

# SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

January/February 2006, Volume 14, Number 1



# SCREENING

## Adds Prevention to Treatment

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**T**o someone with an injury or sudden illness, a visit to a hospital emergency room can seem an endless stretch of anxiety and frustration punctuated by periods of boredom.

But to a health educator, the time a patient spends waiting to see a doctor can be a prime "teachable moment." In a hospital

setting, patients are strongly focused on their health and highly attuned to hearing and acting on the advice they receive.

So powerful is the patient's receptivity within the medical encounter that SAMHSA's Center for Substance Abuse Treatment (CSAT) granted \$108 million over 5 years to six states and one tribal council so that

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### U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Substance Abuse and Mental Health Services Administration
  - Center for Mental Health Services
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# SCREENING

## Adds Prevention to Treatment

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they can harness it to reduce drug and alcohol abuse.

Known as Screening, Brief Intervention, Referral, and Treatment (SBIRT), this CSAT initiative shifts the emphasis to alcohol and drug users whom the traditional system has largely ignored—those who consume more than the medically accepted limits but are not yet dependent.

Rejecting the notion that only people with serious levels of abuse or dependency need targeted interventions, SBIRT assumes that everyone, regardless of current level of alcohol or drug consumption, can benefit from learning the facts about safe alcohol consumption and knowing how their own usage compares to accepted limits.

SBIRT further assumes that many people who consume amounts above those limits do not understand the risks they face but can and will change their behavior when they find out. For that reason, providing education about the consequences of substance abuse is a major part of the program.

The brief interventions made possible by the SBIRT grants “can reorient many people away from behavior that, unchecked, can lead to addiction,” says SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. Starting in 2003, the seven jurisdictions received renewable grants to bring SBIRT services to hospitals, clinics, and other general medical settings. (See box on page 5.)

One of these programs, California SBIRT (CASBIRT), is testing the model by integrating uniform alcohol and drug abuse screening

Norma Devonish, Assistant Operations Manager for Altam Associates, informs Dr. Susan Panah at North County Health Services about her patient’s high-risk alcohol and drug use and the referral she just made for brief treatment services with a CASBIRT counselor.

Cover: Maggie Robles, a Health Educator Supervisor, roleplays screening questions with “patient” Juana Aguilar.

services into 16 emergency rooms, trauma centers, and health clinics in San Diego County. CASBIRT staffers conduct a private interview with every patient who arrives at these facilities and provide each person with an individualized intervention appropriate to the level of risk for abuse.

They have screened more than 225,000 people since January 2004, with impressive results.

“More than half of the people who have that single interaction change their alcohol consumption,” and months later they are still consuming less than before contact with SBIRT, says Tom Stegbauer, M.B.A., a lead public health analyst in the CSAT Division of Systems Improvement.

Such results show that the medical encounter is “too good an opportunity not to deliver a prevention message,” says Linda Peek, Associate Director for Altam Associates, the San Diego company that administers the CASBIRT program under contract with the state of California.

### Adding Screening

SBIRT brings the same approach to alcohol and drug abuse as is used with other chronic conditions, Mr. Stegbauer

says. “We want to catch people early on, talk to them about their consumption of alcohol and drugs. Think of what we do in treating diabetes or what we do with cardiology patients. We don’t wait for the third heart attack to tell people they need to get the cholesterol out of their bloodstream. We screen with cholesterol tests, then we talk to them about diet. We talk to them about their consumption.”

Screening for heart disease or diabetes risk, however, is accepted medical practice. Systematic screening for alcohol and drug abuse has not attained that status, despite the drastic effects of such abuse on health. In addition, physicians have been slow to adopt this new service in their medical encounters with patients.

The most effective way of getting SBIRT services into busy emergency rooms and clinics, Ms. Peek says, is to add “a new member to the health care team” who is exclusively dedicated to providing these services. Known as a peer health educator, this new team member “looks like everybody else” in the medical setting, says J.R. Ayala, CASBIRT Operations Manager.

The secret to an effective SBIRT program is combining the science that



supports the screening and intervention protocols used in the interviews with a strong ability to build rapport with patients, Mr. Ayala adds.

Between arriving at an emergency room and receiving treatment from a physician, “a stream of people” come in contact with the patient, Ms. Peek explains. “One of those individuals is a member of our [CASBIRT] staff wearing the same surgical scrubs and hospital ID as other emergency room personnel,” she continues. “This person is going to be friendly, engaging, and empathetic to the patient.”

The peer health educator is “well trained to be non-judgmental and non-threatening,” and “well scripted” on how to conduct interactions that produce accurate screening results and effective interventions, Ms. Peek adds.

The notable friendliness is no accident, because no part of the CASBIRT encounter is left to chance. “Intense and specific” training guides peer health educators on everything from facial expressions and body language to responses to what patients say, Mr. Ayala states. “The empathy that we provide within the scientifically scripted forms” results in fewer than 1 percent of patients who decline to undergo screening.

## Interview and Intervention

The interview begins with the health educator offering to do something to make the patient more comfortable—bringing an extra pillow or phoning a family member, for example. The educator also explains his or her role as one of helping the doctors who will treat the patient by obtaining information about the patient’s use of medications, non-medical drugs, and alcohol over the past 12 months, all of which can affect health and medical treatment.

Standard screens for alcohol and drug use such as the Alcohol Use Disorders Identification Test and the Drug Abuse Screening Test are administered verbally. Simply asking these questions can serve

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## From the Administrator

### The Value of Screening and Brief Intervention



We at SAMHSA are often asked about the best ways to treat addiction. This issue of *SAMHSA News* highlights one of the most promising: preventing addiction before it starts by screening individuals who use drugs and alcohol but have not developed serious dependence-related problems, and then providing education and intervention.

Findings from SAMHSA’s 2004 National Survey on Drug Use and Health showed that users of drugs and alcohol often do not perceive themselves as having a problem. Of the 21.1 million people who needed but did not receive treatment in 2004, 94 percent did not think they needed treatment for their alcohol or drug use problem.

Unfortunately, their doctors may not perceive a problem either, or if they do, may not know how best to help. Yet, the health care setting provides one of the most advantageous opportunities for intervention.

People are surprisingly receptive to information and instructions about their health when they are in a health care setting. They came for help, and they view this as part of the treatment.

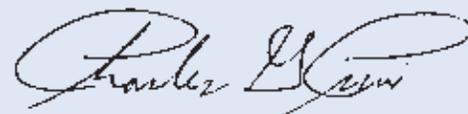
Primary care settings, community clinics, and hospital emergency rooms provide ready-made screening settings. Depending on the results, an array of options is available: (1) a brief intervention, which is typically a short-duration counseling

session delivered within the context of the medical visit to raise awareness and motivate change; (2) brief treatment of approximately two to nine sessions focusing on rapid implementation of strategies for change; and (3) referral to more intensive treatment.

In this way, the paradigm of health care becomes a seamless continuum with help available at every juncture.

Let us be clear: The purpose of screening is not diagnosis. A screening instrument does not enable a clinical diagnosis to be made, but rather indicates whether there is probability that key features of the target problem are present in an individual.

Used intelligently and sensitively, with respect for privacy and confidentiality, screening can provide vital information and can enable people to lead longer, healthier, and ultimately more rewarding lives. ▶

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



Health Educator Jenny Casselman conducts a brief intervention with “patient” Jacqueline Cornejo (a Health Educator Supervisor) at Scripps Mercy Hospital.

# SCREENING

## Adds Prevention to Treatment

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an educational function, Mr. Ayala says, because patients often respond with uninformed statements such as, “I don’t drink alcohol, I just drink beer.”

After the educator determines the patient’s level of consumption, he or she presents an evidence-based, clinically appropriate intervention. Non-users and those at low risk for abuse receive an educational message that congratulates and encourages them to continue their healthy practices.

