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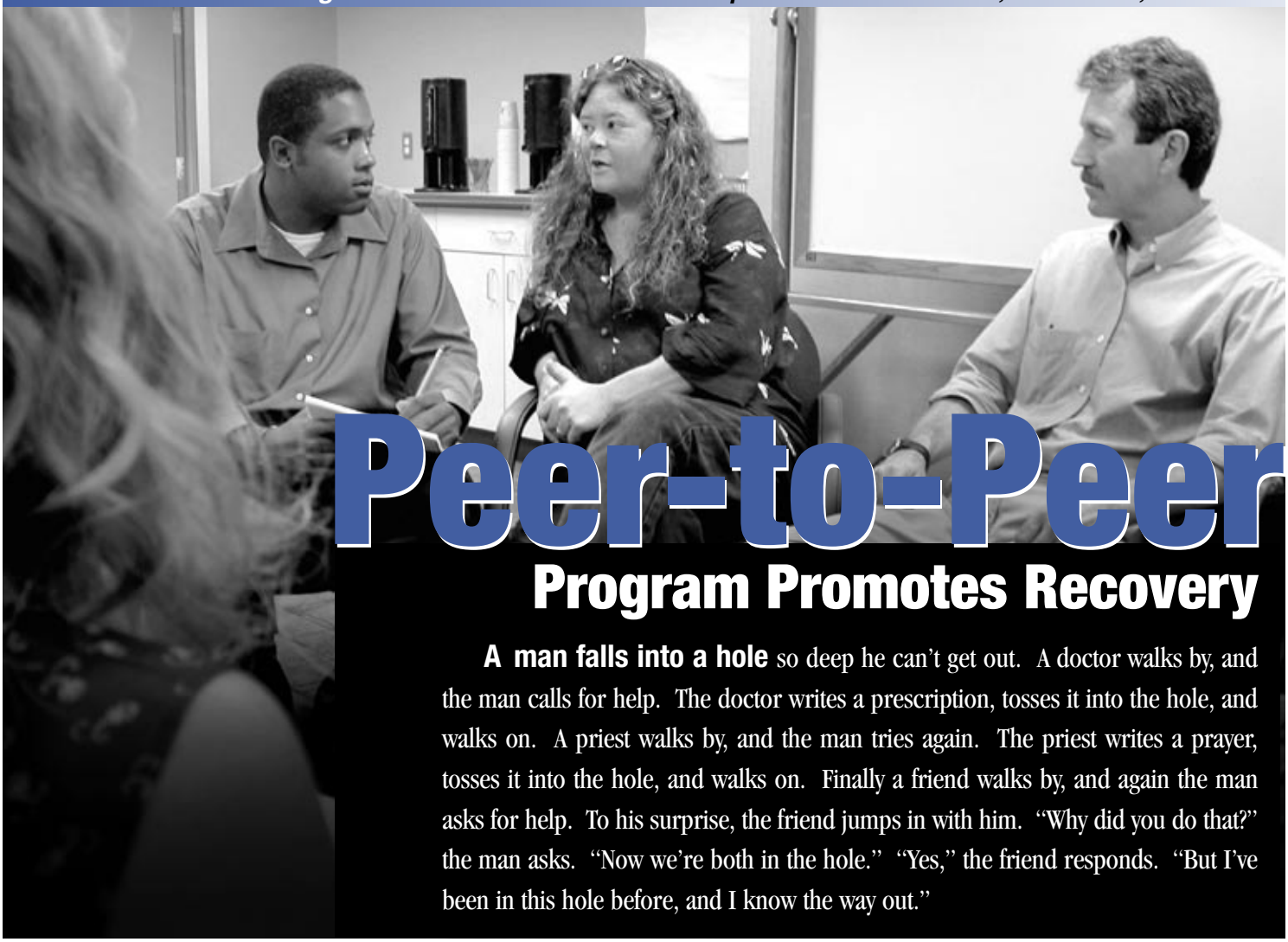

Peer-to-Peer
Program Promotes Recovery

A man falls into a hole so deep he can't get out. A doctor walks by, and the man calls for help. The doctor writes a prescription, tosses it into the hole, and walks on. A priest walks by, and the man tries again. The priest writes a prayer, tosses it into the hole, and walks on. Finally a friend walks by, and again the man asks for help. To his surprise, the friend jumps in with him. "Why did you do that?" the man asks. "Now we're both in the hole." "Yes," the friend responds. "But I've been in this hole before, and I know the way out."

For many people, the story above illustrates perfectly the philosophy of the Recovery Community Services Program at SAMHSA's Center for Substance Abuse Treatment (CSAT). Launched in 2002, the Program promotes the idea that people who have already recovered from alcohol or substance abuse disorders can do a lot to help their peers initiate or sustain their own recovery.

Today, 30 grantees around the Nation are providing peer-to-peer recovery support services to individuals at every stage of recovery, their family members, and other allies. Directed by Catherine D. Nugent, M.S., the Program has three ultimate goals—to prevent relapse, promote recovery, and improve participants' quality of life.

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"The recovery community has become a key player in the addiction, treatment, and recovery fields," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H., noting that peer support complements professional treatment. "Recovery Community Services Program projects are paving the way to concrete improvements in the systems that serve people addicted to alcohol and other drugs. This is an exciting time," Dr. Clark said.

A Long History

The concept of peer support has a long history within the alcohol and substance abuse treatment field. [For information about the parallel history of self-help within the mental health treatment field, see *SAMHSA News,* Spring 1997, "SAMHSA Responds to Growth of the Consumer Movement."]

Since its founding in 1935, for example, Alcoholics Anonymous has brought together millions of people who help each other attain and maintain sobriety. Narcotics Anonymous and similar groups have followed suit. Once the exclusive domain of highly trained professionals, the substance abuse treatment field now embraces self-help groups as a valuable option available to those who need help recovering from alcohol or substance abuse.

"Spending time with others helps create and strengthen those meaningful relationships that are part of our definition of recovery," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Our vision is based on the precept that all people deserve the opportunity for life that includes a job, a home, education, and meaningful relationships with family and friends—in short, a life in the community for everyone. That vision really is the antidote to the emptiness, isolation, and loneliness that weigh heavily on the hearts of people who suffer from addiction."

Underlying the Recovery Community Services Program and other peer-to-peer recovery support efforts is a conceptual framework based on three primary ideas. First, holistic, community-based support services play an important role in helping people sustain long-term recovery from chronic conditions such as alcoholism and substance use disorders. Second, recovery occurs along a "change continuum," and peers can help people move along the continuum by offering hope, motivation, and living proof that treatment works and recovery is possible. Third, social support—in the form of demonstrations of caring, offers of information, concrete assistance, or simple companionship—is important.

"Recovery is a life-long endeavor, but treatment programs end," explained Ms. Nugent, Senior Public Health Advisor in CSAT's Practice Improvement Branch.

"People often need more support than they get from aftercare services or 12-step programs. By drawing on the abilities of people in recovery—and their desire to give something back—we can extend the continuum of recovery services available in the community."

For individuals seeking help, self-help groups offer support, information, and role models in a non-threatening, non-judgmental environment. But participation also helps people who have already recovered, Ms. Nugent stressed. "If you're acting as a role model for recovery, that's a relapse prevention strategy in and of itself," she said.

An Emphasis on Strengths

With the Recovery Community Services Program, CSAT is helping communities create opportunities for people in recovery to help others. The Program grew out of an earlier CSAT effort called the Recovery Community Support Program, which began in 1998.

"That was CSAT's first initiative to reach out directly to people in recovery and their families, ask what their needs were, and begin to organize the recovery community," said Ms. Nugent. "One of the things voiced continually was the need for ongoing support for recovery." In response, the Program's name changed, and its emphasis shifted from mobilizing recovery communities and encouraging their participation in public dialogue about alcohol and drug use to actually providing recovery support services.

Grantees are now at various stages of assessing their specific local needs and developing programs to meet those needs. Some grantees have established peer-led recovery support groups or recovery mentorship programs. Others have focused on education, offering classes or coaching in recovery-related topics and basic life skills such as parenting and job-hunting. Some projects provide concrete assistance to

participants looking for help with housing, employment, parenting, and other everyday tasks, with peers offering assistance with job or school applications, child care, and transportation to support-group meetings. Grantees also provide alcohol- and drug-free social and recreational activities. Some projects offer peer-to-peer services for relatives and friends of people in recovery.

Projects also aim to encourage entire communities to promote recovery. If community norms support being clean and sober, Ms. Nugent explained, people can maintain their recovery with less difficulty.

And no matter what the activity is, the focus is on wellness rather than illness. "These days the recovery field is moving toward a strengths-based approach," said Ms. Nugent. "Instead of focusing on deficits, we're really focusing on what people can bring to the table as gifts. It shifts the lens away from looking at problems to looking for solutions."

Focusing on strengths is also the approach of the Recovery Community Services Program's Technical Assistance Project, housed at Health Systems Research, Inc., in Washington, DC.

"The grassroots leaders we're working with have amazing strengths," said Technical Assistance Manager Tom Hill, M.S.W., a senior policy associate at Health Systems Research. "By taking a strengths-based approach, we can not only meet them where they're at, but also build upon the strengths they already have."

In addition to providing help to grantees, the Technical Assistance Project is summarizing what grantees have learned in a forthcoming series of publications.

