Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

March/April 2005, Volume 13, Number 2

Initiative Helps End Chronic Homelessness

When you're in and out of psychiatric wards, said Gayle Scarbrough, it's hard to maintain a place to live. Suffering from schizoaffective disorder and a drug addiction that only made her hallucinations more terrifying, Ms. Scarbrough slept in parks, under bridges, in shelters, anywhere she could. "My family's kind of messed up, so they couldn't provide any support," she explained. "As for friends, a person can only take so much when I'm having mental issues and drug problems. I didn't really have anywhere to go."

Then Ms. Scarbrough heard about an innovative program called Project Coming Home at Contra Costa County Health Services in nearby Martinez, CA.

Project Coming Home is 1 of 11 sites (see box on page 2) across the Nation participating in a unique collaboration among the U.S. Department of Health and Human Services (HHS)—with participation by SAMHSA and the Health Resources and Services Administration (HRSA)—the U.S. Department of Housing and Urban Development (HUD), and the

continued on page 2

Inside This Issue

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
- Substance Abuse and Mental Health Services Administration
- Center for Mental Health Services
- Center for Substance Abuse Prevention
- Center for Substance Abuse Treatment

www.samhsa.gov

www.samhsa.gov/SAMHSA_News

Homelessness

continued from page 1

U.S. Department of Veterans Affairs (VA). Launched in 2003, the 3-year Collaborative Initiative To Help End Chronic Homelessness is designed to bring a comprehensive approach to bear on the problem. (See *SAMHSA News,* Volume XI, Number 1.)

Each Federal agency is tackling a different piece of the puzzle. Within HHS, SAMHSA is funding substance abuse treatment, mental health care, and related supportive services, and HRSA is funding primary health care services. HUD is funding permanent housing. The VA is offering medical services to homeless veterans. The U.S. Interagency Council on Homelessness, which coordinates the Federal Government's response to homelessness, is helping to coordinate the $55 million effort.

"With this project, SAMHSA and its partners are providing a model at the Federal level of the kind of collaborative relationship we encourage at the local level," said SAMHSA Chief of Staff Gail P. Hutchings, M.P.A. "Working together to help homeless people overcome their multiple problems is the only way to help these individuals move off the streets, into housing, and back into productive lives."

Today, the 28-year-old Ms. Scarbrough is living in a subsidized one-bedroom duplex that the program's staff found for her. She's receiving mental health services. (She has been off drugs for 4 years now.) A caseworker calls and visits frequently to see if she needs food, make sure she's taking her medicine, and help her tackle the new challenges of running a household.

A Complex Problem

According to a series of fact sheets available from SAMHSA's National Resource and Training Center on Homelessness and Mental Illness (see box on page 4), as many as 2 to 3 million Americans experience homelessness at some point each year. Most homelessness is short term. However, about 10 percent of these individuals experience chronic, long-term homelessness.

Lacking a home isn't the only problem. An estimated 20 to 25 percent of homeless people have a serious mental illness, and up to half of those with a serious mental illness also have alcohol and/or drug problems. These problems often go untreated.

Navigating the multiple systems offering services to homeless people can be difficult even for those who don't have a major disability like serious mental illness, said Project Officer Lawrence D. Rickards, Ph.D., Acting Chief of the Homeless Programs Branch of the Division of Service and Systems Improvement at SAMHSA's Center for Mental Health Services.

Some chronically homeless people with mental illnesses initially may not even want treatment. Their priorities are often more concrete—housing, food, health care. "Many of these individuals are distrustful of a system that hasn't treated them well in the past," explained Dr. Rickards. "They may have gone through institutional treatment and been treated poorly, for example. Or they may have been treated with some of the older drug regimens that had many negative side effects or just weren't effective. And often their substance abuse issues were not addressed at all."

Substance abuse also plays a major role in chronic homelessness, said Project Officer Richard E. Lopez, M.A., Ph.D., J.D., a social science analyst in the Co-Occurring and Homeless Activities Branch of the Division of State and Community Assistance in SAMHSA's Center for Substance Abuse Treatment. "When you're on drugs, just about all your focus is on finding drugs and getting high," said Dr. Lopez. "You start losing focus about what it takes to keep an apartment or house of your own."

According to Dr. Rickards, substance abusers may also have cognitive problems as a result of their drug use and they can be difficult roommates, neighbors, or tenants. Family members, friends, and other potential sources of support often become alienated.

Many chronically homeless individuals also have physical disabilities like tuberculosis, heart disease, diabetes, or HIV. Treating such diseases in homeless populations can be especially challenging, said Dr. Rickards. These patients can have a hard time refrigerating medications, for example, or remembering to take them at the right time of day.

As a result of all these untreated conditions, as well as a range of systems barriers, chronically homeless people often land in hospital emergency departments, acute behavioral health facilities, or jails. Because services in these settings are costly, chronically homeless people consume more than half of the resources devoted to the homeless population as a whole.

Initiative Grantees

The following 11 grantees participate in the Collaborative Initiative To Help End Chronic Homelessness:

- Broward County Human Services Division, Fort Lauderdale, FL
- Central City Concern, Portland, OR
- Colorado Coalition for the Homeless, Denver, CO
- Contra Costa County Health Services, Martinez, CA
- Fortwood Center, Chattanooga, TN
- Horizon House, Inc., Philadelphia, PA
- Illinois Department of Human Services, Chicago, IL
- Lamp, Inc., Los Angeles, CA
- Project Renewal, Inc., New York, NY
- San Francisco Department of Public Health, San Francisco, CA
- Southeast, Inc., Columbus, OH.

To tackle this complex interplay of problems, grantees of the Collaborative Initiative To Help End Chronic Homelessness pull together community resources to address comprehensively the housing, mental health, substance abuse, and primary health care needs of the chronically homeless people they serve.

Although each of the 11 grantees takes a slightly different approach, all share a philosophy of housing people as quickly as possible, a goal of making it easy for individuals to get all the services they need, and a strategy of aggressive outreach.

In California

That aggressive outreach is especially important at a site like the Contra Costa County project. In contrast to the conspicuous homeless populations of large cities, homeless individuals here are spread out across an area the size of Rhode Island. They're also well hidden, said Project Officer Cynthia Belon, L.C.S.W., Director of Project Coming Home.

Outreach teams of case managers, peer counselors, health care professionals, and others go out to encampments and other places where homeless people congregate. Once a homeless person is deemed eligible for the project, the goal is to get that person housed as quickly as possible.

"When people were asked what they needed, they said they wanted housing first and foremost," explained Ms. Belon. "They didn't say, 'I want substance abuse treatment or mental health treatment.' They said, 'I need a place to live.' " Project Coming Home first places individuals in interim housing, then in permanent housing scattered throughout the county to help them assimilate into the broader community. Case managers ensure that they get the services they need to stay housed.

An array of partners helps make that happen. The local housing authority provides housing vouchers. The community health clinic and the VA provide health

continued on page 4

From the Administrator

A Life in the Community Starts with a Home

Between 2 and 3 million Americans experience homelessness at some point each year. Of these, an estimated 20 to 25 percent have a serious mental illness and up to half of those with a serious mental illness also have an alcohol or drug use problem.

Chronic homelessness results from a confluence of many factors, including lack of adequate income, diminished social supports, and a shortage of affordable housing. Serious mental illness and substance use create additional risk factors, affecting virtually every aspect of life, including self-care, money management, schooling, work, and social relations. Serious mental illness and drug abuse not only increase risk factors, they also increase the difficulty of overcoming homelessness.

Since the passage of the 1987 Stewart B. McKinney Homeless Assistance Act—the first comprehensive Federal legislation to address homelessness—we have learned much about effective ways to prevent and overcome chronic homelessness. There is no single, simple solution. Rather, success requires engagement at many levels.

For example, any successful effort must involve government at all levels, including Federal, state, and local governments, as well as the private sector, community organizations, service providers, consumers of services, and family members.

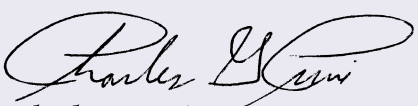
Similarly, people who are homeless and have mental illnesses and substance use disorders need a diverse array of services in addition to treatment. These include outreach, case management, housing options, primary health care, and a range of support services such as rehabilitation and employment counseling.

Finally, individuals with serious mental illnesses and substance use disorders should not have to negotiate multiple service systems in which health care, mental health and substance abuse treatment, social services, and housing services are separate and uncoordinated. They must be able to access these services from systems that are integrated and easily maneuvered.

SAMHSA continues to prioritize the national goals of ending homelessness through a rich array of services grants and technical assistance activities. To optimize our resources and staff talents, we manage our homelessness portfolio through a matrix approach relying heavily on each of SAMHSA's Centers and Offices.

Our vision at SAMHSA is to ensure that everyone has an opportunity for a life in the community. Clearly, the pillars of a fulfilling life must be built on a foundation of safe, stable, and comfortable shelter.

