Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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SAMHSA Responds to Children's Trauma

When America was attacked on September 11, 2001, among those responding were the leaders and staff of 18 organizations newly chosen to be the first grantees of SAMHSA's National Child Traumatic Stress Initiative. Catalyzed by the urgent need created by the events of September 11, and enabled by SAMHSA funding to collaborate, cooperate, and respond, these organizations came together immediately and effectively—transforming the effort from Federal initiative to national service organization in record time.

"The National Child Traumatic Stress Initiative was developed to help us learn about and maximize trauma recovery among children, and the attacks of September 11 were a vivid reminder of just how essential these programs are," said Robert E. DeMartino, M.D., Associate Director of the Program in Trauma and Terrorism within SAMHSA's Center for Mental Health Services. "Through the grant application and review process, SAMHSA had access to the very best people who could respond to the trauma caused by these attacks. Our job was to call on them and support them in giving their best to the communities affected."

Funding availability for the National Child Traumatic Stress (NCTS) Initiative was first announced in May 2001, and grants were awarded in September of that year. The Initiative aims to improve the standard of care and access to services for traumatized children and their families. It is designed to foster collaboration by establishing a national network of centers that cooperatively identify and develop effective treatments and services for children affected by trauma; collect clinical data on child trauma cases and services; develop resources on trauma for professionals, consumers of mental health services, and the public; develop trauma-focused public education, professional training, and field-development activities; and in so doing, improve treatment and services for all children and adolescents in the United States who have experienced traumatic events.

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Photo by Bob Denniston, courtesy of the Center for Multicultural Human Services

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Prescription Drug Abuse Rises: SAMHSA and FDA Educate Public

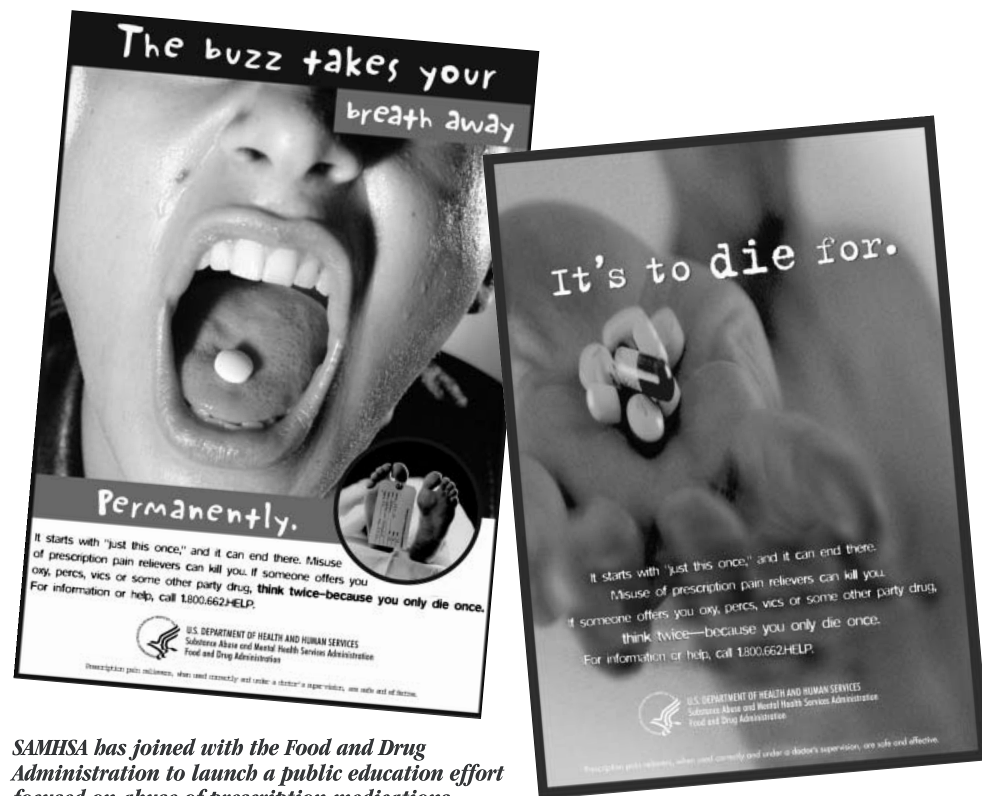
Data from SAMHSA's 2001 National Household Survey on Drug Abuse indicate that abuse of prescription drugs is rising rapidly in the United States. In 2001, almost 3 million youth age 12 to 17 had used prescription medications non-medically in their lifetimes.

"The public needs to know that just because a medication is safe and even life-saving when used appropriately, it is not harmless if used inappropriately," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Abuse of prescription drugs can lead to addiction, misdiagnosis of serious illness, life-threatening circumstances, and even death."

Data from the 2001 National Household Survey on Drug Abuse showed that about 15 percent of 18- and 19-year-olds used prescription medications non-medically in the past year. For persons age 12 to17, 7.9 percent reported past-year non-medical use of prescription medications. Among those age 18 to 25, 12.1 percent used prescription medications non-medically. These figures include: 6.4 percent of 12- to 17-year-olds and 9.6 percent of 18- to 25-year-olds who used prescription pain relievers; 2.2 percent of 12- to 17-year-olds and 3.4 percent of those age 18 to 25 who used stimulants; and 1.7 percent of 12- to 17-year-olds and 4.2 percent of 18- to 25-year-olds who used tranquilizers non-medically.

Young adults, even teens, are taking opioids, anti-depressants, and stimulants for recreation," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment. "They do not seem to realize that this misuse can lead to serious problems with addiction."

An additional report from SAMHSA's Drug Abuse Warning Network shows that visits to emergency departments in hospitals increased significantly from 1994 to 2001 for narcotic prescription pain relievers. Visits naming oxycodone increased 352 percent; methadone 230 percent; morphine 210 percent; and hydrocodone 131 percent. The data show that persons coming to emergency departments often used more than one drug. Multiple drugs were mentioned in 72 percent of the emergency department visits involving narcotic prescription pain medications.



SAMHSA has joined with the Food and Drug Administration to launch a public education effort focused on abuse of prescription medications.

SAMHSA has joined with the Food and Drug Administration (FDA) to launch a public education effort focused on prescription medications.

"FDA recognizes the very real issue of prescription drug abuse," said FDA Commissioner Mark McClellan, M.D., Ph.D. "Our job is to strike a balance—to maximize the potential benefits that patients get from these drugs—while minimizing their risks."

The first products of this cooperative endeavor feature posters, brochures, and print advertisements related to the dangers of abusing prescription pain relievers. Materials include two print public service announcements, *The Buzz Takes Your Breath Away* and *It's to Die For,* and a consumer education brochure titled *The Buzz Takes Your Breath Away—Permanently.* The educational materials are targeted to get the attention of 14- to 25-year-olds, but the materials are relevant for anyone who uses prescription pain relievers for non-medical purposes.

FDA consumer information on the dangers of abusing prescription pain relievers is available by calling 1-(888) INFO-FDA or 1 (888) 463-6332. Summaries of SAMHSA's reports on prescription drug abuse are available at **www.samhsa.gov/oas/facts.cfm.**

SAMHSA Launches Buprenorphine Education Initiative

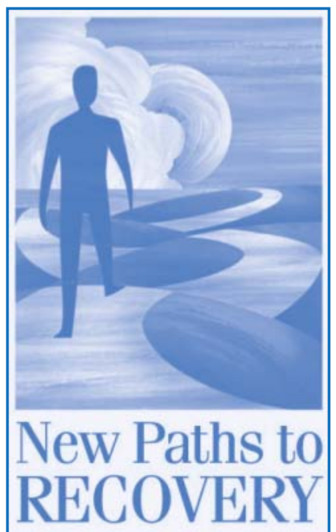
SAMHSA launched an initiative this winter to educate physicians and patients about buprenorphine—a new medication to treat addiction to heroin and other opioid drugs, including prescription painkillers. The Food and Drug Administration approved buprenorphine for treatment use in October 2002.

The approval of buprenorphine enables physicians to treat patients, for the first time, in the privacy of their offices rather than at the specialty clinics required to dispense methadone. (See *SAMHSA News,* summer 2002 and fall 2002.) Service providers hope this will encourage more people to seek treatment.

According to the Drug Addiction Treatment Act of 2000, physicians who want to prescribe buprenorphine must get a waiver exempting them from certain Federal requirements pertaining to prescribing controlled substances for addiction treatment. To obtain waivers, licensed physicians must have subspecialty board certification or training in treating and managing opiate-dependent patients. SAMHSA's Center for Substance Abuse Treatment (CSAT) is funding training sessions through four medical societies.

SAMHSA launched the "New Paths to Recovery" educational initiative in December with a forum in Washington, DC. Similar events are planned to follow in 14 other cities.

At the heart of the initiative is SAMHSA's new Buprenorphine Information Center. (See end of article for contact information.) At the Web site, for example, physicians can learn more about buprenorphine, check a schedule of upcoming training events, or even take advantage of online training that allows them to become qualified without ever having to leave home.



"Congress wanted the fewest barriers possible for physicians to qualify as buprenorphine prescribers," explained Robert Lubran, M.S., M.P.A., Director of CSAT's Division of Pharmacologic Therapies. "Online courses make it convenient for any physician, including those living in rural areas, to get training."

The Web site also features more specialized resources, for both professionals and the public. There's a "Physician Locator" that potential patients can use to find qualified physicians in their area, for instance. Other resources include an explanation of the waiver process and a waiver notification form, a draft curriculum, and model state medical board policy guidelines.

Other New Paths to Recovery resources are still under development. A forthcoming series of brochures, for example, will allow state governments, medical societies, patient groups, and others to alert their members to buprenorphine's availability. CSAT is also developing clinical practice guidelines and an online training course for drug treatment counselors.

In announcing the initiative, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "Buprenorphine alone is not a 'silver bullet' for opiate addiction, but it can open the door to recovery by providing more options to people in need of treatment."

For more information, visit SAMHSA's Buprenorphine Information Center at **www.buprenorphine.samhsa.gov** or e-mail info@buprenorphine.samhsa.gov. A toll-free telephone number—1 (866) BUP-CSAT or 1 (866) 287-2728—is accessible on weekdays between 8:30 a.m. and 5 p.m., e.s.t.

—By Rebecca A. Clay

Recognizing Signs of Drug Abuse

Many physicians have never treated patients addicted to heroin or other injection drugs, according to Robert Lubran, M.S., M.P.A., Director of the Division of Pharmacologic Therapies at SAMHSA's Center for Substance Abuse Treatment (CSAT). As a result, they may miss key signs of drug abuse.

To help physicians and other health care professionals make accurate diagnoses, CSAT developed a new tool, *Classifying Skin Lesions of Injection Drug Users: A Method for Corroborating Disease Risk*. The publication—a series of laminated photocards grouped together by a metal ring—helps health care professionals determine whether lesions are the result of recent injection drug use, past use, or some other cause.

To order a free copy, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or (301) 468-2600; TDD 1 (800) 487-4889. Or visit SAMHSA's Web site, **www.csat.samhsa.gov.**

President's 2004 Budget Proposes "Access to Recovery"

President George W. Bush's proposed Fiscal Year 2004 budget for SAMHSA continues the President's commitment to reduce illicit drug use through the creation of a new treatment-services voucher program called "Access to Recovery." Other priorities include increases in mental health services for children and homeless individuals and an increase in program management dollars that will be used to maintain support for data collection.

The overall budget proposal for SAMHSA totals $3.4 billion—a net increase of $198 million or 6.2 percent over the Fiscal Year 2003 appropriation.

"The President clearly recognizes how serious drug addiction and mental health problems are and how important treatment is," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "His proposed budget supports the matrix of programs and principles that guides our priorities and decisions here at SAMHSA."

Substance Abuse

The proposed budget requests $2.5 billion for substance abuse prevention and treatment activities—a 10-percent increase over last year.

The "Access to Recovery" initiative continues to fulfill the President's promise to invest 1.6 billion new dollars in addiction treatment over 5 years. Of that $1.6 billion, the President proposed $600 million over the next 3 years for this initiative in his State of the Union address. The first $200 million installment is included in the President's proposed 2004 budget for SAMHSA.

