Substance Abuse and Mental Health Services Administration

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Recovery Is Key for Mental Health Action Agenda

Marking a milestone in the history of mental health and mental illness in America, SAMHSA recently released *Transforming Mental Health Care in America—The Federal Action Agenda: First Steps.*

"As we mark the 15th anniversary of the Americans with Disabilities Act, the Action Agenda makes an important contribution for Americans with mental health-related disabilities," said Mike Leavitt, U.S. Secretary of Health and Human Services (HHS).

"The Action Agenda details the initial steps the Federal Government is taking to transform the form and function of the mental health service delivery system in America," said Secretary Leavitt. "HHS and its partners across the Federal Government are committed to a shared goal of collaborating to change fundamentally the way the Nation's mental health care system functions."

SAMHSA led the Action Agenda's development. The Agency aligned six cabinet level departments—Education, Health and Human Services, Housing and Urban Development, Justice, Labor, Veterans Affairs, and the Social Security Administration—in an unprecedented multi-year effort, which includes

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more than 20 Federal agencies to carry out the 70 specific steps of the Action Agenda.

In addition, a Federal Executive Steering Committee was announced to guide the work of mental health system transformation.

The Action Agenda represents the very first "to do" list in the Federal response to Executive Order 13263, which launched President Bush's New Freedom Commission on Mental Health in 2002. The Commission's final report, *Achieving the Promise: Transforming Mental Health Care in America,* released in July 2003, found the Nation's mental health system "fragmented and in disarray." In that report, the Commission called for a complete transformation of the mental health service system. (See *SAMHSA News,* Volume 11, Number 3.)

The Action Agenda builds on the Commission's recommendations with a clear plan to redirect the mental health system to its primary goal: To help adults with serious mental illnesses and children with serious emotional disturbances achieve recovery—to be able to live, work, learn, and participate fully in their communities.

"The Action Agenda is a living document that begins to chart the course for long-term change," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "It is not a 'quick fix' for the problems that have ailed the mental health care system for decades."

Recovery Is Key

The foundation of the Action Agenda rests on the principle that recovery from mental illness is the expectation, not the exception.

"We are counting on consumers and family members to play a meaningful role," said SAMHSA's Center for Mental Health Services Director A. Kathryn Power, M.Ed. "In a transformed mental health system, services and treatments are consumer- and family-centered. Furthermore, care must focus on increasing an individual's ability to cope successfully with life's challenges, on building resilience—not just on managing symptoms—and on facilitating recovery."

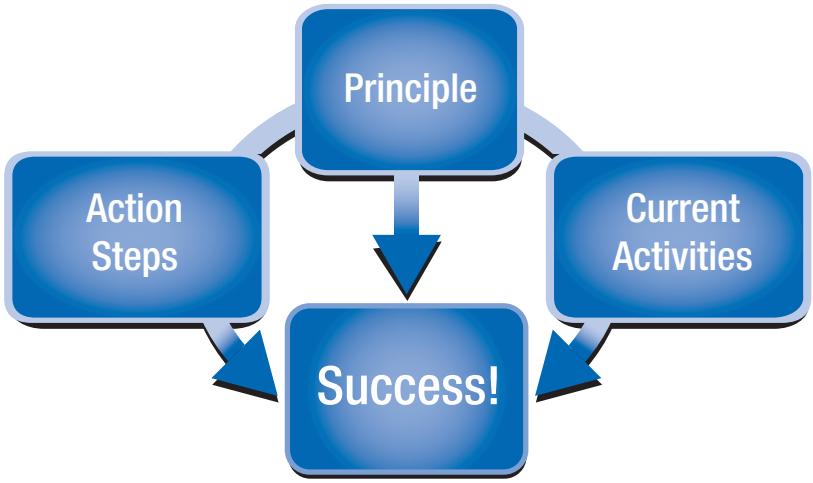
The New Freedom Commission's final report offered good news: Adults with serious mental illnesses and children with serious emotional disturbances can and do recover. But Ms. Power continued, "Success means a system grounded in recovery and resilience, one that demonstrates a commitment to providing recovery-based services, and one that—through its actions—inspires hope for families and consumers alike."

Yet across the United States, many people with mental illness remain untreated. They struggle with an illness that affects their minds, their feelings, and their relationships with others. Approximately 19.6 million adults age 18 or older (9.2 percent) in the United States have a serious mental illness, according to SAMHSA's National Survey on Drug Use and Health. A similar percentage of children, about 5 percent to 9 percent, have a serious mental health problem.

"The reason for the Action Agenda is simple," Mr. Curie continued. "People with mental disorders have a vital role to play. Their ability to participate fully can no longer be derailed by outdated science, outmoded financing systems, and unspoken discrimination. Putting people with mental disorders at the heart of the health care system can be accomplished through the steps outlined in this Action Agenda," he said.

Action Agenda Components

The Action Agenda presents a simple plan to carry out the "to do" list—the five Principles set forth in Executive Order 13263 (see page 3), which established the President's New Freedom Commission on Mental Health in 2002. The following diagram illustrates the components of the Action Agenda:



Each **Principle** represents a specific task. To complete that task or Principle, detailed **Action Steps** are outlined for specific Government agencies and **Current Activities** under way are compiled. These efforts contribute to a **State of Success** and a transformed mental health system.

The Basics

The Action Agenda presents the transformation process in four parts: principles, success markers, action steps, and current Federal activities. This simple format provides all the information required to follow the Federal Government's plan for mental health system transformation.

The Action Agenda is organized around the five **Principles** set forth in the President's 2002 Executive Order establishing the Commission:

Principle A: Focus on the outcomes of mental health care, including employment, self-care, interpersonal relationships, and community participation.

Principle B: Focus on community-level models of care that coordinate multiple mental health and human service providers and private and public payers.

Principle C: Maximize existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers.

Principle D: Use mental health research findings to influence the delivery of services.

Principle E: Ensure innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the states and Indian tribes.

A **"State of Success"** follows each Principle with a list of specific achievements that, as they are accomplished, will herald a transformed mental health system.

Action steps for each Principle will move the mental health service system toward transformation.

Current activities in progress for each Principle are included in the Action Agenda. SAMHSA has completed an inventory of current, relevant Federal activities that respond to the Commission's vision.

Doing the Work

The public sector is the major financial driver in mental health care. Transformation is, however, "a shared responsibility," according to Mr. Curie. Federal agencies

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From the Administrator

Mental Health Care: Transforming Our Vision and Our System

Transforming Mental Health Care in America—The Federal Action Agenda: First Steps, released in July, represents both a vision and a plan. It is both a vision of the attainability of recovery and a living document that charts the initial steps for altering the form and function of the mental health service delivery system (see cover article).

The Action Agenda is a milestone in the evolution of our views of mental illness and mental health. This shift began just 40 years ago, when President John F. Kennedy signed the Community Mental Health Centers Act, which aimed to move psychiatric patients out of state hospitals and into community clinics. President Jimmy Carter continued the momentum by establishing the President's Commission on Mental Health in 1977 and signing the Mental Health Systems Act in 1980.

In 1999, the publication of *Mental Health: A Report of the Surgeon General* documented the scientific evidence that mental illnesses are health conditions that are diagnosable and treatable.

However, many obstacles to care still remain.

President George W. Bush established the New Freedom Commission on Mental Health in 2002 to conduct a comprehensive study of the problems in the mental health system and to make concrete recommendations. The message of the Commission's report in July 2003 was unequivocal: Reform of the mental health care delivery system in the United States is not enough—a fundamental transformation is needed.

The Department of Health and Human Services was charged with reviewing the Commission's report and identifying action steps to accomplish this goal, and asked SAMHSA to lead the effort.

The resulting Action Agenda is particularly noteworthy in the breadth of collaboration it requires among a broad array of Federal partners. Simultaneously, the effort calls for shared responsibility by government at the state and local levels, the private sector, and consumers of services and their family members.

More than 25 years ago, when President Carter's commission released its report, recovery from mental illness was not the expectation. Today, we know more about mental illness, mental health, and recovery than ever before. Now, it is up to us to transform our system of care to make recovery a reality for everyone.