A Closer Look

Grantees are creating a wide range of projects to harness the energy and creativity of recovery communities in their areas.

In Colorado Springs, CO, for example, an American Indian organization called White

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From the Administrator

The Promise of Recovery

Increasingly, people coping with mental and addictive disorders are redefining the meaning of recovery. Historically, recovery has been regarded as abstinence from drugs or the absence of symptoms. But emerging definitions seek to go beyond abstinence or absence to include re-engagement with life.

At SAMHSA, our vision is of a life in the community for everyone—a fulfilling life that includes a job, a home, and meaningful relationships with family and friends. Our mission is to make this vision a reality, by building resilience and facilitating recovery for people with substance abuse and mental illness.

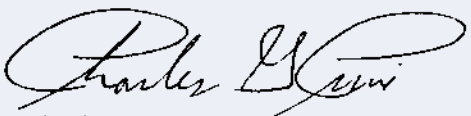
Our vision and our mission guide all our efforts here at SAMHSA: our policies and programs. So it makes sense to evaluate the outcomes of our programs within the context of recovery. SAMHSA has identified several ways to measure resilience and recovery, including, among others, increased or retained employment or school enrollment, increased stability in family and living conditions, and—most important—increased social connectedness. Perhaps more than anything else, a strong support system is essential to help people overcome challenges that might seem insurmountable when confronted alone.

This issue of *SAMHSA News* highlights one such effort—the Recovery Community Services Program—that capitalizes on the unique contribution that people in recovery can make to their peers (see cover story). Services provided by peers in recovery—such as providing information and referral; mentoring others in the areas of life skills, education, and employment; and offering emotional support and guidance based on first-hand experience—complement, extend, and enhance the formal treatment provided by professionals. Peer services simultaneously offer a sense of empowerment to those who have preceded and a positive role model to those who follow.

Equally important, peer services provide the community connectedness and social support that are so necessary to sustain recovery.

At SAMHSA, we recognize that the process of recovery is a highly individualized experience and may include certain components for some people and different ones for others. We likewise recognize that recovery is achieved via many different pathways and that it is a process that may continue in stages that—for many people—may span a lifetime.

Recovery is a journey along a continuum of change. Peers can play a critical role in furthering change by offering hope, motivation, and affirmation that treatment works and recovery is real.



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

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Bison, Inc., has drawn on both Alcoholics Anonymous and Native traditions to create a program called the "Medicine Wheel and 12 Steps." Led by specially trained peers called "firestarters," participants come together in talking circles to support each other in what White Bison calls "wellbriety." There are now about 400 talking circles, more than 700 firestarters, and specialized programs for men, women, boys, girls, friends and family, children of alcoholics, and even prisoners.

This comprehensive approach is key to the project's success, said founder and President Don L. Coyhis, a member of the Mohican tribe. "Say you have a forest of sick trees," he explained. "If you take one of those trees out of the forest, treat it at a nursery until it gets well, and then take it back to the sick forest, what will happen? It will get sick again. If you want to keep the tree healthy, you have to put it back in a circle of trees that are healing."

In Willimantic, CT, a grantee called the Connecticut Community for Addiction Recovery (CCAR) has established the Windham Recovery Community Center. Located in a former crack house in a town once notorious for its heroin use, the center is part of the community's effort to rehabilitate itself. "We're turning Willimantic from 'heroin town' to 'recovery town,' " said CCAR Executive Director Phillip Valentine. "The center's goal is to put a face on recovery and provide a recovery-oriented anchor in the very heart of the community."

Examples of Peer Support Services

- **Recovery support meetings:** Peer-facilitated support groups
- **Peer case advocacy:** Entitlement advocacy with Government agencies for public assistance
- **Life skills instruction:** Courses on money management and saving money, nutrition classes, and workshops on renting an apartment and setting up utilities
- **Health and wellness:** Classes in preventing HIV/AIDS and sexually transmitted diseases and workshops on relapse prevention
- **Education and career planning:** Peer counseling for job readiness, interviewing skills, and appropriate attire.

Staffed by a peer services coordinator who is herself in recovery, the center offers everything from recovery support groups to a database of treatment options, from computer access to a collection of resources that includes "everything CSAT has ever written." There's also a support group for family members of people in recovery. The center's latest project is to map "recovery assets" in a database that will allow the center to match people who have specific skills with people who want to learn them.

"People in recovery generally have a deep gratitude for the second or third or last chance they've been given," said Mr. Valentine. "That's why they want to help people coming up behind them in the process of recovery. What's interesting about 'recovery capital' is that the more you give it away, the more it grows."

In Nashville, the Alcohol and Drug Council of Middle Tennessee used its grant to launch the Nashville Area Recovery Alliance. The alliance achieves its goal of developing the local recovery community's skills through an ongoing series of "recovery learning circles." These free educational opportunities allow people in recovery to share their knowledge with their peers on such topics as legal issues, relaxation, resume writing, and spirituality and religion. There's even a recovery-related book club.

"We exist to help recovering people live better lives by sharing support and skills," explained Rob Simbeck, who serves on the alliance's peer council and facilitates a writing and recovery learning circle. "We form communities that make recovery more fun and teach skills that people desperately need."

The learning circles are not only peer-led but peer-driven. The alliance solicits ideas for possible learning circles from its members, treatment centers, halfway houses, prisons, and elsewhere. Then the group checks a list of its members' strengths to find the best person to facilitate a circle. Most learning circles last an evening or two, although some are ongoing.

"Learning circles are presented by people in or supportive of recovery," explained Mr. Simbeck. "These are people who understand the issues firsthand."

For more information about SAMHSA's Recovery Community Services Program, visit SAMHSA's Web site at **http://rcsp.samhsa.gov.**

—By Rebecca A. Clay

recovering people live better lives by sharing support and skills.

Iowa Has Lowest Drug Use Rate

Past-month illegal drug use by state reached a low of 6.1 percent in Iowa for persons age 12 and older, according to a new report based on SAMHSA's 2002 National Survey on Drug Use and Health (NSDUH). Across the Nation in 2002, an estimated 19.5 million Americans (8.3 percent of the population age 12 and older) had used an illicit drug in the past month. The NSDUH survey is conducted annually by the Agency's Office of Applied Studies (OAS).

The report, *State Estimates of Substance Use from the 2002 National Survey on Drug Use and Health,* estimates state rates of use of illegal drugs, binge drinking, serious mental illness, and tobacco use.

"State-by-state data are powerful tools for policymakers at the Federal, state, and local levels to identify state prevention and treatment needs," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "These data will take on greater value over time, as more data are accumulated and trends can be assessed in greater detail, at both the national and the state levels."

Treatment Need

Regarding treatment for substance abuse, 2.7 percent of persons age 12 or older nationwide (about 6.3 million persons) needed but did not receive treatment for an illicit drug problem, and 7.3 percent needed but did not receive treatment for an alcohol problem in 2002.

States with the highest rates of individuals needing but not receiving substance abuse treatment were mainly in the West, and the states with the highest rates of individuals needing but not receiving alcohol treatment were mainly in the Midwest and West.

Marijuana

Alabama had the lowest rate—4.4 percent—of past-month use of marijuana among persons age 12 and older in 2002. Other states in the lowest fifth for current use of marijuana among persons age 12 and older included Georgia, Iowa, Mississippi, New Jersey, South Carolina, Tennessee, Texas, Utah, and West Virginia.

Other Illicit Drugs

In the category of past-month use of any illicit drug other than marijuana, Alaska, Arizona, the District of Columbia, Louisiana, Nevada, North Carolina, Oklahoma, Oregon, Rhode Island, and Washington comprised the highest tier, with Arizona having the highest prevalence rate, 4.9 percent, among all persons age 12 and older. In the 18-to-25 age group, the rate of past-month use of any illicit drug other than marijuana was highest in Rhode Island (14.1 percent).

Binge Alcohol

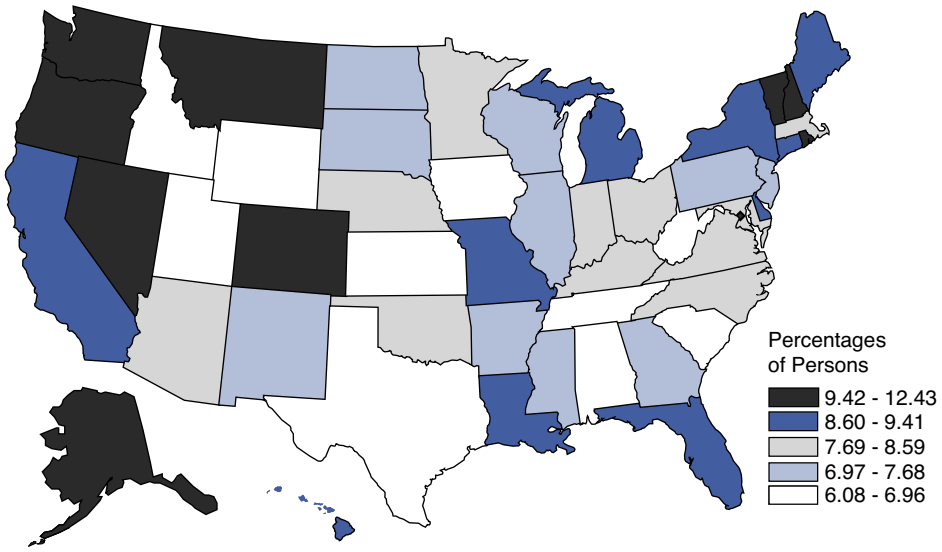
Utah had the lowest rate of binge alcohol use among all persons age 12 and older (16.6 percent), while North Dakota had the highest rate (30 percent). North Dakota also had the highest rate among those age 18 to 25 (55.8 percent) and among youth age 12 to 17 (16.4 percent). Binge alcohol use is defined as drinking five or more drinks on one or more occasions in the past month.