In the first year, the program would provide vouchers to approximately 100,000 people who need alcohol or drug treatment services. In addition to increasing treatment capacity, this new state voucher program would increase consumer choice and access to a comprehensive continuum of options, including faith-based and community-based programs.

To help people who use drugs but aren't necessarily dependent on them, the budget provides $50 million to continue the State Targeted Capacity Expansion program launched in 2003. The program would allow states to expand screening and brief intervention services in communities.

The budget also requests $1.8 billion for the Substance Abuse Prevention and Treatment Block Grant program, which helps support more than 10,500 prevention and treatment organizations around the country.

Substance Abuse and Mental Health Services Administration
Budget Authority by Activity (Dollars in Millions)

	2002	2003[1]	2004	2004 +/- 2003
Substance Abuse:				
• Substance Abuse Block Grant	$1,725	$1,754	$1,785	+$31
• Programs of Regional and National Significance:				
Treatment	291	317	557	+240
Prevention	197	197	148	–49
Subtotal—Substance Abuse	**$2,213**	**$2,268**	**$2,490**	**+222**
Mental Health:				
• Mental Health Block Grant	$433	$437	$433	–4
• Path Homeless Formula Grant	40	43	50	+7
• Programs of Regional and National Significance	230	244	212	–32
• Children's Mental Health Services	97	98	107	+9
• Protection and Advocacy	32	34	32	–2
Subtotal—Mental Health	**$832**	**$856**	**$834**	**–22**
• Buildings and Facilities	$0	$1	$0	–1
• Program Management	91	86	85	–1
• Recovery/Bioterrorism	10	0	0	0
Total—Program Level	**$3,146**	**$3,211**	**$3,409**	**+198**
Less Funds Allocated from Other Sources:				
• Public Health and Social Services Emergency Funds	–$10	$0	$0	$0
• Public Health Service Evaluation Funds	0	–74	–16	+58
Total—Discretionary Budget Authority	**$3,136**	**$3,137**	**$3,393**	**+256**

[1] Amounts reflect an across-the-board reduction of 0.65% for all budget lines based on the FY 2003 Appropriations bill signed by the President.

Mental Health

The President requested $834 million for mental health services.

The budget proposal would increase funding for Children's Mental Health Services to $107 million, a level that would support services for almost 17,000 children and adolescents with serious emotional disorders and their families.

The proposal also increases funding for the Projects for Assistance in Transition from Homelessness program to $50 million, to bring 147,000 homeless people into treatment for mental illness and substance abuse as well as to provide housing. In addition, SAMHSA will be a major contributor to an interagency effort called the Collaborative Initiative to End Chronic Homelessness (See *SAMHSA News,* p. 23).

The budget also includes an increase for homeless "policy academies" that bring state policymakers together to improve service coordination at the state and local levels.

Other budget items include: a New Freedom Initiative demonstration project with the Centers for Medicare & Medicaid Services to allow selected states to establish home- and community-based alternatives for children who previously would have been served in Medicaid-funded residential treatment centers; grants to assist states in developing programs for individuals with co-occurring mental and addictive disorders; and grants to help states decrease use of seclusion and restraints in mental health facilities.

Program Management

The Fiscal Year 2004 budget includes $85 million to support increased contribution to the Agency's national surveys. The request includes savings of $2 million associated with the President's Management Agenda. The reduction reflects anticipated savings from future competitive sourcing of commercial activities, as well as savings in other administrative areas.

U.S. Health and Human Services Secretary Tommy G. Thompson said, "The fact that the budget contains so much investment in the health and welfare of Americans demonstrates President Bush's unwavering commitment to the well-being of our citizens, including those most in need. With this budget, the President recognizes that America's greatest asset is its people, and he invests in making its people as strong and healthy as possible."

For more information, go to **http://hhs.gov/budget/docbudget.htm** and click on "FY 2004 Budget in Brief."

—By Rebecca A. Clay

Transition to Adulthood: SAMHSA Helps Vulnerable Youth

What happens to youth with serious emotional disturbances as they approach adulthood? What happens when they turn 18, if they've been receiving services through the children's mental health service system, and are no longer eligible to receive them?

Partnerships for Youth Transition, an innovative cooperative agreement program launched last fall, is a unique initiative that is seeking solutions. The 4-year program, funded by SAMHSA's Center for Mental Health Services (CMHS) in partnership with the U.S. Department of Education, offers long-term support to young people with serious emotional disorders and emerging serious mental illnesses during the crucial developmental window between the ages of 14 and 25.

"A major goal of the program is to develop models of comprehensive youth transition services to the point where they can be evaluated scientifically for their effectiveness in the future," said Diane Sondheimer, M.S.N., M.P.H., C.P.N.P. Ms. Sondheimer, who initiated and co-directs the program, is Acting Chief of the CMHS Child, Adolescent, and Family Branch.

The program's potential impact on public health is significant, given that experts estimate that between 2 million and 6.5 million youth in transition are believed to have a psychiatric disorder. The majority of these youth remain undiagnosed and underserved due to a lack of coordination across support service systems.

Traditional mental health support services help adults *or* children and adolescents in separate systems of care. Unfortunately, they

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Photo by Erin J. Pond

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do not accommodate the particular needs of young people entering adulthood, who are struggling to further their education, live independently, find and keep jobs, and nurture personal and professional relationships.

According to Crystal Blyler, Ph.D., an employment and evaluation expert in the CMHS Community Support Programs Branch, who is co-directing the program, "The two systems often don't have much communication between them. One reason is that in the children's system, diagnoses such as conduct disorder and attention deficit disorder are prevalent, whereas the adult system serves clients with different diagnoses, such as schizophrenia and mood disorders."

As a result, Dr. Blyler said, "A lot of the kids graduating out of the children's system don't get picked up in the adult system by virtue of their diagnoses." Other changes at age 18 can include cutoffs in clients' social security benefits and a shift from juvenile to adult criminal justice systems.

"It's a cutoff age where adolescents have to change all kinds of systems and supports, so a lot of youth lose services," said Dr. Blyler.

Partnerships for Youth Transition

For coming-of-age youth with serious emotional disorders and serious mental illnesses, this void of continuous support services leaves them bereft of guidance and support when they are at especially high risk and vulnerable to unemployment, homelessness, substance abuse, unplanned pregnancies, arrests and incarceration, and to dropping out of secondary school. Partnerships for Youth Transition is intended to address this paucity of transitional assistance for overcoming such hurdles.

In September 2002, five applicants were awarded nearly $500,000 per year for 4 years to create and launch model programs to usher high-risk youth into their adult years.

The grantees—in Maine, Minnesota, Pennsylvania, Utah, and Washington State—are developing culturally competent programs, involving youth and their families in program planning, and providing services as varied as age-appropriate mental health care, educational support services, substance abuse prevention services, vocational training and career development, and services to help teens develop life and socialization skills. (See box, p. 7.)

Photo by Erin J. Pond

Grantees can also receive help from the Technical Assistance Center on Youth Transition at the Florida Mental Health Institute, University of South Florida, Tampa. The Technical Assistance Center was created by a partnership between SAMHSA, the Annie E. Casey Foundation, and the Jim Casey Youth Opportunities Initiative.

A variety of innovative programs for youth in transition already exist. Connecticut, Vermont, and Ohio have initiatives for helping youth shift from child to adult mental health systems and beyond. In addition, two California communities that are 6-year grantees of SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Program have helped this transitional population, using strategies ranging from job-training skills to independent living programs.

However, these efforts lack control groups and formal evaluation components, and researchers have not assessed their effectiveness empirically. Ms. Sondheimer noted, "There are a lot of transitional programs out there, but none of them—to the extent they need to be—have been rigorously evaluated as a best-practice model."

Origins

The idea for the Partnerships program grew out of a June 2000 meeting sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and supported by SAMHSA. The national experts, Federal agency officials, and youth and family members who gathered were aware that fragmented and short-term funding sources sorely limited the scope of populations that

could be served by most transitional services. Without more consistent cash flow, those gathered predicted that comprehensive and developmentally appropriate systems of care for youth in transition would develop "at a snail's pace." Participants, therefore, pledged to "promote the development of active partnerships between State mental health authorities and other key stakeholders to improve systems serving adolescents who are making the transition from child to adult systems of care."

Following the meeting, SAMHSA staff began seeking Federal and private foundation partnerships to develop a program.

CMHS Acting Director Gail Hutchings, M.P.A., who was Deputy Executive Director of NASMHPD when the June 2000 meeting took place, said the ultimate goal of the program is to help youth become successful adults. To that end, the program will teach them skills that will help them to complete high school, enroll in post-secondary education, thrive in the workplace, and find and keep independent housing.

"Providing appropriate mental health and other types of services is a necessary component of the grant program, but the ultimate goal is for provision of these services to lead to real success in the lives of the youth they serve," Ms. Hutchings said. "In the long run, we hope that launching these youth on the right track early in adulthood will help to prevent many of the long-term negative outcomes of chronic mental illness."

Photo by Erin J. Pond

For more information about Partnerships for Youth Transition, contact Diane Sondheimer at the CMHS Child, Adolescent, and Family Branch, SAMHSA, Room 11C-16, 5600 Fishers Lane, Rockville, MD 20857, or by e-mail at dsondhei@samhsa.gov. Telephone: (301) 443-1334.

—By Peggy Dillon

Grantees: Partnerships for Youth Transition

- **Maine's Department of Behavioral and Developmental Services** is operating "Portfolio for Success," which is unique in including youth with newly emerging serious mental illnesses in its target population. The state is partnering with the Maine Medical Center, which provides evidence-based mental health treatment services and cutting-edge employment services.
- **Minnesota's PACT 4 Families (Putting All Communities Together) Collaborative**—a joint-powers agreement among county governments, public school districts, and more than 85 other partners—is expanding an existing model of individualized support for young people into a rural model of a complete system of care for mental health at all stages of a person's life.
- **Pennsylvania's Allegheny County Department of Human Services** is running its "Comprehensive Youth Transition" program, which coordinates a comprehensive set of services for youth and their families that ranges from mental health treatment to housing assistance to enhancing living skills to job training and assistance.
- **Utah's Division of Mental Health** and partnering organizations are operating "Project RECONNECT (Responsibilities, Education, Competency, Opportunities, Networking, Neighborhood, Employment, and Collaboration for Transition)" to mobilize and coordinate community resources to help youth at risk maximize their potential en route to adulthood.
- **Washington State's Clark County Regional Support Network** is building upon its existing system of care for transition-age youth to further develop a comprehensive, integrated system via enhancements that include previously developed models of the Transition to Independence Project and the Transitional Assertive Community Treatment team.

From Science to Service: Making a Model Program

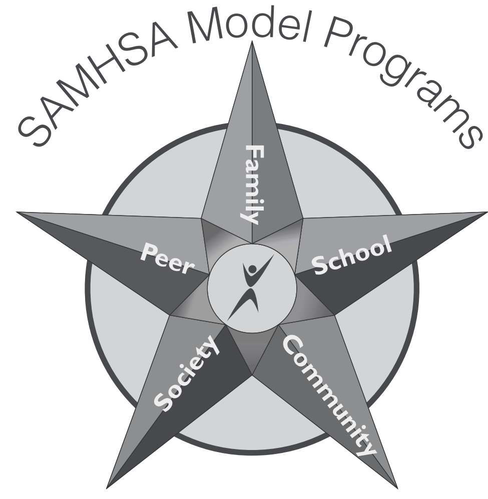
Ask researchers about the frustrations of academic life, and chances are good they'll say that a lot of their research ends up sitting on a shelf somewhere unread.

That's not the case for Linn Goldberg, M.D., a Professor of Medicine and Head of the Division of Health Promotion and Sports Medicine at the Oregon Health and Science University in Portland. Thanks to a Model Programs initiative developed by SAMHSA's Center for Substance Abuse Prevention (CSAP), an intervention he developed to prevent anabolic steroid and other drug use among young athletes is now being used throughout the country.

"When CSAP called us about becoming a model program, my fellow investigator and I were looking at each other and saying, 'Is this for real?' The Federal Government is saying it would like to help us get this program out into the world?" says Dr. Goldberg. "I was totally floored."

