Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

May/June 2006, Volume 14, Number 3

Employment: Help for People with Mental Illness

Very few people with the most serious mental illnesses have jobs, according to Crystal R. Blyler, Ph.D., a social science analyst in the Division of Service and Systems Improvement at SAMHSA's Center for Mental Health Services (CMHS). Yet despite the fact that these individuals want to work, they rarely receive vocational services that could help them find and keep jobs.

A CMHS-funded study called the Employment Intervention Demonstration Program (EIDP) explored ways of helping people with serious mental illnesses fulfill their employment dreams. Launched in 1995,

continued on page 2

Inside This Issue

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
- Substance Abuse and Mental Health Services Administration
- Center for Mental Health Services
- Center for Substance Abuse Prevention
- Center for Substance Abuse Treatment

www.samhsa.gov

Special Report: National Conference on Returning Veterans and Their Families

See pages 7 to 14

Help for People with Mental Illness

continued from cover page

the 5-year, multi-site study sought to answer questions about the kind of services that would be most useful in helping people with serious psychiatric diagnoses obtain and retain jobs (see *SAMHSA News,* Vol. 10, No. 1).

Now the answers are in, and they're already informing the field. Several major journal articles have recently emerged from the study, with more on the way.

"SAMHSA's vision is a life in the community for everyone, and that includes jobs for people with serious mental illnesses," said CMHS Director A. Kathryn Power, M.Ed. "This study gives us the information we need to help make that vision a reality."

An Overview of Findings

With eight sites in Arizona, Connecticut, Maine, Maryland, Massachusetts, Pennsylvania, South Carolina, and Texas, the EIDP examined the impact of innovative employment services for more than 1,600 unemployed people who had schizophrenia, bipolar disorder, major depression, or other serious mental illnesses.

The researchers randomly assigned the participants either to services-as-usual programs or to innovative "supported employment" programs combining vocational rehabilitation with clinical services and other supports. Using uniform data collection methods, the researchers then tracked participants for 2 years to see whether they were able to get and keep jobs.

The jobs weren't the kind people typically associate with disabled job-seekers, emphasized Dr. Blyler. Instead of the sheltered workshops and similar programs that were once common, the participants sought what the researchers call "competitive employment"—regular jobs open to anyone. "People with mental illnesses want to work in the mainstream with everybody else and have the same pay and the same career advancement opportunities," she said.

To help participants achieve that goal, the EIDP offered various kinds of supported employment interventions. All of the services were based on the following common principles:

Integrated services. The programs integrate employment services and mental health treatment, with co-location of services at the same agency, a single case record, and face-to-face interaction between psychiatric and vocational staff at least three times a week.

Consumer preference. The programs focus on getting participants the competitive jobs they want, with job development tailored to their own career interests and capabilities. Job hunts begin immediately after participants announce their intention to start working.

Ongoing support. Unlike some vocational services, the support doesn't stop once participants get jobs. Instead, the program provides support for as long as needed.

"Research shows that supported employment works," said Judith A. Cook, Principal Investigator for the Employment Intervention Demonstration Program's Coordinating Center.

The EIDP's major finding? According to Judith A. Cook, Ph.D., Principal Investigator of the EIDP Coordinating Center and a professor of psychiatry at the University of Illinois at Chicago (UIC), supported employment works.

In an *American Journal of Psychiatry* article co-authored by Dr. Cook, the researchers reported that participants in supported employment programs did a lot better than those in the services-as-usual comparison group.

After taking into account differences in such factors as work history and clinical status, the researchers found that participants in programs integrating psychiatric and vocational services were more than twice as likely to have competitive employment than those in the comparison group. They were also nearly 1.5 times as likely to work at least 40 hours a month. And the more vocational services they received, the better their employment outcomes.

Participants in supported employment programs also earned significantly more than their counterparts in services-as-usual programs, Dr. Cook and her co-authors reported in an article in the *Archives of General Psychiatry.* Those in supported employment programs made an average of $122 a month, compared to $99 a month for those in the comparison group.

And all of these advantages increased during the 2-year study period.

According to Dr. Cook, the EIDP study's value lay in its size. Thanks to its multi-site nature, she explained, the study was big enough to allow the researchers to examine the impact of supported employment on different subpopulations, something that can be difficult to do in smaller, single-site studies. In doing so, she added, the researchers were able to challenge some long-held beliefs in the field.

The idea that individuals with schizophrenia can't work is one example.

"There's still a very entrenched belief that people with schizophrenia can't work—that somehow that diagnosis and the impairments that accompany it make it the one diagnosis where supported employment isn't effective," said Dr. Cook. "We found that wasn't the case."

Another myth the study dispelled was the common belief that parents with mental illnesses who have young children shouldn't work. "There's been some talk that work is too stressful for parents who have a mental illness," said Dr. Cook, noting that 22 percent of the study participants had children under 18 living with them. The study found that supported employment does help parents get competitive employment, just like it does every other subpopulation—men and women, members of different racial and ethnic minorities, people with various diagnoses, individuals with a lot of work experience and those without, residents of high-unemployment areas, and those in low-unemployment areas.

Other Answers

The EIDP study also answered more specific questions:

Demographic factors. A *Community Mental Health Journal* article co-authored by UIC's Jane K. Burke-Miller, M.S., for instance, reports that certain demographic characteristics were associated with employment success.

Having any work history in the previous 5 years roughly tripled study participants' chances of getting a job, for instance. Other demographic characteristics lessened participants' chances of success. With every 10-year increment in participants' age, their chances of getting a job dropped by almost 20 percent. And those with less than a high school education were nearly 40 percent less likely to find jobs. The same characteristics also predicted who did—and didn't—work 40 hours or more a month.

Those findings have important implications for supported employment

continued on page 4

From the Administrator

Employment Can Enhance Recovery

Many people with serious mental illnesses face a dual challenge: recovery from mental illness, and recovery or acquisition of the skills and abilities needed to function successfully within the community—including the workplace.

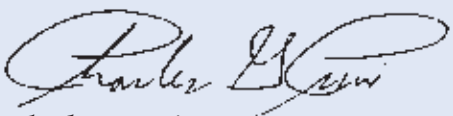
Recovery from a mental illness is a deeply personal process that means different things to different people and may entail a variety of goals. Although it may not be the best option for everyone, a job can motivate an individual to change and offers dignity, self-respect, a clear sense of identity, and hope for the future. In fact, consumers of mental health services often tell us that a job can serve as an aid to their recovery process.

Knowing that many people with serious mental illnesses want to work, what factors keep them from doing so? The stigma associated with mental illness may make employers reluctant to hire them. Loss of entitlement benefits due to increased income combined with a fear of personal failure may cause paralyzing anxiety. Mental illnesses and possible co-occurring substance use disorders may contribute to functional impairments in a person's ability to obtain and sustain a job. A lack of job training may lead to a lack of employment skills.

What are the best ways to overcome these barriers and increase employment success for people with serious mental illnesses? During the past two decades, a number of best practices have been developed, and while particular approaches may differ, those described in this issue of *SAMHSA News* suggest several common elements. These include the integration of employment services with other mental health rehabilitation services; an emphasis on individual preference and practical assistance in finding jobs; ongoing assessment and support during all phases including contemplation of employment, determination, action, maintenance, and possible relapse; and encouragement of vocational goals.

Employment requires not just the ability to perform a set of tasks, but also organizational abilities, priority setting, time management, anger management, and the ability to negotiate with others. These skills simultaneously enhance personal recovery as they contribute to vocational growth.

With the proper encouragement and support, each can nurture and strengthen the other, creating a stronger society with fewer people living in poverty and dependent on disability benefits, and resilient and self-sufficient individuals with fulfilling and satisfying lives.



