Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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SAMHSA Helps Reduce Seclusion and Restraint at Facilities for Youth

At some mental health treatment facilities, children who misbehave risk being tackled, sat upon, and dragged to "seclusion rooms." That's not the case at the Lakeside Treatment and Learning Center, a nonprofit residential treatment facility for emotionally and behaviorally impaired children and adolescents in Kalamazoo, MI.

About a decade ago, the center's leaders realized that those types of restraint and seclusion techniques not only put their clients at risk of injury or even death but also were counterproductive. To avoid retraumatizing already troubled children, staff faced with problematic behavior these days first try strategies designed to calm clients and de-escalate conflicts. They only resort to seclusion or a restraint technique with great reluctance. Even more important, staff members work to prevent certain behaviors from occurring in the first place.

"Our agency is moving away from a culture based on coercive control of children to one based on committed relationships," explained Suzanne Friesner, M.S.W., the center's Assistant Director. "Although we recognize that sometimes safety concerns mandate the use of restraint or seclusion, our vision for the future is to move as much as possible to an environment free of restraint and seclusion."

SAMHSA's Center for Mental Health Services (CMHS) is helping to make that vision a reality. In 2001, CMHS awarded five 3-year demonstration grants to support the development of effective best-practice training models to reduce the inappropriate

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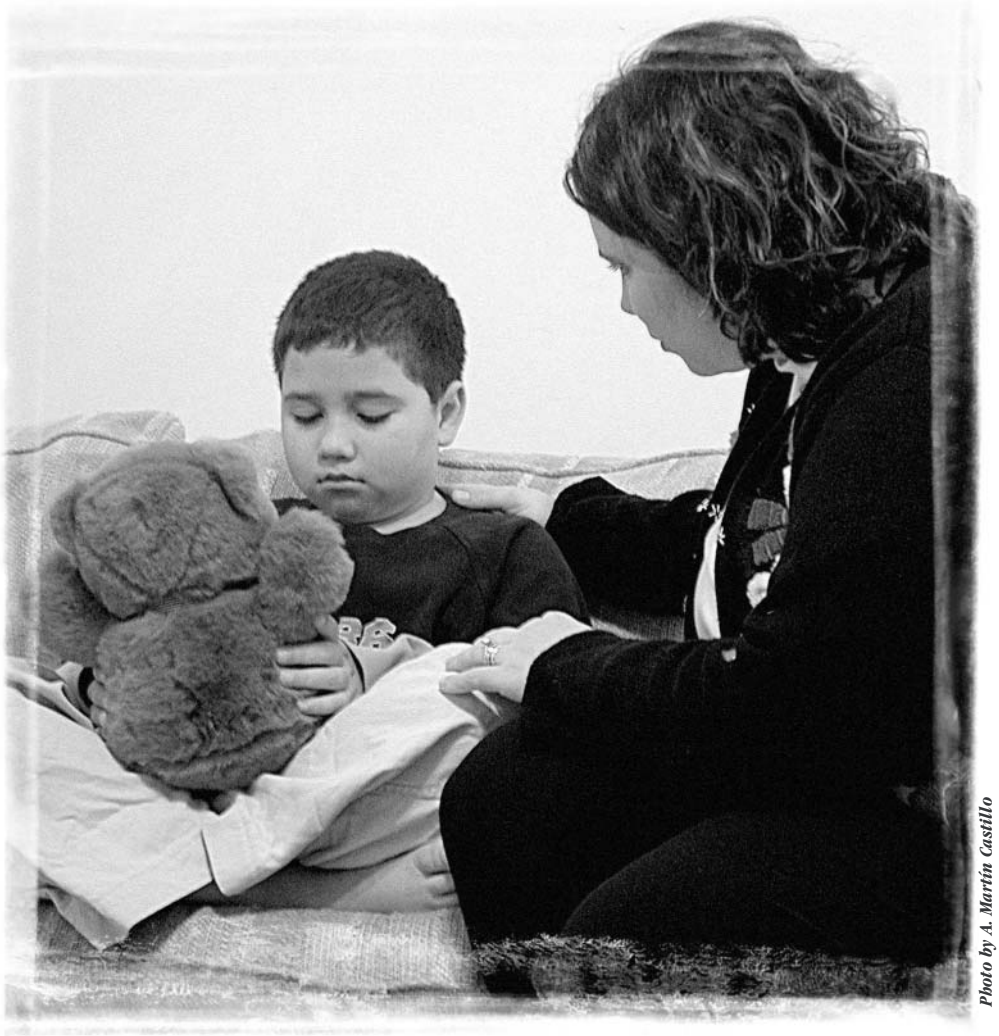

Photo by A. Martin Castillo

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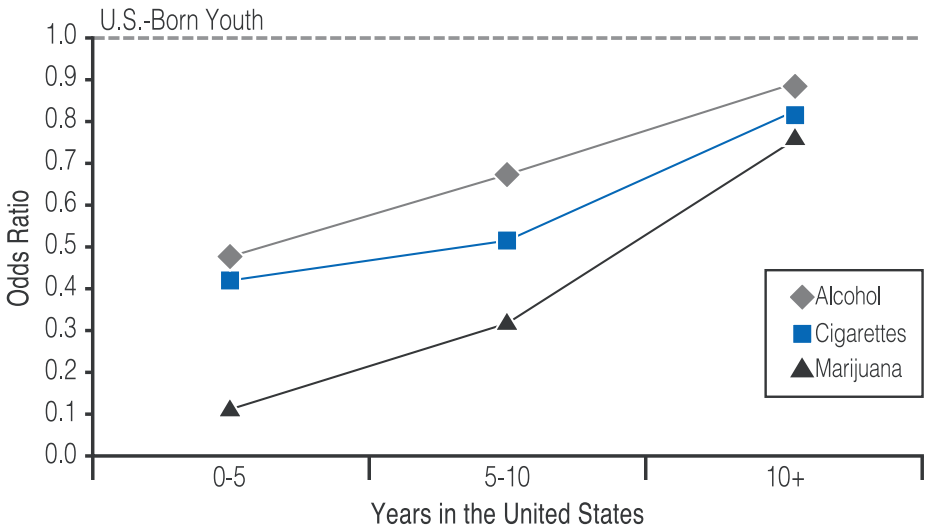
Acculturation Increases Risk for Substance Use by Foreign-Born Youth

Foreign-born youth report lower rates of substance use than U.S.-born youth, but their risk for substance use increases the longer they live in the United States, according to the findings of a new SAMHSA study published in a recent issue of the *American Journal of Public Health.*

The article, "Substance Use Among Foreign-Born Youths in the United States: Does the Length of Residence Matter?" is written by Joseph C. Gfroerer and Lucilla L. Tan of SAMHSA's Office of Applied Studies. The authors discovered that foreign-born youth who had lived in the United States less than 5 years had lower prevalences of substance use than young people who were born in the United States. Yet, prevalence estimates for foreign-born youth who had lived in the United States for 10 years or longer were not significantly different than estimates for U.S.-born youth, except that U.S.-born youth reported substantially higher rates of heavy alcohol use.

