

# SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

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## Across Borders: Reaching Out to Iraq

*U.S. Health and Human Services Secretary Tommy G. Thompson and SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. (center photo, left), meet with Dr. Inas Taha Ahmed Al Hamdani and Dr. Mohamed Ghani Chabuk, Director (center photo, right), at the Al Alwiya women's clinic in Baghdad during a visit to Iraq in February. See page 2 for article.*



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

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# Across Borders: Reaching Out to Iraq

**T**hirty years of armed conflicts and a brutal dictatorship have eroded the health of the people of Iraq and devastated their system of health care. Understaffed, lacking supplies, and with ongoing concerns for their own safety, Iraqi doctors and other health care personnel are attempting to deal with enormous needs.

U.S. Secretary of Health and Human Services Tommy G. Thompson traveled to Iraq at the end of February accompanied by a group of senior Federal health care officials that included SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. Their mission? To explore how the United States can help rebuild the health care delivery system in Iraq and restore the health of the Iraqi people.

Using the analogy of the U.S. Marshall Plan in rebuilding Europe after World War II, Secretary Thompson said, "Because our health, our economies, and our humanitarian values have become truly global in nature, our responses must likewise be global in nature."

Six months prior to the trip, Secretary Thompson and other Federal officials met in the United States with the Iraqi Minister of Health, Khudair Abbas, M.D., and the senior advisor for health to the Coalition

*Iraqi doctors and other health care personnel are attempting to deal with enormous needs.*



Provisional Authority, James K. Haveman, M.S.W. At the meeting, Dr. Abbas and Mr. Haveman identified the three areas most in need of rebuilding within the health care system: surveillance of infectious diseases, oncology, and mental health. As a result, Mr. Curie served as part of the visiting team.

In Baghdad, the team visited the Ministry of Health and the Al Mansour hospital, as well as the Al Alwiya women's clinic.

Iraq's ancient history is distinguished. Often called the "Cradle of Civilization," Iraq (Mesopotamia) was the site of the world's first constitutional system and a center for the study of medicine, science, philosophy, and the arts. The world's first psychiatric hospital was built in Baghdad in 753 A.D.

Today, in addition to the lack of electricity, fuel, and safe drinking water, many hospitals lack basic equipment and supplies. In a country of 25 million people, there are fewer than 100 psychiatrists, according to a report from the World Health Organization. There are no clinical psychologists and very few social workers. Services and psychiatric medications for mental health treatment are also scarce.

The country lacks community mental health services, and the country's only long-term care hospital for people with serious mental illnesses was looted and vandalized near the end of major combat in April 2003. Many of the patients ran away and are still missing.

Ordinary Iraqi citizens have been traumatized by war and debilitated by years of living under an omnipresent, repressive dictatorship with constant surveillance and where a chance remark or spontaneous action could result in punishment or imprisonment.

## **How To Help?**

Any assistance from the United States or the international community, Mr. Curie emphasizes, must be "guided by the Iraqi

*In Baghdad, the team visited the Ministry of Health and the Al Mansour hospital, as well as the Al Alwiya women's clinic.*



government and the Iraqi professionals who make up the mental health field there.”

The new Iraqi Ministry of Health and the Coalition Provisional Authority have decided to focus their efforts on integrating mental health within the primary care clinics that are being established throughout the country, an approach that Mr. Curie strongly supports.

“Because the approach to treating mental illness in Iraq is based primarily on a medical model, initial thinking from individuals there was to rebuild institutions and hospitals,” he says. But considering the small number of psychiatrists, that is not a viable option. “The Iraqis need a longer-term workforce development plan,” Mr. Curie says, “that includes training not only for psychologists and social workers, but also for nurses and behavioral health aides.”

In addition, he points out, “We have models here in the United States that would enable the Iraqis to use methods that are much more cost-effective and treatment-effective.” He cites an example from his visit to the Al Alwiya women’s clinic in Baghdad. “The physician there, to her credit, recognized that women with breast cancer facing mastectomies need emotional support and assistance with mental health—both before and after the surgery and throughout treatment. She was eager to have a psychiatrist come to the clinic more often than the 2 days a week he comes now. In the United States, we have seen that oftentimes the best people to counsel a woman through a mastectomy are other women who have had this procedure themselves. We have found the model of the recovery support group to be very helpful in the treatment of cancer as well as in the treatment of other diseases. This option might be useful at the Al Alwiya women’s clinic.”

The Ministry of Health has established a behavioral health care task force, Mr. Curie says, that is developing an overall strategic plan to address both mental health and

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## *From the Administrator*

### **Mental Health in Iraq**

My recent visit to Iraq reaffirmed my belief in the centrality of mental health to overall health and well-being. As the Iraqis rebuild their country and their physical health after terrible trauma, they also seek to restore a sense of emotional equilibrium and security. Their recognition of the importance of mental health in the rebuilding of their health care system reflects the growing acceptance of this premise not only here in the United States, but also abroad.

Our compassion and our shared humanity dictate the necessity and the value of assisting other countries. But beyond that, we have a responsibility, as a leader among countries with the most advanced services for mental health care, to share what we know and to help others create better mental health services.

Offering assistance also gives us an opportunity to help reshape the attitudes of the larger society toward mental illness. As in our own country, there is still too much stigma attached to mental illness among the Iraqis and too many people still regard it as shameful.

By investing a modest amount of resources, we can contribute to enormous progress in Iraq and thereby forge a new basis of trust on which to strengthen the relationship between our countries. At the same time, promoting the inclusion of mental health services as part of health care abroad helps us further the same agenda here at home.

Right now, we have a unique opportunity to transform the mental health service system here in the



United States. Both the Bush Administration and the Congress are committed to supporting the kind of change called for in the report from the President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* (See *SAMHSA News*, Volume XI, Number 3).

The commonality of our tasks reinforces the importance of each: the Iraqis, to rebuild a devastated mental health service system; ours, to transform a mental health service system that needs fixing “beyond simple repair,” in the words of the Commission’s report. As we ensure that Iraqis achieve a life free of fear and full of choices, we strive to achieve the same goals here in the United States for people with or at risk for mental or substance use disorders. ▀

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

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substance abuse issues. In addition to supporting the plan to integrate such services within the primary health care clinics, Mr. Curie observes that such a system also provides an opportunity for the Iraqis to build a community-based mental health system of care from the ground up.

The specifics of a possible SAMHSA plan to assist the Iraqis are still to be determined. However, SAMHSA is focusing on expanding the capacity of Iraqi health care service providers to assess mental health and substance abuse and on enhancing training for primary care physicians as well as psychologists, social workers, nurses, and health care aides. SAMHSA is considering the possibility of funding a mental health expert to assist the Iraqi behavioral health care task force.

“It’s essential that this individual speak Arabic fluently, and understand Arabic and Moslem culture and concepts of mental

*“All people—whether American or Iraqi—seek lives with jobs, homes, and meaningful relationships.”*

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



health,” Mr. Curie says. “We must engage the Iraqis by approaching them in a culturally sensitive way that includes the ability to connect with tribal and faith-based leaders.”

