Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

November/December 2006, Volume 14, Number 6

Electronic Records:
Health Care in the 21st Century

It's everyone's worst medical nightmare: an unexpected emergency forces you to get health care far from home. The providers know neither you nor your medical history. And they have no access to the records that contain crucial details about your conditions, past treatments, and current prescriptions.

To address this all-too-common problem, the U.S. Department of Health and Human Services (HHS) and other Federal entities are working on a 21st century solution: an electronic health record (EHR). This record is not only complete, it is accessible from anywhere.

But this system, envisioned by President George W. Bush to be fully operational by 2014, raises unprecedented technical and administrative challenges, and privacy and confidentiality issues. It also raises special concerns for people

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Electronic Health Records

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with mental health and substance abuse problems. This is where SAMHSA can help.

SAMHSA's focus is to make sure that the system includes features specifically designed for behavioral health consumers, caregivers, and providers. The Agency is collaborating with a broad variety of stakeholders in the behavioral health field.

SAMHSA's goal is to empower individuals receiving and providing behavioral health care to take full advantage of the opportunities created by the rapidly approaching era of electronic health information and also to receive the protection they deserve for their highly sensitive health information.

Portable Health Information

The emerging system of electronic health records is part of an enormous change coming to the Nation's health care system. By bringing the latest information technology to health care, this process will also bring other important benefits. These include new levels of responsiveness, safety, and "transparency" in health care (see box below). In addition, this new system promises cost-effective treatments for more people, fewer "wrong doors" to obtain behavioral health services, and far more consumer control over personal health care.

When the new electronic system of health records is in place, planners believe it will transform many important aspects of health care. "The HHS team is hoping that EHRs will help make health care more consumer driven," says Richard Thoreson, Ph.D., a public health advisor at SAMHSA's Center for Substance Abuse Treatment (CSAT) Division of State and Community Assistance. "As a result, current and potential substance abuse clients and mental health consumers may gain new prevention and treatment opportunities."

Paper records now used by the great majority of health care providers across the Nation sit in folders in a single medical office.

"Approximately 25 cents out of every health care dollar is spent on record-keeping and 'administrivia,'" says James Kretz, M.A., a senior survey statistician at SAMHSA's Center for Mental Health Services.

Electronic health records, however, could be instantly available to any health care provider in the country. Instead of each professional or health care facility maintaining an individual record of visits

Electronic Health Record System Requirements

Requirements for a national electronic health records (EHR) information system include:

Privacy and Security Standards—Because of the extreme sensitivity of health information, personal information must be secure from attacks by Internet hackers and available only to those authorized to see it. This will require standards to encrypt information (translate it into secret code) to safeguard it from hackers and other illegitimate users, to authorize those entitled to see it, and to authenticate the identities of those seeking access. These standards will involve both hardware and software.

Interoperability Standards—The World Wide Web works for people and computers anywhere ("interoperability") because it is built on consensus standards that everyone can understand. Similarly, the National Health Information Infrastructure (NHII) initiative, led by Health and Human Services (HHS) Secretary Michael Leavitt, is managing the development of consensus standards to make EHRs work anywhere in the country. In fact, the National Health Information Network (NHIN) is being built on the Web. That means electronic health records will work across a broad range of different hardware and software.

Other Standard Functions—The NHII is also selecting standards for other functions that the EHR will perform—such as the type of information collected, stored, and displayed. Selections are made from standards proposed by Standards Development Organizations. In the past year, SAMHSA has participated in standards development sponsored by an international organization known as Health Level 7 (HL7).

Transparency—Health care consumers deserve to know about the quality and cost of their health care. Health care transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value. For more information, visit **www.hhs.gov/transparency.**

A Common Language—The medical terminology used by the various professionals who will enter information into each person's EHR must be uniform so that all can use it correctly and understand what others mean. The National Library of Medicine is the central coordinating body for clinical terminology standards within HHS. For more information on medical terminology, visit **www.nlm.nih.gov/healthit.html.**

and treatments, the EHR would contain a complete medical picture, letting all providers know about the entire range of conditions or prescriptions that could affect an individual's health or treatments.

Rather than accumulating pages of disorganized handwritten notes, the EHR would have electronic features that organize information quickly to provide the practitioner with the most important and relevant facts. The EHR would also have additional electronic features that could monitor care to make sure it's timely and appropriate, and it could warn about harmful interactions or other potential errors. And while the EHR protects the confidentiality of information, the system could also collect anonymous data to alert public health officials of a potential epidemic or bioterrorism incident.

Building a national EHR system requires solving a number of technical challenges. Some of the requirements have already been met, and others are in progress (see box, p. 2).

Behavioral Health Concerns

For EHRs to serve all those involved in mental health and substance abuse treatment—consumers, clinicians, administrators, and payers—information regarding behavioral health must fit seamlessly into the overall system. But, says Sarah A. Wattenberg, M.S.W., a public health advisor at CSAT, "the electronic health records that exist today are based on a primary care or medical model," and certain aspects of behavioral health care impose different requirements.

The projected national EHR system, therefore, must be designed to accommodate these features.

"Developing a consensus around standards in health information technology for behavioral health will influence the design of the overall national system," says Kevin Hennessy, Ph.D., SAMHSA's Science to Service

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Dr. Broderick's Message

Electronic Records: Transforming Behavioral Health Care

The application of information technology to health care will be one of the most important medical advances of the 21st century. It has the potential to allow all segments of the health system to interact seamlessly and to facilitate high-quality care for consumers.

An integrated, nationwide system of electronic health records can reduce harmful medication errors, provide critical background to service providers, and offer consumers a "portable" medical history to carry with them wherever they go. Having such access empowers consumers to evaluate the quality of care provided, determine how best to use the resources they have, and manage their own treatment.

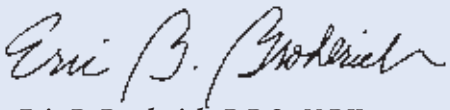
Privacy and confidentiality are essential. The exchange of health information must be accomplished through secure means and include appropriate authorizations from consumers. Such a system should not be constructed as a centralized government database, but rather as a means to connect and exchange health information within the framework of a secure network.

An integrated, secure, and privacy-protected electronic health records system is as valuable in the area of mental health and substance abuse as it is for other health conditions.

The 2001 terrorist attacks underscored the need for an electronic system that physicians could use to prescribe medications for people separated from their regular health care providers. Many patients in SAMHSA-regulated opioid treatment programs were cut off from their daily dose of methadone. Hurricanes Katrina and Rita in 2005 accelerated the efforts of SAMHSA's Center for Substance Abuse Treatment to develop an Internet-based system to ensure continuity of care for patients in treatment for opioid dependence.

The use of technology is mentioned as a key goal in *Achieving the Promise: Transforming Mental Health Care in America,* the 2003 report of the President's New Freedom Commission on Mental Health. Electronic mental health records may enhance quality by including clinical reminders, clinical practice guidelines for treatment and monitoring, tools for decision support, computer entry of health care instructions and prescription dosages, and patient safety alert systems.