At the same time, a life in the community means not just a place, but also a sense of independence balanced with a sense of belonging. The rewards that accrue from a job, meaningful relationships with family and friends, and having a little corner of the world to call one's own can replace the walls of emptiness, isolation, and loneliness created by mental illness, drug use, and homelessness, and provide the key that opens the door to a new life of recovery.



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

Homelessness

continued from page 3

services. The county provides mental health and substance abuse treatment. Community-based organizations provide everything from peer counseling to training in money management. One organization handles all the leasing arrangements with landlords because homeless people frequently have credit problems that prevent them from signing their own leases.

Federal Resources on Homelessness

- SAMHSA's National Resource and Training Center on Homelessness and Mental Illness provides publications, conference information, and links to other resources. **www.nrchmi.samhsa.gov.**
- *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders.* **www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3870/default.asp**
- *Work as a Priority: A Resource for Employing People Who Have Serious Mental Illnesses and Who Are Homeless.* **www.mentalhealth.samhsa.gov/publications/allpubs/SMA03-3834/default.asp**
- *How States Can Use SAMHSA Block Grants To Support Services for People Who Are Homeless.* **www.mentalhealth.samhsa.gov/publications/allpubs/SMA04-3871/default.asp**
- From the Centers for Medicare and Medicaid Services (CMS), *FirstStep* is a tool that case managers and outreach workers can use to help homeless clients access Federal benefit programs. **www.cms.hhs.gov/medicaid/homeless/firststep/index.html.**

In Chicago

The Chicago site also uses the housing first approach in its ACT (Assertive Community Treatment) Resources To End Chronic Homelessness project. "The usual way services are provided is, 'If you maintain a certain level of sobriety or take your medication, then we'll get you housed,' " said Team Leader Jeffrey A. Gilbert of Thresholds Psychiatric Rehabilitation Centers, which receives funding for this project from the Division of Alcoholism and Substance Abuse at the Illinois Department of Human Services. "That's not how we work. We say, 'Let's get you housed first, and then we'll move forward and try to wrap services around you.' "

Targeting chronic homelessness on the South Side, the project uses an ACT model that relies on an eight-person multidisciplinary team to conduct outreach to homeless people in parks, shelters, and other settings. The goal is to get them into housing—a unit at the YMCA or Catholic Charities or a regular apartment—as soon as possible. Even before individuals are housed, the team starts getting them the services they need, whether it's medical and dental care, access to a psychiatrist, or job training. "We use a really aggressive, sometimes intrusive form of case management," explained Mr. Gilbert, noting that participants receive two to seven visits a week from the team once they're housed.

So far, the project has moved 40 people into housing and plans to house 19 more before the project ends. "There are between 10,000 and 15,000 homeless people in Chicago, so getting 59 people housed may sound very trivial," said Theodora Binion Taylor, M.Div., M.S., the Director of the Division of Alcoholism and Substance Abuse. "But it's not. It's almost miraculous." That's especially true when you consider who those individuals are, added Mr. Gilbert. "Those 59 people we're housing are not the easy people," he said. "These are 59 of the most difficult cases."

A Success Story

The initiative as a whole has been equally successful at moving some of the Nation's most vulnerable people into homes, according to the U.S. Interagency Council on Homelessness, which is responsible for tracking the initiative's progress. "The project has successfully moved more than 500 people, representing more than 3,000 years of homelessness, off the streets and out of long-term shelters and into the American promise of a place to live," said Philip Mangano, the Council's Executive Director. "Those years of homelessness represent countless dollars spent on emergency room visits, acute services from the behavioral health system, law enforcement interventions, and temporary periods of incarceration. The project is saving both dollars and lives," he said.

For Gayle Scarbrough, those numbers don't mean as much as the simple fact that she now has her own home. "I've never had my own space before," said Ms. Scarbrough, now a full-time student planning a career as a dental assistant. "I feel clean, respected, and professional. I've actually got a chance—something I've never had before."

—By Rebecca A. Clay

Gayle Scarbrough at home today.

Grants.gov: One Stop for Federal Grants

Grants.gov, the central source for Federal funding information and applications, provides access to grant opportunities offered by the 26 Federal grant-making agencies. There are more than 900 grant programs offered by these agencies in 21 categories, including community development, health, housing, and disaster prevention and relief.

According to Grants.gov staff, nearly 4,000 grant-seeking organizations have already registered at the site, and more than 900,000 grant-opportunity notices are distributed by e-mail each week. On any given day, Grants.gov provides access to more than 2,000 active grant-opportunity notices. And thus far, more than 2,400 grant applications have been submitted.

How Grants.gov Works

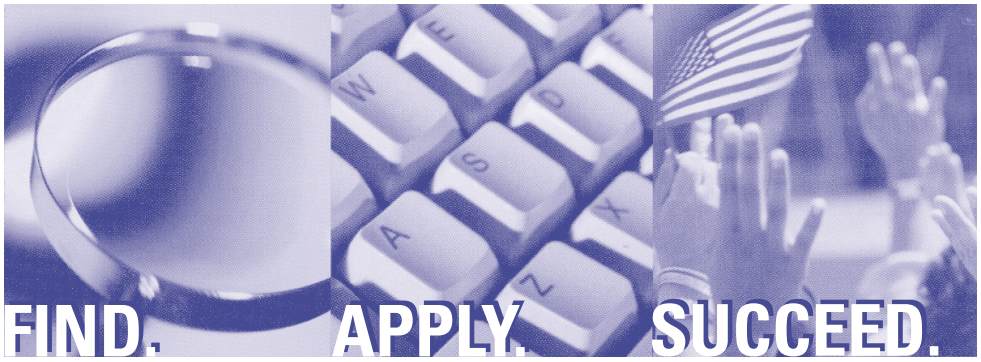
Anyone can access the Grants.gov Web site, search and review grant-opportunity notices, and sign up for weekly e-mail alerts.

To submit an application, applicants follow a four-step process, which usually takes about 3 to 5 business days and includes registering with the Central Contractor Registry. Marge Jacobsohn, the point of contact on Grants.gov issues at SAMHSA's Office of Program Services, cautions against waiting until the last minute. "If any single step gets delayed, the whole process will be held up. It's best to register as soon as possible."

Applicants register at Grants.gov only once. After that, they can access and apply for any available grant.

Navigating Grants.gov

From every page of the Grants.gov Web site, visitors can get online help. Special features such as "Find Grant Opportunities" and "Apply for Grants" are always available, and each section has many other features to support applicants in their search and application process.



All forms requiring signatures must be submitted in hard copy. For SAMHSA grants, for example, forms are submitted to the SAMHSA grant review office. An additional 5 days after the grant deadline is allowed for mailing in hard copies of signed forms—provided those forms were submitted electronically prior to the deadline.

Grants.gov is one of several Federal E-Government initiatives designed to improve access to Government services through the Internet. Grant application processes are now standardized across all agencies.

The SAMHSA Web site still provides full descriptions of the Agency's grant opportunities and awards at **www.samhsa.gov.** For Fiscal Year 2005, the majority of SAMHSA's discretionary grant programs can be submitted through Grants.gov. For Fiscal Year 2006, SAMHSA plans to offer continuation grant applications as well.

For more information about Grants.gov, including materials from a recent Web cast, visit the site at **www.grants.gov.**

Participating Grant-Making Agencies

* Indicates a partner agency collaborating to make Grants.gov a success

U.S. Department of Agriculture*
U.S. Department of Commerce*
U.S. Department of Defense*
U.S. Department of Education*
U.S. Department of Energy
U.S. Department of Health and Human Services*
U.S. Department of Homeland Security*
U.S. Department of Housing and Urban Development*
U.S. Department of the Interior
U.S. Department of Justice*
U.S. Department of Labor*
U.S. Department of State
U.S. Department of Transportation*
U.S. Department of the Treasury
U.S. Department of Veterans Affairs
Agency for International Development
Corporation for National and Community Service
Environmental Protection Agency
Institute of Museum and Library Services
National Aeronautics and Space Administration
National Archives and Records Administration
National Endowment for the Arts
National Endowment for the Humanities
National Science Foundation*
Small Business Administration
Social Security Administration.

ATTC Network Addresses Workforce Development Needs

This is the second article in a series on workforce development. An earlier article focused more on mental health (see SAMHSA News, *November/December 2004). This current article highlights two initiatives by one of SAMHSA's most established workforce development resources in the addiction treatment field, the Addiction Technology Transfer Centers.*

Jean Jones, C.A.P., was so burned out by her job as a program administrator at Operation PAR, Inc., in St. Petersburg, FL, she was ready to abandon the field she had worked in for 27 years. Then she had an experience she credits with saving her career in substance abuse treatment: She attended a leadership institute developed by the Southern Coast Addiction Technology Transfer Center (ATTC). This center is 1 of 14 regional ones funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) to increase the knowledge and skills of addiction treatment practitioners.

The week-long leadership institute and the 6 months of working with a mentor that followed not only cured Ms. Jones' burnout but boosted the morale of her staff, formerly plagued by rapid turnover. The most important lesson? To stop trying to tackle both administrative and clinical tasks.

