

A Better Path: Drug Treatment Courts Offer Hope for Youth



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View from the Administrator: Diverting Youth from the Criminal Justice System



Young people who enter the juvenile justice system often have multiple problems.

According to a study by the National Center for Mental Health and Juvenile Justice, most youth in the juvenile justice system also have a substance use disorder, mental disorder, or both. Almost 30 percent of those youth have problems so severe their ability to function is impaired.

Yet very few get the treatment they need. In fact, in some locales, detention centers and jails have become the de facto treatment centers. That's just not right. We need to get these young people into treatment, not into incarceration. Better yet, we need to make sure they never get into the juvenile justice system to begin with.

That's what SAMHSA's juvenile justice-related programs do—divert young people who have committed offenses away from the juvenile and

criminal justice systems and into substance use treatment.

The Juvenile Treatment Drug Court program, for example, helps expand and enhance substance use treatment services in problem-solving courts that identify substance-using offenders and place them under strict court monitoring and community supervision. (SAMHSA's Adult Treatment Drug Courts program does the same for adults, offering non-violent offenders a chance to get alcohol or drug treatment instead of jail time.)

SAMHSA is also collaborating with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the U.S. Department of Justice in an even more intensive diversion program called Reclaiming Futures. With this initiative, SAMHSA supports the provision of behavioral health services for participants in treatment drug courts established by OJJDP.

SAMHSA's new Teen Court Program, which announced its first round of grantees in September, helps ensure

that young people stay out of the juvenile justice system in the first place. The program supports courts in which young people sentence peers with such punishments as community service or written apologies for minor, first-time offenses. With SAMHSA's support, these grantees will be able to offer substance use referrals and treatment as well.

These programs work. An evaluation has found that Reclaiming Futures and SAMHSA's Juvenile Treatment Drug Court programs have led to increases in abstinence, decreases in emotional problems, and reductions in crime. (See *SAMHSA News* cover story, p. 3.) That's good news for both public health and public safety.

— Pamela S. Hyde, J.D.



For more information on SAMHSA's work in the area of Trauma and Justice, visit

www.samhsa.gov/traumaJustice/ or scan this code with your smartphone.

Youth Trauma and Justice Resources:

- **SAMHSA's Trauma and Justice Programs:**
www.samhsa.gov/traumaJustice/
- **Reclaiming Futures:**
www.reclaimingfutures.org
- **SAMHSA's Teen Court Program:**
www.samhsa.gov/newsroom/advisories/1209250612.aspx
- **The National Child Traumatic Stress Network:**
www.nctsn.org/
- **National Center for Trauma Informed Care:**
www.samhsa.gov/nctic/



DRUG TREATMENT COURTS OFFER HOPE FOR YOUTH

The young Californians served by the Monterey County Health Department's Hope for Youth/Esperanza para los Jóvenes face incredible challenges. Primarily Latino, they live in neighborhoods plagued by gangs, violence, criminal behavior, and easy access to alcohol, marijuana, methamphetamine, cocaine, and other drugs.

After receiving a 3-year Juvenile Treatment Drug Court grant from SAMHSA's Center for Substance Abuse Treatment (CSAT) in 2010, the county has been trying to achieve better outcomes for these youth by getting young offenders involved in a juvenile treatment drug court as an alternative to incarceration. Designed to break the cycle of alcohol and drug use, criminal behavior, and incarceration, the project includes alcohol and drug treatment, regular meetings with the judge, and drug testing.

The approach seems to be working. "The trends are moving in the right direction," said project director Theresa Innis-Scimone, M.F.T., of the county's Behavioral Health Bureau. "Fewer young people are relapsing, re-offending, or moving on to a higher level of care," she said. "Plus, more are staying in school and in their communities."

Like Esperanza para los Jóvenes, SAMHSA's other Juvenile Treatment Drug Court grantees are expanding alcohol and drug

"If a young person with mental, substance use, or co-occurring disorders does get involved with the justice system, we in the behavioral health system have let that young person down." — Larke Huang, Ph.D.

treatment services in "problem-solving" courts that represent an alternative to incarceration for juvenile offenders. "If a young person with mental, substance use, or co-occurring disorders does get involved with the justice system, we in the behavioral health system have let that young person down," said Larke N. Huang, Ph.D., Director of SAMHSA's Office of Behavioral Health

Equity. "They have fallen through the cracks of the behavioral health system and into a system that is not designed to handle mental and substance use disorders."

