Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

September/October 2008, Volume 16, Number 5

PAVING *the road* HOME

RETURNING VETERANS AND BEHAVIORAL HEALTH

Major General Mark Graham and his wife Carol Graham knew their son Kevin had received treatment for depression. A senior ROTC cadet, Kevin had always been a top student in good physical condition. "In hindsight, we didn't see the warning signs—we thought he would just get over it," said Mrs. Graham.

Without a doctor's guidance, however, Kevin had stopped taking his medication because he feared being stigmatized at an ROTC summer camp he was selected to attend. With his depression untreated, he never arrived at the camp. Instead, he took his own life in his college apartment. (To read the Graham family's story, see *SAMHSA News* online, September/October 2008.)

General and Mrs. Graham spoke at the opening plenary session of "Paving the Road Home," SAMHSA's Second National Behavioral Health Conference on Returning Veterans and Their Families, in Bethesda, MD, on August 11.

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General Graham, who commands the Army's Division West and Fort Carson in Colorado, and Mrs. Graham, who works at the national level to raise suicide awareness, brought their message to a capacity audience of 500 behavioral health care providers, officials at all levels of Government, and veterans' organization representatives from across the country.

In addition, at more than 50 Internet conference sites, a nationwide audience simultaneously watched via Webcast.

General Graham said that depression is insufficiently recognized, a factor that contributed to Kevin's death. He warned that the same lack of recognition could endanger many of the 800,000 veterans who have returned home from Iraq and Afghanistan, as well as service members on active duty. Why? Because depression and other behavioral health issues—including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance abuse, and suicide—are risks to all who serve in combat zones.

The need to recognize and help veterans recover from these "unseen wounds" that they may have suffered during their service was the major theme of "Paving the Road Home."

Aiming at Change

"We need to put psychological injuries on par with physical injuries, a task that requires transforming the culture of the military," said Brigadier General Loree Sutton, M.D., Special Assistant to the Assistant Secretary of Defense for Health Affairs.

Employment for America's Heroes

A breakout session at the recent conference focused on employment strategies and support available for returning veterans interested in going back to work.

The panel, moderated by SAMHSA's Crystal Blyler from the Agency's Center for Mental Health Services (CMHS), included representatives from the Departments of Labor (DOL) and Veterans Affairs (VA), and the Social Security Administration (SSA), as well as the National Business Group on Health (NBGH).

To help returning veterans with traumatic brain injury and post-traumatic stress disorder (see page 6) succeed in the workplace, Susan Parker from the DOL's Office of Disability Employment Policy described a new multi-agency initiative—America's Heroes at Work.

"The intended audience of America's Heroes at Work," Ms. Parker explained, "is employers." The program's goal is to raise awareness of the resources available to assist employers in hiring returning veterans.

Working collaboratively with "a dozen departments and other entities," including SAMHSA's CMHS and the SSA, the initiative is an employer-focused education and outreach plan that targets the workforce development community and state agencies.

The recently launched Web site—**www.americasheroesatwork.gov**—includes common employer questions, fact sheets and brochures, veterans' employment success stories, and Web-based training tools.

Other session highlights:

- Ron Finch from NBGH discussed the potential impact of returning veterans on employer-sponsored health plans and worksite programs.
- The Social Security Administration's Jason Olsen described the renewed emphasis on and a revitalization of the *Ticket to Work* program, helping people with disabilities go back to work.
- Jacqueline Haynes, with the VA's Department of Vocational Rehabilitation, talked about the various services and opportunities that the VA offers.

For more on employment strategies for returning veterans, visit *SAMHSA News* online at **www.samhsa.gov/SAMHSA_News.**

AMERICA'S HEROES AT WORK

Of the more than 325,000 returned Iraq and Afghanistan veterans who have been seen at U.S. Department of Veterans Affairs (VA) health facilities, 39 percent have mental health diagnoses, including nearly 68,000 with PTSD and an equal number with TBI, said Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer for the Mental Health Office at the VA.

In 2007, furthermore, about 2,000 active duty service members attempted suicide and 121 succeeded in taking their own lives, the highest number since tracking began in 1980, according to A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services.

Educating About Trauma

In the conference keynote address, Ms. Power emphasized the importance of educating both the military and civilian communities, as well as providers, about the true nature and effects of trauma. "The experience of trauma is not a disease but a public health issue," she explained.

In recent years, SAMHSA has worked to elevate the visibility of trauma and is providing tools for understanding and dealing with its effects, she added, noting that many more models for trauma care exist now than even 10 years ago. The need for trauma awareness and trauma-informed care, which incorporate knowledge about trauma and minimize retraumatization, is especially central in dealing with today's veterans, Ms. Power said.

The long and repeated deployments to conflict areas lacking clear front lines expose service members to trauma and extreme stress, and exacerbate the risk of mental health and adjustment issues among both service members and returning veterans. Service members may also suffer military sexual trauma arising from violence and harassment. Ms. Power added that between 13 and 30 percent of female service members suffered rape, which often goes unreported.

Normal reactions to trauma vary widely among individuals, Ms. Power said. Many

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From Dr. Broderick

Serving Veterans: A Public Health Approach

Eric B. Broderick, D.D.S., M.P.H.

Returning veterans and their families need a comprehensive set of services to support the transition from active-duty military to an engaged and healthy life in the community.

To address that need, SAMHSA recently collaborated with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) at the Second National Behavioral Health Conference on Returning Veterans and Their Families. (See the *SAMHSA News* cover story.)

As Federal agencies, SAMHSA, DoD, and VA each have different roles to play, but we each hold a shared belief in the public health model to promote the health and well-being of our returning troops.

