Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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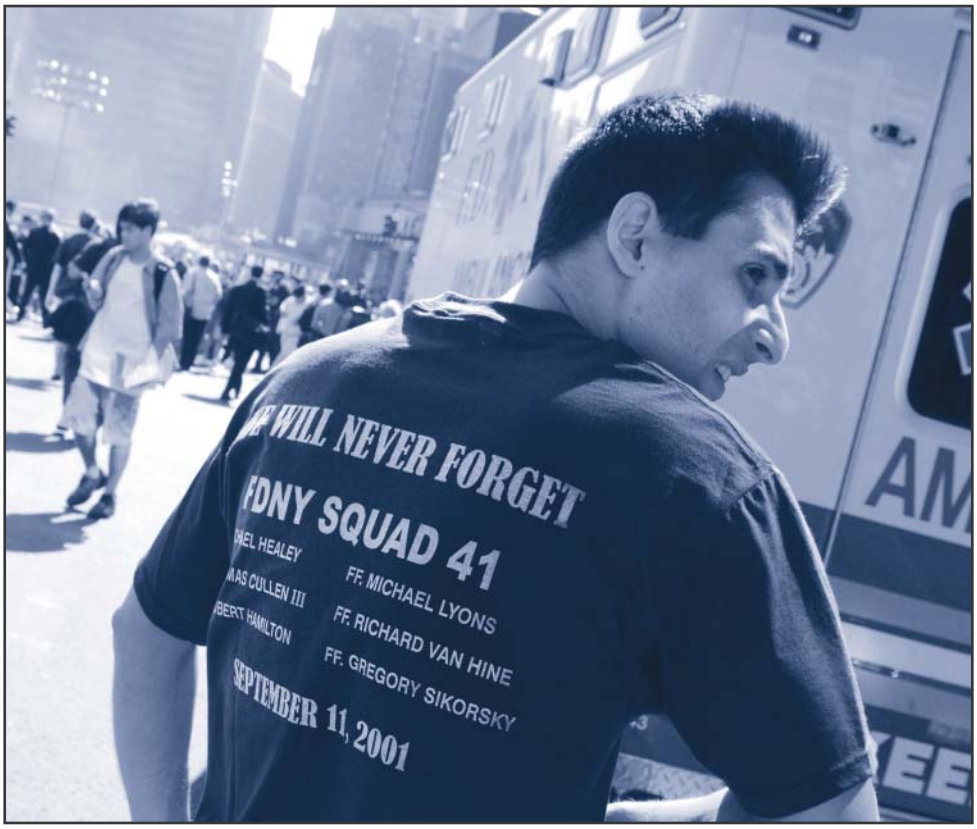
Disaster Preparedness: Mental Health & Substance Abuse

The tragic loss of life from the terrorist attacks on September 11, 2001, was but one outcome of that day's horrendous events. Many people close to the disaster experienced flashbacks, feelings of anxiety and depression, and even Post-Traumatic Stress Disorder. For the mental health and substance abuse treatment communities, and for SAMHSA, these events presented both a challenge and a call to action.

It was a challenge that SAMHSA answered many times before—in the aftermath of the Oklahoma City bombing and natural disasters such as floods and hurricanes—by organizing services to address mental health needs and prevent possible substance abuse in response to severe emotional stress.

But the events of September 11—and the anthrax incidents that followed—highlighted the need to be prepared to respond immediately, nationwide, to disasters of a nature and scale unprecedented in the United States.

The U.S. Department of Health and Human Services (HHS) responded swiftly with funding and staff support for states affected most by the September 11 attacks. HHS—assisted by SAMHSA—also hosted a national summit just 2 months after the attacks that sparked a dialogue on the unique planning needs of state mental health and substance abuse authorities related to these new, complex threats to communities and citizens.



New York firefighter Chris Agazzi at a 9/11 Observance at Ground Zero, September, 11, 2002. Photo by Andrea Booher/Federal Emergency Management Agency (FEMA) News Photo.

It proved to be just the beginning of a series of initiatives by SAMHSA on planning for mental health needs as part of disaster preparedness.

"Emergency preparedness is central to everyone's health," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "It's an area where SAMHSA will continue to invest financial, policy, and human resources. And we welcome the chance to help states focus on

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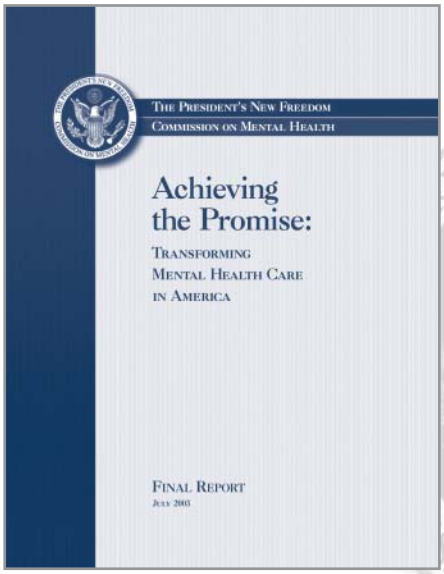
President's Commission Recommends Transforming Mental Health System

President George W. Bush's New Freedom Commission on Mental Health issued its final report, *Achieving the Promise: Transforming Mental Health Care in America,* as part of a week-long recognition in July of the anniversary of the Americans with Disabilities Act. The product of a year of study, the report finds that the Nation's mental health care system is beyond simple repair.



Building on research, expert testimony, and input from over 2,300 consumers of mental health services, family members, service providers, and others, the report concludes that "traditional reform measures are not enough. . . ." Instead, it recommends a wholesale transformation that involves consumers and providers, policymakers at all levels of government, and both the public and the private sectors.

Commission Chair Michael F. Hogan, Ph.D., Director of the Ohio Department of Mental Health, declared, "The time has long passed for yet another piecemeal approach to mental health reform. For too many Americans with mental illnesses, mental health services and supports they need are disconnected and often inadequate. The Commission has found that the time has come for a fundamental transformation of the Nation's approach to mental health care."

He added, "This report provides the President with a roadmap for that transformation. The destination is recovery. We ask consumers, family members, service providers, other members of the mental health community, and all Americans to join us on that journey."

The Commission finds that the current system is unintentionally focused on managing the disabilities associated with mental illness rather than promoting recovery, and that this limited approach is due to fragmentation in the provision of services, gaps in care, and uneven quality of services. These systems problems frustrate the work of many dedicated staff, and make it much harder for people with mental illness and their families to access needed care. Instead, the Commission recommends a focus on promoting recovery and building resilience—the ability to withstand stresses and life challenges.

The approach recommended by the Commission will move toward full community participation for children and youth, adults, and older Americans with mental illnesses—instead of school failure, institutionalization, long-term disability, and homelessness. The Commission presents the President with six goals and a series of specific recommendations for Federal agencies, states, communities, and providers nationwide. Working through both the public and private sectors, the recommendations would achieve the needed transformation in care and put limited resources to their best use.

Commission goals underscore the urgency and magnitude of the proposed changes. The Commission believes that Americans must come to understand that mental health is integral to their overall health, and recommends that mental illnesses be addressed with the same urgency as other medical problems. The stigma attached to mental illness, which discourages people from seeking care, must be eliminated.

The Commission finds that transforming mental health care demands a shift toward consumer- and family-driven services. Consumers' needs and preferences, not bureaucratic requirements, must drive the services they receive. To achieve that goal, the Commission recommends changing Federal programs, upgrading state responsibility for planning effective services, and placing consumers and their families at the center of service decisions.

Members of minority groups and people in rural areas, the Commission finds, have less access to care and often receive services that are not responsive to their needs. As a

result, the burden of mental illness is heavier for these individuals. The Commission urges a commitment to services that are "culturally competent"—acceptable to and effective for people of varied backgrounds.

The Commission's review finds that too often, mental illness is detected late not early. As a result, services frequently focus on living with disability, not the better outcomes associated with effective early intervention. Therefore, the Commission recommends a dynamic shift in care, moving toward a model that emphasizes early intervention and disability prevention. The report notes that, "early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating."

Achieving this goal will require greater engagement and education of first-line health care providers (e.g., primary care practitioners) and a greater focus on mental health care in institutions such as schools, child welfare programs, and the criminal and juvenile justice systems. The goal is integrated care that can screen, identify, and respond to problems early. The Commission also notes that a majority of adults—even those with the most serious mental illness—want to work, but they are held back by poor access to effective job supports, incentives to remain on disability status, and employment discrimination.

The Commission finds that effective services and supports validated by research find their way into practice too slowly. It calls for a more effective process to make evidence-based practices the bedrock of service delivery. This will require that payers of mental health care reimburse such practices, and that universities and professional groups support training and continuing education in research-validated interventions. Acknowledging significant progress in research on mental illnesses, the panel urges the elimination of the 15- to 20-year lag between the discovery of effective treatments and their wide use in routine patient care. It highlights the need for accelerated and relevant research to promote recovery and, ultimately, to cure and prevent mental illnesses.

The Commission recommends that the mental health system move more effectively to harness the power of communications and computer technology to improve access to information and care, and to improve quality and accountability. With strong protections for privacy, these technologies can improve care in rural areas, help prevent medical errors, and reduce paperwork.

