Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter Volume X, No. 2 Spring 2002

Helping Children Exposed to Substance Abuse, Mental Illness, and Violence

Renee, now a married mother of two young daughters, was 8 years old when she was sexually molested by an adult. "I didn't know that I could tell anyone," she said. "I thought I would get into trouble."

The abuse continued. In addition to this trauma, Renee later also experienced substance abuse and mental problems.

Then last year, a boy at school inappropriately touched Renee's daughter, Jennifer, in second grade at the time. Like Renee before her, Jennifer "didn't really think she had a voice" to object, Renee said. But now, thanks to an innovative intervention, Jennifer, "knows she has a choice" about whether and how people touch her, according to Renee. "She sets boundaries for herself." Renee believes that Jennifer, armed with this vital knowledge, now stands a good chance of avoiding problems that marred her mother's life.

SAMHSA's Study

Jennifer learned this essential lesson in a facilitated children's group funded by SAMHSA's Cooperative Agreement to Study Children of Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence—known as the Children's Subset Study for short. The study seeks to identify models of care for the field that will prevent or reduce the intergenerational perpetuation of violence, substance abuse, and mental illnesses, and reduce the impact of violence in the lives of

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Illustration by Martín Castillo

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- Center for Substance Abuse Prevention
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Teachers Receive Information on Underage Drinking

In a unique collaboration between SAMHSA, the U.S. Department of Health and Human Services, and Scholastic, Inc., classroom teachers nationwide this past spring received a two-part set of materials related to underage drinking. This information is designed especially for use by fifth-grade students, their families, and their teachers.

The materials included *Reach Out Now: Talk with Your Fifth Graders About Underage Drinking,* a four-page set of lessons and in-class activities for teachers to use as part of classroom instruction. Also included was a take-home packet for students and their parents: *Talk with Your Fifth Grader About Underage Drinking.* The materials are based on research supported by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health (NIH) and programs funded by SAMHSA's Center for Substance Abuse Prevention (CSAP).

SAMHSA's National Household Survey on Drug Abuse suggests that fifth grade—age 10 to 11—is not too early to begin sending clear messages about underage drinking. Almost 10.5 million youth age 12 to 20—nearly 30 percent—had used alcohol at least once in the month prior to the survey. The average age of first use continues to drop.

"Our message that underage drinking is unacceptable and illegal needs to reach down to elementary and middle school students, teachers, and their families," said Health and Human Services Secretary Tommy G. Thompson. "The benefits of discussion stimulated by the *Reach Out Now* materials can last a lifetime."

"The good news is that 60 percent of young people age 12 to 17 have never had a drink. What parents and teachers may not realize is that their disapproval of underage drinking has been identified as one of the key reasons children choose not to drink,"

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

The *Reach Out Now* materials have been received enthusiastically by the Leadership To Keep Children Alcohol Free, a consortium of Governors' spouses from states across the country, who are helping to raise awareness and promote use of the materials. Additional information about the prevention activities of the Leadership To Keep Children Alcohol Free is available at **www.alcoholfreechildren.org.**

The Leadership To Keep Children Alcohol Free is supported not only by NIAAA and SAMHSA, but also by the Robert Wood Johnson Foundation, NIH's Office of Research on Women's Health and the National Center on Minority Health and Health Disparities, and the Departments of Justice and Transportation.

The Department of Education's Safe and Drug-Free Schools program has announced the availability of the materials for use in school-based programs as well.

Reach Out Now: Talk with Your Fifth Grader About Underage Drinking includes lessons and in-class activities focusing on increasing fifth graders' knowledge about alcohol and its effects on the developing child, ways to make healthy decisions about drinking, and alternative activities to underage drinking. Teachers are shown how to incorporate the materials into classroom curricula in English, social studies, and science.

The take-home packet for students and their parents gives families concrete, health-promoting activities that can help a child reject underage drinking. It provides six key actions parents can take to help children make wise decisions:

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

This public/private partnership allows SAMHSA to merge its knowledge about prevention of underage drinking with Scholastic, Inc.'s, reputation for excellence in the development of classroom materials to help bring this important message about alcohol to America's youth.

For more information about ways to reduce youth alcohol use, 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). Or visit SAMHSA's Web site at **www.samhsa.gov.**

President Launches New Freedom Commission on Mental Health

"Our country must make a commitment: Americans with mental illness deserve our understanding and they deserve excellent care," said President George W. Bush in announcing the establishment this spring of the President's New Freedom Commission on Mental Health.

The Commission will identify the needs of people with mental illness and the barriers to care, investigate community-based care models that have shown success in coordinating and providing mental health services, and formulate policy options to integrate effective treatments and improve service coordination. The Commission is charged with producing an interim report within 6 months of the President's April 29 Executive Order, followed by a final report at a later date to be determined by the Commission chair in consultation with the President.

Currently, numerous Federal, state, and local government entities oversee mental health programs, policy, funding, and the diverse network of public and private providers. The Bush Administration wants to encourage more efficient organization and coordination to ensure effective treatment for those in need.

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "We welcome the opportunity the Commission offers to take a fresh look at ways to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. As the Federal Government's lead Agency for administering mental health and substance abuse services, SAMHSA will clearly have a role in carrying out the Commission's recommendations."

The Commission comprises a maximum of 15 members appointed by the President, including providers, payers, administrators, and consumers of mental health services and their families. The Commission also includes a maximum of seven ex officio members, four of whom will be designated by the Secretary of Health and Human Services and the remaining three of whom will be designated—one each—by the Secretaries of the Departments of Labor, Education, and Veterans Affairs.

"SAMHSA will clearly have a role in carrying out the Commission's recommendations."

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

President Bush has appointed Michael F. Hogan, Ph.D., as Commission chair. Dr. Hogan will also continue in his position as director of the Ohio Department of Mental Health, where he has served since 1991. In this capacity, he implemented comprehensive legislative reform, which devolved mental health care to the community level, reforming forensic services to improve quality and public safety, and developing new approaches to children's services to reduce reliance on out-of-home care.

Claire Heffernan has been selected as executive director, and Stanley Eichenauer serves as deputy executive director.

The Commission's office has already started planning for regional meetings throughout the country to gather information for formulating the report.

In announcing the formation of the Commission, President Bush said, "Millions of Americans are impaired at work, at school, or at home by episodes of mental illness. Remarkable treatments exist, and that's good. Yet many people—too many people—remain untreated."

He identified three major obstacles that interfere with care: the stigma surrounding mental illness "caused by a history of misunderstanding, fear, and embarrassment;" a fragmented mental health service delivery system; and "unfair treatment limitations placed on mental health in insurance coverage."

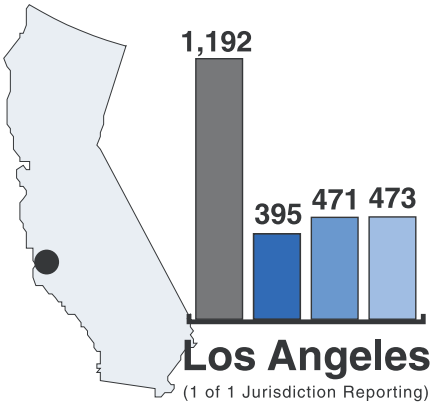
Americans with mental illness, he said, "deserve a health care system that treats their illness with the same urgency as a physical illness." He said that the Commission is charged with making "concrete recommendations for immediate improvements" that "must be implemented by the Federal Government, the state government, local agencies, as well as public and private health care providers."

To contact the office of the President's New Freedom Commission on Mental Health, send inquiries to 5600 Fishers Lane, Room 13C-26, Rockville, MD 20857. Telephone: (301) 443-1545. Fax: (301) 480-1554. Watch for information on a Commission Web site in the next issue of *SAMHSA News*.

Heroin, Cocaine, and Alcohol + Drugs Top Lists of Drug-Related Deaths

Heroin, cocaine, and alcohol-in-combination with other drugs were the three most common substances implicated in drug-related deaths by medical examiners participating in SAMHSA's Drug Abuse Warning Network (DAWN) in 2000. Narcotic analgesics—including methadone, codeine, hydrocodone, and oxycodone—also frequently ranked in the top 10 drugs mentioned by medical examiners in the survey. In 2000, 137 medical-examiner jurisdictions from 43 metropolitan areas reported on drug-related deaths to DAWN.

Among the jurisdictions participating, the highest numbers of drug-related deaths were reported from Los Angeles (1,192), Philadelphia (942), New York (924), Chicago (869), and Detroit (704). Twenty or fewer drug abuse deaths were reported from Boulder, Casper, Fargo, Indianapolis, Manchester-Nashua, Middlesex-Somerset, and Sioux Falls. However, not all jurisdictions within these metropolitan areas necessarily participate in DAWN.



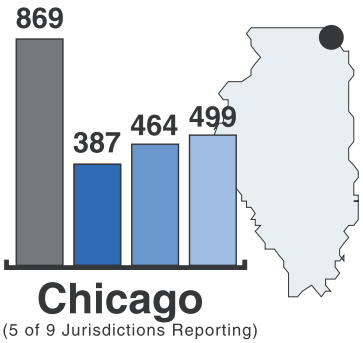
The report, *Mortality Data from the Drug Abuse Warning Network, 2000,* found drug abuse deaths among adolescents and young adults were relatively rare—fewer than 20 percent of deaths reported to DAWN were under age 25. In about half of the participating areas, those under age 25 represented less than 10 percent of all the drug-related deaths. In contrast, more than one-third of all drug abuse deaths in nearly half of the cities were people age 45 and older. In every metropolitan area, more than half of the drug-related deaths were men. In 30 metropolitan areas, more than half of the drug abuse deaths reported to DAWN were drug-induced (overdoses) and usually involved multiple drugs.

"Too many people realize too late that substance abuse can lead to incredible losses. Lost family and friends. Lost jobs and opportunity. And, as this report shows, lost lives," said Health and Human Services Secretary Tommy G. Thompson. "We are committed to supporting treatment programs that combat the personal despair and community disintegration brought by drug addiction."

"One life lost to drugs is one too many. Effective prevention and treatment programs are key to helping reduce the needless loss of life that results from abuse of drugs," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We are working with states and local drug treatment providers to build treatment capacity and to implement the most effective treatment services available."

