Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Meeting the Challenge: Resources for Alaskans

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Regional Administrator
SAMHSA Region X

2016 Alaska Training Institute
Anchorage, Alaska
May 2, 2016
Key Challenges

• Heroin & Prescription Drug Abuse
• Suicide among Alaskans
• Healthcare Integration/Transformation
### Past Year Opioid Use, Abuse or Dependence Among Persons Aged 12 or Older: 2009-2012

Opioids include heroin and nonmedical pain relievers.

**Source:** SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2010 (revised 3/12), 2011-2012.

<table>
<thead>
<tr>
<th>State</th>
<th>Past Year Opioid Use</th>
<th>Past Year Abuse/Dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>30,000</td>
<td>4,000</td>
</tr>
<tr>
<td>Idaho</td>
<td>76,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Oregon</td>
<td>220,000</td>
<td>41,000</td>
</tr>
<tr>
<td>Washington</td>
<td>351,000</td>
<td>62,000</td>
</tr>
</tbody>
</table>

(DHHS Region X States)
2014 NSDUH: NEW DATA, FAMILIAR CONCERNS

Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health

No Past Month Illicit Drug Use
238.1 Million People (89.8%)

Past Month Illicit Drug Use
27.0 Million People (10.2%)

- Marijuana and Hashish: 22.2 million people (4.3%)
- Pain Relievers: 4.3 million people
- Tranquilizers: 1.9 million people
- Stimulants: 1.6 million people
- Cocaine: 1.5 million people
- Hallucinogens: 1.2 million people
- Inhalants: 0.5 million people
- Heroin: 0.4 million people
- Sedatives: 0.3 million people

Millions of People
Past Month Nonmedical Use of Pain Relievers among People Aged 12 or Older, by Age Group: 2002-2014

+ Difference between this estimate and the 2014 estimate is statistically significant at the .05 level.
Rx opioid trends

Past Year Use

Initiation

Past Year Dependence or Abuse

Source: SAMHSA National Survey on Drug Use and Health, 2002-2014
Heroin trends

Source: SAMHSA National Survey on Drug Use and Health, 2002-2014
Rx opioid and heroin overdose deaths

Source: CDC/NCHS NVSS Multiple Cause of Death Files 1999-2013.
Rise in heroin overdose deaths strongly correlated with increase in heroin abuse or dependence

Nonmedical use of Rx opioids significant risk factor for heroin use

3 out of 4 people who used heroin in the past year misused opioids first

7 out of 10 people who used heroin in the past year also misused opioids in the past year

People with other substance abuse or dependence also at increased risk

People with abuse or dependence on:

- Alcohol: 2x
- Marijuana: 3x
- Cocaine: 15x
- Rx Opioid Painkillers: 40x

More likely to have heroin abuse or dependence

Rate of Past Year Opioid Abuse or Dependence and Rate of OA-MAT Capacity (rate per 1,000 persons aged 12 years and older)

Source: Jones CM, Campopiano M, Baldwin G, McCance-Katz E. National and state treatment need and capacity for opioid agonist medication assisted treatment. AJPH. 2015
Response strategy

PREVENT
People From Starting Heroin
Reduce prescription opioid painkiller abuse.
Improve opioid painkiller prescribing practices and identify high-risk individuals early.

REDUCE
Heroin Addiction
Ensure access to Medication-Assisted Treatment (MAT).
Treat people addicted to heroin or prescription opioid painkillers with MAT which combines the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

REVERSE
Heroin Overdose
Expand the use of naloxone.
Use naloxone, a life-saving drug that can reverse the effects of an opioid overdose when administered in time.

HHS SECRETARY BURWELL’S 2015 INITIATIVE

Training and educational resources

Naloxone

Medication-Assisted Treatment
SAMHSA Strategy: Opportunities to support Alaskans?