As described in this issue of *SAMHSA News,* the Agency is committed to the goal of an integrated, privacy-protected, electronic health records system and to the larger goal of transforming behavioral health care in America to offer the hope of recovery to everyone affected by mental and addictive disorders.



Eric B. Broderick, D.D.S., M.P.H.
Assistant Surgeon General
SAMHSA Acting Deputy Administrator

Electronic Health Records

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Coordinator. "And that requires various segments of the field speaking with one voice to the larger community of experts working on system design."

To advance this goal, SAMHSA has convened the Behavioral Health Treatment Standards Work Group to provide a forum where key stakeholder organizations can discuss how best to advance mental health and substance abuse issues within the evolving national health information infrastructure. These issues include:

- The need to assure the security, privacy, and confidentiality of the extremely sensitive behavioral health information stored in each person's EHR.
- The need for information generated by and about behavioral health care to fit seamlessly into the larger national system of EHRs.

Safeguarding Confidentiality

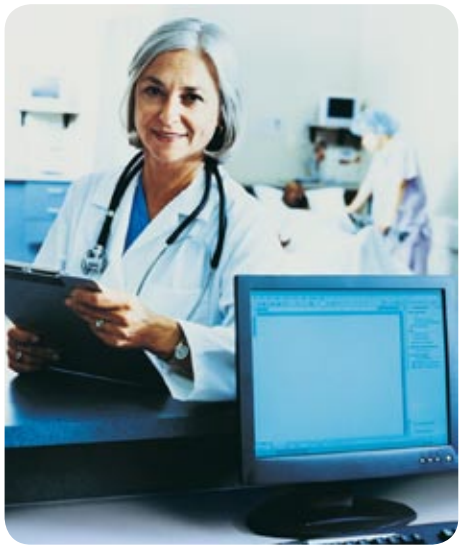
The special security, privacy, and confidentiality needs of behavioral health information are issues of utmost importance for the EHR system to be usable by behavioral health care consumers and clinicians. The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) "governs access and sharing of standard health information but does not sufficiently protect behavioral health information," Ms. Wattenberg says.

That is because "the HIPAA privacy rules allow for the exchange of information among entities such as health plans, clearinghouses, and treatment providers without clients' consent," she explains. "There are also many other provisions in this 'Privacy Rule' that allow for sharing information without consent."

The records of all individuals receiving substance abuse treatment through federally funded programs, however, are governed by additional regulations called the "Confidentiality of Alcohol and Drug Abuse Patient Records" (42 Code of Federal Regulations, part 2). These rules do not allow the exchange of information under most circumstances without the individual's consent.

In addition, many states have established legal protections for mental health information that exceed those in HIPAA. Under the provisions of HIPAA, the more stringent protections, which vary from state to state, are the ones that apply. To better serve behavioral health issues, therefore, SAMHSA is pursuing—through the Behavioral Health Treatment Standards Work Group and other activities—the development of an EHR system architecture that can flexibly accommodate Federal and variable state confidentiality rules.

Developing a consensus around standards in health information technology for behavioral health will influence the design of the overall national system.



Protecting Safety

The requirements of confidentiality must, however, be carefully balanced by considerations of safety. Suppose, for example, that an individual receiving behavioral health care also needs care for an entirely separate matter. The special rules of confidentiality regulate access to the EHR in that encounter as well. That means the individual could refuse to allow other practitioners to see the portion of the EHR referring to substance abuse treatment, for example. In other words, a person taking the medication Antabuse (disulfiram) for alcohol addiction could suffer dangerous respiratory distress if a podiatrist unwittingly treated a foot ailment with an alcohol-based injection.

The fully interoperable system foreseen by the President's Executive Order will have to contain built-in solutions to such conflicts. The system could, for example, inform the health care professional—without disclosing details—that a proposed treatment or substance is counter-indicated by an existing prescription. The individual would then have the choice to allow access to the record. In addition, the system would have a "break the glass" function so that emergency room personnel could immediately access critical records if the individual were unconscious or otherwise unable to give consent.

Only by taking such requirements fully into account could the system adequately serve individuals with behavioral health issues or chronic conditions (e.g., sexually transmitted diseases, epilepsy, cancer).

Building Awareness

Few knowledgeable observers doubt that electronic records will be part of the future of the Nation's health care system or that EHRs will have an enormous impact on everyone receiving, providing, paying for, or administering care.

In developing the complex standards and technologies that will bring that vision to reality, Ms. Wattenberg says, "the question is how do you structure this huge national health information system and electronic health records so that they can accommodate the need for consent when that's required? And, at the same time, we need to provide the safeguards vital for behavioral health." To make sure this is done properly and cost effectively, this consent functionality must be considered from the outset.

"SAMHSA is working hard to ensure that behavioral health is at the table," Ms. Wattenberg continues. "The big issue is that we need to help those developing the system to understand how behavioral health can be part of it, and how technology can serve that purpose without being unduly burdensome to providers, to payers, or to people creating the system."

For more information about electronic health records and health information technology, visit the HHS Web site at **www.hhs.gov/healthit.** For more information on HIPAA, visit SAMHSA's Web site at **www.hipaa.samhsa.gov.**

—By Beryl Lieff Benderly

Designing the System

Some of the organizations involved in creating the electronic health records system include the following:

- *Office of the National Coordinator for Health Information Technology (ONC),* formed within the U.S. Department of Health and Human Services (HHS) by a Presidential Executive Order issued in 2004, coordinates efforts within the Department to meet the President's goal and advises the HHS Secretary. The Executive Order mandated that a fully operational system be in place within a decade. The ONC is leading the efforts of a range of governmental and private groups to define the system requirements needed for health care consumers and providers. For more information about the ONC or other health information technology efforts at HHS, visit **www.hhs.gov/healthit** or **www.hhs.gov/healthinformationtechnology.** For a fact sheet on HHS efforts, "Harnessing Information Technology To Improve Health Care," visit **www.hhs.gov/news/press/2004pres/20040427a.html.**
- *American Health Information Community (AHIC),* a group of stakeholders from the public and private sectors, advises the HHS Secretary on means of accelerating the development of health care information technology. For more information, visit **www.hhs.gov/healthit/ahic.html.**
- *Agency for Healthcare Research and Quality, National Research Center for Health Information Technology,* provides technical assistance and shares new knowledge. For more information, visit **www.ahrq.gov.**
- *Health Level Seven (HL7)* includes standards for electronic interchange of clinical, financial, and administrative information among health care-oriented computer systems on its Web site at **www.hl7.org.**

Database Tools To Assess Child Trauma

The SAMHSA-funded National Child Traumatic Stress Network (NCTSN) has prepared and released a free online searchable database that provides clinicians and researchers with in-depth information to enable them to choose the best instrument to assess children and adolescents who have experienced trauma.

