Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

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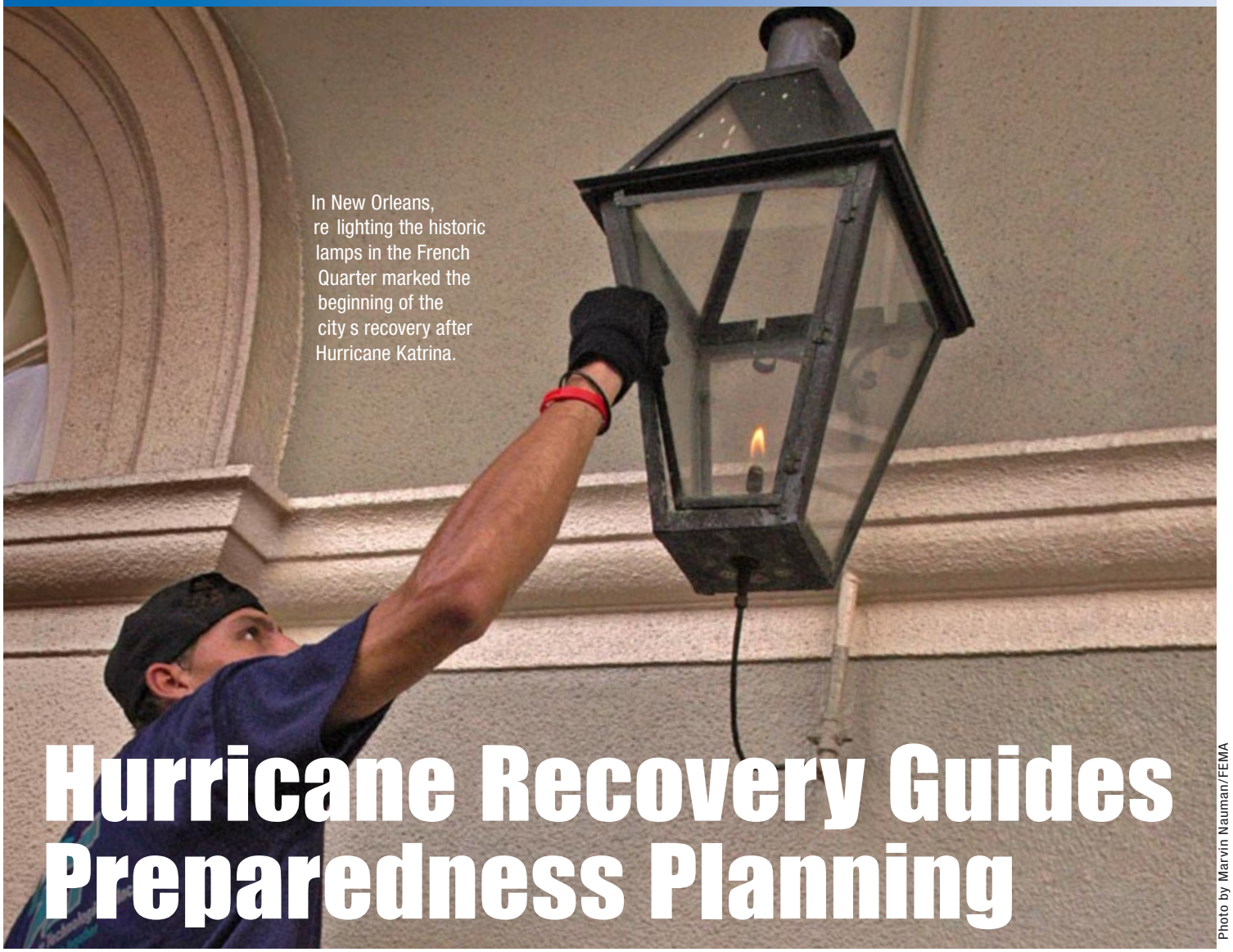

In New Orleans, re lighting the historic lamps in the French Quarter marked the beginning of the city s recovery after Hurricane Katrina.

Photo by Marvin Nauman/FEMA

Hurricane Recovery Guides Preparedness Planning

"What we learned from Hurricane Katrina is not to wait until the water is up to our knees before we start figuring out what to do," said hurricane survivor Michael Patrick, a New Orleans native. Many survivors displaced by the storm, including Mr. Patrick, are now outreach workers in crisis counseling programs throughout the Gulf States.

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of Hurricanes Katrina, Wilma, and Rita."

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Administrator Curie To Leave SAMHSA

Charles G. Curie, M.A., A.C.S.W., will resign as SAMHSA Administrator effective August 5, 2006. In his nearly 5 years at the helm of SAMHSA, Mr. Curie was instrumental in pursuing the New Freedom Initiative and Access to Recovery program—both priorities of the George W. Bush Administration.

The President's New Freedom Commission on Mental Health, established by an executive order on April 29, 2002, articulated a goal of transforming the mental health care system.

Building on the work of the President's New Freedom Commission, SAMHSA developed a Federal action agenda. SAMHSA continues to work with representatives of multiple Federal agencies that form the Federal Executive Steering Committee to achieve the 70 action steps on the agenda.

Reshaping the Nation's approach to mental health has entailed a reshaping of the perception of mental illness. This includes the promotion of the concept that people can recover from mental illnesses and live productive and fulfilling lives in the community.

SAMHSA's substance abuse treatment priorities also focus on facilitating recovery. The Access to Recovery (ATR) Program, launched under Mr. Curie's leadership, has the goal of increasing access to treatment and enhancing choice in services in order to improve treatment outcomes. ATR expands consumer choice through a unique voucher program aimed at increasing recovery options by focusing on both clinical treatment and other recovery support services.

According to SAMHSA's 2004 National Survey on Drug Use and Health, an estimated 4.6 million people experienced co-occurring mental and substance use disorders during the year. Nearly half of the adults with co-occurring disorders received no treatment for either problem and only 6 percent received treatment for both.

During Mr. Curie's tenure, SAMHSA published a landmark Report to Congress recognizing that people with co-occurring disorders are the expectation, not the

continued on the next page

SAMHSA Expands Matrix

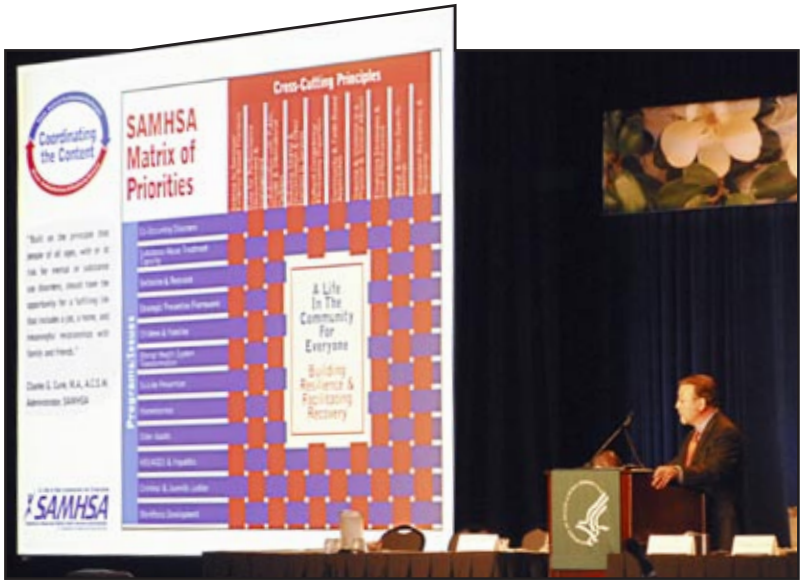
SAMHSA recently released a revised matrix of program priorities and cross-cutting principles. The matrix was developed 5 years ago at the request of SAMHSA Administrator Charles G. Curie, M.A, A.C.S.W., from a series of dialogues with stakeholders in the field. Since then, the matrix has evolved as part of an ongoing dialogue to help shape SAMHSA's future directions and priorities and has guided the Agency's program and policy decisions and resource allocation.

The new matrix includes suicide prevention and workforce development as major program priority areas. Disaster readiness and response was changed from a program priority to a cross-cutting principle because it affects all SAMHSA operations. The cross-cutting principle of collaboration now includes an emphasis on international work, and the principle of reducing stigma includes a new focus on reducing discrimination.

SAMHSA's 12 program priorities include co-occurring disorders, substance abuse treatment capacity, seclusion and restraint, strategic prevention framework, children and families, mental health system transformation, suicide prevention, homelessness, older adults, HIV/AIDS and hepatitis, criminal and juvenile justice, and workforce development.

