst with the National Association of County and City Health Officials. "It's not a problem that can be signed off on by any one group."

Just how many meth users live in rural areas is unknown. Most surveys of meth use in the United States have concentrated on metropolitan areas, such as tracking emergency room and treatment admissions in city hospitals. Surveys of meth use in nonmetro areas tend to focus on a single region of the



"(Its users say) the pleasurable feeling you get from a hug would be worth five dollars, the feeling of getting a new job you desperately wanted would be \$1,000, and with a meth rush, it's a million dollars.

country, or do not break down the data by both type of drug and geographic area of use. As meth's rage continues, though, more studies on its use are emerging.

But studies are making no difference to the rural healthcare providers, social workers, emergency medical services (EMS), and law enforcement personnel who cross meth's fiery path. They've seen enough of meth's searing consequences to know exactly how the drug is exhausting their resources and in many cases endangering their own well-being.

First Responders: In the Line of Fire

Of the more than 30 chemicals that can be used in various combinations to "cook" meth, one-third of them are extremely toxic. For every pound of meth produced, about five pounds of

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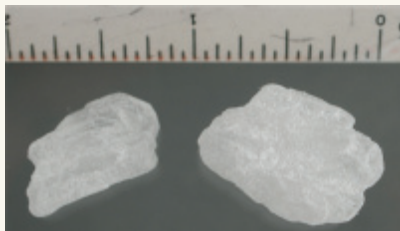
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METH IN A MINUTE: FAST FACTS ABOUT METHAMPHETAMINE



- Methamphetamine can be smoked, snorted, orally ingested and injected.
- The intense rush and high felt from methamphetamine results from the release of high levels of dopamine into the section of the

brain that controls the feeling of pleasure.

- Methamphetamine precursor chemicals usually include pseudoephedrine and ephedrine drug products.
- The price of methamphetamine ranges nationally from \$20 to \$300 per gram.
- Research has shown that as much as 50 percent of the dopamine-producing cells in the brain can be damaged by prolonged exposure to relatively low levels of methamphetamine and that serotonin-containing nerve cells may be damaged even more extensively.
- Street terms for meth include “chicken feed,” “cinnamon,” “peanut butter,” “sketch,” “spoosh” and “tick tick.”
- Methamphetamine users initially experience a short, intense rush that is followed by a sense of euphoria lasting up to eight hours.
- Methamphetamine use increases heart rate, blood pressure, body temperature and rate of breathing. It produces extra energy and stamina, an increased libido, a sense of invulnerability and a decrease in appetite.
- Chronic, high-dose methamphetamine abusers may exhibit increased nervousness, paranoia, schizophrenia-like symptoms, irritability, confusion and insomnia. Violent and erratic behaviors frequently occur in the last phase of meth bingeing.
- Withdrawal from high doses of meth invariably produces depression, which varies in severity and duration but may last for months or even years.
- Products used to make meth can include anhydrous ammonia, lithium camera batteries, matches, charcoal lighter fluid, paint thinner and sulfuric acid.

Sources:

- <http://www.whitehousedrugpolicy.gov/publications/factsbt/methamph/>
- *OVC Bulletin, June 2003, Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice.*

(continued from page one)

highly toxic waste are generated. This creates a dangerous and formidable working environment for law enforcement and first responders, who are frequently called to meth labs because of fires or explosions.

“It (entering meth labs) poses a pretty substantial risk because of the possibilities of coming into contact with a very toxic environment,” said Nels Sanddal, director of the Rural Emergency Medical Services and Trauma Technical Assistance Center (<http://www.remsttac.org>). Sanddal, who has worked for 30 years in emergency medical services, says emergency services volunteers will need even further training in the years to come.

“It’s different when you know you’re going to a car accident or water rescue—you can prepare en route. But a meth home full of toxic residue creates additional training requirements,” Sanddal said.

And, he said, advanced training for meth lab emergencies differs by town.

“The current protocols vary by the experience of the community, but most must wait for law enforcement to secure the site,” Sanddal said. “This is good and bad because it’s safer but it can delay access to care for victims—plus it creates anxiety for the emergency technicians not knowing what to expect.”

However, in this post-9/11 era, better emergency training is taking place.

“Homeland security has brought about heightened awareness and improved training. It has also created new relationships between fire, police and EMS. There is an increasing overlap of tools and training,”

Sanddal said. “This is great but it’s unfortunate we have to think about this.”

Sanddal said another problem sparked by meth abuse is low volunteerism rates in rural emergency services. “If it gets too bad, volunteers may choose not to risk their well-being anymore for the sake of meth,” he said.

