Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

Volume XI, Number 2 2003

President Promotes "Access to Recovery"

SAMHSA expects that a new initiative proposed by President George W. Bush will soon make treatment available for an additional 100,000 people a year. In this year's State of the Union address, the President proposed a 3-year, $600 million program designed to increase treatment capacity. The first $200 million installment is included in his budget proposal for Fiscal Year 2004. Called "Access to Recovery," the initiative will establish a voucher system to ensure that a comprehensive continuum of effective treatment and support service options, including faith-based and community-based programs, becomes more readily available and accessible.

"SAMHSA recognizes that the process of recovery is very personal and can take many pathways, including physical, mental, emotional, and spiritual," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "A voucher will allow recovery to be pursued in an individualized manner."

White House photo by Eric Draper

He added, "To provide treatment services for people who have substance abuse problems, SAMHSA currently funds the Substance Abuse Prevention and Treatment Block Grant and the Targeted Capacity Expansion Grant. The former will continue to support the treatment infrastructure that exists in all states. The latter will continue to enable states and local governments to respond to new and emerging substance abuse trends by enhancing treatment capacity before problems compound. The President's Access to Recovery initiative provides a third funding mechanism to expand substance abuse treatment capacity."

SAMHSA will oversee the initiative through a new grant program. The governor's office in each state will be eligible to apply for funds competitively. The program will give states the flexibility to work out the details of their proposals as they see fit.

As currently envisioned, the voucher initiative would work basically like this: When someone seeks treatment, professionals at that site will assess the individual's needs, offer a voucher for the level of care required, and refer the person to a variety of providers who could offer such services. The individual will then select a provider and "pay" for treatment with the voucher, which will probably have no face value. The provider will then redeem the voucher through the organization administering the state's program.

To assure high quality, SAMHSA will require states to develop certain safeguards.

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For example, states will have to create a plan to ensure that participating providers offer treatment that actually works. They will have to comply with SAMHSA standards and also will have to establish standards for participating providers. In addition, they will have to establish protocols for screening, assessing, and referring clients.

SAMHSA's Three Objectives

According to Mr. Curie, the President's proposal will help SAMHSA fulfill three objectives that substance abuse treatment professionals, policymakers, and consumers themselves have identified as key. First, the program will increase the Nation's treatment capacity. As part of their applications, states must include detailed plans for broadening the base of providers. States also must agree to use this new funding to supplement rather than supplant current funding.

. . . financial incentives not only will encourage providers to use proven treatment approaches, but also will increase accountability.

Second, the program will expand consumer choice. Nonprofit, proprietary, community-based, and faith-based programs that are licensed/certified by the states will all be eligible for the program, allowing individuals to choose the approach that best meets their needs.

Finally, the program will reward performance. States will use data on past costs to set cost ranges for each type of service. They also will consider providers' success in getting clients off drugs and alcohol, and in getting them out of the criminal justice system and into jobs. These financial incentives not only will encourage providers to use proven treatment approaches, but also will increase accountability.

"As the President said, 'Our Nation is blessed with recovery programs that do amazing work,' " Mr. Curie said. "Now we must connect people in need with people who provide the services. We look forward to working with Congress and our Federal, state, and local partners to make this program successful for the people we all serve." ◗

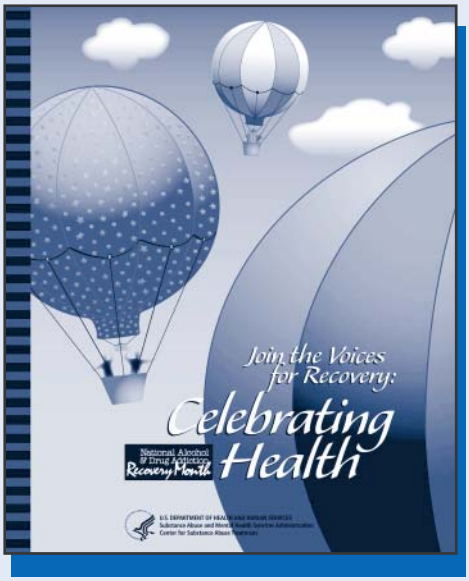
—By Rebecca A. Clay

14th Annual Recovery Month Set for September

SAMHSA's National Alcohol and Drug Addiction Recovery Month will celebrate its 14th observance in September 2003. This year's activities will be centered around a common theme: "Join the Voices for Recovery: Celebrating Health." The theme underscores the need to treat the whole person and spreads the message of hope in treatment and recovery. As in previous years, SAMHSA has produced an activity kit and other online resources to help communities in their Recovery Month activity planning process.

Each September communities plan events to highlight the benefits of substance use disorder treatment, laud the gains and contributions made by millions of recovered individuals, and celebrate the work of counselors, caseworkers, and other health professionals who contribute to making individuals and their families whole again through their work.

This year's kit highlights SAMHSA's *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders* (See *SAMHSA News,* Volume X, Number 4). Materials focus attention on the problem of co-occurring disorders (simultaneous mental and addictive disorders in one person) and co-existing disorders (simultaneous substance abuse and medical or social conditions in one person). Both complicate treatment and recovery.



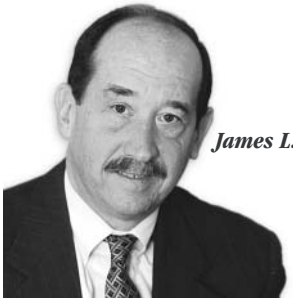
As the lead coordinator for the Recovery Month observance, SAMHSA's Center for Substance Abuse Treatment partners each year with other public sector entities, and national and local coalitions and organizations to develop Recovery Month materials. These partners will join SAMHSA for a national kick-off media event in Washington, DC, on September 4. In addition, SAMHSA-sponsored community forums/events on key treatment and recovery-related issues will be held in more than 30 cities during September.

SAMHSA hosts an award-winning Recovery Month interactive Web site. The site offers news, articles, and information about events throughout the country listed in a state-by-state interactive registry. SAMHSA also hosts live Web chats and Webcasts on the Recovery Month Web site. For more information, visit the Web site at **www.recoverymonth.gov.** ◗

SAMHSA Appoints Senior Staff

SAMHSA Welcomes Deputy Administrator

James L. Stone, M.S.W., has been appointed SAMHSA's Deputy Administrator. Prior to joining the Agency, Mr. Stone served as Commissioner of the New York State Office of Mental Health. In this capacity, he supervised the New York State public mental health system, which includes 27 psychiatric centers serving over 6,000 inpatients and 20,000 outpatients, and he worked with local government to assure effective services and proper regulation and licensure of more than 2,500 programs across the state.



James L. Stone

In announcing the appointment, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "I am truly excited to have James Stone on SAMHSA's executive team. His proven leadership and extensive experience in strategic planning for mental health services; his ability to encourage collaboration among advocacy groups, provider groups, and government agencies; his experience in addressing co-occurring substance abuse and mental disorders; and his management expertise will propel SAMHSA into a new era of responsiveness and efficiency."

Mr. Stone pioneered the concept of service coordination by severity of disorders and location of care that is the standard in the field for determining the level of treatment for those with co-occurring substance abuse and mental disorders.

Following the 9/11 World Trade Center attacks, he worked with SAMHSA and City of New York officials to establish a command center to provide mental health and substance abuse services to those affected.

He holds a bachelor's degree and a master's degree in social work, and he is a recipient of the "Distinguished Alumnus Award" of the Syracuse University School of Social Work.

New CSAP Director Named

Beverly Watts Davis has been appointed Director of SAMHSA's Center for Substance Abuse Prevention (CSAP).

Beverly Watts Davis

Prior to joining SAMHSA, Ms. Watts Davis was the Senior Vice President of United Way of San Antonio and Bexar County, TX, as well as Executive Director of its San Antonio Fighting Back Anti-Drug Community Coalition.

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said "Beverly Watts Davis' respected leadership and extensive experience in community mobilization will be pivotal as we work to reinvigorate CSAP and design and implement a strategic framework for prevention in communities nationwide."