Persons found to be at risk because of overconsumption but not yet dependent on drugs or alcohol receive a single, brief, non-judgmental intervention that explains how their consumption compares to medically accepted limits and what the possible consequences may be.

The intervention also encourages patients to change their use patterns. Individuals at high risk because of excessive consumption—but not dependent—receive an appropriate brief intervention plus a

referral for one to seven sessions of brief treatment conducted by a specially trained master’s- or doctoral-level clinician. These sessions may take place within the same medical setting or at another location.

Finally, persons found to be at severe risk and dependent on alcohol or drugs receive a brief intervention plus referral to a specialized treatment program. CASBIRT can cover the cost of some specialized treatment for people lacking health coverage, but “not more than 15 percent of the dollar value of the grant may be expended in specialty treatment,” Mr. Stegbauer says.

The health educator also conveys to the physician the information gathered from the patient’s screening for use during the examination. Once the patient has seen the doctor and is preparing to leave the emergency room, the health educator may follow up with “another little reminder,” Mr. Ayala says. The patient is told to expect followup by telephone as well.

### Creating Effectiveness

The SBIRT program can reduce drug and alcohol use dramatically, followup data show. “The program’s raw data show that of at-risk, high-risk, or severe-risk individuals, 62 percent reported stopping drug use and

60 percent reduced their alcohol consumption to low-risk levels,” says Mr. Stegbauer.

Preliminary SBIRT data show a total of 74 percent of high-risk individuals reported lowering their drug or alcohol consumption after one or more brief treatment sessions, and 48 percent reported stopping use.

CASBIRT works in part because patients truthfully reveal their behavior, even though it may include the use of illegal substances. “There is a large body of research literature showing that self-report on drug and alcohol use is accurate,” says Ms. Peek. “The health care setting is a very effective environment to elicit the truth.”

“We’re sensitive to the jeopardy concerns that are around these issues, but our focus is on referring each patient to appropriate treatment,” Mr. Stegbauer says. “So far, we haven’t had any problems.” That said, continuing concerns for patients include privacy issues, loss of access to public benefits, and potential reports to health insurance providers.

Another key to success is the quality of the peer health educators. CASBIRT candidates must be bilingual in English and Spanish and have at least a high school diploma and several years’ work experience, preferably with public contact. But the “intangibles” are far more important than paper credentials, says Ms. Peek. Peer health educators “absolutely have to be engaging, confident self-starters, because they’re going to be dealing not just with the patients but with the doctors” and other hospital staff.

Training includes theory as well as field experience in working with both patients and the protocols and documentation forms used in the interactions. In addition, all aspects of their work are closely monitored and documented. “Our screening form is designed to capture every single aspect of

everything they do, as part of our intensive quality assurance system,” Ms. Peek says.

But for all the careful training, “you can’t train the heart” needed to convey real compassion, Mr. Ayala says. “You’ve got to already have that.”

Because CASBIRT uses peer health educators rather than more highly credentialed professionals to do screening, it also is cost-effective. “We’re very encouraged with results thus far,” Mr. Stegbauer says.

Adds Mr. Ayala, “This is prevention at its most dynamic.”

For more information on the SAMHSA Screening, Brief Intervention, Referral, and Treatment program, visit the SAMHSA Web site at [www.samhsa.gov/Matrix/programs\\_treatment\\_sbirt.aspx](http://www.samhsa.gov/Matrix/programs_treatment_sbirt.aspx). ▶

—By Beryl Lieff Benderly

## Current SBIRT Projects

SAMHSA awarded funding in 2003 to six states and one tribal council over 5 years for the Screening, Brief Intervention, Referral, and Treatment program. A short description follows of each grantee:

- **California** is expanding the San Diego model (see main article) to other clinics, emergency rooms, and trauma centers.
- **Alaska’s Cook Inlet Tribal Council** is serving Alaska Natives in Anchorage.
- **Illinois** is providing services at hospitals, emergency rooms, and clinics in Cook County.
- **New Mexico** is targeting rural and non-ethnic populations in three of its five health regions.

- **Pennsylvania** is serving targeted populations of adults in general medical and other community settings in five counties.
- **Texas** is providing services within the Harris County Hospital District in the Houston metropolitan area.
- **Washington State** is serving five hospital emergency departments in counties with the largest volume of emergency room patients.

In addition, SAMHSA recently awarded 12 grants for brief interventions with college and university students at risk of substance abuse. For more information, visit SAMHSA’s Web site at [www.samhsa.gov/news/newsreleases/050706\\_college.html](http://www.samhsa.gov/news/newsreleases/050706_college.html). ▶

## “Fine Line” Detailed in Portraits

SAMHSA is currently hosting a traveling exhibit by photographer Michael Nye, *Fine Line: Mental Health/Mental Illness*. The exhibit is a documentary of voices, stories, and portraits of individuals living with mental illness. Mr. Nye spent 4 years photographing and recording stories.

Speaking at the SAMHSA opening of his exhibit, Mr. Nye said, “I don’t know where mental health ends and mental illness begins. This exhibit is about the fine line that moves through all of our lives as we weave our ways.”

Observing that people often focus on the “dichotomy” between people with mental illness and those not diagnosed with it, Mr. Nye emphasized the “commonality” among people. “Mental illness is often about fear,” he said, “fear of ourselves and fear of others. I ask each person coming into the gallery to listen carefully. Throw away your old definitions of mental illness and start over.

Photographer Michael Nye attended the SAMHSA opening of his exhibit, *Fine Line: Mental Health/Mental Illness*.

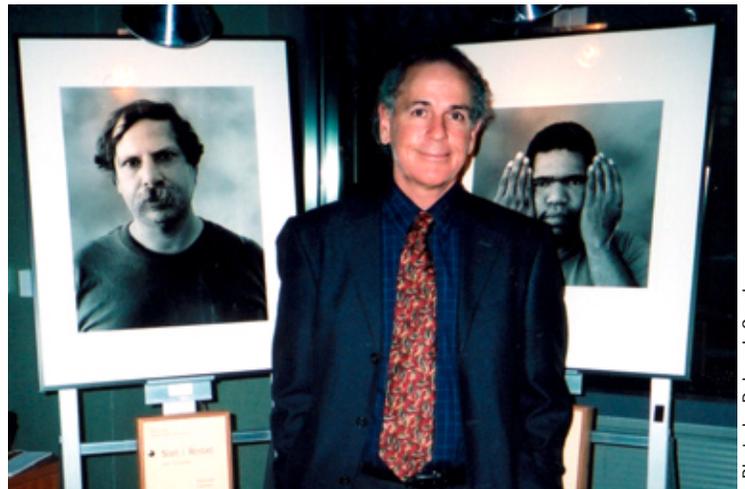


Photo by Deborah Goodman

Listen to each story as if it could be you or your child or your friend or some stranger you will meet tomorrow.”

Mr. Nye has pursued photographic projects throughout the world in places such as Siberia, Iraq, China, and Labrador, and he has had more than 30 one-person exhibits in museums and universities

around the country. *Fine Line* is on display at SAMHSA until February 15.

To view the exhibit, contact Carlton Speight by phone at (240) 276-1949 or by email at [carlton.speight@samhsa.hhs.gov](mailto:carlton.speight@samhsa.hhs.gov). For more information about Michael Nye’s photos, visit <http://MichaelNye.org>. ▶

# Statistics Released on School Services

One-fifth of students receive some type of school-supported mental health services during the school year, according to a new national survey released by SAMHSA.

Elementary, middle, and high schools all cite social, interpersonal, or family problems as the most frequent mental health problems for students.

