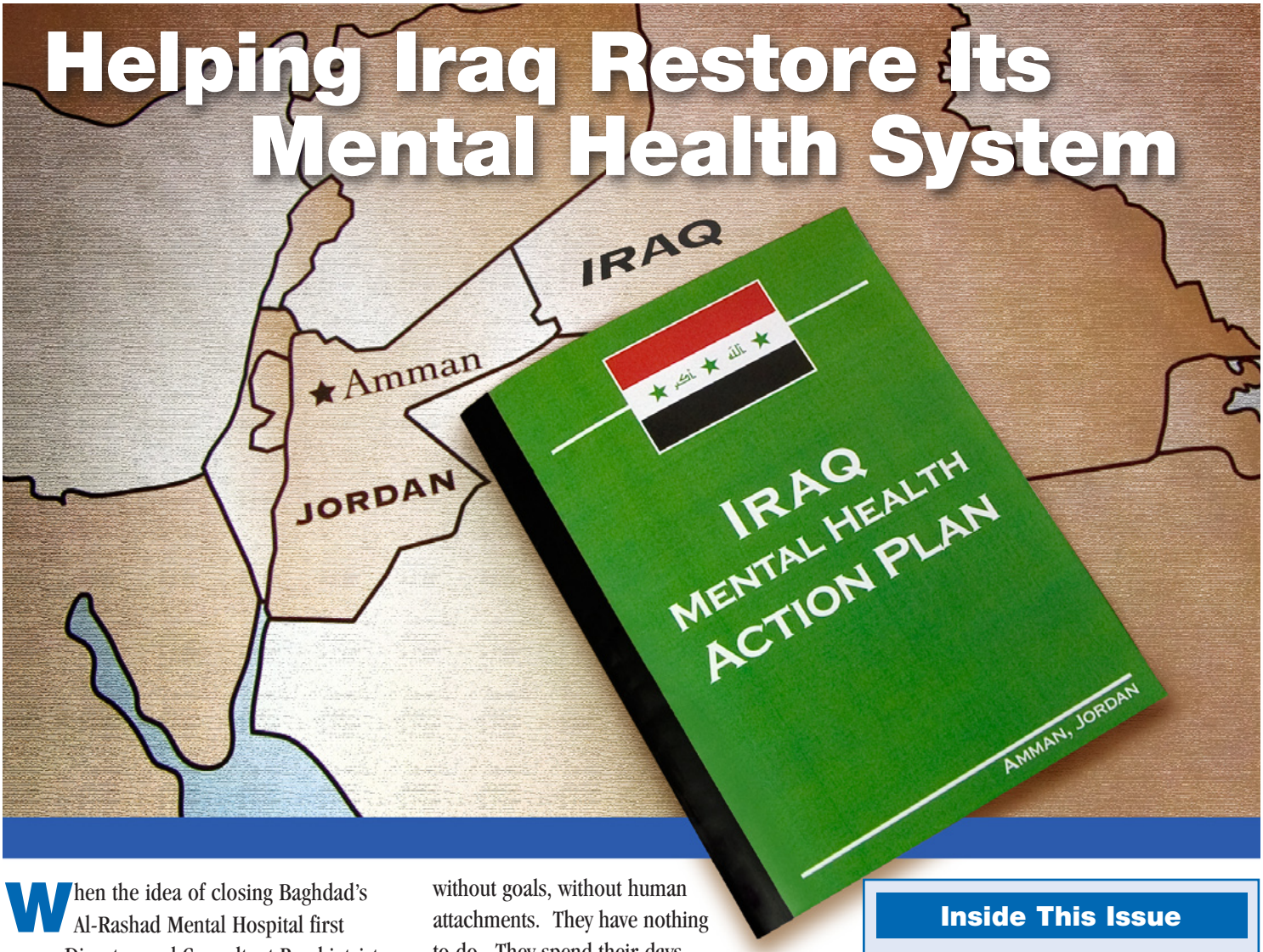
Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

May/June 2005, Volume 13, Number 3

Helping Iraq Restore Its Mental Health System



When the idea of closing Baghdad's Al-Rashad Mental Hospital first arose, Director and Consultant Psychiatrist Muhmmad R. Lafta, M.D., didn't believe it was possible. But after exploring the idea further at a recent conference, he's now committed to closing the hospital as soon as possible—even though it means putting himself out of a job. (See box on page 8.)

"It's not unusual for patients to spend 20 years in the hospital," explained Dr. Lafta. "These are people without rehabilitation, without goals, without human attachments. They have nothing to do. They spend their days waiting for pills. I'm now convinced that a better way to treat patients is to let them live in the community. Instead of just being left in the hospital, they should be treated like human beings."

The event that changed Dr. Lafta's mind was the Action Planning Conference for Iraq Mental Health held in Amman, Jordan, in

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Public Spending for Mental Health, Substance Abuse Treatment Increases

Over the last decade, the mental health and substance abuse field has seen a shift in spending away from inpatient care and toward outpatient care. The field has seen much greater spending on prescription medication. And the Government's share of total spending has increased significantly.

These findings are highlights from a new report, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991-2001.* Presented by SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS), the report tracks trends in national spending on mental health services and substance abuse treatment between 1991 and 2001.

The report provides spending estimates on direct treatment but not on the social costs of substance abuse and mental illness, such as their effect on productivity and link to crime.

"This report provides a bird's-eye view of mental health and substance abuse spending," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., noting that mental health services accounted for 6 percent and substance abuse 1 percent of the almost $1.4 trillion spent on health care overall in 2001.

Key Findings

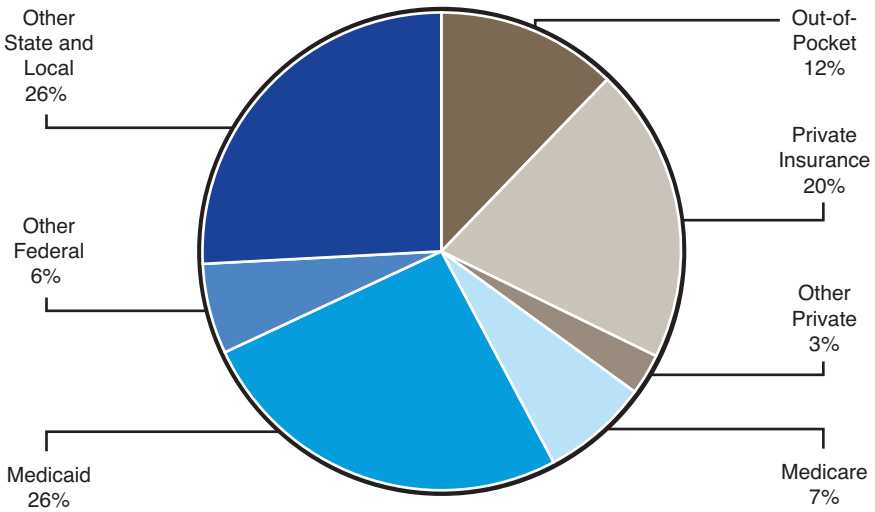
The report identifies several major trends:

- **Spending increases.** Spending on mental health and substance abuse treatment is growing, with expenditures increasing by nearly 6 percent a year between 1991 and 2001. All health care spending grew even faster, approaching 7 percent.
- **Medication's growing importance.** Between 1991 and 2001, several new medications for mental disorders became available, more people started taking these medications, and prices went up. In 1991, for example, prescription drugs represented 1 of every 14 dollars spent on mental health. A decade later, such drugs represented 1 of every 5 dollars. Antidepressants accounted for more than half of these drug expenditures and antipsychotics nearly a quarter.
- **Decline in inpatient treatment.** As a share of total spending, inpatient expenditures—especially those for psychiatric hospitals—declined over the decade. The same trend occurred in the substance abuse field. In 1991, for example, 46 percent of substance abuse treatment spending went to inpatient care. By 2001, that percentage had dropped to 30 percent.
- **Shift to public spending.** An increasing share of the payment for mental health and substance abuse treatment comes from public sources such as local, state, and Federal governments. "It's clear the public sector is now the major financial driver," said Mr. Curie. Public financing of mental health services and substance abuse treatment grew from 58 percent of total spending for those services in 1991 to 65 percent in 2001.

The growth of public financing was even more pronounced in substance abuse treatment, where it jumped from 62 percent of total substance abuse treatment spending in 1991 to a whopping 76 percent in 2001. While private insurance payments for health care overall grew at a rate of almost 7 percent annually, private insurance payments for substance abuse treatment dropped by 1 percent annually.

- **Dominance of Medicaid.** Medicaid is playing an increasingly prominent role. For mental health services, for example, Medicaid spending is growing faster than that of any other payer. As a result, it has become the Nation's largest payer of mental health services.

Distribution of Mental Health Services and Substance Abuse Treatment Expenditures by Payer, 2001



Mental Health and Substance Abuse Treatment = $103.7 billion

Source: SAMHSA. *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991-2001* (page 10).

A Crucial Resource

Who uses this information?

"The target audience is anybody who's concerned with health care spending trends—policymakers, researchers, treatment providers, advocates, and the like," explained Jeffrey A. Buck, Ph.D., one of the report's co-authors and the Associate Director for Organization and Financing at CMHS. "We've already established these reports as the primary source for people to find out what's happening with mental health and substance abuse spending in the Nation."

The report's popularity derives from its comprehensiveness, added Rita Vandivort, M.S.W., another of the report's co-authors, the project officer, and a public health analyst in the Division of Services Improvement at CSAT.

"There's really no other report on mental health and substance abuse services that is comprehensive across all public and private payers like this expenditure study is," she explained. "It provides a benchmark for looking at where we are and how spending for services is changing." Readers can also compare the report to the National Health Accounts from the Centers for Medicare & Medicaid Services, which reports spending on all health services.

SAMHSA produces these spending reports periodically. But because each report takes advantage of better data sources and improved methods, it's unwise to compare spending estimates in one report to those published in earlier documents.

"Every time we do one of these reports, we go back and re-estimate the values for previous years," said Dr. Buck. "Whenever one of these new reports comes out, you should replace your old report with the new one."

For a copy of the full report, visit **www.samhsa.gov** or call SAMHSA's National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686.

—By Rebecca A. Clay

From the Administrator

Tracking Trends To Transform Health Care

Given the prevalence of morbidity and mortality related to mental and substance use disorders, and the wider societal impact they produce, it's important to know how much the Nation is investing in prevention and treatment of these disorders and to what extent prevention and treatment are having an impact in producing change.

A new report from SAMHSA, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991-2001,* highlights the fact that over the last 10 years an increasing share of the payment for mental health and substance abuse treatment comes from public sources such as local, state, and Federal government, with Medicaid playing an increasingly prominent role. (See *SAMHSA News,* page 2.)

In fact, for mental health services, Medicaid's spending is growing faster than that of any other payer. As a result, it has become the largest payer of mental health services in the Nation. State and local dollars grew fastest for substance abuse spending.

With private sources paying an increasingly small percentage of these costs, it's clear that the public sector is now the major financial driver.

Simultaneously, SAMHSA has embarked on a strategy to obtain the data needed to measure and manage the performance of our programs that provide services for substance abuse and mental health. Working in cooperation with states and focusing on a handful of carefully selected National Outcome Measures, SAMHSA will be able to monitor client outcomes and help direct improvements within the service delivery system. *SAMHSA News* will carry an in-depth article on the National Outcome Measures in the next issue.

Why is it so critical for us to track trends and outcomes? Budget makers and financial payers are increasingly basing funding decisions on outcome data. This is true within all sectors—Federal, state, local, and private.

It's no longer enough to show evidence of a need; we must be able to demonstrate results in order to assure funding for the services that we know work. That's public accountability.

Developing a clearer understanding of trends and outcomes is especially important right now, as SAMHSA leads the Administration's initiatives to transform the Nation's mental health services system, expand people's access to substance abuse treatment, and incorporate efforts to prevent substance abuse and promote mental health in community programs.

With these goals, it is imperative that we track expenditures and outcomes from prevention and treatment efforts. This information will inform us as we continue to improve access and quality of care and offer hope to the people we serve.

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

Group Therapy Guide Focuses on Substance Use Treatment

SAMHSA recently unveiled a comprehensive guide on the use of group therapy in treating substance use disorders.

Substance Abuse Treatment: Group Therapy, SAMHSA's Treatment Improvement Protocol 41 (TIP 41), emphasizes that group therapy is effective treatment and is a cost-effective way to deliver treatment.

A consensus panel of experts developed the publication, which is designed to aid substance abuse counselors who use group therapy in the treatment of substance use disorders. The TIP series is produced by SAMHSA's Center for Substance Abuse Treatment (CSAT).

The guide includes detailed, state-of-the-art information about group therapy modalities, techniques, and practices valuable to supervisors and trainers of counselors as well.

The consensus panel found that group therapy offers a number of advantages to participants, including positive peer support, a reduction in their sense of isolation, real-life examples of people in recovery, and help from peers in coping with substance abuse and other life problems.

"Group therapy offers participants a critical pathway for the hope, support, and encouragement needed to break free from substance abuse," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Because of its effectiveness and economy of scale, group therapy has gained popularity. The group approach has come to be regarded as a source of powerful curative forces that are not always experienced by the client in individual therapy," he added.

According to TIP 41, group therapy is effective for several reasons. Group participation engages therapeutic "forces" such as affiliation, support, gratification, and peer confrontation. These properties can bond participants to the culture of recovery. In addition, groups are effective in treating problems that often accompany addiction—including depression, isolation, stigma, and shame.