As a second phase, Mr. Curie suggests, SAMHSA officials are exploring with mental health authorities in England and New Zealand the possibility of sending a team of staff from all three countries to Iraq to provide hands-on consultation and technical assistance.

“Both England and New Zealand are aligned around the same recovery model of mental health that is growing here in the United States,” Mr. Curie says. “The recovery model recognizes that people with mental and substance use disorders can and do recover, and encourages the use of practices that are evidence-based and consumer-driven. Our efforts may be better received by the Iraqis if offered through a team that is international in scope.”

Priority populations for treatment include individuals with serious mental illness—in particular, women and children—and Iraqi victims of torture. Efforts will also address the mental health needs of the general population, still profoundly traumatized.

“On my visit, I was reminded of the universality of human needs,” Mr. Curie said. “Fundamentally, all people—whether American or Iraqi—seek lives with jobs, homes, and meaningful relationships with family and friends, all of which contribute to a sense of stability and fulfillment. We want to communicate to the Iraqi people that the United States supports them as they strive for a better life.” ▸

*—By Deborah Goodman*



*Accompanying Secretary Tommy G. Thompson (center row, fourth from left) on his visit to Iraq were (next to Secretary Thompson, left to right) National Cancer Institute Director Andrew C. von Eschenbach, M.D.; National Institute of Allergy and Infectious Diseases Director Anthony S. Fauci, M.D.; SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.; and Deputy Assistant Secretary for Health Howard A. Zucker, M.D.*

Photos of Iraqi citizens, on pages 1, 2, and 4, courtesy of U.S. Agency for International Development (USAID) Web site at [www.usaid.gov/iraq/photogallery](http://www.usaid.gov/iraq/photogallery). Thomas Hartwell and Debbi Morello, photographers.

# Manuals Guide Teen Marijuana Use Treatment

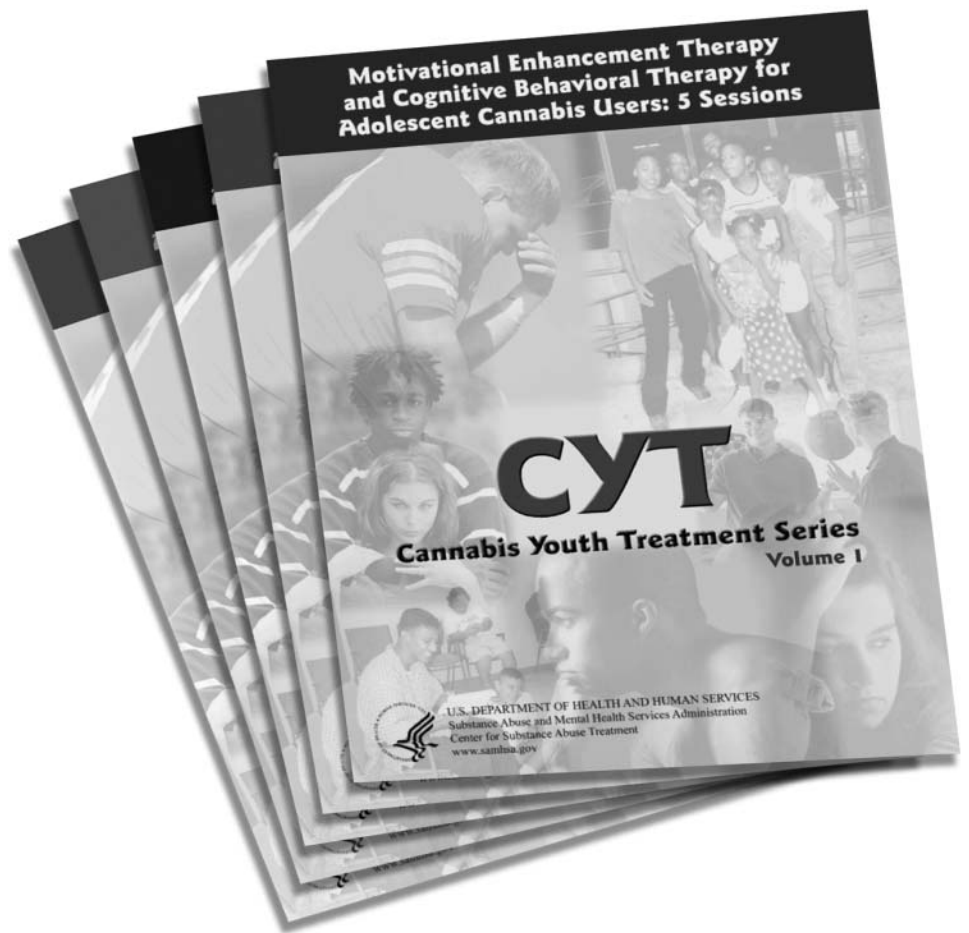
Everyone who's ever bought a new appliance has used a manual, one of those indispensable guides to finding out, step-by-step, how something should be done. But few people associate a book of detailed instructions with a process as sensitive and complex as substance abuse treatment. Now, however, service providers throughout the Nation are using a set of manuals developed and tested in projects funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) aimed at developing evidence-based care for adolescents using marijuana.

The five volumes of the Cannabis Youth Treatment (CYT) Series far exceed the ordinary run of instruction booklets. Each is based on a treatment approach specifically designed for use with adolescents.

A 3-year study beginning in 1997 found that the methods described in the manuals produced "statistically significant treatment outcome results" that were "better than many of the treatments being used at that time," says Jean Donaldson, M.A., who served as the CSAT project officer. (See *SAMHSA News*, Spring 2001.) A just-completed, 30-month followup study has confirmed "significant post-treatment improvement" among adolescents, according to a forthcoming article based on those results in the *Journal of Substance Abuse Treatment*.

The CYT manuals are part of SAMHSA's Science to Services Initiative, which seeks to foster the adoption of effective, evidence-based interventions gleaned from research into routine clinical practice, and then strengthen feedback from the services community to inform research. In keeping with these goals, the CYT manuals are now being distributed nationally.

The treatment methods in the CYT manuals depart from former practices in two important respects. First, each volume



details a specific multi-part intervention and then guides service providers through its various tasks and sessions (see *SAMHSA News*, p. 7). Second, the manual-based interventions all build on a foundation of formal approaches including motivational enhancement therapy, cognitive behavioral therapy, and other models. Unlike more eclectic models traditionally used in many agencies, the CYT interventions specifically focused on equipping adolescents and their families with methods for stopping and preventing use and coping with relapse.

In an informal effort to gauge the effects of the manuals on real-life practices, *SAMHSA News* spoke with front-line treatment providers who use the manuals in a variety

of settings. Their comments cover many aspects of the change to CYT. To begin with, they find CYT-based approaches less confrontational than much of traditional substance abuse treatment.

"I hate confronting these kids," says Tina Long, a case manager at Sojourner Recovery Services in Hamilton, OH. "We don't counsel anybody else that way. There's no reason to counsel a person with substance abuse that way."