1) Improving prescriber practices

2) Increasing the use of naloxone

3) Expanding access to MAT
THE POCKET GUIDE INCLUDES

▲ A checklist for prescribing medication
▲ FDA-approved medications for use in the treatment of opioid use disorder: including extended-release injectable Naltrexone, Methadone, and Buprenorphine
▲ Screening and assessment tools, including an 11-item scale, the Clinical Opiate Withdrawal Scale/MATforOpioids
▲ Best practices for patient care

PUT AN EXPERT IN YOUR POCKET

ORDER OR DOWNLOAD TODAY

bit.ly/MATforOpioids

view here
NEW: SAMHSA SPF Rx Grants
$10,000,000
20 States
PDMP data to prevent Rx Misuse
NALOXONE

- NEW: SAMHSA Prescription Drug Overdose Grants
  - $12,000,000
  - 10 States
  - Purchase, Equip, Train
NEW: SAMHSA Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) Grants

- $25,000,000
- 23 States
- Focus on high-need communities
Continuing education to over **72,000** primary care physicians, dentists, and other healthcare professionals.

**31,552** physicians with a waiver to prescribe buprenorphine for opioid dependence.
Live Prescriber Education Courses

Providers’ Clinical Support System for Opioid Therapies (PCSS-O)

Prescription Drug Monitoring Programs (PDMPs)
Prescriber Education

OpioidPrescribing.com

CME granting trainings in collaboration with Boston University

— Assessment for pain.
— Treatment for each person, including drug-free approaches.
— Monitor a person’s progress (including person’s use of pain medications).
— How to identify medication misuse or abuse and specific actions to take when it occurs.

Physician Clinical Support Systems:

PCSS-buprenorphine
PCSS-opioids
Opioid Prevention Strategies:
SAMHSA Opioid Overdose Toolkit

- Facts for Community Members
- Five Essential Steps for First Responders (Naloxone)
- Safety Advice for Patients & Family Members
- Information for Prescribers (PDMP)
- Resources for Overdose Survivors & Family Members

August 2013
SAMHSA SNAPSHOT: MAT OF OPIOID USE DISORDER
SAMHSA SNAPSHOT: PREVENTION

- Strategic Prevention Framework Partnerships for Success State and Tribal Initiative Grants (SPF-PFS)
- CDC-SAMHSA Prescriber Education Campaign
- Drug Free Communities Support Program Grants (DFC)
- Drug-Free Workplace Program w/ONDCP
National Suicide Statistics

• Suicide is the 10th leading cause of death in the US
• Each year 42,773 Americans die by suicide
• For every suicide 25 attempt
• Suicide costs the US $44 Billion annually
Additional Facts About Suicide in the US

• The annual age-adjusted suicide rate is \textbf{12.93 per 100,000} individuals.
• Men die by suicide \textbf{3.5x} more often than women.
• On average, there are \textbf{117} suicides per day.
• White males accounted for \textbf{7 of 10} suicides in 2014.
• Firearms account for \textbf{almost 50\%} of all suicides.
• The rate of suicide is \textbf{highest in middle age} — white men in particular.

Source: AFSP’s latest data on suicide are taken from the Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report for 2014. Suicide rates listed are Age-Adjusted Rates
<table>
<thead>
<tr>
<th>Rank</th>
<th>State [Division / Region]</th>
<th>Deaths</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Alaska [P / West]</td>
<td>167</td>
<td>22.7</td>
</tr>
<tr>
<td>8</td>
<td>Oregon [P / West]</td>
<td>782</td>
<td>19.7</td>
</tr>
<tr>
<td>9</td>
<td>Idaho [M / West]</td>
<td>320</td>
<td>19.6</td>
</tr>
<tr>
<td>21</td>
<td>Washington [P / West]</td>
<td>1,119</td>
<td>15.9</td>
</tr>
<tr>
<td></td>
<td><strong>Nation</strong></td>
<td>42,773</td>
<td>13.4</td>
</tr>
</tbody>
</table>

*Source: Obtained 18 December 2015 from CDC/NCHS’s *Mortality in the United States: 2014* Public Use File and Web Tables (released and accessed 18 December 2015; Table 19)*
Suicides and Behavioral Health Disorders

~50 percent of those who die by suicide have major depression...the suicide rate of people with major depression is 8x that of the general population.