But helping researchers communicate their findings to the field is the whole point of the Model Programs initiative. Accelerated by SAMHSA's new focus on disseminating effective interventions rather than generating new ones, the initiative gives communities a convenient way to find prevention and treatment programs that have been scientifically proven to work. So far, the initiative has identified dozens of programs that can help communities prevent drug and alcohol use, HIV/AIDS, violence, school absenteeism and dropouts, family dysfunction, and other problems.

"It's been said that the real power of knowledge is unlocked only when it is used to achieve the common good," says SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "And that's what SAMHSA's science-to-services agenda is all about. In partnership with the National Institute on Drug Abuse (NIDA)—and the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Mental Health—we're working to unleash that power of research knowledge to achieve the common good."



A SAMHSA Seal of Approval

Bringing science-to-service delivery is a multi-step process. Staff at SAMHSA's National Registry of Effective Programs scan the literature for evidence-based programs that are likely candidates for the Model Programs initiative. Because the review process is ongoing, researchers can also nominate their own programs at any time.

Once a program is officially submitted for review, experts at the Registry subject it to a rigorous screening process to determine whether or not it is methodologically sound, has produced a pattern of consistently positive results, and is ready to be introduced to a wider audience. The Registry uses more than a dozen criteria—including such factors as theoretical underpinnings, data analysis, attrition rate, and cultural appropriateness—to come up with a score for each nominee.

Depending on the score it receives, a program earns one of three rankings:

1. **A model program** meets the highest scientific standards and its developers have the capacity to provide high-quality materials, training, and technical assistance to communities that wish to use the program.
2. **An effective program** meets every condition as a model except being ready for dissemination. A program's developer might not have the capacity to help other communities adopt the intervention, for example.
3. **A promising program** requires strong evidence of scientific rigor and positive results, but to a lesser degree than that required of an effective program.

SAMHSA then promotes the Model Programs to communities looking for science-based interventions. SAMHSA uses a variety of promotional techniques, including a toll-free hotline, brochures, outreach to national organizations, an annual compendium of Model Programs (See box p. 10), and e-mail alerts about new funding and program developments.

At the heart of the initiative's promotional activities, however, is the Model Programs Web site. Featuring information about all model, effective, and promising programs, the site allows users to search for programs by name or by content focus. Users can even compare various programs according to criteria they themselves select, producing a comprehensive matrix with just a few clicks of a mouse.

The Web site's goal is user-friendliness, emphasizes Paul J. Brounstein, Ph.D., Director of the Division of Knowledge Application and Systems Improvement at CSAP. "Using the Model Programs Web site is

very much like building a model from a box," he explains. "You select the program that matches your needs, read the instructions, and build the program. If you have problems, there's even somebody to go back to and ask for help in fixing it."

The science-to-services cycle doesn't stop once communities have selected a program, however. In addition to the program developers themselves, SAMHSA's six Centers for the Application of Prevention Technologies can provide information, training, and technical assistance to communities using Model Programs. The Model Programs Web site also includes a list of funding resources, and the information specialists who staff the Model Programs hotline also provide information about additional Federal, state, and local resources.

In addition, Dr. Brounstein says, CSAP holds workshops for program developers and their evaluators on ways to document the evidence for their grassroots programs so that this knowledge can then be used to inform research efforts.

A Case Study

Dr. Goldberg's anti-steroid program is a perfect example of how this science-to-services cycle works. The program was born when a medical student—a former college football player who had used steroids himself—approached Dr. Goldberg for help in developing an anti-steroid message to take to boys participating in high school athletic programs. They developed and studied several different approaches—at least one of which actually increased the students' desire to use steroids—before coming up with an intervention that appeared to be successful.

Dubbed ATLAS (Athletes Training and Learning to Avoid Steroids), the intervention relies primarily on student athletes themselves to share anti-steroid information in a highly scripted program. With coaches as facilitators and peers as instructors, student athletes working in small "squads" learn about steroids, alcohol, and other drugs by playing educational games, role-playing ways to refuse drugs, analyzing advertisements for steroids and supplements, and even producing mock public service announcements for each other—with sometimes "hilarious results," Dr. Goldberg says. Pocket-sized food and exercise guides emphasize the lessons well beyond the 10 45-minute sessions.

No matter what the activity, the emphasis is on a drug's immediate impact on athletic performance rather than abstract, long-term consequences. The activities are also designed to be fun.

In one exercise, for instance, the coach asks each squad a question about steroids and offers three, often humorous, answers. If the squad chooses the right answer, a squad member gets a chance to double the squad's points by choosing a target on a poster of "Steroid Man" and then hitting that target—whether it's acne, receding hairline, enlarged liver, shrunken testicles, or another side-effect of steroid use—with a soft, foam ball.

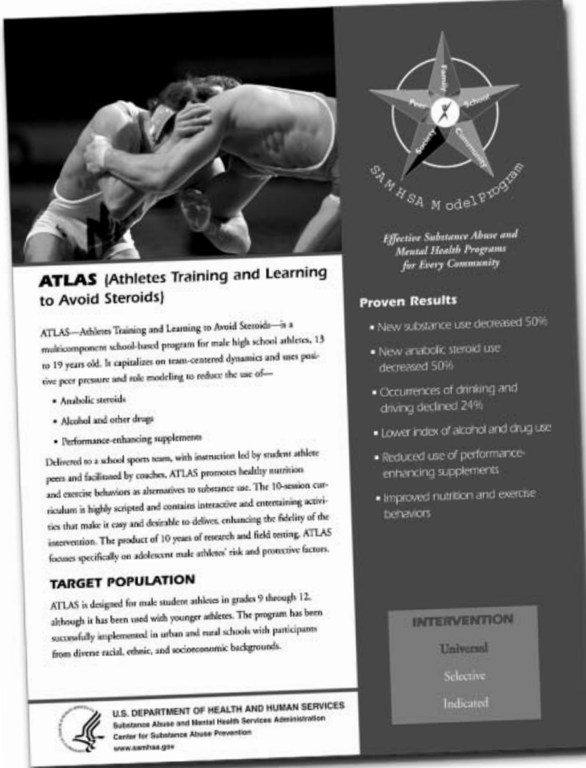
"Nobody's standing up there saying, 'You're going to get this and this and this,' " Dr. Goldberg explains. "But while they're laughing and playing this game, it's imprinting on them that these are the side effects of steroids."

To find out if ATLAS really worked, Dr. Goldberg applied for and received a grant from NIDA. "The folks at NIDA recognized that steroids represented a developing area of drug abuse," says Wilson M. Compton, M.D., Director of NIDA's Division of Epidemiology, Services, and Prevention Research. "It was important to have some research to inform the development of policies and programs."

With the 5-year NIDA grant, Dr. Goldberg was able to conduct a randomized, controlled study of ATLAS with more than 3,200 students in 31 schools in Oregon and Washington. The results were striking: A year after the intervention, new steroid use and new substance use decreased 50 percent in students who received the ATLAS intervention. Drinking and driving declined 24 percent. The students reduced their use of alcohol and illicit drugs, reduced their use of performance-enhancing supplements, and improved their nutrition and exercise behaviors.

"After NIDA got the results, they said to us, 'You should really get this out there,' " Dr. Goldberg recalls. "I said, 'How do you do that?' They said, 'We don't know.' We were all clueless."

Enter the Model Programs initiative. In 2000, Dr. Goldberg and his colleague and co-investigator, Diane Elliott, M.D., received a call from CSAP asking if they would like ATLAS to be considered for Model Program status. After submitting the required documentation, meeting with CSAP staff, and agreeing to help communities interested in using the ATLAS program, Dr. Goldberg found



ATLAS (Athletes Training and Learning to Avoid Steroids)

ATLAS—Athletes Training and Learning to Avoid Steroids—is a multicomponent school-based program for male high school athletes, 13 to 19 years old. It capitalizes on team-centered dynamics and uses positive peer pressure and role modeling to reduce the use of—

- Anabolic steroids
- Alcohol and other drugs
- Performance-enhancing supplements

Delivered to a school sports team, with instruction led by student athlete peers and facilitated by coaches, ATLAS promotes healthy nutrition and exercise behaviors as alternatives to substance use. The 10-session curriculum is highly scripted and contains interactive and entertaining activities that make it easy and desirable to deliver, enhancing the fidelity of the intervention. The product of 10 years of research and field testing, ATLAS focuses specifically on adolescent male athletes' risk and protective factors.

TARGET POPULATION

ATLAS is designed for male student athletes in grades 9 through 12, although it has been used with younger athletes. The program has been successfully implemented in urban and rural schools with participants from diverse racial, ethnic, and socioeconomic backgrounds.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
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SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results

- New substance use decreased 50%
- New anabolic steroid use decreased 50%
- Occurrences of drinking and driving declined 24%
- Lower index of alcohol and drug use
- Reduced use of performance-enhancing supplements
- Improved nutrition and exercise behaviors

INTERVENTION
Universal
Selective
Indicated

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himself the grateful recipient of Model Program status for his creation.

This labor-intensive process is what makes SAMHSA's Model Programs initiative stand out, says Stephen E. Gardner, D.S.W., Acting Deputy Director of the Division of Knowledge Application and Systems Improvement at CSAP. "Providing a list of programs that have good outcomes and good science but aren't necessarily ready for prime time doesn't really fulfill the science-to-services cycle," he explains. "We make sure that once programs are listed, they're up and ready. We give programs the SAMHSA seal of approval."

That seal of approval—and the fact that ATLAS became an exemplary award-winner in the U.S. Department of Education's Safe and Drug-Free Schools initiative in 2001—has helped the program spread to communities around the Nation and even the world. In Salt Lake City, for example, the mayor was looking for science-based prevention programs for the city's schools, consulted SAMHSA's Model Programs, and ended up with ATLAS. To help showcase this success story, SAMHSA provided funding for a press conference and the production of promotional materials.

Drs. Diane Elliott and Linn Goldberg are designers of the ATLAS and ATHENA programs.

In addition to Utah, school districts in Arkansas, Hawaii, and Massachusetts have already received ATLAS training, and school districts in Iowa, Kansas, Louisiana, Maryland, New York, and Tennessee are also planning to implement the program. ATLAS has also expanded to the middle schools and the collegiate level. Portland State University, for instance, is now using the program with some of its athletes.

Drs. Elliott and Goldberg subsequently designed a similar program for girls, "Athletes Targeting Healthy Exercise and Nutrition Alternatives" (ATHENA), which is currently being tested in middle and high schools around Portland.

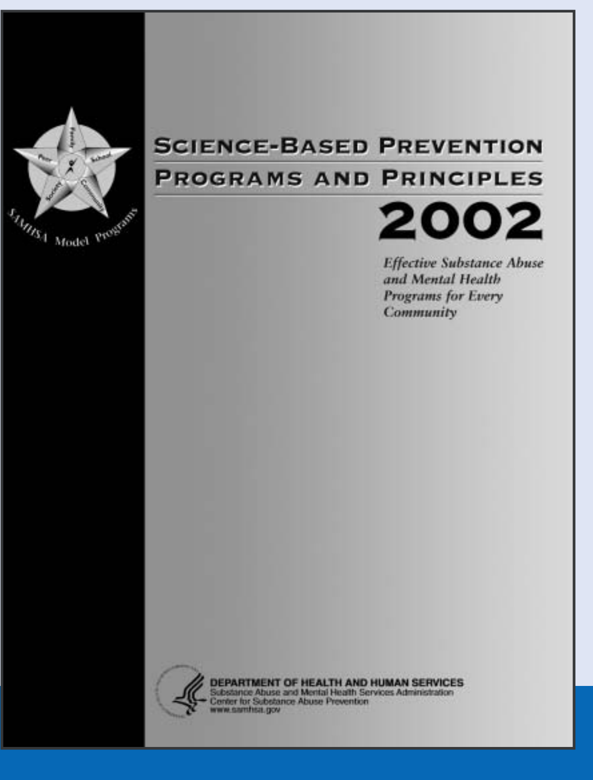
ATLAS has even attracted international interest, with calls coming from communities as far away as Norway, the Netherlands, and the Caribbean.

