Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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Incarceration vs. Treatment:

Drug Courts Help Substance Abusing Offenders

In many courtrooms, judges see the same defendants so often they're practically on a first-name basis. Whether the charges are breaking and entering, driving under the influence, neglecting a child, or some other offense, the underlying cause is often the same: alcohol or drug abuse.

SAMHSA's Center for Substance Abuse Treatment (CSAT) is helping to stop these revolving doors. Since the late 1990s, CSAT has provided funding to support treatment drug courts—often referred to simply as drug courts—that offer offenders access to alcohol or substance abuse treatment instead of incarceration. Today, CSAT's criminal and juvenile justice portfolio funds 62 drug courts, helping adult offenders, juvenile offenders, and parents at risk of losing custody of their children break the cycle of substance abuse, crime, and prison time.

"Providing alcohol and drug abuse treatment

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Incarceration vs. Treatment

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instead of jail is one of the surest ways to put drug-dependent adults on the path to recovery and to prevent juveniles with drug problems from becoming adult criminals," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

An Effective Alternative

The first drug courts were a response to a system in crisis, according to the National Association of Drug Court Professionals (NADCP).

In the late 1980s, substance-abusing nonviolent offenders were overwhelming the criminal justice system. These offenders would receive their sentences, serve their time, and be released—only to start this expensive, time-consuming cycle all over again.

"Judges and prosecutors were fed up with seeing the same drug- and alcohol-dependent people appear before the court over and over and over again," explained C. West Huddleston III, L.P.C., Director of the National Drug Court Institute (NDCI), the association's education, research, and scholarship arm. "They recognized that their traditional responses, whether it was jail, prison, or a probationary sentence, weren't solving the underlying problem. Dependency was the driving force behind their criminal behavior."

Drug courts break the cycle by ensuring that offenders receive substance abuse treatment, which addresses the root cause of their crimes. Instead of sending offenders to jail or prison, judges send them to treatment. Close supervision, drug testing, and the use of sanctions and incentives help ensure that offenders stick with their treatment plan.

That approach really works, said Mr. Huddleston, noting that national, statewide, and local evaluations demonstrate the efficacy of drug courts.

In a 2005 report to Congress, for example, the Government Accountability Office reviewed the evidence about adult drug courts and found that participants had lower rates of re-arrest and re-conviction than comparison groups.

Mr. Huddleston also points to a 2003 study by the Center for Court Innovation, which analyzed the re-conviction rate of participants in New York's drug court system. The study found that the re-conviction rate for 2,135 defendants participating in six of the state's drug courts was 29 percent lower on average over 3 years than the re-conviction rate for similar offenders who didn't participate in drug courts.

That kind of evidence has spurred the growth of drug courts. According to NADCP, there are now 1,753 drug courts of various types in operation, with 212 in the planning stages.

The evidence has also prompted CSAT's continuing commitment to supporting this innovative alternative.

"SAMHSA's vision is a life in the community for everyone," said Kenneth W. Robertson, Team Leader for Targeted Capacity Expansion and Criminal Justice Programs at CSAT. "That includes criminal offenders."

To fulfill that vision, CSAT funds adult treatment drug courts, juvenile treatment drug courts, and family treatment drug courts. The U.S. Department of Justice (DOJ) also funds drug courts through its Bureau of Justice Assistance and Office on Juvenile Justice and Delinquency Prevention. CSAT and DOJ work together to better coordinate drug court funding and provide training. A support contract provides training to CSAT grantees. With funding from DOJ, NDCI helps grantees and any other drug court that needs assistance.

Adult Drug Courts

One of drug courts' defining characteristics is the effort to change the relationship between the offender and the judicial system, said Mr. Robertson. "Drug courts change the adversarial relationships that are typically found in judicial settings into team partnerships where everybody's pulling together," he explained.

That transformation is apparent in the Gosnold Barnstable Action for New Directions (BAND) Drug Court Program in Barnstable County, MA, which received a 3-year CSAT grant in 2002.

When offenders enter the program, there's an entire team working with the judge to make sure that offenders get the treatment they need. In addition to the judge, the team includes case managers, treatment providers, the public defender, a police officer, and representatives from the probation department and district attorney's office.

Any team member—or the offender's attorney—can refer a nonviolent offender to the program once that person is facing incarceration. The team reviews the person's criminal record, substance abuse problem, and circumstances, and then refers those deemed eligible to the district attorney, who gets the final say.

Once they're in, participants begin a yearlong, three-phase treatment program. To move from one phase to the next, they must meet certain criteria, such as having

Photo by Pamela Ames, Director of Communications, Gosnold

Judge Joseph Reardon presides over a drug court session and talks about the value of culturally enriching activities, one of the unique elements of the Massachusetts treatment drug court program.

negative drug tests, participating in treatment, or getting a job. If they don't meet these criteria, they face sanctions ranging from more frequent drug tests or more intensive treatment to an electronic ankle "bracelet" or weekends in jail.

In the meantime, case managers help participants tackle other problems in their lives. Case managers enroll participants in public insurance programs and find them primary care physicians. They help participants enroll in educational programs, write résumés or fill out job applications, and sometimes drive participants to job interviews. The team has even persuaded local health clubs to offer memberships.

The program also has a cultural enrichment component. "These folks are alienated from the community by nature of their criminality," said Project Director Raymond V. Tamasi, M.Ed., Chief Executive Officer of Gosnold, Inc. "We're trying to reconnect—or connect—people to the community."

Along with the judge and members of the drug court team, participants enjoy quarterly visits to the local art museum, the symphony, and community theater. "The judge doesn't have his robes on and isn't sitting behind a bench," Mr. Tamasi noted. "We're just members of an audience watching a performance together."

So far, the team's approach seems to be working. In one study, for example, the team examined the program's effect on the first 50 participants. A total of 29 of them completed treatment in what was then an 18-month program. In the 2 years before joining the program, the total number of arrests for these 29 participants was 76. Two years after they entered the program, the number of arrests had dropped to 8.

There's a side benefit, too, Mr. Tamasi explained. As participants and team members speak to civic groups and local television program viewers, their stories of transforming themselves from tax-users to taxpayers are

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From the Administrator

Treatment Drug Courts Yield Benefits

Breaking the cycle of addiction leading to crime, followed by incarceration, then release, relapse, and recidivism is a priority that requires our attention. The goals of improving public health and public safety are inextricably intertwined, so that improvement in one enhances progress in the other.

When prevention, early intervention, treatment, and recovery support services are targeted to adult and juvenile offenders, the benefits are threefold.

First, if we prevent addiction, drug-related crime will decrease. Second, if we intervene early and get the appropriate treatment services in place, recidivism rates drop. Third, when SAMHSA increases recovery support services, reentry success rates climb and public safety is increased.

This issue of *SAMHSA News* highlights treatment drug courts, a model of intervention that has successfully overcome many of the systemic challenges that have traditionally impeded a unified approach by the treatment and criminal justice systems.

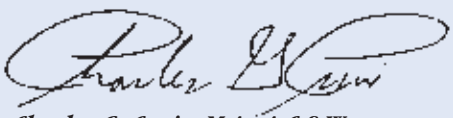
Treatment drug courts, started in the late 1980s, have changed the adversarial nature of the prosecuting attorney, the defense attorney, and the judge in traditional court proceedings to a team approach. All parties are united in finding a way to meet public safety needs while addressing the treatment and recovery needs of the substance-using individual.

Also, treatment drug courts shift the focus of care from episodes of acute symptoms toward the management of long-term recovery, and engage the individual as a partner in his or her own recovery and rehabilitation.

Successful recovery not only includes decreased drug use or decreased involvement with the criminal justice system, but also reflects incremental changes in other areas. SAMHSA's recently launched National Outcome Measures initiative asks treatment programs to evaluate effectiveness by also measuring increased employment or school enrollment, enhanced family stability or stability in living situation, improved retention, and better self-management ability.

The criminal justice system offers numerous opportunities for intervention for people with substance and mental health disorders. To the greatest extent possible, all points of the criminal justice system should have access to the information, staff, and techniques to assess the type and intensity of services needed and identify the appropriate level of intervention that will align with criminal justice requirements.

By combining efforts through partnership and collaboration, the treatment system and the criminal justice system can increase exponentially the chance for both individual recovery and community well-being.



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

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chipping away at the stigma attached to addiction. "Now we're starting to hear people say that putting certain people in prison just doesn't work," he said.