A Different Model

Juvenile treatment drug courts grew out of the adult treatment drug courts model, which has proven successful in reducing rates of re-offending (see "Incarceration vs. Treatment: Drug Courts Help Substance Abusing Offenders," *SAMHSA News*, March/April 2006). But juvenile treatment drug courts have some important differences from their adult-oriented counterparts.

"Originally, after the creation of adult drug courts, juvenile drug courts were created by simply taking their central elements and dropping them into the juvenile justice system," said Kenneth W. Robertson, team leader of the Criminal Justice Grants in CSAT's Division of Services Improvement. "That just doesn't work as the two justice systems have very different goals, approaches, and resources."

There are also some major developmental differences between adolescents and adults. "From a neurodevelopmental standpoint, there are vast differences in brain activity,

Continued on page 4

including judgment and impulse control, in individuals under 25 and adults who are older,” said Mr. Robertson.

In addition, he said, adolescents’ substance use and criminality typically aren’t as firmly entrenched as they are in many older offenders. Unlike adult drug courts, few participants have committed multiple serious offenses, for instance.

That’s one reason juvenile treatment drug courts focus so heavily on family engagement, coordination with the school system, and partnerships with community organizations that can help expand the opportunities available to young people and their families.

“Almost two-thirds of youth in the juvenile justice system have co-occurring disorders,” said David Morrissette, Ph.D., a senior program manager in the Community Support Programs Branch at SAMHSA’s Center for Mental Health Services (CMHS), citing a study by the National Center for Mental Health and Juvenile Justice. “That research has found that up to 70 percent of youth in the juvenile justice system have mental health disorders and more than 60 percent of those also have a substance use disorder.”

Whether youth have co-occurring disorders or just substance use problems, juvenile drug courts can help, according

with self-control declined by 16 percent. The average number of crimes reported dropped by half.

According to the evaluation, a more intensive approach to juvenile treatment drug courts called Reclaiming Futures reached youth with more severe problems, provided more services, and did an even better job of increasing abstinence, reducing emotional problems, and reducing criminal behavior.

Reclaiming Futures, a collaboration among SAMHSA, the U.S. Department of Justice’s Office of Juvenile Justice and Delinquency Prevention, and the Robert Wood Johnson Foundation, provides substance use treatment to youth in the justice system and connects them to positive activities and caring adults. Twenty-nine communities in 17 states have used the model.

“There are six stages in the model,” said SAMHSA Project Officer Holly Rogers, M.A. “These include screening and assessing young people to identify alcohol or substance use problems, coordinating services across agencies, helping kids and families make an initial contact with services, getting them actively engaged in services, and transitioning them out of services and into long-term supports, such as helping relationships and community resources.”

Using a team approach and intensive monitoring, judges, probation officers, substance use treatment professionals, and communities create an individualized plan for each young person.

“Whether it’s Reclaiming Futures or SAMHSA’s Juvenile Treatment Drug Courts,” said Dr. Huang, “the goal is the same: to keep young people from moving deeper into the juvenile justice system or into the adult criminal justice system.”

For more information, see Youth Trauma and Justice Resources on page 2. ■

Photos courtesy Robert Wood Johnson Foundation; photographer Susie Fitzhugh.



Seattle, WA: Judges in the juvenile drug court program listen to each case and make sure youth understand the charges against them, as well as address concerns of parents and attorneys.

Other key elements of juvenile drug courts include collaborative, interdisciplinary planning with youth, families, and drug court teams; frequent judicial reviews; drug testing; and incentives and sanctions designed to reinforce good behavior and modify bad.

While specialized juvenile treatment mental health courts exist throughout the country, juvenile treatment drug courts often find themselves confronting mental disorders as well.

to Michael L. Dennis, Ph.D., of Chestnut Health Systems. In a CSAT-funded analysis, he and other researchers found that the juvenile drug court model works.

