Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

January/February 2005, Volume 13, Number 1

Conference Explores High-Tech Treatments

A patient arrives in the emergency room of a small hospital in rural Tennessee in acute need of psychiatric evaluation. The attending physician lacks the specialty training to evaluate whether the patient is at risk for suicide or harm to others—requiring hospitalization—and the nearest psychiatric hospital is located more than an hour away. What should the physician do?

In the past, a mobile crisis team would have been dispatched over mountainous roads for an hour's drive to make an evaluation. Today, a high-speed video teleconference between a member of the crisis team and the patient—in real time—takes place instead.

This accelerated evaluation procedure, as described by Susan Dimmick, Ph.D., a project manager at the Oak Ridge Associated Universities, in Oak Ridge, TN, is just one of the many applications of communications technology now available to deliver mental health and substance abuse care efficiently. More than two dozen presenters shared their expertise at a recent conference, "E-Therapy, Telehealth, Telepsychiatry, and Beyond," hosted by SAMHSA's Center for Substance Abuse Treatment (CSAT) in December.

Sheila M. Harmison, D.S.W., L.C.S.W., Special Assistant to the CSAT Director, moderated the conference, which drew

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researchers and service providers from across the Nation and from Canada to discuss a wide range of innovative programs that use e-mail, text messaging, Web sites, and voice-over-Internet telephone in addition to video teleconferencing. These technologies overcome barriers—including distance, physical immobility, and other disabilities, and social stigma—that prevent many Americans from receiving needed mental health care.

Examples of these services include:

- Low-income, inner-city mothers who are in recovery from substance abuse stay in daily contact with their counseling program via e-mail.
- Children in remote Alaskan villages receive mental health treatment via video teleconference from providers located in facilities hundreds of miles away.
- Middle school, high school, and college students participate in personalized substance abuse interventions over the World Wide Web.
- Military veterans with post-traumatic stress disorder who live on sparsely settled Indian reservations in South Dakota and Wyoming receive mental health treatment via video teleconference.
- Persons undergoing cognitive behavioral therapy for anxiety disorders use palmtop computers to receive messages of reinforcement and assess their own levels of anxiety while they go about their daily activities.
- Alcoholics in recovery attend group therapy sessions via streaming video and voice-over-Internet from the privacy of their homes.

"Technology can assist in our larger goal to assure a life in the community for everyone," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H. The goal is not to substitute traditional treatments for mental and addictive disorders, he emphasized. "The goal is to leverage the impact of people-based services."

The use of new communications technology in treatment for these disorders is in its infancy, Dr. Clark continued. "And there does appear to be a reluctance to adopt new technology."

Qualified mental health and substance abuse professionals must make use of these new technologies. Charlatans and quacks are trying to exploit the Internet and entice the unwary into many questionable so-called therapies, Dr. Clark cautioned. "If we in the orthodox community refuse to go 'into the ether,' others will have no compunction." In other words, research needs to go forward vigorously to evaluate the usefulness of the various technology-assisted treatment approaches. "We have to determine if e-therapy is a reliable resource for substance abuse and mental health treatment," said Dr. Clark. "I think it is."

Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services, also addressed the conference. "E-health, properly researched and implemented, holds great promise for improving the mental health of millions of Americans nationwide," she said. Not only is e-health incorporated in the goals of the SAMHSA Mental Health Transformation initiative, but through the use of these technologies excellent mental health care is delivered, and research accelerated.

High-Tech Options

As equipment and service costs continue to decrease and the availability of high-speed broadband connections continues to increase, mental health and substance abuse practitioners find themselves with many advanced options for audio, video, and text technologies.

Wireless connections now match the speed of broadband cable modems, said Brent Carter, a product development officer for Verizon Wireless, in his presentation.

Advanced encryption and other security measures allow wireless communications to meet the privacy and confidentiality requirements of mental health and substance abuse professionals, added Donald "Desi" Arnaiz, M.A., President of Virginia Systems, Inc., and an engineer for Comcast. "Everything that you require for the Health Insurance Portability and Accountability Act—HIPAA—is available to you now."

Mental health and substance abuse treatment providers and other health care providers, however, must be sure to use equipment correctly. When selecting devices, for example, they must make certain that they obtain proper security technology. "Most people don't protect their wireless systems, but care providers must take that extra precaution," said Mr. Arnaiz.

Other recommendations include choosing devices appropriate to the intended purpose and making sure that all devices work together. Correcting errors in the integration of devices is in fact his company's "biggest headache," Mr. Arnaiz said. For practitioners to have a successful program, they must also spend time learning to use the equipment.

Some adaptations in treatment techniques will also be needed to meet the demands of technology, noted Ron Adler, Chief Operating Officer of the Alaska Psychiatric Hospital. His experience with the hospital's TeleBehavioral Health video teleconferencing system convinced him that the benefits vastly outweigh the costs in both time and money. "Build this system and the funding will come and the patients will come," he urged conference participants.

Reimbursement for Services

Treatment providers interested in adding new technologies to their practices also need to determine how they will be paid for these new services. As an example, a representative from the Centers for Medicare & Medicaid Services (CMS), addressing the conference through a video-teleconferencing hookup from Baltimore, MD, focused on Medicare reimbursements. Medicare requires interactive telecommunications

technology as a condition of payment for tele-health services along with certain facility and geographic criteria.

Medicare covers a range of mental health services as tele-health services. Those services include individual psychotherapy, pharmacologic management, and psychiatric diagnostic interview examinations. However, services must be furnished by physicians, clinical psychologists, clinical social workers, or clinical nurse specialists. Services by certified addiction counselors are not covered.

Medicare requires an interactive audio and video telecommunications system that permits two-way interaction between the physician or practitioner at the distant site and the beneficiary at the originating site (the location of the patient at the time the tele-health service occurs). This service must be rendered in real time with both the patient and the practitioner present and able to see and hear one another simultaneously.

However, as long as the service requirements meet the regulations for the patient and for the interactive audio and video telecommunications, Medicare imposes no limitations on the type of technology that practitioners may use. For example, wireless or Internet hookups would each be permissible.

Furthermore, the originating site must be located either in a county outside a metropolitan statistical area or in a rural health-professional shortage area.

Finally, the originating site facility must be either a physician's or practitioner's office, hospital, critical access hospital, rural health clinic, or federally qualified health center. Facilities such as a practitioner's office or a rural health clinic must be equipped for video teleconferencing. Medicare will not reimburse tele-mental health services delivered to patients' homes.

