Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

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From Subsistence to Sustainability: Treating Drug Abuse in Alaska

A village elder leads a tour of a remote southwest Alaska village. As the small group of substance abuse counselors and program administrators walks along the unpaved streets, the elder points out "healthy homes"—those with substantial woodpiles, fish hanging from drying racks.

—Phoebe Mills, M.S.W.
former Village Clinical Supervisor
Yukon-Kuskokwim Health Corporation

In the traditional subsistence culture of the Yup'ik and Cup'ik Eskimo people of the Yukon-Kuskokwim Delta of Alaska, the well-being of an individual or family can be measured, at least in part, by the capacity to prepare for the Alaskan winter. Survival depends upon the ability to work cooperatively with others in the village in order to take advantage of seasonal food supplies and to assure adequate provisions for each person, family, tribe, and village.

Within this context, "substance abuse renders individuals incapable of taking care of themselves or their families—which in turn affects the well-being of the entire community," says Kenneth Robertson, Team Leader of the Targeted Capacity Expansion Team within SAMHSA's Center for Substance Abuse Treatment (CSAT).

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Fishing, and the preparation of fish, are among traditional Yup'ik and Cup'ik practices integrated with substance abuse and behavioral health treatment by the Village Services Program.

Founded in 1993 through CSAT's Rural, Remote, and Culturally Distinct Populations Program, and expanded through a CSAT Targeted Capacity Expansion grant, the Village Services Program of the Yukon-Kuskokwim Health Corporation (YKHC) has put into

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North Carolina Improves Evidence-Based Practices

Like most states, North Carolina has limited financial resources. Things are especially tough for those working to reduce alcohol and substance abuse in the state. Substance abuse shares a state government division with mental health and developmental disabilities, but its funding is much more limited than the other two sections. Fortunately, the state has found a way to overcome that problem.

"The way to get more out of your dollar is to improve your practices," explained Flo A. Stein, M.P.H., Chief of Community Policy and Management at the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. "In fact, our legislature has taken the lead in calling for a reformed system that pays for practices that there's evidence to support. As a result, we've been actively encouraging practice change."

Much of that support has come from SAMHSA's Center for Substance Abuse Treatment (CSAT). Since 2001, the state has been using funding from CSAT's Practice Improvement Collaboratives program (See *SAMHSA News,* Volume IX, Number 3, p. 8) to help bridge the gap between research and practice. And now one community in North Carolina is taking the next step to integrate evidence-based practices even further, with a new CSAT grant called Strengthening Treatment Access and Retention, as well as other SAMHSA-funded efforts.

Improving Practices

According to Ms. Stein, the umbrella under which all of the state's practice improvement activities for addiction take place is the Practice Improvement Collaboratives grant. The 3-year project is designed to help grantees set an agenda for improving addiction services and adopting evidence-based treatment practices.

Bringing researchers and practitioners together plays a key role in achieving these goals, explained project officer Susanne R. Rohrer, R.N., a public health analyst in CSAT's Division of Services Improvement. "The goal is to bring researchers and practitioners together to lay the foundation for collaborative efforts," she said. "It's a feedback loop: The researchers encourage the practitioners to adopt best practices, and then the practitioners provide feedback to the researchers."

The way to get more out of your dollar is to improve your practices.

That's just what's happening in North Carolina, where the grantee is a nonprofit organization called the Governor's Institute on Alcohol and Substance Abuse, Inc., in Research Triangle Park. According to principal investigator Wei Li Fang, Ph.D., Director for Research and Development at the Institute, the project ensures that practitioners are not only using best practices, but also using them correctly.

"We've had severe budget cuts in the last few years, so there's not as much money going to continuing education," Dr. Fang explained. "There are also problems with burn-out and staff turnover. What we're trying to do is to identify practitioners' needs and provide them with the necessary training, support, and encouragement to adopt best practices."

The project has four specific objectives:

- Developing and implementing a statewide agenda to improve practices. Dr. Fang and her colleagues have worked with substance abuse directors and clinicians around the state to come up with a training agenda. Training priorities identified so far are relapse prevention, co-occurring substance abuse and mental health disorders, and motivational interviewing. Motivational interviewing is a counseling style designed to help clients change their behavior by exploring and resolving their ambivalence about that behavior.

  Once trained, practitioners are expected to spread the word to others. After providing scholarships to an intensive training program on co-occurring disorders, for example, the Practice Improvement Collaboratives project expects the 17 participating practitioners to make five presentations each to other clinicians and members of the community in the next year.
- Expanding and strengthening the integration of a statewide network of researchers, substance abuse treatment providers, educators, policymakers, advocates, consumers, and others. The project has created five regional consortia to help meet its goals.

- Conducting knowledge adoption studies. After the project trains a site in a particular skill, it will go back and study how well the site's practitioners have put that training to use. If they still have questions or have drifted away from the standard, the project will provide additional training or technical assistance.
- Conducting evaluations. The project evaluates every training and technical assistance event it conducts.

Strengthening Access and Retention

Now, one North Carolina community is taking the idea of practice improvement one step farther. In October, CSAT awarded a Strengthening Treatment Access and Retention grant to the state's Pitt County Mental Health, Developmental Disabilities, and Substance Abuse Center in Greenville. Building on the Practice Improvement Collaboratives' work, this project will apply lessons learned in the field of quality improvement to the provision of substance abuse treatment.

"We view this grant as the next step in the process begun by the Practice Improvement Collaboratives grant program," explained Mady Chalk, Ph.D., Director of CSAT's Division of Services Improvement. "This grant is much more focused, in this case on evidence-based practices having to do with improving access to services and retention in treatment. I'm hoping that over the next few years, the program will move on to other evidence-based practices."

In Pitt County, the 3-year project will work to ensure that alcohol and substance abusers age 17 to 25 who live in this largely rural area in the eastern part of the state get the treatment they need. To improve access to substance abuse treatment, the project plans to develop what it calls "process improvement teams." These teams will receive training and technical assistance to help them improve various aspects of treatment, such as enhancing the referral process or finding ways to reduce waiting times.