Our continuing goal is to speak with a single voice on behalf of men and women coming home from Iraq and Afghanistan bearing the "invisible wounds" of war. The public health model supports the notion that it is inherently better to promote health and prevent illness *before* an illness begins.

Well-being, prevention, and treatment are the cornerstones of this approach to health care. The public health model is well suited to promote an individual's recovery from mental health and substance use disorders and the traumas that may result from combat exposure.

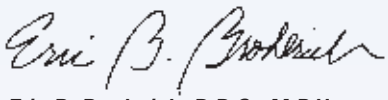
This model recognizes that mental health does not reside solely in the individual but within the web of interactions among the individual, the family, the military unit, the neighborhood, and the community where a returning veteran lives.

Through SAMHSA's collaborations with state mental health and substance abuse authorities, state substance abuse agencies, and community mental health centers, we can provide access to a full range of community-based services for our soldiers who choose to seek our help.

We are also committed to expanding the level of community and provider awareness, education, and capacity that will allow us to connect veterans to the DoD and the VA for services for which they are eligible.

Mental health and substance abuse issues can lead to other health and social problems. The public health approach seeks long-term solutions achieved by high-quality care, before symptoms and co-occurring conditions become severe.

I challenge us all—state and local governments, the research community, the mental health and substance abuse services field, and the private sector—to look for ways to address the needs of the men and women who have returned home.



Eric B. Broderick, D.D.S., M.P.H.
SAMHSA Acting Administrator

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people show resilience, but responses such as PTSD, depression, anxiety, and suicidal thoughts are common. These are not signs of underlying mental illness, Ms. Power emphasized, but rather results of traumatic experience. A third of the 1.64 million individuals who have deployed in the current conflicts have suffered from depression, PTSD, or TBI, she noted. Substance abuse is highly comorbid with these conditions.

"The range of efforts underway to help shows that assisting veterans as they return home involves preparing our communities to do more than have parades and release confetti. We must not only celebrate service but facilitate re-integration," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT).

Recovery is not only possible, but highly likely with appropriate help, Dr. Clark said. Treatment for trauma's effects is improving, and large clinical trials are coming that will evaluate treatment methods.

Although many individuals experience post-traumatic growth as positive changes

Not Alone . . . Helping Children of Military Families

SAMHSA, the Department of Veterans Affairs (VA), and other Federal agencies offer resources that parents, educators, and other concerned adults can use to help children through the challenges of a parent's deployment.

The following Web sites were recommended at a breakout session at the recent "Paving the Road Home" conference.

- **VA Kids (www.va.gov/kids)** offers information appropriate for children in kindergarten through grade 12. A section is also devoted to resources for teachers, providing ideas for activities and age-appropriate information about returning veterans and their needs.
- **Sesame Workshop (www.sesameworkshop.org/tlc)** is the nonprofit organization behind the hit children's television show "Sesame Street." The Web site offers three downloadable videos, "Deployments," "Homecomings," and "Changes," featuring some favorite characters dealing with some of the tough issues military children face.

Companion videos and other materials, including a magazine, facilitator guide, and children's poster, are available for caregivers.

- **Military Child Education Coalition (www.militarychild.org)** is a nonprofit organization that identifies the challenges facing the highly mobile military child, increases awareness of these challenges in military and educational communities, and initiates programs to meet the challenges. Its goal is to help military children achieve success wherever they are located around the world.

Materials available for educators and caregivers include informational booklets, suggested children's books, and training courses.

- **Zero to Three (zerotothree.org/military)** is a nonprofit organization that includes Coming Together Around Military Families, an initiative that increases awareness of the impact of trauma, grief, and loss on very young children, through specialized training and support for the professionals who are supporting military families.

Materials include downloadable letters for pediatricians to explain what is happening in the child's life.

- **Tragedy Assistance Program for Survivors (www.taps.org)** is a nonprofit organization that provides a support network for the surviving families of those who have died in military service. Resources are provided on numerous topics, including suicide, grief support, trauma support, and peer support.

For more information on SAMHSA's resources for veterans and their families, visit **www.samhsa.gov/vets.**

—By Kristin Blank

take hold, he said, only half of service members or veterans who need help actually obtain it.

Building Partnerships

In addition to raising awareness, another conference goal was to build partnerships among the broad range of agencies and organizations serving veterans. One example, cited by Dr. Katz, is the SAMHSA–VA collaboration on the veterans suicide helpline, which has received over 60,000 calls, 30,000 of them from veterans themselves, since its launch in July 2007 (see *SAMHSA News* online, July/August 2008). "It's a major success," Dr. Katz said.

Dr. Katz mentioned a new *Uniform Mental Health Services Handbook* projected for publication by the end of 2009. The VA handbook will define which services must be provided and will give guidance on methods of addressing service gaps caused by distance and other factors, he said. Approaches include increased use of both telemental health and community services.

The U.S. Department of Defense (DoD) will also, as part of its transformation initiative, soon launch a major public information campaign on mental health emphasizing recovery and reintegration, General Sutton said.

Building on Strength

"Service members have a very strong identification with strength," said plenary speaker Marine Sergeant Dan Taslitz, who suffered accidental brain injury in Iraq from carbon monoxide after Marine combat and reconnaissance service. "My identity was shattered. I was no longer a strong athlete and leader," Mr. Taslitz explained. But resilience was a strong element in his recovery. "It opens the door to support," he added.

"The Army's new guidance is to make it a sign of strength, not weakness, to come forward to seek mental health care," General Graham said.