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

Help for People with Mental Illness

continued from page 3

programs, the authors say. The positive effect of recent work history, for instance, supports the idea that individuals should start looking for jobs as quickly as possible. The other findings suggest the need for interventions tailored to older people and to younger people who need help completing secondary and post-secondary education.

Clinical factors. Clinical factors are another important variable, according to an article in the *Journal of Nervous and Mental Disease* co-authored by Lisa A. Razzano, Ph.D., of UIC.

Recent psychiatric hospitalizations, self-rated poor functioning, and negative psychiatric symptoms like low motivation and the monotonous voice, unvaried facial expression, and apathetic demeanor known as "flat affect" are all associated with failure to get jobs and to work at least 40 hours a month. Co-occurring medical conditions and substance abuse were also barriers to getting jobs.

These findings suggest the need to tailor supported employment programs to better fit the needs of various clinical subpopulations, say the study's authors.

Programs should also focus on helping people re-enter the workforce as soon as possible after hospitalizations. In addition, assistance with choosing appropriate jobs and designing workplace accommodations could help people get and keep jobs despite negative symptoms.

Specific services. Other articles focus not on the participants but on the services offered. A *Psychiatric Services* article co-authored by H. Stephen Leff, Ph.D., of the Human Services Research Institute in Cambridge, MA, examines the effect of two specific supported employment services: job development and job support. The researchers defined job development as contact with potential employers or networking with people who might have job information; they defined job support as counseling, support, and problem-solving.

The study's results were mixed. Study participants who received job development services were nearly five times more likely to get jobs than those who didn't, the researchers found. But while job support was associated with participants keeping their first jobs, the researchers questioned whether such services actually caused the improved retention rate.

Site Studies

Some EIDP sites have published articles drawing on data from their own geographic locations.

In an article published in *Schizophrenia Bulletin,* for instance, Paul B. Gold, Ph.D., of the Medical University of South Carolina, and other researchers there and at the South Carolina Department of Mental Health, examined the question of whether supported employment works in rural areas where job opportunities are scarce and services are limited, fragmented, and geographically dispersed.

The answer was "yes." The researchers randomly assigned participants in a rural county to receive either integrated mental health and vocational services or traditional vocational and mental health services provided by two different agencies.

Employment Resources

SAMHSA's Center for Mental Health Services (CMHS) offers a supported employment toolkit designed to help state mental health agencies and others provide help for employment.

Part of the *Evidence-Based Practice Implementation Resource Kit* series, the toolkit offers downloads of articles about supported employment plus information for consumers, families and friends, practitioners, mental health program leaders, and public mental health authorities. The site also provides information about creating supported employment programs and monitoring their effectiveness, including a workbook for practitioners.

The toolkit is available at **www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment.**

With funding from CMHS and the National Institute on Disability and Rehabilitation Research, a publication called *Seeking Supported Employment: What You Need to Know* takes the message directly to consumers themselves.

Co-authored by Judith A. Cook, Ph.D., Principal Investigator of the Employment Intervention Demonstration Program's Coordinating Center, the booklet describes the different ways of finding jobs and then offers suggestions for getting started with supported employment. A checklist allows consumers to rate how well a given program adheres to the evidence base on supported employment.

"People sometimes feel that only scientists or state administrators can understand the evidence base," said Dr. Cook, noting that consumers helped develop the resource. "What we've found is that with a little translation and the creation of an easy-to-use tool, we can really empower people and create more savvy consumers."

The publication is available online at **www.psych.uic.edu/eidp/seekingemployment.pdf.** For more information on other CMHS programs, visit the SAMHSA Web site at **www.samhsa.gov.**

They found that outcomes in this rural area were comparable to outcomes in the large urban areas where supported employment has been studied the most. Sixty-four percent of participants receiving integrated services got competitive jobs, compared to just 26 percent of those receiving parallel services. They also earned more.

Although the participants made significant progress, however, they still didn't earn enough to achieve economic independence. The authors call for public policies to reduce barriers to higher education, promote career-oriented jobs for those with serious mental illnesses, and restore benefits eligibility to those who leave Federal insurance programs to work but later suffer setbacks in their recovery.

Ongoing Data Analysis

Researchers will continue to analyze the EIDP data, said Dr. Cook. They want to study the effect employment has on people's quality of life, for instance. They also want to find ways to help people get higher-paying jobs with health insurance benefits, so it won't matter if they lose their disability benefits and access to Medicaid.

"There are many important questions we still want to address," said Dr. Cook. "After all, we devoted close to 10 years of our lives to the study."

For more information about the EIDP, visit the study's home page at **www.psych.uic.edu.** For information on mental illnesses, visit the SAMHSA Web site at **www.samhsa.gov.**

—By Rebecca A. Clay

References

Burke-Miller, J.K., et al. "Demographic Characteristics and Employment Among People with Severe Mental Illness in a Multisite Study." *Community Mental Health Journal,* 2006. Published online.

Cook, J.A., et al. "Integration of Psychiatric and Vocational Services: A Multisite Randomized, Controlled Trial of Supported Employment." *American Journal of Psychiatry,* 2005. 162(10):1948-1956.

Cook, J.A., et al. "Results of a Multisite Randomized Trial of Supported Employment Interventions for Individuals with Severe Mental Illness." *Archives of General Psychiatry,* 2005. 62:505-512.

Gold, P.B., et al. "Randomized Trial of Supported Employment Integrated with Assertive Community Treatment for Rural Adults with Severe Mental Illness." *Schizophrenia Bulletin,* 2005. Published online.

Leff, H.S., et al. "Effects of Job Development and Job Support on Competitive Employment of Persons with Severe Mental Illness." *Psychiatric Services,* 2005. 56(10):1237-1244.

Razzano, L.A., et al. "Clinical Factors Associated with Employment among People with Severe Mental Illness: Findings from the Employment Intervention Demonstration Program." *Journal of Nervous and Mental Disease,* 2005. 193(11):705-713.

START TALKING BEFORE THEY START DRINKING
www.stopalcoholabuse.gov

Report to Congress Offers Plan To Reduce Underage Drinking

Across the Nation, young people are using alcohol more than any other substance of abuse, including tobacco or illicit drugs. (See *SAMHSA News,* September/October and November/December 2005.)

As part of SAMHSA's leadership role to coordinate the Federal effort to address this problem, the Agency has delivered a new report to Congress. The report, *A Comprehensive Plan for Preventing and Reducing Underage Drinking,* outlines a detailed, goal-driven plan to reduce underage drinking.

In addition, it contains an inventory of Federal programs generated to reduce underage drinking, and an appendix of data on the subject from major Federal surveys.

Developed through the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD), the plan takes a multi-faceted, balanced approach to reduce the demand for alcohol and its availability to youth.

The plan has three primary goals:

- Strengthen a national commitment to reducing underage drinking by increasing broad-based awareness of the problem.
- Reduce demand for, availability of, and access to alcohol among those under 21.
- Leverage the power of knowledge—particularly new research, evaluation, and surveillance findings—to help make underage drinking policies and programs more effective.

To evaluate progress, the plan establishes 5-year annual performance measures and three specific targets to be achieved by 2009. Those targets include reducing the prevalence of past-month alcohol use by persons age 12 to 20 by 10 percent, as measured against the 2004 baseline of 28.7 percent.

The full report, *A Comprehensive Plan for Preventing and Reducing Underage Drinking,* is available online at **www.stopalcoholabuse.gov.**

SAMHSA Reports on Substance Use State by State

California and Wisconsin reported increases in underage alcohol use in the past month between 2002 and 2004, while Michigan and South Carolina showed decreases, according to a new state-by-state report from SAMHSA.