Family Drug Courts

While adult and juvenile drug courts serve individuals who have committed a wide range of crimes, family drug courts target a more specific population—parents whose substance abuse has put them at risk of losing custody of their children.

Unlike adult and juvenile courts, where the focus is on the offender, family drug courts focus on the offenders' children.

"The objective of family drug courts is to find solutions that are in the best interests of the child," explained Mr. Robertson of CSAT. "The purpose of the courts is to find ways to alleviate the problems that exist and make it possible for parents to bring their children back into their homes. Our goal is to keep those children from having to go into foster care or into permanent custody with other families—unless that's what's best for the child."

Family drug courts, he explained, help achieve that goal by eliminating the parental substance abuse that puts parents at risk of losing their children to the state. Compliance with the drug court program can greatly increase parents' chances of getting their children back, Mr. Robertson said.

The Steuben County Family Court Treatment Enhancement Project offers an example. The project received a 3-year CSAT grant in 2002 and is now in a no-cost extension period.

Located in the town of Bass in rural upstate New York, the court serves parents—primarily mothers—who have been charged with neglect of their children due primarily to a substance abuse problem. "For example, they've overdosed," explained Judge Peter C. Bradstreet, J.D. "or they've driven in their car with their children while intoxicated."

When a neglect petition is filed, the family drug court coordinator screens the petition to see if substance abuse is a factor. When it is, the person is eligible for family drug court.

Participants undergo treatment for substance abuse and any mental health issues, while family care workers monitor their progress during home visits. The family drug court program even provides transportation if needed.

In the early stages, participants come before the judge each week. "If I'm hearing that the person doesn't have a good attitude in treatment or won't talk in group therapy, I'll ask them about it when they come before me," Judge Bradstreet said.

The family drug court team meets weekly to discuss participants' progress. Throughout, the team keeps the children's perspective in mind. For example, if a team member suggests cutting back visits with children as punishment for some violation, someone might ask how the children will feel about it and suggest alternative sanctions.

Family drug courts offer several advantages, said Project Director Michael J. Magnani, J.D., Director of the Division of Grants and Program Development at the New York State Unified Court System in Manhattan. They allow much more informed decision-making, because the drug court team thoroughly explores what's going on with parents and children. They allow much quicker decision-making. And there's greater accountability.

"In a traditional court, the judge may tell the person to get some sort of treatment, but it's up to the parent to actually do that," said Mr. Magnani. "By and large, these cases kick around forever."

For Judge Bradstreet, the evidence that the family drug court model works is apparent in the faces of its graduates and their children.

"The parents just look so much better than they did when they first appeared in the court months earlier," Judge Bradstreet noted. "There's a remarkable difference. They've got smiles, bright eyes, healthy-looking skin."

Even more gratifying are the comments from participants' children, who are often invited to speak at the graduation ceremonies. "They say things like, 'Thank you for giving me my mother back,' " said Judge Bradstreet.

For more information about drug courts, visit the SAMHSA Web site at **www.samhsa.gov** or visit the NADCP Web site at **www.nadcp.org.**

—By Rebecca A. Clay

Photo by Pamela Ames, Director of Communications, Gosnold

At the Cape Art Museum in Massachussetts, three drug court participants engage in a discussion with the museum's curator, Michael Giaquinto, about techniques used in furniture finishing more than 100 years ago.

Consensus Statement Defines Mental Health Recovery

SAMHSA recently unveiled a consensus statement outlining principles necessary to achieve mental health recovery. The consensus statement, developed through deliberations by more than 110 expert panelists, represents mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials, and others.

"Recovery must be the common, recognized outcome of the services we support," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "This consensus statement on mental health recovery provides essential guidance."

Fundamentals of Recovery

The Consensus Statement defines mental health recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential."

The 10 fundamental components of mental health recovery include the following principles:

Self-Direction. Consumers determine their own path of recovery with their autonomy, independence, and control of resources.

Individualized and Person-Centered. There are multiple pathways to recovery based on an individual's unique strengths as well as his or her needs, preferences, experiences, and cultural background.

Empowerment. Consumers have the authority to participate in all decisions that will affect their lives, and they are educated and supported in this process.

Holistic. Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, social networks, employment, education, mental health and health care treatment, and family supports.

Non-Linear. Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience.

Strengths-Based. Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer Support. Mutual support plays an invaluable role in recovery. Consumers encourage and engage others in recovery and provide each other with a sense of belonging.

Respect. Eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital.

Responsibility. Consumers have a personal responsibility for their own self-care and journeys of recovery. Consumers identify coping strategies and healing processes to promote their own wellness.

Hope. Hope is the catalyst of the recovery process and provides the essential and motivating message of a positive future. Peers, families, friends, providers, and others can help foster hope.

The National Consensus Statement on Mental Health Recovery is available at SAMHSA's National Mental Health Information Center at **www.mentalhealth.samhsa.gov** or 1 (800) 789-2647.

Mental Health Action Plan Meeting Held

(l to r) A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services; SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.; and Mark B. McClellan, M.D., Ph.D., Administrator of the Centers for Medicare & Medicaid Services, listen to comments at the first meeting of the Federal Executive Steering Committee on Mental Health at the end of January.

The committee will oversee the implementation of action items across Federal agencies as outlined in SAMHSA's *Transforming Mental Health Care in America—The Federal Action Agenda: First Steps,* released in July 2005. SAMHSA's Action Agenda was informed by recommendations from the President's New Freedom Commission on Mental Health. The committee will provide general direction, monitor, and report on the Federal Government's progress. (For more information, see *SAMHSA News,* "Recovery Is Key for Mental Health Action Agenda," September/October 2005.)

SAMHSA Announces Funding Opportunities

SAMHSA recently announced several new grant funding opportunities for Fiscal Year 2006. Announcements include the following:

- **Cooperative Agreements for HIV/AIDS Related Mental Health Services in Minority Communities** (Application due date: May 1, 2006)—Up to 16 cooperative agreement grants, for $525,000 per year for up to 5 years, to expand the provision of effective, culturally competent, HIV/AIDS-related mental health services in minority communities for persons who are living with HIV/AIDS and who have a need for mental health services. These grants will be awarded by SAMHSA's Center for Mental Health Services. Domestic and public and private nonprofit entities may apply. (SM-06-001, $8.4 million)
- **Strategic Prevention Framework State Incentive Grants** (Application due date: May 1, 2006)—12 to 15 cooperative agreement grant awards for $2.3 million or less for up to 5 years, to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking. A minimum of 85 percent of the total grant award must be allocated to community-level organizations for activities at the community level. These cooperative agreements will be administered by SAMHSA's Center for Substance Abuse Prevention. (SP-06-002, $33 million)
- **Co-Occurring State Incentive Grants (COSIG)** (Application due date: May 16, 2006)—Up to 2 awards will be made in Fiscal Year 2006, with up to $2.1 million in funding expected to be available. Awarded by SAMHSA's Center for Substance Abuse Treatment (CSAT), the COSIG grants provide accessible, comprehensive, and evidence-based treatment services to persons with co-occurring substance abuse and mental disorders. Grantees will also participate in a national evaluation of the COSIG program. (TI -06-003, $2.1 million)
- **Cooperative Agreements for Screening, Brief Intervention, Referral and Treatment (SBIRT)** (Application due date: April 27, 2006)—2 cooperative agreement grant awards, for $2.8 million per year for up to 5 years, to expand and enhance state substance abuse treatment systems to include screening, brief intervention, referral, and brief treatment in general medical and other community settings. Funded by SAMHSA's CSAT, the grants will support clinical services for persons at risk for or diagnosed with a substance use disorder.

  The awards also will identify systems and policy changes to increase access to treatment in general and specialist settings. States, territories, and federally recognized tribes and tribal organizations are eligible. (TI-06-002, $5.6 million)
- **Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless** (Application due date: April 6, 2006)—Up to 25 grant awards, for $400,000 per year for up to 5 years, to develop programs that provide comprehensive drug, alcohol, and mental health treatment systems for persons who are homeless. (TI-06-005, $9.7 million)
- **Projects To Deliver and Evaluate Peer-to-Peer Recovery Support Services** (Application due date: April 4, 2006)—7 grant awards, for $350,000 per year for up to 4 years, to deliver and evaluate peer-to-peer recovery services that help prevent relapse and promote sustained recovery from alcohol and drug use disorders.