Ms. Watts Davis has served as the principal investigator for Centers for Disease Control and Prevention Health Promotion Grants and as a co-principal investigator for the University of Texas Health Science Center's Community Outreach Partnership Center Grant.

Ms. Watts Davis received her bachelor's degree in economics, political science, and social sciences, and she is pursuing her master's degree in management and human resources.

New CMHS Director Named

A. Kathryn Power, M.Ed., has been appointed Director of SAMHSA's Center for Mental Health Services.

A. Kathryn Power

Ms. Power previously served as Director of the Rhode Island Department of Mental Health, Retardation and Hospitals. As Director, she initiated community-supported living arrangements and emphasized community-based services. She is known nationwide for her focus on recovery for people with mental illnesses. She has also championed the integration of treatment for co-occurring disorders of mental illness and substance abuse, a priority for SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

"With the release of the President's New Freedom Commission on Mental Health's final report on the horizon, Kathryn's proven leadership and extensive experience in mental health services will help lead the Administration's efforts to transform mental health care in America," Mr. Curie said.

Her handling of workforce issues won her a Program Manager Award from the International Personnel Management Association. She is former President of the Board of Directors of the National Association of Mental Health Program Directors.

Ms. Power holds a bachelor's degree in education and a master's degree in education and counseling. She completed the Women and Power: Leadership in a New Era program at the Kennedy School of Government at Harvard University.

EVIDENCE-BASED PRACTICES

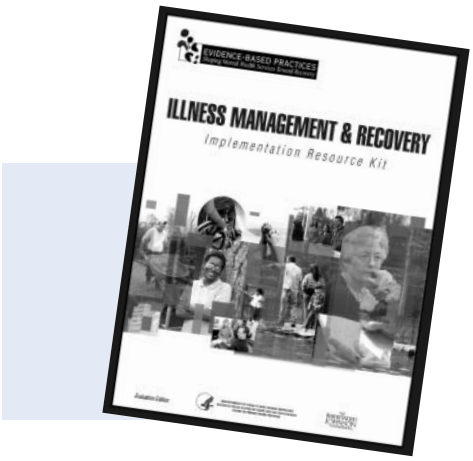
Promoting Recovery With Proven Solutions

SAMHSA's Center for Mental Health Services (CMHS) is currently sponsoring a national project to promote the widespread adoption of six evidence-based practices (EBPs)—treatments that have consistently proven to generate positive outcomes for adults with serious mental illness. Specifically, project teams are working to develop, test, revise, and disseminate comprehensive resource toolkits that will enable practitioners to replicate EBPs successfully and reap the benefits in community settings.

In 1998, during a consensus panel convened by the Robert Wood Johnson Foundation, representatives from all major stakeholder groups first identified these six EBPs as the most effective:

- Assertive community treatment
- Illness management and recovery skills
- Standardized pharmacological treatment
- Family psychoeducation
- Supported employment
- Integrated treatment for co-occurring mental illnesses and substance use disorders.

Two years later, researchers at the New Hampshire-Dartmouth Psychiatric Research Center requested funding to create toolkits for each practice, and CMHS gladly obliged. With additional support from a broad coalition of organizations (see "Widespread Support" below), the proposal has evolved into the National Evidence-Based Practices Project.



This initiative—and EBPs in general—are especially vital for mental health professionals who work in an era defined by increased accountability, constrained budgets, and a growing demand for more effective services.

Developing Toolkits

"The Dartmouth proposal was attractive to us for several reasons," said CMHS Acting Director Gail Hutchings, M.P.A. "They were giving us a chance to put in manual form the exact components of the six most effective interventions. And, they demonstrated a commitment to reaching all stakeholders. This is critical to what we're trying to achieve—the widespread adoption and use of evidence-based practices."

For 2 years, representatives from major stakeholder groups were heavily involved in Phase I of the project. They produced and revised instructive guides, manuals, videos, presentations, scales for measuring fidelity to the models, and several other pieces that offered guidance to practitioners, consumers of mental health services and their families, administrators, and other audiences.

Paul Gorman, Ed.D., Director of the West Institute at New Hampshire-Dartmouth, managed the process of collecting stakeholder input and gathering information for the toolkits. "Consumers [of mental health services] and family advocates changed the way we talk about the six interventions," he said. "They brought a set of life experiences and perspectives to the table that many of us simply don't have."

"For our [co-occurring disorders] kit, we encouraged consumers and family members to do as much writing as possible for materials targeting their respective groups," said Robert Drake, M.D., Professor of Psychiatry and Community and Family Medicine at Dartmouth and coordinator of the Psychiatric Research Center team. "Our researchers mainly provided guidance and polished text for accuracy."

The toolkits are without question the heart and soul of the EBP project. Right now, they're being put to the test.

Gauging Effectiveness

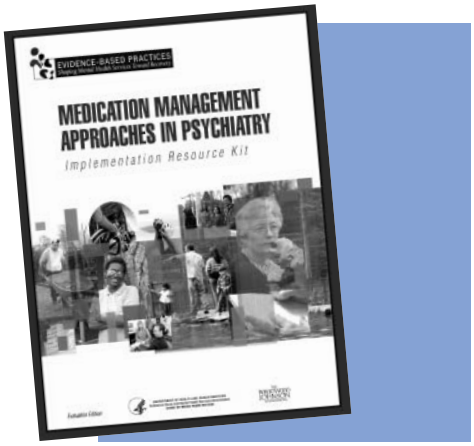
Phase II—started in September 2002—is a 3-year evaluation process to measure the effectiveness of the toolkits. Eight pilot states will evaluate at least one of five toolkits in more than 50 community mental health programs. The medication management toolkit is not included in the state evaluations.

Widespread Support

The National Evidence-Based Practices Project is funded by SAMHSA's Center for Mental Health Services (CMHS). Numerous partners also contribute funding, including the New Hampshire-Dartmouth Psychiatric Research Center, the Robert Wood Johnson Foundation, the MacArthur Foundation, Johnson & Johnson corporate contributions, and the West Family Foundation. The National Association of State Mental Health Program Directors Research Institute also endorses and assists the project.

Specifically, states will determine how well the toolkit materials accomplish their intended goals of training clinicians, educating consumers and their families, and helping administrators adopt the practices in their mental health systems. Where possible, states will also record barriers and solutions they discover.

Each pilot state will create a mechanism to coordinate training and support the chosen communities. As the main Coordinating Center, Dartmouth's Psychiatric Research Center will train individuals chosen to help states during implementation and evaluation. The Psychiatric Research Center will also provide each state with identical evaluation design and data collection instruments to enhance the accuracy of multi-site analyses.



Targeting Challenges

Team members for the project fully expect to encounter some difficulties in gaining nationwide acceptance of their evidence-based publications. "The simple inertia of existing systems can be a major barrier," said Crystal Blyler, Ph.D., social science analyst, CMHS Division of Service and Systems Improvement. "A lot of systems have been delivering treatment the same way for so long that it will take a lot of effort, money, and training to change direction."

Reimbursement is another key issue. "It is imperative that we generate a willingness among insurers like Medicaid to pay for and encourage the statewide use of evidence-based practices," said Ms. Hutchings. She believes the toolkits will be a valuable, tangible blueprint that helps insurers see the benefits of supporting EBPs within the care delivery system.

Shaping the Future

Phase III of the National EBP Project—slated to begin in 2005—will make refined versions of the toolkits widely available to all states. In the meantime, stakeholders will explore the addition of other promising treatments and services as potential EBP candidates. Many researchers and administrators are hopeful that treatments for children and adolescents will be next.

Several initiatives are also now underway to augment the efforts of the National Project and usher EBPs into the mainstream. For instance, SAMHSA's longstanding Community Action Grants continue to help communities build consensus, use toolkits, and explore other exemplary practices. SAMHSA and the National Institute of Mental Health are spearheading a joint project that gives states funding to plan for the implementation of EBPs. In addition, SAMHSA will award 3-year grants to up to nine states beginning in September for training and evaluation efforts.