The study reinforces the results of previous studies pointing to lower rates of substance use among foreign-born youth compared with U.S.-born youth, but increased risk of use as they become assimilated within American society. What makes this study unique is that it offers the first national estimates of the prevalence of substance use among foreign-born youth age 12 to 17. It also explores the relationship between acculturation, which is defined in this study as the length of time a young person has lived in the United States, and substance use.

Past-Month* Substance Use Among Foreign-Born Youth Age 12 to 17 vs. U.S.-Born Youth



*Data from 1999 and 2000. For foreign-born youth, substance use increases to levels of U.S.-born youth as years of residence in the United States increase.

Source: Gfroerer JC and Tan LL. *American Journal of Public Health.* 2003:93;1892-1895.

"A better understanding of these results could be gained by studying how acculturation interacts with known risk and protective factors for substance use," the authors state in the article. "Research in this area should help prevention planners design programs that appropriately consider acculturation to reduce substance use among immigrant youth."

Acculturation within U.S. society occurs through interaction with parents and peers, education, and exposure to television, movies, magazines, and other media—each of which may influence a young person's attitudes about substance use. The authors suggest that youth who are more fluent in English may have more access to substances of abuse because they are more familiar with ways to find and obtain substances of abuse in the community. For example, prevalence estimates for Hispanics were higher among those who responded in English than those who answered questions in Spanish.

The study was based on a sample of 50,947 young people who participated in SAMHSA's 1999 and 2000 National Household Survey on Drug Abuse, an ongoing nationally representative survey of the civilian, noninstitutional population age 12 and older.

Respondents could answer questions in either English or Spanish. Some 7.1 percent of those in the sample were foreign-born, and of those, 28.4 percent were born in Mexico, 5.1 percent in Germany, 4.6 percent in the Philippines, and 3.0 percent in India, Vietnam, and Korea (North and South).

Ready for HIPAA? SAMHSA Can Help

Many Americans have had some personal experience with the Federal Government's Health Insurance Portability and Accountability Act (HIPAA). To ensure privacy, for example, they may have been asked to stand farther away from a customer in line to pick up prescriptions at the pharmacy counter. Or, they've been asked by their physician's office staff to read a "Notice of Privacy Practices" and to sign an acknowledgment of receipt of that information.

"While these may be small day-to-day changes, they reflect larger changes taking place behind the scenes that will benefit everyone," says Sarah A. Wattenberg, L.C.S.W.-C, a public health advisor at SAMHSA's Center for Substance Abuse Treatment (CSAT) and the SAMHSA HIPAA Coordinator.

HIPAA can be complex at times, but the U.S. Department of Health and Human Services (HHS) is working hard to develop resources that can help people better understand the requirements, and SAMHSA is contributing to these efforts.

Streamlining the System

HIPAA was born out of frustration with the inefficiency—and spiraling costs—of the Nation's health care system. As a result of the Act, passed in 1996, HHS was required to create regulations for the electronic exchange of certain kinds of health information and for the security and privacy of that information. Some of the regulations, promulgated over several years, include the following:

- Standards for Electronic Transactions and Code Sets Rule and its Modifications Rule, which had a compliance date of October 16, 2002 (the Administrative Simplification Compliance Act extended this rule for an additional year if covered entities submitted HIPAA compliance plans).
- Privacy Rule and its Modifications Rule, with a compliance date of April 14, 2003.
- Employer Identifier Rule, with a compliance date of July 30, 2004.

- Security Rule, with a compliance date of April 21, 2005. (The additional year for small health plans for Transactions and Code Sets and its Modifications ended October 16, 2003.)

Three types of "covered entities" are subject to HIPAA: health plans, health care clearinghouses that health care providers and plans can use to process and submit their transaction data in a HIPAA-approved manner, and health care providers who electronically exchange health information for which HIPAA has adopted a particular standard. Covered entities must comply with all HIPAA standards, not just one or two.

In addition, business associates of covered entities who have contact with a patient's health information are required to sign contracts agreeing to protect that information. Business associates could include an attorney reviewing a patient's file, or an organization that collects information to evaluate patient care, among others.

What kind of information does HIPAA cover? HIPAA protects any patient information that is created or received by a covered entity and that identifies the individual or could be used to identify an individual, whether the information is in oral, written, or electronic format.

Electronic Transactions Standards

Until now, every health care organization had its own codes for billing and other types of transactions. The result was babel, with health insurers and providers unable to use the same language to "talk to each other." To create a common language, HIPAA's electronic transaction regulations require covered entities to use a standardized content and format when transmitting certain health care information electronically. Standards have been adopted so far for the exchange of information related to plan eligibility, health plan enrollment and disenrollment, premium payments, referral certification and authorization, claims and encounter information, claim status, payment and remittance advice, and benefit coordination.

A National Code

Standard code sets for diagnosis and treatment have not existed up to this point. States have typically used "home-grown" codes for treatment procedures. Now, HIPAA requires that national, uniform codes be used. Certain code sets have been adopted by the HHS Secretary as national standards: the International Classification of Diseases,

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9th Edition, Clinical Modification (Volumes 1, 2, and 3); the Current Procedural Terminology; the Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS); the Code on Dental Procedures and Nomenclature; and the National Drug Codes.

Unfortunately, says Ronald W. Manderscheid, Ph.D., Chief of the Survey and Analysis Branch of the Division of State and Communities Systems Development within SAMHSA's Center for Mental Health Services (CMHS), these code sets did not originally include codes for many of the services offered by mental health and substance abuse treatment providers.