In a 2012 evaluation examining data from 1,934 young people participating in drug courts at 17 CSAT grantee sites, evaluators found that participants saw a 26 percent increase in the number of days they abstained from alcohol and other drugs between intake and a 1-year follow-up. Participants’ scores on a scale measuring emotional problems and difficulties

Decline in Young Adult Nonmedical Prescription Drug Use

The number of people ages 18 to 25 who used prescription drugs for nonmedical purposes in the past month declined from 2.0 million in 2010 to 1.7 million in 2011 (14.3 percent decrease), according to SAMHSA's 2011 National Survey on Drug Use and Health (NSDUH).

“These findings show that national efforts to address the problem of prescription drug misuse may be beginning to bear fruit, and we must continue to apply this pressure to drive down this and other forms of substance use,” said SAMHSA Administrator Pamela S. Hyde, J.D.

As the primary source of statistical information on the use of illicit drugs, alcohol, and tobacco in the United States, NSDUH provides unique insights into current trends in the behavioral health issues that affect communities nationwide. The survey, released by SAMHSA in conjunction with the 23rd annual National Recovery Month observance, also showed that the rates of past-month drinking, binge drinking, and heavy drinking among

people under age 21 continued to decline from 2002, as did the rate of past-month tobacco use among youth ages 12 to 17 and among young adults ages 18 to 25.

Specifically, past-month alcohol use among 12- to 20-year-olds declined from 28.8 percent in 2002 to 25.1 percent in 2011, while binge drinking (consuming 5 or more drinks on the same occasion on at least 1 day in the past 30 days) declined from 19.3 percent in 2002 to 15.8 percent in 2011, and heavy drinking (consuming 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days) declined from 6.2 percent in 2002 to 4.4 percent in 2011. In addition, the rate of past-month tobacco use among 12- to 17-year-olds continued to decline from 15.2 percent in 2002 to 10 percent in 2011.

However, the survey also found increases in the use of other substances, specifically marijuana and heroin. Marijuana continues to be the most commonly used illicit drug, and the current rates of marijuana use increased from



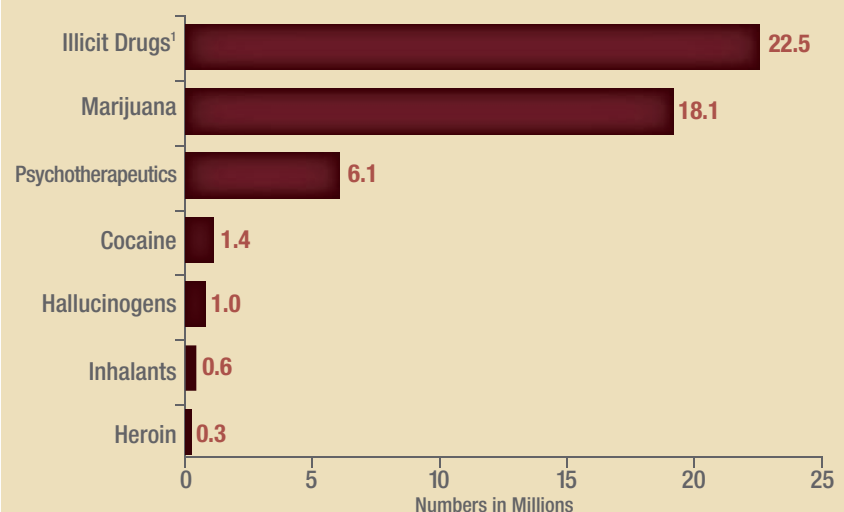
6.7 percent in 2007 to 7.9 percent in 2011 among youth ages 12 to 17, from 16.5 percent in 2007 to 19.0 percent in 2011 among young adults ages 18 to 25, and from 3.9 percent in 2007 to 4.8 percent among adults ages 26 or older. In 2011, 22.5 million Americans ages 12 or older were current users of illicit drugs, including 18.1 million marijuana users—up from 14.5 million in 2007. (See Figure 1)

According to NSDUH, 21.6 million people ages 12 or older needed treatment for an illicit drug or alcohol use problem in 2011. Yet only 2.3 million (or 10.8 percent of those who needed treatment) received treatment at a specialty facility—a continuing disparity.

“Behind each of these statistics are individuals, families, and communities suffering from the consequences of abuse and addiction,” Administrator Hyde said. “We must continue to promote robust prevention, treatment, and recovery programs throughout our country.”

To read the full report of the 2011 National Survey on Drug Use and Health, visit www.samhsa.gov/data/NSDUH.aspx.