The National Association for State Mental Health Program Directors Research Institute established a Center for Mental Health Quality and Accountability, funded in part by CMHS, to serve as a resource for states and to coordinate the state-level evaluation of the national EBP Project. In addition, the Center is supporting a consortium of other states working on their own EBP initiatives in parallel with the eight pilot states.

"We want to develop and support models so that the mental health field can shift to a new way of doing business—even in an era of budget constraints," said the Center's Director, Vijay Ganju, Ph.D. "We want to determine what must happen within our current system to make evidence-based practices part of the norm."

The continuing shift to evidence-based practices exemplifies the Science-to-Services philosophy championed by SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "EBPs respond to demands from stakeholders for proven, cost-effective treatments," he said. "They provide clear, step-by-step direction for delivering treatments in community settings. And they help give consumers genuine hope for optimal recovery and fulfilling lives beyond mental illness."

For more information, contact SAMHSA's National Clearinghouse for Mental Health Information, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or, visit **www.mentalhealth.samhsa.gov.**

—By Steve Herndon

EBP Project Pioneers

Eight states are currently participating in the Phase II toolkit evaluation process:

- Indiana
- Kansas
- Maryland
- New Hampshire
- New York
- Ohio
- Oregon
- Vermont.

EVIDENCE-BASED PRACTICES

Six at a Glance

Components of the six Evidence-Based Practices toolkits are similar, but the practices themselves are diverse, and they may be unfamiliar to some practitioners and supervisors in the field today. The following descriptions provide a glimpse into the practices that are currently the focus of SAMHSA's national project.

Illness Management and Recovery

Empowerment is key in the Illness Management and Recovery model. Consumers of mental health services who experience symptoms of schizophrenia, bipolar disorder, and major depression learn methods for controlling their illness and finding their own paths to recovery.

The program is based on strong collaboration between mental health providers and consumers. It generally consists of weekly sessions in individual or group formats over a 3- to 6-month period. In these sessions, practitioners educate consumers on nine topic areas, ranging from recovery strategies and illness information to coping with stress and finding help in the mental health system.

The toolkit teaches practitioners how to conduct sessions and respond to any

problems that may arise. They also learn how to deploy motivational, cognitive-behavioral, and educational strategies to help consumers.

When using the Illness Management and Recovery model, practitioners often report a high rate of job satisfaction as consumers learn to reduce relapses, avoid hospitalization, and make steady progress toward personalized recovery goals.

Medication Management Approaches in Psychiatry (MedMAP)

Medications play a pivotal role in recovery for most people diagnosed with serious mental illnesses. But many consumers diagnosed with schizophrenia are not prescribed medicines based on clinical guidelines. These consumers are often over- or under-medicated and cannot achieve maximum recovery.

MedMAP responds to these problems by providing research-based algorithms—scientific formulas or procedures—that practitioners can use as a guide for prescribing medications and dosages. The MedMAP toolkit contains practical considerations for carrying out this model as well as an emphasis on the key ingredients: clear, thorough documentation, objective measures of desired outcomes, and shared decision-making between consumers and practitioners.

In addition to helping consumers meet their recovery objectives, MedMAP has the potential to reduce costs and return more value per health care dollar. Research also indicates that consumers whose medications are regulated by algorithms are more satisfied with their treatment and outcomes than consumers who are prescribed medication without algorithms. Although MedMAP currently is designed for use only in treating schizophrenia, researchers hope to expand the approach for treatment of other mental illnesses in the near future.

Assertive Community Treatment (ACT)

The Assertive Community Treatment model delivers comprehensive services to individuals with serious mental illness whose needs have not been met through traditional service delivery. The core of the program is an interdisciplinary team of 10 to 12 practitioners who provide integrated services directly to approximately 100 people in the communities where problems occur—not in offices or clinics.

ACT team members collaborate on assessments, treatment plans, and day-to-day interventions, and they share responsibility for ensuring that consumers receive services that support recovery. The team reviews each consumer's status daily so that the nature and intensity of services can be adjusted quickly as needs change.

It's important to follow the ACT model precisely. Variations can limit or even nullify consumer benefits. Researchers have found

that ACT, when done properly, surpasses alternative approaches such as brokered care or clinical case management programs in regard to consumers' independence, satisfaction, and quality of life.

Family Psychoeducation

Through Family Psychoeducation, practitioners work in partnership with families and consumers to support recovery. Specifically, practitioners educate families about the illness and help them develop coping skills for related problems. The term "family" in this case refers to anyone committed to the care and support of someone with mental illness.

Family Psychoeducation is designed for a single- or multi-family group format. As the toolkit explains, most licensed mental health practitioners—including social workers, psychiatric nurses, psychiatrists, psychologists, occupational therapists, and case managers—can learn to work within this model effectively.

Consumers, family members, and clinicians develop bonds and build their knowledge base through introductory sessions, educational workshops, and problem-solving sessions all devoted to recovery goals and sharing information. Clinicians stand to gain an enhanced understanding of how illness affects family dynamics and how to shift perspectives from being a practitioner to a partner in recovery.

The American Psychiatric Association cites Family Psychoeducation, when used in conjunction with medication, as one of the most effective ways to further the recovery process for schizophrenia. Recent studies also show promising results for people with bipolar disorder, major depression, and other serious mental illnesses.

Supported Employment

People with mental illness have strengths, talents, and abilities that are often overlooked—including the motivation to work. Research and opinion surveys have shown that the majority of adults with a serious mental illness want to work. And, they can do so effectively with the Supported Employment model.

How can Supported Employment generate better outcomes than traditional vocational programs? Primarily, this model focuses on helping consumers find competitive jobs they want in their community—jobs that are open to anyone and provide equal compensation.

The toolkit materials stress the importance of letting consumers choose their work and support options based on their preferences, strengths, and experiences. In the Supported Employment model, vocational services are integrated with treatment. This means that the employment specialists work with the case manager, therapist, psychiatrist, and others on the treatment team. What's more, nobody is excluded from a successful Supported Employment program, and there are no pre-vocational training requirements for participants.

Co-occurring Disorders: Integrated Dual Disorders Treatment

More than half the adults with serious mental illness in public mental health systems are further impaired by substance abuse or a dependence on alcohol or drugs. These people are at high risk for negative outcomes, including hospitalization, overdose, violence, legal problems, homelessness, victimization, HIV infection, and hepatitis.

Research has shown that treating the substance use disorder and mental illness together—as described in the Co-occurring Disorders model—helps to aid recovery. In this model, clinicians learn about the interactions of alcohol and drugs with mental illness. One core team provides integrated services to consumers at different stages of treatment.

At the outset of the program, consumers work with clinicians to form an individualized treatment plan for both disorders. There is also a motivational component in which clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery.

For more information, contact SAMHSA's National Clearinghouse for Mental Health Information, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (800) 889-2647 (TTY). Or visit **www.mentalhealth.samhsa.gov.**

—By Steve Herndon

Data Reveal Need

Help for Children of Addicted Parents

SAMHSA estimates that approximately 6 million children under age 18 were living with at least one parent who abused or was dependent on alcohol or drugs in 2001, based on a new analysis of data in the Agency's 2001 National Household Survey on Drug Abuse.

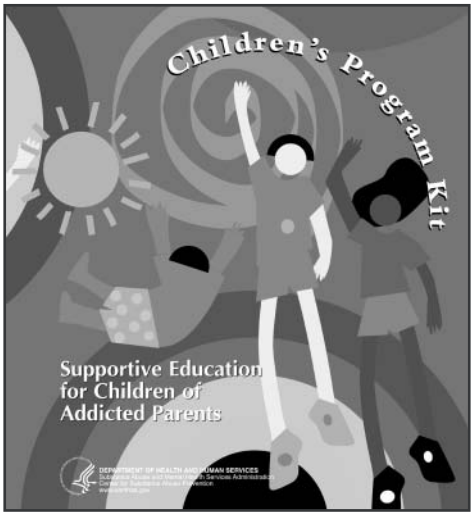
To encourage more services to help these children, U.S. Health and Human Services Secretary Tommy G. Thompson sent a letter to every substance abuse treatment facility in the country this spring, urging them to use SAMHSA's new *Children's Program Kit* to develop appropriate programs.