Health Effects

Even if a meth maker or addict does not meet up with the law, the use of meth itself is dealing its own cruel penalties.

Rural dentists are seeing a rise in what they call “meth mouth,” a condition leaving an addict’s teeth stained, rotten and useless within months.

“What you see is serious decay and deteriorated teeth,” said Dr. Thomas Dimich, a dentist in Thief River Falls, Minnesota.

Several factors are believed to contribute to meth mouth. Using the corrosive drug dries up saliva, which leaves teeth defenseless against cavities. Meth users often report a habit of severe teeth grinding. Adding fuel to the fire is a user’s craving for sugary sodas. That, in addition to poor oral hygiene, creates brittle, broken teeth in a matter of months.

To learn more about meth mouth, dental instructor/researcher Charles Tatlock and dentist Stephen Wagner at the University of New Mexico Health Sciences Center in Albuquerque are beginning a study on the mouths of meth users. It is considered the nation’s first study on the progression of the condition. An earlier study by John R. Richards and B. Tomas Brofeldt of the University of California-Davis, in which

meth users were interviewed in an urban hospital emergency room, found that those who snorted the drug showed significantly higher damage in their upper front teeth than other users of the drug.

Another dire consequence of making meth is the risk of serious burns. Inexperienced meth makers can easily see production go awry with a resulting fire or explosion. Often, burns are serious—so serious that rural healthcare providers must use limited resources to stabilize these patients. Because of the extent of injuries, patients frequently are transferred to regional burn centers to complete their healing. And often, their healing time is extended because of initial poor physical and mental health.

Dr. Lynn Solem, a physician with The Burn Center at Regions Hospital, St. Paul, Minnesota, has treated meth burn patients. “Typically, they don’t do as well,” Solem said. “Their attitude and general health status may not be as good as the normal population.”

With more time in the hospital, whether rural or urban, meth burn victims see their healthcare bills skyrocket. Often, they are unable to pay, because they have no insurance and their money is in drugs. This drains the resources of hospitals.

Meth’s Other Effects

The furor of meth addiction also has ignited another issue: the welfare of children. Children who are present during drug production face acute health and safety risks, including the hazards of fires, explosions, abuse and medical neglect, according to the U.S. Department of Justice. A flood

of incoming children whose meth-addicted parents cannot care for them is straining state child-welfare systems. In Oklahoma, the foster-care system is handling 16 percent more children this year than last; in Kentucky, 12 percent more kids are in foster care. Oregon officials say that their foster-care population would be half the current 5,515 children were it not for meth. Tennessee officials say 700 children were in foster care last year because of their parents’ use of meth, up from 400 in 2003. Complicating the problem is the fact that so many meth users live in rural areas, where social services are minimal, according to the organization Join Together (<http://www.jointogether.org>).

Also affected are those children exposed in utero. Oklahoma was recently chosen to participate in a federally financed study of the effects of methamphetamine on babies born to addicted mothers. In previous studies, researchers found that the babies of meth addicts are often smaller at birth than babies who have not been exposed and that they suffer withdrawal from the drug. They also have more trouble eating or bonding with their parents.

Besides the devastating social costs, how much money is meth costing society? A lot in Multnomah County, Oregon, according to two Portland economists.

Their study, which was reported by the Oregonian newspaper in April 2005, found that the cost of direct damages from meth in the county—including meth-related property crimes, fires, property cleanups, foster care and health—was \$102.3 million, or \$363 per household. Their cost analysis did not include

the police, court, treatment and jail costs of meth, but mostly measured the costs borne by the community-at-large through direct economic losses, higher insurance premiums and other means. By comparison, the average county income-tax payment there is \$355.

The Root of the Problem

While health care continues to respond to meth's consequences, social services workers in rural areas are working on the root of the problem.

"Addiction is a tough thing to treat, but we're getting better at it all the time," said Melissa Dearthmont, a licensed clinical social worker in Wyoming. "Research and better medical models are emerging all the time."

Dearthmont says experts are finding that meth is so highly addictive that

it involves long-term treatment, often taking more than a year of structured intervention to help addicts successfully kick the habit.

"It (meth) is such a different creature," Dearthmont said. "Users say it's an evil drug. They'll say that, for example, the pleasurable feeling you get from a hug would be worth five dollars, the feeling of getting a new job you desperately wanted would be \$1,000, and with a meth rush, it's a million dollars."

Pat, a recovering alcoholic/meth addict (who chooses to withhold his last name), concurs.

"It just feels so g—damn good. There's nothing else like it. It totally takes away your inhibitions," Pat said.

Pat kicked his meth addiction three years ago.

