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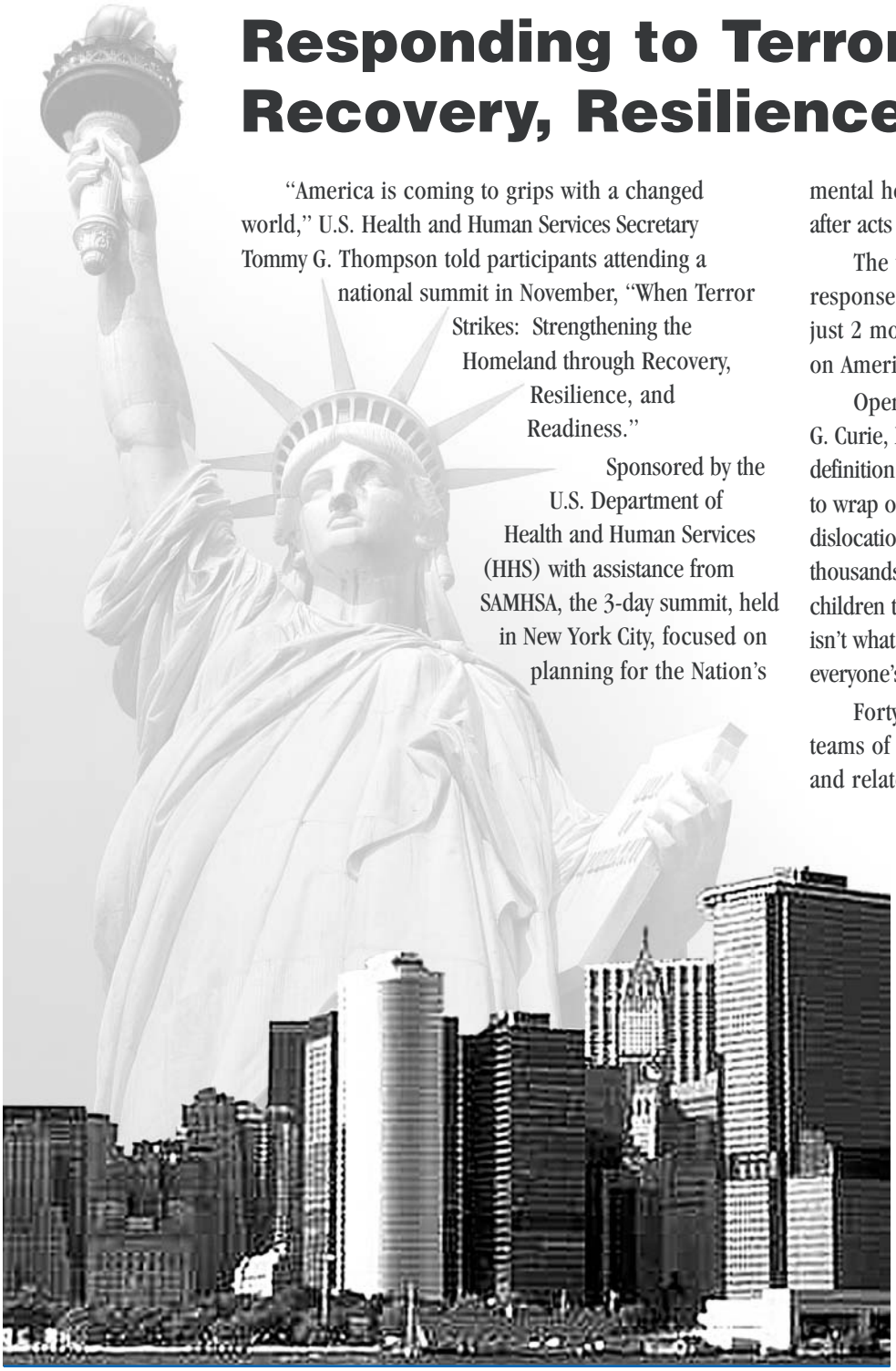

Responding to Terrorism: Recovery, Resilience, Readiness

"America is coming to grips with a changed world," U.S. Health and Human Services Secretary Tommy G. Thompson told participants attending a national summit in November, "When Terror Strikes: Strengthening the Homeland through Recovery, Resilience, and Readiness."

Sponsored by the U.S. Department of Health and Human Services (HHS) with assistance from SAMHSA, the 3-day summit, held in New York City, focused on planning for the Nation's mental health and substance abuse needs during and after acts and threats of terrorism.

The theme of change, and the need for a new response to it, echoed throughout the summit, held just 2 months after the September 11 terrorist attacks on America.

Opening the meeting, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., observed that, "We have a new definition of what 'normal' means, and we're all struggling to wrap our minds around it. From the pain and psychic dislocation of families caused by the wanton deaths of thousands of innocents to the mother who fears taking her children to the zoo or to a movie, 'normal' most certainly isn't what it used to be." Mental health issues are now on everyone's mind, perhaps for the first time, he said.

Forty-two states and the District of Columbia sent teams of senior-level mental health, substance abuse, and related health and human services professionals to the summit. The nearly 650 participants also included representatives from five U.S.

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Arab Americans and American Muslims Express Mental Health Needs

"I have a friend who said, 'In the morning, instead of telling me Good Morning, my boss tells me Hi Terrorist.' And then I asked her, 'But why don't you call the police or call somebody who would be able to help you with this?'

"And she said, 'Adnan, I want you to know that if I call anybody, I will be fired. And I need this job.' "

This incident was related by Adnan Hammad, Ph.D., director of health and medical services at the Arab Community Center for Economic & Social Services in Dearborn, MI, at an Arab American and American Muslim listening session hosted by SAMHSA's Center for Mental Health Services (CMHS) in November, just 2 months after the September 11 terrorist attacks on America.

It is one example of the verbal harassment, vandalism of property, and physical assaults—some resulting in deaths—that many Arab Americans and American Muslims have experienced since the attacks. These events prompted SAMHSA to hold a listening session to examine the effects on the mental health of this community.

CMHS staff—Capt. John Tuskan, Jr., R.N., M.S.N, Teresa Chapa, Ph.D., and Zena F. Itani, M.P.H.—planned and coordinated the meeting, which focused on identifying unmet mental health needs and drafting recommendations to address them. The discussion was facilitated by CMHS National Advisory Council member Abdul Basit, Ph.D., a research associate in the Department of Psychiatry at the University of Chicago and president of the American Islamic Association of Mental Health Professionals.

Problems & Needs

In the wake of September 11, many Arab Americans and American Muslims experienced both grief and fear: grief at the tragedy and loss of life, and fear of being blamed and stigmatized.

The Islamic Center of Long Island received a supportive community response after September 11 because of previous outreach efforts, according to spokesperson Dr. Faroque Khan.

Zahid Bukhari, Ph.D., director of Project MAPS (Muslims in American Public Square) at the Center for Muslim-Christian Understanding, Georgetown University, described the variety of ways in which Muslims were affected by the incidents: some as victims or relatives of victims killed while working in the World Trade Center, some as targets of backlash discrimination, some serving as members of the American military, and some who have received positive expressions of support from other Americans in the wake of the tragedies.

Citing some examples of interfaith solidarity, Sayyid Syeed, Ph.D., secretary general of the Islamic Society of North America, said that when the Toledo, OH, Islamic Center was attacked after September 11, approximately 1,500 people of other faiths circled the Islamic Center and provided protection the next day.

The diversity of societal reactions has created an emotional "roller coaster for Muslims for the last 2 months," Dr. Bukhari observed.

Identity Crisis

Perhaps the most universal experience following the attacks has been a profound self-questioning.

"The same question keeps coming up," said Salma Abugideiri, M.Ed., LPC, of the Center for Multicultural Human Services in Falls Church, VA. "How American am I? What does it mean to be Arab? Can I be Arab American? And what does it mean if I'm a Muslim in America who has, up till now, felt very comfortable, very safe, appreciating the religious freedom . . . and now being forced to answer some very difficult questions."

Listening session participants said that many Arab American and Muslim children born and raised in the United States are now fearful to attend school or go to the movies and have been asking difficult theological questions that their parents cannot answer.

Participants further noted that some first-generation Arab Americans immigrated as refugees fleeing repressive regimes or war-torn countries. The events have caused a retraumatization for them in a country they had considered a haven.

Many Christian Arab Americans also experience confusion and isolation, feeling as if they don't belong in either the Muslim Arab world or in American society at large.

Lack of Appropriate Help

Responding to the mental health needs of this community is complicated.

"Seeking mental health treatment [is] taboo; it's not part of our culture," Ms. Abugideiri said.

As in many other cultures, stigma and a sense that problems should be resolved within the family often prevent individuals from seeking help.

For those receptive to mental health counseling, other problems arise, such as a lack of Arabic-speaking service providers for new immigrants, or a lack of culturally appropriate treatment.

Dr. Basit, who has published articles on this subject, spoke about the pitfalls of cross-cultural diagnosis and treatment.

In an article, "Religious and Ethical Factors in Psychiatric Practice," published in the *Journal of the Islamic Medical Association,* Dr. Basit wrote, "The underpinning of all research, leading to various schools of thought in the field of psychiatry, is without doubt a product of Western scholars, representing the religio-cultural traditions, historical symbols, and narratives of Western society. . . . Consequently, methods and techniques developed in the West may not be suitable for treating American Muslims, whose religious and sociocultural backgrounds are quite different."

In other published papers, he delineates some of the differences between Western and Islamic perspectives on counseling. In the West, he says, primacy is placed on individualism and personal fulfillment, whereas in American Muslim culture, personal goals are often subordinated to the collective goals of the family and community.

Western psychotherapy, he also observes, is secular, focuses on the development of new coping techniques, and often espouses a relativism in ethical issues. In contrast, he says, an Islamic approach is embedded in spiritual faith.

One participant described a cultural sensitivity training session she had given for American social workers in which one of the social workers suggested she remove her *hajab* (head scarf) to avoid discrimination.

"The mental health professionals really can do a great deal of damage, and it only takes one person like that," she said. "The word will spread throughout the community and then [people] won't send their kids to the school counselors for fear that all of the girls then are going to be encouraged to take off their scarves or change other cultural patterns or ways of doing things."

In the current climate, many Arab Americans and Muslims further distrust and avoid social service organizations for fear that if they express themselves openly, they could be detained for questioning or even deported.

Recommendations

Community and Interfaith Outreach

Participants noted that in places where earlier efforts had been made to build bridges with the greater community and to establish interfaith activities before September 11, fewer problems arose.

Faroque Khan, M.B., M.A.C.P., a physician and the spokesperson for the Islamic Center of Long Island, said that his Center's previous outreach and educational activities over several years had resulted in a supportive community response after September 11.

Participants urged that mosques and Muslim community centers invite representatives from the police, fire, and public health departments, as well as churches, synagogues, and temples, to attend events and prayer services.

They also said that offering educational programs about Arabs and Muslims to schools could help foster understanding among children, teachers, and other school personnel.

Culturally Sensitive Services

In addition to providing training in cultural sensitivity to mental health professionals, participants also recommended that mental health professionals work closely with Muslim religious leaders.

As one participant observed, "People in the Muslim community—and it's probably true in Christian and other communities when these crises occur—they will go to the religious leader in the community, and quite often the religious leaders are not trained to intervene properly."

Collaborating with imams and providing them with additional education about mental health would enable the mental health and religious communities to reach and assist people more effectively, participants said.

They called for funding more research on culturally grounded therapeutic approaches for Arab Americans and Muslims, for the development of manuals detailing best treatment practices, and for the compilation of a directory of Muslim resources and services in America.

Participants also expressed a desire to help Americans increase their understanding of Arabs and Muslims. They advocated for more work with the media and entertainment industries to combat negative stereotyping.

Despite their concerns and the enormity of their task, participants still generated a feeling of optimism.

As one observed, "We have come here today because we believe that things can change."