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

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can act as leaders and as facilitators, promoting shared responsibility for change at the Federal, state, and local levels, and in the private sector, in such areas as public education, research, service system capacity, and technology development.

States, however, will be the very center of system transformation. Many states have already begun this critical work. Their leadership in planning, financing, service delivery, and evaluation of consumer and family-driven services will significantly advance mental health transformation.

Furthermore, SAMHSA's Mental Health Transformation State Incentive Grants are a key component of mental health system transformation. This grant program is unique in taking a "big picture" approach to improving service delivery. The focus is on state infrastructure—what a state puts into place to coordinate mental health planning, financing, services, and evaluations conducted by multiple systems to facilitate recovery and promote resilience for individuals and families coping with mental illnesses.

The grants provide seed money for the states to use to make systemic changes based on each state's vision of a comprehensive mental health system. SAMHSA has awarded grants totaling $92.5 million over 5 years to Connecticut, Ohio, Oklahoma, Washington, Maryland, New Mexico, and Texas.

A new Web page of state activities is now available, sponsored by SAMHSA through the National Association of State Mental Health Program Directors (NASMHPD). (See Web Resources on page 15.)

Stakeholder Support

Support for the Action Agenda comes not only from within the Federal Government but also from stakeholder organizations.

The Campaign for Mental Health Reform is a coalition of 16 national mental health organizations. The Campaign's Director, Charles G. Konigsberg, applauded "SAMHSA's coordination of multiple Federal agencies in developing an Agenda to follow up on the Commission."

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Action Agenda Highlights

- Reinforce the message that mental illnesses and emotional disturbances are treatable and that recovery is the expectation.
- Act immediately to reduce the number of suicides in the Nation through implementation of the National Strategy for Suicide Prevention, launched by the U.S. Department of Health and Human Services in 2001.
- Help states develop the infrastructure necessary to formulate and activate comprehensive state mental health plans that include the capacity to create individualized plans of care that promote resilience and recovery.
- Develop a plan to promote a mental health workforce better qualified to practice mental health care that is culturally sensitive and based on evidence-based practices in both specialty settings and at the primary care level.
- Initiate a national effort focused on the mental health needs of children and promote early intervention with informed parental consent for children identified to be at risk for mental disorders. Prevention and early intervention can help forestall or prevent disease and disability.
- Improve the interface of primary care and mental health services.
- Expand the Science-to-Services agenda to develop new toolkits outlining evidence-based practices for use by providers, administrators, educators, and consumers.
- Increase the employment of people with psychiatric disabilities.
- Design and initiate an electronic health records and information system that will help providers and consumers better manage mental health care and that will protect the privacy and confidentiality of each consumer's health information.

SAMHSA Supports Efforts To Prevent Suicide

One night in mid-July, licensed counselor John Paruch picked up a ringing phone at the Behavioral Health Response Crisis Center in St. Louis, MO. The caller was a 50-year-old man who had lost his will to live.

"A number of things had happened in his life," Mr. Paruch says. "He had lost his job, and he had recently lost his wife. It was all related to a substance abuse problem. When he called, he was incredibly distraught. He felt that he was at the end of his rope."

Mr. Paruch needed to act quickly. In the background behind the caller's voice, he heard the clattering noise of trains speeding by. The man was standing at an outdoor pay phone near railroad tracks—deciding, perhaps, if he would live or die.

Over the next 45 minutes, Mr. Paruch tried to coax the man toward a better state of mind. "We talked about his life, his relationship with his wife," Mr. Paruch recalls. "We talked about what motivated him to live, about his three children. He had lost time with them because of his alcoholism; he regretted that."

Realizing that the man's children gave him a sense of purpose, Mr. Paruch scrambled to get the children on the phone by conference call. The man's daughter drove out to where her father was and took him back to his son's house. By phone, Mr. Paruch followed up with him there, helping the man find a local counseling resource by using the Treatment Facility Locator on the SAMHSA Web site.

For Mr. Paruch, there's a deep sense of satisfaction in helping someone in crisis. "You're the last bridge to life for them," he says.

Improving the Safety Net

Suicide is a severe public health problem. According to the National Center for Health Statistics at the Centers for Disease Control and Prevention, more than 30,000 Americans commit suicide every year. Suicide is the third leading cause of death among young people between the ages of 15 and 24 and the eleventh leading cause of death among persons of all ages.

SAMHSA is supporting a broad national effort to stem the tide of suicides. The crisis center where John Paruch works is just 1 of more than 100 centers in communities across the Nation that are part of the National Suicide Prevention Lifeline. The Lifeline uses a single, national toll-free number, 1-800-273-TALK (8255), to connect callers at risk for suicide to trained counselors close to where they live.

Funded by a 3-year, $6.6 million grant from SAMHSA's Center for Mental Health Services (CMHS), the Lifeline came into existence following the 2001 launch of the National Strategy for Suicide Prevention, a broad initiative aimed at reducing the number of suicides across the country. (See *SAMHSA News,* Fall 2002.) In addition to the Lifeline, SAMHSA provides funding for the Suicide Prevention Resource Center, which offers technical assistance, training, and informational materials to support suicide prevention efforts.

These two programs provide essential help for people at risk for suicide, but the nationwide "safety net" created by suicide prevention efforts is becoming stronger and more encompassing. Soon, SAMHSA will expand its grants program exponentially, boosting the number of suicide prevention grantees from 2 to approximately 46.

"SAMHSA will soon be awarding suicide prevention grants to states and tribes, as well as to colleges and universities, as authorized by the Garrett Lee Smith Memorial Act," says Richard McKeon, Ph.D., SAMHSA Special Advisor–Suicide Prevention.

The Garrett Lee Smith Memorial Act, introduced by Senator Gordon Smith (R-OR)

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in memory of his son who died by suicide, is bipartisan legislation that aims to reduce suicide among youth. Signed in 2004, the bill authorized SAMHSA to distribute $82 million in funding over 3 years, $11.5 million of which is available in 2005.

The new funds will allow SAMHSA to take a more active approach to suicide prevention, according to Brenda Bruun, Special Assistant to the Director, Division of Prevention, Traumatic Stress, and Special Programs at CMHS. The idea is to create a continuum of care that addresses the needs of people at risk for suicide long before they become suicidal.

"When we talk about the tools we need for suicide prevention," says Ms. Bruun, "we are including the work we need to do long before an active intervention takes place for someone in a suicidal crisis."

The key to prevention is identifying—at an early stage—people who are at risk. "We need to do adequate depression screening, more public education," says Ms. Bruun. "We need better training of educators, primary care providers, and mental health and substance abuse treatment providers."

A Lifeline

Recently, SAMHSA received the evaluation results from two SAMHSA-funded studies of suicide prevention hotlines—one looking at the outcomes of calls and the other looking at overall quality of care.

The first study showed that outcomes were generally positive. Two weeks after calling the hotline, most callers were experiencing less depression and fewer suicidal thoughts.

The other study, however, showed some inconsistencies in quality of care among the various crisis centers around the country. Counselors were not always evaluating suicide risk in a consistent manner, and when evaluations were made, they were often incomplete.

"It led us to think that there's an issue with training and accreditation," says Ms. Bruun. SAMHSA, through the National Suicide Prevention Lifeline, now has a committee looking at certification standards for crisis center counselors, and out of that analysis will come recommendations for training and supervision.

All this analysis is being used to refine the efforts of the centers involved in the SAMHSA-funded Lifeline. "People in emotional distress or in suicidal crisis can call any time from anywhere in the Nation and speak to a trained worker who will listen to them and assist them in getting the help they need," says John Draper, Ph.D., Director of the Lifeline.

To make the public more aware of the Lifeline, SAMHSA is developing a national marketing campaign to raise awareness of the Lifeline's toll-free number and to make people generally more aware of the availability of help for people in suicidal crisis.

A Resource for States

One of the goals of the National Strategy for Suicide Prevention called for the development of a technical assistance and resource center to help states and communities establish and evaluate suicide prevention programs. "The formation of the Suicide Prevention Resource Center in 2002 realized this goal," says Lloyd Potter, Ph.D., M.P.H., Director of the Center.