The release of *Mortality Data from the Drug Abuse Warning Network, 2000,* marks the debut of a redesigned DAWN report on drug-abuse-related mortality. It replaces the previous DAWN Annual Medical Examiner Data reports. Changes in the format and content of this report are designed to provide more information about the metropolitan areas represented in DAWN and about their component jurisdictions.

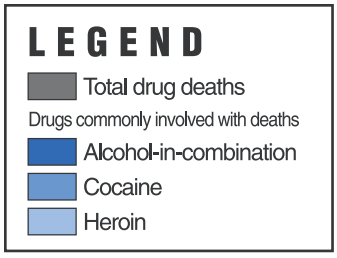
The report now includes three sections: metropolitan area profiles, abbreviated profiles for areas with few cases, and area "spotlights." This design provides more detailed information about the larger metropolitan areas, but also includes basic information about jurisdictions with fewer deaths, without compromising the confidentiality of decedents. Jurisdictions of special interest (such as urban counties) now have their own "spotlight" sections.

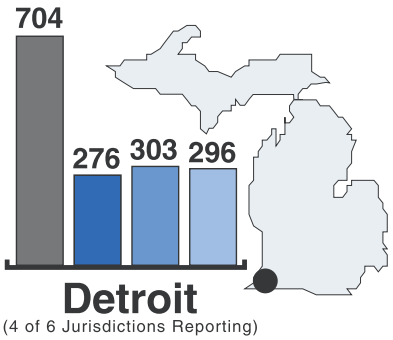


Among other key findings in the report:

Major Drugs of Abuse

- In half of the participating metropolitan areas, heroin, cocaine, and alcohol-in-combination accounted for 40 percent or more of all drug mentions. They accounted for the vast majority of drug mentions in reported cases from Newark (66 percent), Portland (67 percent), and Chicago (74 percent).
- No consistent trends appeared in heroin mentions across the metropolitan areas. From 1999 to 2000, the number of heroin/morphine mentions decreased in 12 metro areas and increased in 13 other metropolitan areas.





- No consistent trends appeared in cocaine mentions across the metropolitan areas. Twelve cities reported a decrease in the frequency of cocaine involvement from 1999 to 2000, while 11 cities saw an overall increase in deaths involving cocaine during that time period.
- In three cities (Minneapolis, Baltimore, and Norfolk), alcohol was involved in more than half of all drug-related deaths.

Other Drugs of Abuse

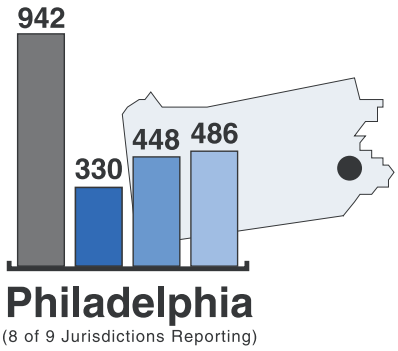
- Only three metropolitan areas had a drug other than heroin/morphine, cocaine, or alcohol-in-combination as the most frequently mentioned substance in their drug abuse-related deaths. Oklahoma City's most common drug was methamphetamine (56 mentions); Louisville's most common drug was cannabis (45); and in Providence, the most frequently mentioned substance was unspecified narcotic analgesics (24).
- Methamphetamine deaths continue to be concentrated in the Midwest and West. Among participating areas on the East Coast, only Long Island had more than a few mentions (38).

Club Drugs

- In DAWN, "club drugs" is a category that includes mentions of the following drugs: Ketamine; methylenedioxymethamphetamine (MDMA or Ecstasy); gamma hydroxy butyrate (GHB) and its precursor gamma butyrolactone (GBL); and flunitrazepam (Rohypnol).
- As in prior years, club drugs together accounted for very few deaths in any of the metropolitan areas participating in DAWN. Only 10 cities reported more than five mentions of club drugs in drug-related deaths. The cities with the most mentions were Los Angeles (27 mentions), Dallas (10), Chicago (9), and Miami (9).
- In nearly all cases, club drugs were reported in combination with at least one other substance.

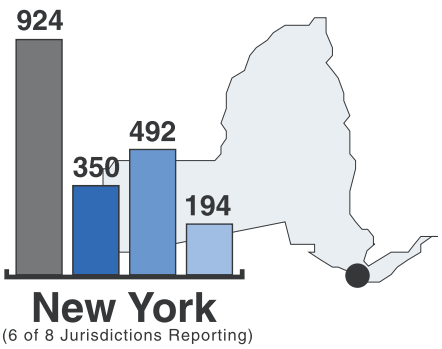
Abuse of Prescription Drugs

- Codeine ranked in the top 10 drugs mentioned in 17 cities, including Philadelphia (216 mentions), Los Angeles (201), Phoenix (124), Detroit (103), San Francisco (92), and Chicago (88).



- Hydrocodone ranked among the 10 most common drugs in 15 cities, including Los Angeles (80 mentions), Detroit (48), Dallas (25), Oklahoma City (22), and San Diego (22).
- Oxycodone ranked among the 10 most common drugs in 15 cities, including Philadelphia (87 mentions), Las Vegas (27), and Boston (21). These mentions *cannot* be attributed to specific brands, such as OxyContin.
- Of non-narcotic prescription drugs, diazepam (a benzodiazepine) and diphenhydramine were the most frequently mentioned.
- Methadone ranked in the top 10 drugs in 19 cities, including New York (146 mentions), Phoenix (47), and Chicago (46).

DAWN reports annually on deaths related to drug abuse, using data provided by participating death investigation jurisdictions in metropolitan areas in the



United States. In 2000, 137 jurisdictions in 43 metropolitan areas participated.

The DAWN mortality data capture deaths where an illegal drug or a legal drug used for nonmedical purposes contributed to a death, either directly (overdose) or indirectly. Deaths involving prescription drugs are reportable to DAWN only when the death involved intentional abuse. Accidental ingestions with no intent of abuse or adverse reactions to drugs taken as prescribed are not reportable.

The drug-abuse deaths described in this report do not represent the Nation as a whole, nor do they necessarily represent the total number of deaths related to drug abuse in any given metropolitan area. Rather, DAWN cases reflect the number of drug abuse deaths reviewed, identified, and reported by participating medical examiners and coroners in selected metropolitan areas. DAWN also collects information on drug-related, emergency department visits from a national sample of hospitals. These data are contained in a separate report, *Emergency Department Trends from the Drug Abuse Warning Network.*

To obtain a copy of *Mortality Data from the Drug Abuse Warning Network, 2000,* and other DAWN reports, contact SAMHSA's National Clearinghouse for Drug and Alcohol 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 found on SAMHSA's Web site, **www.samhsa.gov/oas/DAWN.htm.**

Terrorism: Helping Communities Heal

In the aftermath of the September 11 terrorist attacks, millions of Americans experienced depression, anxiety, and other problems. Yet the stigma associated with mental health services makes many people reluctant to seek out the help that could restore their emotional well-being.

To help, SAMHSA's Center for Mental Health Services (CMHS) worked in partnership with the Federal Emergency Management Agency (FEMA) to award grants funding for immediate public education and crisis counseling efforts to New York, New Jersey, Virginia, Connecticut, Pennsylvania, and Massachusetts. CMHS and FEMA are now in the final stages of reviewing requests for longer-term funding that will allow projects to continue for another 9 months. SAMHSA's Center for Substance Abuse Prevention and Center for Substance Abuse Treatment also provided funds to these states to enhance their capacity to deliver mental health services to residents needing more intensive assistance. All three SAMHSA Centers provided funds to Maryland, Rhode Island, and the District of Columbia for the same purpose.

"Most [disaster relief] volunteers go home a couple weeks after a disaster, but it's really 3 or 4 weeks later that people need mental health interventions," said Beth Nelson, M.S.W., formerly chief of the CMHS Emergency Services and Disaster Relief Branch, and now a senior policy advisor at SAMHSA. "Without the FEMA/CMHS grants and SAMHSA's supplemental funds, the traditional mental health systems wouldn't be able to handle all the increased demand."

Emphasizing Outreach

At the heart of the FEMA/CMHS Crisis Counseling Assistance and Training Program is the belief that survivors, rescue workers, and others affected by a disaster may need help understanding that their distress is a normal reaction to an abnormal situation. Instead of waiting for people to seek help, the program focuses on reaching out to them wherever they are.

To avoid the stigma often associated with mental health services, the program relies heavily on paraprofessionals—everyone from religious leaders to Rotary Club members to neighborhood activists. Recruited from the affected areas, these crisis counselors may not have a formal background in mental health, but they undergo training that orients them to the FEMA/CMHS counseling model. Under supervision from mental health professionals, they then fan out into their communities to provide information about stress responses, talk to people about their experiences, and offer referrals to traditional mental health services if necessary.

"The idea is that these are neighbors checking in to see how people are doing," explained Seth D. Hassett, M.S.W., a public health advisor in the CMHS Emergency Services and Disaster Relief Branch. "They don't say, 'I'm here from the state mental health authority.' They say, 'I'm here from a project designed to see how people are recovering from the disaster.' "

SAMHSA provides more than money to these projects, Mr. Hassett added. Representatives from all three SAMHSA Centers traveled to New York and other sites to help other Federal agencies, state and local agencies, and voluntary organizations plan their response. CMHS staff help train crisis counselors, either providing the training themselves or suggesting consultants. CMHS also provides a series of publications and other materials about disaster response.

New York

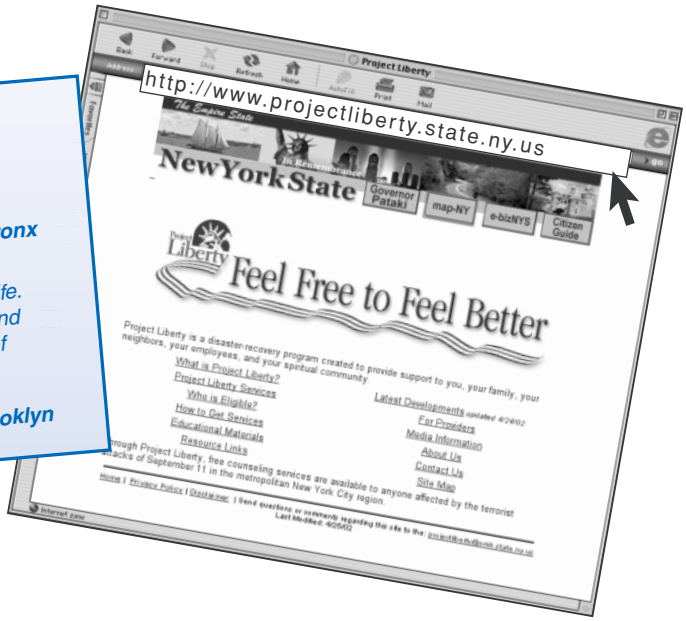
The largest FEMA/CMHS grant went to the New York State Office of Mental Health, which used the money to establish an innovative program called Project Liberty.