For more information, contact Capt. John Tuskan at SAMHSA's Center for Mental Health Services, Room 17C-05, 5600 Fishers Lane, Rockville, MD 20857. Telephone: (301) 443-7790. E-mail: **jtuskan@samhsa.gov.**

—By Deborah Goodman

Summit Promotes Mental Health in the Workplace

"Employers worry that people with mental illnesses can be disruptive to the workplace, but we are here to say that people with mental illnesses don't conform to the stereotypes," said Bernard S. Arons, M.D., Director of SAMHSA's Center for Mental Health Services (CMHS) in welcoming participants to a conference this fall on initiatives to support mental health in the workplace.

Titled "Hand in Hand: It's Worth the Investment! A National Summit on Best Practices for Mental Health in the Workplace," the summit was cosponsored by CMHS, the Department of Labor's Presidential Task Force on the Employment of Adults with Disabilities, and a coalition of public and private organizations including Johnson & Johnson and the W. K. Kellogg Foundation.

The summit highlighted not only the value of hiring people with mental disabilities, but also the importance of encouraging mental health in the workplace for all employees.

As SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., told participants, "Mental health in the workplace represents a true win-win situation for both employees and employers, because employers who focus on mental health in the workplace and the mental health of their employees improve their bottom line."

Leaders from business, government, associations, and health care professions as well as consumers of mental health services shared tools that employers can use to promote hiring of people with psychiatric disabilities, advice about establishing consumer-operated businesses, information on the Americans with Disabilities Act and the Family Leave Act, and success stories. Researchers also discussed findings from their studies. (See *SAMHSA News,* p. 5.)

Featured speakers included Pulitzer Prize-winning humor columnist and author Art Buchwald, and John F. Nash, Jr., Ph.D., the 1994 Nobel Prize winner in economics and subject of the movie, *A Beautiful Mind.*

Mr. Buchwald described the public disclosure of his depression and the tremendous support he received. He noted that support—not only from mental health service providers, but also family, friends, and loved ones—is critical for individuals who suffer from depression. He also discussed the problem of stigma, saying "As far as illnesses of the mind, we are still in the dark. I'm trying to get the message out that depression is just another illness."

Pulitzer Prize-winning humor columnist Art Buchwald.

Dr. Nash said that although he was not officially employed by Princeton University after his hospitalizations, he did have access to computers and other resources at the university. Emphasizing the importance of this to his recovery, he said, "I didn't get official employment, but I got something like 'occupational therapy.' "

Congressional support was expressed by U.S. Representatives Pete Stark (D-CA) and Patrick Kennedy (D-RI), who also addressed participants.

U.S. Health and Human Services Deputy Secretary Claude A. Allen, J.D., told participants in closing, "The President's New Freedom Initiative recognizes that more needs to be done to ensure adequate accommodations for people with disabilities. We must remember that wherever a door is closed to anyone because of a disability, we must work to open it. Working together, we can make this happen."

Employment: A Workable Option Despite Mental Illness

"Very few people with serious mental health disabilities are working, and yet employers consistently tell us that workers with these disabilities do a good job, that their needs are very similar to those of other workers, and that they are a productive segment of the labor force," said Judith A. Cook, Ph.D., a professor in the Department of Psychiatry at the University of Illinois at Chicago.

Dr. Cook spoke at SAMHSA's conference this past fall, "Hand in Hand: It's Worth the Investment! A National Summit on Best Practices for Mental Health in the Workplace." (See *SAMHSA News,* p. 4.)

"The lack of employment among consumers of mental health services reflects a tremendous loss of productivity and potential for these individuals personally and for our society economically," Dr. Cook added.

This sentiment is shared by many stakeholders and advocates in the mental health field. In 1995, SAMHSA's Center for Mental Health Services (CMHS) launched a study, the Employment Intervention Demonstration Program (EIDP), that seeks to answer the question: What do people with psychiatric disabilities need so that they can successfully obtain and retain employment?

Finding answers is a national priority as reflected by related Federal efforts including the Ticket to Work and Work Incentives Act of 1999 and the New Freedom Initiative. (See *SAMHSA News,* fall 2001.)

For 5 years the EIDP tested a host of innovative interventions at eight sites, and now the early results are starting to yield significant findings.

"When CMHS launched this study, there was a school of thought that if you just offer people more clinical services, they will get well and go to work," said CMHS project officer Crystal Blyler, Ph.D. "But what the investigators found was very different."

Dr. Judith Cook

One of the study's most salient findings is that *both* clinical *and* vocational services are necessary for people to find and keep employment; and further, that people who receive well-integrated and coordinated vocational and clinical services have greatly improved outcomes compared to those receiving nonintegrated services.

In fact, says EIDP's principal investigator Dr. Cook, such integration and coordination are "vital to success."

The Study

More than 90 percent of the EIDP participants had a diagnosis in the schizophrenia spectrum, major depression, or bipolar disorder, generally considered among the most serious mental illnesses. Two-thirds of the participants had at some point in their lives experienced a substance abuse disorder. More than 90 percent were taking prescription medications.

Each of the eight demonstration sites designed its own intervention using a variety of innovative approaches. (See *SAMHSA News,* p. 6). Most of the approaches were a variation of supported employment and offered a combination of clinical and vocational services, Dr. Cook said. A common protocol allowed data about outcomes to be compared despite differences across sites.

Dr. Blyler emphasized that the study focused on "*competitive* employment. Previous studies included volunteer jobs, sheltered workshops, and housework. It creates a much higher bar to surmount when a job pays at least minimum wage, is open to anyone, and is in a mainstream setting," she explained.

Participants were followed for 2 years and assessed on an ongoing basis.

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Vocational Models Tested

(By Site)

Arizona: Supported Employment vs. Services as Usual
Connecticut: Individual Placement & Support vs. Services as Usual
Maryland: Individual Placement & Support vs. Services as Usual
South Carolina: Assertive Community Treatment + Individual Placement & Support vs. Services as Usual
Pennsylvania: Long-term Employment Training and Supports vs. Services as Usual
Maine: Employer Consortium and Family-Aided Assertive Community Treatment (FACT) vs. FACT only.
Massachusetts: ICCD Clubhouse vs. Program of Assertive Community Treatment Vocational Model
Texas: Employment Assistance through Reciprocity in Natural Supports and Supported Employment vs. Supported Employment Only.

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Results

In the first eight quarters of their EIDP participation, more than 1,600 participants held 2,230 jobs (an average of 2.2 jobs per worker), earned $4.7 million, and worked 820,293 hours.

At the end of the 2-year period, 64 percent of those receiving EIDP services had worked while participating in the program. "For most participants," Dr. Cook said, "subsequent jobs lasted longer than their first job."

Eighty-six percent of all jobs held were at minimum wage or above, paying an average of $5.91 per hour. Participants worked an average of nearly 20 hours per week.

These results demonstrate that given the proper services, people with mental illnesses "*will* enter the labor force and they *will* stay there," Dr. Cook said.

The successes documented by the program were tempered by certain other findings: Most of the jobs were for lower-skilled positions that were not very interesting or fulfilling and did not offer a path to upward mobility. Less than one-third of the full-time jobs held by participants carried any sick leave, vacation, or health insurance benefits.

The latter is particularly serious because people with mental illness often face the loss of Supplemental Security Income, Social Security Disability Insurance, and Medicaid if they earn money beyond the ceiling at which these benefits pay.

"Consumers of mental health services need jobs that offer more than just a survival wage," Dr. Cook said. "They need to be able to replace the income that is threatened by the loss of financial and medical benefits as they experience employment success."

Recommendations

Drs. Cook and Blyler indicated that the results suggest several recommendations for efforts to encourage employment among people with mental illnesses:

- Vocational rehabilitation services should be offered in settings that integrate them with clinical services and require employment for minimum wage or above.
- When needed and desired, vocational support should be ongoing.
- Vocational supports must be combined with educational services so that jobs will be more interesting, higher paying, and more conducive to upward mobility.
- People should be matched to jobs they prefer.
- Vocational rehabilitation must provide information and support regarding Government entitlements and must include financial planning.
- Vocational service providers should assist in negotiating reasonable accommodations with employers and help to address workplace stigma and discrimination.

"We now have research to support these recommendations and the data to back them

up," said Dr. Cook. "We can use these to work for a better service system."

Dr. Cook observed that "there was not that much difference in outcomes between the different enhanced vocational approaches. What made the most difference to participants was getting a lot of vocational services over a long period of time."

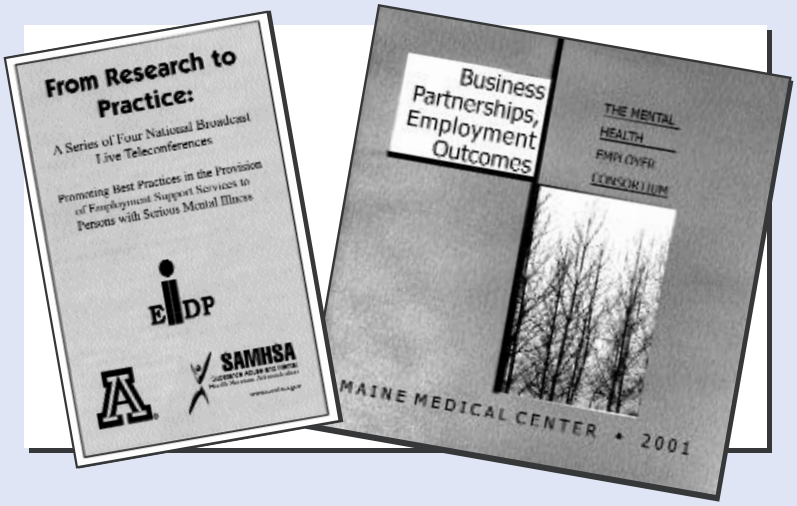
She concluded, "In this program, we were able to move people into the level of the working poor. What remains is to refine and disseminate the methods and remove the barriers and disincentives so that they will move into the working, thriving population."

For more information on the EIDP and resources, see below.

Employment Program Resources

In addition to providing a database, the Employment Intervention Demonstration Program (EIDP) has generated tools useful to other programs promoting employment.

- **The EIDP Arizona site** produced a series of four nationally broadcast satellite teleconferences to describe effective EIDP strategies and highlight key outcomes. The broadcasts can be viewed on the Web at **http://crd.arizona.edu/azpic.** In addition, training modules of each broadcast are available as videos, *From Research to Practice: The Employment Intervention Demonstration Program Satellite Teleconference Series.* The videos can be ordered from the Community Rehabilitation Division, University of Arizona, 721 North Fourth Avenue, Suite 107, Tucson, AZ 85705-8445. Telephone: 1 (800) 724-2855. E-mail: dona@uarizona.edu.
- **The EIDP Maine site** has published a manual, *Business Partnerships, Employment Outcomes: The Mental Health Employer Consortium,* to help others form similar arrangements. The manual describes a successful strategy for helping mental health and vocational service providers and communities of businesses form partnerships to provide employers with information and networking opportunities. To order, contact the Maine Medical Center, Department of Vocational Services, 22 Bramhall Street, Portland, ME 04102. Telephone: (207) 871-2088.



Detailed results of the study and a list of publications are available at the EIDP Web site. Also available are a variety of data-collection and information-assessment tools that can be downloaded for free. These include protocols used to gather information on employment trends as well as instructional manuals for that task. Information can be compiled on individual clients by case managers and then compiled to study results of an entire program.

Contact the EIDP Coordinating Center, Mental Health Services Research Program, Department of Psychiatry, the University of Illinois at Chicago, 104 South Michigan Avenue, Suite 900, Chicago, IL 60603. Telephone: (312) 422-8180, ext. 19. Or visit the EIDP Web site at **www.psych.uic.edu/EIDP.**

On the Web: Prevention Guidance Update

Though still in its infancy, just 1 year old as of September 15, SAMHSA's PreventionDSS (Decision Support System) is successfully providing users with practical, online help in creating and improving substance abuse prevention programs.

Anyone with a computer and a link to the Internet can request and receive expert help at no cost, whether the goal is to reduce smoking in middle schools, help adults build parenting skills, or stop drug-related violence among teens.

