

Medication-Assisted Treatment: Merging with Mainstream Medicine

Imagine you have a chronic condition such as hypertension and have been taking daily medication under medical care for several years. How would you feel if you had to obtain a limited dose of your medication from an inconveniently located treatment program during restricted hours rather than purchasing a 30-day supply from your pharmacy to take every day at home?

These are the kinds of obstacles that patients in treatment for addiction to heroin and other opiates face every day. Unlike the millions of Americans who have some choice in their doctors and hospitals for treatment of chronic diseases such as heart disease or diabetes, people who suffer from the chronic disease of addiction to heroin or other opiates have had to seek care through specialized, federally regulated treatment programs.

Observed urine testing—in which the patient is watched while providing the sample—is yet another hurdle for opioid treatment program patients who've become medically stable in their recovery process.

However, since May 2001, treatment providers and patients nationwide have been witnessing a sea change in opioid addiction treatment. The U.S. Department of Health and Human Services repealed the Food and Drug Administration (FDA)-enforced regulations for methadone treatment, in place for 30 years, and instituted a SAMHSA-directed system that relies on accreditation of



treatment programs. Opioid treatment programs now apply to be accredited by one of four accreditation organizations designated by SAMHSA, and they have greater discretion for individualized patient treatment within the parameters of the accreditation standards.

Because accreditation is standard practice for health care providers in nearly all fields of health care, its use for opioid treatment programs should help addiction treatment begin to look more like other areas of health

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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• Center for Substance Abuse Prevention
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President's Commission on Mental Health Launches Web Site

The President's New Freedom Commission on Mental Health launched a new Web site this spring, www.MentalHealthCommission.gov, to solicit public comments and provide information. The Commission also has met three times since the April 29 announcement of its creation (See *SAMHSA News*, spring 2002).

The Commission is charged with conducting a comprehensive study of the United States mental health service delivery system and advising President George W. Bush about ways to improve the system. The Commission supports the

President's New Freedom Initiative, which aims to remove barriers so that people with physical and mental disabilities can lead full and independent lives within their communities. (See *SAMHSA News*, fall 2001.)

"The Web site illustrates President Bush's commitment to ensuring that all voices are heard as the Commission works to develop a plan to improve the Nation's mental health service delivery system," said Commission Chair Michael Hogan, Ph.D. "We want to use the technology available to spread the word about the Commission's efforts and to gather as much input as possible from a broad range of stakeholders, including people with mental illness and their family members, health care providers, Government agencies, academics, researchers, and others with knowledge about mental health."

In addition to learning about the Commission's mission, leadership, and schedule of meetings, people who log on to the Web site will be able to submit comments and suggestions about the current mental health system and ideas for improvements.

Although all relevant comments are of interest and may be submitted to the Commission at any time, several topics will be listed on the Web site for public comment. The topics will change periodically, focusing first on identifying problems and barriers within the system, and later on identifying solutions. All comments will be most helpful to the Commission if received by December 31, 2002.

Comments may also be mailed to the Commission or presented in person during the public comment period held at every Commission meeting. The Web site provides specific guidelines and instructions for people interested in speaking before the Commission.

The Commission's first three meetings, held in June, July, and August, included the formalization of a work plan, testimony from

the representatives of prominent mental health organizations, testimony by consumers of mental health services, and presentations by experts in the field. Presentation topics included evidence-based practices, children's mental health issues, cultural competence, and employment and income support, as well as descriptions of the 1999 report, *Mental Health: A Report of the Surgeon General*, and the 2001 Institute of Medicine report, *Crossing the Quality Chasm*.

For more information, contact the President's New Freedom Commission on Mental Health, 5600 Fishers Lane, Room 13C-26, Rockville, MD 20857. Telephone: (301) 443-1545. Fax: (301) 480-1554. Web site: www.MentalHealthCommission.gov ▶



New Freedom Commission Chair Michael Hogan and SAMHSA Administrator Charles G. Curie listen intently at one of the first meetings of the President's New Freedom Commission on Mental Health.

Photo courtesy of Tom Olin

Survey Finds Millions of Americans in Denial About Drug Abuse

Findings released recently from SAMHSA's 2001 National Household Survey on Drug Abuse indicated that the number of Americans who could benefit from drug treatment was significantly larger than previously understood. More than 4.6 million Americans who meet the criteria for needing treatment for illicit drug use do not recognize that they have a problem. The annual survey was released as part of the kickoff for the 13th annual National Drug and Alcohol Addiction Recovery Month observance. (See *SAMHSA News*, p. 5.)

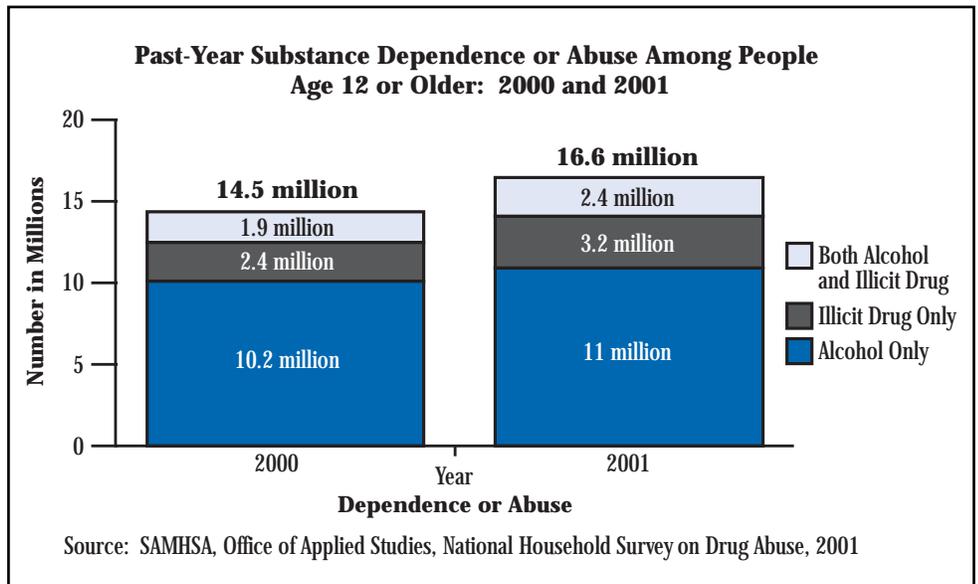
"We have a large and growing denial gap when it comes to drug abuse and dependency in this country," said John Walters, Director of National Drug Control Policy. "We have a responsibility—as family members, employers, physicians, educators, religious leaders, neighbors, colleagues, and friends—to reach out to help these people. We must find ways to lead them back to drug-free lives. And the earlier we reach them, the greater will be our likelihood of success."

Drug Use by Age

Overall, the Household Survey found that 15.9 million Americans age 12 and older used an illicit drug in the month immediately prior to the survey interview. This represents an estimated 7.1 percent of the population in 2001, compared to an estimated 6.3 percent the previous year.

The report highlights that 10.8 percent of youth age 12 to 17 were current drug users in 2001 compared with 9.7 percent in 2000. Youth cigarette use in 2001 was slightly below the rate for 2000, continuing a downward trend since 1999.

Among young adults age 18 to 25, current drug use increased between 2000 and 2001 from 15.9 percent to 18.8 percent. There were no statistically significant changes



in the rates of drug use among adults age 26 and older.

Marijuana

An estimated 2.4 million Americans used marijuana for the first time in 2000. Because of the way trends in the new use of substances are calculated, estimates of first-time use are always 1 year behind estimates of current use. The annual number of new marijuana users has varied considerably since 1965 when there were an estimated 0.6 million new users. The number of new marijuana users reached a peak in 1976 and 1977 at around 3.2 million. Between 1990 and 1996, the estimated number of new users increased from 1.4 million to 2.5 million and has remained at this level.

The measure of perceived risk in the use of marijuana provides an important predictor of drug use, particularly among youth. As perceived risk of using marijuana decreases, rates of marijuana use tend to increase. The perception of great risk from smoking marijuana once or twice a week decreased from 56.4 percent in 2000 to 53.3 percent in 2001. Among youth age 12 to 17, the

percentage reporting great risk in marijuana use declined from 56 to 53.5 percent.

"As the new school year begins, it's yet another opportunity for parents to talk to their children about the dangers of drugs, alcohol and smoking. And it's important that parents, educators, and students work together to keep drugs out of their schools and prevent young people from engaging in drug use," said U.S. Health and Human Services Secretary Tommy G. Thompson. "When young people do not perceive the risk, use increases. This is harmful to youth, harmful to families, and harmful to communities. Nothing less than our children's futures—and their lives—are at stake."

Ecstasy and Oxycontin

The number of people who had ever tried Ecstasy (MDMA) increased from 6.5 million in 2000 to 8.1 million in 2001. There were 786,000 current users in 2001. In 2000, an estimated 1.9 million people used Ecstasy (MDMA) for the first time compared with 0.7 million in 1998. This change represents a tripling in incidence in just 2 years.

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The number of people reporting use of Oxycontin for non-medical purposes at least once in their lifetime increased from 221,000 in 1999 to 399,000 in 2000 to 957,000 in 2001. The annual number of people using pain relievers for non-medical purposes for the first time has also been increasing since the mid-1980s, when there were roughly 400,000 initiates. In 2000, there were an estimated 2 million.

Alcohol

Approximately 10.1 million people age 12 to 20 reported current use of alcohol in 2001. This number represents 28.5 percent of this age group for whom alcohol is an illicit substance. Of this number, nearly 6.8 million (19 percent) were binge drinkers and 2.1 million (6 percent) were heavy drinkers. In 2001, more than 1 in 10 Americans—25.1 million people—reported driving under the influence of alcohol at least once in the 12 months prior to the interview. The rate of driving under the influence of alcohol increased from 10 to 11.1 percent between 2000 and 2001. Among young adults age 18 to 25, 22.8 percent drove under the influence of alcohol.

Tobacco

An estimated 66.5 million Americans age 12 or older reported current use of a tobacco product in 2001. This number represents 29.5 percent of the population.

Youth cigarette use in 2001 was slightly below the rate for 2000, continuing a downward trend since 1999. Rates of youth cigarette use were 14.9 percent in 1999, 13.4 percent in 2000, and 13 percent in 2001.

The annual number of new daily smokers age 12 to 17 decreased from 1.1 million in 1997 to 747,000 in 2000. This translates into a reduction from 3,000 to 2,000 in the number of new youth smokers per day.