. . . What helps me is going out or staying in with the people who make me smile – whether we take a walk, catch a movie, or talk about nothing – just knowing that they are close makes me feel better.

—Marjorie, 24, Bronx

. . . Everyday things became more important because they construct my life. And life is what I'm lucky to have. I was born and raised on this soil. And I stand strong in the knowledge that you can build a lot of new dreams in a whole lot of empty sky.

—La Rhonda, 29 Brooklyn



"Clinical experience has shown that in the wake of traumatic events such as those New York experienced on September 11 and the days that followed, the most effective intervention is short-term individual and group counseling like that provided by Project Liberty," said New York State Mental Health Commissioner James L. Stone, M.S.W., C.S.W. "This effort is doubly important because in addition to helping people get on with their lives, it can identify individuals in need of more traditional mental health services and refer them for treatment."

Aimed at every resident of New York City and 10 surrounding counties, Project Liberty consists of outreach activities almost as diverse as New York itself. In the city, for example, public service announcements featuring actress Susan Sarandon and New York Yankee manager Joe Torre urge residents to call the project's hotline and arrange one-on-one or group education and counseling sessions. Bus and subway ads feature New Yorkers' stories and alert commuters to the project. Children receive a structured program of education and support through a collaboration between the Board of Education and Project Liberty.

Whether the target audience is immigrants, widows, Orthodox Jews, emergency workers, deaf and hard-of-hearing individuals, or other special populations, the project uses "indigenous" crisis counselors who can tailor their outreach methods to reach that community most effectively. "They need to know the communities so they can find people and adjust their outreach efforts," explained April J. Naturale, M.S.W., the project's statewide director.

The program's flexibility is even more apparent upstate. In Westchester County, for example, outreach workers advertised the project with an ad on diner placemats. In Dutchess County, the project invites residents to an art gallery to paint or draw their experiences and display the resulting artwork; visitors can also tell their stories on video. In Orange County, the project has turned to a therapeutic riding program to help traumatized children heal. "They tend to talk to the horses," explained Ms. Naturale. "They tell the animals their stories."

No matter what approach is used, added Ms. Naturale, it all comes down to "the hard work of hitting the pavement." She points to one crisis counselor as the perfect example: An active PTA member, the woman has contacts in every part of the community and draws upon them to talk to people at the beauty shops, in the schools, and everywhere else she goes. She even distributes Project Liberty information at the local supermarkets.

To determine how well the project achieves that aim, the state is using a data collection "toolkit" developed by CMHS and customized to meet the state's unique circumstances.

New Jersey

A FEMA/CMHS-funded program called Project Phoenix is attempting the same feat in the nine New Jersey counties most affected by the disaster.

Home to many who commuted across the Hudson River to the World Trade Center, New Jersey suffered many direct losses when the World Trade Center towers collapsed. As a result, Project Phoenix provides outreach and crisis counseling to widows' groups, older people who lost adult children in the attacks, and children who lost their parents.

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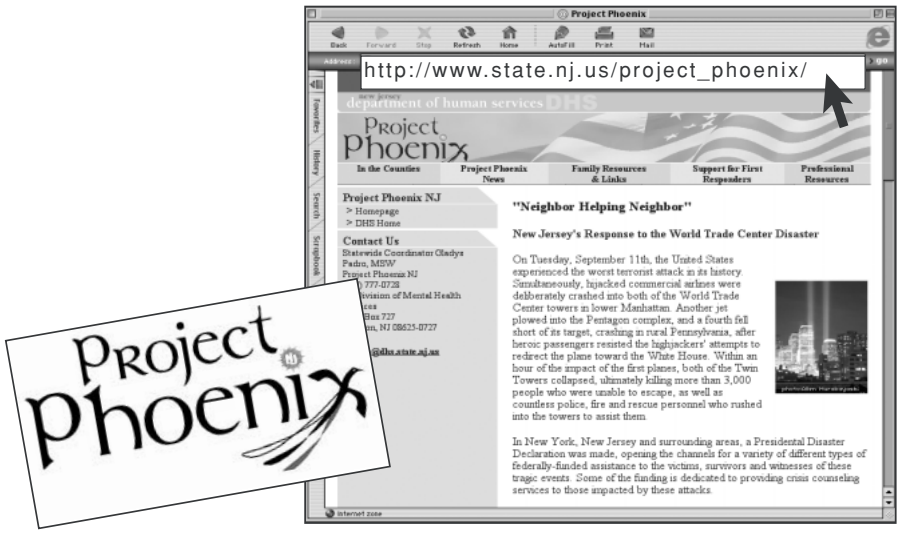
When people need more traditional mental health services, crisis counselors refer them to the public mental health system or the New Jersey Psychological Association.

Project Phoenix is trying to accommodate other groups as well. Disaster coordinator Gladys Padro, M.S.W., of the Division of Mental Health Services in the New Jersey Department of Human Services in Trenton, said "We were kind of overrun with requests from employee assistance programs at corporations that were in New York but relocated to New Jersey, for example." The large Latino population that worked in the restaurant industry in New York needs help. So do the families of military personnel at the state's military bases. Even commuters face additional stresses, because the disaster disrupted train service into the city.

Crisis counselors from Project Phoenix in New Jersey attend local community events as part of their outreach efforts.

Several new initiatives are being developed. For example, the project is working with a science center and several local junior leagues to put together an overnight program that would offer adolescents fun activities during the day and group counseling in the evening. A daytime program would offer similar services to younger children. The project is also working with the department of education to plan a workshop that would help teachers learn how to talk to children, identify signs of children in trouble, and avoid "compassion fatigue." There are plans to train a group of service providers to respond to the special emotional needs of emergency personnel.

In addition, the project sent crisis counselors to a family assistance center the Governor established in Jersey City's Liberty State Park just across the Hudson River from Ground Zero. Crisis counselors even escorted family members on the boat ride from the park to the World Trade Center site, providing emotional support and education during these traumatic visits by family members to pay homage and seek closure at the site where their loved ones died. After 6 months of service to thousands of family members, the center finally closed in March.



Virginia

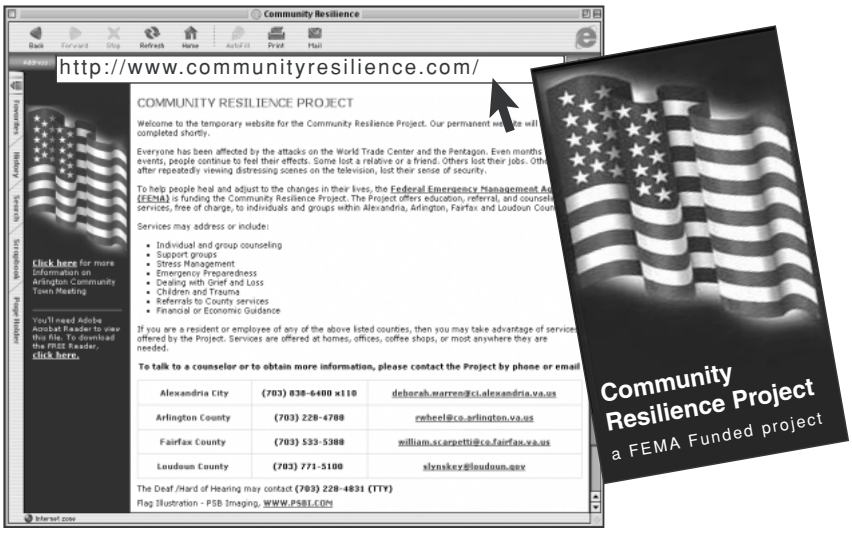
Virginians are also experiencing what disaster mental health coordinator Bill Armistead, M.P.H., calls an "ongoing event." The attack on the Pentagon was only the first trauma to hit northern Virginia, he pointed out. Next came the threat of anthrax-contaminated mail. Then came economic disaster as tourists and convention-goers cancelled their plans to visit nearby Washington, DC.

The area's large immigrant population faces additional stressors. A relatively large Muslim population suffered retaliatory hate crimes, while the attack reawakened memories of war-torn homelands for the area's many Southeast Asian, Latin American, and other immigrants.

Simply living in the area can produce anxiety, said Mr. Armistead, a senior planner in the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services in Richmond. "If you've seen that symbols have been attacked, and you're commuting back and forth past those symbols every day, that can be pretty tough," he explained. "When you add in the CIA, the Norfolk Naval Base, and other Federal Government and military sites in the area, it can feel like you're sitting right on top of a bull's eye."

Helping Virginians handle the stress of all these traumatic events is the goal of the FEMA/CMHS-funded Community Resilience Project. The project targets the 1.8 million Virginians served by the five community services boards in northern Virginia. Supplemental funds from SAMHSA will help the state meet the increased demand for traditional mental health and substance abuse services in the long run. That assistance is especially welcome in the face of the budget cuts the local community services boards faced as the local economy soured in the weeks after the attack.

Northern Virginia's enormous ethnic diversity has made outreach efforts challenging, said Mr. Armistead. For example, the project has had to translate public service announcements and other materials into a variety of languages.



But there are other difficulties as well, said Mr. Armistead. "In our culture, if I look you in the eye when I'm talking to you it would indicate that I'm telling the truth," he explained. "In the Muslim culture, especially if it's a male to female conversation, I should avert my eyes because otherwise it would appear that I'm staring at you rudely."

Like the other FEMA/CMHS-funded projects, the Community Resilience Project tries to avoid such problems by hiring indigenous crisis counselors who can adapt their outreach techniques to suit their own communities.