He is working with his officers and noncommissioned officers at Fort Carson to create a healthy climate where soldiers will seek help without fear that it could hurt their careers. The number of individuals at Fort Carson coming forward for help has increased, he said. "We believe we are on the right track."

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Major General Mark Graham (left), who shared his family's story at the conference's opening plenary, speaks with SAMHSA's A. Kathryn Power (right).

Dr. Eric B. Broderick (left), SAMHSA's Acting Administrator, stops for a photo with Carol Graham (center) and Brigadier General Loree Sutton (right).

Attendees at the "Paving the Road Home" conference visit the exhibit area, which included information from the Departments of Defense, Veterans Affairs, and Health and Human Services on topics such as suicide prevention.

After her plenary presentation, Major Davina French (left) joins Dr. Elizabeth Lopez (right) for a photo. Dr. Lopez is Chief of SAMHSA's Homelessness Services Branch at CMHS. Homelessness was one of the breakout-session topics at the conference.

Photos by Paola Sanmartin

Policy Academy Convenes

Following the public conference day, SAMHSA convened a 2-day Policy Academy for teams from nine states and one territory.

By invitation after a brief competition nationwide, those included Florida, Massachusetts, New Hampshire, New York, North Carolina, Oklahoma, South Carolina, Utah, and Washington, as well as American Samoa.

Team members represented state governments, mental health and substance abuse providers, veterans and faith-based organizations, and family members.

Their goal? A seamless system of care for returning veterans and their families in their home states. A list of challenges to helping veterans included plans for employment, universal health coverage, community coalitions, and support for children and families.

Recommendations from the Policy Academy will be available within 60 days. State plans will be reviewed by SAMHSA, the DoD, and the VA.

For more information as it becomes available on the Policy Academy, visit **www.samhsa.gov/vets.** For a comprehensive list of resources for returning veterans and their families, visit *SAMHSA News* online, January/February 2008.

—By Beryl Lieff Benderly

Treating War's Signature Injury

Traumatic brain injury (TBI), the signature injury of the conflicts in Iraq and Afghanistan, presents new challenges for clinicians and researchers.

Conference speakers at a breakout session on TBI and post-traumatic stress disorder (PTSD) said that many service members who survive explosive attacks have both conditions.

"The symptoms of the two overlap, which complicates diagnosis," said Matthew Friedman, M.D., Ph.D., Executive Director, of the National Center on PTSD at the Department of Veterans Affairs (VA). "The issue is not whether we can diagnose either or both conditions, because we can. The issue is what to do therapeutically when both conditions co-occur, as they often do," he said.

Another complicating factor is that the injuries caused by the pressure wave of blasts from insurgents' homemade bombs and improvised explosive devices (IEDs) differ from those on which much of the existing TBI literature is based—mainly results of auto accidents and athletic injuries, said Maxine Krengel, Ph.D. Dr. Krengel is a clinical neuropsychologist in the Veterans Integrated Services Network of the VA. "This is a very, very complex situation that presents many issues together," she said.

Specifically, for example, Kevlar helmets only do so much to protect the brain's soft tissue, which is vulnerable both to flying shrapnel and to the powerful percussive wave of a blast.

Effective psychotherapeutic treatments exist for PTSD, panelists agreed, especially cognitive behavioral therapy (CBT) and exposure therapy (see Definitions). Medications are also effective in dealing with symptoms, although symptoms may return when medication is stopped. They include "seeing stars," headaches, blurred vision, increased sensitivity to lights and sounds, and feeling dizzy or nauseated.

"Research suggests that psychotherapy can be successful; however, further research is needed," Dr. Friedman emphasized. "There's concern that TBI may impair the capacity for either cognitive therapy or the emotional processing in exposure therapy; however, that is only a concern, not a proven fact," he said. "We need to test how well PTSD/mild TBI patients can use CBT. It's possible that most patients can benefit from these treatments."

For example, in Australia successful CBT trials with motor vehicle accident survivors with PTSD/TBI have shown great promise.

Currently, no drugs have current FDA approval for TBI, although some appear to show benefit, Dr. Friedman added. "This is a clinical challenge," he said. Only additional research can resolve these clinical issues, Dr. Krengel and Dr. Friedman agreed.

For more on TBI and PTSD, visit **www.ncptsd.va.gov.**

Definitions

Traumatic brain injury. A blow or jolt to the head or a penetrating head injury that disrupts the function of the brain.

Exposure therapy. Psychotherapy that involves repeated real, visualized, or simulated exposure to a traumatic memory to help the patient control feelings and thoughts about the trauma.

Mutual Support Groups: Fact Sheet for Providers

Part of SAMHSA's mission is to build resilience and help people with substance use disorders achieve recovery. In September, communities around the Nation celebrate *Recovery Month* (see page 9). For service providers, the work of promoting recovery continues year round.

To help providers support their clients, SAMHSA's Center for Substance Abuse Treatment recently released a new issue of *Substance Abuse in Brief Fact Sheet,* Volume 5, Issue 1, "An Introduction to Mutual Support Groups for Alcohol and Drug Abuse."

Mutual support groups, such as Alcoholics Anonymous, are nonprofessional groups made up of members who share the same problem and voluntarily support one another in recovery. Though they do not provide formal treatment, they are one part of a recovery-oriented systems-of-care approach to substance abuse recovery.

The six-page fact sheet will help health care and social service providers learn about the effect of mutual support groups on recovery, become familiar with different types of mutual support groups, and make informed referrals.

Finding the Right Fit

Not every group is right for every client. Some groups focus on one abused drug. Certain clients may prefer a 12-step approach and others may not.

