Health News & Notes

Our Mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

A Publication of the Northwest Portland Area Indian Health Board June 2012

FIRE AND FIREWORK SAFETY THIS SUMMER

Did you know that there are greater than twice the number of fires reported on July 4th than on any other day in the United States?

There were 1,191 AI/AN burn injuries reported in the 2011 publication of the National Burn Repository, which reports data from hospitals from 2001 – 2010 (ABA, 2011 Version 7.0). AI/AN children ages 5-15 represent 1% of all burn injury admissions reported to the National Burn Registry for that age group. This is consistent with data from the National Fire Prevention Association data which reports that the highest risk of firework injury is in children ages 5 – 14 years. In other age groups, the range is about 0.3% to 0.8%, much lower than any other group. The eldest, those over 80 years show the lowest admissions for burn injuries.

The majority of fire/flame injuries occur at home (60%) with industrial locations (6%) and recreational activities (6%) tied for a distant second place. Street and highway accidents account for an additional 4% of fire/flame injuries, likely as a result of motor vehicle collisions.

Here are some useful tips for firework and fire safety during the summer months.

Fire and Firework Safety

- Kids should never play with fireworks. Things like firecrackers, rockets, and sparklers are just too dangerous. If you give kids sparklers, make sure they keep them outside and away from the face, clothing, and hair. Sparklers can reach 1,800° Fahrenheit (982° Celsius) — hot enough to melt gold.
- Steer clear of others — fireworks have been known to backfire or shoot off in the wrong direction. Never throw or point fireworks at someone, even in jest.

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OUR INJURY PREVENTION ISSUE CONTAINS:

Northwest Portland Area Indian Health Board

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CHAIRMAN'S REPORT

Andy Joseph
Confederated Tribes of Colville,
NPAIHB Executive Chair

I want to focus my report for this newsletter edition on the work of the Direct Service Tribes Advisory Committee (DSTAC). It was in 2004 that the DSTAC was formed by Dr. Charles Grim, former director of the Indian Health Service (IHS). The formation of the DSTAC was driven by Carole Anne Heart, former Director of the Aberdeen Area Tribal Chairman's Health Board and Garland Brunoe, former Chairman, of the Warm Springs Tribe.

All three recognized the importance of making sure that Tribes nationally had representation so that their voice and positions could be heard. Carole Ann and Garland understood affirmatively that all Tribes have the right to contract or compact for their health care services under the Indian Self-Determination and Education Assistance Act and that an equal and sovereign expression of self-determination is the right to not contract, and to have the IHS provide those services. Since its inception the DSTAC has advocated faithfully about the need prevent illness by promoting healthier lifestyles and building healthier communities. We should all strive for these goals as Indian people.

For a short period I served as the Vice-Chair of the DSTAC and I continue to participate as the Portland Area representative. This is important work for me since my tribe (the Confederated Tribes of the Colville) continues to receive their primary care directly from the IHS. I want to focus my report on the DSTAC activities around health promotion and disease prevention (HP/DP) since this is often the theme of this newsletter. Almost all of my work representing Portland Area Tribes involves some aspect of HP/DP to improve the health status of our Indian people. During our DSTAC meetings we always strive to make sure that our agendas and topics address community wellness and values. Many people know that I place a high value on honoring our tradition and culture as Indian people. So I always try to make sure that our work is respectful of these values.

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CHAIRMAN'S REPORT

The DSTAC's work always has some focus on developing and sustaining HP/DP activities in our communities. The DSTAC work involves addressing key issues around HP/DP such as diabetes, nutrition, obesity, physical activity and exercise, and tobacco cessation. We make sure that IHS and Tribes nationally understand the importance of reauthorizing the Special Diabetes Program for Indians (SDPI). Almost all Tribes nationally have a SDPI grant that helps to fund diabetes treatment and prevention in our communities. The SDPI has been extremely effective at addressing diabetes care and providing diabetes education for our Indian people. The DSTAC have also worked to address behavioral health issues by building relationships with the IHS Office of Behavioral Health programs. The Committee has advocated for more funding to address behavioral health issues for our youth and that we must do more within IHS to address youth activities to promote healthier lifestyle choices.

This is just a short sample of some of the DSTAC efforts designed to meet the goal of creating healthier communities. We recognize that we cannot do this work alone and want to continue to collaborate with all Tribal partners including the Tribal Self-Governance Advisory Committee to address these critical issues. In the end, all of these issues are the same for our Indian people whether we are direct service or self-governance tribes. I hope you enjoy this edition of the newsletter and will continue to work with me to build healthier communities for Indian Country.

Whi it Leem (Thank You)
Eu uhootkn (Badger)
Andrew C. Joseph, Jr.

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INJURIES CONTINUE TO CAUSE MANY AI/AN DEATHS

Jenine Dankovchik, Biostatistician, IDEA-NW

Many public health statistics – such as those on mortality, births, immunizations, cancer, injuries, and health spending – are derived from administrative records where American Indians and Alaska Natives (AI/AN) are often misidentified as white, or missing race information altogether. This racial misclassification leads to rates that are artificially low for AI/AN.