~90 percent of people who die by suicide have a mental disorder, substance abuse disorder, or both at the time of their death.
SAMHSA’s Strategic Initiative 1: Prevention of Substance Abuse and Mental Illness—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation’s high-risk youth, youth in Tribal communities, and military families.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.
Five Major Suicide Prevention Components

- National Suicide Prevention Lifeline
- Garrett Lee Smith State and Tribal Suicide Prevention Grant Program
- Garrett Lee Smith Prevention Campus Grant Program
- Suicide Prevention Resource Center
- Native Aspirations
Suicide Prevention

The Lifeline is **FREE**, confidential, and always available.

**HELP**
a loved one, a friend, or yourself.

Community crisis centers answer Lifeline calls.

Learn the Warning Signs.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov
National Suicide Prevention Lifeline

• 1-800-273-TALK (8255)
• 24 hours
• 163 networked crisis centers across the country
• Provides counseling and mental health referrals
• www.suicidepreventionlifeline.org
• Chat services available
• Answered more than 1,000,000 calls in CY2013
• Received more than 7,000 calls on the day of Robin Williams’ death.
Partnership: VA
Preventing Suicide Among Veterans

- Interagency Agreement
- 800-273-TALK “press 1”
- Veterans Crisis Line answered 6,125 calls monthly
  - 85% identified themselves as veterans, service members, or their friends and family members (FY12)
  - Majority of callers are men, ages 50 – 59.
- 7,960 emergency rescues (FY13)
- Chat service 24/7 (+4,000 chats/month)
- Texting
- VA adopted SAMHSA’s Treatment Improvement Protocol *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* and created a complementary training video.
Garrett Lee Smith State and Tribal Suicide Prevention Grant Program

- 124 grants awarded since 2005 (45 different States; 37 different Tribes, and 1 Territory)
- 55 current grants (29 States, 26 Tribes)
- 297,333 trained or educated by GLS State and Tribal grantees
- 43,394 youth screened

Also: Garrett Lee Smith Campus Suicide Prevention Grant Program

- 114 3-year grants to 99 campuses since 2005
- 43 current grantees
- Over 3.5 million college students have been exposed to mental health and suicide awareness messages and campaigns.
Suicide Prevention Resource Center

The Nation’s first and only federally funded suicide prevention resource center

- Advances the goals and objectives of the National Strategy for Suicide Prevention
- Acts as Executive Secretariat for the National Action Alliance for Suicide Prevention
- Technical Assistance for states, tribes, communities, and Garrett Lee Smith Grantees
- Best Practices Registry for Suicide Prevention
- Primary Care Toolkit
- Training Institute
- Partners with American Association of Suicidology, American Foundation for Suicide Prevention, Social Science Research and Evaluation, Inc.
- www.sprc.org
Native Aspirations

- Designed to work with American Indian/Alaska Native communities to develop prevention efforts to address youth violence, bullying, and suicide.
  - Represents a departure from the federal model toward an emphasis on community-guided and community-specific solutions.
- 49 Tribal communities accepted the invitation to participate in the Native Aspirations Project, to date.
  - By the end of the project, 65 American Indian and Alaska Native communities will have developed a prevention plan using cultural-, evidence-, or practice-based interventions as well as a sustainability plan to continue the efforts beyond their time as a NA Project site.
  - Communities have noted a reduction of stigma and increased referrals, increased awareness regarding effective strategies to reduce youth violence, bullying, and suicide.
To Live to See the Great Day that Dawns
Alaska Grantees for Suicide Prevention