Serious Mental Illness

The 2002 NSDUH report estimates that 8.3 percent of the population age 18 and older had serious mental illness in the past year. Oklahoma reported the highest rate in the Nation, 11.4 percent, while New Jersey reported the lowest rate, 6.5 percent.

For a copy of the report, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The report is also available on SAMHSA's Web site at **www.oas.samhsa.gov.**

Percentages Reporting Past-Month Use of Any Illicit Drug Among People Age 12 or Older, by State: 2002



Source: SAMHSA, Office of Applied Studies, *National Survey on Drug Use and Health,* 2002.

Youth in the Justice System: Improving Services

Each year, juvenile justice systems in the United States encounter youth with critical needs that extend well beyond the walls of the courtroom—or the detention center. These often include substance abuse and mental illness—problems that the justice system is not designed to address.

To assist state and local governments in developing a response to these needs, SAMHSA recently joined with the National Institute on Drug Abuse (NIDA) and the Office of Justice Programs within the U.S. Department of Justice to co-sponsor a National Policy Academy on Improving Services for Youth with Mental Health and Co-Occurring Substance Use Disorders Involved with the Juvenile Justice System. The purpose of the meeting was to provide an opportunity for multidisciplinary teams to create or expand strategic plans that are designed to integrate systems and coordinate services for justice-involved youth with mental health and co-occurring substance use disorders.

Eight teams were chosen from more than 50 applicants, each representing a state or local jurisdiction, to attend the Policy Academy, held in June. Each team comprised administrators from state and county mental health departments and substance abuse service systems, juvenile justice and probation officials, and individuals who themselves had gone through the juvenile justice system—or watched family members do so. Teams could also bring additional representatives—from the judiciary, child welfare, and education systems, and the public defender's office.

In addition to breakout sessions where individual teams worked on their action plans, the Policy Academy included panel presentations on numerous topics of interest to participants. These included effective

treatment interventions, diversion and re-entry programs, program implementation and sustainability, and special issues for girls, sexual minority youth, youth of color, and youth with mental health needs in schools.

Emerging evidence suggests that co-occurring mental and addictive disorders appear to be widespread among youth in the juvenile justice system. In his welcoming remarks, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., reported on a Northwestern University study headed by Linda A. Teplin, Ph.D., and funded by SAMHSA, other Federal agencies, and multiple private foundations.

"This longitudinal study on over 1,800 youth detained in Cook County, IL, found that nearly two-thirds of males and nearly three-quarters of females met diagnostic criteria for at least one mental health disorder . . . [and] approximately half of the youth had a substance use disorder," he said.

Gail Wasserman, Ph.D., of the Center for the Promotion of Mental Health in Juvenile Justice at Columbia University, NY, told participants, "A recent examination of all youth suicides in Utah found that 80 percent had contact with the juvenile justice center in the 12 months prior to their death." According to Dr. Wasserman, youth in the juvenile justice system report higher rates of suicide attempts than do their peers, suggesting a concentrated need for mental health services among youth in the juvenile justice system.

Fortunately, efforts across the country have begun to demonstrate measurable progress in meeting the complex needs of justice-involved youth. Several themes were echoed at the Policy Academy.

- **Understanding of the complexities of co-occurring disorders among justice-involved youth is growing.** Wilson Compton, M.D., M.P.E, Director of NIDA's Division of Epidemiology, Services and Prevention Research, described the Criminal Justice-Drug Abuse Treatment Research Studies (CJ-DATS). This ongoing multisite program is designed to test and generate knowledge about integrated models of substance abuse treatment for incarcerated individuals, including juveniles.

Through its nine research centers, including two centers focused on adolescents in the juvenile justice system, and a coordinating center located at the University of Maryland-College Park, CJ-DATS fosters linkages between researchers, criminal justice professionals, and substance abuse treatment providers at the Federal, state, local, and community level; brings science-to-service models; and will generate new knowledge about what works best for incarcerated individuals with substance abuse disorders.

David Stewart, Ph.D., of the University of Washington's Division of Public Behavioral Health and Justice Policy, provided an overview of the shared factors that predispose youth to both mental illness and substance abuse—including family history and environmental factors. He also described the potential interaction between these disorders: "Mental illness can cause impaired self-regulation, which further predisposes a youth to substance abuse; substance-induced impairment negatively impacts mental health, or wreaks havoc on a youth's home life, which in turn worsens mental health."

- **Effective evidence-based treatment models have been identified.** Three family-centered treatment models—Functional Family Therapy, Multisystemic Therapy, and Oregon Treatment Foster Care—are showing measurable success across multiple sites in reducing re-arrest rates, improving family and school functioning, decreasing mental health symptoms, reducing placements, and saving costs, according to Scott Henggeler, Ph.D., of the Family Services Research Center of Charleston, SC. NIDA's CJ-DATS will generate additional data regarding Functional Family Therapy.
- **Interest in providing appropriate treatment for justice-involved youth extends beyond the treatment community.** Conveying interest from the Department of Justice, Deputy Assistant Attorney General Lizette Benedi, J.D., recalled the founding principles of the juvenile justice system: "the belief that virtually all youth can be rehabilitated; that with the proper support and discipline, they can become productive, successful members of their communities."

The Honorable Patricia Clark, judge at the King County Superior Court in Seattle, described efforts by the American Bar Association and other groups to amend the Judicial Canon of Ethics to support more clearly the involvement of juvenile judges in developing resources to address the needs of youth with mental or addictive disorders in the juvenile justice system.

- **It is possible to coordinate diverse systems and funding streams to meet the needs of justice-involved youth with co-occurring disorders.** Bruce Kamradt, M.S.W., Director of Wraparound Milwaukee in Wisconsin, reported on his program's history and success. Originally funded in 1995 through a Systems-of-Care grant from SAMHSA's Center for Mental Health Services, Wraparound Milwaukee was chosen by the President's New Freedom Commission on Mental Health in 2003 as an exemplary model in the delivery of services to children with serious emotional and behavioral needs. Wraparound Milwaukee provides families one-stop access to more than 80 services for children with serious emotional disturbances and their families. Through pooled funding from child welfare, juvenile justice, Medicaid, and mental health systems, Wraparound Milwaukee provides cost-effective, comprehensive, and individualized care to children with serious emotional disturbances.

Since its inception, Wraparound Milwaukee has contributed to a decrease in the average daily residential treatment population (from 375 to 50); a reduction in psychiatric inpatient days (from 5,000 to less than 200 days per year); and reduced Juvenile Court commitments (from 385 to 285 per year). The average monthly per child cost of Wraparound Milwaukee's comprehensive system of care is $4,200—considerably less than the monthly cost of residential treatment ($7,200), correctional placement ($6,000), or psychiatric inpatient care ($18,000).

As the Policy Academy ended, each team shared its preliminary vision: for some teams, next steps include implementing or expanding a model program; for others, more training, education, and data collection are necessary.

For more information on Criminal and Juvenile Justice, visit SAMHSA's Web site at **www.samhsa.gov.**

—By Melissa Capers

National Policy Academy on Improving Services for Youth with Mental Health and Co-Occurring Substance Use Disorders Involved with the Juvenile Justice System

Coordinated by:

- National Center for Mental Health and Juvenile Justice

In collaboration with:

- Council for Juvenile Correctional Administrators
- National Association of State Mental Health Program Directors

Sponsored by:

- SAMHSA
- National Institute on Drug Abuse
- U.S. Department of Justice, Office of Justice Programs.

The Eight Teams

- Jefferson County, Alabama
- DeKalb County, Georgia
- Tarrant County, Texas
- Louisiana
- New Mexico
- North Carolina
- North Dakota
- Pennsylvania.

Strategic Action Plans Clarify SAMHSA Matrix

Individual Strategic Action Plans for each of the 11 program areas identified in the SAMHSA Matrix of Priority Programs are now available on the SAMHSA Web site.

