

## Integrated Behavioral Health and Residents of Public Housing

*Residents of public housing are especially vulnerable to the destabilizing influence of chronic stress caused by unemployment and a lack of financial resources, overcrowding and difficult family life situations, isolation, and living in high crime communities. These stressors place residents at higher risk of physical and behavioral health problems. While the exact number of public housing residents with behavioral health problems, including personality disorders, depression, anxiety, substance abuse, psychoses, and dementia, are unknown, research indicates that behavioral health issues are prevalent in this community. This issue focuses on behavioral health and residents of public housing.*

## Caring for Expectant Mothers with Behavioral Health Issues

By Nicholas H. Apostoleris, PhD, Health Center Director; Stacey Auger, MPH, Associate Director; RoseMarie Spaulding, FNP  
ACTION Health Services Fitchburg, MA

Two recent cases illustrate ACTION Health Services' important work with pregnant women and the integration of primary medical and behavioral health care.

**Case 1:** A 19 year old public housing resident presented to the mobile medical unit after being referred by Community Health Connection, Inc.'s (CHC, Inc.) behavioral health department. With a starting Patient Health Questionnaire (PHQ-9) score of 18 (indicating a high level of depressive symptoms), the patient had recently learned that she was expecting her third child. In addition to depressive episodes, the patient experienced limited weight gain and severe nausea. There was a significant concern among medical staff that the pregnancy might be in danger. After weeks

of missed appointments with her family physician at one of CHC, Inc.'s land-based centers, ACTION Health Services' mobile medical team was able to forge a relationship and assist the patient in finding the appropriate mix of counseling, prenatal care, and medication to stabilize her.

For the next several months the patient was routinely seen on the mobile medical unit, at the CHC, Inc. land-based center, and through home visits with ACTION Health Services' nurse practitioner and LPN. PHQ-9 scores

declined dramatically (indicating lessening frequency of depressive symptoms), weight gain was normal, and regular lab and medical appointments, both at CHC, Inc. and the mobile medical unit, were kept. The patient delivered a healthy full term baby in early February and both mother and daughter are doing well.

**Case 2:** A 33 year old public housing resident with a history of domestic violence and previous high risk pregnancies presented to the mobile medical unit for a pregnancy test. She had five previous pregnancies but had only successfully carried one pregnancy to term due to pre-eclampsia and mood disturbances. At her first visit, she scored a 14 on her PHQ-9 and had a blood pressure reading of 140/88.

The patient continued to receive care on the mobile medical unit as well as through one of the CHC, Inc.'s other land-based centers. With proper medications and follow-up care throughout the entire pregnancy, her PHQ-9 scores did not go above 4 and her blood pressure remained at safe and stable levels both for herself and the baby.

The patient's due date is in early April and ACTION staff members are expecting healthy outcomes for both mother and infant. The patient has requested that ACTION Health Services' Nurse Practitioner provide ongoing care of both she and her child following delivery.

Without ACTION's ability to reach into the neighborhoods to provide care and without the psychosocial sophistication of the mobile treatment team members, these two women likely would not have received the prenatal care that they

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# Psychogeriatric Assessment and Treatment in City Housing: The P.A.T.C.H. Program

By Peter V. Rabins MD, MPH, Vice Chair for Academic Affairs, Dept. of Psychiatry and Behavioral Sciences, Johns Hopkins University, Baltimore, MD

The “Psychogeriatric Assessment and Treatment in City Housing” or “PATCH,” program is a nurse-based service that provides mobile treatment services to elderly people with serious and persistent mental illness who live in public housing for seniors. Services include in-home psychiatric assessment and treatment, improvement and coordination of community services and education for caregivers about special needs of the elderly. The program has been operating since 1986 in conjunction with the Housing Authority of Baltimore City.

In the early 1980s, research carried out in Baltimore, Maryland demonstrated that older individuals residing in city public housing had higher rates of mental illness than those living elsewhere in the city and yet were even less likely to receive needed care. In 1986, a grant was received from the National Institute of Mental Health (NIMH) to establish a demonstration program that targeted improving the detection and treatment of psychiatric disorders in the elderly living in public housing.