The report, *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health,* estimates state rates of illegal drug use, binge and underage drinking, serious mental illness, and tobacco use. SAMHSA combined 2 years of data from the annual National Survey on Drug Use and Health (NSDUH) to enhance the precision of estimates for less populous states.

The report shows that California increased from 24.7 percent of persons age 12 to 20 using alcohol in the past month to 26.3 percent, while Wisconsin increased from 34.7 percent to 38.3 percent. Michigan and South Carolina, however, showed decreases in underage drinking, from 31.8 percent to 30.2 percent for Michigan and from 27.3 percent to 24.1 percent for South Carolina.

Illinois, Nebraska, North Carolina, South Dakota, Vermont, and Virginia registered decreases in current illegal drug use among youth age 12 to 17. There were no statistically significant increases in current drug use among youth in any state, and there were no increases in either the 18 to 25 age group or the 26 and older age group.

The estimates show that past month use of any illicit drug in 2003-2004 ranged from a low of 5.8 percent in Mississippi to a high of 11.8 percent in Alaska for all persons age 12 and older. Four jurisdictions showed decreases between 2002-2003 and 2003-2004 among persons age 12 or older in current use of any illicit drug: the District of Columbia, Florida, Nevada, and Washington.

Marijuana, Cocaine, Narcotic Pain Relievers

Seven jurisdictions had decreases in the past month for use of marijuana between 2002-2003 and 2003-2004 for those age 12 and older: Colorado, the District of Columbia, Florida, Montana, Nevada, New Hampshire, and Washington.

Rhode Island had the highest percentage of persons age 12 or older using cocaine in the past year at 3.5 percent. Ohio was the only state to show a decline in the use of cocaine in the past year, changing from 2.5 percent to 2.1 percent of persons age 12 and older.

In the District of Columbia and Hawaii in 2003-2004, approximately 3.1 percent of persons age 12 or older used narcotic pain relievers nonmedically, while 6.3 percent of those in Kentucky did. Washington and Kentucky were in the highest one-fifth for use of prescription pain relievers nonmedically in all three age groups (age 12 to 17, 18 to 25, and 26 or older).

Arkansas and Maine had increases among those age 12 to 17, while California, Montana, and New York had increases in nonmedical use of prescription pain medications among those age 18 to 25. A decrease in nonmedical use of pain relievers was seen among persons age 12 and older in Hawaii (from 3.9 percent in 2002-2003 to 3.1 percent in 2003-2004).

Psychological Distress

West Virginia had the highest rate of serious psychological distress among persons age 18 and older during the past year (12.7 percent) while Hawaii had the lowest rate (7.1 percent). Increases in serious psychological distress appeared in 10 states—Arizona, California, Florida, Illinois, Iowa, New Jersey, Pennsylvania, Texas, West Virginia, and Wyoming—and were generally the result of increases among persons age 26 and older.

The full report is available on the SAMHSA Web site at **www.oas.samhsa.gov.**

The Road Home

National Conference on Returning Veterans and Their Families

SPECIAL REPORT

Community Services Provide Safety Net for Returning Veterans

When Sgt. Aundrey Sanchez tells the story of his time in Iraq, he uses certain words repeatedly: words like "pride," "patriotism," and "excitement," but also words like "fear," "sadness," and "shock." When the Army mechanic returned home to South Carolina, his wife told him he had become more aggressive and quick to anger.

"Those are changes I had to accept," said Sgt. Sanchez, who now works at an insurance company. "It was no easy transition."

Sgt. Sanchez' successful reintegration back into civilian life makes him one of the lucky ones. Some of the soldiers returning home from Iraq and Afghanistan aren't so fortunate. For them, the rigors of warfare have led to post-traumatic stress disorder (PTSD) and other psychological problems, substance abuse, even suicide.

"The duties of today's soldiers can leave footprints on their psyches," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We owe veterans more than gratitude."

To help repay that debt, SAMHSA sponsored a 3-day conference in partnership with Therapeutic Communities of America (TCA) in Washington, DC, in March. "The Road Home: The National Behavioral Health Conference on Returning Veterans and Their Families" brought together more than 1,000 community mental health and substance abuse treatment providers to discuss evidence-based strategies for restoring hope and building resiliency in veterans, active-duty service members, reservists, National Guard members, and their families.

For TCA Executive Director Linda Hay Crawford, M.Ed., the conference was a way to help providers avoid the mistakes of the past. "For many years after Vietnam, we were seeing people too late in their addictions and their PTSD," she said. "Now we want to catch problems earlier and help families be part of the solution. And

continued on page 8

"The duties of today's soldiers can leave footprints on their psyches. . . . We owe veterans more than gratitude."

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

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

continued from page 7

communities have a definite role to play in welcoming veterans home and helping families prevent behavioral health issues."

A Different Kind of War

In any war, soldiers may witness death and destruction. They may suffer injuries themselves. They may experience relentless stress.

In Iraq and Afghanistan, however, additional factors put soldiers at risk of substance abuse and mental health problems. The lack of a front line, for example, means that soldiers can face danger anywhere—even in supposedly "safe" zones. And medical advances now allow soldiers to survive catastrophic brain injuries, spinal cord injuries, and wounds that would once have been fatal.

Sgt. Audrey Sanchez

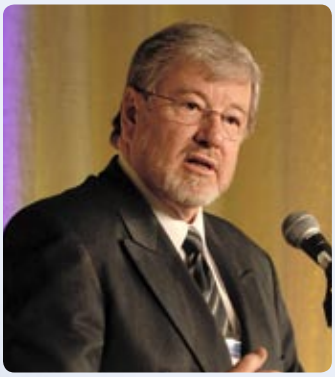
Those fighting in Iraq and Afghanistan also differ from those who fought previous wars. Today's military includes an unprecedented number of women, for instance. And soldiers are more likely than ever before to be National Guard or reserve personnel, who may not be as prepared for combat as regular troops. In fact, roughly half of the 150,000 troops in combat are National Guard members and reservists, according to Richard Steinberg, M.Ed., Immediate Past President of TCA and President and Chief Executive Officer of WestCare.

Most returning veterans do just fine, emphasized H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT). But for some, war's psychological impact can be serious and long-lasting.

Antonette Zeiss, Ph.D.

And most can benefit from support as they make the transition back to civilian life. "During war, soldiers may dream of returning home," said Dr. Clark. "When they return, they often find that things aren't as ideal as they remembered." In addition to problems with money, marriages, child-rearing, jobs, housing, and the like, veterans may feel alienated from family, friends, and society.

Mental disorders are one of the top three conditions that lead veterans to seek care from the U.S. Department of Veterans Affairs (VA), explained Antonette Zeiss, Ph.D., Deputy Chief Consultant in the Office of Mental Health Services at the VA Central Office. Within that category, PTSD is by far the most common diagnosis. Veterans also come in complaining



Richard Steinberg, M.Ed.


Gary M. Baker, M.A.


Gen. Barry McCaffrey (Ret.)


Beverly Watts Davis
Senior Advisor to the SAMHSA Administrator

of depression, anxiety, mood disorders, sexual dysfunction, and substance abuse.

A Critical Safety Net

The military system has plenty of help to offer veterans who experience problems with mental health, substance abuse, or the transition to civilian life.

In addition to rigorous predeployment screening to identify those with pre-existing mental health problems, the U.S. Department of Defense (DoD) screens personnel once a year during active duty, at discharge, and again 3 to 6 months later. The goal? To catch problems early.

Veterans who need mental health or substance abuse treatment then receive care at the Veterans Health Administration (see Veterans Resources, page 14). Medical facilities there offer care for mental health and substance abuse issues as well as care for specialized PTSD problems. In addition, care is available through a network of private providers participating in the DoD's TriCare program.

More informal assistance is available through the 207 Veterans Centers around the country, where veterans offer peers both readjustment counseling and help accessing other programs.