So far, prevention professionals at the state and local levels are welcoming that help, according to usage statistics from SAMHSA's Center for Substance Abuse Prevention (CSAP), which created the site. More than 3,600 users have registered 1,701 distinct prevention work projects in the DSS. Prototype version 3.0 is now in effect, and the DSS Web site—**www.preventiondss.org**—averages 30,000 hits per day.

PreventionDSS follows CSAP's logic model to help users work through a circuit of seven stages of planning, establishing, and evaluating their substance abuse prevention programs. Stages of the model are:

- Assessing local needs and target groups
- Developing capacity and resources for prevention activities
- Selecting science-based intervention programs with evidence of effectiveness
- Implementing programs by adapting and enhancing to suit local context and cultures
- Evaluating programs by collecting, coding, and analyzing data
- Writing reports about the program activities and results, and
- Getting training about scientific methods and best prevention practices online.

The modules are interconnected, yet each one is self-contained. Modules include decision support and a tutorial, so program planners can launch into DSS at whatever stage is appropriate for their prevention project. DSS users can start with "Assess Needs" before planning a new project. Or they may approach the DSS with a project already underway and begin working in more advanced modules or with resources such as the library or descriptions of model programs.

A click of the mouse on any segment of the logic model takes the user to interactive tools and work areas supported by resource links for tutorials, technical assistance, downloadable documents, and presentations. Registered DSS users can save all their work, track their progress through the module, report results, and logon and logoff as needed. DSS user identities and information remain private; not even CSAP has access to individual project records.

Visitors can also use the site without registering, if they prefer. CSAP does not track a visitor's e-mail address.

" 'Simply DSS' is a continuing theme for this effort," said DSS project officer Jon Rolf, Ph.D., a senior public health advisor with CSAP's Division of Prevention Application and Education. "We strive to make prevention work easier. Some prevention providers will want to use consultants for the tools that are more technically advanced, but over the next few years, we'll develop components at different levels, for novices versus experienced practitioners." The system will be updated at 6-month intervals (approximately) for at least the next 4 years.

The DSS also extends the reach and productivity of CSAP's six regional training and technical assistance centers known as "CAPTs," Centers for the Application of Prevention Technology. CAPTs work with states to help local organizations adapt scientifically sound prevention practices to local needs and conditions. They support communities in selecting interventions that best suit the characteristics of their target populations.

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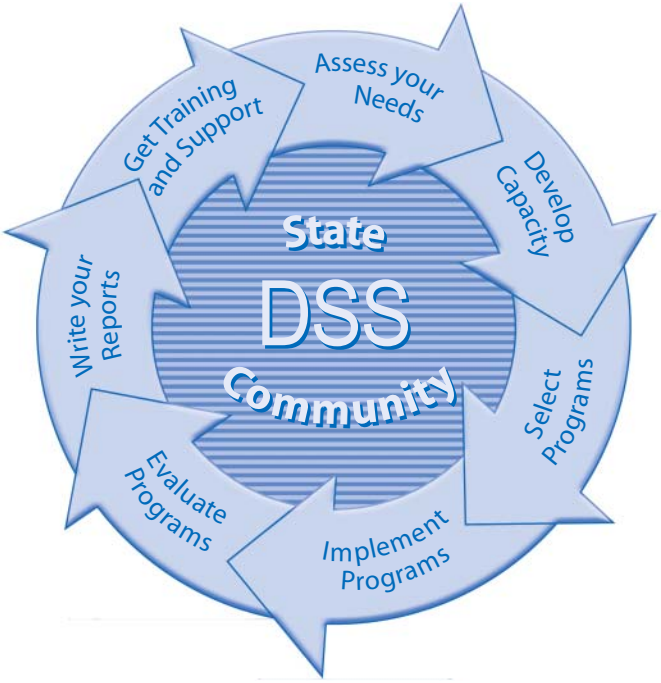


Putting PreventionDSS to Work

Prevention Specialist Alan Zeuge, M.P.A., a relative newcomer to Spokane County Community Services in Washington State, said that the PreventionDSS (Decision Support System) funded by SAMHSA's Center for Substance Abuse Prevention (CSAP) has already proved "extremely valuable" to him. Mr. Zeuge oversees 11 state-funded prevention services contracts for the county, providing technical assistance and liaison to community partners in such areas as substance abuse prevention, violence prevention, and child advocacy.

When one of his contractors came up with a problem he couldn't solve, Mr. Zeuge contacted the Western Center for the Application of Prevention Technology (CAPT), also funded by CSAP. CAPT staff took him through the DSS on the Web and helped him find what he needed.

The project is "HOPE for COAP"—Healthiness Offers Peaceful Enjoyment for Children of Addicted Parents—headed by Julie Wokasch, M.Div., at Colonial Clinic in Spokane. It provides substance abuse prevention services to children growing up in homes where one or more parents are chemically addicted, a serious risk factor for these children. Major project objectives are to reduce the incidence of early onset of drug use by the children and promote a healthy lifestyle.

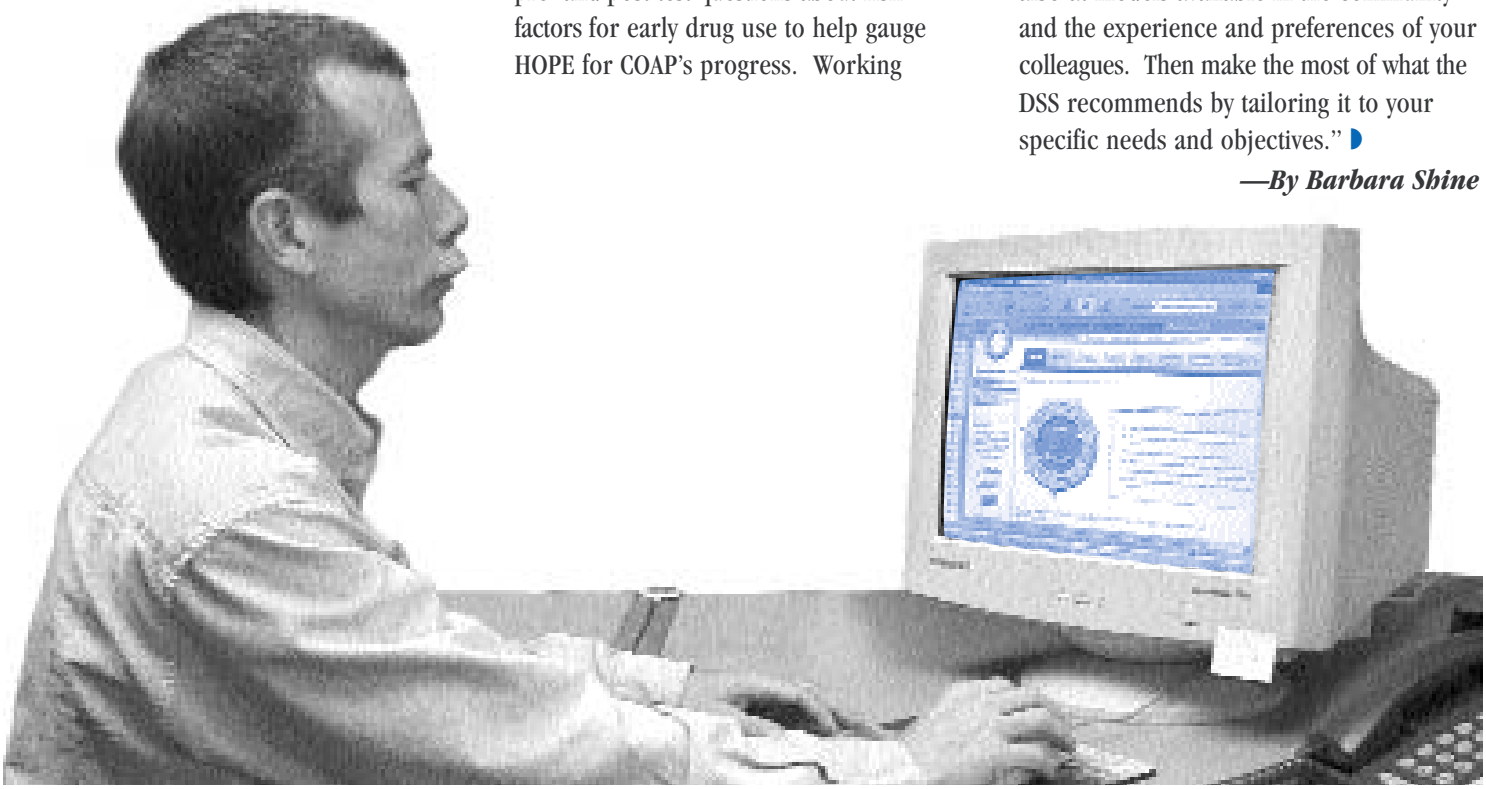
"The intervention strategies used by HOPE for COAP include mentoring, individual and group counseling, education/awareness, and community outreach. Our challenge was to find pre- and post-test materials that would closely measure the project's intended outcomes in terms of modifying the children's risk factor profiles," said Mr. Zeuge.

Working online and by telephone with the Western CAPT, Mr. Zeuge and Ms. Wokasch started searching the system for models of pre- and post-test questions about risk factors for early drug use to help gauge HOPE for COAP's progress. Working through the "Library" and "Evaluate Programs" modules, they looked for measures like 'age of first substance use' and other risk indicators.

"But the DSS guided us to expand the queries," Mr. Zeuge said. "We found we needed to measure not just risk factors, but protective factors, too. The program led us toward bolstering protective factors, and it pointed to scales for measuring elements like parent-child bonding. We queried the system for tests that focus on values—things like attitudes toward illicit drug use and other deviant behaviors, such as shoplifting—and a half-dozen instruments came up for possible use."

There is one caveat to Mr. Zeuge's enthusiastic endorsement of the DSS: "Because there's so much good information and it's so easy to access," he said, "planners need to be careful not to just take the offered examples at face value. You have to look also at models available in the community and the experience and preferences of your colleagues. Then make the most of what the DSS recommends by tailoring it to your specific needs and objectives."

—By Barbara Shine



Alan Zeuge, a prevention specialist at Spokane County Community Services in Washington State, has found the PreventionDSS useful to his work.

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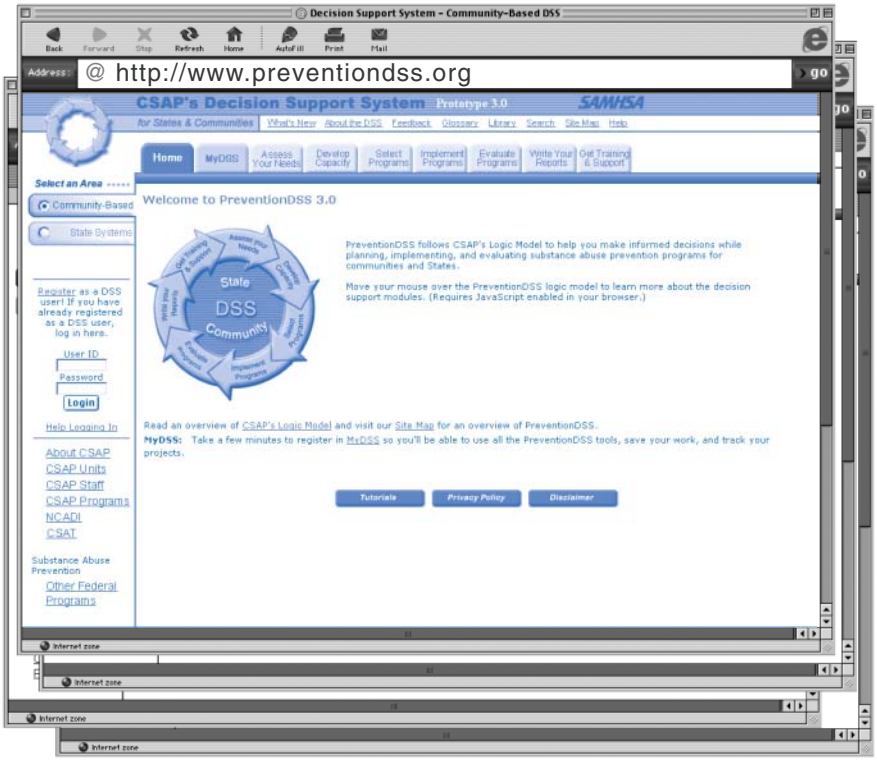
"Prevention professionals are hungry for information, knowledge, and skills," said Robert W. McArdle, C.P.S., prevention applications management coordinator for CSAP's Western CAPT, serving states from Wyoming westward and the Pacific jurisdictions. "Historically, there has not been enough information and support available for preventionists, so the DSS fills an important gap. Many people in the prevention arena are excited to see the DSS evolve even further toward meeting the great promise it offers our field."