  The Recovery Community Services Program focuses on keeping people in recovery and complements SAMHSA's Access to Recovery program, which provides vouchers for treatment. Domestic and public and private nonprofit entities may apply, including state and local governments, state and federally recognized tribes, urban Indian organizations, universities and colleges, and community and faith-based organizations. (TI-06-004, $2.5 million)

For an application kit for any of the awards, call SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686.

For the most up-to-date grant information throughout the year, visit **www.samhsa.gov/grants** or **www.grants.gov,** which features the quarterly e-newsletter, *Succeed.*

"Get Started with Grants.Gov" is a new Web cast available 24 hours a day, 7 days a week at **www.grants.gov/spreadwordwebcast.**

Crisis Counseling Grants Help Hurricane Survivors

SAMHSA recently awarded more than $59 million to 14 states for crisis counseling assistance in the aftermath of Hurricanes Katrina, Rita, and Wilma. (See *SAMHSA News,* November/December 2005.)

These grants are awarded through a longstanding partnership between SAMHSA and the Federal Emergency Management Agency (FEMA).

A total of 20 states are expected to receive this "Regular Services" program funding, which supports state efforts for up to 9 months of additional help. These grants will enable states to address ongoing counseling needs of persons adversely affected by the hurricanes.

A total of 29 states received "Immediate Services" grants totaling $25.8 million within weeks of the hurricanes in August, September, and October 2005.

To date, when combined with the early round of Immediate Services grants, more than $82 million in Federal crisis counseling support has been made available to states.

Six states received approval for the first awards ($22.3 million)—Mississippi, Arkansas, Indiana, Maryland, New Jersey, and Utah. In the second set of awards, an additional $19.2 million was approved for seven states—Texas, Georgia, Illinois, Pennsylvania, Wisconsin, Missouri, and Colorado. Third, Florida was approved for up to $16.5 million for crisis counseling assistance.

Building a Recovery Identity

"It's important that crisis counseling services are provided to disaster survivors in a manner that is as engaging and positive as possible," said Seth Hassett, Chief of Emergency Support Services at SAMHSA's Center for Mental Health Services. "Most people appreciate the availability of counseling services, but for some people this may be the first time they've received any type of mental health support. That's why states have come up with project names that emphasize hope and recovery."

Each crisis counseling program will hire and train people locally to provide outreach to hurricane survivors who need mental health services. Outreach will include mobile services in which trained workers go to shelters, disaster recovery centers, or temporary hotels, and provide supportive contacts, educational materials, and brief counseling services.

Some of the "named" state programs and their approximate approved funding amounts include:

Project Recovery in Mississippi (up to $20 million approved) provides counseling services to people in the 47 counties directly affected by Hurricane Katrina. The state anticipates more than 300,000 persons will need services.

Project AR-K in Arkansas (up to $532,000 approved) provides counseling services to evacuees through outreach efforts, including activities coordinated with local organizations (e.g., health organizations, public housing agencies, and schools).

Indiana's Project Aftermath (up to $690,000 approved) emphasizes field outreach to at-risk populations including children, older adults, and people with disabilities.

Maryland's Project KARE (up to $660,000 approved) establishes outreach programs to provide counseling services to evacuees and serves at-risk populations through community partnerships and special events.

New Jersey's Project Rebound (up to $245,000 approved) focuses on evacuees who are ethnic minorities and children, local families who provide housing, and first responders who were deployed to the affected areas.

Utah Reaching Out (up to $245,000 approved) provides services to evacuees experiencing loss of homes, loved ones, family, and employment.

Colorado Hurricane Evacuee Support and Recovery Project (up to $1.2 million approved) is a counseling program that provides individual and group educational services to hurricane evacuees.

Missouri's Lighthouse Project (up to $545,000 approved) offers a full range of crisis counseling services to hurricane evacuees. Outreach efforts include a statewide telephone crisis hotline.

Pennsylvania Responds (up to $1.1 million approved) will provide education and outreach to several thousand adults and children relocated to Philadelphia and Allegheny counties.

Project Hope in Wisconsin (up to $433,000 approved) is a community-based disaster recovery program addressing the crisis counseling needs of individual evacuees and families.

Florida's Project Hope program received approval for up to $16.5 million for counseling services related to Hurricanes Katrina and Wilma.

Other crisis counseling awards include:

Illinois (up to $643,000 approved) has outreach workers helping individuals and families to link them to appropriate services.

Texas (up to $12.1 million approved) continues outreach and support services to evacuees from Louisiana and Mississippi. Hundreds of thousands of these evacuees began arriving in Texas 48 hours prior to Katrina's landfall and for weeks after.

Georgia (up to $3.2 million approved) continues to assist with the unique crisis counseling needs of this unusually large number of displaced individuals spread over 250 of the state's 254 counties.

For more details on these grants, visit SAMHSA's Web site at **www.samhsa.gov/grants.**

Methamphetamine Abuse Rises

According to a new SAMHSA report, admissions to treatment for methamphetamine abuse increased significantly between 1993 and 2003, moving across the country from West to East.

States in the Midwest and South that had few admissions due to methamphetamine/amphetamine abuse in 1993 are now experiencing higher rates of admissions.

These findings are part of a report released by SAMHSA from continued analysis of the 2003 Treatment Episode Data Set (TEDS).

The report, *Trends in Methamphetamine/Amphetamine Admissions to Treatment: 1993-2003,* combines the two substances of abuse because 3 of the 52 states and jurisdictions in TEDS do not distinguish between the powerful amphetamine, methamphetamine, and all other amphetamines. However, for the majority of states that do distinguish between the substances, 86 percent of primary methamphetamine/amphetamine admissions in 2003 were for methamphetamine.

Methamphetamine/amphetamine admissions increased nationally from 1993 to 2003, from 13 to 56 admissions per 100,000 population ages 12 and older. A total of 18 states experienced methamphetamine/amphetamine treatment rates higher than the national average in 2003.

The climb in admissions to treatment for methamphetamine/amphetamine as the primary substance of abuse rose from 28,000 admissions in 1993 (nearly 2 percent of 1.6 million admissions nationally) to almost 136,000 admissions in 2003 (over 7 percent of the total 1.8 million admissions).

TEDS collects data on the approximately 1.8 million annual admissions to substance abuse treatment facilities, primarily those that receive some public funding. The new report is available on the SAMHSA Web site at **www.oas.samhsa.gov.**

New Treatment Reports Highlight Retirees, Youth

SAMHSA's continued analysis of the 2003 Treatment Episode Data Set (TEDS) on trends in treatment admissions for alcohol and drug use across the Nation generated two recent reports—one on retirees in treatment for alcohol use and one on "first use" of drugs by youth.

Part of SAMHSA's Drug and Alcohol Services Information System (DASIS), TEDS is a compilation of data on the demographic and substance abuse characteristics of admissions to (and more recently, on discharges from) substance abuse treatment. This involves data reported by the 50 states, District of Columbia, and Puerto Rico over the 12-month period of a calendar year.

Retirees

Retired Admissions: 2003 is a new SAMHSA report that examines substance abuse treatment admissions among retired persons.

TEDS data from 29 states and other jurisdictions indicate that 4 out of 5 current retirees in substance abuse treatment needed treatment for alcohol as their primary substance of abuse in 2003. This is a far higher proportion reporting alcohol (80 percent of retirees in treatment) than for all other admissions to treatment in these states (44 percent).

More than half of all states across the Nation reported data on retirees. Only 5 percent of retirees in treatment in the 29 states and jurisdictions reported use of opiates—either heroin or prescription narcotic pain medications—as their primary substance of abuse, compared to 13 percent of other admissions.

Drug Use Before Age 13

The age when people first use drugs is considered an important marker in efforts to control drug abuse. According to SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH), adults who first used substances at a younger age were more likely to be classified with dependence or abuse than adults who began use at a later age.

Age of First Use among Admissions for Drugs: 1993 and 2003 is a new SAMHSA report that looks at age of first use among TEDS admissions for drugs other than alcohol. Up to three substances may be reported in TEDS as being used at the time of admission. The report classifies admissions according to the earliest age at which use began for any of the drugs reported.

The average age of first use among admissions for drug use showed a slight decrease, from age 18.8 in 1993 to age 18.6 in 2003. Between 1993 and 2003, the average age of first use was unchanged among admissions younger than age 18 (age 12.8) and decreased among all other age groups.