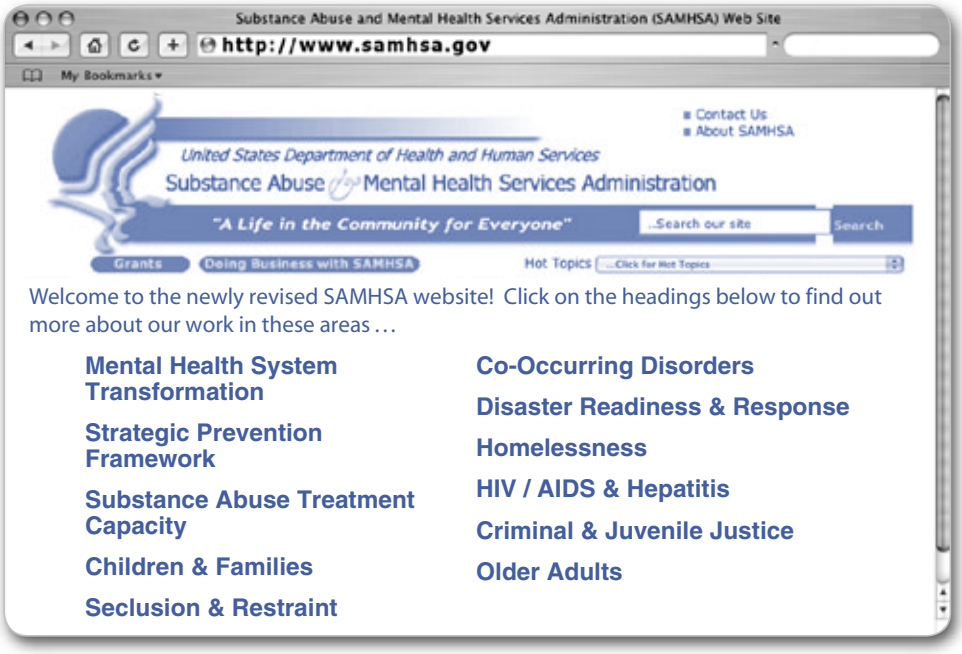
The Agency's priority program areas are Mental Health System Transformation, SAMHSA's Strategic Prevention Framework, Substance Abuse Treatment Capacity, Children and Families, Seclusion and Restraint, Co-Occurring Disorders, Disaster Readiness and Response, Homelessness, HIV/AIDS and Hepatitis, Criminal and Juvenile Justice, and Older Adults.

"The Strategic Action Plans demonstrate how SAMHSA's Priority Matrix provides a blueprint for guiding the Agency's current and future activities," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

As an example of how the Action Plans will work, the SAMHSA Action Plan for Co-Occurring Disorders outlines the Agency's strategy to meet the needs of an estimated 4 million people in the United States affected by co-occurring mental illness and substance abuse disorders.

The plan is driven by two long-term goals. The first goal is to increase the percentage of people with or at risk for co-occurring disorders who receive prevention and treatment services that address both disorders. The second goal is to increase the percentage of people with co-occurring disorders who experience reduced impairment from their co-occurring disorders following appropriate treatment. These goals will be accomplished through a series of activities slated for implementation over the next 2 years. These activities include:

- Continue funding the Co-Occurring State Incentive Grants in fiscal year 2003, and award additional grants in 2004 and 2005.
- Incorporate specific requirements to address co-occurring disorders in state plans developed through the new Child and Adolescent State Incentive Grants.
- Sponsor three National State Policy Academies on Co-Occurring Disorders, each of which will target 10 states, and provide technical assistance to states that participate in the academies.
- Identify peer-reviewed programs and practices focusing on co-occurring disorders that merit inclusion in SAMHSA's National Registry of Effective Programs and Practices.
- Develop and pilot a screening and assessment instrument for co-occurring disorders.
- Work with other Federal agencies to support new research on the prevention and treatment of co-occurring disorders.
- Publish a revised Treatment Improvement Protocol on co-occurring disorders.
- Develop and pilot a resource kit on integrated treatment of co-occurring disorders.
- Provide ongoing technical assistance from SAMHSA's National Co-Occurring Center for Excellence (See *SAMHSA News,* p. 16).
- Work with SAMHSA's partners to improve the quality, availability, and accessibility of treatment for co-occurring disorders.



"Each Action Plan outlines a clear agenda for tackling the challenges before us," Mr. Curie said. "They describe the specific goals we plan to achieve, the activities we intend to support to achieve those goals, and the means by which we will hold ourselves accountable.

"The SAMHSA Priority Matrix continues to be a document in motion," Mr. Curie added. "SAMHSA's stakeholders played an active role in developing the Matrix over the past 2 years, and as their needs evolve, so will the Matrix."

For more information about SAMHSA's Matrix of Priority Programs, visit the SAMHSA Web site at **www.samhsa.gov.**

Complexities of Co-Occurring Conditions Conference

Experts Identify Problems, Examine Solutions

Editor's Note: This article presents an overview of the conference plenaries. Coverage of two specific panels begins on page 14.

Four million American adults suffer from both serious substance abuse disorders and serious mental illness. Yet more than half of these individuals with co-occurring disorders receive neither specialty substance abuse nor mental health treatment, according to a new SAMHSA report.

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., unveiled the report (see details on page 16) at a 3-day conference in June, "Complexities of Co-Occurring Conditions: Harnessing Services Research to Improve Care for Mental, Substance Use, and Medical/Physical Disorders" held in Washington, DC.

Sponsored by SAMHSA, the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Agency for Healthcare Research and Quality (AHRQ), the event attracted hundreds of researchers, prevention specialists, treatment providers, service administrators, policymakers, and consumers. Participants came together in 4 plenary sessions, 25 concurrent panels, and 66 poster presentations to explore ways to better meet the needs of people with co-occurring conditions.

Goals were to encourage collaboration, explore innovative theoretical models and cutting-edge research, and set a research agenda for the future.

"Individuals with co-occurring disorders should be the expectation, not the exception, in the substance abuse treatment and mental health service systems," Mr. Curie told conference participants via video. "Unfortunately, there continue to be many barriers to appropriate treatment and support services. Clearly our systems of services must continue to evolve to reflect the growing evidence base that promotes integrated treatment and supportive services. Both disorders must be addressed as primary illnesses and treated as such."

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Special Report

For additional panel descriptions and more photos, go to *SAMHSA News* online at **www.samhsa.gov/SAMHSA_News.**

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., welcomed conference participants by video telecast. "Individuals with co-occurring disorders should be the expectation, not the exception, in the substance abuse treatment and mental health service systems," he said.

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A Complex Interplay

NIMH Deputy Director Richard Nakamura, Ph.D., opened the conference by describing the prevalence of substance abuse and mental health disorders.

Citing World Health Organization figures, he noted that mental and behavioral disorders such as depression, substance and alcohol use, self-inflicted injury and death, and similar problems play an enormous role in the global burden of disease. "Substance abuse and mental illnesses account for almost 40 percent of the disability in the developed world," he said.

To help conceptualize the complexities of co-occurring conditions, Richard Ries, M.D., a professor of psychiatry at the University of Washington Medical School in Seattle, WA, described a matrix now widely used by states (see illustration on page 11).

Focusing on mental illness and substance abuse, the matrix's four quadrants help users conceptualize levels of severity and the primary focus of treatment for co-occurring disorders. It also shows how the mental health and substance abuse systems may work together to address the needs of this population. For example, treatment for those with high-severity addiction and low-severity mental illness could be based in the addiction system with consultation from mental health. Those with combined high severities of both disorders would need specialized treatment with cross-trained staff, expert on both conditions.

Co-occurring conditions such as HIV/AIDS, hepatitis, or any of the other physical ailments that often accompany mental illness and substance abuse compound the problem.

"As a primary care physician seeing patients who routinely have a half-dozen or more diagnoses, I'm confused by terminology like 'dual diagnosis' and 'comorbidity,' " said Richard Saitz, M.D., M.P.H., an associate professor of medicine and epidemiology at the Boston University Schools of Medicine and Public Health. The former implies there are only two diagnoses, he explained, while the latter implies that one diagnosis is primary.

Urging conference participants to expand their conceptual model to include medical conditions, Dr. Saitz noted that people with psychotic disorders, substance use disorders, or both have higher rates of medical problems like heart disease and asthma than those without mental health conditions. They're also less likely to get optimal care or adhere to treatment regimens.

In the Trenches

How does this complexity play out in real life? Joan Zweben, Ph.D., Executive Director of the 14th Street Clinic and East Bay Community Recovery Project in Berkeley, CA, provided an addiction treatment provider's frontline perspective.

"A unified funding source makes it much easier to provide state-of-the-art treatment," said Dr. Zweben. "It is much more difficult to achieve the same level of services with fragmented funding."

Although the clinic does its best to integrate psychiatric and medical care into its services, it faces several barriers. Graduate training programs, for example, typically don't include substance abuse as part of their core curricula. As a result, said Dr. Zweben, "there's a dearth of cross-trained people." What's needed, she said, is a way to cross-train professionals and to ensure that staff members of substance abuse

Helen Burstin, M.D., M.P.H., Director of the Center for Primary Care, Prevention, and Clinical Partnerships at AHRQ, and Jack B. Stein, Ph.D., Chief of the Services Research Branch at NIDA, welcomed participants to the conference.

Substance abuse is under-addressed despite its contribution to the dynamic of co-occurring conditions, said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment and Co-Lead of SAMHSA's Priority Matrix Program. He added that the tendency to focus on those with the most severe problems means an enormous population in critical need is being overlooked.

treatment programs are developing their skills continuously.

Conflicting licensing, site certification, and other regulations also add to the difficulty of integrating substance abuse, psychiatric, and medical care. While substance abuse treatment programs usually discourage participants from engaging in sexual activity, for example, community care licensing rules prohibit such interference in private lives.

Another barrier is the lack of what Dr. Zweben called a "universal chart," a comprehensive medical record that would cover both substance abuse and mental health treatment. In addition to reducing duplication in data entry, such a chart could also help policymakers keep track of what's happening to those with co-occurring conditions.

An Integrated System

Overcoming those barriers is possible, however. Renata Henry, M.Ed., Director of Delaware's Division of Substance Abuse and Mental Health, described her state's successful model for treating individuals with co-occurring conditions.