The cross-cutting management principles include science to services/evidence-based practices; data for performance measurement and management; collaboration with public, private, and international partners; reducing stigma and discr barriers to services; cultural competency/eliminating disparities; community and faith-based approaches; trauma and violence; financing strategies and cost-effectiveness; rural and other specific settings; and disaster readiness and response.

For more information, visit the SAMHSA Web site at **www.samhsa.gov/matrix/matrix_brochure_2006.pdf.**



Standing beside the SAMHSA matrix of priorities created during his years at the Agency, SAMHSA Administrator Charles Curie addresses participants at a recent conference.

exception, in substance abuse and mental health treatment systems.

This commitment to helping people with co-occurring disorders led to the launch of SAMHSA's Co-Occurring State Incentive Grants. These grants help states develop or enhance their treatment systems to provide accessible, comprehensive, and evidence-based treatment services to people with co-occurring substance use and mental disorders.

"It's been a privilege to serve this whole Nation. I feel very fortunate and humbled."

In addition to these efforts, SAMHSA worked with First Lady Laura Bush's Helping America's Youth Initiative, which joins together the efforts of multiple Federal drug abuse prevention programs to reduce illicit drug use among the Nation's youth (see *SAMHSA News,* p. 19). These efforts include SAMHSA's Strategic Prevention Framework, which will assist 40 states to establish a science-based approach to substance abuse prevention and to build resiliency in young people.

While at SAMHSA, Mr. Curie showed the same dedication to eliminating the use of seclusion and restraint in treatment that he displayed during his years as deputy secretary for mental health and substance abuse services at the Pennsylvania Department of Public Welfare.

Reflecting on his time at SAMHSA, Mr. Curie said, "It's been a privilege to serve this whole Nation. I feel very fortunate and humbled."

From the Administrator

Reflections on Achievements, Future Directions

My initiation to Federal service occurred, by coincidence, at the time of the September 11, 2001, attacks, making it a time of tremendous challenge for me, yet also a moment of limitless possibilities.

One of my first actions as SAMHSA Administrator was to hold a national conference in New York City soon after the attacks. SAMHSA invited a team from every state to attend and work on a disaster preparedness action plan for mental and substance use problems.

As I prepare to leave SAMHSA, I see that the resolve, commitment, and ingenuity displayed at that time by stakeholders in the field working in tandem with SAMHSA staff was a harbinger of how hard we would work and how much we would accomplish together in the years ahead.

Simultaneously, I engaged the field in an ongoing dialogue to help shape the direction of SAMHSA's efforts. The insight and input from these stakeholders helped formulate a mission and vision.

The vision is a life in the community for everyone. People of all ages, with or at risk for mental or substance use disorders, deserve the opportunity for a fulfilling life that includes an education, a job, a home, and meaningful relationships with family and friends.

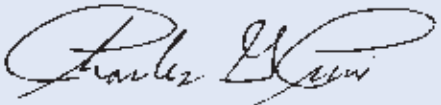
The vision continues to inform Agency efforts today. It infuses SAMHSA's directive from the President's New Freedom Initiative to transform the Nation's mental health service delivery system. It has helped launch transformative programs such as Access to Recovery and the Strategic Prevention Framework that are already taking shape across the Nation.

The vision of life in the community for everyone has also clarified the understanding that there are many pathways to recovery from substance abuse, including the transforming powers of faith. With that in mind, SAMHSA has established broad alliances with community and faith-based service providers to assist citizens seeking help and support in their recovery.

To make the vision accessible to all, SAMHSA remains committed to breaking down the wall between the mental health care and substance abuse treatment systems so that people with co-occurring mental health and substance abuse problems receive comprehensive, coordinated treatment.

More recently, Agency efforts in connection with the 2005 hurricanes in the Gulf States and in the international arena—particularly in Iraq and Afghanistan—have persuaded me even more profoundly about the universality of SAMHSA's vision. Throughout the world, people's needs, hopes, and aspirations are more similar than we may think.

I anticipate watching SAMHSA's achievements grow after I leave, and I look forward to continuing my own efforts to improve the lives of all people with or at risk for mental and substance use disorders.



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

Methamphetamine Jeopardizes Children's Welfare

When Kirsten Smyrni first started using methamphetamine, it seemed like a wonder drug. The burst of productivity the drug provided helped her get more done in her roles as a chef and as the mother of five children. But that new power quickly proved illusory. By the time she hit bottom, she had lost her children, job, and home.

"This is a family disease," explained Ms. Smyrni, who was reunited with her children after she and her husband underwent substance abuse treatment. "People—and that includes my children—can count on me today."

According to SAMHSA's National Survey on Drug Use and Health, 1.4 million Americans age 12 and older in 2004 had used methamphetamine in the past year. But those methamphetamine users aren't just putting themselves at risk for physical and psychological problems like memory loss, psychosis, tremors, and hallucinations. If they're parents, they're also putting their children at risk of neglect and abuse.

Ensuring the safety of those children has become a priority for SAMHSA.

SAMHSA's Center for Substance Abuse Treatment (CSAT), along with the Administration for Children, Youth, and Families' Children's Bureau, funds the National Center on Substance Abuse and Child Welfare (NCSACW). And in May, the two agencies cosponsored a conference—"Methamphetamine: The Child Welfare Impact and Response"—that brought together representatives from the treatment, child welfare, and law enforcement fields as well as Ms. Smyrni and her family and others directly affected by methamphetamine.

"We acknowledge the impact this drug has on our families, specifically the long-term effects it has on our children," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H. "We at SAMHSA have been closely monitoring and responding to the growing impact methamphetamine is having in our communities."

Dr. Nancy K. Young, of the SAMHSA-funded National Center on Substance Abuse and Child Welfare, and Dr. H. Westley Clark, Director of SAMHSA's Center for Substance Abuse Treatment, presented recent data at the conference, "Methamphetamine: The Child Welfare Impact and Response."

Endangering Children

Like other kinds of substance abuse, methamphetamine use by parents puts children at risk.

Problems can begin even before birth, noted NCSACW Director Nancy K. Young, M.S.W., Ph.D. Dr. Young also directs Children and Family Futures, the nonprofit organization that operates the center.

Prenatal exposure to methamphetamine can result in premature birth, birth defects, and low birth weight in the short term and learning disabilities, developmental disorders, and cognitive deficits in the long term, said Dr. Young.

Parents under the influence of methamphetamine are also likely to parent poorly, said Dr. Young, noting that methamphetamine use can result in poor judgment, confusion, irritability, and paranoia. Risks to children's health and well-being include inadequate supervision, inconsistent parenting, chaotic home lives, households without basics like food or utilities, lack of medical care, and abuse.

"Chronic neglect is what brings most kids to the attention of the child welfare system," explained Dr. Young.

Parents who manufacture methamphetamine create additional risks for their children. Even "cooking" small quantities of the drug can expose children to dangerous chemicals, toxic fumes, and fires and explosions, explained Dr. Young, noting that children's higher metabolic rates and developing bodies put them at higher risk than adults.

According to the U.S. Department of Justice National Drug Intelligence Center, there were 2,028 known cases of children present at seized methamphetamine laboratory sites in 2001. Of those, approximately 35 percent of the children tested positive for toxic levels of chemicals in their bodies.

If parents are selling methamphetamine, said Dr. Young, add the presence of weapons, the possibility of violence, the presence of strangers in the household, and the threat of incarceration to the list of dangers.

Working Together

Like the Smyrnis, parents who use methamphetamine can lose their children to foster care or even permanent adoption. Fortunately, treatment for methamphetamine abuse works. "We're having good success treating people with methamphetamine problems, and children are being reunified with

parents as a result," said Cheryl J. Gallagher, M.A., a public health advisor at CSAT.

A treatment approach known as the Matrix Model—which relies on intensive cognitive behavioral therapy, family education, counseling, social support groups, and drug testing in outpatient settings—seems to work especially well.

A CSAT-funded study of nearly 1,000 methamphetamine users from 1999 to 2001—the largest randomized clinical trial of treatment for methamphetamine dependence—found that patients undergoing Matrix treatment attended more sessions, stayed in treatment longer, and had more drug-free urine samples during treatment than clients in the "treatment as usual" study group.

That "larger dose of treatment" is especially important for methamphetamine users, explained Ms. Gallagher, because the damage caused by methamphetamine takes longer to heal than that caused by other drugs.