Throughout the report, the Commission identifies private and public sector model programs that provide examples of how aspects of mental health care have been transformed in selected communities.

These examples of innovation—across America, across the age span, and addressing many needs—illuminate how dramatic change is possible, and serve as beacons for the broader improvements recommended by the Commission.

Responding to the release of the report, U.S. Health and Human Services (HHS) Secretary Tommy G. Thompson said, "Under the leadership of Charles G. Curie, the Administrator of our Substance Abuse and Mental Health Services Administration, HHS will conduct a thorough review and assessment of the recommendations in this report. This work will be important not only in improving our service to those with mental illness and their families, but also as part of our commitment to make every segment of the Nation's health care system work better and work together for all Americans."

Mr. Curie added, "It is SAMHSA's honor to have been asked by Secretary Thompson to undertake the Administration's first review and response to this historic document. The report reminds us that mental illness is a treatable illness and that recovery is possible. As a compassionate Nation, we cannot afford to lose the opportunity to offer hope to those people fighting for their lives to obtain and sustain recovery."

The President's New Freedom Commission on Mental Health was established by Executive Order 13263 on April 29, 2002 (See *SAMHSA News,* Volume X, Numbers 2, 3 and 4). The Commission's work has been an essential part of the President's commitment—embodied in the New Freedom Initiative—to eliminate inequality for Americans with disabilities. With presentation of the report to the President, the charge to the Commission has been fulfilled.

Additional information about the Commission and both its interim report and final report are available online at **www.MentalHealthCommission.gov.** Print copies of the Commission's final report can be obtained by contacting SAMHSA's National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or, visit **www.mentalhealth.samhsa.gov.**

Goals In a Transformed Mental Health System

Goal 1 Americans understand that mental health is essential to overall health.

Goal 2 Mental health care is consumer- and family-driven.

Goal 3 Disparities in mental health services are eliminated.

Goal 4 Early mental health screening, assessment, and referral to services are common practice.

Goal 5 Excellent mental health care is delivered and research is accelerated.

Goal 6 Technology is used to access mental health care information.

Source: *Achieving the Promise: Transforming Mental Health Care in America.* 2003.

Rise in Drug-Abuse-Related Narcotic Pain Medications Seen in Emergency Rooms

Narcotic pain medications implicated in drug-abuse-related emergency room visits rose 20 percent from 2001 to 2002, according to new estimates from SAMHSA's Drug Abuse Warning Network (DAWN). Emergency department mentions of narcotic pain medications rose from 99,317 in 2001 to 119,185 in 2002. The rise from 2000 to 2002 was 45 percent.

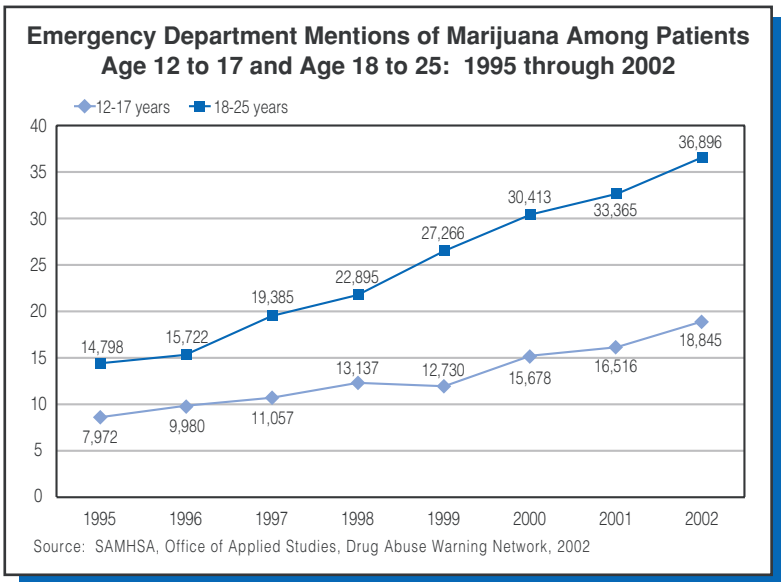
The 2002 DAWN estimates 670,307 drug-abuse-related hospital emergency department visits in the continental United States in 2002—about the same as drug-abuse-related visits in 2001.

In DAWN, a single drug abuse visit may include multiple drug "mentions" as many persons are poly-drug users. On average, each visit involved 1.8 drug mentions.

DAWN measures mentions of specific illicit, prescription, and over-the-counter drugs that are linked to drug abuse in visits to hospital emergency departments. It relies on a sample of hospital emergency departments chosen to represent hospitals nationally and in 21 metropolitan areas. In 2002, 437 hospitals participated in DAWN.

"We must educate the public about the dangers of misuse of prescription medications," said U.S. Health and Human Services Secretary Tommy G. Thompson. "We must continue to strengthen our prevention programs and build substance abuse treatment capacity so that people don't abuse drugs and tax the medical and economic resources of our emergency departments."

The new DAWN data show that emergency department mentions of marijuana increased 24 percent from 2000 to 2002. This is especially noteworthy because in the past, marijuana was frequently reported along with other drugs. Now, the number of visits for only marijuana rose 45 percent from 2000 to 2002. Over the same 2-year period, emergency department mentions of LSD dropped 78 percent but mentions of PCP rose 42 percent.



"This report proves that marijuana is more harmful than many people think," said White House Director of National Drug Control Policy John Walters. "The rising levels of marijuana potency that we've seen over the last several years correspond with dramatic increases in people seeking emergency medical care for marijuana-related incidents. But the huge decline in LSD mentions serves as a lesson that when we push back against a drug problem with a balanced supply-and-demand-reduction strategy, we save lives."

"One life corrupted by drug use is one too many. Effective prevention and treatment programs are key to helping reduce the needless waste of health, justice, and economic resources that results from abuse of drugs," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We are working with states and local drug treatment providers to build treatment capacity. SAMHSA expects that President Bush's new Access to Recovery program will be key to those efforts to provide treatment."

There was a dramatic 84-percent decline in mentions of LSD from 1995 to 2002, but there was a resurgence in visits involving PCP, particularly in Philadelphia and Washington, DC. The two most frequently mentioned substances—alcohol-in-combination with other drugs, and cocaine—were stable over the past 2 years; the rapid growth seen previously for emergency department visits involving Ecstasy and GHB has waned.

The six most frequently mentioned drugs of abuse in the 2002 DAWN were alcohol-in-combination with another drug, cocaine, heroin, marijuana, anti-anxiety drugs (benzodiazepines), and narcotic painkillers. Together, they accounted for 7 of every 10 drug mentions in drug-abuse-related emergency room visits in 2002.

DAWN estimates there were significant increases in emergency room visits related to drug abuse in 3 of the 21 metropolitan areas surveyed in DAWN: New Orleans (increased 22 percent from 2001 to 2002 from 3,729 visits to 4,566); Buffalo (increased 15 percent from 3,356 to 3,844 in 1 year); and Baltimore (an 11-percent increase in drug-abuse-related visits to hospital emergency

departments from 11,625 in 2001 to 12,904 in 2002). Significant decreases in drug abuse visits were found in Dallas and San Diego.

Results by Drug

Marijuana: Marijuana mentions in hospital emergency rooms increased from 19 to 47 mentions per 100,000 population from 1995 to 2002, with the increase affecting patients in all age groups. Increases in marijuana mentions were evident in Newark, Miami, and Baltimore. Decreases occurred in Dallas, San Francisco, Chicago, and Seattle.

Prescription Drugs: Abuse of anti-anxiety drugs (benzodiazepines) and narcotic pain relievers were each mentioned as often in hospital emergency rooms as heroin or marijuana in 2002, but ranked below mentions of cocaine and alcohol. Together, anti-anxiety drugs (benzodiazepines), antidepressants, and narcotic pain medications constituted 287,572 emergency department mentions in 2002, or 24 percent of total emergency department drug mentions. Narcotic pain medications accounted for 10 percent of total drug mentions in hospital emergency department visits related to drug abuse in 2002. Over the 8-year period from 1995 to 2002, mentions of narcotic pain medications rose 163 percent from 45,254 to 119,185.

Cocaine: Cocaine mentions were statistically unchanged from 2001 to 2002, but have increased 47 percent since 1995, from 135,711 to 199,198 in 2002. Over one-fifth of the cocaine mentions in 2002 were attributed to crack.

Heroin: Heroin mentions were statistically unchanged from 2001 to 2002, but increased 35 percent since 1995 from 69,556 to 93,519 in 2002. There were increases in heroin mentions in Seattle, Buffalo, Denver, and Baltimore and decreases in mentions in Dallas, Phoenix, and San Diego.

Methamphetamine: Amphetamines and methamphetamine accounted for 39,340 mentions in hospital emergency departments in 2002. There was no statistical change from 2001 to 2002, but these mentions have increased 54 percent since 1995 when there were 25,515 mentions. Mentions of amphetamines and methamphetamine were concentrated in six metropolitan areas in the western United States: San Francisco, San Diego, Phoenix, Seattle, Los Angeles, and Denver. There were large increases in St. Louis, Minneapolis, and Atlanta, as popularity of the drug moves eastward.