"We must not allow our children to become the forgotten victims of substance abuse," Secretary Thompson said. "By providing appropriate services and programs, we have the power to reduce the fear and confusion that they experience and to provide the knowledge and skills that they need to rebound and succeed as they mature into adults."

SAMHSA's new report, *Children Living with Substance-Abusing or Substance-Dependent Parents,* shows that 9 percent of children lived with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year. Of these 6 million children, more than 4 million lived with parents who abused or were dependent on alcohol; almost 1 million lived with a parent who abused or was dependent on an illicit drug; and more than 0.5 million had a parent who abused or was dependent on both alcohol and an illicit drug.

According to the SAMHSA report, 10 percent of children age 5 or younger, almost 8 percent of children age 6 to 11, and more than 9 percent of youth age 12 to 17 lived with at least one parent who abused or was dependent on alcohol or drugs.

The toolkit is designed to provide materials for substance abuse programs so that they can initiate educational support programs for the children of their clients in substance abuse treatment.



The *Children's Program Kit* was developed by SAMHSA childhood mental health professionals and covers a wide variety of topics and practical teaching strategies for elementary, middle, and high school children. The kit also contains information for therapists to distribute to their clients to help parents understand the needs of their children, as well as training materials for substance abuse treatment staff who plan to offer support groups for children.

"Too often when we concentrate on providing treatment for the affected adult we forget the heavy burden that substance abuse lays on the children of those in treatment," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Often when the needs of the children are ignored, these children grow into substance-abusing adults. The SAMHSA toolkit addresses the needs of these children, so they can grow into healthy adults with the necessary skills to break the intergenerational cycle of addiction."

The toolkit is designed to provide materials for substance abuse programs so that they can initiate educational support programs for the children of their clients in substance abuse treatment. The curricula will teach children skills such as solving problems, coping, social competence, autonomy, and a sense of purpose and future. The toolkit includes stories and videos.

The report, *Children Living with Substance Abusing or Substance Dependent Parents,* is available at **www.samhsa.gov /oas/2k3/children/children.htm.**

For a copy of the *Children's Program Kit,* 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). Or, visit SAMHSA's Web site at **www.samhsa.gov.**

Seclusion & Restraint: Breaking the Bonds

The use of seclusion and restraint in treatment and rehabilitation facilities is controversial. Supporters acknowledge these practices as necessary safety measures of last resort in situations involving imminent risk of physical harm to service recipients and service providers. Detractors say seclusion and restraint are often used inappropriately as punishment or for staff convenience, and that these practices can cause physical injury, emotional trauma, and even death.

Definitions of seclusion and restraint vary widely. The U.S. General Accounting Office (GAO), in 1999 testimony to a U.S. Senate committee, defined restraint as "the partial or total immobilization of a person through the use of drugs, mechanical devices (such as leather cuffs), or physical holding by another person. Seclusion refers to a person's involuntary confinement, usually solitary."

Although these practices have come under increasing scrutiny during the past decade, data documenting their use remain scarce. In 1998, the *Hartford Courant* ran a series of articles examining the use of these practices. The articles cited a statistical estimate by the Harvard Center for Risk Analysis that the annual number of deaths across the Nation due to seclusion and restraint ranged from 50 to 150—or 1 to 3 deaths per week.

In response to congressional concern following the *Hartford Courant* articles, the GAO prepared an evaluation of the issue. The GAO found that "at least 24 deaths that state protection and advocacy agencies investigated in Fiscal Year 1998 were associated with the use of restraint or seclusion." But, the GAO added, "The lack of comprehensive reporting makes it impossible to determine all deaths in which restraint or seclusion was a factor." The GAO testimony emphasized that "Neither the Federal Government nor the states comprehensively track the use of restraint or seclusion, or injuries related to them across all types of facilities that serve individuals with mental illness or mental retardation."

Photo by David Rodriguez

Nevertheless, the seriousness of the consequences demands national attention. Injuries from restraint can include bruises, broken bones, and asphyxia. There are reports describing the use of seclusion and restraint to coerce or punish consumers of mental health services rather than to protect them from harm. Consumers tell of restraints being used, for instance, on a child throwing pencils. The GAO testimony also noted the lack of regulations governing the use of these practices.

Many in the mental health field agree with a statement by SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., that "Seclusion and restraint should no longer be recognized as a treatment option at all, but rather as treatment failure."

To address this issue, SAMHSA, under the leadership of Mr. Curie, has set forth a vision and a plan: to reduce and ultimately eliminate seclusion and restraint from treatment and rehabilitation settings for mental and addictive disorders.

Federal and State Policy

Legislation at the state and Federal level, self-examination within the treatment field, and efforts to formulate best practices have increased in recent years.

For example, in July 1999, the National Association of State Mental Health Program Directors (NASMHPD) issued a statement that "seclusion and restraint including 'chemical restraints,' are safety interventions of last resort and are not treatment interventions."

"Practices are changing rapidly," said Gail Hutchings, M.P.A., Acting Director of SAMHSA's Center for Mental Health Services. "There's renewed hope, based on the experiences of a number of states where there have been successful efforts."

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For example, when Mr. Curie was Deputy Secretary for Pennsylvania's Office of Mental Health and Substance Abuse Services, facilities were able to reduce seclusion and restraint hours by more than 90 percent between 1997 and 2001.

The GAO testimony also cited Delaware, Massachusetts, and New York as states that have developed strategies to reduce the use of restraints in their public mental health or mental retardation service systems. Following the establishment of a new training program emphasizing crisis prevention and new management priorities, one Delaware facility reduced the number of emergency restrictive procedures by 81 percent between 1994 and 1997. Along with this reduction in restraint, residents' behavior improved, and the number of major injuries to residents fell by 78 percent.

The first Federal legislative change came with the Children's Health Act in 2000. This legislation, co-sponsored by U.S. Senators Christopher Dodd and Joseph Lieberman, both of Connecticut, requires regulations for use of seclusion and restraint in all health care facilities—for children and adults—that receive Federal funds and in non-medical, community-based facilities for youth. The Centers for Medicare & Medicaid Services (CMS) and SAMHSA are working on this effort together.

In addition, the CMS Conditions of Participation, for all types of hospitals as well as for psychiatric residential treatment facilities for individuals under age 21, established standards for use of seclusion and restraint. Both sets of standards include the following requirements:

- Prohibiting their use as coercion or discipline
- Excluding their use for any reason but to ensure safety in emergency situations (and emphasizing that only approved methods should be used in those situations)

Photo by David Rodriguez

- Requiring staff and consumer debriefing and reporting of any deaths
- Requiring staff education and training.

SAMHSA's Vision and Plan

SAMHSA's National Action Plan to reduce and eliminate seclusion and restraint has targeted five domains under which to bring change into the field.

Data Collection to measure and track the use of seclusion and restraint: SAMHSA has been working with some states to define and measure usage. The Agency is also pursuing ongoing efforts in this area with state protection and advocacy programs and with NASMHPD.

Evidence-Based Practices and Guidelines to identify and promote approaches that have proven effective in reducing seclusion and restraint: SAMHSA is partnering with NASMHPD's National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Registry for Effective Practice to identify, develop, and disseminate successful models of intervention.

Training and Technical Assistance to help staff learn effective, new approaches: SAMHSA is working on a consumer-based training manual on alternative methods including de-escalation and methods of preventing situations where seclusion and restraint might be used. SAMHSA is also

supporting NTAC in conducting a series of regional training academies for state teams to develop and establish strategic plans to reduce seclusion and restraint at specified state-operated mental health facilities. For Fiscal Year 2004, SAMHSA has proposed a $2.5 million grant program in staff training for nine states. SAMHSA has also proposed a resource center to document and enhance evidence-based practices, provide technical assistance, and act as a clearinghouse on seclusion and restraint issues.

