Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter Volume X, No. 4 Fall 2002

National Strategy Seeks To Prevent Suicide

Terri Ann Weyrauch, M.D., seemed to have everything. She was a bright, beautiful young woman, board certified in internal medicine and rheumatology, and in private practice in Chicago. But she suffered from depression. Despite the fact that she was doing all the right things—seeing a psychiatrist and taking medication—she took her own life in 1987, at the age of 34.

To reduce the occurrence of such tragedies, the Federal Government launched the National Strategy for Suicide Prevention in May 2001. It is a massive effort, spanning several Federal agencies (including SAMHSA), state governments, nonprofit organizations, communities, and others. Since the strategy's release, numerous activities have been initiated in support of its goals.

"Even one death by suicide is one death too many," says SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., noting that more than 90 percent of suicides are associated with mental illness. "Most suicides are preventable. We need to raise awareness that help is available, treatment is effective, and recovery is possible."

Convergence of Efforts

Suicide is a far more common problem than many people realize: For every two homicides in this country, there are three suicides. For every person who dies from HIV/AIDS, two people die by suicide. Every year nearly 30,000 people lose their lives to suicide and 650,000 attempt suicide.

Photo by Ralph Daniel

Elsie and Gerald Weyrauch of Marietta, GA, turned their personal grief into public action by starting the nonprofit group called the Suicide Prevention Action Network to bring the issue to the forefront of national attention. They are holding a "memory quilt" containing a photo of their daughter, Terri.

Suicide is a tragedy that has touched the lives of countless survivors—those who live on after a relative, friend, neighbor, or colleague takes his or her life.

Only recently have efforts to understand and prevent suicide coalesced into a united movement. When Terri Ann Weyrauch ended her life, her parents, Gerald H. Weyrauch, M.B.A., and Elsie Weyrauch, R.N., of Marietta, GA, turned their grief into action. In 1996,

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Agreement Helps Transfer Research Findings to Clinical Practice

SAMHSA and the National Institute on Drug Abuse (NIDA) announced a unique intradepartmental agreement this fall to expedite the application of findings from treatment research into clinical application.

The $1.5 million agreement between NIDA and SAMHSA's Center for Substance Abuse Treatment (CSAT)—both within the U.S. Department of Health and Human Services—will help ensure that findings from NIDA's treatment research will be quickly and readily available to practitioners throughout the country.

Under the agreement, NIDA will provide funding to support CSAT's Addiction Technology Transfer Centers, a network comprised of 14 independent regional centers and a national office charged with increasing the knowledge and skills of addiction treatment practitioners and fostering alliances to support and establish best treatment practices. The purpose of the agreement is to enhance efforts to disseminate and apply findings from NIDA's National Drug Abuse Treatment Clinical Trials Network as well as other NIDA-supported studies to practitioners served by the Addiction Technology Transfer Centers.

Grants totaling almost $6 million were awarded this fall to add three nodes—Northern New England (covering 5 states), New Mexico, and Arizona—to NIDA's Clinical Trials Network. The network is now comprised of 17 research nodes around the country. These nodes are conducting a variety of research protocols on behavioral, pharmacological, and integrated behavioral and pharmacological treatment interventions in 27 states at 120 community treatment sites. More than 3,500 patients are participating in these studies. The Clinical Trials Network is designed to determine treatment effectiveness across a broad range of community-based treatment settings and diversified patient populations.

The National Institute on Drug Abuse, a component of the National Institutes of Health within the U.S. Department of Health and Human Services, supports more than 85 percent of the world's research on the health aspects of drug abuse and addiction.

In announcing the agreement, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., noted that "This partnership is a significant step in our efforts working with the National Institutes of Health to define and develop a 'Science to Services' cycle and to reduce the time between the discovery of an effective treatment or intervention and its adoption as part of community-based care. According to the Institute of Medicine, the adoption into clinical practice of a research-based treatment can take up to 20 years."

NIDA Acting Director Glen R. Hanson, Ph.D., D.D.S., said, "This collaborative effort puts into place a system whereby health care providers can be more rapidly alerted to new and improved medications and behavioral therapies with which to treat patients for drug abuse and addiction."

He added that the intradepartmental agreement would mutually augment the outreach and impact of both NIDA and CSAT efforts to ensure that science-based findings are incorporated into clinical practice. And, the most important beneficiaries will be those individuals in treatment and recovery from substance abuse disorders.

For more information on NIDA's National Drug Abuse Treatment Clinical Trials Network, visit **www.drugabuse.gov/ctn/index.htm.**

For more information about SAMHSA's National Addiction Technology Transfer Centers, visit **www.nattc.org.** Or 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).

Buprenorphine Approved for Opioid Addiction Treatment

The medication buprenorphine was approved by the Food and Drug Administration on October 9 for the detoxification and maintenance treatment of heroin and other narcotic addiction. The new medication enables physicians, for the first time, to treat opioid addiction in an office-based setting provided they meet criteria mandated by Congress and they obtain a waiver through SAMHSA to dispense and prescribe it.

"Buprenorphine allows patients to be treated for addictions in the same manner as they are treated for other chronic illnesses, such as diabetes or hypertension," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

Buprenorphine's unique effects and pharmacology make it an attractive and clinically useful treatment option. (See *SAMHSA News,* summer 2002.) Buprenorphine functions on the same brain receptors as morphine, but does not produce the same euphoria, dependence, or withdrawal syndrome. It is long-lasting, less likely to cause respiratory depression, and well-tolerated by people addicted to heroin or other opioids. Physicians will be required to refer patients to full-spectrum care for their social and psychological needs.

Buprenorphine will not replace methadone therapy, which is currently provided through SAMHSA-certified opioid treatment programs, but the medication gives physicians an additional option to use in treating addiction to opioids, including prescription painkillers. Buprenorphine represents a milestone in the 12-year medication development program of the National Institute on Drug Abuse.

Physicians who are not addiction-medicine specialists, and who want to offer this new option to their patients, must first complete an 8-hour training session to qualify for a waiver from the Controlled Substances Act 21[USC 823(g)], which restricts the use of methadone and other opiate drugs to federally licensed addiction treatment clinics. The waiver permits primary care physicians to provide office-based treatment. To date, approximately 2,000 physicians have received training provided by medical groups funded by SAMHSA.

In the next few months, SAMHSA will establish a nationwide registry of physicians holding this waiver to assist health care workers, and addicted individuals and their families, identify treatment professionals qualified to treat up to 30 patients for detoxification (weaning off opioids) or maintenance (staying off opioids).

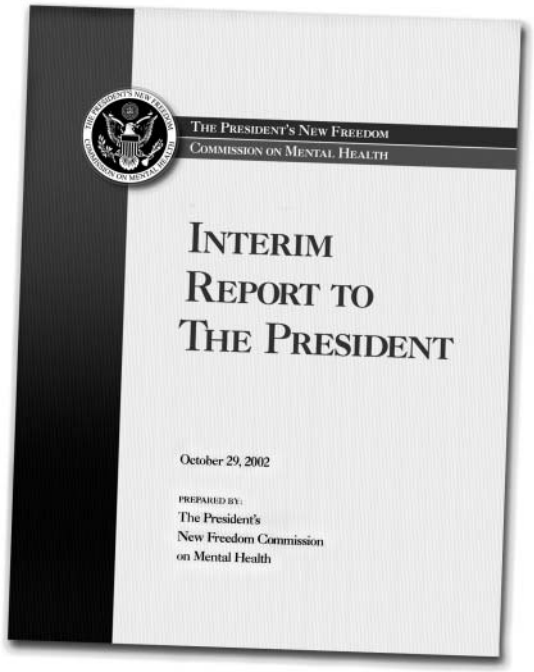
To encourage physicians to participate in buprenorphine training sessions and to inform the public about this new treatment option, SAMHSA's Center for Substance Abuse Treatment will launch an information campaign in the near future.

SAMHSA has set up an information Web site and toll-free number for physicians to call for information. Physicians can get more information by visiting **www.buprenorphine.samhsa.gov** or by calling the SAMHSA Buprenorphine Information Center at 1 (866) BUP-CSAT (287-2728) from 8:30 a.m. to 5 p.m., eastern time.

President's Commission Reports "Mental Health System Is in Disarray"

Calling the mental health system an inefficient maze of private, Federal, state, and local government programs with scattered responsibility for services that frustrates both people with mental illness and providers of care, the President's New Freedom Commission on Mental Health Chairman Michael F. Hogan, Ph.D., released an interim report to the President this fall.

Citing the need for dramatic reform at all levels of service delivery, Dr. Hogan said, "the Commission's challenge now is to identify realistic solutions to help people with mental illness get the quality care that research has shown to be effective."



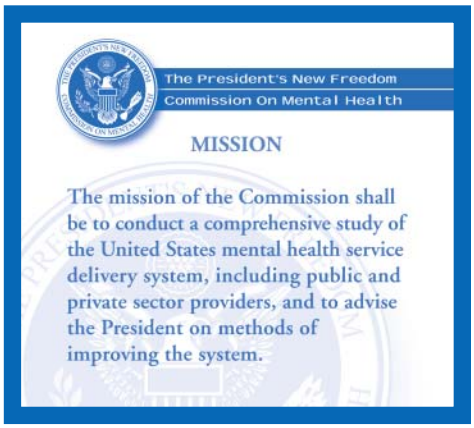
The Commission is charged with conducting a comprehensive study of the U.S. mental health service delivery system and advising the President on methods of improving the system to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. (See *SAMHSA News,* spring 2002.) As part of that goal, President George W. Bush's April 29, 2002, Executive Order creating the Commission requires this interim report to describe barriers to the delivery of effective mental health care. The report also provides examples of community-based care models that show success in coordinating services and providing desired outcomes.