"I was getting into a lot of trouble and going to jail a lot," said Pat, 58,

a college graduate from Gillette, Wyoming who has been involved in successful businesses. "I just one day decided to quit."

Quitting wasn't easy for him, though. Because of this, he said, most others can't quit.

"Getting rid of the meth problem? Yeah right. It's way big—it's big bucks," Pat said. "Putting users and dealers in prison won't work. Users are sick and need help, not prison. When a dealer goes to prison, the next dealer just steps up and takes his place. And meth is everywhere because it can be produced fast—I mean, you can make a batch in your own house and sell it in one day."

Another counselor predicts that meth abuse will continue, even while more money is pumped into fighting it. Daniel Overton sees court-ordered clients at Campbell County Memorial Hospital in Gillette, Wyoming.

FIGHTING BACK

State and local governments and other organizations are working to stop the spread of methamphetamine use through innovative education initiatives, increased law enforcement efforts and specialized addiction treatment programs. Here are some examples of what is being done.

- The National Association of Counties (NACo) has formed a Meth Action Group to provide county leadership for a national initiative to fight the growing meth epidemic.
- Many states, such as Arizona, Kansas, California, Colorado, Iowa, Oregon, South Dakota and

Texas, have established Drug Endangered Children (DEC) programs. A list of DEC programs is available at: http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html

- Tennessee has been the first state to host a state-wide education campaign to reduce meth use by teenagers, with a program created by the Partnership for a Drug-Free America. Information is available at: <http://www.methfreetn.org>
- Washington State has formed the Washington Meth Initiative.
- Minnesota has the new Challenge Incarceration Program. Information is available at:

<http://www.doc.state.mn.us/facilities/cip.htm>

- Nebraska has created an educational CD, brochures and a cleanup volunteer program.
- North Dakota has established the Rural Methamphetamine Education Project, a public awareness campaign aimed at schools, victims, former users and treatment counselors.
- Kentucky has a new Walk Your Land program, which aims to teach property owners how to protect their land against unauthorized meth production.
- Oklahoma became the first state to limit Sudafed purchases.

“The people here see meth as a functional drug because of shift work, long hours and the pressure to produce,” Overton said.

Gillette and Campbell County are a hotbed of oil, coal and methane production. It is estimated that 29 percent of the county’s workers are employed in the energy industry. Overton says those who work the demanding shifts of hard labor are susceptible to seeking the boost meth offers.

“The population here is really prone to a meth problem. I saw a kid the other day who dropped out of 10th grade to work in the mines and make \$5,000 a month. This temptation is a reality. He’s got the money and the motivation to use meth so he can keep up with his boss’ demands to work 60 to 70 hours a week.”

Overton, who has worked in substance abuse treatment across the country for 20 years, says the drug has no geographical or sociological

limitations. He says users are often overachievers.

“They see the drug as helping them to do the work they need to do,” Overton said. “Users will say they put in 70 hours in a week. Our human bodies are not meant to do that,” he said.

For the many Americans who can relate to caffeine addiction, there’s no comparison to meth, Overton says.

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METH INFORMATION RESOURCES

- Seeking funding sources for your meth research? Visit <http://www.nlm.nih.gov/medlineplus/amphetamines.html>
- To find out what the states are doing, visit <http://www.phppo.cdc.gov/od/phlp/Methlab.asp>
- Congress has formed a bipartisan Meth Caucus, with more than 100 members. The Caucus web site, which features background information on meth, meth statistics and links to other web sites, is available at: <http://www.house.gov/larsen/meth/>
- The National Association of Counties (NACo) recently released “The Meth Epidemic in America,” two surveys of U.S. counties on the criminal effect of meth on communities and the impact of meth on children. It is available from: <http://www.naco.org>
- The Rural Assistance Center has a new guide about methamphetamines. Visit http://www.raconline.org/info_guides/meth/
- For several meth publications, facts and resources, go to the U.S. Substance Abuse and Mental Health Services Administration at: <http://www.samhsa.gov>
- For general meth information, log on to: <http://www.whitehousedrugpolicy.gov/drugfact/methamphetamine/>
- For more information on establishing a multidisciplinary meth lab response team, see <http://www.ojp.usdoj.gov/ovc/publications/bulletins/children/pg10.html>
- The U.S. Drug Enforcement Administration (DEA) has a site containing facts sheets that include statistics, data, state DEA office contacts, and information on state activities. Go to: http://www.usdoj.gov/dea/pubs/state_factsheets.html
- The Office of National Drug Control Policy has meth information at: <http://www.whitehousedrugpolicy.gov/statelocal/>
- Join Together, a project of Boston University, has a range of items relating to drug policy, prevention and treatment at: <http://www.jointogether.org>
- KCI (formerly the Koch Crime Institute) has first-person accounts from meth users, a discussion forum and a recovery chat room at: <http://www.kci.org>



Rethinking Human Services

by Tom Corbett, Ph.D.