Data Linkages

The Improving Data & Enhancing Access (IDEA-NW) Project has conducted several data linkages with these data sources over the last year and a half. In a data linkage, we compare the outside data to the Northwest Tribal Registry – a list of AI/AN people who have used an IHS or tribal clinic in Idaho, Oregon or Washington. Looking at several characteristics such as name, date of birth and social security number, we try to find people who appear in both data files (matches). If a match is found, we classify the person as AI/AN race, correcting any who were not classified as AI/AN originally. Throughout the process, we adhere to strict IRB-approved protocols to assure the confidentiality of individual and tribal-specific health related data.

Partnerships with individual tribes and urban Indian organizations have further improved our ability to identify racial misclassification, and to provide accurate region- or tribe-specific disease estimates in the Northwest (e.g., the latest Washington cancer and death certificate linkages were in partnership with Seattle Indian Health Board/Urban Indian Health Institute).

Correcting Errors in Race Data on Death Certificates

Throughout the past year, IDEA-NW has completed data linkages with death certificate files in Idaho, Oregon and Washington. Race coding on death certificates is usually done by funeral directors, coroners, medical examiners or other officials involved with the decedent. There may be some hesitation to ask the next-of-kin questions about race, or assumptions may be made based on appearances. If the next-of-kin is asked, he or she may not answer as the decedent would have. As a result, we found that race misclassification of AI/ANs on death certificates ranged from 13 to 40%.

Once the linkage is complete we are able to analyze the resulting data and report results which are more accurate for the AI/AN population, as these errors have been corrected.

Injury Disparities

Figure 1

Between 2006 and 2009, unintentional injuries were the third leading cause of death for AI/ANs in the Northwest, while suicide was the seventh leading cause of death. Among AI/ANs under 30 years old, suicide is the second leading cause of death in all three states.

Both unintentional (accidental) and intentional (suicide and homicide) injury death rates were higher for AI/ANs than for the majority white population. Figure 2 shows unintentional injury death rates for the three states, comparing AI/ANs to whites. Washington AI/ANs had the highest rates of unintentional injury deaths, and the largest disparity, with rates more than twice that of the white population. Oregon AI/ANs had the lowest rates, but the difference was also more than two times higher than the white population. Idaho had rates slightly

INJURIES CONTINUE TO CAUSE MANY AI/AN DEATHS

below Washington, but the disparity was slightly smaller, about one and a half times higher than the white rate.

Death certificate data were available for 20 years in Washington, and there we found that the rates of unintentional injury deaths were increasing slightly for AI/ANs between 1990 and 2009. Male rates increased on average 1.7% each year, while females increased on average 3.5% each year.

Unintentional injuries can include many kinds of accidents, but the majority of the AI/AN unintentional injury deaths were due to motor vehicle crashes and accidental poisoning. Accidental poisoning deaths were mostly drug overdoses, as opposed to poisoning by toxic chemicals or other methods.

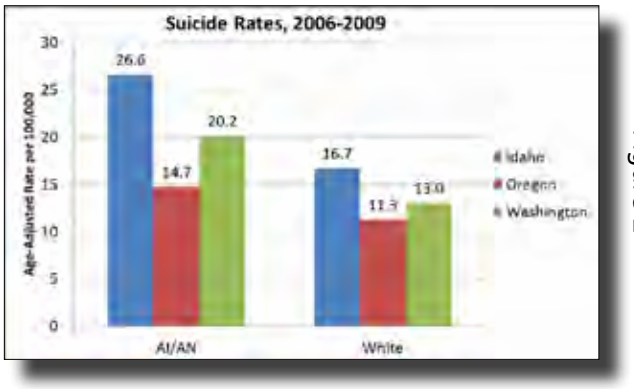

Figure 2

Intentional injuries are made up of suicides and homicides. For AI/ANs, suicide rates were highest in Idaho, followed by Washington, and the lowest rates were in Oregon. Men are more likely to commit suicide across all populations (although females tend to have more unsuccessful suicide attempts), and our data held to this with AI/AN male rates ranging from about two and a half to four times higher than females. Idaho also had the largest disparity compared to white, at about one and a half times higher. AI/ANs in all three states had higher rates of suicide than whites, especially among younger age groups. As seen below, young AI/AN people are suffering from suicide much often than whites of the same age.

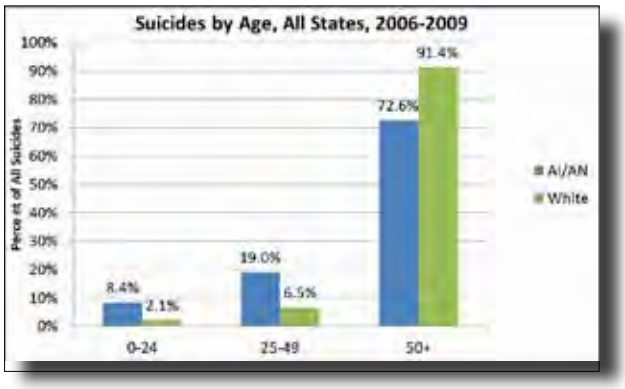

Figure 3

From the Washington data, we learned that there has been no real change in the rate of AI/AN suicides between 1990 and 2009, while white rates have decreased a small but significant amount.