"The National Strategy guides much of the Center's work and products," Dr. Potter explains. "We assist states in their efforts to develop and implement suicide prevention programs. We've also been working to develop training modules for state and community people working to prevent suicide and for clinicians and other professionals who may work with persons at risk for suicide."

The Center is expanding its offerings to provide not only technical assistance but also a storehouse of information for those working in the field of suicide prevention and those whose personal lives have been affected by suicide. "The Center is the only one of its kind that provides technical assistance to grantee programs, and also provides information for researchers, advocates, and survivors," says Ms. Bruun.

Overcoming the Stigma

As SAMHSA and other agencies and organizations work to further the goals of the National Strategy, challenges arise. One of the barriers commonly encountered by professionals who work in suicide prevention is the shame and embarrassment that surround suicide and its contributing factors.

"The stigma surrounding suicide, as well as mental illness and substance abuse, each of which are significant risk factors for suicide, is a continuing challenge," says Dr. McKeon. The stigma often keeps those who need help most—the ones who are most at risk for suicide—from seeking help.

One challenge for the Lifeline staff, according to Dr. Draper, is the simple lack of public awareness of the suicide prevention resources that are available. "Promoting awareness of the toll-free phone number and how hotlines can help prevent suicide—primarily to populations not accustomed to seeking mental health assistance—may well represent the biggest challenge," he says.

Dr. Draper explains that the highest suicide rates are often seen, unfortunately, among populations where service use is lowest—in rural populations and among American Indians and Alaskan Natives, seniors, and white males.

Another at-risk group is youth. SAMHSA recently released a short report, *Suicidal Thoughts among Youths Aged 12-17 with Major Depressive Episode.* Data show that approximately 900,000 youth had made a plan to commit suicide during their worst or most recent episode of major depression, and 712,000 attempted suicide during such an episode of depression.

The data, from the 2004 National Survey on Drug Use and Health, show that about 3.5 million youth age 12 to 17 (14 percent) had experienced at least one episode of major depression in their lifetime.

In response, the Lifeline offers people at risk an easily accessible, free way to get help.

What's Needed Now

Much work remains to be done to reduce the number of suicides in this country.

According to Dr. McKeon, making suicide prevention successful on a national scale will require commitment from both the public and private sectors. "No single agency can do it alone," he says.

In addition, "There are very few evidence-based programmatic strategies for preventing suicide," Dr. Potter explains. He sees a need to identify more programs that have demonstrated sound evidence of effectiveness in promoting mental health and preventing suicide. "The Center has been actively working to identify such programs, and we are working with other programs to encourage development of evidence for their effectiveness."

Dr. McKeon says, "There is also a crucial need to improve training of the mental health and substance abuse workforce, to improve access to care for individuals identified as at risk, and to improve continuity of care for those who have attempted suicide who are discharged from emergency rooms and inpatient facilities."

Dr. Draper also sees the need to educate the public, to help people recognize that suicide and related mental health issues are a public health issue that affects everyone in one way or another. To get there, he says, "Prevention programs will need to tell their 'success stories,' so that more people can recognize how their efforts have made a positive difference in their communities and in the lives of individuals and families."

For more information, contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or 1 (866) 889-2647 (TTY). Or, visit the National Strategy for Suicide Prevention at **www.mentalhealth.samhsa.gov /suicideprevention.** The SAMHSA short report on youth is available at **www.oas .samhsa.gov.**

—By Jon Bowen

Resources

www.sprc.org

The SAMHSA-funded Suicide Prevention Resource Center provides technical assistance, training, and materials to support suicide prevention efforts in states and communities across the country. The Web site carries the latest news related to research and funding opportunities for suicide prevention.

www.suicidepreventionlifeline.org

SAMHSA's National Suicide Prevention Lifeline, 1-800-273-TALK (8255), provides immediate assistance to individuals in crisis by connecting them to the nearest available suicide prevention and mental health service provider through its toll-free telephone number. The Web site contains information about the network, training, technical assistance, and news and events.

www.mentalhealth.samhsa.gov /suicideprevention

The National Strategy for Suicide Prevention is a broad initiative aimed at reducing the number of suicides across the country. The Web site includes suicide facts, information on funding opportunities and state programs, and legislation news.

www.mentalhealth.samhsa.gov /suicideprevention/calltoaction.asp

In 1999, the U.S. Surgeon General issued a call to action to prevent suicide. It described suicide as a serious public health problem and outlined a strategy for reducing the number of suicides in this country.

www.spanusa.org

SPAN USA is dedicated to preventing suicide through public education and awareness, community action, and Federal, state, and local grassroots advocacy. The Web site contains information on state suicide prevention programs and grassroots community organizations.

Youth Drug Use Continues To Decline

SAMHSA recently released new findings that show a 9-percent decline in illicit drug use among American youth between age 12 and 17 from 2002 to 2004. Marijuana use also declined by 7 percent among young adults between age 18 and 25 during this same period.

The findings are from SAMHSA's 2004 National Survey on Drug Use and Health (NSDUH) released at the annual *National Alcohol and Drug Addiction Recovery Month* press conference on September 8.

Marijuana, according to the survey, continues to be the most commonly used illicit drug, with a rate of 6.1 percent (14.6 million current users) for the U.S. population age 12 and older.

Overall, findings show that 19.1 million Americans, or 7.9 percent of the population age 12 and older, were current illicit drug users—meaning that they used an illicit drug in the past month. This rate was similar to the rates seen in 2002 and 2003, or approximately 8 percent of the population age 12 and older.

Particularly striking was a decline in current use—defined as use in the past month—of marijuana among boys age 12 to 17, from 9.1 percent in 2002 down to 8.1 percent in 2004. But marijuana use by girls in that age group did not decline and remained at about 7 percent.

Similarly, for 18- to 25-year-olds, the cohort with the highest illicit drug use rates, there were declines in current marijuana use from 17.3 percent in 2002 to 16.1 percent in 2004, and use of hallucinogens from 1.9 percent in 2002 to 1.5 percent in 2004.

"Our partnerships and the work of prevention professionals, schools, parents, teachers, law enforcement, religious leaders, and local community anti-drug coalitions are paying off," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

An area of concern is the increasing non-medical use of prescription medications among young adults. The 2004 survey shows about 6 percent of young adults used medications non-medically in the past month, and 29 percent had used them in their lifetime.

Photo by A. Martin Castillo

As he presented the findings from SAMHSA's 2004 National Survey on Drug Use and Health and launched the Agency's 16th annual* Recovery Month, *SAMHSA Administrator Charles G. Curie said, "We must continue our efforts to support people in their struggle with substance abuse and mental illness to help ensure they have the opportunity for recovery." SAMHSA's Director of the Center for Substance Abuse Treatment, H. Westley Clark, M.D., J.D., M.P.H., left, looks on with presenters Carrick Forbes and Diedre Drohan Forbes (seated).

From 2002 to 2004, there was an increase in lifetime prevalence of non-medical use of narcotic pain relievers in the 18- to 25-year-old age group, from 22 percent to 24 percent. Hydrocodone and oxycodone products showed increases in lifetime use among young adults age 18 to 25.

More Survey Findings

Marijuana. Among persons age 12 or older who used illicit drugs, 56.8 percent used only marijuana, 19.7 percent used marijuana and some other drug, and 23.6 percent used only a drug other than marijuana. An estimated 8.2 million persons (3.4 percent of the population age 12 and older) were current users of illicit drugs other than marijuana in 2004.

Prescription Drugs. In 2004, most of the people using drugs other than marijuana used psychotherapeutic drugs non-medically (6.0 million, or 2.5 percent of the population).

There were an estimated 4.4 million current users of narcotic pain relievers, 1.6 million users of tranquilizers, 1.2 million used stimulants, and 0.3 million used sedatives. These estimates are all similar to the estimates for 2003.

The drug category with the largest number of recent initiates in 2004 was non-medical use of pain relievers (2.4 million new users), followed by marijuana (2.1 million new users), non-medical use of tranquilizers (1.2 million new users), and cocaine (1.0 million new users).