"Today, people diagnosed with cancer or heart disease benefit from a broad array of effective treatments," Dr. Hogan continued. "People with mental illness deserve no less. Undetected, untreated and poorly treated mental disorders interrupt lives, leading many to disability, poverty, and long-term dependence. The good news is that recovery from mental illness is a reality; a range of safe and effective treatments, services, and supports exist for men, women, and children with mental illness. We know that when mental illness is diagnosed early and treated appropriately, quality of life is tremendously improved. Yet, half of all people who need treatment for mental illness do not receive it. The rate is even lower for racial and ethnic minorities, and the quality of care they receive is poorer."

In its report, the Commission identified barriers to quality care and recovery. Some barriers relate directly to the service delivery system itself, such as fragmentation and gaps in care for children, adults, and older adults. Others encourage dependency through a mix of inadequate rehabilitation services and disincentives to work. Still others reflect a failure to make mental health a national priority. In its next phase of work, the Commission will be addressing ways to break down these barriers to recovery.

Dr. Hogan said, "We need to answer the question, 'Why are 90 percent of adults with serious mental illness unemployed?' After all, studies show that a majority want to work and can work. Instead, our Nation's largest 'program' for people with mental illness is the disability system. Our mental health, rehabilitation, and disability programs unintentionally trap millions of individuals—who want to work—into expensive, long-term dependency."

Dr. Hogan continued, "The barriers that keep adults with mental illness from productive work and children with serious emotional disturbance from school success are a tragedy from both human and economic perspectives. Although most adults with mental illness want to work, they are the largest and fastest growing group of people with disabilities receiving Supplemental Security Income (SSI) and Social Security Disability Income (SSDI)



payments. An estimated $25 billion is spent annually for this population."

He added, "Many people with mental illness find that they cannot afford to go back to work because they would lose their Medicaid coverage and disability benefits, and despite a job, could not afford private health insurance coverage. Too many people with mental illness are trapped in a 'disability welfare system' that badly serves them and needs reform. And although many children with emotional disorders are very bright, fewer than half ever graduate from high school. Our failure to support employment and school success is a disgrace."

To help identify what works best to provide care for people with mental illness, the Commission has already identified some creative, community-based programs that blend the promise of modern science with the compassion of skilled professionals. These exemplary programs often achieve the best results, despite bureaucracies that frequently create fragmentation instead of focus, and that reward dependency instead of recovery. They range from school-based mental health care in Dallas, to home visits by trained nurses for high-risk women during pregnancy and the first year of their child's life, to suicide prevention by the U.S. Air Force, and effective treatment for late-life depression.

"These models," Dr. Hogan said, "can inspire communities nationwide and provide realistic examples of how quality, coordinated care is possible for the millions of Americans with mental illness."

Overall, the Commission's interim report found that the system is not oriented to the single most important goal of the people it serves—the hope of recovery. Many more individuals could recover—

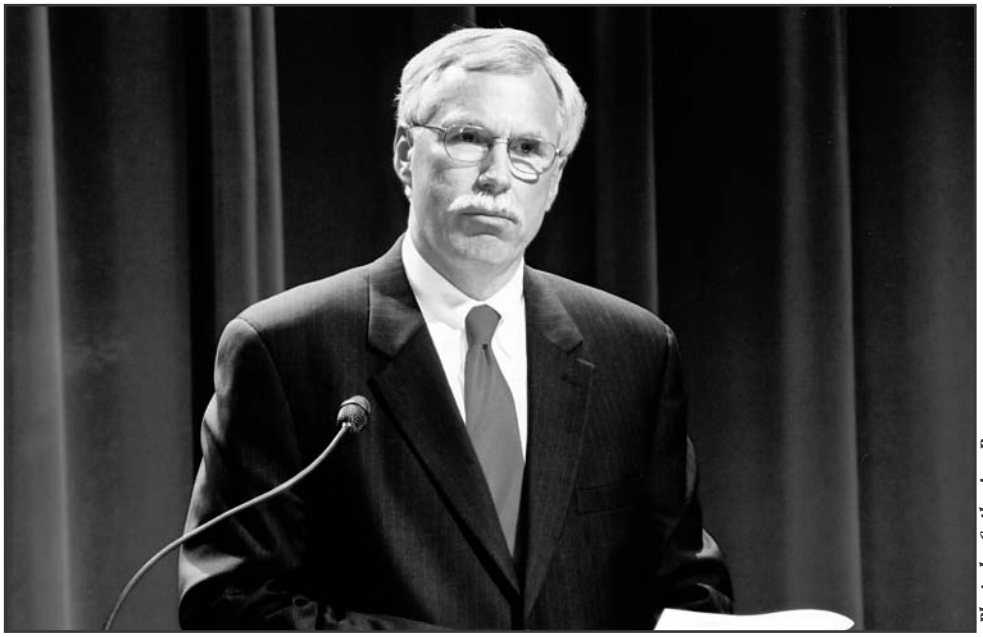
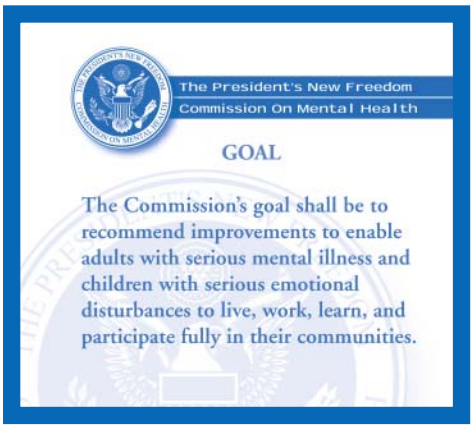


Photo by Catherine Brown

Michael Hogan, Chairman of the President's New Freedom Commission on Mental Health, presented findings from the Commission's Interim Report, now available online.



from even the most serious mental illnesses—if they had access to effective treatments tailored to their needs, and to supports and services in their communities. State-of-the-art treatments, based on decades of scientific inquiry, are not being transferred from research to community settings. At the same time, many outdated and ineffective treatments are still used.

The President tasked the Commission to recommend improvements in the mental health service system and requested a review of both public and private sectors to identify policies that could be implemented by Federal, state, and local governments to maximize the utility of existing resources, improve coordination of treatments and services, and promote a full life in the community for people with mental illness. The Commission's recommendations will be presented in its final report. The document released this fall responds to the legal requirement for an interim report. The Commission's work is essential to the President's commitment—embodied in the New Freedom Initiative—to eliminate inequality for Americans with disabilities.

For a printed copy of the *Interim Report to the President,* contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). For information about the Commission and an electronic copy of the report, visit **www.MentalHealthCommission.gov.**

Report on Co-Occurring Disorders Recommends Integrated Treatment

U.S. Health and Human Services Secretary Tommy G. Thompson provided Congress with a comprehensive *Report to Congress on the Treatment and Prevention of Co-Occurring Substance Abuse and Mental Disorders* this fall. SAMHSA developed the congressionally mandated report for the Secretary.

The report emphasizes that people with co-occurring disorders can and do recover with appropriate treatment and support services. It also finds there are many longstanding systemic barriers to appropriate treatment and support services for people with co-occurring disorders, including separate administrative structures, different eligibility criteria and funding streams, and limited resources for both mental health services and substance abuse treatment.

The report identifies the need for various Federal agencies, state agencies, providers of services, researchers, recovering persons, families, and others to work together to create a system in which both disorders are addressed and treated simultaneously and with equal priority.

"This report tells us that individuals with co-occurring disorders should be the expectation, not the exception in the substance abuse treatment and mental health service systems," Secretary Thompson said. "The blueprint for action outlines how we will work in partnership with the states and local community providers to improve access to integrated services and treatments and find ways to pay for this care."

"I hope that this report will help more people understand the connection between drug use and mental illness," said John Walters, director of National Drug Control Policy. "Recovery from the disease of addiction is a lifelong challenge. Treating co-occurring disorders appropriately can significantly improve the chances of recovery."

"All too often individuals are treated only for one of the two disorders—if they receive treatment at all. If one of the co-occurring disorders goes untreated, both usually get worse and additional complications often arise, including the risk for other serious medical problems, suicide, unemployment, homelessness, incarceration, and separation from families and friends," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "People with co-occurring disorders cannot separate their addiction from their mental illness, so they should not have to negotiate separate service delivery systems."

According to the report, 7 to 10 million individuals in the United States have at least one mental disorder as well as an alcohol or drug use disorder. From studies and firsthand experiences in the substance abuse and mental health fields, many researchers and clinicians believe that both disorders must be addressed as primary and treated as such. The report discusses a number of evidence-based interventions and programs that demonstrate improved outcomes with integrated services and treatments.

The report shows there are an increasing number of states and communities throughout the country that are initiating system-level changes and developing innovative programs that overcome barriers to providing services for individuals of all ages who have co-occurring disorders. In fact, many make use of their funds from Substance Abuse Prevention and Treatment and Community Mental Health Service Block Grants. States and communities that are successful build consensus around the need for an integrated response to co-occurring disorders, develop aggregated financing mechanisms, cross-train their staffs, and measure their improvements in terms of client functioning and quality of life.

Mr. Curie noted, "Our goal is to create a system that allows any door to be the right door for the services an individual needs. It is the right thing to do. Any person entering mental health care, substance abuse treatment, or primary health care should be screened for mental illness and for substance abuse, and then provided appropriate treatment."

To help move the Nation to such a system, the report laid out a 5-year action plan that includes:

- Creating a new SAMHSA-funded State Incentive Grant for Co-Occurring Disorders to help enhance state infrastructure and treatment systems
- Establishing a national co-occurring disorders prevention and treatment technical assistance and cross-training center
- Increasing Federal agency collaboration within the U.S. Department of Health and Human Services to enhance research attention to co-occurring disorders and the field's research needs
- Increasing collaboration between SAMHSA and the Centers for Medicare & Medicaid Services in conjunction with the Agency for Healthcare Research and Quality to explore ways to use existing reimbursement mechanisms for services for people with co-occurring disorders
- Convening a national summit on co-occurring disorders to share practices and lessons learned, and to discuss initiatives and cross-funding opportunities with Federal partners and key stakeholders
- Continuing work to improve, refine, test, and apply consistent outcome measures for co-occurring disorders
- Disseminating successful strategies for appropriate use of the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants to serve individuals with co-occurring disorders.