According to the fact sheet, service providers can do several things to help individuals find a group that works for them. They can:

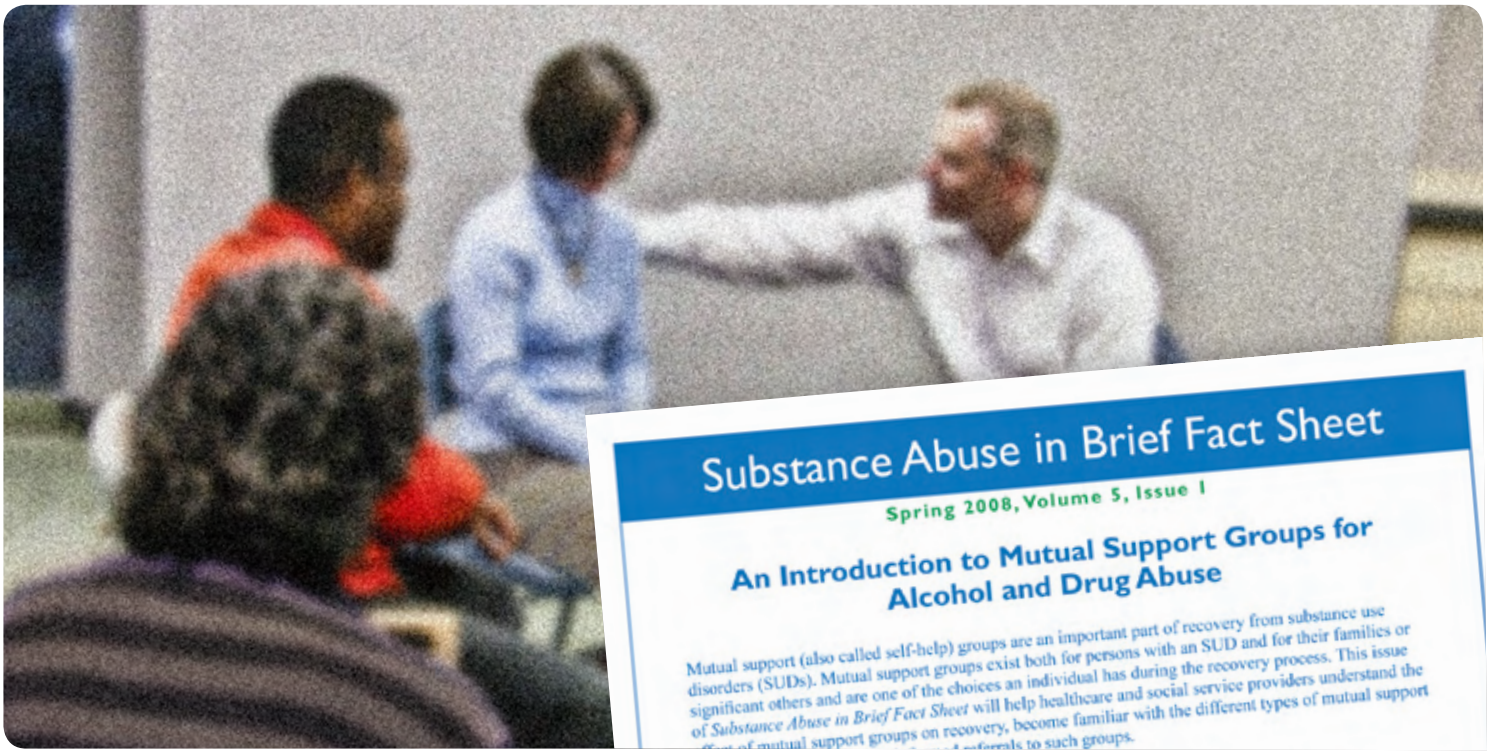
- Learn about the different types of support groups, their philosophies, and whether they are locally active.
- Attend open meetings to gain firsthand experience with the groups and establish contacts who can work with providers to get clients to meetings.
- Inquire into a client's experiences with mutual support groups, their concerns and misconceptions, and their personal beliefs.
- Start the conversation between a client and a support group contact person.
- Refer family members who may be affected by a client's substance use; doing so may encourage participation by providing social support.

Other Resources

The fact sheet provides a list of more than a dozen mutual support groups and their Web addresses, as well as additional SAMHSA materials, including a link to a Webcast entitled, "Mutual Support Groups: What Everyone Needs To Know."

Online, "An Introduction to Mutual Support Groups for Alcohol and Drug Abuse" is available on SAMHSA's Web site at **www.kap.samhsa.gov.** To order a free print copy, contact SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) or 1-800-487-4889 (TDD). Request inventory number SMA08-4336.

—By Kristin Blank and Gale Harris



Youth Substance Use Declines

Adult Prescription Drug Misuse Increases

National Alcohol and Drug Addiction Recovery Month launched its 19th year with SAMHSA presenting new data that show a drop in illicit drug use among youth.

SAMHSA's 2007 National Survey on Drug Use and Health (NSDUH) showed that prescription drug misuse is still a concern. Data also show an increase in drug use among 50- to 59-year-olds.

SAMHSA's Acting Administrator Eric B. Broderick, D.D.S., M.P.H., and the Director of the Center for Substance Abuse Treatment (CSAT) H. Westley Clark, M.D., J.D., M.P.H., presented this and other data at the National Press Club event held in early September.

"The numbers support the fact that treatment and prevention programs are making marks in certain segments of the population," Dr. Clark said.

Findings

Although the current illicit drug use rate among youth age 12 to 17 remained stable from 2005 to 2007, the rate significantly declined since 2002 among this age group, from 11.6 percent in 2002 to 9.5 percent in 2007.

