

SAMHSA NEWS

Screening Works: Update from the Field

In the 5 years since SAMHSA launched the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative, the program has increasingly become an integral part of medical practice in clinics, emergency rooms, and other treatment settings.

The acceptance and value of the SBIRT approach is evidenced by the large number of patients screened, the decrease in their substance use, and the recent adoption of billing codes by insurance companies and Government

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Screening Works: Update from the Field



Continued from page 1

payers that enable treatment providers to be reimbursed for these services.

“We’re seeing a lot of positive results,” said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA’s Center for Substance Abuse Treatment (CSAT).

The approach focuses on individuals who use drugs or drink more than they should but aren’t yet dependent.

The idea is to screen everyone who comes into a participating primary health facility, clinic, emergency room, campus health service, or other venue. For those who need it, information and tools are offered to help stop substance use issues before they escalate. (For details, see *SAMHSA News* online, January/February 2006.)

So far, CSAT has funded a dozen college campuses, 10 states, and 1 tribal organization to develop SBIRT demonstration projects.

Lessons Learned

SBIRT’s approach is simple, and its findings are definitive.

Almost a quarter of those screened have substance use problems.

SBIRT’s state and tribal grantees have screened more than 600,000 patients so far. Twenty-three percent of them have substance use problems. “On college campuses, the prevalence is even higher,” said Tom Stegbauer, Ph.D., lead public health analyst in the Division of Services Improvement at CSAT.

At one grantee school, for example, the percentage of students reporting binge drinking was 60 percent. And it’s not just substance abuse issues that these individuals face, Mr. Stegbauer added. With substance use comes a host of potential medical problems, he explained, from diabetes to behavioral health disorders.

SBIRT works. Thanks to SBIRT, many of these individuals are making big changes in their lives. At the 6-month followup, for instance, almost half of the participants in the state and tribal SBIRT programs who were consuming alcohol at inappropriate levels reported that they hadn’t had a drink in the past 30 days.

More than half of the participants who were using illicit drugs or misusing prescription medications had stopped that behavior.

SBIRT saves money. The literature reports a four to one savings with the SBIRT approach, said Mr. Stegbauer.

In a 2002 study published in the journal *Alcoholism: Clinical and Experimental Research* (Vol. 26, No. 1), for example, researchers found that every dollar invested in an SBIRT-like approach saved \$4.30 in future health care costs.

Some SBIRT grantees are experiencing even more dramatic results. In Texas, for instance, an analysis of 853 SBIRT participants revealed that the approach saved

the Harris County Hospital District more than \$4 million in the year after the patients received services. Emergency room usage dropped, explained Mr. Stegbauer. There also was a shift from inpatient to outpatient treatment, which is much less costly. “This was a performance study and not a research project, but we were pleased with the outcomes,” said Mr. Stegbauer.

New Billing Codes

“The SBIRT Initiative isn’t just about funding services,” said Dr. Clark. “It’s also about changing policy to ensure the approach’s sustainability.”

New billing codes that allow practitioners to be reimbursed for providing SBIRT services are a key way to achieve that goal. CSAT and a team of experts helped draft proposals that became a reality in January.

Current Procedural Terminology (CPT) codes allow providers treating privately insured patients to be reimbursed for providing SBIRT services. Because by law Medicare cannot cover screening unless it’s mandated, the Centers for Medicare & Medicaid Services (CMS) created “G codes,” which offer reimbursement to providers serving Medicare patients. “H codes”

About SBIRT

The approach to SAMHSA’s Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative is simple.

Screening. With just a few questions on a questionnaire or in an interview, practitioners can identify patients who have alcohol or substance use problems and determine how severe those problems already are.

Brief Intervention. If screening results indicate moderate risk, individuals receive brief interventions. The intervention educates them about their substance use,

alerts them to possible consequences, and motivates them to change their behavior.

Brief Treatment. If individuals are at moderate to high risk, the next step is brief treatment. Similar to brief intervention, this emphasizes motivations to change and client empowerment.

Referral to Treatment. For those whose screening indicates a severe problem or dependence, the next step is referral to substance abuse treatment.

Visit www.sbirt.samhsa.gov. ▶

allow reimbursement for providers serving Medicaid patients.

“The next step is to ensure that states adopt the H codes in their Medicaid programs,” explained Research Professor Eric N. Goplerud, Ph.D., Director of Ensuring Solutions to Alcohol Problems at the George Washington University Department of Health Policy in Washington, DC. Dr. Goplerud worked closely with SAMHSA and key stakeholders to help get the codes established.

Next Steps

In the coming months, SAMHSA plans to award up to four new Cooperative Agreements to states and/or tribes to demonstrate how SBIRT works in various settings. The Agency also plans to award grants to teach medical residents skills to incorporate screening and brief interventions into their clinical practice in primary care settings. (See box on page 5.)

In addition, SAMHSA will provide trainings on the use of the new billing codes for health care providers as well as billing and coding professionals and office managers. Educational materials also are in development to build awareness.

SAMHSA will continue to work with the field to provide guidance on upcoming SBIRT programs and on how best to use the codes for reimbursement.

In the near future, CSAT will be sponsoring state SBIRT policy academies designed to help states incorporate SBIRT into their continuum of care.

As more information becomes available, *SAMHSA News* will keep you informed on the progress of these efforts to expand the SBIRT model nationwide through training, grants, and other venues.

For a descriptive, “at a glance” chart of information about the new codes, visit SAMHSA’s SBIRT Web page at www.sbert.samhsa.gov/coding.htm. ▀

—By *Rebecca A. Clay*

See pages 4 & 5 for more on SBIRT.