To obtain a copy of the report, visit SAMHSA's Web site at **www.samhsa.gov,** click on Hot Topics.

Initiative Helps Offenders Reenter Society

Ask any expert how well most inmates are prepared for life beyond prison walls, and the answer is usually the same: Not very well at all.

"In many jurisdictions, offenders still just get a cheap suit and a bus ticket," said Cheri Nolan, deputy assistant attorney general in the Office of Justice Programs at the U.S. Department of Justice. "Often that bus drops them off at one of the worst places in town for them to return to, a place where decisions about which way they want their life to go are made for them. Quite often it's the local pawn shop and drug dealer who are waiting to welcome them." Not surprisingly, the majority of offenders soon find themselves back behind bars.

Now, SAMHSA has joined Ms. Nolan and representatives from several other Federal entities to try to break that cycle. Last summer, the Federal Government announced $100 million in grants under its new "Serious and Violent Offender Reentry Initiative." Sixty-eight grantees in 49 states, the District of Columbia, and the U.S. Virgin Islands are now developing comprehensive programs that give high-risk adult and juvenile offenders the education, job training, life skills, substance abuse and mental health treatment, and other services they need to become productive, law-abiding members of society upon release. The ultimate goal is to improve public safety by making sure released offenders don't return to a life of crime.

In keeping with an emphasis on collaboration at the local level, the initiative is also a collaboration at the Federal level. The U.S. Department of Health and Human Services (led by SAMHSA), the Department of Justice, and the U.S. Department of Labor provided funding for the initiative. Also participating are the U.S. Departments of Education, Housing and Urban Development, Commerce, Agriculture, Veterans Affairs, and Social Security Administration.

Photo of jail cells (background) courtesy of Federal Bureau of Prisons

"It has taken courage to move this initiative forward," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "It has taken a willingness to leave agendas and turf issues behind. It took courage to recognize and come to grips with the magnitude of the problem, including the significant numbers of people with mental illness and addictions being housed in correction facilities. And it takes courage to assume shared responsibility for finding community-based solutions for adult and juvenile offenders after incarceration."

The Revolving Door

Finding solutions has become increasingly urgent. Last year, prisons released an estimated 630,000 offenders—about 160,000 of them violent offenders—back into their communities.

While incarceration rates have soared over the last few decades, the Nation's penal philosophy has shifted dramatically. Instead of flexible sentencing, today's judges and other correctional authorities often have limited discretion. The emphasis on rehabilitation that dominated corrections in the past is now giving way to a desire to crack down on criminals. The parole system has undergone similar changes, with caseloads growing and parole officers increasingly viewing surveillance as a higher priority than rehabilitation. As a result of these trends, prisoners now spend more time behind bars but receive less help in preparing for life on the outside.

Prisoners who have substance abuse or mental health disorders have an even harder time once they're released. According to the Department of Justice's Bureau of Justice Statistics, 83 percent of inmates in state

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prisons report a history of drug use and 57 percent used drugs in the month before their current offense. But while the percentage of state inmates enrolled in self-help groups, peer groups, or drug education classes has increased, the percentage who reported receiving formal substance abuse treatment from trained professionals dropped from 25 percent in 1991 to just 10 percent in 1997.

Even when prisoners do receive treatment behind bars, individuals typically don't continue treatment once they're outside. "In many cases," said Kenneth W. Robertson, a public health advisor in the Systems Improvement Branch at SAMHSA's Center for Substance Abuse Treatment, "the treatment received in prison is the first such treatment offenders have ever received, so they know very little about how to access resources in the community even if such resources exist."

Prisoners with mental health disorders face similar problems. According to the Bureau of Justice Statistics, more than 16 percent of inmates in state prisons may be mentally ill. Mental health treatment in prisons is limited, however, and few offenders make the transition to community-based mental health services once they're released.

Untreated mental health disorders can also make post-release life difficult, said David Morrissette, D.S.W., a social science analyst in the Division of Service and Systems Improvement at SAMHSA's Center for Mental Health Services. Such offenders may lack coping skills. They may be unable to navigate the complicated process of obtaining medication, psychotherapy, and other crucial support services. And they face a double stigma when they start looking for legal ways of supporting themselves.

"It's one thing to say you have a mental illness when you're looking for a job," said Dr. Morrissette. "It's another to say that you have a criminal history. Imagine what it must be like to say you have both." Inmates who have substance abuse disorders on top of mental health problems face a "triple whammy," Dr. Morrissette added.

These and other factors—the dearth of affordable housing and offenders' lack of workplace habits, skills, and experience, for instance—contribute to an astonishingly high rate of recidivism. Within 3 years of release, the Bureau of Justice Statistics reports, 67 percent of former inmates of state prisons are arrested again. Most of these rearrests occur within 1 year of a former convict's release from prison.

A New Approach

The Serious and Violent Offender Reentry Initiative seeks to close that revolving door. "Until this government-wide initiative, there never was a concerted effort to deal with the issues surrounding the reentry of offenders back into the population," said Ms. Nolan. She noted that a handful of innovative models ranging from a reentry court in Indiana to a Christian mentoring program in Texas are already having a dramatic impact on recidivism rates. The goal of this initiative is to build on such scattered successes to create a variety of prototypes that can help adult and juvenile offenders who pose the greatest risk to public safety make a successful transition to life in their communities. An evaluation of the project as a whole and 10 of the sites will determine how effective such efforts really are.

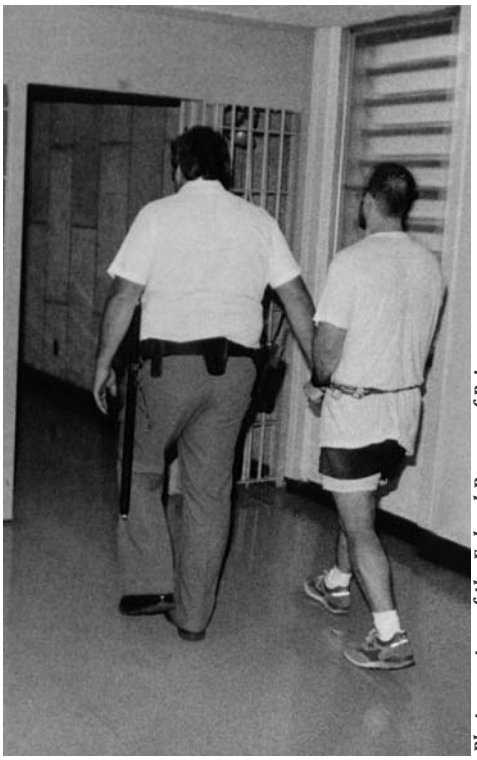

Photo courtesy of the Federal Bureau of Prisons

The initiative represents a different way of doing business, said Ms. Nolan and other Federal partners. The initiative doesn't seek to create brand-new reentry programs. Instead, grantees are taking existing programs and making them more comprehensive by filling in gaps. The primary task of the initiative's Federal partners is to identify resources that are already available, and help states and communities make better use of them as they enhance and expand their reentry programs. That way, the partners say, the program will be sustainable even after the 3-year grants end.

Most prisoners are eligible for a wide array of services once they're released, such as Medicaid, food stamps, Social Security Disability Insurance, educational and job training programs, Temporary Aid for Needy Families, and housing. For a variety of reasons, few former inmates actually take advantage of these resources. In some cases, offenders may not be aware of the programs or their eligibility for them. In other cases, programs simply aren't interested in serving former prisoners.

That's just not right, said Terrence S. Donahue, M.P.A., senior adviser to the Assistant Attorney General in the Office of Justice Programs at the Department of Justice. "The bottom line is that these individuals have every right to receive these services," he said. "They desperately need them if they're ever going to turn their lives around."

Building on existing models, each grantee will develop a comprehensive program that ensures that offenders going back to their communities have a seamless continuum of services to ease that transition.

That means close collaboration among correctional facilities, law enforcement agencies, education and job training institutions, housing agencies, mental health and substance abuse treatment services, faith-based organizations, and other groups.

Grantees may tailor their programs for youth offenders age 14 to 17, young adult offenders age 18 to 24, adult offenders age 25 to 35, or some combination of these groups. No matter which age group is targeted, however, each program must address the three phases of reentry.

In the "Protect and Prepare" stage, programs based in correctional facilities will begin preparing offenders to reenter society. Correctional institutions will begin by assessing inmates' risk of recidivism, evaluating their needs, and coming up with holistic reentry plans that address those needs. The institutions will then provide such services as mental health and substance abuse treatment, education, vocational training, and parenting and life skills training.

The "Control and Restore" stage balances supervision and services as offenders make the transition back into the community. Working with offenders before and immediately after their release, community-based programs will continue to provide whatever services individuals need.

The initiative doesn't stop there, however. In the "Sustain and Support" phase, individuals and agencies will come together to support offenders who are no longer being supervised by the criminal justice system. The goal is to hook them up with whatever support groups, social service agencies, or community-based organizations they need.

To help grantees develop such programs, the initiative offers ongoing technical assistance and training through a technical assistance coordinating center. "We're certainly not trying to say that the Feds have all the answers," said the initiative's technical assistance coordinator, Allen L. Ault. Ed.D., chief of special projects at the National Institute of Corrections. "It's really a working partnership among the counties, states, and Federal agencies."

A Closer Look

Although grantees are still fine-tuning their final program plans, they're already convinced that the initiative will have a big impact on crime.

For example, the Texas Department of Criminal Justice plans to use money from the Serious and Violent Offender Reentry Initiative to offer services to prisoners who currently receive none. The Huntsville-based department is planning to target prisoners in administrative segregation (ad-seg)—an area of a prison where inmates deemed dangerous to other inmates or staff or in danger themselves are kept in nonpunitive isolation. Confined to their cells except for showers and up to an hour of recreational activity each day, these prisoners are currently ineligible for any of the programs the prison offers to other inmates.