Jack Wilson of the Snohomish County Human Services Department in Washington State is a substance abuse prevention specialist who has used the Web site and sees the PreventionDSS as an important part of his agency's future.

"People in community prevention are . . . often unsure whether their efforts are really making a difference," Mr. Wilson said. "The DSS can help them answer the question, 'Have I accomplished anything with my project?' "

"I like to think we're giving parents and others in the community power tools rather than just hammers and saws to construct their projects," Mr. Wilson added. "With the DSS, I can be sure I'm pointing people to the most current, scientifically validated prevention guidance. Our local project organizers won't have to spend a lot of money to get access to the latest information about what works."

With its focus on ease of navigation, the PreventionDSS is powered to support even the most technology-shy computer novices. Tutorials are available on basics such as the use of Web browsers, saving and printing files, and installing plugins like Adobe Acrobat Reader. Because the DSS is Web-based and all data are stored on Web servers, users can access the DSS from any location,



build any number of projects, and get detailed progress notes without exhausting their computer's memory. They don't even have to buy any special software.

CSAP Director Ruth Sanchez-Way, Ph.D., described the DSS as "the cornerstone" in CSAP's efforts to build a national prevention program, and "a means for getting the best prevention methods and programs into communities nationwide. With the DSS, we can offer end-users an enormous virtual library that's as accessible and friendly as their local library branch."

The system is evolving with continual input from the prevention field as well as CSAP program units and other Federal agencies. "Building the boat while we're sailing it," is how Dr. Rolf described the process. "For example," he said, "DSS users have told us they'd like more opportunities for collaboration and referrals for contacts with other organizations. Features promoting collaborations will be incorporated in the 'My DSS' section soon.

"Feedback from the field plays a big role in our improving and maintaining the system," Dr. Rolf continued. "Users can provide feedback via an e-mail link or through the toll-free (800) phone number. CSAP will continue partnering with prevention providers and other users at all levels to ensure we're meeting their needs."

To access the Decision Support System Web site, type **www.preventiondss.org.**

—By Barbara Shine

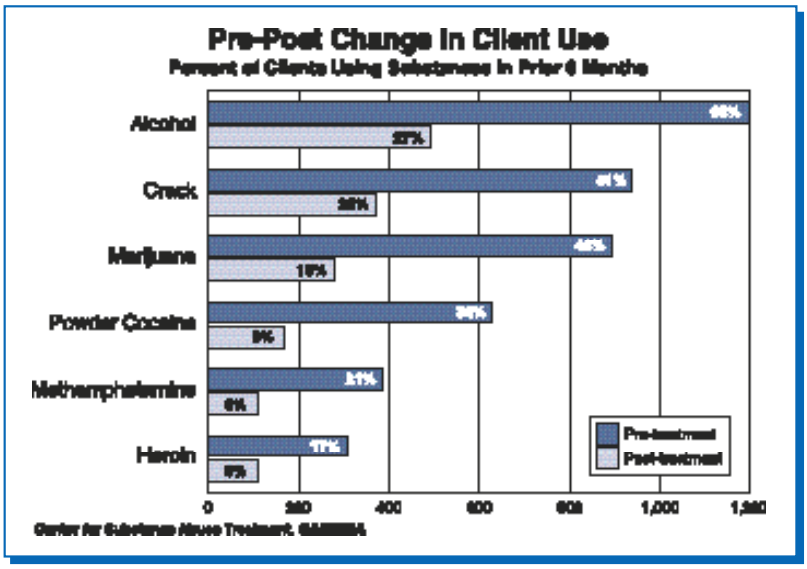
Women and Children: Treatment Improves Health

Just by looking, Ginny Vicini could tell that the family focus of the substance abuse treatment project she ran was working. When women and their children first arrived, she would look out her office window and see them walking across the parking lot with 5 feet of space between them. After 3 or 4 months of treatment, she'd see them walking across the parking lot holding hands.

"It sounds so corny," said Ms. Vicini, now executive director of Chrysalis House in Lexington, KY. "But it was the most moving thing."

Now Ms. Vicini has the data to back up her anecdotal evidence. Last fall, SAMHSA's Center for Substance Abuse Treatment (CSAT) issued findings from a study in a white paper, *Benefits of Residential Substance Abuse Treatment for Pregnant and Parenting Women: Highlights from a Study of 50 Centers for Substance Abuse Treatment Demonstration Programs.*

The study evaluated Chrysalis House and 49 other CSAT-funded residential treatment programs designed specifically for substance-abusing women who were pregnant or the mothers of infants or young children. Just as Ms. Vicini suspected, the study found that such programs significantly improve the health of the women, their offspring, and the family unit itself.



An Innovative Model

Launched in 1993, the CSAT grant programs had a dual purpose: expanding women's access to long-term residential treatment and developing model programs that could provide a basis for evaluating such programs' effectiveness. The Pregnant and Postpartum Women's program offered 5 to 6 years of funding to projects serving substance-abusing women who were pregnant or mothers of children less than 1 year old; the Residential Women's and Children's program focused on treatment for women with older children.

Serving cities, rural areas, and Indian reservations around the country, the 50 CSAT-funded projects differed in their admission criteria, philosophies, and treatment approaches. All of them, however, shared several key features, including:

- Treatment services designed especially for women
- Culturally appropriate treatment
- Comprehensive services for the women, including substance abuse treatment, medical and mental health care, vocational training, parenting advice, legal assistance, transportation, and other support services
- Onsite residential care for the women's children
- Supervised parenting, and
- Comprehensive services for children, including prenatal and pediatric care, nurseries, and preschools.

Several aspects were considered major innovations when the programs were first launched, according to James M. Herrell, Ph.D., a co-author of the white paper and acting branch chief of CSAT's Treatment and Systems Improvement Branch.

"At the time this project was initiated back in the early 1990s," he said, "the idea of designing treatment programs just for women and letting women bring their children into treatment with them was relatively novel and daring."

In addition to the 50 projects, CSAT also funded a cross-site evaluation that assessed the projects' effectiveness. Between 1996 and 2001, the researchers collected data about providers' treatment approaches and clients' characteristics and outcomes.

Impressive Results

That cross-site evaluation proved that this innovative approach worked. In some cases, the approach not only worked but succeeded far beyond what anyone at CSAT anticipated.

For example, there was an 84-percent reduction in the risk of low birth weight among infants born to women in the programs compared to babies born to alcohol or drug abusers who hadn't received treatment.

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Similarly, there was a 70-percent risk reduction for premature delivery and a 67-percent risk reduction for infant mortality.

These rates are not only lower than those of untreated substance abusers, they are also lower than the rates reported for all American women. Premature delivery rates were 7 percent for the former substance abusers compared to 11 percent for all American women; low birth weight rates were 6 percent compared to 8 percent; and infant mortality rates were 0.4 percent compared to 0.7 percent nationwide.

The women's relationships with their older children also improved. The percentage of participants with physical custody of their children increased from 54 percent shortly before entering treatment to 75 percent 6 months after discharge. The number of participants with one or more children living in foster care dropped from 28 percent to 19 percent.

At the root of those family-related outcomes were significant reductions in alcohol and drug use. More than 60 percent of participants reported being completely alcohol- and drug-free during the 6 months following discharge. An additional 13 percent suffered relapses at some point after being discharged but claimed to be completely alcohol- and drug-free in the past month.

Paralleling that reduction in alcohol and drug use was a reduction in criminal activity. Only 7 percent of the participants were arrested for alcohol- or drug-related offenses, such as selling drugs, driving while intoxicated, or being publicly intoxicated, during the 6 months following discharge, compared to 28 percent in the year before entering treatment. The percentage of participants arrested for other crimes, such as shoplifting, burglary, prostitution, or assault, dropped from 32 percent to 11 percent.

The longer the women stayed in treatment, the more they improved. For example, 68 percent of the women who stayed in treatment longer than 3 months remained alcohol- and drug-free, compared to 48 percent of those who left within the first 3 months of treatment. Only 9 percent of women who stayed in treatment past the 3-month point were arrested, compared to 20 percent of those who left before then.

More important, staying in treatment for a reasonable amount of time helped almost everyone who participated in the programs.

"We went to a lot of trouble statistically to try to tease out things either at the client level or program level that would have had a differential effect. That means we looked to see if a particular type of treatment worked better for younger women versus older women or for African American women versus Caucasian women," explained Dr. Herrell. "What we found was that there weren't any major predictors of who would benefit.

"That's good news for program managers as well as participants," added Dr. Herrell. "It means program designers don't have to fine-tune programs to match every possible situation."

Although cost analyses are still ongoing, Dr. Herrell and others at CSAT are already convinced the programs can save states money.

"These programs indicate that substance abuse treatment can save taxpayers money that otherwise would be spent on other medical costs," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H.

Many of the states that hosted the CSAT-funded projects are also convinced that investing in treatment services will pay off. Take Kentucky, for example. Armed with evaluation data, staff from the Chrysalis House project persuaded the state legislature to provide funding that will allow the project to create a new 40-apartment complex for women in recovery.

"If I had told our legislators in Frankfurt the story about watching the women walking across the parking lot hand-in-hand with their children, those people couldn't care less," said Ms. Vicini. "If it hadn't been for the research data, we would not have been able to sustain the program."

The white paper on findings from the residential treatment programs study is available at **www.samhsa.gov.** See also companion article, *SAMHSA News,* p. 13.

—By Rebecca A. Clay

Pregnancy Outcomes

Outcome Rate per 100 Live Births

Outcome Measure	Untreated Substance Abusers (n varies)	All U.S. Women (n=3.8 million)	Client In-Treatment Deliveries (n=699)
Premature Deliveries	24.0*	11.4	7.3
Low Birth Weight	35.00**	7.5	5.7
Infant Death	1.2***	0.7	0.4

*N=2,837 from 12 recent hospital-based studies of outcomes for cocaine-using women
**N=9,737 from 10 recent hospital-based studies of outcomes for cocaine-using women
***N=10,816 previous pregnancies of clients, as reported at treatment admission

Center for Substance Abuse Treatment, ***SAMHSA***

Women and Children: The Faces Behind the Numbers

Homeless and addicted to heroin, Jackie entered the Matri-Ark program at Seabrook House in Seabrook, NJ, in 1995 after giving birth to an infant who tested positive for several drugs.

Jackie is just one of the 5,110 women served by residential treatment programs funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) and designed specifically for substance-abusing women who are pregnant or the mothers of infants or young children. Their stories underlie the statistics described in the CSAT white paper, *Benefits of Residential Substance Abuse Treatment for Pregnant and Parenting Women: Highlights from a Study of 50 Center for Substance Abuse Treatment Demonstration Programs.* (See *SAMHSA News,* p. 11.)

Jackie spent a year in the Matri-Ark project, a residential program that emphasizes reunifying mothers and their children. With the help of her counselors, she stopped using alcohol and drugs and addressed the emotional problems behind her addiction. She found safe housing and learned how to keep a budget and prepare nutritious meals.

"Our services are holistic. They address the medical, spiritual, emotional, vocational, and mental health needs of women and their children," explained Rebecca J. Taylor, N.C.A.C.–Level II, the former project director of the Matri-Ark program and now vice president of treatment services at Seabrook House. "We look at the whole family."

After several months of treatment, Jackie's sons joined her at Seabrook House and got treated right alongside her. They took advantage of the program's pediatric evaluations, early development services, and onsite day care.

By the time Jackie graduated from the program in 1996, she could see a big change not only in her own life but in that of her older son. "It's such a blessing that he's able to see a different mom these days and that he no longer has to live in fear," she said. "Now my children live in a house where there's no alcohol and no people running in and out. It's clean. They have food. It's totally different."