Group therapy models described in TIP 41 include the following:

- **Psycho-educational.** Educate clients about substance abuse.
- **Skills development.** Cultivate the skills needed to attain and sustain abstinence.
- **Cognitive-behavioral.** Alter thoughts and actions that lead to substance abuse.
- **Support.** Provide a forum to share practical information about abstinence and ways to sustain day-to-day, chemical-free living.
- **Interpersonal process.** Delve into major developmental issues that contribute to addiction and can interfere with recovery.

TIP 41 also offers information on specialized groups that do not fit neatly into the five-model classification mentioned above, especially those groups that focus on solving a single problem.

TIP 41 helps counselors:

- Understand why groups work so well in treating substance abuse and how to tailor group therapy to substance abuse treatment.
- Weigh considerations before placing a client in a particular group (e.g., stage of recovery and client diversity).
- Compare "fixed" and "revolving" types of therapy groups and understand how to prepare clients for participation.
- Understand stages of treatment.

Group therapy is not equivalent to a 12-step program, the guide emphasizes. But the two are complementary to the recovery process.

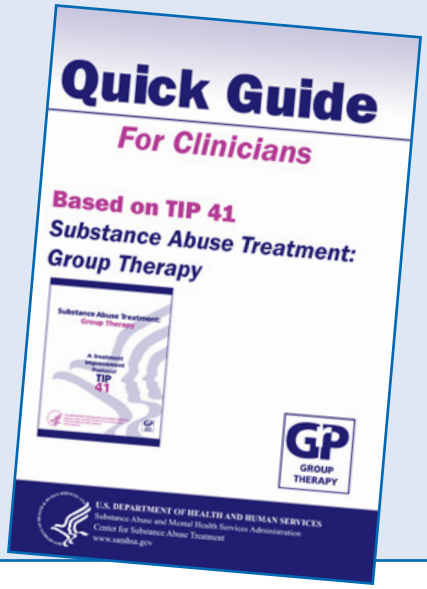
For more information, visit **www.kap.samhsa.gov/products/manuals/tips/numerical.htm.**

Quick Guide for Clinicians

This booklet is a pocket companion to the 184-page Treatment Improvement Protocol 41 (TIP 41)—*Substance Abuse Treatment: Group Therapy.* Based on TIP 41, this publication offers clinicians concise, easily accessible information. A glossary of terms is also included.

To obtain TIP 41 or the *Quick Guide for Clinicians,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD).

You can review the entire TIP series by topic or by number. To review the list of available TIPs or to access online links, visit **www.kap.samhsa.gov/products/manuals/tips/numerical.htm.**



Treatment in Lieu of Jail: Diversion Succeeds

When San Antonio police took 36-year-old Letty Trinidad to jail last year, it was the culmination of a series of incarcerations and suicide attempts fueled by drug and alcohol dependency and major depression that had plagued the mother of three since her teens.

This time, however, staff from the jail diversion program at the San Antonio Center for Health Care Services (CHCS) intervened on her behalf and arranged for her admission to a drug and alcohol rehabilitation center.

Today, Ms. Trinidad attends support group meetings at CHCS. She also takes classes and volunteers at the San Antonio chapter of the National Alliance for the Mentally Ill, learning how to help others with mental illnesses and substance abuse. She is living on her own, with her three children. And she found a job. "I know I can do this," said Ms. Trinidad. "I just feel good about myself."

Ms. Trinidad's success story is one of many in Bexar (pronounced "bear") County, TX. San Antonio is 1 of 20 community sites nationwide currently funded by SAMHSA's Targeted Capacity Expansion (TCE) grants for Jail Diversion Programs. "Bexar County initiated its program to help people with severe mental illness get out of county jails, off the streets, into treatment programs, and back to meaningful, productive lives," said Leon Evans, Executive Director of the CHCS jail diversion program.

Similar success stories are unfolding in other communities assisted by SAMHSA's TCE grants.

SAMHSA's Center for Mental Health Services (CMHS) has awarded these TCE grants since 2002. Participating communities receive up to $300,000 annually for up to 3 years and contribute at least $100,000 per year from local resources toward the implementation of the project.

Letty Trinidad, a mother of three, is one of the success stories from San Antonio's jail diversion program in Bexar County, TX.

In addition, CMHS funds a national Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion, which assists grantees in planning, establishing, and evaluating their programs and provides technical assistance and resources to other communities interested in developing similar programs.

"The jail diversion program really is a transformational effort," said Neal Brown, M.P.A., Chief of the Community Support Program Branch at CMHS. "What communities such as San Antonio are doing is getting people with mental illness and co-occurring substance abuse disorders out of the criminal justice system and into community treatment programs, giving them opportunities to stay out of jail."

An Ongoing Problem

"Some of our jails are our largest mental hospitals," said Linda A. Teplin, Ph.D., a public health researcher and expert on mental health and criminal justice issues. She is the Owen L. Coon Professor of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University. Dr. Teplin has studied the interface between the mental health and criminal justice systems for the past 29 years.

According to the Bureau of Justice Statistics, at mid-year 2004, 713,990 inmates were held in local jails across the Nation, up from 691,301 at mid-year 2003—an increase of 3.3 percent. "Our best guess," Dr. Teplin added, "is that as many as 90,000 of those individuals may have a severe mental disorder." And of those 90,000, many have co-occurring substance abuse disorders as well.

According to the President's New Freedom Commission on Mental Health, the problem is inescapable in nearly every urban community. Ironically, the majority of these individuals have committed only minor offenses such as disturbing the peace. Typically poor and uninsured, these individuals often are homeless and have co-occurring substance abuse and mental disorders. They cycle in and out of shelters, hospitals, and jails, occasionally receiving mental health and substance abuse treatment services, but most likely receiving no treatment at all.

Cost studies suggest that communities (and taxpayers) can save on costs by supporting proven jail diversion programs as an alternative to incarceration.

In Bexar County, according to a December 2004 policy analysis report, an estimated 14 percent of the county's jail population has severe mental illness, and 75 percent have co-occurring substance abuse problems. Many of San Antonio's large homeless population—some 25,000 to 30,000 people—have a mental illness. The Texas CHCS, the county's mental health authority, is spearheading the turnaround for Bexar County in close collaboration with city, county, and state law enforcement authorities in addition to judicial and health care entities.

To be effective, most jail diversion programs coordinate a comprehensive set of services at the community level. The cooperation of all involved agencies

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Leon Evans (l), Executive Director of Bexar County's jail diversion program, and Neal Brown (r), Chief of the Community Support Programs Branch at SAMHSA's Center for Mental Health Services.

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helps integrate mental health care and substance abuse treatment, physical health care, and social services, such as housing, food, and clothing.

Programs work to bridge the barriers between the mental health and criminal justice systems and help identify detainees who need mental health treatment and meet the jail diversion criteria. This is done through the initial screenings and evaluations at the crisis triage center, arraignment court, or jail.

Bexar County's diversion program relies on three phases of intervention. The first phase uses Deputy Mobile Outreach Teams and Crisis Intervention Teams to divert offenders with mental illness before they are arrested or booked in the county jail. During the second phase, the program identifies persons with mental illness within the system and makes recommendations for alternatives to incarceration, such as mental health bonds or release to treatment facilities. The third phase focuses on providing appropriate services upon their release from jail or prison.