From the Administrator

Behavioral Health Screening and Primary Care

One of SAMHSA’s most effective programs—the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative—is reporting excellent outcomes in the field. (See the *SAMHSA News* cover story.)

Preliminary SBIRT data show a total of 74 percent of high-risk individuals reported lowering their drug or alcohol consumption after one or more brief treatment sessions, and 48 percent reported stopping use.

Making behavioral health screening part of primary care makes sense. By taking a public health approach to substance abuse and mental health issues, we can lower health care costs because we’re reaching individuals before they need specialized treatment.

Another step forward in support of screening comes from the American Medical Association (AMA). In January 2008, the AMA introduced new health care codes for substance abuse screening and brief intervention.

These new codes offer a mechanism for health care providers to be reimbursed for using these tools. The codes will increase the likelihood that those with substance abuse problems receive an appropriate intervention before developing a disorder, and those with a disorder will be linked to appropriate treatment and recovery support services.

The Centers for Medicare & Medicaid Services (CMS) recently approved



Terry L. Cline, Ph.D.

“HCPCS codes” to reimburse for screening and brief interventions under Medicaid. Those codes now can be used on a state-by-state basis for early screening and intervention for substance use disorders.

For use under Medicare, CMS created “G codes” to reimburse providers for these services.

These changes signal a meaningful shift in how substance abuse is being viewed by those in general health care, in health policy, and in health care reimbursement.

The SBIRT model holds great promise. To help the Initiative reach its full potential, SAMHSA will be coordinating with many Federal agencies, including the Office of National Drug Control Policy, the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism. ▀

Terry L. Cline, Ph.D.
Administrator, SAMHSA

Screening in Action

For SBIRT Grantees Across the Nation, Flexibility Helps

One of the main advantages of the SBIRT model is its flexibility: You can use it just about anywhere.

That flexibility is reflected in the wide range of settings involved in the SBIRT Initiative. Because each grantee has multiple projects, more than 125 sites are now participating nationwide.

In California, for instance, the state's Department of Alcohol and Drug Programs is offering SBIRT in primary care clinics, federally qualified health centers, and emergency rooms and trauma centers.

In Florida, the Department of Children and Families is focusing on older adults, which means bringing the SBIRT approach to such settings as senior nutrition programs, public health settings, primary care offices, and similar venues.

The New Mexico Department of Health uses telehealth technology to conduct clinical interviews and provide counseling to patients across the large, rural state.

The Initiative's campus-based grantees are using the model at a wide range of schools. At Bristol Community College in Fall River, MA, for example, the SBIRT model features bilingual clinicians who understand the community's Portuguese culture and work to eliminate its high rate of heroin use.

At the University of Hartford, Connecticut, the SBIRT program focuses primarily on students referred from the university's judicial office for violations of its alcohol and substance abuse policy.

The University of Tennessee in Knoxville offers students the opportunity to participate

in its SBIRT program when they open their university email accounts.

What do these programs look like in action? Read about two grantees—one from Alaska and one from Massachusetts.

In Alaska: Screening Is Part of Routine Care

To Shannon R. Sommer, Director of Recovery Services for the Cook Inlet Tribal Council, Inc., one reason for SBIRT's success is its strategy of making drug and alcohol screening just as routine as screening for heart problems or diabetes. That approach helps battle stigma, she said.

The Council received a 5-year SBIRT grant in 2003 to offer SBIRT to Alaska Natives and others in Anchorage.

"If you incorporate the screening into regular appointments, people don't think, 'Oh, my goodness, they must know that I use or think I have a problem,'" said Ms. Sommer.

The process typically begins when a patient comes to the council's partner organization, the Southcentral Foundation, for primary health care.

A medical assistant asks a few questions to assess the patient's risk level, then passes the results on to a behavioral health consultant. Patients who need brief interventions receive two to five 15-minute sessions. Others receive brief therapy, which consists of about half a dozen weekly sessions. Those with the most serious problems receive referrals to substance abuse treatment.

The goal of brief interventions and brief therapy is to motivate the person to change. "As in many other cultures, direct confrontation doesn't work very well with this population," said Ms. Sommer. "It tends to shut people down." As a result, the interventions emphasize motivational interviewing and negotiation.

The results have been "almost unbelievable," said Ms. Sommer, noting

SBIRT Resources

For more information about SAMHSA's Screening, Brief Intervention, and Referral to Treatment Initiative, visit www.sbirt.samhsa.gov. Specific resources include:

- Coding for SBIRT reimbursement: www.sbirt.samhsa.gov/coding.htm
- General tools and resources: www.sbirt.samhsa.gov/tools_resources/index.htm
- Resources for colleges and universities: www.sbirt.samhsa.gov/colleges_resources.htm
- Resources for trauma centers: www.sbirt.samhsa.gov/providers_resources.htm

For more on California's SBIRT program, read January/February 2006 *SAMHSA News* online at www.samhsa.gov/samhsa_News/VolumeXIV_1/Index.htm.



that 25 percent of those screened have alcohol or drug problems.

Between intake and a 6-month followup, the percentage of individuals with no past-month substance use more than doubled—from almost 26 percent to 57 percent.

The percentage of patients reporting no or reduced consequences from alcohol or illegal drug use jumped from almost 77 percent to almost 94 percent. Improvements also included the percentages of individuals who had stable housing, who had jobs or were in school, and who had no involvement in the legal system.

“Just this one basic screening has a phenomenal impact,” said Ms. Sommer.

Screening on Campus: Effective and Available

Although campus grantees use the SBIRT model in a variety of ways, their goals are the same.

No matter what the approach, grantees work to combat underage drinking and substance use, and they make screening and brief intervention a regular part of student health care.