For a copy of the reports, visit SAMHSA's Web site at **www.oas.samhsa.gov.**

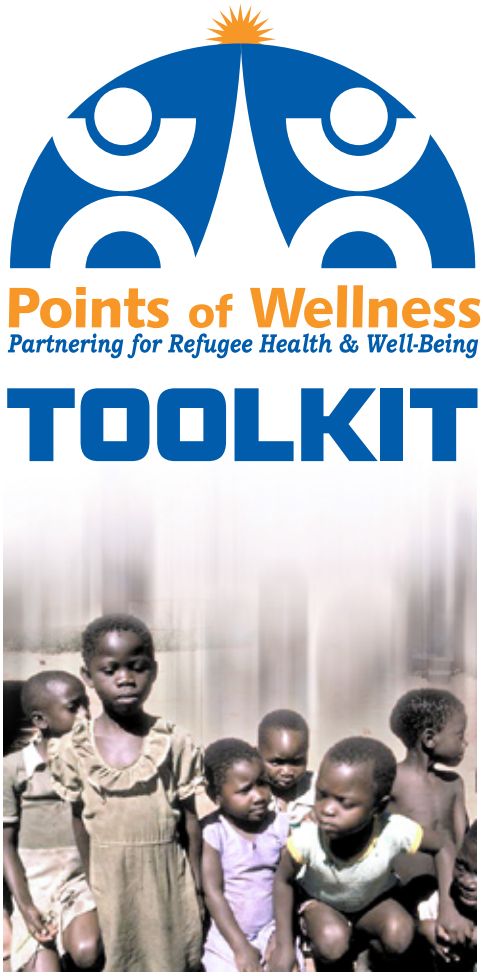
Toolkit Supports Refugee Mental Health

Refugees who seek safety and shelter in the United States can face various health challenges before, during, and after they settle into their new communities.

To help community organizations engage in activities to promote health and prevent diseases among refugee populations, SAMHSA's Center for Mental Health Services' Refugee Mental Health Program recently prepared the *Refugee Health Promotion and Disease Prevention Toolkit* in collaboration with the Office of Refugee Resettlement and the Office of Global Health Affairs within the U.S. Department of Health and Human Services.

In their home countries, these individuals may have been exposed to infectious and parasitic diseases as well as physical and psychological trauma. And as they make their journey to their new home, they are often malnourished and exposed to rapidly spreading diseases, especially while they are housed at crowded refugee settlements or camps. After migration and resettlement, they confront chronic diseases that affect the general population in the United States. These diseases include obesity, high blood pressure, heart disease, and diabetes. Refugees also may be at higher risk for developing mental health problems.

Introduced as a key part of the *Points of Wellness—Partnering for Refugee Health and Well-Being* initiative, the free toolkit is designed for community organizations such as churches or other faith-based groups, mutual assistance associations, and nonprofit groups concerned with refugee health. The toolkit offers basic guidance and reference materials to help organizations encourage the physical, mental, and social well-being of refugees, which includes preventing disease, improving quality of life, and reducing health disparities.



"We hope any group of individuals concerned about refugee health will use these materials to improve the long-term health of refugees in the United States and help them feel strong, active, wise, and worthwhile," said CAPT John J. Tuskan, Jr., Director of SAMHSA's Refugee Mental Health Program.

The toolkit contains the following components:

- **Manual:** Includes guidance on how to plan and conduct culturally appropriate activities that build individual awareness of health issues.
- **Training guide and PowerPoint slides:** Provide step-by-step guidance as organizations begin to share the information in the manual with others.
- **Article:** Provides an orientation to the field and activities of health promotion and disease prevention.
- **Video:** Provides an introduction to promoting health among refugees
- **CD-ROM:** Contains an electronic version of the entire manual and PowerPoint slides.

The main component of the toolkit is the manual, which offers ways for groups to develop and implement health promotion activities in refugee communities, addresses the importance of cultural sensitivity in health promotion work, and provides helpful resources. Used as either a reference tool or a program development guide, the manual helps meet the needs of individual organizations.

The manual shows users how to assess the health needs of their communities, how to identify existing resources, and how to use partnerships to promote community health successfully.

"The toolkit gives communities the capacity to plan, implement, and evaluate whatever works for them," said CAPT Tuskan. "Having communities take ownership of the health status of their residents is the best way to ensure long-term health improvement for everyone."

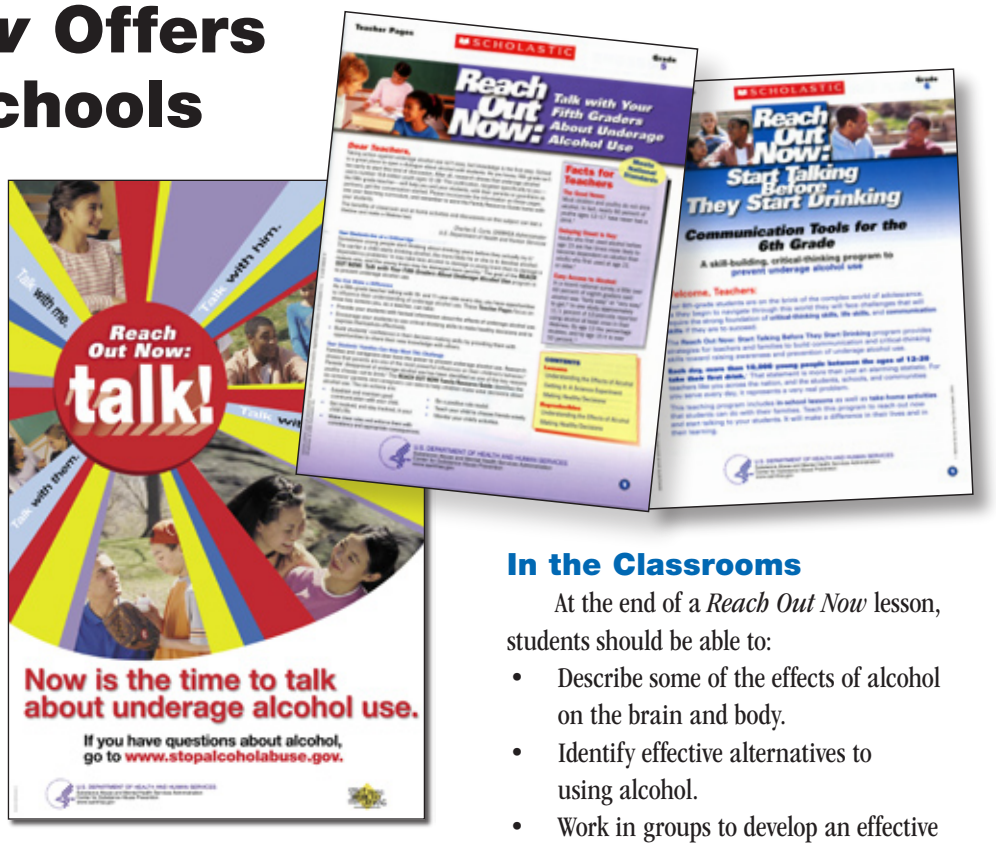
Because every community has varying needs, the toolkit describes a range of programs that can be used to promote health and prevent disease, including support groups and health fairs.

The toolkit is available on the SAMHSA Web site at **www.refugeewellbeing.samhsa.gov.**

Limited print copies of the toolkit are available from SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY).

—By Ellen Robinson and Riggin Waugh

Reach Out Now Offers Materials to Schools



To highlight Alcohol Awareness Month in April, SAMHSA and Scholastic, Inc., are sponsoring a nationwide teach-in for fifth- and sixth-graders from April 3 to 7.

Alcohol use among children and adolescents starts early and increases with age, according to data from SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH). In that survey, about 10.8 million youth age 12 to 20 (nearly 30 percent) reported using alcohol at least once in the month prior to the survey.

This year's teach-ins to prevent underage drinking are part of SAMHSA's annual *Reach Out Now* activities. The effort gives prominent national, state, local, and youth leaders an opportunity to use the research-based curriculum to educate students, parents, and other community members about the dangers of underage alcohol use.

According to NSDUH, more than 40 percent of individuals who start drinking before age 15 will develop alcohol abuse or alcohol dependence at some point in their lives.

SAMHSA and Scholastic sent materials to fifth-grade teachers across the country for the first time in 2002. Beginning in 2004, similar materials were distributed to sixth-grade teachers nationwide.