Integrating Services with Different Institutional Cultures

In this column I have made several interrelated arguments. First, many rural areas disproportionately suffer from economic challenges that disadvantage families and create complex service needs. When we look at the residential location of low-income families, we find higher rates of lower income families (living on less than 200 percent of the poverty threshold) residing in non-metro areas as opposed to cities and suburbs across the country. Social, geographic, and economic forces in rural areas intersect in ways that make it difficult for families to get ahead.

Second, getting these disadvantaged families the help they need is more difficult in remote areas. Services are not necessarily available, excessive stigma is often attached to their use, and access can be problematic even when services purportedly are available. Researchers investigating several rural welfare to work initiatives characterized the contextual challenge as follows:

The way rural welfare-to-work programs operate is linked to their context—that is, areas characterized by limited job opportunities and service capacity, population dispersion, and tight-knit communities. The experiences of these demonstration programs suggest that welfare-to-work services may be most valuable for rural clients when they help address both employment needs and a variety of other personal and logistical issues.¹

Third, ensuring the kind of comprehensive and coherent help required by families with multiple challenges demands that we rethink and restructure the basic ways we organize and deliver human services. This new way of doing business is typically pursued through the development of what are called integrated service models.

Integrated service models pull together existing benefits and service systems and attempt to deliver packages of help in ways that are timely, individualized, comprehensive, and coherent. They do this by, among other things, blending together diverse types of assistance provided by existing systems in ways that are transparent and seamless to the customer. As outlined in the last article, the trick is to do this blending of policy protocols and especially people in ways that minimize tensions and friction among staffs drawn from differing institutional cultures.

Why this problem with institutional culture? Well, each existing system has its own way of doing things which we think of as a unique culture. As I argued before, acknowledging these different cultures across agencies and programs is critical as you think about ways of bringing them together.

But how do we do that? First, as policy entrepreneurs we have to distinguish between those things about the programs we want to blend together that we can easily see and change and those things we cannot. For example, as we put together a one-stop service center, most planners are likely to think about and probably include modifications to practice protocols, administrative systems, and each program's policies.

These are the factors that my colleagues and I think of as being “above the waterline,” or visible to practitioners of public policy. By only focusing on these issues, however, we may miss much of what is important to the potential success of service integration efforts.

My colleagues and I further suggest that three contextual dimensions that lie “below the water line,” less visible to policy entrepreneurs, fundamentally shape how individual organizations and systems operate, and therefore inform whether true integration will be achieved. These dimensions are *leadership style*, *organizational culture*, and *institutional systems*.² They can generally be thought of as follows:

- *Leadership style*—Who creates and articulates the vision for change? How well is it communicated, internally and with the outside world? How is responsibility and authority shared? Where do leaders look for input? How do leaders deal with impediments and obstacles, and how well do they see and exploit opportunities?

- *Organizational culture*—How do the people in any program or agency perceive themselves and others? How do they communicate with others in their program, or others they professionally relate to, and what vocabulary do they use? What are the basic rules that govern institutional life?

- *Institutional systems*—What infrastructural supports does a system have available to it, and how flexible and adaptive are they? How restrictive are the rules and protocols that govern the lifeblood of any institution or agency—money and information?

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Look What's Coming

by Wayne Myers, M.D.

Telehindsight

“Telemedicine” has been around for a long time. Certainly patients and clinicians have been using the telephone to talk about Johnny’s croup and Momma’s labor pains for as long as there have been phones. But it seems the term “telemedicine” has a more restricted meaning. By “telemedicine” we mean the use of some sort of electronically transmitted image in the diagnosis or management of a health problem. Why, then, do we assume that the picture is the essential?

This summer I heard the manager of the Danish health information system discuss their progress. I’ll say more about the Danish system in a moment, but first let me tell you about the “Aha! Moment” her presentation elicited for me. In brief, I realized that we’ve been captured by the idea of “health care by television,” and how that misfortune came about.

Commercial radio and television changed profoundly in the early 70s. Until that time a broadcast reached only as far as the signal of a station. If the west coast was to receive the same TV news broadcast as the east coast, that program was recorded on tape and flown on a jet from coast to coast for local rebroadcast. We in Alaska watched the Monday evening news on Tuesday.