Further, the Child Welfare League of America and the Federation of Families for Children's Mental Health are in the middle of a 3-year, $6 million SAMHSA-funded grant program at multiple sites to determine best practices in staff training to reduce deaths and injuries.

Leadership and Partnership Development to help ensure widespread change: Elimination of seclusion and restraint will require buy-in from top leadership in all stakeholder groups. To that end, SAMHSA and NASMHPD convened a national leadership conference in May 2003, at which a broad spectrum of partners contributed to the action agenda for the elimination of seclusion and restraint. (See "Seclusion & Restraint: Historic Conference," *SAMHSA News,* p. 12).

Rights Protection to uphold and enforce existing safeguards for consumers: SAMHSA advocates for consumer rights through its $32 million Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, responding to allegations of rights violations related to seclusion and restraint, as well as providing technical assistance to state PAIMI programs.

The issue has received more attention in settings providing mental health services than in substance abuse treatment settings, but consumers with addictive or co-occurring disorders can also be at high risk for injury or death under seclusion and restraint, in part because of the possibility of increased agitation.

According to Claudia Richards, M.S.W., of SAMHSA's Center for Substance Abuse Treatment, "We're exploring ways to track the frequency and incidence of seclusion and restraint used on youth—particularly those with co-occurring serious emotional disturbances and substance abuse—who may be in settings like community-based residential treatment programs where there is currently no centralized reporting system to monitor the use of these practices."

Reflecting on all the recent activity in this area, Ronald S. Honberg, J.D., Director for Legal Affairs at the National Alliance for the Mentally Ill, observed, "There's a deep need for Federal leadership, and SAMHSA has stepped up to the plate."

Photo by David Rodriguez

Seclusion & Restraint Resources

The following resources provide more information about seclusion and restraint:

- 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). Or visit the Web site at **www.mentalhealth.samhsa.gov.**
- NASMHPD's National Technical Assistance Center for State Mental Health Planning at **www.nasmhpd.org/ntac.**
- The Child Welfare League of America and Federation of Families for Children's Mental Health staff-training project, funded by SAMHSA, available at **www.cwla.org /programs/behavior.**
- *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/ Seclusion in Behavioral Health,* available at **www.psych.org/clin_res /learningfromeachother.cfm.**

This 42-page publication was created by the American Psychiatric Association, American Psychiatric Nurses Association, and the National Association of Psychiatric Health Systems with Support from the American Hospital Association Section for Psychiatric and Substance Abuse Services. A description and a copy of the resource guide are available.

Seclusion & Restraint Historic Conference

A clear goal and focused plan to change a controversial practice in mental health and related services emerged at a groundbreaking national conference on May 5 in Washington, DC. Titled "A National Call to Action: Eliminating the Use of Seclusion and Restraint," the conference was sponsored by SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD).

"The use of seclusion and restraint clouds our vision and impedes our mission," SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said in his conference address. "I have made it a priority for SAMHSA to work with states, consumers of mental health services, advocates, service providers, and provider organizations ultimately to eliminate the use of such practices. Today we are launching our national action plan to accomplish that goal."

NASMHPD Executive Director Robert Glover, Ph.D., emphasized the organization's position, issued in July 1999, that seclusion and restraint are safety interventions of last resort and are not treatment interventions, and that they "should never be used for the purposes of discipline, coercion, staff convenience, or as a replacement for adequate levels of staff or active treatment."

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NASMHPD Executive Director Robert Glover

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SAMHSA Administrator Charles G. Curie

Conference participants included leaders from national mental health organizations; professional and provider organizations; Federal, state, and local mental health agencies; clinical training programs; federally funded research, training, and technical assistance centers; and mental health service consumers and people in recovery from addictions and their family members. Participants examined solutions, shared experiences and information, and contributed to a national agenda, which SAMHSA will disseminate.

Jacki McKinney, M.S.W., advocate for the National Association of People of Color Consumers, recounted a night in seclusion spent listening to the man locked in the tiny room next door become increasingly distressed, to the point of death. "Each time [an attendant] came I said, 'I'm going to tell them about the man next door.' But I couldn't, I was so scared for myself. Isn't this dehumanizing—to force me to make a decision between my life and somebody else's?"

"The challenge we're still facing is addressing a culture where people believe restraint helps," said Laura Prescott, Executive Director and founder of Sister Witness International, in remarks at the meeting.

Diverse viewpoints also found a forum. Lynn C. DeLacy, M.S., R.N., C.N.N.A., chair of the Task Force on Seclusion and Restraint for the American Psychiatric Nurses Association, expressed concern, in light of the national nursing shortage, about the labor-intensive work required to prevent seclusion and restraint. Charles Riordan, M.D., chair of the American Psychiatric Association's Committee on Standards and Survey Procedures, predicted problems in eliminating seclusion and restraint without a major commitment of money and resources. He warned of possible unintended consequences of proposed reporting requirements, such as hospitals' refusals to admit certain patients.

The conference ended with a session in which participants submitted recommendations for consideration in pursuing SAMHSA's National Action Plan.

—By Sara Wildberger

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Jacki McKinney

SAMHSA Creates Resources for Teen Substance Abuse Treatment

The idea that adolescents need specialized substance abuse treatment—treatment different from that offered to adults—emerged from the field only within the past 20 years. Since then, many programs for treating adolescents have been established. But which ones work?

"In the past, these programs haven't had the money for evaluation," said Randolph D. Muck, M.Ed., Team Leader for Adolescent Programs in the Division of Services Improvement at SAMHSA's Center for Substance Abuse Treatment (CSAT). "They've had no way of knowing whether they were doing any good and neither did anyone else. They might claim success, but those claims were mostly based on anecdotal evidence."

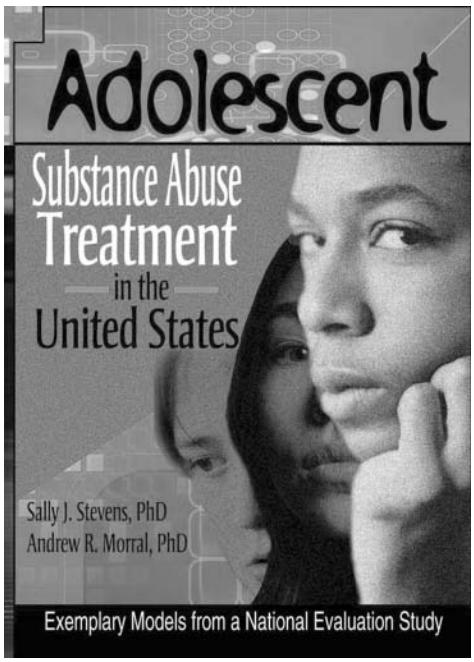
To address this lack of information, CSAT launched the Adolescent Treatment Models (ATM) project in 1998 to identify promising programs at 10 sites and evaluate their effectiveness. Although the project is not yet completed, the programs—based on a wide variety of models—all show positive preliminary results.

A Research Gap

Adolescents have special needs that differ from adults. Motivation, for instance, can be a special problem for adolescents. They're much more likely than adults to be in treatment under duress and less likely to see their substance use as a problem.

In the late 1990s, practitioners started developing programs designed to meet these and other challenges. However, there were few evaluations of these programs. Those that did exist were marred by unstandardized approaches, small sample sizes, and inadequate followup.

That started to change in 1997 with CSAT's Cannabis Youth Treatment (CYT) study. This large-scale program took five theory-based outpatient models for treating adolescent marijuana use, put them into practice, and evaluated their effectiveness. CSAT found that these models reduced adolescent substance abuse dramatically (see *SAMHSA News,* spring 2001).



Following this study, CSAT staff decided to test and compare the effectiveness of several already existing treatment programs for adolescent drug use, including drugs other than marijuana. The result was the ATM project. Collecting a core set of the same data as the CYT study, the ATM project evaluated a wide range of existing programs that appeared promising. Models included inpatient and residential treatment programs as well as outpatient programs (see box, p. 14).