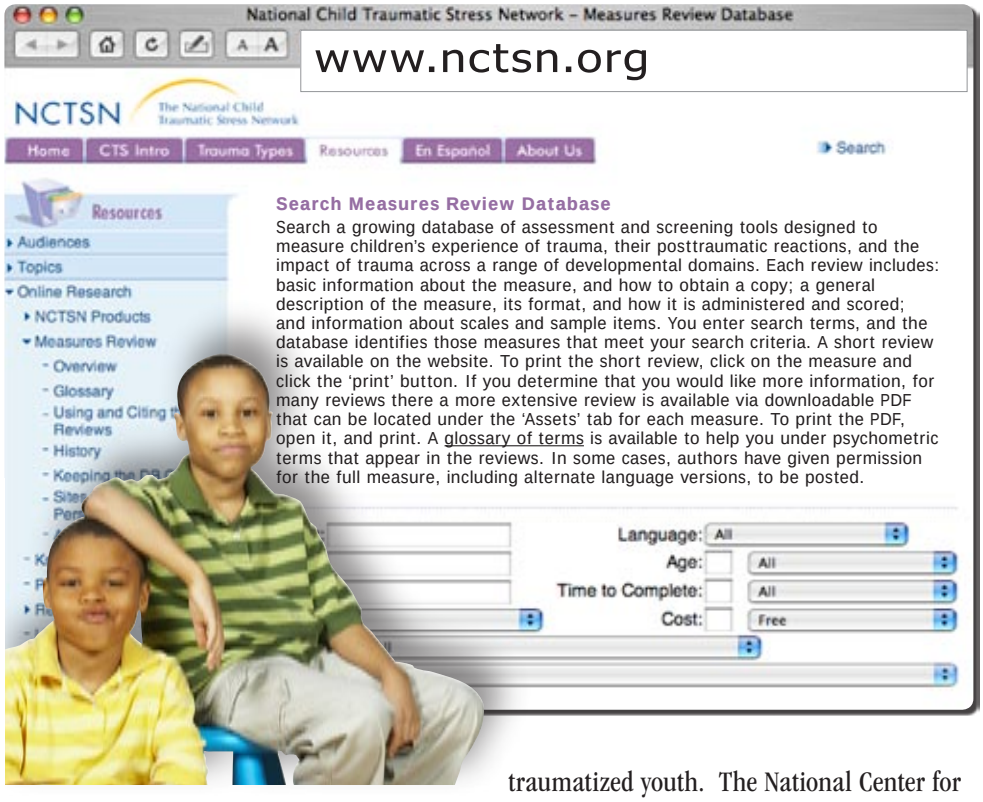
The Measures Review Database fills an important gap in the field. The purpose of the database is to promote the use of state-of-the-art measures for improved clinical intervention and research on child trauma.

The database currently provides information on 62 assessment tools for different populations, including children and adolescents as well as parents and caregivers. Reviews indicate the degree to which a specific assessment tool has been used with diverse cultural and ethnic groups and with children exposed to different types of traumas. Additional assessment tools will be added to the database in the coming months.

Each database review provides the following information:

- A general description of the measure
- Domains the measure assesses
- Evidence validating or supporting the measure's use
- Scoring and interpretation of test results
- Available languages and psychometrics of translated versions
- Age range
- Summary of studies that have used the measure
- Training for administration and scoring of the measure
- Pros and cons of using each measure
- Information on how to obtain the measure.

The Measures Review Database has been a high priority project of the NCTSN. Chandra Ghosh Ippen, Ph.D., of the NCTSN's Early Trauma Treatment Network at the University of California, San Francisco, led the project.



The database debuted in early November 2006.

The National Child Traumatic Stress Network's goal is to improve the quality, effectiveness, and availability of services for traumatized youth. The National Center for Child Traumatic Stress, at both the Duke University Medical Center and the UCLA Neuropsychiatric Institute, coordinates the NCTSN.

For more information about the Measures Review Database and other topics related to child traumatic stress, visit **www.nctsn.org.**

Developing the Review Template

In 2002, during the first meeting of the NCTSN Measures Committee, members raised the possibility of creating a database of evaluation measures and formed a subcommittee to develop criteria. This subcommittee identified criteria by reviewing the literature on psychometrics and measure development; consulting with experts in the field; consulting with NCTSN members regarding important psychometric, clinical, and practical properties of measures; and gathering information from other templates developed and used by NCTSN Centers.

The goal was to develop a user-friendly measure review template that contained not only descriptive and psychometric fields, but information about the clinical use of the measure with diverse populations. The template was submitted for review to NCTSN consultants. Once the final version was approved, subcommittee members developed a brief version of the template that would be available on the NCTSN Web site and would contain searchable fields and other key information. For more details, visit the NCTSN Web site at **www.nctsn.org.**

SAMHSA Launches Anti-Stigma Campaign

Only One in Four Americans Believe People Are Sympathetic Towards Those with Mental Illnesses

SAMHSA, in partnership with the Ad Council, recently launched a national awareness campaign designed to decrease the negative attitudes that surround mental illness.

The campaign's public service announcements (PSAs) also encourage young adults to support their friends who are living with mental health problems. The PSAs are being distributed to media outlets nationwide.

Survey Results

Despite the fact that an overwhelming majority of Americans (85 percent) believe that people with mental illnesses are not to blame for their conditions, only about one in four (26 percent) agree that people are generally caring and sympathetic toward individuals with mental illnesses, according to a new HealthStyles survey.

The survey is conducted annually by Porter Novelli, a global public-relations company that licenses use of the data. The new 2006 survey data also found that only one-quarter of young adults believe that a person with a mental illness can eventually recover.

And, slightly more than one-half (54 percent) of young adults who know someone with a mental illness believe that treatment can help people with mental illnesses lead normal lives.

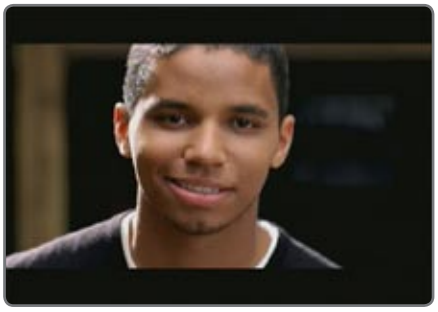
According to SAMHSA, in 2005 an estimated 24.6 million adults age 18 or older experienced serious psychological distress (SPD), which is highly correlated with serious mental illness. Among 18 to 25 year olds, the prevalence of SPD is high (18.6 percent for 18 to 25 year olds vs. 11.3 percent for all adults 18+). Yet, this age group shows the lowest rate of help-seeking behaviors. People with mental health conditions in this segment have a high potential to minimize future disability if social acceptance is broadened, and they receive the right support and services early on.

Friendship Is Key

Created pro bono by Grey Worldwide, the new PSA campaign aims to reach 18- to 25-year-old adults who have friends living with mental illnesses. The campaign highlights the importance of their providing support. Featuring a voiceover by actor Liev Schreiber, the television and radio spots illustrate how friendship is the key to recovery. The campaign also includes print and interactive advertising as well as a new Web site.