Community mental health and substance abuse treatment providers can supplement this care by serving as a critical "safety net," explained Mr. Steinberg.

To play that role effectively, community providers need to become knowledgeable about the resources available to returning veterans and the rules for using them.

They need to know that veterans aren't automatically eligible for VA care, for instance. "In general, the veteran must take the first step and apply for the benefit," explained Gary M. Baker, M.A., Director of the VA's Health Eligibility Center.

Iraq and Afghanistan combat veterans—including active-duty military with honorable discharges, reservists who completed their tours, and National Guard members activated for Federal duty—have certain privileges. There's a special rule that gives them priority access and no-cost care of combat-related problems for the 2 years following their discharge. The only catch? They must register in the VA system within 2 years of discharge or risk losing access to VA care later on. This 2-year "window" is covered through the military treatment facilities and TriCare, along with the VA. More information on this topic is available on the DoD and VA Web sites.

In addition to screening veterans and referring them to DoD or VA facilities for care, community providers also need to be ready to provide services themselves. That's because some veterans return to geographically isolated communities where VA services aren't available. Others aren't eligible for services even if they are available. Stigma, denial, or anger at the military keep others away. And symptoms of PTSD may not show up until long after the war is over.

Community providers should routinely ask clients—both men and women—whether they've served in the military or experienced trauma. They should also assess them for PTSD, other mental disorders, and substance abuse. "If you don't ask," said Dr. Clark, "they're not going to tell."

And not asking could prove fatal, warned Col. Jonathan W. Coffin, Ph.D., staff psychologist for the Vermont National Guard and Outpatient Director at the Howard Center. "I guarantee that every one of you will have the opportunity to save a veteran's life," he said.

A Warm Welcome Home

Veterans aren't the only ones local providers and the community as a whole can help: Families of active-duty service members and veterans may also need support.

That's a message Susan A. Storti, Ph.D., R.N., Director of the CSAT-funded Addiction Technology Transfer Center of New England, has taken to heart.

When her fiancé was deployed with the Rhode Island National Guard, she jumped into action. She assessed the needs of soldiers, veterans, and their families; identified available resources; and helped create a "Rhode Island Blueprint" to fill the gaps.

continued on page 10


Susan A. Storti, Ph.D., R.N.

continued from page 9

Now the entire community is involved in welcoming veterans home and supporting families while they're gone. Experts train community providers in such areas as traumatic brain injury. Support groups give families tips on stress management and opportunities to vent. Researchers are studying ways of enhancing resilience in children. Even the local theater company has gotten into the act, with a play drawing on the words of soldiers, journalists, and others who have been to Iraq.


Major Gen. Arthur T. Dean (Ret.)

Simply welcoming veterans home can help, said Major Gen. Arthur T. Dean (Ret.), Chairman and Chief Executive Officer of Community Anti-Drug Coalitions of America.

"The way many of my contemporaries were received when they came back from Vietnam set them up for failure," he said. "We can all participate in welcoming and embracing today's troops as they return home."

Dr. Clark agreed. "With the active cooperation of all of society," he said, "the road home for our veterans can be further improved and the journey home can be made easier."

Electronic files of the presentations from the conference are available online at the SAMHSA Web site, **http://www.samhsa.gov/conference/va_conference.**

—By Rebecca A. Clay

Resources

Deployment Health Clinical Center
www.pdhealth.mil
(866) 559-1627

General Information 24/7
www.MilitaryOneSource.com
(800) 342-9647

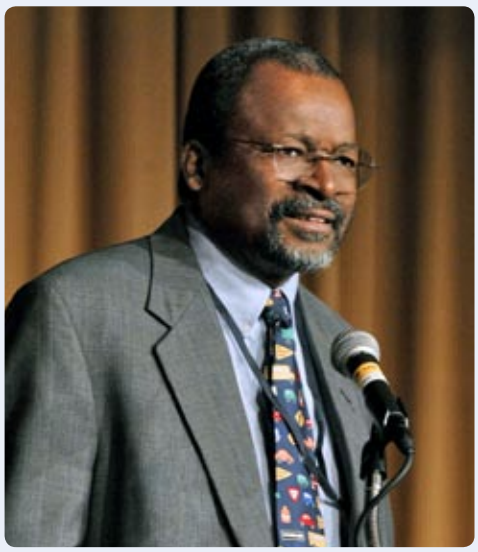
National Center for PTSD
www.ncptsd.va.gov
(802) 296-6300

SAMHSA's National Clearinghouse for Alcohol and Drug Information
www.health.org
(800) 729-6686
TDD: (800) 487-4889

SAMHSA's National Mental Health Information Center
www.mentalhealth.samhsa.gov
(800) 789-2647
TDD: (866) 889-2647

VA Health Eligibility Center
www.va.gov/healtheligibility/HECHome.htm
(877) 222-8387

VA Office of Seamless Transition
www.seamlesstransition.va.gov


H. Westley Clark, M.D., J.D., M.P.H.
SAMHSA's CSAT Director

"With the active cooperation of all of society, the road home for our veterans can be further improved and the journey home can be made easier."

—H. Westley Clark, M.D., J.D., M.P.H.
CSAT Director

Addressing Special Needs of Veterans

When veterans need help, the concerns they express are often ones that providers find especially challenging.

A panel presentation at "The Road Home: National Behavioral Health Conference on Returning Veterans and Their Families" offered an introduction to some of these issues: post-traumatic stress disorder (PTSD) and homelessness.

PTSD

Bert Bauer, L.C.S.W., a social work officer for the Army Reserve's 3rd Medical Command and a clinical social worker at Pathways Transition Programs, provided an overview of PTSD.

A one-time traumatic event can lead to PTSD, he emphasized, but so can ongoing stress. A harsh climate, austere living conditions, constant danger, the low tolerance for errors—these and other stressors add up. "We need to think about how people get worn down during their deployments," said Mr. Bauer.

Bert Bauer, L.C.S.W.

Some people are at even higher risk. Some are just biologically predisposed to PTSD, said Mr. Bauer. Past experiences can also increase risk: People who have already been traumatized run the risk of being retraumatized during wartime. "Citizen soldiers"—those serving in the National Guard or the Reserves—are another high-risk group. "One day they own a shop; the next day they get an order and they're off to battle," said Mr. Bauer. Both reservists and active-duty personnel need more preparation about what to expect, he added.

Another potential cause of PTSD is military sexual trauma. Defined as physical assault of a sexual nature or sexual harrassment of a threatening character committed by one's colleagues during military training or service, this type of trauma is now receiving greater attention, explained Susan J. McCutcheon, Ed.D., R.N., Program Manager for Special Projects in the Office of Mental Health Services at the U.S. Department of Veterans Affairs (VA).

Carol Davidson, L.C.S.W., CASAC

It's important to screen all veterans for military sexual trauma, added Dr. McCutcheon, noting that the VA has specialized sexual trauma programs. "Statements like 'Violence is common in our society, so I ask all my patients about this' can help normalize screening," she said.

Homelessness

Some veterans don't seek help until PTSD, substance abuse, and other problems have robbed them of everything, including their homes.

Carol Davidson, L.C.S.W., CASAC, shared what she has learned about this population

continued on page 12

Susan J. McCutcheon, Ed.D., R.N.

Addressing Special Needs

continued from page 11

as Program Director of Samaritan Village Veterans Program, a 48-bed residential treatment program for veterans with drinking or drug problems and a history of homelessness.

Peer-to-peer assistance lies at the heart of this "therapeutic community" approach. "We talk so much about veterans' problems, but not enough about their strengths, such as their camaraderie," said Ms. Davidson. "Veterans understand each other in ways no one else can."

That understanding helps veterans overcome a major barrier to treatment: their unwillingness to talk about secret, shameful, or literally unspeakable matters with outsiders.