Deputy Mobile Outreach Teams, composed of county deputies and mental health clinicians, are available for onsite mental health assessments and interventions 24 hours a day, 7 days a week. Their mission is to screen high-risk individuals with mental illness and refer or transport them to the CHCS Crisis Center for further evaluation.

Crisis Intervention Teams are staffed by police officers trained to work with persons with mental illness. Their goal is to respond and to resolve conflict so that individuals with mental illness can be safely transported to the Crisis Center or, if necessary, the jail.

CHCS representatives also make home visits, helping people order their lives through cognitive adaptive training (CAT). CAT involves strategic placement of objects and lists of things they need to do, to keep them on track and taking their medications. "Jail diversion is also about identifying people who need additional supports and helping them maintain their good mental health and reintegrating them into the community," said Mr. Evans.

The CAT program also employs recovering people with schizophrenia to help gain the trust and participation of persons with mental disorders. Paul Eisenhauer, a 45-year-old man who suffers from the disorder, is doing well. He hasn't heard voices for more than a decade. Early diversion efforts helped him get out of jail and into a state hospital conducting clinical trials of a new antipsychotic medication. Today, he teaches police officers (who used to arrest him) about schizophrenia. "They really want to know what it's like to be schizophrenic," said Mr. Eisenhauer. "One officer came up to me and said, 'A lot of people are scared of schizophrenics,' and I said, 'A lot of people are scared of cops.' "

Paul Eisenhauer gives a presentation at San Antonio's Center for Health Care Services.

So how is the San Antonio program doing? Interim results show a significant number of jail diversions and potential savings in criminal justice costs. County officials are optimistic that added costs for mental health care will diminish as the long-term benefits of the program take hold.

"We're creating 'steps up' for people in jail into residential facilities, and we're getting them involved in active treatment and employment skills and starting them looking for housing," said Mr. Evans. And Texas is currently making plans to apply the Bexar County jail diversion model throughout the state.

"What's very impressive about the San Antonio program is the way they brought all these services together—the small providers, the big providers, the county judges, the university, primary health care, and the state legislature," said Mr. Brown. "They are transforming the way mental health services are delivered. And this is exactly what we had in mind with this program—to help bring about this kind of transformation and to change the public's view of people struggling to overcome co-occurring mental illnesses and substance abuse."

SAMHSA will announce the 2005 Jail Diversion Program awards in September. For information about the program, call the TAPA Center at 1 (866) 588-TAPA (8272) or visit the SAMHSA Web site at **www.samhsa.gov.**

—By Arnold Mann

SAMHSA, FDA Launch Campaign for Older Adults

SAMHSA celebrated Older Americans Month in May by joining with the Food and Drug Administration (FDA) in a campaign to encourage older adults to take special care when using prescription pain relievers.

The campaign, "Do the Right Dose," comes just in time. A recent SAMHSA report showed a 32-percent rise in admissions for substance abuse treatment among older adults (age 55 and older) over the 8-year period from 1995 to 2002.

SAMHSA released a new report, *Older Adults in Substance Abuse Treatment: Update,* which found that the percent of older adults with opiates as their primary substance of abuse increased from 6.8 percent to 12 percent in this time period. Opiates include prescription pain medications and heroin, and they are the second most frequent reason for treatment admissions among older adults, after alcohol.

To counter the upward trend in the abuse of opiates, SAMHSA and the FDA are sponsoring campaign advertising that includes print ads, television and radio public service announcements (PSAs), and posters. SAMHSA also updated the Agency brochure *As You Age.* (See *SAMHSA News,* May/June 2004.)

The brochure emphasizes that prescription pain medications are safe and effective when used correctly, but if misused, could lead to addiction or other problems.

"We are only beginning to realize the pervasiveness of substance abuse among older adults," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We have made older adults a priority at SAMHSA.

The "Do the Right Dose" campaign also has the support of the Administration on Aging, which works to warn older adults that medicine must be taken appropriately.

More Data and Statistics

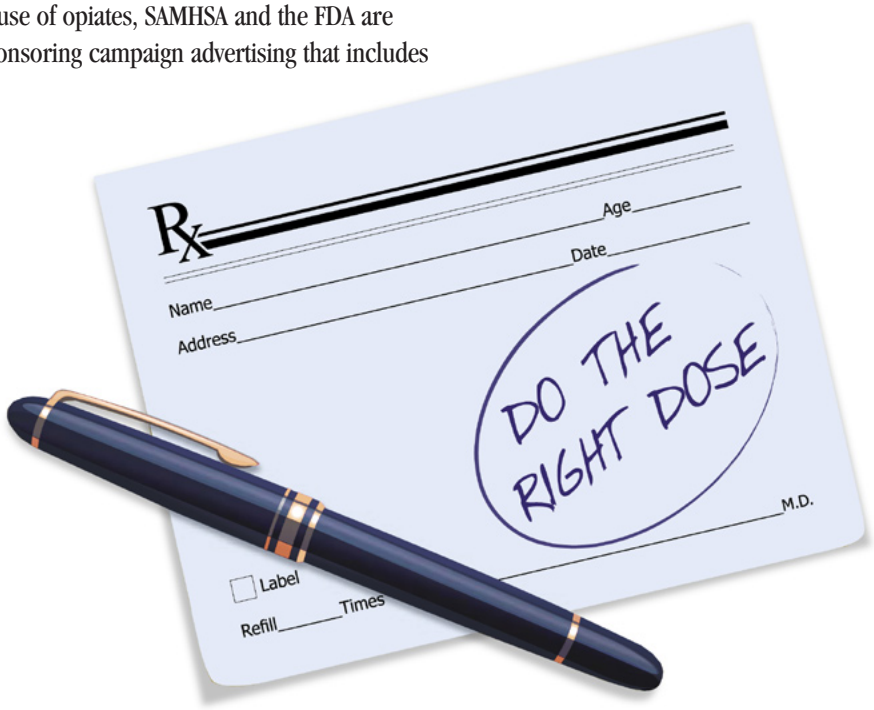
According to the SAMHSA report from the Office of Applied Studies' (OAS) Treatment Episode Data Set, alcohol is still the primary substance of abuse among older adults. But the proportion of older admissions reporting alcohol as their primary substance declined from 86.5 percent in 1995 to 77.5 percent in 2002. Drug admissions among persons age 55 and older increased by 106 percent for men and 119 percent for women between 1995 and 2002.

The report shows that between 1995 and 2002 the number of substance abuse treatment admissions among persons age 55 and older increased by 32 percent. In 2002, 66,500 admissions age 55 or older were admitted to substance abuse treatment facilities in the United States compared to 50,200 in 1995. This increase outpaced the total treatment population increase of 12 percent during the same time period.