Ms. Henry began by adding to the list of barriers to integration.

State mental health and substance abuse systems are typically separate and uncoordinated, she explained. Funding streams usually require single diagnoses, so that individuals need a substance abuse-related diagnosis to get treatment from a substance abuse treatment program and a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition* to get mental health treatment. The two workforces often have different educational backgrounds and treatment philosophies. And there's not a lot of research on evidence-based practices for treating co-occurring disorders.

Faced with such obstacles, Delaware took action. With the state's substance abuse and mental health divisions already integrated administratively, leaders committed to improving services for individuals with co-occurring conditions. They blended funding streams, and they developed a training program so that staff in the mental health, substance abuse,

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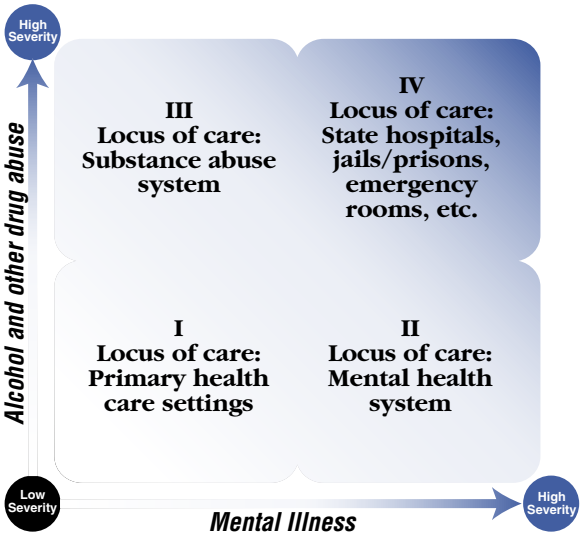


The four-quadrant model provides a conceptual framework for understanding the range of co-occurring conditions and the level of coordination that service systems need to address them.

Joan Zweben, Ph.D.

Renata Henry, M.Ed.

continued from page 11

homelessness, criminal justice, and health care systems are able to treat people no matter what treatment "door" they enter.

More needs to happen to eliminate barriers, Ms. Henry said. Administrators need to establish standards, initiate dialogues, disseminate information and tools, and remove funding and regulatory barriers. The Federal Government should develop policies that encourage integration, eliminate funding barriers, and improve dissemination of research.

Noting that people with alcohol dependence are more likely to have mood disorders, personality disorders, and other drug problems, NIAAA Director Ting-Kai Li, M.D., explained that problem drinkers may be medicating themselves to relieve stress and other conditions.

What Works?

Researchers are already busy trying to determine what treatments work best. But conducting research on co-occurring conditions requires investigators to ask new questions and develop new ways of working, noted Constance Weisner, Dr.P.H., M.S.W., a professor of psychiatry at the University of California and an investigator in the Division of Research at Northern California Kaiser Permanente.

"We need to move away from the traditional paradigm of investigators setting the research agenda alone and move toward developing questions in collaboration with clinicians," she said, noting that health plan administrators, primary care providers, accrediting bodies, policymakers, and others should be involved. She described a cyclical process: a continuous loop of brainstorming questions, studying interventions, implementing findings, and using the results to identify new questions.

Researchers also need to put more emphasis on studying the elements that influence adoption of best practices, said Dr. Weisner. Although a lot of research shows that integrated treatment is effective, for instance, most clinical trials focus on homogeneous populations, which may not represent the demographics of a particular treatment center or service provider accurately.

Incentives for Quality

Financing is one of the real-life factors that affect the treatment of co-occurring disorders.

"Over the last 5 years, national attention on the financing of services for co-occurring conditions has been growing," said Mady Chalk, Ph.D., Director of the Division of Services Improvement at SAMHSA's Center for Substance Abuse Treatment (CSAT). The Institute of Medicine's 2001 report on gaps in health care quality led to an increased focus on measuring quality and developing financial incentives, Dr. Chalk said. The Institute is now drafting a report specifically on substance abuse and mental health.

Constance Horgan, Sc.D., Director of the Schneider Center for Behavioral Health at Brandeis University, called for a

Constance Weisner, Dr.P.H, M.S.W.

Margarita Alegria, Ph.D.

Barriers to Integration of Care

- Separate and uncoordinated systems
- Separate funding streams
- Lack of cross-training
- Philosophical differences
- Conflicting regulations
- Lack of research.

clear and direct link between quality and financing of services for individuals with co-occurring conditions.

As an example, Dr. Horgan described the work of the Washington Circle, a group of researchers, substance abuse treatment providers, health care policy experts, and others convened by CSAT in 1998. The group developed a framework for performance measures across the continuum of care based in four core domains—prevention/education, recognition, treatment, and maintenance of treatment effects. To drive quality improvement in substance abuse treatment, the group has initially developed and tested measures that focus on the front end of treatment: identification, initiation, and engagement.

The National Committee for Quality Assurance, the U.S. Department of Veterans Affairs, and many public systems have adopted these measures or are considering doing so.

In one study of individuals who get health insurance through large employers, the group found that private sector health plans needed to improve significantly on ways to identify substance abusers, and to initiate and sustain treatment.

Health Disparities

Another area that needs improvement is access to treatment of co-occurring conditions for members of all racial and ethnic backgrounds, the conference's last plenary session emphasized.

For example, HIV/AIDS is a condition that often goes hand in hand with substance abuse. The epidemic disproportionately affects African Americans, said NIDA Director Nora D. Volkow, M.D.

She noted that African Americans represent half of all HIV/AIDS cases and that African American women represent about 70 to 75 percent of all infected women. Injection drug use accounts for 30 percent of cases, she explained. Drugs and alcohol play a role in heterosexual transmission of the disease because many individuals are under the influence when transmission occurs.

Pervasive ethnic and racial disparities in substance abuse and mental health treatment are the norm, reported Margarita Alegria, Ph.D., a professor at Harvard Medical School and Director of the Cambridge Health Alliance's Center for Multicultural Mental Health Research. The underlying reasons for these disparities in services are not fully understood, Dr. Alegria said. She emphasized that understanding these factors is critical because of the rapid growth of ethnic and racial minority populations across the Nation.

For more information on co-occurring disorders, visit SAMHSA's Web site at **www.samhsa.gov.** More details about the conference are available at **www.cccconference.com.**

—By Rebecca A. Clay

Resources on Co-Occurring Disorders

SAMHSA's Report to Congress

The full text of SAMHSA's *2002 Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders* is available on the SAMHSA Web site. Chapters include information on characteristics and needs of individuals with co-occurring disorders, evidence-based practices, barriers to treatment, Federal block grants and state program activities, and the Agency's 5-year blueprint for action. Visit **www.samhsa.gov/reports/congress2002/index.html.**

Developing Treatment Programs

SAMHSA's *Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders* provides information on methodology and key lessons on designing services for adults with co-occurring disorders. This resource also includes appendices with information from expert panels and telephone surveys, as well as training curricula.

Both publications are available from SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the publications are available at **www.oas.samhsa.gov.**

NIDA Director Nora D. Volkow, M.D., speaks about the importance of ensuring that children and adolescents are one of the primary focuses of prevention research because they are at the greatest risk when it comes to substance abuse. An important component of this research is studying developmental changes—particularly in the brain—that may make adolescents more susceptible to addiction.

Conference Panel: *Improving Outcomes*

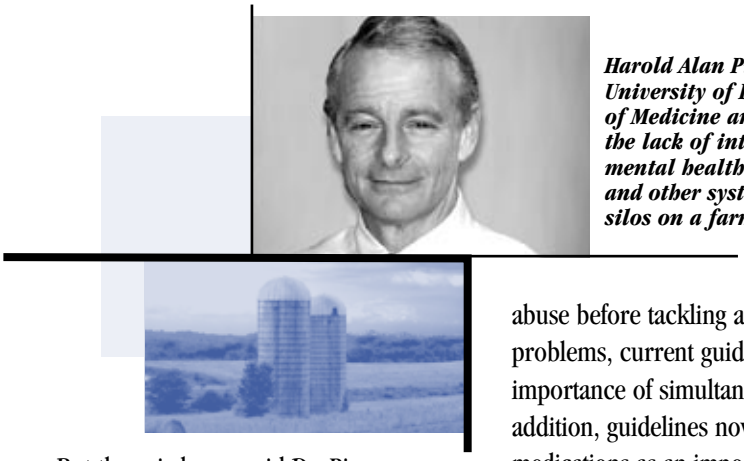
Editor's Note: Twenty panels convened over 3 days at the Complexities of Co-Occurring Conditions Conference held in Washington, DC, June 23 to 25. Two panels are described here. Additional panel coverage and photos are available online at ***www.samhsa.gov/SAMHSA_News.***

A farm scene was probably the last thing conference participants expected to see at a session on "Improving Outcomes Through Organizational and Policy Change."

But to Harold Alan Pincus, M.D., a professor and Executive Vice Chair of the Psychiatry Department at the University of Pittsburgh School of Medicine, the image's depiction of silos perfectly illustrated the lack of integration between mental health and substance abuse systems. "Silo-ization" is one of the biggest barriers to integrating services for co-occurring disorders, said Dr. Pincus, who is also a senior scientist at the RAND Corporation and Director of the RAND-University of Pittsburgh Health Institute.