This change requires that service providers become "convinced that they don't really have to confront resistance," says psychologist Win Turner, Ph.D., a project director for the New England Institute of Addiction Studies. Dr. Turner has trained and

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helped supervise the implementation of CYT Volume 1 at community treatment agencies across Vermont. "When people first do motivational enhancement therapy, they think that if the client says, 'I'm not ready to give this up,' that you have to convince them to change. But you say, 'I hear you, you're not ready to quit. Perhaps we could talk about what brought you here.' The idea is to roll with resistance and to listen more, so the client feels understood."

Another difference is that cognitive behavioral therapy calls for "practicing what seem to be rote exercises," Dr. Turner continues.

"That can seem trivial . . . but it becomes very significant" over time. With experience, service providers learn that "teaching a skill [needed to prevent or stop use] is just as important as talking about how I feel," says Julia Hemphill, a counselor at Operation PAR in St. Petersburg, FL.

The detailed structure laid out in the manuals is also new to many service providers. "People think that service providers are going to hate these manuals, but in fact they find that it makes their working environment a learning environment," Dr. Turner says.

Ms. Long finds the structure very helpful. "I don't walk into a session ever feeling unprepared. If any situation arises, I have got a procedure to deal with it. And it's gone through tests to know that it's going to work."

Thanks to the manual, Ms. Hemphill adds, "you don't have to do your own research or put it together yourself."

The detailed progression of topics, however, does more than save time for service providers and build their confidence. It also gives them "a way to bring up a subject without pointing the finger," says Matt Hassler, M.S.W., another Operation PAR counselor. Sessions have "a structure that clients don't have to take personally. That means clients can choose if they want to talk about a topic."

That predetermined structure, however, makes some service providers "feel like occasionally I lose a little on the creativity side," Mr. Hassler says.

At the beginning, "the assumption is that the curriculum is a rigid entity," Dr. Turner notes. "But that's not true. It is always advisable to follow along and learn the manual as it stands. Once you feel you have a sound understanding, you can then apply it in a different way, as long as the essential components are left intact."

"You learn the principles, but as to how you implement the principles, you have a good bit of flexibility," agrees Reginald Simmons, Ph.D., of the Connecticut Division of Children and Families, who is coordinating the use of four CYT curricula in Hartford. "You're not really in lockstep like a robot. It still takes a skilled clinician who is a good therapist to know how to implement the principles. There's a great deal of creativity that can be exercised."

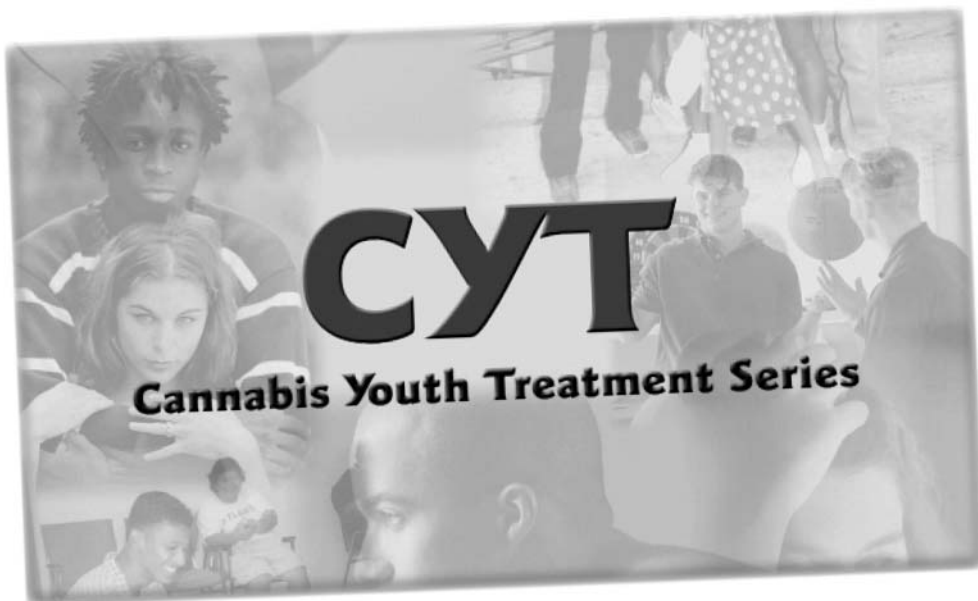
Mr. Hassler agrees. "Even within the boundaries of the manual, I can be really creative," he says. In fact, he finds creativity essential because "there has to be some adaptation" of the manual to each particular case as well as "little tweaks for personal style."

Service providers agree that the manuals afford plenty of leeway to meet a client's particular needs. "I find it very flexible," says Ms. Long. "It puts you on the right track and shows the frame of mind you need to be in" to deal with particular situations.

For example, in a rural state like Vermont, Dr. Turner says, "we don't have big groups of people coming in at one time." Elements of the program originally designed for groups "can be done for individuals as well."

Some service providers find the adjustment to this way of working straightforward. "I'm a manual reader," says Ms. Long. "I read those VCR manuals. I went through the CYT manual and read everything. Each of the sections gives you a little synopsis of how to talk." But, she notes, "Somebody who's been in the substance abuse field and is used to a confrontational style, when given this manual, is going to be really challenged to change their approach."

For some service providers, learning to do the manual-based treatment involves "cognitive dissonance," Dr. Turner says. "You're used to having very fluid conversations, so when you're first learning manual-based treatment, it seems awkward."



## Cannabis Youth Treatment Series by Volume

Each of the five volumes in the *Cannabis Youth Treatment Series* highlights a different approach to treating teen users of marijuana:

- *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions, Volume 1* (158 pages). NCADI number BKD384.
- *The Motivational Enhancement Therapy and Cognitive Behavioral Therapy Supplement: 7 Sessions of Cognitive Behavioral Therapy for Adolescent Cannabis Users, Volume 2* (162 pages). NCADI number BKD385.
- *Family Support Network for Adolescent Cannabis Users, Volume 3* (148 pages). NCADI number BKD386.

- *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users, Volume 4* (252 pages). NCADI number BKD387.

- *Multidimensional Family Therapy for Adolescent Cannabis Users, Volume 5* (242 pages). NCADI number BKD388.

To order copies of these manuals, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Note the NCADI order number. To order online, go to [www.ncadi.samhsa.gov](http://www.ncadi.samhsa.gov). ▀

The more you work with the manual, though, you can fit it into your own scripts that you've had with clients anyway. If you're doing motivational therapy, there are four or five skills that you need to learn and hone. If you're doing cognitive-behavioral therapy, you provide an activity, go over a skill, and then rehearse it. Those foundational elements are not awkward once you integrate them. But it takes a little while."

Adjusting to doing manual-based interventions is "really about practice," Ms. Long agrees. "I've probably done 50 functional analyses of substance abuse as outlined in one of the manuals, and every time I do it, I learn something new about a client and I learn something new about the procedure."

The challenge that service providers face in learning a new way to work is "a parallel process" to what clients experience trying to break out of behavior patterns, Dr. Turner continues. For clinical supervision, "that's a beautiful metaphor. Implementing the manuals and practicing new clinical skills puts clinicians in the experience of change. This moves them a little closer to the client who is attempting a fundamental change that is "much more intense."