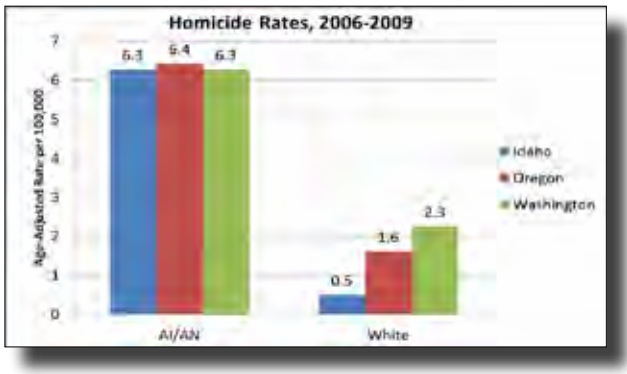

Figure 4

Homicide rates make up the other part of intentional injuries, but occur less frequently than suicides. AI/ANs in all three states had very similar rates of death from homicide, and all three were markedly higher than their white counterparts. Between 1990 and 2009 in Washington, homicide death rates among AI/ANs have seen a slow but steady decline (decreasing on average 3.9% annually), and while the AI/AN rate remains above the white rate, the decline has actually been outpacing that seen among whites, so the gap is closing in recent years.

The results of this linkage confirm much of what we already know about mortality disparities, but the data shed new light on differences across the Northwest and how things are changing, or staying the same.

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INJURIES CONTINUE TO CAUSE MANY AI/AN DEATHS

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An understanding of this information can be used to direct health priorities for Northwest tribes and throughout Indian Country. Other programs featured in this issue of Health News and Notes such as the Injury Prevention Program and Native CARS are working to address some of the disparities noted in these data, and IDEA-NW Project intends to continue linking with state vital statistics records and reporting the results so we can all stay informed as the picture changes.

Note **-** The IDEA-NW Project can provide health data for your community, and is available for data partnerships with Northwest tribes. Please contact Megan Hoopes at mhoopes@npaihb.org or 503-416-3261 for more information.

FIRE AND FIREWORK SAFETY THIS SUMMER

Continued from page 1

- Don't hold fireworks in your hand or have any part of your body over them while lighting. Wear some sort of eye protection, and avoid carrying fireworks in your pocket — the friction could set them off.
- Point fireworks away from homes, and keep away from brush and leaves and flammable substances. The National Fire Protection Association estimates that local fire departments respond to more 50,000 fires caused by fireworks each year.
- Don't allow kids to pick up pieces of fireworks after an event. Some may still be ignited and can explode at any time.
- Soak all fireworks in a bucket of water before throwing them in the trash can.
- Think about your pet. Animals have sensitive ears and can be extremely frightened or stressed on the Fourth of July. Keep pets indoors to reduce the risk that they'll run loose or get injured.
- When all else fails, use common sense. Respect fireworks and sparklers as the great American tradition they are, but also respect the fact that the must be used with caution.

References:

National Council on Firework Safety
http://www.fireworksafety.com/home.htm

National Fire Prevention Association
http://www.nfpa.org

The American Burn Association
http://www.ameriburn.org

PREVENTION IN DROWNING

Drowning: The Reality
We all want to keep our families safe and secure and help them live to their full potential. Knowing how to prevent the leading causes of child injury, such as drowning, is a step toward this goal.

Did you know?
Every day in the US, about ten people die from unintentional drowning. Drowning is the sixth leading cause of unintentional injury death for people of all ages, and the second leading cause of death for children ages 1 to 14 years. When most of us are enjoying time around water, injuries aren't the first thing on our minds. Parents can play a key role in protecting the children they love from drowning.

Water Safety Tips

- **Learn life-saving skills.** Everyone should know the basics of swimming (floating, moving through the water) and cardiopulmonary resuscitation (CPR).
- **Watch children** whenever they are in or near water: bathtubs, toilets, wading/ swimming pools, hot tubs, water-filled buckets, rivers, irrgation ditches, lakes, ocean or any standing water. Closely supervise them at all times and stay within an arm's reach. Adults watching kids in or near water should avoid distracting activities like playing cards, reading, talking or texting on the phone, visiting with others, and using alcohol or drugs. Children can drown in the time it takes you to answer the phone and in less than an inch of liquid.
- **Make life jackets a "must."** Even if they know how to swim, children should always wear US Coast Guard approved life jackets when swimming or boating in open water such as rivers, lakes or the ocean. Keep an eye on the weather, waves and currents. Life jackets can be used in and around pools for weaker swimmers too. Remember, inflatable water toys are not safety devices.
- **If you have a swimming pool, you must:**
  - Install four-sided 4-5 foot fencing that completely encloses the pool.
  - Install child-safe locks, alarms on doors and gates that lead to the pool area.

Information for this article was derived from the following websites:

www.cdc.gov/safechild/Drowning/index.html

www.ihs.gov/headstart/index.cfm?module=hs_families_injury_prevention

www.safekids.org/safety-basics/safety-guide/water-safety-guide/open-water-safety

HELP PREVENT SUICIDE IN YOUR TRIBAL COMMUNITY

Colbie Caughlan, MPH – Suicide Prevention Manager, THRIVE

Suicide is 100% preventable. This may sound like a strong statement but it is entirely true and hopefully the information in this article can assist you and your community members to know what signs to look for in a person who may be contemplating suicide and how to assist them. The more people who understand and can identify these signs of suicidal ideation, the more lives we will save.