Crisis counselors have also worked to multiply their effect by reaching out to clergy members, physicians, and others who may come in contact with people who need help. For example, crisis counselors and their supervisors from the community services boards have offered training designed to teach primary-care physicians how people respond after disasters and where they can get additional help.

"In traditional mental health, you have a clinic and people come to it for help," said Mr. Armistead. "That's not going to happen in a disaster. Members of the public aren't going to come out and say they need help. You have to go out to them."

For more information about disaster relief and mental health, contact SAMHSA's National Mental Health Services Knowledge Exchange Network at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or (301) 443-9006 (TDD). Or visit SAMHSA's Web site at **www.samhsa.gov,** click on "Helping America Heal."

—By Rebecca A. Clay

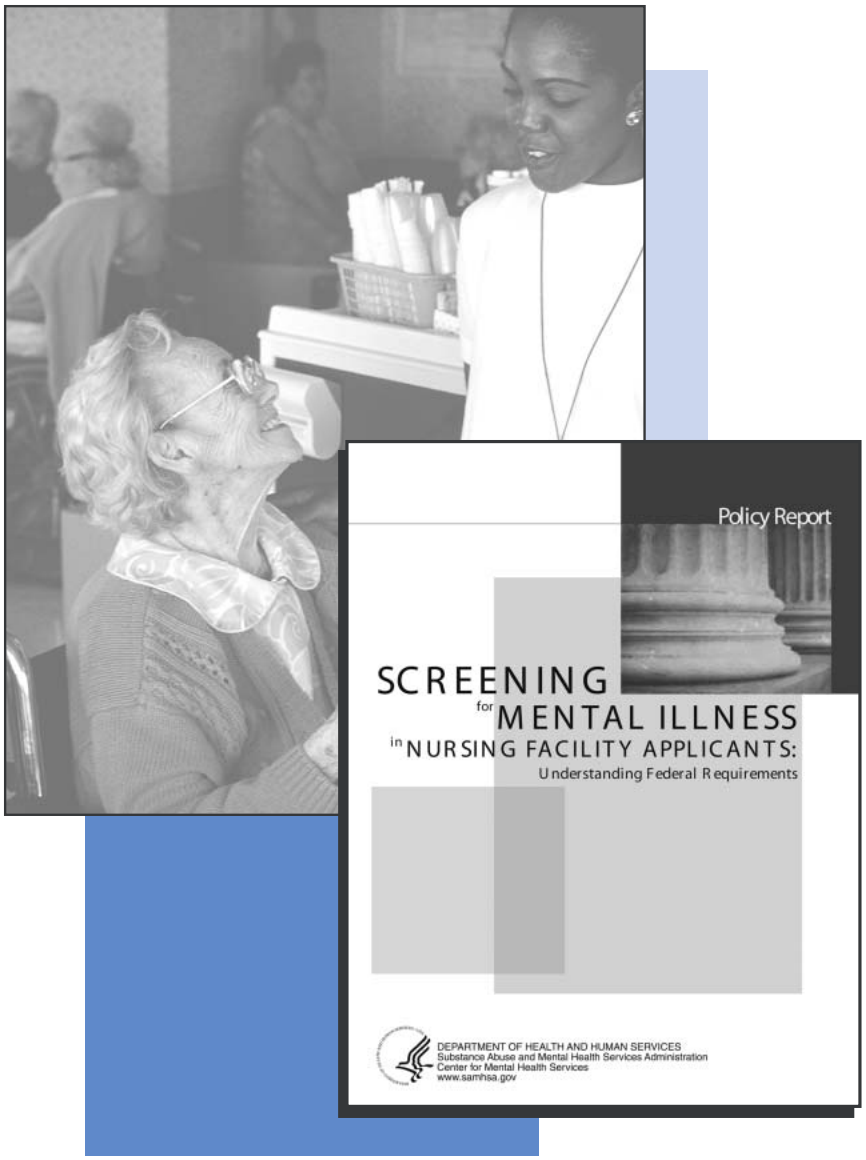
The Community Resilience Project in Virginia responded to the area's enormous ethnic diversity by hiring crisis counselors indigenous to the community who have adapted their outreach techniques for the people they serve.

Screening Nursing Home Applicants for Mental Illness

SAMHSA has released a new guide to understanding Federal requirements in screening for mental illness in nursing home applicants. Under Federal law, all applicants for admission to a nursing facility must be screened to identify those suspected of having a mental illness, and those suspected of having serious mental illness must be referred to a more indepth assessment called the Preadmission Screening and Resident Review (PASRR).

The purpose of the PASRR screen is to determine whether a prospective nursing facility resident requires the level of services (medical/physical) that the nursing facility provides. Furthermore, this screen also must determine if an applicant needs specialized mental health services. A new PASRR assessment also is required when a nursing facility resident's physical or mental status changes.

The PASRR program has been in place since the early 1990s, as part of the Nursing Home Reform Act. Federal PASRR Regulations provide some leeway in interpretation of policy to the states, resulting in some variation in implementation. This report of PASRR policy, prepared by SAMHSA's Center for Mental Health Services, is based on a review and comparison of current law, regulations, and state guidance. It is intended to help state and local authorities and nursing facilities understand their responsibilities for ensuring appropriate admission and treatment of individuals with mental illness applying to and residing in nursing facilities.



To obtain a copy of the new report, *Screening for Mental Illness in Nursing Facility Applicants: Understanding Federal Requirements,* contact SAMHSA's National Mental Health Services Knowledge Exchange Network at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (4267), or (301) 443-9006 (TTD).

The report can also be downloaded from SAMHSA's Web site at **www.samhsa.gov,** click on Publications, click on Managed Care, click on Featured Publications.

Promoting Older Adult Health: Guide Offers Assistance

Inadvertent misuse and abuse of alcohol and medications. Depression. Anxiety. These problems often are overlooked in adults age 65 and older by service providers, family members, and even by older adults themselves.

To assist in addressing these issues, SAMHSA and the National Council on Aging (NCOA) partnered to produce a guide for community-based organizations that help seniors.

The new guide, *Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol and Mental Health Problems,* provides concrete, practical guidance for mental health, substance abuse, primary care, and aging services providers to help them join together to provide education, prevention, screening, referrals, and treatment for seniors experiencing or at risk for substance abuse and mental problems.

"As many as 17 percent of older adults are affected by alcohol and/or prescription drug misuse, and an estimated 20 percent of older adults experience mental disorders that are not a normal part of aging. Yet, older adults often are reluctant to seek help for these preventable and treatable problems," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "This guide helps facilitate collaborations among mental health, substance abuse, and aging services providers to the benefit of millions of older Americans."

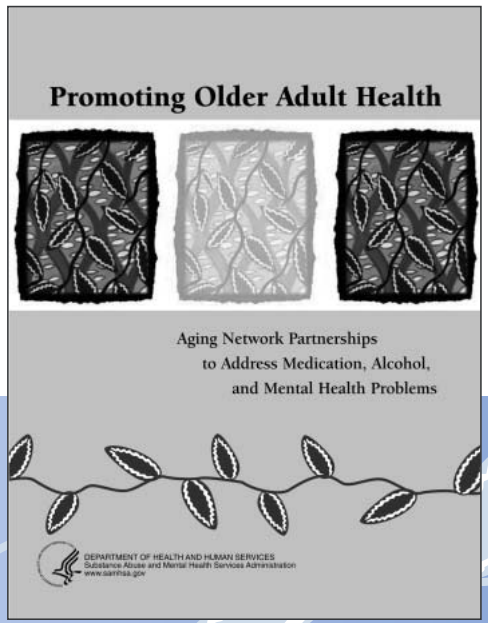
"There are innovative program models and creative funding strategies described in this book," said James P. Firman, NCOA president and CEO. "However, the real success of this joint effort will be measured in the improved quality of life for countless older Americans, both today and for decades to come."

The guide identifies programs across the country that link with community partners to provide seniors with needed support without requiring individual organizations to commit large amounts of staff time or money. It highlights *how* these programs operate and offers lessons from their successes. Finally, it shows how a direct approach to addressing medication, alcohol, and mental problems among older adults can enhance the capabilities of aging services and foster healthy aging in older adults.

The guide is based on findings of a national search by the NCOA to identify exemplary programs that make the needed service linkages. Fifteen programs are profiled in depth and an additional 25 noted. National and state contact information is provided to help organizations find resources and advice.

NCOA is a national, nonprofit group of individuals and organizations that promotes the dignity, independence, well-being, and contributions of older people. NCOA's members include senior centers, area agencies on aging, adult day services providers, faith congregations, senior housing agencies, health centers, employment services organizations, and consumer organizations.

The publication (HHS Publication No. MS 02-3628) is available free from SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Or visit SAMHSA's Web site at **www.samhsa.gov.**



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children whose mothers have co-occurring mental and addictive disorders and histories of trauma.

The study participants are the children of women enrolled in SAMHSA's ongoing Women, Co-Occurring Disorders, and Violence study, begun in 1998 to test interventions to help women who have experienced trauma and who have both substance abuse and mental illnesses. In 2000, 2 years into the study, SAMHSA launched the substudy aimed at finding ways to help the children of these women strengthen their ability to cope with experiences that threaten their safety and self-esteem.

Four of the participating women's sites —in Massachusetts, Colorado, and one each in northern and southern California—were chosen to participate in the Children's Subset Study.

All three SAMHSA Centers are participating in the study, which is funded by SAMHSA's Center for Substance Abuse Treatment (CSAT).

"We continue to see how this study provides the medium to learn about safety for children, the role of protective factors and resiliency, and the importance of teaching children alternatives to violence," said Melissa Rael, R.N., M.P.A., CSAT senior program management officer.

No previous research has systematically examined the combined effects on children exposed to all three risk factors, according to Jeanette Bevett-Mills, M.Ed., M.S., a public health advisor at SAMHSA's Center for Substance Abuse Prevention.

However, she said, "Past experience suggests that they are at high risk for substance abuse," highlighting the need to "break the intergenerational cycle" of substance abuse within affected families. "Because early experiences are crucial to development throughout the life cycle," she said, finding ways to help vulnerable children develop constructive ways to avoid substance abuse later in life appears to be a promising strategy.