Administrative obstacles include separate funding streams, different licensing and credentialing requirements, and an overall scarcity of resources that leads to increased competition. Clinical obstacles include the dearth of empirical data, confusion about appropriate roles, and the fact that one condition can exacerbate the symptoms of another and prevent successful engagement in treatment.

Important philosophical differences also exist between the two communities. Substance abuse treatment providers are often reluctant to allow psychotherapeutic medications for individuals with mental illness. On the other hand, mental health treatment providers often require individuals to be both alcohol- and drug-free as a condition for entry into treatment.



Harold Alan Pincus, M.D., of the University of Pittsburgh School of Medicine and RAND, compared the lack of integration among the mental health, substance abuse, and other systems to separate silos on a farm.

But there is hope, said Dr. Pincus, citing SAMHSA's *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders,* the Agency's State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders, and the creation of a Co-Occurring Center for Excellence (see page 16).

Audrey Burnam, Ph.D., of RAND then described how state mental health, substance abuse, and Medicaid authorities are tackling the problem of co-occurring disorders.

Summarizing the results of a 23-state study, she said that all made broad efforts to build consensus and cross-train workforces. Some states already had changed regulations or policies to facilitate integration, such as adapting reimbursement rules, modifying licensing requirements, and setting standards for provider competence.

Katherine E. Watkins, M.D., M.S.H.S., a natural scientist in the health program at RAND, summarized a literature review of evidence-based practices for those with substance use disorders and affective or anxiety disorders.

Surveying documents produced between 1990 and 2002, the researchers noticed two broad shifts in thinking. While earlier publications urged providers to treat substance abuse before tackling any mental health problems, current guidelines emphasize the importance of simultaneous treatment. In addition, guidelines now view psychiatric medications as an important part of treatment for those with co-occurring conditions.

Robert Drake, M.D., Ph.D., Vice Chair for research in the psychiatry department at Dartmouth Medical School, then reviewed the data for people with more severe mental illness and less severe substance abuse, a category of co-occurring conditions that has been more extensively studied than others.

There is plenty of evidence—29 controlled studies so far—to show that integrated treatment does work, according to Dr. Drake.

Although it's still not clear which specific interventions work best, researchers have identified several key components of integrated treatment:

- Persons should receive individualized treatment from a clinician or team able to address both mental health and substance abuse disorders.
- Treatment should proceed in stages. Providers should first engage individuals in treatment, provide therapy designed to motivate them to change, and only then provide active treatment.
- Treatment providers should also address other problems individuals face, such as housing, jobs, and family issues.

—By Rebecca A. Clay

Conference Panel: *Housing and Treatment*

A man who is homeless and mentally ill is attacked and set on fire. After medical treatment of his injuries, he is discharged back to the streets, where an infection develops that results in the amputation of both his legs.

What do you do when this man tells you that it's hard for him to live indoors, and he wants to go hang out on the streets with his buddies? If you're Joshua Bamberger, M.D., M.P.H., Medical Director of the San Francisco Department of Health's Division of Housing and Urban Health, you provide housing through the Direct Access to Housing (DAH) program—and a bus ticket—so that after spending a day with his friends, this man can make his way back home safely.

Dr. Bamberger shared this story at the "Housing and Treating the Homeless" panel as a way of describing the balance between housing and treatment in San Francisco's DAH program. Safe, permanent housing is a central priority of the DAH program. Homeless persons with mental health and substance use disorders are moved into permanent housing directly from emergency shelters, emergency rooms, mental hospitals, and the street, without a requirement that they engage or remain in treatment.

Treatment is available, residents are safer than they would be on the street, and DAH staff members are trained in a management approach called "active engagement." Going well beyond the traditional landlord role, DAH staff members check on and provide support to residents. They offer services that can include rental assistance and treatment referrals.

Positive Outcomes

Dr. Bamberger and other panelists presented evidence suggesting that the provision of housing can have multiple positive outcomes for homeless people with co-occurring disorders—including increasing the effectiveness of substance abuse treatment. Several of the programs described during the panel presentation are ongoing and funded by SAMHSA.

Margot Kushel, M.D., M.P.H., and Eric Kessel, Ph.D., of the University of California-San Francisco compared health care usage among residents of San Francisco's DAH housing in the 2 years before and after housing placement. They found a significant reduction in emergency department visits and inpatient medical hospitalizations after placement.

Carole Siegel, Ph.D., and Judith Samuels, Ph.D., of the Center for the Study of Issues in Public Mental Health, in Orangeburg, NY, conducted an analysis of resident outcomes in different types of housing programs as part of a nationwide multi-site SAMHSA Housing Initiative. They found that residents of housing programs that provided access to—but did not mandate—treatment were more likely to stay in housing longer and use crisis services less than residents of structured programs with mandatory treatment.

Susan A. Pickett-Schenk, Ph.D., of the University of Illinois at Chicago, and Ed Stellon, M.A., and Karen Batia, Ph.D., presented findings from Heartland Health Outreach in Chicago. These researchers found that participants who requested but did not receive housing were twice as likely to abuse substances 1 year after treatment as were those who received requested housing services.

Carole Siegel, Ph.D.

Joshua Bamberger, M.D.

Keeping the Balance

Although the panelists agreed that housing should be a central priority in providing treatment and services for homeless persons with co-occurring mental health and substance abuse disorders, they also agreed that housing alone is not the answer. Residents need a wide range of services. Research and evaluation in this area must continue in order to shape and improve future housing and treatment approaches.

—By Melissa Capers

4 Million Have Co-Occurring Serious Mental Illness, Substance Abuse

People with co-occurring serious mental illness and substance abuse often do not recognize that they need treatment, according to data from SAMHSA's 2002 National Survey on Drug Use and Health (NSDUH), conducted annually by SAMHSA's Office of Applied Studies. The data show that 61 percent of those with both serious mental illness and a substance use disorder who had not received treatment for either illness perceived no unmet need for treatment.

The data also show that more than half (52 percent) of the 4 million adults age 18 and older with co-occurring serious mental illness and a substance use disorder received neither mental health nor specialty substance use treatment during the past year. An estimated 34 percent only received treatment for mental disorders, 2 percent only received specialty substance abuse treatment, and close to 12 percent received treatment for both mental and substance use disorders.

In 2002, 17.5 million adults (8 percent) age 18 and older were estimated to have serious mental illness. Of these, 4 million (23 percent of adults with serious mental illness) were also dependent on or abused alcohol or an illicit drug. Among adults without serious mental illness, the rate of dependence or abuse was only about 8 percent.

Further analysis of the data showed that adults with a substance use disorder in 2002 were almost three times as likely to have serious mental illness (20.4 percent) as those who did not have a substance use disorder (7.0 percent).

The rate of serious mental illness was 19.0 percent among those with alcohol dependence or abuse, 29.1 percent among those with illicit drug dependence or abuse, and highest among adults who had both drug and alcohol dependence or abuse (30.1 percent).

The data show that 33.2 million adults age 18 and older had a serious mental illness or a substance use disorder in 2002. Of these adults, 40.4 percent (13.4 million) had only a serious mental illness; 47.4 percent (15.7 million) had only a substance use disorder; and 12.2 percent (4.0 million) had both serious mental illness and a substance use disorder.

Although 47.9 percent of adults with both serious mental illness and a substance use disorder received some type of treatment, only 11.8 percent of these adults received both mental health and substance abuse services.

Two recent SAMHSA publications discuss these findings in more detail. *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders, 2002,* is a 132-page report based on analysis of the 2002 NSDUH data. *Adults with Co-Occurring Serious Mental Illness and a Substance Use Disorder* is part of a series of short reports on selected topics published by SAMHSA. To obtain copies, contact the National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Electronic versions are available online at **www.oas.samhsa.gov.**

Co-Occurring Center for Excellence

The National Co-Occurring Center for Excellence (COCE), launched in 2004, is designed to support state and community-based efforts to provide effective treatment services to people with co-occurring substance abuse and mental disorders.

COCE technical assistance and cross-training is targeted to states currently receiving one of SAMHSA's State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders (COSIG) grants. These grants, first awarded in 2003, are intended to improve states' abilities to provide integrated treatment services to people with co-occurring disorders.

In addition, COCE services are available to all other states, cities, counties, tribes and tribal organizations, community-based providers, educational establishments, criminal justice-related entities, and other social and public health providers seeking to enhance their ability to deal with individuals with co-occurring disorders.

On issues related to co-occurring disorders, COCE will provide technical assistance and cross-training on a range of topics; convene national and regional conferences, meetings, and workshops; conduct literature searches; and prepare analyses papers, articles, and conference presentations to disseminate state-of-the-art information on these issues.

A technical assistance Web site is forthcoming. For more information, contact COCE at (301) 951-3369, or e-mail samhsacoce@cdmgroup.com.

SAMHSA Appoints New Members to National Advisory Council

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., has announced the appointment of three new members to the Agency's National Advisory Council.

The appointees are James R. "Duke" Aiona, Jr., Hawaii's Lieutenant Governor; Columba Bush, First Lady of Florida; and Kenneth D. Stark, Director of Alcohol and Substance Abuse for the State of Washington's Department of Social and Health Services.

"Each new member brings a valuable perspective, critical expertise, and new energy to the SAMHSA National Advisory Council," said Mr. Curie, after he introduced them at the 35th National Advisory Council Meeting in Washington, DC. "I look forward to working with each of them on advancing SAMHSA's vision and mission."