According to the CDC (2011) from 1999-2008, in the American Indian/Alaska Native (AI/AN) population, the suicide rate was 14.68 per 100,000 ppl. while the overall U.S. suicide rate was 11.15. The CDC (2010) also reports that among AI/ANs aged 15-34 years suicide rates are almost double the rates of the national average for that age group (20 vs. 11.4 per 100,000). Suicide is the second leading cause of death for AI/ANs aged 10-34 years (CDC, 2011).

As stated above there are many signs of suicide ranging anywhere from behavioral cues to verbal and non-verbal cues. These signs may be very obvious in nature or very subtle. If one knows what to be watchful for these signs can be identified and discussed with the suicidal person to show support, to show that people do care about them, and refer the person to a healthcare professional or someone who has been trained in suicide interventions.

Signs of suicide may include:

- ***Withdrawing from family and friends***
- ***Giving away prized possessions***
- ***Talking about killing oneself***
- ***Previous attempts***
- ***Mental illness***
- ***Increased substance abuse***
- ***Hopelessness***
- ***Reckless behavior***
- ***Sleeping too little or too much***
- ***Mood swings***
- ***Feeling trapped or like a burden to others***
- ***Experience a serious loss or traumatic event***

For friends, family, and community members, to assist someone who is suicidal, one must know what local resources exist and who or where you can refer the person to. The referral does not need to be to a healthcare professional or mental health clinic. The referral can simply be to a trusted adult who has preferably been trained in suicide interventions but ultimately who is supportive and has time to listen and talk with the suicidal person. The helper can be a family member, close friend, elder, mentor, religious leader, healthcare professional, coach, crisis line staff, etc.

To become more comfortable and confident addressing suicide with a friend, family member, co-worker, or community member there are many trainings one can participate in. Three popular trainings include: Question, Persuade, Refer (QPR); Suicide Alert For Everyone: Talk, Ask, Listen, Keepsafe (safeTALK); and Applied Suicide Intervention Skills Training (ASIST). QPR and safeTALK are shorter half day trainings for participants to become suicide prevention gatekeepers and understand how to identify the signs of suicide, be comfortable with identifying them, asking a person about and discussing their suicidal thoughts, and referring them to an appropriate person or clinic. ASIST is a 2-day workshop and the participants learn to be suicide interveners. In addition to the skills learned through a gatekeeper training, ASIST teaches participants how to review a suicidal persons' risk, how to discuss reasons for living and dying, and what techniques and questions should be asked to help keep

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SAFE DISPOSAL OF PRESCRIPTION MEDICINES

Erik Kakuska, Zuni Pueblo
IDEA-NW Project Coordinator

Prescription drug abuse is a growing problem and major concern for most families and communities across the United States. In the Pacific Northwest, the concern is just as great. Statistics show that prescription drug abuse impacts American Indian/Alaska Native communities at a higher rate than any other racial group. IHS officials told *U.S. Medicine*, "National studies indicate that prescription-drug abuse appears to strongly correlate with alcohol-use disorders and found AI/ANs to be at particular risk for his combination of conditions." (online article, U.S. Medicine, *IHS Grapples with Pervasive Prescription Opioid Misuse in Tribal Areas*, January 2012). In fact, according to a 2009 national survey, "6.2% of AI/ANs reported engaging in current non-medical use of prescription drugs, more than twice the rate of whites and the highest rate of all races nationally" (IHS Division of Behavioral Health, Office of Clinical and Preventive Services, *American Indian/Alaska Native Behavioral Health Briefing Book*. Retrieved May 24, 2012, from http://www.ihs.gov/medicalprograms/Behavioral/documents/AIANBHBriefingBook.pdf

Prevention, along with educating the public about safe disposal of prescription medicines, especially painkillers and sleep aids, has been one of the main focuses in Indian Country in recent days. The Northwest Portland Area Indian Health Board has heard the concerns from our elders and has answered back with an all-day conference comprised of working groups, presentations on prescription drug abuse, and a 1 hour concert performed by Music Mentors Academy. Area physicians, councelors, and various health professionals were in attendance. The conference, *Washington State Prescription Drug Abuse Prevention Education Conference* held in Shelton, WA, was funded by the Attorney General's Office of Washington. The conference was intended to combat the increasing abuse of prescription drugs; particularly among teens and young adults.

The NPAIHB conducted the all-day education conference with break-out sessions regarding multiple issues on prescription drug abuse. Most topics were regarding issues on how to prevent abuse, as well as educate the tribes. But the most talked about issue was on proper disposal.

Although most experts agree on the nature of the problem, finding a solution presents more of a challenge. Unlike illegal drugs, prescription drugs serve an important purpose when used properly. The fact that medical providers prescribe these substances, and that they are legal in that specific context, may blur the lines for some would-be abusers who mistakenly believe that prescription drugs are safe to use.

What can parents, other relatives, and caregivers do?