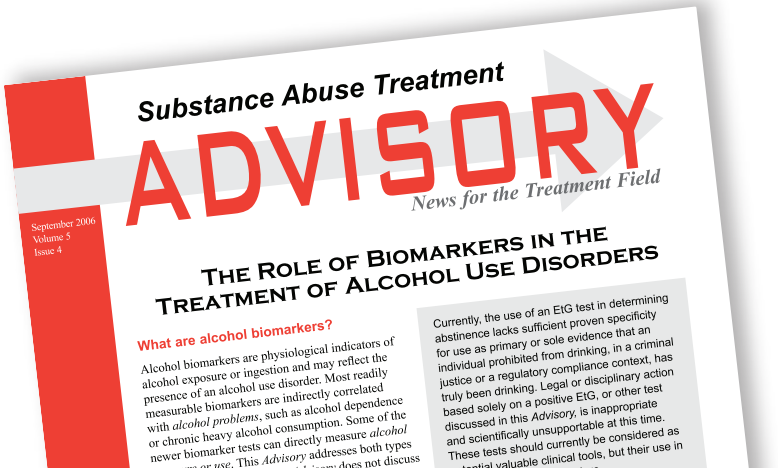
The PSAs were distributed to more than 28,000 media outlets nationwide and will air in advertising time that will be donated by the media. For more information and to view the new ads, please visit **www.whatadifference.samhsa.gov.**

www.whatadifference.samhsa.gov



Above are images from one of SAMHSA's new public service announcements (PSAs)—"What a Difference a Friend Makes"—part of the Agency's new mental health campaign to increase awareness nationwide and encourage young adults to play a role in a friend's recovery.

SAMHSA Advisory: Lab Tests for Alcohol Abuse



SAMHSA has issued an Advisory that cautions licensure bodies, other monitoring organizations, and staff in criminal justice settings that a widely used test for alcohol consumption is "scientifically unsupportable" as the sole basis for legal or disciplinary action.

The EtG (ethyl glucuronide) urine test, often used to detect alcohol use among individuals legally prohibited from drinking because of their job or parole status, is "inappropriate" as the sole basis for a definitive, life-altering decision.

According to the SAMHSA Advisory, "The Role of Biomarkers in the Treatment of Alcohol Use Disorders," the EtG urine test is one of an evolving group of highly sensitive tests for the ingestion of alcohol.

The EtG test and other similar highly sensitive tests are not able to distinguish between alcohol absorbed into the body from exposure to many common commercial and household products containing alcohol or from the actual consumption of alcohol. Calling such a test "positive" for consumption or relapse, especially at low concentrations, could have devastating consequences for someone who signs an alcohol abstinence contract or is required to be abstinent by law.

"This Advisory is a clarification," said addiction psychiatrist Kenneth Hoffman, M.D., M.P.H., of SAMHSA's Center for Substance Abuse Treatment Division of Pharmacologic Therapies. "The Agency wants officials to know that the EtG test, for example, is fine for use in clinical settings. But it should not be used as a stand-alone test in a forensic situation where someone's job is at stake."

The EtG test, identified as a "direct biomarker," is highly sensitive, Dr. Hoffman explained. (See box.) "For example, there's a popular hand sanitizer that's about 64-percent ethanol. That alcohol can be absorbed through the skin and metabolized to EtG and EtS (ethyl sulfate)," he said. "With tests highly sensitive to detecting EtG or EtS, that might mean that these tests are reported positive for other reasons, even though no alcohol was consumed. A positive EtG or other similar highly sensitive test alone may have nothing to do with relapse or inappropriate use of alcohol."

To order a copy of "The Role of Biomarkers in the Treatment of Alcohol Use Disorders," call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Ask for NCADI number MS996. Online, for more information on the Advisory or to view the full text in PDF format, visit **www.kap.samhsa.gov/products/manuals/advisory.**

What Are Alcohol Biomarkers?

Alcohol biomarkers are physiological indicators of alcohol exposure or ingestion. SAMHSA's recent Advisory focuses on "indirect" and "direct" biomarkers.

Indirect biomarkers. Traditional alcohol biomarkers are generally considered "indirect." Indirect biomarkers suggest heavy alcohol consumption by detecting the toxic effects that alcohol may have had on organ systems or body chemistry. Indirect measures generally screen for elevations of specific liver serum enzymes—which may result from heavy drinking—or changes in red blood cells—which reflect nutritional problems related to alcohol use.

Direct biomarkers. Breath or blood alcohol tests used by police officers to identify potentially drunk drivers are familiar examples of a direct alcohol biomarker. These tests reliably determine a motorist's blood alcohol concentration. An evolving group of tests for alcohol—"direct" biomarkers, or analytes of alcohol metabolism—are now available through some laboratories for either clinical or forensic use. Tests for EtG (ethyl glucuronide) and EtS (ethyl sulfate), typically measured in urine, can be used to screen individuals for alcohol exposure or use. These tests may be reported positive after even low-level exposure to alcohol and may remain detectable for several days. Tests for indications of heavy alcohol use have proven helpful in clinical treatment settings and can complement self-report measures of drinking.

Recommended Citation: Center for Substance Abuse Treatment. The Role of Biomarkers in the Treatment of Alcohol Use Disorders. *Substance Abuse Treatment Advisory.* Volume 5, Issue 4, 2006.

Who's Drinking? More Than Half Underage College Students

SAMHSA's National Survey on Drug Use and Health (NSDUH) has examined trends and patterns in the rates of alcohol use by full-time college students age 18 to 20. Data show that between 2002 and 2005 the rates of past-month, binge, and heavy alcohol use are holding steady, but not decreasing.

