SAMHSA's Strategic Initiatives

Mission

The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) is to reduce the impact of substance abuse and mental illness on America's communities.

Improving the Lives of People

Individuals and families cannot be healthy without positive mental health and freedom from addictions and substance abuse. Prevention, treatment, and recovery support services for behavioral health are important parts of health service systems and communitywide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments.

Achieving a high-quality, self-directed, satisfying life integrated in a community includes:

Health—Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;

Home—A stable and safe place to live that supports recovery;

Purpose—Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, as well as the independence, income, and resources to participate in society; and

Community—Relationships and social networks that provide support, friendship, love, and hope.

Taking Action

SAMHSA provides leadership and devotes its resources—programs, policies, information and data, contracts, and grants—toward helping the Nation act on the knowledge that:

- Behavioral health is essential to health;
- Prevention works;
- Treatment is effective; and
- People recover.

Behavioral Health Is Essential to Health: Key Facts

- Almost one fourth of all adult stays in U.S. community hospitals involve mental or substance use disorders.[1]
- People with serious mental illness have shortened lifespans, on average dying 25 years earlier than the general population.[2]
- Nearly 70 percent of antidepressants are prescribed by primary care offices, hospitals, outpatient programs, or surgical offices.[3]

- In 2006, health expenditures on mental disorders reached $57.5 billion, an increase from $35.2 billion in 1996. Mental disorders were the third most costly health condition in 2006, even with cancer but behind heart conditions and injury-related disorders.[4]
- The Agency for Healthcare Research and Quality (AHRQ) reported that a study of 2002 expenditures showed that 5 percent of the population accounted for almost 50 percent of total costs. Chronic conditions and multiple co-morbidities, severe mental illness, and services that are fragmented among multiple providers are key drivers of this high utilization.[5]

Prevention Works: Key Facts

- Cost-benefit ratios for early treatment and prevention for addictions and mental illness programs range from 1:2 to 1:10—meaning $1 in investment yields $2 to $10 savings in health costs, criminal and juvenile justice costs, educational costs, lost productivity, etc.[6]
- Project SUCCESS—1 of 58 substance abuse prevention interventions listed on National Registry of Evidence-based Programs and Practices (NREPP)[7]—shows:
  - At the first-year posttest, self-reports showed a 37 percent decrease in alcohol, tobacco, and other drug (ATOD) use;
  - Of the students using ATOD at pretest, 23 percent stopped ATOD use; and
  - At the second-year follow up, of the students who reported using ATOD at pretest, 33.3 percent reportedly stopped using alcohol, 45.0 percent reportedly stopped using marijuana, and 22.9 percent reportedly stopped using tobacco.
- Preventive intervention for adolescents can reduce the incidence of depressive disorders by 22 percent.[8]
- Almost one quarter (24 percent) of pediatric primary care office visits involve behavioral and mental health problems in a study of rural pediatric offices.[9]

Treatment Is Effective: Key Facts

- Every $1 invested in substance abuse treatment has a return of $7 in cost savings from social benefits such as reduced health costs, crime, and lost productivity.[10]
- Collaborative Care for Treating Late-Life Depression in Primary Care Settings reduced prevalence and severity of symptoms or resulted in complete remission.[11]
- The Treatment of Adolescents with Depression Study (TADS) found that long-term treatment of adolescents with major depression is associated with continuous and persistent improvement of depression symptoms in most cases.[12]
- The reduction of depressive symptoms in teenagers by early intervention showed up as better improvement in the classroom behavior.[13]
- Federally funded substance abuse treatment programs[14]:
  - Reduced illicit drug use by half (48 percent);
  - Improved physical and mental health;
  - Reduced the number of inpatient mental health visits by 28 percent; and
  - Reduced criminal activity by as much as 80 percent.