"I thought I was supporting my staff by helping out," said Ms. Jones, who noted that she became a supervisor in 1998 without any real training or certainty about what she was doing. Her mentor saw her hands-on approach differently, asking whether she really trusted her staff to do things right. "I backed off a lot as a result," said Ms. Jones. "And when I backed off, my staff blossomed. I was getting in their way."

Helping to build an effective workforce is exactly what the ATTCs were designed to do. Established in 1993, the ATTC network consists of a national office and 14 regional centers (see box below) dedicated to conveying the latest scientific knowledge to the field and improving the work of addiction treatment practitioners. Serving as resource centers, the network creates initiatives, services, and products as specific local or national needs emerge.

Training Emerging Leaders

The leadership institute in which Ms. Jones participated, for example, was the Southern Coast ATTC's response to rapid turnover in the addiction workforce. "With so many people retiring and so much turnover in the field, we're just not grooming people for leadership positions," said Southern Coast ATTC Director Pamela Waters, M.Ed., who developed the institute model. "People move up the ladder quickly because there are vacancies and agencies are scrambling." The institute model gives each class of 15 to 20 mid-level staffers a chance to learn leadership skills ranging from communicating with staff to being assertive in meetings, from managing time to setting priorities.

The process begins with what's called a 360-degree assessment of participants. Participants' supervisors, peers, staff, and participants themselves log on to the U.S. Department of Agriculture (USDA) Graduate School Web site and assess participants' performance in 27 different leadership competencies.

Participants next attend an intensive, week-long training provided by ATTC staff and USDA trainers. They then develop individual leadership development plans and spend the next 6 months working with a mentor on an individual project to enhance one or more competency areas identified as needing extra work during their assessments. During that time, participants are required to take an additional 20 hours of continuing education.

"The training isn't free," said Workforce Development Team Leader Karl D. White, Ed.D., of CSAT. "Each agency that sends a participant must agree to free the trainee from regular duties for enough time over the next 6 months following the immersion training to ensure completion of the continuing education requirements. In some ATTC regions, these activities are free of charge. In other regions, depending on an individual's needs, some continuing education activities may have tuition attached."

The ATTC Network

Launched in 1993 by SAMHSA's Center for Substance Abuse Treatment, the Addiction Technology Transfer Center (ATTC) Network comprises 14 independent regional centers and a national office.

The purpose of the ATTCs is to communicate the latest research-based information to treatment providers and other professionals, thereby encouraging the best care for people with substance use disorders.

The ATTCs provide education and professional development opportunities to the workforce, develop substance abuse treatment and recovery curricula, and promote regional and national alliances among practitioners, researchers, policymakers, funders, and consumers of services. (For a description of a sample workforce development activity, see the main article.)

Each regional center offers valuable information online (see box on page 7). The National Office's Web site is located at **www.nattc.org.**

All the ATTCs are now replicating the leadership institute model in their own regions. Regional leadership conferences are being funded and produced by the ATTCs in a joint venture with CSAT's Partners for Recovery program.

Enhancing Clinical Supervision

The Northwest Frontier ATTC responded to a different problem: an extremely diverse addiction workforce. "We have counselors who have everything from graduate degrees in clinical services to people who learned their counseling skills on the job," explained Steve Gallon, Ph.D., the center's principal investigator and an adjunct associate professor of public health and preventive medicine at Oregon Health Sciences University in Salem, OR, where the ATTC is housed. In response, Dr. Gallon created a curriculum to train supervisors how best to supervise this diverse clinical workforce.

Supervisors play a key role in ensuring that counselors, no matter what their backgrounds, are doing things right, said Dr. Gallon. "The clinical supervisor is really the agency's representative in terms of encouraging staff to follow the agency's policies, procedures, and guidelines," he explained. "And there's a fair amount of research indicating that if you train someone to implement an evidence-based practice but don't supervise the delivery of that practice, within a fairly short period of time the person's proficiency degrades, the quality of care diminishes, and pretty soon what you think is common practice is something different in every single counselor's office."

Teaching supervisors the clinical supervision skills they need to mentor counselors effectively is the goal of the highly interactive, 21-hour curriculum Dr. Gallon created. Entitled "Clinical Supervision One: Building Chemical Dependency Counselor Skills," the curriculum focuses on the teaching and mentoring aspects of supervision.

After an overview of a clinical supervisor's tasks and functions, the curriculum teaches participants how to observe counselors performing their clinical duties, assess counselors' proficiencies, prepare feedback, structure meetings with counselors, and design learning plans to improve counselors' performance.

As a framework, the curriculum uses SAMHSA's Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.*

Dr. Gallon estimates that somewhere between 500 and 1,000 supervisors in the Northwest Frontier region have undergone the training. Idaho, in particular, is taking the curriculum very seriously. A majority of the state's clinical supervisors have already undergone the training, especially now that the state requires agencies to provide clinical supervision and reimburses such supervision at the same rate as counseling.

The Northwest Frontier ATTC has trained trainers in some states outside its region. And other regions have adapted the curriculum to meet their specific needs and provide the training. For the future, more curricula are on the way, said Dr. Gallon, noting that upcoming topics will include dealing with difficult supervisory situations.

"The feedback has been extremely positive," said Dr. Gallon. "We have many people saying they wish they had this training years ago when they first started doing supervision."

For more information, visit the National ATTC Web site at **www.nattc.org.**

—By Rebecca A. Clay

ATTCs Nationwide

Caribbean Basin and Hispanic ATTC
Puerto Rico, U.S. Virgin Islands
http://cbattc.uccaribe.edu

Central East ATTC
Delaware, District of Columbia, Kentucky, Maryland, Tennessee
www.ceattc.org

Great Lakes ATTC
Illinois, Indiana, Michigan, Ohio, Wisconsin
www.glattc.org

Gulf Coast ATTC
Louisiana, Mississippi, Texas
www.utattc.net

Mid-America ATTC
Arkansas, Kansas, Missouri, Oklahoma
www.mattc.org

Mid-Atlantic ATTC
Maryland, North Carolina, Virginia, West Virginia
www.mid-attc.org

Mountain West ATTC
Colorado, Montana, Nevada, Utah, Wyoming
www.mwattc.org

New England ATTC
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
www.attc-ne.org

Northeast ATTC
New Jersey, New York, Pennsylvania
www.neattc.org

Northwest Frontier ATTC
Alaska, Hawaii, Idaho, Oregon, Pacific Islands, Washington
www.nfattc.org

Pacific Southwest ATTC
Arizona, California, New Mexico
www.psattc.org

Prairielands ATTC
Iowa, Minnesota, Nebraska, North Dakota, South Dakota
www.pattc.org

Southeast ATTC
Georgia, South Carolina
www.sattc.org

Southern Coast ATTC
Alabama, Florida
www.scattc.org.

Co-Occurring Disorders: A Guide for Service Providers

SAMHSA recently published Treatment Improvement Protocol 42 (TIP 42), *Substance Abuse Treatment for Persons With Co-Occurring Disorders,* to help addiction counselors and other practitioners treat clients with co-occurring substance abuse and mental disorders.

Often, clients are treated for only one or the other problem in either a substance abuse or mental disorder treatment setting, whereas the use of an integrated approach enhances treatment outcomes. To this end, TIP 42 describes a variety of practical, evidence- and consensus-based approaches that can be used in either setting.

TIP 42 cites data from research over the last decade showing that co-occurring disorders are common, create multiple problems, and have a profound impact on treatment processes and outcomes.

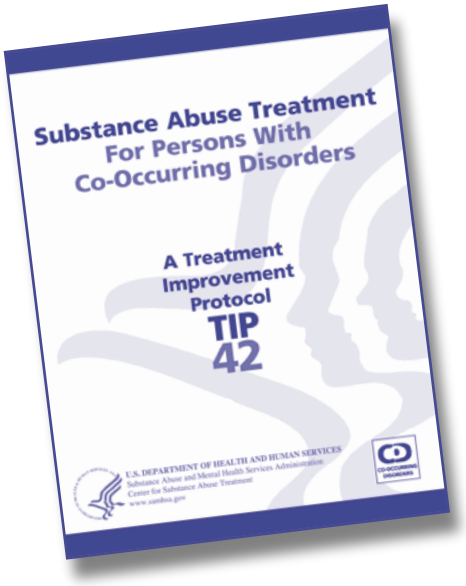
Created by a panel of experts and reviewed by the field, TIP 42 is designed primarily for service providers who treat clients on a regular basis, but also is useful for administrators, primary care providers, criminal justice staff, and other health care and social service personnel who encounter people with co-occurring disorders.

The TIP contains nine chapters and 14 appendices and includes case studies as examples for counselors.

Highlights

Early chapters cover the treatment of co-occurring disorders as an evolving field, the important developments leading to the creation of TIP 42, the publication's scope and intended audience, and the criteria used to select the strategies, techniques, and models that are described in subsequent sections.

- **Definitions and terms** defines, describes, and reviews terms and classification systems for co-occurring disorders as they relate to substance abuse, mental disorders, clients, treatment, programs, and treatment systems.