According to CMS, current Medicare reimbursement requirements are legal mandates that only the U.S. Congress can

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From the Administrator

High-Tech Options Expand Horizons

The benefits of information technology have taken hold all around us, from banks to grocery stores. To make sure these benefits extend to the health care arena as well, the Bush administration created the new Office of the National Coordinator for Health Information Technology in April 2004 and called for a nationwide electronic health information network within the next decade.

This issue of *SAMHSA News* highlights some of the most exciting activities to date in the application of technology to the treatment of mental and addictive disorders. If we harness it wisely, technology can increase exponentially our capacity to reach many underserved populations, including rural clients, American Indian communities, youth engaged with the juvenile justice system, older Americans, and people who abuse prescription drugs.

Emerging technologies have the potential to transform the mental health service system, which is a key goal of SAMHSA's action agenda, informed by the President's New Freedom Commission on Mental Health.

At the most fundamental level, electronic access can benefit both the consumer and the provider of services. Consumers can access their own health care records and use them to help shape their own treatment. Providers can gain a more complete picture of their patients' overall health as well as better access to the latest research-based information.

Technology can also enhance service delivery by providing data on which treatments work best. Having access to consistent measures enables payers to assess quality of care and eliminate redundancy.

SAMHSA is developing an overall data strategy to standardize measurement of treatment outcomes and consolidate data across agency programs, and is designing an electronic system for collecting and reporting substance abuse prevention and treatment service data from all SAMHSA-funded programs. The Agency is also examining questions raised by the new technologies, including issues of privacy, confidentiality, ethics, standards of care, and licensure.

SAMHSA is committed to exploring and refining all strategies that may help us move from today's health care information system to tomorrow's, with the goal of building resilience and facilitating recovery for all people with or at risk for substance abuse and mental illness.

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

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change. Medicaid, however, may cover a wider range of technology-assisted services, and coverage may vary among individual states.

Other Issues

As presentations revealed, the range of professional services now offered as well as the technology issues to be addressed are well beyond what's widely used. Mental health and substance abuse professionals across the Nation are adapting effective treatment methods to the capabilities of various technologies and the needs of varied consumers. Dozens of hospitals, clinics, and state and local agencies already deliver mental health services through video teleconferencing. Technology-based substance abuse programs range from primary prevention for children to aftercare for adult addicts in recovery. These programs use e-mail, chat rooms, live over-the-Internet groups, and interactive Web sites.

Technology-based interventions using an equally wide range of equipment address issues including smoking cessation, weight loss, eating disorders, and depression among breast cancer patients.

Consumers receive services in schools, workplaces, their own homes, and over mobile devices, wherever they are throughout the day. Still, these technological approaches face widespread skepticism or even opposition among some treatment professionals. But compared to the needs of underserved groups such as rural residents, these objections are minor. More than 80 percent of master's-level social workers and 90 percent of psychologists and psychiatrists practice in metropolitan areas. More than 60 percent of rural Americans reside in federally designated shortage areas for mental health services, stated Dennis Mohatt, Director of the Western Interstate Commission for Higher Education's Mental Health Program.

The promise of e-therapy and tele-mental health also comes laden with many unanswered legal, ethical, and clinical questions. "Most state laws make no mention of these new services," said Anthony Ragusea, a predoctoral intern in psychology at Washington State University. He added that there is "no actual case law on this yet . . . still, most professional organizations in mental health have approved the practice of online therapy."

Because of state control of licensure, however, electronic services that cross state lines or even national borders are a "crucial legal issue" that has yet to be resolved, said Jeffrey Barnett, Psy.D., a licensed psychologist in private practice.

Service providers using electronic technologies face other serious challenges:

- Difficulty in diagnosing or evaluating patients without actually seeing or hearing them in person
- Requirement to ascertain true identities and obtain valid consent in the anonymity of cyberspace
- Importance of protecting confidentiality and privacy (Who else may have access to a client's computer or e-mail account?)
- Possibility of having to deal with emergencies or make service provider referrals in distant places.

In addition, practitioners must find ways to maintain a professional tone in electronic interactions and to make up for the nuances of facial expression, tone of voice, and body language that some technologies do not transmit.

Numerous professional associations are currently grappling with the ethics of new technologies, but a general consensus on these issues has yet to emerge, Mr. Ragusea said.

To date, research on technology-assisted services finds the outcome to be favorable and comparable to traditional methods in general, reported Aaron Rochlen, Ph.D., an assistant professor of counseling psychology at the University of Texas. Only a small number of studies have been conducted. "The importance of research cannot be overstated," Dr. Rochlen said, especially of "big-number studies" with control groups to evaluate outcomes.

"It is time for new strategies to deliver much needed care," said Dr. Clark as the conference concluded. "The discussion will continue."

—By Beryl Lieff Benderly

E-Glossary and Resources

The "E-Therapy, Telehealth, Telepsychiatry, and Beyond" conference sponsored by SAMHSA is one of a series of ongoing Federal initiatives that apply new communications technologies to substance abuse treatment and mental health services. A glossary of terms follows:

- **Video teleconferencing** is an interactive tool that incorporates audio, video, and computing and communications technologies to allow people in different locations to collaborate face to face electronically, in real time, and to share data, documents, sound, and images.
- **Voice-over-Internet telephone** uses a high-speed broadband Internet connection to make local and long-distance telephone calls. Calls are cheaper than normal switch-based calls making up the current telephone infrastructure.
- **Interactive Web sites** offer users prompts that "talk back" with images, icons, and words.
- **Resources** include **www.fcc.gov/voip.** For more information, visit SAMHSA's Web site at **www.samhsa.gov.**

A Decade of Progress:
Dare To Act Affirms Vision

More than 200 trauma survivors, service providers, researchers, and policymakers gathered in Baltimore in early December to celebrate a decade of progress and develop plans for further growth in the understanding and awareness of trauma in the lives of individuals seeking substance abuse and mental health services.

"Dare To Act: Trauma Survivors, Practitioners, Researchers, and Policymakers Creating a Blueprint for Change" was sponsored by SAMHSA and the National Trauma Consortium. The conference provided a forum where participants shared recent research findings regarding trauma and trauma services, strategies for addressing trauma within the fields of substance abuse and mental health services, and personal stories of survival and triumph.

The Dare To Act conference recalled the 1994 Dare To Vision conference in its title, scope, and structure (see *SAMHSA News* Volume II, No. 4, Autumn 1994). Both conferences sought to shed light on the prevalence of trauma, especially among persons with mental and addictive disorders, and to assure trauma survivors a voice in the development and implementation of services to address their needs.

The 1994 conference focused attention on revictimization by seclusion and restraint practices, which were not widely acknowledged within the treatment field at that time.

At the 2004 conference, topics addressed aspects of trauma and recovery, from assuring cultural competence in service delivery to addressing the needs of children of parents seeking integrated mental health, substance abuse, and trauma services.