PATCH trains those who work in public housing such as building managers, security staff, mail deliverers and tenant service workers to identify people at risk for mental illness. This is done through a series of educational sessions.

The second element of the program is the provision of evaluation and treatment on site, usually in the person’s apartment. This is provided by a trained geriatric psychiatric

nurse with back up from a psychiatrist and, when needed, a social worker.

Since its inception more than 20 years ago the program has treated several thousand individuals. The program is now supported by the Maryland Department of Mental Hygiene, the state cabinet level agency that oversees all state-funded mental health programs. The funding is supplied through Baltimore Mental Health Systems to Johns Hopkins University, and the the medical school administers the program.

Among the common problems treated by the team are dementia, schizophrenia, major depression, and substance abuse. The program seeks to refer individuals to existing community treatment programs within 6 months so that its resources can remain focused on identifying and treating those with untreated problems. About 15% of those treated in the program are cared for by the Hopkins team long term because they will not receive care any other way.

The effectiveness of the PATCH was documented by a clinical trial published in 2000 (JAMA 2000; volume 283, pages 2802-9). It has been recognized as one of the few “evidence based” geriatric psychiatry treatment programs.

*More information can be obtained by emailing the Program Director, Peter Rabins at [pvrabins@jhmi.edu](mailto:pvrabins@jhmi.edu) ■*

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## Caring for Expectant Mothers with Behavioral Health Issues

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and their babies needed and deserved. The Bureau’s Public Housing Primary Care funding allows for this service to function in North Central Massachusetts.

ACTION Health Services, which stands for Accessible Comprehensive Treatment In Our Neighborhoods, is

operated by Community Health Connections, Inc. (CHC, Inc.) in Fitchburg, Massachusetts. In

total, the organization serves approximately 30,000 patients each year. As CHC’s Public Housing Primary Care program, ACTION



Health Services provides medical, dental, behavioral health, and supportive services to publically housed children and adults throughout northern Worcester County, Massachusetts.

Early diagnosis of pregnancy and early prenatal care is critical to ensure that expecting women receive appropriate and timely care and are supported and provided with guidance to achieve the best possible birth outcomes for their children. Establishing an early relationship with an expecting mother helps instill trust and builds the foundation for an ongoing patient-provider relationship and connection to the health care community following the pregnancy.

*For more information contact Nicholas Apostoleris at [nbaphd@gmail.com](mailto:nbaphd@gmail.com) ■*

## Health Care for Residents of Public Housing Conference

The goal of the conference is to strengthen the capacity of health centers to meet the specialized primary care needs of residents of public housing. This is the only national conference with a focus on federally funded Public Housing Primary Care programs and other health centers that provide services to residents of publicly subsidized housing.



Conference workshops will focus on the areas of operations and administration, clinical, resident training and health education, current research and partnerships with housing authorities and residents.

This conference will offer continuing education credit from the National Association of Social Workers and is under review with the American Academy of Family Physicians and the American Nurses Association.

Save money by registering early! The registration fee increases June 12th. Agenda and registration are online at:

[www.healthinpublichousing.org](http://www.healthinpublichousing.org)



## HRSA Funds Nine New PHPC Health Center Grantees

The new Public Housing Primary Care (PHPC) health centers were funded by HRSA through the American Recovery and Reinvestment Act. The new sites add 3 new states and a territory to the PHPC program: Puerto Rico, Virginia, Tennessee, and Arkansas.

### **Bond Community Health Association**

Tallahassee, FL

### **Consejo de la Salud de La**

Ponce, PR

### **Daily Planet, Inc.**

Richmond, VA

### **Houston Area Community Services, Inc.**

Houston, TX

### **North Central Texas Community Health Center**

Wichita Falls, TX

### **The Floating Hospital**

Long Island City, NY

### **North Side Christian Health Center**

Pittsburgh, PA

### **United Neighborhood Health Services**

Nashville, TN

### **White River Rural Health Center, Inc.**

Augusta, AR

## Inspiring Hope and Change in Public Housing

By Cindy V. Culp, Tribune-Herald staff writer Waco, TX

From the outside, Shirley Langston's office looks the same as the other units at the Estella Maxey Place housing complex - drab and dated. Once visitors step through Langston's door, though, it's immediately apparent she is on a mission. The office's elegant drapes, stylish furniture and richly hued walls create undeniable warmth. That feeling is bolstered by decorations with messages, such as "Laugh often," "Dream big" and "Prayer helps."