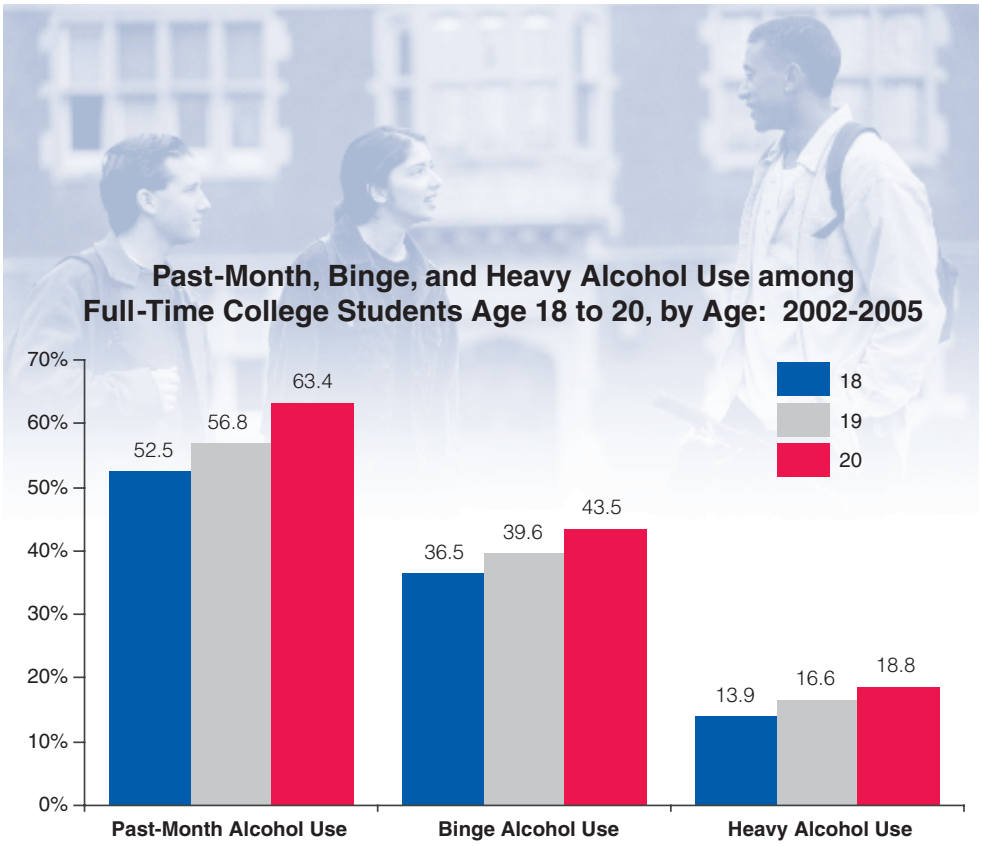
Based on combined NSDUH data from the 2002 to 2005 surveys, 57.8 percent of full-time college students underage for legal drinking used alcohol in the past month, 40.1 percent engaged in binge drinking, and 16.6 percent engaged in heavy drinking.

For full-time college students age 18 to 20, males were more likely than females to have used alcohol in the past month (60.4 percent vs. 55.6 percent), binge drank (46.9 percent vs. 34.4 percent), or drank heavily (22.7 percent vs. 11.5 percent).

Among full-time college students age 18 to 20, those living with a parent, grandparent, or parent-in-law were less likely to have used alcohol in the past month than those who were not living with a parental relative (51.2 percent vs. 67.0 percent).

From 2002 to 2005, an average of 5.2 million young adults age 18 to 20 were enrolled full time in college each year. This represents 41.3 percent of young adults in this age range. Full-time college students included an average of 2.8 million women age 18 to 20 (46.0 percent of women in this age group) and 2.4 million men age 18 to 20 (36.9 percent of men in this age group) each year.

To read the full text of this short report, *Underage Alcohol Use among Full-Time College Students,* visit **www.oas.samhsa.gov/2k6/college/collegeUnderage.htm.**



Source: SAMHSA Office of Applied Studies. *Results from the 2002, 2003, 2004, and 2005 National Surveys on Drug Use and Health.*

Definitions

SAMHSA's National Survey on Drug Use and Health asks respondents age 12 or older to report their frequency and quantity of alcohol use during the month before the survey. Results use the following definitions for alcohol consumption:

- **Binge Alcohol Use.** Drinking five or more drinks on the same occasion (i.e., drinks are consumed at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.
- **Heavy Alcohol Use.** Drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days. All heavy alcohol users are also binge alcohol users.

Misuse of Prescription Drugs: A National Concern

With the misuse of prescription drugs second only to marijuana as the Nation's most prevalent drug problem, the annual average number of people using pain relievers nonmedically for the first time exceeds the number of new marijuana users, according to a recent study released by SAMHSA.

The report, *Misuse of Prescription Drugs: Data from the 2002, 2003, and 2004 National Surveys on Drug Use and Health,* covers four broad classes of prescription psychotherapeutics. These include pain relievers, tranquilizers, stimulants, and sedatives, along with specific information on OxyContin (a pain reliever) and methamphetamine (a stimulant). Nonmedical use (or misuse) is defined as use of these medications without a prescription or simply for the experience or feeling the drug can cause.

"While marijuana continues to be the most commonly used illicit drug, the misuse of prescription drugs is clearly a growing national concern that requires action from multiple segments of our society," said Assistant Surgeon General Eric B. Broderick, D.D.S., M.P.H., SAMHSA Acting Deputy Administrator.

Based on combined data from SAMHSA's 2002 through 2004 National Surveys on Drug Use and Health, an annual average of 2.7 million persons age 12 or older began misusing a prescription psychotherapeutic drug in the past year, while an annual average of 2.1 million people age 12 or older started using marijuana.

An annual average of 11.3 million persons age 12 or older were using prescription pain relievers nonmedically in the past year compared with an annual average of 25.5 million past-year users of marijuana. This includes new users and users who had started more than 12 months previously.

Prescription Drugs and Young Adults

The report shows that, among specific age groups, young adults age 18 to 25 tended to have the highest rates of nonmedical use in the past year. This group is followed by youth 12 to 17, with most of these young people getting prescription drugs from friends or family members—not the Internet. (See box on page 11.)

"We know that 70 to 80 percent of those 12 years or older said they got their drugs from a friend or relative and, very likely, those came from the family medicine cabinet," said Dr. Broderick. "Only 4.3 percent got the pain relievers from a drug dealer or other stranger and only 0.8 percent reported buying the drug on the Internet. Parents and other caregivers should store their prescription drugs carefully and dispose of any unused drugs before they can fall into the wrong hands."

New The DAWN Report
DRUG ABUSE WARNING NETWORK

Nonmedical Use of Cough Medicine

Dextromethorphan (DXM), an ingredient commonly found in over-the-counter cough and cold remedies, contributed to an estimated 12,584 visits to hospital emergency departments during 2004.

According to SAMHSA's Drug Abuse Warning Network (DAWN), 5,581 of those visits were attributed to nonmedical use.

The DAWN study, *Emergency Department Visits Involving Dextromethorphan,* shows that of those visits related to nonmedical use, almost half (48 percent) involved patients age 12 to 20.

In this report, nonmedical use of DXM includes those taking more than a prescribed or recommended dose, as well as other forms of drug misuse or abuse, and does not include accidental ingestion, suicide attempts, or medical use.

DXM is generally recognized as safe when marketed according to FDA's regulations. But when taken in large amounts, it can produce hallucinations and a "high" similar to psychotropic drugs, such as phencyclidine (PCP). Serious side effects have included blurred vision, loss of physical coordination, abdominal pain, and rapid heartbeat.

To assist parents, SAMHSA has developed educational information about dextromethorphan at **www.family.samhsa.gov/get/otcdrugs.aspx.**

The rate of emergency department visits resulting from nonmedical use of this product was 7.1 visits per 100,000 people age 12 to 20, compared with 2.6 visits or fewer per 100,000 people in other age groups. Alcohol was also implicated in 36 percent of those same nonmedical use visits for patients age 18 to 20 and in 13 percent of visits for patients age 12 to 17.