Figure 1: Past Month Illicit Drug Use Among Persons Aged 12 or Older: 2011



¹Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically (pain relievers, stimulants, tranquilizers, sedatives).
Source: SAMHSA, 2011 National Survey on Drug Use and Health.

Community Coalitions Prevent Underage Drinking

In 2003, a high school principal in rural Hunterdon County, NJ, learned that his junior high school-aged son was given alcohol at a party. This and other reports of social hosting—the practice of parents supplying children with alcohol or making it accessible at home—led the principal and other community leaders to join together and create Hunterdon Safe Homes, a group dedicated to reducing the social availability of alcohol to youth.

The group involved schools, parents, law enforcement, and others in their efforts to address the access by minors to alcohol as well as the perceived lack of harm of underage drinking and parental approval. This collaboration led to the development of the *Safe Homes* directory, where parents could identify themselves as parents committed to hosting alcohol-free gatherings for youth.

Drug Free Communities Support Program

While Hunterdon Safe Homes made significant progress with limited resources, there was still more work to do. In 2009, with help of a Drug Free Communities Support Program (DFC) grant, they changed their name to the Safe Communities Coalition (www.safecoalition.org) and expanded their reach into the community. Sponsored by the White House Office of National Drug Control Policy (ONDCP), and managed and monitored by the Substance Abuse and Mental Health Services Administration (SAMHSA), DFC grants harness the power of community coalitions to reduce and ultimately prevent substance use among young people.

Safe Communities Coalition Project Director Lesley Gabel said they closely followed the DFC model and received training through the Community Anti-Drug Coalitions of America's (CADCA) National Coalition Institute. Founded



This advertisement was posted in liquor store windows and on alcohol packaging as part of Safe Communities Coalition's "Know the Law" Campaign in 2010.

in 2002, the Institute helps strengthen the capacity of community coalitions by providing training on a variety of topic areas including effective community problem-solving strategies, assessing local substance use related problems, and developing comprehensive plans to address them. Ms. Gabel credits the DFC grant for helping the coalition expand recruitment efforts within various sectors of the community.

"The DFC grant gave us a structure, a prevention model, funding, and the training tools we needed to develop a high-functioning coalition," said Ms. Gabel. "Many people didn't understand the complexities of our local problems, but when they learned what we were trying to do, they joined us."

Environmental Approach

In 2010, with the additional support from the DFC program resources, and collaboration between local business owners, Safe Communities Coalition launched the Know the Law campaign. The campaign included signs posted in local liquor store windows and on alcohol packaging. The signs informed patrons

about the repercussions of providing alcohol to minors: a \$1,000 fine and up to 6 months in jail. Subsequent initiatives included a social norms campaign and a highly successful collaboration with local law enforcement and the prosecutor's office to increase private property ordinance enactment from 8 percent to 35 percent. Many ordinances were modified to include loss or delay of driver's license for teens found drinking.

The Coalition also invited young people to join a new youth coalition. Youth were encouraged to get involved by organizing school assemblies, participating in community service, and making public service announcements. "Involving young people has allowed us to develop strategies that will work for them," Ms. Gabel said. "They can also deliver a credible message to their peers and encourage teens to talk about these issues."

In 2012, the Coalition expanded to include Somerset County, NJ. Today, the *Safe Homes* directory is online with more than 1,000 parents pledging to provide alcohol-free gatherings for their teens. The coalition has also added prevention of other drug use to its mission.

DFC Program Success

Like the Safe Communities Coalition, DFC programs across the country are working with local law enforcement to reduce underage alcohol and substance use. DFC programs are also facilitating local policy changes to effectively address the accessibility and availability of alcohol, tobacco, and other drugs. Since the passage of the DFC Act in 1997, the DFC program has funded nearly 2,000 coalitions and mobilizes nearly 9,000 community volunteers nationwide.

According to a recent ONDCP-funded National Evaluation, in the past 8 years that DFC has been evaluated, DFC-funded communities have achieved significant reductions in youth alcohol, tobacco, and marijuana use. For middle school youth living in DFC-funded communities, data from the DFC National Evaluation indicate a 16 percent reduction in alcohol use. High school-aged youth have reduced their use of alcohol by 9 percent.