Dependence and Abuse

The Household Survey includes a series of questions designed to measure more serious problems resulting from the use of substances. Overall, an estimated 16.6 million people age 12 and older were classified with dependence on or abuse of either alcohol or illicit drugs in 2001 (7.3 percent of the population). Of these, 2.4 million were classified with dependence or abuse of both alcohol and illicit drugs, 3.2 million were drug dependent or abused illicit drugs but not alcohol, and 11 million were dependent on or abused alcohol but

not illicit drugs. The number of people with substance dependence or abuse increased from 14.5 million (6.5 percent of the population) in 2000 to 16.6 million (7.3 percent) in 2001.

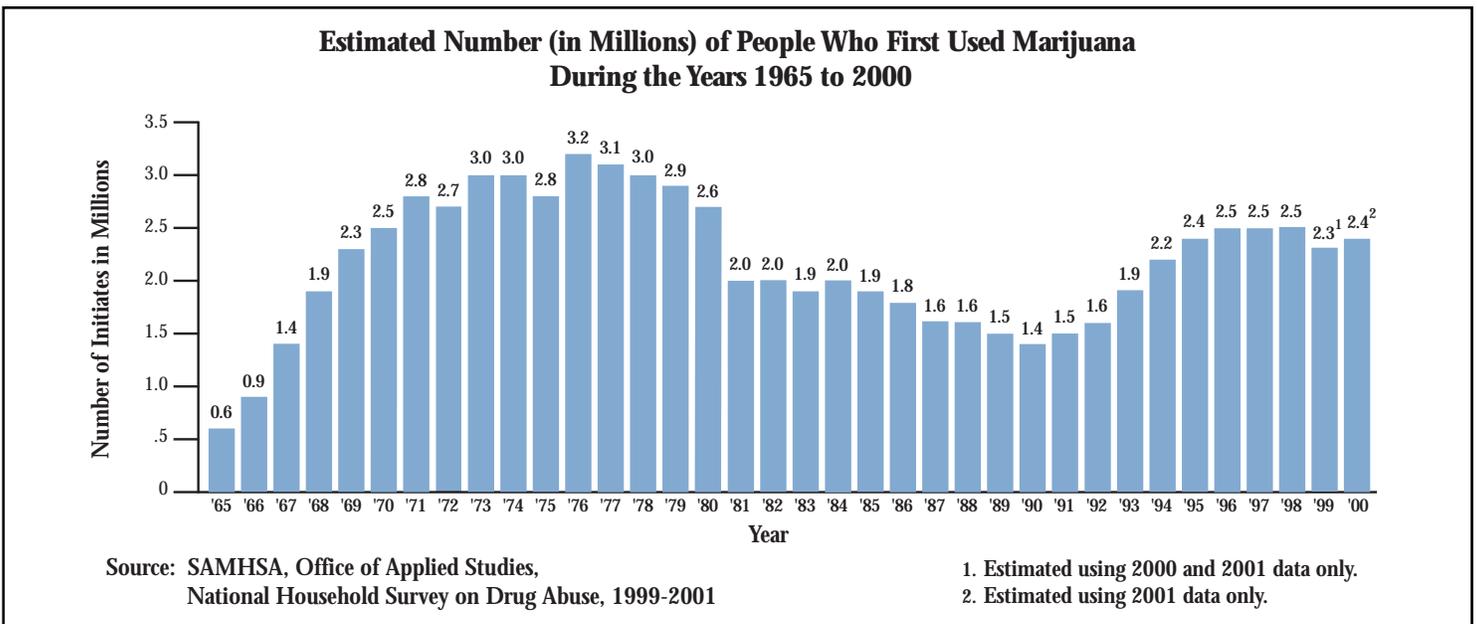
Treatment and Need

Between 2000 and 2001, there was a significant increase in the estimated number of people age 12 and older needing treatment for an illicit drug problem. This number increased from 4.7 million in 2000 to 6.1 million in 2001. During the same period, there was also an increase from 0.8 million to 1.1 million in the number of people receiving treatment for this problem at a specialty facility. However, the overall number of people needing but not receiving treatment increased from 3.9 million to 5 million.

Of the 5 million people who needed but did not receive treatment in 2001, an estimated 377,000 reported that they felt they needed treatment for their drug problem. This includes an estimated 101,000 individuals who reported that they made an effort but were unable to get treatment and 276,000 who reported making no effort to get treatment.

Mental Illness

For the first time, the 2001 Household Survey included questions for adults that



measure serious mental illness. Both youth and adults were also asked questions about mental health treatment in the past 12 months.

The survey found a strong relationship between substance abuse and mental problems. Among adults with serious mental illness in 2001, 20.3 percent were dependent on or abused alcohol or illicit drugs; the rate among adults without serious mental illness was 6.3 percent. An estimated 3 million adults had both serious mental illness and substance abuse or dependence problems during the year.

In 2001, there were an estimated 14.8 million adults age 18 and older with serious mental illness. This represents 7.3 percent of all adults. Of this group with serious mental illness, 6.9 million received mental health treatment in the 12 months prior to the interview.

In 2001, an estimated 4.3 million youth age 12 to 17 received treatment or counseling for emotional or behavioral problems in the

12 months prior to the interview. This represents 18.4 percent of this population and is significantly higher than the 14.6 percent estimate for 2000. The reason cited most often by youth for the latest mental health treatment session was "felt depressed" (44.9 percent of youth receiving treatment), followed by "breaking rules or acting out" (22.4 percent), and "thought about or tried suicide" (16.6 percent).

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., noted that "Behind these numbers are real children and adults affected by drug use. Drug use continues to be a serious public health crisis that affects every aspect of our society. We must refuse to give up on people who have handed over their aspirations and their futures to drug use. People need to know help is available, treatment is effective, and recovery is possible."

The Household Survey, conducted by SAMHSA's Office of Applied Studies, interviews approximately 70,000 people age 12 and older in every state over a 12-month period. It is important to note that because of the year-to-year variations in Household Survey data, conclusions about trends are best made by looking at estimates from 3 or more years. This initial report presents only national estimates. State estimates will be presented in future reports.

To obtain a copy of *Results from the 2001 National Household Survey on Drug Abuse*, 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). The complete report can also be downloaded from SAMHSA's Web site at www.DrugAbuseStatistics.samhsa.gov, click on NHSDA. ▸

Survey Findings Launch Recovery Month

U.S. Health and Human Services Secretary Tommy G. Thompson unveiled the findings of SAMHSA's National Household Survey on Drug Abuse at a September 5 press conference marking the launch of the 13th annual National Alcohol and Drug Addiction Recovery Month. (See *SAMHSA News*, p. 3.)

The month-long observance, sponsored by SAMHSA's Center for Substance Abuse Treatment, unites public and private sector partner organizations nationwide in an effort to highlight the societal benefits, importance, and effectiveness of drug and alcohol abuse treatment. In addition, the observance aims to reduce the stigma associated with substance abuse treatment, and to celebrate people in recovery and those who serve them. This year's theme is "Join the Voices of Recovery: A Call to Action."

In launching Recovery Month, Secretary Thompson said, "We welcome people in recovery back into the community and as contributing members of our society."

Other Recovery Month events include the 7th annual National Run for Recovery in Washington, DC, sponsored by the Vanguard Foundation, as well as community forums throughout the country, among others.

For more information and to obtain a Recovery Month toolkit, 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). Or visit SAMHSA's Web site at www.samhsa.gov. ▸



U.S. Health and Human Services Secretary Tommy G. Thompson

Photo by Catherine Brown

Triple Diagnosis: Surmounting the Treatment Challenge

Jane* and her health care providers knew she had three big problems. She'd been diagnosed with HIV. She was suffering from depression. She was addicted to heroin. Unfortunately, only one of her providers knew she had a fourth problem.

When Jane's health care providers finally started talking, the physician from the HIV/AIDS clinic Jane sporadically attended revealed that Jane also had hepatitis. That wasn't the only surprise for the other clinicians treating her. It turned out the depression medication and the methadone they were giving her made her hepatitis worse. By the time the physician called Jane in to check her liver functioning, it was too late. Soon after, she died of liver failure.

"Jane is a poster child for the need to integrate care," said Marcia D. Andersen, Ph.D., R.N., F.A.A.N., C.S., who arranged the meeting of Jane's caregivers in her role as vice president of the Well-Being Institute, Inc., in Detroit, MI. "When you get providers talking to each other, you can save lives."

SAMHSA's Center for Mental Health Services (CMHS) together with several other Federal entities, is seeking solutions to scenarios like Jane's. Launched in 1998, the 5-year HIV/AIDS Treatment Adherence, Health Outcomes, and Cost Study will determine whether integrating treatment for HIV/AIDS, mental illness, and substance abuse for "multiply diagnosed" people like Jane can improve adherence to treatment regimens, enhance health, and provide cost-effective services.

The Well-Being Institute and seven other sites across the Nation (see sidebar, p. 7) are testing various models of integration with the assistance of a coordinating center.

"With new medications, people with HIV/AIDS are living much longer," said Federal program director Mary C. Knipmeyer, Ph.D., of the CMHS Office of the Associate Director for Medical Affairs. "We need to know how to help people face the challenges of adhering to complicated new HIV/AIDS treatment regimens while taking other medications for their mental and addictive disorders. We also need to know how to provide cost-effective care."

In keeping with the study's emphasis on integrating various treatment realms, the project is a collaboration among six Federal entities. While CMHS has the lead administrative responsibility, SAMHSA's Center for Substance Abuse Treatment (CSAT), the HIV/AIDS Bureau at the Health Resources and Services Administration, and the National Institute of Mental Health, National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism at the National

HIV/AIDS Treatment Adherence Health Outcomes & Cost Study

Institutes of Health are all actively involved. Representatives from each organization participate in a Federal collaborators group as well as the study's steering committee. A representative from each site, a representative from the coordinating center, and a consumer liaison comprise the steering committee.

"Having so many Federal entities involved is unusual," said Jennifer Todd, Dr.P.H., a social science analyst in CSAT's Division of Practice and Systems Development. This kind of interagency collaboration does more than just provide a model of the kind of integration the Federal Government would like to see at the local level. It also helps each organization



Members of the Well-Being Institute's outreach team gather in front of the program's outreach van.

*Name changed to protect privacy.

fulfill its mission. “Ultimately we’re all serving the same people, so it’s important that we coordinate as a team,” explained Dr. Todd. “Although it can be harder to get consensus in a large group, in the long run it will help us better serve people with multiple disorders.”