Take the University of Massachusetts Amherst, for example. Historically, like

At the University of Massachusetts Amherst, screening for substance abuse is part of every student's experience during a visit to the university clinic. Since 2005, the campus has followed the individual SBIRT approach in its Brief Alcohol Screening and Intervention for College Students (BASICS) program. Results are impressive. The frequent heavy episodic drinking rate is down 38 percent.



many other campuses, the school has a high rate of binge drinking.

In 2003, almost 77 percent of students reported drinking five or more drinks in a sitting—what prevention experts call “heavy episodic drinking.” Forty percent of students were frequent heavy episodic drinkers, consuming alcohol in this way three or more times over a 2-week period. Now, these numbers are dropping.

In 2005, the university used a strategic plan to reduce high-risk drinking, integrating individual and environmental prevention strategies. The campus follows the individual SBIRT approach in its Brief Alcohol Screening and Intervention for College Students

(BASICS) program, said Project Director Diane Fedorchak, M.Ed., C.A.G.S., at University Health Services.

BASICS targets students who have violated the school's alcohol policies, including possessing alcohol if they're underage or having an open container in a public space.

The intervention consists of two hour-long sessions. At the first, a master's level prevention specialist builds rapport; assesses the student's drinking patterns, drug use, and family history; and provides information. “We talk about what a drink is so students have a more accurate sense of their drinking. The intention is for students to understand that ‘two drinks’ is two 1.5-ounce servings of vodka, not two Nalgene bottles full of vodka,” explained Ms. Fedorchak.

At the second session, the prevention specialist reviews questionnaire results, compares the student's drinking with that of other students, and offers suggestions for reducing the amount consumed.

Results are impressive on both campus and individual levels, said Ms. Fedorchak. The frequent heavy episodic drinking rate is down 38 percent. The heavy episodic drinking rate has declined 26 percent. “Our ‘heavy hitters’ are changing their habits,” she said.

For more information about SBIRT, visit SAMHSA's Web site at www.samhsa.gov/sbirt.

—By Rebecca A. Clay

SBIRT Funding Opportunity

SAMHSA is accepting grant applications for the Screening, Brief Intervention, Referral and Treatment (SBIRT) Medical Residency Program.

The primary purpose of this cooperative agreement is to develop training programs to teach medical residents skills to provide evidence-based screening, brief intervention, brief treatment, and referral to specialty treatment for patients who either have or are at risk for a substance use disorder.

The cooperative agreements will be awarded by SAMHSA's Center for Substance Abuse Treatment (CSAT).

Application due date: April 30, 2008

Awards: Up to 10 cooperative agreement grant awards, each for \$375,000 per year for up to 5 years, to develop training programs.

Grant Number: TI-08-003, \$3.75 million

Applications are available by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) or by downloading from the Federal Government's comprehensive grants Web site at www.grants.gov.

For more about SAMHSA grants, visit SAMHSA's Web site at www.samhsa.gov/grants.

President's Budget Focuses on Priority Initiatives

SAMHSA recently presented its Fiscal Year (FY) 2009 Congressional Justification, outlining a budget request totaling \$3.2 billion. The request reflects President George W. Bush's focus on balancing the budget by 2012.

The Justification also echoes SAMHSA's focus on sustaining important initiatives to build resilience and promote recovery for people across the Nation.

Although the budget request reflects a 6-percent reduction from the FY 2008 enacted level, it continues support for the priority initiatives identified by President Bush and Health and Human Services Secretary Michael O. Leavitt.

The President's Budget also makes performance-driven, targeted reductions in areas where grantees have not demonstrated improved health outcomes, grant periods are ending, activities can be supported through other funding streams, or efficiencies can be realized.

With a focus on a life in the community for everyone, SAMHSA's Congressional Justification provides a financial incentive for states and territories to improve their substance abuse prevention and treatment services.

The Justification also provides flexibility for states and localities to respond to their unique behavioral health needs. It also prioritizes programs that use local resources to achieve improved health outcomes.

"SAMHSA's budget request is built around a public health approach that seeks to reduce the risk for substance abuse and mental illness in the community," said SAMHSA Administrator Terry L. Cline, Ph.D. "This approach is comprehensive and also is designed to help those in need of treatment services to obtain them."

The President's FY 2009 Budget for SAMHSA's Programs of Regional and National Significance proposes \$155.3 million for the Center for Mental Health



Services (CMHS), \$158.0 million for the Center for Substance Abuse Prevention (CSAP), and \$336.8 million for the Center for Substance Abuse Treatment (CSAT).

New Programs

SAMHSA's Congressional Justification supports several new programs.

Mental Health and Prevention Targeted Capacity Expansion (TCE). More than \$14 million is proposed to help communities bridge gaps in mental health and prevention services. Grants will be awarded to state and local governments, communities, and tribes to provide evidence-based treatment and prevention practices to address emerging health needs.

Mental Health TCE. Up to 14 TCE grants will be awarded to address emerging mental health needs, including those for school violence, post-traumatic stress disorder, homelessness, and the needs of older adults.

Prevention TCE. Up to 14 TCE grants will be awarded to address needs related to methamphetamine or alcohol activities, or other local priority areas.

Data Evaluation. Slated to begin in 2009, \$2.5 million is allotted for a comprehensive needs assessment and evaluation of substance abuse data surveillance systems across the Government in order to improve data collection, reduce costs, and eliminate duplicative systems.

All SAMHSA data collection programs will be evaluated, including the National Survey on Drug Use and Health (NSDUH), the Drug Abuse Warning Network (DAWN), the National Survey of Substance Abuse Treatment Services (N-SSATS), and the Treatment Episode Data Set (TEDS).

Program Increases

SAMHSA's Congressional Justification also provides additional funding for successful grant programs.