The report, *School Mental Health Services in the United States, 2002-2003*, provides the first national survey of mental health services in a representative sample of the approximately 83,000 public elementary, middle, and high schools and their associated school districts in the United States.

Mental health services were defined as those services and supports delivered to individual students who have been referred and identified as having psychosocial or mental health problems.

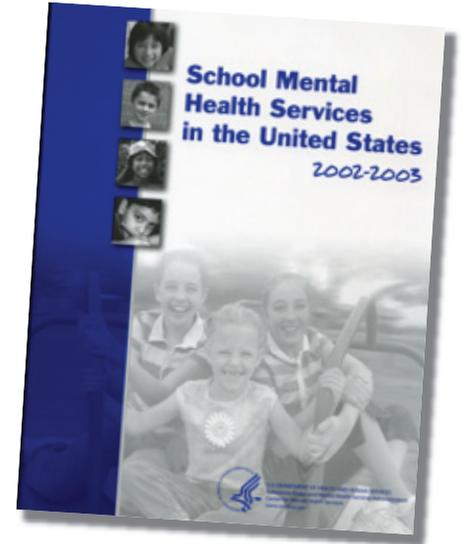
“Taking action to address childhood mental health problems now can save lives, especially when school personnel work with

parents to identify children and intervene appropriately before they develop significant problems,” said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

Topics explored in the survey include mental health problems encountered in school settings; mental health services that schools are delivering; numbers and qualifications of school staff providing mental health services; types of arrangements for delivering mental health services in schools, including collaboration with community-based providers; and major sources of funding for school mental health services.

Findings include:

- Virtually all schools reported having at least one staff member whose responsibilities included providing mental health services to students.
- The most common types of school mental health providers were school counselors, followed by nurses, school psychologists, and social workers. School



nurses spent approximately one-third of their time providing mental health services.

For a print copy, contact SAMHSA's National Mental Health Information Center at 1 (800) 789-2647. To download an online copy of this publication, visit SAMHSA's Web site at [www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4068](http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4068). ▀

## Adolescents, Adults Report Major Depression

SAMHSA's Office of Applied Studies recently released two reports revealing that millions of American adolescents and adults experienced major depression at least once in 2004, with those suffering from depression more likely to have used illicit drugs.

According to one report, based on data from the 2004 National Survey on Drug Use and Health (NSDUH), 9 percent of adolescents age 12 to 17 (an estimated 2.2 million) experienced at least one major depressive episode (MDE) in the 12 months prior to the survey, with the lifetime prevalence of depression among adolescents estimated at 14 percent.

In the survey, a major depressive episode was defined using the diagnostic criteria in the fourth edition of the *Diagnostic and Statistical*

*Manual of Mental Disorders (DSM-IV)*. These criteria specify a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure and other symptoms, such as problems with sleep, eating, energy, concentration, and self-image.

Adolescents who had experienced a major depressive episode in the past year were more than twice as likely to have used illicit drugs in the past month (21.2 percent) than their peers who had not (9.6 percent).

Less than half of the affected adolescents (40.3 percent) received treatment for depression during that time, but those with health insurance at the time of the survey were more likely to have received treatment (41.2 percent) than those without it (26.9 percent).

In a related NSDUH report, 8 percent of adults age 18 or older (an estimated 17.1 million) reported experiencing at least one MDE in the 12 months prior to the survey.

The rate of past-month illicit drug use was nearly twice as high among adults who had experienced an MDE (14.2 percent) compared with those who had not (7.3 percent).

Among affected adults, 65.1 percent had received treatment for depression. The percent of adults receiving treatment for depression increased from 46.3 percent for persons age 18 to 25 to 73.9 percent for persons age 50 to 64.

The reports, *Depression among Adolescents* and *Depression among Adults*, are available online on the SAMHSA Web site at [www.oas.samhsa.gov](http://www.oas.samhsa.gov). ▀

# Officials Plan for Flu Pandemic

As global concerns escalate over a potential flu pandemic, Federal officials say there's no reason for panic about any number of possible scenarios for the spread of avian flu, commonly called "bird flu."

"Prepare and plan" are the watchwords at the U.S. Department of Health and Human Services (HHS), where Secretary Mike Leavitt has launched a new information Web site, [www.pandemicflu.gov](http://www.pandemicflu.gov). HHS is taking the lead on the Federal effort.

"As part of HHS, SAMHSA has a key role to play in planning and preparing for, responding to, and recovering from the behavioral health impact of a disaster," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

At the White House, the National Strategy for Pandemic Influenza details the Nation's approach to any possible flu threat. The three pillars of the White House strategy are preparedness and communication, surveillance and detection, and response and containment.

The HHS Pandemic Influenza Plan provides guidance to national, state, and local policymakers and health departments to achieve a state of readiness and quick response.

The HHS Plan offers an overview of the threat of pandemic influenza, an outline of key roles and responsibilities, and opportunities to increase basic public preparedness for a pandemic, including checklists on family health information and recommended supplies to have on hand at home.

Major components of the HHS Plan:

- Intensify surveillance and collaboration on containment measures—both international and domestic.
- Stockpile antivirals and vaccines, and expand production of these medical aids.
- Create a seamless network of Federal, state, and local preparedness,

especially to handle surges in health care needs.

- Develop public education and communications efforts to keep the public informed.

Several overarching principles guide the HHS Plan, including close cooperation among Federal, state, and local governments and partners in the private sector, and an informed and responsive public.

## SAMHSA's Support

In addition to making sure people receiving mental health or substance abuse treatment continue to receive care, SAMHSA has an important role in helping people cope with mental and addictive disorders that may develop during a crisis, according to Daniel Dodgen, Ph.D., SAMHSA Emergency Management Coordinator.

For example, planning efforts must address how communities can carry out key functions when a large part of the workforce—including physicians, nurses, psychologists, drug treatment counselors,

political leaders, and people of other professions—are not able to work due to illness.

Schools may be closed to control infection among children, forcing parents to stay home from work and possibly jeopardizing the financial stability of families. In addition, family members and caregivers of those who are ill may have to cope with strong feelings and perhaps grief.

Although the SARS (severe acute respiratory syndrome) outbreak provided some important lessons, Dr. Dodgen said there is little research on how a pandemic influenza outbreak might contribute to mental and addictive disorders.

"SAMHSA will have a role in crafting important messages for the public," he said, "such as coping with fears about getting sick, dealing with the death of a loved one, or talking effectively with children about what they're thinking and feeling."

For more information, visit [www.pandemicflu.gov](http://www.pandemicflu.gov). ▶

—By Craig Packer

## PandemicFlu.gov



### Avian versus Pandemic Flu

Avian flu and pandemic flu are two separate issues potentially connected by a viral leap between species.

- **Avian flu** currently is an infection caused by viruses that occur naturally in birds. At this time, human beings are not easily susceptible to avian flu. However, some domesticated birds—including chickens, ducks, and turkeys—have become fatally infected and passed the

virus to some people who tended them. Avian flu is one of many types of influenza that could lead to a pandemic.

- **Pandemic flu** refers to a global threat from any new, rapidly spreading influenza virus for which there is little or no immunity in human beings.

For more information, visit [www.hhs.gov/pandemicflu/plan](http://www.hhs.gov/pandemicflu/plan). ▶

# Guidelines Released on Marijuana Counseling

SAMHSA's Center for Substance Abuse Treatment (CSAT) recently published *Brief Counseling for Marijuana Dependence: A Manual for Treating Adults*.

Based on the research protocol developed by counselors at CSAT's Marijuana Treatment Project, the new treatment manual provides brief marijuana dependence counseling (BMDC) guidelines for counselors, social workers, and psychologists in both public and private settings.