Suicide attempts accounted for 14 percent of DXM-related emergency department visits and ranged from 1.4 to 1.7 per 100,000 people age 12 to 34.

DAWN collects data from emergency departments in a national sample of short-term, general, non-Federal hospitals and publishes estimates of emergency department visits involving illicit drugs, alcohol, and nonmedical use of pharmaceuticals. The report is available on the SAMHSA Web site at **dawninfo.samhsa.gov.**

Pain relievers were used nonmedically in the past year by 11.8 percent of young adults compared with 7.5 percent of youth and 3.1 percent of adults age 26 or older. Among adults age 18 or older, the risk of dependence or abuse for psychotherapeutics was greater for persons who initiated nonmedical use before age 16 compared with those who initiated use at age 16 or older.

Although overall patterns for misuse of any prescription psychotherapeutic drug and for specific classes of psychotherapeutics continued to show stable rates, significant increases in the prevalence of lifetime misuse from 2002 through 2004 were observed for some specific types of drugs. Among persons age 12 or older, nonmedical use of pain relievers in the hydrocodone category (e.g., Vicodin) at any time in the individuals' lives increased from 5.9 percent in 2002 to 7.4 percent in 2004. And use of medications in the oxycodone category (e.g., Percocet or OxyContin) increased from 4.3 percent to 5.0 percent over that period.

Misuse by Area

Almost 2 million people age 12 or older met criteria for past-year dependence or abuse of prescription drugs, including 1.4 million people for pain relievers, 573,000 for tranquilizers, 470,000 for stimulants, and 128,000 for sedatives. Only 12.5 percent of those with a prescription drug use disorder in the past year received specialty treatment for drug problems in that period. Specialty treatment includes treatment at a hospital (inpatient), a rehabilitation facility (inpatient or outpatient), or a mental health center.

Persons age 12 or older who were living in small metropolitan areas with populations of fewer than 250,000 had the highest rates by population density for misuse of any prescription psychotherapeutic drug (7.1 percent), pain relievers (5.4 percent), tranquilizers (2.6 percent), and stimulants (1.7 percent).

Colorado, Kentucky, and Washington State ranked among the states with the highest prevalences of nonmedical prescription pain reliever use among persons age 12 or older. The District of Columbia and the midwestern states of Iowa, Nebraska, and South Dakota were among the areas with lower prevalences of pain reliever misuse for persons age 12 or older.

Misuse of Prescription Drugs: Data from the 2002, 2003, and 2004 National Surveys on Drug Use and Health is based on an annual survey of the civilian, noninstitutionalized population of the United States age 12 years or older. The National Survey on Drug Use and Health is sponsored by SAMHSA and is planned and managed by SAMHSA's Office of Applied Studies. This report is available for free download on SAMHSA's Web site at **www.oas.samhsa.gov/prescription/toc.htm.**

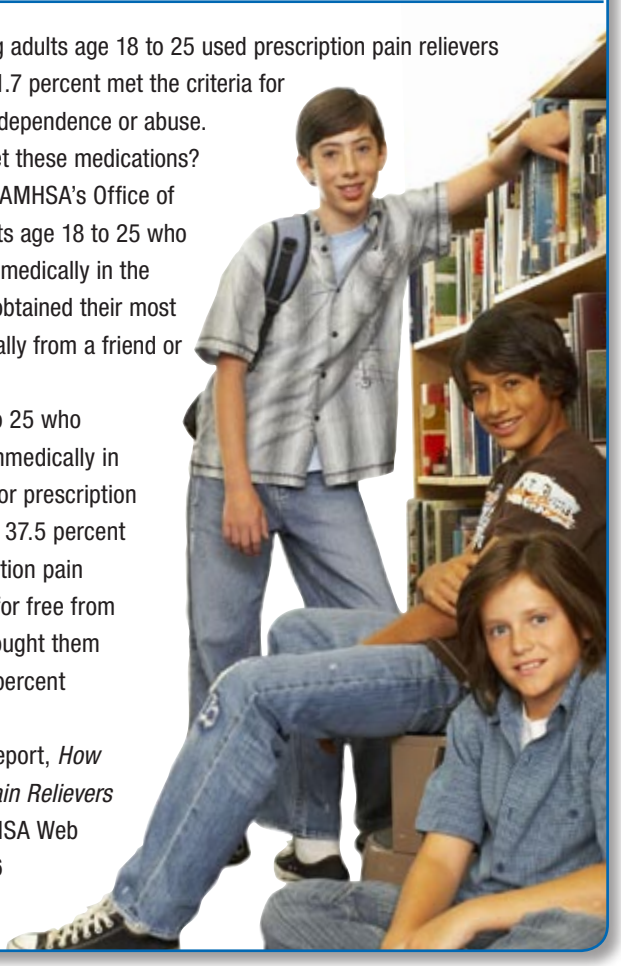
Young Adults & Prescription Pain Relievers

In 2005, 12.4 percent of young adults age 18 to 25 used prescription pain relievers nonmedically in the past year, and 1.7 percent met the criteria for past year prescription pain reliever dependence or abuse.

How did these young adults get these medications? According to a recent report from SAMHSA's Office of Applied Studies, among young adults age 18 to 25 who used prescription pain relievers nonmedically in the past-year, over half (53.0 percent) obtained their most recent pain reliever used nonmedically from a friend or relative for free.

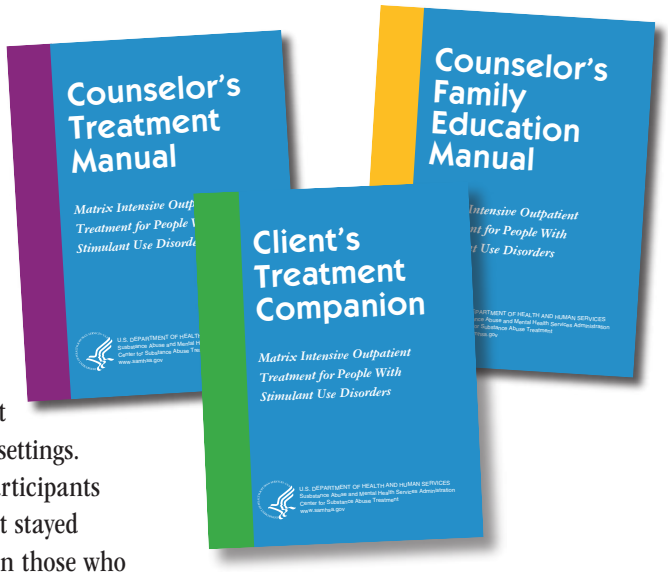
Among young adults age 18 to 25 who used prescription pain relievers nonmedically in the past year and met the criteria for prescription pain reliever dependence or abuse, 37.5 percent obtained their most recent prescription pain relievers for nonmedical purposes for free from a friend or relative, 19.9 percent bought them from a friend or relative, and 13.6 percent obtained them from one doctor.