To improve retention, the project plans to train treatment providers in motivational enhancement therapy, an approach that helps clients determine their own treatment goals and protocols. "It's a best practice," explained Glenn Buck, M.S.W., Substance Abuse Program Director for the Pitt County Mental Health, Developmental Disabilities, and Substance Abuse Center in Greenville. "We're hoping that a well-trained staff using an evidence-based approach will lead to better retention."

Bringing researchers and practitioners together plays a key role in achieving these goals.

Because the grant is administered in collaboration with the Robert Wood Johnson Foundation's Paths to Recovery program, Pitt County and other CSAT grantees will participate in a "learning community" with the foundation's grantees. As part of the community, they will attend two learning community meetings a year, participate in teleconferences and Web-based educational events, and receive on-site technical assistance from a learning community expert once a year.

"The learning community will serve as a resource to the field on quality improvement," said project officer Frances Cotter, M.P.H., a team leader in CSAT's Division of Services Improvement. "Educational events, case studies, and process improvement strategies will be available from SAMHSA in the near future."

Setting an Agenda for Improvement

That's not all Pitt County is doing to improve substance abuse services. A nonprofit organization called the Eastern Carolina Council on Substance Abuse—an offshoot of the county's substance abuse center—is working to get the entire community involved in reducing substance abuse.

As part of SAMHSA's National Alcohol and Drug Addiction Recovery Month in September, the council sponsored a community forum to discuss the county's substance abuse problem, develop a community plan for addressing the problem, and create a coalition that can put the plan into action. The SAMHSA-funded event brought together substance abuse counselors, the city manager, the police chief, the county sheriff, physicians, attorneys, representatives from the public school system and local university, people in recovery, and others.

"The coalition will provide a focus for improving our area's services," said Council President David Ames, M.D., Medical Director of the Pitt County Mental Health, Developmental Disabilities, and Substance Abuse Center in Greenville. "What I see the coalition doing is getting to work on all the things that SAMHSA targets, such as promoting prevention, improving access, and addressing stigma."

For Dr. Fang of the Governor's Institute, the coalition's work is just another of the multiple efforts that add up to a more effective whole. "We're all working toward the same goal," she said. "We're all working to improve addiction services for clients."

—By Rebecca A. Clay

SAMHSA Offers Alcohol Prevention Strategies to Youth

Think children age 9 to 13 are too young for anti-alcohol messages? Think again.

By eighth grade, many students are already drinkers. In SAMHSA's 2002 National Survey on Drug Use and Health, for example, 6.5 percent of 13-year-olds reported that they had downed at least one drink in the last month. And the average age of kids taking their first drink is dropping, the survey reports. Underage drinking doesn't just harm children's physical and psychological development, either. It also sets them up for problems later in life. In fact, the survey warns that kids who first try alcohol at age 14 or younger are 4½ times more likely to develop alcohol abuse or dependence problems later in life than those who have their first drink at 18 or older.

To stop such problems before they begin, SAMHSA's Center for Substance Abuse Prevention (CSAP) recently launched a national public education initiative called "Too Smart to Start." Part of the Centers for Disease Control and Prevention's National Youth Media Campaign to Change Children's Health Behaviors, the initiative provides research-based materials and strategies that professionals and volunteers at the local level can use to educate their communities' children—and parents or other caregivers—about the dangers of underage drinking.

To help get the message out, several national organizations—the American Medical Association, Community Anti-Drug Coalitions of America, Mothers Against Drunk Driving, National Association of State Alcohol and Drug Abuse Directors/National Prevention Network, National Council on Alcoholism and Drug Dependence, National Family Partnership, and PRIDE Youth Programs—will help publicize the initiative and disseminate its materials to their community-based affiliates. Ten community-based projects around the country will also be involved as pilot programs.

Together they will work to meet the initiative's specific objectives of increasing the number of conversations children and adults have about the harms of underage drinking, increasing the percentage of 9- to 13-year-olds and their parents or other caregivers who view underage drinking as a problem, and increasing the general public's disapproval of underage drinking. An evaluation will assess the initiative's impact in the 10 pilot sites.

"It's a whole lot easier to keep children from starting to use alcohol in the first place than it is to intervene once they've become drinkers," said CSAP Director Beverly Watts Davis. "With this initiative, every member of the community can help us keep youngsters from taking that first sip of alcohol."

Young people participate in "Too Smart to Start" activities in Cincinnati, OH, this summer.

Event volunteers include (l to r) John Overback, Mark Clegg (holding baby Elizebeth), and Shondolyn Lagdameyo, a staff member at the Coalition for a Drug-Free Greater Cincinnati.

A Multifaceted Approach

Developed with input from 9- to 13-year-olds and their parents and other caregivers, "Too Smart to Start" puts the issues important to young people at its center. The initiative's philosophy is to allow young people themselves to offer advice and help create prevention efforts rather than simply participate in them. As young people introduce their parents and other caregivers to today's youth culture, adults' roles shift from directing activities to acting as partners and supervisors. While kids learn the importance of not drinking, adults learn how to listen and modify their own behavior.

The initiative provides everything that children, parents, and other community members need to start their own ongoing campaigns against underage drinking.

One key resource is the *Too Smart to Start: Community Action Kit,* which features an implementation guide offering information about underage drinking and step-by-step advice on starting local projects. The guide explains how to research target audiences, assess local needs, identify partners, create an action plan, and raise public awareness through presentations, special events, educational programs, and the mass media. It also features such resources as a needs assessment form, talking points for

too SMART to START

presentations, a quiz, press release guidelines, and a sample letter to the editor. In addition to the guide, the kit includes a brochure, a poster, a "SmartSTATS" data book, booklets for parents, PowerPoint presentations, and sample public service announcements for print, radio, and television.