- **Workforce development** addresses critical issues in workforce development, including values, competencies, education, and training.
- **Assessment** includes a review of key principles, highlights of the selected instruments, and a description of the 12 steps in an "ideal" assessment process. TIP 42 encourages counselors to collect patient information on a continuous basis and to revise assessments often as the patient moves through recovery.
- **Treatment approaches** provides counselors with principles, strategies, and models for treating clients with co-occurring disorders wherever they come for treatment—including facilities for treatment of substance abuse or mental health, or medical offices.
- **Traditional settings and models** describes practices that have proven effective for treatment of persons with co-occurring disorders in residential and outpatient settings. Several distinctive models are highlighted.
- **Special settings and specific populations** explores the particular needs of people with co-occurring disorders within three key "special" populations: homeless persons, criminal justice populations, and women. Recommendations cover the means and methods of providing treatment to clients with co-occurring disorders in acute care and other medical settings, and the ways such programs can be sustained. Emerging "dual recovery mutual self-help" programs are also described.
- **Mental disorders** contains key information about substance abuse and particular mental disorders, highlighting advice to help counselors work effectively with clients who have co-occurring disorders.

To obtain TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Ask for NCADI No. BKD515.

For more information, visit SAMHSA's Co-Occurring Center for Excellence at **www.coce.samhsa.gov.**

To Find TIPs Online

For information and online links to other Treatment Improvement Protocol (TIP) publications, visit **www.kap.samhsa.gov/products/manuals/tips/numerical.htm.** You can review the entire TIP series by topic or by number.

Utah Has Lowest Illicit Drug Use Rate, Alaska Has Highest

Utah has the lowest rate of past-month illicit drug use as well as the lowest rate for binge drinking in the Nation, according to a new report based on SAMHSA's National Survey on Drug Use and Health (NSDUH). Alaska has the highest rate of illegal drug use, while North Dakota has the highest rate for binge drinking. The Agency's Office of Applied Studies conducts the annual survey.

The report, *State Estimates of Substance Use from the 2002–2003 National Surveys on Drug Use and Health,* estimates state rates of illegal drug use, binge drinking, serious mental illness, and tobacco use by persons age 12 and older.

Marijuana

Tennessee had the lowest rate (7.4 percent) for marijuana use in the past year, while Alaska had the highest rate (16.7 percent). These rates compare to the national rate of 10.8 percent for marijuana use in the past year. For current use—that is, use in the past month—Utah had the lowest rate (4.0 percent), and New Hampshire had the highest rate (10.2 percent). The national current use rate for marijuana was 6.2 percent.

Other Illicit Drugs

Estimates of past-month use of any illicit drug ranged from a low of 6.3 percent in Utah to a high of 12.0 percent in Alaska for all persons age 12 and older. Any illicit drug use includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically. Colorado, the District of Columbia, Montana, Nevada, New Hampshire, New Mexico, Oregon, Rhode Island, and Vermont also displayed high rates of past-month illicit drug use. The 10 states with the lowest rates of past-month illegal drug use, including Utah, were Alabama, Iowa, Kansas, Mississippi, New Jersey, South Dakota, Tennessee, Texas, and West Virginia.

Binge Alcohol

Utah had the lowest rate (15.9 percent) in the Nation for binge alcohol use in the past month. Binge alcohol use is defined as drinking five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey. North Dakota had the highest rate (31.4 percent). Colorado, Iowa, Massachusetts, Minnesota, Montana, Nebraska, Rhode Island, South Dakota, and Wisconsin also had high rates of binge drinking. The 10 states with the lowest rates of binge drinking, including Utah, were Alabama, Kentucky, Mississippi, North Carolina, Oklahoma, Oregon, Tennessee, Virginia, and West Virginia.

Substance Dependence and Abuse

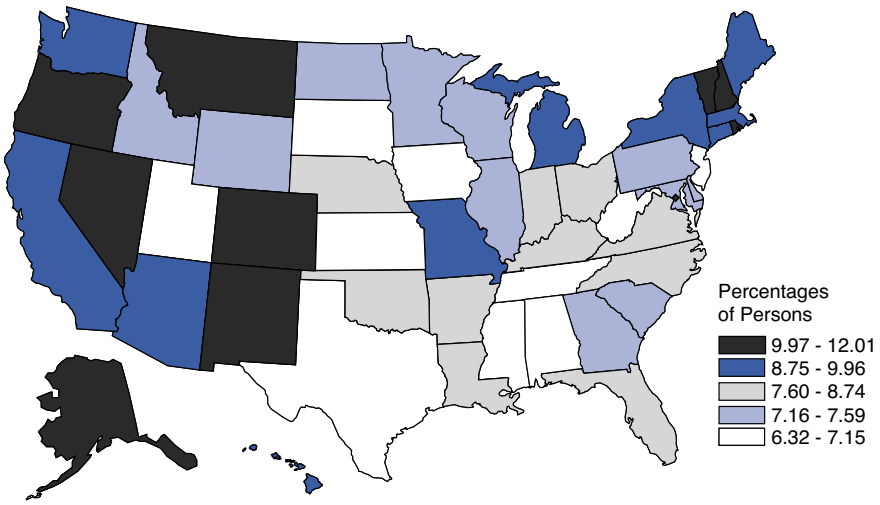
Tennessee had the lowest rate (6.0 percent) of past-year alcohol dependence or abuse, and North Dakota had the highest (10.8 percent). Alabama, Kentucky, Mississippi, and New Jersey had low rates (6.5 percent or less). Kansas and Iowa had the lowest rate of past-year illicit drug dependence or abuse (each with 2.5 percent). Massachusetts, New Mexico, Rhode Island, and Vermont also had high rates of illicit drug dependence or abuse in the past year, while Alabama, New Jersey, Pennsylvania, South Dakota, Texas, Wisconsin, and Wyoming had low rates.

Serious Mental Illness

NSDUH estimated serious mental illness for persons age 18 and older. Rhode Island had the highest rate (11.0 percent) in the Nation, and Hawaii had the lowest rate (7.2 percent).

The report is available from SAMHSA's National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The report is available on SAMHSA's Web site at **www.oas.samhsa.gov.**

Percentages Reporting Past-Month Use of Any Illicit Drug Among People Age 12 or Older, by State: 2002 and 2003



Source: SAMHSA, Office of Applied Studies, *National Survey on Drug Use and Health,* 2002 and 2003.

SAMHSA Addresses Global Burden of Mental Illness

The burden of mental illness on health and productivity in the United States and throughout the world has long been underestimated.

According to a *Global Burden of Disease* study by the World Health Organization (WHO), Harvard University, and the World Bank, mental illness—including suicide—accounts for more than 15 percent of the burden of disease in countries with established market economies. This is more than the disease burden caused by all cancers.

To help address this public health challenge, SAMHSA is working at home and abroad to identify what needs to be done to effect change.

Around the world, the goal is to investigate and explore all available methods to create flexible, accessible, and sustainable mental health care systems. SAMHSA has met with public health officials from many countries—including England, Afghanistan, Iraq, Russia, New Zealand, Australia, Italy, and countries affected by the tsunami in South Asia—to share information and gain insight on how to address the global mental health crisis.

The Agency is working to find common ground and partner with the international community to move initiatives forward, map out plans for advanced training for care providers, strategize funding possibilities, and prepare to respond to natural disasters and to terrorism as well as to the needs of countries in post-conflict recovery.

SAMHSA's international efforts include:

Work with Post-Conflict Countries

Project 1 Billion is an effort that convenes meetings with post-conflict countries to enable them to work together to address the mental health needs of their peoples. In December 2004, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., addressed attendees in Rome, Italy, at Project 1 Billion: International Congress of Ministers of Health for Mental Health and Post-Conflict Recovery.

In Rome, Italy, SAMHSA Administrator Charles G. Curie and James Lavelle, LICSW, of the Harvard Program in Refugee Trauma joined with other leaders from around the world at the 2004 Project 1 Billion conference.

Calling the project "an excellent roadmap for our work on global mental health issues," Mr. Curie emphasized how collaboration "will help to define our roles as leaders who have a genuine desire to work together to help recovery around the globe."

At this 2004 meeting, participants endorsed a mental health action plan and distributed *Project 1 Billion Book of Best Practices: Trauma and the Role of Mental Health in Post-Conflict Recovery.*

Mental Health Leadership

SAMHSA is actively supporting Afghanistan and Iraq to re-establish mental health services in their countries, where decades of conflict have destroyed most of the mental health care system and deeply affected the populations.

Currently, SAMHSA chairs the Planning Group on Iraq Mental Health. At a meeting in December 2004 (see *SAMHSA News,* January/February 2005), the Planning Group—including Dr. Sabah Sadik, Iraq's National Mental Health Advisor—developed plans for the Action Planning Conference on Iraq Mental Health. That conference convened March 14 to 18, 2005, in Amman, Jordan, as part of an ongoing effort to help rebuild Iraq's mental health care system. (*SAMHSA News* will report on this conference in an upcoming issue.)