Partnering with SAMHSA, Scholastic offers resources such as classroom lessons and take-home tools to encourage the discussion of underage drinking in school and at home, provide children with accurate information on the effects of alcohol on the body, and help children practice critical thinking and self-expression skills that are needed to make healthy decisions.

Teach-in participants receive packets of information that include a lesson plan as well as a media kit and CD-ROM that contain templates for creating press releases and pitch letters. The packets also include *Too Smart To Start* crossword puzzles and word searches that reinforce parts of the curriculum, such as symptoms of alcohol use, as well as congratulatory certificates for students who complete the program and for adults who lead the teach-ins. SAMHSA's *Too Smart to Start* initiative is an alcohol awareness program that focuses on 9- to 13-year-old children and their parents and caregivers. (See *SAMHSA News,* March/April 2005.)

In addition to teaming with Scholastic, SAMHSA has also joined with several other national partners, including Mothers Against Drunk Driving (MADD) and Community Anti-Drug Coalitions of America (CADCA), to expand overall awareness and reach of the event.

Based on a two-part set of materials, *Reach Out Now: Talk with Your Fifth Grader About Underage Alcohol Use* and *Reach Out Now: Start Talking Before They Start Drinking,* the national teach-in event alerts children, parents, and teachers about the dangers of underage alcohol use and reinforces the message that it is unacceptable at school and at home.

In the Classrooms

At the end of a *Reach Out Now* lesson, students should be able to:

- Describe some of the effects of alcohol on the brain and body.
- Identify effective alternatives to using alcohol.
- Work in groups to develop an effective alcohol prevention message.

Communities nationwide are encouraged to participate, and anyone who has a positive influence on young people can be a teach-in presenter. Participants at previous events include governors and lieutenant governors, mayors, congresspersons and senators, faith leaders, school personnel, and health care professionals.

Playing a Vital Role

Parents, teachers, and caregivers play a vital role in influencing children's attitudes about alcohol. They give children the knowledge to recognize the dangers of underage drinking, help children build skills to reject alcohol offered by peers, express clear and consistent messages that alcohol use is unacceptable, and reinforce children's ability to make healthy decisions.

Additional information about SAMHSA's underage drinking prevention programs is available at **www.teachin.samhsa.gov** and **www.toosmarttostart.samhsa.gov.**

—By Leslie Quander Wooldridge

Town Hall Meetings Convene on Underage Drinking

More than 1,200 communities will hold a series of town hall meetings, on or around March 28—just before April, which is Alcohol Awareness Month—to focus national attention on underage drinking and hear about successful strategies for prevention. SAMHSA is playing a key role in this effort.

To assist local communities with preparation, SAMHSA offers a planning kit that includes templates for the production of customized posters and flyers, press releases for the media, and invitation letters for potential panelists.

The meetings continue the momentum of the recent national conference in Washington, DC, "Preventing Underage Alcohol Use: A National Meeting of the States." The conference was sponsored by the Interagency Coordinating Committee on the Prevention of Underage Drinking, which is chaired by SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. (See *SAMHSA News,* November/December 2005.)

Town hall meetings are intended to bring together communities in a public forum to discuss issues of concern related to underage use of alcohol, which is the most widely used substance of abuse among America's youth.

The town hall meetings are strategically timed to help energize communities about *Reach Out Now* teach-in events (see page 10). Communities holding town hall events are encouraged to use these teach-in materials in their schools.

In January, regional trainings to prepare for the town hall meetings were held in Boston, MA, and Reno, NV. The trainings focused on two objectives:

- Help local community coalitions convene town hall meetings focused on underage drinking prevention.
- Promote local use of the *Start Talking Before They Start Drinking* public service announcements developed in collaboration with the Ad Council.

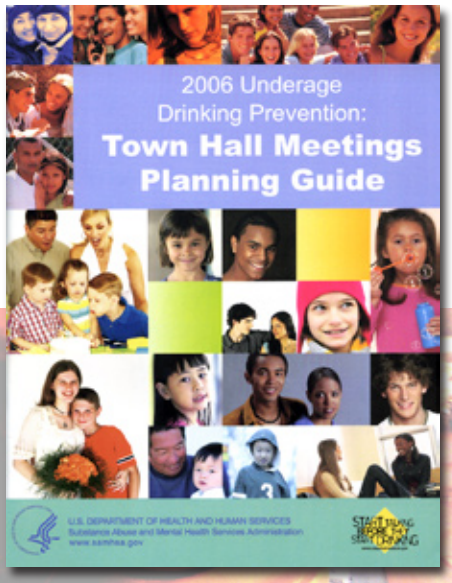
Regional trainings are highlighted in two Web casts to help local community coalitions get involved in these efforts.

Planned activities include the governors and first ladies of many states, including the following:

- In **Arizona,** a number of coalitions and organizations are planning 25 town hall meetings, with teach-ins to follow.
- In **Florida,** 43 of 67 counties will participate in town hall meetings, with an event in Tampa scheduled to be broadcast live on all Florida PBS stations and taped by other local affiliates. The state's first lady will attend the Tampa meeting along with Federal leaders and state agency heads.
- In **Maine,** the Attorney General is holding town hall-style meetings in every county in the state. The meetings, held in 24 communities, are the first step in developing a regional plan of action and will highlight current state and local efforts.
- In **North Carolina,** the state's first lady will speak at a town hall meeting in Chapel Hill on March 28. The event is hosted by a community coalition, the Committee for Alcohol & Drug Free Teenagers of Chapel Hill, and the town of Carrboro. Drug Free Community grantees will take part.
- In **Ohio,** town hall meetings will take place in various communities on March 28. Plans call for a central meeting to be held in Cleveland.
- In **Washington, DC,** the mayor has planned a town hall-style meeting devoted to underage drinking for March 28.
- In **Wyoming,** on April 6, the state's first lady will host a live call-in broadcast on Wyoming Public Television.

Other states involved in town hall meetings include California, New Mexico, Oklahoma, Pennsylvania, Maryland, Virginia, and Kentucky.

For additional information, or to view the training Web casts, visit **www.stopalcoholabuse.gov/townhall.**



Hepatitis Vaccination Pilot Project Launched

A new 1-year pilot project from SAMHSA's Center for Substance Abuse Treatment (CSAT) will provide free vaccine against hepatitis A and hepatitis B.

Programs that will distribute the vaccine include the SAMHSA Minority AIDS Initiative Targeted Capacity Expansion grantees, Opioid Treatment Programs regulated by SAMHSA, and treatment sites using the medication buprenorphine for opioid addiction.

The CSAT pilot project is part of an infection prevention measure to reduce the risk of hepatitis A or B in persons who are eligible for services.

Those individuals are either infected with HIV (human immunodeficiency virus) or hepatitis C virus (HCV), or they are at high risk for contracting these infections as a consequence of injection drug use or other substance use.

Vaccination against hepatitis A and B virus infections can supplement care and improve treatment strategies to prevent progression of liver disease.

Vaccine distribution began in January and will be completed by September 2006. "The vaccine demand has been higher than initial estimates among programs quick to respond to the invitation letter," said Kenneth Hoffman, M.D., M.P.H., Project Officer for the program. "All available vaccine was committed by the end of January."

About 30 sites have agreed to participate in the project. To participate, programs must demonstrate that they have an established immunization program as part of their core treatment or outreach approach.

The project will assess the likelihood of reaching individuals at risk for vaccine-preventable infectious hepatitis in methadone and buprenorphine treatment facilities and nontraditional substance abuse prevention and treatment facilities.

Vaccination against hepatitis A and B virus infections can improve treatment strategies to prevent progression of liver disease.

HCV, which spreads through contact with an infected person's blood, and HIV are frequent co-occurring infectious diseases in drug users, especially injection drug users. And co-occurring infections complicate the medical management of substance abuse treatment.

Who Is Receiving the Vaccine?

For persons age 18 and older, the Centers for Disease Control and Prevention (CDC) recommends immunization for both hepatitis A and B for all susceptible persons who are at risk for either exposure to both viruses, or at risk for serious complications from infection with these viruses. These individuals include residents of drug and alcohol treatment centers and patients with chronic liver disease.

The SAMHSA pilot project purchased Twinrix,® the only combination vaccine for both hepatitis A and hepatitis B. Use of the combined vaccine simplifies the dose schedule by using one vaccine and decreases the number of shots needed for full protection from five shots to three.

Even one shot of the combination vaccine can provide significant protection against infection, with up to 50 percent of those vaccinated being protected against hepatitis B for a short time.