Sharing stories helps veterans make sense of their experiences, said Ms. Davidson, adding that the great thing about residential treatment is that participants don't have to go home after sessions.

"In combat, it's about staying alive and fulfilling the mission," she explained. "There's very little time for grieving or expressing feelings."

—By Rebecca A. Clay

Preventing Suicide among Veterans

A workshop on suicide prevention and mental health promotion at "The Road Home: The National Behavioral Health Conference on Returning Veterans and Their Families" presented some of the military's current strategies for helping veterans cope.

Richard T. McKeon, Ph.D., M.P.H., Special Expert in the Prevention Initiatives and Priority Programs Development Branch at SAMHSA's Center for Mental Health Services (CMHS), moderated the panel of experts.

A New Attitude

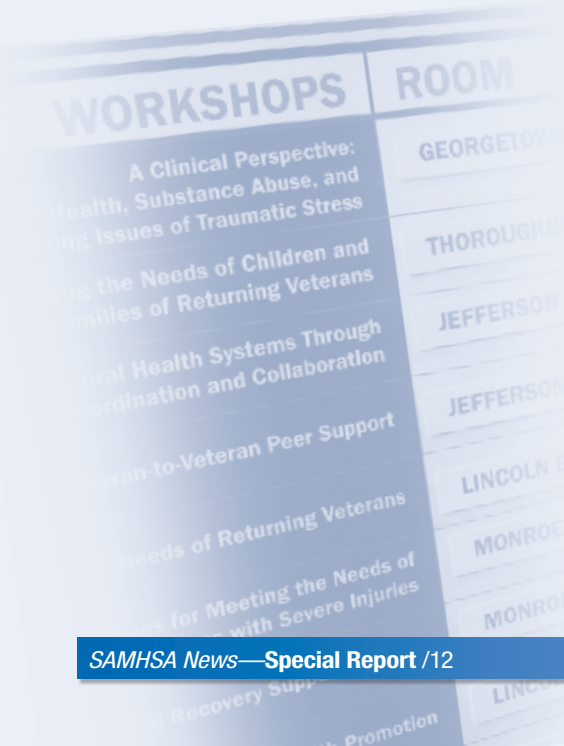
The military's attitude toward suicide prevention has changed dramatically, said Col. Robert R. Ireland, M.D., D.Min., Program Director for Mental Health Policy in the Office of the Assistant Secretary for Health at the U.S. Department of Defense.

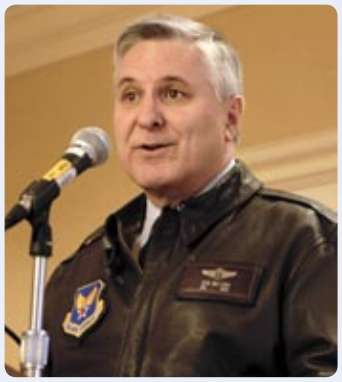
In the old days, he said, leaders often wouldn't tolerate any sign of weakness among the troops. In contrast, today's leaders make it widely known that they want people to take care of themselves. "If you're a lousy shot, you go out on the range and practice," said Col. Ireland. "If you're having mental health problems, you work on that."

Each of the Nation's armed services—Army, Navy, Marines, and Air Force—has its own suicide prevention program, but they share common elements. "Suicide prevention is more than just getting people together and saying, 'Don't kill yourselves,' " said Col. Ireland.

His own approach emphasizes informality, part of his effort to make mental health providers more approachable. He writes scripts of hard-times scenarios and asks volunteers to act out the over-the-top tales of failing marriages, troubled kids, and financial woes. By customizing the scripts for each locale, he helps units visualize what trouble might look like and how they should respond.

Educating leaders is also key. The Air Force, for instance, has a "Leader's Guide for Managing Personnel in Distress," which lists common sources of trouble, danger signs, and




Col. Robert R. Ireland, M.D., D.Min.

supportive actions leaders should take. "It's cookbook mental health," said Col. Ireland.

At the Clinical Level

Lawrence E. Adler, M.D., Director of the Veterans Integrated Service Network 19 Mental Illness Research, Education, and Clinical Center at the U.S. Department of Veterans Affairs, then shifted the discussion to the clinical level.

About 90 percent of people who die from suicide have at least one of the serious mental illnesses in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* said Dr. Adler, noting that such disorders often have genetic components. Because psychiatric illnesses significantly increase the chance


Lawrence E. Adler, M.D.

of suicide, Dr. Adler emphasized, early identification and intervention are critical.

Other conditions, such as AIDS, brain and spinal cord injuries, and sexual trauma, also increase the risk of suicide. So do alcohol and substance abuse. And so does access to weapons. Signs of potential trouble include impulsivity, aggression, accidents, and withdrawal. Clinicians even need to be aware of geographic risk factors, said Dr. Adler.

He pointed out that rural areas and western states have higher suicide rates.

Clinicians should also understand that behaviors that seem illogical may make sense to patients, said Dr. Adler. He described one patient who had a loaded pistol on the seat of his car and a disconcerting habit of avoiding traffic jams by veering into the wrong lane.

"What do I tell him—that we can get him on medication and relaxed?" Dr. Adler asked. The paradox is that in wartime such behavior makes perfect sense for survival. "If this patient stops acting like that, he'll be in grave danger once he goes back."

—By Rebecca A. Clay

Resources

SAMHSA's National Suicide Prevention Lifeline
www.suicidepreventionlifeline.org
(800) 273-8255
TTY: (800) 799-4889

Air Force Suicide Prevention Program
http://afspp.afms.mil

Army Center for Health Promotion and Preventive Medicine
http://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx
(410) 671-4656

Navy Environmental Health Center
www-nehc.med.navy.mil/hp/suicide
(757) 953-0959

Marine Corps Suicide Prevention Program
www.usmc-mccs.org/suicideprevention/ml/index.cfm

Centers for Disease Control and Prevention
www.cdc.gov/ncipc/factsheets/suicide-overview.htm
(800) 232-4636
TTY: (888) 232-6348

National Institute of Mental Health
www.nimh.nih.gov/suicideprevention
(866) 615-6464
TTY: (866) 415-8051

National Center for PTSD
www.ncptsd.va.gov/facts/problems/fs_suicide.html
(802) 296-6300

Resources for Veterans

U.S. Department of Health and Human Services (HHS)

(877) 696-6775 (toll-free)
www.hhs.gov

SAMHSA

SAMHSA's publications on veterans include several short reports from the Agency's Office of Applied Studies (OAS). Recent reports include *Substance Use, Dependence, and Treatment among Veterans* and *Alcohol Use and Alcohol-Related Risk Behaviors among Veterans* (see *SAMHSA News,* January/February 2006). Visit SAMHSA's Web site at **www.oas.samhsa.gov** for a complete list under the topic "Veterans." Other SAMHSA resources include:

SAMHSA's National Mental Health Information Center
(800) 789-2647 (toll-free)
(240) 276-2550
www.mentalhealth.samhsa.gov

SAMHSA's National Clearinghouse for Alcohol and Drug Information
(800) 729-6686 (toll-free)
(800) 487-4889 (TDD) (toll-free)
(877) 767-8432 (Spanish) (toll-free)
www.ncadi.samhsa.gov

SAMHSA's National Helpline
(800) 662-HELP (4357) (toll-free)
(English and Spanish)
(800) 487-4889 (TDD) (toll-free)

SAMHSA's Substance Abuse Treatment Facility Locator
This is a searchable directory of alcohol and drug treatment programs.
www.findtreatment.samhsa.gov

Other Federal Agencies

U.S. Department of Defense (DoD)
Main Office: (703) 681-0064
www.defenselink.mil

Office of Assistant Secretary of Defense for Public Affairs
(703) 428-0711
www.defenselink.mil/pubs/almanac/asdpa.html