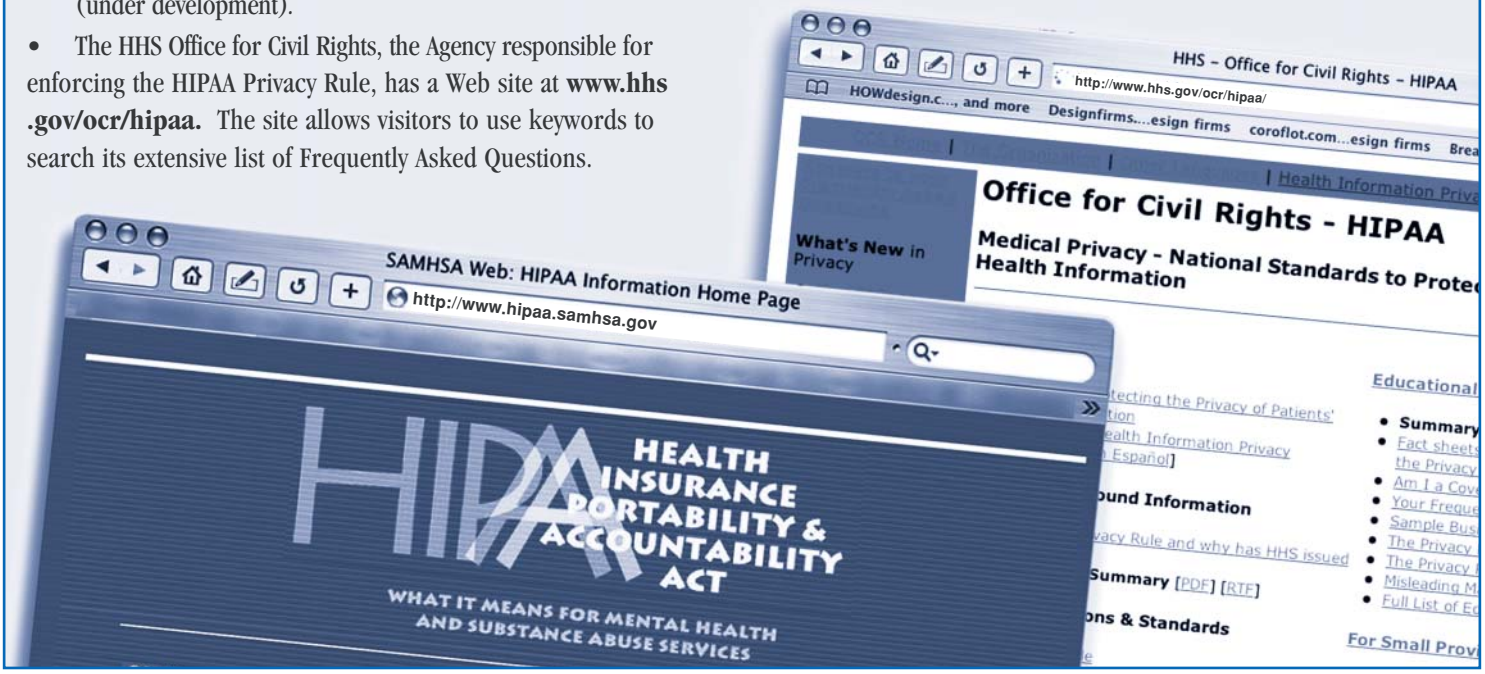
For the past 2 years, CSAT, the CMHS Decision Support 2000+ Initiative, and other groups worked to solve the problem by creating a more complete code set for behavioral health services and proposing them for inclusion into the CMS HCPCS code set. The large majority of these codes were adopted by the CMS and are now posted on the CMS Web site.

Also, while some providers may be able to adapt existing systems to comply with HIPAA's electronic transactions provision, most will need outside help, Dr. Manderscheid says. Providers can use health care clearinghouses to translate their transaction data into acceptable formats or purchase software to do the job.

HIPAA Compliance Resources

SAMHSA, the Office for Civil Rights, and the Centers for Medicaid & Medicare Services (CMS)—all within the U.S. Department of Health and Human Services (HHS)—offer a variety of resources to help providers comply with HIPAA:

- SAMHSA's HIPAA Web page at **www.hipaa.samhsa.gov** offers a wealth of information, including:
  - A searchable database of documents related to HIPAA compliance
  - An updated list of procedure codes for mental health and substance abuse treatment
  - Audioconferences on different HIPAA standards
  - A document called *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs* (under development).
- The HHS Office for Civil Rights, the Agency responsible for enforcing the HIPAA Privacy Rule, has a Web site at **www.hhs.gov/ocr/hipaa.** The site allows visitors to use keywords to search its extensive list of Frequently Asked Questions.
- CMS, the Agency responsible for enforcing the electronic transactions and code sets standards, the security standards, and the identifier standards, also has a Web site at **www.cms.hhs.gov/hipaa/hipaa2.**
- A SAMHSA-HIPAA listserv offers up-to-the-minute updates to anyone interested in new resource materials. To subscribe, send an e-mail request to Sarah Wattenberg at swattenb@samhsa.gov.
- Handbooks about each of the eight electronic transactions covered by HIPAA are available at **www.mhsip.org/ds2k+.htm.** The handbooks include transaction descriptions, definitions, and data checklists.



Either way, Dr. Manderscheid's advice is the same: *caveat emptor* (buyer beware). "The burden of proof concerning the accuracy of the data ultimately lies with the provider or plan," he explains. Providers who go the software route should consult SAMHSA's handbooks for each of the eight electronic transactions to ensure that they're meeting the standards. (See "Resources," p. 4.)

While some providers may be able to adapt existing systems to comply with HIPAA's electronic transactions provision, most will need outside help.

Protecting Privacy

"Before HIPAA, patients were very concerned about how the general health care system was handling information about them," says Ms. Wattenberg. "In fact, in 1999, the California HealthCare Foundation conducted a survey and found that one out of seven Americans reported evasive actions to avoid inappropriate use of their health care information. For example, someone wouldn't tell the truth to their primary care physician about a chronic physical condition for fear the information might get back to their employer," says Ms. Wattenberg. "That's a pretty upsetting statistic. It means that patients may not be giving their doctors important health information that's needed for appropriate and effective treatment," she added.

For this reason, HIPAA requires that covered entities obtain authorization from patients before they use or disclose information. This applies unless otherwise allowed by the Privacy Rule, such as, for example, information can be shared without authorization for treatment (so that your physician can discuss your x-rays with another provider, like a radiologist); for payment (e.g., so that information can be used to process claims); or for operations (e.g., so that information can be used or disclosed to oversee the quality of the health care you are receiving).

Among other requirements, covered entities also need to establish privacy policies, put privacy safeguards in place, train staff, designate a privacy officer, and establish a grievance process.

Consumers of health care services also have new rights under HIPAA and they need to be informed of these rights. For example, patients can review their medical records, make a copy of the records, and request changes.

"Mental health and substance abuse treatment providers should not have a hard time complying with HIPAA's privacy rule," says Ms. Wattenberg. "For mental health providers, state laws and professional ethics have always dictated high standards for protecting the sensitive information treatment providers create or receive about their clients."