“Collaboration is the key to the success of the DFC Programs,” said Charles Reynolds, Division Director of SAMHSA’s Center for Substance Abuse Prevention Division of Community Programs. “Schools, community leaders, law enforcement, policy makers, parents, and youth must work together and leverage each other’s strengths and resources in order to prevent underage alcohol and drug use in communities across the country.”

Safe Communities Coalition will be recognized February 4 through 7, 2013, at CADCA’s 2013 National Leadership Forum as the winner of CADCA’s 2012 GOT OUTCOMES Coalition of Excellence Milestone Award. The award recognizes coalitions that show community-level changes that prove they are on the right track towards reaching their long-term goals.

SAMHSA will kick off CADCA’s conference at the Gaylord Hotel and Convention Center in National Harbor, MD, on February 4, 2013 with SAMHSA’s 9th Annual Prevention Day. SAMHSA’s

Prevention Day is an opportunity for DFC Program grantees and other SAMHSA program grantees to attend training workshops, network, and share best practices.

For more information, visit:

DFC Programs:

www.whitehouse.gov/ondcp/drug-free-communities-support-program

DFC Grants:

www.samhsa.gov/grants/2011/sp_11_002.aspx

CADCA’s Coalition for Excellence Awards:

www.cadca.org/resources/detail/cadca-congratulates-2012-got-outcomes-coalition-excellence-award-winners

CADCA’s National Leadership Forum and SAMHSA’s Prevention Day 2013:

<http://forum.cadca.org>

Safe Communities Coalition:

www.safecoalition.org ■

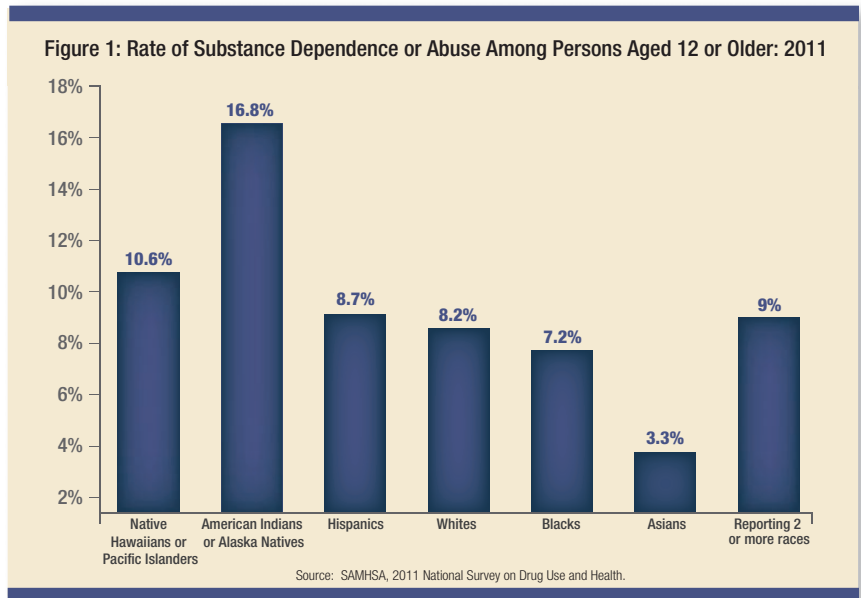
This Safe Communities Coalition traveling advertisement focused on youth and perceptions of social acceptance of underage drinking.



Addressing Substance Use in Tribal Communities

Alcoholism and addiction are among the most severe public health problems facing American Indian and Alaska Native people. According to SAMHSA's 2011 National Survey on Drug Use and Health (NSDUH), the rate of substance dependence or abuse among American Indians or Alaska Natives age 12 or older was twice that of other ethnic backgrounds (See Figure 1). The rate of current heavy alcohol use among this population was the highest at 11.6 percent. To address these issues, and in accordance with the Tribal Law and Order Act (TLOA), SAMHSA has created the Office of Indian Alcohol and Substance Abuse (OIASA).

As directed by Congress through TLOA, SAMHSA has taken a lead role in establishing OIASA and coordinating efforts among the U.S. Department of Health and Human Services (HHS), the Department of the Interior (DOI), and the Department of Justice (DOJ). President Obama signed TLOA into law in July 2010. The law requires a significant amount of interagency collaboration in order to build upon previous efforts that address alcohol and substance abuse in Indian Country as well as create a sustainable model for the future.