For a print 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 *As You Age* brochure is also available from NCADI. Posters, print PSAs, and other campaign materials are available online at **www.asyouage.samhsa.gov/dotherightdose.**

For additional data on older adults, visit SAMHSA's Web site at **www.oas.samhsa.gov/aging.htm.**



The message to older adults from the new SAMHSA/FDA campaign is clear: Take your prescription as directed. To get answers about your pain reliever, call your doctor. For information about addictions, call 1 (800) 662-HELP (4357).

This year's theme for Older Americans Month is "Celebrate Long-Term Living!"

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March. The conference brought together 30 Iraqis—along with more than 20 American and British experts serving as resources—to figure out how to go about rebuilding the country's mental health system. SAMHSA organized and funded the event.

"The fact that the Iraqis recognize the centrality of mental health bodes well for their country's recovery," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We're committed to doing what we can to help."

Working Together

The conference came about when SAMHSA asked Sabah Sadik, MBCHB, FRCPsych, DPM, National Advisor for Mental Health at the Iraqi Ministry of Health, if he needed any help restoring Iraq's mental health system (see *SAMHSA News,* January/February 2005). Dr. Sadik is a psychiatrist who also serves as Medical Director of the West Kent National Health Service and Social Care Trust in England. In response to that offer of assistance, Dr. Sadik explained that what he needed most was help organizing an action planning conference.

Dr. Sadik and his colleagues were ready. Iraq's National Mental Health Council—a group comprising representatives from several government ministries including the Ministry of Health, as well as other interested persons outside the government—had already developed an initial plan with an ambitious agenda. "The purpose of the conference was really to consider that plan carefully and figure out what was missing and what was most urgent," explained conference organizer Winnie Mitchell, M.P.A., International Officer at SAMHSA.

Another conference goal was to help build a team to take on that work. Developed by a Planning Group on Iraq Mental Health chaired by SAMHSA, the conference brought together Iraqis from all parts of the country. It also brought together Iraqis from all sectors of society, including mental health professionals, government officials, judges, educators, human rights advocates, and religious leaders from the Muslim (including both Shiite and Sunni) and Christian faiths.

"Many of them had never met each other," said Ms. Mitchell. "Dr. Sadik

In Transition: Al-Rashad Mental Hospital

When Muhmmad R. Lafta, M.D., took over as Director of Baghdad's Al-Rashad Mental Hospital 2 years ago, the situation was so dire many of the patients didn't even have clothes. "They were naked," he said.

The lack of clothing was not the only evidence of serious neglect. "Just a few weeks before the war, the ex-regime released the convicted criminal patients into the streets," Dr. Lafta explained. "And during the war, almost all the patients ran away." Two-thirds of them were returned by families, neighbors, or police, but a third never returned. "We lost them."

The hospital itself has been bombed and looted of its equipment and drugs. Patient records have been destroyed. Located on the outskirts of Baghdad, the hospital now has the Americans on one side and insurgents on the other. "When there's fire between them, the patients start to cry and try to run away," said Dr. Lafta. "It's very dangerous."

Even without a war raging outside, the hospital would have a hard time. Iraq's main psychiatric institution, the hospital offers both inpatient and outpatient services. Its 1,200 beds, including 250 forensic beds in a secure unit, are always full. There are only eight psychiatrists to serve these patients, very few allied health professionals, and barely any medications available.

The intense stigma attached to mental disorders and the lack of rehabilitation and government support make families reluctant to take back patients even once they've stabilized. Some of the psychiatrists at the hospital are ashamed to admit where they work.

Now that Dr. Lafta has seen community-based services in England and the United States, he's convinced that's the model to use. He envisions patients living in group homes staffed by nurses or even in their own families' homes. The government could provide small salaries to family members, who would serve as patients' case managers. Psychiatrists could visit weekly or monthly. And Al-Rashad would be transformed into an institution serving only forensic patients.

Dr. Muhmmad Lafta

Trained in Iraq, Dr. Lafta began his studies hoping to be a physician specializing in neurology. Because such specialized training was unavailable, he shifted to the next closest thing—psychiatry. Before coming to Al-Rashad, he served as a psychiatrist and officer in Iraq's army, treating patients in military hospitals and lecturing at the military medical school. "The old regime focused on the army and neglected civilian patients," he explained. What will he do once the hospital closes? "Iraq needs hundreds of psychiatrists," he laughed. "I'm not worried."

SAMHSA Administrator Charles G. Curie listens as Dr. Sabah Sadik, Iraq's National Advisor for Mental Health, comments on the Mental Health Action Plan.

really meant the conference to be a team-building exercise."

Joining the Iraqis were representatives from the United States, the United Kingdom, and international entities such as the World Health Organization and the World Bank. These experts, including Mr. Curie and other SAMHSA representatives, served as resources during the didactic sessions that began the conference.

Mr. Curie and Dr. Sadik, for example, gave a joint presentation on leadership and team building in mental health services. Anita Everett, M.D., Senior Medical Advisor at SAMHSA, summarized the history of deinstitutionalization and the creation of community-based services in the United States. Other topics included the integration of mental health services and primary care, health care financing, and staff and professional development.

Recommending Action

Participants then split into four work groups, with Dr. Sadik urging them to come up with "clear and defined decisions" rather than recommendations.

One of the most important decisions was to create a mental health system very different from the country's previous one.

"The Iraqis had a very medicalized, institution-based model of mental health care in the past, but there was clear agreement at the conference that the country would now prioritize the development of an integrated, community-based care model," explained Ms. Mitchell. "Iraq will not only be re-establishing mental health care, but doing it around a different model."

Closing Al-Rashad Hospital wasn't the only suggestion to come out of the Mental Health Services Work Group. Other recommendations include integrating mental health and primary care; establishing rehabilitation programs for people with chronic and severe mental illness; creating substance abuse treatment programs; developing specialty services for children, older adults, and forensic patients; and reaching out to spiritual leaders of all faiths.

The Mental Health Policy and Support Work Group compiled a list of action items designed to promote coordination and collaboration within Iraq's Ministry of Health and the government as a whole. The government should allow the National Mental Health Council to "steer" the country's mental health program, the group urged. The group also called for joint training in mental health issues for government employees working in health, criminal justice, education, and other areas.

Other urgent action items include developing a code of practice outlining patient rights and practitioner standards, developing a referral system for primary care physicians, creating a medical records system, and launching a general public awareness campaign on mental health.

The Mental Health Training and Education Work Group sought ways to overcome the country's severe shortage of professionals trained to diagnose and treat mental illness. One key action item is to expand the workforce by developing training programs for primary care physicians, psychologists, clinical social workers, psychiatric nurses, and paraprofessional community mental health workers.

The Scientific Programs and Research Capacity Work Group called for developing policies about research ethics and creating a committee to establish standards, review research proposals, and protect research participants. The group also recommended the creation of at least one "Mental Health Center of Excellence," which would conduct interdisciplinary studies of mental problems common in Iraq, train clinicians and researchers, and provide model programs for clinical services.