• SOUTHCENTRAL FOUNDATION
  Program: State/Tribal Suicide Prevention Grants

• ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
  Program: Native Connections 2014

• YUKON-KUSKOKWIM HEALTH CORPORATION
  Program: Native Connections 2014

• TANANA CHIEFS CONFERENCE, INC.
  Program: State/Tribal Suicide Prevention Grants

• TANANA CHIEFS CONFERENCE, INC.
  Program: Native Connections 2014
Alaska Grantees for Suicide Prevention (2)

• FAIRBANKS NATIVE ASSOCIATION
  Program: State Tribal Youth Suicide

• MANIILAQ ASSOCIATION
  Program: Native Connections 2014

• ASA'CARSARMIUT TRIBAL COUNCIL
  Program: Native Connections 2014

• KAWERAK, INC.
  Program: State Tribal Youth Suicide

• SELAWIK VILLAGE COUNCIL
  Program: Native Connections 2014
Alaska Healthcare Transformation

• Medicaid Expansion: How many new eligible covered lives?
• Medicaid Redesign: rethinking Medicaid waivers?
• Alaska Behavioral Health-Primary Care Integration?
• What’s a provider to do??
What do we know?

### Table 1. Chronic Health Conditions among Persons Aged 18 or Older with and without Mental Illnesses in the Past Year: 2008 and 2009

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>High Blood Pressure (%)</th>
<th>Asthma (%)</th>
<th>Diabetes (%)</th>
<th>Heart Disease (%)</th>
<th>Stroke (%)</th>
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</thead>
<tbody>
<tr>
<td>Any Mental Illness (AMI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>21.9</td>
<td>15.7</td>
<td>7.9</td>
<td>5.9</td>
<td>2.3</td>
</tr>
<tr>
<td>No</td>
<td>18.8</td>
<td>10.6</td>
<td>6.6</td>
<td>4.2</td>
<td>0.9</td>
</tr>
<tr>
<td>Serious Mental Illness (SMI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21.6</td>
<td>19.1</td>
<td>7.7</td>
<td>5.2</td>
<td>2.6</td>
</tr>
<tr>
<td>No</td>
<td>17.7</td>
<td>12.1</td>
<td>6.6</td>
<td>4.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Major Depressive Episode (MDE)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>24.1</td>
<td>17.0</td>
<td>8.9</td>
<td>6.5</td>
<td>2.5</td>
</tr>
<tr>
<td>No</td>
<td>19.8</td>
<td>11.4</td>
<td>7.1</td>
<td>4.6</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note: All percentages were adjusted for (a) age group, (b) gender, (c) race/ethnicity, (d) education, (e) marital status, (f) current employment status, and (g) county type/metropolitan status. All associations between mental illnesses and chronic health conditions are statistically significant at the 0.05 level, except for marginally significant associations for SMI and diabetes (significant at the 0.10 level) and SMI and heart disease (significant at the 0.10 level). Source: 2008 and 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).
Overview of Primary Care and Behavioral Health Care Integration (PBHCI)

“As soon as your dentist gets here, we’ll begin.”
Primary and Behavioral Health Care Integration

• Improve the physical health of people with SMI by supporting communities to coordinate and integrate primary care services into publicly funded behavioral health settings

• Grantees will form partnerships to develop or expand their offerings with primary health care services for people with SMI, thus improving overall health status

• Eligible applicants comprise community behavioral health agencies in partnership with primary care providers
Overview of PBHCI

• **Purpose**: to establish projects for the provision of coordinated and integrated services through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

• **Goal**: to improve the physical health status of adults with serious mental illnesses (SMI) who have or are at risk for co-occurring primary care conditions and chronic diseases

• **Objective**: to support the triple aim of improving the health of those with SMI; enhancing the consumer’s experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care.
Four Quadrant Model of health risk & status

- **Quadrant I**: Physician with on-site behavioral health staff
- **Quadrant II**: Specialty behavioral health programs with linkages to primary care
- **Quadrant III**: Primary care or in the medical specialty system
- **Quadrant IV**: Both specialty behavioral health settings and primary care (with a strong need for collaboration between the two)

**Behavioral health risk/status**

**Physical health risk/status**

Milbank 2010—Adapted from Mauer
What are We Learning?