People Recover: Key Facts

- There are many pathways to recovery.[15]
- Long-term care strategies of medication management and continued monitoring produce lasting benefits.[16]
- Addiction can be successfully treated. Relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma. [17]
- Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.[18]
- Intensive psychosocial treatment as an adjunct to pharmacotherapy is more beneficial than brief treatment in enhancing stabilization from bipolar depression. [19]
- Switching to or adding cognitive therapy after a first unsuccessful attempt at treating depression with an antidepressant medication is generally as effective as switching to or adding another medication, but remission may take longer to achieve. [20]
- Second-generation drugs can be more effective in preventing relapse in schizophrenia. The relapse rate for second-generation medications after one year was 15% compared to 23% among first-generation medications.[21]
- Recovery is a process of change whereby individuals work to improve their own health and well-being and to live a meaningful life in a community of their choice while striving to achieve their full potential.

Advancing Behavioral Health

The Mental Health Parity and Addiction Equity Act (2008) and the Affordable Care Act (2010) changed the American health care landscape. More people than ever before will be soon covered by their insurance for behavioral health services. The recognition that both quality and cost-savings goals of health reform can be significantly addressed by bringing together historically separated behavioral health services and the general health care system is driving service integration. Integration moves all health, including behavioral health practitioners and systems, towards care driven by patient and family needs - and this in turn requires changes in attitudes and practices at a rather fundamental level.

SAMHSA plays a unique role in advancing service delivery systems and community-wide strategies that improve health status and well-being by providing:

- Leadership and voice;
- Funding;
- Surveillance and data;
- Public awareness and education;
- Regulation and oversight; and
- Practice improvement in community-based, primary, and specialty care.

SAMHSA has identified eight Strategic Initiatives to focus work on areas of urgency and opportunity. Each Initiative has an overarching purpose, specific goals, action steps, and measures for determining success. In addition, three issues cut across all of the Initiatives: health disparities, health reform, and workforce development. This strategic approach will guide SAMHSA through 2014 as it sets budget and policy priorities; manages grants, contracts, technical assistance, agency staff, and interagency efforts; engages partners at every level; and measures and communicates progress.

Strategic Initiative #1
Prevention of Substance Abuse and Mental Illness

Lead: Frances M. Harding, Director, Center for Substance Abuse Prevention

Overview: Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

Key Facts

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.[22]
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.[23]
- Annually, tobacco use results in more premature deaths (443,000 per year) than AIDS, unintentional injuries, suicide, homicide, and alcohol and drug abuse combined. Almost half of these deaths occur among people with mental and substance use disorders.[24,25,26]
- In 2010, an estimated 3.0 million persons aged 12 and older used an illicit drug for the first time within the past 12 months, an average of 8,100 initiates per day.[27]
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three fourths by age 24.[28]
- Adults who began drinking alcohol before age 21 are more likely to be later classified with alcohol dependence or abuse than those who had their first drink at or after age 21.[29]
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.[30]
- One estimate puts the total economic costs of mental, emotional, and behavioral disorders among youth in the United States at approximately $247 billion.[31]
- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion.[32]
- In 2008, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness; 2 million youth aged 12 to 17 had a major depressive episode during the past year.[33]
- In 20010, an estimated 23.1 million Americans aged 12 and older needed treatment for substance use.[34]
- Among persons aged 12 and older who used prescription pain relievers non-medically in the past 12 months, 55.0 percent got them from a friend or relative for free.[35]

- A range of studies indicate that lesbian, gay, and bisexual adults and youth are much more likely to be smokers than their heterosexual counterparts.[36]
- In 2010, the percentage of female youth aged 12 to 17 (13.5 percent) who were current drinkers was similar to the rate for male youth aged 12 to 17 (13.7).[37]
- In 2010, transition age youth aged 18 to 25 had the highest rates of binge drinking (40.6 percent) and heavy alcohol use (13.6 percent) of any age group.[38]

Goals

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families; lesbian, gay, bisexual, and questioning (LGBTQ) youth; and American Indians and Alaska Natives.