Methamphetamine. Use of methamphetamine remained unchanged from 2002 to 2004 at approximately 5-percent lifetime use and 0.6-percent past-year use, and 0.2 percent for current use. In 2004, 583,000 persons were current users of methamphetamine and 1.4 million persons age 12 and older used methamphetamine in the past year. The rates of use declined among young people age 12 to 17.

Cocaine. In 2004, there were an estimated 2.0 million current cocaine users,

0.8 percent of the population age 12 and older. Of these, 467,000 used crack in the past month (0.2 percent). These estimates are similar to those in 2002 and 2003. Among 12- to 17-year-olds, past-year use of cocaine fell 8 percent between 2002 and 2004.

Heroin. Heroin was used by 0.1 percent of the population age 12 and older in the past month in 2004. There were 166,000 current heroin users. This is similar to 2002 and 2003. Lifetime heroin use fell 16 percent (from 3.7 million individuals to 3.1 million) between 2003 and 2004.

Alcohol. More than one-fifth (22.8 percent) of persons age 12 or older (55 million people) participated in binge drinking at least once in the 30 days prior to being surveyed in 2004. Binge drinking is defined as five or more drinks on the same occasion at least once in the past 30 days. These figures are similar to estimates in 2002 and 2003.

In 2004, about 10.8 million underage persons age 12 to 20 (28.7 percent) reported drinking alcohol in the past month. Nearly 7.4 million were binge drinkers (19.6 percent), and 2.4 million were heavy drinkers (6.3 million). These figures were similar to the 2002 and 2003 estimates.

Among young adults age 18 to 25, 41.2 percent engaged in binge drinking and 15.1 percent in heavy alcohol use. The rate of binge and heavy drinking in 2004 peaked at age 21.

SAMHSA is preparing to launch a major campaign against underage drinking this fall.

Prevention Measures. In 2004, 60.3 percent of youth age 12 to 17 reported that they had talked at least once in the past year with at least one of their parents about the dangers of drug, tobacco, or alcohol use. This rate represents an increase from the 2003 rate of 58.9 percent and the 2002 rate of 58.1 percent. Among youth who reported having had such conversations with their parents, rates of current alcohol and cigarette use and past year and lifetime use of alcohol, cigarettes, and illicit drugs were lower than among youth who did not report such conversations.

Need for Treatment. In 2004, the estimated number of persons age 12 or older needing treatment for an alcohol or illicit drug use problem was 23.5 million (9.8 percent of the total population). The estimated number of persons needing but not receiving treatment for a substance use problem was slightly higher in 2004 (21.1 million) than in 2003 (20.3 million), but this difference was not statistically significant.

Co-Occurring Substance Use and Mental Illness. In 2004, adults who used illicit drugs in the past year were more than twice as likely to have serious psychological distress than those who did not use an illicit drug (20.6 percent vs. 8.3 percent). This pattern has remained stable since 2002 and was reflected in most demographic subgroups.

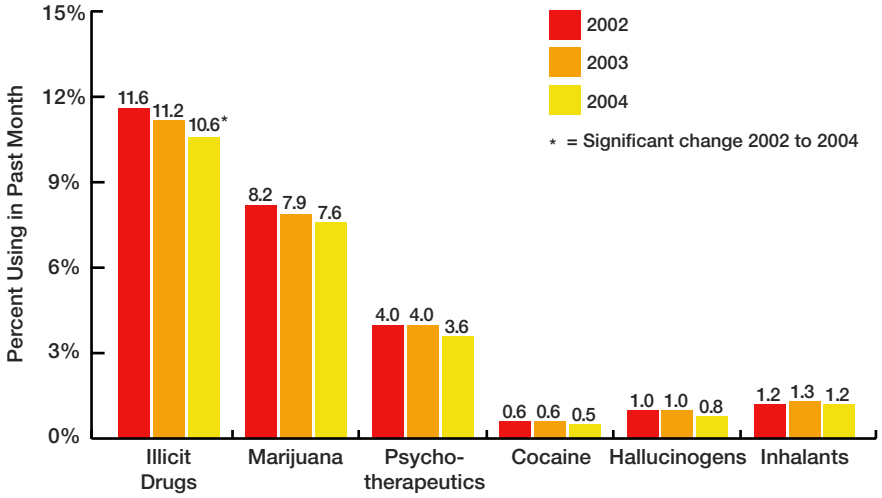
Among adults with serious psychological distress, 27.6 percent used an illicit drug in the past year compared with 11.8 percent among those without serious psychological distress.

In 2004, almost half (47.5) percent of adults with both serious psychological distress and a substance use disorder received no treatment for either problem.

The National Survey on Drug Use and Health is an annual survey of close to 70,000 people. The survey collects information from residents of households, residents of non-institutionalized group quarters, and civilians living on military bases.

For a copy of the survey or the overview, 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 survey is also available online on the SAMHSA Web site at **www.oas.samhsa.gov.** Electronic versions of *Recovery Month* materials are available at **www.recoverymonth.gov.**

Past-Month Use of Selected Illicit Drugs Among Youth Age 12 to 17: 2002-2004



Source: SAMHSA Office of Applied Studies. *Overview of Findings From the 2004 National Survey on Drug Use and Health,* page 12.

Recovery Month is observed annually in September to recognize the accomplishments of people in recovery, the contributions of treatment providers, and advances in substance abuse treatment. This year is the 16th annual observance. The theme, "Join the Voices for Recovery—Healing Lives, Families and Communities," emphasizes that addiction to alcohol and drugs is a chronic, but treatable, public health problem that affects everyone in the community.

Tribes Weave Visions for Healthy Future

The third annual "National Behavioral Health Conference on Alcohol, Substance Abuse and Mental Health: Weaving Visions for a Healthy Future" held in San Diego, CA, in June drew more than 500 American Indian and Alaska Native substance abuse treatment and mental health practitioners, tribal representatives, traditional healers, health care providers, state program directors, consumers, and their families.

Co-sponsored by SAMHSA and the Indian Health Service, the conference was held to develop recommendations, stimulate discussion, and identify opportunities for collaboration and coordination of alcohol and substance abuse treatment and prevention efforts in Indian communities.

The 3-day conference was preceded by a forum on "Best Practices in Substance Abuse Treatment for American Indians and Alaska Natives," which highlighted several current or past SAMHSA grantees.

SAMHSA's Center for Substance Abuse Treatment (CSAT) sponsored the forum.

Dale Walker, M.D., a member of the Cherokee tribe and Director of the One Sky Center, emphasized the symbolism of the conference title. "Weaving our vision is so important in Indian Country," he said. "It's a bringing together of many different resources and efforts."

He explained, "It's like a two gray hills rug. In other words, the partnership is complementary in its ability to work together and produce positive results in the same way that the classic Navajo weave of a two gray hills rug is complementary in color, style, and strength. That should be our metaphor as a system of care reaching out into the Indian community."

The Directors of all three SAMHSA Centers addressed forum attendees, and SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., and Indian Health Service (IHS) Director Charles W. Grim, D.D.S., M.H.S.A., both addressed the conference.

"You are on the cutting edge, on the frontier," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H., to forum attendees. Dr. Clark acknowledged the current lack of evidence-based practices that apply to American Indians and Alaska Natives specifically. "Native communities need to ensure that they are included in research studies and clinical trials. Right now, you can't turn to the academic literature for the answers," Dr. Clark added. "The answers are within you."

SAMHSA's Center for Substance Abuse Prevention Director Beverly Watts Davis told forum attendees that the Agency's Fetal Alcohol Spectrum Disorders Center for Excellence is working on an American Indian and Alaska Native initiative that will focus on FASD in Indian Country.

In addition to recognizing program successes, the conference also recognized the recent tragedies at the Red Lake and Standing Rock reservations involving youth suicides. A multi-agency team including representatives from SAMHSA, IHS, state agencies, and the One Sky Center provided on-site assistance.

With special funding provided by SAMHSA through the One Sky Center, a panel of youth attended the conference to share their feelings about the crisis.

A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services, told participants, "Suicide is robbing Native communities of their most valuable resources: their children and their future."