But for parents to get the treatment they need, the substance abuse, child welfare, and law enforcement communities all need to work together. And that hasn't always happened. Law enforcement personnel, for example, may not be aware just how effective treatment is. "Many don't think methamphetamine users can get well," said Ms. Gallagher. "But

According to Cheryl J. Gallagher, a CSAT public health advisor, and Sharon Amatetti, a CSAT senior public health analyst, SAMHSA has had success treating parents with methamphetamine problems and reunifying them with their children.

of results—59- to 69-percent success rates—with methamphetamine users going through treatment and getting into recovery as we do with other drugs."

Collaboration has become especially important since the Adoption and Safe Families Act of 1997, said Sharon Amatetti, M.P.H., a senior public health analyst at CSAT. The law speeds up the timeline for making decisions about whether children should be reunified with their parents or be put in permanent foster care or adoption, making it imperative to get parents into treatment as quickly as possible.

NCSACW aims to educate each field about the others. "There's still a lot of stigma about addiction and myths about the effectiveness of treatment, and child welfare workers sometimes feel it's hopeless," said Ms. Amatetti. "Through communication and collaboration, the child welfare field learns that's not necessarily true." Similarly, those in the treatment field need to know about the child welfare system and the pressures and rules child welfare workers face. Law enforcement and court personnel need to learn about both fields.

The center's resources and technical assistance can help. One free online curriculum teaches child welfare workers about addiction and treatment, for instance, and another teaches addiction professionals about child welfare. "To date, more than 5,000 people have completed these online trainings," said Ms. Amatetti.

For more information, visit the NCSACW Web site at **www.ncsacw.samhsa.gov.** The site includes a list of methamphetamine-related resources at **www.ncsacw.samhsa.gov/MethamphetamineList.htm.**

Photo by Meredith Hogan Pond

A Healing Family. Reunited after both parents—Kirsten (far left) and John (far right)—recovered from methamphetamine abuse, the entire Smyrni family traveled to the recent conference in Washington, DC, to tell their story of healing and hope. The Smyrni children include (l to r) Lee, Zane, little Alex, Sophia, Quinn, and Nicki.

Curriculum on Restraint Reduction Available

SAMHSA recently released a new training curriculum to give mental health providers the latest information on prevention strategies and alternative approaches to avoid and reduce the use of seclusion and restraint.

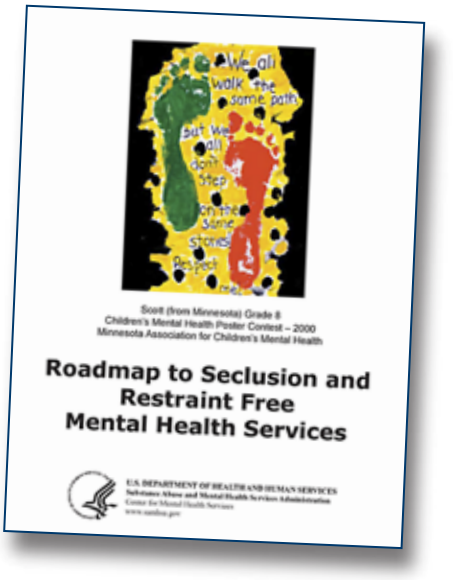
The training curriculum, *A Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages,* is organized in seven modules and emphasizes the importance of creating cultural change within organizations to effect reduction in seclusion and restraint practices.

Specifically, the document outlines best practices in the use of trauma-informed care and other aspects to support resiliency and recovery of people with mental illnesses while avoiding seclusion and restraint practices that can harm rather than help.

Curriculum modules discuss specific strategies including self-care approaches, peer-provided services, arts programs, comfort rooms, and other approaches designed to enhance service environments and consumer participation as means to avoid the use of restraint and seclusion.

In addition, a range of other approaches are described, including advance directives, mediation, and communication approaches. Each represents a potential tool for providers to ensure consumer safety. Techniques for sustaining reduction efforts via consumer and staff involvement as well as a listing of resources are included.

The curriculum employs a unique consumer-driven approach that was successfully pilot-tested prior to publication.



Available in CD-ROM format, the curriculum provides complete lesson plans and handouts for each training module. Online, the curriculum is available from SAMHSA's National Mental Health Information Center at **www.mentalhealth.samhsa.gov/publications/allpubs/sma06-4055.**

Treatment Directory Updated

SAMHSA recently updated the Agency's guide to finding local substance abuse treatment programs. The guide, *National Directory of Drug and Alcohol Abuse Treatment Programs 2006,* provides information on thousands of alcohol and drug treatment programs located in all 50 states, the District of Columbia, Puerto Rico, and 4 U.S. territories.

Offering a nationwide inventory of nearly 11,000 drug abuse and alcoholism treatment programs and facilities, the directory is organized and presented in state-by-state format for quick reference by health care providers, social workers, managed care organizations, and the public. The publication lists public and private facilities, all of which are licensed, certified, or otherwise approved by substance abuse agencies in each state.

Designed to provide quick, key information about the location of specific facilities and the nature of the programs and services, the directory includes levels of care offered and areas of service specialization. Those include programs for adolescents, persons with co-occurring substance abuse and mental disorders, individuals living with HIV/AIDS, and pregnant women.

The 2006 directory identifies long- and short-term residential treatment facilities and facilities that provide residential beds for clients' children.

Online Treatment Locator Services

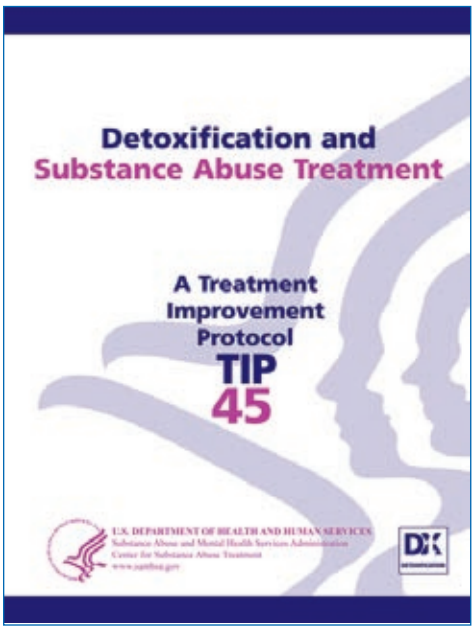
The updated directory is a paper-based complement to SAMHSA's Web-based *Substance Abuse Treatment Facility Locator Service.* Continuously updated, this searchable online directory includes listings for marijuana, cocaine, and heroin addiction treatment programs, as well as drug and alcohol treatment programs for adolescents and adults.

The locator service also provides driving directions to the nearest treatment facilities, including residential treatment centers, outpatient treatment programs, and hospital inpatient programs for drug addiction and alcoholism, in addition to descriptions of services available and contact information such as addresses and telephone numbers.

By following simple instructions available online through this service, users can locate public and private substance abuse treatment facilities in any state, city, or community anywhere in the Nation. Visit **http://findtreatment.samhsa.gov.**

To obtain a copy of the *National Directory of Drug and Alcohol Abuse Treatment Programs 2006,* call SAMHSA's Clearinghouse at 1 (800) 729-6686.

Treatment Protocol Focuses on Detoxification



SAMHSA's Center for Substance Abuse Treatment (CSAT) recently released Treatment Improvement Protocol 45 (TIP 45)—*Detoxification and Substance Abuse Treatment.*

Prepared by a consensus panel of experts in detoxification services, the TIP provides the clinical evidence-based guidelines, tools, and resources necessary to help substance abuse counselors and clinicians treat clients who are dependent on substances of abuse.

The new publication is a revision of TIP 19, *Detoxification From Alcohol and Other Drugs,* which was published by CSAT in 1995.

- **Urgent Needs.** TIP 45 emphasizes the importance of detoxification as one component in the continuum of health care services for substance-related disorders. It reinforces the urgent need for non-traditional settings—such as hospital emergency departments, medical and surgical wards, and acute care clinics—to be prepared to help get patients in need of detoxification services into treatment as quickly as possible.
- **Treatment Settings.** Matching patients to appropriate treatment settings presents a challenge to detoxification programs, given the wide variety of settings and the unique needs of individual patients. Matching patients' clinical needs with the appropriate care setting in the least restrictive and most cost-effective manner is a complex task.

Another challenge for detoxification programs is to provide effective linkages to substance abuse treatment services. Patients often leave detoxification without followup to the treatment needed to achieve long-term abstinence.