The atmosphere is by design. The aim of Langston's organization, called Restoration Haven, is to create a sanctuary of sorts for public housing residents. Langston wants to give them the resources they need to dig out of poverty and to offer that help in a hopeful environment. Restoration Haven opened its doors in June 2007 after Langston got permission from the Waco Housing Authority to use an apartment as an office.

The 58-year-old is so committed to the cause that she works full time without a salary. She lives on her retirement and savings so she can funnel all of the contributions she receives into her work. Even so, Langston still ends up footing some of the organization's operating expenses. Last year, it spent about \$20,000, she said, with about 25 percent of that coming out of her pocket. Some people have told her she's crazy to dip into her nest egg that way, Langston said. But after moving back to Waco after a career in Dallas, she was so dismayed by what she saw at Estella Maxey and the surrounding area, she felt compelled to act.

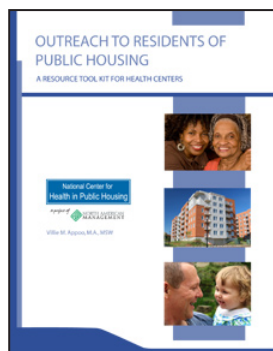
"I grew up in this community at a time when it was growing," Langston said of her East Waco neighborhood. "I felt very safe. I got a good education. . . . I want to see what I saw as a kid."

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# Outreach to Residents of Public Housing: A Resource Tool Kit for Health Centers

By David Bates, Program Assistant, National Center for Health in Public Housing, Arlington, VA

This resource tool kit was developed by the National Center for Health in Public Housing to support health centers in utilizing community health workers to outreach to residents of public housing. The primary author of this tool kit was Willie Appoo, NCHPH Technical Assistance/Training Center Manager. The resource tool kit is divided into the following sections.



## Module I. Getting Started:

This section focuses on assessing community needs and resources, agency needs and resources and developing an outreach plan.

## Module II. The Community Health Worker:

This section examines who community health workers (CHW) are, the qualities of an excellent CHW, and the responsibilities of the community health worker.

**Module III. Community Health Education and Health Literacy:** This section defines and explains importance of health education and health literacy.

**Module IV. Effective Training Methods:** This section focuses on developing effective training programs, effective training methods, and facilitating training and learning.

**Module V. Outreach Strategies that Work:** This section focuses on community support, effective outreach methods, effective outreach tools, and overcoming barriers and challenges to recruitment and retention.

**Module VI. Evaluating the Training Programs:** This section covers the role and value of evaluation, major types of program evaluators, program evaluation methods and community collaboration.

**Module VII. Resources:** This section contains resources for community health workers to become knowledgeable about common health conditions that they may encounter.

Attachments include: duties/responsibilities of a community health worker, CHW self-assessment tool, role play scenarios, ice breakers, door to door outreach log, pre and post survey evaluation, training evaluation and references.

For more information please contact David Bates at [dbates@nambco.com](mailto:dbates@nambco.com) ■

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## Inspiring Hope and Change in Public Housing

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That might sound like an impossibly tall order. But if anyone can bring about the kind of change Langston talks about, it's her, said Janice Chase, associate director at Family Health Center, one of Langston's partner organizations.

Langston's history gives her credibility with Estella Maxey's residents, Chase said. Langston grew up just down the road from the housing complex and chose to return to the neighborhood when she moved back to town. Plus, she has triumphed over her own struggles as a single mother, after becoming pregnant her junior year in high school. "(Clients) respect her," Chase said. "She relates to them. . . . When she talks, I can see everybody listens because she is so passionate about what she is saying."

Langston is a member of the local Community HealthCorps program. Run by the Family Health Center, it's a health-oriented version of the Peace Corps. Langston helps connect residents with Family Health Center's network of clinics. Many either do not know the center can treat them for little or no cost, or they are not aware the clinics offer services such as dental care, officials said.