She acknowledged that a "serious challenge to achieving our goal is the current disparities of care—too few providers in remote locations." She also pointed to a "lack of cultural competency in our programs and provider training. We don't know enough about Native cultures and the differences between them," she said.

At both the forum and the conference, participants not only described substance abuse prevention and treatment programs and practices that are working, but also emphasized the common bonds that Native people share regardless of tribe. "Indian people don't see treatment and prevention as different," said Dr. Walker. "They see them as part of the same holistic system."

Photo by Meredith Hogan Pond

SAMHSA Administrator Charles G. Curie (left) and Dr. R. Dale Walker, Director of the One Sky Center, in Portland, OR, were in San Diego, CA, in June for the third annual behavioral health conference.



Photos by Meredith Hogan Pond

The American Indian and Alaska Native "Best Practices" forum included (left to right) Eva Petoskey, Inter-Tribal Council of Michigan; Linda Woods, Little Traverse Bay Band of Odawa Indians; Don Coyhis, White Bison, Inc.; McClellan Hall, National Indian Youth Leadership Project; Laverne Alexander, Tanana Chiefs Conference; Valerie Naquin, Cook Inlet Tribal Council; Jodi Trojan, Tanana Chiefs Conference; and Donald Charley, Old Minto Recovery Camp.

Common Themes

Common themes centered on how traditional Native cultures enhance substance abuse treatment and prevention; how important families are in the recovery process; how communities can heal; and how a vision of success can produce positive results.

"Alaska Natives are resilient people who take their resilience into their programs," said Valerie Naquin of the Cook Inlet Tribal Council. "Alaska Natives have survived thousands of years in some of the worst weather in the world." In developing Alaska Native best practices, she said, "We're a lot farther along than we thought we were. Many of our traditional practices are Medicaid billable now." These practices include walking on the tundra, gathering clams by the shoreline, berry picking, and the traditional steam bath, which is the Alaska Native version of the sweat lodge.

"Usually for grants you have to put in all the horrible things," said Ms. Naquin, who helps locate funding resources for the tribal council. "But we include stories and poems and describe the strengths in Alaska Native culture."

Eva Petoskey, a member of the Grand Traverse Band of Ottawa and Chippewa Indians in Peshawbestown, MI, has many years of experience in evaluation of substance abuse and prevention with rural reservation communities in the Great Lakes area. "Engaging people in evaluation can be part of community healing," she said. "It's important to bring people in when you have the opportunity—members of the community, the tribal council, consumers."

To honor the traditional spiritual basis for change, Ms. Petoskey starts all her evaluation sessions with ceremony and prayer. "Prayer is a healing process," she said. "Prayer helps with your work because we are walking with our ancestors, walking in mutual respect."

The best way to formulate outcomes is to start in a special sacred place," said Ms. Petoskey. "And it's important to feed people who participate in a focus group or survey," she added, "then people will want to be there."

"We know that culture is prevention," said Don Coyhis, a member of the Mohican tribe and president of White Bison, Inc., in Colorado Springs, CO. "When we turn to our Native culture, there are no suicides, no meth, no alcohol. When we start talking about our communities as healthy communities with sober leadership, then our communities are ready to mobilize."

The success of traditional practices in the recovery process was described by Laverne Alexander of the Tanana Chiefs Conference in Fairbanks, AK. "The Old Minto Recovery Camp is unique," she said. "Because entire families come together for the healing of addiction." Old Minto's goal is to bring people back to their culture. "The camp brings us back to our roots, brings us back together as a community, where we started," she said. "The emphasis is on subsistence living and gathering in traditional ways."

Another successful Native program guided by traditional Native values is Project Venture, based in Gallup, NM. McClellan Hall is executive director of Project Venture's National Indian Youth Leadership Project. The national Model Program develops healthy and resilient youth and community through leadership, service, and challenge. Activities focus on developing team building, problem solving, and cooperation skills through the use of experiential games and outdoor adventures including mountain biking.

"In order to be strong in your life, you need a vision of success. You have to be able to see it to believe it," said Iris Heavyrunner, M.S.W., a member of the Blackfeet tribe and a Ph.D. candidate in social work at the University of Minnesota. "Once you have a vision, you have a clear expectation of yourself. Students who graduated from college, for example, told me they could see themselves walking across the stage and reaching their hand out for their diploma. That's how clear their vision was. A vision is powerful."

—By Meredith Hogan Pond

Tribes, Providers, Agencies Look to One Sky Center as National Resource

The One Sky Center, funded by SAMHSA, is the very first National Resource Center for American Indians and Alaska Natives dedicated to improving prevention and treatment of substance abuse and mental health disorders.

"This is a unique center," said Michelle Singer, a member of the Navajo tribe and communications coordinator for One Sky. "The Center is for—and created by—Native people."

The Center's Director, R. Dale Walker, M.D., is a member of the Cherokee tribe and professor of psychiatry at the Oregon Health & Science University (OHSU)—One Sky's home base in Portland, OR. "We want to be more than a listening post," said Dr. Walker. "We actively respond to requests for prevention- and treatment-related technical assistance from tribal organizations around the country."

What does "One Sky" signify? "For us, all Indian Nations and people are under one sky on Mother Earth," said Ms. Singer.

Accordingly, an important part of the One Sky Center's work is building networks and coalitions and fostering relationships with both tribal and non-tribal entities—in academia, the private sector, and Government—with the goal of promoting healing among individuals, families, and communities.

"Working with stakeholders from across the country, the One Sky Center provides a blueprint for comprehensive services that honor the traditional ways of living and healing among Native Americans," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

For example, One Sky's national reach has been enhanced and extended by its partnerships with several Native programs including the Alaska Native Tribal Health Consortium, and the Cook Inlet Tribal Council.

SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) jointly fund the One Sky Center in a 3-year cooperative agreement with OHSU that began in summer 2003.

Photo by Ken Blackbird

The One Sky Center helped bring together tribal leaders, traditional healers, and others for a day of sharing Native program success stories and lessons learned in an all-day forum before the start of the third annual Indian Health Service/SAMHSA conference in San Diego this June. (See *SAMHSA News,* page 10.)

Now beginning its third year, the Center continues working on its three main objectives:

- Promote and nurture effective and culturally appropriate substance abuse prevention and treatment services.
- Identify culturally appropriate and effective evidence-based substance abuse prevention and treatment practices and disseminate them so that they can be applied with relevance across diverse tribal communities.
- Provide training, technical assistance, and products to expand the capacity and quality of substance abuse prevention and treatment practitioners serving this population.

In 2 years, the Center has visited more than 100 communities around the country and provided many products and resources for Native organizations. "What we've really done is talk to the communities so we can modify the resources to fit community needs," said Dr. Walker.

In an effort to promote effective and culturally appropriate prevention and treatment, the One Sky Center has an online Native Programs Directory that hightlights programs funded by CSAT and CSAP.

The One Sky Center also receives funds from SAMHSA's Center for Mental Health Services. With this funding, the One Sky Center is continuing to develop an online American Indian/Alaska Native resource database for mental health prevention programs. The goal is to create a resource directory for dissemination to schools around the country with substantial American Indian and Alaska Native enrollment.

In the coming year, suicide intervention and prevention will be an increasing part of One Sky's work. "There is no way we can leave that out," said Dr. Walker, "because of its deep interrelation with all the other health care problems. We have to look at the whole concept of disease—or *dis-ease*—in the Native communities."

"Tribal programs, tribes themselves, and American Indians and Alaska Natives across the country actually have enriched understandings of how to recover and how to avoid and step away from illness," said Dr. Walker. "We need to include that knowledge in evidence-based practices."

One Sky's Web Site

The One Sky Center's Web site offers downloadable newsletters, monographs, training manuals, directories, and congressional testimonies as well as several new information packages for all Indian communities. To order publications, contact the Center by email to onesky@ohsu.edu or phone (503) 494-3703. For more information, visit the Center's Web site at **www.oneskycenter.org.**

—By Meredith Hogan Pond

Buprenorphine Update: Clinical Support, Legislation on Patient Limits

SAMHSA recently announced the availability of the Physician Clinical Support System (PCSS) to assist physicians who prescribe or dispense the medication buprenorphine to their patients dependent on heroin or prescription drugs containing opioids.