According to this TIP, each year, at least 300,000 patients with substance use disorders or acute intoxication obtain inpatient detoxification in general hospitals; additional numbers obtain detoxification in other settings. Only 20 percent of people discharged from acute care hospitals receive substance abuse treatment during that hospitalization. Only 15 percent of people who are admitted to a detoxification program through an emergency department, and then discharged, go on to receive treatment.

- **Medical and Non-Medical Management.** The consensus panel recognizes that medically assisted withdrawal is not always necessary or desirable. A non-medical approach can be highly cost-effective and provide inexpensive access to treatment for individuals seeking aid. The panel agreed on several guidelines for non-medical detoxification programs.

Management of withdrawal without medication may well serve young people in good health with no history of previous withdrawal reactions. However, supervisory personnel in non-medical settings should be trained to identify life-threatening symptoms and to solicit help through the emergency medical system as needed.

- **Protocols.** TIP 45 provides medical information on detoxification protocols for specific substances as well as considerations for individuals with co-occurring medical conditions including mental disorders. Although the TIP is not intended to take the place of medical texts, it provides practitioners with an overview of common medical complications seen in people who use substances.

The existence of co-occurring medical disorders also influences the setting in which detoxification occurs. It is highly desirable that primary care practitioners—physicians, physician assistants, and nurse practitioners—with some experience in substance abuse treatment assess people undergoing detoxification.

People with a history of severe withdrawals, multiple withdrawals, delirium tremens (a potentially fatal syndrome associated with alcohol withdrawal), or seizures are not good candidates for detoxification programs in non-medical settings.

- **Sensitivity.** Physicians, nurses, substance abuse counselors, and administrators are in a unique position to ensure a safe and humane withdrawal from substance abuse as well as to cultivate patients' entry into treatment. Regardless of their role in providing detoxification services, all personnel should keep in mind that patients undergoing detoxification are in the midst of a personal and medical crisis. For many patients, this crisis represents a window of opportunity to acknowledge their substance abuse problem and become willing to seek treatment.

The primary audiences for this TIP include substance abuse treatment counselors, administrators of detoxification programs, directors of single state agencies, psychiatrists, and other physicians working in the field.

To obtain TIP 45, *Detoxification and Substance Abuse Treatment,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Ask for NCADI No. BKD541. Online, TIP 45 is available at **www.kap.samhsa.gov/products/manuals/tips/numerical.htm.**

—By Riggin Waugh

Afghanistan, Iraq: SAMHSA Supports Mental Health Efforts

When Nahid Aziz, Psy.D., returned to her native Afghanistan this past May for the first time since she fled the Russian invasion at age 12, the most moving moment came during a visit to the reconstructed School of Medicine at Kabul University. She well remembered her many childhood visits there with her late father, a professor of medicine and one of Afghanistan's first western-trained physicians. The school had since been heavily damaged, and in the Taliban era, women had been excluded.

But this spring, nearly half the students on the rebuilt campus were women. A class of 300 new physicians was about to graduate. In the auditorium stands a commemorative wall listing the pioneers of modern medical care in Afghanistan. With deep emotion, Dr. Aziz saw among them the name of her father, Dr. Mohammad Hossein Nasrat.

But her return to Kabul was no mere sentimental journey. Dr. Aziz, a clinical psychologist and associate professor at Argosy University in Washington, DC, regards it as continuing her family's tradition of working for better health care for the Afghan people. She traveled there as a member of SAMHSA's delegation to an international conference, cosponsored by Afghanistan's Ministry of Public Health and SAMHSA. The conference focused on the continuing process of planning for the reconstruction of the nation's mental health system.

SAMHSA cosponsored two such conferences this spring. In addition to the one in Kabul, SAMHSA convened a meeting in Cairo for Iraqi health professionals. Other participants at that meeting included colleagues from Egypt's Ministry of Health and representatives from the World Health Organization (WHO). The WHO has played a significant role in the mental health training provided to Iraqis over the last several years.

The Cairo conference tracked the progress made since last year's similar, smaller meeting on Iraq in Amman, Jordan (see *SAMHSA News,* May/June 2005). All the meetings underscore SAMHSA's commitment to support the expansion of mental health services in both Iraq and Afghanistan.

At the only mental health hospital in all of Afghanistan, SAMHSA Administrator Charles G. Curie visited the kindergarten/day care center established for the children of employees. Some of the children are wearing traditional tribal garb.

Afghanistan

"Mental health is crucial to fostering a constructive relationship between health and development," Afghanistan's Minister of Public Health, S. Mohammad Amin Fatamie, M.D., told the more than 70 mental health professionals who gathered in Kabul from around the country. The 3-day meeting provided an opportunity to gather together representatives of several ministries of the Afghan government; international agencies including USAID, the WHO, and the United Nations; and the non-governmental organizations (NGOs) involved in providing mental health services.

"The Afghans are really looking at a time when the NGOs will [leave] and the Afghans will be providing services," said Winnie Mitchell, M.P.A., International Officer at SAMHSA. Much of the discussion in Kabul, therefore, centered on how the NGOs could train community health workers and staff, and also, in the longer term, on the curriculum and education needed at the Kabul medical school.

Training emerged as a crucial need of Afghanistan's mental health system because of the country's severe lack of mental health personnel, including, for example, "not one practicing psychiatrist," said Hussain Tuma, Ph.D., a consultant to SAMHSA who attended both the Kabul and Cairo conferences. Of the two qualified psychiatrists in the country, one works at a ministry and the other with an NGO. "The top people that we met are first rate," Dr. Tuma said, but far too few Afghans have had the opportunity to receive mental health training.

Formal presentations in Kabul focused on mental health services, substance abuse programs and—probably most significant—capacity building for mental health services. A major accomplishment of the conference, and of the breakout groups that did the work, was

prioritizing the strategies within Afghanistan's National Mental Health Plan and discussing specific next steps. Participants emphasized that the entire Afghan population has been exposed to violence but that women and children are most vulnerable. They also identified a need to develop screening methods for mental health and substance abuse problems and to define quality standards for psychosocial interventions.

Despite these challenges, participants emphasized that Afghan society possesses significant strengths in regard to mental health, especially the nation's strong faith and close-knit families. Particularly in times of trauma and loss, Dr. Aziz told *SAMHSA News*, Afghanistan's tradition of close and vigorous extended families provides bereaved or traumatized individuals far more emotional and practical support than is typically available elsewhere. The strength of this support has been a major element in the people's resilience over years of violence and oppression, she said.

Iraq

The effects of violence and trauma in Iraq were evident at the Cairo conference, participants told *SAMHSA News*. One could sense "hopelessness among the Iraqis at the beginning of the conference because of the challenges they are facing," said Husam Alathari, M.D., staff psychiatrist at the Northern Virginia Mental Health Institute in Falls Church, VA. An expatriate Iraqi, Dr. Alathari attended the conference as part of the SAMHSA delegation. "You can really sense that the Iraqis are very stressed out. On top of this, physicians have been a target for the insurgents." But as the week progressed, "everyone was very impressed by the amount of energy that was generated by the conference. There is a lot determination. They are not losing hope."

The keynote address by Iraq's National Advisor for Mental Health Sabah Sadik, MBCHB, FRCPsych, DPM, opened with a report on services, training, and research and policy accomplishments during the previous 12 to 18 months. These included finalizing Iraq's National Strategy for Mental Health; drafting and submitting to the government a much-needed national mental health law; aiding the establishment of a Child Mental Health Association; establishing a number of mental health clinics; arranging for the return to professional work of numerous experienced psychiatrists, psychologists, and social workers who had for a variety of reasons stopped working; and conducting a course for trainers of nurses in mental health, 1 of more than 50 training events involving more than 2,000 individuals.

In this Afghan government antidrug poster, poppies growing in a field are mowed down by a tractor. Because heroin and opium are derived from poppies, they are portrayed under a "devil" image with horns, claws, and black clothing.

"It was very impressive to see what people had achieved," Dr. Alathari told *SAMHSA News*. "Absolutely, progress had been made [that] was beyond our expectations." These accomplishments, he added, are "even more impressive given all these challenges" that Iraqi health professionals face.

Dr. Sadik's talk enumerated some of the challenges, including the need to encourage greater teamwork, re-establish professional and service standards, develop collaboration with institutions of higher learning that will enhance competence in the mental health professions, develop leadership training, and build an effective information system. "Sadly," he observed, the need to function in a poor security situation has "hindered" international support and contributions.