The initiative offers plenty of other materials to support local efforts. Additional "Too Smart to Start" materials include posters for both children and adults, ready-to-use public service announcements, booklets that help parents and other caregivers talk to children about drinking, and a board game designed to dispel common myths about alcohol use and encourage open discussion about drinking.

Communities don't have to use every single resource, however. Flexibility is one of the initiative's hallmarks, say its developers, noting that communities can customize their own initiatives to reflect local needs and resources. The "Too Smart to Start" brochure even outlines options for more or less intensive campaigns. Communities with limited resources, for instance, could make the core tactic called "Mosaic Messages"—public service announcements featuring snippets of interviews with local children and adults—the centerpiece of their efforts. Communities with greater resources could also create documentaries allowing children to give their own perspectives on underage alcohol use.

All "Too Smart to Start" materials are available free of charge; the initiative also offers communities free technical assistance on a wide range of topics. To order materials or arrange technical assistance, write to SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345; or call 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD); or go to **www.ncadi.samhsa.gov.**

—By Rebecca A. Clay

Red Ribbon Week: Preventing Youth Substance Abuse

SAMHSA recently released a community action guide to support the National Family Partnership and community organizations nationwide in the October celebration of Red Ribbon Week. The annual event helps promote awareness of substance abuse prevention among youth.

"Red Ribbon Week is making important contributions to substance abuse prevention awareness in America," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We are proud to join the National Family Partnership to encourage parents and other adults to unite in raising drug-free youth."

The event honors the memory of a drug enforcement officer, Enrique Camarena, who was murdered in 1985. Red Ribbon Week encourages individuals, families, and communities to take a stand against the use of alcohol, tobacco, and illegal drugs. The observance focuses on educating the public on the destructive effects of alcohol and drugs, and the health-positive alternatives that are available to youth and adults. This year, approximately 80 million people across the country participated in Red Ribbon Week and demonstrated their support for promoting healthy, drug-free lifestyles.

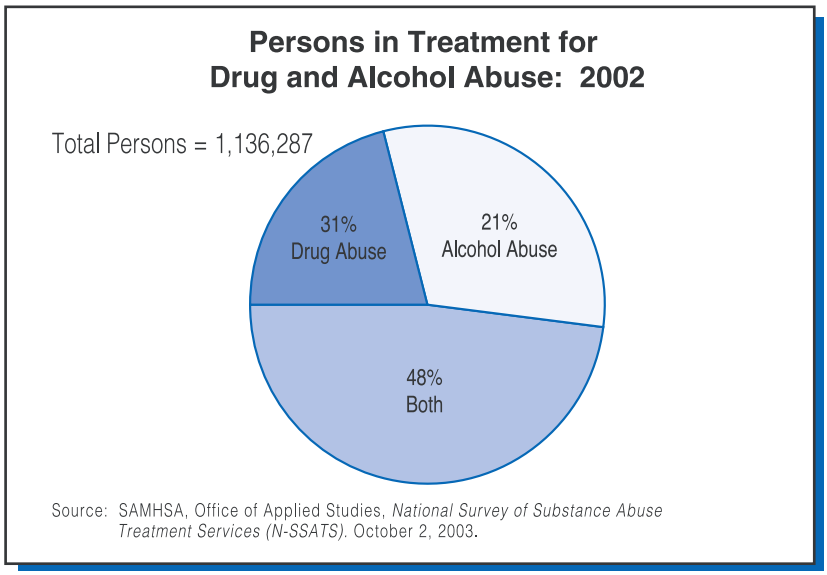
The guide, *Unite for a Drug Free World: A Call to Action for Parents, Schools, and Communities,* contains a wealth of resources that can be used by parents, teachers, administrators, advocates, health educators, and others working to prevent substance abuse among young people. For example, the guide offers a fact sheet, talking points, a print-ready article, print and radio public service announcements, a sample media pitch letter, and a sample proclamation. The guide also provides practical tips for engaging the media in promoting Red Ribbon Week and ideas for shaping media coverage.

As part of Red Ribbon Week observances across the Nation, participants wear or display a red ribbon to symbolize zero tolerance for illegal drug use by youth and a commitment to substance abuse prevention. For Red Ribbon Week 2003, schools and community groups organized a variety of activities including contests, workshops, rallies, theatrical and musical performances, and other family-centered and educational events.

To order the community action guide, 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). For more information about Red Ribbon Week, visit the National Family Partnership's Web site at **www.nfp.org.**

Survey: Nearly Half in Treatment for Both Drug and Alcohol Abuse

According to the 2002 National Survey of Substance Abuse Treatment Services by SAMHSA's Office of Applied Studies, nearly half of the more than 1.1 million people receiving treatment for addiction were in treatment for both drug and alcohol abuse. In fact, 48 percent of the 1,136,287 people receiving substance abuse treatment on a typical day in 2002 were in treatment for both drug and alcohol abuse—compared to 21 percent being treated for alcohol abuse alone and 31 percent receiving treatment for drug abuse alone. Eight percent of those receiving substance abuse treatment were under age 18.



Source: SAMHSA, Office of Applied Studies, *National Survey of Substance Abuse Treatment Services (N-SSATS)*. October 2, 2003.

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "This survey tells us where the substance abuse treatment system is going, to help us analyze system trends and forecast resource requirements. At SAMHSA, building treatment capacity is a top priority. We are hopeful that the President's Access to Recovery program will be funded to allow an additional 100,000 people to enter treatment and rebuild their lives."

The purpose of the survey is to collect data on where services are offered, what types of services are available, and to what extent alcohol and drug treatment facilities and services are used. The survey covers all 50 States, the District of Columbia, and other U.S. jurisdictions. In 2002, a total of 13,720 facilities—or 96 percent of eligible facilities—participated in the survey.