According to Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services (CMHS), the 1994 Dare To Vision conference was "the first time . . . national attention [was] focused on the effect of physical and sexual abuse in the lives of women with mental illnesses." Trauma survivors at the 2004 conference reported that one of their greatest hurdles was simply being believed when they spoke of the violence they had experienced, as well as having their trauma histories considered to be a significant factor in their illness and recovery.

Trauma Awareness

Ms. Power reported on significant efforts in the field in the last 10 years. Among the studies cited was a SAMHSA-funded study conducted through the National Association of State Mental Health Program Directors. "The Damaging Effects of Violence and Trauma" (2004) reported that up to two-thirds of adults in substance abuse treatment programs reported childhood abuse or neglect, and nearly 90 percent of homeless mentally ill women experienced severe abuse as children and adults.

Robert F. Anda, M.D., Ph.D., a senior research fellow at the Centers for Disease Control and Prevention, reported on the Adverse Childhood Experiences (ACE) Study. Published in 2003, the ACE Study demonstrates a relationship between adverse childhood experiences of violence and abuse and various adult health problems—including smoking, alcoholism, suicide attempts, and early mortality. By establishing a connection between trauma and lifetime health among birth cohorts throughout the 20th century, the ACE Study

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All artwork by Anna Caroline Jennings

Anna Caroline Jennings (1960–1992) expressed the trauma of childhood sexual abuse in her life vividly and poignantly through her sketches, oil paintings, water colors, and writings.

Anna's work was exhibited at the recent Dare To Act conference in Baltimore. More than a decade ago, Anna's work was shown at the 1994 Dare To Vision conference.

Since then, at many hospitals and numerous conferences across the Nation, Anna's images continue to tell her story. To see more of her work and her story, visit **www.AnnaFoundation.org.**

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makes a strong case for the centrality of trauma in the lives of many Americans and the critical need to make trauma services available.

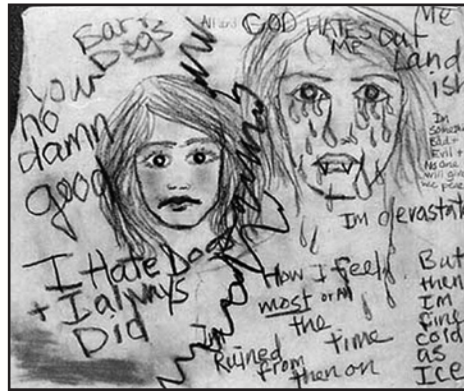
Progress in Treating Trauma

While these studies help to promote a greater awareness of the prevalence and effects of trauma on the individuals seen by service providers in the mental health and substance abuse fields, SAMHSA's Women, Co-Occurring Disorders, and Violence Study provides a base of data on the effectiveness of services designed to acknowledge and address the effects of trauma within mental health and substance abuse services.

A 5-year study from 1998 to 2003, funded by all three SAMHSA Centers, the Women, Co-Occurring Disorders, and Violence Study supported 14 sites in developing programs to provide integrated mental health, substance abuse, and trauma services to women. Nine sites were chosen to complete a 3-year implementation and evaluation, and four of these sites also participated in a Children's Subset Study—providing a group intervention for children of women enrolled in the Women, Co-Occurring Disorders, and Violence Study.

More than 2,000 women were enrolled in the study. Each study site conducted both an intervention and a comparison group, with the intervention focused on providing integrated counseling to address mental health, substance use, and trauma symptoms. After 6 months, women in all the intervention groups had, on average, significantly lower drug use and trauma symptoms compared to women in usual care.

Of women who reported using drugs at baseline, 50 percent of those who received integrated counseling reported not using drugs after 6 months versus 34 percent of women in the usual care group. More than half (54 percent) of women who reported using alcohol at baseline and participated in the integrated counseling reported



alcohol use after 6 months, compared with 37 percent of women in usual care who reported using alcohol at baseline.

Among women with poor mental health status at baseline, 59 percent of those who received integrated counseling reported improved mental health symptoms after 6 months versus 49 percent of women in usual care. These improved outcomes were achieved at no greater service-use costs than usual care.

During 2005, numerous publications are planned based on data derived from both the Women, Co-Occurring Disorders, and Violence Study and the Children's Subset Study. With the end of SAMHSA funding of the study, members of the nine study sites formed the National Trauma Consortium to support and advance integrated services for women affected by trauma, mental illness, and substance abuse.

Looking Forward, Reaching Out

The recent conference offered a wide variety of workshops. Trauma intervention models presented included those tested during the Women, Co-Occurring Disorders, and Violence Study and the Children's Subset Study. Additional workshops focused on the intersection of services to address trauma and alcohol abuse, strategies to support the involvement of persons with actual experiences of trauma in all aspects of programming, and the financing of trauma services.

All artwork by Anna Caroline Jennings

The diversity among trauma survivors was recognized in workshops focused on providing appropriate services to Hispanics, African Americans, refugee and immigrant women, and members of groups affected by historical trauma, such as American Indians, Alaska Natives, Holocaust survivors, and those affected by the internment of Japanese Americans during World War II. Workshops also addressed particular symptoms and circumstances, such as self-inflicted violence or homelessness.

Overall, the need for wide and deep systems change threaded through many of the workshops and presentations. Conference participants—many of whom "dared to vision" a decade ago—are continuing to work with SAMHSA and other Federal agencies to effect these changes.

For more information on SAMHSA's efforts, visit **www.mentalhealth.samhsa.gov/womenandtrauma.** ◗

—By Melissa Capers

SAMHSA Grants: $20.6 Million for Prevention of HIV/AIDS

To help prevent substance abuse and HIV/AIDS among minority populations in high-risk areas, SAMHSA recently released a Notice of Funding Availability (NOFA) for Fiscal Year 2005 to fund 59 to 82 cooperative agreements. These grants will help prevent the onset of substance abuse, and the transmission of HIV/AIDS and hepatitis, among communities across the Nation.

Administered by SAMHSA's Center for Substance Abuse Prevention, these strategic prevention framework projects will develop a solid foundation for delivering effective substance abuse prevention and related services.

Average annual awards should range from $250,000 to $350,000 per year for up to 5 years.