Today Jackie is a mother who attends parent-teacher association meetings and serves as team mom when her son plays sports. She's also a community life skills counselor, helping other clients at Seabrook House learn how to make the transition to a sober life.

The Matri-Ark program is also flourishing. In fact, the program was so successful that it received additional funding from CSAT and the state once its original CSAT grant ended in 1997. That money allowed the program to expand the number of women it serves, increase the age of

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children accepted into treatment, and provide additional services to children.

Vicki, a graduate of the Chrysalis House project in Lexington, KY, is another face behind the statistics.

Before Vicki landed at Chrysalis House, her life was a mess. Addicted to alcohol and drugs, she'd spent years bouncing in and out of prison and living on the streets. Pregnant, strung out on crack cocaine, and facing felony charges for drug dealing, she finally entered a residential treatment program. But when she reached the program's time limit almost 1 year later, she was still struggling.

Especially difficult was learning how to be a good parent to her two small children once child protective services returned them to her. Vicki's own mother had killed herself when Vicki was little, and her father had used alcohol to help him cope with the rigors of raising three children on his own. Lacking a role model, Vicki watched helplessly as her suicidal young son was repeatedly hospitalized.

"You have these dreams of how wonderful it's going to be when you get your kids back, but it's just not," said Vicki. "It's hard. Any alcoholic or addict with expectations that high and no strong foundation in recovery has a really good chance of falling back into old ways."

The CSAT-funded Satellite Apartment project at Chrysalis House was designed specifically to keep that from happening. The dozen apartments were home to women who had completed treatment and been reunited with their children. Although the women paid rent and lived independently, onsite counselors helped them learn basic parenting tasks, build trusting relationships with their children, and make the transition back to normal life. "Many of the women had never parented sober, so it was a whole new world for them," said Ginny Vicini, who served as project director for the program.

Vicki left the apartment in 1995. Two years later, she was back at Chrysalis House —this time as a member of the staff. Today Vicki is special projects coordinator at Chrysalis House, developing a new housing project for single women. Her daughter is a happy second grader and her son a tenth grader with good grades and dreams of law school. They live together in the house Vicki bought last year. "I'm living proof that treatment works," said Vicki.

For accounts of the programs from the perspective of the grantee staff, see the CSAT publication, *Telling Their Stories: Reflections of the 11 Original Grantees That Piloted Residential Treatment for Women and Children for CSAT.* To order, contact the National Clearinghouse for Alcohol and Drug Information at P.O. Box 4235, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Web access: **www.samhsa.gov.**

—By Rebecca A. Clay

Adolescent Admissions for Addiction Treatment Increase

The number of adolescents age 12 to 17 admitted to substance abuse treatment increased 20 percent between 1994 and 1999 according to the latest Treatment Episode Data Set (TEDS) report released this past winter by SAMHSA.

Admissions for marijuana use grew from 43 percent of adolescent admissions in 1994 to 60 percent in 1999. In 1999, about half (51 percent) of adolescent marijuana admissions were referred to treatment through the criminal justice system. Among all admissions to substance abuse treatment for marijuana in 1999, more than half (57 percent) first used marijuana by age 14, and 92 percent by age 18.

TEDS treatment admissions were dominated by four substances in 1999: alcohol (47 percent), opiates (16 percent, primarily heroin), cocaine (14 percent), and marijuana/hashish (14 percent). These four substances together accounted for 91 percent of admissions.

The 1999 TEDS report provides information on the characteristics of the approximately 1.6 million annual admissions to treatment for abuse of alcohol and drugs in facilities that report to their states. These facilities are licensed or certified by the state substance abuse agency to provide substance abuse treatment, and are required by the states to provide data.

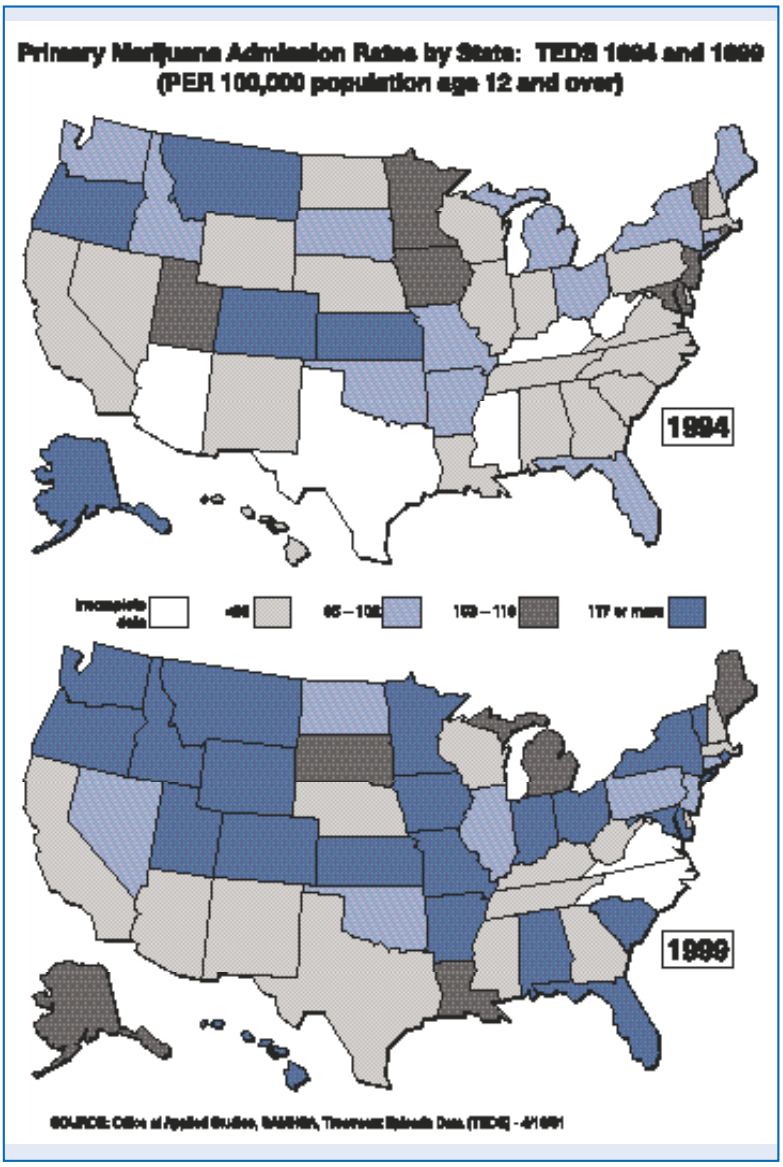
By providing information on changing geographic and demographic patterns in treatment admissions, TEDS reflects underlying trends in substance abuse with significant implications for program planning.

"Providing treatment for people in need is both compassionate public policy and a sound investment," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We need to ensure that the critical links are made at the community level among treatment providers, criminal justice, education, and social service systems. We also need to ensure that effective treatments—such as the tested and effective treatment models for

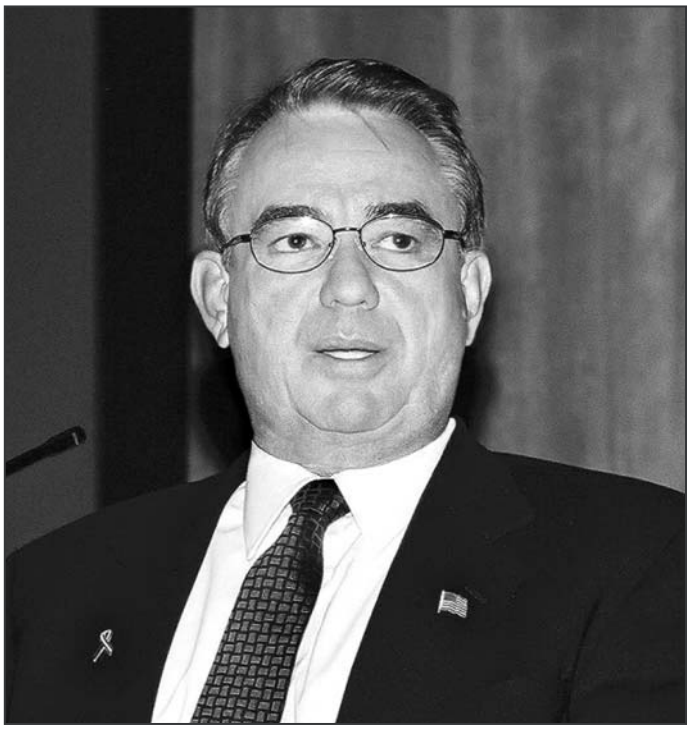
marijuana dependence developed by SAMHSA—are being used at the local level."

Additional key findings include:

- **Alcohol** admission rates generally were highest in the Pacific Northwest, North Central, and Northeast states. The rate for the United States as a whole declined by 19 percent between 1994 and 1999, from 418 per 100,000 age 12 and over to 337 per 100,000. This rate of decline was equaled or exceeded in 16 states (Colorado, Florida, Georgia, Illinois, Kansas, Louisiana, Michigan, Montana, Nebraska, New Jersey, New Mexico, North Dakota, Oklahoma, South Dakota, Tennessee, and Utah).
- **Heroin** admission rates were highest in the Pacific and Middle Atlantic states. The rate for the United States as a whole was stable over the period between 1994 and 1999. However, heroin admission rates increased between 1994 and 1999 by 100 percent or more in 15 states (Alabama, Delaware, the District of Columbia, Idaho, Indiana, Louisiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Rhode Island, Utah, Vermont, and Wisconsin).
- **Cocaine** admission rates were generally highest in the Middle Atlantic and some Southern states. Trends indicated stable or declining admission rates for cocaine abuse. Cocaine admission rates decreased from 1994 to 1999 by 25 percent or more in 18 states (Alaska, Colorado, Connecticut, Georgia, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Pennsylvania, and South Carolina).
- **Marijuana** treatment admission rates showed substantial increases across a large number of states. The U.S. admission rate for marijuana abuse increased from 69 per 100,000 persons age 12 and over in 1994 to 103 per 100,000 in 1999. In 13 states, 1999 rates were at least double the rates reported in 1994. (Alabama, Delaware, the District of Columbia, Hawaii, Idaho, Indiana, Iowa, Missouri, Nevada, Ohio, South Carolina, Washington, and Wyoming).
- Since 1994, **methamphetamine/amphetamine** admission rates increased, spreading east from the Pacific states into the Midwest and South. In 16 states, rates at least doubled between 1994 and 1999. (Alabama, Arkansas, Hawaii, Idaho, Indiana, Iowa, Minnesota, Missouri, Nebraska, New Hampshire, North Dakota, South Dakota, Tennessee, Utah, Washington, and Wyoming).



To obtain a copy of the *Treatment Episode Data Set (TEDS) 1994-1999* report, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847. Telephone: 1-800-729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The report can also be downloaded from the SAMHSA Web site at **www.samhsa.gov,** click on OAS.



U.S. Health and Human Services Secretary Tommy G. Thompson

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territories and two tribal organizations, as well as nearly 100 national public service, faith, and community organizations.

The summit's primary goal was to help the teams craft a state action plan for responding to future acts of terrorism. State teams were requested to submit their action plans as well as summaries of their technical assistance and training needs to HHS at the end of the summit. Participants also provided recommendations for all the HHS agencies in a listening session at the conclusion of the meeting.

In addition to the time set aside for development of the plans, conference sessions included first-person accounts from survivors and first responders to acts of terrorism including the September 11 attacks, the 1995 Oklahoma City bombing, and the 1988 explosion of Pan Am flight 103; disaster-response lessons shared by state mental health and substance abuse officials; presentations on the threat of bioterrorism; discussions of the unique needs of children and adolescents; the contributions of faith-based organizations; and the need for data, research, and evaluation in connection with disaster readiness and response.

Calling HHS the "Department of Compassion," Secretary Thompson told attendees that mental health and substance abuse support must become an integral part of emergency response at every level. "This is a battle against fear," he said. "Life in America is going forward, and that is the ultimate repudiation of terrorism."