The survey found that nearly half of all facilities, 49 percent, offered special programs for those diagnosed with co-occurring substance abuse and mental disorders. Over one-third of facilities, 37 percent, provided programs to treat adolescents. Special programs or groups for drugged or drunk-driving offenders were offered by 35 percent of facilities.

The survey also found that 81 percent of facilities offered outpatient treatment, making it the most widely available type of care. In fact, 90 percent of patients in treatment on the survey date (March 29, 2002) were enrolled in some type of outpatient care. Of these, 54 percent were in regular outpatient care.

Some patients, however, need more intensive treatment than traditional outpatient care. Forty-four percent of the facilities surveyed offered intensive outpatient care, and 12 percent of patients used these services. Day treatment and partial hospitalization services were offered by 15 percent of all facilities, and these services treated 3 percent of patients.

Opioid treatment programs were offered by 8 percent of facilities, and 19 percent of all patients received outpatient methadone/LAAM maintenance at these facilities.

Residential detoxification was offered by 8 percent and hospital inpatient detoxification was offered by 7 percent, and each mode treated less than 1 percent of patients. About 8 percent of patients were in residential rehabilitation and less than 1 percent were in hospital inpatient rehabilitation.

Private nonprofit facilities make up the bulk of the treatment system (61 percent) with private for-profit accounting for another 25 percent. State or local governments own 11 percent of treatment facilities and the Federal Government owns 2 percent. Tribal governments own 1 percent of reporting facilities.

The data show that programs or groups for women only are available in 38 percent of facilities, while 30 percent of facilities provide programs for men only. About 14 percent of facilities have programs for seniors and older adults and 13 percent have programs for gay males and lesbians.

For information on where to find treatment centers in your community, visit SAMHSA's Facility Treatment Locator at **http://findtreatment.samhsa.gov.**

To obtain a copy of the report, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2002, Data on Substance Abuse Facilities,* 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). The report can also be downloaded from the SAMHSA Web site at **www.drugabusestatistics.samhsa.gov.**

An End to Bullying: SAMHSA Expands 15+ Program

Parents who spend 15 minutes or more a day with their children can have a positive effect on their children's behavior and the family as a unit. This evidence-based knowledge is the core principle of SAMHSA's bullying prevention campaign, *15+ Make Time to Listen, Take Time to Talk . . . About Bullying,* to be launched in 2004.

Created to address the widespread problem of bullying among America's youth, the campaign will have three main goals, to raise public awareness of bullying, recommend a call to action, and create opportunities to handle and prevent bullying behavior.

The campaign expands the first in a series of campaigns called, *15+ Make Time to Listen, Take Time to Talk,* launched in fall 2000.

Louise Peloquin, Ph.D., of the Special Programs Development Branch within SAMHSA's Center for Mental Health Services (CMHS) explains, "15+ is our brand, with the idea that every few years we add something to it."

The first campaign supports the Safe Schools/Healthy Students Initiative, a grant program created to respond to youth violence in schools. Supported by SAMHSA within the U.S. Department of Health and Human Services (HHS) and by the U.S. Departments of Justice and Education, this campaign provides parents and caregivers with practical guidelines for improving communication with their children and promoting healthy behaviors.

Three Core Products

SAMHSA's bullying prevention campaign includes three core products for parents and caregivers:

- *15+ Make Time to Listen, Take Time to Talk . . . About Bullying* is an easy-to-read brochure that helps parents understand the range of feelings children may experience about bullying and bullying prevention and provides guidelines for listening and talking to children appropriately.
- *Bullying is NOT a Fact of Life: A Guide for Parents/Teachers* provides greater insight into how parents, teachers, or school personnel can target their conversations about bullying.
- Conversation starter cards promote behaviors that protect against bullying or the potential for becoming a bully. In playing card format, these cards provide specific questions about bullying that a parent or teacher can discuss with children or youth.

Related products from other organizations within HHS will be added when appropriate. In addition, SAMHSA has planned four public service announcements with local ABC affiliate ABC-7 (WJLA-TV) to be aired during the school year. Parents and other adults are the primary target audience. All public service announcements will include a toll-free number for callers to request copies of print materials.

All campaign products will be available on the Internet in an easily downloadable format. Internet users will have the option to customize products by printing local contact information on the flipside. SAMHSA's campaign will begin as a 6- to 9-month pilot in the Washington, DC, metropolitan area and later will be extended throughout the United States.

Additional Bullying Prevention Activities

As an additional bullying prevention activity, SAMHSA is collaborating with Norwegian researcher Dan Olweus, Ph.D., and his American colleagues, who will provide training in the Olweus Bullying Prevention Model. This scientifically developed model is the basis for SAMHSA's campaign. SAMHSA is also collaborating with the Health Resources and Services Administration on its national bullying prevention campaign, which is targeted to children age 9 to 13.

For more information on SAMHSA's bullying prevention campaign, contact SAMHSA's National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). For program information, contact Louise Peloquin, Ph.D., of the CMHS Special Programs Development Branch by e-mail at lpeloqui@samhsa.gov or by telephone at (301) 443-7790.