Manual-based therapy has benefits for the field as a whole as well as for individual service providers. "It tries to make treatment consistent," says Dr. Turner. The CYT curricula give a common "template" to service providers who have "come into the substance abuse field from all avenues of training."

Historically, the substance abuse field has had "an inadequate amount of quality assurance," adds Dr. Simmons. "What are therapists doing? How do they know it even works? You hear therapists say, 'Oh, this just feels good.' How do you know?" he asks. But "a manual-based intervention that has been shown to be effective . . . allows you to really assess what a therapist is doing and how that relates to outcome."

In addition, "a manual-based approach really helps you to think about what you are doing," Dr. Simmons continues. By forcing service providers "to really plan their work, it gives a platform to evaluate your work." The CYT manuals also permit the program in Hartford to use "a treatment-matching process including comprehensive assessment to help determine what treatment each kid should receive." The availability of several "evidence-based interventions that have been shown to work allows us to really match the treatments to the population."

The CYT manuals are not perfect, however. The treatment providers suggest several ways in which future manuals could be improved. These manuals "have to be updated periodically" to match changing times, Mr. Hassler notes. Ms. Long would like to see some advice for young therapists like herself on "building rapport with parents."

Dr. Turner suggests clinicians need "a short introduction to the process of adopting

a new clinical model" and learning what helps clients get ready for this experience of change. "Vermont therapists asked for more examples and strategies for working with difficult clients," he adds.

In addition, he believes, a separate workbook-like "implementation binder" containing all the checklists, handouts, and forms should be provided. Dr. Simmons warns that CYT "may not work everywhere." An "agency's characteristics" will influence "whether this model will work for them."

But the benefits of the CYT manuals outweigh their limitations and the challenge of adjusting to a new method of work, the service providers interviewed for this article agree. Through structure, consistency, and research-based techniques, Dr. Turner says, the manuals have "provided a tighter framework for clinicians to provide effective treatment for adolescents." ▀

—By Beryl Lieff Benderly

# President's National Drug Control Strategy Includes Key Role for SAMHSA

The Bush Administration's 2004 National Drug Control Strategy calls for a new focus on reducing the illegal diversion and non-medical use of prescription drugs in the United States while continuing the emphasis articulated 2 years ago on using a balanced approach to reducing drug use through treatment, prevention, and enforcement.

Recent data confirm the wisdom of this approach. Results from the most recent survey show an 11-percent drop in the use of drugs among youth between 2001 and 2003—exceeding the President's goal of 10 percent.

The National Drug Control Strategy has three national priorities: stopping use before it starts, healing America's drug users, and disrupting the market. SAMHSA plays a key role in achieving the first two.

SAMHSA will continue to support the National Drug Control Strategy by maintaining state substance abuse treatment systems through its Substance Abuse Block Grant and identifying and responding to new and emerging trends in drug use through the Targeted Capacity Expansion program. SAMHSA also tracks progress on the Strategy's goals through its National Survey on Drug Use and Health, formerly called the National Household Survey on Drug Abuse.

To address the abuse of prescription medications, SAMHSA will continue to work with the Food and Drug Administration on a collaborative public education effort. Products so far have included posters, brochures, and print advertisements related to the dangers of abusing prescription pain relievers.

In addition, SAMHSA is launching two major efforts in support of the National Drug Control Strategy.

## Healing America's Drug Users

Announced by President Bush in his 2003 State of the Union Address, Access to Recovery provides people seeking drug and alcohol treatment with vouchers to pay for a range of effective substance abuse clinical treatment and recovery support services. In obtaining services, people will have access to faith- and community-based programs.

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*“ . . . There are many pathways to recovery from addiction.”*

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

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“Access to Recovery is based on the knowledge that there are many pathways to recovery from addiction,” says SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. “The promise of this initiative—founded on a belief in individual choice—is that it ensures the availability of a full range of treatment options, including the transforming power of faith. Making these choices available to people who want and need them will provide opportunities for meaningful, contributing lives in their communities.”

Funded by Congress at \$100 million in Fiscal Year 2004, Access to Recovery promotes consumer choice, improved outcomes, and increased treatment capacity. The President's 2005 budget request for SAMHSA proposes to double Access to Recovery's appropriation. (See *SAMHSA News*, March/April 2004.)

Funds will be awarded to states, territories, the District of Columbia, and tribal organizations through a competitive grant process. Applicants have considerable flexibility in designing their approach and may target efforts to areas of greatest need, to areas with a high degree of readiness, or to specific populations such as adolescents. The funds are required to *supplement*, not *supplant*, current funding and build on existing programs, thus expanding both capacity and available services.

## Stopping Use Before It Starts

The President's Fiscal Year 2005 budget proposal includes \$196 million to support SAMHSA's new Strategic Prevention Framework. This effort is an approach to prevention and early intervention that is built on accountability, capacity, and effectiveness at the Federal, state, and local levels. The Strategic Prevention Framework uses a step-by-step process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors in all areas of a person's life—at home, at school, and in the community.

SAMHSA has begun to use the Framework in its everyday activities in programs within the Agency. In Fiscal Year 2005, the Framework will focus on promoting the replication of effective programs at the community level, with an emphasis on preventing underage drinking.

More information about the President's National Drug Control Strategy is available at [www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov).

For more information about SAMHSA's Access to Recovery program and the Strategic Prevention Framework, visit SAMHSA's Web site at [www.samhsa.gov](http://www.samhsa.gov). **D**



# Majority of Youth Obtain Marijuana from People They Know

How do teenagers obtain marijuana?

They often get it from their friends or from family members or relatives, according to recent data from SAMHSA's 2002 National Survey on Drug Use and Health (NSDUH), formerly the National Household Survey on Drug Abuse.

The survey, analyzed by gender and racial/ethnic groups for comparative purposes, asked youth age 12 to 17 to report on their use of marijuana during the prior year. The survey asked past-year marijuana users specifically to report on the last time they used the drug—how they obtained it, from whom, and where.

The survey shows that almost 4 million youth in this age group (16 percent) used marijuana at least once in the past year. Of those youth, more than 60 percent obtained their "most recently used" marijuana for free or shared someone else's marijuana, and about one-third purchased their marijuana. The majority received marijuana from a friend—regardless of whether they bought it, obtained it for free, or shared it (see chart).

Compared to youth who obtained marijuana for free or shared it, those who bought their marijuana were more likely to get it from someone they just met or did not know well. Youths who bought their marijuana were more likely to obtain it from relatives or family than youths who got it free or shared it.

Regardless of how these youth obtained their marijuana, the most common place where they got it was inside a home, apartment, or dorm. And youth who received marijuana for free or shared it were more likely than youth who bought it to obtain the drug in three locations (48 versus 35 percent). Youth who bought marijuana were more likely than youth who received it for free or shared it to have obtained it in a public building, outside in a



public area, inside a school building, or outside on school property.

Females (72 percent) were more likely than males (52 percent) to obtain their marijuana for free or share it. On the other hand, males (41 percent) were more likely than females (22 percent) to pay for their marijuana.