Screening, Brief Intervention, and Referral to Treatment (SBIRT). The FY 2009 budget includes \$56.2 million for SBIRT, an increase of \$27.0 million over FY 2008. Initiated in CSAT in 2003, the program educates patients about the consequences of substance abuse and integrates screening, brief intervention, referral, and treatment services into general medical and primary care settings. (See cover story.)

The SBIRT approach allows providers to intervene early, before individuals become addicted, to help prevent the harmful effects of substance abuse.

Treatment Drug Courts. In support of increased collaboration and coordination with the U.S. Department of Justice, a total of \$40.0 million is proposed for drug and mental health treatment courts—an increase of \$30.0 million from FY 2008.

Mental Health Drug Courts. Of the total, \$2.2 million is proposed for five grant awards to help ensure clients have access to a full range of mental health and recovery support services. Mental health courts seek to reduce recidivism by offering the possibility of dismissal of charges or reduced sentencing upon successful completion of mental health treatment.

Treatment Drug Courts. The allotment will fund all grant and contract continuations and create 82 new grants. SAMHSA's criminal justice program grantees focus on diversion and reentry for adolescents and adults with substance use disorders. Treatment drug courts are designed to combine the sanctioning power of courts with effective treatment

services to break the cycle of child abuse and neglect or criminal behavior, alcohol and drug use, and incarceration. (See *SAMHSA News* online, March/April 2006.)

Children’s Mental Health. The budget includes \$114.5 million, an increase of \$12.2 million from FY 2008, to fund 75 children’s mental health services grants and contracts. This program directly supports SAMHSA’s Children and Families priority area.

First authorized in 1992, the program supports the development of comprehensive, community-based systems of care for children and adolescents with serious emotional disorders and their families. (See *SAMHSA News* online, May/June 2007.)

Projects for Assistance in Transition from Homelessness (PATH). In FY 2009, the PATH formula grant program is allotted \$59.7 million, an increase of \$6.4 million from FY 2008. These funds are expected to allow the program to contact approximately 150,000 people.

Established in 1991, PATH funds community-based support services to individuals with serious mental illnesses who are homeless or at risk of becoming homeless. Grantees help link hard-to-reach people who are homeless with mental health and substance abuse treatment and housing, regardless of the severity and duration of these individuals’ illnesses.

Substance Abuse Prevention and Treatment (SAPT) Block Grant. The budget includes \$1.8 billion, an increase of \$20 million from FY 2008, for the SAPT Block Grant. The program’s overall goal is to support and expand substance abuse prevention and treatment services while providing maximum flexibility to the states, territories, and tribes receiving funding.

The SAPT Block Grant program has expanded treatment by supporting more than 1.8 million client admissions to treatment programs that receive public funding.

Access to Recovery (ATR). The President’s ATR initiative, which gives vouchers to clients in substance abuse treatment so they can access treatment and support services, is slated to be funded at \$99.7 million in FY 2009.

This funding will support 24 continuation grants to states and tribal organizations and includes \$1.7 million in Public Health Service evaluation funds.

Other Funding

Science and Service Activities.

Science and Service programs promote the identification and increase the availability of practices that are thought to have broad potential for service improvement.

SAMHSA’s Congressional Justification requests funding for Science and Service programs for CMHS (\$8.6 million), CSAP (\$13.2 million), and CSAT (\$14.1 million).

Funding supports various activities, including those related to fetal alcohol spectrum disorders, the National Registry of Evidence-Based Programs and Practices, HIV/AIDS education, the SAMHSA Health Information Network, and Addiction Technology Transfer Centers.

SAMHSA’s Congressional Justification is available at <http://samhsa.gov/Budget/FY2009/index.aspx>. For more detailed information about the President’s FY 2009 Budget, visit www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf. ▀

SAMHSA Budget Authority by Activity (Dollars in Millions)

	2007	2008	2009
Substance Abuse:			
Substance Abuse Block Grant	\$1,759	\$1,759	\$1,779
Programs of Regional and National Significance:			
Treatment	399	400	337
Prevention	193	194	158
Subtotal, Substance Abuse	\$2,350	\$2,353	\$2,273
Mental Health:			
Mental Health Block Grant	\$ 428	\$ 421	\$ 421
PATH Homeless Formula Grant	54	53	60
Programs of Regional and National Significance	263	299	155
Children’s Mental Health Services	104	102	114
Protection and Advocacy	34	35	34
Subtotal, Mental Health	\$ 884	\$ 911	\$ 784
Program Management	\$ 93	\$ 93	\$ 97
Total, Program Level	\$3,327	\$3,356	\$3,158
Less Funds Allocated from Other Sources:			
PHS Evaluation Funds	-121	-122	-133
Total, Budget Authority	\$3,206	\$3,234	\$3,025
FTE	528	534	528

Source: U.S. Department of Health and Human Services Web site, “Budget in Brief,” at www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf (page 43, PDF format).

Teens and Drug Use



Stimulant Use and Delinquent Behavior

More than half a million adolescents age 12 to 17 used stimulants nonmedically in the past year, according to a new report from SAMHSA.

Across adolescent age groups, the rate of past-year nonmedical stimulant use increased from 0.7 percent among youth age 12 or 13 to 3.3 percent among those age 16 or 17.

The report, *Nonmedical Stimulant Use, Other Drug Use, Delinquent Behaviors, and Depression among Adolescents*, examines the nonmedical use of stimulants, like methylphenidate and methamphetamine, among youth age 12 to 17 and its association with other illicit drug use, delinquent activity, and major depressive episodes (MDEs).