"For substance abuse providers, most treatment programs have been required for decades to comply with the Federal Confidentiality of Alcohol and Drug Abuse Patient Records regulation, 42 C.F.R. Part 2," says senior program management officer Captain Ann G. Mahony, M.P.H., of CSAT's Division of Systems Improvement. "Covered entities should read both laws together," she advises. When HIPAA conflicts with the "Part 2" regulations or with state laws, the more stringent rule applies.

Patients will enjoy even more protection when HIPAA's security standard goes into effect. The standard will require covered entities to assign a security officer who will be responsible for conducting risk assessments and other measures to assure the integrity, confidentiality, and availability of identifiable health information that covered entities store, maintain, or transmit.

For more information on HIPAA, visit SAMHSA's Web site at **www.hipaa.samhsa.gov.**

—By Rebecca A. Clay

Before HIPAA, patients were very concerned about how the general health care system was handling information about them.

SAMHSA Simplifies, Clarifies Grants Process

SAMHSA has revamped its methods of coordinating and announcing opportunities for funding through discretionary grant programs for FY 2004. In the past, SAMHSA made as many as 30 separate grant announcements—each unique to a particular program—in a year. The Agency is looking forward to a streamlined future, in which just four standard grant announcements—available to applicants year-round—simplify and clarify the process by which the Agency solicits and supports grantees in advancing the field of substance abuse and mental health services in the United States.

In October 2002, SAMHSA leadership developed a cross-organizational Discretionary Grants Re-Engineering Team comprised of representatives from each of SAMHSA's three Centers and from the Agency's planning and grants management offices. This team reviewed past grant announcements across the Agency and concluded that most SAMHSA Requests for Funding Applications fall into one of four categories: Services Grants; Infrastructure Grants; Best Practices Planning and Implementation Grants; and Service-to-Science Grants (see box, p. 7). Standard grant announcements for each of these broad categories were then developed, and they are now available at the SAMHSA Web site at **www.samhsa.gov/grants** or from the SAMHSA information clearinghouses—the National Clearinghouse for Alcohol and Drug Information, and the National Mental Health Information Center.

These standard grant announcements address elements common to each grant category, including the purpose of funding, standard of evidence, general size of awards, eligibility, allowable activities, and review criteria. In addition, appendices in each standard announcement contain resources to assist applicants in planning effective programs and developing competitive applications. These resources include SAMHSA's National Registry of Effective Programs and a bibliography of publications on effective treatment practices for professionals treating individuals with substance abuse disorders.

Ongoing Grant Opportunities

For the most recent SAMHSA grant announcements, check the Agency's Web site at www.samhsa.gov/grants on a regular basis.

The year-round availability of these standard announcements will allow potential applicants to begin to gather data and review best practices and standards in their field in anticipation of the opportunity to apply for SAMHSA support. This change alone will decrease the burden on potential grantees. In the past, they faced daunting application requirements, sometimes on very short deadlines.

New Standard Grant Announcements

Potential grantees should not submit an application at will; specific funding opportunities will be triggered through a Notice of Funding Availability (NOFA) published first in the *Federal Register,* and then at the Federal grants Web site at **www.grants.gov** and on the SAMHSA Web site at **www.samhsa.gov/grants.** Each NOFA will identify the program for which funding is available, the applicable grant category, and the criteria required in addition to (or different from) the standard announcement.

For example, a NOFA to provide mental health services to homeless people would identify information regarding targeted homeless populations that would be required in completing an application for a Services Grant. A grant program to provide substance abuse and HIV/AIDS prevention services to incarcerated adults would use the same standard announcement, but would require different additional information and evidence.

Benefits of the Change

The four grant categories, taken as a whole, provide a structure to support proven practices—and to prove the promising ones. Service-to-Science Grants help grantees evaluate promising practices; Infrastructure Grants support grantees in developing the necessary structures to deliver and evaluate services effectively; Services Grants address gaps and unmet needs in the substance abuse and mental health service system; and Best Practices Planning and Implementation Grants promote the use of practices that prove effective.

A very few SAMHSA funding opportunities, such as grants for training, conferences, or technical assistance, don't fit within the four-category structure. These opportunities will continue to be announced through separate, individual Requests for Applications.

"Simplifying the application and review process will increase clarity and help both applicants and SAMHSA," says Frank Sullivan, Ph.D., Director of Organizational Effectiveness at SAMHSA. Applicants now have greater opportunity to familiarize themselves with Federal expectations regarding applications

for funding. In addition, Dr. Sullivan hopes that the new structure will enable SAMHSA to provide more time between the publication of NOFAs and the due date for applications.

According to Dr. Sullivan, the ultimate goal of redesigning the grants process is "to advance the SAMHSA mission of building resilience and facilitating recovery for citizens affected by substance abuse and mental health issues." Clarifying SAMHSA's expectations through the use of standard grant announcements will advance applicants' understanding of the Agency's needs and priorities. Stronger applications and additional SAMHSA support can lead to better developed—and better documented—community-based programs.

"A clearer process," says Dr. Sullivan, "will help SAMHSA communicate goals and expectations more easily, and will help the field work with us more effectively. Good communication will help grantees learn and share the knowledge they gain. And, through that shared knowledge, we can advance the field of substance abuse and mental health services. Our collective knowledge is one of our greatest resources."

In addition to communicating more clearly with local, state, and community-based organizations, SAMHSA intends the new grants process to facilitate cooperation across and within the three SAMHSA Centers. Using standard Services or Best Practices announcements, for example, the Centers could collaborate to develop a NOFA for programs targeting individuals with co-occurring mental and substance abuse disorders. The standard announcements will thereby assist SAMHSA in developing new field-ready programs.

SAMHSA staff, who will no longer be required to develop full grant announcements for each of several grant programs, will be better able to assist applicants and grantees in developing applications and delivering services.

"We want to shift staff energy from the front end of the process—writing and reviewing funding announcements—to emphasize grantee support, program productivity, and client outcomes," says Dr. Sullivan. "Preserving staff resources for grant monitoring and support will enable SAMHSA to help grantees more effectively solve problems they encounter as they activate their programs; help one another through their lessons learned; and help themselves through the development and implementation of evaluations that more clearly communicate the efficacy and cost efficiency of their programs."