Once the project is up and running, about 100 ad-seg prisoners a year will start receiving services at two yet-to-be-determined sites—one a unit for female offenders and the other a unit for males. Under the proposed plan, prisoners will spend 6 months in a program designed to teach them anger management, literacy, and the other skills they'll need in the world outside. Upon their release, they will transition to resource centers run by the parole board. During this year-long phase, the parole board will assess their needs and capabilities and connect them with whatever they need to ensure success once they're on their own.

"Some of our ad-seg prisoners have been in prison for a number of years and go directly from ad-seg into the community," said Linda Patteson, assistant director of the department's Programs and Services Division. "We want to help them coexist with people, make better decisions, and behave more responsibly once they're back in their communities."

For more information about the Serious and Violent Offender Reentry Initiative, visit the "Reentry" Web site at **www.ojp.usdoj.gov/reentry.**

—Rebecca A. Clay

Symposium Guides Faith-Based and Community Organizations

Stressing the importance of "a level playing field," for all groups that want to compete for Federal funding, White House Office of Faith-Based and Community Initiatives Director James Towey welcomed participants to SAMHSA's 6th Annual Symposium for Faith- and Community-Based Organizations. The Symposium, titled "Bringing Effective Prevention, Treatment, and Mental Health Services to Every Community," was sponsored by SAMHSA in Washington, DC, from August 14 to 17.

The purpose of the symposium was to promote collaboration among government agencies, community organizations, and faith-based groups in addressing substance abuse and mental health. Sessions included instruction on ways to obtain financial support from both public and private sector organizations and highlighted the methods and results of effective faith- and community-based programs for substance abuse prevention and treatment and mental health services.

Incorporating a Faith Perspective

Support for President Bush's Faith-Based and Community Initiative is pervasive throughout Government, Mr. Towey told more than 200 representatives of Government, lay community-based groups, and faith-based organizations of Christians, Muslims, Buddhists, Sikhs, American Indians, and others who attended the meeting. Nonetheless, he said, no organization can receive Federal funds unless it meets accepted standards of separation of church and state. Faith-based groups, for example, must establish separate, nonreligious, nonprofit entities to handle government grants and they must not discriminate on religious grounds or make religious belief or practice a goal or requirement of service.

"If you take Government money, you welcome the person that comes in" regardless of his or her beliefs and you do not 'force religion,'" Mr. Towey said. In awarding grants, the Government does not ask organizations "Do you believe in God?" but rather, "Does your program work?" For this reason, some faith groups do not want Federal funds, and "that's OK," he said, warning that if "religion gets addicted to Government money," it is "bad news."

For faith-based organizations to compete for funding "in the same manner" as other groups, they need detailed information on the process, stated Robert Polito, Director of the U.S. Department of Health and Human Services Center for Faith-Based and Community Initiatives, at the Symposium's general session. Because the initiative should "permeate everything we do," he said, steps are being taken to "literally teach folks how to" negotiate SAMHSA's "sophisticated program" for awarding funding.

"The staff of SAMHSA has been committed for years" to the goals of the Faith-Based and Community Initiative, Mr. Polito continued, and a working group within SAMHSA, the Faith-Based and Community Initiatives Workgroup, is active in putting them into effect.

Although "everything we do should have a faith element," Mr. Polito emphasized that there are "no faith-based set-asides." However, he observed, a "disconnect" based on unfamiliarity and bureaucratic complexity has long discouraged faith-based groups from accessing Government funds.

Central to the effort to equip faith-based and community groups to compete, he explained, is the Compassion Capital Fund, which will make available to organizations that need it the expertise of intermediary organizations knowledgeable in Federal procedures. This will help grassroots groups to understand the requirements and create the infrastructure and procedures needed to obtain and manage Government grants. In addition, the Fund will develop research on

From left to right, Charles G. Curie, SAMHSA Administrator; James Towey, Director of the White House Office of Faith- and Community-Based Organizations; and Asa Hutchinson, Administrator of the Drug Enforcement Administration, exchange ideas about "what works and why" at the 6th Annual Symposium, "Bringing Effective Prevention, Treatment, and Mental Health Services to Every Community."

"what works and why" in faith-based and grassroots organizations and create a National Resource Center to "draw a map" of resources within the U.S. Department of Health and Human Services to help groups find the right offices and application procedures.

[*Note:* on October 3, 2002, U.S. Health and Human Services Secretary Tommy G. Thompson announced awards from the Compassion Capital Fund to 21 intermediary organizations, 4 research groups, and a resource center. For more information and a list of the grantees, visit **www.hhs.gov/fbci.**]

The opportunity to obtain prevention services, addiction treatment, or mental health services from a faith-based organization needs to be "an option for the clientele. If they desire those programs, they should have them," said Mr. Polito. Secular providers must also be available to those who prefer them, he emphasized.

Eliminating "undue barriers" to participation by faith- and community-based groups is an effort to offer wider options to those SAMHSA ultimately seeks to serve, indicated SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., in remarks at the opening ceremony. "Being relevant to you makes us relevant to the people" receiving services and advances SAMHSA's goal of helping every individual with addiction or mental illness attain "growth, recovery, and inclusion in the community and achieve a quality of life that includes family and friends," he told the organizational representatives.

Faith can make a tremendous contribution toward that goal "when it's integrated into good treatment," stated Asa Hutchinson, Administrator of the Drug Enforcement Administration within the U.S. Department of Justice, in remarks at the opening ceremony. But fighting drug abuse also involves changing drug-infested communities, he said, adding that his agency is currently attempting to do that in several pilot projects conducted in partnership with faith organizations.

Law enforcement is "on the same team" as prevention and treatment workers, Mr. Hutchinson emphasized. Thus it is "important that the voice of enforcement be out there talking about the importance of prevention, the importance of treatment."

Workshops

Symposium workshops focused on specific issues relevant to treatment and prevention programs and covered topics including accountability, program evaluation, community mobilization, selecting best practices, coalition building, and attracting support from national foundations and other private funders. Some sessions highlighted the work of effective community- and faith-based prevention, treatment, and mental health programs.

A particularly timely discussion—in light of the millions of Americans who responded to the September 11 terrorist attacks by turning to their churches, synagogues, temples, and mosques for solace and support—occurred during a workshop on "Faith-Based and Community Organizational Response to Disasters." Not only in the days immediately after a catastrophe, but in the months and years that follow, faith communities have unique capacities for helping people to find courage and meaning in their suffering. These communities offer ways to cope with post-disaster emotions that can encourage use of addictive substances, according to workshop co-leader John Tuskan, R.N., M.S.N. (Captain, U.S. Public Health Service), of SAMHSA's Center for Mental Health Services.

Participants from diverse religious perspectives and geographic regions of the country discussed the challenges their organizations could face and the approaches that could help in serving both their own members and their larger local communities in case of a disaster, either natural or man-made. The workshop also focused on SAMHSA's ongoing efforts to develop materials useful to such groups in planning for the possibility of disaster.

Robert Polito, Director of the U.S. Department of Health and Human Services Center for Faith-Based and Community Initiatives, answers questions from Symposium participants.

The Tools to Compete

To help level the competition for groups unfamiliar with Federal procedures, the Symposium also offered an extensive array of skill-building workshops that provided information on the sources, requirements, and techniques of competing for, obtaining, and managing Federal grants. Hands-on workshops in the techniques of proposal writing were offered at the beginning, intermediate, and advanced levels. These provided both conceptual information and practical exercises in developing potentially successful proposals. They also familiarized participants with the procedures used to evaluate proposals.

As a continuation of this capacity-building activity, SAMHSA's Grassroots Training Initiative will bring grant-writing training to small faith-based and community groups in more than 40 locations across the Nation through May 2003. The training will be based on a manual, *Developing Successful SAMHSA Grant Applications,* which will be made available to all training participants later this year.

For a list of training locations and dates, as well as more information on faith-based activities within SAMHSA, visit **www.samhsa.gov,** click on Faith-Based and Community Programs.

—By Beryl Lieff Benderly

Goals of the National Strategy for Suicide Prevention

Goal 1
Promote awareness that suicide is a public health problem that is preventable.

Goal 2
Develop broad-based support for suicide prevention.

Goal 3
Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Goal 4
Develop and implement suicide prevention programs.

Goal 5
Promote efforts to reduce access to lethal means and methods of self-harm.

Goal 6
Implement training for recognition of at-risk behavior and delivery of effective treatment.

Goal 7
Develop and promote effective clinical and professional practices.

Goal 8
Improve access to and community linkages with mental health and substance abuse services.

Goal 9
Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

Goal 10
Promote and support research on suicide and suicide prevention.

Goal 11
Improve and expand surveillance systems.

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they started a nonprofit group called the Suicide Prevention Action Network (SPANUSA) to bring more attention to the issue and act as "a catalyst, a conscience, and a prod to action," in Gerald Weyrauch's words.

Elsie Weyrauch explains, "The people who formed SPANUSA wanted to empower survivors—those close to someone who committed suicide as well as suicide attempt survivors—by helping them make a difference. The World Health Organization's 1996 document, *Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies,* suggested steps we could take to push for development of a national suicide prevention strategy and helped us come together as a grassroots advocacy organization."

SPANUSA provided the impetus for the formation of an innovative public/private partnership that sponsored a National Suicide Prevention Conference in Reno, NV, in 1998. Participants assembled a list of 81 recommendations that were presented to the U.S. Surgeon General. SPANUSA also collaborated with several other nonprofit groups to form the National Council for Suicide Prevention in 1999, aimed at bringing the issue to the forefront of national attention.

In 1997, galvanized by the memory of his own father's suicide, U.S. Senator Harry Reid (D-NV) took the lead in persuading the Senate to pass a resolution calling for action on the issue. A similar resolution passed in the U.S. House of Representatives in 1998.