SAMHSA Administrator Charles G. Curie

Recovery

When terrorism strikes, it's natural to focus first on those who have been physically injured or killed. But large-scale attacks produce more psychological casualties than physical ones, some of the conference presenters observed.

According to Robert E. DeMartino, M.D., associate director for the Program in Trauma and Terrorism within SAMHSA's Center for Mental Health Services (CMHS), the ratio of behavioral to physical casualties following a mass biological attack, in a best-case scenario, could be as low as 4 to 1. In a worst-case scenario, it could jump to as much as 10 to 1, he said.

The shocking events of September 11 had an especially profound effect. In a RAND Corporation survey in the days following the attack, 44 percent of American adults reported substantial symptoms of stress, and 9 out of 10 had some degree of stress reactions. More than one-third of children age 5 and older had stress symptoms and almost half said they worried about their safety or that of their families.[1]

First Responders

Six years after the 1995 Murrah Building bombing, a mental health program for first responders in Oklahoma City is still funding services for more than 50 clients, according to Lawrence Johnson, M.A., senior deputy chief of police in Oklahoma City in 1995 and now chief of police in Little Rock, AR.

Trained to cope with fear and stress and to act effectively in emergencies, rescue workers are more familiar with danger and loss of life than many. Yet, while the public holds them up as heroes, those who respond first to disaster are among the most vulnerable to emotional and substance abuse disorders.

1. Schuster, M.A. & Others at RAND. (2001) A National Survey of Stress Reactions after the September 11, 2001, Terrorist Attacks. *New England Journal of Medicine.* Vol. 345, No. 20, 1507-1512.

"We are just people," Chief Johnson reminded conference participants. "We feel like everyone else." For rescue workers, exposure to the gruesome or grotesque aspects of a disaster can have long-term emotional consequences.

After the Murrah Building bombing, Oklahoma City's fire fighters saw a 300-percent increase in their divorce rate, and five of the city's rescue workers committed suicide after the event, according to Chief Johnson.

Mental Health

In a culture ambivalent about violence and focused on immediate gratification, Americans often have unrealistic expectations of how long healing will take and what their Government, leaders, and individuals can do to help, Brian Flynn, Ed.D., of CMHS told conference participants.

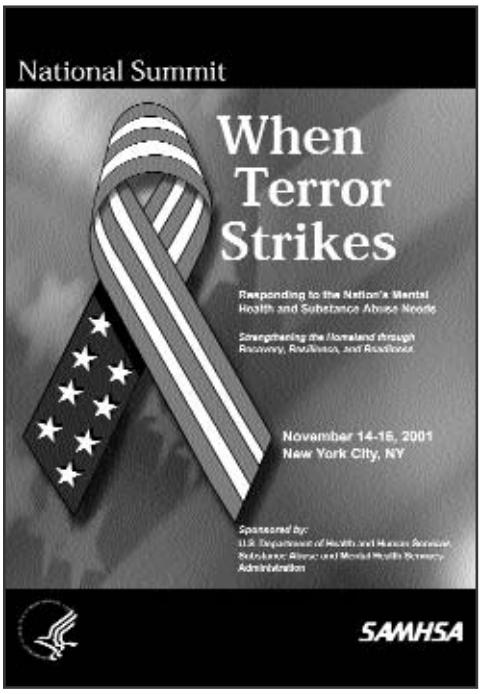
Public health models for disaster response and recovery provide opportunities to reinvent community mental health, according to Dr. Flynn. But with an enemy whose goal is to terrorize the whole country, he believes the Nation needs a new public health model that deals quickly with localized events while reaching out to the whole population and monitoring the potential spread of such threats as bioterrorism. "Anthrax isn't contagious. Fear is!" Dr. Flynn emphasized.

Despite the imperative to focus on all the victims of terror, both direct and indirect, it's just as important not to assume mental disorder where it doesn't exist, or "overpathologize," said Dr. Flynn. "While there is a huge need for healing after a terrorist attack, the greater story is resilience, hope, and health."

Meredith Alden, M.D., Ph.D., director of residency training in the Department of Psychiatry at the University of Utah and a SAMHSA National Advisory Council member, pointed out that in addition to the post-traumatic stress disorder resulting from terrorist acts, "substance abuse is very often an outcome of that also." She recommended "increasing service capacity for people with both substance abuse and mental illness."

Resilience

In the face of terrorism and possible threats of more to come, Americans have found unexpected sources of resilience, especially in their communities, their faiths, and their families.



Community

For all the stresses on emergency workers, the support of community is essential to their resilience.

"No one puts out a fire by himself. People work in teams. They take care of each other," said Malachy Corrigan, director of the New York Fire Department's Counseling Unit. The fire department not only serves the community, it is its own community.

With 343 of their own lost in the World Trade Center disaster, firefighters reached out with characteristic compassion to survivors in 61 firehouses who lost colleagues, 800 children who lost fathers, and 270 women whose husbands and significant others died in the attack. Today, fire department counselors work with surviving spouses, parents, and siblings at several locations around the city.

In the close-knit family culture of firefighters, many emotional issues are worked out around the kitchen table in the firehouse, where members spend much of their time. The department is sending nearly 30 counselors to the firehouses to offer bereavement sessions and private counseling.

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Captain Susanne Caviness, Ph.D., of SAMHSA's Center for Substance Abuse Treatment, provided behavioral health trauma services at the former World Trade Center site following the September 11 attacks. "Leaving the site after one of my 12-hour shifts," she said, "I saw 30 to 40 dump trucks lined up to come in and remove the twisted metal that had been taken down. Eventually, the metal may be gone, but the scars will remain."

Dr. Robert Pynoos

Dr. Meredith Alden

Dr. Brian Flynn

Eileen Monetti

Dr. Robert DeMartino

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"There was a great public outpouring of support for firefighters after 9-11," Mr. Corrigan said. "So firehouses uncharacteristically kept their doors open. They didn't want to close people out, but they needed to be grieving. Eventually, we had to tell them to close the door and go back to the kitchen. They needed the rituals and support of the firehouse family," and the resilience it provides day in and day out.

Faith

For faith communities, kindness encompasses both a spiritual and material response to crisis. Mickey Caison, director of the Disaster Response for the North American Mission Board within the Southern Baptist Convention, spoke of the church's partnership with the American Red Cross and the Salvation Army to provide more than 500,000 meals in lower Manhattan after the 9-11 attack.

At the same time, chaplains providing pastoral care met both profound human needs and unexpected challenges, such as limited access to Ground Zero and lack of training and experience with disaster relief.

"We need a national standard for training disaster-relief chaplains, perhaps based on the military chaplain model," Mr. Caison suggested.

In addition, he said that in the next 2 years, New York should expect high attrition in local clergy, as with other first responders, and that spiritual and emotional intervention is needed for these caregivers.

Family

When Pan Am Flight 103 exploded over Lockerbie, Scotland, in 1988, Eileen Monetti's world changed forever. Her 20-year-old son Rick, on his way home from a semester abroad, lost his life in the crash, along with 269 others.

Ms. Monetti said that she and her husband turned to other surviving families for help in the difficult days and years ahead. "The group has been vital emotional support all the way through the trial last March of Libyan nationals accused of this act of terror," she said. "Most families are strong. People are basically healed, but we will never be the same."

While acknowledging the vital role of Federal agencies in helping families, she felt the Government in 1988 was unprepared to support the terrorist victims' families adequately. When disaster strikes, "first impressions of Government are lasting," she said. "Victims of terrorism and their survivors need special care. Their needs are real and longstanding, and subsequent political and terrorist events deeply affect their mental health."

Ms. Monetti now works with surviving families of World Trade Center attack victims.

Helping parents cope with the consequences of disaster, from losing a loved one to losing a job, can directly affect their children's mental health, Assistant Surgeon General Susan J. Blumenthal, M.D., M.P.A., pointed out. Fostering resiliency in young people is one of the most important challenges our country now faces, she said.

"For children, parental demoralization is the real issue of living under danger," said Robert Pynoos, M.D., professor of Psychiatry at the University of California at Los Angeles and director of the National Center for Child Traumatic Stress. When a family's sense of safety is threatened, children need extra closeness from parents who are likely to be preoccupied and irritable, he explained.

Successful treatment for children affected by a disaster may include such simple tasks as remembering to take a child's hand when walking by the scene of the trauma. In treatment, young children may also be helped by replaying the event in a "time machine" to manipulate the outcome. In doing so, the child can "move closer to speaking about what it would be like to have a loved one back with them and get help with feelings of loss," Dr. Pynoos said.

Readiness

Readiness for future attacks demands continuous planning for the unimaginable. The anthrax attacks following 9-11 highlighted the challenges of preparing for a new kind of warfare that includes biological and chemical attacks. What lessons from past disasters can help guide future emergency planning?

- **"We don't know what we don't know."** This is the first thing to remember when a strike occurs, according to Stephen

Mayberg, Ph.D., director of the California Department of Mental Health. Every disaster is unique, he said, whether it is natural or man-made. Experience with earthquakes has taught that even with the best preparation, responders should be prepared for some chaos and uncertainty. "There's a lot you figure out as you go along," he said.

- **Don't expect things to work.** Dr. Mayberg added that in a physical disaster, responders should anticipate the failure of vital services such as phones and electricity and have backup plans.
- **Bioterrorist events are different from natural disasters.** They're less predictable and more drawn out; losses are human, not material; and while the "worst it can get" tends to be obvious in a fire or flood, the low point is less clear when the agent of disaster is biological, according to Dr. DeMartino. Not knowing when to expect things to improve heightens stress. These factors intensify feelings of loss of control and can reduce public confidence in the agencies designated to protect against and deal with disaster.
- **Preparation itself is stressful.** This is especially true when the threats are insidious. When the onset of an attack is invisible, as it is with anthrax, or the agents are easily obtainable, as are many chemical agents, new worries complicate the preparations for a possible attack.
- **Identifying victims of bioterrorism is challenging.** Minor symptoms of other illnesses like the flu may initially mirror those of a biological attack. Emergency plans should include preparing for rapid identification of potentially dispersed casualties.
- **Biological and chemical attacks call on a different set of first responders.** In the early hours and days of a biological or chemical attack, first responders typically are not police and firefighters, according to Martha B. Knisely, M.A., District of Columbia Mental Health director. Based on her recent experience dealing with the anthrax crisis in the Nation's capital, she told listeners that "our first responders were lab technicians, mental health workers, public health workers, pharmacists, and physicians." Emergency planning needs to include these professionals.
- **Government can help.** In an emergency, Government agencies provide consistency, structure, reassurance, and authority, Dr. Mayberg has found. "When you rush in to help, you need legitimate identification and a defined role," he said.
- **Communications are critical.** Officials can help the public manage fear by describing threats clearly and accurately, outlining what is being done and what the public can do, and promoting realistic expectations of public agencies, Dr. DeMartino explained.
- **Plan for a marathon.** As with all emergency responders, mental health and substance abuse workers should pace themselves for the long haul when terrorism strikes, Dr. Mayberg counseled. "Compassion fatigue" and burnout are common among crisis workers.
- **Build on the current knowledge base for the future.** Paul Puccio, of the New York State Office of Alcoholism and Substance Abuse Services, spoke for many participants when he said, "This conference was tremendous in terms of giving us a framework we can build upon. But I suspect that most of the state teams . . . came away with the understanding that we need to learn a lot more and develop a lot more."

Based on feedback from the summit, SAMHSA will assess and respond to states' requests for technical assistance and will hold a series of regional meetings to follow up on state plans.

"Many of the words we've heard over these days remind us why we do what we do," Mr. Curie told the conference. "They help us move forward along these unmarked roadways since September 11, so we can be prepared to help others. How we act—not just react—in the coming weeks and months will help millions of our fellow Americans who are struggling with the new definition of normal."

—By Jane Tully

Captain Carol Coley, M.S., of SAMHSA's Center for Substance Abuse Treatment, provided behavioral health trauma services at the former World Trade Center site. "I have returned home a different person, a stronger person," she said. "I have a reinforced view of the kindness and dedication that can be exhibited by others in times of crisis. Regrettably, I also have a vision seared into my brain of the horror that can be created by a few terrorists."