The rate of past-year marijuana use was similar among young men and young women

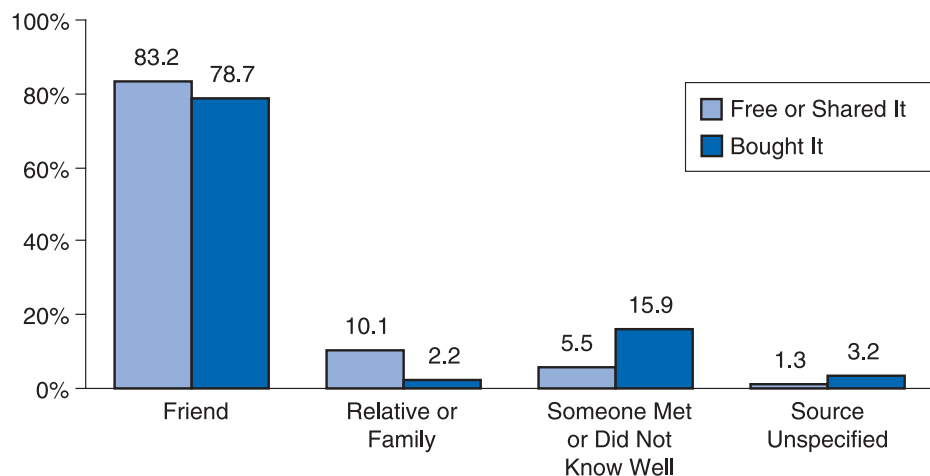
in this age group, but white youth were more likely to report using marijuana in the past year than Hispanic or black youth.

According to the data, blacks were more likely than whites to obtain marijuana outside in a public area and less likely than whites or Hispanics to receive it inside a home, apartment, or dorm, regardless of whether the marijuana was purchased.

The report showed that marijuana is often bought and sold in and around schools. Nearly 14 percent of youth who bought marijuana did so on school property (9 percent inside a school and 5 percent outside on school property).

For a copy of this report, *How Youths Obtain Marijuana*, 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 can also be downloaded from the SAMHSA Web site at [www.drugabusestatistics.samhsa.gov](http://www.drugabusestatistics.samhsa.gov). ▶

Percentages of Past-Year Marijuana Users Age 12 to 17 Reporting Source of Their Most Recently Used Marijuana by Method Obtained: 2002



Source: Office of Applied Studies, *National Survey on Drug Use and Health*, 2002.

# SAMHSA Releases Guide for Clergy

SAMHSA's Center for Substance Abuse Treatment (CSAT) is helping to break through the "wall of silence" that isolates clergy from discussing substance abuse problems with their congregants.

A new CSAT report, *Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family Members*, summarizes the basic knowledge, skills, and attitudes that ministers, priests, rabbis, imams, and other religious leaders need to help addicted individuals and their families.

Developed in partnership with the National Association for Children of Alcoholics (NACoA) and the Johnson Institute, the report outlines a dozen key steps.

"These core competencies will give clergy an effective tool to help address drug abuse and alcoholism before individuals and families are in crisis," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H.

Congregational leaders have many opportunities to provide information, guidance, and comfort to congregants and family members affected by alcohol and drug dependence. But all too often, those opportunities are lost.

"Every week, religious leaders of different faiths look out into their congregations and see people who are dealing with substance abuse issues," said NACoA Executive Director Sis Wenger. "Many of them, however, don't recognize the symptoms of substance abuse or the fear and confusion felt by the children of persons with substance use disorders. As a result, they don't offer their support."

A big part of the problem is that clergy simply aren't trained to recognize or address such problems. In fact, a panel of experts convened by SAMHSA in 2001 found that few clergy training programs specifically address the topic of addiction or its effects on children and families. To fill that gap, the



panel recommended the development of a set of core competencies clergy members should have.

Determining what those competencies should be was the goal of a 2-day meeting convened by SAMHSA in 2003. Congregational leaders, researchers, physicians, academicians in both secular and religious institutions, and others representing diverse religious perspectives and congregations came together to reach a consensus on ways to address this pervasive problem.

Designed to provide a general framework that religious leaders can apply to diverse situations, the core competencies reflect the typical clergy member's multiple roles. Several competencies, for example, address the clerical role of providing comfort and support to parishioners. To fulfill that role with substance-abusing individuals and their families, clergy members should learn to recognize signs of dependence, understand addiction's effect on individuals and their families, and know the characteristics of each stage of recovery.

But getting congregants the help they need means more than just making referrals, the report emphasizes. "While referrals may be appropriate," the report notes, "alone

they are insufficient." Well-prepared clergy should know how treatment can benefit addicted individuals and their families, be familiar with 12-step groups and other community resources that can help them, and be able to express concern, caring, and hope. Children need special attention, the report stresses, because substance abuse affects the whole family. Clergy and other pastoral ministers can connect them with appropriate support services and act as safe, reliable confidants.

After establishing a list of core competencies, the panel assembled suggestions for dissemination. A public education campaign using what the report calls "an interdenominational voice" was one suggestion for reaching religious, professional, and lay audiences.

Even more important, the participants offered recommendations for integrating the core competencies into both seminary and post-ordination training programs for clergy.

"These core competencies establish the base for possibly the biggest cross-denominational educational effort of its kind," said Johnny W. Allem, president of the Johnson Institute. "They pave the way for community-based pastoral counseling

training centers and 185 accredited American seminaries to have a common approach to bring both faith and science to bear on this disease.”

The American Association of Pastoral Counselors (AAPC) is partnering with NACoA and the Johnson Institute to include the core competencies in its pastoral counseling and credentialing programs. According to Douglas Ronsheim, D.Min., AAPC Executive Director, “Congregational leaders are responding to issues of substance abuse and affected family members at increasing rates.” At the same time, they are hesitant to counsel in areas outside their expertise. The core competencies will increase the clergy’s capacity to respond more effectively to the needs of their congregational members.

The report suggests the development of several educational tools based on the

competencies, including a continuing education curriculum, a preaching and teaching guide with sample sermons, and a bibliography of resources on addiction and spirituality.

Clergy members’ influence can extend beyond their own congregations, the report points out. By reshaping congregational attitudes and norms, the clergy helps to reshape wider community norms.

“The people whom SAMHSA serves are the very same people who turn to clergy every day,” said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. “This report is the beginning of a long process that will result in educational segments being incorporated into seminary courses that will help train clergy and pastoral ministers across denominations to deal with substance abuse issues.”

—By Sarah Priestman  
and Rebecca Clay



Photo by Erin J. Pond

## Core Competencies for Clergy

The following core competencies are essential for clergy and pastoral ministers to meet the needs of people with alcohol or drug dependence and their family members.

- Be aware of the generally accepted definition of alcohol and drug dependence and the societal stigma attached to alcohol and drug dependence.
- Be knowledgeable about the signs of alcohol and drug dependence, characteristics of withdrawal, effects on the individual and the family, and characteristics of the stages of recovery.
- Be aware that possible indicators of the disease may include, among others, marital conflict, family violence (physical, emotional, and verbal), suicide, hospitalization, or encounters with the criminal justice system.
- Understand that addiction erodes and blocks religious and spiritual development, and be able to communicate effectively the importance of spirituality and the practice of

religion in recovery, using the scripture, traditions, and rituals of the faith community.