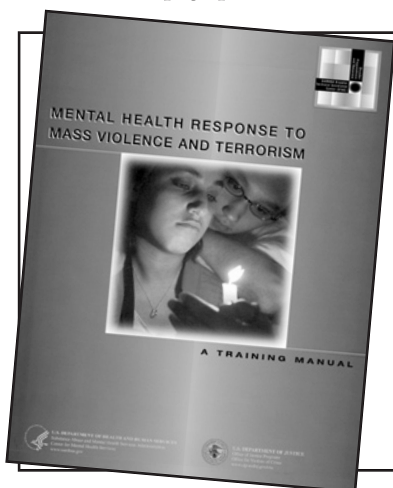
Eligible applicants include non-profit, community-based organizations, faith-based organizations, colleges and universities, health care delivery organizations, local governments, tribal governments, and tribal urban Indian groups. Eligibility is limited to applicants from geographic areas with high AIDS case rates. Eligible are geographic areas in states with an annual AIDS case rate of at least 10 cases per 100,000 people, or metropolitan statistical areas with an annual AIDS case rate of at least 20 cases per 100,000 people among minority populations.

How To Apply: Applications for these grants (SP 05-001) are available by calling SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686 and from the SAMHSA Web site at **www.samhsa.gov** (click on Grants). Or, visit **www.grants.gov.** For questions on program issues, contact Claudia Richards, M.S.W., at (240) 276-2409 or send an e-mail to rhti@samhsa.gov. **Application Due Date: March 17, 2005.**

SAMHSA Administrator Charles G. Curie (left) received the McGovern Award for Leadership in Drug Abuse Prevention from Robert L. DuPont, M.D. (right), President of the Institute for Behavior and Health, Rockville, MD, at the Community Anti-Drug Coalitions of America's National Leadership Forum XV on January 10. The McGovern Award recognizes people who have successfully used innovative ideas to reduce illegal drug use.

Training Manual Released

SAMHSA's Center for Mental Health Services recently published *Mental Health Response to Mass Violence and Terrorism: A Training Manual* under an Interagency Agreement with the U.S. Department of Justice. The 184-page publication includes chapters on human responses to mass violence and terrorism; mental health interventions; organizational preparation; and stress prevention, management, and intervention. A comprehensive training course outline is provided as well as a discussion of additional training needs.



This publication can be ordered through 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). Online, the publication can be accessed at **www.mentalhealth.samhsa.gov/publications/allpubs/SMA-3959/default.asp.**

Correction: Dr. Harold Alan Pincus was incorrectly identified as Dr. Alan Pincus in *SAMHSA News,* November/December 2004.

Suicide Prevention Lifeline

SAMHSA's Center for Mental Health Services recently launched the National Suicide Prevention Lifeline—1 (800) 273-TALK (8255). Part of the National Suicide Prevention Initiative, the lifeline offers immediate assistance to individuals in suicidal crisis. The goal is to reduce the incidence of suicide across the Nation. Currently, more than 100 local crisis centers throughout the United States are participating. Visit **www.suicidepreventionlifeline.org** for more information.

Across Borders: Rebuilding Iraq

In 1979, Sabah Sadik, MBCHB, FRCPsych, DPM, a doctor with 3 years of experience in general practice and 1 year in psychiatry, left his native country of Iraq. Twenty-five years later, in December 2003, he returned to visit relatives in Najaf, 100 miles south of Baghdad. What he saw saddened him profoundly, and he resolved to do all he could to assist in restoring mental health and rebuilding the country's mental health service system.

Three months later, Dr. Sadik was appointed National Advisor for Mental Health to the Iraqi Ministry of Health.

This past December, Dr. Sadik attended a meeting of the Planning Group on Iraq Mental Health, chaired by SAMHSA as part of its commitment to help rebuild Iraq's health care system for mental and addictive disorders. In addition to SAMHSA staff, Dr. Sadik, and other Iraqi officials, the ongoing planning group includes representatives from the National Institute of Mental Health at the National Institutes of Health, the U.S. Department of Defense, and the U.S. Army.

The meeting built on the process initiated when SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., accompanied the U.S. Secretary of Health and Human Services on a visit to Iraq in February 2004 (See *SAMHSA News*, May/June 2004). The purpose of the meeting was to plan for an international conference in Amman, Jordan, on ways to strengthen Iraq's mental health system. At the meeting, Dr. Sadik discussed the work that he and colleagues from Iraq, England, and throughout the world have undertaken.

Challenges

Dr. Sadik described the deterioration of mental health services in the country since the mid-1980s, when an "exodus of psychiatrists" occurred "due to poor and intimidating working environments, shortages of medication, poor quality information systems, and a lack of access to up-to-date knowledge and education."

An initial tally of mental health staff in Iraq—a country with a population of roughly 25 million—produced just 154 psychiatrists, 20 clinical psychologists (of whom only 3 had appropriate training), 25 social workers (none of whom were trained in mental health), and 45 nurses (also not properly trained in mental health). The few existing mental health facilities had antiquated ECT machines over 20 years old and very limited medication.

In addition to these meager resources and the instability and shortages due to three disastrous wars, 12 years of international sanctions, and ongoing violence, Dr. Sadik noticed more insidious problems as well upon his return.

"Iraqi society changed during the previous regime," he said, "primarily correlated to the way the individual and communities have been oppressed. There is a noticeable lack of confidence in one's self and one's abilities, an indecisiveness, and a lack of initiative for fear of mistakes and fear of reprisals." He likened the phenomenon to that of refugees from concentration camps after World War II, suddenly liberated but simultaneously paralyzed by inaction.

Fortunately, Dr. Sadik said, he also found that "Iraqis quickly embrace new ideas and remain enthusiastic and willing to work on issues and services for the new country."

Mental Health

Under Dr. Sadik's leadership, a National Council for Mental Health was formed with representatives from other government ministries as well as from mental health disciplines outside the government.

The National Council's first priority was to draft national plans for mental health. The plans are based on several underlying principles. The first is the concept of universal coverage of essential mental health care for the population.

The plans also emphasize primary care at the community level and integration of mental health care with general primary care services. This includes the establishment of mental health services in the 150 primary health centers to be built or renovated throughout the country. Dr. Sadik noted that currently, Iraq does not distinguish between primary and secondary health care, and yet primary health care providers are

Members of the planning group met in December at SAMHSA. (L to R) Jim Haveman, who served as Senior Advisor to Iraq's Coalition Provisional Authority; SAMHSA Administrator Charles Curie; Dr. Sabah Sadik, National Mental Health Advisor, Iraq; and Jon Wilkes, West Kent Trust, England.

seeing many people with somatization, overt depression, and anxiety.

The plans address the following areas: primary care services (mental health services provided in the primary care setting); secondary care (traditional mental health services for persons with mental illnesses); mental health training and education/human resource development; building scientific programs and research capacity; and policies and support for mental health programs.

To decrease stigma and meet service needs, the plans include education efforts for members of the public and health care personnel. Community initiatives are encouraged by offering support to families and organizations. The plans urge more research on mental health problems in Iraq, as well as appropriate legislation and administrative structure to support the program.