The group also urged the National Mental Health Council to work with other ministries to establish research priorities. Studies on stress and coping should be a top priority, the work group recommended. Also important are studies to determine the prevalence of mental disorders and substance abuse in Iraq and the public health, economic, and social burdens these problems place on individuals, families, and the country itself.

Following Up

Conference participants are already taking action. Iraq's Deputy Minister of Health, Dr. Ammar Al Safar, has approved all

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of the work groups' recommendations. Dr. Sadik is sharing their recommendations with Iraq's new Minister of Health, Abdel-Muttalib Mohammed Ali Al-Rubayee.

Conference participants are also determined to maintain—and strengthen—the connections made at the conference.

Mr. Curie, for instance, traveled to the United Kingdom in early May to meet with Dr. Lafta and nine other Iraqi psychiatrists who are undergoing 3 months of specialized training with Dr. Sadik at the West Kent National Health Service and Social Care Trust. Dr. Lafta's fellowship focuses on psychotherapy and community-based service delivery; the others are focusing on such topics as child psychiatry, geriatric psychiatry, and forensic psychiatry.

With funding from SAMHSA, Dr. Lafta was also able to come to the United States to visit SAMHSA and service providers, attend the American Psychiatric Association's 2005 annual meeting along with Dr. Everett, and go on rounds with another conference participant, an expatriate Iraqi psychiatrist named Husam Alathari, M.D. In 2006, the participants plan to meet again—if possible, in Baghdad—for another SAMHSA-sponsored conference, at which participants will report their progress in accomplishing the recommended actions.

In the meantime, participants remain hopeful. "It's easy to get discouraged by the news from Iraq," said Dr. Alathari, who also attended the conference in Jordan. Dr. Alathari is Staff Psychiatrist at the Northern Virginia Mental Health Institute and Assistant Clinical Professor of Psychiatry at George Washington University. He has been in the United States since 1992. "But when I met Dr. Lafta and the other Iraqis, it changed my perspective. They're working very hard at rebuilding the country."

And, Dr. Alathari pointed out, the Iraqis don't have to start from scratch. "Thirty years ago, Iraq was a regional leader in health care," he said. "We're not talking about establishing a new system. It's already there. It has just collapsed."

—By Rebecca A. Clay

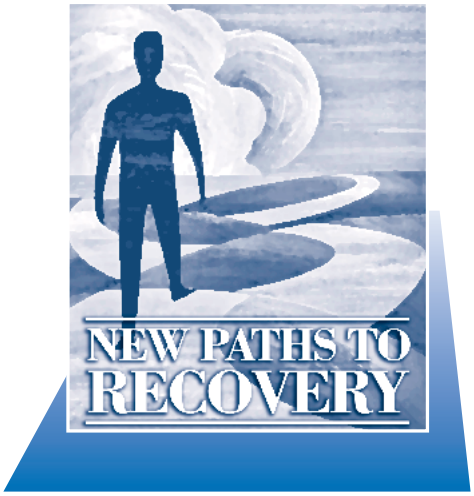
Buprenorphine: New Paths to Recovery

SAMHSA's education initiative, "New Paths to Recovery," recently organized a multi-state tour to inform physicians and the public about the medication buprenorphine, a new office-based treatment for addiction to prescription pain relievers and other opiate drugs, including heroin. (See *SAMHSA News,* Volume 12, Number 2.)

The four-stop tour began in mid March in Huntington, WV, and continued on to Jackson State University (JSU), in Jackson, MS, in April. The forums offered information about the science of buprenorphine and the Federal requirements for establishing this office-based treatment option.

After the JSU event, a buprenorphine training session for physicians convened in New Orleans, LA.

For the Agency's third stop, SAMHSA traveled to the Singletary Center for the Arts in Lexington, KY, for another community education event. Buprenorphine training sessions for interested physicians followed in Knoxville, TN, and Cincinnati, OH.



On August 6, SAMHSA will complete the tour with a stop in St. Louis, MO.

SAMHSA targeted states with large rural populations because they are affected by community problems with drug abuse or dependence on opiates, including heroin. The Agency's goal is to get more physicians, pharmacists, and treatment providers familiar with this new office-based treatment option.

SAMHSA partnerships in this effort include the Mississippi State Department of Mental Health's Division of Alcohol and Drug Abuse; Jackson State University's Metro Jackson Community Prevention Coalition; the Kentucky Department of Mental Health and Mental Retardation Services, Division of Mental Health and Substance Abuse Services; the Division of Alcohol and Drug Abuse Office of Behavioral Health Services, West Virginia Department of Health and Human Resources; and the Division of Alcohol and Drug Abuse, Missouri Department of Mental Health.

SAMHSA is sponsoring physician trainings in collaboration with four organizations: the American Society of Addiction Medicine, the American Academy of Osteopathic Addiction Medicine, the American Academy of Addiction Psychiatry, and the American Psychiatric Association.

For more information on buprenorphine, visit SAMHSA's Web site at **buprenorphine.samhsa.gov.**

Treatment Updates Include Directory, Facility Locator

SAMHSA's updated guide, *the National Directory of Drug and Alcohol Abuse Treatment Programs 2005,* provides information on thousands of alcohol and drug treatment programs located in all 50 states, the District of Columbia, and four U.S. territories.

The directory is a nationwide inventory of substance abuse and alcoholism treatment programs and facilities that is organized and presented in a state-by-state format for quick reference by health care providers, social workers, managed care organizations, and the general public.

The Agency also updated the online Treatment Facility Locator available on the SAMHSA Web site. The locator is a searchable database of addiction treatment programs around the country. To help users, SAMHSA's Office of Applied Studies (OAS) recently released a short report, *Using the Substance Abuse Treatment Facility Locator*, a detailed set of instructions on how to search.

The locator's Web site also includes a list of state substance abuse agencies, contact information for those agencies, and links to their Web sites. In addition, a link is provided to SAMHSA's Buprenorphine Physician Locator, which identifies physicians—by ZIP code, city, county, or state—who are authorized to prescribe buprenorphine.

To access SAMHSA's Treatment Facility Locator, visit SAMHSA's Web site at **http://findtreatment.samhsa.gov.**

To obtain a copy of the *National Directory of Drug and Alcohol Abuse Treatment Programs 2005* or the OAS short report, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 or 1 (866) 889-2647 (TTY). The short report is also available online at **www.oas.samhsa.gov.**

Marijuana: Age at First Use Has Impact

A new report from SAMHSA's Office of Applied Studies (OAS), *Age at First Use of Marijuana and Past Year Serious Mental Illness,* found that among persons age 18 or older, those who first used marijuana before age 12 were twice as likely to have serious mental illness in the past year as those who first used marijuana at age 18 or older.

"Kids today are using marijuana at younger ages, putting them at greater risk for future health and mental health problems," said Mr. Curie. "We have found that younger persons who start smoking marijuana are at greater risk of developing an addiction and serious mental illness later in life."

Marijuana is the most widely used illicit drug, and it is usually the first drug used by persons who use illicit drugs.