Nonetheless, optimism about the future of mental health care was high among the Iraqis present, said Dr. Alathari, who was last in Iraq in the early 1990s. At the conference, he spoke with a number of former colleagues and classmates from the days when he was receiving his education there. "They said, 'Fortunately, we have the best opportunity of any health system in the world. We can look at all the models, and we can design our own, starting from scratch.' At the same time, they have the opportunity to look at all the other challenges that other health systems have gone through and not repeat the mistakes." After "15 years of intellectual isolation, they want to catch up," Dr. Alathari continued. They relished "the opportunity to attend an international conference and interact with professional organizations."

"It was very evident that [the Iraqi participants] have a clear idea of how to re-establish mental health services in Iraq," Ms. Mitchell added.

Once the security situation improves, Dr. Tuma believes, progress on rebuilding Iraq's mental health system will be rapid.

In support of that process, "the conference has been very effective in enhancing team work, partnership, and collaboration," Dr. Sadik told *SAMHSA News*. "Delegates were relaxed, participated actively, and felt valued as colleagues and contributors. I am confident that the skills they acquired and the networking they established will make a significant impact in the short and long term."

Spending time in safety among supportive international colleagues proved a "sanctuary" for the Iraqi health professionals and provided them tremendous emotional support, said Dr. Tuma. "When you're working under stress, you don't know whether you want to go on. . . . But what these doctors and mental health professionals are doing in Iraq is important. As a group, we wanted to let them know that."

—By Beryl Lieff Benderly

Hurricane Recovery Guides Preparedness Planning

continued from cover page

More than 600 participants—state disaster management leaders, crisis counselors, researchers, first responders, consumers of mental health services, hurricane survivors, and others—gathered for the 3-day event to share ongoing challenges, take stock of last year's disaster response, and plan for the future.

"In the Gulf States and beyond, people have experienced profound change in this unprecedented disaster called Katrina," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "To be prepared for future disasters, we need to reassess our priorities at the regional and national levels, and then we need to take the results back home to our communities and continue to build a plan."

SAMHSA convened the summit to review lessons learned from the 2005 hurricanes, to improve and consolidate ongoing efforts to respond to mental health and substance use needs, and to build better preparedness and response plans for future disasters of any kind.

The basic principle of all-hazards planning is that each state's response to any disaster, natural or human-made, shares certain core elements. The commonality of language and format allows for improved communications among potential regional partnerships (see Disaster Readiness Resources, page 14).

"This summit is similar to the one SAMHSA held in New York City after the terrorist attacks of September 11," said conference emcee Kermit Crawford, Ph.D., Director, Center for Multicultural Mental Health, Boston University School of Medicine. "So we're moving forward by looking back." Dr. Crawford also participated in SAMHSA's disaster preparedness conference in 2003 (see *SAMHSA News,* summer 2003).

Laying the Groundwork

Effective disaster response planning begins with understanding human behavior. When drafting emergency plans, especially evacuation plans, officials must consider in advance how people are going to behave.

For example, in Texas during Hurricane Rita, "The state planned for an 'orderly evacuation,' with people leaving town in stages," said Dave Wanser, Ph.D., Deputy Commissioner, Behavioral and Community Health, Texas Department of State Health Services. "But everybody left all at once." Misreading the public's intentions could cost lives, Dr. Wanser said.

Furthermore, within jurisdictional lines, disaster response leaders should plan to establish social and health resources along probable evacuation and transportation routes. One mental health counselor in Shreveport, LA, described an unexpected challenge among evacuees from Hurricane Katrina. "We were able to offer food, clothing, and clinical assistance when survivors were staying in the emergency shelters," she noted. "But as evacuees were relocated to hotels or trailers, especially those that were not on bus lines, it was difficult to provide services. People couldn't get to us. Even worse, when we got to them, there was no privacy, no place to sit down and talk."

H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment, urged participants to consider substance abuse in their disaster planning. "There are people in recovery who may relapse, and people with no prior history of substance abuse who may turn to substances of abuse to cope," he said.

To make emergency shelters work at optimum levels, disaster planners should identify qualified counselors in the pre-disaster phase, well before disaster strikes. "We are hearing again and again that the day of a disaster, the phone rings off the hook with volunteers," said A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services. "But 2 weeks into the crisis, it's difficult to find people to help."

In addition, participants recommended the establishment of a central cross-state repository of qualified behavioral health service providers for deployment. This would necessitate cross-state credentialing, standardized trainings, mutual assistance systems, and other regional cooperative efforts.

Culture and heritage can affect levels of trust and attitudes toward authority, among other factors. For effective behavioral health planning, understanding local cultures is important in predicting how a disaster may affect a particular community.

Hurricane Katrina survivors Michael Patrick (right) and Maryann Powell began new lives after the hurricane. Mr. Patrick is now a crisis outreach worker for Project Recovery in Mississippi. Ms. Powell provides counseling services for Project Hope in Florida. See *SAMHSA News* online for other stories and photos.

"For example, if we have a lack of sensitivity about the community or if we're not aware," said Dr. Clark, "then we open shelters, but nobody arrives; we establish evacuation routes and pathways, but nobody follows them." Among issues requiring sensitivity, Dr. Clark included age, ethnicity, sexual orientation, disability, and HIV/AIDS status.

"With each new disaster, we learn more about the breadth of reactions and emotional responses that we must respect and incorporate into our work," said Ms. Power.

The Importance of Practice

At every level—local, state, and national—regular drills and tabletop exercises can help prepare staff for the unexpected and avoid mass confusion in the face of a crisis. Furthermore, conducting drills and exercises helps people learn incident command structures and how to get things done in the midst of chaos.

Robert Glover, Ph.D., said, "It's important to take the time to prepare well before the disaster hits." Dr. Glover, Executive Director, National Association of State Mental Health Program Directors, joined in a leadership panel with Dr. Wanser and Lewis Gallant, Ph.D., Executive Director, National Association of State Alcohol and Drug Abuse Directors.

Dr. Gallant and others emphasized the after a disaster. That documentation should include not only daily situation reports in the emergency response center, but also lists of resources, phone numbers, names, and written records of emergency shelter services (e.g., medicines, counseling) to promote continuity across shifts and throughout staff changeovers. As a historical record, the information also provides valuable guidance for workers responding to future disasters.

Presenters strongly encouraged conference participants to familiarize themselves with the Federal National Response Plan (NRP) and the National Incident Management System (NIMS). Acronyms and other terms included in these documents should be part of a disaster team's vocabulary, and the NRP and NIMS should serve as procedural models for setting up emergency response centers. (See Disaster Readiness Resources, page 14, for links to the NRP and NIMS.)

And for success at all levels, emergency response centers should train staff and volunteer providers on field interventions such as psychological first aid (see *SAMHSA News,* page 13).

Top Regional Challenges

Regional coordination, planning, partnerships, and response are complex ability to navigate interstate agreements, funding strategies, and licensing issues. Specific challenges include obtaining adequate supplies of medications such as treatments for opioid dependency, psychotropic medications, and other pharmaceuticals.

One of the barriers cited was the lack of opportunities for ongoing, face-to-face collaboration among disaster planning teams in neighboring states. To improve basic communications, recommendations included more Web-based communications, such as listservs and bulletin boards.

As Federal, state, and local agencies; advocacy organizations; consumer networks; peer support groups; and others continue to work together, synergy is created.

"One of the things we've learned," said Ms. Power, "is that no one agency is solely responsible for a disaster response. Hurricane Katrina taught us that more than anything. We need to draw on the strength and resilience of the entire community to make this work."

For more information about the conference, including a complete outline of regional and national priorities as well as downloadable PowerPoint presentations, visit SAMHSA's Web site at **www.samhsa.gov.**

—By Meredith Hogan Pond

Richard Campanelli, Esq. (left), Counselor to the Secretary for Human Services Policy at the U.S. Department of Health and Human Services, and SAMHSA Administrator Charles G. Curie (right) addressed participants at the Spirit of Recovery conference in New Orleans.

A. Kathryn Power, Director of SAMHSA's Center for Mental Health Services (left), and Dr. H. Westley Clark (right), Director of SAMHSA's Center for Substance Abuse Treatment, confer before a joint conference presentation.

Post-Disaster Response: Learning from Research

"It's reasonable to expect that we are going to have disasters time and time again. So it's essential to think critically now about how we can prepare ourselves for what history tells us is inevitable," said Sandro Galea, Ph.D., Dr.P.H., at the SAMHSA-sponsored "Spirit of Recovery" Conference in New Orleans in May. Dr. Galea, an associate professor of epidemiology at the University of Michigan School of Public Health, spoke as part of the panel titled, "Understanding and Addressing Mental Health and Substance Abuse Needs Over Time: What Research Tells Us."