Additional doses increase the percentage protected up to 75 percent with a second dose, and 90 to 95 percent with a third dose, and the length of protection is extended to many years. Protection against hepatitis A is even higher with a single dose, and 100 percent after all three doses.

Side effects are minimal, the most common being transient fatigue, headache, nausea, or aching following immunization.

SAMHSA, in collaboration with the CDC, has educational materials available to all substance abuse treatment programs and to patients beyond the pilot period, whether or not the site is participating in the demonstration project.

Because the vaccine is given in three separate injections, the program will collect data on whether patients complete the entire vaccination process. An evaluation team will provide data that reflect the demographics and risk factors of people receiving the immunization and the number of immunizations received by those individuals.

The importance of preventing, identifying, and treating hepatitis as part of comprehensive services in an opioid treatment program is covered in detail in a SAMHSA monograph on hepatitis, which will be available soon.

For more information about SAMHSA's pilot hepatitis vaccination project, visit the SAMHSA Web site at **http://dpt.samhsa.gov.** Or contact Dr. Kenneth Hoffman in the CSAT Division of Pharmacologic Therapies at (240) 276-2701.

"Partners for Recovery" Posts Web Site

SAMHSA recently announced the launch of a Web site dedicated to building partnerships that support the advancement of prevention, treatment, and recovery from substance use and mental health disorders.

The new Partners for Recovery (PFR) Web site, at **www.pfr.samhsa.gov,** offers a central resource for organizations and groups that work to help individuals and families achieve and maintain recovery.

Sponsored by SAMHSA's Center for Substance Abuse Treatment (CSAT), the recovery initiative provides technical resources, including important journal articles and reports, and support through the new Web site.

In 2005, Partners for Recovery was broadened from a focus on addiction treatment to a SAMHSA-wide initiative. The initiative's Steering Committee, which guides and provides leadership to the effort, now includes Agency representatives from all three disciplines: substance abuse prevention, addiction treatment, and mental health.

Five key priorities are highlighted on the Web site:

Recovery is an ongoing process that starts before sustained abstinence is achieved (see *SAMHSA News,* page 5, for the Consensus Statement on Recovery).

Collaboration occurs when organizations and systems that help people with (or at risk for) substance abuse disorders work together to create a continuum of recovery support services, including prevention, intervention, and treatment.

Stigma reduction is a top priority for the initiative. Training sessions are under way to inform individuals and organizations about their rights under Federal and state laws. A national public education campaign is being coordinated through the National Council on Alcoholism and Drug Dependence.

Workforce development addresses complex issues facing the addiction treatment field, such as recruitment, retention, and staff skills development.

Leadership development includes the sponsorship of regional leadership institutes to focus on developing a cadre of emerging leaders. Many current leaders who work in the field of addiction services are preparing to retire.

National leaders in the field identified these five topics as the most important and compelling issues for the growth and advancement of treatment and recovery across the Nation. Focusing on these topics furthers SAMHSA's mission to build resilience and facilitate recovery for people with alcohol and drug problems or mental illnesses.

In addition to links to related Web sites and reports, resources include the *Know Your Rights* brochure for people in treatment for (and recovery from) alcohol and drug problems. Other Web site features include presentations on issues facing the addiction treatment workforce, peer-reviewed papers on developing new leadership, the President's New Freedom Commission Report on Mental Health, the Annapolis Coalition on Behavioral Health, and other state and Federal resources on developing recovery-oriented systems of care.

"The Web site's content currently reflects its original focus—substance use disorders. However, over time, the content will include the initiative's broadened focus on substance abuse prevention and mental health issues as well," said Donna M. Cotter, M.B.A., Partners for Recovery Coordinator at CSAT.

Goals of the initiative include defining recovery and providing models and tools to support it; fostering collaboration among the various systems that affect people with substance use disorders (such as mental health, primary care, and child welfare); and reducing the stigma associated with addiction.

Individuals as well as organizations and states working on recovery issues, stigma reduction, workforce development, and leadership development in the areas of addiction prevention, treatment, and mental health are invited to share information so it can be made available on the Partners for Recovery Web site.

For additional information on Partners for Recovery, visit **www.pfr.samhsa.gov.**

President Proposes $3.3 Billion Budget for SAMHSA

President George W. Bush has proposed a budget of $3.3 billion for SAMHSA in Fiscal Year (FY) 2007 that renews the Agency's emphasis and innovation in two primary areas—Access to Recovery (ATR) and Mental Health System Transformation.

The proposed $3.3 billion budget is similar to Fiscal Year 2006 funding levels in spite of a $67 million decrease that, in part, reflects a large number of grant programs coming to a natural end in FY 2006.

The budget includes:

- $1.8 billion for the Substance Abuse Prevention and Treatment Block Grant, and $428 million for the Community Mental Health Services Block Grant.
- $98 million for the ATR program, which includes approximately $70 million for the Voucher Incentive Program, $25 million for the Methamphetamine Voucher Program, and $3 million to evaluate the ATR program.
- $20 million for seven Mental Health Transformation State Incentive Grants; in addition, states will be required to use part of their Community Mental Health Services Block Grant funds to support state-based mental health transformation activities.
- More than $95 million to continue Strategic Prevention Framework (SPF) state incentive grants and contracts.

"The proposed FY 2007 budget continues our commitment to making solid, lasting changes that will place consumers and families at the center of an improved delivery system," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., at a Constituent Budget Briefing held January 9 at SAMHSA headquarters. "The budget offers a glimpse of what SAMHSA can accomplish in the next few years. It is a fiscally responsible budget that sets priorities and holds Government programs accountable for real results," he said.

"Most importantly," Mr. Curie added, "SAMHSA is not ending or terminating any grants in FY 2007."

Substance Abuse

The FY 2007 budget includes $2.3 billion for substance abuse treatment and prevention activities. It also proposes level funding for the Substance Abuse Prevention and Treatment Block Grant at $1.8 billion.

Pathways to Recovery. The budget provides $375 million, a reduction of $24 million, for Substance Abuse Treatment Programs of Regional and National Significance. Of this, $98 million is for the ATR voucher program. Beginning in FY 2007, states will have incentives to use part of their Block Grant funds for drug treatment vouchers for people seeking treatment or recovery support from a qualified community provider of their choice, including faith-based organizations. In addition, $25 million in new funding will be targeted to areas with high rates of methamphetamine use to fund vouchers to cover treatment and/or recovery support services.

Other Substance Abuse Treatment Programs. The FY 2007 budget proposes to increase the Screening, Brief Intervention, Referral, and Treatment Program to more than $31 million. It also calls for $8 million to support a new group of Addiction Technology Transfer Centers, which distribute research-based knowledge throughout the field. Several Center for Substance Abuse Treatment grant programs and contracts are coming to a natural end, including the general Targeted Capacity Expansion grants, and a few programs targeting pregnant and postpartum women, children, and adolescents. Nevertheless, SAMHSA's FY 2007 budget will support 499 grants and contracts, which include 378 continuation grants and 121 new competitive awards.

Prevention. The budget proposes $181 million for Substance Abuse Prevention Programs of Regional and National Significance, a reduction of $12 million from FY 2006. For example, the Strategic Prevention Framework, which will be funded at $95 million next year, allows states to better use prevention resources, implement effective prevention programs, and coordinate prevention among different agencies and funding streams. In FY 2007, SAMHSA will strengthen the Agency's focus on preventing underage drinking. The budget also calls for level funding of programs to help communities prevent methamphetamine and inhalant abuse.

SAMHSA will continue working with the Office of National Drug Control Policy to support some 720 grantees funded through the drug-free communities grant program. In addition, the budget proposes nearly $40 million for the Substance Abuse Prevention and HIV Prevention in Minority Communities Services Grants program, and nearly $10 million to sustain the Fetal Alcohol Spectrum Disorders Center for Excellence.

Mental Health

The budget proposes $849 million for mental health services, a decrease of $35 million from FY 2006.

Mental Health Block Grant. The budget calls for continued transformation of the Community Mental Health Block Grant, funded at $428 million, consistent with the recommendations of the President's Commission on Mental Health. The FY

2007 budget seeks to encourage reform of the mental health system so that:

- Americans understand that mental health is essential to overall health.
- Mental health care is consumer- and family-driven.
- Disparities in mental health services are eliminated.
- Early mental health screening, assessment, and referral to services are common practice.
- Excellent mental health care is delivered, and research is accelerated.
- Technology is used to access mental health care and information.