Columba Bush

Duke Aiona, Jr.

Kenneth D. Stark

Columba Bush

Florida's First Lady is involved with a variety of substance abuse issues, including prevention among young people, in her state. She is a spokesperson and member of Informed Families of Florida, a non-profit organization involved in educating families on the dangers of drug abuse. Mrs. Bush is also a member of the Governors' Spouses Leadership Forum, an organization focused on reducing youth alcohol abuse.

At the national level, Mrs. Bush is a board member of Columbia University's Center on Addiction and Substance Abuse, a resource institution on prevention of substance abuse. Mrs. Bush also serves as the national *Madrina* for SAMHSA, empowering young Latina women to avoid drugs and alcohol (see *SAMHSA News,* Vol. X, Number 4). In addition, she serves on the Leadership Initiative to Keep Children Alcohol Free, targeting alcohol abuse by children age 9 to 15, founded by the National Institute on Alcohol Abuse and Alcoholism, which SAMHSA also funds.

James R. "Duke" Aiona, Jr.

A former member of the Corrections Population Management Commission, Hawaii's current Lieutenant Governor was appointed Administrative Judge of the newly created Hawaii Drug Court in 1996. As a judge, he became concerned about the link between substance abuse and crime, and the detrimental effect that illicit drug use can have on families, especially Native Hawaiian families.

After his election as Lieutenant Governor in 2002, he focused on addressing public safety issues, including substance abuse, health, and education. Part of Mr. Aiona's strategy to combat the state's substance abuse problem includes protecting young children from becoming involved with drugs and increasing treatment services for those who have become addicted to illegal drugs.

Kenneth D. Stark

As a counselor and manager, Mr. Stark has worked in various areas of the alcohol and drug field since 1971. He has operated residential and outpatient treatment programs, and served as a consultant and educator on alcohol and drug issues.

Since 1988, Mr. Stark has managed the Division of Alcohol and Substance Abuse within the Washington State Department of Social and Health Services, which is responsible for funding and regulating alcohol and drug prevention and treatment programs throughout the state.

Mr. Stark is currently Research Committee Chair and Region X Director for the National Association of Alcoholism and Drug Abuse Directors (NASADAD) and has served as the NASADAD Treasurer. He has also served on SAMHSA's National Committee for Women's Services.

SAMHSA's National Advisory Council advises, consults, and makes recommendations to the Secretary of Health and Human Services and to the SAMHSA Administrator concerning activities carried out by and through the Agency. The Council meets twice a year. Transcripts and additional information from past meetings are available on the SAMHSA Web site at **www.samhsa.gov.**

President Announces $100 Million Award for Substance Abuse Treatment

President George W. Bush announced $100 million in Access to Recovery grants in August to provide people seeking drug and alcohol treatment with vouchers for a range of appropriate, community-based services. By providing vouchers, the grant program promotes client choice, expands access to a broad array of clinical treatment and recovery support services —including services provided by faith- and community-based programs—and increases substance abuse treatment capacity.

The grants were awarded to 14 states and one tribal organization. In fiscal year 2005, President Bush has proposed doubling the funding for Access to Recovery to help even more of those seeking treatment.

"Giving people the power to choose a treatment program that reflects their values and needs can help them triumph over addiction and achieve recovery," said Health and Human Services Secretary Tommy G. Thompson. "Access to Recovery will help Americans who are seeking treatment but are unable to obtain care. This program is designed to help people reach recovery in body, mind, and heart."

John Walters, Director of National Drug Control Policy, said, "Treatment works. But addiction is not a one-size-fits-all disease. This program represents the next step in our ability to treat this disease, opening the door to a full range of treatment providers, and offering treatment access to thousands of Americans who would otherwise remain trapped in the maze of addiction."

SAMHSA administers the grant program. SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "Access to Recovery is based on the knowledge that there are many pathways to recovery from addiction. The promise of this initiative—founded on a belief in individual choice —is that it ensures the availability of a full range of treatment options, including the transforming power of faith. That was the President's intent in creating this program in the first place, and requesting $600 million over 3 years in his 2003 State of the Union address."

Clients will be assessed, given a voucher for identified services, and provided with a list of appropriate service providers from which to choose. Grantees proposed a broad range of innovative approaches and target populations. The grantees were competitively chosen from applications from 44 states and 22 tribes and territories.

Access to Recovery Awardees by State, Tribal Organization

In 2004, SAMHSA has awarded Access to Recovery grants to 14 states and one tribal organization:

- **California**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Connecticut**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Florida**—Awarded $6.8 million per year for each of 3 years for a total of approximately $20.4 million.
- **Idaho**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Illinois**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Louisiana**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Missouri**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **New Jersey**—Awarded approximately $4 million per year for each of 3 years for a total of approximately $12.2 million.
- **New Mexico**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Tennessee**—Awarded $5.9 million per year for each of 3 years for a total of approximately $17.8 million.
- **Texas**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Washington**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Wisconsin**—Awarded $7.6 million per year for each of 3 years for a total of approximately $22.8 million.
- **Wyoming**—Awarded $978,000 per year for each of 3 years for a total of approximately $2.9 million.
- **California Rural Indian Health Board**—Awarded $5.7 million per year for each of 3 years for a total of approximately $17.1 million.

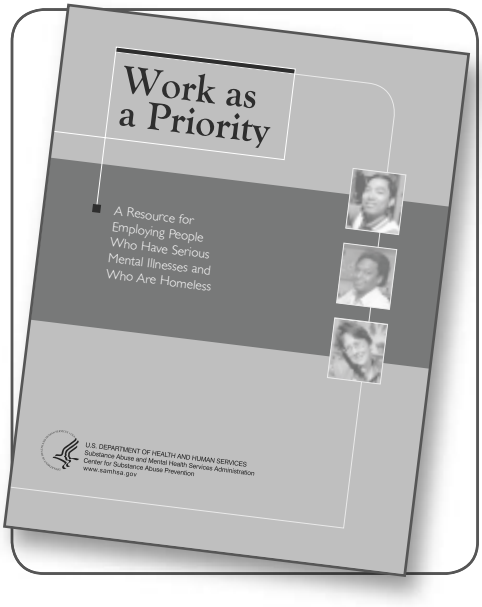
Resource Promotes Employment Despite Homelessness, Mental Illness

People with mental illness who are homeless often realize that having a job would improve their lives dramatically, and most service providers know that finding employment for them is a crucial step in their journey from lives of dependency and despair to lives of independence and hope.

Day to day, however, individuals who are homeless often are derailed by the debilitating effects of their mental illness, and service providers are faced with ongoing challenges to find adequate resources.

To help, SAMHSA has published a new guidebook that provides a blueprint for increasing employment possibilities. *Work as a Priority: A Resource for Employing People Who Have Serious Mental Illnesses and Who Are Homeless* is designed to help service providers, as well as policymakers, program managers, case managers, and employment specialists, make informed decisions as they guide people who are homeless and have mental illnesses into employment. This new guide offers practical guidance for assisting individuals in finding jobs through employment service programs.

In preparation for this guidebook, providers of services for mental health and homelessness across the Nation were surveyed. Text includes summaries of innovative programs that readers can use as models to create new programs. One example is New York City-based Project Renewal, a program committed to showing people who are homeless and who have serious mental illnesses how to make the transition. The organization's Culinary Arts Training Program, a 6-month tutorial in commercial food preparation, has graduated 40 people since it opened its doors in 1995. The program's job placement rate is 85 percent.



In addition to its culinary program, Project Renewal provides clients with a variety of tailored employment services and training in life skills necessary for getting and keeping a job.

Another program, Life Link in Santa Fe, NM, created its own business advisory committee to stay attuned to the training and hiring needs of local businesses and to facilitate employer-employee match-ups. LAMP, Inc., a homeless services agency in the Skid Row district of Los Angeles, has made a commitment to hiring graduates of its programs to work within the agency. Approximately one-third of staff members are former guests of LAMP.

First-person testimonials illustrate how important work is to individuals with serious mental illnesses. One woman writes, "The thought of employment seemed far-fetched and out of the question for me. But my mind was changed by seeing other tenants working at various jobs within the building. I thought to myself, I can do that."

The guidebook includes a review of the relevant literature, a summary of promising employment programs, and a discussion of policies and laws addressing

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employment support services for people who are homeless and have serious mental illnesses.

The information is presented in seven chapters:

1. What We Know So Far

This chapter contains a brief review of writings and research studies on employment for people who have serious mental illnesses and are homeless. Findings presented in this chapter demonstrate that mental health recovery and homelessness reduction are directly linked to an individual's ability to obtain and retain a job. This chapter also outlines the critical elements of successful employment programs, with case studies provided as examples.

2. A Recovery-based Foundation

Many people who are mentally ill and homeless view employment as crucial to their recovery. This chapter presents a framework for providing recovery-based employment and outlines specific program elements that work. Cultural and environmental factors are also discussed in this chapter. Health practitioners are encouraged to build their awareness of cultural differences among the individuals they serve.

3. Employment Approaches

For the past two decades, a number of best practices have been developed to increase employment success for people with serious mental illnesses. This chapter summarizes a variety of proven employment models. The evidence supports that "long-term worker role recovery" happens through employment that provides work at competitive wages, offers the opportunity to work with non-disabled co-workers, and offers long-term, post-placement support. Information in this chapter can help service providers plan and establish programs that are designed to facilitate recovery, provide marketable skills, and expand opportunities needed for successful employment.