The panel, moderated by Farris Tuma, Sc.D., M.H.S., Chief of the Traumatic Stress Disorders Research Program at the National Institute of Mental Health, presented the available information about the epidemiology of disaster-related trauma, the array of interventions, and the implications for the Gulf State populations affected by the fall 2005 hurricanes.

Dr. Matthew Friedman (left), Dr. Sandro Galea (center), and Dr. Farris Tuma (right), the panel moderator, talk with Spirit of Recovery conference participants after presenting their research findings.

Epidemiology

Dr. Galea emphasized that the majority of people in the proximity of the disaster are very resilient and do not develop psychopathology. To understand the impact of disasters, he said, "It's useful to conceptualize a hierarchy of persons affected."

The largest group in a pyramid of those affected is the general population. The next levels, in ascending order of proximity, are persons in the area of the disaster, rescuers, family members of those killed or injured, and people directly injured in the disaster (see Figure A).

Dr. Galea described a related pyramid for conceptualizing the psychological consequences of disasters (see Figure B). The emotional resilience of the majority of people forms the base. The next tier includes people who have concerns and may experience some behavior changes—a reaction that he said is normal. This tier is followed (again in ascending order) by people with non-specific psychological distress, individuals with acute stress disorder, those with short-term psychopathology, and those with long-term psychopathology.

According to this schema, the severity of the psychological consequences in the second pyramid corresponds to the level of proximity to the disaster in the first pyramid. Because of this, research results that might at times appear conflicting "are in fact different results for different groups," Dr. Galea said.

He also noted that the bulk of clinical and research resources "focus on the smallest group of people at the top of the pyramid."

Dr. Galea used data from a study he conducted after the March 11, 2004, terrorist train bombing in Madrid and from another study he conducted after the September 11, 2001, attacks in New York City to discuss differences in psychological response following each event. He attributed the much higher level of post-traumatic stress disorder (PTSD) in the general population of New York City to the highly visible nature of the 9/11 attacks and the fact that the attacks took place in a busy downtown area.

Dr. Galea also said that populations already stressed for any pre-existing reason—social, economic, or health-related—have a higher incidence of PTSD following a disaster. "The course of psychopathology is complicated after disasters," he said, indicating a need for more research.

Interventions

Matthew J. Friedman, M.D., Ph.D., Executive Director of the National Center for PTSD at the VA Medical Center in White River Junction, VT, focused his presentation on interventions for psychosocial distress following disasters.

He outlined a variety of possible psychosocial responses—including anger, fear, sleep problems, increased alcohol use or smoking, and social isolation, among others. He noted that PTSD is only one of many post-disaster responses.

Dr. Friedman emphasized the need to distinguish between the acute trauma response

that most people display and the acute trauma response that leads to chronic disorders.

"Virtually all PTSD symptoms are reported at very high rates in the initial weeks after trauma," he said, but "most people will adapt in the following 3 to 6 months."

For many years, the most commonly used intervention immediately after a disaster was *psychological debriefing,* based on the assumption that disclosure of emotions and thoughts has a beneficial result, he said. Debriefing usually takes place as a single, 1- to 3-hour session within 72 hours after trauma exposure. The affected person discusses the thoughts and emotions surrounding the event. The goal is to provide education, brief coping strategies, and referral information.

Despite its popularity, Dr. Friedman said, multiple studies have shown that there is no evidence that debriefing reduces PTSD, and other evidence has shown that it may cause some harm.

More recently, another intervention, *psychological first aid,* has received considerable attention. The goal of this intervention is to establish a sense of safety and security, connect the individual to restorative resources, and reduce stress.

Psychological first aid can be used immediately after the event or extended as needed, can be provided in single or multiple sessions, and can be adapted for use in group settings. Not yet tested empirically, the intervention is closer to the principle of "first do no harm" than to methods that use emotional processing.

Dr. Friedman also described *cognitive behavior therapy (CBT),* typically used several weeks after trauma for acute stress disorder. Following a traumatic event, acute stress disorder is characterized by dissociation, a re-experiencing of the event, avoidance behavior, and arousal.

Dr. Friedman cited study findings showing that individuals receiving CBT—typically given only to severely distressed individuals who meet diagnostic criteria for acute stress disorder—had better outcomes than those who received supportive counseling.

He briefly touched on the use of *pharmacotherapy* to reduce excessive stress responses, enhance inadequate stress responses, and promote rapid recovery of normal function—including immunologic function—which may be compromised by psychological stress.

For people who progress from acute distress to chronic PTSD, selective serotonin re-uptake inhibitors (SSRIs) such as Zoloft and Paxil have been found to be the best pharmacological treatment, he said.

New Orleans

Howard J. Osofsky, M.D., Ph.D., presented findings from work he and his wife, Joy D. Osofsky, Ph.D., performed in Louisiana following the fall 2005 hurricanes (see related article, *SAMHSA News,* p. 15). Dr. Howard Osofsky is a professor and chairman of the Department of Psychiatry at Louisiana State University Health Sciences Center, and clinical director of the SAMHSA-funded Louisiana Spirit program that provides supportive counseling to assist people with feelings of trauma, grief, and loss following the hurricanes.

Dr. Osofsky presented preliminary findings from his work with Louisiana Spirit, which handled 300,000 brief mental health contacts and 100,000 extended contacts with New Orleans residents following the hurricanes.

In conjunction with the SAMHSA-funded National Child Traumatic Stress Network, Dr. Osofsky and his co-workers performed a needs assessment and screening on more than 4,000 children. The survey sample included children of first responders living on cruise ships, children returning to

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FIGURE A

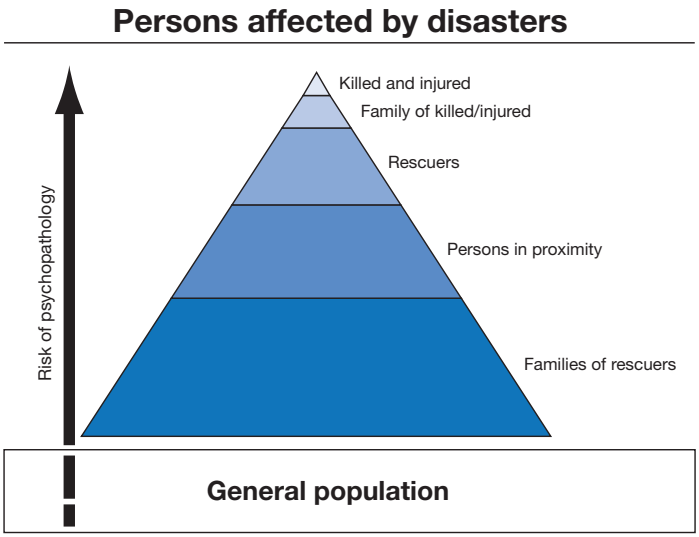
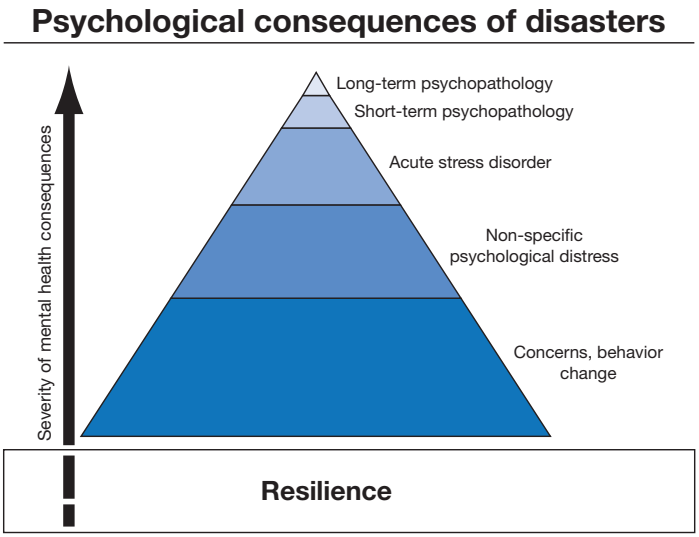


FIGURE B



To explain the impact of disasters, Dr. Sandro Galea created two related pyramids. The level of proximity to a disaster in the first pyramid corresponds to the severity of the psychological consequences in the second.

Post-Disaster Response: Learning from Research

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school in the devastated St. Bernard Parish, children returning to school in New Orleans, and displaced children in the Louisiana Rural Trauma Services Center located in St. John Parish.