—By Darlene Colbert

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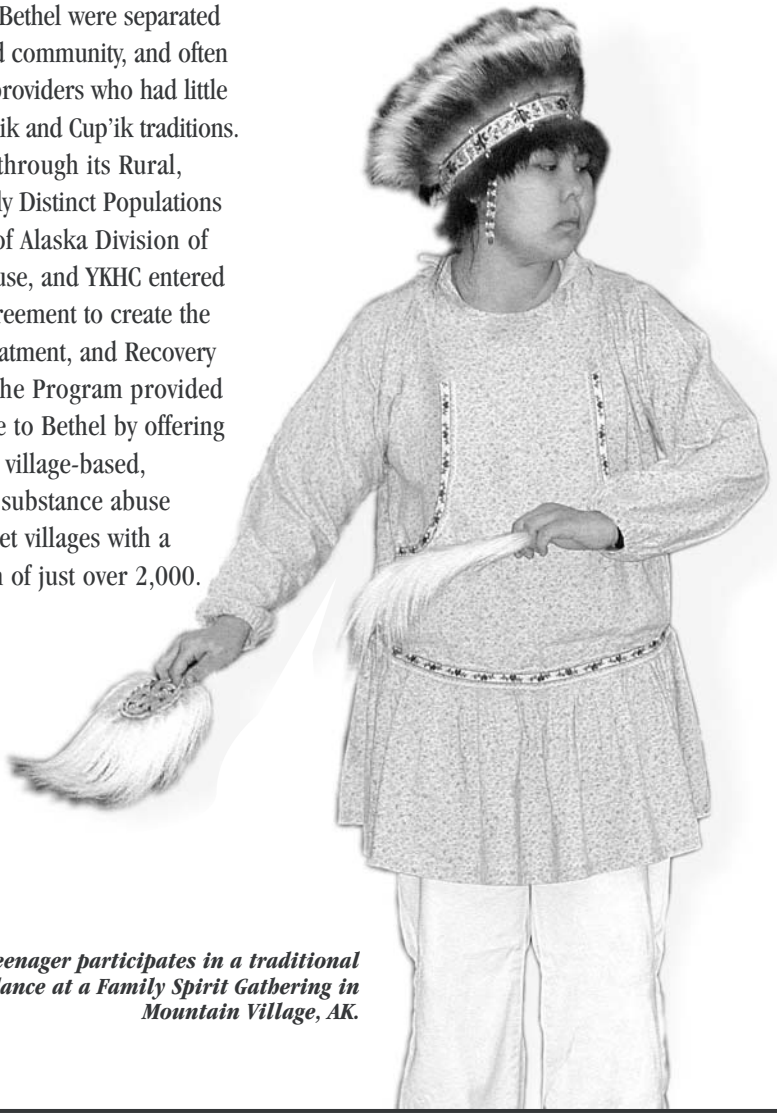
practice a clear understanding of the relationships between Yup'ik and Cup'ik individuals and their tribes, between survival and well-being, subsistence activities and healing. Through successfully integrating traditional subsistence activities with Western substance abuse and behavioral health treatment, YKHC—with CSAT support—has established a system of services that is proving to be both financially viable and culturally competent.

History of the Village Services Program

Prior to 1993, the nearest substance abuse treatment programs available to Yup'ik and Cup'ik villagers were located in Bethel, AK, 150 air miles from the nearest targeted Yup'ik and Cup'ik village. Villagers who made the trip to Bethel were separated from family, tribe, and community, and often worked with service providers who had little understanding of Yup'ik and Cup'ik traditions.

In 1993, CSAT (through its Rural, Remote, and Culturally Distinct Populations Program), the state of Alaska Division of Alcohol and Drug Abuse, and YKHC entered into a cooperative agreement to create the Chemical Misuse, Treatment, and Recovery Services program. The Program provided a welcome alternative to Bethel by offering access to established village-based, culturally competent substance abuse services in three target villages with a combined population of just over 2,000.

After the cooperative agreement expired in 1998, CSAT awarded YKHC a Targeted Capacity Expansion grant that allowed YKHC to "use and integrate the learning from the previous cooperative agreement," according to Mr. Robertson. This was done by creating a successor, the Village Sobriety Project, later renamed the Village Services Program. The Program, now nearing its 10th anniversary, is providing services to more than 50 villages across the Yukon-Kuskokwim Delta, and has proven self-sustaining in that effort for the past 3 years.



A teenager participates in a traditional dance at a Family Spirit Gathering in Mountain Village, AK.

Reconciling Cultures

The fledgling Village Services Program faced several challenges in reconciling the needs of each partner organization with the needs of the population the Program is intended to serve. In some instances, the needs of each partner were complementary. CSAT required that the Program establish a Policy Steering Committee in each village. These committees, comprised of village elders and leaders, as well as YKHC service providers, contributed expertise and direction to the Program and served as a bridge between service providers and the village community.

Other issues required greater effort and understanding from all parties. For example, to assure cultural competence, wellness counselors from each target village were recruited, hired, trained, and certified as level I substance abuse counselors. Providing ongoing supervision to these new counselors and assuring their compliance

with reporting requirements necessitated the use and development of new technologies. Miles of tundra separated wellness counselors from one another and from the Bethel-based village clinician, while a traditional oral culture impeded the counselors' embrace of written recordkeeping systems. Teleconferencing allowed for weekly case management meetings between all parties. Some of the first commercially available personal digital assistants (PDAs) and software developed in conjunction with Program staff and steering committee members facilitated the data entry and coordination necessary to meet the requirements for reporting, evaluation, and reimbursement.

Other strategies were used to address the discomfort villagers and clients felt toward written instruments and records. For example, videos and focus groups were used in program evaluation, and informal procedures were established to provide services to clients unwilling to fill out the paperwork required by various agencies and organizations.

Integrating Services

Members of the policy steering committee worked with state Medicaid officers to identify traditional practices, analyze the potential healing aspects of each practice, and correlate those aspects to Medicaid service categories. According to YKHC Clinical Administrator Sandra Mironov, L.P.C., R.N., Alaska Medicaid officers "really understood…the advantages of working with native populations in culturally competent ways, and showed us how to move [through the state system]."

"When we submit billing," continues Ms. Mironov, "we submit billing for family counseling, individual counseling, and so on. We provide the same counseling you could receive in an office. We just provide that counseling in the most appropriate format [for Yup'ik and Cup'ik clients]."

In traditional Yup'ik and Cup'ik culture, elders serve as the human repositories of practice and wisdom. In cooperation with the Village Services Program, the State of Alaska established a Traditional Counselor Lifetime Certification, thus identifying—and legitimizing to funding agencies—those individuals recognized by their local communities for their knowledge of traditional practices. These traditional counselors serve as teachers and resource persons to clients and the Village Services Program.