Goal 1.4: Reduce prescription drug misuse and abuse.

Strategic Initiative #2 Trauma and Justice

Lead: Larke Huang, Director, Office of Behavioral Health Equity

Overview: Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in, or at risk of involvement in, the criminal and juvenile justice systems.

Key Facts

- Trauma is strongly associated with mental and substance use disorders[39]
- More than 6 in 10 U.S. youth have been exposed to violence within the past year, including witnessing a violent act, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly 1 in 10 was injured.[40]
- An estimated 772,000 children were victims of maltreatment in 2008.[41]
- Adverse childhood experiences (e.g., physical, emotional, and sexual abuse, as well as family dysfunction) are associated with mental illness, suicidality, and substance abuse.[42]
- A lifetime history of sexual abuse among women in childhood or adulthood ranges from 15 to 25 percent. The prevalence of domestic violence among women in the United States ranges from 9 to 44 percent, depending on definitions.[43]
- The cost of intimate partner violence, which disproportionately affects women and girls, was estimated to be $8.3 billion in 2003. This total includes the costs of medical care, mental health services, and lost productivity.[44]
- In a 2008 study by RAND, 18.5 percent of service members returning from the conflicts in Afghanistan and Iraq symptoms consistent with post-traumatic stress disorder (PTSD) or depression.[45]

- More than half of all prison and jail inmates (people in State and Federal prisons and local jails) meet criteria for having mental health problems, 6 in 10 meet criteria for a substance use problem, and more than a third meet criteria for having both a substance abuse problem and a mental health problem.[46]
- The use of seclusion and restraint on persons with mental and substance use disorders has resulted in deaths and serious physical injury and psychological trauma. In 1998, the Harvard Center for Risk Analysis estimated deaths due to such practices at 150 per year across the Nation.[47]
- Racial incidents can be traumatic and have been linked to PTSD symptoms among people of color.[48]
- Evidence suggests that some communities of color have higher rates of PTSD than the general population.[49,50]
- LGBT individuals experience violence and PTSD at higher rates than the general population.[51]
- In the United States, 18.9 percent of men and 15.2 percent of women reported a lifetime experience of a natural disaster.[52]
- In 2008, an estimated 4.8 percent of American males under the age of 18 experienced sexual victimization in the past year, and an estimated 7.5 percent experienced sexual victimization in their lifetime.[53]

Goals

Goal 2.1: Develop a comprehensive public health approach to trauma.

Goal 2.2: Make screening for trauma and early intervention and treatment common practice.

Goal 2.3: Reduce the impact of trauma and violence on children, youth, and families.

Goal 2.4: Address the needs of people with mental disorders, substance use disorders, co-occurring disorders, or a history of trauma in the criminal and juvenile justice systems.

Goal 2.5: Reduce the impact of disasters on the behavioral health of individuals, families, and communities.

Strategic Initiative #3 Military Families

Lead: A. Kathryn Power, Director, Center for Mental Health Services

Overview: Supporting America's service men and women—active duty, National Guard, Reserve, and veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

Key Facts

- Approximately 18.5 percent of service members returning from Iraq or Afghanistan have post-traumatic stress disorder (PTSD) or depression, and 19.5 percent report experiencing a traumatic brain injury during deployment.[54]
- Approximately 50 percent of returning service members who need treatment for mental health conditions seek it, but only slightly more than half who receive treatment receive adequate care.[55]