Most of Langston's work is informal, however. She provides abuse counseling to residents with traumatic pasts. She helps

people fill out applications for food stamps and jobs. She accompanies clients to meetings with juvenile justice officials when their children get in trouble. The list goes on and on.

Not counting youth activities, Langston estimates Restoration Haven serves about 200 clients each month. The reach of the organization is likely at least triple that, however, since most clients have others in their households. Most live at Estella Maxey, but a few are from the surrounding community. As word of mouth spreads, Langston said she expects her client load to grow. Fortunately, she now has two other HealthCorps members, two Baylor University interns and an intern from another local charity to help her.

Milet Hopping, senior vice president and chief operating officer for the Waco Housing Authority, said that broad reach is what the housing authority appreciates most about Langston's work. The housing authority tries to provide residents with opportunities to interact with community organizations, but budget constraints limit what it can do.

*Originally printed in the Tribune-Herald, "Waco Woman Looks to Encourage, Energize Low-Income Community," March 09, 2009. For the full article, contact Cindy V. Culp at [cculp@wacotrib.com](mailto:cculp@wacotrib.com), or (254) 757-5744. ■*

# Integrated Primary Care: Co-management of Physical and Behavioral Health

By Rebecca Vlam MSS, LCSW, Behavioral Health Consultant; Emily Duffy, MSS, LSW, Behavioral Health Consultant, Eleventh Street Family Health Services, Philadelphia, PA

Eleventh Street Family Health Services of Drexel University, in partnership with Family Practice and Counseling Network, is a Federally Qualified Health Center located in lower North Philadelphia directly adjacent to four public housing developments. We primarily serve African-American (89 percent) and a growing Latino (6 percent) patient population. While behavioral health problems cut across socioeconomic and cultural lines, the incidence is estimated to be higher among low-income families.

The behavioral health system in place is overburdened by multiple month long waiting lists and closed waiting lists. Patient behavioral health needs remained unaddressed causing misuse of and over-use of primary care services. We needed to redesign our primary care system to meet the true needs of our patient population. We began a total system redesign creating a transdisciplinary team approach to care. Our larger, transdisciplinary team includes: primary care, fitness, physical therapy, optometry, podiatry, behavioral health consultation, social work, nutrition, health educator, and certified yoga/reiki instructor. Every patient can be seen by all or one of the above providers on the same days as their primary care office visit. This article will focus on the integration of the embedded Behavioral Health Consultants (BHC) into the Primary Care Department.

In April 2007, Rebecca Vlam MSS, LCSW, became the first embedded BHC practicing one day a week in primary care. On this day, Rebecca remained strictly available to the Nurse Practitioner to consult about patients or directly with patients within the exam room. Her presence quickly became invaluable and NPs would have patients return on the day Rebecca was available quickly inundating her with consults. In June 2007, Emily Duffy, MSS, LSW, was hired as a full-time embedded behavioral health consultant focusing on the pediatric (0-17 years old) patient population. In February 2008, Rebecca, became embedded full-time to focus on the adult (18+years old) patient population.

The BHC's goal is to work as a team with the primary care department to provide prevention, early recognition and immediate brief consults for behavioral health concerns and psycho-social problems presented during a primary care office visit. This approach allows the patient immediate access to behavioral health services, medication management if appropriate and diminishes the perceived stigma patients often feel when seeking out-patient behavioral health treatment.

The BHC's main services include "brief consults" and "brief treatment". These interventions fit the fast paced model of primary care. Both brief consults and brief treat-

ment involve directly assisting the primary care provider with treatment planning and monitoring, accessing community resources, cognitive behavioral interventions, or pharmacotherapy. BHC services are available to any patient referred by primary care team member for any reason regardless of the nature, intensity, or severity of the concerns presented. It is the responsibility of the BHC to determine whether an assessment and intervention for a particular patient is within the scope of their practice and to make an appropriate referral if necessary. Some common referrals made by the primary care team are (but not limited to) chronic health issues, well-child checks, teen sexual health, anxiety, depression, issues with medication/health care adherence, insomnia, substance use/abuse, chronic pain, acute or chronic stress, and trauma. Generally, consults focus on functional restoration, self determination, and are solution focused, not process oriented. The primary goal is to develop a biopsychosocial care plan that is attainable, manageable, and well-rounded.