The development of broadcast relay satellites changed all that, first for audio broadcasts and then for full broadcast quality television a few years later. The National Aeronautics and Space Administration (NASA) wanted to know what potential this satellite technology

had for health care. More specifically, how much of the capacity of this wonderful new tool should be reserved for health? NASA needed a name for this new possibility. The term “telemedicine” was born and served up with a good many millions of dollars in grants to explore possibilities.

The technology was marvelous but the culture was distracting...TV studios, producers, pastel shirts, Klieg lights, “Back to you, David.” We were seeing what could be done, not what needed to be done. And the effort was shaped by medical schools that were good at thinking of the possible rather than the pragmatic.

By the end of the decade the money was spent. A few university TV stations inherited some leftover equipment. We had learned that a picture contributes relatively little to the accuracy of the diagnosis or the appropriateness of the management plan produced by a consultant, though the generalist seeking the consultation is more confident that the problem has been clearly understood than if the process had been only by audio.

More significant, we had established the name “telemedicine” and linked it to the idea of television. And we had developed a small cadre of true believers within referral centers. Over the intervening quarter century we’ve found some valuable niches for telemedicine: dermatology, eye exams, behavioral evaluation, remote reading of imaging studies and education for place-committed people, but we still have not recognized the underlying po-

tential of electronic information organization and transfer. Nor have we developed a tradition of asking rural patients what they need and want when it comes to telemedicine development.

So what does this have to do with Denmark? Over the past 15 years the Danes have built a national health information system covering all 5.4 million of its citizens. Paper and voice-mediated prescriptions have been supplanted by more accurate digital messages. Essential medical records are available with appropriate safeguards in any legitimate facility at any hour of the day or night. Island communities have a growing menu of telemediated specialty clinics with strong local support. And, some clinics even have video pictures.

Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: editor@raconline.org.

Around the Country

by Hope Hanson

California

Dancing to Deter Diabetes

Can diabetes prevention be fun? It can when Annie Barnes gets involved.

Barnes, program director for the “Reach Out” project in rural Lake County, California, helps diabetics learn about nutrition and medication. And, they dance.



Dancers exercise to discourage disease at events sponsored by Reach Out.

“Exercise is a key in diabetes prevention, and our motto is fun. So we do everything from aerobics to hip-hop,” Barnes said. “It gives energy and personality to our efforts.”

Serving the tribal, migrant, Latino and African American communities, as well as low-income residents, Reach Out is funded through a federal Office of Rural Health Policy (ORHP) Rural Health Outreach Grant, which Barnes wrote.

Reach Out offers education on nutrition, exercise, medication, case management and regular check-ups. Diabetes is the most common health problem in the African American, Latino and Native American population of Lake County.

The population of Lake County has a number of unmet needs. Approximately one-third of all children under age five live in families under the poverty level.

In addition, Lake County has double-digit unemployment, a high rate of alcohol and substance abuse and a high rate of crime, including a disproportionate number of tribal children who are the victims of child abuse. But, through Reach Out’s efforts, this looks to change.

“Our original goal was to impact 300 people,” Barnes said. “Our database now includes 1,000 people.”



Reaching those people, Barnes said, has been done through the popular “promotores model” in which local volunteers, or “lay people,” introduce the diabe-

tes prevention materials to their friends, relatives and neighbors.

“Using the promotores model is effective because the people delivering the messages are sensitive to the communities and cultures they serve,” Barnes said, “and they are often more effective at improving community health than health professionals alone. It’s neighbors helping neighbors.”

Access barriers to services in Lake County include poverty; rural isolation and lack of transportation; language and communication barriers; distrust of government, state agencies and services; and a high rate (60 percent) of residents who are uninsured or underinsured. The service area is a designated Health Professional Shortage Area. Lake County has been designated as one of the 786 most Medically Underserved Areas in the United States.

The Reach Out program partners are the Lake County Tribal Health Consortium, the California Human Development Corporation, the Latino Coalition and Middletown United Methodist Church.

For more information, contact: Annie Barnes, Lake County Tribal Health, 925 Bevins Court, PO Box 1950, Lakeport, CA 95453; phone (707) 263-8382 Ext. 134; or fax: (707) 263-0329.

Connecticut

SPARC Project Saves Women’s Lives

Life goes better when you can bundle two things together—your flu shot and mammogram appointment.

“It’s relatively easy, inexpensive and it saves women’s lives,” said Linda Cormier, registered nurse and program manager of SPARC (Sickness Prevention Achieved through Regional Collaboration), a nonprofit health organization that serves residents of the four counties at the junction of Connecticut, Massachusetts and New York.

In October and November 2003, SPARC’s collaborators visited 32 flu clinics to help women get mammograms. They administered the flu shots, and helped women find a mammogram provider and make appointments.