Youth drug use declined for nearly every type of drug, including marijuana, LSD, ecstasy, pain relievers, stimulants, and methamphetamine (see chart).

Photo by Paola Sanmartin

CSAT Director Dr. H. Westley Clark (at podium) discusses new findings from the 2007 National Survey on Drug Use and Health at the *National Alcohol and Drug Addiction Recovery Month* briefing held at the National Press Club in Washington, DC. Acting SAMHSA Administrator Dr. Eric B. Broderick (left) and Director of the White House Office of National Drug Control Policy John P. Walters (center) also presented findings.

The level of alcohol use also dropped among 12- to 17-year-olds, from 17.6 percent in 2002 to 15.9 percent in 2007. "These new, recently declining rates in alcohol use among the youngest participants in the survey may be a leading indicator of an emerging pattern consistent with the goals of the Surgeon General's *Call to Action to Prevent and Reduce Underage Drinking,*" Dr. Broderick said.

Rise in Prescription Drug Misuse

Despite many positive trends, the survey also reveals some less encouraging data. Among young adults age 18 to 25, the level of current nonmedical use of prescription pain relievers has risen 12 percent (from 4.1 in 2002 to 4.6 percent in 2007). Among adults age 26 and older, the rate also increased, from 1.3 to 1.6 percent.

Overall, 6.9 million people (2.8 percent) age 12 or older used prescription-type psychotherapeutic drugs nonmedically in the past month. Of these, 5.2 million used pain relievers, the same number as in 2006.

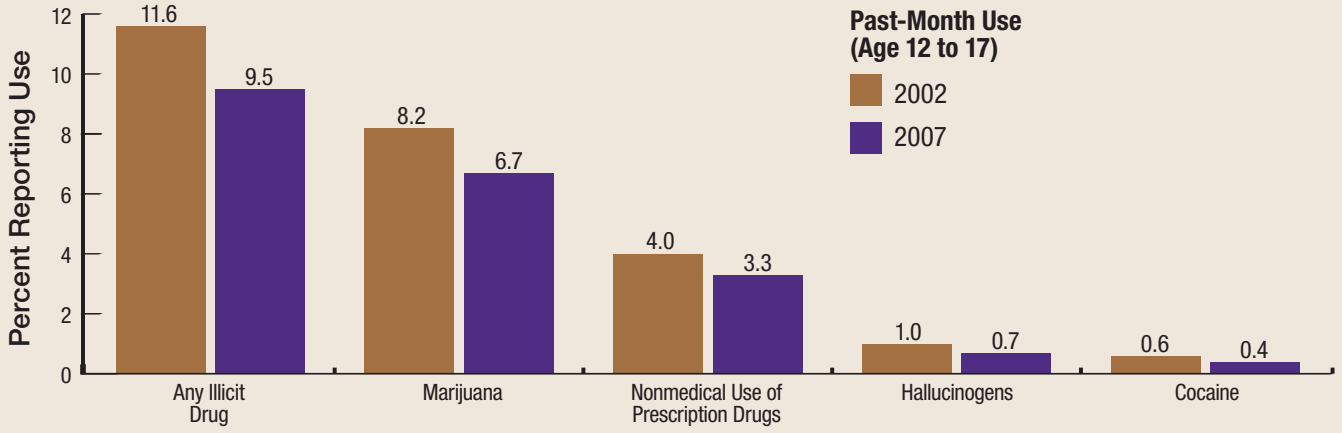
Among people age 12 or older who used pain relievers nonmedically in the past year, 56.5 percent reported that the source of the drug the most recent time they used was a friend or relative for free. Another 18.1 percent reported they got the drug from one doctor.

Baby Boomers Still Using

Among adults age 50 to 59, the rate of current illicit drug use showed an increasing trend between 2002 and 2007. For those age 50 to 54, the rate increased from 3.4 percent in 2002 to 5.7 percent in 2007.

The level of current illicit drug use among people age 55 to 59 more than doubled from 1.9 percent in 2002 to 4.1 percent in 2007.

Significant Changes in Current Use of Selected Illicit Drugs among Youth, 2002 vs. 2007



Source: SAMHSA, 2007 *National Survey on Drug Use and Health* (September 2008).

Marijuana was the most commonly used illicit drug (14.4 million past-month users). Among people age 12 or older, the rate of past-month marijuana use in 2007 (5.8 percent) was similar to the corresponding estimates for 2005 and 2006.

Current marijuana use among youth age 12 to 17 declined from 8.2 percent in 2002 to 6.7 percent in 2007. Most of the decline occurred between 2002 and 2005.

NSDUH is a scientifically conducted annual survey of approximately 67,500 people throughout the Nation. It is a primary source of information on the levels of illicit drug, alcohol, and tobacco use as well as certain mental health conditions. Because of improvements to the survey in 2002, the 2002 data constitute a new baseline for tracking trends.

Complete NSDUH findings are available on the SAMHSA Web site at **www.oas.samhsa.gov/NSDUHlatest.htm.**

National Alcohol & Drug Addiction Recovery Month

Recovery Month Testimonials

Two consumers spoke about their personal experiences with addiction to highlight this year's *Recovery Month* theme, "Real People, Real Recovery."

Candy Finnigan works as a drug and alcohol interventionist. A former alcoholic with more than 20 years of sobriety, she spoke about the importance of involving the entire family in recovery. "I've found that one addict affects 50 people," she said. "Because this is a family disease, I start at the top."