For SAMHSA's Administrator, the ATLAS story is the perfect example of SAMHSA's evolving mission. "SAMHSA is working increasingly to get evidence-based practices to communities, to services providers, to consumers of services, and to their families," says Mr. Curie. "At its root, it's really all about leveraging our resources across SAMHSA and the National Institutes of Health to identify and implement best ways to take new knowledge to the communities where it can best be used."

For more information about the ATLAS program, visit **www.ohsu.edu/som-hpsm/atlas.html.** To learn more about the Model Programs initiative, visit **www.modelprograms.samhsa.gov,** send an e-mail to modprog@samhsa.gov, or call toll-free at 1 (877) 773-8546. For a copy of *Science-Based Prevention Programs and Principles, 2002,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information, at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD).

—By Rebecca A. Clay

SAMHSA's Center for Substance Abuse Prevention recently published *Science-Based Prevention Programs and Principles, 2002,* a booklet containing a listing of SAMHSA programs identified as model, effective, or promising. The booklet provides prevention practitioners with practical tools for assessing programs as well as information about science-based practices. To obtain a copy of this publication, see ordering information at the end of this article.



Mental Health Commission Examines Service Fragmentation

With its Interim Report complete, the President's New Freedom Commission on Mental Health has shifted its attention to critical improvements needed in the Nation's mental health services delivery system. At the December meeting in Arlington, VA, the Commission focused on the issue of fragmentation in the service delivery system.

Charged with conducting a comprehensive study of America's mental health service delivery system and advising President George W. Bush on ways to improve it, the Commission comprises 22 members appointed by the President, including SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

In welcoming Commission members and guests, Commission Chair Michael F. Hogan, Ph.D., described the fragmented services system as "a huge challenge." Mental health experts and business leaders addressed the Commission about personal experiences, possible solutions, and repercussions of service system fragmentation as one of the continuing barriers to care faced by consumers of mental health services and their families nationwide.

Photo by Catherine Brown

(l. to r.) Nancy Domenici, Charles G. Curie, and U.S. Senator Pete Domenici (R-NM) at a recent meeting of the President's New Freedom Commission on Mental Health.

The Commission also listened to three business executives who shared their own experiences with depression and the fear of losing their employment because of this very common mental illness.

As described in its Interim Report, published last fall (See *SAMHSA News,* fall 2002), the Commission acknowledged that "the reasons for fragmentation of the mental health system are complex and driven by historical forces." According to the report, the system itself is actually a loose collection of diverse programs that deliver or pay for treatments, services, or other supports such as disability, housing, or employment. The programs are funded by myriad sources, such as Medicaid, Medicare, state agencies, local agencies, foundations, or private insurance. Within this array of programs and funding streams, there are great differences in mission, setting, and funding that contribute to inconsistency, complexity, and a lack of coordination.

Dr. Steve Sharfstein presents his recommendations to the Commission on possible solutions to fragmentation of care.

A panel of three experts spoke on "Dealing with Fragmentation in the Service Delivery System." The Commission heard from Steve Sharfstein, M.D., President and CEO of the Sheppard Pratt Health System, in Baltimore, MD; Timothy A. Kelly, Ph.D., who served as Commissioner of the Virginia Department of Mental Health from 1994 to

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1997; and Laurie Flynn, Director, Carmel Hill Center for Early Diagnosis and Treatment at Columbia University in New York City. The following day, Ron Diamond, M.D., described "A Model To Reduce Fragmentation." Dr. Diamond is Medical Director of the Mental Health Center of Dane County in Madison, WI, an innovative model for integrated consumer services.

Seeking Solutions

In his presentation to the Commission, Dr. Sharfstein described himself as a "community psychiatrist and leader of the largest not-for-profit mental health system in Maryland." He reported, "Fragmenting of funding has led to fragmenting of care. The fee-for-service system, which has replaced grants in Maryland in terms of public services, has led to less coordination of care." Dr. Sharfstein described Sheppard Pratt's paperwork for consumers as an "administrative nightmare."

Theorizing that things may be getting worse because states are in deficit due to the economic downturn, Dr. Sharfstein said that increasing numbers of people find that their mental health care is not funded. From his unique perspective, he outlined some fundamental principles upon which reform of the mental health system should be based, including:

- Interpreting "costs" broadly to include budgets of criminal justice, general health care, and welfare and disability systems
- Integrating care for treatment of substance abuse and mental illness, developmental disabilities and mental illness, and medication management with psychotherapy support
- Creating "continuous healing relationships" in community-based settings
- Ensuring parity in payments for mental health services, including payments through Medicare and Medicaid.

In his recommendations to the Commission, Dr. Kelly pinpointed three related areas that "would go a long way towards reforming the fragmented system of care." These three areas are quality of care, cost effectiveness, and agency accountability. To improve quality of care, Dr. Kelly emphasized the critical need for standardized, reliable, clinical outcome data made available for wide use. Data showing positive results from specific consumer services help keep those services from being cut by policymakers. For that reason, he said, "data are an important way of increasing the voice of consumers in the service system."

To maximize cost effectiveness, Dr. Kelly suggested that valuable mental health resources need to be redirected to innovative community care, and ineffective programs need to be ended. And, he said, by making agencies take responsibility at the Federal, state, and local levels, agency accountability will inevitably "lead to

Senator Domenici Addresses Presidential Commission

In January, Senator Pete Domenici (R-NM) and his wife, Nancy, addressed the President's New Freedom Commission on Mental Health.

Acknowledging both his personal and professional commitment to mental health issues, Sen. Domenici said that fragmentation happened in the American mental health system because care of people with mental illness "got started in different ways—started here and there, one state then another—with bits and pieces."

He also said that the stigma of mental illness played a part in the current lack of support and fragmentation of services. "How can there be sufficient resources for mental illness when we didn't believe that people were sick for most of America's history?

"Somebody made an exception in an insurance policy and it's stood ever since . . . as if it's some kind of dogma," he said. "You can cover the heart for all kinds of operations and research, but you can't cover the brain for diseases of the brain. That was a terrible exception that was made by insurance policies and it still lives with us. And, we're about to give the business community a big tax break, so it's OK to ask for a little health insurance for the sick."

Photo by Catherine Brown

Senator Pete Domenici (R-NM) emphasizes the need for full insurance coverage for mental illness.

He urged the Commission to "support, right off the bat, full parity—full insurance coverage for mental illness. Don't be scared of it because the President already knows we need that. Say 'We know you agree with this Mr. President. We just need to get it done.' "

innovation, flexibility, and true reform." According to Dr. Kelly, current mental health policy tends to support the status quo, funding services regardless of effectiveness.

After working for 16 years with the National Alliance for the Mentally Ill (NAMI), Laurie Flynn said that current service system fragmentation comes in part from "our not knowing what to do, and from doing a lot of things poorly." Ms. Flynn recommended that the Commission support mental health screenings in schools, clinics, shelters, youth clubs, residential treatment centers, juvenile justice settings, and work with PTAs, NAMI chapters, substance abuse communities, and others.

"Early intervention and treatment can reduce disability and save lives," she said.

Laurie Flynn and Timothy Kelly address the Commission.

Destigmatizing Depression

The Commission also heard testimony on workplace issues that are affected by mental health. In the presentation, "Business Executives Share Personal Experiences with Depression," Tom Johnson, Retired Chair and CEO, CNN News Group, and Larry Gellerstedt, III, President and COO, the Integral Group, both from Atlanta, described their ongoing commitment to the destigmatization of mental health issues in the workplace based on their own struggles with depression.

"Each of us kept the secret about depression," Mr. Johnson said. He addressed the need to make employees who may be fearful of losing their job or status feel that it is "ok to go for treatment."

A third VIP panelist, philanthropist J. B. Fuqua, Chairman, The Fuqua Companies, answered questions from Commission members. Mr. Fuqua offered matching seed funding of $1 million to start a pilot project, "Defeating the Stigma of Depression," which would help people perceive depression as an illness like any other disease.

Together, the three men proposed to the Commission the launch of a "national awareness campaign to promote the understanding of, treatment for, and elimination of the stigma associated with depression." They also recommended the creation of a National Depression Information Center similar to existing Federal information centers on diseases such as cancer, heart disease, and stroke.

One Program's Experience

With more than 20 years of service as Director of the Dane County Mental Health Center's community treatment program in Madison, WI, Dr. Ron Diamond has strong opinions on the positive results that come from an integrated community treatment program, which is a key element of the center's system of care.

Dr. Diamond distinguished between a system and a set of programs. Traditional systems have clinical programs that decide what services they want to offer, and the person is expected to fit into the available services. If the person needs a service not offered by the program, it is the person's problem, not the system's problem. For example, a system may offer a program for psychotherapy, but a client may need housing assistance, which is not offered.

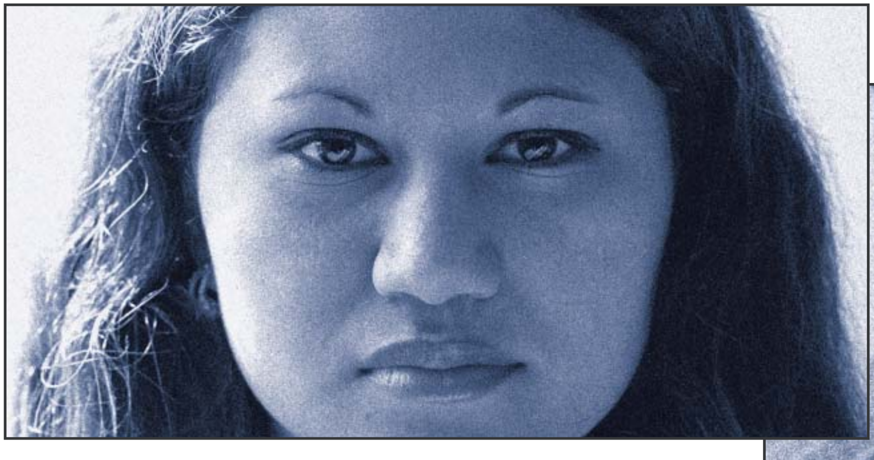
In contrast, an effective mental health system does whatever is required to meet the needs of its clients, and individual program components support one another as part of a larger, integrated system.

Emphasizing the idea of responsibility, he said, "If you are schizophrenic and you're in Dane County, you are my problem. I don't care if you are in jail, in the hospital, homeless, at a university hospital, or a state hospital—you are my problem."

Dr. Diamond also recommended local control of both Federal and state funding, saying, "If you could have true managed care—that is if a local organization or entity had access to all the resources and all the responsibilities for the public good . . . I think you could have more efficiencies than the current hodge-podge of what you have now." In short, we need to "reduce the conflict we have between different funding sources," he said, by considering the notion of wrapping disparate Federal and state resources together under local control.

For a copy of the *Interim Report to the President,* contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). For information about the Commission and an electronic copy of the report, visit **www.MentalHealthCommission.gov.** ◗

—By Meredith Hogan Pond



Photos by Bob Denniston, courtesy of the Center for Multicultural Human Services

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The architecture of the NCTS Network created by the Initiative is embedded in a three-tiered grant structure:

- One grant established a National Center for Child Traumatic Stress, co-directed by Robert S. Pynoos, M.D., M.P.H., of the University of California–Los Angeles, and John Fairbank, Ph.D., of Duke University.
- Five grants supported Intervention Development and Evaluation Centers to identify, support, improve, or develop effective treatment and service approaches for different child populations and different types of trauma. Most of these centers are affiliated with universities or other academic sites.
- Twelve grants supported Community Treatment and Service Centers to provide and evaluate treatment and services in community settings.

An infusion of supplemental funding later allowed the NCTS Network to double in size, to a total of 10 Intervention Development and Evaluation grantees, and 26 Community Treatment and Service Centers.

According to Dr. Pynoos, the funding structure "provided a unique opportunity to integrate the scientific rigor of the academic centers with the wisdom of community-based service providers."

Grants were made for 3-year periods, beginning October 1, 2001. Grantees were asked to build into their proposal a 6-month planning period, and to address specifically the ways in which they intended to collaborate and support the NCTS Network and the National Center for Child Traumatic Stress.