A Treatment Challenge

Although treatment advances have improved the prospects of people living with HIV/AIDS, mounting research suggests that those who also have mental and addictive disorders are least able to take advantage of these life-prolonging medications. What’s more, treating these multiply diagnosed individuals costs more than treating other people with HIV/AIDS.

“Individuals with these diagnoses often are unable to participate in antiviral regimens because their mental health and substance use disorders get in their way,” explained principal coordinating center director James Bell, M.A., president of James Bell Associates in Arlington, VA. The combined effects of addiction and mental disorders along with the struggle to meet basic survival needs like food and shelter can keep people from making health a priority. Even when they receive antiviral prescriptions, their other disorders can make it hard for them to stick to the complicated regimens these medications demand.

Dr. Knipmeyer noted that the stigma of mental illness and substance abuse discourages some physicians from even offering or suggesting complicated medication regimens.

Although study sites offer different interventions, all use the same assessment tools to track participants’ progress from the time they begin to 1 year later.

This standard battery includes such elements as:

- **Structured Clinical Interview for the Diagnostic and Statistical Manual IV** designed to determine accurate mental health and substance use diagnoses

Participating Sites

Triply diagnosed people aren’t all the same. Nor are local HIV/AIDS service systems. To reflect this diversity, the HIV/AIDS Treatment Adherence, Health Outcomes, and Cost Study uses a multisite design that allows for demographic and services diversity. Assisted by Federal collaborators and a coordinating center housed at James Bell Associates, eight sites are participating in the study:

- **The Boston Medical Center** offers brief motivational therapy to multiply diagnosed individuals.
- **Duke University** relies on case managers and transportation services to help multiply diagnosed people in rural areas access intensive outpatient mental health and substance abuse counseling and HIV/AIDS care.
- **The CORE Center**, Cook County Bureau of Health Services, has created integrated primary care, mental health, substance abuse, and case management treatment teams in an urban Chicago HIV/AIDS clinic.

- **Montefiore Medical Center** works with individuals in methadone maintenance clinics and is particularly interested in individuals diagnosed with Borderline Personality Disorder.

- **The National Development and Research Institutes, Inc./Guadenzia, Inc.**, offers a “therapeutic community” aftercare program to triply diagnosed graduates of its residential substance abuse treatment program.

- **The University of Missouri in St. Louis** uses a multidisciplinary mental health and substance abuse treatment team coordinated by case managers.

- **The University of Washington in Seattle** offers individualized counseling and group counseling, both aimed at improving treatment adherence.

- **The Well-Being Institute, Inc.**, relies on intensive case management by nurses to get triply diagnosed women “lost” to medical followup re-engaged in treatment. ▀

- **Addiction Severity Index-Lite** to track substance abuse, a modified form of the Adults AIDS Clinical Trials Group Adherence Instrument designed to track changes in treatment adherence

- **Health Services Utilization Questionnaire** that assesses utilization costs.

The individual projects also are drawing on data from medical charts, administrative records, and random urine sampling.

By the time the study ends, the eight study sites will have extensive data from more than 1,000 individuals.

Consumer Involvement

To make the study as reality-based as possible, consumers of treatment services play a vital and essential role. Each study site has a

consumer advisory board comprised of people living with HIV/AIDS and mental and addictive disorders. The advisory boards help develop effective local strategies for recruiting and retaining participants and assist project staff with program design and participant feedback. One member from each local board also serves as a consumer representative to the study’s multisite consumer workgroup of the steering committee.

“This emphasis on consumer involvement is both novel and effective,” said Phil Meyer, L.C.S.W., a Los Angeles consultant living with HIV who also serves as the consumer representative on the study’s steering committee. Mr. Meyer uses monthly conference calls with the local consumer

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representatives to gather their suggestions and concerns, and then shares these with the steering committee in his role as one of 11 voting members.

“The consumers have had a real impact,” said Mr. Meyer. For example, when the steering committee was developing the intake procedures to determine study participants’ baseline characteristics, the consumer representatives took a draft version of the battery of tests. The consumers’ comments—“Pages and pages and pages of questions!”—led the steering committee to reshape the final form of the baseline protocol significantly. The steering committee reduced the length of the assessment, removed certain measures, shuffled others, and developed an administrative procedure that was much less stressful.

Now the consumers are focusing on publishing articles in journals and magazines. One of their main goals is to highlight the importance of consumer involvement as vital to the success of the study.

“Becoming an advocate is the next phase of treatment for people,” Mr. Meyer explained. “What we’re learning is that people who are actively in recovery have a real desire to give back to the community.”

Maxine, the Well-Being Institute’s representative, is a perfect example. Before she participated in the pilot program designed to test the Institute’s intervention, she was in bad shape. Although she worked as a nurse, she drank heavily and secretly smoked crack cocaine. And despite having been diagnosed with HIV, she wasn’t going to a doctor or taking medication.

“I thought, ‘Oh, well, I’m dying anyway, so forget it,’” she explained. “But the Well-Being program was a real stepping stone for me.”

Now 59 years old with an undetectable viral load, Maxine has a new career as an activist. Along with other members of her

(l. to r.) Maxine, Carita, and Dr. Marcia Andersen, all of the Well-Being Institute, Inc., in Detroit, MI.



consumer advisory board, she talks to current participants about how well the program is working and shares their suggestions with the Well-Being Institute staff. She also speaks out at conferences and teaches others how to advocate for themselves. “People are really listening,” she said.

One Site’s Intervention

The Well-Being Institute’s nurse-based intervention targets women with HIV who haven’t shown up for appointments at an HIV clinic, sometimes for years. Armed with lists of these women, a friendly outreach “hostess,” a nurse, and a driver locate the women.

Whether the women are randomly assigned to the intervention or control arm, participation in the actual study begins with a warm welcome from the hostess. For those assigned to the intervention arm, the process continues with a “bonding” session with a nurse and an initial assessment. The nurse then accompanies the woman to consultations with treatment providers for HIV/AIDS, mental health, and substance abuse who offer recommendations for care. Drawing on these recommendations and the patient’s own concerns, the nurse develops an integrated treatment plan and negotiates its acceptance

by all involved. The institute then does whatever it takes to help the women adhere to those plans, such as providing transportation and accompaniment to appointments or offering individual and group counseling. Re-assessments at 3-month intervals help fine-tune the participants’ treatment goals and provide needed information for the multisite study.

For study participants such as Carita, the Well-Being Institute’s intensive, one-on-one approach is working wonders. Before the study began, Carita was just too emotionally exhausted to endure the three bus rides it took to get to her HIV clinic. “When you’ve been diagnosed as long as I have, you just get tired,” she explained. Now the institute transports her to appointments, helps her keep track of the medication she takes for HIV and depression, and provides a variety of vouchers.

“Many of the women we serve live near a major medical center,” said Dr. Andersen. “They live in the shadow of the castle, but they can’t get over the castle walls.” With help from the Well-Being Institute, they may now have the key. ▀

—By Rebecca A. Clay

Substance-Abusing Youth at Greater Risk for Suicide

Data from SAMHSA's National Household Survey on Drug Abuse for the year 2000 show that youth who reported alcohol or illicit drug use during the past year were more likely than those who did not use these substances to be at risk for suicide during this time period.

Among youth who used alcohol, 19.6 percent thought about or attempted suicide in the past year, compared with 8.6 percent among youth who did not use alcohol. Among those who used illicit drugs, 25.4 percent thought about or attempted suicide compared with 9.4 percent among those who did not use drugs.

Overall, approximately 3 million youth age 12 to 17 thought about or attempted suicide in 2000. Unfortunately, only 36 percent of these at-risk youths received mental health treatment during this same time period.

"Even one death by suicide is one death too many," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "The challenge is to identify, evaluate, and promote

community-based suicide prevention programs that work—systems of services in which every door can be the right door to help."

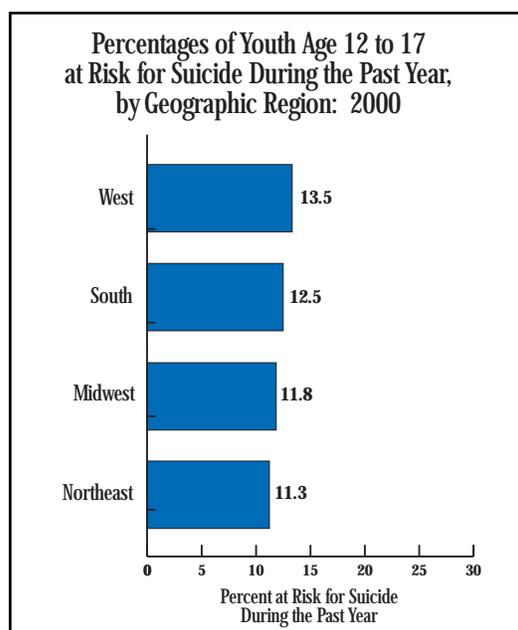
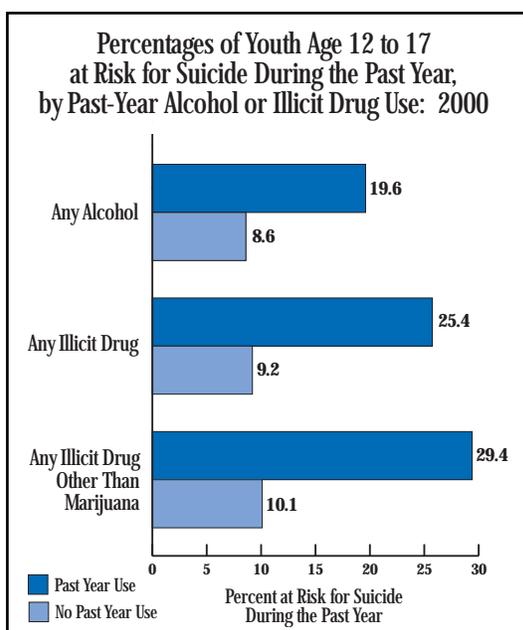
Mr. Curie noted that among SAMHSA initiatives to combat teen suicide is the "Signs of Suicide" project that is educating teens about depression and the signs of depression. "We need to help teens make the link between untreated depression and the risk for suicide, and help them identify serious depression or suicide risk in a friend. We must encourage teens to tell a responsible adult when a friend is at risk for suicide."

The data reveal that the risk of suicide was similar among white, black, Hispanic, and Asian American youth. Regionally, youth from the West (14 percent) were more likely to be at risk for suicide during the past year than those who lived in the Midwest (12 percent) or Northeast (11 percent). The risk of suicide was similar among youth from large metropolitan, small metropolitan, and nonmetropolitan counties.