In June, it was announced that the project was the winner of the Aetna Susan B. Anthony Award for Excellence in Research on Older Women and Public Health from the American Public Health Association (APHA).

“It’s wonderful to have the efforts of our many collaborators and colleagues recognized in this way.”

Cormier said. "I'm thrilled to have the opportunity to share this work with others."

As the prizewinner, Cormier will write a journal-length article, which Aetna will publish. She will also give a presentation at the APHA meeting in New Orleans in November.

"I hope others will replicate this project in their own communities," Cormier said. "I strongly believe that this project has great merit. Simply identifying that the diagnosis of breast cancer was made by one or two mammograms scheduled at a flu clinic builds a compelling case for expanding this project into other rural communities."

Cormier credits SPARC's 150-plus collaborators, including the American Cancer Society, area health departments, visiting nurse associations and mammography providers, who worked together to make the project a success. SPARC also promotes the use of: vaccinations; other cancer detection tests including pap smears and colon cancer screenings; and cardiovascular tests including cholesterol and blood pressure checks. Funding for the project comes from an ORHP Rural Health Outreach Grant.

For more information, visit <http://www.sparc-health.org>; e-mail info@sparc-health.org; write SPARC, PO Box 746, 318 Main Street, Lakeville, CT 06039; phone toll free (888) 557-7272; or fax (860) 435-8193.

Georgia

Healing Center Helps Children

As the saying goes, "If you're handed lemons, make lemonade."

This is what physical therapist Cathy Wisdom did.

Cuts in Medicaid benefits to children with disabilities were so extensive that many patients who were receiving therapy from Global Pediatric Therapy outside of Macon were forced to stop altogether.

"Ceasing treatment, even temporarily, can have a tremendous effect on the growth and development of disabled children," Wisdom said.

So, Wisdom made lemonade; she created the Healing Center Foundation for Children with Disabilities in February 2004.

The Healing Center Foundation for Children with Disabilities Inc. is a nonprofit organization dedicated to enriching the lives of children with disabilities in middle Georgia. The Healing Center provides financial assistance in physical, occupational, music, massage, speech, hippo, aquatic and mental therapies.

"Our goal is to involve the community and bring awareness to everyone on the needs of these special children," said Kimberly Smith, the foundation's executive director. "No matter the cost we hope to help these children in every way possible."

The foundation is expanding to start funding more facilities around the middle Georgia area. Patients



Blane Beck works on stretching exercises with therapeutic riding instructor Erika Meganck at Hearts and Hooves Stables, one of the facilities supported through The Healing Center Foundation.

who are eligible are between the ages of two and 21.

"We also have plans to build an aquatic therapy center, bringing more therapeutic options for these children to middle Georgia," Smith said.

The foundation receives funding through local donors, community civic groups and grants, and continues to seek further tax-deductible contributions.

For more information, visit <http://www.thehealingcenterfoundation.com>; write 2484 Ingleside Avenue, Bldg C, Suite 101-B, Macon, GA 31204; or phone (478) 743-1314.

Tennessee

Public Health Certificates Offered

State public health workers at the Tennessee Department of Health can now learn more online. In less than 20 online credit hours, Department staff can earn certificates in applied epidemiology, health leadership or

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Spotlight on Rural Research

by Hope Hanson

Meth Mayhem Prompting More Research

Research is drawing closer to the pace of the wild spread of methamphetamine production and abuse in rural America. One group, the National Institute on Drug Abuse (NIDA), has been conducting basic research on meth for more than 20 years; however, as meth's use has increased, NIDA's research efforts in that area have also increased. In fact, NIDA funding of meth-related research increased almost 150 percent from 2000 to 2004. NIDA has been studying how meth affects the brain, meth's short-term and long-term behavioral and physical effects, and effective treatments for meth addiction.

Below is a synopsis of what NIDA has most recently found. For more information on NIDA, visit <http://www.drugabuse.gov>.

Monitoring the Future Survey

This study assesses the extent of drug use among adolescents (8th-, 10th-, and 12th-graders) and young adults across the country. The survey is funded by NIDA and conducted by the University of Michigan's Institute for Social Research. The survey has tracked 12th-graders' illicit drug use and related attitudes since 1975; in 1991, 8th- and 10th-graders were added to the study. Recent data from the survey indicate that in 2004, 6.2 percent of high school seniors had reported lifetime use (referring to use at least once during a respondent's lifetime) of methamphetamine. Lifetime use was measured at 5.3 percent of 10th-grade students. For more

information on the survey, see <http://monitoringthefuture.org/>.