Types of Behavior

In 2005 and 2006, an estimated annual average of 8.7 million youth age 12 to 17 (34.5 percent) engaged in at least one of six types of delinquent behaviors in the past year:

- Got into a serious fight at school or work
- Got into a group fight
- Carried a handgun
- Sold illegal drugs
- Stole anything worth more than \$50
- Attacked someone with intent to cause serious injury.

Youth who used stimulants nonmedically in the past year were more likely to have participated in each of the six delinquent behaviors in the past year compared with other youth. For example, more than twice the number of youth who used stimulants nonmedically in the past year got into a serious fight compared with youth who did

not use stimulants nonmedically in the past year (47.2 versus 22.5 percent).

Other Findings

In 2005 and 2006, youth age 12 to 17 who used stimulants nonmedically in the past year were more likely to have used other illicit drugs—e.g., marijuana, pain relievers, and inhalants—in the past year compared with youth who did not use stimulants nonmedically in the past year (see chart).

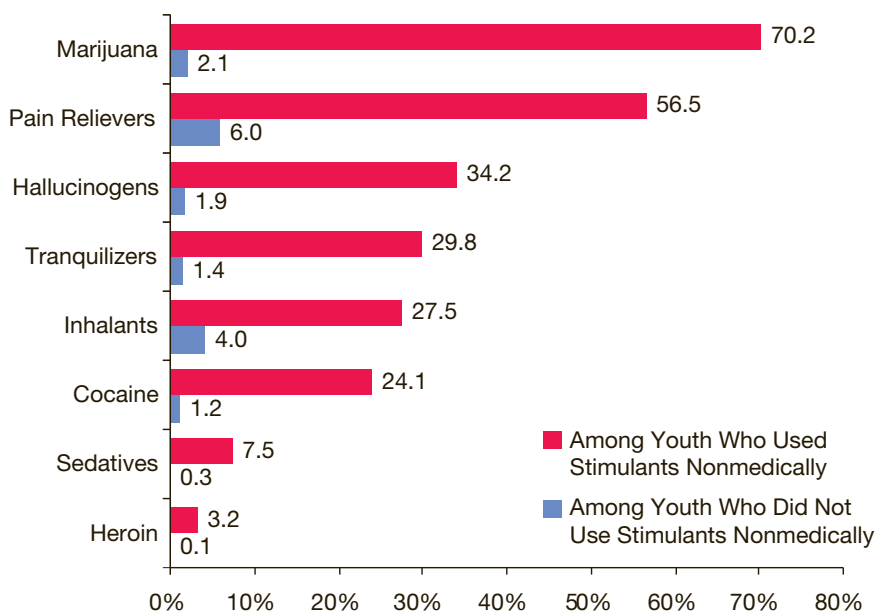
An estimated 2.1 million (8.3 percent) youth experienced at least one MDE in the past year. Youth who used stimulants nonmedically

in the past year were more likely to have experienced a past-year MDE than youth who did not use stimulants nonmedically in the past year (22.8 versus 8.1 percent).

All findings presented are annual averages based on combined 2005 and 2006 National Survey on Drug Use and Health (NSDUH) data.

The full report, *Nonmedical Stimulant Use, Other Drug Use, Delinquent Behaviors, and Depression among Adolescents*, is available for free download from SAMHSA's Office of Applied Studies Web site at <http://oas.samhsa.gov/2k8/stimulants/depression.pdf>. ▀

Percentages of Youth Age 12 to 17 Using Illicit Drugs in the Past Year, by Past-Year Nonmedical Stimulant Use: 2005 and 2006



Source: SAMHSA, Office of Applied Studies (February 28, 2008). The NSDUH Report: *Nonmedical Stimulant Use, Other Drug Use, Delinquent Behaviors, and Depression among Adolescents*.



Statistics on Inhalants Show Young Teens at Risk

For some 12-year-olds and 13-year-olds, getting high is as simple as looking under the sink in the kitchen or out in the garage.

Household cleaning fluids, solvents, glue, and spray paints are among the most frequently abused, common substances categorized as “inhalants.” Inhalants are defined as liquids, sprays, and gases that people sniff or inhale to get high.

According to *Inhalant Use across the Adolescent Years*, a recent report from SAMHSA’s National Survey on Drug Use and Health (NSDUH), inhalants are used by young teens age 12 to 13 more than any other class of drugs.

Glue, shoe polish, and toluene (a solvent) were the most frequently mentioned types of

inhalants used among youth age 12 to 17 who used inhalants for the first time in the 12 months before the survey. A total of 29.6 percent of respondents reported use of inhalants in this category. Gasoline or lighter fluid and spray paints (25.7 and 24.4 percent, respectively) followed.

As part of National Inhalants and Poisons Awareness Week in March, SAMHSA released this report as well as a report on treatment admissions for inhalant abuse.

In addition to household products, inhalants are found in a range of inexpensive and readily available office, industrial, and automotive products.

Young Teens

In the report, combined data from 2002 to 2006 indicate that an annual average of 593,000 adolescents age 12 to 17 had used inhalants for the first time in the year before they took the survey.

While percentages of adolescents using most illicit drugs generally increased with age, the rates of past-year inhalant use increased steadily from 3.4 percent at age 12 to 5.3 percent at age 14, then declined to 3.9 percent by age 17.

Types of inhalants used also varied by age. Among past-year initiates age 12 to 15, common inhalants included gasoline or lighter fluid. Comparatively, nitrous oxide or whippets were the most common type of inhalant used among past-year inhalant initiates age 16 or 17.

Treatment Admissions

In another report from SAMHSA, *Adolescent Admissions Reporting Inhalants: 2006*, data showed that adolescents age 12 to 17 represented 48 percent of all substance abuse treatment admissions reporting inhalants. The report from the Drug and Alcohol Services Information System (DASIS) examines adolescent substance abuse treatment admissions who reported using inhalants and compares them with those adolescent admissions who did not report using inhalants.