September 11 Catalyst

The 6-month planning periods that grantees had scheduled were dramatically cut short by the events of September 11, 2001. Not yet officially announced when the terrorist attacks took place, the NCTS Network nevertheless provided a resource of expertise and experience that quickly mobilized to action.

"Ten minutes after we got notice of our award, we were asked to establish and lead a Traumatic Bereavement Task Force," recalls Judith A. Cohen, M.D., Project Director of the Allegheny General Hospital Center for Child Abuse and Traumatic Loss, an Intervention Development and Evaluation grantee.

This Task Force, comprised of New York City NCTS Network sites and other Initiative sites with related expertise, quickly developed four main goals:

- To gather and distribute psycho-educational materials on traumatic bereavement in children to mental health professionals, teachers, and parents
- To obtain standardized assessment instruments for childhood traumatic grief
- To compile and assess what treatment materials on traumatic bereavement were available
- To develop a manual for the treatment of preschool children suffering from traumatic bereavement.

Dr. Cohen reports that the Task Force members provided and quickly accessed a "diverse wealth of information regarding the exposure of children to traumatic grief." She and her colleagues at Allegheny General Hospital had already developed treatment manuals for individual and group treatment of children age 5 to 15. National Center Co-Director Pynoos had likewise participated in the development of a group treatment manual for adolescents.

The Traumatic Bereavement Task Force members reviewed the two treatment manuals and provided critical feedback and suggestions to assure cultural sensitivity and to incorporate the special aspects of the September 11 attacks. The manuals were then revised and distributed to more than 200 child trauma treatment professionals in New

York City; Washington, DC; Pennsylvania; and other areas.

At the request of the Task Force, guidelines for treating traumatic grief in preschool children were developed by another Initiative grantee, the Early Trauma Treatment Network at the University of California at San Francisco, under the leadership of Alicia Leiberman, Ph.D. These guidelines were reviewed in fall 2002 with the aim of distributing them to professionals this summer.

Task Force member organizations also used SAMHSA support to leverage funding from the New York Office of Mental Health Services, the New York Times Fund, and the Silver Shield Foundation. Through combining these funding sources, Traumatic Bereavement Task Force members were able to conduct and videotape "train the trainer" workshops for professionals who treat New York City children, and to begin randomized treatment trials of Dr. Cohen's manual. Robin Goodman, Ph.D., and Elissa Brown, Ph.D., of the New York University Child Study Center (another Intervention Development and Evaluation Center) are conducting the randomized trials of the manual in collaboration with Dr. Cohen and her colleague, Anthony Mannarino, Ph.D., in Pittsburgh.

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Sample Activities: National Child Traumatic Stress Initiative

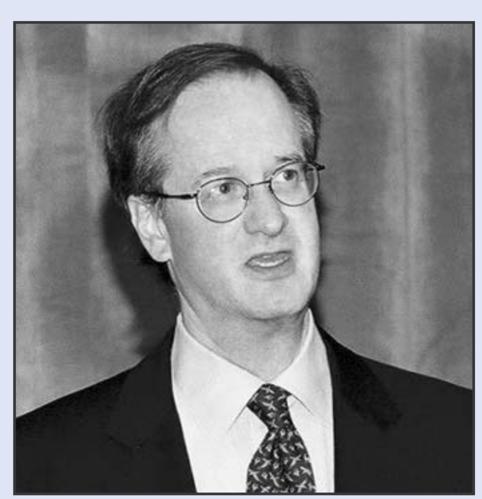
"Children exposed to trauma may have difficulty building relationships, concentrating at school, and controlling their emotions" says Robert S. Pynoos, M.D., M.P.H., Co-Director of the National Center for Child Traumatic Stress.

Unfortunately, trauma is all too common in our communities: school shootings, domestic violence, community violence, accidents, and even invasive medical procedures all can have profound psychological, social, and even biological effects upon children.

The grantees of the National Child Traumatic Stress (NCTS) Initiative address a variety of child populations, traumas, and other issues. Independently and in collaboration with one another, they seek to serve children in urban centers and rural areas, from families affected by domestic violence, from refugee groups fleeing civil wars, and in American neighborhoods riddled with ongoing violence.

The following are samples of grantee activities:

- The Early Trauma Treatment Network, based at the University of California–San Francisco, is working to develop and disseminate a uniform assessment protocol to measure the effects of trauma on preschool children. With additional funding from the National Institute for Mental Health, grantees are developing a manual on psychotherapy for children and parents together to mitigate the effects of domestic violence on children and families.
- Organizations that seek to serve children of refugees often have difficulty reaching these children. Fear and distrust among some members of the refugee population, or different cultural expectations of children, can hamper efforts to smooth children's transition to life in the United States, as well as their recovery from the trauma of relocation and the trauma(s) that forced such relocation. At the Center for Multicultural Human Services in Falls Church, VA, funding from the NCTS Initiative has allowed the careful documentation, assessment, and evaluation of staff efforts to contact and serve children of refugees from Sierra Leone. Through initial contact with community leaders at churches and mosques, the Center for Multicultural Human Services built trust within the local Sierra Leonian population and learned more about community values and needs. The Center intends to create a model for service to refugee children that will be applicable to communities across the country.



Dr. Robert S. Pynoos, Co-Director of the National Center for Child Traumatic Stress.

- Salt Lake City serves as the center of the Child Trauma Treatment Network of the Intermountain West (CTTN-IW). In some of the most sparsely populated regions of the country, general practitioners and family doctors can be the first—and only—resource for physical and mental health care. Through professional training and support, CTTN-IW seeks to build the confidence and capacity of both health and mental health professionals to assess and treat traumatic stress in children.

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"It is incredible," says Dr. Cohen. "In less than a year, a manual was developed, revised, and distributed. More than 100 kids have been evaluated thus far, and a controlled research study is underway." According to Dr. Cohen, "This is the first known randomized and controlled trial specifically evaluating the impact of alternative treatments on childhood traumatic grief."

September 11 brought "unanticipated pressure to bear" on the NCTS Network, reports Dr. Cohen, with results that might be compared to the results of fission, or the way that pressure transforms a seam of coal into a diamond. In the same way, the urgency of September 11 formed an immediate culture of collaboration and cooperation. Grantees based in New York City began to work together in an accelerated way, and the Traumatic Bereavement Task Force brought together professionals from grantee organizations across the country in a way that would not have happened in the absence of such an emergency.

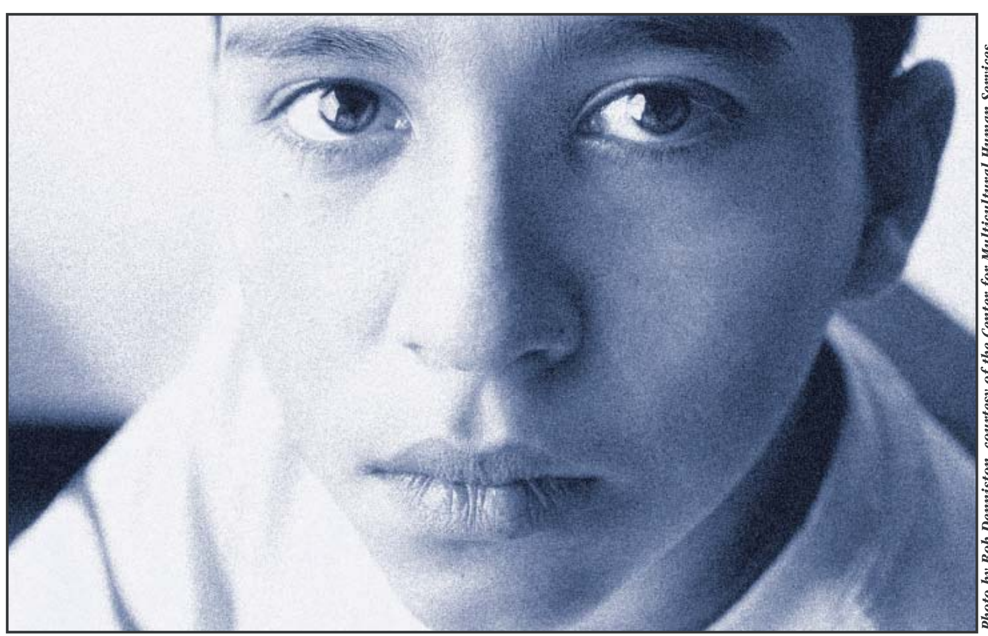


Photo by Bob Denniston, courtesy of the Center for Multicultural Human Services

The Network

The NCTS Network functions through a web-like structure of task forces and committees, through which various grantee organizations communicate and collaborate on projects of special interest, particular needs of the Network, and/or particular issues in child traumatic stress.

In addition to the Traumatic Bereavement Task Force, the Network supports a Forensic Medical Examination Working Group to establish ways to begin immediate therapeutic interventions for children receiving forensic medical examinations for sexual abuse, and a Complex Trauma Task Force to explore approaches to the assessment and treatment of children and adolescents with complex trauma histories.

Several committees focus on cross-cutting issues including data operations, measures, and training. The Child Sexual Abuse Task Force and Early Childhood Training Task Force each seek to enhance trauma treatment for children in these defined target populations.

These task forces and committees necessarily overlap. Grantees in the Forensic Medical Examination Working Group, for example, clearly have a special interest in the work of the Child Sexual Abuse Task Force, and may even serve both groups. Similarly, grantees working on developing a training curriculum for childcare providers will likely access the expertise of network members addressing various traumas in order to develop the best blend of age appropriate, trauma-specific information. These multiple and varied linkages keep the NCTS Network cohesive, and prevent development of exclusive pockets of interest or expertise.

The relatively recent emergence of the field of child traumatic stress helps to invigorate the NCTS Network. "The treatment of child traumatic stress is a fairly young field," explains Dr. Pynoos. "It was not until the late 1970s that professionals even began talking directly to children affected by trauma." From that point on, professionals recognized the need to communicate with one another, share knowledge, gain a greater understanding of how trauma affects children, and establish effective treatments designed specifically for traumatized children and adolescents.

Reflecting on the influence of the September 11 attacks, Dr. Pynoos observes, "In the same way that wars have brought attention to the effects of combat trauma, the events of September 11 have brought to the forefront the horrific impact of trauma on children, as well as on adults."

As the healing from September 11 is woven more completely into the fabric of the Nation's life, the task of the National Center and the NCTS Network will be to continue their original mission of education, training, and service, and to assure that the national learning that resulted from this tragedy is not lost as time passes.

For more information about the work of the National Center for Child Traumatic Stress and the National Child Traumatic Stress Network, visit **www.mentalhealth .samhsa.gov/child/childhealth.asp,** click on "The National Child Traumatic Stress Network." ◗

—By Melissa Capers

"E-Therapy" Raises Questions, Possibilities

Therapy in cyberspace? It sounds like something out of Aldous Huxley's futuristic novel, *Brave New World.* Yet both service providers and recipients are already using the Internet as a tool in the delivery of treatment services for mental and addictive disorders.

How does "e-therapy" work? What are its limitations? And is it useful?