Ecstasy, GHB, PCP, and LSD: Increasing trends in emergency department mentions of Ecstasy (MDMA) and GHB appear to have leveled off with GHB mentions lower in 2002 than in 2000, dropping from 4,969 to 3,330. PCP mentions in emergency rooms increased 28 percent from 1995 to 2002. There was a 42-percent increase from the 5,404 seen in 2000 to 7,648 in 2002. There were significant increases in PCP mentions in Washington, DC; Newark; Philadelphia; Baltimore; and Dallas. Chicago had a decrease in mentions of PCP, declining 48 percent from 874 in 2001 to 459 in 2002. Estimates of LSD mentions in emergency rooms decreased, with 12 of 21 surveyed metropolitan areas posting declines.

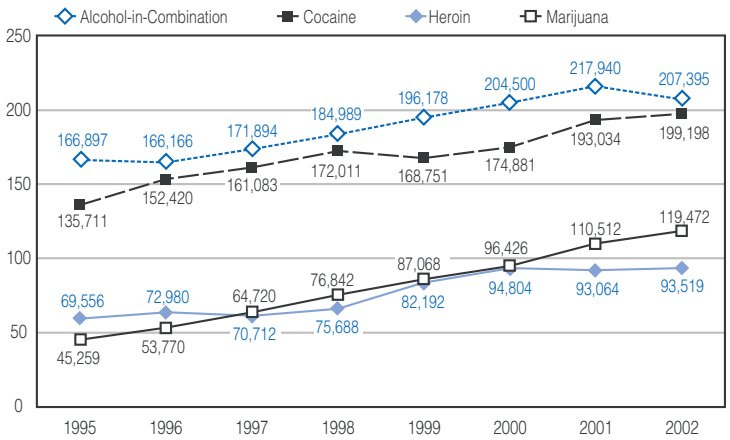
Inhalants: Mentions of inhalants in emergency rooms increased 187 percent from 522 in 2001 to 1,496 in 2002, but show no consistent pattern from year to year. Denver was the only metropolitan area, among 21 surveyed, to exceed 50 mentions of inhalants in 2002.

Alcohol-in-Combination with Other Drugs: Mentions of alcohol-in-combination with another drug, while statistically unchanged from 2001 to 2002, have increased over the long term—from 1995 to 2002—by 24 percent, from 166,897 to 207,395. Significant increases were found in Seattle, Buffalo, New Orleans, and Baltimore. Decreases were noted in Dallas, Denver, Phoenix, and San Francisco.

Demographics of emergency department drug-abuse-related visits indicate increases for patients age 18 to 25 from 127,110 to 140,475 from 2001 to 2002. This compares to an increase from 88,540 to 101,541 in the age group 45 to 54, and an increase from 26,036 to 30,987 in the age group 55 and older.

To obtain a copy of the report, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The full report, as well as detailed tabulations for each of the 21 metropolitan areas, are also available online at **http://DAWNinfo.samhsa.gov.**

Emergency Department Mentions of Alcohol-in-Combination, Cocaine, Heroin, and Marijuana: 1995 through 2002



Source: SAMHSA, Office of Applied Studies, Drug Abuse Warning Network, 2002

Minority Fellowship Program Extends Training, Expands Treatment

Social worker Blanca E. Alvarado, M.S.W., has seen firsthand the misunderstandings that can occur when white health care professionals treat racial/ethnic minority patients. For example, while working in a domestic violence clinic, she was told by one of her colleagues that a Latina client was pathologically dependent. The evidence? Her mother lived with her.

"If that counselor understood our culture, she would know that we do whatever we can to keep our families together," said Ms. Alvarado, now a doctoral student in sociology and social work at Boston University. "Through all the troubles the patient was having, she was able to keep her family together. But instead of being seen as a strength, it was seen as a weakness."

Now Ms. Alvarado and other participants in SAMHSA's Minority Fellowship Program are working to decrease the occurrence of such misunderstandings. Celebrating its 30th anniversary this year, the program enables the Council on Social Work Education, American Psychological Association, American Psychiatric Association, and American Nurses Association to recruit and support racial/ethnic minority students interested in doctoral and postdoctoral programs in the areas of mental health and substance abuse. SAMHSA also funds the Jeanne Spurlock Minority Medical Student Clinical Fellowship in Child and Adolescent Psychiatry at the American Academy of Child and Adolescent Psychiatry.

"The Minority Fellowship Program's goal is to facilitate the entry of ethnic minority students into mental health and substance abuse treatment training and increase the pool of minority professionals who can become leaders in the field, train the next generation, and provide services to underserved populations in our increasingly diverse society," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "The Program addresses many of SAMHSA's priorities, including cultural competency, workforce development, and co-occurring disorders."

The Program is supported by each of SAMHSA's three Centers.

Cultural Differences

Linguistic differences are the most obvious barrier to services. "You cannot deliver behavioral health services when you cannot speak the client's language," said Minority Fellowship Program Project Officer Paul Wohlford, Ph.D., a psychologist in the Division of State and Community Systems Development within SAMHSA's Center for Mental Health Services. "Having bilingual interpreters is only a partial solution. It's best to have someone who speaks the same language and understands the client's culture."

But cultures also differ at more fundamental levels. Asian Americans, for example, are often reluctant to talk openly with counselors, explained former Senior Program Manager Linda Roll, M.A., of the American Psychiatric Association. Cultures also differ in the way they define mental illness.

"People from the Philippines tend to be very superstitious," noted Ms. Roll, a Filipina herself. "I might say 'I saw my father's ghost.' Someone who's not familiar with our culture might think I'm nuts!"

And treatment traditions may be very different. Some Latinos, for example, may prefer to seek help from folk healers known as *curanderos* rather than from credentialed service providers.

Such differences can result in under-utilization of services for mental health and substance abuse, even when such services are available. "When institutions are perceived as culturally sterile or racially dissimilar, people don't go," explained James M. Jones, Ph.D., Director of the American Psychological Association's Minority Fellowship Program and a professor of psychology at the University of Delaware in Newark. "It doesn't make sense that people would want to go to an alien environment for help of the most intimate and sensitive nature."

According to Dr. Jones, incidents like the infamous Tuskegee Syphilis Study of 1932-1972—in which the U.S. Public Health Service studied the disease in almost 400 poor African American men without obtaining their consent, informing them of their diagnoses, or offering treatment—have fueled that mistrust.

Expanding Opportunities

It can be just as difficult to get racial/ethnic minority students to consider careers in the mental health and substance abuse fields. Like patients considering their health care options, minority students may view training programs as culturally alien. Racial/ethnic minority students may also have fewer financial resources and greater responsibilities, said Faye A. Gary, Ph.D., R.N., F.A.A.N., Ohio Medical Mutual Professor of Nursing for Vulnerable and At-Risk Populations at Case Western Reserve University in Cleveland, OH, and chair of the American Nurses Association committee responsible for the Minority Fellowship Program. "Especially with blacks, Hispanics, and Native Americans, we find that Fellows are not only responsible for their immediate families but often for their mothers, grandmothers, aunties, sisters' children, and others as well."

The Minority Fellowship Program is designed to address these and other concerns. Although each professional society recruits its own Fellows and administers the Program a little differently, all Fellows receive a stipend that helps pay their expenses during training. Depending on the availability of funds, they may also receive tuition assistance and travel grants that allow them to attend professional meetings.

The networking that the Program facilitates is almost as important as the financial support, said E. Aracelis Francis, D.S.W., Director of the Minority Fellowship Program at the Council on Social Work Education. "The fellowship helps students network with each other so they're not as isolated as they generally are," she said. "That's especially important when you're the only person of color in a doctoral program."

Conferences, newsletters, listservs, and online chats give Fellows a sense of community. The first SAMHSA Minority Fellowship Program national conference convenes in Washington, DC, this September. Organizers anticipate that all 90 current Fellows as well as a large number of former Fellows will attend.

Ensuring that all Fellows receive training to address substance abuse as well as mental health has become a priority in recent years.

"We've been energetically trying to make them aware of substance abuse as a field so they'll have another choice of career after they've completed their fellowships," said Thomas Edwards, M.A., Chief of the Systems Improvement Branch of SAMHSA's Center for Substance Abuse Treatment.

Dr. Wohlford adds, "Our goal is not only to train Fellows to practice in both fields—mental health and substance abuse—but also to equip them to treat individuals with co-occurring mental and addictive disorders."

Reaching students even earlier in their education is another priority. To achieve that goal, SAMHSA helps fund the American Academy of Child and Adolescent Psychiatry's minority medical student program. The program allows Fellows to carry out a clinical research project for up to 12 weeks with a child and adolescent psychiatrist mentor and to present their research findings at the Academy's annual meeting.

"One of the real benefits is that it turns people on to the excitement of child psychiatry, even when they weren't originally disposed toward child psychiatry or even psychiatry in general," said Virginia Q. Anthony, American Academy of Child and Adolescent Psychiatry Executive Director.