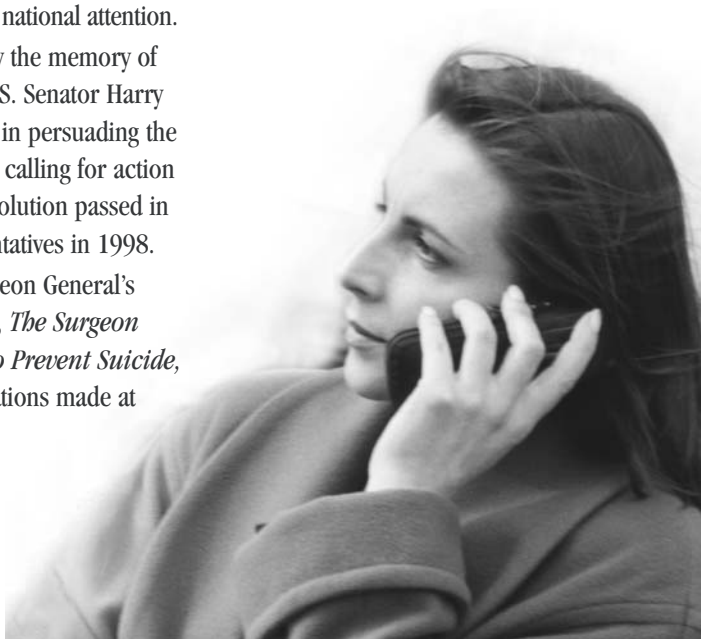
In 1999, the U.S. Surgeon General's office issued a brief report, *The Surgeon General's Call to Action to Prevent Suicide,* based on key recommendations made at the Reno Conference.

Six Federal agencies, including SAMHSA, provided funding in the year 2000 to the Institute of Medicine to assess scientific information on the causes of suicide and to recommend strategies to prevent it. The report was published in 2002.

One of the most significant developments was the 2001 release of the National Strategy for Suicide Prevention. Prepared by a group of public and private sector partners with leadership and support from the Surgeon General, it has guided many of SAMHSA's efforts in this area.

In designing the National Strategy, a Federal Steering Group assisted by the National Council for Suicide Prevention and others, created 11 goals and 68 objectives for preventing suicide. These range from promoting awareness that suicide is preventable to improving access to mental health services to reducing the stigma of mental illness and substance abuse. (See box at left.)

The National Strategy aims to provide better resources for people—in all age groups, every region of the country, and all walks of life—dealing with the physical, emotional, and other conditions that can lead to suicide. It also aims to support people whose loved ones died by suicide, reduce the stigma attached to mental illness,



Suicide Prevention WebLinks

The National Strategy for Suicide Prevention
www.mentalhealth.samhsa.gov/suicideprevention

This site links to the full report on the goals and objectives of the *National Strategy for Suicide Prevention,* the Institute of Medicine's *Reducing Suicide: A National Imperative,* and the *Surgeon General's Call to Action to Prevent Suicide.* Additional links include news stories on suicide and other health-related sites with information on the subject.

Centers for Disease Control and Prevention
www.cdc.gov/ncipc/factsheets/suifacts.htm

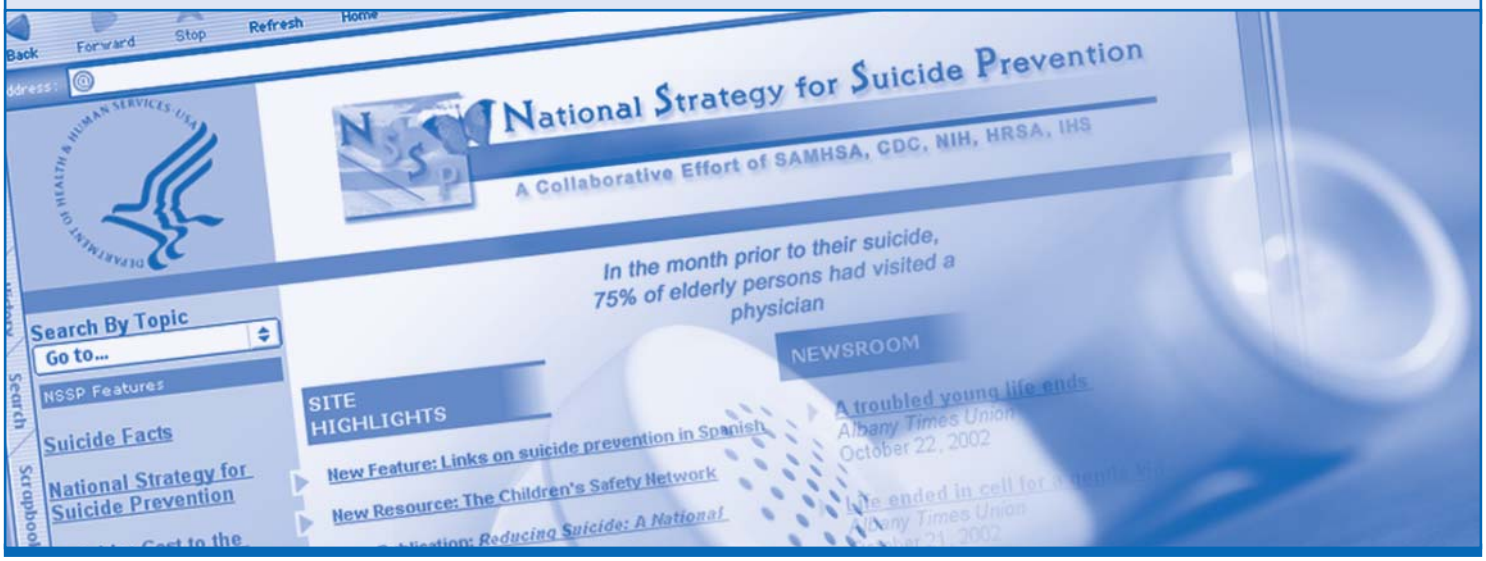
This fact sheet presents statistics on suicide across the country from 1999, the most recent figures available.

National Institute of Mental Health
www.nimh.nih.gov/publicat/depsuicidemenu.cfm

This site links to several publications on suicide for the public and for professionals. Among them are a fact sheet, frequently asked questions, information on teens and the elderly, what to do when a friend is depressed, and information on the Suicide Research Consortium.

Reducing Suicide: A National Imperative
books.nap.edu/books/0309083214/html/index.html

This report by the Institute of Medicine at the National Academy of Sciences covers the incidence, causes, and prevention of suicide as well as research into suicidality, treatments for people who are suicidal, and recommendations for reducing suicide.



and improve the coverage of mental illness, drug addiction, and suicide in the media.

"As we were developing the National Strategy, it became quite clear that public health efforts like this need to have a broad coalition involved in their implementation," says Col. David A. Litts, O.D., special adviser to the Surgeon General for suicide prevention. "No single entity or group can carry these things off alone."

A number of states are moving ahead to develop or implement their own suicide-prevention plans, adds Dr. Litts. "Many are literally lifting the words out of the National Strategy, using the National Strategy as their guide to implementing their state plans," he says.

SAMHSA's Contributions

The Federal Steering Committee overseeing the National Strategy includes representatives from SAMHSA, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Indian Health Service, the National Institutes of Health, and the Office of the Surgeon General. Each Federal agency is contributing expertise. For example, the National Institutes of Health conducts research into the causes of suicide; the Centers for Disease Control and Prevention tracks the incidence of suicide and collects statistics. SAMHSA likewise has a unique role.

"SAMHSA acts as the link between the Federal effort, states, and local communities," says Gail Hutchings, M.P.A., Acting Director of SAMHSA's Center for Mental Health Services. "By providing resources, funding programs, and evaluating the results, SAMHSA serves as a key connection to the Federal Government for stakeholders seeking to prevent and reduce the incidence of suicide."

A SAMHSA grant of $2.5 million was awarded this fall to create a National Suicide Prevention Technical Resource Center to provide information and other help for clinicians, researchers, survivors, advocates, local and state governments, and tribal organizations. The Education Development Center in Newton, MA, received the funding for 3 years to collaborate with the American Association of Suicidology, the American

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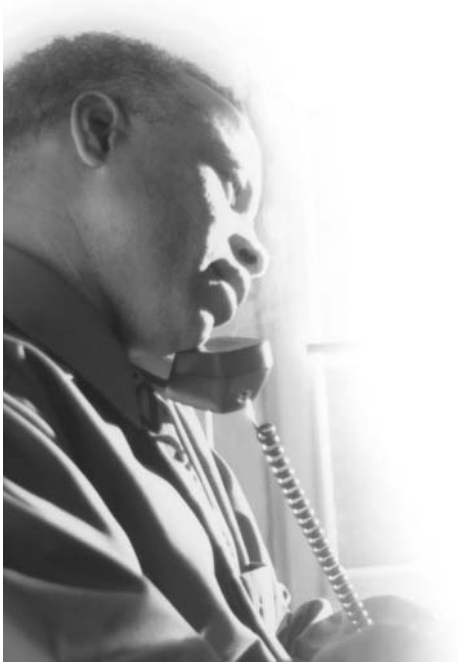
Foundation for Suicide Prevention, and the Suicide Prevention Action Network on the effort.

SAMHSA awarded another grant, for $9 million, 1 year ago. In the first year of this 3-year grant, the American Association of Suicidology has been working on ways to improve access to crisis centers and hotlines. Lanny Berman, Ph.D., executive director of the association, has three goals: to improve the quality of crisis hotlines across the country, to establish one nationwide number to connect callers with the hotline nearest them, and to build in a system of evaluation to see if hotline services are effective.

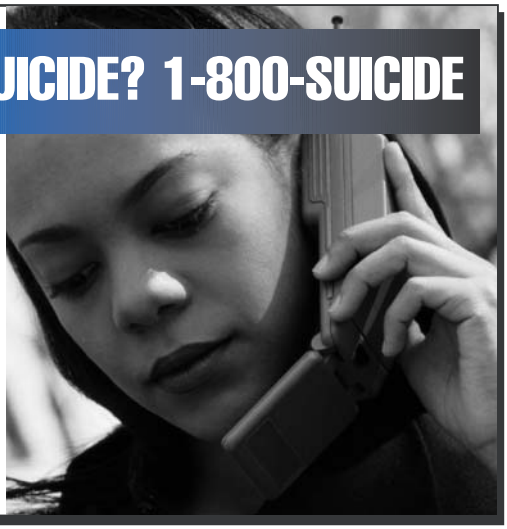
The national hotline (1-800-SUICIDE) is already up and running and adding crisis centers to its roster all the time. The goal is to have between 200 and 300 hotlines in the network by the end of the grant period. "If you don't have a center listed in your phone book and you're in a crisis—and you want to call what in effect is a 911 number—you can call this number and it would route your call to the nearest hotline," he says.