Several efforts have already been launched. For example, for the last 20 years Iraq has lacked proper mental health legislation that would establish such things as a code of practice and relevant training standards. In October 2004, the Iraqi cabinet approved such a plan drafted by the National Council for Mental Health together with the Iraqi Ministry of Justice.

The National Council also has supported activities by Nongovernmental Organizations (NGOs) from several different countries. For example, an NGO from Italy, Movimondo, sponsored a project for children in Baghdad. The organization "Together," from Slovenia, sponsored a psychosocial support effort for children and families in Babylon. Diakonia of Sweden offered psychotherapy and services for children in Duhook, Erbil, and Suleymania.

Japan also ran a training course for 40 senior Iraqi nurses in Egypt in September and November 2004.

Key Elements of Iraq's Plans for Mental Health

- Mental Health Services: primary, secondary, specialty care
- Mental Health Training and Education
- Scientific Programs and Research
- Policies and Support for Mental Health Programs. ◗

Substance Abuse

Dr. Sadik said that there are indications of an emerging drug abuse problem in Iraq, although the exact extent is unclear due to the limited resources for monitoring the situation. He suggested several contributing factors, including the instability and lack of law enforcement coupled with a rapidly changing social and economic situation. Unemployment is prevalent, he said, especially among youth. The geographic location of Iraq, the lack of border controls, and the proximity to countries that traffic in opium and heroin, have also increased the availability of drugs, he added. Finally, he noted that thousands of criminals imprisoned during the previous period had been released.

"The previous regime claimed that there was no substance abuse problem in Iraq," said Dr. Sadik, "so people providing treatment had to work in secrecy." Because of this, there is an urgent need to build expertise and establish programs. Currently, substance abuse treatment in Iraq is limited mostly to detoxification and not rehabilitation.

A plan to address the issue of drug misuse was recently finalized in collaboration with the regional World Health Organization team. Five broad strategies guide the development of drug abuse services in Iraq:

- Understand the dimension of the problem through surveys and rapid assessment studies.
- Organize services and integrate them with general health care and community care services.
- Develop human resources and provide needed training.
- Launch prevention programs, especially in schools.
- Provide administrative support.

Noting the similarities in strategies and principles, Dr. Sadik said, "Planning for both mental health and substance abuse services is proceeding hand in hand."

Looking to the future, he added, "I remain optimistic in spite of all the difficulties. The idea of returning to Iraq came out of love for the country and for the Iraqi people. The Iraqi population has been very resilient. I think a great asset to them has been the achievements of the past, and that it is possible to rebuild once there is stability, clear lines of accountability, and funding. Added to that, there is a great asset in the Iraqi professionals outside the country and what they can offer in terms of the process of cross-fertilization."

Speaking about his visit to the United States, Dr. Sadik added, "Seeing colleagues from various parts of the world who are committed to supporting Iraq and have worked so hard in putting ideas and proposals together has enhanced my hope. It says a lot about the goodwill that exists." ◗

—By Deborah Goodman

Assistance to Iraq

SAMHSA and its partners in the Planning Group on Iraq Mental Health provide assistance on an ongoing basis and will host an action planning conference in March that addresses Iraq's plans for mental health and:

- Modern concepts of mental illness and mental health
- Components of community-based mental health care
- Integration of services for serious mental illness with community-based mental health services
- Leadership and team-building in mental health services
- Models for funding services
- Staff and professional development. ◗

Retailers Cut Cigarette Sales to Youth

New data from SAMHSA surveys show that efforts to curb retail sales of tobacco to persons under the age of 18 are having the desired effect—they're keeping tobacco out of the hands of America's children. Overall, the national retailer violation rate dropped to 12.8 percent in reports submitted by states in 2004, down from 14.1 percent reported in 2003 and down from 40.1 percent since the annual surveys began in 1996.

Results of the most recent survey show that 48 of the 50 states achieved the legislative goal of cutting retailer sales of cigarettes to minors to no more than 20 percent. Thirty-eight states achieved a retailer violation rate of no more than 15 percent. In 21 states, the retailer violation rate was 10 percent or below.

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

"States that meet their Synar goals share certain characteristics," SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said. "Generally, these states employ a comprehensive strategy that combines vigorous enforcement efforts, political support from the state government, and a climate of active social norms that discourage youth tobacco use. These states use merchant and community education, media advocacy, and use of community coalitions to mobilize support for restricting youth access to tobacco. SAMHSA will continue to provide extensive technical assistance to all states to implement these comprehensive strategies."

Data reported in Fiscal Year 2004 indicate that the District of Columbia failed to meet its negotiated retailer violation target. The District government is committing additional state funds for tobacco enforcement as an alternative to losing part of its SAMHSA block grant funding, as specified in the law. Two other states, Kansas and Texas, did not reach the 20-percent goal, but were within the margin of error allowed by SAMHSA.

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

Retailer Violation Rates for 2004*

State Name	Target	Reported		State Name	Target	Reported		State Name	Target	Reported
Alabama	20.0	8.7		Kentucky	20.0	6.7		North Dakota	20.0	7.3
Alaska	20.0	10.2		Louisiana	20.0	7.4		Ohio	20.0	13.5
Arizona	20.0	8.9		Maine	20.0	8.8		Oklahoma	20.0	10.0
Arkansas	20.0	16.6		Maryland	20.0	12.1		Oregon	20.0	16.3
California	20.0	12.2		Massachusetts	20.0	11.6		Pennsylvania	20.0	10.8
Colorado	20.0	10.5		Michigan	20.0	18.7		Rhode Island	20.0	16.9
Connecticut	20.0	18.9		Minnesota	20.0	12.1		South Carolina	20.0	11.9
Delaware	20.0	3.9		Mississippi	20.0	3.9		South Dakota	20.0	8.5
District of Columbia	20.0	41.9		Missouri	20.0	8.9		Tennessee	20.0	13.5
Florida	20.0	7.1		Montana	20.0	11.2		Texas	20.0	23.8
Georgia	20.0	6.2		Nebraska	20.0	15.5		Utah	20.0	8.9
Hawaii	20.0	6.2		Nevada	20.0	11.4		Vermont	20.0	15.9
Idaho	20.0	14.7		New Hampshire	20.0	10.7		Virginia	20.0	10.2
Illinois	20.0	16.8		New Jersey	20.0	13.0		Washington	20.0	10.8
Indiana	20.0	16.6		New Mexico	20.0	14.9		West Virginia	20.0	10.3
Iowa	20.0	5.2		New York	20.0	9.4		Wisconsin	20.0	18.5
Kansas	20.0	22.1		North Carolina	20.0	14.8		Wyoming	20.0	8.0

* *Note: These survey results are from inspections conducted in 2003 and reported in 2004.*

Financing Health Care

In the past, many providers of public mental health services simply avoided Medicaid.