United States Army
Army Center for Substance Abuse Programs (ACSAP)
(703) 681-5583
http://acsap.army.mil

United States Marine Corps
Marine Corps Community Services (MCCS)
(703) 784-9526
www.usmc-mccs.org

United States Navy
Navy Alcohol and Drug Abuse Prevention Program (NADAP)
www.npc.navy.mil/commandsupport/NADAP

U.S. Department of Veterans Affairs (VA)
VA Benefits: (800) 827-1000 (toll-free)
www.va.gov

Non-Government Resources

AMVETS
(301) 683-4030
www.amvets.org

Disabled American Veterans (DAV)
(859) 441-7300
www.dav.org

National Alliance on Mental Illness (NAMI)
(800) 950-NAMI (6264) (toll-free)
www.nami.org

National Coalition for Homeless Veterans (NCHV)
(800) VET-HELP (838-4357) (toll-free)
www.nchv.org

National Mental Health Association (NMHA)
(800) 969-NMHA (6642) (toll-free)
(800) 433-5959 (TTY)
www.nmha.org

National Veterans Foundation (NVF)
(877) 777-4443 (toll-free)
www.nvf.org

Recovery Month Includes Veterans

National Alcohol and Drug Addiction Recovery Month (Recovery Month), held annually in September, is a celebration of people and families in recovery from substance use disorders.

Military personnel, veterans, supporting organizations, health care providers, and family members can contribute to *Recovery Month* in many ways. For example, veterans can share their stories with other military personnel and veterans who may have a substance use or mental health disorder or a co-occurring disorder.

SAMHSA is offering an outreach information fact sheet on substance use and co-occurring disorders among veterans and the military in this year's *Recovery Month* comprehensive planning toolkit.

The fact sheet, "Substance Use and Co-Occurring Disorders Among Military and Veterans," presents reasons for veterans' susceptibility to substance use disorders, barriers to treatment, stigma, and stress-related problems. For health care providers, the fact sheet also explains the need to screen veterans for substance use.

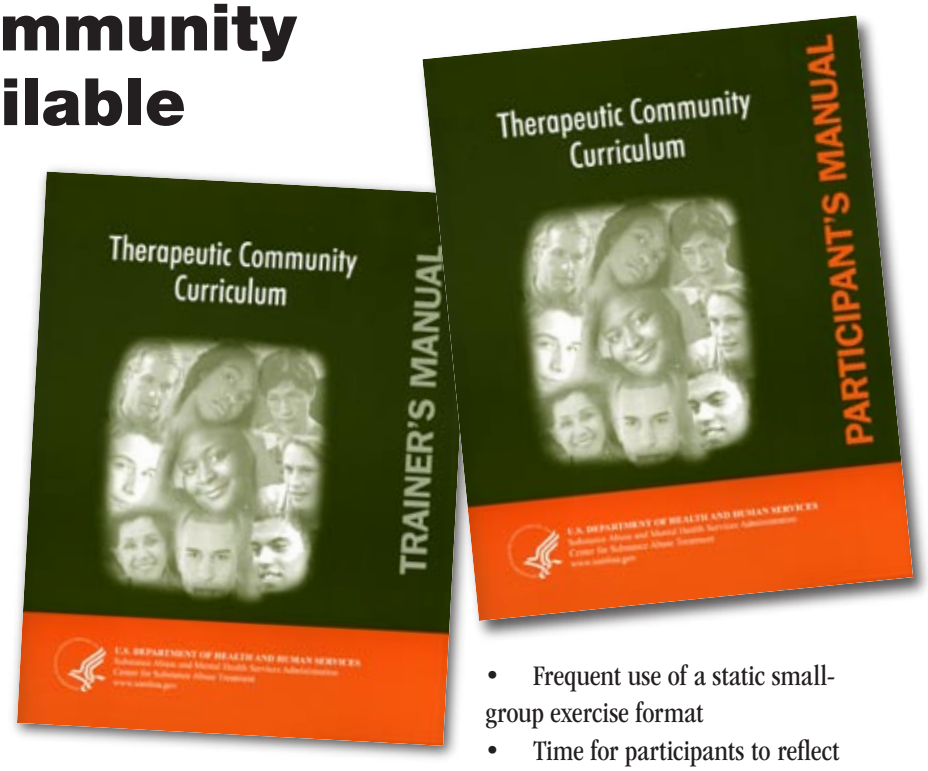
Statistics and data are included from SAMHSA's National Survey on Drug Use and Health, the U.S. Veterans Administration, and the Department of Defense as well as a variety of other published reports and studies.

The fact sheet is available on the *Recovery Month* Web site at **www.recoverymonth.gov/2006/kit/html/targeted_outreach/military.aspx.**

For *Recovery Month* information and materials, visit the *Recovery Month* Web site at **www.recoverymonth.gov** or call 1 (800) 662-HELP (4357).

Conference photos on pages 7 to 13 by David Kasamatsu for SAMHSA. Photo illustration on page 7 by A. Martín Castillo.

Therapeutic Community Curriculum Available



SAMHSA recently released the *Therapeutic Community Curriculum* training package to meet the need for training entry-level staff in the basics of the therapeutic community model of treatment.

The long tradition of community as a method of treatment fosters personal growth by changing an individual's lifestyle through a community of concerned people working together to help themselves and each other.

Therapeutic communities have evolved to serve an ever-increasing range of special populations with substance use disorders, including women with children, older adults, adolescents, people with co-occurring mental disorders, people with HIV/AIDS, people who are homeless, and people involved with the criminal justice system.

The newly released training package was developed in response to a need for a document based on Therapeutic Community principles. SAMHSA's Center for Substance Abuse Treatment (CSAT) and a panel of experts met in 2000 to provide guidance for the initial development of the curriculum. Only experienced trainers who are familiar with the therapeutic community treatment model should present the curriculum, which is geared primarily toward clinical and nonclinical staff working in a therapeutic community for the first time.

The curriculum provides an understanding of the essential components and methods of the therapeutic community model. Its primary goals are to provide a common knowledge base for all staff members working in these communities and to encourage training participants to work on their professional growth and development.

The package contains a trainer's manual, a participant's manual that can be photocopied for each training participant, and a CD-ROM with PowerPoint presentations for the modules. The PowerPoint slides also can be printed and copied onto overhead transparencies.

The trainer's manual includes general preparation instructions and two appendices ("Ice Breakers" and "Positive Visualizations") that are applicable to all modules. In addition, each module includes detailed, session-specific instructions for trainers; exercises for participants; a module overview, including goals and objectives and a content timeline; and the presentation. The participant's manual includes the participant orientation, resource sheets, module summaries, and a module review, which functions as a learning assessment.

The curriculum comprises 11 modules designed to allow for flexible delivery schedules. The complete in-service training can be delivered over several consecutive days or can be offered over the course of several weeks or months. Each module also can be used separately to target a specific training need. This learning approach includes:

- A mixture of presentations, discussions, and exercises to simulate the self-help and mutual self-help learning processes used in therapeutic communities
- Frequent use of a static small-group exercise format
- Time for participants to reflect on and write their thoughts and feelings in personal journals
- An assessment of learning to be completed by participants in their small groups at the end of each session.

Participants who complete the training will experience and understand the therapeutic community process through participation in simulations and role-plays and will experience an enhanced sense of belonging to a therapeutic community. Although the curriculum is designed as an entry-level training, it is not intended to take the place of immersion or other clinical skills training or ongoing clinical supervision.