One goal of the grant is to urge more hotline and crisis centers to take advantage of a certification program that the organization established more than 20 years ago. Certification, says Dr. Berman, "is a statement to their community that these centers have policies, processes, training, and quality of service that the community can trust."



COMPTEMPLATING SUICIDE? 1-800-SUICIDE

For emergency help, please contact your local crisis center or call 1-800-SUICIDE (1-800-784-2433).



In addition to the grants, SAMHSA is developing suicide-prevention guidelines for schools based on a model called the Youth Suicide Prevention Strategy developed in New Zealand. The guidelines are being designed to identify students at risk for suicide and to promote a safe, comfortable environment where they can seek and receive help. The goal is to provide a useful tool to school personnel (including teachers), to help them establish evidence-based programs in their facilities.

Another program is the Signs of Suicide Evaluation project, started by a nonprofit group called Screening for Mental Health. This project also targets schools, in particular high school students. During the 2000-2001 school year, 220 high schools participated in a screening for depression and suicidal behavior among students. As part of the program, teens learned about depression and how to recognize it in their peers. Funding from SAMHSA is allowing the organization to take a detailed look at how much teens learned from the program and evaluate its effect on students' suicidal behaviors.

As various efforts are mobilizing, Lloyd B. Potter, Ph.D., M.P.H., associate director of the Center for Violence and Injury Prevention at the Newton, MA, Education Development Center, has taken on the job of developing baseline data as a way eventually of measuring whether the National Strategy's goals and objectives are achieved. That means finding ways of measuring everything from increasing the number of states with suicide prevention plans to promoting research on suicide prevention to providing training to medical personnel, clergy, and teachers—and much more.

Crucial to the success of the National Strategy, says Robert E. DeMartino, M.D., who, as SAMHSA's Associate Director of the Program in Trauma and Terrorism, oversees the Agency's suicide prevention efforts, "is a willingness on the part of all of the players to function as one unit, with one goal: to save lives. We have to keep speaking with one voice."

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.**

—By Marilyn Dickey

Fewer Retailers Sell Cigarettes to Youth

SAMHSA reported in September that retailers continue to reduce sales of tobacco to children under age 18. Overall, the national retailer violation rate dropped to 16.3 percent in 2001 from 40.1 percent in 1996.

"It's a good sign that fewer stores are selling cigarettes to children, but we still have a long way to go if we hope to prevent another generation of smokers," said U.S. Health and Human Services Secretary Tommy G. Thompson. "Keeping tobacco out of the hands of children is one of the keys to preventing the unhealthy habit that too often causes heart disease and cancer later in life. All of us, including retailers, must remain committed to helping our youth make the healthy decision not to smoke."

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

In 2001, 38 states achieved the overall goal of a 20-percent violation rate, and 13 states and the District of Columbia achieved their negotiated target rates for 2001. Wisconsin was the only state that failed to meet its negotiated, annual violation rate target, and agreed to commit additional state funds totaling $3,012,615 to enforcement efforts in order to avoid stringent penalties in the law.

"States that successfully meet their Synar goals tend to share certain characteristics," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Generally, these states employ a comprehensive strategy that combines vigorous enforcement efforts, political support from the state government, and a climate of active social norms that discourage youth tobacco use. Tobacco control programs in these states also tend to be well coordinated and include targeted merchant and community education, media advocacy, and use of community coalitions to mobilize support for restricting minors' access to tobacco."

For more information, visit **http://prevention.samhsa.gov/tobacco.** Or, 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).

State Retailer Inspections for 2001

State Name	Inspections 2001		State Name	Inspections 2001		State Name	Inspections 2001	
	Target for 2002	Reported		Target for 2002	Reported		Target for 2002	Reported
Alabama	20.0	17.0	Kentucky	20.0	12.3	North Dakota	24.0	16.8
Alaska	28.0	27.2	Louisiana	20.0	8.5	Ohio	20.0	22.6
Arizona	20.0	20.3	Maine	20.0	6.7	Oklahoma	20.0	22.4
Arkansas	20.0	14.8	Maryland	25.0	25.0	Oregon	23.0	16.3
California	20.0	17.1	Massachusetts	20.0	9.7	Pennsylvania	25.0	27.9
Colorado	22.0	7.2	Michigan	26.0	17.2	Rhode Island	21.0	12.3
Connecticut	20.0	13.1	Minnesota	22.0	19.0	South Carolina	20.0	17.1
Delaware	24.0	10.2	Mississippi	22.0	5.7	South Dakota	20.0	4.5
District of Columbia	23.0	15.5	Missouri	24.0	16.7	Tennessee	20.0	20.4
Florida	20.0	7.7	Montana	22.0	22.7	Texas	20.0	12.9
Georgia	20.0	13.2	Nebraska	20.0	18.9	Utah	20.0	18.8
Hawaii	20.0	7.7	Nevada	20.0	21.2	Vermont	20.0	19.7
Idaho	24.0	18.9	New Hampshire	20.0	10.5	Virginia	20.0	18.5
Illinois	20.0	11.5	New Jersey	24.0	22.1	Washington	20.0	11.2
Indiana	23.0	24.5	New Mexico	20.0	11.6	West Virginia	20.0	11.9
Iowa	28.0	18.0	New York	20.0	13.0	Wisconsin	22.0	33.7
Kansas	25.0	21.1	North Carolina	22.0	19.9	Wyoming	43.0	9.5

SAMHSA Awards New Grants

SAMHSA announced 572 new grant awards this fall for Fiscal Year 2002. The awards reflect the priorities and cross-cutting principles articulated by SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

"Our efforts are based on an underlying precept that people of all ages, with or at risk for mental or substance abuse disorders, should have the opportunity for a fulfilling life in the community that includes a job, a home, and meaningful relationships with family and friends," he explained.

In support of this goal, SAMHSA is focusing attention on areas such as homelessness, children and adolescents, criminal justice, terrorism, and HIV/AIDS, among others. All Agency efforts emphasize collaboration across service systems and among organizations.

SAMHSA is funding two new efforts to reduce the homelessness that is often a consequence of mental illness and drug abuse. SAMHSA's Center for Substance Abuse Treatment (CSAT) awarded nearly $11 million for **Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless.** The purpose of these grants is to enable communities to expand and strengthen their treatment services for homeless people with substance abuse disorders, mental illness, or with co-occurring substance abuse disorders and mental illness.

"On any given night, upwards of 600,000 persons are homeless," Mr. Curie noted. "These funds will help meet needs by promoting entry to housing and helping individuals remain housed while they are receiving the treatment they need for substance abuse, mental illness, or both."

SAMHSA is funding another program on homelessness jointly with a sister agency, the Health Resources and Services Administration (HRSA). Each agency is contributing approximately $1.4 million to the **Collaboration to Link Health Care for the Homeless Programs and Community Mental Health Agencies.** Grant recipients will use the money to increase the availability of both mental health and primary health care services for homeless people with serious mental illness.

The "homeless" individuals in these grants include people who are "doubled up." That is, they are at imminent risk for becoming homeless because they are sharing another person's dwelling on a temporary basis. These persons are sheltered as long as the primary occupant of a home is willing to continue the arrangement. They could be thrust out on the street at any time without notice.

"We must make substance abuse treatment programs for youth a priority," said Mr. Curie, in announcing $8 million in grants for **Adolescent Residential Treatment** programs. The CSAT-funded grants are designed to enhance or expand residential treatment services for youth age 21 and younger who require treatment for a drug or alcohol problem. Programs may also include a continuum of aftercare services to keep youth engaged with the substance abuse treatment system and prevent relapse into drug use.

SAMHSA's Center for Mental Health Services (CMHS) is likewise addressing the needs of youth with $17 million in funding for the **Comprehensive Community Mental Health Services Program for Children and Their Families.** This program is designed to develop systems of care that deliver comprehensive, individualized mental health services in the community for children with serious emotional disturbance and their families.

CMHS also funded, for the first time, a new **Partnership for Youth Transition Program.** Nearly $2.3 million was awarded

"Our efforts are based on an underlying precept that people of all ages, with or at risk for mental or substance abuse disorders, should have the opportunity for a fulfilling life in the community that includes a job, a home, and meaningful relationships with family and friends."

—Charles G. Curie, SAMHSA Administrator

SAMHSA is focusing attention on areas such as homelessness, children and adolescents, criminal justice, terrorism, and HIV/AIDS. All Agency efforts emphasize collaboration across service systems and among organizations.

for 5 cooperative agreement grants to develop and implement transition programs for youth with serious emotional disturbance as they enter adulthood so that they can lead productive lives as adults.

SAMHSA aims to help both children and their parents through grants for **Drug Courts for Families, Juveniles, and Adult Offenders.** CSAT awarded $10.4 million to community drug treatment courts to provide substance abuse treatment for parents charged with abuse and neglect of their minor children, substance-abusing adults charged with criminal offenses, and juveniles. There are two types of awards—one for civil family courts, and a second for juvenile courts and adult drug courts.

"It's time to reunite families torn apart by drug abuse and neglect of children by ensuring that parents are given the opportunity for substance abuse treatment and recovery," said Mr. Curie. "With the strict time limits set by the Adoption and Safe Families Act, there is a dire need for civil family drug courts that can help parents keep their children."