- **PARTNERSHIP MODELS**
  - Partnering with a Community Health Center
  - Partnering with a Hospital
  - Implementing Integration on Own

- **ENGAGEMENT**
  - Leadership (organization, local, state) Engagement
  - Client Engagement
  - Community Engagement

- **WELLNESS ACTIVITIES**
  - Tobacco Cessation
  - Physical Activity
  - Nutrition
  - Diabetes Prevention and Control
  -- Dental Services
What are We Learning?

- **WORKING WITH SPECIFIC POPULATIONS**
  - Racial/Ethnic/LGBT Populations
  - Consumers who Experience Homelessness
  - Rural Populations
  - Deaf Consumers

- **OPERATIONS**
  - Team-based Care (roles and responsibilities), including workflow analysis
  - Continuous Quality Improvement Practice
  - Culture Change (primary care “versus” behavioral health)
  - Use of Health Information Technology
  - Sustainability Planning
What is ACA Section 2703?

“State Option to Provide Health Homes for Enrollees with Chronic Conditions”*

Goal: enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness

The health home provision provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs
ACA Section 2703

Population Served

- Eligible individuals are those with chronic conditions, meaning an individual who is eligible for medical assistance under the State plan or under a waiver of such plan and has at least
  - 2 chronic conditions; or
  - 1 chronic condition and is at risk of having a second chronic condition; or
  - 1 serious and persistent mental health condition

- Chronic conditions must include:
  - A mental health condition
  - A substance use disorder
  - Asthma
  - Diabetes
  - Heart disease
  - Being overweight, as evidenced by having a BMI >25
SAMHSA’s Connection to 2703

According to the November 16, 2010 “Dear State Medicaid Director” letter

- Section 1945(e) of the Act requires States to consult and coordinate with SAMHSA in addressing issues of prevention and treatment of mental illness and substance use disorders for individuals who are low-income and/or have one or more chronic illnesses who are at greater risk of developing mental health and substance use disorders

- Since 2011, SAMHSA has done 39 consultations with 25 states
 ABOUT CIHS

SAMHSA-HRSA Center for Integrated Health Solutions

CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.

› LEARN MORE

TOP RESOURCES

JUNE 3, 2013
Integration Grantees Share their Successes

JUNE 16, 2013
Learn About Medication-Assisted Treatment for Substance Use Disorders

JUNE 10-16, 2013
A Review of SAMHSA Strategic Initiative #8, Public Awareness and Support, as it Applies to PBHCI

MAY 1, 2013
Presidential Proclamation -- National Mental Health Awareness Month, 2013

The President of the United States has
Dedicated to promoting the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.
The Center for Integrated Health Solutions

Since 2010 CIHS has served as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care.

CIHS is jointed funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA).

CIHS is run by the National Council for Behavioral Health.

The Center’s primary goals are to:

- Support relevant funded grants and cooperative agreements working to integrate primary and behavioral health care, providing training and technical assistance (TTA) to communities with cooperative agreements awarded by SAMHSA and HRSA.