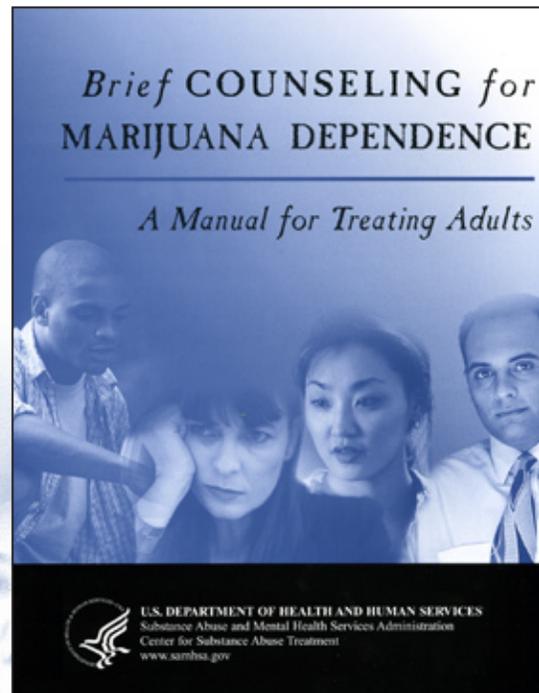
Ten weekly one-on-one sessions offer techniques and strategies to help adult clients end their dependence on marijuana.

The counseling approach presented in this manual comprises three key intervention components: motivational enhancement, cognitive behavioral skills training, and case management. The manual includes guidelines, protocols, assessment forms, and client handouts for each session, as well as supporting information on prevalence of use, clinical research, and program implementation.

Each session presents examples of how a counselor might reinforce the client's resolution to stop using marijuana, provide skills training, and help the client access needed community support.

Case examples of people seeking treatment for marijuana dependence are included along with background information on treatment for marijuana use disorders, current findings about marijuana use, an overview of the Marijuana Treatment Project, and criteria for marijuana dependency counselors.

In addition, the theoretical basis for BMDC treatment is presented in detail. Information includes the therapeutic tasks of the approach, a description of the target population, and suggested sequencing for counseling sessions.



The manual also addresses common treatment issues and potential pitfalls in the BMDC model. Some identified problems are not specific to marijuana treatment and may apply generally to substance use disorders or clinical counseling.

## Getting Started

Strategies for initiating counseling with clients include building rapport, assessment procedures, and motivational enhancement therapy techniques for engaging clients and identifying specific goals and change strategies.

Assessment and scoring tools are provided for completing each client's personal feedback report, which is a critical tool in BMDC implementation. Counselors use the completed report to make clients aware of the effects of marijuana use on critical life areas and to increase motivation.

The manual offers guidelines on how to reinforce each client's efforts to initiate change, review goals, and plan alternative strategies for behavior change, and to encourage support from friends or relatives.

Skill building is a critical factor in ending marijuana use. Cognitive behavioral strategies are outlined for building client motivation and maintaining treatment gains. Six core skill topics are presented that include coping with other life problems, understanding marijuana use patterns, coping with cravings and urges to use, managing thoughts about marijuana use, problem-solving, and marijuana refusal skills.

To obtain a copy of *Brief Counseling for Marijuana Dependence: A Manual for Treating Adults*, 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). Ask for NCADI Publication No. BKD520.

This manual also is available online at <http://kap.samhsa.gov/products/brochures/pdfs/bmdc.pdf>. For more information, visit the SAMHSA Web site at [www.samhsa.gov](http://www.samhsa.gov). ▀

## 2006 Recovery Month Web Site Launched

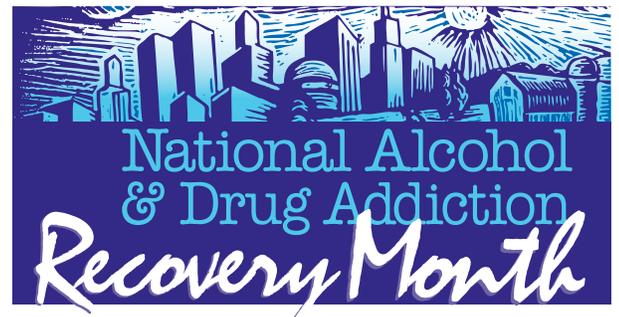
The Web site launch for 2006 National Alcohol and Drug Addiction Recovery Month marks the beginning of this annual SAMHSA event's 17th year of celebrating the hope of recovery. Sponsored by SAMHSA's Center for Substance Abuse Treatment (CSAT), Recovery Month activities are held nationwide during the month of September.

This year's theme is "Join the Voices for Recovery: Build a Stronger, Healthier Community."

The Web site offers the "Road to Recovery 2006" series, which will air 10 Web casts to premiere on the first Wednesday of each month and be archived for viewing at any time immediately afterwards.

The first Web cast, posted on January 11, serves as an informative introduction to September's 2006 Recovery Month observance. "The 2006 Road to Recovery" features CSAT Director H. Westley Clark, Associate Director for Consumer Affairs Ivette Torres (program host), and recovery community representatives from across the Nation.

Suggestions are provided to help individuals and communities nationwide discover how to become involved in Recovery Month at the local level.



Currently, downloadable 2006 flyers in English and Spanish also are available online. In addition, information is available on how to receive periodic email updates on activities leading up to Recovery Month in September.

Visit [www.recoverymonth.gov](http://www.recoverymonth.gov). ▶



## Reach Out Now

To alert children, parents, and teachers about the dangers of underage alcohol use and reinforce the message that it is unacceptable at school and at home, SAMHSA is encouraging national, state, and local leaders to conduct teach-ins for fifth- and sixth-grade classrooms nationwide during the week of April 3-7, 2006.

As a part of the Reach Out Now education program, SAMHSA and Scholastic Inc. have provided school-based materials on underage alcohol use prevention in time for Alcohol Awareness Month each April, sending the materials to fifth-grade teachers nationwide since 2002. Beginning in 2004, similar materials also were sent to sixth-grade classrooms nationwide.

For more information, visit [www.teachin.samhsa.gov](http://www.teachin.samhsa.gov). ▶

## SAMHSA Announces Funding Opportunities

SAMHSA recently announced two new grant funding opportunities for Fiscal Year 2006.

• **Strengthening Treatment Access and Retention—State Implementation Cooperative Agreements (TI-06-006)**  
Up to \$2.2 million will be available to fund up to 7 cooperative agreements for states to create system changes to improve access to and retention in substance abuse outpatient treatment. The annual awards, made by SAMHSA's Center for Substance Abuse Treatment, are expected to be \$325,000 per year for up to 3 years. The actual award may vary depending on the availability of funds.

For questions on program issues, contact Suzanne Cable at (240) 276-1568 or by email at [Suzanne.Cable@samhsa.hhs.gov](mailto:Suzanne.Cable@samhsa.hhs.gov), or Frances Cotter at (240) 276-1569 or by email at [Frances.Cotter@samhsa.hhs.gov](mailto:Frances.Cotter@samhsa.hhs.gov).

*Application due date: March 24, 2006.*

For an application kit, call SAMHSA's clearinghouses at 1 (800) 729-6686 (drug abuse) or 1 (800) 789-2647 (mental health). For the most up-to-date grant announcement listings throughout the year, visit [www.samhsa.gov/grants](http://www.samhsa.gov/grants) or [www.grants.gov](http://www.grants.gov). ▶

• **Family Centered Substance Abuse Treatment Grants for Adolescents and Their Families (TI-06-007)**  
Up to \$5.2 million will be available to fund up to 17 awards for grantees to provide services to adolescent substance abusers and their families. SAMHSA expects grantees to use proven effective treatment protocols that involve families as an integral part of the treatment process. The annual awards, made by SAMHSA's Center for Substance Abuse Treatment, are expected to be \$300,000 per year for up to 3 years. The actual award may vary, depending on the availability of funds.