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The American Psychiatric Association and American Psychological Association have launched similar programs designed to attract students to behavioral health.

Three Decades of Success

Since its inception in 1973, the Minority Fellowship Program has helped train nearly a thousand racial/ethnic minority psychiatrists, psychologists, psychiatric nurses, and social workers. Today, many of these professionals serve in key leadership positions in academia, Government, and direct service.

Marketa M. Wills, M.D., one of the American Psychiatric Association's current Fellows, hopes to follow in the footsteps of these Program alumni.

Dr. Wills isn't just using her Minority Fellowship Program award to fund her training in the Massachusetts General McLean Adult Residency Training Program. The funding also allowed her to establish a small mental health clinic within the Dimock Community Health Center in Dorchester, the heart of Boston's African American and Latino community. Supervised by a psychiatrist, she sees racial/ethnic minority patients with chronic mental illness and substance abuse. In addition, she and another Minority Fellowship Program recipient are planning a lecture series on minority mental health they hope will eventually become a book.

Dr. Wills' long-term goals include becoming the administrator of a state or local department of mental health, getting involved in policy issues affecting children, and continuing to practice at least 1 day a week—exactly the kind of future the Minority Fellowship Program is designed to promote.

For more information, visit **www.mentalhealth.samhsa.gov/publications/allpubs/NMH02-0143/default.asp.**

—By Rebecca A. Clay

Initiative Counters Stigma and Discrimination

SAMHSA recently launched an Elimination of Barriers Initiative in eight states: California, Florida, Massachusetts, North Carolina, Ohio, Pennsylvania, Texas, and Wisconsin. The Initiative is a 3-year effort aimed at identifying effective public education approaches to combat the stigma and discrimination associated with mental illnesses.

"All Americans must understand that mental illnesses are illnesses that can be diagnosed reliably and treated effectively, and that recovery is possible," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Sadly, misconceptions about mental illness continue, and many people hide their symptoms and avoid treatment. The Elimination of Barriers Initiative is designed to help more Americans understand the facts surrounding mental illness, reduce stigma, and increase their willingness to seek help for mental health problems."

The Initiative, funded with $5.4 million over 3 years, will allow for a series of meetings in each state to reach consensus on steps to reduce the stigma associated with mental illness. Strategies developed by the Initiative are expected to focus on opportunities for action in schools and businesses.

In any given year, about 5 to 7 percent of adults have a serious mental illness, according to several nationally representative studies. A similar percentage of children, about 5 to 9 percent, have a serious emotional disturbance. The annual prevalence figures translate into millions of adults and children disabled by mental illness. Almost half of these individuals do not seek treatment, in part because of the shame associated with mental illnesses in American society.

The President's New Freedom Commission on Mental Health—whose goal is to recommend improvements to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities—has identified stigma as one of the major barriers to mental health care in America. (See *SAMHSA News,* Volume X, Number 4; and Volume XI, Number 2.)

> *"All Americans must understand that mental illnesses are illnesses that can be diagnosed reliably and treated effectively, and that recovery is possible."*
>
> *—Charles G. Curie*
> *SAMHSA Administrator*

To launch the Initiative, a state partnership meeting will take place in each of the target states. This meeting will provide an overview of the Elimination of Barriers Initiative, as well as a public forum for stakeholders and other interested parties to discuss ways to counter stigma and discrimination. This input will then be used to make the Initiative more effective.

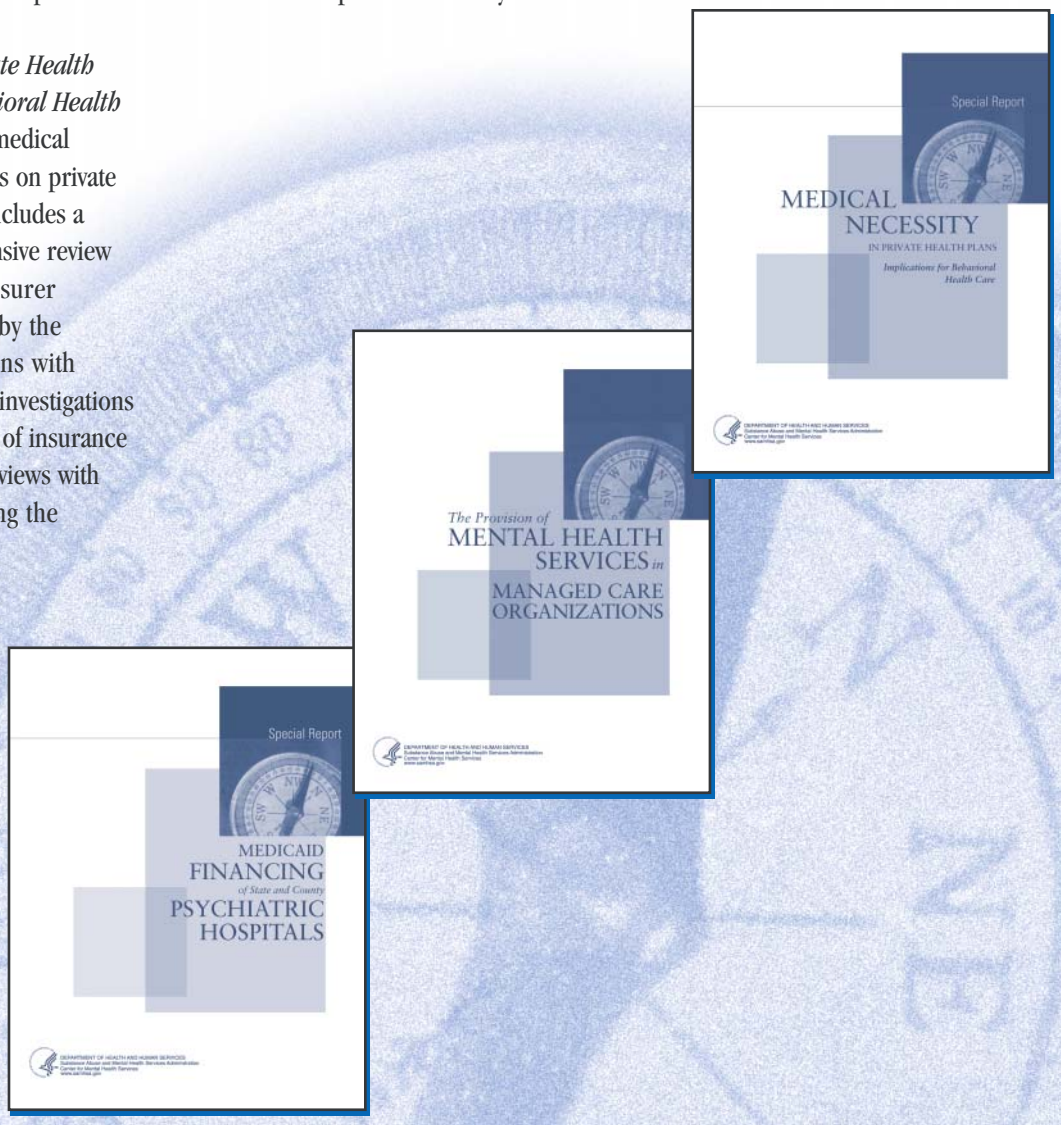
For more information, contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or, visit **www.mentalhealth.samhsa.gov.**

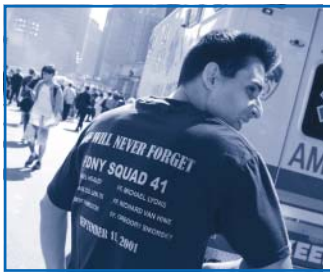
Publications Available on Financing of Mental Health Services

SAMHSA recently published three reports that examine public and private sector financing of mental health services.

- *The Provision of Mental Health Services in Managed Care Organizations* reports on a nationally representative survey of managed care organizations that examined how mental health services were provided in 1999 and how the provision varied by product type and contracting arrangement. The publication describes the prevalence and characteristics of different methods that managed care organizations use to provide behavioral health care.
- *Medical Necessity in Private Health Plans: Implications for Behavioral Health Care* addresses how the term "medical necessity" is defined in decisions on private health insurance coverage. It includes a review of the literature, an extensive review of legal cases that challenge insurer decisions, materials prepared by the insurance industry, consultations with experts in the field, a review of investigations conducted by state departments of insurance and attorneys general, and interviews with health care executives regarding the decision-making process.
- *Medicaid Financing of State and County Psychiatric Hospitals* addresses the lack of comprehensive information on the nature and scope of Medicaid support for individuals in psychiatric institutions. The study identifies potential sources of Medicaid funds paid on behalf of public psychiatric hospitals, and provides an estimate of the amount of such funds in 2001. The Medicaid funding experiences of public psychiatric hospitals in five states—Arkansas, California, Iowa, Maryland, and New Jersey—were examined in depth for this study.

For copies of the publications, contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or, visit **www.mentalhealth.samhsa.gov.**





Disaster Preparedness

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preparedness so they can tell the people they serve that, come what may, they'll be ready."

Strengthening States

The key to responding efficiently and effectively to disasters depends on the ability of each state, territory, and community of the United States to respond both individually and as part of a network.