Brief consults are defined as 1-3 visits that are 15-30 minutes long. The first visit typically occurs during primary care office visit at the request of a member of the primary care team. Follow up visits can be scheduled in conjunction with a primary care office visit or just with BHC. Brief treatment is defined as 4+ visits that are 15-30 minutes long. This service is used for patients who need more assistance, but are not appropriate for out-patient traditional mental health services. Patients with chronic behavior health or medical problems benefit from intermittent supportive services.

This effort not only improves patient's overall health, but is preventive, too. We have begun to witness improved treatment adherence and self management among chronic illness patients, childhood behavioral health issues that would have been misdiagnosed or undetected are being addressed appropriately, and patients who have presented with somatic symptoms that were medically unexplained now receive a comprehensive biopsychosocial assessment and care plan. Patient and provider satisfaction surveys showed an overwhelmingly positive response to the integrated model. Gail Partridge, CRNP now states "I would never practice without behavioral health consultants again!" In addition, patients now refer family and friends to the Center because of the holistic and patient centered care received. We are currently collecting statistical information through data collection and surveys to create an evidenced based model.

*For more information, please contact Rebecca Vlam at [rebecca.c.vlam@drexel.edu](mailto:rebecca.c.vlam@drexel.edu) ■*

# Adolescents Living in Urban Public Housing: Assessing the Protective Effects of Community Cohesion

By Von E. Nebbitt, PhD, Professor, Howard University, Washington, DC

The Surgeon General's Office has identified adolescent mental health as a top public health priority for Healthy People 2010 (HHS, 2000). Due to their exposure to community violence and other neighborhood risk factors, this area of concern is particularly salient for minority adolescents living in public housing developments in cities like Washington, DC and Philadelphia.

Current research has contributed to our understanding of how neighborhoods, peers, and families influence African American adolescents' mental health symptoms and health-risk behaviors within urban public housing developments. Studies that examine various neighborhood (violence and crime) and social (peers and family) factors that impact minority adolescents' alcohol and other drug use are notably absent from this research. Studies that are also missing from this research are those that examine whether community cohesion reduces alcohol and other drug use among adolescents and whether community cohesion buffers the effects of risk factors on adolescents' alcohol and other drug use. Using a sample of African American adolescents living in public housing developments in three large cities, this study contributes to this gap in knowledge on the behavioral health of minority youth living in urban public housing developments.

*Sample.* Participation was limited to adolescents ages 11 – 19 who reside in family only housing developments in one Mid-Atlantic and two Northeastern cities. Youth who could not provide assent and/or consent, and who could not demonstrate the capacity to give informed consent (see, Capacity-to-Consent Screen; Zayas, Cabassa, & Perez, 2005) were excluded from the study.

*Study Design.* Using flyers, recruitment cards and other techniques, youth were recruited from housing developments and from community centers in or adjacent to the housing development. Eligible participants met at local community centers in groups of 20 to 25 youth to complete the survey. The survey was composed of standardized instruments that measure community and domestic violence, affiliation with delinquent peers and adolescents' patterns of alcohol and other drug use. All measures have been frequently used with minority urban youth.

*Results.* The sample consisted of 663 African American youth. Ages range from 13 – 19, with an average age 15. Females were 48 percent of the sample. Males reported higher substance use, delinquent behavior and household violence. Females reported higher symptoms of Post Traumatic Stress Disorder (PTSD) symptoms. Community violence did not differ by gender. Older adolescents with higher PTSD,

greater delinquency, and more delinquent peers used more substances. Furthermore, witnessing domestic and community violence increased alcohol and other drug use in adolescents. On the other hand, youth who perceived their housing development as cohesive reported using less alcohol and other drugs. Moreover, the negative effects of community and domestic violence, and delinquent peers on adolescents' alcohol and other drug use were less impactful for youth who perceived their housing developments to be highly cohesive.