Other Agency efforts include the International Initiative for Mental Health Leadership (IIMHL), a joint endeavor of SAMHSA, the National Institute for Mental Health in England, and the Ministry of Health New Zealand. Mr. Curie serves as a founding member.

The IIMHL developed from a worldwide effort to share best practices and provide support and collaborative opportunities for global leaders in mental health services from developed countries. The group holds annual conferences and leadership exchanges hosted by member countries on a rotating basis.

When the United States hosted the Second IIMHL conference in 2004, SAMHSA played a key role in the preparations. The agenda focused on consumer involvement in the mental health system, reducing the use of seclusion and restraint, and on the transformation of mental health services from institutional services to community-based, consumer-driven services.

SAMHSA also participated in the 2005 conference in Wellington, New Zealand.

SAMHSA has joined in collaborations with the World Health Organization, the World Federation for Mental Health, the

Clifford Beers Foundation, the Carter Center, and others. The focus of these efforts is to promote mental health and decrease the incidence and disease burden of mental and behavioral disorders worldwide, principally through establishing the Global Consortium for the Worldwide Advancement of Promotion and Prevention in Mental Health (GCAPP) as an international resource.

While in New Zealand in September 2004 at a meeting of the GCAPP, Mr. Curie participated in the International Alliance for Child and Adolescent Mental Health and Schools (Intercamhs). SAMHSA has provided the seed money to launch Intercamhs, which advances the idea that schools have a part to play in promoting and protecting the mental health of the community.

Training and Support

Functional mental health care systems require trained mental health care providers. SAMHSA is helping to plan programs for mental health professionals from developing nations to receive training in the United States and elsewhere.

For example, SAMHSA provided support for Afghan representatives to attend a pilot meeting of Ministers of Health of post-conflict countries, held in Sarajevo.

SAMHSA also supported representatives from mental health systems in Afghanistan and Iraq to attend Masterclasses in Refugee Trauma and Treatment provided by the Harvard Project on Refugee Trauma.

Other efforts to strengthen mental health systems abroad have included a collaboration with the State Department to develop a two-part project on substance abuse prevention for use in Russia. The project provided support for a substance abuse prevention curriculum based on the evidence-based Life Skills model in every grade in Russian schools. In addition, the project offered a training curriculum for all health care workers on prevention screening for substance abuse, based on SAMHSA's Treatment Improvement Protocol 24, *A Guide to Substance Abuse Services for Primary Care Clinicians.*

International Resources

For more information about international relief efforts by the U.S. Department of Health and Human Services (HHS), visit **www.globalhealth.gov.**

Other international initiatives and programs for mental health include:

- Project 1 Billion: International Congress of Ministers of Health for Mental Health and Post-Conflict Recovery at **www.project1billion.org.**
- International Initiative for Mental Health Leadership (IIMHL) at **www.iimhl.com.**
- Global Consortium for the Worldwide Advancement of Promotion and Prevention in Mental Health (GCAPP) at **www.gcappmentalhealth.org.**
- International Alliance for Child and Adolescent Mental Health and Schools (Intercamhs) at **www.intercamhs.org.**

Tsunami Disaster Relief

SAMHSA is supporting U.S. Department of Health and Human Services (HHS) efforts to help countries in South Asia devastated by the December 26, 2004, tsunami. The HHS Mental Health Team, which includes SAMHSA staff, is supporting efforts of the United Nations and non-governmental organizations to address mental health issues in the communities along the west coast of Sumatra, Indonesia.

For example, 50 HHS staff (including staff from SAMHSA) traveled on the USNS Mercy to the Indian Ocean in January to provide assistance.

In addition, SAMHSA's National Center on Child Traumatic Stress prepared information on children and trauma for distribution to humanitarian aid workers and victims of the tsunami.

Also, in a partnership with the Centers for Disease Control and Prevention (CDC), SAMHSA enhanced the mental health and substance abuse elements of CDC's disaster response, and the two agencies are collaborating to make more online information available on the psychological impact of disasters.

SAMHSA is currently exploring other ways to provide specific support to the area.

For more information, visit **www.samhsa.gov.**

Official U.S. Navy photo

SAMHSA Announces Funding Opportunities

SAMHSA recently announced several grant funding opportunities for Fiscal Year 2005. Selected announcements include the following:

- **Mental Health Transformation State Incentive Grants** (Application due date: June 1, 2005)—6 to 13 cooperative agreement grant awards, for $1.5 million to $3 million per year for up to 5 years, to provide support for infrastructure and service delivery improvement activities to help build a solid foundation for delivering and sustaining mental health and related services. These grants will support new and expanded planning and development to promote transformation to systems explicitly designed to foster recovery and meet the multiple needs of consumers. (SM-05-009, $18.8 million)
- **Comprehensive Community Mental Health Services for Children and Their Families Program** (Application due date: May 17, 2005)—up to 24 cooperative agreement grant awards, for up to $1 million in years 1 and 6, $1.5 million in years 2 and 5, and $2 million in years 3 and 4, for the Child Mental Health Initiative to build effective systems of care for children with serious emotional disturbances and their families. (SM-05-010, $24 million)
- **Targeted Capacity Expansion Grants To Meet the Mental Health Services Needs of Older Adults** (Application due date: May 5, 2005)—11 grant awards, from $375,000 to $400,000 per year for up to 3 years, to help provide direct services and to build the necessary infrastructure to support expanded services for meeting the diverse mental health needs of older persons who are at risk for or are experiencing mental health problems. (SM-05-012, $4.4 million)
- **Targeted Capacity Expansion Grants for Jail Diversion** (Application due date: May 24, 2005)—6 grant awards, for $400,000 per year for up to 3 years, for jail diversion programs to divert individuals with mental illness away from the criminal justice system and into community-based, integrated mental health and substance abuse treatment and appropriate support services. (SM-05-011, $2.4 million)
- **Mental Health Services for Adolescents at Risk of Suicide** (Application due date: June 1, 2005)—8 cooperative agreement grant awards, for $250,000 per year for up to 2 years, to evaluate voluntary school-based programs that focus on the identification and referral of high school youth who are at risk for suicide or suicide attempts. (SM-05-019, $1.8 million)
- **State-Sponsored Youth Suicide Prevention** (Application due date: June 1, 2005)—up to 14 cooperative agreement grant awards, for up to $400,000 per year for up to 3 years, to build on the foundation of prior suicide prevention efforts and support states and tribes in developing and implementing youth prevention and early intervention strategies, as authorized under the Garrett Lee Smith Memorial Act. (SM-05-014, $5.5 million)
- **Campus Suicide Prevention** (Application due date: June 1, 2005)—20 grant awards, for up to $75,000 per year for up to 3 years, with an equivalent match from the applicant's organization, to support institutions of higher education to enhance services for students with mental and behavioral health problems, as authorized under the Garrett Lee Smith Memorial Act. (SM-05-015, $1.5 million)
- **Suicide Prevention Resource Center** (Application due date: June 1, 2005)—1 cooperative agreement grant award, for $2.6 million per year for up to 5 years, to create and operate a national suicide prevention resource center that will assist states, territories, tribes, and communities in their efforts to plan for the development, implementation, and evaluation of suicide prevention programs, as authorized under the Garrett Lee Smith Memorial Act. (SM-05-017, $2.6 million)

National Child Traumatic Stress Initiative

- **Community Treatment and Services Centers** (Application due date: May 17, 2005)—19 grant awards, for $400,000 per year for up to 4 years, for community treatment and services centers under the National Child Traumatic Stress Initiative to improve treatment and services for children and adolescents who have experienced traumatic events. (SM-05-006, $7.6 million)
- **Treatment and Service Adaptation Centers** (Application due date: May 6, 2005)—8 grant awards, for $600,000 per year for up to 4 years, to improve treatment for all children and adolescents who have experienced traumatic events by providing national expertise and serving as the lead organizations for identifying and adapting effective treatment and services for specific types of trauma. (SM-05-005, $4.8 million)

For the most up-to-date listings, and for information regarding applications, visit **www.grants.gov** or **www.samhsa.gov/grants.**