Family histories of substance abuse, mental illnesses, and exposure to trauma may place children at risk for a range of mental health problems, according to Kana Enomoto, public health analyst in SAMHSA's Center for Mental Health Services. Although some of the study children receive individual counseling or psychotherapy, the study hypothesizes that group work among peers facing similar problems "can help in ways that individual interventions cannot," Ms. Enomoto said. Knowing that others also face these issues may help children develop greater understanding and effective coping strategies "in ways they cannot do alone," she added.

Recruiting Participants

Jennifer attended group sessions in her hometown of Fall River, MA, at Stanley Street Treatment and Resources (SSTAR), one of two agencies in different parts of the state that are participating as a single study site. Called the Women Embracing Life and Living (WELL) Child Study, the project is supervised from offices in Cambridge by principal investigator Norma Finkelstein, Ph.D. The project will compare results from intervention sites where 30 children receive several specially designed services to those from a comparison site where 30 children receive what she calls "services as usual." Interviews with mothers or caretakers conducted every 3 months will provide outcome data.

As participants enter the women's study through agency referrals, they are informed of the children's project and offered the opportunity to enroll their children.

Some mothers, however, refuse permission, though "they want obviously what's best for their kids," said Karen Gould, LICSW, project director of the WELL Child study. "They might say, 'This is wonderful.' But when a group starts, they say 'maybe this isn't such a good time.' " Perhaps they do not trust the agency, she suggested, or maybe they are "nervous about the fact that their child would hear

Courtney (l.) and Jennifer (r.) with their mother, Renee, have benefited from the Women Embracing Life and Living (WELL) Child Study funded by SAMHSA's Children's Subset Study.

things . . . that maybe no one had ever really talked about." Some may fear that their children will divulge sensitive family information.

Some, Dr. Finkelstein said, simply need "a little more sobriety, more recovery [before] they can focus on their children because they are mostly focused on themselves."

For mothers who do enter their children in the study, a clinical assessment of both parent and child comes next.

"By the time I meet the women for assessment," Ms. Gould said, "they know exactly what they're getting into and . . . they're very motivated. What they'll say is 'This is exactly what my child needs.' "

Program Components

Each site participating in the Child Subset Study includes the following elements:

- A uniform **clinical assessment** for both mother and child
- Ongoing **case management,** including service coordination and advocacy
- A **skills-building group intervention** for the children that helps them to establish boundaries, improve their self-care and sense of identity, and develop a personal safety plan.

Susan O'Donnell, M.A., who serves SSTAR as both child clinician advocate for the WELL Child project and integrated care facilitator for the WELL women's study, stressed the importance of the second component, which includes "resource coordination and advocacy and/or case management, getting the kids services, and coordinating the services." Services can include psychotherapy, various kinds of after-school programs, and more.

Though the study's design permits only one child per family to enroll, Ms. O'Donnell said, "If there are other children in the family, I'll try and find services for them as well." In her role as clinician advocate, she said, "I help the parent as much as possible" obtain the services that both study children and their siblings need. As integrated care facilitator, she added, "I also case manage for the woman [and] the whole family."

Helping the parents throughout the process is a consumer coordinator who works in both the WELL and the WELL Child projects, Dr. Finkelstein said. In addition, the consumer coordinator recruits other women who've participated in the WELL program "who are further along [in their own recovery and] who have volunteered to be consumer advisors or consumer assistants to other women who might have questions," Dr. Finkelstein explained.

"It's one thing [for the mothers] to talk to me, a professional, but it's another to know that they can talk to another consumer" of treatment services, Ms. Gould added.

The program's third component—the skills-building groups—is based on a curriculum modified from *Groupwork with Children of Battered Women: A Practitioner's Manual,* by Einat Peled and Diane Davis. Because the Peled-Davis program focuses only on domestic violence, "it excluded some of [the] pieces" needed by children whose "moms have the three issues: mental health, substance abuse, and trauma," Ms. O'Donnell said.

Before the groups begin, parents receive a detailed orientation, learning what they might expect from group participation, including both positive and negative side effects. For example, Ms. Gould said, "the child might come home and start talking about how it's not okay or it wasn't okay when I saw this or that," a change the mother may find "uncomfortable."

Ms. Gould explained, "We learned from Peled and Davis that success depends on parents understanding that their kids are going to be introduced to [ideas and information] that no one may have ever taken the time to process [with them] at length." Children might, for example, "feel empowered to maybe challenge" their parents. Or the mother might experience reactions "triggered by the kids."

Designed for two age groups, 5- to 7-year-olds or 8- to 10-year-olds, each group meets for 1 hour and 15 minutes for 10 consecutive weeks, with "booster" sessions 1 and 2 months after the regular program ends. (See box.)

To ensure sufficient group size and the opportunity for broader participation, the groups are generally open to all children age 5 to 10 of women receiving treatment at the sites, whether or not they are formally

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The Skills-Building Intervention

All group sessions conform to a detailed curriculum. The succession of subjects is as follows:

Introduction:	Orientation Session	**Week 4:**	It's Not Always Happy at My House/Substance Abuse
Week 1:	Getting to Know Each Other/It's Okay To Feel and Express Feelings	**Week 5:**	Sharing Personal Experiences About Violence
Week 2:	What Hands Can Do/ What Is Abuse	**Week 6:**	Touch
Week 3:	Anger	**Week 7:**	Assertiveness
		Week 8:	Protection Planning
		Week 9:	Review and Goodbye

Booster Session 1: Review of "What Hands Can Do" from Week 2
Booster Session 2: Review of "Safety Protection Plan" from Week 8

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enrolled in the Children's Subset Study. For example, Jennifer's sister, Courtney, belonged to a group for 5- to 7-year-olds while Jennifer attended with the children age 8 to 10.

The sessions tackle complex issues such as a parent's substance abuse, exposure to violence, appropriate touch, expression of anger, and the right to be safe.

Each tightly structured session begins with a check-in that allows the children to discuss feelings about the previous session or other issues in their lives. In addition, each session takes a particular feeling—such as anger or sadness—as a theme for the day. The aim is to legitimize feelings the children experience and help them understand appropriate ways to express them. Or, as Ms. O'Donnell, who serves as a facilitator at SSTAR, put it, to help the child "connect . . . feelings, to get a vocabulary of feelings."

The children learn, for example, that "It's okay to be angry and express anger, but it's not okay to abuse others with my anger," she explained.

Specified activities make each session's lessons concrete. For example, the children discuss violence in terms of "what hands can do." Children trace outlines of their own hands. The younger children trace onto a group poster; the older ones onto individual posters. Then they suggest "ways that hands can help, [and] ways that hands can hurt," which are written around the fingers, Ms. O'Donnell said.

A snack and a ritualized closing add to the comfort of each session. Everyone forms a circle, holds hands, and "pass[es] the squeeze."

The curriculum's "strength-based model" allows the project "to build on the kids' strengths," Dr. Finkelstein said. As the weeks pass, they learn that they have the right to be safe, to assert themselves, and to protect the privacy of their bodies. The children devise concrete strategies for dealing with unsafe situations, and create "safety plans" that include safe people and places and how to reach them in case of need.

"Repeatedly what I hear [from parents] is, 'I wish I would have known about this when I was their age,' " Ms. O'Donnell said.

How Children Respond

The groups become extremely important to their young members. "Every child we've had in the groups—except for one—we have kept throughout all the group sessions," Dr. Finkelstein said.

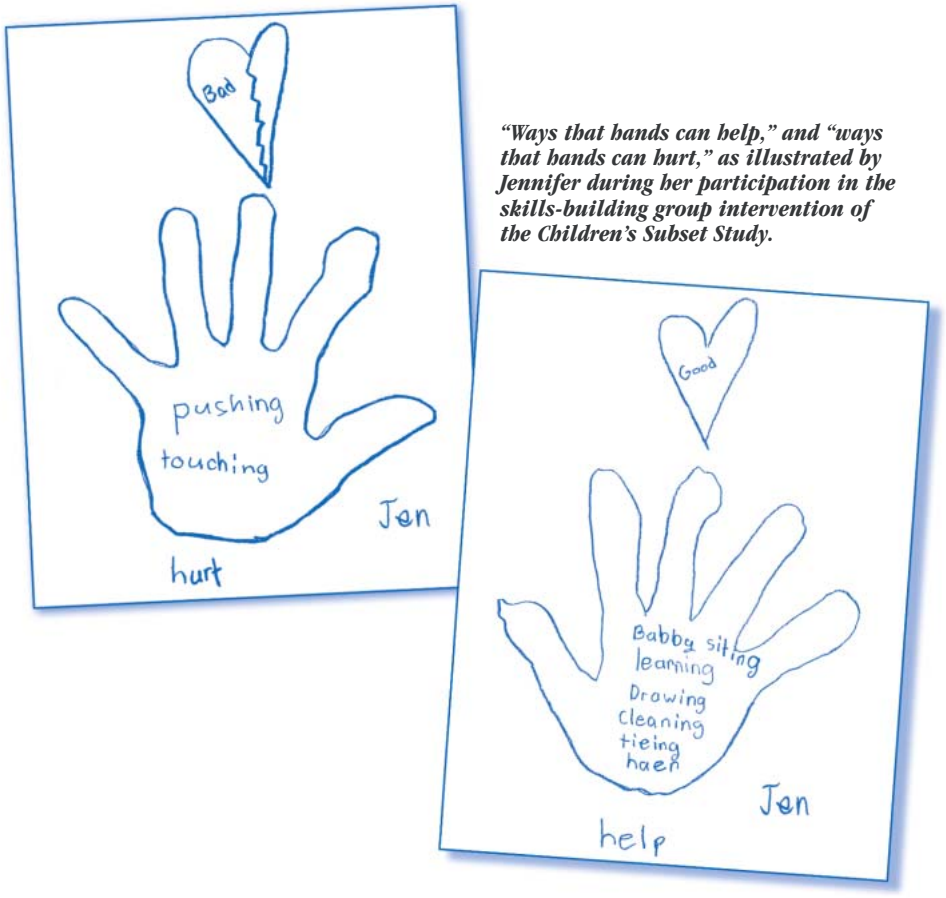
For example, Ms. Gould recalled, when one mother told staffers that medical appointments and transportation problems would keep her daughter away for 2 weeks, "the little girl, just impromptu, said, 'You don't understand mommy, this is very important work going on here and I can't miss the group.' "

Ending the program is "extremely hard" for the children, Ms. O'Donnell said. So, the project added monthly "reunion groups."