*Principal Findings.* The most salient finding of this study is that cohesive communities are associated with lower alcohol and other drug use in African American adolescents and that cohesive communities also buffer some of the negative effects of living in tough public housing developments. It is important to note, however, that violence and negative peer affiliations exacerbate substance use in African American adolescents living in urban public housing. Also, the study indicates that adolescents with mental health and behavior problems have an increased risk of substance use.

Findings from this study have important implications to service providers within urban public housing. That is, interventions must focus on reducing risk factors and increasing perceived community cohesion. Creating positive peer groups and establishing conflict mediation teams in the housing development may be helpful. Also, involving youth on important decision-making boards may increase their perceptions of cohesiveness. There may be a need for gender specific programs considering how health-risk behavior and mental health symptoms differed by gender.

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## NCHPH Technical Assistance

The National Center for Health in Public Housing (NCHPH) has produced a brochure that details the training and technical assistance that we can offer to meet the challenging needs of health centers.

You can view the technical assistance brochure at: [www.healthinpublichousing.org](http://www.healthinpublichousing.org)

To discuss how we can help you, please contact Deborah Murphy at 703-812-8822 or [dmurphy@nambco.com](mailto:dmurphy@nambco.com).

# Clinicians' Corner

## Bridging the Chasm: Treating Mental Health in Public Housing Primary Care



By Anna M. Gard, FNP-BC, ACU and Judith Stern, PsyD, FPCN, Philadelphia, PA

As a Family Nurse Practitioner at Family Practice and Counseling Network (FPCN) in Philadelphia, I cared for a young, African American, single mother who had lived in public housing her entire life. She had been a patient at the health center since early adolescence. She came to the clinic almost weekly for very minor health complaints for herself or her two sons. She looked sad, had a flat affect, made poor eye contact, and never smiled. As a participant in the Health Disparities Depression Collaborative, FPCN clinicians asked two depression screening questions at every patient visit. If positive, we administered a depression screening tool. Her screening score was positive for severe depression. At each visit, I expressed concern, but she adamantly refused to acknowledge her depression. A psychologist in our Behavior Health Department suggested that perhaps the patient only knew that she did not feel good, but did not identify her feelings as “depression.” After four years and many, many visits, she trusted me enough to agree to a trial of pharmacologic treatment. However, she continued to decline counseling services. After six weeks of medication, she returned to the clinic smiling and laughing with her children. She reported that she had attended a party and danced! It took several trials of medications and 18 months before she would agree to begin therapy with a Behavioral Health Therapist in our health center. I believe she agreed because we had developed a trusting, therapeutic relationship over many visits through the years. The continuity and stability of the patient-clinician relationship paved the supportive bridge between the patient and the psychologist. This “bridge” is part of an integrated team approach aimed at diminishing the patient’s mistrust and fear of the health care system.

Judith Stern, PsyD, a FPCN staff psychologist who co-managed this patient’s care provides further insight. The close collaboration between primary care and behavioral health offers multiple ways of reaching patients. The psychologists can suggest alternative explanations for a patient’s behavior and their view of the world. Integrating primary care and behavioral health creates a setting in which psychologists can meet the patient in an informal way. This facilitates a smooth transition into therapy because psychotherapy is now a territory that is less of a mystery.

This young woman had been feeling depressed and anxious, especially in social situations, for as long as she could remember. She had never received help – no reassurance, support, or attempts to assist her in finding ways of becoming more comfortable with her peers. She spontaneously showed the nurse practitioner her elementary educational

evaluations, which labeled her learning disabled. The label bothered her very much. Although she may have a learning disability, it is also possible that her social anxiety and depression made her so uncomfortable in class that she was forced to focus on coping with the situation, rather than learning. Had she been treated while a child, her experiences in school may have been more positive. She might have enjoyed learning and may have developed friendships. This would have provided her with the foundation we all need in order to formulate future goals that we perceive as possible.