In July 2011, a Memorandum of Agreement was signed by HHS Secretary Kathleen Sebelius, DOI Secretary Ken Salazar, and Attorney General Eric Holder. The agreement outlined how OIASA will coordinate tribal substance abuse programs across the Federal Government with special emphasis on promoting programs geared toward reaching youth and offering alternatives to incarceration.

Today, OIASA is offering technical assistance to tribal governments that need help in developing their Tribal Action Plans (TAP). The TAP coordinates resources and programs to assist tribes in achieving their goals in the prevention, intervention, and treatment of alcohol and substance abuse.

Rod Robinson joined SAMHSA as the new Director of OIASA in September. Mr. Robinson has been working with tribes throughout the United States and Canada in the areas of substance abuse prevention, intervention, treatment, and strategic planning for over 30 years and is an enrolled member of the Northern

Cheyenne tribe in Montana. “With the enactment of the Tribal Law and Order Act of 2010,” said Mr. Robinson, “the tribes and Congress very wisely created a Tribal Action Planning process as a dynamic opportunity to gain greater justice, safety, and wellness in Indian Country.”

With a structure in place for the Federal Government to work holistically with tribal communities through OIASA, Mr. Robinson said that momentum is building. Tribes have elevated their level of commitment to how they are going to address substance use and treatment within their communities. He also emphasized the importance of respecting local leadership and culture throughout this process. “Tribes want to find a real solution,” said Mr. Robinson. “OIASA is committed to continuing to ensure that a tribal perspective is considered in the process of developing interdepartmental cooperation.”

For more information about OIASA and TLOA including resources to download, visit www.samhsa.gov/TLOA. ■

BHbusiness: Helping Providers Navigate Health Reform

Preventing and treating mental and substance use disorders require more than clinical skills. To be effective, providers must also have excellent business skills. The Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and other changes are making such skills now more important than ever.

“With 2014 fast approaching, behavioral health providers need to be getting up to speed now to make sure their businesses are prepared to cope with the changes full implementation of health reform will bring,” said SAMHSA Administrator Pamela S. Hyde, J.D.

The new SAMHSA-funded BHbusiness: Mastering Essential Business Operations initiative will offer targeted training and support to 30 BHbusiness learning networks, each consisting of up to 30 organizations. The State Associations of Addiction Services (SAAS) will administer the project in partnership with the National Council for Community Behavioral Healthcare, NIATx, and Advocates for Human Potential.



Learning Networks

“Providers are doing an excellent job in the clinical areas, but many just aren’t prepared in the business operations part of this new landscape,” said Becky Vaughn, M.S.Ed., Chief Executive Officer of SAAS.

Using a combination of online courses and discussion groups, webinars, individual

and small group consultation, and in-person meetings, the learning networks will focus on five key areas:

- **Strategic business planning.** After conducting market and organizational assessments, participants will create business plans that address expanded access to care, new reimbursement models, and other aspects of the changing environment.
- **Third-party billing and compliance.** Participants will learn such skills as how to implement third-party billing systems and identify core compliance measures.
- **Third-party contract negotiations.** Participants will learn how to demonstrate the value of their services and how to market those services to new payers.
- **Eligibility determinations.** Health reform will expand access to Medicaid and create new state-based insurance Exchanges, so participants will learn how to determine eligibility and get patients enrolled.
- **Meaningful use of health information technology.** Participants will learn how to take advantage of technology and meet “meaningful use” standards.

In order to demonstrate practical application of the knowledge gained, each provider will also tackle a related organization-specific project as part of the process.

“Research shows that people learn better when they have opportunities to interact and to practice what they’re learning,” said Kimberly Johnson, M.S.Ed., M.B.A., Co-Deputy Director of NIATx. “We’re trying to mix up the online and the in-person and the synchronous and asynchronous,

so that people are actively engaged but also have the ability to do things in their time frame, not ours,” she said.

Of course, participants will also learn from each other, said Neal Shifman, M.A., President and CEO of Advocates for Human Potential. “One of the advantages of learning networks is the peer-to-peer influence that occurs when like-minded organizations share real-life stories, experiences, and answers about improving their business processes,” he said.