He found that slightly more than half met the cut-off criteria for consideration for mental health referral. Approximately one-third showed PTSD symptoms, including talking repeatedly about the hurricane, experiencing upsetting thoughts, avoidance, and worry about the future. Approximately one-third showed depressive symptoms, including feelings of sadness, difficulty concentrating, and irritability.

Dr. Osofsky also collected data from 394 first responders in New Orleans and St. Bernard Parish, including police, firefighters, and emergency medical technicians. Almost all were separated from their families and most had witnessed death and/or injury.

Twelve percent reported symptoms of PTSD and 26 percent reported symptoms of depression. The higher percentage of first responders with depression likely stemmed from demoralization due to the continuing devastation, slowness of recovery, and economic and personal uncertainties, Dr. Osofsky suggested. Close to half of the first responders reported increased marital conflict and expressed a wish for mental health services.

All three presenters acknowledged the exponential impact of disasters on pre-existing disabilities, medical conditions, and immunologic function.

"Emergency room doctors in hurricane-affected areas have been swamped with patients," Dr. Osofsky said, citing an increase in cases of asthma. He also observed that a disproportionate number of elderly people had been dying.

Dr. Friedman cited the examples of diabetes worsening or hypertension increasing after a disaster. He added, "Social support is the best way to prevent trauma after a disaster."

Dr. Tuma said that excellent sources of social support—often overlooked—include commonality with other trauma survivors, the compassion of strangers, and the bonds of family.

For information and resources on the behavioral health impact of disasters and appropriate responses, see box below.

—By Deborah Goodman

Disaster Readiness Resources

Department of Health and Human Services
Information on Hurricane Katrina and all-hazards response
www.hhs.gov/emergency/index.shtml
www.hhs.gov/katrina

SAMHSA
Disaster Technical Assistance Center
www.mentalhealth.samhsa.gov/dtac
1 (800) 308-3515

Disaster Recovery Resources for Substance Abuse Treatment Providers
www.samhsa.gov/csatdisasterrecovery

Disaster Resources at a Glance for Relief Workers and First Responders
Hotline numbers, psychological first aid, treatment locators, etc.
www.mentalhealth.samhsa.gov/disasterrelief/pubs/manemotion.asp

Hurricane and Other Disaster Relief Information
www.mentalhealth.samhsa.gov/cmhs/katrina/pubs.asp

All-Hazards Response Planning for States (5 pages)
www.samhsa.gov/csatdisasterrecovery/preparedness/allHazardsResponsePlanningForState.pdf

Hurricane Mental Health Awareness Campaign
www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx

National Child Traumatic Stress Network
www.nctsn.org

Department of Veterans Affairs, National Center for Post-Traumatic Stress Disorder
www.ncptsd.va.gov

Psychological First Aid Manual
www.ncptsd.va.gov/pfa/PFA_9_6_05_Final.pdf

Department of Homeland Security
National Response Plan (NRP) full text (426 pages), brochure, quick reference guide
www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml

Federal Emergency Management Agency (FEMA)
The National Incident Management System
www.fema.gov/emergency/nims/index.shtm

Disaster Research Education and Mentoring Center
www.sph.umich.edu/drem

Schools Offer Stability for Children of Disasters

"Children are really happy to get back to school after a disaster," said Joy Osofsky, Ph.D., at the SAMHSA-sponsored "Spirit of Recovery" Conference in New Orleans in May. Dr. Osofsky, Professor of Pediatrics and Psychiatry at Louisiana State University Health Sciences Center, spoke as part of a panel, "Addressing the Needs of High-Risk Populations: Children and Adolescents."

The panel was facilitated by SAMHSA's Larke Huang, Ph.D., Senior Advisor on Children in the Office of the Administrator and former member of the President's New Freedom Commission on Mental Health. Panelists offered hands-on experiences and insights into how children respond and show resilience to traumatic events such as Hurricane Katrina, and how frontline providers can use strategies such as psychological first aid in the early response to children experiencing trauma.

New Orleans

"Resilience is the primary thing we're seeing in children now," Dr. Osofsky said, "But children are much more resilient if they have support from their family." Dr. Osofsky and her husband (see *SAMHSA News,* pages 13, 14) are part of the Louisiana Spirit Crisis Counseling program, which has served thousands of children and families in the New Orleans area since the hurricanes.

She reported that school enrollments in St. Bernard Parish have increased from 365 students in November 2005 when the schools re-opened to 2,300 students by the end of May 2006. "Many young people are graduating from their high schools, too," she said. (See related article below.)

Another panelist, Marleen Wong, Ph.D., agreed. "Parents serve as a protective shield for children in a disaster," she said. Dr. Wong is the Director of Crisis Counseling for the Los Angeles Unified School District. Dr. Wong's program is also a participating site in the SAMHSA-funded National Child Traumatic Stress Network (NCTSN). Through this network, she provided technical assistance to the New Orleans area after Hurricane Katrina.

Dr. Wong emphasized that schools provided the frontline of stability and services for children who were traumatized by evacuation, relocation, and readjustment after the hurricane. "Teachers are now becoming first responders," she said. "They need help and interventions as much as anyone."

The intersection between mental health and education is important, said Dr. Wong, citing one of the six recommendations of the President's New Freedom Commission. "We need to rebuild mental health services in schools," she said. "Teachers, school counselors, and social workers can play a part."

Austin, Texas

The panel also focused on how "receiving" communities, such as Austin, responded to children relocating from New Orleans after Hurricane Katrina. Enrollment in school offered these children their first chance at stability since the disaster occurred. With the end of the school year, however,

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Documentary Features New Orleans High School Seniors

Seniors at Benjamin Franklin High School in New Orleans are the subject of a documentary, Yearbook 2006 Project, which chronicles the school year after Hurricane Katrina. Some students were relocated to other cities and new schools, but others were determined to return to New Orleans to complete their studies and attend senior prom and graduation. The interactive Web site for the project is expected to be launched on the first anniversary of Hurricane Katrina, August 29, 2006.

At the Spirit of Recovery conference, documentary filmmakers Josh Goldblum (left) and Joshua Cogan (right) presented the video profile of Benjamin Franklin High School Senior Jordan Bridges (center).

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new challenges are emerging. "Our focus is shifting," said Jay Koonce, M.S.W., L.C.S.W., Clinical Director, Phoenix Academy, Austin, TX. "We're developing summer camps and providing continuing support and structure to 'in home' environments." Mr. Koonce served as a certified mental health responder for the Office of Emergency Management in Austin during the aftermath of Hurricane Katrina when the city hosted thousands of guests.

Organizing parents to help their children was important; however, approaching parents required sensitivity and respect. "Saying 'Want to come to a meeting on how to help your kids?' received a lot more positive and cooperative responses than 'We're having a therapy group,' " said Mr. Koonce. He noted that the stigma associated with therapy and counseling is still strong. People want to be perceived as competent, he said. "Two things we all need in life are to feel loved and to feel capable. Treating people with respect is what it takes."

After her presentation at the Spirit of Recovery conference, Dr. Marleen Wong (right) talks to Seth Hassett, Chief of the Emergency Mental Health and Traumatic Stress Services Branch at SAMHSA's Center for Mental Health Services.

For more information on this panel and others at the conference, including PowerPoint presentations, visit the SAMHSA Web site at **www.samhsa.gov.**

Note: Through NCTSN and the Louisiana Rural Trauma Services Center, Drs. Joy and Howard Osofsky have recently made available a booklet, *Helping Children and Families Cope with Hurricanes.* To access that publication in PDF format, visit **www.futureunlimited.org/katrina/Hurricane_Booklet2.pdf.**

—By Meredith Hogan Pond

Drug Abuse Linked to More than a Million Emergency Room Visits

A new SAMHSA report shows that among the nearly 2 million drug-related emergency department visits that occurred across the country in 2004, almost 1.3 million visits were associated with drug misuse or abuse.

The report, *Drug Abuse Warning Network, 2004: National Estimates of Drug-Related Emergency Department Visits,* reveals that 30 percent of the 1.3 million drug-related emergency room visits involved only illicit drugs; 25 percent involved only prescription or over-the-counter medications; 8 percent involved alcohol only in patients under age 21; 15 percent involved illicit drugs and alcohol; 8 percent involved both illicit drugs and pharmaceuticals; and 14 percent involved illicit drugs, pharmaceuticals, and alcohol (all three types of drugs in one visit).

According to the Drug Abuse Warning Network (DAWN), cocaine was involved in an estimated 383,350 visits to emergency rooms in 2004; marijuana was involved in 215,665 visits; heroin was involved in 162,137 visits;

stimulants, including amphetamines and methamphetamine, were involved in 102,843; and other illicit drugs such as PCP, Ecstasy, and GHB were involved with less frequency.