For questions on program issues, contact Randolph Muck at (240) 276-1576 or by email at [Randy.Muck@samhsa.hhs.gov](mailto:Randy.Muck@samhsa.hhs.gov).

*Application due date: March 29, 2006.*

# Mental Health Campaign Supports Hurricane Survivors

SAMHSA and the Ad Council recently launched an outreach campaign that includes public service announcements (PSAs) to help survivors of hurricanes Katrina, Rita, and Wilma.

The Hurricane Mental Health Awareness Campaign's objective is to encourage and help adults, parents, caregivers,

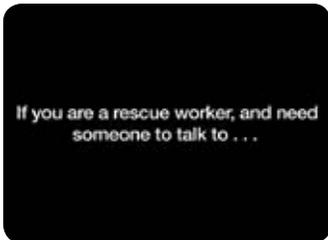
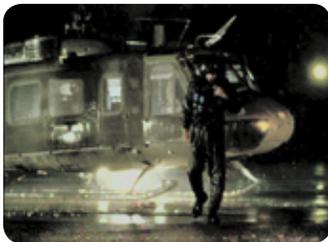


Photo by A. Martin Castillo

Health and Human Services Secretary Mike Leavitt

children, and first responders who may be experiencing psychological distress following these recent hurricanes to consider seeking mental health services.

The television and radio spots in both English and Spanish address the fears, concerns, and questions faced by survivors. These PSAs will be distributed to 12,000 media outlets nationwide.

In addition, SAMHSA has created a Web site of disaster relief information at [www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx](http://www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx). The Web site includes a national hotline for survivors to call for assistance—1 (800) 789-2647. Publications, related topics, and important links are also posted (see Resources on page 11).

## The PSAs

For adults, the PSA messages ask, "Having trouble coping? Help is waiting!" In Spanish, "¿Estás teniendo problemas enfrentando la situación? Puedes encontrar ayuda."

For parents and caregivers concerned about their children, one PSA asks, "What's going on in the mind of a child who's lived through a hurricane?" A child's voice

answers, "You can drown in your bed if you fall asleep."

For first responders, one PSA explains, "Sometimes the bravest thing you can do is take care of yourself."

## Background

According to SAMHSA, past research on the mental health consequences of major floods and hurricanes suggests that the psychological effects of the recent disasters could be extensive. SAMHSA estimates that in areas devastated by the hurricanes, 25 to 30 percent of the population may experience clinically significant mental health needs and an additional 10 to 20 percent may show subclinical (but not trivial) needs.

Up to 500,000 people may be in need of assistance.

"Since the beginning of this unprecedented disaster, we have been concerned about the mental well-being of those affected by the storms," said Health and Human Services Secretary Mike Leavitt.

People who were displaced by the storms have lost their homes, schools, communities, places of worship, daily routines, social support, personal possessions, and much more. In some cases, the emotional toll includes the sorrow of losing a loved one or witnessing death, widespread destruction, and criminal violence.

The psychological impact of these experiences can be both serious and long-lasting. Symptoms of post-traumatic stress disorder—including depression, grief, and anger—are to be expected. Survivors may also develop physical health and behavior problems, such as substance abuse disorders among adults

**SAMHSA and the Ad Council** collaborated on several public service announcements (PSAs) to help rescue workers, adults, and parents and families cope with the aftermath of the recent hurricanes. **Relief workers (left):** Outreach to first responders through this PSA provides an opportunity for rescue workers to get help through a toll-free number.

**For parents and families (right):** It's difficult to know what's going on in the mind of a child who's lived through a hurricane. To help, this PSA provides parents and family members with a toll-free number to call for guidance to calm their children's fears, reassure them, and make sure children are coping as best they can.



SAMHSA Administrator Charles G. Curie

Photo by A. Martin Castillo

## Who May Need Help

The campaign's PSAs aim to reach adult survivors and first responders directly, as well as parents and caregivers who can assess their children's emotional well-being. On the surface, it's obvious that survivors may need help; however, it is much less obvious that first responders may need help.

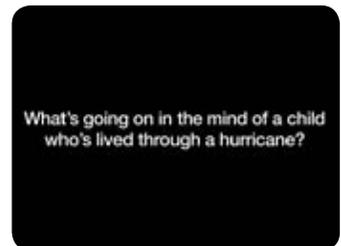
The effects of disasters on first responders—those emergency personnel and rescue workers who helped people survive these storms—may include mild or serious mental health problems from witnessing so much pain and suffering. Many turn to alcohol or drugs, too.

Viewers and listeners of the PSAs are asked to take time to check in on how they and their families are doing, and call a confidential toll-free number—1 (800) 789-2647 for adults/parents and 1 (800) 273-TALK for first responders—to speak to a trained professional who can assist with information and referrals to local services.

“As survivors struggle to rebuild their lives and focus on their immediate physical needs, it is important for them to also consider their

and conduct problems among children in school or at home. Some of these problems may not surface for months or years.

“Most hurricane survivors demonstrate remarkable resiliency and will rebuild their lives without significant mental health or substance abuse issues,” said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. “We also know that there are a significant number of people who will have difficulty achieving recovery without professional assistance. And now help is a phone call away.”



## Resources

The following resources are included on the SAMHSA Web site for disaster relief information at [www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx](http://www.mentalhealth.samhsa.gov/disasterrelief/psa.aspx).

### National hotline for assistance

- 1 (800) 789-2647 (adults/parents)
- 1 (800) 273-TALK (first responders)

### Publications

- Communicating in a Crisis: Risk Communications Guidelines for Public Officials*
- A Guide to Managing Stress in Crisis Response Professions*
- Disaster Counseling*

- Helping Children Cope with Fear and Anxiety*

### Online links

- National Child Traumatic Stress Network [www.nctsn.org](http://www.nctsn.org)
- National Center for Post-Traumatic Stress Disorder [www.ncptsd.org](http://www.ncptsd.org)
- Federal Emergency Management Agency [www.fema.gov](http://www.fema.gov)

short- and long-term emotional needs,” said Peggy Conlon, President and CEO of the Ad Council. “This poignant campaign, created pro bono by Grey Advertising, will encourage victims to get help.”

The PSAs are being distributed to television and radio stations nationwide via the FastChannel Network, and they will air in advertising time donated by the media.

For more information or to view the PSAs, visit the SAMHSA Web site at [www.samhsa.gov](http://www.samhsa.gov).

# Transforming State Mental Health Systems

As SAMHSA's Mental Health Action Agenda guides the national effort to transform mental health systems across America to more consumer-driven and recovery-oriented programs, the states are becoming "the center of gravity" for that transformation.

According to Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services (CMHS), "State mental health agencies are working to reduce fragmentation of services across systems, to increase their prevention and early intervention programs, and to enhance their investments in new technologies to improve services and accountability for achieving measurable results."

To jumpstart that process and create models of transformation for the states, CMHS recently awarded Mental Health Transformation State Incentive Grants to Connecticut, Maryland, New Mexico, Ohio, Oklahoma, Texas, and Washington State. These grants total \$92.5 million over 5 years.

"State by state, a recovery-focused system is truly within our grasp," said Ms. Power, who noted the unprecedented amount of evidence now available about what works when it comes to helping individuals with mental illness become productive members of society. "We are at the threshold of a system of care in which recovery—not disability—is the expected outcome," she explained.

## Models of Transformation

The President's New Freedom Commission on Mental Health issued a final report in 2003 calling for a radical overhaul of the Nation's mental health system. (See *SAMHSA News*, Summer 2003.)