Females (16 percent) were almost twice as likely as males (8 percent) to be at risk for suicide during the past year. The likelihood of suicide risk was also greater among youth age 14 to 17 (13.7 percent) than it was among those age 12 or 13 (9.4 percent).

SAMHSA's Office of Applied Studies conducts the National Household Survey on Drug Abuse annually. The 2000 survey obtained information from nearly 72,000 persons age 12 and older, including more than 25,000 youth age 12 to 17.

Information about youth substance use and suicide risk is contained in *The NHSDA Report: Substance Use and the Risk of Suicide Among Youth*. For a copy of the report, 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). To download a copy, visit SAMHSA's Web site: www.samhsa.gov/oas/nhsda/htm.



Source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 2000.

Early Marijuana Use Linked to Adult Dependence

A new SAMHSA report concludes that the younger children are when they first use marijuana, the more likely they are to use cocaine and heroin and become dependent on drugs as adults.

The report, *Initiation of Marijuana Use: Trends, Patterns and Implications*, found that 62 percent of adults age 26 or older who initiated use of marijuana before they were 15 years old reported that they had used cocaine in their lifetime. More than 9 percent reported they had used heroin and 53.9 percent reported non-medical use of psychotherapeutics. This compares to a 0.6-percent rate of lifetime use of cocaine, a 0.1-percent rate of lifetime use of heroin, and a 5.1 percent rate of lifetime non-medical use of psychotherapeutics for those who never used marijuana. Increases in the likelihood of cocaine and heroin use and drug dependence are also apparent for those who initiate use of marijuana at any later age.

The report is based on the National Household Survey on Drug Abuse for 1999

and for 2000 conducted by SAMHSA's Office of Applied Studies.

The report found that 18 percent of people age 26 and older who began using marijuana before age 15 met the criteria for either dependence or abuse of alcohol or illicit drugs, compared to 2.1 percent of adults who never used marijuana. Among past-year users of marijuana who had first used marijuana before age 15, 40 percent met the criteria for either dependence or abuse of alcohol or illicit drugs.

White House Office of National Drug Control Policy Director John Walters said, "Every day in this country, more than 5,000 people—most of them under the age of 18—use marijuana for the first time. Their early marijuana use exposes them to risks of drug dependencies, long-term physical and cognitive consequences, and social problems. We must keep our young people out of harm's way by educating them on the dangers of marijuana use, preventing

initiation of the drug, and getting them help if they have already starting using it."

Overall, the report found that an estimated 2 million Americans age 12 or older indicated they used marijuana for the first time in 1999. This was fewer than the 2.5 million new users in 1998, but still more than 1.4 million new users, found in 1989 and 1990.

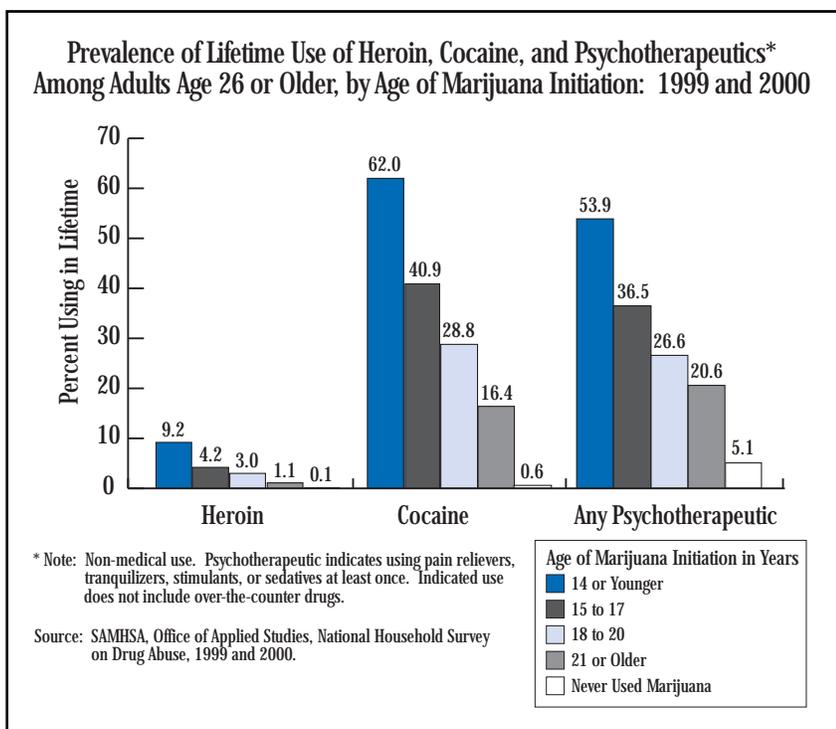
SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "Among recent initiates of marijuana, nearly three-quarters had first used between the ages of 13 and 18. More than a quarter initiated before age 15. These findings are of grave concern."

Among persons age 12 to 25 who had never used marijuana, those who had smoked cigarettes were an estimated 6 times more likely than nonsmokers to initiate marijuana use within 1 year. Alcohol users were an estimated 7 to 9 times more likely than nonusers to start using marijuana within a year. Daily cigarette smoking was associated with a twofold increase in risk for marijuana initiation.

The nine states with the highest rates of recent new marijuana users age 12 to 17 were Arizona, Colorado, Delaware, Hawaii, Massachusetts, Nevada, New Hampshire, New Mexico, and Vermont.

The lowest rates of recent marijuana initiates age 12 to 17 were in Alabama, the District of Columbia, Idaho, Louisiana, Mississippi, New Jersey, Pennsylvania, Texas, Utah, and Virginia.

For a copy of the report, 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). The report is also available on the SAMHSA Web site at <http://www.samhsa.gov/oas/drugs.htm#MJ>.



Self-Help Booklets Promote Mental Health Recovery

A new series of self-help guides for people with mental health disabilities offers practical and positive advice on topics ranging from making friends to developing a wellness lifestyle to reducing the effects of trauma.

The six booklets, released in July by SAMHSA's Center for Mental Health Services (CMHS), are part of a publication series titled *Recovering Your Mental Health*. They offer specific information guided by an understanding of consumer self-help issues and are intended to enhance the quality of life for people from a variety of backgrounds. The booklets, ranging in length from 30 to 50 pages, are titled *Action Planning for Prevention and Recovery*, *Dealing With the Effects of Trauma*, *Speaking Out for Yourself*, *Developing a Recovery and Wellness Lifestyle*, *Building Self-Esteem*, and *Making and Keeping Friends*. They are available as single copies or in a packet containing all six copies, along with the original publication titled *Recovering Your Mental Health: A Self-help Guide*, published in 2001.

"The self-care skills and strategies outlined in the guides can be used to complement other mental health care treatment," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "The guides offer practical steps that people need to keep in mind as they work on their own recovery."

Former CMHS Director Bernard S. Arons, M.D., said, "These user-friendly guides will help people living with mental illness to achieve wellness, stability, and recovery."

Each booklet contains ideas, strategies, and resources that people from all walks of life have found helpful in managing their own illnesses and obtaining services, and in relieving and preventing feelings of mental and emotional distress.



- *Action Planning for Prevention and Recovery* gives simple, low-cost ideas for maintaining and supporting mental health, such as developing a "Wellness Toolbox" and a daily maintenance plan, and identifying and dealing with trigger factors for stressful situations.
- *Dealing With the Effects of Trauma* discusses the difficulties in dealing with and overcoming upsetting, frightening, and traumatic events, and offers ways to heal and feel better on a daily basis.
- *Speaking Out for Yourself* tells people with emotional or psychological disorders how to advocate effectively for themselves and become their "own best champion."
- *Developing a Recovery and Wellness Lifestyle* talks about ways people can take charge of their lives, whether it's taking a course, eating less fast food, obtaining good health care, or getting enough exercise.

- *Building Self-Esteem* helps readers find ways to feel better about themselves, such as attending to their needs and wants, changing negative thoughts about themselves to positive ones, and engaging in activities that make them feel good about themselves.
- *Making and Keeping Friends* describes ways to meet new people, keep friendships strong, establish and honor boundaries, and resolve relationship problems.

Single copies of the six *Recovering Your Mental Health* guides, or packets of all six, along with the booklet *Recovering Your Mental Health: A Self-help Guide*, are available free of charge by contacting SAMHSA's National Mental Health Services Knowledge Exchange Network at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or log on to www.mentalhealth.samhsa.gov, click on publications. ▾

—By Shelly Burgess and Peggy Dillon

Prevention Programs Receive Government Seal of Approval

SAMHSA announced the names of 25 exemplary substance abuse prevention programs in June that received a Government “seal of approval” for preventing and reducing illegal drug use, alcohol abuse, and other risky behaviors in communities across America. The programs were selected after a review of more than 200 substance abuse prevention programs. The review was based on criteria requiring that the programs use scientifically rigorous evaluations and achieve consistently positive outcomes.

At a formal awards luncheon on June 7, SAMHSA’s Center for Substance Abuse Prevention in partnership with the National Association of State Alcohol and Drug Abuse Directors, the National Prevention Network, and the Community Anti-Drug Coalitions of America, presented the winning programs with the Exemplary Substance Abuse Prevention Programs Award.

“Our message today is that prevention is possible and that models of excellence are available,” said U.S. Health and Human Services Secretary Tommy G. Thompson in



announcing the awards. “Communities across America should insist upon and work toward the same level of excellence. As a Nation, we can settle for no less.”

The 25 model programs that received the Exemplary Substance Abuse Prevention Program Award are listed in SAMHSA’s

National Registry of Effective Prevention Programs. The Registry is part of SAMHSA’s ongoing efforts to identify and disseminate information nationwide about science-based prevention programs that have demonstrated consistently positive results.

After model programs are identified by the Registry, SAMHSA’s National Dissemination System creates materials and Web-based information; provides training and technical assistance; and works with states, localities, and the private sector to ensure effective implementation. During 3 years of designating model programs, 662 programs have been reviewed and 41 enrolled in SAMHSA’s Registry.

SAMHSA also honored five promising programs. These five were recognized as innovative, community-based programs that have shown good preliminary results in preventing youth from engaging in the use of alcohol and illicit drugs. These promising programs were nominated by state agencies and national organizations and were selected



SAMHSA Administrator Charles G. Curie talks with Joseph A. Califano, Jr., president of CASA.

in collaboration with the National Association of State Alcohol and Drug Abuse Directors and the Community Anti-Drug Coalitions of America.