The *Therapeutic Community Curriculum* training package is available free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD for hearing impaired). Ask for NCADI Publication No. BKD533 (trainer's manual) or BKD534 (participant's manual). The curriculum also can be downloaded from SAMHSA's KAP Web site at **www.kap.samhsa.gov.**

—By Riggin Waugh

Community-Based Care Helps Children

As part of the first-ever National Children's Mental Health Awareness Day, SAMHSA released data showing that children and youth with serious mental health needs make substantial improvements through community-based services.

SAMHSA presented the findings at a special briefing on Capitol Hill hosted by the Federation of Families for Children's Mental Health, the National Mental Health Association (NMHA), the National Association of Social Workers (NASW), and the National Alliance on Mental Illness (NAMI).

The SAMHSA data, from the Agency's 2005 national evaluation of the Comprehensive Community Mental Health Services Program for Children and Their Families, show that children and youth in "systems of care" spend less time in inpatient mental health care, experience fewer arrests, make improvements in their overall mental health, and do better in school than before enrollment in the program.

A system of care is a coordinated network of community-based services. Families and youth work in partnership with both public and private organizations so that services and supports are effective, build on an individual's strengths, and address each person's cultural and linguistic needs.

"The systems of care approach helps children thrive in their homes and communities. It is a wise investment of scarce resources," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

2005 Key Outcomes

The SAMHSA data suggest that systems of care save taxpayers money when compared to the traditional mental health service delivery systems. In 2005, for children and families in systems of care programs, positive outcomes included the following:

- **Reduced costs due to fewer days in inpatient care.** The average reduction in per-child inpatient hospital days from entry into services to 12 months translated into an average per-child cost savings of $2,776.85.
- **Decreased use of inpatient facilities.** The percentage of children who used inpatient facilities within the previous 6 months decreased 54 percent from entry into systems of care to 18 months after systems of care.
- **Reduced arrest results in per-child cost savings.** From entry into systems of care to 12 months after entry, the average reduction in number of arrests per child within the prior 6 months translated into an average per-child cost savings of $784.16.
- **Mental health improvements sustained.** Emotional and behavioral problems were reduced significantly or remained stable for nearly 90 percent of children after 18 months in systems of care.
- **Suicide-related behaviors were significantly reduced.** The percentage of children and youth who had deliberately harmed themselves or had attempted suicide decreased 32 percent after 12 months in systems of care.
- **School attendance improved.** The percentage of children with regular school attendance (i.e., 75 percent of the time or more) during the previous 6 months increased nearly 10 percent with 84 percent attending school regularly after 18 months in systems of care.
- **School achievement improved.** The percentage of children with a passing performance (i.e., C or better) during the previous 6 months increased 21 percent, with 75 percent of children passing after 18 months in systems of care.
- **Significant reductions in juvenile detention.** Children and youth who were placed in juvenile detention or other secure facilities within the previous 6 months decreased 43 percent from entry into services to 18 months after entering systems of care.

Plans are under way to make Children's Mental Health Awareness Day an annual event during Children's Mental Health Awareness Week, which is the first week in May (Mental Health Month). For 2007, the event is scheduled for May 8.

For more information on these SAMHSA data or the Comprehensive Community Mental Health Services Program for Children and Their Families, visit the SAMHSA Web site at **www.systemsofcare.samhsa.gov.**

Updates on SAMHSA Grants

Funding Opportunities

SAMHSA recently announced the following funding opportunities for Fiscal Year 2006.

Three Suicide Prevention grants are authorized under the Garrett Lee Smith Memorial Act, which provides funding for programs to prevent suicide. They are administered by SAMHSA's Center for Mental Health Services (CMHS):

- **State/Tribal Youth Suicide Prevention** (Application due date: May 16, 2006)—Up to 12 cooperative-agreement grant awards, for up to $400,000 per year for up to 3 years, for state-sponsored youth suicide prevention and early intervention programs. The grants will be used to build on the foundation of prior suicide prevention efforts by states and tribes to develop and implement statewide or tribal youth suicide prevention. (SM-06-005, $4.8 million)
- **Campus Suicide Prevention** (Application due date: May 16, 2006)—Approximately 31 grant awards for $75,000 each for Fiscal Year 2006, plus an equivalent match from the applicant organization. These grants provide funding to institutions of higher education to enhance services for students with mental and behavioral health problems, such as depression, substance abuse, and suicide attempts. (SM-06-004, $2.3 million)
- **Hurricane Katrina-related Suicide Prevention** (Application due date: June 1, 2006)—2 cooperative agreement grant awards, for approximately $400,000 for up to 3 years, for Hurricane Katrina-related state-sponsored youth suicide prevention and early intervention. (SM-06-010, $800,000)

Other funding opportunities include:

- **Targeted Capacity Expansion for Treatment of HIV/AIDS Services** (Application due date: May 16, 2006)—Up to 12 awards, for $500,000 per year for up to 5 years, to enhance and expand substance abuse treatment, and outreach and pretreatment services in conjunction with HIV/AIDS services in African American, Latino/Hispanic, and other racial or ethnic communities highly affected by the related epidemics of substance abuse and HIV/AIDS. These grants will be administered by SAMHSA's Center for Substance Abuse Treatment (CSAT). (TI-06-010, $5.3 million)
- **Prevention of Methamphetamine Abuse** (Application due date: May 16, 2006)—9 to 11 grant awards, from $300,000 to $350,000 per year for up to 3 years, to support expansion of methamphetamine prevention interventions and/or infrastructure development. The grants, administered by SAMHSA's Center for Substance Abuse Prevention, will help communities expand prevention interventions. (SP-06-005, $3.3 million)
- **Treatment of Pregnant and Postpartum Women** (Application due date: May 16, 2006)—Up to 8 grant awards, for $500,000 per year for up to 3 years, to expand the availability of comprehensive, high-quality, residential treatment services for pregnant and postpartum women who suffer from alcohol and other drug use problems, and for their minor children affected by prenatal and environmental effects of maternal substance use and abuse. These grants will be administered by SAMHSA's CSAT. (TI-06-008, 3.4 million)

Applications are available by calling SAMHSA's clearinghouse at 1 (800) 789-2647, or by downloading the application from **www.grants.gov** or the SAMHSA Web site at **www.samhsa.gov.** Applicants are encouraged to apply online at **www.grants.gov.**

Awards

SAMHSA recently announced the following grant awards:

- **For Suicide Prevention**—$9.6 million over 3 years for 8 new grants to support youth suicide prevention and early intervention programs nationally. This program is authorized under the Garrett Lee Smith Memorial Act and will be administered by CMHS. Additional 2006 awards are under review.
- **For Jail Diversion**—$7.2 million over 3 years to divert individuals with mental illness away from the criminal justice system and into community-based mental health and substance abuse treatment services. Grantees will coordinate with social service agencies to ensure that life skills training, housing placement, vocational training, job placement, and health care are available.
- **For Crisis Counseling for Hurricane Survivors**— SAMHSA, in partnership with the Federal Emergency Management Agency, awarded an additional $2.8 million in crisis counseling grants in the aftermath of Hurricanes Katrina, Rita, and Wilma.

This brings the total amount awarded for "Regular Services" crisis counseling grants to more than $60 million. When combined with the early round of "Immediate Services" crisis counseling grants, over $100 million has been made available in Federal crisis counseling support.

New grants include: "Project Rebound" in Alabama approved for $976,491 to provide crisis counseling services as well as an additional $1.43 million in a separate grant award. "Reaching Out . . . Nebraska" was approved for $257,339. And, Iowa was approved for $206,636 to provide counseling to hurricane evacuees.