- Talk with children about the dangers of misusing medicine.
- Keep track of the number of pills in all family members' prescriptions and monitor refills
- Friends and relatives need to be aware of the potential risks of their medications to others. Everyone should monitor their medications more closely.
- Keep all medicines, both prescription and over-the-counter, in a locked cabinet or box.
- Discard expired or unused prescription drugs.
    - Find a local "Take Back" program
    - Only discard drugs in the trash if they are mixed with a wet undesirable substance, such as used coffee grounds or kitty litter and only as a 'last-resort'. *"Unused prescription drugs thrown in the trash can be retrieved and abused or illegally sold…. Take back programs are the best way to dispose of old drugs."* **- DEA, April 30, 2011**

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OBSERVING CURRENT CHILD SAFETY SEAT RECOMMENDATIONS: KEEPING CHILDREN AT A LOWER RISK FOR MOTOR VEHICLE RELATED INJURY AND DEATH

Tam Lutz (Lummi Nation) and Nicole Smith, Native CARS Study

As parents we get excited for our child's developmental milestones; but, transitioning to the next stage of child safety seat should never be rushed. Placing a child in a child safety seat that the child is not physically and or developmentally ready for can put the child at a greater risk of severe injury or death in the event of a crash than placing the child in a child safety seat that is appropriate for their age and size.

In April 2011 the American Academy of Pediatrician released a new policy statement that advises parents and caregivers to keep toddlers in rear-facing car seats until they are age 2, or until they exceed the highest height or weight limit for the car seat. Height and weight limits of a seat can be found on the back of the seat as well as the box the seat comes in. Rear facing infant seat height and weight limits vary by seat manufacturer from 22, 30 to 35 pounds. Convertible seat height and weight limits in a rear facing position vary by seat manufacturer from 30, 35, 40 and sometime as much as 45 pounds.

It may seem more convenient to place a child forward facing earlier but keeping the child rear facing allows for the best protection of the child's head, neck and spine in the event of a crash because it distributes the force of the crash over the entire body. Recent new data has shown that children under age 2 are 75% less likely to die or be severely injured in a crash if they are rear facing. (Henary B et al, *Inj Prev*. 2007) Therefore, all children who are within rear facing height and weight limits of their seat, no matter what their age are safer rear facing and should stay rear facing until at least 2 years.

In the 2011 Native CARS child safety seat observational survey conducted in six Northwest tribes, we found that 16% of infants were being prematurely graduated to a forward facing seat. Some drivers had already adopted the new recommendations and had 1-year-old children in a rear-facing seat (9%). Most of the 1-year-old children observed were restrained in a forward facing seat, most often a convertible seat which could easily be turned rear facing to meet the new recommendations and provide added safety for the child.

Once children have outgrown the height and weight limits for a rear facing seat, they should then be kept

CURRENT AAP GUIDELINES – APRIL 2011

All infants and toddlers should ride in a **rear-facing car safety seat (CSS) until they are age 2**, or until they reach the highest weight or height allowed by the manufacturer of the their CSS. (The old policy from 2002 cited age 12 months and 20 pounds as a minimum for when to turn a seat around.)

All children 2 years or older, or those younger than **2 years who have outgrown the rear-facing weight or height limit** for their CSS, should use a **Forward-Facing CSS** with a harness for as long as possible, up to the highest weight or height allowed by the manufacture of the their CSS..

All children whose weight or height is above the forward-facing limit for their CSS should **use a belt-positioning booster seat** until the vehicle lap-and-shoulder seat belt fits properly, typically when they **have reached 4 feet 9 inches tall** and are between 8 and 12 years old.

All children **younger than 13 years** should be restrained in the **rear seats of a vehicle** for optimal protections

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OBSERVING CURRENT CHILD SAFETY SEAT RECOMMENDATIONS: KEEPING CHILDREN AT A LOWER RISK FOR MOTOR VEHICLE RELATED INJURY AND DEATH

in a forward facing position in a forward facing car seat with a 5-point harness. These forward facing car seats may be a 1) convertible seat that can be used as a rear facing seat or forward facing seat, 2) combination seat that can be used with the 5-point harness or without the harness as a booster seat or 3) forward facing seat only. Regardless of the type of forward facing car seat, a child should remain in the forward facing car seat until they exceeded the maximum weight requirement (usually 40-80lbs), their ears are taller than the top of the child safety seat or their shoulders are than the top harness strap slot. Otherwise children are safe to remain in their forward facing car seat until they reach these limits. There is no rush to move them to a seat belt positioning booster seat just because they have reached 4 years old. Native CARS data showed that 67% of 4-year-olds were restrained in either a booster seat or harness seat with twice as many children in boosters than harness seats. Some 4-year-olds (11%) weighed less than 40 lbs and were riding in booster seats when they could have remained in their forward facing seats.

In the Native CARS Study we have also found that children most at risk for being improperly restrained were children 5-7, who were of booster seat eligible age. Half of 5-year-old children were properly restrained, and proper restraint decreased to only 38% for 6 and 7-year old children. Booster seat eligible children are children who are over 4 years old or have exceeded the recommendation of their forward facing car seats. To safely use a booster seat there should be a lap and shoulder belt in the vehicle where the child will sit and use the booster seat. Children should remain using booster seats until they can properly fit a vehicle seat belt. Proper fit of a vehicle seat belt can be determined

by using the following 5-Step Test developed by SafetyBeltSeat USA.

The 5-Step Test

- Does the child sit all the way back against the auto seat?
- Do the child's knees bend comfortably at the edge of the auto seat?
- Does the belt cross the shoulder between the neck and arm?
- Is the lap belt as low as possible, touching the thighs?
- Can the child stay seated like this for the whole trip?

If your child has not met each bullet in the 5-Step test, then your child should remain in a booster seat until they do, which is usually about the time that they are about 4'9" in height. In the Native CARS study, only 19% of 8-year-old children were reportedly 4'9" tall. It is becoming more and more common for 9 and 10 year-old children to ride in booster seats until the vehicle seat belt fits correctly.