Mohini Venkatesh, M.P.H., Senior Director of Public Policy at the National Council for Community Behavioral Healthcare, agreed. “One of the challenges we have with technical assistance is making sure recipients are sustainably implementing practices that will live well beyond the consultation,” she said. “Learning networks really facilitate that, because the way they’re structured helps cultivate communication.”

BHbusiness will target behavioral health providers with limited business capacity to participate in third-party reimbursement networks. Within provider organizations with limited third-party billing capacity, special emphasis will be given to recovery peer support providers and providers serving vulnerable populations. However, use of the BHbusiness curricula will not be limited to providers formally involved in learning networks. BHbusiness will make the curricula available online for public use to ensure the widest distribution possible.

For more information about BHbusiness learning networks, visit www.saasnet.org/node/175 and for additional information about health reform visit www.samhsa.gov/healthreform. ■

SAMHSA 20TH Anniversary Celebration

SAMHSA Administrator Pamela S. Hyde, J.D., welcomed former SAMHSA Administrators, current staff members, and behavioral health stakeholders on October 4th, 2012, for SAMHSA: A Celebration of 20 Years. The event, which capped the celebration of SAMHSA's 20th year of service to the behavioral health community, was held at SAMHSA's offices in Rockville, MD. Administrator Hyde reflected on the past 20 years and also talked about SAMHSA's role moving forward. "Today, we lead through the transformation of our nation's health system via the Affordable Care Act, making sure that behavioral health is essential to the health of America and making sure that America and its leaders and its communities know that prevention works, treatment is effective, and people recover from addiction and from mental health conditions."

Administrator Hyde served as moderator for two panel discussions. The first panel included five former SAMHSA administrators who discussed the evolution of behavioral health services in America. The panel noted that, throughout its existence, SAMHSA had the opportunity to influence public policy regarding mental and substance use disorders, which has had an impact on how behavioral health is perceived in America.

In the second panel discussion, four expert panelists discussed achieving behavioral health imperatives in America and the progress that has been made in improving behavioral health services. The event closed with presentations of Administrator's Awards to current and former SAMHSA staff members including recognizing SAMHSA staff members who have been with SAMHSA since its creation in 1992. ■



SAMHSA's Former Administrators with Administrator Pamela S. Hyde, J.D. L to R: Elaine McDowell, Ph.D., Joseph H. Autry, III, M.D., Charles Curie, M.A., Terry Cline, Ph.D., Eric Broderick, RADM, D.D.S., M.P.H., Pamela S. Hyde, J.D. Missing: Former Administrator Nelba Chavez, Ph.D.

Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans



Since 2001, more than 2.2 million U.S. veterans have served in Afghanistan (Operation Enduring Freedom) and Iraq (Operation Iraqi Freedom). The *In Brief* "Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans," introduces healthcare and social service providers to some of the behavioral health issues facing these veterans. These include substance abuse, post-traumatic stress disorder, depression, and suicide. This document also includes information about how providers can use brief intervention tactics and provide online screening tools for assessing behavioral health problems among veterans. Resources for veterans and their families are also included.

Download or order the *In Brief* at www.store.samhsa.gov ■

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Disaster Response Template Toolkit Includes Customizable Resources

SAMHSA's Disaster Behavioral Health Information Series (DBHIS) contains themed installments of resources and toolkits in disaster behavioral health. Each installment focuses on a specific population, disaster type, or other topic pertinent to disaster behavioral health preparedness, response, and recovery.

DBHIS has released a new Disaster Response Template Toolkit featuring public education materials that disaster behavioral health response programs can use to create resources for reaching people affected by a disaster. The template kit includes print materials such as brochures, door hangers, flyers, newsletters, tip sheets, wallet cards, and postcards that can be completely customized. The toolkit also has web and multimedia materials such as sample blog posts and public service announcement scripts. Many of the links contain downloadable templates and online tools that have been used in previous disaster situations across the country. The templates can be adapted for future use as desired. For example, an organization may add specific program contact information, point of contact reference, or branding such as logos. In addition, the content can be tailored to fit specific program needs.



To download the templates and learn more visit www.samhsa.gov/dtac/dbhis/dbhis_templates_intro.asp.

For additional DBHIS resources visit www.samhsa.gov/dtac/dbhis/ ■

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