- The Army suicide rate reached an all-time high in June 2010.[56]
- In the 5 years from 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours.[57]
- In 2010, the Army's suicide rate among active-duty soldiers dropped slightly (162 in 2009, 156 in 2010), but the number of suicides in the National Guard and Reserve increased by 55 percent (80 in 2009, 145 in 2010).[58]
- More than half of the Army National Guard members who killed themselves in 2010 had never deployed.[59]
- In 2007, 8 percent of soldiers in Afghanistan reported using alcohol during deployment, and 1.4 percent reported using illegal drugs/substances.[60]
- Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder.[61]
- Mental and substance use disorders caused more hospitalizations among U.S. troops in 2009 than any other cause.[62]
- According to an assessment by the Departments of Housing and Urban Development and Veterans Affairs, nearly 76,000 veterans were homeless on a given night in 2009. Some 136,000 veterans spent at least one night in a shelter during that year.[63]
- Cumulative lengths of deployments are associated with more emotional difficulties among military children and more mental health diagnoses among U.S. Army wives.[64,65]
- Children of deployed military personnel have more school-, family-, and peer-related emotional difficulties, compared with national samples.[66]

Goals

Goal 3.1: Improve military families' access to community-based behavioral health care through coordination among SAMHSA, TRICARE®, U.S. Department of Defense, and Veterans Health Administration services.

Goal 3.2: Improve the quality of behavioral health-focused prevention, treatment, and recovery support services by helping providers respond to the needs within the military family culture.

Goal 3.3: Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health and prevent suicide.

Goal 3.4: Develop an effective and seamless behavioral health service system for military families through coordination of policies and resources across Federal, national, State, Territorial, Tribal, and local organizations.

Strategic Initiative #4 Recovery Support

Lead: A. Kathryn Power, Director, Center for Mental Health Services

Overview: Partnering with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

Key Facts

- For those with substance use disorders, a comprehensive array of services assists recovery from substance use disorders,[67] and social supports improve recovery outcomes.[68]
- A study has shown that at 24 months follow up, individuals entering Oxford House (supported housing) after substance use disorders treatment had significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates than did those entering usual care.[69]
- One third of individuals with severe mental illnesses who received community mental health services after lengthy stays in a State hospital achieve full recovery in psychiatric status and social function, and another third improve significantly in both areas.[70]
- Of the more than 6 million people served by State mental health authorities across the Nation, only 21 percent are employed. Despite this exceptionally low rate, only 2.1 percent of people served receive evidence-based supported employment services.[71]
- A qualitative study found that of those participants who dropped out of treatment 15.4% felt the program did not address their individual needs, 5.2% felt they were not included in the treatment plan decisions, and 5.2% felt the topics should have been more relevant.[72]
- Supported employment programs that help people with the most serious mental illnesses place more than 50 percent of their clients into paid employment.[73]
- In 2010, more than half of the 4.1 million persons aged 12 and older who received treatment for alcohol or illicit drug use in the past year received that treatment at a self-help group.[74]
- A recent 10-year study suggests that supported employment initiatives for people who are high users of mental health services can reduce their need for such services, saving public funding over time.[75]
- In 2006, 13 percent of admissions to substance abuse treatment were homeless.[76]
- Sixty-four percent of persons who are homeless have an alcohol or substance use disorder.[77]
- One third (32.7 percent) of individuals aged 12 and older who attended a self-help group for substance abuse in the past year also received specialty treatment for substance use during that same period.[78]
- Conversely, 66 percent of persons aged 12 and older who received any alcohol or illicit drug use specialty treatment in the past year also attended a self-help group during the same timeframe.[79]
- Research indicates that a combination of long-term housing, treatment, and life-affirming services leads to improved residential stability and reductions in substance use and psychiatric symptoms.[80]
- In one research study, providing housing for individuals with mental illness who are homeless reduced criminal justice involvement by 38 percent and prison days by 84 percent.[81]
- More than half of the adolescents in the United States who fail to complete high school have a diagnosable psychiatric disorder. The proportion of failure to complete school that is attributable to a psychiatric disorder is estimated to be 46 percent.[82]

Goals

Goal 4.1: (Health) Promote health- and recovery-oriented service systems for individuals with or in recovery from mental and substance use disorders.

Goal 4.2: (Home) Ensure that permanent housing and supportive services are available for individuals with or in recovery from mental and substance use disorders.