"I've been in the child psychiatry field for 20 years, and the attitude has been that you can't talk directly to kids [this young] around these kinds of serious issues," Ms. Gould said. But the Children's Subset Study shows that "with the right resources you can really talk with these kids on their developmental level and they get it. . . . If anybody would have told me we would be talking with 5-year-olds about such supposedly adult topics, it would have seemed impossible."

More results will emerge as the study continues. A common interview protocol and intervention will allow data to be pooled, analyzed, and reported across sites. ◗

—By Beryl Lieff Benderly



"Ways that hands can help," and "ways that hands can hurt," as illustrated by Jennifer during her participation in the skills-building group intervention of the Children's Subset Study.

Care Improves for Vulnerable Children

Youngsters who participate in a national program for at-risk children receive greater access to critically important health and social services, improve learning skills that are crucial for their future school success, and strengthen their family ties, according to early findings of a study sponsored by SAMHSA and the Casey Family Programs.

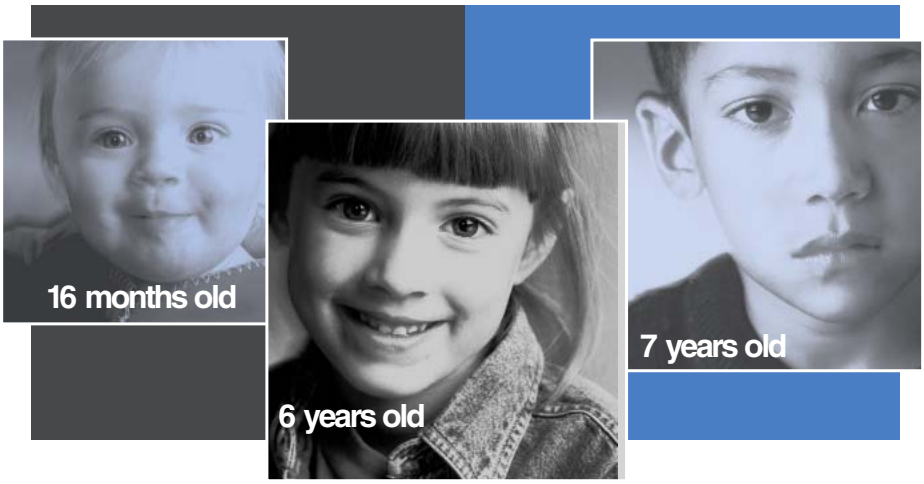
The early findings were from a study of 2,908 children from 12 sites across the Nation who participate in Starting Early Starting Smart (SESS). This program targets children from birth to age 7 whose family or community environments put them at risk for mental and addictive problems.

The 4-year grant study is a collaborative effort among all three SAMHSA Centers and the Casey Family Programs, which is a private foundation with services that include support for children from foster care to adoption.

"Eighty percent of parents who participate in the program stay in the program. This is a clear indication of the program's positive influences," said Ruth Sanchez-Way, Ph.D., Director of SAMHSA's Center for Substance Abuse Prevention.

"We know that removing children from their families during their formative, bonding years needs to be avoided," said Ruth Massinga, president and CEO of Casey Family Programs. "Starting Early Starting Smart shows that there are viable strategies and approaches to prevent out-of-home placement. When we provide a system of integrated services and consistent, skilled supports required to ensure safe, nurturing, and loving homes, parents who may be struggling with substance abuse and mental health issues stand a much better chance of keeping their families together."

Based on the success of previous, similar programs, SESS uses a child-centered, family-focused, community-based approach that includes assistance in substance abuse prevention, mental health services, and substance abuse treatment. These services, defined as behavioral health services, are provided in settings that parents with infants and preschool children normally frequent.



The demonstration project includes a total of 12 sites (see box) and a coordinating center—Evaluation, Management & Training Associates, located in Folsom, CA.

The SESS program figures were collected by the 12 grantees, with nearly 3,000 children participating in the study. Rigorous evaluation of the project has produced five major early findings demonstrating that SESS programs have succeeded in:

- Increasing access to needed services for participating families.

SESS programs increased caregiver participation in educational and therapeutic services concerning parenting and family functioning. Thirteen percent more SESS caregivers participated in these programs compared to similar families receiving a basic standard of care. Moreover, in programs that emphasized the selection of families in need of substance abuse services, 7 percent more of the SESS caregivers in need of services received treatment, compared to the standard-

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SESS Project Sites

Five Starting Early Starting Smart (SESS) project sites are housed in primary care physician centers. These sites are:

- **Boston Medical Center,** Boston, MA
- **The Casey Family Partners,** Spokane, WA
- **University of Miami,** Miami, FL
- **University of Missouri,** Columbia, MO
- **University of New Mexico,** Albuquerque, NM.

The remaining seven are housed at sites that provide early childhood care:

- **Asian American Recovery Services, Inc.,** San Francisco, CA
- **Child Development, Inc.,** Russellville, AR
- **Children's National Medical Center,** Washington, DC
- **The Johns Hopkins University,** Baltimore, MD
- **Division of Child and Family Services,** Las Vegas, NV
- **The Tulalip Tribes,** Marysville, WA
- **The Women's Treatment Center,** Chicago, IL

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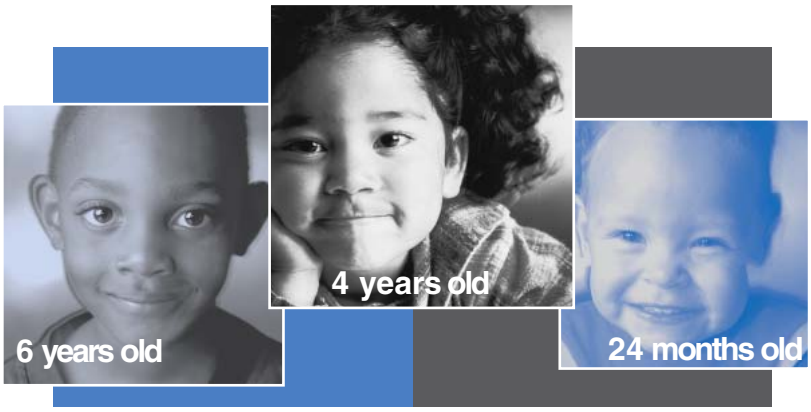
of-care families. Similarly, 12 percent more SESS than comparison families in need of mental health services received treatment.

- Helping participating families strengthen the ways in which they guide and support the development of their young children.

In several areas of family functioning and parenting behaviors, SESS families made significant improvements compared to standard-of-care families. For example, SESS families reduced verbal aggression in the home 17 percent more than comparison families, where reported verbal aggression actually increased on average. SESS families also reported statistically significant improvements relative to comparison families in the use of appropriate discipline (3.2 percent), the use of positive reinforcements (2.2 percent), and in the variety of experience provided children in homes with limited opportunity (4.1 percent).

- Decreasing drug use among caregivers when programs targeted caregivers and infants in the early months of life.

In SESS programs operating in pediatric care settings, caregivers in need of substance use treatment reduced their reported drug use 35 percent more than comparison caregivers in need of substance abuse treatment services.



- Strengthening positive interaction between participating caregivers and infants in the early months of life.

Coding of videotaped interactions between caregivers and infants were more positive for SESS caregivers and children than for comparison caregiver-child dyads in both feeding and play situations. At 6 months into the program, randomly assigned caregiver-child dyads in SESS programs interacted more positively than randomly assigned comparison caregiver-child dyads by statistically significant margins.

- Strengthening the development of young children in the program in ways that are crucial for school success.

Preschool-age children in SESS improved significantly in social-emotional and cognitive development relative to comparison youth. These developmental areas are crucial to school readiness. For example, SESS children improved their performance on use of linguistic concepts 8 percent more than comparison youth. For children with high need in this area, SESS children did better by 21 percent. As reported by teachers, SESS children reduced externalizing problem behaviors 21 percent more than comparison children, and reduced internalizing problem behaviors 23 percent more than comparison children.

To learn more about Starting Early Starting Smart, visit **www.samhsa.gov /programs/content/brief2001/kda /01kda_csap-12.htm.**

Prevention Programs Reduce Drug Use Among High-Risk Youth

A nationwide study of federally funded substance abuse prevention programs for youth at high risk for substance abuse found that the programs yielded reduced rates of alcohol, tobacco, and marijuana use according to a SAMHSA report.

Reported first-time use of cigarettes, alcohol, and marijuana was 12 percent lower at program exit than for comparison youth, and 6 percent below comparison youth 18 months later. Substance use by youth who had already begun to use substances was 10 percent lower at exit than among comparison youth; and 18 months later use levels were 22 percent below comparison youth.

The 5-year study, the *National Cross-Site Evaluation of the High-Risk Youth Demonstration Program,* involved more than 10,500 youth in 48 communities that are characterized by high levels of risk, such as poverty, crime rates, and ambient substance use.

"This study provides an unprecedented opportunity to learn about preventing and reducing substance abuse among high-risk youth," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We will use the findings on what works and why to provide a benchmark and help strengthen prevention programs in communities across the Nation."

The study identified six program components that can help reduce the likelihood of substance use. Among the

successful programs were those emphasizing life skills development, connectedness to constructive peers and adults, and self-examination.

Program design and implementation also had an effect. Favorable results were more likely when programs had a clear purpose and evidenced-based strategy, maintained intensive participant contact, and were offered in after-school settings at times when youth are most at risk for substance use.

The diversity of program participants also allowed analysis of patterns in risk and protective factors, and substance use as youth mature through adolescence, across genders, and across racial and ethnic groups. The study confirmed a "web of influence" among individual, family, peer, school, and community factors on youth substance use.

For example, when families are strong, family supervision and parental attitudes have a strong influence on the peers with whom young people choose to associate and also influence the choice to use substances or not. Likewise, when youth are strongly connected to school and are successful in school, they tend to associate with peers who do not use substances and tend not to use them themselves.