At the awards luncheon, White House Drug Czar John Walters said, "The model programs recognized today are making important differences every day where it matters most: in our neighborhoods. Initiatives like these help galvanize local communities in the national effort to reduce substance abuse through sound, science-based prevention."

"Reducing risk for destructive behaviors and increasing opportunities for safe passage to adulthood are possible when communities embrace science-based prevention programs for young people," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "We are allocating funds and forming partnerships with national, state, and grassroots organizations to help bring about the use of model programs nationwide."

One of the exemplary programs, the Center on Addiction and Substance Abuse—Striving Together to Achieve Rewarding Tomorrows (CASASTART), is a community-based, school-centered program designed to keep high-risk 8- to 13-year-old youth free of drug and crime involvement through a coordinated effort of preventive services and law enforcement activities. Impact analyses found that children in the program, when compared to the matched control group at the 1-year followup, were significantly less likely to use gateway and stronger drugs, less likely to report involvement in drug trafficking, and more likely to be promoted to the next grade in school.

"We are very pleased that SAMHSA recognizes, as we do, the need to reach kids at a young age, and the community and family involvement essential to keep them substance free," said Joseph A. Califano Jr., president of CASA, which is located at Columbia University.



White House Drug Czar John Walters

"SAMHSA and CASA also share a recognition of the importance of continually measuring outcomes to assure the maximum return on every dollar invested. A child who reaches age 21 without using drugs, smoking cigarettes, or abusing alcohol is virtually certain never to do so."

Another exemplary program, Family Matters, involves family members in supervising, communicating with, and discouraging substance use among 12- to 14-year-old adolescents. The program provides booklets and activities to parents with oversight from a health educator. Families are encouraged to establish rules regarding adolescent alcohol and tobacco use.

Findings from an evaluation study reported significant reductions in the prevalence of smoking and drinking in the intervention group at 3-month and 12-month followups. An article on the program reported that Family Matters was successful in changing several aspects of the family environment regarding substances. In addition to setting rules, parents in the program were more likely to discuss peer and media influences on alcohol use and provide encouragement not to smoke.

"Science has taught us a tremendous amount about the factors involved in the initiation and escalation of drug use and some of the best ways to prevent it," said Glen R. Hanson, Ph.D., D.D.S., Acting Director of the National Institute on Drug Abuse. "The ultimate worth of science lies in the extent to which it is useful and used. We look forward to working closely with SAMHSA and others to determine the most effective ways to implement these programs in the communities that need them."

"The National Institute on Alcohol Abuse and Alcoholism conducts and supports research for two essential reasons: to understand the causes of alcohol abuse, alcoholism, and alcohol-related problems and to develop new and improved strategies to treat and prevent them," said Institute Acting Director Raynard S. Kington, M.D., Ph.D. "We are most gratified when research-based programs are put to work to improve lives and communities."

For more information on the SAMHSA Model Programs, visit www.modelprograms.samhsa.gov. Or, send an e-mail to modprog@samhsa.gov. Telephone: 1 (877) 773-8546. ▀

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care and reduce widespread prejudice against patients in addiction treatment.

Mark W. Parrino, M.P.A., president of the American Association for the Treatment of Opioid Dependence, explains some of the misconceptions behind this prejudice. "Some critics of methadone treatment believe that it represents substituting one drug for another. Such critics see no distinction between heroin as an illicit drug and methadone as a medication that is used in conjunction with other treatment services."

Other critics, he says, "include people in recovery from other drugs of abuse, including alcohol. They claim that since they are able to be abstinent without pharmacotherapy, methadone maintenance does not represent a 'true' state of recovery."

In fact, Mr. Parrino says, "methadone treatment has been rigorously studied for more than 35 years and the results are found to be uniformly positive." He adds, "The changes we're seeing under the new accreditation guidelines from SAMHSA may seem small, but they are nothing short of a revolution."

"The new SAMHSA rule puts the patient first. It gets the Federal Government away from directing medical practice in addiction medicine," says Robert Lubran, M.S., M.P.A., Director of the Division of Pharmacologic Therapies within SAMHSA's Center for Substance Abuse Treatment (CSAT). "Rather than dictating how opiate-addicted patients are to be treated, the regulations have made it clear that medical and clinical treatment professionals should be encouraged to apply their training and expertise in making patient care determinations without undue concern about burdensome Federal restrictions—more like mainstream medical care."

One Program's Experience

Evergreen Treatment Services in Seattle, WA, illustrates SAMHSA's view that medications such as methadone and LAAM should be used in conjunction with a clinical program of therapeutic services.

"Treatment at Evergreen has always been individual-oriented," says Carol Davidson, M.S.W., C.D.P., Evergreen's treatment director, "and individual counseling is an important part of treatment planning. Individual counselors also serve as case managers, referring patients for group counseling—either men's or women's groups, alternative therapy such as acupuncture, psychiatric assessments, or community mental health services, as needed."

Evergreen has chosen to seek accreditation from the Washington State Department of Social and Health Services. "We're very fortunate and a bit ahead of the game," says Ms. Davidson. "Because we've always had to meet Washington State licensing requirements, we're already doing a lot of the things that the new CSAT accreditation standards call for. The State standards have always been high."

"This new system will be good for the patients and good for the drug abuse treatment field," says T. Ron Jackson,

M.S.W., Evergreen's executive director. "Our patients are already seeing benefits. Even in the early stages of the accreditation process, we've been able to implement more generous schedules for take-home medication under the CSAT guidelines."



Carol Davidson and T. Ron Jackson

Both Ms. Davidson and Mr. Jackson predict beneficial outcomes from CSAT's new accreditation process. "After 30 years in this field," says Mr. Jackson, "I'm struck with how hard our patients work in methadone treatment programs and how little credit or respect they get in the community. This change to accreditation is a solid move toward the medical model for addiction treatment, and it's sure to help the image of opioid treatment for our patients." ▾

Standards, Not Controls

Under the former system of FDA regulation, methadone maintenance treatment programs were monitored by Federal inspectors to ensure their adherence to rules limiting the amount of methadone given to each patient in a daily dose and rules for detailed record-keeping practices. Monitoring the distribution of a controlled substance—methadone—appeared to be the primary objective.

The new SAMHSA rules, by contrast, shift the direction of Federal oversight to ensuring that more than 1,100 opioid treatment programs across the country are applying the best clinical practices as described in the CSAT accreditation guidelines. The guidelines are based on recommendations from the 1997 National Institutes of Health *Consensus Statement on Effective Medical Treatment of Opiate Addiction*, the 1995 Institute of Medicine report, *Federal Regulation of Methadone Treatment*, and the deliberations of a panel of field experts. The accreditation bodies have all adopted new standards for the treatment of opiate addiction that emphasize improving the quality of care through individualized treatment planning, greater medical supervision, and assessment of patient outcomes.

Buprenorphine: Expanding the Treatment Toolbox

Buprenorphine, a promising new anti-addiction treatment medication currently under review for approval by the Food and Drug Administration (FDA), is expected to be the first opioid treatment medication available for administration by primary-care physicians and specialists in their own offices.

Susanne Caviness, Ph.D. (Capt., U.S. Public Health Service), of SAMHSA's Center for Substance Abuse Treatment (CSAT) explains, "Office-based opioid treatment is very promising. For example, a knowledgeable family physician who has cared for a patient over a period of years could detect early signs of drug addiction. Then the physician can quickly intervene with appropriate medication and counseling. The result would be more continuity of care since the patient would not have to be referred to a community clinic for separate addiction treatment."

Although the FDA had not yet approved buprenorphine at the time *SAMHSA News* went to press, approval is anticipated before the end of 2002.

Buprenorphine is similar to full agonist medications such as methadone and LAAM in two ways:

- It reduces cravings for illicit opiates and suppresses the opiate abstinence withdrawal syndrome.
- It produces morphine-like subjective effects and cross-tolerance to other opiates.

However, buprenorphine has a ceiling effect. Dosages above a certain amount do

not produce corresponding increases in effect. Thus, for certain pharmacologic effects, e.g., respiratory depression, buprenorphine may be safer in some ways than methadone and LAAM. It offers lower abuse potential, relatively mild withdrawal symptoms, and effectiveness for some patients with dosing only 3 times per week.

Although buprenorphine will not replace methadone, it provides yet another alternative in the treatment of opiate addiction—particularly for maintenance therapy.

While FDA's role is to approve the use of buprenorphine, SAMHSA's role is to approve waiver nominations for office-based physicians to dispense or prescribe it. The Drug Addiction Treatment Act of 2000 permits qualified physicians to seek a waiver from the Federal requirement to obtain the separate registration that is necessary for methadone treatment programs. The waiver nominations are submitted to SAMHSA. CSAT is already processing and evaluating submissions for waivers, which will be issued once buprenorphine is approved by FDA.

To obtain such a waiver, licensed physicians must be qualified either through subspecialty board certification or completion of training in treatment and management of opiate dependent patients. SAMHSA is funding onsite and online training in office-based opioid treatment, currently available through the American Psychiatric Association, American Academy of Addiction Psychiatry, American

Osteopathic Association, and the American Society of Addiction Medicine.

CSAT worked with the Federation of State Medical Boards, representing 68 states and territories, to develop buprenorphine clinical practice guidelines. The guidelines should help physicians make practical decisions in treating patients with this medication.



Practitioners throughout the Nation are enthusiastic about the prospect of office-based opioid treatment with buprenorphine, according to CSAT's Division of Pharmacologic Therapies Director Robert Lubran, M.S., M.P.A.

For more information, go to <http://buprenorphine.samhsa.gov>. Or contact the CSAT Buprenorphine Information Center via e-mail at info@buprenorphine.samhsa.gov, or by telephone at 1 (866) BUP-CSAT (287-2728). Operators are available to answer calls Monday through Friday from 8:30 a.m. to 5 p.m., Eastern Time. ▀

CSAT's accreditation guidelines for optimal care in addiction treatment programs have been translated into measurable standards by accrediting organizations. The standards of care are designed to ensure, for example, that patient care is tailored to individual needs.

Arbitrary restrictions—such as ceilings on methadone doses and observation of urine tests—have been removed. And, in the Nation's health care system, patients with the disease of addiction are treated with the same respect afforded patients with other chronic diseases.

The Accreditation Process

Each treatment program must apply to a SAMHSA-approved accrediting organization. Four organizations were approved by SAMHSA in December 2001 for the purpose of accrediting opioid treatment programs.