For more information on the report, *How Young Adults Obtain Prescription Pain Relievers for Nonmedical Use,* visit the SAMHSA Web site at **www.oas.samhsa.gov/2k6/getPain/getPain.cfm.**



While the prevalence of methamphetamine use appeared in this report to remain stable from 2002 to 2004, patterns noted in another SAMHSA report on treatment admissions indicated that the number of those seeking treatment for methamphetamine use increased from 44,000 admissions recorded in 1994 to approximately 150,000 in 2004. A comprehensive 324-page report on treatment admissions for many drugs of abuse, *Treatment Episode Data Sets (TEDS): Discharges from Substance Abuse Treatment Services,* is located on SAMHSA's Web site at **http://wwwdasis.samhsa.gov/teds04/tedsd2k4web.pdf.**

Stimulant Use Disorders: Evidence-Based Treatment Tools



To mark the end of its Methamphetamine Treatment Project, SAMHSA's Center for Substance Abuse Treatment (CSAT) recently released training manuals that provide a structured, evidence-based approach to treat stimulant disorders.

Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders is a package of publications that gives counselors proven tools to treat clients who have problems with methamphetamine, cocaine, or other stimulants. The manuals and other materials offer step-by-step instructions for providing treatment plus continuing care for clients and their families.

"Stimulants, especially methamphetamine, can have a devastating impact on individuals, families, and communities," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H. "This new publications package expands access to needed treatment."

A Proven Approach

Community-based treatment providers are the main audience for this package, said Project Officer Cheryl J. Gallagher, M.A., a public health advisor at CSAT. The treatment approach has its roots in an outpatient treatment model developed in the mid-1980s by the Matrix Institute on Addictions of Los Angeles, CA.

Aimed at individuals with cocaine and methamphetamine use disorders, the model provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Clients receive direction and support from trained therapists, learn about addiction and relapse, and familiarize themselves with self-help programs. In addition, the program also includes education for family members. Urine testing also helps ensure that clients stay drug-free.

CSAT launched the Methamphetamine Treatment Project in 1999 to test the effectiveness of the Matrix model. The largest randomized clinical trial of treatment for methamphetamine dependence to date, the study compared a "manualized" version of the Matrix model to standard treatment in eight community-based outpatient settings.

The study found that participants undergoing Matrix treatment stayed with the program longer than those who received traditional treatment. They were also more likely to have drug-free urine samples during treatment and more likely to complete treatment.

Components of the new package are:

- ***Counselor's Treatment Manual*** contains everything counselors need to conduct individual and group sessions using the Matrix approach. After an introductory section about the Matrix model, the manual provides specific instructions for conducting each session. The manual also includes a bibliography for counselors interested in further reading.
- ***Counselor's Family Education Manual*** guides counselors through the process of conducting the family sessions that are a key part of the Matrix approach. Intended to be psychoeducational opportunities rather than family therapy, these sessions teach families about drug use, recovery, and their role in supporting their family members. An accompanying CD-ROM contains slides that can be used in presentations or as handouts.
- ***Client's Handbook*** contains all of the handouts used in treatment sessions. While some handouts summarize information, others require participants to come up with their own answers to such questions as what triggers their drug use or what kind of leisure activities could offer a sense of rejuvenation. Clients can also review the handbook once treatment is over as a way of strengthening their commitment to recovery.
- ***Client's Treatment Companion*** gives clients a handy place to record their own ideas and reasons for staying in recovery. The booklet begins by asking users to insert a photo that's important to them and then asks them to explain the subject's role in their recovery. The booklet also offers space for users to list the phone numbers of people to call for help, their reasons for staying abstinent, their favorite ways to reduce stress, ideas for rewarding success, and so on. "It's a pocket-sized book," explains Ms. Gallagher. "Because it's small enough to carry with them, clients can use it to reinforce their relapse prevention."

Ms. Gallagher added, "SAMHSA grantees can arrange for training on the use of these materials through their project officers at the Agency."

To order copies, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the publications are available at **http://kap.samhsa.gov/products/manuals/matrix/index.htm.**

—By Rebecca A. Clay

Addressing Issues in Outpatient Treatment

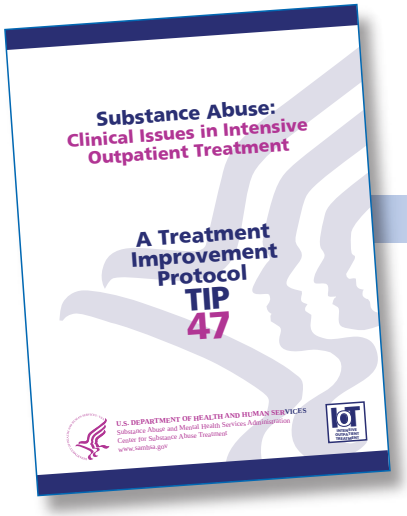
SAMHSA's Center for Substance Abuse Treatment (CSAT) recently released two Treatment Improvement Protocols (TIPs) for clinicians and administrators who work in outpatient treatment programs.

Developed as a result of discussions among members of CSAT's Knowledge Application Program (KAP) expert panel, TIP 46 is titled *Substance Abuse: Administrative Issues in Outpatient Treatment.* The companion text, TIP 47, is titled *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.*

These TIPs update the subject matter of CSAT's TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse,* published in 1994. Since the original TIP was published, substantial changes have occurred in almost every aspect of the way treatment services are conceptualized and delivered.

Outpatient programs are now widely used for clients of all ages with a moderate range of problems. In addition, these programs serve adolescents, clients who are homeless, and persons with co-occurring mental disorders.

As outpatient programs serve a broader client population than ever before, program administrators face an array of challenges, including high turnover in the administrative and clinical ranks. And, as intensive outpatient treatment (IOT) programs have expanded in popularity, clinicians have had to keep abreast of new treatment approaches and services provided beyond their own programs.



For Administrators

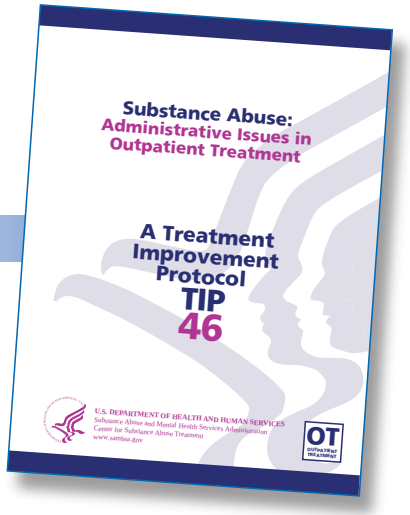
Most of the concepts and guidelines in TIP 46 apply to the administration of outpatient treatment programs for substance abuse, including those considered "intensive" settings. This publication focuses on strategies for program survival and growth and provides basic information about running an outpatient treatment program.