At the national level, SAMHSA responded by developing the Mental Health Action Agenda, which details the

***"Transformation implies profound changes in organizational policies, practices, and funding. And transformation requires equally momentous shifts in our own attitudes, beliefs, and values about mental health."***

**A. Kathryn Power, M.Ed.**  
**Director, Center for Mental Health Services**

steps the Federal Government will take to transform mental health services. (See *SAMHSA News*, September/October 2005.)

However, states are playing a pivotal role in transformation. These grants will help states create mental health systems that focus on consumer and family needs, build resilience, and facilitate recovery.

"Transformation implies profound changes in organizational policies, practices, and funding," Ms. Power said. "And transformation requires equally momentous shifts in our own attitudes, beliefs, and values about mental health."

With these grants, states must offer a comprehensive continuum of services, ranging from mental health promotion and mental illness prevention activities for healthy individuals to treatment and recovery options for those with mental disorders, especially children with serious emotional disturbances and adults with serious mental illnesses. States must also offer services appropriate for all ages, including children, adults, and older adults. And states must involve consumers and families as active participants in transformation.

"The hope is that other states will adopt these practices until every mental

health system in the country is transformed," said Program Coordinator Nancy J. Davis, Ed.D., a public health advisor at CMHS.

"The seven states will serve as models for learning about what works and what doesn't work when it comes to transforming mental health and related systems," Dr. Davis explained. "We expect these states to share successful strategies with other states, territories, and tribes and tribal organizations."

The seven model states are already coming up with innovative approaches to achieving these goals. For example:

- **Connecticut** will continue to develop a recovery-oriented system of mental health care in which state and local systems work together seamlessly. (See box on page 13.)
- **Maryland** will continue strengthening partnerships among public sector providers, private sector providers, and academics as a way of promoting evidence-based practices in addition to emphasizing a recovery-focused approach to service.
- **New Mexico** will integrate the behavioral health services offered by 15 different state agencies into one coherent whole, bring together critical partners locally throughout communities across the state, and expand behavioral health coverage to remote areas of the state.

- **Ohio** plans to orient mental health and other systems to recovery, resilience, and culturally competent practices.

Youth and adult consumers and families will be actively engaged in their service and recovery experiences, which will include person-centered planning, peer support, and recovery and resilience-oriented policymaking.

- **Oklahoma** will develop a strong sustainable infrastructure to promote lasting changes across state agencies, enabling persons with mental illness to access individualized care and support expeditiously and to achieve and sustain recovery.

- **Texas** will foster recovery, improve quality of life, and meet the multiple needs of mental health consumers in addition to moving to a coordinated system of care that offers promotion, prevention, and treatment services to residents across their life spans.

- **Washington State** plans to build the infrastructure for an ongoing process of planning, action, learning, and innovation in mental health care.

The state will launch a social marketing campaign to increase awareness of mental illness and reduce its stigma as well as strengthen efforts for consumer and family support.

To learn more about mental health transformation activities within the states, visit the SAMHSA Web site at [www.samhsa.gov/matrix/mhst\\_TA.aspx](http://www.samhsa.gov/matrix/mhst_TA.aspx). Current and back issues of SAMHSA's *Transformation Trends* newsletter are also available at [www.samhsa.gov/matrix/MH\\_transformation\\_trends.aspx](http://www.samhsa.gov/matrix/MH_transformation_trends.aspx).

Updates of specific state activities are available online on the National Association of State Mental Health Program Directors' Web site at [www.nasmhpd.org/targeted\\_ta.cfm](http://www.nasmhpd.org/targeted_ta.cfm). Click on "Recent State Activities Under the New Freedom Commission." ▶

## Connecticut's Transformation Experience

When Connecticut's Department of Mental Health and Addiction Services (DMHAS) decided its services needed to become more consumer-oriented and recovery-focused, it went straight to the source—consumers themselves.

At the department's request, advocacy groups representing people recovering from psychiatric disorders and substance abuse identified values that make care truly recovery-oriented. Those values—things like consumer involvement, comprehensive care, cultural competence, and peer support—guided the development of a policy statement whose title, "Promoting a Recovery-Oriented Service System," sums up the department's new goal.

"Instead of the system being oriented to acute care and problems, we're making services more focused on helping people improve their existing strengths and increasing their involvement in the recovery process," said Wayne F. Dailey, Ph.D., a senior policy advisor and public information officer at DMHAS.

Working with the Yale University School of Medicine, Connecticut has already created a Recovery Institute to train providers in the theory and practice of recovery. This ongoing series of trainings has covered topics ranging from why peer-run programs are beneficial to how to increase consumers' involvement in managing their own illnesses.

"These trainings have a different slant than the traditional training practitioners undergo, because of the emphasis on recovery and consumer empowerment," said Dr. Dailey. "We're trying to help people understand why we're making these changes, what the changes are all about, and what they would look like in actual practice." More than 5,000 practitioners around the state have undergone the training so far.

Yale also helped the department craft guidelines and standards for recovery-oriented services. There's also a recovery self-assessment tool that service providers can use to see if what they're currently doing is in line with the department's recovery-oriented ideals.

In addition, 16 "centers of excellence" in the state are testing innovative programs exemplifying recovery-oriented practices, such as having programs run by peers or putting peer advocates in emergency departments. Two "practice improvement initiatives" involving 27 mental health and substance abuse agencies use technical assistance and a train-the-trainer approach to spread evidence-based, recovery-promoting practices around the state.

The Mental Health Transformation State Incentive Grant that SAMHSA recently awarded to the state—\$14.7 million over 5 years—will help solidify these gains, said Dr. Dailey.

"The big challenge of transformation is not only to make the change but to have it become permanent," he explained. "We don't want it to be something you just do a little while before slipping back into your old ways." ▶

—By *Rebecca A. Clay*



# Town Hall Meetings Planned

Planning is under way for Town Hall Meetings to be held on or around March 28 in communities across the country as part of a comprehensive plan to prevent and reduce underage alcohol use.

The Town Hall Meetings are part of a national effort to increase the understanding of underage drinking and its consequences, and to encourage individuals, families, and communities to address the problem.

The meetings will provide an opportunity for communities to learn more about the new research on the issue and to discuss how their local area can best prevent underage alcohol use. These Town Hall Meetings are designed to alert and empower the community and to generate interest from the media.

The Interagency Coordinating Committee on the Prevention of Underage Drinking is encouraging states and communities to hold these meetings as a followup to the recent national conference in Washington, DC, "Preventing Underage Alcohol Use: A National Meeting of the States." This conference brought together teams of state officials and prevention, treatment, and enforcement professionals from nearly every state, territory, and the District of Columbia (see *SAMHSA News*, November/December 2005).

Each state or community organization will take the lead in coordinating local events.

The Coordinating Committee is chaired by SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., and includes members from

12 Federal agencies and offices, including the Office of National Drug Control Policy, and the U.S. Departments of Education, Justice, Defense, Transportation, and Treasury.

For more information, visit the comprehensive portal of Federal resources on underage drinking at [www.stopalcoholabuse.gov](http://www.stopalcoholabuse.gov). To view the public service announcements developed by SAMHSA and the Ad Council, visit [www.adcouncil.org/campaigns/underage\\_drinking](http://www.adcouncil.org/campaigns/underage_drinking).

For questions, contact SAMHSA's Steve Wing, Associate Administrator for Alcohol Prevention and Treatment Policy, at [Stephen.Wing@samhsa.hhs.gov](mailto:Stephen.Wing@samhsa.hhs.gov).

## Underage Drinkers Seek Help in Emergency Rooms

A new report released from SAMHSA's Drug Abuse Warning Network (DAWN) estimates that 142,701 alcohol-related emergency room visits to U.S. hospitals were made by individuals age 12 to 20 during 2004.