Drawing on the experience of approximately 2,000 adolescents, grantees collected data about substance abuse and other areas of interest at baseline, 6 months, and 12 months after the initial assessment.

Documenting Effectiveness

To the researchers' surprise, the ATM programs were just as effective as the CYT programs.

"Programs already in use typically have limited resources, haven't gone through a lot of rigorous evaluation, and are loosely based on theory," said Mr. Muck. "We figured that CYT would have better outcomes than the ATM projects, but that didn't turn out to be the case."

Overall, the ATM programs produced fairly substantial reductions in adolescents' substance use, emotional problems, and illegal activities in the year following intake, according to Michael L. Dennis, Ph.D., Director of the project's Data Coordinating Center and senior research psychologist at Chestnut Health Systems. There was a 50- to 60-percent reduction in the number of days adolescents used drugs, for example.

That's good news, according to Dr. Dennis. Although most parents and policymakers hope for zero drug use post-treatment, he explained, complete recovery isn't a very realistic goal without lots of aftercare. "Many people evaluate treatment as if substance abuse is an acute problem like a broken leg," he said. "What we need to do is switch to a chronic disease model. We'll see, as with cancer or hepatitis, that they're moving in and out of recovery."

That's especially true for adolescents, who tend to cycle in and out of recovery more than adults. In the ATM project, 20 to 30 percent of the adolescents were in recovery at the 1-year point, but more than two-thirds had periods of recovery during the year.

The project also found that different levels of treatment intensity produced different patterns of recovery. For adolescents in residential programs, drug use tended to drop

continued on page 14

continued from page 13

off quickly and then start climbing again. Adolescents in outpatient treatment didn't see that kind of dramatic short-term reduction but instead reduced their use gradually. However, all the adolescents—whether in short-term residential, long-term residential, or outpatient treatment—ultimately achieved a similar level of recovery at the 1-year point.

Next Steps

While awaiting additional analysis and additional data, CSAT already is supporting efforts to make information about these models available to the field.

Two of the ATM principal investigators have edited a book called *Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study*.

"All of us were struck by how little information there was about the real nuts and bolts of [adolescent treatment] programs," said co-editor Andrew R. Morral, Ph.D., principal investigator for the Phoenix Academy project and senior behavioral scientist at RAND's Drug Policy Research Center in Arlington, VA. "You could find programs' names in directories, but you wouldn't know what was in them." The book addresses this paucity of information by offering detailed descriptions of the ATM projects. Grantees are also preparing manuals describing their models so that other programs can replicate them.

New Avenues

The ATM results are also prompting new avenues of inquiry. "Now that we recognize that adolescents aren't just little adults, we need to recognize that not all adolescents are alike," emphasized co-editor Sally J. Stevens, Ph.D., principal investigator of the two Arizona sites and research professor at the University of Arizona's Southwest Institute for Research on Women. For example, drug use and treatment needs of girls differ from those of boys; some adolescents come from relatively supportive families and others do not; and the developmental level of adolescents even between ages 13 and 17 can differ tremendously. Moreover, treatment providers need to recognize that many adolescents live in chaotic, violent circumstances or environments in which drug use is only one of many problems, Dr. Stevens said.

An e-mail discussion group called the Society for Adolescent Substance Abuse Treatment Effectiveness listserv—an outgrowth of the ATM project—facilitates ongoing conversation and sharing of information. The listserv is open to anyone in the field.

"The adolescent treatment field is coalescing into a national group," said Mr. Muck. "Adolescent treatment providers and researchers weren't really organized before. Now we have a kind of learning community around the country."

To obtain a copy of *Adolescent Substance Abuse Treatment in the United States* contact Haworth Press at 1 (800) 429-6784 weekdays between 9 a.m. and 5 p.m., est. Or visit **www.HaworthPress.com.** To learn more about the listserv for the Society for Adolescent Substance Abuse Treatment Effectiveness, e-mail Donna Williams at dwilliam@samhsa.gov. ◗

—By Rebecca A. Clay

Adolescent Treatment Sites and Models

SAMHSA'S Adolescent Treatment Models project evaluated promising programs at 10 sites.

- EMPACT-SPC of Phoenix, AZ; Chestnut Health Systems of Bloomington, IL; and Epoch Counseling Center of Catonsville, MD, tested outpatient substance abuse treatment. The Village, Inc., in Miami, FL, evaluated outpatient family therapy.
- Mountain Manor Treatment Center in Baltimore, MD, examined a short-term, intensive inpatient treatment program.
- The Four Corners Regional Adolescent Center in Shiprock, NM, tested a moderate-term residential program aimed at American Indian youth.
- CODAC Behavioral Health Services in Tucson, AZ, looked at a moderate-term "step-down" program in which adolescents move from residential treatment to intensive outpatient treatment to outpatient treatment.
- The Phoenix Academy in Los Angeles and Thunder Road in Oakland, CA, evaluated modified therapeutic community treatment programs. Dynamic Youth Community, Inc., in Brooklyn, NY, looked at a model combining a modified therapeutic community and a step-down approach. ◗

SAMHSA Awards New Grants

SAMHSA announced several new grant awards this spring. Grants awarded so far include:

Recovery Community Services Grants

10 awards totaling $3.25 million this year were made to support development of peer support services for people recovering from alcohol and drug use disorders. The services that will be developed and delivered under this SAMHSA program are expected to expand the capacity of the treatment delivery system by providing peer-to-peer services that help prevent relapse and promote long-term recovery for participants.

Grantees include the following:

Recovery Community Organizations: Women in New Recovery, Mesa, AZ; Group Ministries, Inc., Buffalo, NY; Voices for Addiction Recovery NC, Inc., Ashville, NC; Recovery Resource Center, Maywood, IL; and Association of Persons Affected by Addiction, Dallas, TX. These five awardees are organizations comprised of and led primarily by people in recovery and their family members.

Facilitating Organizations: Asian Counseling and Referral Service, Seattle, WA; AIDS Service Center of Lower Manhattan, Inc., New York City, NY; Central City Concern, Portland, OR; Western MA Training Consortium, Inc., Holyoke, MA; and Detroit Public Health Department, Detroit, MI.

These organizations will assist recovery groups in forming an independent recovery community organization to provide peer recovery support services, or will assist them in developing another organizational structure that enables recovery community members to provide peer services in an autonomous manner.

State Incentive Grants

Governor's offices in the two states and the U.S. Virgin Islands received grants to reduce illegal drug, alcohol, and tobacco use among youth.

Awards will be made over a period of 3 years to California for $12 million, to Alabama for $9 million, and to the Virgin Islands for about $3.75 million.

The State Incentive Grants will support statewide planning and strategies to reach youth, parents, and families at the community level with effective substance abuse prevention programs. A full 85 percent of funds awarded through the incentive grant program are directed to support the work of community-based programs.

Treatment Drug Courts

$15 million over 3 years for 13 grants to allow for expansion and enhancement of Family Treatment Drug Courts, Juvenile Treatment Drug Courts, and Adult Treatment Drug Courts that are currently operating. These courts are designed to target effective treatment services to break the cycle of child abuse or criminal behavior, alcohol or drug abuse, and incarceration, by funding services that support substance abuse treatment.

2 grants were awarded to Family Treatment Drug Courts in Suffolk County, NY, and San Diego County, CA.

11 grants were awarded to Adult and Juvenile Drug Courts in Santa Clara County, CA; Osceola County, FL; Queens, NY; City and County of Denver, CO; Pinellas County, FL; Cuyahoga County, OH; Madison County, IN; Lexington County, SC; Salt Lake Reservation, Maricopa County, AR; Benton County, OR; and Utah County, UT.

Targeted Capacity Expansion Grants

$10.4 million for 7 grants to expand or enhance substance abuse treatment capacity in local communities. These 3-year grants are part of SAMHSA's program to target funding in local areas where there are serious, emerging substance abuse problems or the need for rapid response to demands for alcohol and drug treatment services.