For more information about the four new SAMHSA standard grant announcements and the changes to SAMHSA Discretionary Grant Funding Opportunities, visit **www.samhsa.gov/grants.** This Web site also includes a downloadable manual on developing competitive SAMHSA grants, which contains a glossary of terms, references, and additional Web resources. A list of 2003 grant awardees is available at **www.samhsa.gov/grants,** along with dates for upcoming grant-writing training and technical assistance workshops for community-based, faith-based, and grassroots organizations across the Nation. ◗

—By Melissa Capers

Discretionary Grant Categories

During the grants re-engineering process in 2003, all of SAMHSA's discretionary grant programs were reviewed and most were placed in one of the following four broad categories for funding.

- **Services Grants** address gaps in services and/or increase the applicant's ability to meet the unmet needs of specific populations and/or specific geographical areas with serious, emerging problems. Up to 20 percent of grant funds may be used to monitor services and costs, and up to 15 percent of grant funds may be used to develop infrastructure for service delivery. Planned services should be evidenced-based, and should begin within 4 months of the grant award.
- **Infrastructure Grants** increase the capacity of the mental health and/or substance abuse service systems through needs assessments, the coordination of funding streams, and/or the development of provider networks, workforces, data infrastructure, etc. Up to 15 percent of grant funds may be used to conduct implementation pilots to assess the effectiveness of these changes on service delivery.
- **Best Practices Planning and Implementation Grants** help grantees identify substance abuse treatment and prevention and mental health practices that could effectively meet local needs, develop plans for implementation of these practices, and pilot-test practices prior to full-scale implementation. Planning and consensus building activities will be supported for up to 18 months, and up to 3 years of pilot testing and evaluation may be supported.
- **Service-to-Science Grants** support and evaluate innovative practices that are already in place. Funds may be used to stabilize and document the practice prior to a full evaluation.

A few funding opportunities will continue to be announced as stand-alone Requests for Applications. All current funding opportunities are announced in the *Federal Register,* the Federal grants Web site at **www.grants.gov,** and the SAMHSA Web site at **www.samhsa.gov/grants.** ◗

SAMHSA Helps Reduce Seclusion and Restraint

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use of seclusion and restraint in non-medical, community-based, residential and day treatment facilities for children and youth. Lakeside and four other grantees across the country are developing methods to train staff who work with children and youth in facilities providing mental health services (see *SAMHSA News,* p. 9). The Child Welfare League of America, in collaboration with the Federation of Families for Children's Mental Health, serves as the project's coordinating center. Together, the coordinating center and demonstration sites are developing best practices in training to reduce the use of restraint and seclusion.

"Restraint and seclusion represent treatment systems' failures," said CMHS Director A. Kathryn Power, M.Ed. "Through this initiative and others, consumers of mental health services will have improved opportunities for recovery."

Emphasis on Training

Over the last decade, investigations revealed that inappropriate use of restraint and seclusion can result in psychological trauma, physical injury, or even death (see "Breaking the Bonds," *SAMHSA News,* Volume XI, Number 2). Children are at especially high risk.

Now, a patchwork of state laws and a series of Federal regulations and laws have been established to try to prevent such problems. The Children's Health Act of 2000 requires SAMHSA and the Centers for Medicare & Medicaid Services (CMS) to develop regulations governing use of restraint and seclusion in health care facilities receiving Federal dollars and in non-medical, community-based facilities for youth.

> *"Restraint and seclusion represent treatment systems' failures."*
>
> *—A. Kathryn Power, M.Ed.*
> *CMHS Director*

As part of its Conditions of Participation, CMS already established standards that prohibit hospitals and residential psychiatric treatment facilities for people under age 21 from using restraint and seclusion except to ensure safety during emergencies. The regulations also require facilities to report deaths, debrief staff and consumers after incidents, and provide education and training to staff.

That last requirement is especially important, said Paolo del Vecchio, M.S.W., Associate Director for Consumer Affairs at CMHS. Because of the field's high turnover rates, staff may not receive adequate training. "Staff members need ongoing training on seclusion and restraint—most importantly, in how to prevent the use of such techniques in the first place," said Mr. del Vecchio. "Focusing on alternatives to the use of restraint and seclusion is the real key."

And that's just what the CMHS grants do. The program's goals are to develop a range of effective models for training professional and support staff in the appropriate use of restraint and seclusion and to analyze the training's impact on use, safety, and other outcomes.

Mural of the Lakeside Treatment and Learning Center by one of the center's young clients.

A Range of Approaches

Demonstration sites were chosen with diversity in mind, said SAMHSA project officer Karen Saltus Armstrong, M.S.S.W., J.D., of the Protection and Advocacy Section of the CMHS Division of State and Community Systems Development. "The demonstration sites are quite different in terms of the populations they serve, locations, and other factors," said Ms. Armstrong. "We're hoping to come out of this project with many different training models."

For example, the three Connecticut facilities that joined together for the CMHS grant exemplify the range of models under

study. Klingberg Family Centers use a continuing education model, bringing in experts to train staff in specialized topics such as attachment disorder. Riverview Hospital for Children and Youth, within the Connecticut Department of Children and Families, launched a training program in cultural diversity after the facility discovered that staff members were more likely to use seclusion and restraint on minority children. And, the Devereux Glenholme School takes a high-tech approach to training. To help staff members assess their crisis prevention and intervention skills, the facility developed a CD-ROM that presents users with various scenarios and then automatically grades their responses. Background information on each child depicted in the program is available by clicking on the child's image; guidance is available from an on-screen "supervisor."

All the sites view training as just one part of the solution, however.

"Even though this is a training grant, it appears that training isn't everything," explained Principal Investigator Darren Fulmore, Ph.D., a research associate at the Child Welfare League. "Knowledge is only half the battle." What's really important, he said, are the expectations of facility managers as embodied in policies and practices.

In Michigan, the Lakeside Treatment and Learning Center's program takes to heart that kind of comprehensive approach. Ongoing training is a crucial part of the center's effort to reduce the use of restraint and seclusion.

Focusing on crisis prevention, the training program teaches all staff members skills such as how to de-escalate crises verbally, resolve conflicts, avoid power struggles with children, and recognize what triggers incidents. Children who have been sexually abused or witnessed the abuse of others, for example, may come to the aid of peers being restrained and end up being restrained themselves. A child desperate for human contact may actively seek out restraint just to meet that need—a need that could be better met by building appropriate touch into the child's day. The training program also covers such topics as cultural competency, anger management, and the need to increase consumer involvement. Once trained, staff members receive feedback from mentors with proven de-escalation skills.

While underscoring the potential risks of restraint and seclusion, the program also teaches staff how to use such techniques safely and effectively if they become necessary. All direct-care staff undergo annual certification in physical restraint techniques, with interim training as needed.