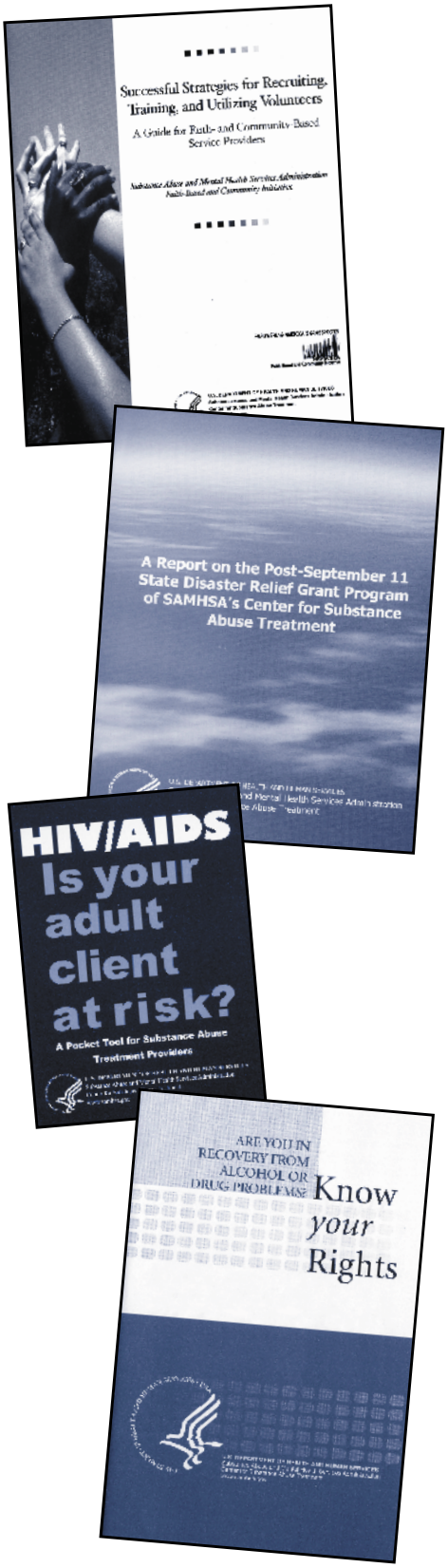
Drug Free Communities Support Program Grants (Application due date: May 31, 2005)—20 grant awards (approximately) to new programs and 19 competing renewal Mentoring Program awards. Award amounts will be up to $75,000 per year for up to 2 years. Grants will be administered by SAMHSA from money provided by the Office of National Drug Control Policy under the Drug Free Communities Support Program. (SP-05-003, $2.9 million).

Recruiting, Training, and Using Volunteers

This 56-page handbook—*Successful Strategies for Recruiting, Training, and Utilizing Volunteers: A Guide for Faith- and Community-Based Service Providers*—offers help for organizations seeking to make the most of the skills of their volunteers and expand their services to the community. The handbook focuses on prevention, treatment, and recovery services for substance abuse and mental illness; however, the principles described apply to any field and may help organizations understand how to start and manage a successful volunteer program. Chapters describe specific steps to take in carrying out an effective volunteer program: planning, recruiting, training, managing, and evaluating. Volunteer profiles throughout the handbook showcase the talent, passion, and commitment of volunteers and illustrate the diversity of volunteer positions. Appendices include sample forms and worksheets, a glossary, and print and Web-based resources. NCADI No. BKD519.

Screening Substance Abuse Clients for HIV/AIDS

Because substance abuse is associated with the risk of HIV infection, screening for HIV/AIDS is recommended for clients receiving substance abuse treatment. This pocket tool for substance abuse treatment providers—*HIV/AIDS: Is Your Adult Client at Risk?*—contains questions that may help identify what (if any) types of risky behavior a client may be engaging in as well as specific talking points to engage clients in a discussion about how to change or avoid such behaviors. NCADI No. MS965.



Post-9/11 Disaster Relief Grant Program

A Report on the Post-September 11 State Disaster Relief Grant Program of SAMHSA's Center for Substance Abuse Treatment focuses on the program activities undertaken by the nine states—Connecticut, District of Columbia, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and Virginia—that received SAMHSA disaster relief following the September 11, 2001, attacks. The 32-page report details cross-cutting themes for states that received the grants and provides an overview of the contributions of Single State Authorities for Alcohol and Substance Abuse Services with respect to disaster planning, training, and providing substance abuse treatment services. State-specific observations from participating states also are included. NCADI No. BKD516.

In Recovery? Know Your Rights

For general guidance on the legal rights of individuals with alcohol or drug problems, *Are You in Recovery? Know Your Rights* informs people in recovery of their rights, including Federal laws that protect them from discrimination in employment and job training, housing, Government services and programs, health care, and education. This 15-page brochure lets readers know what they can do to prevent or remedy violations to their rights and overcome barriers due to current or past drug- or alcohol-related problems. NCADI No. PHD1091.

These publications are available from SAMHSA's National Clearinghouse for Alcohol and Drug Information. Call 1 (800) 729-6686 or 1 (800) 487-4889 TDD (for the hearing impaired), or visit **www.samhsa.gov.**

President's 2006 Budget Proposes $3.3 Billion for SAMHSA

President George W. Bush's Fiscal Year 2006 budget for SAMHSA proposes $50.8 million in new funds for the President's Access to Recovery Initiative for drug treatment and $6 million in new funding to continue revamping the Nation's mental health system. In all, the President's budget proposes $3.3 billion in SAMHSA funding for Fiscal Year 2006.

While the budget request reflects a $56 million reduction in SAMHSA program-level funding from 2005, SAMHSA officials pointed out that the President's budget sustains SAMHSA efforts to:

- Expand substance abuse treatment capacity in new and innovative ways.
- Strengthen and streamline substance abuse prevention efforts.
- Achieve a wholesale transformation of the Nation's mental health service delivery system.
- Improve accountability and increase state flexibility in using Block Grant funds.

"For the upcoming year, we have once again proposed an aggressive agenda for SAMHSA that supports our vision and mission, while at the same time upholding fiscal responsibility and good stewardship of the people's money," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "It has focused SAMHSA staff and the field on planting a few 'redwoods' rather than letting 'a thousand flowers bloom.' "

Substance Abuse

The Fiscal Year 2006 budget includes $2.4 billion, a net increase of $10 million, for effective substance abuse treatment and prevention activities.

Opening New Pathways to Recovery. The President proposes a 50-percent increase for his Access to Recovery State Voucher Program, bringing the total funding level for the program to $150 million. Access to Recovery allows people seeking treatment and recovery services to choose among qualified community providers, including those that are faith-based. The program recognizes that there are many pathways to recovery from addiction. Through this program, individuals are assessed, given a voucher for appropriate services, and provided with a list of service providers from which they can choose. Additional funding will enable SAMHSA to expand this innovative program to 7 more states in Fiscal Year 2006, for a total of 22 participating states. States will have the flexibility to focus their efforts on the areas of greatest need.

The budget request also includes $31 million for the Screening, Brief Intervention, Referral, and Treatment Program, which allows states to expand the continuum of care to include services for non-dependent drug users. In Fiscal Year 2006, SAMHSA plans to fund an additional two states, for a total of nine states receiving funding.

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

	2004	2005	2006
Substance Abuse:			
Substance Abuse Block Grant	$1,779	$1,776	$1,776
Programs of Regional and National Significance:			
Treatment	419	422	447
Prevention	199	199	184
Subtotal, Substance Abuse	**$2,397**	**$2,397**	**$2,407**
Mental Health:			
Mental Health Block Grant	$434	$433	$433
PATH Homeless Formula Grant	50	55	55
Programs of Regional and National Significance	241	274	210
Children's Mental Health Services	102	105	105
Protection and Advocacy	35	34	34
Subtotal, Mental Health	**$862**	**$901**	**$837**
Program Management	$92	$94	$92
Total, Program Level	**$3,351**	**$3,392**	**$3,336**
Less Funds Allocated from Other Sources:			
PHS Evaluation Funds	-117	-123	-121
Total, Discretionary BA	**$3,234**	**$3,269**	**$3,215**
FTE	519	558	558

Source: U.S. Department of Health and Human Services Web site, "Budget in Brief," at **www.hhs.gov/budget/05budget/fy2005bibfinal.pdf** (page 40, PDF format).

Promoting Effective Prevention. The President's budget request underscores the need to build capacity for comprehensive, evidence-based substance abuse prevention programs. Of the $184 million allocated for substance abuse prevention, $93 million is earmarked for SAMHSA's Strategic Prevention Framework. SAMHSA awarded its first Strategic Prevention Framework grants in 2004 to 21 states and territories.

Substance Abuse Block Grant. The President's budget includes $1.8 billion for the Substance Abuse Prevention and Treatment Block Grant—the same level as Fiscal Year 2005. The Block Grant provides funding to more than 10,500 community-based organizations and is the cornerstone of states' substance abuse financing.

Mental Health

The budget includes $837 million for mental health services, a decrease of $64 million from Fiscal Year 2005. However, transforming the Nation's mental health system remains one of SAMHSA's highest priorities—as recommended by the President's Commission on Mental Health. Funding also is provided to sustain discretionary grant activities.

Transforming the Mental Health System. The Fiscal Year 2006 budget proposes $26 million for State Incentive Grants for Transformation, an increase of $6 million over 2005. These grants encourage states to develop comprehensive state mental health plans to reduce system fragmentation and, ultimately, improve quality of mental health care for people with mental illness. SAMHSA will award eight State Incentive Grants for Transformation in Fiscal Year 2005, as well as three new grants in 2006.

New grantees will undertake planning and coordination activities in tandem with a diverse array of agencies such as criminal justice, housing, child welfare, labor, and education. In the second year of funding, states can use 85 percent of grant funds to support the community-based programs identified in their state plans. The remaining 15 percent will be used to support ongoing planning activities.

The President's request also proposes to maintain the same level of funding for the Community Mental Health Services Block Grant—the only Federal program that provides funds to every state to deliver mental health services and improve the public mental health system. The Block Grant also gives states the flexibility to transform the system of care for people with mental illness on a statewide basis.