"They didn't like the paperwork, didn't like Medicaid's orientation to services, that sort of thing," said Jeffrey A. Buck, Ph.D., Associate Director for Organization and Financing in SAMHSA's Center for Mental Health Services (CMHS). "Now it's impossible for providers in most states to think they're going to be able to remain in business and get along nicely without in some way dealing with Medicaid."

Today, Medicaid—the Federal/state partnership that pays the medical and long-term care expenses of many of the Nation's most vulnerable people—has become the largest payer of public mental health services.

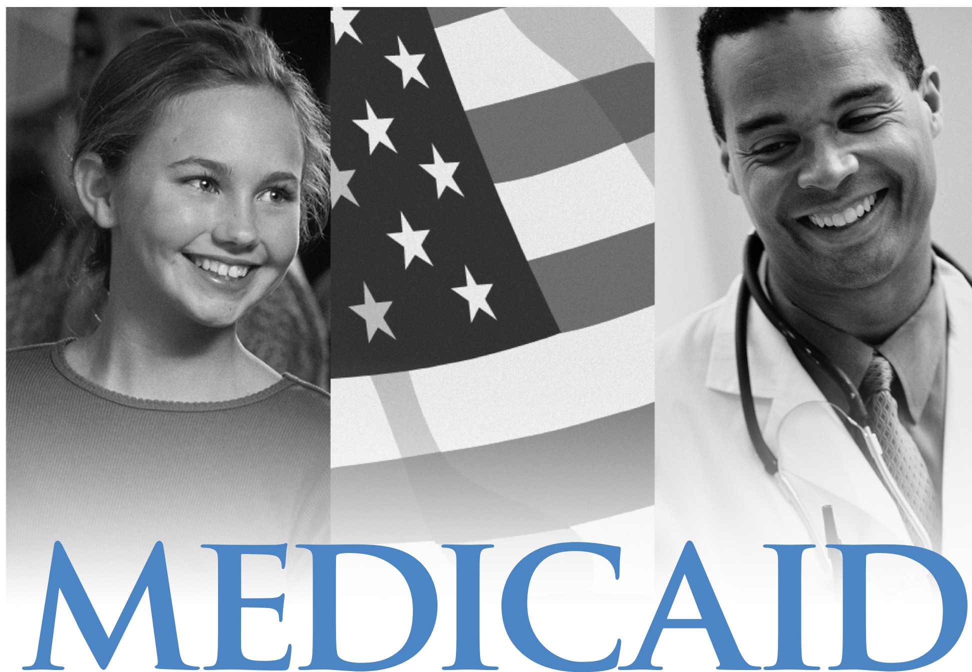
Providers need to acknowledge the program's growing prominence, Dr. Buck said. They need to be aware of emerging trends and new regulations that may affect their provision of services to both Medicaid recipients and non-recipients alike. And they should know about resources available from SAMHSA and other organizations that can help them navigate this complex program (see box on page 12).

A Safety Net

Created in 1965 as part of the Social Security Act, Medicaid is basically a health insurance program for certain individuals and families who lack the income or resources to pay for medical care. The program covers doctor and hospital bills, prescription drug costs, and other medical expenses, providing payment directly to health care providers.

Medicaid is financed jointly by the Federal Government and state governments, with the Federal Government matching the amount that states spend.

UNDERSTANDING MEDICAID



The Federal Government sets broad standards; states decide the details. Subject to Federal approval, states decide who is eligible for the program, what services the program will cover, how much providers will be paid, and so forth. While the Federal Government requires states to offer coverage for such basic services as doctor visits and inpatient hospital stays, for example, states can also offer certain optional services. This flexibility means that eligibility, services, and other details may vary from state to state and from year to year.

It's important to keep in mind that Medicaid is primarily a medical program, emphasized Dr. Buck. "People sometimes expect Medicaid to pay for everything," he said, citing as examples some advocates' calls for housing and educational support to be covered. "But Medicaid is intended to be a medical assistance program similar to other kinds of health insurance."

A Growing Role

Mental health service providers need to be aware of several trends, according to Dr. Buck and other Medicaid experts.

The most important of these trends is Medicaid's increasingly dominant role in the provision of mental health services. Over the last 10 or 15 years, said Dr. Buck, a major shift took place in the way that states fund, organize, and deliver public mental health services. In the old days, he explained, state mental health authorities set their own policies and paid designated providers directly for the services they provided. Now that system is being displaced by state Medicaid programs, which are more like health insurance plans in their approach to organization and financing.

"States have moved more and more services into Medicaid that weren't Medicaid services before," said Dr. Buck, noting that the budget crunch affecting many states has accelerated the trend. Coupled with changes

continued on page 12

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that broadened eligibility in the late 1980s, this trend led to explosive growth in the size of state Medicaid programs.

"Medicaid is already the largest single payer of mental health services in the United States," CMHS Director Kathryn Power, M.Ed., told participants at the 2004 Invitational Conference on Medicaid and Mental Health Services in Baltimore, MD, last October. "It's larger than private insurers. Larger than Medicare. Larger than all other state and local payers combined!"

Medicaid already funds more than half of all public mental health services that states provide, Ms. Power noted. And if current trends continue as predicted, that number could jump to two-thirds over the next 10 to 15 years.

This growing dominance also makes Medicaid a key player in another trend—the call to transform the mental health system, issued by the President's New Freedom Commission on Mental Health. "Medicaid figures so prominently in the transformation equation that without Medicaid on board, transformation will not happen," Ms. Power told the audience in Baltimore.

SAMHSA has already launched a number of projects designed to ensure that the mental health system's transformation takes Medicaid into account.

One key activity is data collection and analysis. For the first time ever, for example, SAMHSA is developing comprehensive statistics on Medicaid mental health services in every state. SAMHSA is also surveying state Medicaid authorities about how they administer mental health services, developing profiles of all Medicaid-funded mental health programs, and working with one state to develop a program for integrating de-institutionalized patients back into the community with Medicaid's help.

Collaboration between SAMHSA and the Centers for Medicare & Medicaid Services (CMS) is also critical. The agencies will be working together to help states develop plans for financing mental health services that take into account the growing role that Medicaid plays. SAMHSA and CMS are also collaborating on technical assistance papers about specific Medicaid policies.