- Be aware of the potential benefits of early intervention to the addicted person, family system, and affected children.
- Be aware of appropriate pastoral interactions with the addicted person, family system, and affected children.
- Be able to communicate and sustain an appropriate level of concern and messages of hope and caring.
- Be familiar with and utilize available community resources to ensure a continuum of care for the addicted person, family system, and affected children.
- Have a general knowledge of and, where possible, exposure to the 12-step programs—Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Nar-Anon, Alateen, Adult Children of Alcoholics, and other groups.

- Be able to acknowledge and address values, issues, and attitudes regarding alcohol and drug use and dependence in oneself and one’s own family.
- Be able to shape, form, and educate a caring congregation that welcomes and supports persons and families affected by alcohol and drug dependence.
- Be aware of how prevention strategies can benefit the larger community.

*Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family Members* is available online at [www.samhsa.gov](http://www.samhsa.gov) or in print 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).

# 5 Million Parents Have Alcohol Problems

SAMHSA recently released new data that show nearly 5 million alcohol-dependent or alcohol-abusing parents have at least one child living at home with them. According to the report, these parents are more likely than other parents to smoke cigarettes, use illicit drugs, and report household “turbulence.”

Data from SAMHSA’s 2002 National Survey on Drug Use and Health (NSDUH), formerly the National Household Survey on Drug Use, show that the 5 million parents with alcohol problems who have children under age 18 at home account for more than 25 percent of all adults with alcohol problems.


The data also reveal a connection between alcohol misuse and the use of illicit

drugs. According to the survey, more than 35 percent of parents with past-year alcohol dependence or abuse also used illicit drugs in the past year. In comparison, only 11 percent of parents without alcohol problems used illicit drugs.

“There is good news,” said SAMHSA Administrator Charles G. Curie M.A., A.C.S.W. “Children of alcoholic parents can be helped to build on their strengths and develop resilience to overcome their difficulties.”

SAMHSA partnered with the National Association for Children of Alcoholics to develop and distribute materials to community organizations. A Children’s

Program Kit is available. (See *SAMHSA News*, Volume XI, Number 2.)

The report, *Alcohol Dependence or Abuse Among Parents with Children Living in the Home*, is based on interviews with 68,126 respondents in their homes. For a print copy of the report or the Children’s Program Kit, 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 can also be downloaded from the SAMHSA Web site at [www.drugabusestatistics.samhsa.gov](http://www.drugabusestatistics.samhsa.gov). 

## Rules Proposed for Workplace Drug Testing

SAMHSA has proposed a new rule that would allow Federal agencies to use sweat, saliva, and hair in Federal drug testing programs that now test only urine. The proposal would also allow selected specimen testing at the time and place it is collected.

The proposal is based on scientific advances that will allow use of hair, saliva, and sweat specimens to be used with the same level of confidence applied to urine specimens.

The proposed rule spells out when these alternative specimens and testing devices may be used, the procedures that must be used in collecting samples, and the certification process for approving a laboratory to test these alternative specimens.

“These proposed rules will largely affect Federal employees and job applicants in safety and security-related positions,” explained SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

About 400,000 Federal workers in testing-designated positions—those who

have security clearances, are presidential appointees, carry firearms, or deal with public safety or national security—are drug tested when they apply for jobs.


Under the proposed rule, Federal agencies will choose whether to use the new tests. There is no requirement to test hair, saliva, or sweat. Agencies will consider their own needs and whether employees may consider these tests less intrusive and less invasive of privacy than collecting urine specimens.

The proposed rule would implement procedures to ensure that all Federal agencies divide each collected specimen—whether hair, oral fluid, sweat, or urine—into two parts: one-half for immediate testing, and one-half to be held in reserve. This added safeguard benefits both the person tested and the agency, by providing a system that would permit the person tested to request an immediate double-check if a specimen comes back from the laboratory as positive for drugs.

SAMHSA also has issued a new rule to establish standards for certification of laboratories engaged in urine testing for Federal agencies.

These new standards ensure that validity testing and reporting procedures are uniformly applied to all Federal agency urine specimens. This specific revision has been added in response to increased availability in the marketplace of products used to try to beat drug tests by adulterating urine specimens.

Although this is a final rule, comments are requested on one element of this revision—creatinine levels, which are used to help establish whether a urine specimen has been adulterated. Comments are requested because the information on which this change is based came in after the close of the comment period on the proposal.

For more information, visit SAMHSA’s Web site at [www.samhsa.gov](http://www.samhsa.gov). 

# SAMHSA Launches Two Major Efforts on Underage Drinking

SAMHSA introduced two major public education programs on underage drinking in April, Alcohol Awareness Month.

At a press conference on April 20 in Washington, DC, SAMHSA launched *Too Smart To Start*, a new national program to keep pre-teens, age 9 to 13, from initiating alcohol consumption.

Later in the month, SAMHSA teamed with Scholastic, Inc., for the *Reach Out Now* National Teach-In Week, April 26 to 30, to educate students in fifth-grade classrooms nationwide on the dangers of underage alcohol use.

SAMHSA's 2002 National Survey on Drug Use and Health found that more than 2.6 million adolescents age 12 to 17 binged on alcohol in 2002 and 630,000 were heavy drinkers already. One-third—2.3 million—of alcohol-dependent adults age 21 or older in 2002, had first used alcohol before age 14. More than 80 percent—5.8 million—had first used before they were age 18. The rate of dependence for those who first drank at age 21 or older was 1 percent.

## Too Smart To Start

The idea behind *Too Smart To Start* is to reach out to children and caregivers before these children start drinking alcohol. The program provides materials to community groups with the objective of enhancing communication between parents and children about the harm of underage alcohol use. A community action kit is available that provides step-by-step information on how to raise awareness about underage drinking in local communities.

Field tests of the program took place in New Castle County, DE; Miami, FL; Noble County, IN; Newaygo County, MI; Cincinnati, OH; Portland, OR; Pittsburgh, PA; Nashville, TN; and San Antonio, TX. National partner organizations are now taking the program



nationwide. Funding for the program comes from the Centers for Disease Control and Prevention.

## Reach Out Now

This is the third year of *Reach Out Now*. In 2003, *Reach Out Now* materials were distributed to more than 100,000 classrooms nationwide reaching more than 3 million students. The materials—developed by SAMHSA's Center for Substance Abuse Prevention and Scholastic, Inc.—were based on research supported by SAMHSA and the National Institutes of Health's National Institute on Alcohol Abuse and Alcoholism. (See *SAMHSA News*, Volume XI, Number 1.)

Fifth-grade teachers received a two-part set of underage drinking materials including *Reach Out Now: Talk with Your Fifth Graders About Underage Drinking*. This year for the first time, a new curriculum and parents' guide for sixth graders was distributed to schools nationwide to reinforce the message for fifth-graders.