And in late July, Congress passed legislation to adjust the 30-patient limit for physician group practices that dispense buprenorphine in an office-based setting to individuals with opioid dependence. Now, each physician in a group practice will be allowed to treat 30 patients with buprenorphine.

Prior to this new legislation, an entire group practice could treat only 30 patients—no matter how many physicians had waivers and were certified to prescribe buprenorphine.

In addition to assisting physicians in the appropriate use of buprenorphine, the PCSS promotes improved patient care, research, and education. To accomplish this work, the Agency is collaborating with the American Society of Addiction Medicine (ASAM) and other specialty addiction medicine, psychiatric, pain, and general medicine associations.

"The PCSS is oriented towards the needs of primary care physicians, pain specialists, psychiatrists, and other physicians who are often reluctant to treat patients dependent on heroin or prescription pain medication containing opiates," said SAMHSA's Anton C. Bizzell, M.D., a medical officer in the Division of Pharmacologic Therapies at the Center for Substance Abuse Treatment. "This will assist in increasing access to the millions of untreated prescription opioid- and heroin-dependent persons in the country."

A free service, PCSS will offer support on patient selection, induction, dosing and patient monitoring, and treatment of dependence on more than one substance or co-occurring conditions.

The PCSS is designed to increase access to buprenorphine treatment for these patients. Similarly, an amended Controlled Substances Act resulting from the recent legislation should also increase access to treatment for those who need it.

The PCSS is a national network of 45 trained physician mentors with expertise in addiction treatment and skilled in clinical education, who are supported by a PCSS medical director and by 5 physicians who are national experts in the use of buprenorphine. The physicians within the network provide services via telephone, email, and/or at the place of clinical practice, thereby allowing others to observe them providing office-based treatment with buprenorphine.

For more information on the 30-patient-limit legislation, see details in the July 27, 2005, *Federal Register.*

To find a PCSS clinician in your region, to become a PCSS mentor, or for more information about the project, email the PCSS staff at PCSSproject@asam.org. You can also call the toll-free line at 1-877-630-8812. Visit the PCSS Web site at **www.PCSSmentor.org.**

For a listing of physicians who can prescribe buprenorphine to patients with addiction to opioids, or a downloadable version of *Treatment Improvement Protocol 40—Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction,* or other information, visit SAMHSA's buprenorphine Web site at **www.buprenorphine.samhsa.gov.**

Medicare Web Page Available

SAMHSA recently posted a Web page explaining the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and its implications for prescription drug coverage. The Web page includes information on the cost of the program to individual participants, how and when to enroll, and resources for education and outreach. The Web page can be accessed at **www.samhsa.gov/mma.**

The July/August 2005 issue of *SAMHSA News* carried an extensive explanation of the Medicare Prescription Drug, Improvement, and Modernization Act for people with mental illnesses and for those with mental illness who are eligible for both Medicare and Medicaid. The July/August 2005 issue is available online at **www.samhsa.gov/SAMHSA_News.**

Future *SAMHSA News* issues will continue to update readers on developments pertaining to Medicare.

SAMHSA Awards 2005 Grants

SAMHSA recently announced additional grant awards for Fiscal Year 2005. (See *SAMHSA News,* July/August 2005 for previous awards.) New grants include:

Circles of Care

$6.7 million over 3 years to provide tribal and urban Indian communities with tools and resources to design systems of care to support mental health services for children, youth, and families in American Indian and Alaska Native communities.

These grants provide support to American Indian and Alaska Native community members in their efforts to assess service system needs, gaps, potential resources, and plan infrastructure development strategies that meet identified needs.

The first year total is $2.2 million.

Grants were awarded to the Denver Indian Family Resource Center, Lakewood, CO; Cook Inlet Tribal Council, Inc., Anchorage, AK; Indian Health Care Resource Center of Tulsa, Inc., Tulsa, OK; the Muscogee (Creek) Nation Okmulgee, OK; Native American Rehabilitation Association of Portland, OR; Sinte Gleska University, Mission, SD; Quileute Tribe, La Push, WA.

Treatment for Juveniles Returning from Incarceration

$19.2 million for 11 awards over 4 years to support substance abuse treatment and related services for juveniles and young adults up to age 24 returning to their families and communities from incarceration.

The grants will be used to form partnerships among community organizations, including correctional or juvenile facilities, to plan, develop, and provide substance abuse treatment and related reentry services.

Awards were made to Turning Point Center Youth/Family, Fort Collins, CO; Institute for Behavioral Change, Washington, DC; Operation Par, Inc., Pinellas Park, FL; Cobb County Community Services, Smyrna, GA; CAB Health and Recovery Services, Danvers, MA; Hunter Doyle Memorial Institute, Rochester, NY; the Hispanic Urban Minority Alcoholism and Drug Abuse Outreach Program, Cleveland, OH; Volunteers of America of Oregon, Portland, OR; Aliviane Inc., El Paso, TX; Chesterfield County Re-entry Court Program, Chesterfield County, VA; and Clark County Department of Community Services, Vancouver, WA.

Access to Adolescent Treatment Services

$19 million over 3 years to 16 states to coordinate substance abuse treatment.

These grants are designed to build capacity to provide effective and affordable substance abuse treatment for youth and their families. In addition to increasing access to treatment services for young people, each state will create a staff position dedicated to ensuring resources available for substance abuse treatment are being used in the most efficient manner possible.

This year's grantees include the Arizona Department of Health Services Division of Behavioral Health, Phoenix, AZ; Connecticut Department of Children and Families, Hartford, CT; The DC Youth Substance Abuse Treatment Coordination Program, Washington, DC; Florida Office of Drug Control, Tallahassee, FL; Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities and Addictive Diseases, Atlanta, GA; Kentucky Youth First Project, Frankfort, KY; the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse, Chicago, IL; the Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Boston, MA; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Raleigh, NC; Ohio Department of Alcohol and Drug Addiction Services, Columbus, OH; Adolescents Treatment Coordination in Columbia, SC; State of Tennessee Office of Children's Care Coordination, Nashville, TN; the State of Vermont Department of Health, Burlington, VT; State Adolescent Substance Abuse Treatment Coordination, Richmond, VA; Washington Adolescent Substance Abuse Treatment Statewide Coordination, Lacey, WA; and Adolescent Treatment Coordination, Madison, WI.

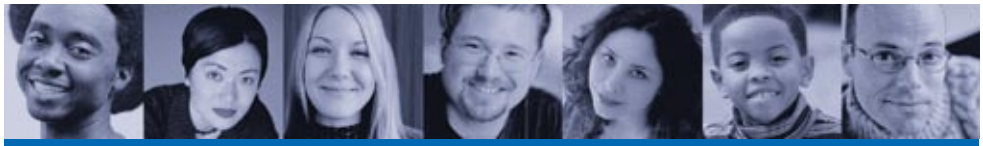
Treatment for Methamphetamine Abuse

$16.2 million over 3 years for 11 new grants to support treatment for abuse of methamphetamine and other emerging drugs for adults residing in rural areas that have been particularly hard hit by methamphetamine abuse.

Grantees include the Kern County Rural Targeted Capacity Expansion Project, CA; the Mendocino County Department of Public Health, CA; The San Mateo County Human Services Agency, CA; North Georgia's Union County Commission, New Hope Counseling, GA; the Montana Department of Justice, Helena, MT; Gila Regional Medical Center, Silver City, NM; Methamphetamine Expanded Treatment Program, Grants Pass, OR; Tennessee Department of Mental Health, Nashville, TN; The City of Robstown, TX; the Webb County (Laredo) Expand Access to Substance Abuse Treatment in Rural Areas Project, TX; Zapata County Serenidad Border Infrastructure Development Project, TX.

For the latest information on SAMHSA grant awards or new funding announcements, visit **www.samhsa.gov** or **www.grants.gov.**

As *SAMHSA News* went to press, SAMHSA announced 37 grants with a first-year total of $9.7 million to support national suicide prevention efforts. These grants will support a suicide prevention resource center, suicide prevention efforts on college campuses, and state and tribal youth suicide prevention and early intervention programs across the country.