Just as the health of a household might be measured by the presence of fish drying outside the home in traditional Yup'ik and Cup'ik culture, the healing of a household might occur through participation in a fishing trip. As Ray Watson, YKHC Certified Clinical Supervisor puts it, "[traditional counseling] hasn't been documented, but it has been going on for centuries. Traditionally, grandpa would sit down and teach you to make fish baskets. And, in passing on that tradition, he would pass along some wisdom, too."

The successful integration of traditional and Western treatment modalities ultimately came to rest on the willingness of partner organizations to embrace the traditional

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One measure of a "healthy home" is many fish hanging from drying racks nearby. The well-being of a family is based, in part, on how prepared that family is for Alaska's harsh winter.

Matrix of Yup'ik and Cup'ik Traditional Modalities and Applicable Medicaid Service Categories

Yup'ik and Cup'ik Traditional Modality	Western Modality					
	Rehabilitation Treatment Services	Intensive Outpatient Services	Care Coordination	Individual Counseling	Family Counseling	Group Counseling
Pissuryaq (hunting)	X	X		X		
Aqevyigsuq/Ar'sasuq (berry picking)			X		X	
Neqsuq-Kuvyiiluuni (fishing)	X	X		X		
Kaluukaq (to hold a feast, potlatch, ceremony)					X	X
Qugtaq (gathering wood)	X	X		X		
Eqiurtauq (chopping wood)	X	X		X		
Cuilqerluni (tundra walk)	X	X		X		
Makiirag (gathering edible and medicinal plants)			X		X	
Maqiq (steambath)	X	X	X	X		
Caliinguaq (traditional arts and crafts)	X	X				X

Source: *J. Psychoactive Drugs.* **2003; 35(1):85-88.**

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context in which this treatment is provided. Wellness counselors of the Village Services Program "go and do things [with clients] that are part of their lifestyle and part of their lives," says Ms. Mironov. She adds, "this approach shows people how to apply the therapy [in their day-to-day life]."

And, Mr. Watson asserts, the traditional activity "brings another piece to the treatment plan." When a counselor goes on a fishing trip with a client, "you get something from the treatment," says Mr. Watson. But "maybe another outcome is the fish." The fish, the berries, the woodpile—concrete benefits of treatment provided through traditional activities—build clients' confidence in themselves and their community.

According to Mr. Watson, providing services through traditional activities also makes services more accessible to Yup'ik and Cup'ik villagers. A client's reluctance to be seen entering a clinic or a wellness counselor's home—whether that reluctance stems from discomfort about treatment or concern about rumors starting in the village—can be overcome when the wellness counselor instead meets a client at a village-wide seal bladder festival, or accompanies a client on a tundra walk.

The willingness of all parties to recognize and assure the equivalence of treatment provided in Western and traditional contexts has allowed the Village Services Program to become self-sustaining. Training, certification, and ongoing supervision of wellness and elder counselors, as well as the development of written treatment plans, allowed the Program to receive Medicaid reimbursement.

Local tribes provided a remarkable show of support for the Program by passing resolutions identifying YKHC as their health care provider and identifying substance abuse issues as a funding priority. As a result of these local actions, YKHC's Village Services Program receives funding for staff positions from the Indian Health Service.

Evidence suggests the Village Services Program is providing effective, culturally competent treatment services. Community health aides in one of the demonstration villages report fewer alcohol-related injuries, and public safety officers report fewer incidences of disturbing the peace, assault, domestic violence, and possession of alcohol during holidays.

Mr. Watson observes that "people have gotten over the stigma attached to counseling. It used to be that any time you went to counseling, it was a bad thing. Now it's seen as a good thing." In the three demonstration villages where wellness counseling has the longest tradition, wellness counselors have the highest client load, suggesting that the perceived openness to services is real.

According to Ms. Mironov, villagers also acknowledge that they used to see public drunkenness as a source of amusement. Now, they see it as serious issue—and see less of it. "They tell me it's no longer the norm," she reports, "which means their children are no longer exposed to it." Instead, through the Village Service Program, Yup'ik and Cup'ik children and adults have ever greater opportunities to be exposed to the strength and healing of their traditional culture.

—By Melissa Capers

SAMHSA Awards New Grants

SAMHSA's grant awards this fall for Fiscal Year 2003 reflect a commitment to building resilience and facilitating recovery for people with or at risk for substance abuse and mental illness.

The funding focuses not only on providing resources for early interventions for children, adolescents, and adults at risk for substance abuse, but also on expanding the ability of states and local entities to respond to emerging needs. Awards also focus on the need to enhance current treatment services and prevention education and information for public health challenges such as the twin epidemics of substance abuse and HIV/AIDS. In addition, SAMHSA funding continues to support services for people with co-occurring mental health and substance abuse disorders.

To reach people at risk of dependence on alcohol or drugs, SAMHSA's Center for Substance Abuse Treatment (CSAT) awarded $103.7 million over 5 years to expand and enhance **Screening, Brief Intervention, Referral, and Treatment** services in hospitals, community health clinics, schools, and other community and medical settings.

"SAMHSA is helping states add brief interventions to their spectrum of care, so that substance abuse treatment is addressed before the patient needs residential care or intensive outpatient care to overcome addictions to alcohol and drugs," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. Funding for the programs is awarded to six states, including California, Illinois, New Mexico, Pennsylvania, Texas, Washington, and one tribal organization, the Cook Inlet Tribal Council, Inc., of Alaska.

To increase the effectiveness of alcohol and drug abuse treatment for adolescents age 12 to 21, CSAT awarded $16.2 million over 3 years to 22 projects nationwide to

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SAMHSA Administrator

Adopt/Expand Effective Adolescent Alcohol and Drug Abuse Treatment. The purpose of the grants is to expand substance abuse programs that combine two types of therapy—motivational enhancement therapy and cognitive behavioral therapy—to youth within their communities.