4. The Impact of Homelessness

Many housing programs are not equipped to provide job training and assistance for people with serious mental illnesses. This chapter addresses personal, program, and system-level challenges to employment. Case studies provide examples of how to meet these challenges.

5. Joining the Workforce

Service providers cannot use a "one-size-fits-all" approach to meet the employment needs of people who are homeless and have serious mental illnesses. This chapter highlights agencies across the Nation that use flexible and innovative programs to coordinate employment services. The chapter also describes how collaboration with area businesses and public housing authorities can help service providers expand and enhance the employment opportunities they provide. Key factors for developing successful employment services are also included.

6. The State Office of Vocational Rehabilitation

State departments of vocational rehabilitation (VRs) can be powerful allies in the effort to find employment for people with mental illnesses who are also homeless. This chapter provides an overview of VR services, discusses their effectiveness in meeting the employment needs of people with mental illnesses, and considers ways to create collaborations between mental health and VR systems. The chapter describes how selected VRs are working with people who are homeless and who have serious mental illnesses, as well as recent VR/mental health integration efforts.

7. The Right to Work

Several Federal statutes provide a foundation to help people with disabilities find jobs. This chapter highlights those statutes, including the Americans with Disabilities Act, the Workforce Investment Act, and the Ticket to Work/Work Incentives Improvement Act.

For a print copy of *Work as a Priority: A Resource for Employing People Who Have Serious Mental Illnesses and Who Are Homeless,* contact the National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Online, the publication is available through SAMHSA's National Resource Center on Homelessness and Mental Illness at **www.mentalhealth.samhsa.gov.** For more information on homelessness, visit **www.samhsa.gov.**

—By Jon Bowen

SAMHSA "Short Reports" on Statistics

SAMHSA's Office of Applied Studies (OAS) recently released several "short reports," which are based on statistics and data from the Drug Abuse Warning Network (DAWN), the Treatment Episode Data Set (TEDS), and the National Survey on Drug Use and Health (NSDUH). DAWN data measure mentions of drug abuse linked to emergency room visits, and TEDS is a compilation of data on the substance abuse and demographic characteristics of those admitted for treatment.

Treatment Admissions for Painkillers

Between 1992 and 2002, treatment admission rates for abuse of narcotic pain medications more than doubled, according to a new report based on information reported to TEDS in 2002. The proportion of new users—those entering treatment within 3 years of beginning use—increased from 26 percent in 1997 to 39 percent in 2002. The median duration of use before first seeking treatment decreased from 9 years of use in 1992 to 7 years in 1997 to 4 years in 2002.

ER Visits for Club Drugs

Emergency room visits related to abuse of club drugs—GHB, ketamine, LSD, and Ecstasy—remained stable or declined in 2002, according to a new DAWN report. Visits associated with GHB decreased by one-third between 2000 and 2002, and visits involving LSD declined rapidly between 1999 and 2002. Ecstasy-related visits remained steady at 2001 levels, while ketamine-related visits remained at the lowest levels seen since 1998.

Criminal Justice Referrals

The Nation's criminal justice system was the principal source of referral for 36 percent of all substance abuse treatment admissions in 2002, according to new data compiled from TEDS. The report also notes that admissions referred by the criminal justice system were more likely to report alcohol as the primary substance of abuse compared to all other admissions (45 percent vs. 42 percent).

Drug and Alcohol Use Among Runaways

Young people age 12 to 17 who had run away from home in the prior 12 months were more likely to have used alcohol, marijuana, or an illicit drug other than marijuana in the past year than those who had not run away, according to the 2002 NSDUH Report. Although runaways were more likely to be male (55 percent), alcohol use was higher among female youth (55 percent) who had run away compared to males (46 percent).

ER Data on Oxycodone and Hydrocodone Abuse

Of the 119,000 mentions of narcotic pain medications in emergency room visits in 2002, 40 percent involved either oxycodone or hydrocodone, according to a new DAWN report. The report found 47,594 mentions of oxycodone and hydrocodone in 42,808 emergency room visits related to drug abuse. Approximately three-quarters of these hospital visits involved other drugs in addition to oxycodone (71 percent) and hydrocodone (78 percent).

Painkiller Treatment Rates in Urban and Rural Areas

Overall, treatment admission rates for narcotic painkillers increased by 155 percent between 1992 and 2002, based on data compiled from TEDS. Increases in treatment admission rates for abuse of narcotic painkillers were evident in all urban levels, but were greatest in more rural areas. The proportions of narcotic painkiller treatment admissions taking the drugs orally or inhaling them increased, while the proportion injecting them decreased.

For a copy of these reports, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, these and other publications are available at **www.oas.samhsa.gov.**

We Would 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 available resources.

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

I found these articles particularly interesting or useful:

- ❑ Peer-to-Peer Program Promotes Recovery
- ❑ From the Administrator: The Promise of Recovery
- ❑ Iowa Has Lowest Drug Use Rate
- ❑ Youth in the Justice System: Improving Services
- ❑ Strategic Action Plans Clarify SAMHSA Matrix

Special Conference Report: Complexities of Co-Occurring Conditions

- ❑ Experts Identify Problems, Examine Solutions
- ❑ Conference Panel: Improving Outcomes
- ❑ Conference Panel: Housing and Treatment
- ❑ 4 Million Have Co-Occurring Serious Mental Illness, Substance Abuse
- ❑ SAMHSA Appoints New Members to National Advisory Council
- ❑ President Announces $100 Million Award for Substance Abuse Treatment
- ❑ Resource Promotes Employment Despite Homelessness, Mental Illness
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Thank you for your comments.

Building Bridges

SAMHSA's Center for Mental Health Services (CMHS) recently published *Building Bridges: Mental Health Consumers and Members of Faith-Based and Community Organizations in Dialogue.* The 29-page booklet summarizes the findings and recommendations of a CMHS-sponsored dialogue between mental health consumers and members of diverse faith traditions and community organizations.

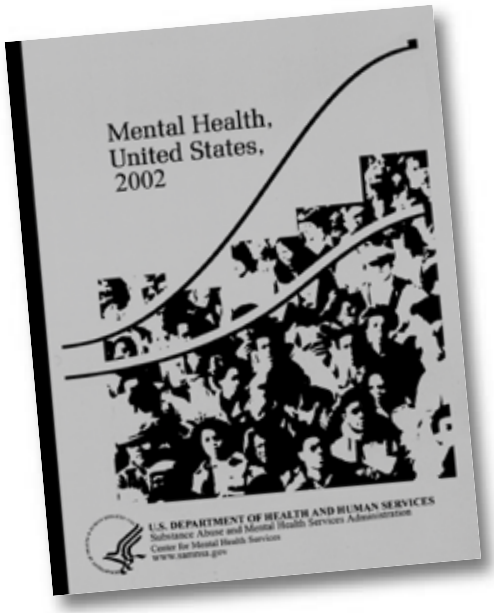
Two dozen invited participants attended the 2-day meeting, held in Baltimore in October 2002, to explore the roles of faith-based and community organizations in recovery for people with mental disorders. The dialogue themes and findings presented address factors that promote recovery, factors that hinder recovery, and system-level issues that impact recovery. To improve relationships between consumers and faith-based organizations, participants developed recommendations for CMHS, for faith-based organizations, and for consumers and consumer advocates. The booklet also includes excerpts from President George W. Bush's message on the faith-based and community organization initiative.

This publication can be ordered through SAMHSA's National Clearinghouse for Alcohol and Drug Information Web site at **www.ncadi.samhsa.gov** or by phone at 1 (800) 729-6686 or 1 (800) 487-4889 (TDD).

Mental Health Publication

SAMHSA's Center for Mental Health Services Survey and Analysis Branch recently released *Mental Health, United States, 2002.* This 390-page resource covers the areas of good decision-making, population and insurance dynamics, the status of mental health services, and national mental health statistics. The 21 chapters include "Community Mental Health Centers at the 40-Year Mark: The Quest for Survival," "Sixteen-State Study on Mental Health Performance Measures," "Mental Heath in New York City After the September 11 Terrorist Attacks: Results from Two Population Surveys," and "Children and Adolescents Admitted to Specialty Mental Health Care Programs in the United States, 1986 and 1997."

To order this publication (SMA 3938), contact SAMHSA's National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Online, visit **www.samhsa.gov.**



2003 Survey Released

SAMHSA's Office of Applied Studies released the *2003 National Survey on Drug Use and Health* at the 15th annual launch of September's National Alcohol and Drug Addiction Recovery Month. The survey—the largest of its kind Government-wide—includes findings on illicit drug and alcohol use, tobacco use, trends in lifetime prevalence of substance use, trends in initiation of substance use, youth prevention-related measures, and prevalence and treatment of mental health problems across the Nation.

For a copy of the survey, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the publication is available at **www.oas.samhsa.gov.**

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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
Beverly Watts Davis, Director

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

Editor
Deborah Goodman

Your comments are invited.
Phone: (240) 276-2130
Fax: (240) 276-2135
E-mail: *deborah.goodman@samhsa.hhs.gov*
Mail: Editor, *SAMHSA News*
Room 8-1037
1 Choke Cherry Road
Rockville, MD 20857

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