Community Epidemiology Work Group (CEWG)

Results reported at the most recent CEWG meetings indicate that methamphetamine abuse and production continue at high levels in Hawaii, West Coast areas and some Southwestern areas of the United States—but methamphetamine abuse also is continuing to spread eastward. The percentage of adult male arrestees testing positive for methamphetamine in 2003 was highest in Honolulu (40.3 percent), Phoenix (38.3) San Diego (36.2) and Los Angeles (28.7).

Several other items of significance were reported.

- From 1999 to 2004, methamphetamine lab incidents increased in Midwestern states (Illinois, Michigan and Ohio), and in Pennsylvania. In 2004, more lab incidents were reported in Illinois (926) than in California (673). In 2003, methamphetamine lab incidents reached new highs in Georgia (250), Minnesota (309), and Texas (677).

- In the first six months of 2004, nearly 59 percent of substance abuse treatment admissions (excluding alcohol) in Hawaii were for primary methamphetamine abuse. San Diego followed, with nearly 51 percent. Notable increases in methamphetamine treatment admissions occurred in Atlanta (10.6 percent in the first six months of 2004, as compared with 2.5 percent in 2001) and Minneapolis/St. Paul (18.7 percent in the first six months of 2004, as compared with 10.6 percent in 2001).

- Some MDMA (ecstasy) and cocaine users are switching to methamphetamine, ignorant of its severe toxicity.

- In many gay clubs found throughout New York City and elsewhere, methamphetamine is often used in an injectable form, placing users and their partners at risk for transmission of HIV, hepatitis C and other STDs.

SAMHSA Compares Treatment Outcomes

The Substance Abuse and Mental Health Services Administration (SAMHSA) is another major agency continuing meth research. One avenue of study is its Methamphetamine Treatment Project (MTP), a multi-site initiative to study the treatment of methamphetamine dependence. Jointly implemented by the University of California, Los Angeles Integrated Substance Abuse Programs, and the Matrix Institute on Addictions, its goal is to generate new and better treatments that can be used effectively in the community drug treatment system. The project is funded by SAMHSA and the Center for Substance Abuse Treatment.

Researchers use the Matrix model, which is a three-times-per-week outpatient treatment experience that combines behavioral, educational and 12-step counseling techniques. The current study will compare treatment outcomes of the 16-week Matrix program, and the usual treatment given at the programs. Each agency will treat approximately 150 clients, selected using inclusion/exclusion criteria, over a three-year period. See <http://www.samhsa.gov> for more information.

National Survey on Drug Use and Health (NSDUH)

According to the 2003 NSDUH, 12.3 million Americans age 12 and older had tried methamphetamine at least once in their lifetimes (5.2 percent of the population), with the majority of past-year users between 18 and 34 years of age. NSDUH (formerly known as the National Household Survey on Drug Abuse) is an annual survey conducted by SAMHSA. Findings from the latest survey are available at: <http://www.samhsa.gov>.

DASIS Report Looks at Smoked Meth

Other research from SAMHSA includes "The DASIS Report: Smoked Methamphetamine/Amphetamines, 1992-2002." DASIS is the Drug and Alcohol Services Information System,

which is conducted by SAMHSA's Office of Applied Studies.

This report found that the rate of methamphetamine/amphetamine treatment admissions for those who had smoked methamphetamines or amphetamines was 50 percent in 2002, compared with 12 percent in 1992. In 1992, 36 percent of smoked methamphetamine/amphetamine admissions were referred to treatment by the criminal justice system. By 2002, the criminal justice system was the source of referral in 55 percent of the smoked methamphetamine/amphetamine treatment admissions. The report also indicated that in 2002, only one state, Ohio, had a decrease in the proportion of methamphetamine/amphetamine admissions that were for smoked methamphetamines or amphetamines. Hawaii continued to have more than 90 percent of its methamphetamine/amphetamine admissions for those who had

smoked the drug. In nine states, more than 50 percent of the methamphetamine/amphetamine admissions smoked the drug in 2002; for five of these states (Colorado, Iowa, Nevada, Utah, and Washington), the rate of smoked methamphetamine/amphetamine was only 10 percent or less in 1992.

For more information, go to: <http://oas.samhsa.gov/2k4/methSmoked/methSmoked.cfm>.

NIDA Encouraging Further Meth Research

The National Institute on Drug Abuse is offering grant opportunities for research on treating methamphetamine addiction, as well as reducing the accompanying risk of infectious disease among those receiving treatment. For more information, visit <http://www.drugabuse.gov/Funding/Resfundlist.html>.

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healthcare management through the Tennessee Public Health Workforce Development Consortium.