According to the report, adolescents who reported inhalant abuse were more likely to have a co-occurring mental health problem. Forty-five percent of adolescent admissions reporting inhalants had a concurrent psychiatric disorder, in contrast to only 29 percent who did not report inhalants.

Both reports are available online on SAMHSA’s Web site at www.oas.samhsa.gov. ▶



State by State: Substance Use, Mental Health Statistics

A new report from SAMHSA gives a state-level view of substance abuse and mental health problems across the Nation.

The report, *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*, focuses on data collected from interviews with youth and adults. The report offers estimates for 23 measures, with topic areas including illicit drug use, alcohol use, tobacco use, and mental health problems.

Illicit Drug Use

The combined data from 2 years of SAMHSA's National Survey on Drug Use and Health (NSDUH) show that 10.4 percent of all persons age 12 or older reported marijuana use in the past year. Young adults reported the highest rate of past-year use of marijuana (28.0 percent).

Vermont had the highest rates of past-year and past-month marijuana use among persons age 12 or older (15.5 percent and 9.7 percent, respectively). Vermont also had the highest rates of past-year

and past-month marijuana use among persons age 18 to 25 (41.9 percent and 28.3 percent, respectively).

In contrast, Utah had the lowest rates of past-year and past-month marijuana use among persons age 18 to 25 (18.9 percent and 9.6 percent, respectively), and that state also had the lowest rates of past-year and past-month marijuana use among persons age 12 or older (4.3 percent).

During 2005 to 2006, 5.0 percent of all people age 12 or older reported having used pain relievers nonmedically in the past year—an increase of 4.8 percent over the previous period of 2004 to 2005. (See *SAMHSA News* online, November/December 2007 and January/February 2008.)

Substance Dependence and Abuse

Past-year dependence on or abuse of alcohol remained unchanged between 2004 to 2005 and 2005 to 2006 at 7.7 percent for all persons age 12 or older.

Nationally, in 2005 to 2006, about 2.8 percent of people age 12 or older were dependent on or had abused illicit drugs in the past year. Among youth age 12 to 17, the rate of illicit drug dependence or abuse was 4.7 percent in 2005 to 2006, down from 5.0 percent in 2004 to 2005.

Eight states that ranked in the highest fifth for past-year alcohol dependence or abuse also ranked in the top fifth for past-year dependence on or abuse of alcohol or illicit drugs among people age 12 or older (Colorado, District of Columbia, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming).

Mental Health Problems

In 2005 to 2006, 11.3 percent of adults age 18 or older reported experiencing serious psychological distress (SPD). Nationally the rate of adults age 18 to 25 experiencing SPD decreased from 19.4 percent in 2004 to 2005 to 18.1 percent in 2005 to 2006.

The rate of people age 18 or older having a past-year major depressive episode (MDE) was 7.3 percent, a decrease from 2004 to 2005 (7.7 percent). For this population, Nevada had the highest rate (9.4 percent) of experiencing MDE in the past year, and Hawaii had the lowest rate (5.0 percent).

In addition, in 2005 to 2006, there were national-level decreases in MDE rates among youth age 12 to 17 and adults age 18 to 25 as compared to levels in 2004 to 2005.

State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health is available on the Web at www.oas.samhsa.gov/2k6state/2k6state.pdf. For related publications and information, visit the Web site of SAMHSA's Office of Applied Studies at www.oas.samhsa.gov.

State Statistics on Alcohol Use

Recent state data (2005 to 2006) include the following:

Past-month alcohol use. Among all persons age 12 or older, the rate of past-month alcohol use ranged from a low of 32.4 percent in Utah to a high of 63.1 percent in Wisconsin.

Binge alcohol use. The rate of binge alcohol use among youth age 12 to 17 decreased from 10.5 percent in 2004 to 2005 to 10.1 percent in 2005 to 2006. However, the rates among young adults age 18 to 25 and those age 26 and older did not change. The highest rate of binge drinking

occurred among people age 18 to 25, with North Dakota posting the highest rate in the age group (56.5 percent).

Underage drinking. At the national level, no significant change occurred in underage alcohol use between 2004 to 2005 and 2005 to 2006. Past-month underage drinking ranged from a low of 21.5 percent in Utah to a high of 38.3 percent in Vermont. Georgia had the lowest rate for past-month underage binge drinking, and North Dakota had the highest rate (28.5 percent). ▶

New Data on Treatment Admissions

Alcohol Abuse Highest, but Methamphetamine, Marijuana, Prescription Painkillers on the Rise

Problems with alcohol as a primary substance of abuse accounted for 40 percent of the 1.8 million admissions in 2006 for substance abuse treatment in the United States.

The latest SAMHSA report, *Treatment Episode Data Set (TEDS) Highlights—2006: National Admissions to Substance Abuse Treatment Services*, presents details of the demographic and substance abuse characteristics of these admissions for alcohol or drug abuse treatment.

2006 Highlights

Five substances accounted for 96 percent of all TEDS admissions in 2006: alcohol (40 percent); opiates (18 percent, primarily heroin); marijuana/hashish (16 percent); cocaine (14 percent); and stimulants (9 percent, primarily methamphetamine). Of primary alcohol admissions, 45 percent reported secondary drug abuse as well.

Although the largest share of treatment admissions is still for alcohol, this percentage is markedly lower than the 51-percent share of admissions for alcohol abuse treatment in 1996. The TEDS 2006 report also reveals that, over the same 10-year period, the percentages of admissions for abuse of methamphetamine, prescription painkillers, and marijuana increased.