SAMHSA also awarded $3.9 million for the CMHS **Targeted Capacity Expansion Grants for Jail Diversion Programs.** This program is intended to help 10 communities build capacity to divert persons with mental illness from the criminal justice system to community-based mental health and supportive services such as health care, housing, and job placement. Within this program, a separate grant was awarded for a national **Technical Assistance and Policy Analysis Center.** This Center will provide information and assistance to the 10 grantees and other communities implementing the jail diversion, and will establish a national database on diversion program evaluations.

SAMHSA awarded $33.9 million for **Substance Abuse Treatment in HIV/AIDS Minority Communities.** This program is intended to provide substance abuse treatment, along with HIV/AIDS services, in African American, Latino/Hispanic, and other racial/ethnic communities that have been affected by the twin epidemics of substance abuse and HIV/AIDS. The awards implement a congressional directive to enhance the quality of services and expand capacity for substance abuse treatment programs in high-risk communities of color that are affected by both high rates of HIV/AIDS and serious substance abuse problems.

"These awards will help communities with both large numbers of people infected by HIV and large numbers addicted to alcohol and drugs," Mr. Curie said. "By targeting our efforts in these communities, we are helping to develop local capacity to deal with these problems and stop the spread of HIV."

SAMHSA's Center for Substance Abuse Prevention (CSAP), likewise responding to the Congressional Black and Hispanic Caucuses, awarded more than $22 million in grants to support effective substance abuse prevention services that are integrated with HIV prevention services directed at youth and other at-risk populations in minority communities. Approximately $5.8 million of this was awarded through the **Targeted Capacity Expansion Initiatives for Substance Abuse Prevention and HIV Prevention in Minority Communities** for planning grants to support the creation of a service delivery infrastructure in communities. The other $16.2 million was awarded through the same initiative for service grants to provide prevention services in 48 communities.

Responding to the reality of terrorism, SAMHSA awarded $2.4 million in grants to provide mental health services to public safety workers who responded to the 2001 terrorist attacks. The **Public Safety Workers Mental Health Program** will provide needed mental health services to firefighters, search and rescue personnel, emergency medical personnel, law enforcement officers and personnel, public health workers, emergency services personnel, construction workers, and transportation workers who were directly involved in recovery work and the search for remains of victims following the September 11 attacks.

"Trained to cope with fear and stress, and to act effectively in emergencies, rescue

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"Our effort rests on the firm belief that by working in partnership with the states and focusing our nation's attention, energy, and resources at the local level, real progress can be made."

—Charles G. Curie, SAMHSA Administrator

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workers are more familiar with danger and loss of life than many," Mr. Curie said. "Our experience with the 1995 Oklahoma City bombing warns they are also among the most vulnerable to long-term emotional and substance abuse problems. These grants will sustain our initial efforts to support the front line at home."

As part of a strategy to encourage greater collaboration, CSAP recently awarded $7.6 million to governors in three states to help them consolidate all of their resources—both programmatic and financial—to create a comprehensive, statewide strategy for reducing youth substance abuse. **The State Incentive Cooperative Agreements for Community-Based Action** (known informally as **State Incentive Grants**) were awarded to Nevada, Ohio, and Michigan.

"We are committed to waging an all out effort to reduce illegal drug, alcohol, and tobacco use among young people in America," said Mr. Curie. "Our effort rests on the firm belief that by working in partnership with the states and focusing our Nation's attention, energy, and resources at the local level, real progress can be made."

A full 85 percent of funds awarded through the State Incentive Grants are directed to support the work of community-based programs. With this announcement, a total of 39 states, Puerto Rico, and the District of Columbia have joined the program. In total, over 2,700 communities across the country now are implementing science-based prevention models reaching more than 1 million young people. Funds also will help the states use measures, including state-level data from SAMHSA's National Household Survey on Drug Abuse, to establish benchmarks and to report progress in reducing substance use.

Other SAMHSA grants awarded include the following from SAMHSA's three Centers.

Center for Mental Health Services

- **Youth Violence Prevention. $4.5 million.** 28 grant awards for use in communities and schools to develop and enhance youth violence prevention activities and mental health.
- **Violence Prevention Coordinating Center. $2.5 million.** A continuation of a cooperative agreement to provide technical assistance to the Safe Schools/Healthy Students grantees.
- **Older Adults' Mental Health Services. $3.6 million.** 9 grant awards to support programs and services to meet the mental health needs of older adults. Services will be adapted to different cultures and ethnic communities.
- **Suicide Prevention Resource Center. $2.5 million.** 1 grant award to establish a national suicide prevention resource center. The center will assist survivors, clinicians, advocates, scientists, and Federal, state, local, and tribal organizations with suicide prevention program planning, identification, and implementation of best practices. (See *SAMHSA News,* p. 1.)
- **Mental Health Workforce Training. $1.5 million.** 4 grant awards to develop, implement, and evaluate training programs that will increase mental health workers' ability to provide culturally appropriate services to racial and ethnic minorities.
- **Violence and Behavioral Health Technical Assistance Resource Center. $3.9 million.** 1 grant award to develop and operate a technical assistance center for the prevention of violence and behavioral health problems.
- **State Mental Health Data Infrastructure. $400,000.** 5 grant awards to develop and sustain state and community data infrastructure to support community-based systems of care for children and adults with mental illness or at risk of developing mental illness.
- **Targeted Capacity Expansion: National Technical Assistance Center for the Mental Health Services Needs of Older Adults. $900,000.** 1 grant award to identify, synthesize, and disseminate the knowledge base for mental health outreach, prevention, early intervention, assessment, and treatment services for older adults.

- **Community Action Grants Program. $6.6 million.** 47 grant awards to support the adoption and implementation of exemplary practices related to the delivery and organization of services for children with serious emotional disturbances or adults with serious mental illness. The target population may also have co-occurring disorders, such as substance abuse or other mental, emotional, or behavioral disorders.

Center for Substance Abuse Prevention

- **Prevention of Club Drugs and Inhalent Abuse. $8.8 million.** 27 grant awards to support infrastructure development and interventions to prevent the use of Ecstasy and other club drugs, methamphetamine, and inhalants. 13 of the 27 grant awards will develop prevention infrastructure; 14 of the 27 grant awards will focus on prevention interventions.
- **National Community Anti-Drug Coalition Institute. $2 million.** 1 grant award to develop and implement a National Community Anti-Drug Coalition Institute.

Center for Substance Abuse Treatment

- **Integrate Substance Abuse Treatment into Public Health for American Indian and Alaska Native Populations. $1.75 million.** 7 grant awards, part of the Targeted Capacity Expansion Initiative, to integrate substance abuse treatment with mental health, primary care, and other public health services, as well as expand access for appropriate care in rural and remote areas to American Indian, Alaska Native, and rural communities.
- **Targeted Capacity Expansion. $12.3 million.** 26 grant awards to expand or enhance substance abuse treatment capacity in local communities. This program is designed to address gaps in treatment capacity by responding to unmet, specific, local needs for alcohol and drug treatment services.
- **State Data Infrastructure. $3.4 million.** 35 grant awards to help Single State Authorities report performance measures for planned Substance Abuse Prevention and Treatment Block Grant Performance Partnerships.
- **Rehabilitation and Restitution Cooperative Agreement Program. $2 million.** 2 cooperative agreement grant awards to study the effectiveness of a sophisticated, multi-system program for certain non-violent, substance-abusing ex-felons to improve treatment retention and outcome; reduce the stigma of past substance abuse and non-violent, criminal activity; reduce criminal activity; and assist program clients in becoming more fully functioning citizens.
- **Grants for Accreditation of Opioid Treatment Programs. $1.6 million.** 4 grant awards to reduce the costs of basic accreditation education and accreditation surveys (site visits) for Opioid Treatment Programs participating in the accreditation process.
- **Cooperative Agreements for Addiction Technology Transfer Centers. $5 million.** 8 cooperative agreement grant awards to Centers to develop research-based and culturally appropriate substance abuse treatment and recovery curricula, and to provide academic and continuing education, professional development, and practicum training to students and practitioners in the substance abuse treatment and related fields.
- **Community Action Grants for Service Systems Change. $700,000.** 5 grant awards to support the adoption of specific exemplary practices related to the delivery or organization of services or supports into systems of care for adolescents and adults seeking treatment for alcohol and/or other drug use problems. The program seeks to encourage the adaptation of service models to meet local needs.

For information on current SAMHSA funding opportunities, visit SAMHSA's Web site, **www.samhsa.gov,** click on Grants.

—By Brian Campbell

The Targeted Capacity Expansion program is designed to address gaps in treatment capacity by responding to unmet, specific, local needs for alcohol and drug treatment services.

Anger Management Offers Adjunct to Treatment

For many people who abuse substances, anger may be a particularly challenging concomitant problem. Anger and violence often play a causal role in the initiation of drug and alcohol use, yet they can also be a consequence of substance abuse.

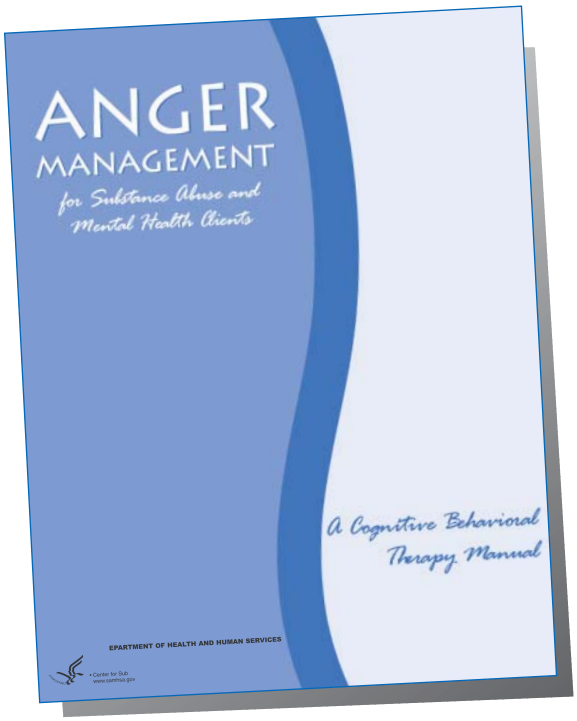
The inappropriate or frequent expression of anger can have damaging consequences such as police arrest, physical injury, alienation from loved ones, or termination from a treatment or social service program.