Management Issues. Guidelines for developing structural elements of a successful program include strategic planning and partnerships, bylaws, and program policy. Also addressed in TIP 46 are day-to-day management issues of a treatment program, including policies and procedures, staffing, and budgets.

Cultural Diversity. A challenge to outpatient treatment programs is expanding cultural diversity. Currently, the majority of treatment providers are white; however, nearly half of clients are from various ethnic groups. TIP 46 discusses this issue in detail and explains how to conduct community, client, and program assessments of cultural competence. The TIP also provides recommendations and an annotated list of resources to assist programs in cultural competence education, assessment, and training.

For Clinicians

TIP 47 is intended to be useful to all IOT programs, including day treatment and partial hospitalization programs. Focusing on clinicians working in outpatient programs, TIP 47 explores the treatment options available as well as the most important skills required to work in the field.



Principles of Treatment. TIP 47 synthesizes information from the convergence of research and practice during recent years, and presents 14 guiding principles for IOT. Principles include assessing and addressing individual treatment needs, monitoring abstinence, and providing ongoing care.

Program Services. TIP 47 describes the core services that IOT programs should provide and the enhanced services that often are delivered onsite or through established links with community-based providers. The core services include group counseling and therapy in addition to monitoring substance use. Enhanced services include adult education and parenting classes.

To order free copies of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment,* or TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Request NCADI number BKD545 for TIP 46 or NCADI number BKD551 for TIP 47. Online, TIP 46 is currently available at **www.kap.samhsa.gov/products/manuals/tips/numerical.htm.** TIP 47 will be available online and in print soon.

—By Leslie Quander Wooldridge

IN BRIEF . . .

Anger Management: Spanish-Language Pubs Available

Substance use and abuse are often closely linked with anger and violence. To help counselors and treatment providers expand their support to Spanish-speaking individuals in recovery, the Agency has released two new publications in Spanish.

Released in English in 2002, *Anger Management for Substance Abuse and Mental Health Clients,* was one of SAMHSA's most frequently ordered publications. To reach a wider audience, SAMHSA's Center for Substance Abuse Treatment recently released the manual and workbook in Spanish: *Programa para el manejo del enojo en clientes con problemas de abuso de sustancias y trastornos de salud mental.*

Both sets of manuals are intended for use as part of a 12-week treatment program. Individuals who participate in the sessions learn how to manage their anger and how to diminish the impact anger can have on their lives.

To obtain free copies, contact SAMHSA's National Clearinghouse for Alcohol and Drug information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the workbook is now available in PDF format at **www.kap.samhsa.gov/mli/docs/spanish/angermanagement_spanish_workbook.pdf.**

President Nominates Terry L. Cline

President Bush has nominated Terry L. Cline, of Oklahoma, to be SAMHSA Administrator. Dr. Cline currently serves as the Oklahoma Secretary of Health and Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services. Prior to this, he served as a Health Care Policy Fellow at SAMHSA. Earlier in his career, he served as Clinical Director of the Cambridge Youth Guidance Center. Dr. Cline received his bachelor's degree from the University of Oklahoma. He received his master's degree and Ph.D. from Oklahoma State University.

November 30 is Methamphetamine Awareness Day

For more information, visit SAMHSA's Web site at www.samhsa.gov

Notice of Erratum: Treatment Improvement Protocol 43

SAMHSA's Center for Substance Abuse Treatment (CSAT) has issued corrections to Chapter 13, page 219, of Treatment Improvement Protocol (TIP) 43: *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (2005 printing).

Typographical errors and some confusing wording are on page 219. If left uncorrected, these text errors could lead to mistakes in treatment of neonatal abstinence syndrome.

The following erratum details the errors in TIP 43 (2005 printing) and their correction.

Chapter 13, page 219:

- Column 1, line 9 from the bottom, reads "0.4 mg/kg/dose." It should read "0.4 mg/kg/day."
- Column 1, line 6 from the bottom, reads "0.4 mg/kg/dose." It should read "0.04 mg/kg/dose."

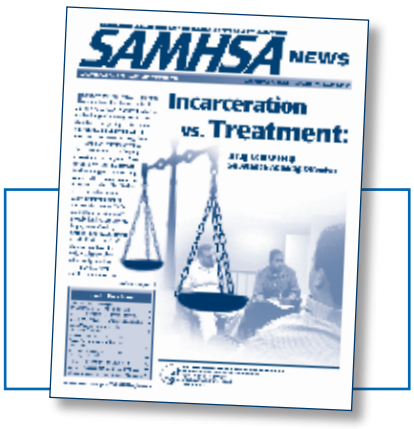
In subsequent printings of TIP 43, page 219, the paragraphs regarding this topic have been changed to read:

"If pharmacological management is indicated, several methods have been found useful. The American Academy of Pediatrics Committee on Drugs policy statement on Neonatal Drug Withdrawal (1998) describes several agents for the treatment of NAS including methadone, tincture of opium, paregoric, and morphine. One method (J. Greenspan, Thomas Jefferson University Hospital, Philadelphia, personal communication, October 2006) uses neonatal opium solution (0.4 mg/mL morphine-equivalent; starting dosage, 0.4 mg/kg/day orally in six to eight divided doses [timed with the feeding schedule]). Dosage is increased by 0.04 mg/kg /dose until control is achieved or a maximum of 2.0 mg/kg/day is reached. If Neonatal Abstinence Scores stay high but daily dosage nears maximum, symptoms are reassessed and concurrent phenobarbital therapy considered. When control is achieved, the dosage is continued for 72 hours before pharmacological weaning, in which dosages are decreased 10 percent daily or as tolerated. When 0.2 mg/kg/day is reached, medication may be stopped. Decisions about dosage decrease during pharmacological weaning are based on Neonatal Abstinence Scores, weight, and physical exams."

CSAT regrets any confusion these errors have caused and requests your assistance to correct the text in all copies of the first (2005) printing of TIP 43 to which you have access. Please help us ensure that word of this correction reaches as many TIP 43 readers as possible.

SAMHSA News *2006 Index—Volume 14*

This index includes entries for six issues of *SAMHSA News* for 2006. Each issue is numbered: January/February (1), March/April (2), May/June (3), July/August (4), September/October (5), and November/December (6). Specific pages follow. Entries in *italics* are publications.



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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: _____

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

- ❑ Electronic Records: Health Care in the 21st Century
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- ❑ Database Tools To Assess Child Trauma
- ❑ SAMHSA Launches Anti-Stigma Campaign
- ❑ SAMHSA Advisory: Lab Tests for Alcohol Abuse
- ❑ Who's Drinking? More Than Half Underage College Students
- ❑ Misuse of Prescription Drugs: A National Concern
- ❑ DAWN: Nonmedical Use of Cough Medicine
- ❑ Young Adults & Prescription Pain Relievers
- ❑ Stimulant Use Disorders: Evidence-Based Treatment Tools
- ❑ Addressing Issues in Outpatient Treatment
- ❑ In Brief . . .
- ❑ *SAMHSA News* 2006 Index—Volume 14
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