- Develop materials about integrated care for a national audience meeting the needs of SAMHSA and HRSA through researching, developing and disseminating critical information and documents, therein creating greater awareness of the importance of integrating primary and behavioral health care to the overall health of the nation.
Center for Integrated Health Solutions

• Target Populations
  – SAMHSA Primary & Behavioral Health Care Integration (PBHCI) Grantees
  – SAMHSA Minority AIDS Initiative Continuum of Care (MAI-CoC) Grantees
  – HRSA Behavioral Heal Expansion Grantees
  – Broad Stakeholder Community
Community Behavioral Health Organizations

- Majority are CMHCs, ~40+% are SA providers
- 79% partnering with a Federally Qualified Health Center (FQHC)
- Served over 60,000 adults with SMI and/or COD

Grantee Cohorts:
- 13 awarded 2009
- 43 awarded 2010
- 8 awarded 2011
- 30 awarded 2012
- 6 awarded 2013
- 26 awarded 2014
- 59 awarded 2015
Alaska PBHCI Grantees

- Alaska Islands Community Services (III)
- Southcentral Foundation (IV)
- Juneau Alliance for Mental Health Inc. (VIII)
Minority AIDS Initiative Continuum of Care Pilot

- 34 grantees
- A four grant focused on integrating HIV prevention and medical care into mental health and substance abuse treatment programs for racial/ethnic minority populations.
- The goal is to increase HIV testing, awareness of HIV status, linkage and retention to HIV medical care, linkage and adherence to anti-retroviral treatment, attainment of viral suppression, and adherence to behavioral health treatment.
HRSA Behavioral Health Expansion

- HHS awarded $105.9M to 431 health centers in the U.S. & Puerto Rico
- The purpose is to expand or establish mental health and substance abuse treatment for over 890,000 people nationwide, specifically those patients who currently have an unmet need for BH services in health centers.
- Sites are required to describe plans for increasing level of integration; Implement SBIRT; and train current staff and hire at least one licensed BH provider.
Services Available from CIHS

• **Tools:**
  – Web-based Resources (http://www.integration.samhsa.gov)
  – Curated Content /Snackable Content
  – Issue Briefs and Factsheets
  – Monthly eSolutions Newsletter

• **Group Learning Experiences:**
  – Regional and Online Learning Communities
  – Trainings and Presentations
  – National Webinars

• **Individual Technical Assistance:**
  – Phone and video consultations, e-mail, site visits
Technical Assistance

- PBHCI TTA: 1,034 total instances of specific TTA in FY13
- National Webinars: 10 webinars with an average participation of 1,000+
- Workforce: 8 New Training Curriculums
- State TTA: Integrated Health State Dialogues, Regional & State Consultation, Health Homes
- Substance Use: Medication Assisted Treatment (MAT) Health Network Learning Collaborative, SU/PC Integration
- HIE/HIT: 95% of the PBHCI HIT grantees achieved Meaningful Use
Outcomes from CIHS Efforts

- **PBHCI Grantee Improvements** – Baseline Health Indicator data collection rates increased for 55 of the 62 grantees. A significant increase and a clear reflection on TTA and interpersonal relationships with each grantee.

- **CIHS’ Investment in the Field** – WHAM, Case to Care training, Medicaid Health Homes/State Dialogues, SU Clinician Online Course, Addressing Health Disparities Leadership Program

- **Expansion of Our Reach** – 60,000+ new subscribers added to our email distribution list as a result of CIHS communications

- **Strategic Partnerships** – Regular communication and engagement with ARHQ, CMS, OMH, ATTCs, NACHC, ….
For More Information & Resources

- Visit [www.integration.samhsa.gov](http://www.integration.samhsa.gov) or e-mail [integration@thenationalcouncil.org](mailto:integration@thenationalcouncil.org)
What are we trying to achieve?