"SAMHSA is promoting a strategy of strengthening and coordinating planning efforts within and among state mental health and substance abuse authorities," said Gail Hutchings, M.P.A., Senior Advisor to the SAMHSA Administrator and former Acting Director of SAMHSA's Center for Mental Health Services (CMHS). "Federal agencies cannot and should not do the job alone. Through the states, we can leverage existing resources, build on the knowledge gained from the experience of each, and achieve a more comprehensive response."

SAMHSA's commitment to this strategy recently crystallized with the announcement of new State Capacity Expansion Grant awards, which divided nearly $3.5 million among 35 inaugural recipients.

State mental health and substance abuse directors will use the grants—as well as assistance from SAMHSA's three Centers—over the next 2 years to create and enhance local disaster plans.

The funds will enable recipients to seek help from disaster planning experts, build infrastructure for disaster response, and establish new partnerships.

Team Planning

The 35 grant recipients were announced during another highly anticipated SAMHSA initiative—a conference held this June in Washington, DC, called "Creating a Road Map for Disaster Preparedness: Strengthening State Capacity for Disaster Mental Health and Substance Abuse Response." (See related article, *SAMHSA News,* p. 13.)

Approximately 250 professionals gathered from across the country and several U.S. territories to explore strategic solutions for bolstering their preparedness efforts. They represented local and state mental health and substance abuse agencies, plus emergency management, public health, interfaith, and other partner groups.

"There was a time when working on preparedness at the state level was a lonely experience," said Seth Hassett, M.S.W., Chief of the CMHS Emergency Mental Health and Traumatic Stress Services Branch. "It's easy to lose focus and energy. But events like these are reinvigorating. People hear new ideas and think about planning in different ways. And they realize they're not alone in their efforts and that they can turn to colleagues across the country for support."

Manual Provides Guidance

The conference provided the perfect platform to introduce *Mental Health All-Hazards Disaster Planning Guidance,* a new manual targeted to states, developed by the National Association of State Mental Health Program Directors under contract

Representatives from areas most affected by the events of September 11 presented at a conference panel, "Roads Traveled and Lessons Learned: Legacy of September 11, 2001." L to R: April Naturale, NY; Dr. Kermit Crawford, VA; Shauna Spencer, Washington, DC; Stephen Crimando, NJ; Dr. Ruby Brown, VA. Not pictured: James Siemianowski, CT.

Photo by David Kasamatsu, for SAMHSA

The conference included representatives from both the substance abuse and mental health fields. Shown here are (l to r) Dr. Robert W. Glover, Executive Director, National Association for State Mental Health Program Directors; Dr. Lewis E. Gallant, Executive Director, National Association of State Alcohol and Drug Abuse Directors; and Dr. Bryan Flynn, Associate Director, Center for Studies of Traumatic Stress, Uniformed Services University of the Health Sciences.

Photo by David Kasamatsu, for SAMHSA

from the CMHS Emergency Mental Health and Traumatic Stress Services Branch.

The manual complements the *Guide for All-Hazard Emergency Operations Planning* published by the Federal Emergency Management Agency in 1996 and offers recommendations at every stage of planning.

The fundamental principle behind all-hazards planning is that successful disaster preparedness plans include several common elements. The SAMHSA guide outlines these elements, as well as other hazard-specific details. (See related article, *SAMHSA News,* p. 14.)

One-Stop Assistance

Valuable disaster-planning help is never more than a phone call away, thanks to the new SAMHSA Disaster Technical Assistance Center (DTAC) supported by all three SAMHSA Centers.

DTAC helps public authorities in states and U.S. territories by answering questions, organizing on-site training events and workshops, coordinating logistics for meetings, maintaining a Web site with vast resources, and brokering knowledge gained by states with disaster-related experience. State mental health and substance abuse authorities and local providers can request assistance and information from DTAC. Call 1 (800) 308-3515; fax (240) 744-7006; e-mail DTAC@esi-dc.org; or send a written request to: DTAC, 7735 Old Georgetown Road, Suite 400, Bethesda, MD 20814.

Science-to-Service Projects

Despite the difficulties of conducting empirical studies on disaster response (e.g., lack of control samples, dangerous environments, and the need to attend immediately to serious physical injuries), readiness for future disasters demands constant efforts to build on the knowledge base. Research must inform service delivery, and vice versa.

continued on page 12

Professionals from across the Nation and several U.S. territories attended the conference. Pictured here (l to r) are Kerio Walliby, of Micronesia Health Services and Theodore Iyechad of Guam.

Photo by David Kasamatsu, for SAMHSA

DISASTER PREPAREDNESS: *Resources*

The following resources are available for more information on important topics related to disaster preparedness.

Federally Sponsored

U.S. Department of Health and Human Services
Office of Emergency Preparedness
National Disaster Medical System
www.ndms.dhhs.gov
1 (800) USA-NDMS (872-6367)

Substance Abuse and Mental Health Services Administration
http://samhsa.gov/centers/clearinghouse/clearinghouses.html
1 (800) 729-6686
1 (800) 789-CMHS (2647)

Centers for Disease Control and Prevention
www.cdc.gov/nceh/emergency/default.htm
1 (888) 246-2675

Federal Emergency Management Agency
www.fema.gov/onp/ncb.shtm#planning
1 (800) 621-FEMA (3362)

Health Resources and Services Administration
www.hrsa.gov/bioterrorism.htm
1 (888) Ask-HRSA (275-4772)

National Center for Post-Traumatic Stress Disorder
www.ncptsd.org
1 (802) 296-6300

Private

American Psychiatric Association
www.psych.org/pract_of_psych/disaster_psych.cfm
(703) 907-7300

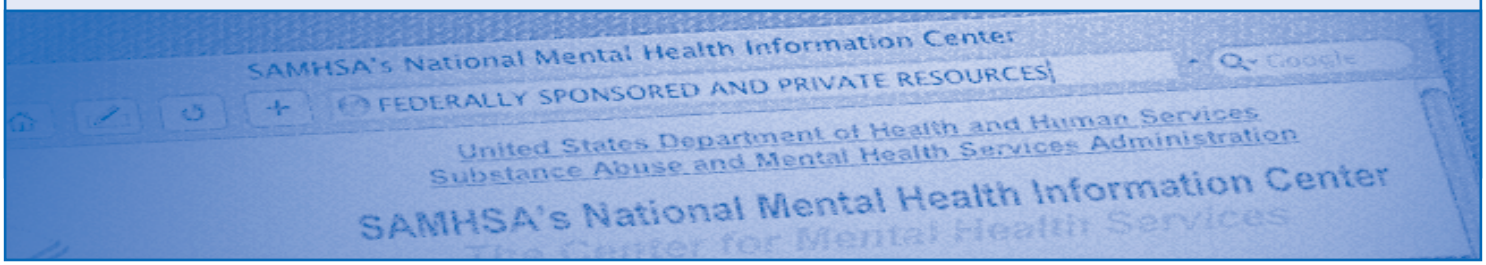
American Psychological Association
www.apa.org/psychnet/coverage.html
1 (800) 374-2721

American Red Cross
www.redcross.org
(202) 639-3520

National Mental Health Association
www.nmha.org
1 (800) 433-5959

National Voluntary Organizations Active in Disasters
www.nvoad.org
(301) 890-2119

SAMHSA Disaster Technical Assistance Center
1 (800) 308-3515
Fax: (240) 744-7006



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To this end, SAMHSA recently initiated an interagency agreement with the National Center for Post-Traumatic Stress Disorder (NCPTSD) within the U.S. Department of Veterans Affairs. The agreement will launch several projects designed to develop consensus among experts on best practices, produce guidance materials, and improve state and community needs-assessment processes after disasters. NCPTSD will also conduct a case study of New York's response to the September 11 World Trade Center attacks. The resulting information will help other planners nationwide improve preparedness.

"After September 11, SAMHSA's interstate forums brought together directors of the remarkable programs that emerged to serve the affected areas," said Mr. Hassett. "We learned a considerable amount about responding to terrorist events and how to help states prepare. Now we're concentrating on transferring this knowledge across the country."

SAMHSA is also collaborating on research case studies and expert panels with the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism—all from the National Institutes of Health.

"SAMHSA will serve states in both preparedness and response activities, while forging new partnerships everywhere we can," said Daniel Dodgen, Ph.D., SAMHSA's Emergency Coordinator. "It's a theme throughout disaster preparedness—bringing people together who need to work together but haven't yet. Because even though we can't address every issue or predict every event, we can train people, enhance capacity to respond, and build a foundation that promotes resilience when we need it most."

—By Steve Herndon

Disaster Preparedness: Conference Strengthens State Efforts

From June 18 to 20, approximately 250 mental health, substance abuse, public health, and emergency management professionals came to Washington, DC, to participate in SAMHSA's conference, "Creating a Road Map for Disaster Preparedness: Strengthening State Capacity for Disaster Mental Health and Substance Abuse Response."

Researchers, administrators, clinicians, and representatives from valuable partner organizations in 48 states and 8 U.S. territories exchanged ideas, networked, and received help to enhance their plans for disaster response.