Goal 4.3: (Purpose) Increase gainful employment and educational opportunities for individuals with or in recovery from mental and substance use disorders.

Goal 4.4: (Community) Promote peer support and the social inclusion of individuals with or in recovery from mental and substance use disorders in the community.

Strategic Initiative #5 Health Reform

Lead: John O'Brien, Senior Advisor for Behavioral Health Financing

Overview: Increasing access to appropriate high-quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.

Key Facts

- In 2014, 32 million more Americans will be covered by health insurance because of changes under the Affordable Care Act. Between 20 to 30 percent of these people (4 to 6 million) will have a mental or substance use disorder.[83,84]
- The Affordable Care Act will increase the number of people who are insured. Currently, individuals with a mental disorder are twice as likely to be uninsured as those without a mental disorder.[85]
- Among the currently uninsured aged 22 to 64 with family income of less than 150 percent of the Federal poverty level, 32.4 percent had illicit drug or alcohol dependence/abuse or mental illness.[86]
- As of 2005, Medicaid paid for 28 percent of all spending on mental health services and 21 percent of substance abuse treatment in the United States.[87]
- As of 2005, Medicare paid for 8 percent of all spending on mental health services and 7 percent of substance abuse treatment in the United States.[88]
- Medicaid is a primary source of support for mental health services at the State level—44 percent of mental health funding managed by State mental health authorities comes from Medicaid.[89]
- In 2006, nearly 7.5 million individuals were dually eligible for both Medicare and Medicaid at a cost of approximately $200 billion.[90,91] Fifty-two percent of these people had a psychiatric illness.[92]
- Many individuals with mental and substance use disorders will no longer pay significant out-of-pocket expenses for medication owing to the closing of the “doughnut hole” in Medicare Part D.[93]
- States spend as much as 75 percent of their Medicaid mental health funds for children on residential treatment and inpatient hospital services.[94]

- The Mental Health Parity and Addiction Equity Act (MHPAEA) affects 140 million individuals participating in group health plans.[95]
- LGBTQ, racial, and ethnic populations are disproportionately represented in the ranks of the uninsured. In 2008, 22 percent of gay and lesbians reported having no health insurance.[96] In 2009, 34 percent of Hispanics, 28 percent of American Indians and Alaska Natives, 23 percent of African-Americans, and 18 percent of Asian-Americans were uninsured, compared with 14 percent of White Americans.[97]

Goals

Goal 5.1: Ensure that behavioral health is included in all aspects of health reform.

Goal 5.2: Support Federal, State, Territorial, and Tribal efforts to develop and implement new provisions under Medicaid and Medicare.

Goal 5.3: Finalize and implement the parity provisions in the MHPAEA and the Affordable Care Act.

Goal 5.4: Develop changes in SAMHSA Block Grants to support recovery and resilience.

Goal 5.5: Foster the integration of primary and behavioral health care.

Strategic Initiative #6: Health Information Technology

Lead: H. Westley Clark, Director, Center for Substance Abuse Treatment

Overview: Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of health information technology (HIT) and interoperable electronic health records (EHRs).

Key Facts

- Of 175 substance abuse treatment programs surveyed, 20 percent had no information systems, email, or even voice mail.[98]
- On average, information technology spending in behavioral health care and human services organizations represents 1.8 percent of total operating budgets—compared with 3.5 percent of the total operating budgets for general health care services.[99]
- Fewer than half of behavioral health and human services providers possess fully implemented clinical electronic record systems.[100]
- State and Territorial laws vary on the extent that providers can share medically sensitive information, such as HIV status and treatment for psychiatric conditions.
- A study of 56 mental health clinicians in an academic medical center revealed that their concerns about privacy and data security were significant and may contribute to the reluctance to adopt electronic records.[101]

Goals

Goal 6.1: Develop the infrastructure for interoperable EHRs, including privacy, confidentiality, and data standards.