To support these goals, states will be required to use at least $153 million for mental health system transformation. In addition, $20 million is included to continue existing State Incentive Grants for Transformation.

Other Mental Health Programs. SAMHSA's suicide prevention programs will be funded at $35 million. This includes $27 million for Garrett Lee Smith Memorial Act suicide prevention activities and approximately $3 million in new funding for an American Indian/Alaska Native Youth Suicide Prevention Initiative. The Co-Occurring State Incentive Grants program will be funded at nearly $8 million, while $29 million is proposed for the National Child Traumatic Stress Initiative. SAMHSA's school-based violence prevention activities will receive $76 million in funding, which reflects an $18 million reduction as a result of the Safe Schools/Healthy Students and Youth Violence Prevention grants coming to a natural end.

In addition, the budget proposes level funding for three other Center for Mental Health Services programs—the Children's Mental Health Services program ($104 million), Projects for Assistance in Transition from Homelessness ($54 million), and the Protection and Advocacy for Individuals with Mental Illness program ($34 million).

SAMHSA Budget Authority by Activity (Dollars in Millions)

	2005	2006	2007
Substance Abuse:			
Substance Abuse Block Grant	$1,776	$1,759	$1,759
Programs of Regional and National Significance:			
Treatment	422	399	375
Prevention	199	193	181
Subtotal, Substance Abuse	**$2,397**	**$2,350**	**$2,315**
Mental Health:			
Mental Health Block Grant	$ 433	$ 429	$ 428
PATH Homeless Formula Grant	55	54	54
Programs of Regional and National Significance	274	263	228
Children's Mental Health Services	105	104	104
Protection and Advocacy	34	34	34
Subtotal, Mental Health	**$ 901**	**$ 884**	**$ 849**
Program Management	$ 94	$ 92	$ 97
Total, Program Level	**$3,392**	**$3,327**	**$3,260**
Less Funds Allocated from Other Sources:			
PHS Evaluation Funds	-123	-121	-126
Total, Discretionary BA	**$3,268**	**$3,206**	**$3,134**
FTE	535	558	558

Source: U.S. Department of Health and Human Services Web site, "Budget in Brief," at **www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf** (page 40, PDF format).

SAMHSA Data Activities. The budget includes an increase of $5 million for the Drug Abuse Warning Network. In addition, SAMHSA will continue to develop and fully implement National Outcome Measures across all Agency programs.

"We're focusing on accountability," Mr. Curie said. "We are moving past providing funding for treatment services to providing funding for the most effective, evidence-based treatment and recovery support services that move consumers and families along the path of recovery. The measures we use to define the recovery process will point to treatment failures, identify treatment improvements, and give consumers more confidence to seek care that is proven to work."

Mr. Curie added that, while states will be responsible for reporting outcomes data, SAMHSA will support their efforts with infrastructure and technical assistance through the State Outcomes Measurement and Management System.

Online Links

SAMHSA's Web site offers downloads of the FY 2007 budget in both PDF and Word formats at **www.samhsa.gov/budget.** Also, a "Budget in Brief" is available at the U.S. Department of Health and Human Services Web site at **www.hhs.gov.**

Recovery Web Cast Focuses on Veterans

Veterans face higher risks of alcohol and substance abuse than other people, according to a new SAMHSA Web cast, "Recovery and the Military: Treating Veterans and Their Families."

The second in a series of nine *Road to Recovery 2006* Web casts to be developed by SAMHSA's Center for Substance Abuse Treatment (CSAT), the hour-long program offers information about preventing, identifying, and treating alcohol and substance abuse problems in veterans and their families.

In this series, a new Web cast premiers the first Wednesday of each month and is available for viewing anytime after that. The Web casts are part of the year-round activities leading up to *National Alcohol and Drug Addiction Recovery Month* in September.

In addition to CSAT Director H. Westley Clark, M.D., J.D., M.P.H., the panel discussion features Patricia B. Getty, Ph.D., Supervisory Public Health Advisor at SAMHSA's Center for Substance Abuse Prevention; Richard T. Suchinsky, M.D., Associate Chief Consultant for Addictive Disorders at the U.S. Department of Veterans Affairs (VA); Ezekial Pankey, Followup Counselor and Case Manager at the Maryland Center for Veterans Education and Training; treatment providers; and veterans themselves. Associate Director for Consumer Affairs Ivette Torres of CSAT hosts the program.

Soldiers exposed to combat "see things that most people don't witness, such as colleagues getting wounded or killed," explains Dr. Clark, noting that soldiers also are isolated from their family, friends, and communities. Once they're back home, veterans may begin using alcohol or drugs as a way of handling anxiety, depression, or post-traumatic stress disorder.

These attempts at self-medication can spiral out of control and even lead to domestic violence, divorce, and homelessness. Spouses and children also are at risk of substance abuse. Fortunately, the Web cast explains, help is available for both veterans and their families through the VA and civilian counseling services and substance abuse treatment.

To view the Web cast, visit **www.recoverymonth.gov/2006/multimedia/w.aspx?ID=470.** As part of *Road to Recovery 2006* and the Ask the Expert series, Dr. Suchinsky answers viewers' followup questions at **www.recoverymonth.gov/2006/multimedia/expert1.aspx.**

Additional information on veterans and substance abuse is available through SAMHSA's Office of Applied Studies at **www.oas.samhsa.gov** (see *SAMHSA News,* January/February 2006).

Conference Supports Veterans

As *SAMHSA News* went to press, a national conference on veterans' health was planned for March 16 to 18 in Washington, DC. The May/June issue of *SAMHSA News* will feature coverage of "The Road Home: The National Behavioral Health Conference on Returning Veterans and Their Families—Restoring Hope and Building Resiliency."

1.8 Million Youth Initiate Inhalant Abuse

An average of 598,000 youth age 12 to 17 initiated inhalant use in the past 12 months, based on data from 2002 to 2004, according to a new report from SAMHSA released recently at a press conference by the National Inhalant Prevention Coalition to kick off National Inhalants & Poisons Awareness Week in March.

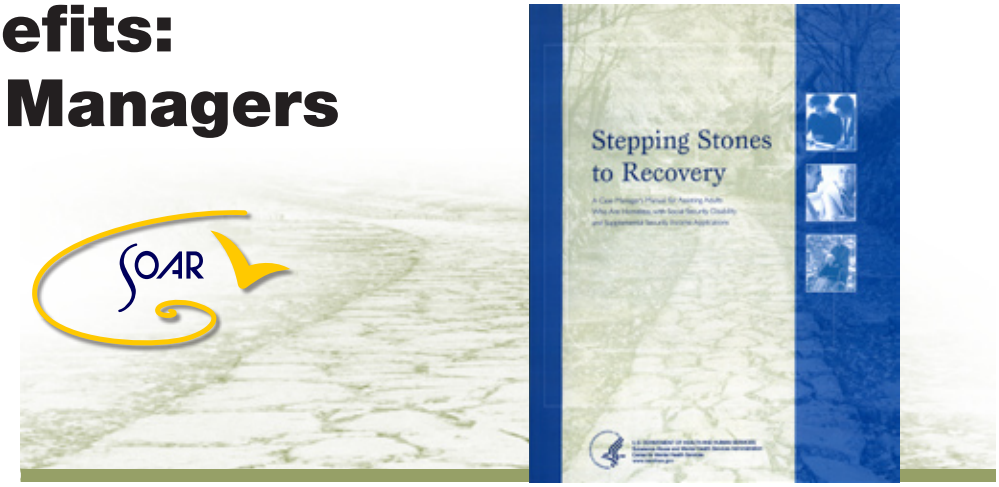
This number represents an estimated 1.8 million new initiates to inhalants in 3 years. The report's data are extracted from 3 years of the National Survey on Drug Use and Health.

Thirty percent of those initiating inhalant use in the 12 months prior to being surveyed were age 12 or 13, 39.2 percent were age 14 or 15, and 30.8 percent were age 16 or 17. The majority of these youth were white and from homes with incomes well above the poverty line.

The report, *Characteristics of Recent Adolescent Inhalant Initiates,* indicates that the most popular categories of inhalants among those who are recent initiates to the practice are glue, shoe polish, or toluene (used by 30.3 percent of new initiates); gasoline or lighter fluid (used by 24.9 percent); nitrous oxide or "Whippets" (used by 24.9 percent); spray paints (used by 23.4 percent); correction fluid, degreaser, or cleaning fluid (used by 18.4 percent); other aerosol sprays (used by 18.0 percent); amyl nitrite or "poppers," locker room deodorizers or "rush" (used by 14.7 percent); and lacquer thinner or other paint solvents (used by 11.7 percent).