For optimal protection children should always be restrained in the rear seats of vehicles until they are they are at least 13 years of age.

Current state and tribal laws vary in their timely observance of these national recommendation, so for

DISTRACTED DRIVING

WHAT IS DISTRACTED DRIVING?

Distracted driving is any activity that can side track a person's mind from the task of driving. *All* distractions put the driver, passenger, and others in danger. These activities include:

- Texting
- Using a cell phone or Smartphone
- Eating and drinking
- Talking to passengers
- Combing hair
- Applying makeup
- Reading, including maps
- Using a navigation system
- Watching a video
- Adjusting a radio, CD player, or MP3 player

But, because texting uses the eye, hand and brain, it is the most dangerous.

Key Facts and Statistics in the U.S.

- In 2009, 5,474 people were killed in crashes involving driver distraction. About 448,000 were injured.
- 16% of fatal crashes in 2009 involved distracted driving.
- 20% of injury crashes in 2009 involved distracted driving.
- In the month of June 2011, more than **196 billion** texts were sent or received in the US.
- Teen drivers are more likely to be involved in a fatal crash where distraction is reported. In 2009, 16% of teen drivers involved in a fatal crash were reported to have been distracted.
- Text messaging creates a crash risk 23 times worse than driving while not distracted.
- Sending or receiving a text takes a driver's eyes from the road for an average of 4.6 seconds. This is like driving at 55 mph for the entire length of a football field, blind.
- Using a cell phone while driving, whether it's hand-held or hands-free, delays a driver's reactions as much as having a blood alcohol level at the legal limit of .08 %.
- Driving and using a cell phone at the same time reduces the amount of brain use for driving by 37%.

For more information see the National Highway Transportation Safety Page www.distraction.gov.

Information adapted from the National Highway Transportation Safety, 2012.

STOP KIDS INTOXICATED DRIVING (SKID)

Luella Azule,
Injury Prevention Coordinator

At the beginning of May, I attended a SKID demonstration with Rachel Ford, NPAIHB's Public Health Improvement Manager, at Aloha High School, attended by the student body. The SKID Program began in Washington County, Oregon in 1998. The program brings what appears to be a fatal alcohol-related traffic crash to local high schools to illustrate the consequences of drunk driving, texting, and not wearing seat belts. SKID is a graphic and realistic portrayal of crushed vehicles and injured bodies.

The demonstration starts with a pre-recorded audio of the high school student actors stating their names, what their interests are, and what they hope to accomplish in the future: which colleges they want to attend and what careers they hope to enter.

An audio description sets the scene: It's prom night, 1:30 AM [party sounds]. Five students had drunk a case of beer between them [dancing music.] Students attempt to coerce a reluctant student to drink, but he refuses. The students decide to attend another party just down the road. A non-drinker declines to drive because he can't drive a stick shift, another teen states even though he has been drinking, he is fine and can drive. During the drive, we hear: a male passenger egging on the driver to show him what the vehicle can do, speeding motor sound, girls laughing, someone yelling "car!" and "stop!," skidding tire sounds, passengers screaming, then a loud thud as they crash into another vehicle.

Tarps are removed to reveal two crashed vehicles: a white SUV and a red Blazer. A male student is draped over the hood of the white SUV. The audio explains: He was texting about the party and didn't put on his seat belt. He sustained extensive head trauma and was killed instantly. We see the driver with blood on his face, and the back seat passengers with wounds on their faces and heads. The second vehicle had passengers in front seat. The driver of the Blazer is slumped over the steering wheel and her passenger isn't moving either.

A Female voice is heard calling 911 from the crash scene. She describes the collision to the 911 dispatcher and requests an ambulance. The dispatcher calls the police and ambulance, and states that help is on the way. A radio announcer states there has been a crash and gives the location, "Two vehicles were involved, with several high school students in one vehicle. There appears to be a fatality and alcohol appears to have been involved." Cars are being rerouted around the collision and crash investigation. Another student arrives at the scene, recognizes the boy on the hood of the SUV, and calls his parents.

A half-dozen motorcycle police arrive. They administer first aid to the less severely injured victims, leaving the severely injured victims in their cars, and begin the crash investigation, taking pictures and measurements. The parents of the victim in the white SUV arrive on the scene. The mother becomes extremely distraught, goes to son's side and attempts to "wake him up." Her husband and the police pull her away from body and lead her to side of road...

Two fire engines arrive, and firefighters trained as emergency medical technicians and paramedics determine that there has been a fatality and at least one critical injury. They then use the jaws of life to remove the top of the red Blazer, put the critically-injured driver in a neck brace and on body board, and take her to the life flight helicopter. She is loaded in and the helicopter lifts off. Another victim is loaded into an ambulance and driven away. A police officer administers a field sobriety test to the driver of the white SUV, determines that he is drunk, arrests him, and puts him in the patrol car. The medical examiner arrives to declare that student on the hood is deceased and put identifying information on his arm. Representatives from the funeral home arrive, and firefighters put the student into a body bag and then into the funeral vehicle, which drives off.