Goal 6.2: Provide incentives and create tools to facilitate the adoption of HIT and EHRs with behavioral health functionality in general and specialty health care settings.

Goal 6.3: Deliver technical assistance to State HIT leaders, behavioral health and health providers, patients and consumers, and others to increase adoption of EHRs and HIT with behavioral health functionality.

Goal 6.4: Enhance capacity for the exchange and analysis of EHR data to assess quality of care and improve patient outcomes.

Strategic Initiative #7: Data, Outcomes, and Quality

Lead: Peter Delany, Director, Center for Behavioral Health Statistics and Quality

Overview: Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

Key Facts

- Access to comprehensive health insurance coverage and the provision of services with a strong evidence base leads to improved health and behavioral health outcomes[102,103]
- Fragmented data systems reinforce the historical separateness of service systems.
- Discrete service systems can limit access to appropriate care, lead to uneven quality in service delivery and coordination, and increase information silos.
- Distinct funding streams for State, Territorial, and Tribal mental health, substance abuse, and Medicaid agencies underscore the importance of common measures and data collection reporting strategies.[104]
- Increasing understanding of practice-based evidence and making data and research more accessible for policy audiences significantly affect their use by policymakers.[105]

Goals

Goal 7.1: Implement an integrated approach for SAMHSA's collection, analysis, and use of data.

Goal 7.2: Create common standards for quality of care, outcomes measurement, and data collection to better meet stakeholder needs.

Goal 7.3: Improve the quality of SAMHSA's program evaluations and services research.

Goal 7.4: Improve the quality and accessibility of surveillance, outcome and performance, and evaluation information for staff, stakeholders, funders, and policymakers.

Strategic Initiative #8: Public Awareness and Support

Lead: Mark Weber, Director, Office of Communications

Overview: Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Key Facts

- In 2009, 12.0 million adults aged 18 and older (5.3 percent) reported an unmet need for mental health care in the past year. These respondents included 6.1 million adults who did not receive any mental health services in the past year. Among the 6.1 million, several barriers to care were reported, including cost, lack of health insurance coverage, and not knowing where to access care.[106]
- Only about half of American children and teenagers with some common mental disorders (generalized anxiety disorder, panic disorder, eating disorders [anorexia and bulimia], depression, attention deficit hyperactivity disorder [ADHD], and conduct disorder) receive professional services.[107]
- Two thirds of Americans believe that treatment and support can help people with mental illnesses lead normal lives.[108]
- One in five Americans feels that persons with mental illness are dangerous to others.[109]
- Two thirds of Americans believe addiction can be prevented.[110]
- In 2010, 95 percent, or 19.5 million, of the 20.5 million people classified as needing substance use treatment because of the problems they experienced did not feel they needed treatment.[111]
- Among persons aged 12 and older who needed but did not receive treatment at a specialty facility and perceived a need for treatment, the lack of coverage or the inability to cover the cost of treatment were among the most common reasons given for not receiving illicit drug or alcohol use treatment.[112]
- Seventy-five percent of Americans believe recovery from marijuana, alcohol and prescription drugs is possible.[113]
- Twenty percent of Americans say they would think less of a friend or relative if they discovered that person is in recovery from an addiction.[114]
- Thirty percent of Americans say they would think less of a person with a current addiction.[115]
- Ninety-four percent of primary care physicians in a study conducted in 2000 failed to diagnose substance use disorders properly in adults.[116]

Goals

Goal 8.1: Increase public understanding about mental and substance use disorders, the reality that people recover, and how to access treatment and recovery supports for behavioral health conditions.

Goal 8.2: Create a cohesive SAMHSA identity and media presence.

Goal 8.3: Advance SAMHSA's Strategic Initiatives and U.S. Department of Health and Human Services (HHS) priorities through strategic communications efforts.

Goal 8.4: Provide information for the behavioral health workforce.

Goal 8.5: Increase social inclusion and reduce discrimination.

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