The materials have been enthusiastically endorsed by the Leadership to Keep Children Alcohol Free, a consortium of governors'

spouses from states across the country, and the teach-ins included the participation of the first ladies of 15 states and other public figures.

For more information on the *Too Smart To Start* program, visit SAMHSA's Web site at [www.samhsa.gov](http://www.samhsa.gov). For *Reach Out Now*, visit [www.teachin.samhsa.gov](http://www.teachin.samhsa.gov). To order materials available for these programs, contact the National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345; or call 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). ▀



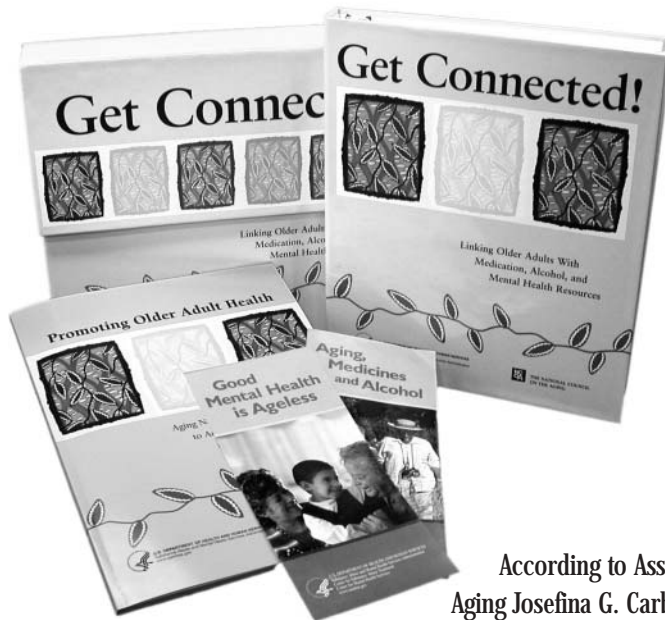
# Kit Links Service Providers to Resources for Older Adults

To help service providers address alcohol abuse and medication misuse among older adults, SAMHSA, the Administration on Aging (AoA), and the National Council on the Aging (NCOA) recently released a toolkit, *Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources*.

Older Americans comprise fewer than 13 percent of the population, but receive between 25 and 30 percent of all prescriptions and account for more than half of the hospitalizations resulting from drug reactions. About 17 percent of older adults experience problems with abuse of alcohol or misuse of prescription drugs, and 20 percent of the mental health problems experienced by those over 55 are not part of the normal aging process.

The toolkit is designed for organizations that provide services to older adults, such as senior centers, adult day care services, nutrition programs, state agencies, health and social service programs, and faith-based initiatives. It introduces service providers

to substance abuse and misuse issues and mental health problems in older adults. The toolkit also gives them a 5-step process to establish a program, develop resources, conduct education sessions, and plan future programming.



According to Assistant Secretary on Aging Josefina G. Carbonell, “Too many of our elders struggle to cope with difficult life situations or mental health and substance abuse concerns that negatively affect their ability to participate fully in life. This exciting collaboration between SAMHSA, AoA, and NCOA makes important information and resources available that can enhance the well-being of all older Americans.”

“The *Get Connected!* toolkit addresses the needs of this population by promoting new linkages that will help older adults gain access to needed substance abuse and mental health services,” said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

The materials provided in the toolkit allow a services coordinator to:

- Determine if the organization is ready, willing, and able to establish the program.
- Create or enhance the organization’s resource database.
- Conduct educational sessions for staff and older adults, or identify an appropriate person who can conduct these sessions.
- Help the organization draft a plan for future programs.

See box for a description of toolkit contents and directions for ordering. ▶

—Sarah E. Michaud

## What’s in the Toolkit?

Selected materials include:

- *Program Coordinator’s Guide*: This guide provides an overview of substance misuse and mental health problems among older adults, a description of the toolkit contents, and a summary of the five steps to establish a program.
- *Promoting Older Adult Health*: This resource highlights programs throughout the country that have established linkages to provide seniors with needed support without spending large amounts of money.
- *Substance Abuse Among Older Adults: A Guide for Social Service Providers*: This handy desk reference, a condensed version

of SAMHSA’s Treatment Improvement Protocol (TIP) 26, gives service providers information to help them screen and assess substance abuse among older adults and make referrals for appropriate treatment.

- A selection of handouts, brochures, sample forms, and a video.

To order the *Get Connected!* 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). Ask for publication GCKIT. ▶

# Disaster Assistance Center Offers Resources for Service Providers

Natural and manmade disasters affect every member of a community—including those struggling with mental health and substance abuse issues. State governments and local service providers seeking to prepare for and respond to the need for trauma-related mental health and substance abuse services after a disaster can find support and guidance at the SAMHSA Disaster Technical Assistance Center (SAMHSA DTAC).

SAMHSA DTAC offers a toll-free number through which states, territories, and local service providers can access resources and information and request technical assistance. SAMHSA DTAC's Web site provides a wealth of information about disaster-related and trauma-related services, including *Dialogue*, SAMHSA DTAC's quarterly publication for state mental health commissioners, substance abuse commissioners, and disaster mental health coordinators. The Web site also includes emergency plans from several states; Federal resources for disaster, trauma, and mental health as well as publication information; and, an events calendar.



SAMHSA DTAC staff members provide on-site technical assistance to numerous states. Currently, they are hosting a series of regional all-hazards trainings to support

disaster preparedness for mental health and substance abuse service systems.

For further information about SAMHSA DTAC, visit [www.mentalhealth.samhsa.gov/dtac](http://www.mentalhealth.samhsa.gov/dtac) or call 1 (800) 308-3515. ▶

## Corrections & Clarifications

The March/April 2004 issue of *SAMHSA News*, Volume 12, Number 2, should have noted that most of the funding for the program described in “Buprenorphine in Action: One Community’s Story,” was provided by the Mifflin County Commissioners and Mifflin County District Attorney, with some additional revenue raised via application fees and in-kind and monetary contributions from other segments of the community.

The article, “SAMHSA Helps Bring Buprenorphine to the Field,” which appeared in the March/April 2004 issue of *SAMHSA News*, Volume 12, Number 2, did not intend to imply that specialized methadone clinics are not an important treatment option for people addicted to opioid drugs. SAMHSA supports the use of both methadone and buprenorphine in the medication-assisted treatment of opioid-dependent patients.