Accrediting Organizations Chosen for Methadone Treatment Programs

SAMHSA selected four organizations this past fall to accredit substance abuse treatment programs that use methadone and other medications to treat heroin and similar addictions. The four organizations are the Commission on Accreditation of Rehabilitation Facilities, the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation for Children and Family Services, and the State of Washington Department of Social and Health Services Division of Alcohol and Substance Abuse.

"Accreditation of methadone treatment programs is a fundamental shift in the way we approach drug abuse treatment in our Nation."

—Charles G. Curie, M.A., A.C.S.W. SAMHSA Administrator

The selection is part of an ongoing SAMHSA initiative to improve the quality and oversight of opioid treatment programs that use methadone or Levo-Alpha-Acetyl-Methadol (LAAM). Accreditation, proven over the years to produce effective outcomes in other parts of the health care industry, is a widely adopted external quality assessment system used by the Federal Government, states, managed care firms, insurers, and others to ensure accountability for quality treatment.

The move to accreditation followed recommendations made by a 1997 consensus panel at the National Institutes of Health. The panel concluded that existing Federal and state regulations limit the ability of physicians and other health care professionals to provide methadone maintenance services to patients and recommended accreditation in lieu of regulations to improve the quality of care. The changes are also consistent with a 1995 report by the Institute of Medicine that stressed the need to readjust the balance among regulations, clinical practice guidelines, and quality assurance systems. The accreditation process replaced a 30-year-old inspection program conducted by the Food and Drug Administration (FDA). Accreditation organizations will apply specific opioid treatment standards as part of their reviews.

Opioid treatment programs were required to apply for certification to one of the four accreditation organizations by March 4. Treatment programs previously approved by FDA will have until May 19, 2003, to complete the accreditation process.

"Accreditation of methadone treatment programs is a fundamental shift in the way we approach drug abuse treatment in our Nation," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Accreditation can help reduce stigma and discrimination by moving drug abuse treatment into mainstream medicine. Physicians and other health care professionals will make decisions based on standards that emphasize the best care for patients—just like treatment for other diseases."

H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT), pointed out that "as a benchmark of quality, accreditation indicates that an organization meets certain critical performance standards. This should enhance community confidence in opioid treatment and enhance the ability of treatment programs to access managed care contracts."

"This should enhance the ability of treatment programs to access managed care contracts."

—H. Westley Clark, M.D., J.D, M.P.H. CSAT Director

CSAT, which oversees the accreditation program, is providing technical assistance to opioid treatment programs to help them meet the accreditation standards of the organization they have selected. Questions about technical assistance should be directed to 1 (800) 839-6120. Questions about Federal regulations or the Federal certification program should be directed to 1 (866) 463-6687. Questions about the accreditation process should be directed to the accreditation organization chosen by the opioid treatment program.

Ending Homelessness: Conference Emphasizes Solutions

About 20 percent of homeless people spend more than 2 or 3 weeks on the streets, according to the SAMHSA-funded National Resource Center on Homelessness and Mental Illness. Although the lack of affordable housing obviously plays a key role in chronic homelessness, so do mental illness and substance abuse.

Approximately 800 service providers, consumers of mental health and substance abuse treatment services, and policymakers gathered in Washington, DC, in December to learn more about serving this vulnerable population. Hosted by SAMHSA's Center for Mental Health Services (CMHS), the conference was cosponsored by all three SAMHSA Centers, the Health Resources and Services Administration's Bureau of Primary Health Care, the U.S. Department of Veterans Affairs, and several nonprofit organizations. "We Can Do This! Ending Homelessness for People with Mental Illnesses and/or Substance Use Disorders" was the first national training conference of its kind. In addition to tours of local programs, the conference featured workshops on topics such as mental health and substance abuse treatment services, supportive housing, Federal initiatives, and advocacy efforts. A special preconference institute offered participants training in "Homelessness 101: At the Nexus of Mental Illness and Substance Use Disorders."

"For too many years, too many people considered homelessness the result of individuals' character flaws rather than treatable illnesses going untreated," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., in welcoming the participants. "I'm gratified to see the tremendous response to this conference. It tells me that people are really committed to doing something about homelessness."

Sister Mary Scullion, M.S.W., of Project HOME in Philadelphia, delivered the keynote address. She noted that the field had made remarkable progress over the last 25 years. For example, CMHS has identified effective strategies for integrating homeless people back into the mainstream. Grassroots activists have built housing, lobbied Congress, and won courtroom battles against discrimination. And homeless people themselves have left the streets and become productive members of society in jobs such as nurses, teachers, administrators, and organizers.

Sister Mary Scullion

Three key elements remain in the fight against homelessness, said Sister Mary. First, there's an urgent need for affordable housing. Providing services to people with mental illness living on the streets costs just as much as providing them with supportive housing, she said, citing a recent study by Dennis P. Culhane, Ph.D., of the University of Pennsylvania. Providing such housing also has a positive effect on everything from residents' employment prospects to neighborhood safety.

Second, all levels of government need to address the problem of discrimination in health care and housing. Third, the Nation must commit to ending poverty.

"We will never end homelessness unless we really struggle to end its root cause," said Sister Mary. "That is poverty." To achieve these goals, she added, activists will have to expand their coalitions, engage the media, educate policymakers and the public, and combat apathy.

Luncheon speaker Nan Roman, M.S., president of the National Alliance to End Homelessness, said that current approaches to ending homelessness aren't working. She noted that the number of homeless people has actually been increasing along with the amount of money spent on serving them.

In response, the Alliance has developed a plan for ending homelessness within the next decade. The Alliance wants to "close the front door" into the homeless assistance system and stop prisons, hospitals, and other institutions from discharging people into shelters. The Alliance also wants to "open the back door" by getting homeless people the affordable housing and higher incomes they need to get off the streets. In the meantime, the goal is to create 200,000 units of permanent, supportive housing across the Nation—a challenge that will require obtaining more public support, enhancing the capacity of nonprofit and community development organizations, and using incentives to get the private sector involved.

"Ending homelessness is a doable proposition," Ms. Roman said. "We can turn the tide."

—By Rebecca A. Clay

Curie Articulates SAMHSA Priorities

Editor's Note: *In recent testimony before the U.S. House of Representatives Appropriations Subcommittee on Labor/Health and Human Services/Education, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., who assumed leadership of the Agency this fall, articulated a vision for the future that reinforces SAMHSA's focus on mental health and substance abuse services and highlights the translation of scientific advances to community practice.* SAMHSA News *excerpts his testimony. For more information on President George W. Bush's New Freedom Initiative, please see* SAMHSA News, *fall 2001.*

In the short time since November that I have spent as Administrator, I've had a chance to begin to learn about SAMHSA's internal activities and external relationships with state and local governments; consumers of services for mental and addictive disorders; families; service providers; professional organizations; our colleagues in the Departments of Health and Human Services (HHS), Education, and Justice; the Office of National Drug Control Policy; and Congress.

At SAMHSA, I have found a staff dedicated to achieving the vision of providing people of all ages with or at risk for addictive disease and/or mental disorders the opportunity for recovery and a fulfilling life that includes a job, a decent place to live, family support, and meaningful relationships.

Ours is a shared vision of hope and recovery focused on providing individuals an opportunity for a meaningful life in their community. To provide focus for our activities, we have identified a matrix of investment priorities and cross-cutting principles.

Among our investment priorities is the Bush Administration's New Freedom Initiative. Its focus on providing community-based alternatives for people with mental illnesses is central to SAMHSA's overall vision.

Also, within the context of the New Freedom Initiative is the forthcoming President's Mental Health Commission. The commission will provide an action plan for investing and coordinating Federal, state, and local resources to serve people with serious mental illnesses and children with serious emotional disturbances.

SAMHSA Administrator Charles G. Curie

Another priority for change is eliminating the abuse of seclusion and restraint. After all, the use of this practice represents a failure of our treatment system.

The President and HHS Secretary Tommy G. Thompson also have expressed their commitment to reducing drug use, building treatment capacity, and increasing access to services that promote recovery and help people rebuild their lives. The President has proposed an increase of $127 million in our budget to help states and local communities to provide increased access to treatment services.

SAMHSA's National Household Survey on Drug Abuse found that in 2000 approximately 381,000 people recognized their need for drug treatment. A total of 129,000 of these people reported that they had made an effort but were unable to get treatment. The other 252,000 reported making no effort at all. We are working with the Office of National Drug Control Policy and the states to implement a plan to reach out and bring these people into quality addiction treatment services.

The President's National Drug Control Policy calls for a 25-percent reduction in current use of illegal drugs by young people age 12 to 17 within 5 years. It also calls for a similar 25-percent reduction in current use of illegal drugs by adults age 18 and older in the same timeframe. These outcome goals, being tracked by SAMHSA's National Household Survey, are the guideposts for our prevention and early intervention efforts.

The recently released evaluation findings from SAMHSA's High-Risk Youth demonstration grant program found an overall decrease of 25 percent in the frequency of substance use among program participants. These new data add to the growing evidence that prevention can work.

To support the delivery of effective substance abuse prevention services at the community level, SAMHSA proposes to expand its State Incentive Grant Program for Community-based Action. Already, this grant program has promoted the development of state/citywide strategies to make optimal use of science-based prevention resources by the governors in 39 states and Puerto Rico, and the mayor of the District of Columbia. In Fiscal Year 2002, the State Incentive Grant program is providing resources to approximately 2,700 community-based and faith-based organizations, community antidrug partnerships and coalitions, local governments, schools, and school districts.

Most are implementing science-based substance abuse prevention strategies, many of which have been evaluated and endorsed by SAMHSA as effective models. On average, these model prevention programs, listed in our National Registry of Effective Prevention Programs, produce a 25-percent reduction in substance use by program participants.

Another priority includes working with the criminal justice system. Too often, jails and prisons are substituting for community-

based care for far too many people with mental illness and drug problems.

Reentry and diversion programs need to encompass not only treatment, but also housing, vocational and employment services, and long-term support. Only when we address the issues of mental illness and addiction will the revolving door between prison and life in the community stop spinning.

Some of these very same issues explain why reducing homelessness is on our list of priorities. We know that many of the people who are homeless and have mental and/or addictive disorders have similar needs for treatment and long-term support.

SAMHSA also has a critical leadership role to play in addressing the needs of people with co-occurring mental and addictive disorders. A large number of people who are in our substance abuse or mental health systems have co-occurring disorders. Too often, they get care for one or the other disorder but don't get care for both.

That's not just bad health policy, it's bad economic policy, too. We could serve more people if we spent that money more wisely in the first place.

People with HIV/AIDS who abuse substances or live with mental illness have another kind of co-occurring illness that remains high on our list of priorities. Our efforts will continue to grow in the area of HIV/AIDS.

Finally, the terrorist attacks of September 11 put a new public spotlight on mental health and substance abuse. Under the direction of Secretary Thompson, SAMHSA convened a national summit within 8 weeks of the attacks with representatives from 42 states, the District of Columbia, five U.S. territories, two Native American tribes, and 100 national public service, faith, and community and membership organizations.

We convened to examine and enhance the local, state, and Federal roles in addressing the mental health and substance abuse needs of individuals and communities before, during, and after acts and threats of terrorism. (See *SAMHSA News,* p. 1.)

SAMHSA Priorities: Programs and Principles Matrix[1]	Programs[2]											
Cross-Cutting Principles												
Evidence-Based/Data/Outcomes												
Collaboration												
Resiliency/Well-Being												
Culturally Competent												
Health Care Disparities												
Geographic Diversity												
Community and Faith-Based												
Violence (e.g., physical and sexual abuse)												
Planning and Cost-Effectiveness												
Private Sector Partnerships												
Other:_____												

1. The designation of these priorities applies to all resource allocations, including grants and contracts. SAMHSA must balance attention to these priorities while maintaining a response capacity to existing and emerging issues. Note that this is not intended to be an exhaustive list of those issues considered important, but rather it presents a graphical depiction that illustrates the need to intersect programs and principles.
2. All SAMHSA priority programs and issues align with Health and Human Services Departmental priorities. (SAMHSA's seclusion and restraint priority falls under the Department's patient safety concerns.)