Awards were made to: Cook Inlet Tribal Council, Inc., Anchorage, AK; San Francisco Department of Public Health, San Francisco, CA; City of Gallup, NM; City of Milwaukee, WI; Fairbanks Native Association, Fairbanks, AK; City of Huntington, WV; and Lancaster County, NE.

Health Services to Homeless

14 grants totaling $23 million over 3 years to provide substance abuse and mental health services to homeless individuals. These grants will support treatment programs and other services for people who are homeless, as well as people who are at imminent risk for becoming homeless. Grant awards will total almost $7.8 million each year for 3 years, subject to continued availability of funds and progress achieved by the grantees.

This year's grantees for Treatment for the Homeless projects include: Bonita House, Inc., Oakland, CA; New Directions, Inc., Los Angeles, CA; University of Colorado Health Science Center, Denver, CO; Brandywine Counseling Inc., Wilmington, DE; Agency for Community Treatment Services, Inc., Tampa, FL; Chicago Health Outreach, Inc., Chicago, IL; Heritage Behavioral Health Center, Inc., Decatur, IL; Boston Medical Corporation, Boston, MA; ServiceNet, Inc., Northampton, MA; Goodwill Industries of Greater NY, and NJ Inc., Astoria, NY; CASES, New York City, NY; North Oklahoma County Mental Health Center, Inc., Oklahoma City, OK; Aliviane, Inc., El Paso, TX; and Prestera Center for Mental Health Services, Huntington, WV.

For more information or to learn more about current SAMHSA grant opportunities, visit **www.samhsa.gov/grants/grants.html.**

SAMHSA-Funded Projects Highlight American Indians & Alaska Natives

Four SAMHSA grantees published articles about their programs in the January–March 2003 issue of the *Journal of Psychoactive Drugs,* a publication of Haight-Ashbury Free Clinics, Inc., San Francisco, CA. The issue focuses on efforts in American Indian and Alaska Native communities to address health disparities and provide culturally competent substance abuse and mental health treatment through the integration of traditional, indigenous practices, and Western treatment techniques.

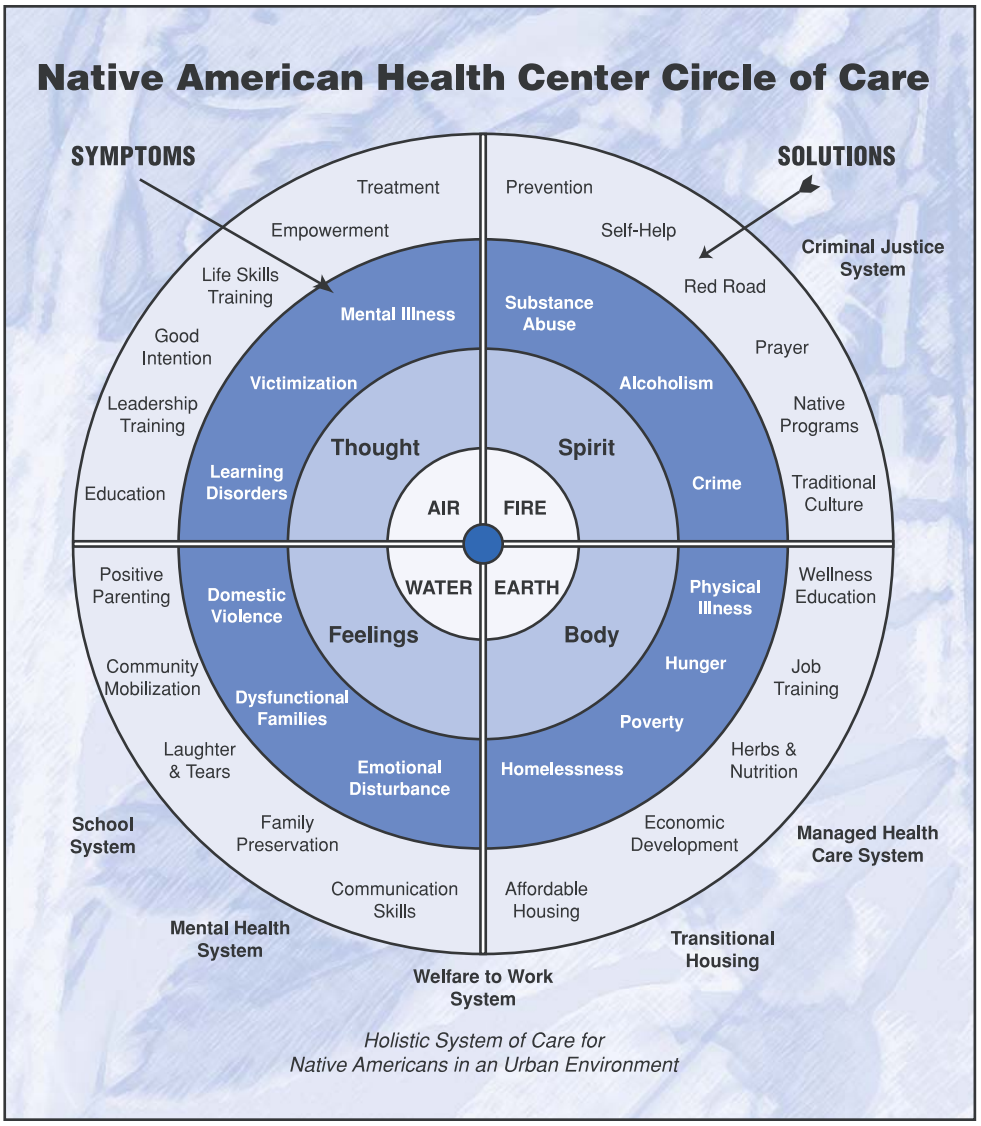
Family and Child Guidance Clinic, Native American Health Center, San Francisco

Founded in 1972, the Native American Health Center provides a variety of medical and social services to urban communities of American Indians and Alaska Natives in the San Francisco Bay Area. This locale has one of the highest concentrations of American Indians living in urban areas of the United States. Outpatient mental health and substance abuse treatment is provided through the Family and Child Guidance Clinic (FCGC).

In "A Holistic System of Care for Native Americans in an Urban Environment," Ethan Nebelkopf, Ph.D., and Janet King describe the strategic planning process used to develop appropriate services to meet critical community needs. In 1998, a 3-year planning grant from SAMHSA's Circle of Care Initiative supported the FCGC in developing a Circle of Care—a local system of care rooted in cultural values within the community. Through interviews with diverse community stakeholders, the FCGC identified key issues and resources in the community of more than 80,000 individuals representing more than 100 different tribes. They created a holistic, solutions-focused model that develops bridges between traditional spirituality and values and community systems of care.

Beginning in a central circle representing the Creator, an illustration of the FCGC Circle-of-Care model represents morbidities such as substance abuse, hunger, domestic violence, and mental illness as imbalances within the quadrants of spirit, body, feelings, and thought. These quadrants of human experience are coordinated to the four traditional elements of creation—fire, earth, water, and air—and to community systems of care, including the criminal justice system; the housing, managed health care, welfare, and mental health systems; and schools. The model focuses on solutions, and highlights both Native "exemplary practices" (e.g., the talking circle) and Western ones (e.g., case management).

In another article, "The Women's Circle Comes Full Circle," Karen Saylors, Ph.D., describes the history and impact of the Women's Circle project of the FCGC. Initiated in 1996, the Women's Circle



Holistic System of Care for Native Americans in an Urban Environment

focuses on HIV prevention for American Indian and Alaska Native women. In 1999, SAMHSA supported expansion of substance abuse treatment services and the provision of mental health services within the Women's Circle, where culturally based interventions are combined with Western psychotherapeutic and medical services.

Ninety-five different tribal affiliations are represented among Women's Circle clients, and individual clients vary in their desire to engage in traditional practices. In response to this individual and cultural diversity, clinical assessment at the Women's Circle includes a spiritual/cultural domain, which is used in the development of an individual treatment plan. The treatment plan may include sage, cedar, or sweet grass smudges, along with singing, drumming, sweat lodge ceremonies, talking circles, and other cultural healing activities.