Other Mental Health Programs. The budget maintains funding for community-based systems of care for children and youth, services for people who are homeless, and protection and advocacy programs. It provides $67 million for youth violence prevention, $30 million for the National Child Traumatic Stress Initiative, and more than $16 million for suicide prevention.

The President's budget also calls for more than $5 million in new funding for the SAMHSA HIV/AIDS Minority Mental Health Services Program, which will enable SAMHSA to award 11 new grants in Fiscal Year 2006. It also provides resources to increase access to mental health services to some of the Nation's most vulnerable citizens, including people with co-occurring mental and substance abuse disorders, older Americans, and traumatized children.

Data Strategy Vision. As a part of its data strategy, SAMHSA, in collaboration with states and other grantees, has agreed to implement the National Outcome Measures (NOMS) to standardize the measures monitoring, assessing, and evaluating all SAMHSA programs. SAMHSA will initiate a new program, the State Outcomes Measurement and Management System, in Fiscal Year 2005 to support information technology upgrades, training, and analysis required for collection and use of the NOMS. Reporting of NOMS by all states will be phased in over 3 years.

Gathering information on a common and focused set of national outcomes will help SAMHSA, states, and local communities collect relevant data that are useful to assess program performance and identify any specific populations that need special assistance. Over time, use of the standardized outcome measures will help track progress toward state-established targets and will provide for continuous program improvement at Federal and state levels.

For more information, visit the SAMHSA Web site at **www.samhsa.gov/budget/budget.html.** In addition, a "Budget in Brief" is available at the U.S. Department of Health and Human Services' Web site at **www.hhs.gov.**

Online Links to Budget Information

SAMHSA's Web site offers downloads of the Fiscal Year 2006 Budget in both PDF and MS Word formats at **www.samhsa.gov/Budget/index.aspx.**

SAMHSA's Drug Abuse Warning Network Increases Data Options

Since 1972, the Drug Abuse Warning Network (DAWN) has monitored trends in drug-related emergency room visits and drug-related deaths. Now SAMHSA's national surveillance system has had an extreme makeover. "Basically, only DAWN's name has remained the same," said Judy K. Ball, Ph.D., M.P.A., DAWN Team Leader in SAMHSA's Office of Applied Studies.

To reflect the dramatic changes over the last three decades in both the Nation's demographics and its health care system, DAWN recently underwent a multi-year process of evaluation and redesign. The result is a system that's more useful than ever before to the Federal agencies, state and local governments, pharmaceutical companies, hospitals, and others that rely on these data.

Redesigning DAWN

Initially a project of the Drug Enforcement Administration, DAWN became SAMHSA's responsibility in the early 1980s. For a long time, DAWN didn't change much. But by the mid-1990s, the Agency took a close look at whether DAWN was still reflecting the Nation's substance abuse issues accurately.

"The health care system had changed a lot, and so had our country's population," explained Dr. Ball, noting that Americans were continuing to migrate south and west. "It was clear we needed to take a look at DAWN and see how it could be improved to reflect those and other changes."

To find out, SAMHSA convened a panel of experts in 1997 to consider the question. DAWN was worth continuing, the panel concluded, but needed major changes to stay relevant. A 2-year assessment of every aspect of DAWN followed. Based on the resulting recommendations, a totally new protocol was introduced in January 2003.

The new DAWN differs from the old network in three major ways.

First, there's a new sample of hospitals that better reflects the Nation's changing demographics and health care system. Because it would be too expensive to collect data from every emergency room across the country, since the mid-1980s DAWN has relied on a scientific sample of emergency rooms across the Nation and in selected metropolitan areas.

The new sample better reflects the Nation's shifts in population. It includes cities such as Houston, for example, one of the Nation's largest. And the sample now covers the entire United States (previously, Alaska and Hawaii were excluded). Because DAWN doesn't use a sample for medical examiners and coroners, it is now expanding its recruitment efforts to cover the entire area where there are hospital samples. In addition, DAWN is adding medical examiners and coroners for a number of states.

Second, the new DAWN defines eligible cases more broadly than the old DAWN, which collected data about substance abuse cases only, and defined substance abuse in narrow terms. In other words, the only cases that counted were ones in which medical charts documented that patients had used drugs because of dependence, a suicide attempt, or the desire to achieve a "high."

That also meant that DAWN was missing a lot of cases that should have been included. "That kind of specificity about why a patient used a drug is something that's often missing from medical charts," explained Dr. Ball. "Why the patient took the drug may not be clinically relevant. Also, in some states, insurers can deny payment for emergency department visits associated with substance abuse. That is a real disincentive for writing it down."

Casting its net more broadly, DAWN now collects data about all kinds of drug-related emergency department visits, whether they're due to illegal drugs, prescription or over-the-counter medications, dietary supplements, or non-pharmaceutical inhalants.

And third, DAWN now uses a new "case-finding" technique. DAWN "reporters"—the people who collect the data—used to rely on shortcuts to find the eligible cases. To avoid having to review every patient's chart, they would check logs or use billing codes to find cases likely to be related to drug abuse. SAMHSA's evaluation revealed that such shortcuts missed a substantial number of cases. Now DAWN reporters review the charts of every single patient who is treated in the emergency room.

"Drug-related cases in emergency departments are not terribly frequent relative

DAWN
DRUG ABUSE WARNING NETWORK

to the total number of visits," explained Dr. Ball. "Basically, we're looking for a needle in a haystack. Under the old DAWN, we only looked through part of the hay. Now we know that if we're going to find those needles, we have to go through the whole haystack."

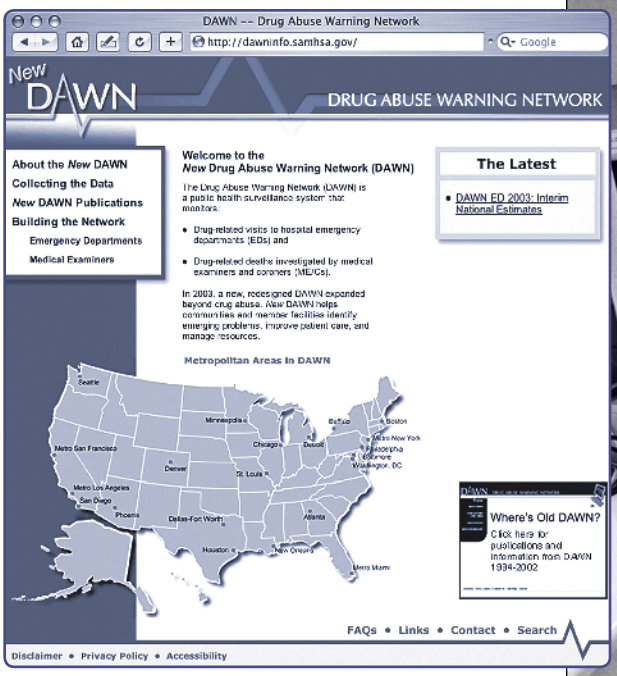
Putting the Data to Use

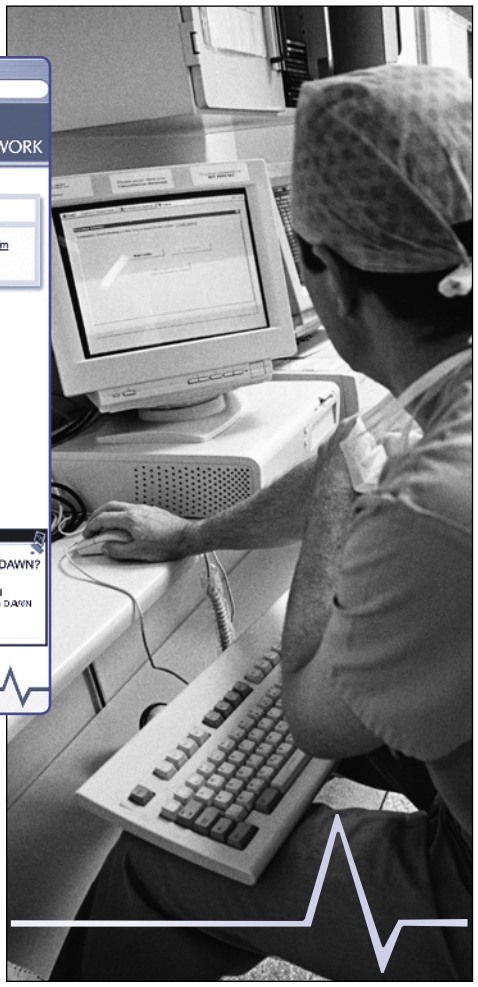
Although the Public Health Service Act requires SAMHSA to collect the data, there's no law requiring emergency rooms, medical examiners, or coroners to participate in DAWN. Since January 2004, SAMHSA has met with more than 200 hospitals at 23 community meetings convened as part of a major recruitment drive designed to encourage participation.