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To date, the Washington State Department of Social and Health Services is the only government accrediting organization. The other three accrediting bodies are the Commission on Accreditation of Rehabilitation Facilities, the Commission on Accreditation of Services to Families and Children, and the Joint Commission on Accreditation of Healthcare Organizations. Treatment programs may choose to apply to any one of these four accrediting organizations.

Ray Hylton, a CSAT public health advisor, explains that “Each accreditation survey involves a 1- to 3-day site visit, when the surveyors review clinic records, interview staff members and patients, and meet with community representatives and the local government.”

The surveyors look at such factors as:

- Is each patient receiving the amount of medication and counseling best suited to his or her needs? Are various types of counseling available?
- Are all members of the treatment staff adequately trained?
- Are patients referred for infectious disease testing, social services, and other community resources when appropriate?
- Are treatment decisions based on medical factors? Are co-occurring conditions taken into account?
- How well is the program working for patients? Are the patients holding down jobs and abstaining from illicit drugs? Has criminal activity been reduced?

Programs may be accredited for 1 year or 3 years, depending on their level of compliance to the standards.

Some patients and advocates have expressed concern about how clinic operations could be affected by the extra work involved in accreditation.

“We’re hearing reports that clinics are raising fees to pay for their accreditation,”



says Chris Kelly, director of the Washington, DC, chapter of Advocates for Recovery through Medicine. “One local clinic is closing down for all but 2 hours a day just to handle the paperwork,” she added. “The CSAT guidelines are great in principle, but the clinics and accreditation groups are going to have to work hard to make it work.”

“Preparing for accreditation may seem daunting, but it’s doable and affordable,” Mr. Hylton says. “In our impact study, conducted from 1997 to 2002 and involving 129 representative programs in 15 states, more than 99 percent earned their accreditation using the standards and survey system now in place.”

To ease the transition, CSAT has provided grants to SAMHSA-approved accrediting organizations to reduce the cost for treatment programs of the initial cycle of accreditation inspections. CSAT is also offering technical assistance from experts and consultants and has convened a series of training workshops to help treatment centers meet the new standards.

Educational Activities

Along with oversight of the accreditation process, CSAT is supporting innovative treatment models that are attempting to make services more accessible to populations or areas currently underserved. Educational activities geared to patients and health practitioners are also a priority.

CSAT established a detailed Web page in spring 2002 devoted to opioid addiction and treatment. The Web page, www.samhsa.gov/centers/csat/content/dpt, provides up-to-date, reliable information on opioid treatment medications (including methadone, LAAM, naltrexone, and buprenorphine), guidelines for medications and alternative therapies, and standards to ensure the highest possible quality of care. Program administrators and accrediting bodies will find comprehensive information on the opioid treatment programs accreditation process with helpful links to relevant studies, legislation, and regulations.

In September 2000, CSAT brought together the leading national organizations for patient support and education for a 2-day meeting to discuss opioid dependency and the stigma associated with its related medication-assisted treatments. Through this effort, the Methadone Patient Support and Community Education Project was formed. More information about this project is available on CSAT’s Web page on medication-assisted treatment.

Educating health professionals about addiction treatment will also be an important part of getting opioid treatment patients into the mainstream, according to Malcolm Dickson, national director of Advocates for Recovery through Medicine. “Better education about addiction treatment is needed in medical schools,” says Mr. Dickson, “and family practitioners should be required to have continuing education in managing methadone patients.”

For more information about medication-assisted treatment, go to www.samhsa.gov/centers/csat/content/dpt. Or contact CSAT’s Division of Pharmacologic Therapies at 5600 Fishers Lane, Rockwall II, Suite 740, Rockville, MD 20857. Telephone: (301) 443-7745; Fax: (301) 480-3045; E-mail: opt@samhsa.gov.

—By *Barbara Shine*

Survey Paints Picture of Substance Abuse Treatment Facilities

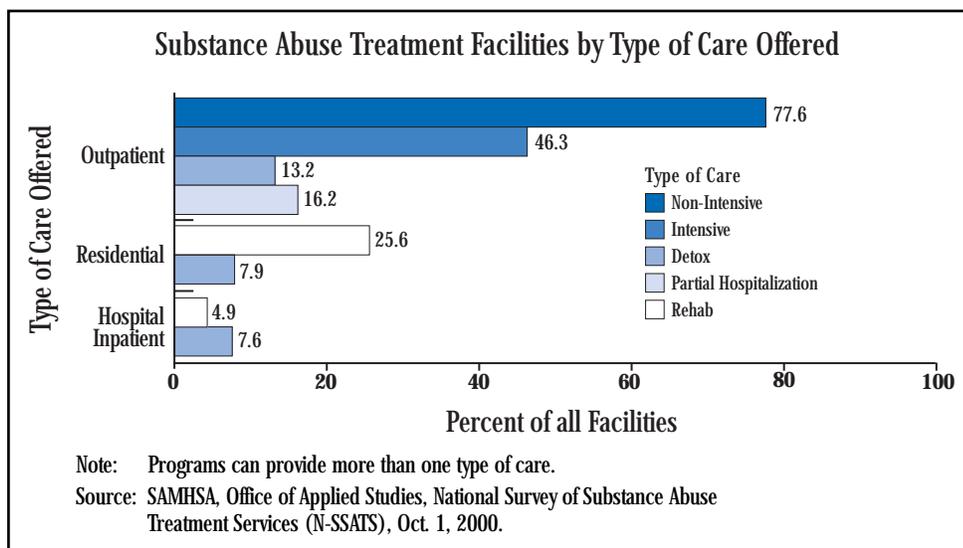
On any given day, approximately 1 million people are receiving treatment for drug or alcohol addiction, according to SAMHSA's National Survey of Substance Abuse Treatment Services for the year 2000. The large majority of these clients (89 percent) were enrolled in some type of outpatient care.

The purpose of the annual survey, conducted by SAMHSA's Office of Applied Studies, is to collect data on the location, characteristics, and use of alcoholism and drug treatment facilities and services throughout the 50 states, the District of Columbia, and other U.S. jurisdictions. A total of 13,428 facilities (94 percent of eligible facilities) participated in the survey. The survey was conducted on October 1, 2000.

Nearly half (48 percent) of all clients were in treatment for both alcohol and drug abuse. Twenty-nine percent of clients were in treatment for drug abuse only, while the remaining 23 percent were in treatment for alcohol abuse only.

Nine percent of those in addiction treatment were in residential rehabilitation. The remaining three categories (residential detoxification, hospital inpatient rehabilitation, and hospital inpatient detoxification) together accounted for 2 percent of clients.

In 2000, private nonprofit facilities made up the bulk of the system (60 percent), followed by private for-profit (26 percent), and state and local government (11 percent). Outpatient rehabilitation was the most widely available type of care, with non-intensive outpatient rehabilitation offered by 78 percent of all facilities and intensive outpatient treatment offered by 46 percent. Residential rehabilitation was offered by 26 percent of all facilities. Partial hospitalization programs were offered by 16 percent of facilities, and outpatient detoxification by 13 percent. Residential detoxification and hospital



inpatient treatment (either detoxification or rehabilitation) were each offered by 8 percent of all facilities.

The vast majority of facilities (95 percent) treated both alcohol and drug abuse. They also offered treatment programs designed to address the specific needs of certain groups. These groups include dually diagnosed people (persons with mental illness and co-occurring substance abuse), adolescents, persons with HIV/AIDS, older adults, and pregnant or postpartum women. Special programs may also be designed for groups of men or women (other than pregnant or postpartum women), or persons in the criminal justice system. Many facilities offered treatment for persons arrested while driving under the influence of alcohol or drugs (DUI) or driving while intoxicated (DWI).

Overall, half (50 percent) of all facilities provide programs for dually diagnosed people. About 37 percent of facilities offered programs for adolescents. About one-fifth (22 percent) of facilities offered programs for persons with HIV/AIDS. Programs for pregnant or postpartum women were offered by 21 percent of facilities. Programs for

other women's groups were provided by 38 percent of facilities. Programs for men only were provided by 33 percent of all facilities. Eighteen percent of all facilities provided programs for seniors or older adults. Thirty-eight percent of all facilities offered programs for persons in the criminal justice system. Special programs for those arrested for DUI/DWI were offered by 36 percent of all facilities.

The number of facilities that had managed care contracts continued to increase. More than half (54 percent) of all facilities had managed care contracts in 2000, as compared to 42 percent in 1996.

To obtain a copy of the report, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2000, Data on Substance Abuse Treatment Facilities*, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The report can also be downloaded from the SAMHSA Web site at www.samhsa.gov, click on Statistics and Data, click on "What's New" on the top banner. ▀

Marijuana- & Cocaine-Related Emergency Department Visits Up

Emergency department mentions of cocaine increased 10 percent and marijuana increased 15 percent from 2000 to 2001, according to new data from SAMHSA's Drug Abuse Warning Network (DAWN).

The 2001 DAWN data show 638,484 drug-related hospital emergency department visits in the continental United States in 2001, an increase of 6 percent over the year 2000 for emergency department visits involving drugs and mentions of drugs. In DAWN, a single drug abuse episode may have multiple drug mentions.

Marijuana mentions, which rose to the same level as heroin mentions in 1997, continued to increase. Marijuana mentions increased 15 percent from 96,426 to 110,512 between 2000 and 2001 and were concentrated in patients age 12 to 34. Increases for marijuana were reported in Minneapolis, San Diego, Seattle, San Francisco, and Baltimore. Decreases were recorded only in New Orleans.

"This report shows one more cost of drug abuse to our society," said U.S. Health and Human Services Secretary Tommy G. Thompson. "We must continue to strengthen our prevention programs and build substance abuse treatment capacity so that people don't abuse drugs and end up in costly emergency departments, taking resources away from other urgent care needs."

"Marijuana-related medical emergencies are increasing at an alarming rate, exceeding even those for heroin. This report helps dispel the pervasive myth that marijuana is harmless," said White House Drug Czar John Walters. "In reality, marijuana is a dangerous drug, and adults and youth alike should be aware of the serious consequences that can come from smoking it."

Although marijuana is most often present with other drugs, about a quarter of drug abuse-related emergency department visits involving marijuana (a total of 27,061 in 2001) involved marijuana as the only drug.

Cocaine mentions increased 10 percent, from 174,881 to 193,034 from 2000 to 2001, with 24 percent of these mentions attributed to crack. Increases for cocaine were noted in Atlanta, Minneapolis, San Francisco, and Boston. Decreases in cocaine reports occurred in New Orleans, San Diego, and Dallas.