Dr. Saylors emphasizes that, "… the way cultural interventions often occur is on the individual level, with counselors assessing a client's desire or readiness to work with traditional ways."

Providing individualized, culturally based treatment appears quite effective: Rates of substance abuse among clients decreased sharply after treatment at the Women's Circle.

Dine´ Center for Substance Abuse Treatment, Navajo Nation

In October 1993, the Navajo Nation founded the Dine´ Center for Substance Abuse Treatment as one of six Rural, Remote, and Culturally Distinct Populations projects funded by SAMHSA. The traditional healing practices used by the Dine´ Center in alcohol and substance abuse treatment included sweat lodge ceremonies. In 1994, these ceremonies were made available to inmates in the Navajo Nation's Window Rock Jail. There, 190 men participated in a 3-year study (from 1996 to 1999) of the effect of these ceremonies in jail-based substance abuse treatment. Weekly alcohol education classes were paired with weekly group psychotherapeutic sessions conducted within the context of a sweat lodge ceremony.

The way cultural interventions often occur is on the individual level, with counselors assessing a client's desire or readiness to work with traditional ways.

The results of this study are reported in "Sweat Lodge Ceremonies for Jail-Based Treatment," by J. Phillip Gossage, Ph.D., Louie Barton, Lenny Foster, Larry Estsitty, Clayton Lone Tree, Carol Leonard, M.P.H., and Philip A. May, Ph.D. The small sample size and data collection challenges faced by investigators limit the conclusions that can be drawn from this study. However, the data show a decrease in the average number of drinks participants consumed at drinking sessions (from a mean of 6.7 to a mean of 5.3) and improvement in participants' world view, suggesting that further efforts and study on the provision of culturally based treatment for American Indians within the criminal justice system are necessary and appropriate.

Village Sobriety Project, Hooper Bay and Scammon Bay, Alaska

The Village Sobriety Project, funded by a 3-year SAMHSA grant (from 1999 to 2002), preserves and honors traditional practices by weaving them into mental health and substance abuse treatment. In "Incorporating Yup'ik and Cup'ik Eskimo Traditions Into Behavioral Health Treatment," Phoebe A. Mills, M.S.W., reports on efforts in the Yukon-Kuskokwim Delta of southwest Alaska to preserve culture and enhance outcomes, as well as to ensure access to services through developing Medicaid-reimbursable treatment plans that incorporate traditional and Western healing practices.

Before the project, the authors say, treatment services for this population "were approached solely from the Western framework, operating with such tools as the DSM-IV, cognitive therapy, rational-emotive therapy, play therapy, and art therapy. One premise behind the incorporation of traditional modalities into behavioral health treatment is that if Western modalities can utilize play and art in therapy, then traditional cultural activities can be considered just as valid in formal treatments."

Some of the traditional cultural practices incorporated into treatment included hunting, chopping wood, taking tundra walks, and gathering edible and medicinal plants. Through making clear correlations between traditional activities and Medicaid service components, and meeting certain requirements regarding staff qualifications and documentation of treatment, program staff were able to develop a service model that is not only culturally competent, but also financially sustainable and accessible to clients.

In *Mental Health: Culture, Race, and Ethnicity* (1999), the U.S. Surgeon General reported that culture plays a role in the effectiveness of mental health treatments, and that racial and ethnic minorities are less likely than the general population to receive quality services. The efforts highlighted in the *Journal of Psychoactive Drugs* (Jan-Mar 2003) suggest that both of these concerns might be addressed through culturally competent mental health and substance abuse services blending traditional Native and contemporary Western practices.

—By Melissa Capers

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:

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- ❑ 14th Annual Recovery Month Set for September
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- ❑ Promoting Recovery With Proven Solutions
- ❑ Six at a Glance
- ❑ Help for Children of Addicted Parents

Seclusion & Restraint:

- ❑ Breaking the Bonds
- ❑ Resources
- ❑ Historic Conference
- ❑ SAMHSA Creates Resources for Teen Substance Abuse Treatment
- ❑ Adolescent Treatment Sites and Models
- ❑ SAMHSA Awards New Grants
- ❑ SAMHSA-Funded Projects Highlight American Indians & Alaska Natives
- ❑ Opioid Treatment Programs Can Now Offer Buprenorphine

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Thank you for your comments.

Opioid Treatment Programs Can Now Offer Buprenorphine

SAMHSA has announced an interim final rule that will permit opioid treatment programs serving persons addicted to heroin or narcotic pain relievers to offer buprenorphine treatment along with methadone and ORLAAM.

The rule enables opioid treatment programs that are certified by SAMHSA to use newly approved buprenorphine products, Subutex® and Suboxone®, for the maintenance or detoxification treatment of dependence on opioids such as heroin or prescription pain relievers. The rule went into effect May 22, 2003, with a comment period open for 60 days, until July 21.

"The availability and application of buprenorphine marked a new day in the treatment of addiction," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "With this interim final rule, physicians for opioid treatment programs will be able to improve, expand, and tailor treatment for the individual needs of their patients."

This amendment to the rules for opioid treatment programs will give these 1,200 programs two more medications for their approximately 205,000 patients. As with other medical conditions, some patients will do better with one of the buprenorphine medications while others will require methadone or ORLAAM.

Subutex® is formulated as a sublingual tablet that contains either 2 or 8 milligrams of buprenorphine. Suboxone® is a fixed combination sublingual tablet that contains 2 milligrams of buprenorphine with 0.5 milligrams of naloxone, or 8 milligrams of buprenorphine together with 2 milligrams of naloxone. Naloxone is an opioid antagonist and is present in the Suboxone® formulation to reduce its risk of intravenous abuse.

To offer these buprenorphine medications, opioid treatment programs will need to review their state licensing laws and regulations, and modify their registration with the Drug Enforcement Administration (DEA) to add Schedule III narcotics to their registration certificates. Opioid treatment programs can initiate this process by fax or letter. The letter should include the opioid treatment program's DEA registration number and request that the registration be amended to list Schedule III narcotic drugs. In addition, the letter must be signed by the program sponsor (program director) or medical director.

The completed letter can be either faxed to Ms. Ghana Giles at (202) 353-1125 or mailed to her at DEA, Registration Unit–ODRR, Washington, DC 20537. Following receipt and review, DEA will issue a modified registration certificate to each opioid treatment program. Opioid treatment programs may contact their local DEA office for additional information on the status of their registration modification.

Interested opioid treatment programs may contact DEA by telephone at 1 (800) 882-9539 or online at **www.deadiversion.usdoj.gov/drugreg/change_requests/sched_change.htm.**

Once registration is modified, opioid treatment programs can order Subutex® and Suboxone® directly from the product manufacturer by calling 1 (866) 882-2107.

Comments on the interim final rule should be submitted to DPT Federal Register Representative, Division of Pharmacologic Therapy, Center for Substance Abuse Treatment, SAMHSA, Rockwall II, Room 6-18, 5600 Fishers Lane, Rockville, MD 20857. Comments can be faxed to (301) 443-3994 or e-mailed to DPT_Interimrule@samhsa.gov. Closing date for comments is July 21, 2003.

"With this interim final rule, physicians for opioid treatment programs will be able to improve, expand, and tailor treatment for the individual needs of their patients."

—Charles G. Curie, SAMHSA Administrator

SAMHSA News

Substance Abuse and Mental Health Services Administration

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

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

CENTER FOR SUBSTANCE ABUSE PREVENTION
Beverly Watts Davis, Director

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

EDITOR
Deborah Goodman

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

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Mail: Brian Campbell, *SAMHSA News,* Room 13C-05
5600 Fishers Lane, Rockville, MD 20857

Fax: Brian Campbell (301) 443-9050

Phone: (301) 443-8956

E-mail: *bcampbel@samhsa.gov*

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