At the close of the presentation, a student reads a poem about how it wasn't fair that the boy who died

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STOP KIDS INTOXICATED DRIVING (SKID)

didn't drink and wasn't driving. We learn that the drunk driver was sentenced to 10 years in prison.

The dramatization was so realistic, I got caught up in the emotions of the moment, and tears ran down my face. Some of the students even forgot that the scene wasn't real – many were also moved to tears.

SKID educates high school students about the dangers of drinking and driving. To date, the program has been presented to more than 95,850 students. There have been 3 deaths and 5 injuries, from a total of 7 alcohol related crashes, that have involved students who were members of school assemblies where the program has been shown, but these numbers are much lower than the national average. According to a 2008 report from the National Highway Traffic Safety Administration (NHTSA), out of every 100,000 teenagers, 59 will die as a result of an alcohol related crash. The SKID schools have a rate that is about 5% of the national average in teenage drinking and driving crashes.

Organizations that participated in the SKID demonstration program in Aloha included: Tualatin Valley Fire & Rescue, 97.1 Charlie FM radio, AMR Ambulance services, Life Flight Air Ambulance, Washington County medical examiner, and Springer and Son Funeral Home.

SKID is willing to assist other area high schools in providing this demonstration. For more information, visit www.skidprogram.org, or contact:

Stop Kids Intoxicated Driving (SKID) Program
PO Box 3058
Hillsboro, OR 97123
(Tim Moore, SKID Founder)
Phone: 971-285-5110
Alt Phone: 503-504-4585
skidprogram_tim@yahoo.com

Crash scene revealed

EMTs removing driver from the 2nd vehicle on a backboard, after cutting away roof of vehicle

Non-drinking student being placed in body bag, then into a funeral vehicle and driven away

Distraught parents viewing their deceased son, being told by a policeman, "He didn't make it."

Life flight arriving; driver being arrested for DUII

Photos taken by NPAIHB staff at SKID event

TEEN DATING VIOLENCE

Carrie Sampson (Umatilla, Walla-Walla)
Sexual Assault Prevention Project Coordinator

Teen dating violence is defined by the CDC as the physical, sexual or psychological/emotional violence within a dating relationship, as well as stalking. Teen dating violence may also be known as: relationship abuse, intimate partner violence, relationship violence, dating abuse, domestic abuse or domestic violence. In a nationwide survey, 9.8 percent of high school students report being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend in the 12 months prior to the survey. (Centers for Disease Control and Prevention, 2009 Youth Risk Behavior Survey). About 1 in 5 women and nearly 1 in 7 men who ever experienced rape, physical violence, and/or stalking by an intimate partner, first experienced some form of partner violence between 11 and 17 years of age (Centers for Disease Control and Prevention, 2010 National Intimate Partner and Sexual Violence Survey). There is limited or non-existent information available on this health issue for American Indian and Alaska Native females, however, a 1992 Minnesota youth study found that 92% of American Indian girls who reported having sexual intercourse have been forced against their will to have sex. In addition, 62% of those girls reported to have been pregnant by the 12th grade. (The University of Minnesota. "The State of Native American Youth Health". 1992)

Teen dating violence isn't something commonly heard or may be hidden because teenagers may not be aware that what they're experiencing is a type of violence. Because teenagers are inexperienced in relationships, easily influenced by peer pressure, have inaccurate views of love or seek independence from parents and adults they are less likely to disclose evidence of violence to adults or law enforcement. Signs that a teenager is experiencing dating violence include: physical signs of injury, truancy or dropping out of school, failing grades, indecisiveness, changes in mood or personality, use of alcohol/drugs, pregnancy, emotional outbursts or isolation. (Delaware Coalition Against Domestic Violence newsletter, Winter 1999)

There is limited information about teen dating violence specific to American Indian/Alaska Native populations. The Native American Women's Health Education Resource Center has developed a Teen Dating Violence Prevention Curriculum and Workbook for Native American Girls to address this issue. This information can be found at http://www.nativeshop.org/resources/health-book.html#teen

For more information or resources:

- CDC's Dating Matters: Strategies to Promote Healthy Teen Relationships: www.cdc.gov/violenceprevention/datingmatters
- National Dating Abuse Helpline: 1-866-331-9474 or text 77054
- National Sexual Assault Hotline: 1-800-656-HOPE (4673)
- National Sexual Violence Resource Center: www.nsvrc.org
- Dating Matters: Understanding Teen Dating Violence Prevention: www.vetoviolence.org/datingmatters

Continued from....

OBSERVING CURRENT CHILD SAFETY SEAT RECOMMENDATIONS:

Continued from page 11

the best protection of your children and most current recommendations look to nationally recognized bodies that aim to protect children from motor vehicle injury and death, such as the American Academy of Pediatrics and the National Highway Traffic Safety Administration for your most update to date recommendations.

For more information about the Native CARS Study please contact Tam Lutz, Native CARS Study Project Director at 503 416 3271 or tlutz@npaihb.org.

For more information specifically about child safety seats or current recommendation see:
www.thecarseatlady.com ,
www.nhtsa.gov/Safety/CPS
or
www.healthychildren.org/English/News/pages/AAP-Updates-Recommendations-on-Car-Seats

HELP PREVENT SUICIDE IN YOUR TRIBAL COMMUNITY

Continued from page 8

the suicidal person safe for one more day, one more week, one more month, or hopefully even longer than that. The NPAIHB's project THRIVE primary focuses on suicide prevention and currently offers these three trainings to the NW Tribes. For more information about the trainings please visit www.qprinstitute.com or www.livingworks.net. For more information on project THRIVE and the trainings offered please visit: http://www.npaihb.org/epicenter/project/thrive/ or contact Colbie Caughlan at ccaughlan@npaihb.org.