The compensation hospitals receive for their participation—not enough to cover the full costs, Dr. Ball said—isn't the only benefit they receive. One of the major advantages is immediate access to their data via a new feature called *DAWN Live!* Authorized users can log on to see how many drug-related cases their emergency room is treating, what drugs are involved, and where the patients ended up. "That information wasn't necessarily available to them before," she added.

One hospital used DAWN data to detect a sudden surge in the number of semi-comatose young people landing in the emergency room, identify the little-known drug they were using, and train emergency department staff how to respond. Other hospitals use the data to determine how many patients are admitted as inpatients and where they're admitted. This information allows them to make more informed decisions about resource allocation. Others have used the data to demonstrate the need for specialized substance abuse services.

Take the emergency room at Boston University, for example. Faced with a cocaine and heroin epidemic in the mid-1990s, the department used DAWN data to win a grant from SAMHSA's Center for Substance Abuse Treatment that funded a project to screen patients, provide brief interventions, and refer them to treatment. Once that grant ended, the department used the data again to convince the hospital to make the project a line item in its budget.





"The data are now much more sophisticated, and the information is right at your fingertips," said Edward Bernstein, M.D., Professor and Vice Chair for Academic Affairs in the emergency medicine department at Boston University School of Medicine. "Before, for example, we could find 'seeking detox.' Now we have data showing whether someone's actually referred or not." Data also allow the department to track its progress compared to its own past performance or to emergency rooms in Boston or across the Nation.

Hospitals aren't the only ones that use these data. Federal agencies are one of the primary users, said Dr. Ball. Community epidemiologists supported by the National Institute on Drug Abuse, for example, use the data to assess substance abuse problems in different parts of the country. The Food and Drug Administration uses DAWN data to track adverse reactions to prescription drugs and look at the potential for abuse. And municipalities involved in the Office of National Drug Control Policy's 25-Cities Initiative are using DAWN data as a way of measuring progress.

The only downside to the new DAWN is that data collected under the new protocol cannot be compared to data collected under the old network. "It's a short-term problem," said Dr. Ball. "You don't take a statistical series that's been going on for many years and break it without a good reason. We decided the benefits of making the changes far outweighed the costs."

For more information about SAMHSA's Drug Abuse Warning Network, visit **dawninfo.samhsa.gov.**

—By Rebecca A. Clay

We'd 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.

Comments: _____

_____

_____

I'd like to see an article about: _____

_____

_____

Name and title: _____

Address and affiliation: _____

_____

Phone number: _____ E-mail address: _____

Field of specialization: _____

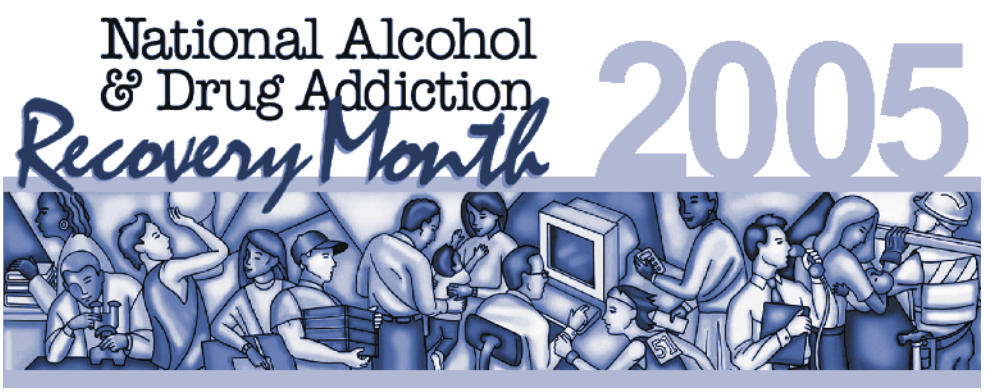
In the current issue, I found these articles particularly interesting or useful:

- ❑ Initiative Helps End Chronic Homelessness
- ❑ From the Administrator: A Life in the Community Starts with a Home
- ❑ Grants.gov: One Stop for Federal Grants
- ❑ ATTC Network Addresses Workforce Development Needs
- ❑ Co-Occurring Disorders: A Guide for Service Providers
- ❑ Utah Has Lowest Illicit Drug Use Rate, Alaska Has Highest
- ❑ SAMHSA Addresses Global Burden of Mental Illness
- ❑ SAMHSA Announces Funding Opportunities
- ❑ In Brief . . .
- ❑ President's 2006 Budget Proposes $3.3 Billion for SAMHSA
- ❑ SAMHSA's Drug Abuse Warning Network Increases Data Options
- ❑ *Recovery Month* 2005
- ❑ Reach Out Now To Raise Awareness About Underage Drinking
- ❑ ***SAMHSA News*** online at **www.samhsa.gov/SAMHSA_News**

Mail, phone, fax, or e-mail your response to:

SAMHSA News
Room 8-1037
1 Choke Cherry Road
Rockville, MD 20857
Phone: (240) 276-2130
Fax: (240) 276-2135
E-mail: *deborah.goodman@samhsa.hhs.gov*

Thank you for your comments!



Across the Nation, plans are well under way for September's 16th annual National Alcohol and Drug Addiction *Recovery Month.*

This year's theme is "Join the Voices for Recovery: Healing Lives, Families, and Communities," which celebrates the positive impact of treating alcohol and drug use disorders in communities.

Coordinated by SAMHSA's Center for Substance Abuse Treatment, the *Recovery Month* campaign highlights ways to create awareness that alcohol and drug use disorders can be managed effectively when an entire community supports those who suffer from these treatable diseases.

Individuals, organizations, schools, and communities are preparing for a variety of local activities. SAMHSA's award-winning Web site for *Recovery Month* offers planning resources, fact sheets, online publications, and downloadable Web banners. The site will also list events across the country in a state-by-state interactive registry. In addition, SAMHSA hosts the Road to Recovery 2005 multimedia series, featuring a new Web cast each month.

Visitors to the Web site can also sign up to receive ongoing updates about *Recovery Month* events and download *Recovery Month* fliers in both English and Spanish.

Recovery Month planning kits and commemorative posters will be available soon.

For more information about this year's *Recovery Month,* visit **www.recoverymonth.gov/2005.** To order *Recovery Month* toolkits, posters, or other materials, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD).

Reach Out Now

To Raise Awareness About Underage Drinking

SAMHSA is collaborating with Scholastic, Inc., to provide parents and teachers of fifth- and sixth-grade students with resources on ways to encourage young people to avoid drinking alcohol. *Reach Out Now* materials include family guides, classroom handouts, fact sheets, and true-false quizzes.

Developed by the Agency's Center for Substance Abuse Prevention, these materials are being released as part of April's Alcohol Awareness Month activities.

"Starting a dialogue about underage alcohol use isn't easy," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "But the benefits of that dialogue can last a lifetime."

Materials for teachers include:

- Reach Out Now: Talk with Your Fifth Graders about Underage Alcohol Use
- Understanding the Effects of Alcohol
- Alcohol: A True/False Quiz

Materials for parents include:

- Reach Out Now Family Resource Guide: Talk with Your Fifth Grader About Underage Alcohol Use
- Reach Out Now: Prevent Underage Alcohol Use by Talking with Your Sixth Grader
- Open the Door to Discussion
- Learning About Peer Pressure

To order *Reach Out Now* materials, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686. For more information, visit **www.samhsa.gov.**

SAMHSA NEWS

Published bimonthly by the Office of Communications

Send a copy to:

Editor, *SAMHSA News*
Room 8-1037
1 Choke Cherry Road
Rockville, MD 20857

Substance Abuse and Mental Health Services Administration
Charles G. Curie, M.A., A.C.S.W., Administrator

Center for Mental Health Services
A. Kathryn Power, M.Ed., Director

Center for Substance Abuse Prevention
Beverly Watts Davis, Director

Center for Substance Abuse Treatment
H. Westley Clark, M.D., J.D., M.P.H., Director

Editor
Deborah Goodman

SAMHSA News Team
at IQ Solutions, Inc.:
Managing Editor, Meredith Hogan Pond
Publication Designer, A. Martin Castillo
Publications Manager, Mike Huddleston

Your comments are invited.
Phone: (240) 276-2130
Fax: (240) 276-2135
E-mail: *deborah.goodman@samhsa.hhs.gov*

To receive *SAMHSA News* or to change your address:

Web: Go to **www.samhsa.gov**
Click on "Mailing List: Sign Up!"

E-Mail: Send your subscription request or address change to **SAMHSAnews@iqsolutions.com**
Include your mailing address with your name, street, apartment number, city, state, and ZIP code

Phone: Call 1 (888) 577-8977 (toll-free)
Call (240) 221-4001 in the Washington, DC, metropolitan area

Fax: *SAMHSA News,* (301) 984-4416
Attention: Rudy Hall

Mail: Send your new mailing information to:

SAMHSA News Subscriptions
Attention: Meredith Pond
c/o IQ Solutions, Inc.
11300 Rockville Pike, Suite 901
Rockville, MD 20852

Visit *SAMHSA News* online at
www.samhsa.gov/SAMHSA_News

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Rockville MD 20857

Official Business
Penalty for Private Use $300