"Over the years, research has developed effective treatment strategies that meet the specific needs and challenges of young people with drug problems," said Mr. Curie. "Now, we are focusing our resources on bringing these effective, science-based services to community-based practice."

The first round of funding will give $5.4 million to 22 projects (approximately $250,000 each) to provide treatment to youth locally. Funding will continue for 2 years, depending on outcomes and the availability of funds.

From Burlington, VT, to Yakima, WA, SAMHSA's Center for Mental Health Services (CMHS) is funding a total of 27 grants totaling $8.8 million over 2 years in support of the **Community Collaborations to Prevent Youth Violence and Promote Youth Development** program. The purpose of these grants is to support collaborations of community organizations and constituencies to aid in the prevention of youth violence, substance abuse, delinquency, suicide, or other mental health and behavior problems. Three funding categories—general violence prevention (10 grants), violence prevention for females (9 grants), and service for justice-involved youth (8 grants)—will offer specific services.

To continue support of expanded systems of mental health care for children, CMHS awarded $41.9 million over 6 years for **Cooperative Agreements for the Comprehensive Community Mental Health Services Program for Children and their Families.** With consumer- and family-oriented services encouraged in the final report of the President's New Freedom Commission on Mental Health, grantees will focus on community service systems for their targeted population and participate in a national multisite evaluation to strengthen their capacity to care for children and adolescents with serious emotional disturbances and their families. Mr. Curie emphasized, "It is important that children in need of mental health services can be treated with quality services within their communities." He added, "These grants will promote more effective ways to organize, coordinate, and deliver mental health services that are comprehensive and culturally competent."

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As part of the **State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG),** both CMHS and CSAT awarded seven states approximately $36.6 million over 5 years. The purpose of the grants is to increase the capacity of each state to provide effective, coordinated, and integrated treatment services.

"This program builds on SAMHSA's *Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders,"* Mr. Curie said. "That report acknowledged that too often individuals are treated for only one of the two disorders, if they receive treatment at all. These grants are part of SAMHSA's action plan to help states create a system for treating people for both disorders."

Part of SAMHSA's overall goal is to use proven, scientifically based practices to address substance abuse and mental illness. In support of that goal, CMHS announced awards totaling $8.5 million over 3 years to nine states to implement and evaluate evidence-based practices for treating mental illness. The **State Training and Evaluation of Evidence-Based Practices** program requires grantees to provide training and continuing education for mental health service providers. Each grantee will implement one or more of six previously developed SAMHSA resource kits, which include instructive manuals, videos, and other materials on family psychoeducation, illness management recovery, and integrated treatment for co-occurring disorders. The purpose of these grants is to improve treatments currently offered by both states and communities.

CSAT also awarded $7.7 million over 3 years to fund 13 grants for **Practice Improvement Collaborative Cooperative Agreements: Strengthening Treatment Access and Retention (STAR)** programs. The purpose of the STAR programs is to improve client access to substance abuse treatment and also retention in treatment programs. By creating effective clinical and administrative practices, service providers are able to encourage people to stay for the full course of addiction treatment.

"Clinical and administrative practices can affect whether patients present for treatment and how long they remain in treatment," Mr. Curie said. "We need to reduce the time between referral to treatment and admission, as well as ensure that the immediate needs of the patient are addressed first. Only then will people engage long enough to begin a new life without drugs."

SAMHSA is helping to meet the public health challenges of the twin epidemics of substance abuse and HIV/AIDS with a total of $152 million in grants over 5 years—$114.6 million for treatment and $37.4 million for prevention. CSAT awarded 50 treatment grants totaling $22.8 million for the first year in communities across the Nation for the **Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services.** The 21 5-year prevention grants, the **Targeted Capacity Expansion Initiatives for Substance Abuse Prevention,** will fund efforts by community-based organizations, faith communities, minority-serving colleges and universities, and others to provide effective HIV services in high-risk minority areas. And, CSAP's 44 1-year planning grants, totaling $4.4 million will help communities begin strategic planning efforts for HIV prevention in areas suffering from addiction problems.

These grants target African American, Hispanic/Latino, and other racial and ethnic minority communities affected by the disease. According to Mr. Curie, "The current trend in HIV/AIDS shows that a disproportionate number of minorities who live in inner cities are affected by or are at risk for contracting HIV. Often this population is poor, hard to reach through traditional public health methods, and in need of a wide range of health and human services."

SAMHSA grants are also working at the grassroots level to eliminate specific drugs of abuse. The Center for Substance Abuse Prevention (CSAP) awarded 1-year targeted capacity grants totaling $4.1 million for

As part of the State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders, both CMHS and CSAT awarded seven states approximately $36.6 million over 5 years.

CSAP awarded $12 million over 3 years to grants creating 12 prevention program sites in 11 states across the Nation under the Targeted Capacity Expansion of Methamphetamine and Inhalant Prevention.

Cooperative Agreements to Conduct Targeted Capacity Expansion of Ecstasy and Other Club Drugs Prevention Interventions. In addition, CSAP also awarded $12 million over 3 years to grants creating 12 prevention program sites in 11 states across the Nation under the **Targeted Capacity Expansion of Methamphetamine and Inhalant Prevention.**

CSAT also awarded $8.9 million over 3 years for a **Services Grant Program for Residential Treatment of Pregnant and Postpartum Women** to provide quality residential substance abuse treatment services.