DAWN estimates that 495,732 visits to emergency rooms in 2004 related to non-medical use of prescription or over-the-counter pharmaceuticals. More than half of these visits involved more than one drug (57 percent). Opiate and opioid analgesics (prescription pain relievers) and benzodiazepines (anti-anxiety drugs) were the most frequent pharmaceuticals; they were involved in nearly one-third (32 percent and 29 percent) of non-medical-use visits.

The most frequently used of the prescription pain relievers were hydrocodone products (42,491 emergency room visits), oxycodone products (36,559 visits), and methadone (31,874 visits). Alprazolam (49,842 visits) and clonazepam (26,238 visits) were the most frequently used benzodiazepines.

DAWN measures alcohol in combination with illicit drugs for all ages, and alcohol alone in a patient under age 21, but not alcohol alone for those of legal drinking age. DAWN estimates show 96,809 emergency room visits involving alcohol for patients under age 21. There were 363,641 emergency department visits by persons of all ages involving the use of alcohol in combination with another substance.

For a copy of this report, call SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, visit SAMHSA's Web site at **http://dawninfo.samhsa.gov.**

SAMHSA Releases New Spanish-Language *Fotonovela*

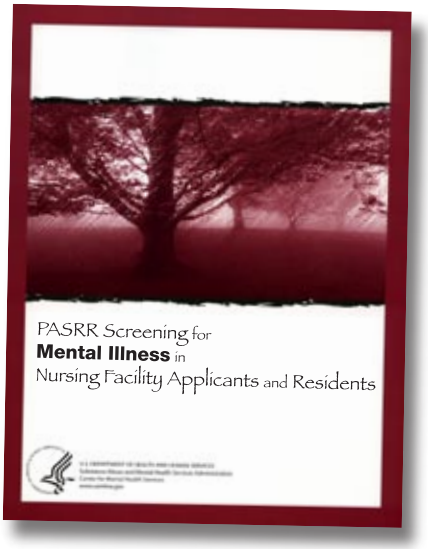
SAMHSA's Center for Substance Abuse Treatment has developed a new *fotonovela* in Spanish for the Hispanic community on finding the motivation to change. The *fotonovela* tells the story of Mario, a young Hispanic man who recently immigrated to the United States with his family.

Because of the pressures of leaving his country behind, learning a new language, and trying to fit in, Mario has turned more and more towards drinking as an outlet. It is not until an alcohol-related accident kills his best friend, injures Mario, and causes his girlfriend to break up with him that Mario is motivated enough to seek professional help. Thanks to the counseling and his family's support, Mario realizes that he indeed has a problem and is able to make positive changes in his life.

To obtain this publication, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Ask for NCADI No. PHD1133.

Screening for Mental Illness in Nursing Homes

Preadmission screening and resident review (PASRR) programs may help identify people with serious mental illness, according to recent findings in a new report from SAMHSA's Center for Mental Health Services. The report is called *PASRR Screening for Mental Illness in Nursing Facility Applicants and Residents.*



Medicaid regulations require states to maintain a PASRR program to screen nursing facility applicants and residents for mental retardation and serious mental illness in order to ensure that they are placed in the most appropriate setting and have access to specialized mental health services where suitable.

PASRR programs assess, through progressive screening, whether applicants have a mental illness and if the nursing facility is an appropriate placement.

The Level I test screens for potential mental illness. All who test "positive" must receive a more in-depth screen, Level II, which more accurately identifies the mental illness and assesses whether individuals need specialized services and nursing facility level of care.

The report is available from SAMHSA's National Mental Health Information Center. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 TDD.

September Is *Recovery Month!*

This September marks the 17th annual celebration of *National Alcohol and Drug Addiction Recovery Month (Recovery Month).* Across the Nation, communities will be participating in activities to acknowledge the efforts of individuals in recovery from substance use disorders and the ongoing support of their families and friends.

This year, *Recovery Month*'s theme is "Join the Voices for Recovery: Build a Stronger, Healthier Community." Events and activities will help raise awareness throughout the year about the effectiveness of treatment and recovery. Activities will also focus on how people are overcoming stigma, discrimination, and other barriers to treatment and recovery support services.

Toolkit Available

To help reach local audiences, SAMHSA's Center for Substance Abuse Treatment has created a comprehensive planning toolkit—available on the *Recovery Month* Web site—in conjunction with national planning partners, including treatment providers and other community organizations.

This toolkit includes promotional event ideas, planning instructions, and ways to speak effectively with the media.

To help encourage local media to cover *Recovery Month* activities, sample materials include a media advisory, a news release, and an "op-ed" opinion piece. In addition to the toolkit and news about *Recovery Month* events, the Web site provides media updates and archived Web casts.

Online, toolkit materials are available for download in PDF format. For a hard copy, call SAMHSA's Clearinghouse at 1 (800) 662-HELP. And for more information, visit **www.recoverymonth.gov.**

We'd Like To Hear From You!

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

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

Comments: _____

_____

_____

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Phone number: _____ Email address: _____

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

- ❑ Hurricane Recovery Guides Preparedness Planning
- ❑ Message from the Administrator: Reflections on Achievements, Future Directions
- ❑ Administrator Curie To Leave SAMHSA
- ❑ SAMHSA Expands Matrix
- ❑ Methamphetamine Jeopardizes Children's Welfare
- ❑ Curriculum on Restraint Reduction Available
- ❑ Treatment Directory Updated
- ❑ Treatment Protocol Focuses on Detoxification
- ❑ Afghanistan, Iraq: SAMHSA Supports Mental Health Efforts
- ❑ Post-Disaster Response: Learning from Research
- ❑ Disaster Readiness Resources
- ❑ Schools Offer Stability for Children of Disasters
- ❑ Drug Abuse Linked to More than a Million Emergency Room Visits
- ❑ In Brief . . .
- ❑ First Lady Reaches Out to Youth
- ❑ ***SAMHSA News*** online—for the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

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Thank you for your comments!

Photo by Mark Weber

First Lady Reaches Out to Youth

"Schools are at the heart of helping America's youth," said First Lady Laura Bush on a recent visit to a classroom of second graders in Albuquerque, NM. SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., joined her there to highlight the First Lady's Helping America's Youth Initiative.

To help children avoid risky behaviors like alcohol use, this elementary school is incorporating into its curriculum a SAMHSA Model program, started by Mothers Against Drunk Driving. This prevention curriculum, *Protecting You/Protecting Me,* is taught in more than 30 Albuquerque public elementary schools with nearly 400 teachers trained to use the program. A Spanish-language version of the curriculum is also available.

Protecting You/Protecting Me, created for grades 1 to 5, is a science-based program that shows students how alcohol affects the developing brain. The program also emphasizes safety skills.

Research shows that the risk for alcohol and drug use dramatically increases in the 6th grade, so it's important to reach children with meaningful, age-appropriate messages before they reach that decision point in life.

Mr. Curie also joined the First Lady and others in a roundtable discussion with 5th grade students on underage drinking.

The Community Guide to Helping America's Youth, part of the First Lady's Initiative, was introduced by Mr. Curie last year at the Helping America's Youth Conference (see *SAMHSA News,* November/December 2005). The guide helps communities assess their unique local needs and find programs and resources to meet them. Developed by several Federal agencies, the guide is available online.

This summer, regional conferences will convene to raise public awareness and give local leaders intensive, hands-on training with the Community Guide to Helping America's Youth.

This initiative emphasizes the importance of motivating caring adults to connect with youth in three key areas: family, school, and community. And forming "community coalitions" is an important step in reaching children who need help. Community coalitions bring together everyone in a community—teachers, mentors, pastors, parents, police officers, substance abuse experts, social service providers, and business leaders.

"Children want us in their lives, and children need us in their lives," said Mrs. Bush. "And as I've learned from the remarkable men and women I've met across our country, each of us has the power to bring hope and opportunity to children."

For more information on the First Lady's Helping America's Youth Initiative and the community guide, visit **www.helpingamericasyouth.gov.** For more information on SAMHSA's programs on children and families, visit the SAMHSA Web site at **www.samhsa.gov.**

First Lady Laura Bush (first row, second from right) visited a classroom in Albuquerque, NM, which is incorporating into its curriculum a program to help children avoid risky behaviors like alcohol use. SAMHSA Administrator Charles G. Curie joined the First Lady and students to talk about this SAMHSA model program, *Protecting You/Protecting Me,* started by Mothers Against Drunk Driving.

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