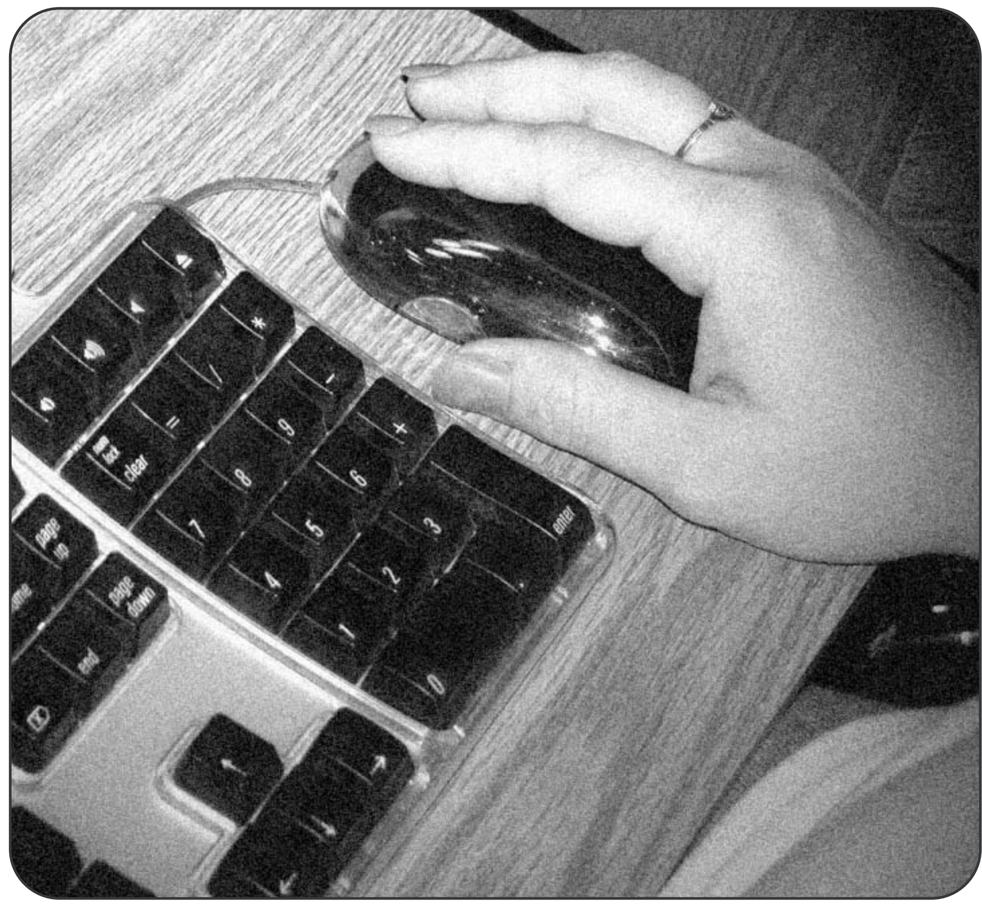
SAMHSA's Center for Substance Abuse Treatment (CSAT) sponsored a meeting last year to explore some of these questions and to launch a dialogue on this recent innovation.

In his opening remarks, CSAT Director H. Westley Clark, M.D., J.D., M.P.H., identified the most fundamental issue: What is e-therapy? He noted, "We currently have no solid definition for this new mode of treatment."

David Nickelson, Psy.D., J.D., Director of the Office of Technology Policy and Projects for the American Psychological Association, suggested that in order to define e-therapy, several questions would need to be answered: Is it traditional psychotherapy using a new medium? Or is it actually a new type of therapy? Should it be considered something other than therapy, such as counseling?

He identified some questions pertaining to health service as well, such as:

- How do ethical and legal guidelines apply to e-therapy?
- Should e-therapy be regulated?
- Can e-therapy sessions be kept private and confidential?
- Is it clinically appropriate to use the Internet in this way?



Advantages/Disadvantages

Gary Walz, Executive Director of the ERIC Counseling and Student Services Clearinghouse at the University of North Carolina–Greensboro, said that people who are in the midst of a serious crisis are not good candidates for e-therapy. This includes people who are suicidal or are experiencing a serious drug addiction.

Mr. Walz further noted that some clients might feel uncomfortable discussing important subjects online, and that the lack of immediacy and nonverbal cues could be a disadvantage. He also observed that no state licensor codes deal with e-therapy, no legislation guides its use, and many professional liability insurance policies will not cover it.

Dr. Nickelson added that some pathologies might present problems to treatment online. For example, when individuals are online, they can alter their identities and claim to be a different age or gender. This could be particularly problematic in the treatment of people with certain personality disorders, he said.

Several participants expressed concern about establishing rapport between client and therapist—often considered vital to successful therapy—over the Internet.

But participants also discussed the potential advantages that e-therapy offers. Mr. Walz noted that therapy online could help reach underserved populations, including those in remote geographical regions. Also, counselors could continue to treat clients who relocate to other areas. Clients with time constraints or difficult schedules might find e-therapy more convenient, he said. All of these factors could enable many more people to receive treatment then receive it currently.

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Guidelines and Standards

Professional organizations are developing professional guidelines and standards for addressing practices that are unique to Internet counseling. Doug Gilbert, Ph.D., NCC, ethics officer for the National Board of Certified Counselors, discussed his organization's process for developing standards. These standards address such issues as verifying the identity of the Internet client, determining if a client is a minor and therefore in need of parental or guardian consent, and explaining to clients the procedures for contacting an Internet counselor offline.

Donna Ford, NCC, LPC, Past President of the American Counseling Association, recommended that counselors provide individual online counseling only through a secure Web site or e-mail application that uses appropriate security measures including encryption. Even so, she said, clients should be informed that some information transmitted may not be secure. Client waivers should acknowledge the understanding of the limitations in ensuring confidentiality of information. She added that counselors should identify potential situations to clients in which confidentiality would have to be breached.

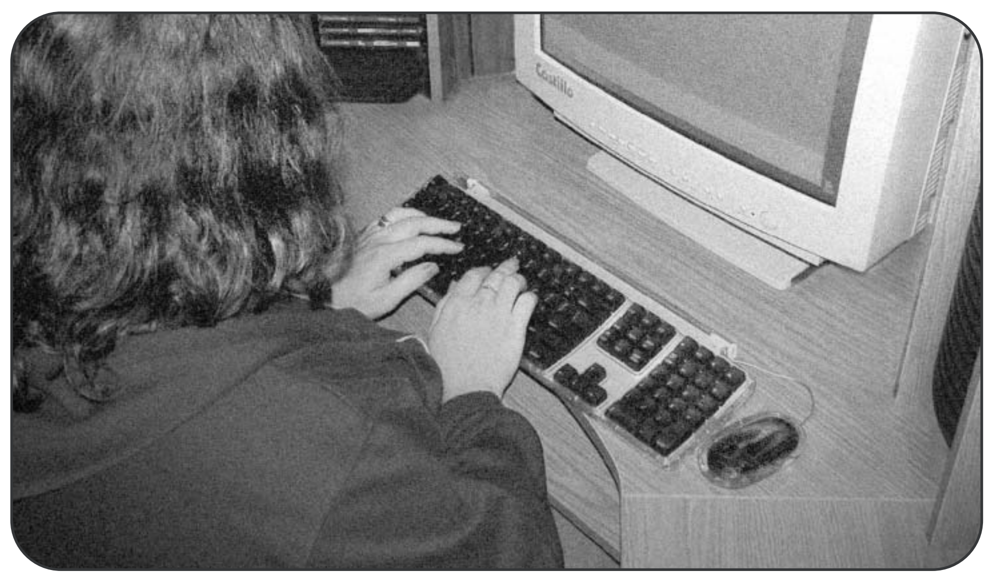
> *"E-therapy is at a critical juncture and will remain a valid enterprise or fade away. . . ."*
>
> *—H. Westley Clark, CSAT Director*

E-Therapy in Action

Judi Kosterman, Ed.D., Vice President of business relations for eGetgoing, an e-therapy program founded in 1999 for alcohol and drug abuse treatment, gave a demonstration of the site's operation. EGetgoing, an affiliate of CRC Health Corporation (a traditional provider of substance abuse treatment), is the only such program so far accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Rehabilitation Accreditation Commission.

All counselors are fully credentialed. And, all therapy sessions are archived for clinical supervision and so that clients are able to view online, support-group chat sessions that they may have missed.

Dr. Kosterman said that clients do better when they can see the counselor through a visual aid provided by streaming video. When the counselor's picture is absent, she said, client participation in the group therapy sessions drops and the atmosphere resembles that of a conference call rather than that of a therapy session.



Future Directions

Participants agreed that there was a need for client outcome data and for evaluation of treatment efficacy. Since the CSAT-sponsored meeting, Dr. Kosterman has been collecting baseline and subsequent data from eGetgoing's sessions and plans to use this data to address the research void.

Participants also are calling for unified efforts to define terms and to define clearly requirements for licensing and practicing across state lines.

Dr. Clark wants to maintain momentum on the issue of e-therapy. CSAT plans to invite e-therapy recipients to make presentations and discuss their experiences and also plans a followup to the initial meeting later this year.

"E-therapy is a high-tech enterprise that may become increasingly cost-effective over time," said Dr. Clark, using the analogy of the cost difference between laser eye surgery 10 years ago and today. He added, "E-therapy is at a critical juncture and will remain a valid enterprise or fade away like many other trends. It is important to learn how this treatment works, what its limitations are, and whether it is useful." ◗

More Older Americans Will Need Substance Abuse Treatment by 2020

The need for substance abuse treatment for older Americans is expected to nearly triple in 2020 as the baby boom carries its substance abuse into older ages. This is the conclusion of a study by Joseph Gfroerer of SAMHSA's Office of Applied Studies and Michael Penne, Michael Pemberton, and Ralph Folsom of the Research Triangle Institute, published in the March issue of the journal *Drug and Alcohol Dependence.*

The study projects that the number of adults age 50 and older, who will need treatment for a substance abuse problem, will grow to 4.4 million in 2020, compared to 1.7 million in 2000 and 2001.

According to the authors, baby boomers and the post-baby-boom birth cohort (those Americans born between 1946 and 1970) have used alcohol and illicit drugs at higher rates than earlier birth cohorts and will as a result exhibit problematic drug and alcohol use at higher rates than their elders.

Using data collected from a representative sample of 13,000 Americans age 50 and older through SAMHSA's National Household Survey on Drug Abuse in 2000 and 2001, the authors used logistic regression analysis to identify significant variables predicting the need for substance abuse treatment among this population. Gender, cigarette use, age at first alcohol use, and age at first marijuana use were found to be significant predictors of treatment need: males were more likely than females to need treatment; those who smoked cigarettes daily before age 31, those who used alcohol before age 15, and those who used marijuana before age 31 were more likely to need treatment than those who did not. In addition, the younger the age at first marijuana use, the greater the risk of treatment need.

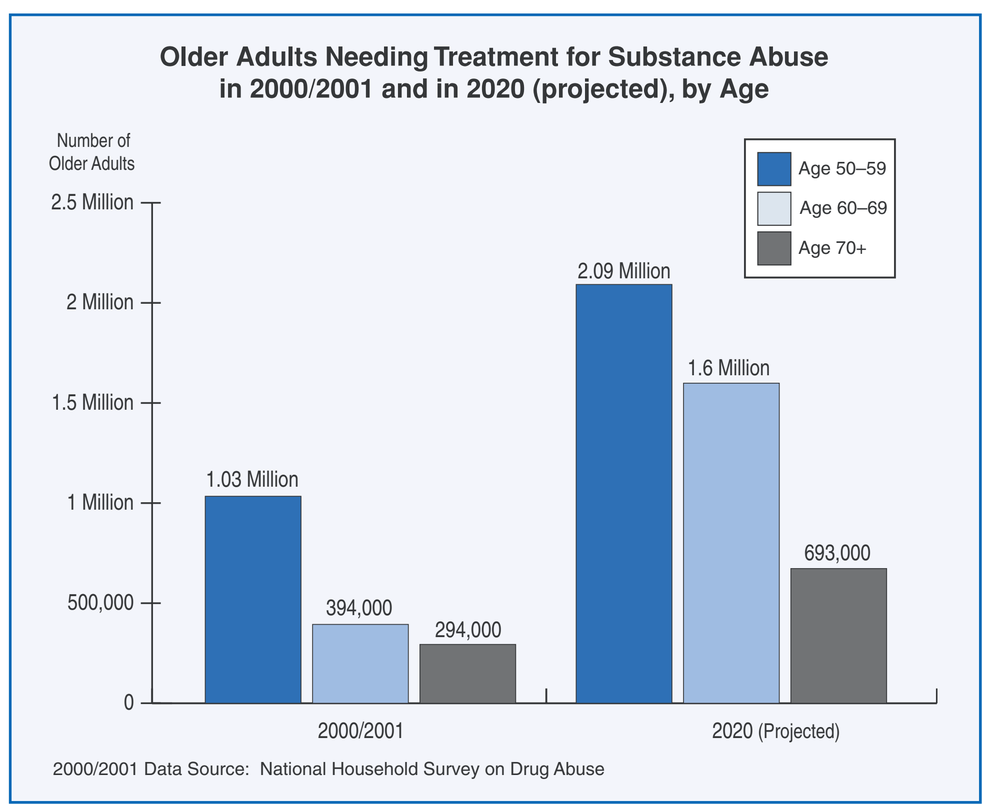
Regression model results were then applied to the projected U.S. population age 50 and older in 2020, based on Household Survey data on Americans age 30 and older in the 2000 survey and age 31 and older in the 2001 survey, combined with U.S. Census Bureau population projections for 2020. Population projections were adjusted to account for future shifts in the population by age, gender, and race, as well as the higher mortality rates experienced by substance abusers.