DAWN collects data from a national sample of hospitals on emergency department (ED) visits related to recent drug use. The report shows nearly half (42 percent) of drug-related ED visits among patients age 12 to 20 involved alcohol.

In addition, patients age 18 to 20 were approximately three times as likely as patients age 12 to 17 to have an alcohol-related ED visit, with this difference by age similar whether the visit was for alcohol alone or for alcohol with other drugs.

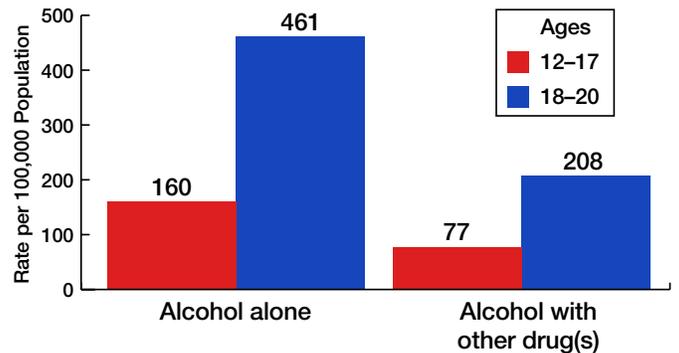
Visits involving alcohol with other drugs (19 percent) were nearly two times as likely

to result in admission to the hospital for inpatient care when compared to visits involving alcohol alone (10 percent).

Among admissions, the visits involving alcohol with other drugs were most likely to require intensive or critical care (35 percent), but nearly one in five (19 percent) were admitted to psychiatric units.

The report, *Emergency Department Visits Involving Underage Drinking*, is available from SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345,

**ED Visit Rates for Alcohol Only and Alcohol with Other Drug(s)**



Source: Drug Abuse Warning Network, Office of Applied Studies, SAMHSA, 2004.

Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). The report is available on the SAMHSA Web site at <http://dawninfo.samhsa.gov>.

# Rebuilding Afghanistan's Mental Health System

Afghanistan has an ambitious vision for bringing mental health services to its people. Deputy Minister of Public Health Faizullah Kakar, Ph.D., envisions a country where “all of our health care services provide the most essential mental health care,” where the various regions have facilities “to treat patients we can’t treat today,” and where there exist “some very good hospitals” and “enough doctors in proportion to the population,” he told *SAMHSA News* in a recent interview.

But making that come true in a nation torn by decades of war and political oppression will take hard work, careful planning, and technical expertise. “We would like SAMHSA to play a strategic role in developing our mental health care,” he said.

Two major challenges stand in the way of attaining Dr. Kakar’s vision. First, because of the people’s suffering during the wartime years, the need for mental health services is widespread. Second, mental health care traditionally has not had a high priority within health care in Afghanistan. But then, in January 2005, these two realities came together to spark change.

Dr. Kakar was reviewing the national strategy being developed to guide the rebuilding of the country’s health system. Much of the country’s physical infrastructure has been decimated, and many of Afghanistan’s educated professionals were killed or fled the country during widespread violence and oppression.

In the midst of this task, Dr. Kakar got the “very disturbing news that there were young women [in one of the main cities] committing suicide.” Suicide prevention and other mental health issues, he noticed, did not even appear among major health care priorities enumerated in the plan. He immediately realized that they belonged high on that list.



(Left to right) Dr. Faizullah Kakar, Afghanistan’s Deputy Minister of Public Health, and Dr. Ruhullah Nassery, Mental Health Coordinator of Afghanistan’s Ministry of Public Health, prepare to address the Workgroup on Afghanistan Mental Health recently at the Embassy of Afghanistan in Washington, DC.

Photo by Meredith Hogan Pond

## A Top Priority

Given that a 2002 nationwide survey documented that more than 70 percent of women and 60 percent of men suffer from depression, Dr. Kakar knew that mental health issues are “a big public health burden in Afghanistan.”

Minister of Public Health S. Mohammad Amin Fatimie, M.D., quickly agreed that mental health deserved high priority.

Dr. Fatimie called a meeting with the foreign non-governmental organizations (NGOs) assisting the Ministry. Some donors objected to including mental health because of the cost. “If Kakar wants mental health,” the Deputy Minister recalled them saying, “he needs to find the money.” And so Dr. Kakar came to Washington. “I asked, though it was not on the agenda, ‘Who is interested in mental health?’ ” He “was very surprised” to receive an immediate, affirmative reply. Prominent among those encouraging him was SAMHSA.

In December 2005, during a second visit to Washington, Dr. Kakar told this story during a meeting at the Embassy of Afghanistan. Seated around the conference table were members of the Workgroup on Afghanistan Mental Health—a team of experts from SAMHSA and additional members from the National Institute of Mental Health, the Office of Global Health Affairs at the U.S. Department of Health and Human Services, and the Embassy of Afghanistan.

Also present were Ruhullah Nassery, M.D., Mental Health Coordinator of Afghanistan’s Ministry of Public Health, and SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. Other representatives included the Afghan-American Physicians Association, the World Health Organization (WHO), and the Department of Defense.

The Workgroup, inspired by Dr. Kakar’s visit earlier in the year, had already been busy for several months exploring how U.S. assets could aid in the rebuilding

*continued on page 16*

*continued from page 15*

of the human resources and physical infrastructure needed to bring mental health services to Afghanistan's population.

Along with this meeting, the schedule for Dr. Kakar's December visit to the United States included meetings at the Centers for Disease Control and Prevention in Atlanta, GA. Dr. Nassery visited a psychiatric hospital and a community-based mental health center in a Virginia suburb of Washington, DC.

Mr. Curie expressed SAMHSA's strong support for the Ministry's focus on mental health as a crucial element of the overall public health plan. Key to the partnership, he emphasized, is listening closely to the priorities developed by Afghanistan, which will guide SAMHSA's efforts to help the country provide its people with culturally competent services that become part of their day-to-day lives.

## **A Nation Traumatized**

Given Afghanistan's many years of turmoil and destruction, the number of people suffering from identifiable mental disorders or substance abuse is "very high and needs prompt intervention," Dr. Nassery told the meeting.

"War and substance abuse have interacted to produce more people who

are addicted," Dr. Kakar added. Many families have lost loved ones or are caring for individuals disabled, either physically or mentally, by the conflict, causing continuing stress for family caregivers who lack access to mental health resources.

Because of these pressing needs, mental health now ranks among the top five essentials in the "Basic Package of Health Services" designated in the strategic plan developed by the Ministry of Public Health. The top four priorities are basics such as newborn health, child health and immunization, nutrition, and communicable diseases.

Despite a high priority, however, Afghanistan has a "severe shortage of mental health professionals," according to Dr. Nassery. The WHO's *Global Health Atlas* lists the country as having 8 psychiatrists and 20 psychologists, but Dr. Nassery believes those numbers are too high.

Even using the WHO statistics, he added, Afghanistan has substantially fewer psychiatrists, psychologists, and psychiatric nurses per 100,000 residents than in neighboring countries such as Pakistan and Iran.

Mental health, Dr. Nassery added, currently receives little attention in general health care. Overall, mental health facilities

are inadequate and heavily concentrated in the cities of this predominantly rural country. The nation's sole psychiatric hospital has 60 beds. In addition, psychotropic medications are in short supply.

Afghanistan currently lacks the legislation and policies needed to develop a modern mental health system as well as the necessary staffing and technical support in the Ministry of Public Health. Nor does mental health receive adequate attention in the curricula of the institutions within Afghanistan that train health care professionals. In general, public awareness of mental health issues is low.

## **How SAMHSA Can Help**

In designing its National Strategic Plan for Mental Health, the Ministry has decided on a bottom-up, community-based strategy of integrating mental health services into existing primary care, an approach that can bring at least basic care to people in need relatively quickly. This strategy suits the country's limited resources and pressing needs far better than would a top-down approach of modernizing existing facilities, training specialist professionals, and then doing outreach to the nation, Dr. Nassery said.