The President's 2003 request continues SAMHSA's involvement by proposing to support activities focused on post traumatic stress disorders, the mental health needs of first responders, and preparation for potential future bioterrorism emergencies.

To ensure that all SAMHSA programs are science-based, results-oriented, and aligned with with both SAMHSA and HHS missions, we have initiated a strategic planning process that will guide our decision-making in planning, policy, communications, budget, and programs. The process is evolving around three core themes: Accountability, Capacity, and Effectiveness—in short, ACE!

Even before that plan is set in place, we have already taken steps to expand our partnership with the National Institutes of Health (NIH) to produce a comprehensive "Science to Services" agenda that is responsive to the needs of the field.

We have initiated a dialogue and found a common commitment to this agenda. Over the next year, we will be working together to define and develop a "Science to Services" cycle that reduces the time between the discovery of an effective treatment or intervention and its adoption as part of community-based care. Today, the Institute of Medicine tells us it can take up to 20 years. With the near doubling of the NIH budget driving even more clinical research and development, that gap may grow still greater unless a fundamental change occurs in how scientific advances are incorporated into community care.

Our matrix of program priorities and cross-cutting principles, our strategic planning process, and our commitment to speeding research findings to community-based care will allow us to see real progress in the outcomes we seek.

The ultimate measure of our effectiveness will be gauged by our ability to provide people of all ages with mental and addictive disorders an opportunity to realize the dream of equal access to full participation in American society.

2003 Budget Targets Substance Abuse Treatment Gap

President George W. Bush's proposed budget for SAMHSA in Fiscal Year (FY) 2003 totals $3.2 billion, a net increase of $57 million, or 2 percent, over the FY 2002 enacted level. The SAMHSA budget focuses on narrowing the substance abuse treatment gap and maintaining mental health services.

Reducing the Drug Treatment Gap

In an effort to reduce the treatment gap, an increase of $127 million has been included to fund the President's Drug Treatment initiative. In total, SAMHSA's budget proposes $2.3 billion for substance abuse treatment and prevention activities. These additional funds will allow states and local communities to provide treatment services to approximately 546,000 individuals, an increase of 52,000 over FY 2002.

Nationwide, there continues to be a great need to expand the capacity to treat individuals who use and are addicted to illegal drugs. The drug treatment gap revolves around three issues: accessibility, affordability, and availability.

The Office of National Drug Control Policy estimates that as many as 5 million Americans are in need of drug abuse treatment services. However, fewer than half actually receive services, leaving a treatment gap of 3.9 million individuals.

SAMHSA's National Household Survey on Drug Abuse from the year 2000 estimates that 14 million Americans used an illicit drug in the past month. Further, 9.7 percent of youth age 12 to17 reported illicit drug use in the past month. Marijuana is the most commonly used illicit drug; it is used by 76 percent of current illicit drug users. In 2000, an estimated 6.5 million persons had tried the drug Ecstasy at least once in their lifetime. This represents an increase of 1.4 million individuals over the estimated 5.1 million users in 1999.

A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, an increase of $60 million over FY 2002. The SAPT Block Grant is the cornerstone of state substance abuse programs, providing support for over 10,500 community-based treatment and prevention organizations.

Overall, substance abuse prevention will be reduced by $45 million, and greater emphasis will be placed on providing treatment services.

In the past several years, many SAMHSA-sponsored projects have proven to be successful in providing effective treatment services. For example, a program for youth and families in St. Petersburg, FL, reported that within 6 months of intake into treatment the percentage of adolescents with no past-month drug use increased from 4 percent to 34 percent.

The SAMHSA budget focuses on narrowing the substance abuse treatment gap and maintaining mental health services.

The budget also includes an increase of $67 million to support programs that provide direct substance abuse treatment services. In FY 2003, SAMHSA will begin a new $50 million program for approximately 12 states within the targeted capacity expansion authority. Funds would be allocated to states based on their commitment to performance goals and relative need. The results of the National Household Survey would measure state performance. SAMHSA will also consider factors such as states leveraging other funds, and the efficiency and effectiveness of a state's treatment system. This program would require a commitment to achieving performance goals.

Another success story is an HIV Substance Abuse program in Wilmington, DE. The goal of this program is to provide a comprehensive array of substance abuse, mental health, and HIV educational and medical services to drug dependent women in Wilmington. Of those women in treatment for 12 months or longer, 75 percent of clients were found to remain drug-free.

Mental Health

The budget includes $832 million for mental health activities, which maintains the FY 2002 funding level. Mental health activities will continue to work to improve service quality and expand capacity.

Included is $10 million to assist states in developing solutions to mental health problems from bioterrorism and other traumatic events.

Of this amount, $47 million is for the Projects for Assistance in Transition from Homelessness (PATH) program. This is a $7 million increase over FY 2002. These funds will allow SAMHSA to reach out to 163,000 homeless individuals in an effort to get them off the streets and into mental health and substance abuse treatment services as well as into adequate housing.

Included in the President's request is $10 million to assist states and local organizations in developing solutions to the mental health problems that result from bioterrorism and other traumatic events.

In FY 2003, SAMHSA will support the President's New Freedom Commission on Mental Health. This commission will study and make recommendations for the mental health delivery system, including recommendations on the availability and delivery of new treatments and technologies for people with severe mental illness. The budget also reduces funding for Programs of Regional and National Significance by $7 million.

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

Program/Activity	FY 2001 Enacted	FY 2002 Current Estimate	FY 2003 President's Budget	Increase/ Decrease from 2002
Programs of Regional and National Significance:				
Mental Health	$203,390	$229,918	$223,067	-$6,851
Substance Abuse Prevention	174,919	198,011	152,815	-45,196
Substance Abuse Treatment	255,985	291,383	357,994	+66,611
Total, PRNS	**634,294**	**719,312**	**733,876**	**+14,564**
Children's Mental Health Services	**91,645**	**96,631**	**96,694**	**+63**
Protection & Advocacy Program	**30,000**	**32,500**	**32,500**	**—**
PATH Formula Grant	**36,855**	**39,855**	**46,855**	**+7,000**
Mental Health Block Grant	**420,000**	**433,000**	**433,000**	**—**
Substance Abuse Block Grant	**1,665,000**	**1,725,000**	**1,785,000**	**+60,000**
Buildings & Facilities 1/	**6,500**	**—**	**—**	**—**
Program Management	**81,784**	**94,253**	**79,779**	**-14,474**
Emergency Response & Recovery Funds	**28,000**	**10,000**	**—**	**-10,000**
TOTAL, SAMHSA Program Level	**$2,994,078**	**$3,150,551**	**$3,207,704**	**+$57,153**
Less Emergency Response & Recovery Funds 2/	-28,000	-10,000	-10,000	—
TOTAL, SAMHSA Discretionary Budget	**$2,966,078**	**$3,140,551**	**$3,197,704**	**+$57,153**

1/ Funding included in the FY 2001 Supplemental Appropriation, Public Law 107-20.
2/ Emergency Response Fund amounts allocated to SAMHSA in FY 2001 and FY 2002 and proposed for FY 2003.

Data Collection

In FY 2003, SAMHSA will continue to engage in an extensive national data collection effort to evaluate both the prevalence of drug addictions and the effectiveness of efforts to treat or prevent these problems. A total of $107 million in FY 2003 will be directed to a wide variety of national surveys and data efforts.

Of this amount, $11 million is included for the National Treatment Outcomes Monitoring System (NTOMS). This is an increase of $6 million over FY 2002. These funds will be used to continue the collection of data on an ongoing basis and provide drug treatment providers nationwide with a source of information needed to identify changes in drug facilities. The purpose of NTOMS is to provide on a continuous basis the information needed to identify change in drug abuse treatment outcomes.

In addition to NTOMS, there are three SAMHSA surveys that serve as the major sources of information to Federal and state officials in their efforts to fight substance abuse:

- National Household Survey on Drug Abuse
- Drug Abuse Warning Network
- Drug and Alcohol Services Information System.

Program Management

The FY 2003 budget reflects the Bush Administration's interest in restructuring and "delayering" the Federal workforce. The budget includes $80 million for program management, a decrease of $15 million over FY 2002.

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.

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- ❑ Summit Promotes Mental Health in the Workplace
- ❑ Employment: A Workable Option Despite Mental Illness
- ❑ On the Web: Prevention Guidance Update
- ❑ Putting PreventionDSS to Work
- ❑ Women and Children: Treatment Improves Health
- ❑ Women and Children: The Faces Behind the Numbers
- ❑ Adolescent Admissions for Addiction Treatment Increase
- ❑ Accrediting Organizations Chosen for Methadone Treatment Programs
- ❑ Ending Homelessness: Conference Emphasizes Solutions
- ❑ Curie Articulates SAMHSA Priorities
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Phone: (301) 443-8956
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E-mail: *dgoodman@samhsa.gov*

Thank you for your comments.

On the Web: Statistics in Short Format

SAMHSA's Web site is making short reports available on substance abuse-related topics such as alcohol-use trends among young adults, availability of drugs to female teenagers, and what young people believe about the risks of using drugs.

The Web documents are designed to extract information and data from lengthy reports, supply answers that address specific concerns and groups—such as youth or pregnant women—and make the data more readily accessible, readable, and easier to understand.

Presented in fact sheet format, the material is derived from key substance use information sources such SAMHSA's National Household Survey on Drug Abuse, which provides annual estimates of the prevalence of illicit drug, alcohol, and tobacco use in the United States and monitors trends in use over time.

Another valuable information source, the Drug Abuse Warning Network, captures information about emergency department visits that are induced by or related to the use of an illegal drug or the nonmedical use of a legal drug.

In addition, the Drug and Alcohol Information System provides data on services available for addiction treatment and the characteristics of people admitted to treatment.

The online short reports, a service of SAMHSA's Office of Applied Studies (OAS), are targeted to health professionals; health care prevention and treatment providers; public health program administrators, researchers, and educators; and members of the press and media interested in obtaining more specific and targeted information, statistics, and data on substance use and abuse. New reports are posted weekly, and all contain links enabling users to access the more comprehensive versions.

Each short report begins with a two- to three-bullet summary of the most salient findings, followed by an introduction to the topic, a series of brief paragraphs highlighting specific statistics, and downloadable charts and tables.

Titles are listed by topic areas, including Youth; Risky Behaviors and Violence; Treatment; American Indians, Alaska Natives, and Other Racial and Ethnic Groups; Alcohol and Tobacco; Marijuana; Heroin; Club Drugs, Cocaine, and Other Specific Drugs; Polydrug Use; Women, Pregnancy, and Other Topics on Women; and Attitudes and Perceptions About Drug Use.

Selected titles include *Club Drugs; Polydrug Use Among Treatment Admissions; Youth Who Carry Handguns; Beliefs Among Youths About Risks from Illicit Drug Use; Obtaining Marijuana Easy for Youths; How Men and Women Enter Substance Abuse Treatment; Women in Substance Abuse Treatment; Tobacco and Alcohol Use Among Pregnant Women; Pregnancy and Illicit Drug Use; Older Adults in Substance Abuse Treatment;* and *Growth of Managed Care in Substance Abuse Treatment.*

To access the reports, visit **www.samhsa.gov/oas/facts.cfm.**

The findings are also available in printed form by contacting the Publications and Data Dissemination Team, OAS/SAMHSA, Parklawn Building, Suite 16-105, 5600 Fishers Lane, Rockville, MD 20857. Telephone: (301) 443-6239.

—By Brian Campbell

SAMHSA News

Substance Abuse and Mental Health Services Administration

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

CENTER FOR MENTAL HEALTH SERVICES
Bernard S. Arons, M.D., Director

CENTER FOR SUBSTANCE ABUSE PREVENTION
Ruth Sanchez-Way, Ph.D., 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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5600 Fishers Lane, Rockville, MD 20857

Fax: Brian Campbell (301) 443-9050

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E-mail: *bcampbel@samhsa.gov*

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