Although the percentage of admissions for primary heroin abuse is at about the same level it was a decade ago (14 percent), the percentage of treatment admissions for other opiates—mainly misused prescription painkillers—increased from 1 percent in 1996 to 4 percent in 2006.

The proportion of admissions for primary marijuana abuse increased from 12 percent in 1996 to 16 percent in 2006. The average age of those admitted for marijuana



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- Opiates (18 percent, primarily heroin)
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- Cocaine (14 percent)
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treatment was significantly younger (age 24) than the average age for all substance abuse treatment admissions (age 34).

Smoked cocaine (crack) represented 71 percent of all primary cocaine admissions in 2006. Among non-smoked cocaine admissions, 80 percent reported inhalation as the route of administration, 11 percent reported injection, and 7 percent reported oral.

Although relatively small, the percentage of treatment admissions primarily due to methamphetamine/amphetamine abuse nearly tripled from 3 percent in 1996 to 9 percent in 2006.

Referrals

The criminal justice system was the principal source of referral for 55 percent of all the treatment admissions for methamphetamine/amphetamine abuse. Of TEDS admissions in 2006, 63 percent

entered ambulatory treatment, 20 percent entered detoxification, and 17 percent entered residential/rehabilitation treatment.

The TEDS 2006 report is the latest in a series of yearly reports providing demographic and other information on substance abuse treatment admissions from state-licensed treatment facilities (most of them publicly funded).

The report does not include information on all treatment admissions. However, TEDS is the largest, most comprehensive study of its kind in the United States.

The TEDS report is available on the SAMHSA Web site at <http://oas.samhsa.gov/teds2k6highlights/TOC.cfm>, or by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). Ask for publication number SMA08-4313. ▶

What Is TEDS?

TEDS is an administrative database. States collect information on clients admitted to treatment from providers (facilities) as part of standard administrative procedures. States then extract common data elements from this information and submit them to SAMHSA. These common data elements comprise TEDS. ▶

Study Helps Dispel Substance Use Myth

Rural Communities at Risk

Is substance abuse among adolescents predominantly an urban problem? According to a recent study, it's not.

The results of a national comparison of drug use patterns across various types of counties throughout the United States dispel the myth that substance use among adolescents is higher in metropolitan areas.

On the contrary, based on data from the 2002 to 2004 National Survey on Drug Use and Health (NSDUH), adolescents in rural and urbanized nonmetropolitan counties are just as likely to use illegal drugs as their counterparts in metropolitan areas.

"This analysis is significant because we were able to take the most detailed look to date at drug use patterns in rural areas of the United States," said Joseph C. Gfroerer, Director, Division of Population Surveys, at SAMHSA's Office of Applied Studies (OAS).

The redesign and expansion of the NSDUH in 1999 enhanced its capability for studying rural substance use because of the much larger sample and better coverage. Previous studies on national drug use have offered limited information on use in rural areas, explained Mr. Gfroerer.

Study results were reported in an article, "Drug Use Patterns and Trends in Rural Communities," which appeared recently in *The Journal of Rural Health*. Mr. Gfroerer was one of the authors along with another OAS staff member, James D. Colliver, Ph.D.

"Data from this study can guide treatment professionals and prevention planners in thinking about where the problems are and what needs to be done," Dr. Colliver said.

Data on rural drug use may be helpful to substance abuse counselors and other health providers in developing substance use interventions specifically for youth. Targeting prevention resources to young people in rural areas could prevent a future increase in drug use among rural adults as today's adolescents grow older.

In addition, by knowing basic drug use patterns and differences across geographic areas, care providers and other medical professionals may be able to meet the need for treatment services more efficiently.

Major Findings

According to the report:

- Adolescents (age 12 to 17) across all types of counties generally displayed similar levels of illegal drug use.
- Adolescents in rural counties were more likely to have used stimulants and methamphetamine in the past year than their counterparts in metropolitan counties. Rural youth also had higher rates of alcohol and tobacco use.
- Ecstasy use among adolescents was higher in metropolitan and urbanized nonmetropolitan counties than in rural counties.

The researchers also surveyed adults (age 18 or older) about their drug use. Overall, rural adults were less likely to have used illegal drugs and alcohol than adults in metropolitan areas. However, rural adults were more likely to have used methamphetamine and showed higher rates of tobacco use.

Marijuana Use Patterns

Overall, levels of marijuana use were similar for adolescents in rural and metropolitan counties. The researchers compared risk factors for marijuana use and found that regardless of county type, marijuana use was higher among youth who used cigarettes and alcohol.

Other risk factors varied by county type. For example, in rural counties, males and females were equally likely to have used marijuana. In other counties, males were at higher risk for marijuana use than females.

In rural counties, adolescents whose family income was below \$20,000 were at greater risk for marijuana use. This pattern was not seen in other counties.

For adolescents in all types of counties, the risk of marijuana use was higher for American Indians than for whites. In metropolitan counties, American Indian adolescents were 50 percent more likely to use marijuana than white adolescents, but in rural counties they were 500 percent more likely to do so.

For more on rural issues related to substance use, read *SAMHSA News*, July/August 2007. For additional reports and statistics, visit SAMHSA's OAS Web site at www.oas.samhsa.gov. Data collected from the 2007 NSDUH will be available later this year. ▶

—By *Erin Bryant*

Citation: Joseph C. Gfroerer, B.A.; Sharon L. Larson, Ph.D.; James D. Colliver, Ph.D. Drug Use Patterns and Trends in Rural Communities. *The Journal of Rural Health* (2007); Volume 23, Issue s1, pages 10–15. ▶



Impact of Hurricanes Katrina, Rita

Among persons living in areas affected by Hurricanes Katrina or Rita, adults forced from their homes for 2 weeks or longer were much more likely to report mental health and substance abuse problems than those who were not displaced, according to a recent report from SAMHSA's National Survey on Drug Use and Health (NSDUH).