In 2020, the number of people age 50 and older will be 50 percent larger than in 2000/2001 (112.5 million in 2020 versus 74.8 million in 2000/2001). In addition, the lifetime rate of reported illicit drug use among baby boomers is nearly twice that of the older group: only 26 percent of those age 50 to 69 in 2000/2001 had ever used illicit drugs or used prescription drugs non-medically; but 56 percent of those who will be age 50 to 69 in 2020 (age 30 to 49 in 2000/2001) reported these behaviors. As a result, 3.9 percent of those who will be age 50 and older in 2020 were projected to need substance abuse treatment, nearly twice the rate of need estimated for those who were age 50 and older in 2000/2001 (2.3 percent).

In response to the magnitude of the problems projected, the authors call for an increase in substance abuse treatment capacity and increased focus on the special needs of an older population of substance abusers.

Commenting on the study findings, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "This study warns us that we will have to focus increased resources on older citizens within the next 2 decades. Baby boomers continue to use both illicit drugs and prescription drugs non-medically as they age. This Administration's effort to expand treatment capacity in communities nationwide provides the opportunity for baby boomers to recognize their dependence and seek help now, before their drug abuse is complicated by the challenges of old age."

—By Melissa Capers



Alcohol Abuse: Prevention for People of All Ages

In connection with Alcohol Awareness Month this April, SAMHSA is again co-sponsoring two prevention efforts for children and adults that highlight the effects of alcohol abuse.

Children

When do you begin to discuss alcohol use and its problems with young children? The sooner, the better! That was one of the key messages gleaned from SAMHSA's 2001 National Household Survey on Drug Abuse. The survey found that not only are there nearly 10.1 million underage drinkers between the ages of 12 and 20 throughout the United States, but also that the average age of a child's first use of alcohol continues to drop.

To address this problem, SAMSHA, in collaboration with Scholastic, Inc., is offering the successful *Reach Out Now* curriculum for fifth grade teachers, their students, and parents. The effort was launched for the first time last year. Divided into two parts—one for teachers and the other for parents—the free *Reach Out Now* curriculum provides a wide variety of prevention materials related to underage drinking.

For teachers, easy-to-use materials, including *Reach Out Now: Talk With Your Fifth Graders About Underage Drinking,* are provided for use in the classroom to educate students on the effects of underage drinking. Included in the materials packet is a four-page set of lessons and in-class activities, with instructions on how to incorporate the materials into classroom curricula in English, social studies, and science.

Instructions are provided to teachers on presenting three lessons in sequence:

- **Understanding the Effects of Alcohol** increases students' knowledge about alcohol through interactive classroom discussion, such as "Check your alcohol IQ" and "Alcohol: A True/False Quiz."
- **Getting It: A Science Experiment** helps students understand the effects of alcohol on the developing child through a science-based experiment in which they observe the effects of pouring alcohol on an egg.
- **Making Healthy Decisions** demonstrates ways to make healthy decisions and find alternative activities to underage drinking using critical-thinking skills.

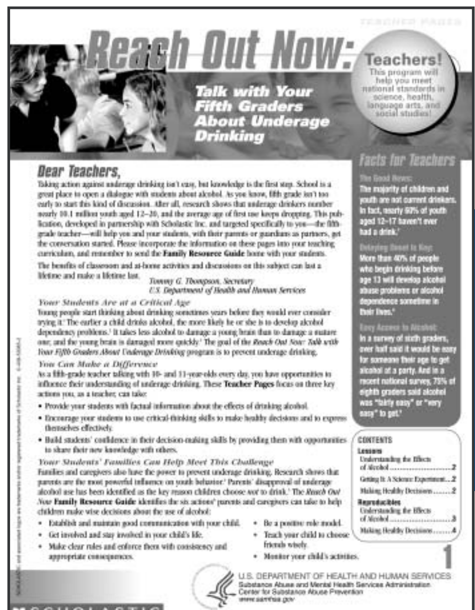
Because parents are the most powerful influence on youth behavior, the *Reach Out Now* materials also include a Family Resource Guide to bring alcohol-awareness education into the home. This guide offers six constructive actions that parents and caregivers can use to help their children make wise decisions:

- Maintain good lines of communication.
- Get involved in the child's life.
- Make and enforce clear and consistent rules.
- Serve as a positive role model.
- Help a child know how to choose friends wisely.
- Be aware of the child's activities.

To help parents take these steps, activities for each are suggested. For example, in one role-playing activity, the parent helps the child develop different ways of refusing alcohol. In addition, parents are encouraged to create a family calendar to keep track of the activities of all family members so that the parent is more involved in the child's life.

In 2002, the *Reach Out Now* materials reached nearly 100,000 teachers and more than 3 million students nationwide.

To obtain a copy of *Reach Out Now,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information, at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). To access electronically, visit SAMHSA's Web site at **www.samhsa.gov.**



Reach Out Now:

Talk with Your Fifth Graders About Underage Drinking

Teachers! This program will help you meet national standards in science, health, language arts, and social studies!

Dear Teachers,

Taking action against underage drinking isn't easy, but knowledge is the first step. School is a great place to open a dialogue with students about alcohol. As you know, fifth grade isn't too early to start this kind of discussion. After all, research shows that underage drinkers number nearly 10.1 million youth aged 12–20, and the average age of first use keeps dropping. This publication, developed in partnership with Scholastic Inc. and targeted specifically to you—the fifth-grade teacher—will help you and your students, with their parents or guardians as partners, get the conversation started. Please incorporate the information on these pages into your teaching curriculum, and remember to send the **Family Resource Guide** home with your students.

The benefits of classroom and at-home activities and discussions on this subject can last a lifetime and make a lifetime last.

Tommy G. Thompson, Secretary
U.S. Department of Health and Human Services

Your Students Are at a Critical Age

Young people start thinking about drinking sometimes years before they would ever consider trying it. The earlier a child drinks alcohol, the more likely he or she is to develop alcohol dependency problems. It takes less alcohol to damage a young brain than to damage a mature one; and the young brain is damaged more quickly. The goal of the *Reach Out Now: Talk with Your Fifth Graders About Underage Drinking* program is to prevent underage drinking.

You Can Make a Difference

As a fifth-grade teacher talking with 10- and 11-year-olds every day, you have opportunities to influence their understanding of underage drinking. These **Teacher Pages** focus on three key actions you, as a teacher, can take:

- Provide your students with factual information about the effects of drinking alcohol.
- Encourage your students to use critical-thinking skills to make healthy decisions and to express themselves effectively.
- Build students' confidence in their decision-making skills by providing them with opportunities to share their new knowledge with others.

Your Students' Families Can Help Meet This Challenge

Families and caregivers also have the power to prevent underage drinking. Research shows that parents are the most powerful influence on youth behavior. Parents' disapproval of underage alcohol use has been identified as the key reason children choose *not* to drink. The *Reach Out Now* **Family Resource Guide** identifies the six actions parents and caregivers can take to help children make wise decisions about the use of alcohol:

- Establish and maintain good communication with your child.
- Get involved and stay involved in your child's life.
- Make clear rules and enforce them with consistency and appropriate consequences.
- Be a positive role model.
- Teach your child to choose friends wisely.
- Monitor your child's activities.

Facts for Teachers

The majority of children and youth are not current drinkers. In fact, nearly 60% of youth aged 12–17 haven't ever had a drink.

More than 40% of people who begin drinking before age 13 will develop alcohol abuse problems or alcohol dependence sometime in their lives.

In a survey of sixth graders, over half said it would be easy for someone their age to get alcohol at a party. And in a recent national survey, 75% of eighth graders said alcohol was "fairly easy" or "very easy" to get.

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1

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

SCHOLASTIC

FAMILY RESOURCE GUIDE

Talk with Your Fifth Grader About Underage Drinking

Reach Out Now

Your fifth grader is trying on new clothes, new friends, and new behaviors. Could alcohol be involved in those new behaviors? Nearly 10.1 million youth aged 12–20 are underage drinkers, and the average age of first use keeps dropping. So fifth grade is not too early to start talking with your child about underage drinking. Getting a dialogue going about underage drinking isn't easy, but this publication, developed in partnership with Scholastic Inc., can help you and your fifth grader get started. You may be amazed by what you learn about your child and what your child can learn from you. The benefits of that dialogue can last a lifetime.

Tommy G. Thompson, Secretary
U.S. Department of Health and Human Services

You Can Make a Difference

Parents' disapproval of underage alcohol use has been identified as the key reason children choose *not* to drink. The goal of the *Reach Out Now* program is to prevent underage drinking.

Use the ideas and activities presented here as guidelines to adapt to your own style and your own words. Remember, no one knows your child as well as you do, and no one has more influence on your child's behavior.

In Fifth Grade, Your Child Is at a Critical Age

Many parents feel that their 10- or 11-year-old child is too young to discuss underage drinking. While it is true that most fifth graders do not drink alcohol, some 10- and 11-year-olds have begun experimenting with alcohol use. In one study, one third of fourth graders and more than half of sixth graders reported having been pressured by friends to drink alcohol.

Now is the time to talk about underage drinking. After all, your child may already have access to alcohol and may have been faced with making decisions for which he or she is not yet prepared. Help provide the knowledge and understanding children need to recognize why they should not be drinking and help them build the practical skills to reject alcohol.

Six Key Actions

Here are six actions you can take to help your child make wise decisions about the use of alcohol:

- Establish and maintain good communication with your child.
- Get involved and stay involved in your child's life.
- Make clear rules and enforce them with consistency and appropriate consequences.
- Be a positive role model.
- Teach your child to choose friends wisely.
- Monitor your child's activities.

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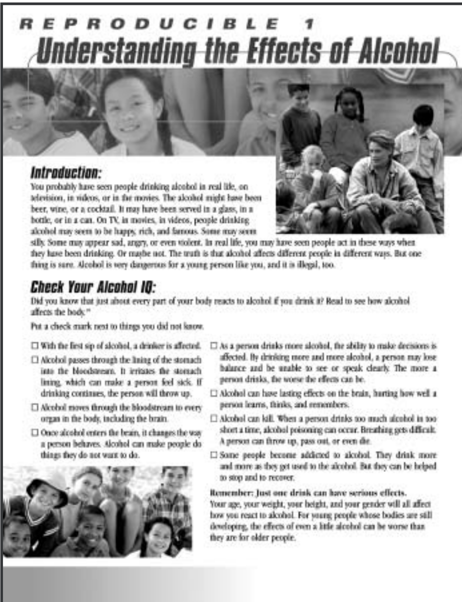


REPRODUCIBLE 1

Understanding the Effects of Alcohol

Introduction:

You probably have seen people drinking alcohol in real life, on television, in videos, or in the movies. The alcohol might have been beer, wine, or a cocktail. It may have been served in a glass, in a bottle, or in a can. On TV, in movies, in videos, people drinking alcohol may seem to be happy, rich, and famous. Some may seem silly. Some may appear sad, angry, or even violent. In real life, you may have seen people act in these ways when they have been drinking. Or maybe not. The truth is that alcohol affects different people in different ways. But one thing is sure. Alcohol is very dangerous for a young person like you, and it is illegal, too.

Check Your Alcohol IQ:

Did you know that just about every part of your body reacts to alcohol if you drink it? Read to see how alcohol affects the body.

Put a check mark next to things you did not know.