Focusing on alternatives to the use of restraint and seclusion is the real key.

But training is just one part of an overall strategy to reduce the use of restraint and seclusion, said Ms. Friesner. That commitment permeates every aspect of life at Lakeside. Supervisors, for instance, hire staff who have the temperament for relationship-building and then evaluate them in ways that reward those qualities. The center's group therapist, activities coordinator, and other staff members work to keep the children busy and happy. The children themselves learn coping skills, so they can manage their anger, frustration, and other emotions without misbehaving.

Thanks to this comprehensive approach, Lakeside has seen a steady decline in the use of restraint and seclusion. What's more, Ms. Friesner believes that the approach may represent a solution for the field's notoriously high rate of staff turnover. "Staff members who feel the safest when they feel more in control have resisted the changes," she explained. "But those who believed all along in the primacy of committed relationships have embraced the changes with open arms."

Preliminary Results

The project's implementation phase ended and its evaluation phase began in mid-2002. According to the project's latest National Evaluation Quarterly Report Card, the average number of seclusion incidents has dropped by more than half. Two sites eliminated their seclusion rooms altogether.

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Demonstration Sites

SAMHSA awarded Grants to Support Restraint and Seclusion Training in Programs That Serve Children and Youth to a wide range of programs:

- Connecticut Collaboration for Training Excellence, which encompasses the Klingberg Family Centers in New Britain, the Devereux Glenholme School in Washington, and the Riverview Hospital for Children and Youth within the Connecticut Department of Children and Families, in Middletown
- Girls and Boys Town National Resource and Training Center in Boys Town, NE, in partnership with the A.B. and Jessie Polinsky Children's Center, a public emergency shelter for children and youth, operated by the city of San Diego, CA
- Lakeside Treatment and Learning Center in Kalamazoo, MI
- Methodist Home for Children and Youth in Macon, GA
- University of Alabama's Brewer-Porch Children's Center in Tuscaloosa.

The Child Welfare League of America in Washington, DC, in collaboration with the Federation of Families for Children's Mental Health, serves as the project's Coordinating Center.

SAMHSA Helps Reduce Seclusion and Restraint

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The data on restraint use reveal more mixed results. The one site that submitted data on the use of mechanical restraints—devices that reduce or restrict an individual's ability to move his or her arms, legs, or head freely—showed dramatic improvement, with incidents falling from 25 per 1,000 patient days to just under 4. The use of physical restraints—the application of physical force by one or more people to reduce or restrict an individual's ability to move—rose slightly. However, a closer look at the data reveals that one site's consistently higher incident rate is skewing the numbers. And while the use of restraint is up overall, Dr. Fulmore notes that all of the non-medical, community-based sites have reduced its use.

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Similarly, the overall number of injuries and rate of injuries per incident are going up for both children and staff members. Again, one site has a disproportionate number of injuries, accounting for almost half of the reported injuries to children and almost 70 percent of injuries to staff.

Behind the Numbers

The Coordinating Center collected valuable data that help explain what's going on behind the numbers. For example, data reveal what kinds of events tend to precipitate interventions. Of the events reported, 60 percent were child-on-staff assaults; 25 percent were property damage; and 22 percent were child-on-child assaults.

Several sites tracking non-physical interventions indicate that nearly 37 percent of incidents requiring intervention were de-escalated successfully. The most frequently used strategies employed to de-escalate crises were redirecting the child's attention, using time-outs, and encouraging the child to use self-calming techniques.

Focusing on crisis prevention, the training program teaches all staff members skills such as how to de-escalate crises verbally and resolve conflicts.

To help sustain the project's gains even after the grant ends, the Federation of Families for Children's Mental Health recently provided advocacy training to nine family members from three of the sites. The goal was to help them understand the value and possibilities for family involvement in the project, identify roles for themselves at their sites, and support them in their efforts to get families involved.

"Research shows us change is possible," said Dr. Fulmore. "Now we're looking to see what factors can help us really sustain those changes."

—By Rebecca A. Clay

IN BRIEF . . .

Events

During the week of January 18, SAMHSA will launch **Too Smart To Start,** an underage alcohol use prevention initiative aimed at 9- to 13-year-olds and their parents. The initiative focuses on increasing the perception of harm, parent-child communications, and public disapproval of underage alcohol use. The initiative is a product of an interagency agreement between SAMHSA and the Centers for Disease Control and Prevention. (See *SAMHSA News,* Volume XI, Number 4.) "Too Smart to Start" offers communities technical assistance on a wide range of topics and a variety of materials free of charge. For more information, go to **www.ncadi.samhsa.gov.**

February 8 to 14 is **Children of Alcoholics Week,** and SAMHSA will join the National Association for Children of Alcoholics to highlight ways to reach and promote resilience among children and youth living in families with alcoholism. SAMHSA will be sending out materials, including a community action guide, to partner organizations involved in substance abuse prevention. Partners initiate local activities and build support among community leaders and the media to help reach these children and the adults in a position to help them. For more information, go to **www.ncadi.samhsa.gov/seasonal/coaweek.**

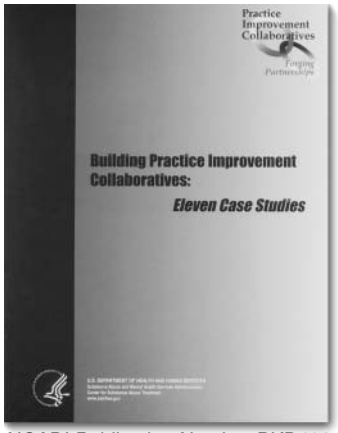
The **12th Annual National Inhalants & Poisons Awareness Week** Campaign, sponsored by the National Inhalant Prevention Coalition, is set for March 21 to 27. The campaign is designed to increase awareness about the risks of inhalant use. SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., will make a presentation at the campaign's kickoff on Thursday, March 18, at the National Press Club. For more information, visit the Coalition's Web site at **www.inhalants.org.** And, see SAMHSA's online advisory on inhalants at **www.samhsa.gov/centers/csat2002/pubs/ms922.pdf.**

Publications

SAMHSA's Center for Substance Abuse Treatment (CSAT) recently published *Building Practice Improvement Collaboratives: Eleven Case Studies.* The 104-page monograph covers 11 case studies of CSAT's Practice Improvement Collaboratives (PIC) program. The PIC program was designed to help improve substance abuse treatment by expanding the adoption of evidence-based practices through the collaborative efforts of providers, researchers, and policymakers. (See *SAMHSA News,* Volume XI, Number 4.)