Medicaid-Related Resources

SAMHSA's Center for Mental Health Services (CMHS) and other agencies offer many resources to help mental health service providers learn about Medicaid:

- Invitational Conference on Medicaid and Mental Health Services. Cosponsored by SAMHSA and the Centers for Medicare & Medicaid Services (CMS), this annual invitation-only event brings together state Medicaid and mental health departments.
- Technical assistance papers. The Medicaid subcommittee of the President's New Freedom Commission on Mental Health urged CMHS to provide more technical assistance to states. CMHS is now working with CMS to develop papers clarifying policies and highlighting promising practices. The first, "Psychotropic Medications: Addressing Costs without Restricting Access," is available at **www.cms.hhs.gov/promisingpractices/psychotropicmeds.pdf.**
- Data. CMHS gathers and analyzes data on Medicaid and mental health. See **www.mentalhealth.samhsa.gov/cmhs.**

Other organizations also offer:

- In-depth Medicaid information from CMS at **www.cms.hhs.gov/medicaid/default.asp.**
- The National Alliance for the Mentally Ill offers a comprehensive publication called *Medicaid Facts: What You Need to Know* at **www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Policy_Research_Institute/NAMI-Medicaid_Facts.pdf.** The publication includes fact sheets, a glossary, and a bibliography.

Recent Changes

In addition to these broad trends, there have been several recent changes that affect the provision of mental health services by state Medicaid programs.

The Balanced Budget Act (BBA) of 1997 institutionalized the use of managed care in Medicaid and applied specific beneficiary protections. States continued to require waivers for services to disabled children and children's mental health programs.

One important change concerns calculating capitation rates, the fixed amount that a provider receives per patient over a set period of time, no matter how much or how little service that patient actually receives. Pre-BBA, states paid capitated providers in the form of an upper payment limit based on the traditional Medicaid funding. Post-BBA, capitation rates must be "actuarially sound," or based on the actual cost of services provided in the managed care setting. Regardless of how the rates were set, pre-BBA or post-BBA, all Medicaid funds were to be spent only on Medicaid services to Medicaid enrollees.

"Before the BBA, a lot of states thought they didn't have to track every unit of service," Dale Jarvis, C.P.A., managing consultant and Director at Seattle's MCPP Healthcare Consulting, Inc., told the Baltimore conference participants. "Folks assumed that under managed care, there was added flexibility to give clients what they need, even if it didn't fit into a defined service code, and recording and tracking every unit of service was not as important as 'doing the right thing' for the client."

The shift to actuarial soundness also inadvertently revealed cases of the improper use of Medicaid. This means more careful recordkeeping for some providers.

"We discovered that Medicaid funds were being used inappropriately,"

explained Brenda Jackson, M.P.P., a health insurance specialist in the Kansas City, MO, CMS Regional Office.

Some states were using their savings—the difference between a $1 capitation rate and the 80 cents actually spent—on non-eligible services to non-eligible individuals. Furthermore, some states used leftover money to enhance their overall system for non-Medicaid eligibles. One state used the Medicaid mental health money to purchase county sheriff cars.

The increased awareness of the inappropriate uses of Medicaid funds may mean budget trouble ahead for some states that used Medicaid to fund public systems for non-Medicaid enrollees. Before this recent change, for example, a state might have received a capitation rate of $1 per patient per month but only spent 80 cents on Medicaid services to Medicaid eligibles. Under the new regulations requiring that capitation rates must be actuarially sound, that state would receive only 80 cents from Medicaid the following year. Even before this change, some states were already trimming services, eligible populations, or both.

Another piece of legislation that may have an impact on the provision of state mental health services is the Medicare Modernization Act, which provides a prescription drug benefit to Medicare beneficiaries.

Although the legislation focuses on Medicare—the Federal Government's health care program for older Americans and some people with disabilities—it will affect some beneficiaries who are eligible for both Medicare and Medicaid. These "dual-eligibles" may see changes in what they pay for their medications, where they obtain them, and whether they have access to specific drugs at all—a big concern for those who depend on psychotropic medications.

"The Medicare prescription drug benefit is the most significant thing coming down the pike," said Dr. Buck. "But since the rules are still in development, it's difficult to say what the potential impact will be." ◗

—By Rebecca A. Clay

Teen Drug Use Continues Decline

Results from the annual Monitoring the Future (MTF) survey indicate an almost 7-percent decline of any illicit drug use in the past month by 8th, 10th, and 12th graders combined from 2003 to 2004. Trend analysis from 2001 to 2004 revealed a 17-percent cumulative decline in drug use and an 18-percent cumulative drop in marijuana past-month use.

"The new Monitoring the Future survey results are a clear indication that our efforts in substance abuse prevention are paying off. The Nation has surpassed the 2-year goal set by President Bush's National Drug Control Strategy," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "And we are well on our way to addressing the 5-year goal." The President set a national goal of reducing youth drug use by 10 percent within 2 years. The 5-year goal sets the mark for a 25-percent reduction in current use of illegal drugs by this age group.

The MTF survey is designed to measure drug, alcohol, and cigarette use and related attitudes among 8th-, 10th-, and 12th-grade students nationwide. In 2004, 49,474 students from 406 public and private schools participated in the survey, which is overseen by the National Institute on Drug Abuse (NIDA) at the National Institutes of Health and conducted by the University of Michigan. Survey participants report their drug use behaviors across three time periods: lifetime, past year, and past month.

Just as drug use among teens is dropping, more teens are refraining from cigarette smoking as well. In 2004, lifetime cigarette smoking decreased in 10th graders, following declines in lifetime use in all grades from 2002 to 2003. The survey results also showed evidence of a decrease in heavier smoking among 10th graders, with a significant decline in the smoking of a pack of cigarettes or more per day.

Inhalants and Painkillers Still Pose a Threat

Survey results show that lifetime inhalant use for 8th graders increased significantly. Inhalants are easily accessible in the form of household and office products. Commonly abused inhalants include glue, shoe polish, and gasoline.

"We are concerned about the increasing number of 8th graders using inhalants," said NIDA Director Nora D. Volkow, M.D. "Research has found that even a single session of repeated inhalant abuse can disrupt heart rhythms and cause death from cardiac arrest or lower oxygen levels enough to cause suffocation. Regular abuse of these substances can result in serious harm to vital organs including the brain, heart, kidneys, and liver," Dr. Volkow said.

Painkillers, including Vicodin and OxyContin, are of concern, too. While the rates of Vicodin abuse did not change significantly from 2003 to 2004, Vicodin was used by 9.3 percent of 12th graders, 6.2 percent of 10th graders, and 2.5 percent of 8th graders in the past year. OxyContin was used in the past year by 5 percent of 12th graders, 3.5 percent of 10th graders, and 1.7 percent of 8th graders in 2004. These rates were not significantly different from the rates in 2003; however, with all three grades combined, the survey shows a significant increase in past-year OxyContin use between 2002 and 2004.