Mental Health Action Agenda, ***continued from page 4***

At the National Association for the Mentally Ill, Executive Director Michael Fitzpatrick hailed the Action Agenda as "an important first step in defining the role that the Federal Government can play, in partnership with states and communities, in establishing a coherent and cohesive mental health system in America."

According to Robert Glover, Ph.D., Director of NASMHPD, "A series of important activities have occurred that we believe will fundamentally change the way we care for people with mental illnesses and improve and save many lives—the creation of the President's New Freedom Commission on Mental Health, the issuance of the Commission's final report, and now, the release of SAMHSA's *Transforming Mental Health Care in America—The Federal Action Agenda: First Steps.*"

Dr. Glover continued, "This Action Agenda dedicates virtually every agency of the Federal Government to the goal articulated by the President more than 3 years ago in his Executive Order: That all people with mental disorders live, work, learn, and participate fully in their communities."

For a print copy of *Transforming Mental Health Care in America—The Federal Action Agenda: First Steps,* contact the National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). For an electronic copy of the Action Agenda, visit SAMHSA's Web site at **www.samhsa.gov,** and click on Mental Health Action Agenda.

Web Resources Available

- *Transforming Mental Health Care in America—The Federal Action Agenda: First Steps* on the SAMHSA Web site at **www.samhsa.gov /Federalactionagenda/NFC_TOC.aspx**
- President's New Freedom Commission on Mental Health Web site, including the Commission's final report, *Achieving the Promise: Transforming Mental Health in America,* at **www.mentalhealthcommission.gov**
- State-by-state mental health transformation activities Web page at **www.samhsa.gov/Matrix/MHST_TA.aspx**
- *Transformation Trends* on the SAMHSA Web site at **www.samhsa.gov/matrix /matrix_mh.aspx.**

Retailers Cut Cigarette Sales to Youth

Retailers continue to reduce sales of tobacco to children under age 18, according to data released recently by SAMHSA. The national retailer violation rate dropped to 12.0 percent in reports submitted by states in 2005, down from 12.8 percent reported in 2004 and 40.1 percent since the annual tobacco retailer inspections began in 1996.

Results of the most recent survey of inspections show that 49 of the 50 states achieved the legislative goal of cutting retailer sales of cigarettes to minors to no more than 20 percent. A total of 43 states achieved a retailer violation of no more than 15 percent. In 21 states, the retailer violation was 10 percent or below. The retailer violation rate is based on unannounced state inspections of cigarette retailers.

The survey's findings are based on reports submitted by states in response to a Federal law established in 1992 restricting access to tobacco by youth under age 18. The measure, known as the Synar Amendment, and its implementing regulations require states and U.S. territories to enact and enforce youth tobacco access laws; conduct annual random, unannounced inspections of tobacco outlets; achieve negotiated annual retailer violation targets; and attain a final goal of 20 percent or below for retailer non-compliance. The Synar law was named for the late Representative Mike Synar of Oklahoma.

Data reported in Fiscal Year 2005 indicate that Kansas failed to meet its negotiated retailer violation target. Kansas is committing additional state funds for tobacco enforcement as an alternative to losing part of its SAMHSA block grant funding, as specified in the law.

For more information, visit **http://prevention.samhsa.gov/tobacco.** For questions on program requirements or the data being reported, contact Alejandro Arias, SAMHSA's Synar Program Lead, at alejandro.arias@samhsa.hhs.gov.

Treatment Guide Focuses on Adult Offenders in Criminal Justice System

SAMHSA recently published a guide for substance abuse treatment counselors and administrators who work with clients in the criminal justice system.

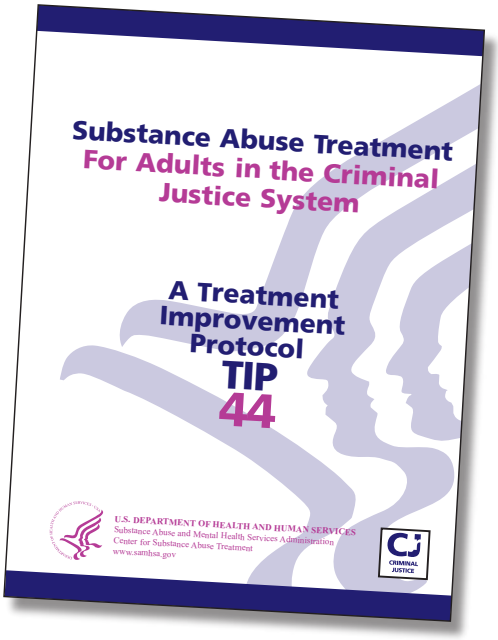
Substance Abuse Treatment for Adults in the Criminal Justice System, SAMHSA's Treatment Improvement Protocol 44 (TIP 44), presents clinical guidelines to help substance abuse treatment counselors address issues that arise from their clients' status in the criminal justice system. In addition, it will aid personnel in the criminal justice system in understanding and addressing the challenges of working with offenders with substance use disorders.

The goals of this TIP are to provide relevant information that will enable treatment providers to be more effective in their approach to offender and ex-offender populations; help people in community treatment understand the criminal justice system and how it works with their treatment services; and encourage collaboration between the criminal justice and substance abuse treatment communities.

TIP 44 also presents multiple perspectives: public safety, public health, substance abuse treatment, and corrections. Differing client needs, issues of culture and society, and characteristics of the local criminal justice system are also discussed.

The TIP is organized into 11 chapters:

- **Chapter 1: Introduction** provides an overview of the purpose of the TIP and key definitions for language used in the text.
- **Chapter 2: Screening and Assessment** includes information about relevant domains for screening and assessment and a discussion of special concerns (e.g., gender and sexual orientation, literacy, a client's primary language, and learning disabilities) and specific populations.



- **Chapter 3: Triage and Placement in Treatment Services** reviews the complex area of treatment matching. Because no single treatment has been shown to be effective for all offenders, effective matching of services to an individual's needs improves the likelihood that the client will successfully complete treatment.
- **Chapter 4: Substance Abuse Treatment Planning** discusses the available treatment options in the criminal justice system. It also presents guidelines for developing treatment plans.
- **Chapter 5: Major Treatment Issues and Approaches** addresses the issues for offenders with substance use disorders, including engagement and retention, stigma and shame, the client-counselor relationship, and treatment levels (e.g., residential, non-residential, outpatient, community supervised, and self-help and other ancillary services).
- **Chapter 6: Adapting Offender Treatment for Specific Populations** describes treatment issues and approaches for specific populations who might require modifications in treatment: people of ethnic and racial minorities, women, violent offenders, people with disabilities, older inmates, people with co-occurring substance use and mental disorders, and sex offenders, among others.
- **Chapters 7 through 10** describe the specific treatment needs and strategies for individuals in four particular criminal justice settings: pretrial and diversion settings, jails, prisons, and community supervision settings.
- **Chapter 11: Key Issues Related to Program Development** discusses the issues that frame effective programming and coordination. For example, Federal, state, and local policies have a tremendous effect on the quality and availability of substance abuse treatment for offenders, as do policies and procedures within individual programs.

To obtain TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System,* 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). Ask for NCADI No. BKD526.

To Find TIPs Online

For information and online links to other Treatment Improvement Protocol (TIP) publications, visit **www.kap.samhsa.gov/products/manuals/tips/numerical.htm.** You can review the entire TIP series by topic or by number.

Upcoming TIPs include *TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* to be released this fall.

New Multi-Language Publications

The following new brochures produced by the Multi-Language Initiative of SAMHSA's Knowledge Application Program are available:

- *Aging, Medicines and Alcohol*—Available in Chinese, Korean, Russian, and Spanish.
- *Good Mental Health Is Ageless*—Available in Chinese, Korean, Russian, and Spanish.
- *Helping Yourself Heal: A Recovering Woman's Guide To Coping with Childhood Abuse Issues*—Available in Chinese, Korean, and Spanish.
- *Helping Yourself Heal: A Recovering Man's Guide To Coping with the Effects of Childhood Abuse*—Currently available in Spanish only.
- *Tips for Teens: The Truth About Inhalants*—Coming soon in Navajo.