In regards to preparedness, SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., set the tone by declaring, "The state is where the action is."

Participants devoted their attention to disaster preparedness and the challenges of all-hazards planning in small, inter-state group discussions. The consensus? Disaster planning must be ongoing, with special consideration given to establishing partnerships, designing communication strategies, and increasing resources. Indeed, at a time when agencies are consistently expected to do more with less, state and local contacts can be valuable sources of financing and technical assistance.

Participants also urged that volunteers be incorporated and credentialed to ensure that human resources remain plentiful. Representatives from the American Red Cross and the National Voluntary Organizations Active in Disaster encouraged participants to go home and ask volunteer agencies and faith-based organizations to join them at the planning table.

Breakout sessions during the conference shed light on a range of targeted topics, such as substance abuse, cultural competence, fiscal mechanisms, interagency collaborations, maintaining communication systems in times of crisis, and planning for possible bioterrorist threats.

Substance abuse experts, in particular, emphasized the need for their field to become more involved in disaster planning—especially as research provides new information on issues involving alcohol and drug use after traumatic events.

SAMHSA's Center for Substance Abuse Treatment Director H. Westley Clark, M.D., J.D., M.P.H., said, "Following a disaster or attack, we have seen an increased demand for services from people currently in treatment and people with histories of substance-related disorders. Substance use disorder treatment programs need to be prepared to address this."

"These are our experts," announced Bonnie Selzler, Ph.D., the state liaison from SAMHSA's Disaster Technical Assistance Center, as she introduced representatives from the six jurisdictions affected most by the September 11 and anthrax attacks. Each presenter provided planning insights that could apply to any region. For instance, establishing an immediate presence at a disaster scene is important, even if your services aren't immediately needed. It's equally crucial to clarify inter-jurisdictional relationships and responsibilities ahead of time—particularly when a terrorist attack could easily span multiple regions or involve military and civilian populations.

Ruby Brown, Ph.D., Project Director of the Arlington County Community Resilience Project, described how easily confusion could have ensued after the Pentagon burst into flames following the September 11 terrorist attacks. Paramedics, firefighters, police, Red Cross workers, and criminal investigators were called to the scene and all knew their jurisdictional roles. They were able to work together to bring the scene under control as quickly as possible.

Photo by David Kasamatsu, for SAMHSA

SAMHSA Emergency Coordinator Dr. Daniel Dodgen discusses Federal resources with a participant at "Creating a Road Map for Disaster Preparedness: Strengthening State Capacity for Disaster Mental Health and Substance Abuse Response."

Field staff also recommended preparing for a response that could last more than 1 year and that would use informal outreach approaches to counter stigma attached to mental health and substance abuse treatment.

Conference participants identified a range of components that improve mental health and substance abuse emergency preparedness efforts, including:

- Develop relationships ahead of time with state emergency management agencies.
- Establish a cadre of qualified trainers.
- Involve outside volunteers, including the faith community.
- Forge interstate and other cross-jurisdictional collaborations.
- Integrate/coordinate the efforts of mental health and substance abuse authorities.
- Tap into existing state and local resources.
- Tailor plans to specific ethnic and minority cultures and special populations.

SAMHSA is also sponsoring a series of regional summits to continue helping states with emergency preparedness planning.

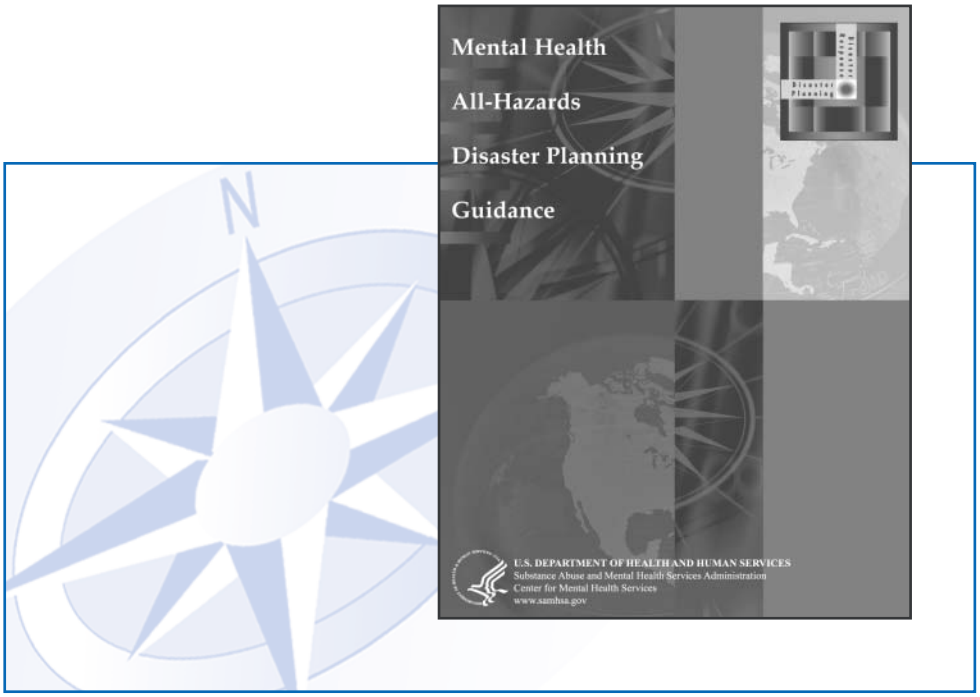
Disaster Preparedness: Manual Provides Guidance

SAMHSA's Center for Mental Health Services recently contracted with the National Association for State Mental Health Program Directors to create a new resource manual for state and local mental health and substance abuse authorities: *Mental Health All-Hazards Disaster Planning Guidance.*

Written primarily by Brian W. Flynn, Ed.D., Associate Director of the Center for Studies of Traumatic Stress, Uniformed Services University of the Health Sciences, the guide is targeted to states and outlines the necessary components of all successful disaster plans as well as hazard-specific details.

"The principle of all-hazards planning is that successful plans, regardless of the disaster, include the same core elements," said Dr. Flynn. "We've gathered all these elements into one comprehensive document."

The manual is structured as a companion document to the *Guide for All-Hazards Emergency Operations Planning,* published in 1996 by the Federal Emergency Management Agency (FEMA). The mental health manual mirrors the language and format of the FEMA guide to help planners integrate mental health and substance abuse activities into overall emergency response operations.



Pre-Planning

As state authorities begin planning or improving an existing plan, they are encouraged to review emergency plans from other states for relevant information. Forging relationships with partners before an event is vital, especially with the state's emergency management agency. This agency's planning documents may already contain solutions to common problems.

State authorities should also identify:

- A leader for plan formulation
- Benefits to potential partners as incentives to participate
- Purpose of the plan
- Planning office's legal obligations.

From the outset, the planning team must involve local mental health and substance abuse partners. Planners should also include willing participants beyond the typical circle of stakeholders, such as interfaith groups, school systems, and organizations serving special populations such as children or older adults.

Plan Components

All successful disaster plans include several common elements—that's the driving principle behind the all-hazards approach. A good introduction, for instance, will clearly outline a plan's purpose and describe the most likely scenarios and vulnerable populations/facilities in a given area.

Similarly, a "Concept of Operations" component will define what should happen, when, and who should direct the division of responsibility (state, local, Federal); and who can request aid and in what situations.

Plans will organize and assign responsibilities by listing team tasks and responsible parties, and describing tasks for anyone outside the core group.

An administration/logistics/legal section will plan for recording program activities,

expenditures, and human resource utilization; support needs (food, water, shelter, etc.) and equipment maintenance; and legal issues (jurisdictions, liability, emergency waiver of procurement rules, etc.).

The ideal plan will also feature a glossary, communication methods, public information strategies, and procedures for mobilizing staff and services.

Hazard-Specific Planning

With core elements in place, state plans can address specific events—from natural disasters to community violence. These sections should identify high-risk areas and the unique aspects of each hazard. For example, during a hurricane, long-standing floodwaters in low-lying areas may delay repair to homes. These delays can displace victims for long periods of time and cause additional individual and family stress.

Terrorism preparedness, which deserves its own section, must address myriad details, including identification of potential targets; an understanding of potential hazards including biological, chemical, nuclear/ radiological, explosive, cyber, or a combination; and situational considerations such as climate, geography, urban/rural, and transport patterns.

With checklists, a wealth of resources, and sample forms, *Mental Health All-Hazards Disaster Planning Guidance* is an invaluable tool for state and local mental health and substance abuse administrators who must be prepared for anything.

Other publications available on related topics are described in the box above.