For further information about the 2004 MTF survey, visit **www.drugabuse.gov/DrugPages/MTF.html.** ◗

We'd Like To Hear From You!

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

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

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Thank you for your comments!

SAMHSA “Short Reports” on Statistics

SAMHSA’s Office of Applied Studies (OAS) recently released several “short reports,” which are based on statistics and data from the Treatment Episode Data Set (TEDS) and the National Survey on Drug Use and Health (NSDUH). For print copies of short reports described below, contact SAMHSA’s National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686. For Web versions in HTML and PDF formats, visit **www.oas.gov** or use the URLs provided.

Young People and DUI

Recent data from the 2002 and 2003 NSDUH show that more than 4 million young people age 16 to 20 drove under the influence (DUI) of either alcohol or drugs in the past year. Motor vehicle crashes were the leading cause of death among this age group in 2002. In that year, 6,327 young people were involved in fatal crashes. **www.oas.samhsa.gov/2k4/youthDUI/youthDUI.cfm.** (Web only)

Smoked Methamphetamine/ Amphetamine

In 2002, according to TEDS, 50 percent of primary methamphetamine/amphetamine admissions reported smoking the drug, up sharply from 12 percent in 1992. Also, the proportion of smoked methamphetamine/ amphetamine admissions age 30 and older increased from 34 percent in 1992 to 47 percent in 2002. **www.oas.samhsa.gov/2k4/methSmoked/methSmoked.cfm.** (Print and Web)

Daily Marijuana Users and Unemployment

In 2003, an estimated 3.1 million persons age 12 and older used marijuana daily (i.e., on 300 or more days) in the past year according to NSDUH data. Daily marijuana users were more likely to be unemployed compared with those who used it less than daily and those who did not use it at all in the past year. Nearly two-thirds of daily marijuana users also reported using at least one other illicit drug in the past 12 months. **www.oas.samhsa.gov/2k4/dailyMJ/dailyMJ.cfm.** (Print and Web)

National Survey on Drug Use and Health

The NSDUH Report

September 24, 2004

Risk and Protective Factors for Substance Use among American Indian or Alaska Native Youths

In Brief

- American Indian or Alaska Native youths were more likely to perceive moderate to no risk of substance use
- A larger percentage of American Indian or Alaska Native youths did not perceive strong parental disapproval of youth substance use than youths in other racial/ethnic groups
- American Indian or Alaska Native youths were more likely to believe that all or most of the students in their school get drunk at least once a week

Recent reports have shown higher rates of substance use among American Indians or Alaska Natives compared with persons from other racial/ethnic groups. Among American Indian or Alaska Native youths aged 12 to 17, the rates of past month cigarette use, binge drinking, and illicit drug use were higher than those from other racial/ethnic groups.[1,2] The National Survey on Drug Use and Health (NSDUH) collects data on a variety of risk and protective factors found to be associated with youth substance use. Risk factors for substance use typically are associated with an increased likelihood of substance use (e.g., drug availability), whereas protective factors are associated with a decreased likelihood of substance use (e.g., perceived parental disapproval of alcohol or drug use). Research has shown similar associations with risk and protective factors and substance use among American Indian or Alaska Native youths compared with youths in other racial/ethnic groups.[3,4]

Drug and Alcohol Services Information System

The DASIS Report

January 7, 2005

Smoked Methamphetamine/ Amphetamines: 1992-2002

Amphetamines and methamphetamine are central nervous system stimulants. They[1] were the primary substance of abuse in more than 125,000 substance abuse treatment admissions in 2002 (almost 7 percent of all admissions) reported to the Treatment Episode Data Set (TEDS).[2] TEDS is an annual compilation of data on the demographic characteristics and substance abuse problems of those admitted for substance abuse treatment.

Methamphetamine/amphetamines can be consumed by smoking, inhalation, or injection. Smoked methamphetamine is often referred to as “ice” or “crystal meth.” This report will look at the characteristics of those whose primary route of administration was smoking the drug.

In Brief

- In 2002, 50 percent of primary methamphetamine/amphetamine admissions reported smoking the drug, up from 12 percent in 1992
- The proportion of smoked methamphetamine/amphetamine admissions aged 30 or older increased from 34 percent in 1992 to 47 percent in 2002
- The proportion of methamphetamine/amphetamine admissions reporting smoking the drug increased in many states across the country between 1992 and 2002

Primary Methamphetamine/ Amphetamine Admissions

In 1992, 39 percent of primary methamphetamine/amphetamine treatment admissions inhaled the substance, 32 percent injected, and 12 percent smoked

Prescription and OTC Drugs

Prescription and over-the-counter (OTC) drugs were the primary substances of abuse for 4 percent of the 1.9 million treatment admissions reported to TEDS in 2002. Of the more than 78,000 admissions for primary prescription or OTC drug abuse, 55 percent were for prescription narcotics, 28 percent for prescription stimulants, 10 percent for tranquilizers, 6 percent for sedatives, and less than 1 percent for OTC medications. **www.oas.samhsa.gov/2k4/prescriptionTX/prescription.cfm.** (Print and Web)

Alcohol Dependence/Abuse and Age at First Use

NSDUH data show that individuals who first used alcohol before age 15 were more than five times as likely to report past-year alcohol dependence or abuse than persons who first used alcohol at age 21 and older. Among the 14 million adults age 21 and older who were classified as having past-year alcohol dependence or abuse, over 13 million (95 percent) had started using alcohol before age 21. **www.oas.samhsa.gov/2k4/ageDependence/ageDependence.cfm.** (Print and Web)

Risk Factors for American Indians, Alaska Natives

NSDUH data show that American Indian and Alaska Native youth were more likely than youth in other racial/ethnic groups to perceive moderate to no risk associated with substance use. Also, a larger percentage of American Indian and Alaska Native youth did not perceive strong parental disapproval of substance use. They were more likely to believe that all or most of the students in their school get drunk at least once a week. **www.oas.samhsa.gov/2k4/AmIndianYouthRF/AmIndianYouthRF.cfm.** (Print and Web)

Heroin—Changes in Use

Data on substance abuse treatment admissions from TEDS show that between 1992 and 2002, inhalation increased as the route of administration from 20 to 33 percent of primary heroin admissions, while injection decreased from 77 to 62 percent. **www.oas.samhsa.gov/2k4/HeroinTrends/HeroinTrends.cfm.** (Web only) ◗

SAMHSA NEWS

Published bimonthly by the Office of Communications

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