Candy Finnigan

Echoing her sentiments was Nathaniel Anderson, a 24-year-old who started using alcohol and other drugs at age 13. Eventually, he became addicted to OxyContin, until he entered treatment. He has been in recovery since 2004.

For Mr. Anderson, it was the support he received from his family that allowed him to get well. He wanted to set a good example for his younger siblings and make his parents proud. "I show up for my family today," he said. "I am a respected member of my community, my school, and my family."

Nathaniel Anderson

Photos by Martín Castillo

Recovery Month recognizes the accomplishments of people in recovery, the contributions of treatment providers, and advances in substance abuse treatment. This year's theme, "Real People, Real Recovery," highlights the people who have a renewed outlook on life thanks to treatment and long-term recovery.

—By Kristin Blank

Grant Awards Announced

SAMHSA recently announced grant awards for the following programs:

• **Targeted Capacity Expansion for Substance Abuse and HIV/AIDS Treatment Services for Traditionally Underserved Communities**— Approximately $105 million for 49 grant awards over 5 years to community service providers across the United States offering substance abuse and HIV/AIDS treatment services. The purpose of the program is to enhance and expand substance abuse treatment and/or outreach/pretreatment services in conjunction with HIV/AIDS services in traditionally underserved communities. Awardees providing treatment services will average $450,000 in funding each year, while programs providing outreach services will average about $350,000 each year. [TI-08-006]

• **Screening, Brief Intervention, Referral and Treatment (SBIRT) Programs**—$66 million for 15 cooperative agreement awards over 5 years to provide communities with expanded capacity to identify individuals with substance abuse problems and intervene appropriately. These programs will help health care providers learn how to recognize patients at risk for problems related to substance abuse and how to provide timely and effective help. Four SBIRT programs will receive between $10.2 million and $12.5 million over the next 5 years—between $2 million and $2.5 million per program per year. In addition, 11 cooperative agreements totaling $3.75 million per year, or $19 million over 5 years, will be awarded for the SBIRT Medical Residency program. [TI-08-001; TI-08-003]

• **Project LAUNCH**—More than $27.5 million for 6 grant awards over the next 5 years to state and tribal programs to promote the well-being of young children in communities across America. Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is a new program to promote the wellness of young children from birth to age 8 by addressing emotional, social, and behavioral aspects of development. Grant awards are approximately $900,000 each year. [SM-08-011]

• **Tribes/Tribal Suicide Prevention and Early Intervention**—$16 million for 12 grant awards over 3 years to support suicide prevention efforts undertaken by tribes/tribal organizations. This grant program is authorized under the Garrett Lee Smith Memorial Act, which provides funding for programs to combat suicide. Total funding for year 1 is nearly $6 million. [SM-08-001]

• **Drug-Free Communities (DFC) Grants**— $24.4 million to 199 communities across the country for local youth drug prevention programs. The DFC program provides grants of up to $625,000 over 5 years to community organizations that facilitate citizen participation in local drug prevention efforts. An additional $55 million, released in July, supports the continuation of awards to 568 DFC coalitions and 17 DFC Mentor Continuation coalitions. DFC coalitions work collaboratively at the local level to prevent and reduce drug and alcohol abuse among youth. An additional 14 new grants totaling $1 million were awarded through the DFC Mentoring Program. SAMHSA administers these grants in partnership with the White House Office of National Drug Control Policy. [SP-08-002; SP-08-003]

• **Residential Substance Abuse Treatment for Pregnant and Postpartum Women**—$22.9 million for 16 grant awards over 3 years to expand the availability of comprehensive residential treatment services for pregnant and postpartum women, their children, and family members. Grantees will receive approximately $500,000 per year.

First-year funding totals approximately $7.6 million. [TI-08-009]

• **Campus Suicide Prevention Grants Program**—$4.5 million for 17 grant awards for up to 3 years to prevent suicide on college campuses. The program assists colleges and universities in their efforts to prevent suicide attempts and completions and enhances services for students with mental and behavioral health problems.

The annual award amount is up to $100,000 per year. [SM-08-002]

• **Opioid Treatment Program (OTP) Accreditation**—$3 million for 3 grant awards over 3 years to help OTPs reduce the cost of basic accreditation education and accreditation/reaccreditation surveys or site visits. Total funding for year 1 is nearly $1 million. [TI-08-008]

For more information, visit SAMHSA's Web site at **www.samhsa.gov/grants** or the Federal Government's grants Web site at **www.grants.gov.**

Milestone: NREPP Posts 100th Evidence-Based Practice

Registry Helps Communities Access Rated Interventions

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) recently posted its 100th intervention to the online database. This milestone marks a fourfold increase in the number of interventions posted since the Registry launched in March 2007.

An integral part of SAMHSA's Science and Service Initiative, NREPP provides descriptive information and expert ratings for evidence-based programs submitted by researchers and intervention developers across the Nation.

In the near future, summaries of newly reviewed interventions are slated to be posted at the rate of 3 to 7 per month. More than 120 additional evidence-based programs currently are in queue for review.

By providing information on tested interventions, NREPP's online database may help reduce the lag time between generating new research results and using those results "hands on" in the field.

NREPP as a Resource

In the health care field, evidence-based practices—also called EBPs—refer to approaches to prevention or treatment that are validated by some form of documented scientific evidence. Offering a library of rated programs for review, NREPP is intended to assist states and communities in identifying and selecting EBPs that may meet their particular requirements.

Program developers should note that evidence-based practices are not bound to a single, authoritative definition or expectation. "SAMHSA recognizes that 'evidence' can mean different things to different people," said Kevin D. Hennessy, Ph.D., SAMHSA's Science and Service Coordinator. "Users should take the time to review NREPP entries and make their own judgments about which interventions are best suited to their needs and resources."