Past-month illicit drug use was reported by 10.5 percent of adults displaced for 2 weeks or longer compared to 4.9 percent for those who had not been dislocated. Similarly, 25.7 percent of those experiencing prolonged dislocation suffered from serious psychological distress compared to 9.2 percent of those adults who were not forced from their homes.

For the complete report in PDF and HTML formats, visit SAMHSA's Web site at <http://oas.samhsa.gov/2k8/katrina/katrina.pdf>. ▶



Community Prevention Day 2008

SAMHSA's Center for Substance Abuse Prevention (CSAP) convened the fourth annual Community Prevention Day on February 11. The theme of this year's event is leadership and how it affects the vulnerable populations and communities that CSAP serves. This unique gathering of CSAP grantees, community organizations, prevention leaders, and public health activists from across the country came together to learn more about training and assistance available on topics related to substance abuse prevention. ▶

New Funding Opportunities: Circles of Care, Jail Diversion, Child Traumatic Stress

For Fiscal Year 2008, SAMHSA funding opportunities include the following:

- **Circles of Care IV: Infrastructure Development for Children's Mental Health Systems in American Indian/Alaska Native Communities** (Application due date: May 9, 2008)—up to 7 grants for up to 3 years, each totaling up to \$305,875 per year, to provide tribal and urban Indian communities with tools and resources to design a holistic, community-based system of care to support mental health and wellness for their children, youth, and families. (SM-08-012, \$2.14 million)
- **Jail Diversion and Trauma Recovery Program—Priority to Veterans** (Application due date: May 8, 2008)—up to 6 grants for up to 5 years in the amount of up to \$412,500 annually to reach the growing number of individuals with post-traumatic stress disorder and trauma-related disorders

involved in the justice system. (SM-08-009, \$2.48 million)

- **Adult Criminal Justice Treatment** (Application due date: May 2, 2008)—up to 7 grants over 3 years, each totaling up to \$400,000 annually, to address gaps in substance abuse treatment services for adults involved with the criminal justice system. (TI-08-012, \$2.7 million)
- **National Child Traumatic Stress Initiative Community Treatment and Services Center** (Application due date: April 29, 2008)—up to 7 grants for up to 4 years, each for up to \$400,000 a year, to improve treatment and services for children and adolescents who have experienced traumatic events, with priority given to applicants in the Gulf Coast areas of Louisiana, Florida, Texas, Alabama, and Mississippi. (SM-08-010, \$3 million)

- **Targeted Capacity Expansion for Community Substance Abuse Services** (Application due date: April 18, 2008)—up to 14 Category 1 grants for American Indian/Alaska Native and Asian American/Pacific Islander populations, up to \$250,000 annually for up to 3 years; 8 Category 2 grants for Local Recovery-Oriented Systems of Care, up to \$400,000 annually for up to 3 years. (TI-08-005, \$7 million) ▶

Applying for a Grant

Applications are available by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). For more information, visit SAMHSA's Web site at www.samhsa.gov/grants or the Federal grants Web site at www.grants.gov. ▶



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, grant awards and funding opportunities, and available resources in print and online.

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Making Workplaces Drug-Free

Data show that the majority of Americans who use illicit drugs or abuse alcohol are employed full time (see *SAMHSA News* online, September/October 2007).

To help employers establish a drug-free workplace, SAMHSA's Division of Workplace Programs recently released a new resource—*Making Your Workplace Drug-Free: A Kit for Employers*.

In an expandable 3-ring binder, the kit can be tailored for public and private workplaces of all sizes.

What's in the Kit

The kit contains 9 brochures, 13 fact sheets, a bumper sticker that reads, "Welcome to a Drug-Free Workplace," and 2 large posters for display. The fact sheets cover prevention resources, building awareness, principles of successful programs, and information about drug testing.

SAMHSA's kit offers extensive guidance through the process.

- **Understand the legal requirements.** Federal, state, and local statutes and regulations should be taken into account when developing a drug-free workplace

policy. The kit provides background materials and resources to assist employers.

- **Build a team.** Cooperation, collaboration, and shared responsibility are the cornerstones of a successful drug-free workplace program. Team members frequently include representatives from management, human resources, security, and the general workforce population.

- **Assess your workplace.** Employers should examine what substance abuse issues their workplace faces. Employers can identify resources and strengths, examine policy and program options, and take the best steps to prevent and reduce alcohol- and other drug-related problems.

- **Develop a policy.** A drug-free workplace program includes a written policy available to all employees. The kit offers key elements for a policy, including information on laws and regulations.

- **Plan and execute a program.** Steps are listed to help employers build a customized program. They include identifying resources and selecting an employee assistance program, a health/wellness program, a drug-testing plan, employee education, and/or supervisor training.

- **Evaluate the program.** Most employers want to know the success of their efforts. The kit provides well-established tools and guidance to evaluate drug-free workplace programs that allow for process, outcome- and cost-related findings.

The kit was developed using the most accepted evaluation tools and methods from researchers and employers in the field—including those from SAMHSA's National Registry of Evidence-Based Programs and Practices.

To order *Making Your Workplace Drug-Free: A Kit for Employers*, contact SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) or 1-800-487-4889 (TDD). Request inventory number SMA07-4230.

For more information, visit SAMHSA's Web site at <http://workplace.samhsa.gov/WPWorkit/index.html>. ▶

Call the Workplace Helpline at 1-800-WORKPLACE!





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