In the 11 case studies presented in the monograph, PIC participants describe their activities and accomplishments, challenges, and lessons learned during the 12-month developmental phase of the program.

This publication can be ordered through **www.ncadi.samhsa.gov** or by phone at 1 (800) 729-6686 or 1 (800) 487-4889 (TDD).



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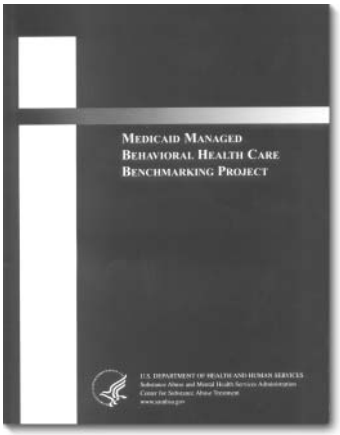

NCADI Publication Number BKD489

This CSAT report, *Medicaid Managed Behavioral Health Care Benchmarking Project* (61 pages), builds on performance measure efforts of SAMHSA, the Mental Health Statistics Improvement Program, the National Committee for Quality Assurance, Health Plan Employer Data and Information Set, and the Washington Circle Group. The project identified the important differences in measures for organization, financing, and target populations for Medicaid waiver programs. Seventeen states, five counties, and the District of Columbia participated in the project. All have Medicaid managed care programs that include behavioral health services.

This publication can be ordered through **www.ncadi.samhsa.gov** or by phone at 1 (800) 729-6686 or 1 (800) 487-4889 (TDD).

SAMHSA Offers New Resource for Helping Homeless Persons with Mental Disorders

With a scar on her face betraying a history of physical abuse, Helen reported being homeless for 3 years. She had experienced audio hallucinations since girlhood. And, she never received any mental health treatment or managed to benefit from substance abuse treatment.

People like Helen were once thought to be unreachable. But after more than 15 years of study, research shows that homeless people who have mental illness and/or co-occurring substance abuse disorders can indeed benefit from integrated mental health services, substance abuse services, and supportive housing. Now, a forthcoming publication from SAMHSA's Center for Mental Health Services (CMHS) gathers that evidence and offers practical advice for planning, organizing, and sustaining comprehensive services designed to end homelessness. Featuring Helen's story, *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders* is available in an online version on SAMHSA's Web site. The print version of the book should be available early this year.

"We know what works," said Frances L. Randolph, Dr.P.H., Chief of the Homeless Programs Branch at CMHS, noting that the book will be sent to state officials nationwide. "Now we must put what we know to work. This book will be a useful roadmap for states and communities that are serious about ending chronic homelessness."

Step-by-Step Guidance

An estimated 200,000 Americans experience chronic homelessness. More than 40 percent may have substance use disorders, and 20 percent have serious mental disorders. Some homeless persons have both.

Over the years, SAMHSA and other Federal Agencies sponsored research and demonstration programs to determine how to best serve this complex population. In addition, hundreds of community-based providers continue to work on the problem. Together, they have replaced many misconceptions with evidence-based findings.

Consider outreach to homeless people with mental illness and/or substance abuse disorders. Once thought of as a non-traditional service, outreach is now recognized as the most important step in connecting such individuals to the services they need. Housing is another consideration. In the past, group homes for people with mental illness were the norm. Now, researchers know that these individuals prefer regular housing and that housing with supportive services can help them recover. What's more, researchers discovered that providing regular housing is actually cheaper than allowing people to remain homeless.

Getting states and communities to put those kind of research findings to work is the goal of *Blueprint for Change*.

The book comprises four main sections:

- **Before You Begin.** In this section, readers learn more about the changing context of care and our Nation's response. Risk factors for homelessness and challenges in serving this population are described. And, the principles needed for a comprehensive system of care are explained.
- **Plan for Services.** This section provides detailed suggestions for how to establish and finance a comprehensive, integrated system of care.

- **Organize Services.** Communities don't have to start from scratch to organize services to help homeless people with mental illnesses and substance abuse. This section offers an overview of proven practices that have worked in the field in the past. Also, specific tips are provided on how to make the best use of Federal resources.
- **Sustain Services.** It's often easier to create a new program than it is to sustain an existing program once the original funding ends. Evaluation is a critical step because funding entities need to see that a program is actually achieving its goals. It's also important to know how to put the wide array of mainstream resources to work for people who are homeless.

Blueprint for Change also includes a comprehensive list of additional resources.

According to *Blueprint,* these types of integrated services helped Helen regain control of her life. Referred by a homeless shelter, she moved into a supportive residential program at the local YMCA. There, she worked with staff on basic life skills like hygiene and food preparation, started seeing a psychiatrist at the on-site mental health clinic, and stopped drinking. Today, she lives in a large studio apartment, happy to be cooking her own meals again and enjoying her own space.

To download a free copy of *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders,* go to SAMHSA's National Resource Center on Homelessness and Mental Illness Web page at **www.nrchmi.samhsa.gov.** For additional free copies, please call the Center at 1 (800) 444-7415. The Center's Web site also features fact sheets; additional publications; information about training and technical assistance opportunities; bibliographies; contact information for national organizations concerned with mental illness, housing, and homelessness; and other resources.

For more specific information related to this topic, contact Fran Randolph at the CMHS Homeless Branch at (301) 443-3706.

—By Rebecca A. Clay

Report Cites Reasons for Not Receiving Substance Abuse Treatment

According to a new SAMHSA report, even when people recognize they are having problems with alcohol or drugs, many do not seek treatment because they are not ready to stop using. *Reasons for Not Receiving Substance Abuse Treatment* presents data collected by SAMHSA's National Survey on Drug Use and Health (NSDUH), formerly known as the National Household Survey on Drug Abuse. According to the report, many people do not believe they can afford to obtain substance abuse treatment.

The report estimates that about 6 million persons with illicit drug dependence or abuse in 2002 did not seek specialty treatment for their illicit drug use. An estimated 17 million persons in 2002 with alcohol dependence or abuse did not receive specialty treatment. Only 6 percent of those with untreated illicit drug problems and 4.5 percent of those with untreated alcohol problems perceived a need for treatment.