Other first-year grants awarded include the following:

- **Evaluation Technical Assistance Center.** (CMHS) **$800,000.** 1 cooperative agreement grant award to provide technical assistance to states and the mental health community on how to evaluate programs and service systems and how to interpret and use the results of evaluation and mental health services research to improve the planning, development, and operation of adult services provided under the CMHS block grant program.
- **Targeted Capacity Expansion—Prevention and Early Intervention.** (CMHS) **$1.2 million.** 3 grant awards to increase the capacity of cities, counties, and tribal governments to provide prevention and early intervention treatment services to meet emerging and urgent mental health needs.
- **Community Action Grant for Service Systems Change—Phase II.** (CMHS) **$1.5 million.** 10 grant awards to promote the adoption of exemplary community mental health practices. Available only to former or current Community Action Phase I grantees.
- **National Consumer and Consumer Supporter Self-Help Technical Assistance Centers.** (CMHS) **$2 million.** 5 cooperative agreement grant awards to support 3 national consumer self-help technical assistance centers and 2 national consumer-supporter self-help technical assistance centers to improve state and local mental health systems by providing consumers of mental health services, as well as supporters, service providers, and the general public, with skills to foster self-help and self-management approaches.
- **American Indian/Alaska Native National Resource Center for Substance Abuse Services.** (CSAP) **$1 million.** 1 cooperative agreement grant award for a national resource center dedicated to the identification and fostering of effective and culturally appropriate substance abuse prevention and treatment programs and systems for American Indian and Alaska Native populations.

Other Fiscal Year 2003 grants announced previously in *SAMHSA News* earlier this year include the following:

- 11 grants totaling 22.2 million over 3 years for an interdepartmental **Collaborative Initiative To Help End Chronic Homelessness.** (See *SAMHSA News,* Volume XI, Number 1, p. 23, and Number 2, p. 15.)
- 35 state **State Emergency Response Capacity** grants from CSAT totaling nearly $3.4 million for up to 2 years. (See *SAMHSA News,* Volume XI, Number 3, p. 10.)
- 7 **Targeted Capacity Expansion** grants totaling $2 million from CSAT to expand or enhance substance abuse treatment capacity in local communities. (See *SAMHSA News,* Volume XI, Number 2, p. 15.)
- **State Incentive Planning and Development Grants** from CSAP to governors' offices in 14 states and territories to reduce illegal drug, alcohol and tobacco use among children, youth, and young adults. (See *SAMHSA News,* Volume XI, Number 2, p. 15.)
- 10 grant awards totaling $3.2 million for the **Recovery Community Services Program (RCSP II).** (See *SAMHSA News,* Volume XI, Number 2, p. 15.)
- 6 grant awards totaling $1.5 million for the **American Indian/Alaska Native and Rural Community Planning Program.** (See *SAMHSA News,* Volume XI, Number 3, p. 19.)

For information on current SAMHSA grant opportunities, visit SAMHSA's Web site at **www.samhsa.gov/grants/grants.html.**

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:

- ❑ From Subsistence to Sustainability: Treating Drug Abuse in Alaska
- ❑ North Carolina Improves Evidence-Based Practices
- ❑ SAMHSA Offers Alcohol Prevention Strategies to Youth
- ❑ Red Ribbon Week: Preventing Youth Substance Abuse
- ❑ Survey: Nearly Half in Treatment for Both Drug and Alcohol Abuse
- ❑ An End to Bullying: SAMHSA Expands 15+ Program
- ❑ SAMHSA Awards New Grants
- ❑ New Report Points to Cost as a Major Barrier to Mental Health Care
- ❑ *Now on the Web:* SAMHSA's Award-Winning Newsletter

Other comments: _____

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Thank you for your comments.

New Report Points to Cost as a Major Barrier to Mental Health Care

Less than half of U.S. adults with a serious mental illness received treatment or counseling for a mental health problem during the past year, according to a recent short report from SAMHSA's National Survey on Drug Use and Health, formerly the National Household Survey on Drug Abuse. Among the more than 2 million adults with serious mental illness who did not receive treatment but felt that they needed it, half (50 percent) reported that the cost of care was a reason they did not receive treatment.

Other major barriers to receiving treatment included having concerns about what family members, friends, or employers might think (28 percent), not knowing where to go for treatment (26 percent), the fear of being committed or having to take medication (9 percent), and the lack of time or transportation (8 percent).

For the purposes of this study, prepared by SAMHSA's Office of Applied Studies (OAS), treatment is defined as receiving services or counseling in an inpatient or outpatient setting, or taking prescription medication to help alleviate a mental or emotional condition.

The survey found that females (11 percent) were more likely to have serious mental illness in the past year than males (6 percent). Females with serious mental illness were more likely to have received treatment than their male counterparts. Young adults age 18 to 25 had higher rates of past-year serious mental illness (13 percent) than adults age 26 to 49 (10 percent) and those age 50 or older (5 percent).

Yet, of the three age groups, only 34 percent of young adults with serious mental illness received treatment in the past year compared to 54 percent of those age 26 to 49 and 46 percent of adults age 50 and older. Whites with serious mental illness (52 percent) were more likely than blacks (37 percent) or Hispanics (38 percent) to have received mental health treatment in the past year.

To obtain an electronic copy of this report, *Reasons for Not Receiving Treatment Among Adults with Serious Mental Illness,* go to SAMHSA's Web site at **www.samhsa.gov/oas/2k3/MhnoTX/MhnoTX.cfm.** For other OAS reports on mental health, go to **www.samhsa.gov/oas/mh.cfm.**

Now on the Web
SAMHSA's Award-Winning Newsletter

Starting with this issue, you can access a fully linked version of SAMHSA's award-winning newsletter directly from the SAMHSA Web site. Back issues include fall 2002 (Volume X, Number 4) through summer 2003 (Volume XI, Number 3) for quick and easy reference.

Each online version offers all articles, sidebars, and photos that appear in the print version, including updates and information on Agency programs and initiatives, grant award announcements and grantee activities, data and statistics on drug and alcohol abuse, prevention and treatment updates, coverage of peer-reviewed journals and findings related to substance abuse and treatment, and links to new publications from SAMHSA.

In addition, with the January 2004 issue, SAMHSA is pleased to announce that *SAMHSA News* will be published bimonthly, six issues per year, to give you more timely information about the Agency and its programs and services.

To access *SAMHSA News* online, go to **www.samhsa.gov,** click on "About SAMHSA," click on *SAMHSA News.*

SAMHSA News

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