Using NREPP

As a first step to find interventions, visit SAMHSA's NREPP site at **www.nrepp.samhsa.gov.** Search features allow users to identify and sort interventions by criteria such as desired outcomes, target populations, and service settings.

Organizations that explore interventions on the easy-to-navigate Web site may save time in identifying effective interventions. "Through NREPP, SAMHSA is providing information on programs that have worked in various communities across the Nation," Dr. Hennessy said. "Practitioners can view information and ratings for each intervention and then follow up directly with developers to better determine 'goodness of fit' for their community."

With many interventions specifically tested to serve clients in ethnic communities, Dr. Hennessy noted that the Registry's diverse listings speak to SAMHSA's commitment to reach out to members of these populations.

"We're hoping to encourage program developers to build evidence-based interventions for various clients," Dr. Hennessy said, noting that NREPP is a voluntary, self-nominating system, and developers choose to present their programs for review. "Over time, NREPP may have broad appeal. It can help practitioners and stakeholders improve both the type and quality of services offered in their communities."

—By Leslie Quander Wooldridge

Making Mental Health Services Accessible in Primary Care Settings

A recent report proposes strategies to overcome barriers associated with the reimbursement of mental health services provided in primary care settings.

Jointly funded by SAMHSA and the Health Resources and Services Administration (HRSA), with the technical expertise of the Centers for Medicare & Medicaid Services (CMS), the report is titled, *Reimbursement of Mental Health Services in Primary Care Settings.*

"Improving access to timely and targeted mental health services in primary care settings can improve patient health and compliance with treatment," said A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services.

Stakeholders in this improvement process include primary care providers, state Medicaid officials, and others billing for mental health services in the public sector. The goal is to work together to promote a greater understanding of mental health reimbursement policy.

"HRSA's collaboration with SAMHSA and CMS on this issue is generating positive results," said HRSA Administrator Elizabeth M. Duke, Ph.D. "Community health centers are a good example. Actions identified in this report can help improve reimbursements for these centers and other safety-net providers that deliver mental health services in primary care settings."

Recommended Actions

Action steps and creative ideas came in from mental health service consumers, practitioners, providers, researchers, and Government officials. Collectively, they identified seven barriers to reimbursement of mental health services in primary care settings, and made suggestions for action.

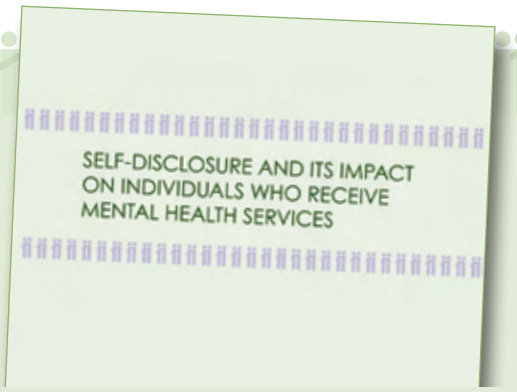
Recommendations include the following:

- Increase leadership collaboration at the Federal and state levels among Government policymakers in Medicare, Medicaid, primary care, and mental health.
- Disseminate revised policies and procedures to patients, payers, practitioners, providers, and managers of care.
- Encourage flexibility in state Medicaid benefit designs to cover mental health services in primary care settings.
- Increase payment for professional services by nonphysician practitioners under Medicare and Medicaid, particularly in underserved rural and urban areas.
- Activate policies at the state level for appropriate reimbursement of telemedicine services.
- Provide reimbursement for mental health prevention and screening services.

The full report is available on SAMHSA's Web site at **http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf.**

Additional information about billing for mental health services is available at **www.hipaa.samhsa.gov/hipaacodes2.htm.**

Pros and Cons of Self-Disclosure



A new monograph, released by SAMHSA's Center for Mental Health Services (CMHS), examines current research related to self-disclosure of mental health problems. *Self-Disclosure and Its Impact on Individuals Who Receive Mental Health Services* offers personal stories and describes benefits and risks that promote or deter self-disclosure.

Benefits include:

- Connecting with others who may have similar experiences
- Not worrying about hiding experiences related to mental illness
- Finding someone who can provide assistance in the future
- Promoting a sense of personal power and standing up against discrimination.

Risks include:

- Encountering alienation, disapproval, or gossip
- Experiencing discrimination in employment, housing, and other areas
- Fearing that future relapses could cause more stress because others are "watching"
- Feeling increased anxiety because of perceptions that people are thinking about or pitying you.

For a print copy of the CMHS monograph, contact SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727). Request inventory number SMA08-4337.

First-Time Versus Repeat Admissions: New Data

Maintaining recovery from substance use disorders can be a challenge. Often, people relapse into old habits after a period of staying away from drugs or alcohol.

A new SAMHSA report describes how individuals who are re-admitted to treatment (repeat admissions) often exhibit different substance use and characteristics than individuals admitted to treatment for the first time.

The report, *First-Time and Repeat Admissions Aged 18 to 25 to Substance Abuse Treatment: 2006,* examines the characteristics of 18- to 25-year-old substance abuse treatment admissions, the age group that makes up nearly a quarter (22 percent) of all admissions in 2006.

Information cited in the report comes from the Treatment Episode Data Set (TEDS), an annual compilation of data on the demographic characteristics and substance abuse problems of those admitted to treatment.

TEDS is part of the Drug and Alcohol Services Information System, the primary source of national information on the services available for substance abuse treatment and the characteristics of admitted individuals.