National Survey on Drug Use and Health

The NSDUH Report

November 7, 2003

Reasons for Not Receiving Substance Abuse Treatment

In Brief

- In 2002, about 6 million persons with illicit drug dependence or abuse did not receive specialty treatment for their illicit drug problem. Among these untreated illicit drug abusers, only 6 percent perceived an unmet need for treatment
- In 2002, an estimated 17 million persons with alcohol dependence or abuse did not receive specialty treatment for their alcohol problem. Among these untreated alcohol abusers, only 4.5 percent perceived an unmet need for treatment
- Among those who perceived an unmet need for treatment, the most common reasons reported for not receiving treatment were not being ready to stop using the substance and the cost of treatment

Studies show that many individuals who have substance use problems do not receive treatment for those problems.[1,2] The National Survey on Drug Use and Health (NSDUH) asks persons aged 12 or older to report on their symptoms of dependence on or abuse of alcohol or illicit drugs. "Any illicit drug" includes marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically. NSDUH defines dependence or abuse using criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV), which includes such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school or home during the past year (Table 1).[3]

Respondents were also asked whether they had received treatment for a substance use problem. In these analyses, an individual was defined as receiving treatment only if he or she reported receiving specialty treatment for alcohol or illicit drugs in the past year.[4] Specialty treatment is delivered at alcohol or drug rehabilitation facilities (inpatient or outpatient), hospitals (inpatient only), and mental health centers. It excludes treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. Persons are classified

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Of the 362,000 untreated persons who recognized the need for treatment for their drug problems, 39 percent indicated that they were not ready to stop using illicit drugs, and 37 percent perceived the cost of obtaining treatment as too high. Of the 761,000 untreated persons who recognized in the past year that they needed treatment for alcohol problems, 49 percent indicated they were not ready to stop their alcohol use and 40 percent said that cost was a factor in their not receiving treatment.

"It is tragic that a major reason people continue to abuse illicit drugs and alcohol is that they do not believe they can afford appropriate treatment," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "President George W. Bush has proposed a 3-year 'Access to Recovery' program to provide $200 million more each year for substance abuse treatment. This program would provide someone in need of substance abuse treatment with a voucher to pay for the services. We really need this program if we are to provide treatment to the large numbers who say they cannot afford it."

Reasons for Not Receiving Substance Abuse Treatment is based on interviews with 68,126 respondents in their homes. This NSDUH report is available online at **www.DrugAbuseStatistics.samhsa.gov**.

We Would Like To Hear From You!

SAMHSA News strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies, and available resources.

Are we succeeding? We'd like to know what you think.

I found these articles particularly interesting or useful:

- ❑ SAMHSA Helps Reduce Seclusion and Restraint at Facilities for Youth
- ❑ Acculturation Increases Risk for Substance Use by Foreign-Born Youth
- ❑ Ready for HIPAA? SAMHSA Can Help
- ❑ SAMHSA Simplifies, Clarifies Grants Process
- ❑ In Brief . . .
- ❑ SAMHSA Offers New Resource for Helping Homeless Persons with Mental Disorders
- ❑ Report Cites Reasons for Not Receiving Substance Abuse Treatment
- ❑ SAMHSA "Short Reports" on Statistics

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SAMHSA News
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Rockville, MD 20857
Phone: (301) 443-8956
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E-mail: *dgoodman@samhsa.gov*

Thank you for your comments.

SAMHSA "Short Reports" on Statistics

SAMHSA's Office of Applied Studies (OAS) recently released several "short reports" based on statistics and data from the National Survey on Drug Use and Health (NSDUH), formerly known as the National Household Survey on Drug Abuse, and from the Drug and Alcohol Services Information System (DASIS).

Substance Abuse Treatment Among Veterans

The proportion of substance abuse treatment admissions among veterans declined from 10 percent in 1995 to 7 percent in 2000, according to a new SAMHSA report. However, the proportion of veteran admissions among females increased from 4 percent in 1995 to 6 percent in 2000. The report also points to an important change in the age of veterans seeking treatment.

Alcohol Use and Risks by College Enrollment Status

Full-time college students age 18 to 21 had higher rates of binge drinking (consuming five or more drinks on the same occasion at least 1 day in the past 30 days) than non-students in the same age group. Full-time students also were more likely to drive while under the influence of alcohol than non-students. However, non-students were less likely than full-time students to use seat belts while driving.

Quantity and Frequency of Cigarette Use

Data from the 2002 NSDUH survey showed that 26 percent of respondents age 12 or older were current smokers, and 63 percent of current smokers were daily smokers. Current smokers age 26 and older were more likely to be daily smokers than smokers age 18 to 25 or smokers age 12 to 17. A higher percentage of current female smokers smoked on a daily basis than current male smokers.

www.DrugAbuseStatistics

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Substance Use in the 10 Largest Metropolitan Statistical Areas

SAMHSA reports that the rate of past-month illicit drug use was higher than the national average in the Boston, Detroit, and Chicago metropolitan statistical areas (MSAs) during the combined years of 1999 to 2001. Among the 10 largest MSAs, the Boston, Chicago, and Philadelphia MSAs had higher rates of binge drinking than the national average. Only the Detroit MSA had a rate of past-month cigarette use that was higher than the national average.

Substance Use Among School Dropouts

In 2002, approximately 3.2 million 18- to 24-year-olds were considered to be school dropouts. The 2002 NSDUH data show that more than half of school dropouts smoked cigarettes during the past month. School dropouts were less likely to have used alcohol during the past month than non-dropouts, but rates of illicit drug use were similar among the two groups.

Discharges from Outpatient Treatment: 2000

Data from the 2000 Treatment Episode Data Set reveal that 34 percent of outpatient substance abuse treatment episodes involved individuals who completed treatment while 8 percent involved those who were transferred to further treatment. The outpatient treatment completion rate was highest, at 41 percent, for episodes where alcohol was the primary substance. The median length of stay for completed outpatient treatment episodes was 91 days. ◗

SAMHSA News

Substance Abuse and Mental Health Services Administration

ADMINISTRATOR
Charles G. Curie, M.A., A.C.S.W.

CENTER FOR MENTAL HEALTH SERVICES
A. Kathryn Power, M.Ed., Director

CENTER FOR SUBSTANCE ABUSE PREVENTION
Beverly Watts Davis, Director

CENTER FOR SUBSTANCE ABUSE TREATMENT
H. Westley Clark, M.D., J.D., M.P.H., Director

EDITOR
Deborah Goodman

Comments are invited.
Phone: (301) 443-8956
Fax: (301) 443-9050
E-mail: *dgoodman@samhsa.gov*
Or, write to: Editor,
Room 13C-05
5600 Fishers Lane
Rockville, MD 20857

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Attention: Sarah Michaud

Mail: Send your name, street address, apartment number, city, state, and zip code:

To: *SAMHSA News*
c/o IQ Solutions, Inc.
11300 Rockville Pike, Suite 901
Rockville, MD 20852

DEPARTMENT OF HEALTH & HUMAN SERVICES

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