To obtain copies of the publication, contact SAMHSA's National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or, visit **www.samhsa.gov.**

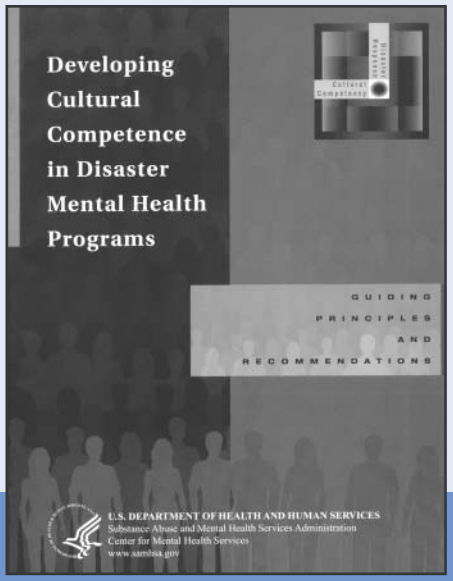
DISASTER PREPAREDNESS: *Publications*

Mental Health All-Hazards Disaster Planning Guidance and *Developing Cultural Competence in Disaster Mental Health Programs* **www.mentalhealth.samhsa.gov** These two publications are available through SAMHSA's National Mental Health Information Center: P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or 1 (866) 889-2647 (TTY).

Guide for All-Hazard Emergency Operations Planning, State and Local Guide (SLG) 101, Federal Emergency Management Agency (FEMA) **www.fema.gov/rrr/gaheop.shtm** This document is available in hard copy from FEMA's Printing and Publications Branch. To place an order, write to FEMA, P.O. Box 2102, Jessup, MD 20794-2012; fax: (301) 362-5335; or telephone: 1 (800) 480-2520. Include title, item number (9-1051), short title (SLG 101), quantity requested, and name, address, and daytime phone number.

Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy, Institute of Medicine **www.nap.edu/catalog/10717.html.** Call 1 (888) 624-8373 (customer service line for the publisher, National Academies Press).This Institute of Medicine (IOM) report highlights critical issues in responding to the psychological effects of terrorism. The report includes recommendations for training and educating service providers to ensure appropriate guidelines for the protection of service providers. Information is also included on how to develop public health surveillance for factors leading to psychological consequences. To assist the committee preparing the report, SAMHSA, together with the IOM and the National Institute of Mental Health, sponsored a workshop to assess the immediate and long-term consequences of terrorism. Several SAMHSA staff members were among those presenting at the workshop.

Communicating in a Crisis: Risk Communications Guidelines for Public Officials, **www.riskcommunication .samhsa.gov.** This SAMHSA publication is available online or call 1 (800) 789-CMHS (2647). See *SAMHSA News,* Volume X, Number 3, for highlights.



22 Million Americans Suffer from Substance Dependence or Abuse

In 2002, an estimated 22 million Americans suffered from substance dependence or abuse due to drugs, alcohol, or both, according to the newest results of SAMHSA's Household Survey. There were 19.5 million Americans (8.3 percent of the population age 12 or older) who used illicit drugs currently, 54 million who participated in binge drinking in the previous 30 days, and 15.9 million who were heavy drinkers.

The report highlights that 7.7 million people (3.3 percent of the total population age 12 and older) needed treatment for a diagnosable drug problem and 18.6 million (7.9 percent of the population) needed treatment for a serious alcohol problem. Only 1.4 million received specialized substance abuse treatment for an illicit drug problem and 1.5 million received treatment for alcohol problems. More than 94 percent of people with substance use disorders who did not receive treatment did not believe they needed treatment.

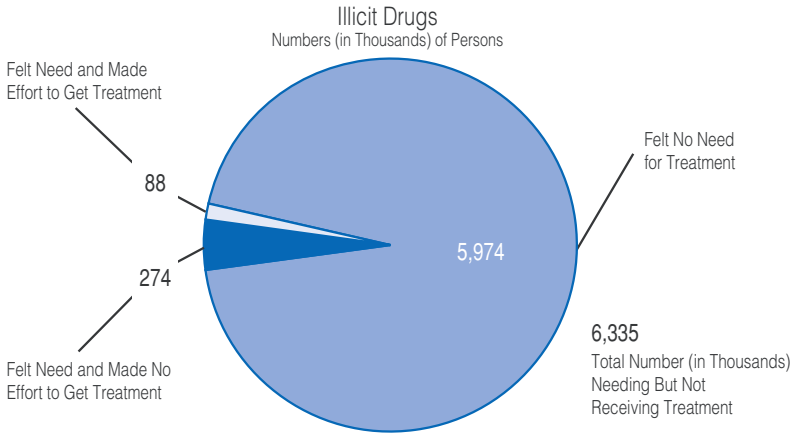
There were 362,000 people who recognized they needed treatment for drug abuse. Of these, 88,000 tried but were unable to obtain treatment for drug abuse in 2002. There were 266,000 who tried, but could not obtain treatment for alcohol abuse.

"There is no other medical condition for which we would tolerate such huge numbers unable to obtain the treatment they need," said U.S. Health and Human Services Secretary Tommy G. Thompson. "We need to enact President Bush's Access to Recovery Program to provide treatment to those who seek to recover from addiction and move on to a better life.

The new 2002 Household Survey has been renamed the National Survey on Drug Use and Health. The survey creates a new baseline with many improvements.

John Walters, White House Director of National Drug Control Policy, pointed out that "a denial gap of over 94 percent is intolerable. People need to understand the addictive nature of drugs and not presume that they are 'all right' when everyone around them knows better. Families and friends need to urge their loved ones to seek treatment when they experience the toll that addiction takes on loved ones and communities."

Perceived Treatment Need and Efforts To Get Treatment Among Persons Who Needed But Did Not Receive Treatment for Illicit Drugs: 2002



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

The 2002 survey found that marijuana is the most commonly used illicit drug, used by 14.6 million Americans. About one third, 4.8 million, used it on 20 or more days in the past month. There was a decline in the number of adolescents under age 18 initiating use of marijuana between 2000 and 2001, according to the 2002 survey. There were 1.7 million youthful new users in 2001, down from 2.1 million in 2000. The percentage of youth age 12 to 17 who had ever used marijuana declined slightly from 2001 to 2002, from 21.9 percent to 20.6 percent. Most adolescents age 12 to 17 reported that the last marijuana they used was obtained without paying, usually from friends.

"Prevention is the key to stopping another generation from abusing drugs and alcohol," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "It is gratifying to see that fewer adolescents under age 18 are using marijuana. Now, we need to step up our prevention activities to drive the numbers down further."

The survey found that 30 percent of the population age 12 and older—71.5 million people—use tobacco. Most of them smoke cigarettes. But, the number of new daily smokers decreased from 2.1 million per year in 1998 to 1.4 million in 2001. Among youth under age 18, the decline was from 1.1 million per year in each year between 1997 and 2000 to 757,000 in 2001. This is a decrease from about 3,000 new youth smokers per day to 2,000 per day.

In 2002, 2 million persons currently used cocaine, 567,000 of whom used crack. Hallucinogens were used by 1.2 million people, including 676,000 who used Ecstasy. There were 166,000 current heroin users. Among adolescents age 12 to 17, inhalant use was higher than use of cocaine.

The second most popular category of drug use after marijuana is the non-medical use of prescription drugs. An estimated 6.2 million people, 2.6 percent of the population age 12 or older, were current users of prescription drugs taken non-medically.

Of these, an estimated 4.4 million used narcotic pain relievers, 1.8 million used anti-anxiety medications (also known as tranquilizers), 1.2 million used stimulants, and 0.4 million used sedatives. The survey estimates that 1.9 million persons age 12 or older used OxyContin non-medically at least once in their lifetime.

Current illicit drug use is highest among young adults age 18 to 25, with more than 20 percent using drugs. Youth age 12 to 17 also are significant users, with 11.6 percent currently using illicit drugs. Among adults age 26 and older, 5.8 percent reported current drug use. There were also 9.5 million full-time workers, 8.2 percent, who used illicit drugs in 2002. Of the 16.6 million illicit drug users age 18 or older in 2002, 12.4 million were employed either full or part time.

The 2002 survey found that 11 million people, 4.7 percent of the population age 12 or older, reported driving under the influence of an illicit drug during the past year. Those age 21 reported the highest rate of driving while drugged, 18 percent, but the rate was 10 percent or greater for each age from 17 to 25.

Other findings included:

Alcohol Use

Approximately 10.7 million people age 12 to 20 (28.8 percent of this age group) reported drinking alcohol in the month prior to the survey interview. Of these, 7.2 million were binge drinkers (19.3 percent) and 2.3 million were heavy drinkers (6.2 percent). There were 33.5 million Americans who drove under the influence of alcohol at least once in the 12 months prior to the interview.

Treatment

Of those 3.5 million people age 12 or older who received some kind of treatment related to the use of alcohol or illicit drugs in the 12 months prior to the survey interview, 974,000 received treatment for marijuana, 796,000 for cocaine, 360,000 for non-medical use of narcotic pain relievers, 277,000 for heroin, and 2.2 million received treatment for alcohol.

Trends in Lifetime Use

Trends in lifetime use of substances were calculated from the 2002 survey based on reports of prior use. Use of pain relievers non-medically among those age 12 to 17 increased from 9.6 percent in 2001 to 11.2 percent in 2002, continuing an increasing trend from 1989 when only 1.2 percent had ever used pain relievers non-medically in their lifetime. Among young adults age 18 to 25, the rate of ever having used pain relievers non-medically increased from 19.4 percent in 2001 to 22.1 percent in 2002. This rate was 6.8 percent in 1992.