Gender plays an important role in risk, protection, and substance use. Boys participating in the study programs used substances at a much lower rate than comparison boys at program exit (29 percent lower), and at 6 months after exit (22 percent lower), but this effect had faded by 18 months after the program ended.

Program benefits for girls developed later, but were increasingly positive throughout the study period. Substance use rates for girls participating in the study program were 3 percent lower than comparison girls at program exit, and 9 percent lower 18 months later.

While programs that use multiple, science-based practices identified in the study produced stronger and longer lasting effects for both boys and girls, some program elements work better for one gender than the other. For girls, programs that focus on behavior-related life skills are particularly important for sustaining positive effects on substance abuse throughout the 18-month period of followup. For boys, participation in programs that emphasize interactivity with peers or adults are particularly important for strengthening program effects on substance use.

The 48 community programs studied were funded by SAMHSA's Center for Substance Abuse Prevention (CSAP) through the High-Risk Youth Demonstration Grant Program during 1994 and 1995. Programs were selected to ensure coverage of different regions of the country, various funding initiatives, and diverse target population characteristics. The objective was to assess the effectiveness of programs that spanned a broad range of strategies, capabilities, and participation.

Of the 10,500 youth involved in the study, 6,031 participated in High-Risk Youth programs; and 4,579 similar youth from the same communities did not receive services from the CSAP programs. All responses from study participants were collected using CSAP's National Youth Survey at four different times during the study: at program entry, at program exit, and at 6 and 18 months after youth exited the program.

"This study has significantly expanded our understanding of the prevention strategies that have the greatest potential to help even our most vulnerable youth lead drug-free lives," said CSAP Director Ruth Sanchez-Way, Ph.D.

For more information on the study, visit SAMHSA's Web site, **www.samhsa.gov,** click on CSAP.

Systems of Care Help Youth with Serious Emotional Disturbance

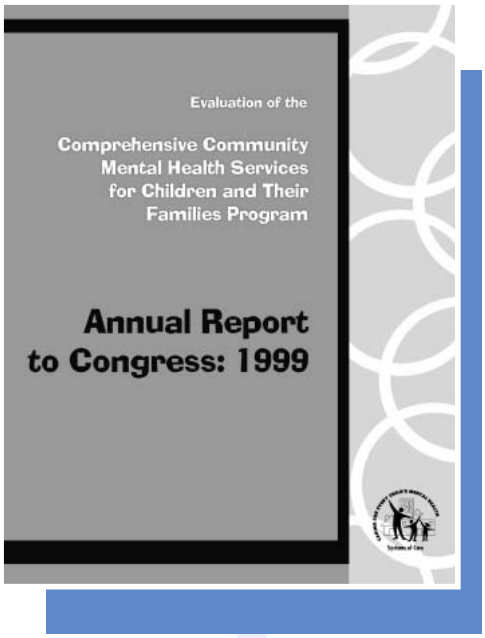
Comprehensive systems of care enhance the social functioning, improve school attendance and grades, and reduce severe behavioral and emotional problems and contact with law enforcement in children with mental health problems according to the findings of a SAMHSA report. The findings are contained in the *Annual Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program, 1999.*

After 2 years of receiving services, 42 percent of the children in the program showed a significant reduction in severe behavioral and emotional problem symptoms. An additional 48 percent of the children were stabilized. The report also shows that after 1 year in systems of care, the percentage of children with serious emotional disturbances receiving average or above-average grades in school increased nearly 20 percent.

Likewise, the percentage of children in special education classes receiving average or above-average grades increased by nearly 15 percent. Other data indicate that systems of care lead to other marked improvements in the lives of children, such as significantly fewer arrests and more stable living arrangements.

Serious emotional disturbances are diagnosed behavioral, emotional, and mental disorders that result in functional impairment and substantially interfere with or limit major life activities. Systems of care help children with serious emotional disturbances and their families by integrating community services into a single, comprehensive, family-focused, culturally competent, and community-based service system that is able to meet their highly diverse and changing needs.

Since the enactment of the Children's and Communities Mental Health Services Improvement Act of 1992, the Comprehensive Community Mental Health Services for Children and Their Families Program has supported the development of systems of care in communities across the United States. This report presents data accumulated through August 1999 from 31 grant communities that established systems of care for approximately 40,000 children and their families.



"Many people do not realize that about one in 10 children in the United States has a serious emotional disturbance, and one in five has a diagnosable mental health disorder," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "The data illustrate the progress that 'systems of care' are making. Our job now is to work with states and communities to use our latest findings about 'systems of care' to implement effective treatments, services, and supports nationwide."

In addition to positive outcomes for children, the report shows that systems of care also are achieving another important objective, which is actively involving family caregivers in the decision-making process for their children's treatment plans. Nearly 75 percent of those families surveyed indicated that they were asked for ideas and opinions concerning their child's treatment, and more than 75 percent said they "always" or "usually" had a choice in the range of services their children received. Also, more than 75 percent rated the quality of their child's mental health services as "excellent" or "good."

"Active family involvement is one of the keys to success for systems of care," said Bernard S. Arons, M.D., Director of SAMHSA's Center for Mental Health Services. "Families actually take the lead in helping their children get the effective, individualized services that they need," he added.

For a copy of the report, contact SAMHSA's National Mental Health Services Knowledge Exchange Network at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647). Web access: **www.samhsa.gov,** click on Mental Health Services, click on Children, Adolescents, & Families, click on *1999 Annual Report to Congress.*

Estimating Cost of Preventive Services in Mental Health

A recent SAMHSA-funded study, *Estimating the Cost of Preventive Health Services in Mental Health and Substance Abuse Under Managed Care,* examines typical costs for providing a range of services.

The study presents cost estimates for providing six preventive interventions including:

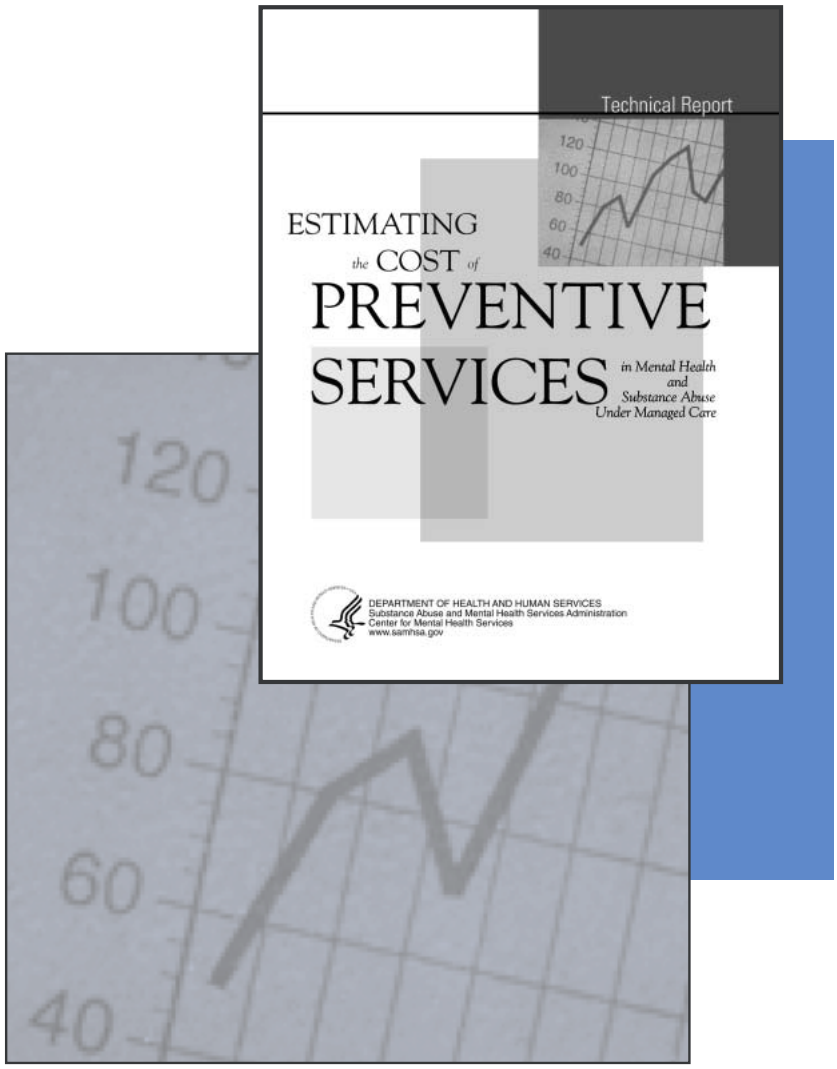
- Prenatal visits to mothers at risk from substance abuse
- Targeted cessation counseling for smokers
- Targeted short-term mental health therapy
- Health promotion through "self care" education
- Presurgical education for adults
- Brief counseling sessions for older adults needing help to reduce their alcohol use.

The estimates project the range of potential costs for members of managed care health plans in a "per member per month" format. Factors weighed include the number of health plan enrollees, prevalence of the target condition, time required to deliver each intervention, number of sessions needed, salaries of those delivering services, and administrative and other overhead.

Smoking cessation programs aimed at pregnant enrollees were shown to help improve health outcomes such as low birth weight and perinatal death. Data found that such programs could demonstrate savings as high as $17 for each dollar spent by the plan.

Another example involved programs to lessen anxiety for adults about to undergo surgical procedures. A model intervention involved a bedside visit by an anesthetist the night before surgery, and further assistance by nurses, psychologists, and others. Workbooks and other materials were also furnished to patients. In their best outcomes, these interventions were reported to increase patient compliance with doctors' orders, reduce the need for narcotics, and reduce the length of hospital stays.

Estimating the Cost of Preventive Services in Mental Health and Substance Abuse Under Managed Care was produced by SAMHSA's Center for Mental Health Services. To obtain a copy of this report, contact SAMHSA's National Mental Health Services Knowledge Exchange Network at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647). The document can also be downloaded from the Internet at **www.mentalhealth.org/cmhs/ManagedCare/pubs.asp.**



Long-Term Marijuana Use Affects Memory and Attention

A new study of marijuana users seeking treatment determined that long-term users performed worse on most of the memory, attention, time judgment, and information processing tests. The study, "Cognitive Functioning of Long Term Cannabis Use," is published in the March 6, 2002, issue of the *Journal of the American Medical Association* (JAMA).