A person-centered system of care that realizes improved outcomes and better services and value.
SAMHSA Funding to Alaska

**Formula Funding**

- Substance Abuse Prevention and Treatment Block Grant: $5,539,999
- Community Mental Health Services Block Grant: $793,287
- Projects for Assistance in Transition from Homelessness (PATH): $300,000
- Protection and Advocacy for Individuals with Mental Illness (PAIMI): $428,000

**Subtotal of Formula Funding:** $7,061,286

**Discretionary Funding**

- Mental Health: $8,757,762
- Substance Abuse Prevention: $2,376,321
- Substance Abuse Treatment: $1,514,419

**Subtotal of Discretionary Funding:** $12,648,502

**Total Funding**

- Total Mental Health Funds: $10,279,049
- Total Substance Abuse Funds: $9,430,739
- Total Funds: $19,709,788
SAMHSA Store
www.store.samhsa.gov

A TREATMENT IMPROVEMENT PROTOCOL
Trauma-Informed Care in Behavioral Health Services

TIP 57

Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience

Tips for Talking With and Helping Children and Youth Cope After a Disaster or Traumatic Event: A GUIDE FOR PARENTS, CAREGIVERS, AND TEACHERS

Tips for Talking With and Helping Children and Youth Cope After a Disaster or Traumatic Event:

Adult support and reassurance is the key to helping children through a traumatic time.

Children and youth can face emotional strains after a traumatic event such as a car crash or violence. Disasters also may leave them with long-lasting harmful effects. When children experience a trauma, watch it on TV, or overhear others discussing it, they can feel scared, confused, or anxious. Young people react to trauma differently than adults. Some may react right away; others may show signs that they are having a difficult time much later. As such, adults do not always know when a child needs help coping. This tip sheet will help parents, caregivers, and teachers learn some common reactions, respond in a helpful way, and know when to seek support.

Possible Reactions to a Disaster or Traumatic Event:

PRESCHOOL CHILDREN, 0–5 YEARS OLD

Children and youth can face emotional strains after a traumatic event such as a car crash or violence. Disasters also may leave them with long-lasting harmful effects. When children experience a trauma, watch it on TV, or overhear others discussing it, they can feel scared, confused, or anxious. Young people react to trauma differently than adults. Some may react right away; others may show signs that they are having a difficult time much later. As such, adults do not always know when a child needs help coping. This tip sheet will help parents, caregivers, and teachers learn some common reactions, respond in a helpful way, and know when to seek support.

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Possible Reactions to a Disaster or Traumatic Event:

PRESCHOOL CHILDREN, 0–5 YEARS OLD

Very young children may go back to thumb sucking or wetting the bed at night after a trauma. They may fear strangers, darkness, or monsters. It is fairly common for preschool children to become clingy with a parent, caregiver, or teacher or to want to stay in a place where they feel safe. They may express the trauma repeatedly in their play or tell exaggerated stories about what happened. Some children’s eating and sleeping habits may change. They also may have ashes and pains that cannot be explained. Other symptoms to watch for are aggressive or withdrawn behavior, hypervigilance, and psychosocial and behavioral problems.

* Infants and Toddlers, 0–2 years old, cannot understand that a trauma is happening, but they know when their caregiver is upset. They may start to show the same emotions as their caregivers, or they may act differently, like crying for no reason, withdrawing from people, and not playing with their toys.

* Children, 3–5 years old, can understand the effects of trauma. They may have trouble adjusting to change and loss. They may depend on the adults around them to help them feel better.
This New Year, resolve to promote positive behavioral health in your community. SAMHSA has resources that can help address some of the toughest mental health and substance use challenges, including suicide prevention, bullying prevention, behavioral health following a disaster, and underage drinking prevention.

- **Suicide Safe** helps health care providers integrate suicide prevention strategies into their practice and address suicide risk among their patients.
- **KnowBullying** provides information and guidance on ways to prevent bullying and build resilience in children. A great tool for parents and educators, KnowBullying is meant for kids ages 3 to 18.
- **SAMHSA Disaster App** provides responders with access to critical resources—like Psychological First Aid and Responder Self-Care—and SAMHSA’s Behavioral Health Treatment Services Locator to help responders provide support to survivors after a disaster.
- **Talk. They Hear You** is an interactive game that can help parents and caregivers prepare for one of the more important conversations they may ever have with children—underage drinking.
Questions?

Thank you!

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