Abused Substances

In 2006, repeat admissions age 18 to 25 were more likely than first-time admissions of the same age to report heroin and other opiates as the primary substance of abuse (27 versus 12 percent). Repeat admissions also were more likely to report the use of multiple substances (67 versus 56 percent).

Repeat admissions age 18 to 25, however, were less likely than first-time admissions to report alcohol (26 versus 35 percent) or marijuana (22 versus 28 percent) as the primary substance of abuse. The proportion of admissions in this age group reporting marijuana as their primary substance decreased with increasing age.

Geographic Characteristics

The majority of admissions age 18 to 25 to substance abuse treatment in the northeast (61 percent) and midwest (52 percent) were repeat admissions in 2006. However, less than one-third (31 percent) of treatment admissions of the same age in the south and less than half (40 percent) in the west were repeat admissions.

Treatment histories for admissions age 18 to 25 varied by region. The south was unlike any other region in that a majority of all admissions in this age group were first-time instead of repeat admissions, regardless of primary substance of abuse.

In contrast, the midwest showed similar proportions of first-time and repeat admissions among those age 18 to 25 reporting primary alcohol or marijuana abuse, but admissions of the same age reporting primary cocaine, heroin and other opiates, or stimulant abuse were predominantly repeat admissions.

In the northeast, the majority of 18- to 25-year-old admissions reporting primary cocaine, heroin and other opiates, or stimulant abuse were repeat admissions.

Other Findings

In 2006, the average age of first use was younger for repeat substance abuse treatment admissions age 18 to 25 than for first-time admissions the same age. Depending on the primary substance of abuse, the difference ranged from 5 to 14 months.

Overall, repeat and first-time admissions in the 18- to 25-year-old age group were almost equally likely to have private types of health insurance.

However, first-time admissions between 18 and 25 years of age were consistently more likely than repeat admissions of the same age to report having no health insurance. Overall, 65 percent of first-time admissions age 18 to 25 reported having no health insurance compared with 59 percent of repeat admissions of the same age.

First-Time and Repeat Admissions Aged 18 to 25 to Substance Abuse Treatment: 2006 is available on SAMHSA's Web site at **http://oas.samhsa.gov/2k8/timesTX/timesTX.pdf.**

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

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

Comments: _____

_____

_____

I'd like to see an article about: _____

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Name and title: _____

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Field of specialization: _____

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

- ❑ Paving the Road Home: Returning Veterans and Behavioral Health
- ❑ Employment for America's Heroes
- ❑ From Dr. Broderick: Serving Veterans: A Public Health Approach
- ❑ Not Alone . . . Helping Children of Military Families
- ❑ Treating War's Signature Injury
- ❑ Mutual Support Groups: Fact Sheet for Providers
- ❑ Youth Substance Use Declines
- ❑ *Recovery Month* Testimonials
- ❑ Grant Awards Announced
- ❑ Milestone: NREPP Posts 100th Evidence-Based Practice
- ❑ Making Mental Health Services Accessible in Primary Care Settings
- ❑ Pros and Cons of Self-Disclosure
- ❑ First-Time Versus Repeat Admissions: New Data
- ❑ Bullying: Starting the Conversation
- ❑ ***SAMHSA News*** online—for the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

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Thank you for your comments!

Bullying: Starting the Conversation

On the subject of bullying, parents, relatives, teachers, counselors, and school administrators sometimes find themselves needing to ask children difficult but necessary questions.

One of those questions might be "Are you scared to go to school because you are afraid of being bullied?" Trying to start a dialogue with a "loaded" question like that, however, often fails to encourage a child to talk about his or her actual experiences in the schoolyard.

To help, SAMHSA recently updated Conversation Starter Cards, a set of more than 50 laminated 3.5- by 4.5-inch cards that offer many ways to begin a dialogue. The purpose of this tool is to help decrease bullying and increase a child's mental well-being.

The cards are part of SAMHSA's 15+ Make Time to Listen . . . Take Time to Talk—About Bullying program. The campaign encourages parents to take a minimum of 15 minutes per day to spend quality time talking and listening to their children.

. . . Not a Fact of Life

A companion booklet, *Bullying is Not a Fact of Life,* helps continue the conversation. The booklet helps dispel myths about schoolyard behavior, and continues the goals of the ongoing Safe Schools/Healthy Students campaign.

The booklet's prevention program outlines four essential points for concerned adults:

- **Identify the problem.** An anonymous survey called the Olweus Bully/Victim Questionnaire helps gather concrete information about bullying in the individual school.
- **Create a plan.** Parents and teachers use this information to design interventions, including improved supervision of break times and individual work with students who have been identified as bullies and victims.
- **Set rules.** Teachers and students work together to establish and reinforce a set of rules about bullying, thereby creating a positive, anti-bullying climate.
- **Provide supports.** Finally, parents and teachers must cooperate to provide effective protection to victims of bullying.

—By Virginia Hartman

Bullying Resources

For more information about 15+ Make Time to Listen…Take Time to Talk—About Bullying, visit **www.mentalhealth.samhsa.gov/15plus/aboutbullying.asp.**

To download a copy of the booklet *Bullying is Not a Fact of Life,* visit **www.mentalhealth.samhsa.gov/publications/allpubs/SVP-0052.**

The Conversation Starter Cards are available in PDF format at **http://download.ncadi.samhsa.gov/ken/pdf/SVP-0051/SVP-0051.pdf,** or in print by calling SAMHSA's Health Information Network at 1- SAMHSA-7 (1-877-726-4727) or 1-800-487-4889 (TDD). Request inventory number SVP-0051.

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