The data arose as part of a substudy of the adult Marijuana Treatment Project, a cooperative agreement between SAMHSA's Center for Substance Abuse Treatment (CSAT), the University of Connecticut Medical School, the University of Washington, the University of Connecticut Health Center, and The Village South, Inc., in Miami. Consulting organizations included the National Drug and Alcohol Research Centre of the University of New South Wales, Australia; the University of Wollongong, Australia; the Virginia Polytechnic Institute and State University; and Evergreen Treatment Services of Seattle.

"The findings show that there are significant long-term negative effects of marijuana use," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Young people need to know that marijuana is not the harmless substance some have made it out to be. We are committed to continue educating our youth on the damaging effects of marijuana use on both their health and their future."

"This study shows that long-term use of marijuana may have consequences for both individuals and their productivity and performance in the workplace," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H. "There is good treatment available for those who are habitual marijuana users, and we urge them to seek appropriate services through the treatment networks in their communities."

Authors of the study include Nadia Solowij, Robert Stephens, Roger Roffman, Thomas Babor, Ronald Kadden, Michael Miller, Kenneth Christiansen, Bonnie McRee, Janice Vendetti and Jean Donaldson, project officer for CSAT's Marijuana Treatment Project.

SAMHSA Awards New Grants

SAMHSA announced several new grant awards this spring and will continue to make awards throughout the summer. Grants so far include:

- $5.85 million for eight new awards to help strengthen and expand community-based systems for drug and alcohol addiction identification, referral, and treatment for young people.

Awards were made to: the Inter-tribal Council of Michigan in Sault Ste. Marie, MI; seven counties in greater Louisville, KY; the State Department of Children and Families in Hartford, CT; the Cuyohoga County Board of Commissioners in Cleveland, OH; Codac Behavioral Health Services of Pima County, Inc., of Tucson, AZ; Adolescent Treatment Centers, Inc., of Oakland, CA; Phoenix Programs of New York, Inc., of New York City; and the University of Iowa, Iowa City.

- $4.4 million awarded for eight Addiction Technology Transfer Centers (ATTCs). These new awards complete the national network of ATTCs, a program of SAMHSA's Center for Substance Abuse Treatment (CSAT).

ATTCs provide state-of-the-art education and training programs about addiction treatment to health care professionals, state and local government officials, and community-based treatment providers. Drawing on current health services research from such sources as the National Institutes of Health as well as SAMHSA's own program evaluations, ATTCs help upgrade standards of professional practice for treatment providers, prepare practitioners to function in managed care settings, and promote the inclusion of addiction treatment training in academic programs.

Addiction Technology Transfer Centers (ATTCs) provide state-of-the-art education and training programs about addiction treatment to health care professionals, state and local government officials, and community-based treatment providers.

The ATTC network will now include 14 regional centers and one national coordinating center. Grantees include: University of Missouri-Kansas City, Kansas City, MO; University of Illinois at Chicago, Chicago, IL; University of Iowa, Iowa City, IA; University of California, Los Angeles, CA; Universidad Central del Caribe, Bayamon, PR; Morehouse School of Medicine, Atlanta, GA; Florida Certification Board, Tallahassee, FL.

ATTCs help upgrade standards of professional practice for treatment providers and promote the inclusion of addiction treatment training in academic programs. The ATTC network will now include 14 regional centers and one national coordinating center.

Seven regional centers, in Rhode Island, Pennsylvania, Virginia, Maryland, Texas, Nevada, and Oregon, were named in September 2001.

- $428,384 for three awards to support development of substance abuse treatment services in rural communities experiencing problems with addiction to heroin or prescription pain relief medications containing oxycodone.

The awards will help treatment providers in rural Oregon, rural Maine, and rural Connecticut implement effective treatment strategies that utilize medications, including opioid agonists such as methadone or ORLAAM, in communities where access is limited or nonexistent.

The three projects include a grant of $128,409 to the Oregon Health & Science University to fund an opiate medication initiative for rural residents in Southwest Oregon; a grant of $150,000 to the Connecticut Department of Mental Health and Addiction Services to implement a culturally appropriate evaluation for Latinos in northwestern Connecticut, near Danbury; and a grant of $149,975 to the Regional Medical Center at Lubec, ME, to confront the crisis in abuse of narcotics in Washington County, ME, by developing and implementing comprehensive treatment services for addicted persons and their families.

We Would Like To Hear From You!

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

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

I found these articles particularly interesting or useful:

- ❑ Helping Children Exposed to Substance Abuse, Mental Illness, and Violence
- ❑ Teachers Receive Information on Underage Drinking
- ❑ President Launches New Freedom Commission on Mental Health
- ❑ Heroin, Cocaine, and Alcohol + Drugs Top Lists of Drug-Related Deaths
- ❑ Terrorism: Helping Communities Heal
- ❑ Screening Nursing Home Applicants for Mental Illness
- ❑ Promoting Older Adult Health: Guide Offers Assistance
- ❑ Care Improves for Vulnerable Children
- ❑ Prevention Programs Reduce Drug Use Among High-Risk Youth
- ❑ Systems of Care Help Youth with Serious Emotional Disturbance
- ❑ Estimating Cost of Preventive Services in Mental Health
- ❑ Long-Term Marijuana Use Affects Memory and Attention
- ❑ SAMHSA Awards New Grants
- ❑ Recovery Month To Celebrate 13th Anniversary

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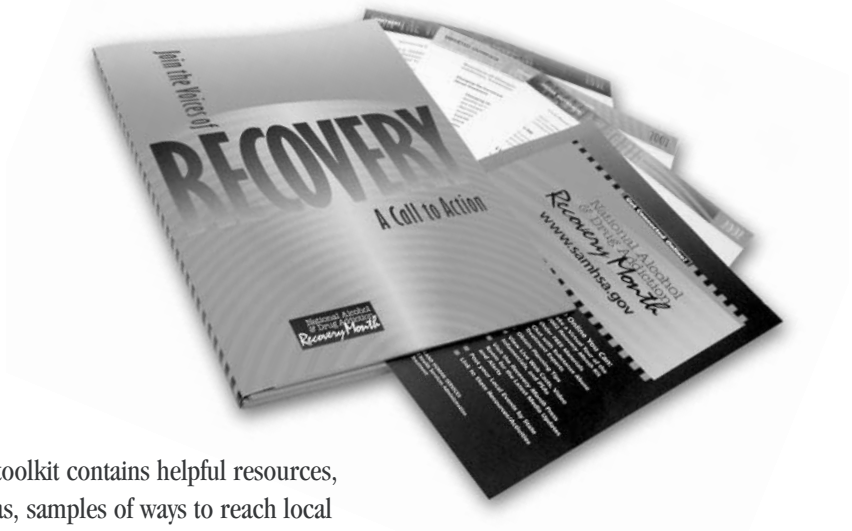
Thank you for your comments.

Recovery Month To Celebrate 13th Anniversary



This September will mark the 13th Anniversary of National Alcohol and Drug Addiction Recovery Month, sponsored annually by SAMHSA's Center for Substance Abuse Treatment (CSAT).

The month-long observance unites public and private sector partner organizations nationwide in an effort to highlight the societal benefits, importance, and effectiveness of drug and alcohol treatment. In addition, the observance aims to reduce the stigma associated with substance abuse treatment. Recovery Month also celebrates people in recovery and those who serve them.

"This year's theme, 'Join the Voices of Recovery: A Call to Action,' is intended to focus the Nation's attention on responding to Americans who seriously need substance abuse treatment," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

CSAT Director H. Westley Clark, M.D., J.D., M.P.H., added, "According to SAMHSA's National Household Survey on Drug Abuse from the year 2000, there are 14.5 million people in the United States who have a diagnosable substance abuse problem. Millions of these people who need help do not receive treatment."

The activities and materials for the Recovery Month Campaign are wide ranging. They include the Recovery Month toolkit, Web site, TV and radio public service announcements, community forums, radio tours, and community-sponsored events.

The centerpiece of the Recovery Month outreach effort is the Recovery Month campaign toolkit. A total of 75,000 kits will be distributed to various national and local organizations; Federal, state, and local government agencies and officials; grantees; professional treatment associations; and public and private treatment organizations.

The toolkit contains helpful resources, event ideas, samples of ways to reach local media, and fact sheets for key constituency groups and special audiences to initiate and conduct a successful public education campaign. The kit also includes information for launching a comprehensive education campaign through local print and broadcast media, as well as for educating parents and families, schools and educators, health and wellness professionals, health insurers, criminal justice system professionals, elected officials and civic leaders, labor and trade organizations, community organizations, the faith community, and employers.

SAMHSA also offers an interactive Web site where the entire toolkit and other materials can be downloaded or ordered. The Web site includes additional planning resources, media updates, Web events, and a schedule of activities planned across the country.

In support of Recovery Month, CSAT has produced two television public service announcements in English and Spanish. They will be sent to more than 800 TV stations and networks, and will be submitted for inclusion as part of the Media Match Campaign by the White House Office of National Drug Control Policy (ONDCP).

CSAT will further support local outreach efforts by sponsoring community forums in 31 host cities, including Honolulu, Los Angeles, San Antonio, Detroit, Boston, Baltimore, and San Juan, Puerto Rico. The forums will examine key treatment- and recovery-related issues, define specific objectives and action steps, and look for solutions to broaden and support individual access to treatment.

Recovery Month has grown considerably across the country in the past few years. Last year, for example, the Recovery Month radio tour reached more than 4 million listeners—almost double the number of the prior year. The Recovery Month Web site logged more than 500,000 visitors, up from just over 100,000 the year before.

In calling for participation in Recovery Month, ONDCP Director John P. Walters said, "Healing America's drug users is one of the cornerstones of our national drug control strategy."

Health and Human Services Secretary Tommy G. Thompson said, "Providing treatment for people in need is compassionate public policy and a sound investment."

For a Recovery Month toolkit, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information, at P.O. Box 2345, Rockville, MD 20847. Telephone: 1 (800)792-6686 (English and Spanish) or 1 (800)487-4889 (TDD). Kits may be ordered or downloaded in a PDF file from SAMHSA's Web site at **www.samhsa.gov**.

SAMHSA News

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