- ☐ With the first sip of alcohol, a drinker is affected.
- ☐ Alcohol passes through the lining of the stomach into the bloodstream. It irritates the stomach lining, which can make a person feel sick. If drinking continues, the person will throw up.
- ☐ Alcohol moves through the bloodstream to every organ in the body, including the brain.
- ☐ Once alcohol enters the brain, it changes the way a person behaves. Alcohol can make people do things they do not want to do.
- ☐ As a person drinks more alcohol, the ability to make decisions is affected. By drinking more and more alcohol, a person may lose balance and be unable to see or speak clearly. The more a person drinks, the worse the effects can be.
- ☐ Alcohol can have lasting effects on the brain, hurting how well a person learns, thinks, and remembers.
- ☐ Alcohol can kill. When a person drinks too much alcohol in too short a time, alcohol poisoning can occur. Breathing gets difficult. A person can throw up, pass out, or even die.
- ☐ Some people become addicted to alcohol. They drink more and more as they get used to the alcohol. But they can be helped to stop and to recover.

Remember: Just one drink can have serious effects.
Your age, your weight, your height, and your gender will all affect how you react to alcohol. For young people whose bodies are still developing, the effects of even a little alcohol can be worse than they are for older people.

ACTIVITY

Alcohol: A True/False Quiz

Directions

Read each statement aloud, then discuss the answers given below. Use this as an opportunity to explain your family's rules about underage drinking. Your child's teacher will use this quiz as part of a lesson about the effects of alcohol.

Alcohol slows down your body and mind.
True. Alcohol is a depressant; it leaves you unable to think, react, and make decisions as you normally would. If you drink enough to get alcohol poisoning, your brain slows down so much you can fall into a coma or even die.

Alcohol affects different people in different ways.
True. Alcohol's effects depend on a person's age, sex, and body weight, and on hereditary factors. The same person can be affected differently at different times of the day, depending on how much they've eaten, how tired they are, and many other factors. Because young people's bodies are smaller and still developing, alcohol has a greater effect on their bodies and brains than it does on those of an adult.

You feel alcohol's effects right away.
True. Alcohol is absorbed very quickly (within 5–10 minutes). It passes from your stomach directly into your bloodstream and affects every organ, including your brain.

Beer and wine coolers are as harmful as other forms of alcohol.
True. There is about the same amount of alcohol in a 12-ounce can of beer as there is in a mixed drink that contains 1 ounce of hard liquor or in a 5-ounce glass of wine or in a wine cooler.

Sources for More Information

Substance Abuse and Mental Health Services Administration (SAMHSA): *www.samhsa.gov*

SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI): (800) 729-6686 *www.ncadi.samhsa.gov*

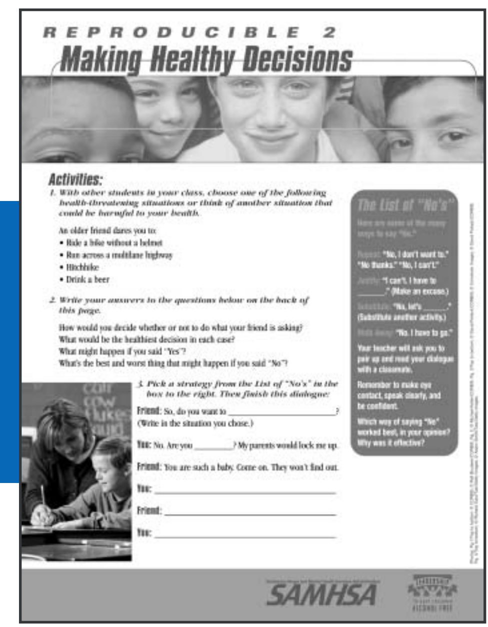
National Institute on Alcohol Abuse and Alcoholism (NIAAA): *www.niaaa.nih.gov*

Cool Spot: *www.thecoolspot.gov*

Leadership to Keep Children Alcohol Free: *http://alcoholfreechildren.org*

Some of the signs that a person has a problem with alcohol are:
- Believing that alcohol is necessary to have fun.
- Lying about how much alcohol he or she is using.
- Forgetting what happened while drinking.
- Getting drunk on a regular basis.

True. You can and should help by encouraging the person to stop drinking and to seek professional help.



REPRODUCIBLE 2

Making Healthy Decisions

Activities:

1. With other students in your class, choose one of the following health-threatening situations or think of another situation that could be harmful to your health.

An older friend dares you to:
- Ride a bike without a helmet
- Run across a multilane highway
- Hitchhike
- Drink a beer

2. Write your answers to the questions below on the back of this page.

How would you decide whether or not to do what your friend is asking?
What would be the healthiest decision in each case?
What might happen if you said "Yes"?
What's the best and worst thing that might happen if you said "No"?

3. Pick a strategy from the List of "No's" in the box to the right. Then finish this dialogue:

Friend: So, do you want to ________________?
(Write in the situation you chose.)

You: No. Are you ________? My parents would lock me up.

Friend: You are such a baby. Come on. They won't find out.

You: ________________

Friend: ________________

You: ________________

The List of "No's"

"No, I don't want to." "No thanks." "No, I can't."

"I can't. I have to ________." (Make an excuse.)

"No, let's ________." (Substitute another activity.)

"No. I have to go."

Your teacher will ask you to pair up and read your dialogue with a classmate.

Remember to make eye contact, speak clearly, and be confident.

Which way of saying "No" worked best, in your opinion? Why was it effective?

SAMHSA

Adults

Children aren't the only ones at risk for alcohol abuse—adults are too. According to SAMHSA's National Household Survey on Drug Abuse, there were 13.4 million persons in the United States classified with dependence on or abuse of alcohol in 2001.

Over the years, scientists have documented the effects of alcohol on many of the body's organ systems and its role in the development of a variety of medical problems, including cardiovascular diseases, liver cirrhosis, and fetal abnormalities. Alcohol use and abuse contribute to injuries, automobile collisions, and violence. Alcohol can markedly affect worker productivity and family interactions. Further complicating this picture is the fact that many people don't know that they have a problem with drinking.

For this reason, SAMHSA, in collaboration with the National Institute on Alcohol Abuse and Alcoholism and Screening for Mental Health, Inc. (a nonprofit organization that coordinates nationwide mental health screening programs), are focusing this year's annual National Alcohol Screening Day on the impact of drinking on health. The annual observance will be held on Thursday, April 10, at an anticipated 1,500 sites nationwide.

Last year nearly 90,000 people attended National Alcohol Screening Day events nationwide, and the sponsors anticipate that the numbers will increase this year.

Using the theme, "Alcohol and Health: Where Do You Draw The Line?", National Alcohol Screening Day highlights the effects of alcohol on the body, with particular attention to specific medical conditions, such as diabetes, heart disease, and cancer. By attending the free, anonymous screenings, attendees can assess their alcohol use and learn what to do and where to go if they need help. If the individual requests it, referrals to treatment can be obtained at one of these sites or through SAMHSA's Substance Abuse Treatment Facility Locator (See box).

Addressing a wide range of drinking behaviors from risky drinking to alcohol dependence, the National Alcohol Screening Day program is a community-based program, which involves various community organizations, colleges, hospitals, emergency rooms, and primary care practices. The program includes educational presentations, alcohol screenings, and opportunities for participants to meet with a health professional. ◗

—By Laura Schmidt

For More Information

National Alcohol Screening Day
1 (800) 405-9200
www.NationalAlcoholScreeningDay.org

Substance Abuse Treatment Facility Locator
1 (800) 622-HELP (622-4367)
www.findtreatment.samhsa.gov

SAMHSA's National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
1 (800) 729-6686 (English and Spanish)
or 1 (800) 487-4889 (TDD)
www.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 Responds to Children's Trauma
- ❑ Prescription Drug Abuse Rises: SAMHSA and FDA Educate Public
- ❑ SAMHSA Launches Buprenorphine Education Initiative
- ❑ President's 2004 Budget Proposes "Access to Recovery"
- ❑ Transition to Adulthood: SAMHSA Helps Vulnerable Youth
- ❑ From Science to Service: Making a Model Program
- ❑ Mental Health Commission Examines Service Fragmentation
- ❑ "E-Therapy" Raises Questions, Possibilities
- ❑ More Older Americans Will Need Substance Abuse Treatment by 2020
- ❑ Alcohol Abuse: Prevention for People of All Ages
- ❑ Collaborative Effort Combats Chronic Homelessness

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Thank you for your comments.

Collaborative Effort Combats Chronic Homelessness

On January 27, the U.S. Department of Health and Human Services (HHS) joined with the Departments of Housing and Urban Development (HUD) and Veterans Affairs (VA) to announce the $35 million Collaborative Initiative To Help End Chronic Homelessness.

"We are keenly aware that serious health, psychiatric, and substance use disorders contribute to the complexities of long-term and repeated homelessness," said HHS Secretary Tommy G. Thompson. "The expert contributions of health care professionals, combined with the provision of permanent housing [in the Initiative] will help break the cycle of chronic homelessness and put people on the road to recovery and self-sufficiency."

HHS will contribute $10 million to the Initiative—$7 million directed toward substance abuse treatment, mental health and related support services from SAMHSA, and $3 million for primary health care services from the Health Resources and Services Administration (HRSA). These funds will be combined with $20 million from HUD to fund permanent housing for chronically homeless persons and $5 million of in-kind support from the VA, to assure the provision of services to homeless veterans.

"Our goal," says Philip Mangano, Executive Director of the U.S. Interagency Council on Homelessness, which is coordinating the Initiative, "is to focus on those who are most at risk and to offer a permanent solution."

Of the approximately 2 million people who experience homelessness in the United States each year, approximately 10 percent are considered chronically homeless—they have been continuously homeless for more than a year, or experienced repeated episodes of homelessness over multiple years.

According to SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., "For many, the most significant reason for chronic

Photo by Erin J. Pond

homelessness is the existence of serious mental illnesses combined with addictive disorders."

The chronically homeless population uses a disproportionate amount of homeless services, and yet chronically homeless individuals do not have sufficient access to mainstream services for which they qualify, including Medicaid, Temporary Assistance for Needy Families, Food Stamps, and mental health or drug/alcohol addiction programs.

"The barriers include fragmented service systems in which services are offered in different locations and have different eligibility criteria. Also, staff may not have experience with the array of needs exhibited by chronically homeless individuals," explains Michael English, J.D., Director of the Division of Service and Systems Improvement within SAMHSA's Center for Mental Health Services.

Applicants for Initiative funding must demonstrate a comprehensive and integrated provision of services designed to meet the housing, mental health, substance abuse, and primary health care needs of chronically homeless persons—including veterans.

"Rather than make the individual try to integrate a fragmented system of services," explains Mr. English, "the comprehensive plan should do the job of making applications for services easier for the individual client. The housing and stability needs of chronically homeless people must be addressed early on in order for treatment and recovery efforts to take hold."

Applicants for Initiative funding must also address agency specific requirements tied to the four funding streams (HUD, HHS-SAMHSA, HHS-HRSA, VA). SAMHSA funding may be used for a variety of programs and activities, including: street outreach and engagement, intensive case management, and motivational interventions, among others.

"This collaboration assures that there is no wrong door for chronically homeless people seeking services," says Jane Taylor, Ph.D., Chief of the Co-Occurring and Homeless Activities Branch within SAMHSA's Center for Substance Abuse Treatment. "They will be able to enter the system anywhere and have access to all the services they require."

For further information, visit the Web site for the Interagency Council on Homelessness at **www.ich.gov.** For information regarding SAMHSA's role, contact Lawrence Rickards, Ph.D., SAMHSA, Room 11C-05, 5600 Fishers Lane, Rockville, MD 20857. Telephone: (301) 443-3707; e-mail: lrickard@samhsa.gov. Or contact Melissa Rael, SAMHSA, Rockwall II, Room 7-213, 5600 Fishers Lane, Rockville, MD 20857. Telephone: (301) 443-8236; e-mail: mrael@samhsa.gov.

—By Melissa Capers

Substance Abuse and Mental Health Services Administration

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

CENTER FOR MENTAL HEALTH SERVICES
Gail Hutchings, M.P.A., Acting Director

CENTER FOR SUBSTANCE ABUSE PREVENTION
Elaine Parry, Acting 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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