The report, from SAMHSA's National Survey on Drug Use and Health (NSDUH), cites recent research pointing to an association between early marijuana use and a heightened risk of developing schizophrenia or other psychological disorders.


National Survey on Drug Use and Health

The NSDUH Report

May 3, 2005

Age at First Use of Marijuana and Past Year Serious Mental Illness

In Brief

- Among lifetime marijuana users aged 18 or older, 2.1 percent reported that they first used marijuana before age 12, while almost one half (45.2 percent) reported that they first used marijuana at age 18 or older
- Males aged 18 or older were more than twice as likely as females to report that they first used marijuana before age 12
- Among persons aged 18 or older, those who first used marijuana before age 12 were twice as likely to have

Marijuana is the most widely used illicit drug, and it is usually the first drug used by persons who use illicit drugs.[1] Recent research points to an association between early marijuana use and a heightened risk of developing schizophrenia or other psychological disorders.[2,3,4] The National Survey on Drug Use and Health (NSDUH) asks persons aged 12 or older to report on their use of marijuana, including their age at first use. For persons aged 18 or older, NSDUH also asks questions to assess serious mental illness (SMI) during the 12 months prior to the survey. Individuals are classified as having SMI if at some time during the past 12 months they had a diagnosable mental, behavioral, or emotional disorder that met *Diagnostic and Statistical Manual of Mental*

Data from NSDUH show that among persons age 18 or older who reported lifetime marijuana use, 55 percent reported first using marijuana before age 18.

In addition, males age 18 or older were more than twice as likely as females to report that they first used marijuana before age 12.

In 2002 and 2003, 42.9 percent of persons age 18 or older (an estimated 90.8 million persons) had used marijuana at least once in their lifetime. Among adults age 18 or older, lifetime marijuana use varied by gender—48.4 percent of males reported lifetime use, while 37.9 percent of females reported lifetime use.

All of the findings presented in this report are annual averages based on the combined data from the 2002 and 2003 surveys.

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For a copy of the OAS report, *Age at First Use of Marijuana and Past Year Serious Mental Illness,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the report is available on the SAMHSA Web site at **www.oas.samhsa.gov.**

SAMHSA Participates in Disaster Response Exercise

Imagine this scenario: A large explosion during a waterfront festival in New London, CT, injures 240 people and releases mustard gas on hundreds more during the explosion. At the same time, 48 people in New Jersey have reported to hospitals showing symptoms of pneumonic plague. Then it's confirmed. A coordinated terrorist attack is under way on U.S. soil. At the frontline of response, SAMHSA and other agencies at the U.S. Department of Health and Human Services (HHS) prepare for immediate action.

Fortunately, the "attack" was only a simulation, part of TOPOFF (Top Officials) 3, the third in a series of exercises mandated by Congress to test the Nation's ability to respond to a terrorist attack involving biological and chemical weapons. The TOPOFF 3 exercise took place in early April and involved 275 Federal, state, and local agencies.

"SAMHSA was represented on all teams for TOPOFF 3," said Seth Hassett, M.S.W., Chief of the Emergency Mental Health and Traumatic Stress Branch at SAMHSA's Center for Mental Health Services (CMHS). SAMHSA's involvement included participation in the HHS Secretary's Emergency Response Team (SERT) in both Connecticut and New Jersey, as well as in the HHS Secretary's Operations Center.

"Any time people are involved in a disaster, HHS will be there," said SAMHSA Emergency Management Coordinator Daniel Dodgen, Ph.D. "SAMHSA's overall role is to serve as the lead in the behavioral health effort—We are the lead for substance abuse and mental health services in disaster response."

SAMHSA was involved in a number of activities in TOPOFF 3, specifically because the exercise simulated a public health attack. The National Response Plan for terror attacks includes a public health and medical component, and SAMHSA's participation is integral to this effort. "SAMHSA participated as a full partner with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) in representing HHS during the exercise," Dr. Dodgen said.

The SAMHSA team was deployed in a number of locations, in a variety of roles. Dr. Dodgen, assigned to the New Jersey "Control Cell," coordinated the HHS response from a central location where staff from various agencies worked to ensure that the exercise played out as planned. Other members of the SAMHSA team included CAPT Carol Rest-Mincberg, who collaborated with CDC staff to enhance mental health support; Mr. Hassett in Washington, DC, at the HHS Secretary's Operations Center; Brenda Bruun at SAMHSA's Emergency Response Center in Rockville, MD; and others in Connecticut and

Everyone involved in TOPOFF 3 was aware that the events were simulated, but Dr. Dodgen noted that Agency personnel were focused on getting the job done well during the 5-day exercise. "People take these exercises very seriously," he said, "because this is our chance to learn how to maximize our preparedness."

What was the exercise like? "It was a very intense and exhausting experience," Dr. Dodgen remarked. "However, it was also a great opportunity to further our goal of integrating mental health and substance abuse into the overall public health strategy for preparedness and response."

For more information about SAMHSA's Disaster Readiness & Response Matrix program, visit **www.samhsa.gov.**

—By Jon Bowen

A fictitious news station, VNN, breaks the story that sets the TOPOFF 3 exercise in motion on April 4, 2005. With strategic maps, a statement from Connecticut's governor, and continuing newscasts, the exercise tested the Nation's ability to respond to a terrorist attack involving biological and chemical weapons.

SAMHSA Hosts HBCU Conference in Baltimore

The 7th Annual Lonnie E. Mitchell National Historically Black Colleges and Universities (HBCU) Substance Abuse Conference, sponsored by SAMHSA, convened in Baltimore, MD, April 19 to 23. Attendees included more than 600 HBCU faculty and students, members of the faith-based community, SAMHSA, the National Institute on Drug Abuse, other Federal agencies, and private sector agencies and organizations.

The annual conference's goal is to serve as a critical regional and national forum for HBCUs. Designed to inform, educate, and stimulate students, researchers, and faculty, the conference focuses on issues related to substance abuse. This year's theme, "Navigating New Pathways in Addressing Substance Abuse and Mental Health Challenges," highlighted the exchange

The Dr. Lonnie E. Mitchell
National HBCU
Substance Abuse Conference

of ideas on what works and what doesn't work in dealing with substance abuse in communities around the Nation.

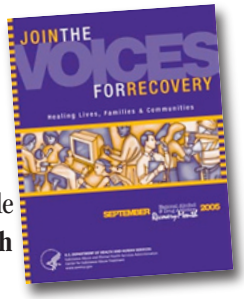
The conference provided an opportunity for participants to focus on the many ways that substance use is affecting young people, adults, and older adults in our communities. In addition, the conference gave individuals time to interact with others who are working to effect a positive change in their local areas.