"Eight of every 10 drug mentions come from seven substances—alcohol-in-combination with other drugs, cocaine, marijuana, heroin, benzodiazepines, antidepressants, and analgesics," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Dependence and suicide were the most frequently cited motives for taking substances. People need to know help is available, treatment is effective, and recovery is possible."

Heroin mentions (93,064) were statistically unchanged from 2000 to 2001. Increases in heroin mentions in emergency departments were evident in Atlanta, Minneapolis, Detroit, Denver, Miami, and Boston. Decreases occurred in New Orleans, San Diego, Seattle, Baltimore, Newark, and Los Angeles.

Methamphetamine showed no significant nationwide change in the number of mentions between 2000 and 2001. Emergency department mentions of methamphetamine in 2001 were concentrated in five western cities: Los Angeles, San Diego, San Francisco, Phoenix, and Seattle. Among these cities, methamphetamine mentions increased 10 percent in Los Angeles and decreased 27

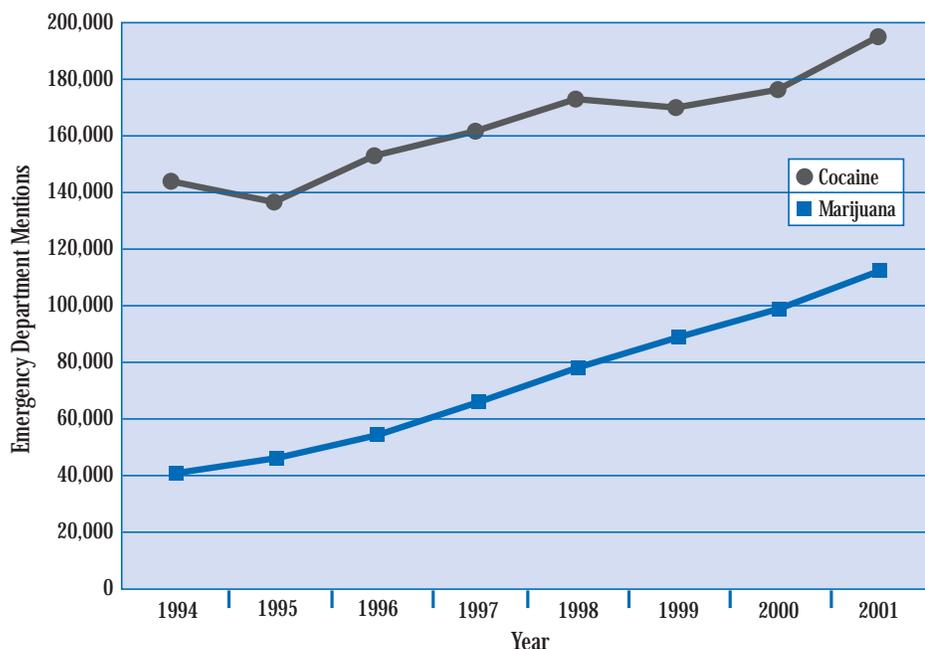
percent in Seattle. Amphetamines mentions did not change significantly between 2000 and 2001, and were also concentrated in the same western cities.

There were no significant changes in reports of **club drugs** between 2000 and 2001. However, emergency department mentions of MDMA (Ecstasy) were nearly double the levels from 1999 (5,542 versus 2,850 in 1999). In 2001, DAWN estimates 3,340 episodes involved GHB, and 679 involved Ketamine. Other club drugs like flunitrazepam, known as Rohypnol, had estimates too imprecise for publication from 1995 through 2001. Ecstasy increased in emergency department mentions in Atlanta, Miami, Philadelphia, and San Francisco. Decreases were seen in Chicago, Los Angeles, and Seattle. Ecstasy mentions were highest in persons age 18 to 25, at 10 mentions per 100,000 population. There were no significant increases in GHB, but decreases were evident in Los Angeles, Atlanta, and Chicago.

DAWN estimates indicate that **alcohol-in-combination with other drugs** was statistically unchanged from 2000 to 2001, but mentions increased 36 percent, from 160,798 to 218,005, between 1994 and 2001. Increases in mentions of alcohol-in-combination with other drugs were found in Minneapolis, San Francisco, Boston, Miami, Phoenix, Baltimore, and Washington, DC. A decrease in mentions of alcohol-in-combination with other drugs was found in New Orleans.

Mentions of **hallucinogens** such as LSD and PCP remained stable from 2000 to 2001. PCP incidences rose in Philadelphia and Washington, DC. There were no significant increases seen for LSD, but there were decreases evident in Phoenix, Seattle, Chicago, and Los Angeles.

Trends in Emergency Department Mentions of Cocaine and Marijuana in the Coterminous United States, 1994-2001



Source: SAMHSA, Office of Applied Studies, Drug Abuse Warning Network, 2001

Mentions of **inhalants** in emergency departments decreased 56 percent from 2000 to 2001 from 1,522 to 676.

DAWN estimates that 43 percent of the 1.1 million emergency department drug mentions in 2001 were primarily for the **non-medical use of legal prescription or non-prescription medications**. There were 220,289 mentions of psychotherapeutic agents (19 percent) and 210,685 mentions of central nervous system agents (18 percent).

Among the **psychotherapeutic agents**, anxiolytics (anti-anxiety drugs), sedatives, and hypnotics comprised 12 percent of total drug-related emergency department mentions (135,949). This includes abuse of benzodiazepines (103,972 mentions). There were 61,012 mentions of antidepressants. From 2000 to 2001, mentions of benzodiazepines rose 14 percent from 91,078 to 103,972. Among the benzodiazepines with significant increases from 2000 to 2001, alprazolam (drugs such as, but not limited to, Xanax) mentions were up 16 percent from 22,105 to 25,644.

Benzodiazepines not identified by name were up 35 percent, from 22,376 to 30,302.

Among the **central nervous system agents**, narcotic analgesics and combinations were the most frequently mentioned in drug-related emergency department visits in 2001, constituting 9 percent of all emergency department mentions (99,317). Mentions of these narcotic analgesics and combinations rose 44 percent from 1999 to 2001 and 21 percent from 2000 to 2001.

Significant long-term increases between 1994 and 2001 in emergency department mentions of narcotic analgesics and combinations were found for hydrocodone and its combinations (up 131 percent since 1994), methadone (up 230 percent), morphine and its combinations (up 210 percent), oxycodone and its combinations (up 352 percent) and narcotic analgesics that were not identified by name (up 288 percent).

In one year, from 2000 to 2001, methadone mentions increased by 37 percent,

and oxycodone and its combinations rose 70 percent. Unspecified narcotic analgesics rose 24 percent. Mentions of analgesics containing hydrocodone were statistically unchanged from 2000 to 2001, but were 41 percent higher than in 1999.

The DAWN system also captures the **non-medical uses of new drugs** approved by the Food and Drug Administration. During the period between 1994 and 2001, there were over 1,000 mentions each for seven new drugs including citalopram, mirtazapine, and nefazodone, which are antidepressants; olanzapine and quetiapine, which are antipsychotics; and tramadol and Cox-2 inhibitors, which are analgesics.

DAWN is a nationally representative survey of hospitals with emergency departments conducted annually by SAMHSA's Office of Applied Studies. In 2001, 458 hospitals participated in DAWN. The survey is designed to provide information about emergency department visits that are induced by or related to the use of an illegal drug or the nonmedical use of a legal drug. Because up to four drugs can be reported for each emergency department visit, there are more "mentions" than "visits." The survey also provides estimates for 21 metropolitan areas. DAWN does not measure the frequency or prevalence of drug use in the population, but rather the health consequences of drug use that are reflected in visits to hospital emergency departments.

To obtain a printed copy of the report, *Emergency Department Trends from the Drug Abuse Warning Network, Final Estimates 1994-2001*, 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). The complete report (text and tables) is available online at www.DrugAbuseStatistics.samhsa.gov. ▀

Coalition Seeks To Reduce Inappropriate Incarceration

A store manager calls the police to report a woman out front shouting obscenities at shoppers. A police officer on patrol sees an unkempt man urinating in public. A frightened family asks police to intervene with a family member struggling with mental illness.

Scenarios such as these can sometimes end in violence, when the police officer or the individual responds with force to a perceived threat. But more often, such encounters lead to the needless incarceration of a disproportionately large number of people with untreated mental illness.

Recently, the Criminal Justice/Mental Health Consensus Project published a report aimed at improving the criminal justice system's response to people with mental illness. The report was produced by a broad-based coalition funded by SAMHSA within the U.S. Department of Health and Human Services, and the Office of Justice Programs within the U.S. Department of Justice, together with private sector sources. The coalition spent 2 years developing the recommendations, presented to a congressional committee in June.

Led by the Council of State Governments, the Criminal Justice/Mental Health Consensus Project includes the Association of State Correctional Administrators; the Bazelon Center for Mental Health Law; the Center for Behavioral Health, Justice, & Public Policy; the National Association of State Mental Health Program Directors; the Police Executive Research Forum; and the Pretrial Services Resource Center.

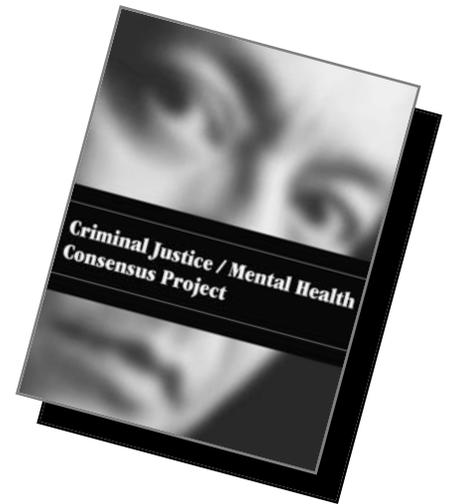
These partners began by seeking information from a group of bipartisan experts in criminal justice and mental health. More than 100 clinicians, state mental health directors, mental health advocates, substance abuse treatment experts, law enforcement officials, policymakers, judges, corrections

officials, victims' advocates, consumers of mental health services, family members, and others shared their ideas. Supplementing that input with surveys and literature reviews, the partners then developed a consensus from these sometimes opposing viewpoints.

The result is a comprehensive plan that local, state, and Federal policymakers, criminal justice and mental health professionals, and advocates can use as a guideline to develop the supports that keep people with mental illness out of the already overburdened criminal justice system. The report features 46 policy statements that address the entire criminal justice continuum—from the time someone calls the police for help to an offender's release from prison. Following each policy statement are specific recommendations for putting the statement into practice, plus examples of programs and policies that some jurisdictions are already using.