"Despite the connection between anger and substance abuse, few treatments have been developed to address anger among people who abuse substances," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT). "Clinicians have found the dearth of treatment approaches disheartening."

In response to this need, CSAT recently published both a manual for service providers and a participant workbook titled *Anger Management for Substance Abuse and Mental Health Clients.*

The publications are for use as part of a 12-week treatment program of cognitive behavioral group therapy to help people in recovery learn skills to manage their anger and diminish the destructive impact it can have on their lives.

The treatment model of cognitive behavioral therapy combines relaxation, cognitive, and communications skills interventions. The relaxation interventions are targeted at the emotional and physiological components of anger, while the cognitive interventions target thought processes such as hostile appraisals and attributions, irrational beliefs, and inflammatory thinking. Enhanced communications skills counter deficits in assertiveness and improve conflict resolution abilities.



The intervention provides lessons on topics such as ways clients can identify situations that trigger anger and ways they can measure the degree of their anger. Participants develop personal anger control plans, which they modify as they learn strategies for coping appropriately. Strategies include breathing and muscle

Cues to Anger: Four Categories

The following "cues to anger" are listed along with examples of the feelings or actions that accompany each one.

1. Physical	Rapid heartbeat, tightness in chest, and feeling hot or flushed
2. Behavioral	Pacing, clenching fists, raising the voice, or staring
3. Emotional	Fear, hurt, jealousy, guilt
4. Cognitive/thoughts	Hostile self-talk, images of aggression and revenge

Source: *Anger Management for Substance Abuse and Mental Health Clients*

relaxation exercises as well as the technique of "timeouts" to think instead of to react.

Participants learn the A-B-C-D model developed by Albert Ellis to conceptualize anger management treatment. The approach consists of identifying irrational beliefs and disputing them with more rational or realistic perspectives. "A" stands for an activating "red-flag" event. "B" represents our beliefs about the activating event and our interpretations of it. "C" stands for the emotional consequences of these beliefs about the event. "D" stands for dispute, in which we examine our beliefs and expectations to determine if they are unrealistic or irrational.

For example, a client may receive feedback on a work project from a supervisor. Receiving this feedback is the activating event (A). The client may believe (B) that the supervisor is being critical and dislikes him. The consequence (C) is that the client may feel demeaned. The final component is for the client to examine his or her beliefs to determine if they are realistic and, if not, to dispute them (D).

The manual describes each 90-minute session in detail with specific instructions for group leaders, tables, and figures illustrating key concepts, and homework assignments for participants. The companion participant workbook provides clients with a summary of core concepts, worksheets for homework assignments, and space to take notes during the sessions.

The treatment model can accommodate clients from different racial or cultural groups and can be used with both men and women. Also, it has been effective when used with non-substance-abusing clients in an outpatient mental health clinic.

The treatment is based on research conducted with support from the National Institute on Drug Abuse and the Department of Veterans Affairs (VA) to the San Francisco VA Medical Center, San Francisco Treatment Research Center, Department of Psychiatry, University of California, San Francisco. SAMHSA funded the preparation and publication of the manual and workbook based on the research.

"This project is an example of the kind of effort we encourage through SAMHSA's new Science-to-Services agenda," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "The focus is to identify successful practices developed through research and bring them to the community in an accessible format. We want to take the knowledge generated through research on mental and addictive disorders and enable service providers to put it to use immediately."

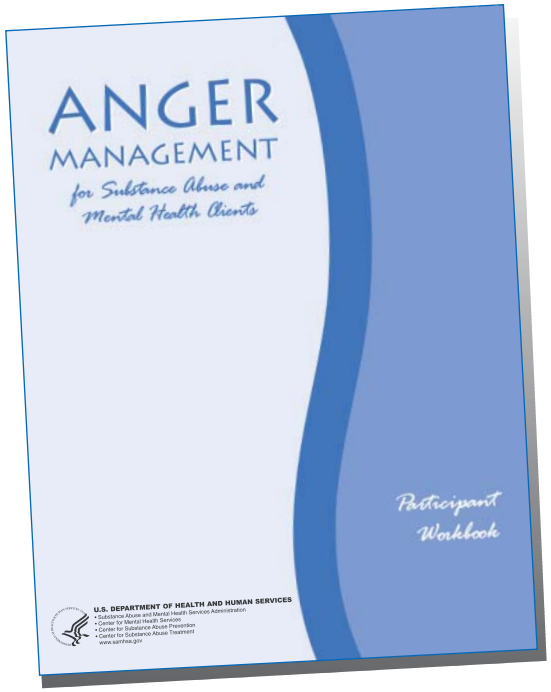
Patrick M. Reilly, Ph.D., and Michael S. Shopshire, Ph.D., wrote the manual and also developed the workbook together with Timothy C. Durazzo, Ph.D., and Torri A. Campbell, Ph.D.

To obtain copies of the manual and the workbook, 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). Or order from SAMHSA's Web site at **www.samhsa.gov.**

Sample Anger Control Plan

1. Take a timeout (formal or informal).
2. Talk to a friend (someone you trust).
3. Use the Conflict Resolution Model to express anger.
4. Exercise (take a walk, go to the gym, etc.).
5. Attend 12-step meetings.
6. Explore primary feelings beneath the anger.

Source: *Anger Management for Substance Abuse and Mental Health Clients*



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.

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- ❑ Fewer Retailers Sell Cigarettes to Youth
- ❑ SAMHSA Awards New Grants
- ❑ Anger Management Offers Adjunct to Treatment
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Thank you for your comments.

¡Soy Unica! ¡Soy Latina! Arrives in Miami

SAMHSA's ¡Soy Unica! ¡Soy Latina! bilingual public education initiative received a boost this fall through the participation of two prominent Latina community leaders. Florida's First Lady Columba Bush and New York State Health Commissioner and former U.S. Surgeon General Antonia Novello, M.D., agreed to serve as "Madrinas" (godmothers, mentors, spokespersons) for the campaign, whose title translates as "I am unique! I am Latina!

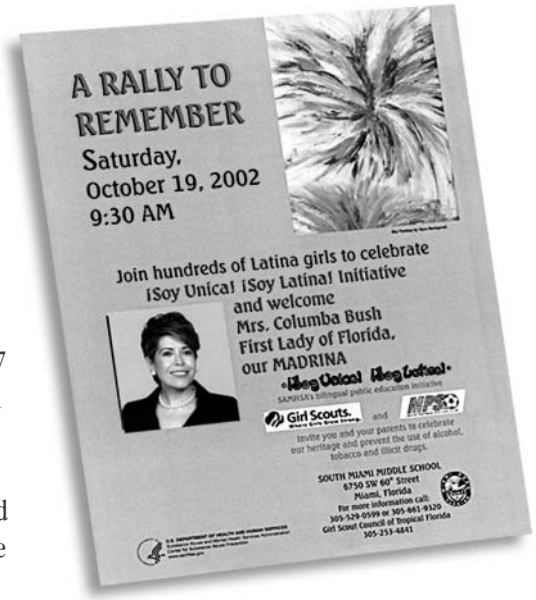
The ¡Soy Unica! ¡Soy Latina! initiative is designed to help Latinas age 9 to 14, their mothers, and other caregivers build self-esteem, mental health, decision-making skills, and assertiveness to prevent the abuse of alcohol, tobacco, and illicit drugs. SAMHSA joined with the Hispanic/Latino community to develop educational materials for the initiative.

¡Soy Unica! ¡Soy Latina! educational materials are part of SAMHSA's **Hablemos en Confianza** family of products that are designed to strengthen the dialogue between Spanish-speaking Hispanic/Latino parents and their children about the dangers of substance abuse.

According to SAMHSA's 2001 National Household Survey on Drug Abuse, a significant number of Latinas turn to alcohol and illicit drugs. Almost one in five Latinas age 12 to 17 reported past-year illicit drug use. More than one in four reported lifetime use of an illicit drug. Almost one-third, 31 percent, reported past-year alcohol use and 17 percent reported past-year use of cigarettes. Other studies have found Hispanic girls rank higher in rates of pregnancy, depression, and suicide than any other racial or ethnic group.

Mrs. Bush and Dr. Novello joined SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., and Miami Dade County Commissioner Jimmy Morales on Saturday, October 19, at South Miami Middle School to encourage hundreds of Latinas to celebrate their heritage and prevent the use of alcohol, tobacco, and illicit drugs.

"We have joined with the Hispanic/Latino community to help parents send a clear and consistent message to their children—that drugs are illegal, dangerous, and addictive," said Mr. Curie. He added, "The key is talking with our children early and often. ¡Soy Unica! ¡Soy Latina! is about helping young Latinas get the information they need and helping mothers talk about a subject that can be difficult for them."



The October rally for ¡Soy Unica! ¡Soy Latina! was one in a series planned to alert Latino communities to the initiative. For this rally, SAMHSA partnered with Miami Premier Soccer Club, Miami Dade County, and Girl Scouts Council of Tropical Florida.

The ¡Soy Unica! ¡Soy Latina! materials, in English and Spanish, include activity books for Latinas ages 9 to 11 and 12 to 14 and advice for mothers on talking with and learning from their daughters. An interactive Web site, **www.SoyUnica.gov,** engages young Latinas in activities and encourages dialogue that promotes healthy, drug-free lifestyles. A parallel Web site, **www.SoyUnica.gov/adults,** is geared to parents and gatekeepers.

SAMHSA has created special toll-free telephone numbers to obtain free ¡Soy Unica! ¡Soy Latina! materials. Girls may call 1 (800) 773-8546, and adults can call 1 (877) 767-8432.

Photo courtesy of VANDADES Magazine

(from left to right) Charles G. Curie, Columba Bush, and Antonia Novello join Henry Lozano who helped design ¡Soy Unica! ¡Soy Latina! Initiative materials.

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