These brochures are translations and adaptations of English-language brochures produced by SAMHSA's Center for Substance Abuse Treatment. They are available online and can be printed electronically. For an index of available publications, visit **http://kap.samhsa.gov/mli/index.htm.**

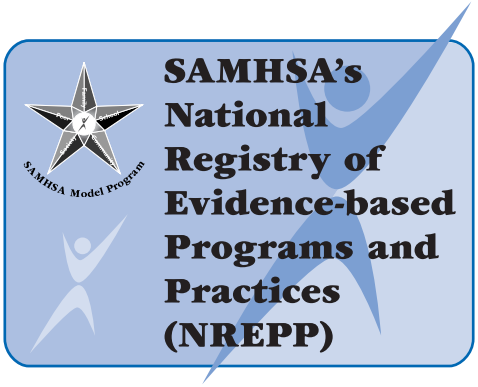
Public Comments on National Registry Expansion

SAMHSA recently announced the proposed expansion of the National Registry of Evidence-based Programs and Practices (NREPP). The announcement was published in the *Federal Register* dated August 26.

Now a nationally recognized tool, NREPP is useful for identifying and promoting effective interventions to prevent substance abuse. The proposed expansion will create a national resource for the latest information on the scientific basis and practicality of interventions to prevent and also treat mental and substance use disorders.

To participate in review and public comments, read the *Federal Register* notice as well as other supporting documents, which are available on the SAMHSA Web site at **www.samhsa.gov.**

Click on "National Registry of Evidence-based Programs and Practices FRN" under the "Quick Picks" section on the SAMHSA home page. Written comments can be sent by U.S. mail to SAMHSA, c/o NREPP Notice, 1 Choke Cherry Road, Rockville, MD 20857 or electronically at nrepp.comments@samhsa.hhs.gov.



Practice Improvement Collaboratives: Final Report

SAMHSA's Center for Substance Abuse Treatment (CSAT) recently released *Practice Improvement Collaboratives: Final Report.* The 47-page report documents the successes of the 14 Practice Improvement Collaboratives (PICs) established throughout the United States as part of a 1998 SAMHSA initiative to facilitate the use of evidence-based practices in substance abuse treatment settings.

SAMHSA developed the program to assist organizations in creating collaborative networks at the city, state, and regional levels and awarded 3-year implementation grants to enable the networks to apply a science-to-service model in their programs. The PICs comprise practitioners, researchers, policymakers, and people in recovery. They respond to community needs and promote the adoption of evidence-based practices.

To obtain 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).

We'd Like To Hear From You!

SAMHSA News strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies, and available resources.

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

Comments: _____

_____

_____

I'd like to see an article about: _____

_____

_____

Name and title: _____

Address and affiliation: _____

_____

Phone number: _____ Email address: _____

Field of specialization: _____

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

- ❑ Recovery Is Key for Mental Health Action Agenda
- ❑ From the Administrator: Mental Health Care: Transforming Our Vision and Our System
- ❑ SAMHSA Supports Efforts To Prevent Suicide
- ❑ Youth Drug Use Continues To Decline
- ❑ Tribes Weave Visions for Healthy Future
- ❑ Tribes, Providers, Agencies Look to One Sky Center As National Resource
- ❑ Buprenorphine Update: Clinical Support, Legislation on Patient Limits
- ❑ Medicare Web Page Available
- ❑ SAMHSA Awards 2005 Grants
- ❑ Retailers Cut Cigarette Sales to Youth
- ❑ Treatment Guide Focuses on Adult Offenders in Criminal Justice System
- ❑ In Brief
- ❑ SAMHSA Responds to Hurricane Katrina
- ❑ ***SAMHSA News*** online—for the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

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Thank you for your comments!

SAMHSA Responds to Hurricane Katrina

When Hurricane Katrina unleashed its fury on the Nation's Gulf Coast at the end of August, SAMHSA brought its full complement of resources to bear on the recovery effort.

The mission was to ensure that crisis counseling and supportive services were available to residents and evacuees of areas affected by Katrina and to see that people with serious mental illnesses or addictive disorders continued to receive treatment.

The havoc wreaked by Katrina has bred a sense of desperation among many Gulf Coast residents, particularly among those who were already troubled by mental health disorders or addictions. The SAMHSA-funded National Suicide Prevention Lifeline (1-800-273-TALK [8255]) (See *SAMHSA News,* p. 5) was expanded to receive calls from people in crisis in the storm-affected areas. Counselors in Louisiana reported a dramatic increase in calls, from 150 per day before the hurricane to 900 per day after the hurricane.

Within days of Katrina's landfall, SAMHSA had approved $600,000 in SAMHSA Emergency Response Grants for clinical services and pharmaceuticals for four states: $200,000 for Louisiana; $150,000 for Mississippi; $100,000 for Alabama; and $150,000 for Texas, where many of the evacuees from the Gulf Coast region sought shelter.

SAMHSA is also working with the Federal Emergency Management Agency (FEMA) to provide crisis counseling program grants to Louisiana, Mississippi, Alabama, Texas, and other states that receive evacuees.

The SAMHSA Emergency Response Center was activated on September 1 to assist state officials and support staff deployed in the field, and to communicate with other Federal and voluntary agencies dealing with the devastation. In addition, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., accompanied Health and Human Services Secretary Mike Leavitt to the affected areas twice to meet with evacuees and service providers.

SAMHSA also mobilized its Disaster Technical Assistance Center to support state officials in their efforts to conduct needs assessments, provide services, support ongoing administrative operations, access financial assistance, and plan for long-term recovery.

SAMHSA officials have been in touch with other Federal agencies to identify credentialed mental health and substance abuse service providers within the Federal system who can assist in the efforts. The Agency is also working with constituent groups to recruit non-governmental professionals willing to provide mental health services to people in need. These professionals include substance abuse and mental health counselors, psychologists, chaplains, and social workers. Non-Federal health care professionals interested in volunteering can call a toll-free number (1-866-KAT-MEDI) or visit the Web site **https://volunteer.hhs.gov.**

The disaster created special problems for people with opioid addiction. Patients receiving methadone and buprenorphine suddenly found themselves without access to medication, and people dependent on opioids but not enrolled in addiction treatment also needed help. Texas is using the Emergency Response Grant money received from SAMHSA for the provision of methadone and related activities.

To assist treatment programs nationwide, SAMHSA issued guidance on the provision of emergency medication for opioid addiction. The guidance outlined short- and long-term procedures to ensure that no disruptions in services would occur. These guidelines are available at SAMHSA's Web site at **www.samhsa.gov.**

As *SAMHSA News* was going to press, Administrator Curie observed, "As time passes since the hurricane's landfall, urgent physical health needs are giving way to long-term human service needs including mental health and substance abuse treatment. The immediate task of saving lives is being supplanted by tasks that continue to sustain life and address the quality of life. SAMHSA will continue to assist with meeting those needs."

Disaster Relief Resources

Crisis Hotline: 1-800-273-TALK (8255)
www.suicidepreventionlifeline.org

Department of Health and Human Services Volunteer Line: 1-866-KAT-MEDI
https://volunteer.hhs.gov

Medication-Assisted Treatment Guidelines
www.samhsa.gov/disaster/katrina_curie_050909.aspx

SAMHSA's Substance Abuse Treatment Facility Locator: 1-800-662-HELP (4357)
http://dasis3.SAMHSA.gov

National Child Traumatic Stress Network
www.nctsnet.org

SAMHSA's Disaster Technical Assistance Center
www.mentalhealth.samhsa.gov/dtac

Mental Health and Disaster Publications
www.mentalhealth.samhsa.gov/cmhs/katrina/pubs.asp

Fact sheets and publications available for downloading include:

- *How Families Can Help Children after a Disaster*
- *After a Disaster: Self-Care Tips for Dealing with Stress*
- *A Guide to Managing Stress in Crisis Response Professions.*

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