Already, projects under way in the eastern part of the country have shown the effectiveness of providing short-term training in the essentials of mental health care to health care personnel and supplying psychiatric medications to local health centers, Dr. Nassery said.

The plan calls for building on such successful experimental programs, expanding them to other regions, and ultimately, when adequate capacity and resources are available, to the country at large. Over the long term, psychiatric facilities and clinical interventions will be established and professional training in mental health upgraded and expanded.

The key to Afghanistan's current strategy is developing the country's human resources because "we do not expect NGOs to stay forever," Dr. Nassery said. Beyond the crash

Ruins of a building in downtown Kabul.



Photo by Cpl Matthew Roberson, USMC/USAID

courses for existing health care personnel needed to carry out the first stages of the Ministry's strategic plan, educating the rising generation of health care professionals about mental health will require new curricula, materials, and programs.

Campaigns to raise public awareness about mental health issues using mass media, including radio and TV as well as the cooperation of local leaders, will also require new materials and training programs. Behavioral health awareness will also be integrated into the public school curriculum, and teachers will receive training in how to teach about it and how to identify possible problems among their students.

Creating effective educational and awareness programs for these various sectors will require cooperation among the Ministry of Public Health and other agencies of Afghanistan's government such as the Ministry of Higher Education. Discussions between Ministries are already under way, according to Dr. Kakar.



Photo by Meredith Hogan Pond

At the recent meeting of the Workgroup on Afghanistan Mental Health: Dr. Kakar (left), SAMHSA's Winnie Mitchell (center), and SAMHSA Administrator Charles Curie (right). "SAMHSA's role is to be a partner," Mr. Curie said.

Within the priorities articulated by the Ministry of Public Health, SAMHSA can use its expertise, contacts, and other resources to help Afghanistan build its mental health programs and capacity, according to

Mr. Curie. "My vision of SAMHSA's role is to be a partner," Mr. Curie said, "standing ready and prepared for a long commitment to help Afghanistan rebuild." ▸

—By Beryl Lieff Benderly

## Cultural Traditions Aid Mental Health Treatment

For people in Afghanistan, mental health problems generally fall into the category of "*jinn*"—invisible beings known to English speakers as the genies of the *Arabian Nights*.

This cultural belief helps make mental health treatment acceptable to a wide range of the population, according to Deputy Minister of Public Health Faizullah Kakar, Ph.D. Because these powerful and malicious creatures are believed able to attack anyone at will—much as Americans believe that everyone is susceptible to the viruses causing colds and the flu—mental health issues and treatments carry less stigma in Afghanistan than they often do in the West, he told *SAMHSA News* during a recent interview at the Embassy of Afghanistan.

Afghan culture has long used traditional methods to counter the ravages of *jinn*, including sojourns at religious shrines, where sufferers undergo treatments that include deprivation of food and drink, Dr. Kakar said. In order to affect real improvement, he noted, "It is important that people know also that [modern medications] are good for *jinn*" and can provide lasting relief.

During training in the United States, Dr. Kakar recalled, he was struck by the amount of attention that American mental health professionals paid to the issue of stigma, a situation much different in Afghanistan.

The popular belief in *jinn*, along with a widespread traditional acceptance of drugs to change mood, creates a receptive environment for bringing mental health treatment to a large population that needs

it, he continued. "In a society where 70 to 80 percent of the people" show symptoms of anxiety, depression, or other mental health conditions resulting from decades of warfare, the suffering that these conditions cause "becomes normal" and people do not realize that genuine relief is possible, he said. He emphasized the importance of informing "the public that they don't have to suffer" and that, whether or not *jinn* caused their conditions, "help is available."

Often when mental health professionals explain modern treatments, "the patient is amazed [and says,] 'I didn't know there was help for this.'" This makes all the more urgent the need to bring modern treatment to as many people as possible. "If we create lots of expectation," he said, "we need the capacity to meet it." ▸

—By Beryl Lieff Benderly

## ***We'd Like To Hear From You!***

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

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

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Field of specialization: \_\_\_\_\_

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

- |  |  |
|--|--|
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| <input type="checkbox"/> From the Administrator: The Value of Screening and Brief Intervention | <input type="checkbox"/> Transforming State Mental Health Systems  |
| <input type="checkbox"/> "Fine Line" Detailed in Portraits                                     | <input type="checkbox"/> Town Hall Meetings Planned  |
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**Thank you for your comments!**

# Two Reports: Substance Use Among Veterans

Substance use, dependence, risk behaviors, and treatment are the focus of two new SAMHSA short reports on American veterans.

The reports present data that show veterans are more likely than non-veterans to use alcohol and marijuana, smoke cigarettes daily, and drive under the influence of alcohol or illicit drugs. Veterans are also more likely to receive treatment for a substance abuse disorder.

Both reports are based on data from the National Survey on Drug Use and Health (NSDUH).

One report, *Substance Use, Dependence, and Treatment among Veterans*, shows that in 2003, an estimated 3.5 percent of veterans had used marijuana in the past month, compared with 3.0 percent of their non-veteran counterparts. Past-month heavy use of alcohol was also more prevalent among veterans (7.5 percent) than comparable non-veterans (6.5 percent). An estimated 0.8 percent of veterans had received specialty treatment for a substance use disorder (alcohol or illicit drugs) in the past year, compared with 0.5 percent of comparable non-veterans.

The second report, *Alcohol Use and Alcohol-Related Risk Behaviors among Veterans*, shows that in 2003, an estimated 56.6 percent of veterans used alcohol in the past month compared with 50.8 percent of comparable non-veterans. An estimated 13.2 percent of veterans reported driving while under the influence of alcohol or illicit drugs in the past year, compared with 12.2 percent of comparable non-veterans. An estimated 18.8 percent of veterans reported smoking cigarettes daily in the past month, compared with 14.3 percent of comparable non-veterans.

In 2003, there were an estimated 25 million veterans comprising roughly

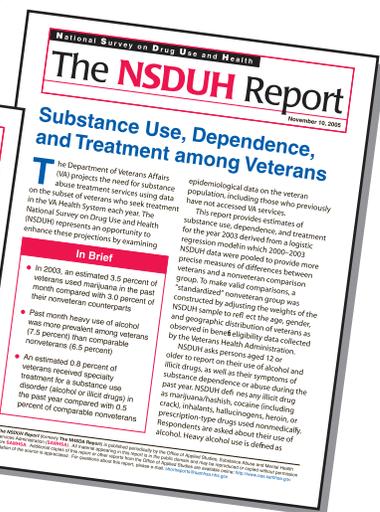
11.5 percent of the 217 million non-institutionalized civilians age 17 or older in the United States. Approximately 93 percent of veterans were male, and 8.4 percent were between age 17 and 34. An estimated 30.1 percent were between age 35 and 54; 42.3 percent between age 55 and 74; and 19.2 percent age 75 or older.

## The Road Home: Veterans Conference Planned

SAMHSA, in partnership with the Therapeutic Communities of America, will convene a national conference to address issues facing returning veterans and their families.

“The Road Home: National Behavioral Health Conference on Returning Veterans and Their Families,” is scheduled for March 16 to 18 in Washington, DC.

The conference will give Federal, state, public, and private service providers the evidence-based information and approaches they need to help veterans and their families build resiliency and to prevent and treat complex problems, such as mental disorders (including post-traumatic stress disorder), substance abuse, suicide, and co-occurring disorders.



The reports are available from SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the reports are available on the SAMHSA Web site at [www.oas.samhsa.gov](http://www.oas.samhsa.gov). ▶

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