For updated information on grant awards, visit SAMHSA's Web site at **www.samhsa.gov/grants.**

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: _____

_____

_____

I'd like to see an article about: _____

_____

_____

Name and title: _____

Address and affiliation: _____

_____

Phone number: _____ Email address: _____

Field of specialization: _____

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

- ❑ Employment: Help for People with Mental Illness
- ❑ Report to Congress Offers Plan To Reduce Underage Drinking
- ❑ SAMHSA Reports on Substance Use State by State
- ❑ Therapeutic Communitiy Curriculum Available
- ❑ Community-Based Care Helps Children
- ❑ Updates on SAMHSA Grants
- ❑ In Brief . . .

The Road Home: National Conference on Returning Veterans and Their Families

- ❑ Community Services Provide Safety Net for Returning Veterans
- ❑ Addressing Special Needs of Veterans
- ❑ Preventing Suicide among Veterans
- ❑ Resources for Veterans
- ❑ Recovery Month Includes Veterans

❑ ***SAMHSA News*** online—for the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

Mail, phone, fax, or email your response to:

SAMHSA News
Room 8-1037
1 Choke Cherry Road
Rockville, MD 20857
Phone: (240) 276-2130
Fax: (240) 276-2135
Email: *deborah.goodman@samhsa.hhs.gov*

Thank you for your comments!

Summit To Discuss Disaster Preparedness

SAMHSA is convening a national summit in New Orleans from May 22 to 24 to help states and U.S. territories assess the progress made on their disaster preparedness behavioral health plans. Existing barriers and needs in the planning process will also be addressed.

Fifty-four states and territories are sending governor-appointed teams of mental health, substance abuse, and other professionals to participate.

In a peer-to-peer environment, participants will:

- Review lessons learned from Hurricanes Katrina, Rita, and Wilma.
- Identify opportunities for consolidation of the ongoing response to behavioral health issues resulting from the 2005 hurricanes.
- Strategize "all-hazards preparedness" efforts for future disasters.

For more information, visit the SAMHSA Web site at **www.samhsa.gov** or **www.spiritofrecoverysummit.com.**

SAMHSA Hosts HBCU Conference

The 8th Annual Lonnie E. Mitchell National Historically Black Colleges and Universities (HBCU) Substance Abuse and Mental Health Conference, funded by SAMHSA, convened in Washington, DC, in April.

The conference was sponsored through a SAMHSA grant to Morehouse School of Medicine, in partnership with all 104 HBCUs.

This year's theme, "The Time is Now! Moving the Issues of Substance Abuse and Mental Health to the Forefront of Society," presented participants with the opportunity to focus on the community impact of substance abuse and mental health.

In his keynote address, H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT), said communities should be "invested in tomorrow."

The conference assists HBCUs in developing strategies to deal with alcohol and drug abuse problems facing the local, state, and national population.

The conference continues the legacy and work of the late Lonnie E. Mitchell, Ph.D., M.A., an esteemed educator, administrator, and psychotherapist. For more information on the conference, visit **www.msm.edu/lem.**

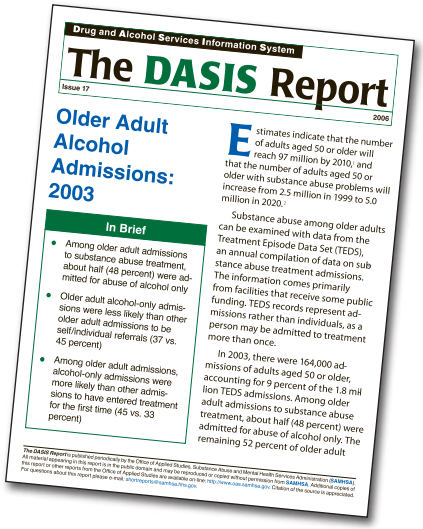
Photo by *SAMHSA News*

CSAT Director H. Westley Clark answers a question from CSAT staff member Rosallah Karim before his keynote address at the HBCU Conference in Washington, DC.

Older Adult Treatment Admissions: Almost Half for Alcohol

According to a recent SAMHSA report, almost half of the admissions to substance abuse treatment among people age 50 and up were specifically for alcohol abuse (48 percent of 164,000 admissions in 2003).

The report, *Older Adult Alcohol Admissions: 2003,* also notes that older adults in this age group admitted to substance abuse treatment solely for alcohol abuse were more likely to be first-time treatment participants than were persons admitted for other reasons.



Drug and Alcohol Services Information System

The DASIS Report

Issue 17 2006

Older Adult Alcohol Admissions: 2003

In Brief

- Among older adult admissions to substance abuse treatment, about half (48 percent) were admitted for abuse of alcohol only
- Older adult alcohol-only admissions were less likely than other older adult admissions to be self/individual referrals (37 vs. 45 percent)
- Among older adult admissions, alcohol-only admissions were more likely than other admissions to have entered treatment for the first time (45 vs. 33 percent)

Estimates indicate that the number of adults aged 50 or older will reach 97 million by 2010,[1] and that the number of adults aged 50 or older with substance abuse problems will increase from 2.5 million in 1999 to 5.0 million in 2020.[2]

Substance abuse among older adults can be examined with data from the Treatment Episode Data Set (TEDS), an annual compilation of data on substance abuse treatment admissions. The information comes primarily from facilities that receive some public funding. TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once.

In 2003, there were 164,000 admissions of adults aged 50 or older, accounting for 9 percent of the 1.8 million TEDS admissions. Among older adult admissions to substance abuse treatment, about half (48 percent) were admitted for abuse of alcohol only. The remaining 52 percent of older adult

The full report, from continued analysis of the 2003 Treatment Episode Data Set (TEDS), is available from SAMHSA's Office of Applied Studies at **www.oas.samhsa.gov.**

More information about aging, alcohol, and drugs can be found on the SAMHSA Web site at **http://asyouage.samhsa.gov.** For a free copy of the brochure, *As You Age . . . A Guide to Aging, Medicines, and Alcohol,* call 1 (800) 662-HELP (4357).

SAMHSA's home page at **www.samhsa.gov** (click on "Older Adults") presents the Agency's *Action Plan for Older Adults for Fiscal Years 2006 and 2007.*

SAMHSA NEWS

Published bimonthly by the Office of Communications

Articles are free of copyright and may be reprinted. Please give proper credit.

Send reprints to:

Editor, *SAMHSA News*
Room 8-1037
1 Choke Cherry Road
Rockville, MD 20857

Substance Abuse and Mental Health Services Administration
Charles G. Curie, M.A., A.C.S.W., Administrator

Center for Mental Health Services
A. Kathryn Power, M.Ed., Director

Center for Substance Abuse Prevention
Dennis O. Romero, M.A., Acting Director

Center for Substance Abuse Treatment
H. Westley Clark, M.D., J.D., M.P.H., Director

Editor
Deborah Goodman

SAMHSA News Team
at IQ Solutions, Inc.:
Managing Editor, Meredith Hogan Pond
Publication Designer, A. Martín Castillo
Publications Manager, Mike Huddleston

Your comments are invited.
Phone: (240) 276-2130
Fax: (240) 276-2135
Email: *deborah.goodman@samhsa.hhs.gov*

To receive *SAMHSA News* or to change your address:

Web: Go to **www.samhsa.gov**
Click on "Mailing List: Sign Up!"

Email: Send your subscription request or address change to **SAMHSAnews@iqsolutions.com**
Include your mailing address with your name, street, apartment number, city, state, and ZIP code

Phone: Call 1 (888) 577-8977 (toll-free)
Call (240) 221-4001 in the Washington, DC, metropolitan area

Fax: *SAMHSA News* (301) 984-4416
Attention: Rudy Hall

Mail: Send your new mailing information to:

SAMHSA News Subscriptions
Attention: Meredith Pond
c/o IQ Solutions, Inc.
11300 Rockville Pike, Suite 901
Rockville, MD 20852

Visit *SAMHSA News* online at
www.samhsa.gov/SAMHSA_News

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Rockville MD 20857

Official Business
Penalty for Private Use $300