When the patient began therapy, she again brought in her school records. It was as if she were saying, “I want you to know me and I want to show you what my problems are, but I am scared to talk and I have no clue about what to say or how to say it.” The patient is continuing to work on “taking the floor” and on self-expression, as the first steps toward feeling more comfortable with herself. She can then utilize these skills in other relationships.

This compelling story demonstrates the vital need for early screening of mental health in primary care and supports the concept of a “medical home” with culturally sensitive continuity of care provided by multidisciplinary health care teams. Integrated treatment approaches must address barriers of mistrust, fear, discrimination and cultural difference.

FPCN is following the increasing trend for integrated mental health services in primary care. The Institute of Medicine reports that 1 in 10 young people suffer from mental illness severe enough to cause some level of impairment, with fewer than 20 percent receiving treatment in any given year. In 2006, FQHCs reported 1.4 million visits for depression and other mood disorders. Safety net primary care providers play a unique role for medically underserved populations and the provision of behavioral health services in the primary care setting is a critical component. The Integration of Mental Health/Substance Abuse and Primary Care Evidence Review concluded that people treated for depression in primary care clinics which provide coordinated services for mental and physical health have decreased symptoms and improved outcomes compared to patients who are treated at sites that provide health services only. Studies also show that simply increasing access to mental health services by locating them in public housing does not prompt public housing residents to seek care.

*For more information contact Anna Gard at: [anna.gard@comcast.net](mailto:anna.gard@comcast.net)  
Resources connected to this article can be found on the next page. ■*

# SAMHSA Study: More Than 1 in 10 Children Live with a Substance Abusing Parent

Almost 12 percent of children under the age of 18 years of age live with at least one parent who was dependent on or abused alcohol or an illicit drug during the past year, according to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA). The report is based on national data from 2002 to 2007.

“The research increasingly shows that children growing up in homes with alcohol- and drug-abusing parents suffer – often greatly,” said SAMHSA Acting Administrator Eric Broderick, D.D.S., M.P.H. “The chronic emotional stress in such an environment can damage their social and emotional development and permanently impede healthy brain development, often resulting in mental and physical health problems across the lifespan. This underlines the importance of preventive interventions at the earliest possible age.”

Among the findings:

- Almost 7.3 million children lived with a parent who was dependent on or abused alcohol

- About 2.1 million children lived with a parent who was dependent on or abused illicit drugs
- 5.4 million children lived with a father who met the criteria for past year substance dependence or abuse, and 3.4 million lived with a mother who met this criteria.

Findings for Children Living with Substance-Dependent or Substance-Abusing Parents: 2002 to 2007 are drawn from the National Survey on Drug Use and Health, an annual nationwide survey of persons aged 12 and older. The full report is available <http://oas.samhsa.gov/2k9/SAParents/SAParents.cfm> or call 1-877-726-4727.

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## Clinicians' Corner Resources:

**Depression Toolkit.** Available at: [DepressionMacarthurToolkit—DartmouthDuke\\_2003\[1\].pdf](#)

**Early Childhood Mental Health consultation/evaluation tool kit.** Available at: [www.gucchd.georgetown.edu/object\\_view.html](http://www.gucchd.georgetown.edu/object_view.html)

**Integrated Primary Care in Practice.** Available online at: [www.integratedprimarycare.com/inpractice.htm](http://www.integratedprimarycare.com/inpractice.htm)

**National Depression Screening Day Primary Care Program.** Available at: <http://www.mentalhealthscreening.org/careprov/primary.aspx>

Brody, DS, Dietrich AJ, deGruy F 3rd, Kroenke K. **The Depression in Primary Care Tool Kit.** *Int J Psychiatry Med.* 2000;30(2):99-110.

**Integrating Primary Care and Behavioral Health Services: A Compass and a Horizon.** Mountain view Consulting Group. Available at: [www.va-srhp.org/docs/2009-summit/behavioral-health-integrationpdf](http://www.va-srhp.org/docs/2009-summit/behavioral-health-integrationpdf)

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The Quarterly Information Bulletin is prepared under a Cooperative Agreement with the Health Resources and Services Administration (HRSA). The contents of this publication are the views of the authors and do not necessarily represent the official views of HRSA or North American Management.

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