Youth Prevention-Related Measures

For teens age 12 to 17, the lifetime LSD rate is down from 3.3 percent of this population to 2.7 percent, the Ecstasy rate is up slightly from 3.2 percent to 3.3 percent, cocaine use is up from 2.3 percent of this population to 2.7 percent, and inhalant use is up from 9 percent in 2001 to 10.5 percent in 2002.

In 2002, the survey found over 83 percent of youth age 12 to 17 reported having seen or heard alcohol or drug prevention messages outside of school in the past year. Youth who had seen or heard these messages indicated a slightly lower past-month use of an illicit drug (11.3 percent) than teens who had not seen or heard these types of messages (13.2 percent).

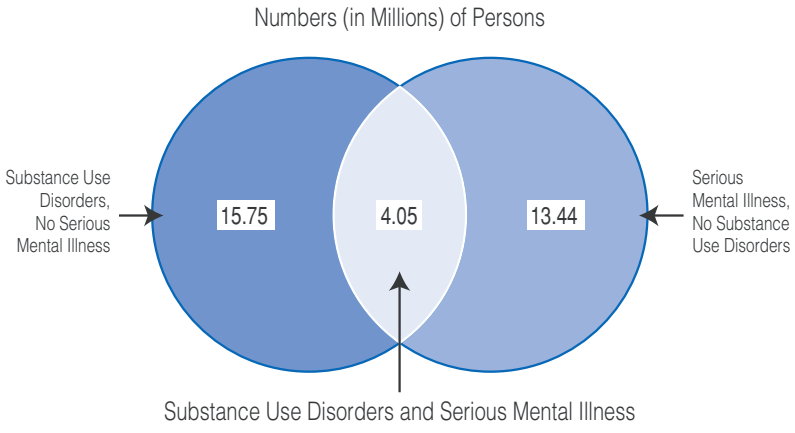
Serious Mental Illness

There are 4 million adults who have both a substance use disorder and serious mental illness. In 2002, there were an estimated 17.5 million adults age 18 or older with serious mental illness. This is 8.3 percent of all adults. Adults who used illicit drugs were more than twice as likely to have serious mental illness as adults who did not use an illicit drug. Among adults who used an illicit drug in the past year, 17.1 percent had serious mental illness in that year, compared to 6.9 percent of adults who did not use an illicit drug.

Among adults with serious mental illness in 2002, over 23 percent were dependent on or abused alcohol or illicit drugs. The rate among adults without serious mental illness was only 8.2 percent. Among adults with substance dependence or abuse, 20.4 percent had serious mental illness, compared with 7 percent among adults who were not dependent on or abusing alcohol or drugs.

Findings from the 2002 National Survey on Drug Use and Health are available online at **www.DrugAbuseStatistics.samhsa.gov.**

Co-Occurrence of Serious Mental Health Illness and Substance Use Disorders Among Adults Age 18 or Older: 2002



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

We Would Like To Hear From You!

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

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

I found these articles particularly interesting or useful:

- ❑ *Disaster Preparedness:*
  - ❑ Mental Health & Substance Abuse
  - ❑ Conference Strengthens State Efforts
  - ❑ Manual Provides Guidance
- ❑ President's Commission Recommends Transforming Mental Health System
- ❑ Rise in Drug-Abuse-Related Narcotic Pain Medications Seen in Emergency Rooms
- ❑ Minority Fellowship Program Extends Training, Expands Treatment
- ❑ Initiative Counters Stigma and Discrimination
- ❑ Publications Available on Financing of Mental Health Services
- ❑ 22 MIllion Americans Suffer from Substance Dependence or Abuse
- ❑ SAMHSA Offers Manual for Competitive Grant Applications

Other comments: _____

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Field of specialization: _____

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Thank you for your comments.

SAMHSA Offers Manual for Competitive Grant Applications

SAMHSA recently released a publication, *Developing Competitive SAMHSA Grant Applications: A Participant Manual,* to provide guidance to prospective grant applicants.

"SAMHSA recognizes that grassroots operations often are in the best position to make healthy changes in their communities," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. He added, "This manual is designed to help all potential applicants, including community- and faith-based organizations, develop comprehensive, competitive Federal grant applications."

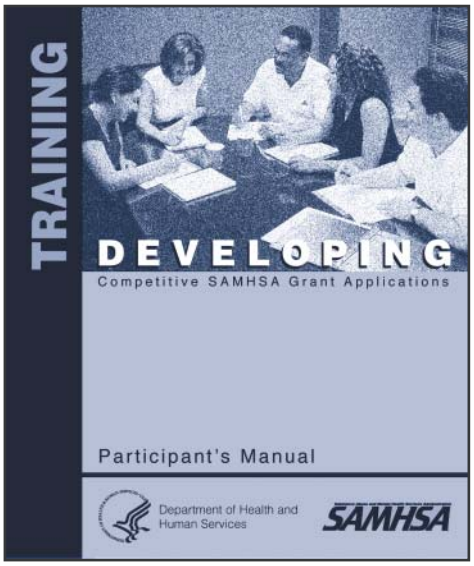
The manual can be used as a self-directed reference tool or as a companion text to a workshop presentation. It is divided into six modules that describe the preparation process in comprehensible stages.

Module 1, "Know SAMHSA and Its Centers," provides an overview of SAMHSA's mission and organization. Module 2, "Preplan and Organize," helps applicants articulate their organization's mission statement, form partnerships, and review the available resources and relevant background literature on the topic.

Module 3, "Link Your Project to Funding Opportunities," introduces applicants to funding terminology, steps in the grant award process, and ways to request application kits. In Module 4, "Understand Grant Announcements," applicants learn about the components of the grant application kit, ways to analyze eligibility requirements, and the principles of what works best in preparing applications.

Module 5, "Write Your Grant Application," helps applicants develop the application components such as the project description, evaluation plan, budget, and abstract. It also describes the various approaches that applicants can use to design their project's goals, objectives, and tasks.

A final section, Module 6, "Study the Grant Review Process," gives applicants an understanding of what happens after they submit their applications. The module explains the review cycle and the screening, scoring, funding, and notification processes.



Worksheets, charts, resource lists, and references are also included in the manual to provide additional help to applicants. Changes in the Federal grant application process will be incorporated into the manual on an ongoing basis, so that applicants will have continuous access to the latest information.

To obtain a copy of the manual, conveniently printed on 3-hole-punch paper for storage in a loose-leaf binder, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889. Or contact SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). The manual is also available online at **www.samhsa.gov/grants.**

SAMHSA seeks feedback from users about the manual's content. Please send your suggestions and comments via e-mail to TAManual@samhsa.gov. ◗

SAMHSA Awards New Grants

American Indian/Alaska Native Community Substance Abuse Treatment Plans

SAMHSA recently announced $1.5 million in grants to help six rural American Indian and Alaska Native communities develop local substance abuse treatment systems. Awards for each community total $250,000 or less for the 18-month project period. Plans covered by the grant include combining substance abuse and related services into a comprehensive program, strategic planning for substance abuse training for youth up to age 25, community-based strategic planning of the delivery of culturally appropriate treatment and related services, development of a traditional substance abuse services model, assessment of community needs and a strategic consensus-based system of care, and identification of gaps in services and creation of a tribal service plan.

Emergency Planning Grants

A total of 35 state governments are recipients of nearly $3.5 million in grants from SAMHSA to develop effective mental health and substance abuse response systems for use in response to both natural and man-made emergencies. (See *SAMHSA News,* p. 10 for more details.) ◗

SAMHSA News

Substance Abuse and Mental Health Services Administration

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SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

Volume XI, Number 3 2003

Disaster Preparedness: Mental Health & Substance Abuse

The tragic loss of life from the terrorist attacks on September 11, 2001, was but one outcome of that day's horrendous events. Many people close to the disaster experienced flashbacks, feelings of anxiety and depression, and even Post-Traumatic Stress Disorder. For the mental health and substance abuse treatment communities, and for SAMHSA, these events presented both a challenge and a call to action.

It was a challenge that SAMHSA answered many times before—in the aftermath of the Oklahoma City bombing and natural disasters such as floods and hurricanes—by organizing services to address mental health needs and prevent possible substance abuse in response to severe emotional stress.

But the events of September 11—and the anthrax incidents that followed—highlighted the need to be prepared to respond immediately, nationwide, to disasters of a nature and scale unprecedented in the United States.

The U.S. Department of Health and Human Services (HHS) responded swiftly with funding and staff support for states affected most by the September 11 attacks. HHS—assisted by SAMHSA—also hosted a national summit just 2 months after the attacks that sparked a dialogue on the unique planning needs of state mental health and substance abuse authorities related to these new, complex threats to communities and citizens.

New York firefighter Chris Agazzi at a 9/11 Observance at Ground Zero, September, 11, 2002. Photo by Andrea Booher/Federal Emergency Management Agency (FEMA) News Photo.

It proved to be just the beginning of a series of initiatives by SAMHSA on planning for mental health needs as part of disaster preparedness.

"Emergency preparedness is central to everyone's health," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "It's an area where SAMHSA will continue to invest financial, policy, and human resources. And we welcome the chance to help states focus on

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