"The consensus report and recommendations are a testament to a commitment to create a new future for people who find themselves at the intersection of the mental health and criminal justice systems," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Consistent with SAMHSA's own policy directions, the report supports a community-based treatment philosophy for people with mental illness."

The first half of the report focuses on opportunities for identifying people with mental illness and reacting in ways that recognize their needs and civil liberties while simultaneously protecting the public. For example, when a person in need of mental health services comes into contact with the criminal justice system, there are a variety of options available. The report recommends training police dispatchers and officers to determine whether mental illness may be a



factor in an incident, establishing protocols to help officers respond appropriately, promoting accountability by documenting interactions between officers and people with mental illness, and collaborating with mental health professionals to reduce the need for subsequent interactions.

The second half of the report discusses the broad, systemic changes necessary for achieving the coalition's specific recommendations. These changes include:

- **Promoting extensive collaboration.** Neither the criminal justice system nor the mental health system can bring about change by taking action alone, the report emphasizes.
- **Educating all involved.** Training can help law enforcement personnel, court officials, corrections staff, and mental health professionals respond appropriately. Community education can raise the public's awareness.
- **Developing an effective, accessible mental health system.** The report calls for mental health services that are accessible, user-friendly, evidence-based, culturally competent, and integrated with other service systems.
- **Measuring and evaluating outcomes.** Evaluation can determine whether programs and policies are successful and help build continued support for changes.

For more information about the project, go to www.consensusproject.org. ▾

—By Rebecca A. Clay

Remembering Max Schneier, Mental Health Advocate

Max Schneier, J.D., one of SAMHSA's first National Advisory Council members and an internationally recognized advocate for people with mental illnesses, died in June after a brief illness. He was 85 years old. Friends, colleagues, and mental health professionals alike took time to remember Mr. Schneier.

SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., said, "Max Schneier put the issue of co-occurring mental and addictive disorders on the map—arguing that its time had come, long before many in our fields had the same realization."

Obituaries in the *New York Times* and the *Los Angeles Times* among others told the story of a man with a personal cause who gained the ear and the respect of mental health professionals and policymakers across the Nation.

"Max Schneier was the consummate advocate—totally committed, tenacious, and effective," said Herbert Pardes, M.D., president and chief executive officer of the New York Presbyterian Hospital, and a former director of the National Institute of Mental Health. "His persistent efforts helped shape how mental illness is defined today. He opened up the way for the mentally ill to get help, and he encouraged advocacy in this country."

Mr. Schneier was galvanized to action in 1969 by the serious mental illness of his daughter. Outraged by the obstacles his family encountered as they sought help, Mr. Schneier left his successful business and dedicated the rest of his life—more than 30 years—to his prodigious work as an unpaid activist.

His efforts brought impressive results. Motivated by his belief in psychosocial rehabilitation leading to recovery, he established three innovative community residence programs in New York and California.



Max Schneier

"Max was a founding father of SAMHSA's Community Support Program," said Community Support Program Branch Chief Neal Brown, M.P.A. "And, for over 30 years he was a primary supporter of community mental health treatment and rehabilitation across the country."

"Max Schneier never backed down when he thought the cause was just," said Ruth Hughes, Ph.D., C.P.R.P., of the International Association of Psychosocial Rehabilitative Services (IAPRS). "Over the years he continually fought for rehabilitation and recovery services for all people with mental illness."

From the point of view of consumers of mental health services, Mr. Schneier was a champion for the cause. "He was relentless," said J. Rock Johnson, J.D. "That is the best single word to describe him. He knew what was right, and he fought for us—rights protection and enforcement, services and support, accreditation standards—all focused on improving our quality of life."

He helped found the Federation of Parent's Organizations for New York State mental institutions, the first statewide advocacy group for families of people with mental illness. He was also instrumental in

helping to create the National Alliance for the Mentally Ill (NAMI) in 1979, a national mental health advocacy organization for people with serious mental illnesses and their families.

Soon after Mr. Schneier's death, the NAMI Web site posted anecdotes and recollections from staff members. Ron Honberg, NAMI's legal director, remembered Mr. Schneier's contribution in connection with a friend-of-the-court brief in a Florida case. "Max appointed himself as my personal law clerk and spent several days in a law library reading cases and finding obscure citations and precedents. He would call me at home at midnight, reading me quotes from cases and insisting I insert them into the brief. And of course, he was right on point!" Deciding that he needed to enhance his advocacy skills, Mr. Schneier earned a law degree in 1986 at the age of 69.

Mr. Schneier helped change the standards used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to evaluate hospitals providing psychiatric services, and worked to limit the use of seclusion and restraint in mental health facilities. "His powerful voice influenced the improvement of Joint Commission standards respecting psychiatric rehabilitation, discharge planning, and the treatment of co-occurring disorders, as well as many other important issues," said Paul M. Schyve, M.D., senior vice president at the JCAHO.

Irene Levine, Ph.D., professor of psychiatry at New York University School of Medicine and a former deputy director of SAMHSA's Center for Mental Health Services, said, "With his words, his pen, and his telephone, Max Schneier moved mountains and changed the landscape of mental health. In doing so, he reminded each of us of the power of one committed individual." ▀

We Would Like To Hear From You!

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

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

I found these articles particularly interesting or useful:

- Medication-Assisted Treatment: Merging with Mainstream Medicine
- President's Commission on Mental Health Launches Web Site
- Survey Finds Millions of Americans in Denial About Drug Abuse
- Survey Findings Launch Recovery Month
- Triple Diagnosis: Surmounting the Treatment Challenge
- Substance-Abusing Youth at Greater Risk for Suicide
- Early Marijuana Use Linked to Adult Dependence
- Self-Help Booklets Promote Mental Health Recovery
- Prevention Programs Receive Government Seal of Approval
- Survey Paints Picture of Substance Abuse Treatment Facilities
- Marijuana- & Cocaine-Related Emergency Department Visits Up
- Coalition Seeks To Reduce Inappropriate Incarceration
- Remembering Max Schneier, Mental Health Advocate
- Communicating in a Crisis

Other comments: _____

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Thank you for your comments.

Communicating in a Crisis

In a crisis due to a disaster or terrorist act, delivering accurate and timely messages that inform people without frightening them requires careful preparation that should be part of all emergency planning. Inadequate preparation can contribute to confusion and misunderstanding between public officials and the media, and to fear-driven, potentially damaging reactions from the public. Effective communication can promote the trust and confidence that are vital to calming any crisis situations.

To help, the U.S. Department of Health and Human Services, assisted by SAMHSA, has produced a publication, *Communicating in a Crisis: Risk Communication Guidelines for Public Officials*.

Understanding the Media

The booklet explains that journalists have six key questions they must answer in their stories: who, when, where, what, how, and why. They work under demanding time and space constraints. Effective communication comes in adapting to these limitations. The booklet advises public officials to:

- Be sure of your facts and be able to cite sources and key statistics.
- Have information available in concise fact sheets.
- Make sure your primary message gets delivered in the time allowed.
- Discuss what you know, not what you think.
- Familiarize yourself with opinions and positions contrary to yours and be able to answer questions about them.

The booklet emphasizes that risk communication efforts should receive the same degree of preparation as other elements of emergency planning. To plan, the booklet suggests the following:

- Form a risk communications team and assign responsibilities.

- Decide who will speak to the media.
- Develop and maintain media lists as well as lists of experts for media use.
- Plan press briefing logistics ahead of time.
- Anticipate information needs and develop background materials.

Communication Fundamentals

Before issuing any comment, public officials should clarify their communication goals and key messages. Goals and messages should be simple, straightforward, and realistic.

For example, the goal could be “to ease public concern.” The associated messages would be “the risk is low,” “the illness is treatable,” and “symptoms are easily recognized.”

Staying “on message” is a form of artful repetition to ensure that your messages are heard. To stay on message, the booklet advises:

- Raise your points often.
- Take opportunities to begin or end statements with a reiteration of your message.
- Don’t repeat your message word for word.

Scientific and Technical Information

The booklet advises that when officials must communicate about complex scientific issues, they should use clear, nontechnical language so that information is more accessible to the public.

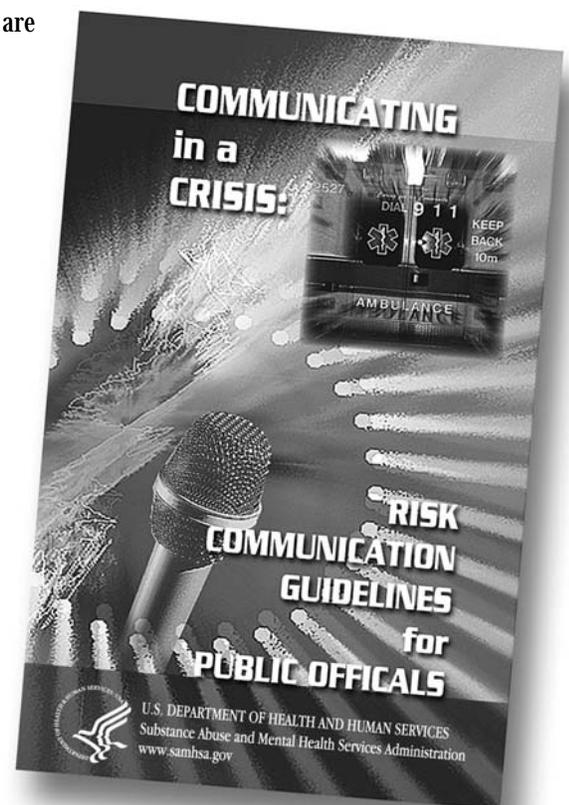
To communicate such information:

- Use consistent terms throughout a crisis situation.
- Avoid acronyms and jargon.

- Use familiar frames of reference and accurate analogies.
- Develop graphs and charts that illustrate your points and use them to support key messages.

Other sections of the booklet include “Correcting Errors and Rumor Control,” “Assessing Personal Strengths and Weaknesses,” “Building Support from Colleagues and Other Spokespersons,” and “Recognizing Opportunities to Speak Out.” Suggested reading materials, resources, and references are presented in lists at the back.

To obtain copies of the booklet, contact SAMHSA’s National Mental Health Services Knowledge Exchange Network at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-CMHS (2647) or 1 (866) 889-2647 (TTY). Web access: www.riskcommunication.samhsa.gov.



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