"Right now these graduate-level courses take students toward the educational enhancement of a Certificate of Accomplishment, but we're working on establishing an online master's degree in public health program," said Program Coordinator Aleshia Hall-Campbell.

The state Department of Health pays tuition and fees for Department staff members who have been approved to participate in this program. All other students pay the full tuition and fees established by the campus on which they are enrolled.

"The program covers expenses for health department employees only, but we hope to expand this opportunity to the private sector," Hall-Campbell said.

Prospective certificate recipients must enroll as graduate students at one of the three consortium institutions: East Tennessee State University, University of Tennessee-Knoxville or the University of Tennessee Health Science Center.

Hall-Campbell says an advantage of the program is that working men and women can be in grad school without giving up their jobs.

"All the courses are online, so it's flexible for working people," Hall-

Campbell said. "Additionally, these courses can take you beyond the certificate level to a master's degree down the road."

The first student, Melinda McDaniel of the Cocke County Health Department, received her certificate in applied epidemiology in May 2005. Twelve students are studying to earn their certificates in December 2005.

For more information, visit <http://www.utmem.edu/TNConsortium/>; contact Aleshia Hall-Campbell, Program Coordinator, The Center for Health Services Research, 66 N. Pauline, Suite 463, Memphis, TN 38163; phone (901) 448-3026; fax (901) 448-8009; or e-mail ahall18@utmem.edu.

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“It’s the difference between a bicycle and a Hummer.”

Overton estimates that one in five people become addicted to meth after the first use.

“It’s all about pleasure—meth heightens every satisfying sensation you have,” he said.

“When you become addicted, you become the drug—you do what the drug tells you to do. You adopt its personality. (In treatment) you have to pull the person out and separate

the addict,” Overton said. “Addicts are the same—the people underneath are different,” he said. “Somewhere underneath all that stuff is self.”

“We’re all searching for something—the meaning of life, the way to happiness, whatever. For many people, drugs appear to be a quicker, easier way to that end,” Overton said.

So how are government, health care, law enforcement and society going to beat the meth epidemic?

“We’re not,” Overton said. “This is the go-go-go generation. Americans are conditioned from birth to be super-vigilant and super-productive. Drug use will continue until we back off of this philosophy.”

Overton says when meth gets too expensive or difficult to produce, users will switch to a different drug.

“I doubt if we’ll ever get on top of illegal drug use, and I’m actually an optimist,” Overton said. “But that doesn’t mean we shouldn’t put up a fight.”

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The implicit message of this “below the waterline” perspective is simple. Each separate program that is considering collaboration must first look at what is going on below its own water line. Then some hard questions need to be addressed. How well do its deep dimensions comport with what we know about pursuing systems integration?

Think about this for a moment. What is likely to happen when you integrate a program with a top-down leadership style with a program where decision making is shared? Or what problems might arise when you blend one program where workers follow rules and work in isolation from one another with another where professional collaboration is the norm? Or what about bringing together systems where customer data is zealously protected in one and openly shared in another?

Ideally, planners would perform some kind of comparative analysis where the compatibility across the

systems they purport to integrate is compared. Program A focuses on eligibility issues and accuracy of benefits given out, program B on improving family functioning. In program A, workers are punished for making mistakes and deviating from following detailed rules; in program B they are rewarded for exercising initiative, taking chances, and achieving positive outcomes.

If these systems are brought together, workers and managers are likely to be confused and irritated by the styles of their new “partners;” at the worst, relations may sink into mutual suspicions and acrimony. Bringing together organizations where the “below the waterline” fit is less than ideal may require considerable retraining of staff, or repeated sessions where staff can work out differences and form new understandings.

In the next article, I examine this vexing issue of culture clash in greater detail.

Endnotes

¹ See Andrew Burwick, Vinita Jethwani, and Alecia Meckstroth, “Implementing Welfare-to-Work programs in Rural Places: Lessons from the Rural Welfare-to-Work Strategies Demonstration Evaluation,” Final Report. (Princeton, NJ: Mathematica Policy Research, April 2004), available online at: <http://www.mathematica.org/publications/PDFs/WtWcross-site.pdf>.

² For a deeper discussion of these concepts, see *The Challenge of Institutional “Milieu” to Cross-Systems Integration* by Thomas Corbett, James Dimas, James Fong, and Jennifer L. Noyes, forthcoming in the next volume of *FOCUS* (Institute for Research on Poverty: Madison WI, Summer/Fall 2005).

Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty where he served as Associate Director. He has worked on welfare reform issues at all levels of government and continues to work with a number of states on issues of program and systems integration.