If you or someone you know is thinking about suicide please contact the National Suicide Prevention Lifeline at: 1-800-273-TALK (8255)

SAFE DISPOSAL OF PRESCRIPTION MEDICINES

Continued from page 9

- Do not flush medications down the drain or toilet

- Supervise children when they take their prescribed medication, then immediately lock up the medication.

- To help prevent unauthorized refills, remove any personal information from prescription bottles of pill packages before you throw them away.

Take-Back Days

Prescription drug "take-back" days allow communities to safely dispose of leftover medicines that are lingering around the house. This prevention effort may prove helpful in curbing prescription drug abuse, since studies show that the majority of abusers obtain their drugs from family, friends, or their home medicine cabinet.

To add a take back day to your community's prescription drug abuse prevention efforts, consider participating in any of the "Take Back" days, located in your community and throughout the Pacific Northwest. To find out more information about this initiative and participating 'take back' locations, please visit: http://www.justice.gov/dea/. Or refer to the area links below.

Take-back Programs in the Northwest:

- Idaho: http://www.odp.idaho.gov/prevention/prescription.html
- Oregon: http://www.deq.state.or.us/lq/sw/hhw/DrugTakeBackSites.pdf
- Washington: http://www.takebackyourmeds.org/

Additional References:

- http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm

New Face At The Board

Congratualtion to Colbie and Steve Caughlan on the arrival of
Sydney
Born June 3, 2012 at 8 lbs, 19.5 inches

Upcoming Events

JUNE

June 25 – 29
2nd Annual National Health Promotion Conference
Portland, OR

June 25 – 28
IHS Behavior Health Conference
Bloomington, MN

June 25-29
2nd Annual THRIVE Conference
Portland, OR

JULY

July 16-19
Native Research Network Annual Conference
Seattle, WA

July 17-18
Dental Prevention Coordinator Meeting
Airway Heights, WA

July 17-18
Medicaid, Medicare, CHIP and ACA Training
TBD

July 22-26
National Tribal Best Practices
San Diego, CA

July 25
WA State DOH Competitive Grant Writing
Anacortes, WA

July 25-26
CMS Tribal Technical Advisory Group Face-To-Face Meeting
Washington, DC

July 31-August 5
Advancing Native Health & Wellness (AAIP) 41st Annual Meeting
Anchorage, AK

July 31- August 1
IHS Information Systems Advisory Committee Bi-Annual Meeting
TBD

AUGUST

August 7-8
Tribal Consultation Summit
Denver, CO

August 7-8
Native Fitness
Beaverton, OR

August 8
WA HCA & AIHC Tribal Workgroup Meeting
Olympia, WA

August 10
AIHC Meeting
Sequim, WA

August 12-15
ACOG/IHS Postgraduate Women's Health Course
Salt Lake, UT

August 14-15
9th Annual Tribal Public Health Emergency Preparedness Conference
Shelton, WA

August 14-16
Direct Service Tribes National Meeting
Tucson, AZ

August 21-23
Improving Patient Care Program Learning Session
Phoenix, AZ

August 26-30
National Tribal Environmental Council Conference
Traverse City, MI

August 27
Native American Women/Girls & Men/ Boys Conference
Camp Hudson, WA

August 27-31
National Tribal Transportantion Safety Summitt
TBD

SEPTEMBER

September 11-12
HHS Secretary's Tribal Advisroy Committee
Washington, DC

September 12
WA HCA & AIHC Tribal Workgroup Meeting
Olympia, WA

September 24-28
NIHB 29th Annual Conference
Denver, CO

September 24-27
ATNI
Pendleton, OR

September 28
7th Annual Dancing In the Square PowWow
Downtown, Portland, OR

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S APRIL 2012 RESOLUTIONS

Resolution #12-03-01
Support for the Submission of a Grant to the Centers for Disease Control and Prevention for Funding for the Northwest Tribal Comprehensive Cancer Program

Resolution #12-03-02
Preventing Violence and Violence Related Injury

Resolution #12-03-03
"Support for NPAIHB EpiCenter Access to the Indian Health Service Portland Area-wide RPMS Database"

Resolution #12-03-04
"Support for EpiCenter proposal for NIMHD: Social, Behavioral, Health Services, and Policy Research on Minority Health and Health Disparities (R01)

Resolution #12-03-05
"The Tobacco Regulation Awareness, Communication, and Education Program (U1A)

Resolution #12-03-06
CSC Recommendation to Support Funding for New/Expanded Programs and to Share Data Purposes of Developing CSC Shortfall Reports

Resolution #12-03-07
Reauthorization of the SDPI in the 112th Congress

Resolution #12-08-03
"Support $403 million Budget increase for the IHS Budget FY 2013"

Resolution #12-03-09
Support NPAIHB Comment Letter on OMB Proposals Published Federal Resister, Tuesday, February 20, 2012

Resolution #12-03-10
Support for the NW Tribal Injury Prevention Action Plan

Resolution #12-03-11
Program Operation Manual Revisions