For a copy of the report, visit the SAMHSA Web site at **www.oas.samhsa.gov.** For more information, visit the National Inhalant Prevention Coalition Web site at **www.inhalants.org** or visit the National Institute on Drug Abuse Web site at **www.inhalants.drugabuse.gov.**

Obtaining Benefits: Help for Case Managers



Individuals who are homeless and have mental illnesses often face overwhelming challenges in obtaining disability benefits through the Social Security Administration (SSA). A complex application system, confusion over eligibility criteria, and lack of a fixed address can all create seemingly insurmountable hurdles.

A new SAMHSA manual, *Stepping Stones to Recovery: A Case Manager's Manual for Assisting Adults Who Are Homeless with Social Security Disability and Supplemental Security Income Applications,* assists case managers and other professionals in obtaining critical services for their clients. In addition, SAMHSA's Project for Assistance in Transition from Homelessness (PATH) offers curriculum training to support use of the manual.

These disability benefits through the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs often make the difference for individuals who are homeless to take the first steps toward recovery and employability and a new life of independence.

"Case managers who better understand SSA's requirements and the need for appropriate documentation can facilitate the process, decreasing the time SSA takes to issue determinations and reducing the need for appeals," said Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services (CMHS).

Historically, only about 37 percent of all applicants, and a much lower percentage of homeless applicants, are successful the first time they try to get benefits. Although some applicants appeal, and most who do obtain benefits, the appeals process can take years—while applicants continue to go without benefits.

Stepping Stones Manual

"The manual focuses on the disability eligibility criteria and the documentation process, so case managers can help applicants furnish the information that SSA needs to make a decision and determine proper benefit amounts," said Fran Randolph, Dr.P.H., Director of the CMHS Division of Service and Systems Improvement.

The manual also describes ways to ensure that people approved for disability benefits receive the correct amount and explains the appeals procedure if an individual believes an application has been denied in error.

"Although the manual is mainly for case managers working with individuals who are homeless," Dr. Randolph said, "the information will be useful for anyone who provides assistance with the disability benefit application process, as well as for applicants themselves."

SOAR-ing to New Heights

"SSI/SSDI Outreach, Access, and Recovery (SOAR) is a new SAMHSA training initiative that provides a key step in increasing access to SSA disability benefits," according to SOAR Project Director Deborah Dennis. Using the *Stepping Stones to Recovery* curriculum, trainers are now equipping case managers across the Nation with the knowledge they need to put together successful and timely benefits applications.

The curriculum gives an overview of the SSI/SSDI programs, introducing terms used by SSA. It provides strategies for engaging applicants, including interview techniques. Special attention is paid in the curriculum to co-occurring mental illnesses and substance use disorders.

The SOAR project conducted strategic planning forums in 13 states and the city of Los Angeles between September 2005 and January 2006. Each forum included SSA and Disability Determination Services representatives as well as Health Care for the Homeless grantees and PATH grantees.

In December of last year, the SOAR project held a Train-the-Trainer program to increase the capacity of states to train frontline staff in preparing disability applications. Forty-seven trainers from 14 states participated.

"This curriculum and the strategic plans that were developed during the forums are designed to increase access to SSI/SSDI for homeless people to rates of 60 to 95 percent on initial application," added Michael Hutner, Ph.D., Director of the PATH program.

SAMHSA staff will track outcomes to ensure dissemination of promising practices.

For a print version of the manual, contact SAMHSA's National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). The manual is also on SAMHSA's Web site at **http://pathprogram.samhsa.gov/SOAR/tools/manual.asp.**

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 programs, and available print and Web resources.

Are we succeeding? We'd like to know what you think.

Comments: _____

_____

_____

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_____

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

- ❑ Incarceration vs. Treatment: Drug Courts Help Substance Abusing Offenders
- ❑ Message from the Administrator: Treatment Drug Courts Yield Benefits
- ❑ Consensus Statement Defines Mental Health Recovery
- ❑ Mental Health Action Plan Meeting Held
- ❑ SAMHSA Announces Funding Opportunities
- ❑ Crisis Counseling Grants Help Hurricane Survivors
- ❑ Methamphetamine Abuse Rises
- ❑ New Treatment Reports Highlight Retirees, Youth
- ❑ Toolkit Supports Refugee Mental Health
- ❑ *Reach Out Now* Offers Materials to Schools
- ❑ Town Hall Meetings Convene on Underage Drinking
- ❑ Hepatitis Vaccination Pilot Launched
- ❑ "Partners for Recovery" Posts Web Site
- ❑ President Proposes $3.3 Billion Budget for SAMHSA
- ❑ Recovery Web Cast Focuses on Veterans
- ❑ 1.8 Million Youth Initiate Inhalant Abuse
- ❑ Obtaining Benefits: Help for Case Managers
- ❑ In Brief . . .
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Thank you for your comments!

Second Annual Voice Awards Set for August

SAMHSA has announced that the second annual Voice Awards will take place on August 23 at the Skirball Cultural Center in Los Angeles, CA.

The Voice Awards honor writers and producers of television programs and movies who provide accurate portrayals of people with mental illnesses. Nominations for the Voice Awards will be accepted through Friday, April 7, 2006.

To give voice to people with mental health problems, SAMHSA is partnering with the Writers Guild of America, West. Other organizations involved include the Ad Council, American Psychiatric Foundation, American Psychological Association, National Association of State Mental Health Program Directors, Mental Health Media Partnership, United Behavioral Health, and NARSAD—the Mental Health Research Organization.

Eligible honorees include entertainment industry writers or professionals who have created an original production that depicts recovery from mental health problems; portrays people with mental health problems in a respectful, accurate, and dignified manner; covers the topic of mental health with sensitivity and accuracy; and highlights the contributions people with mental health problems make to their families, friends, workplace, or community.

Nominations are also being accepted to honor outstanding efforts of mental health consumer leaders who have helped reduce stigma associated with mental illness.

Nominations are considered for original productions created between January 1, 2005, and December 31, 2005.

The Voice Awards are part of the National Anti-Stigma Campaign, a 3-year program sponsored by SAMHSA in conjunction with the Ad Council. Visit **www.allmentalhealth.samhsa.gov/voiceawards.**

SAMHSA Changes National Registry of Evidence-Based Programs

SAMHSA recently released a report that details changes to the Agency's National Registry of Evidence-based Programs and Practices (NREPP). The report was published in the March 14 Federal Register, and it is also available on the SAMHSA Web site.

Historically, NREPP has served as a nationally recognized tool to identify and promote interventions that work to prevent substance abuse. The new changes, which follow an extensive period of public comments, will broaden NREPP to include the latest information on the scientific basis for specific programs and interventions to prevent and/or treat mental health and substance use disorders.

The new protocols and procedures are designed to help reduce the significant lag-time between new scientific knowledge and its application by community-based prevention and treatment programs and providers. The changes provide transparency, accuracy, and timeliness of both the NREPP process and the end product—the registry itself.

For more information, including a copy of the report, click on "National Registry of Evidence-based Programs and Practices FRN" on the SAMHSA home page at **www.samhsa.gov.**

Anti-Bullying Campaign Wins Emmy Award

SAMHSA's "15+ Make Time to Listen—Take Time To Talk . . . About Bullying" multimedia campaign is the national winner of the 2004-2005 Community Service Emmy Award from the National Academy of Television Arts and Sciences.

Sponsored and produced by WJLA-TV ABC7 and SAMHSA, the campaign includes a prime-time television special, five public service announcements, and print materials, which were created to increase awareness and change behavior around bullying.

Only one national community service Emmy is presented each year to a local television station and its community organization for a campaign that provides an excellent example of outstanding social messages and services to its community.

A winner is chosen from several hundred entries by a blue-ribbon panel of judges including community leaders, clergy, educators, businesspeople, and artists.

For more information, visit the SAMHSA Web site at **www.mentalhealth.samhsa.gov/15plus/aboutbullying.asp.**

Louise Peloquin, Ph.D., Senior Public Health Advisor and Project Director for SAMHSA's 15+ Anti-Bullying campaign accepted the Community Service Emmy Award from the National Academy of Television Arts and Sciences.

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