Trends Marks a New Start in Mental Health

SAMHSA's Web site recently posted the premiere issue of *Mental Health Transformation Trends,* a periodic briefing to help "identify how the transformation of the mental health care system can happen" across the Nation. The briefing will also articulate steps that the Agency and its partners are taking toward creating a Federal Action Agenda for Mental Health, which will be a roadmap for transformation at the national level. Both SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., and Center for Mental Health Services Director Kathryn Power, M.Ed., contributed to the welcome message. To read the first issue, visit **www.samhsa.gov/matrix/mhst.**

Recovery Month Kit Now Online

You'll find everything you need on SAMHSA's Web site to prepare for *National Alcohol and Drug Addiction Recovery Month* in September. Now available, the online *Recovery Month* toolkit includes materials tailored to key constituent groups, templates of media outreach materials, and suggestions for educating your community about addiction treatment and recovery.



This year's theme is *Join the Voices for Recovery: Healing Lives, Families, and Communities!* The online toolkit is available at **www.recoverymonth.gov/2005/kit.**

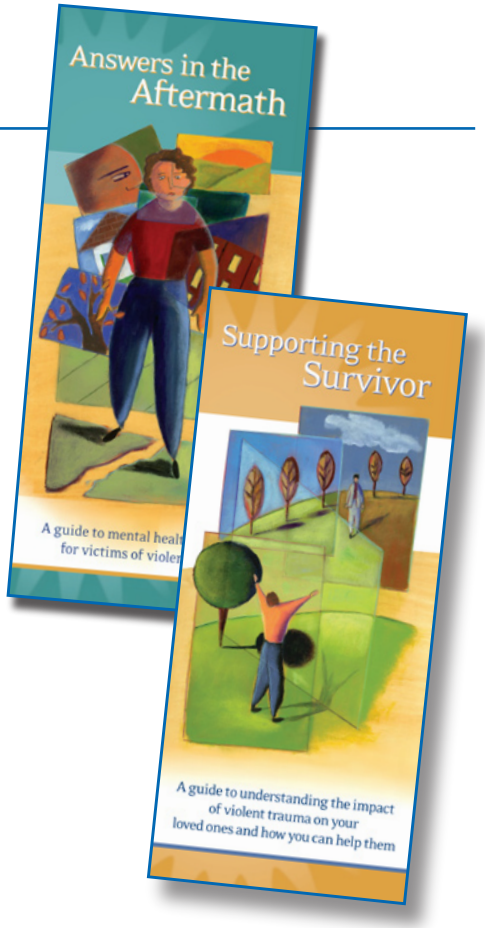
For Victims of Crime

Two new brochures from SAMHSA—*Answers in the Aftermath* and *Supporting the Survivor*—address mental health and substance use issues facing crime victims.

Answers in the Aftermath explains conditions that victims of violent crime often face, including post-traumatic stress disorder and substance abuse. The brochure gives information on how crime victims can deal with these obstacles.

Supporting the Survivor is a resource for the loved ones of crime victims. The brochure addresses the mental health and substance use issues a crime victim may face and how a supporter can help a loved one.

Contact SAMHSA's National Mental Health Information Center for print copies of these brochures at 1 (800) 789-2647. Online, you can download copies of each brochure. Visit the SAMHSA Web site at **www.samhsa.gov.**



We'd Like To Hear From You!

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

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

Comments: _____

_____

_____

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

- ❑ Helping Iraq Restore Its Mental Health System
- ❑ Public Spending for Mental Health, Substance Abuse Treatment Increases
- ❑ From the Administrator: Tracking Trends To Transform Health Care
- ❑ Group Therapy Guide Focuses on Substance Use Treatment
- ❑ Treatment in Lieu of Jail: Diversion Succeeds
- ❑ SAMHSA, FDA Launch Campaign for Older Adults
- ❑ Buprenorphine: New Paths to Recovery
- ❑ Treatment Updates Include Directory, Facility Locator
- ❑ Marijuana: Age at First Use Has Impact
- ❑ SAMHSA Participates in Disaster Response Exercise
- ❑ In Brief . . .
- ❑ Quick Statistics Available Online
- ❑ ***SAMHSA News*** online—for the current issue and archives—at **www.samhsa.gov/SAMHSA_News**

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Thank you for your comments!

Quick Statistics Available Online

The most up-to-date information relating to substance abuse treatment is now easily accessible online. SAMHSA's Office of Applied Studies (OAS) has created a new "Quick Statistics" Web site that presents state- and jurisdiction-level profiles for both the Treatment Episode Data Set (TEDS) and the National Survey of Substance Abuse Treatment Services (N-SSATS).

Using Quick Statistics, researchers, policy analysts, and Federal and state substance abuse program planners and managers can access data on admissions to substance abuse treatment and to treatment facilities. From N-SSATS and TEDS, data are available for all 50 states, the District of Columbia, and the U.S. territory of Puerto Rico. N-SSATS data also include four additional U.S. territories—the Virgin Islands, Guam, Palau, and the Federated States of Micronesia.

TEDS Data

TEDS is a compilation of data on the demographic and substance abuse characteristics of persons who are admitted to and discharged from substance abuse treatment for a given year. For each year in which TEDS data have been compiled, Quick Statistics produces summary tables of admissions by primary substance of abuse and demographic characteristics—sex, age group, race, and ethnicity. Tables can be run for individual states and for all states combined.

A useful feature of TEDS Quick Statistics is that it provides access to as yet unpublished data for individual states for the most recent calendar year. Because some states report data to TEDS as late as the end of the year (following the admission year), there is typically a lag of 2 years before a complete year of data for all states can be compiled for analysis and publication.

With TEDS Quick Statistics, however, preliminary data are available for individual states that submit their data early. Currently, 2003 data are available for many states and 2004 data for a few states. Because data for the total United States can only be assembled after all states have reported to TEDS, these data are not yet available for 2003 or 2004.

N-SSATS Data

N-SSATS is an annual survey of all known public and private substance abuse treatment facilities in the United States, the District of Columbia, and the five U.S. territories. N-SSATS collects information on location, characteristics, treatment services offered, and utilization of treatment services. Like TEDS, data from the N-SSATS can be analyzed at both the state and national level. Currently, N-SSATS Quick Statistics includes data from the 2002 and 2003 surveys.

Additional TEDS and N-SSATS data are available through the Substance Abuse and Mental Health Data Archive (SAMHDA) in the form of additional online analyses and public use files. SAMHDA information can be accessed at **www.icpsr.umich.edu/SAMHDA/archive.html.**

To access the OAS short report on *Quick Statistics,* visit SAMHSA's Web site at **www.oas.samhsa.gov/2k5/Quick/Quick.cfm.**

To Access TEDS and N-SSATS Quick Statistics

Step 1: Go to **http://wwwdasis.samhsa.gov/webt/newmapv1.htm** and select the state/jurisdiction of interest or select "United States."

Step 2: Select "National Survey of Substance Abuse Treatment Services (N-SSATS) or Treatment Episode Data Set (TEDS)."

Step 3: Select the year of data that interests you from a drop-down menu. Each year must be run separately.

SAMHSA NEWS

Published bimonthly by the Office of Communications

Send a copy to:

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Room 8-1037
1 Choke Cherry Road
Rockville, MD 20857

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