The “Buprenorphine Resources” box in the March/April 2004 issue of *SAMHSA News*, Volume 12, Number 2, should have included the Web link for upcoming training offered by NAADAC-The Association for Addiction Professionals: [www.naadac.org/documents/display.php?DocumentID=94](http://www.naadac.org/documents/display.php?DocumentID=94). With SAMHSA cosponsorship, NAADAC developed a training curriculum for counselors who work with patients treated with buprenorphine. ▶

# SAMHSA Announces Funding Opportunities

SAMHSA recently announced grant funding opportunities for Fiscal Year 2004. Selected Notices of Funding Availability include the following:

- **Cooperative Agreement for Ecstasy and Other Club Drugs Prevention Services** (Application due date: June 18, 2004)—15 awards, up to \$300,000 for 5 years, to prevent youth involvement with Ecstasy and club drugs through effective and culturally appropriate prevention services. (SP 04-004, \$4.5 million)
- **State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Health Disorders** (Application due date: June 8, 2004)—4 grants, up to \$1.1 million per year in two phases, to increase state and local capacity to provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services to persons with co-occurring substance abuse and mental health disorders, and their families. (SM 04-012, \$4.5 million)
- **Access to Recovery Grants** (Application due date: June 4, 2004)—15 grants, up to \$15 million per year for 3 years, for states to implement voucher programs that support client choice among substance abuse clinical treatment and recovery providers, expand access to clinical treatment and recovery support options, and increase substance abuse treatment capacity. (TI 04-009, \$100 million)
- **Program To Aid Reentry of Young Offenders into the Community** (Application due date: June 15, 2004)—12 to 14 awards, from \$300,000 to \$500,000 for up to 4 years, to expand and enhance substance abuse treatment and related reentry systems for juveniles and young adults sentenced to prisons, jails, or juvenile detention centers. (TI 04-002, \$6 million)

- **Substance Abuse Services Research** (Application due date: June 1, 2004)—5 grants, up to \$30,000 for 2 years, to support dissertation research involving data analysis on substance abuse services issues. The dissertation must examine in a quantitative way a problem or issue in the area of substance abuse. (PA 04-001, \$150,000)

## Infrastructure Grants

- **State Mental Health Data Infrastructure Grants for Quality Improvement** (Application due date: June 16, 2004)—51 awards, up to \$150,000 per year for 3 years, to support state and local mental health authorities to improve the management of delivery of mental health services. (SM 04-005, \$8.25 million)
- **Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants** (Application due date: June 3, 2004)—7 awards, up to \$750,000 per year for 5 years, to expand and strengthen treatment services for children, adolescents, and youth in transition with serious emotional disturbances, substance abuse disorders, and/or co-occurring disorders, and their families. (SM 04-006, \$5.3 million)
- **Drug-Addiction-Treatment-Act-of-2000 (DATA) Physician Clinical Support System** (Application due date: June 2, 2004)—1 award, up to \$500,000 per year for up to 3 years, to develop a coordinated, clinical support program for physicians who are treating addicted patients with buprenorphine products. (TI 04-005, \$500,000)
- **State Incentive Grants To Build Capacity for Alternatives to Restraint and Seclusion** (Application due date: June 1, 2004)—8 awards, up to \$237,000 per year for up to 3 years, to support state

efforts to adopt best practices to reduce and ultimately eliminate the use of restraint and seclusion in all mental health services settings. (SM 04-007, \$1.9 million)

## Services Grants

- **Residential Substance Abuse Treatment for Pregnant and Postpartum Women and Their Children** (Application due date: June 2, 2004)—14 awards, up to \$500,000 per year for up to 3 years, to expand the availability of comprehensive, high-quality, resident substance abuse treatment services for pregnant, postpartum, or parenting low-income women, and parenting women and their minor children with limited access to health services. (TI 04-004, \$7 million)
- **Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless** (Application due date: May 28, 2004)—35 awards, up to \$400,000 each year for 5 years, to expand and strengthen treatment services for homeless individuals with substance abuse disorders, mental illness, or with co-occurring substance abuse disorders and mental illness. (TI 04-001, \$13.9 million)

## More Information

For the most up-to-date listings, and for information regarding applications, visit [www.SAMHSA.gov/grants](http://www.SAMHSA.gov/grants). Information is also available at [www.grants.gov](http://www.grants.gov) and the *Federal Register*. Or, telephone the National Mental Health Information Center at 1 (800) 789-2647 or the National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686. ▶

—By *Melissa Capers*



# Center Assists People with Substance Abuse and Child Welfare Issues

The dilemma for service providers posed by the intersection of parental substance abuse with child neglect and maltreatment is one of the most difficult to resolve.

In response, SAMHSA's Center for Substance Abuse Treatment (CSAT) joined with the Office on Child Abuse and Neglect, Children's Bureau, of the Administration on Children, Youth, and Families to launch the National Center on Substance Abuse and Child Welfare in 2002.

The National Center's goal is to improve outcomes for children and families affected by substance use disorders and child abuse or neglect. It is staffed through a California-based organization called Children and Family Futures and supported by a consortium of national associations and organizations involved in child welfare and substance abuse issues. The National Center shares its expertise and knowledge with communities, policymakers, and other professionals. Its strategies are focused on promoting collaboration between the substance abuse treatment system, child welfare system, and dependency courts to improve practices and policies.

The National Center's Web site offers training materials, presentations, and professional literature on related topics including substance abuse treatment issues, children's services, and dependency courts with jurisdiction in cases of child abuse and neglect.

The first in a series of online tutorials and trainings, "Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals" provides training in child welfare and dependency court procedures and is available on SAMHSA's Web site. Other


## Conferences Set for July

The National Center for Substance Abuse and Child Welfare will host two conferences in Baltimore, MD, this July:

**Women Across the Life Span:  
A National Conference on Women,  
Addiction, and Recovery**

**July 12 to 13, 2004**

More than 50 invited speakers—including nationally recognized experts on women's substance abuse treatment and practitioners testing innovative and promising new practices—will discuss current issues and practices in providing gender-specific treatment to women throughout their lives. Topics to be addressed include co-occurring mental health disorders, services for children and families, homelessness, criminal justice, trauma, and violence.



**Putting the Pieces Together:  
1st National Conference on Substance Abuse,  
Child Welfare and the Dependency Court**


July 14-15 2004  
Baltimore Marriott Inner Harbor

**Putting the Pieces Together:  
1st National Conference on  
Substance Abuse, Child Welfare,  
and the Dependency Court**

**July 14 to 15, 2004**

Targeted to front-line practitioners and administrators of child welfare, substance abuse, and dependency court services, conference sessions will focus on four areas: serving children of substance abusers in the child welfare system; practice and clinical issues; increasing collaboration, funding, and systems issues; and workforce and staff development.

For detailed information about these conferences or to register, visit [www.samhsa.gov/conferences/main.htm](http://www.samhsa.gov/conferences/main.htm). Or call Ayanna Dixon at (301) 495-3787, extension 3130, for the Women's Conference, and Lani Daly at (714) 505-3525 for the Child Welfare Conference. ▶



**Women Across the Life Span:  
A National Conference on Women,  
Addiction and Recovery**

July 12-13 2004  
Baltimore Marriott Inner Harbor

tutorials geared to child welfare service providers, judicial officers, and legislators will be available in 2005.

The National Center also offers in-depth technical assistance to states and territories. This work is building closer collaboration among substance abuse, child welfare, and

court systems in Colorado, Michigan, Florida, and Virginia.

For more information about the National Center for Substance Abuse and Child Welfare, visit [www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov), call (714) 505-3525, or e-mail [ncsacw@samhsa.gov](mailto:ncsacw@samhsa.gov). ▶

# 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:

- Across Borders: Reaching Out to Iraq
- From the Administrator: Mental Health in Iraq
- Manuals Guide Teen Marijuana Use Treatment
- President's National Drug Control Strategy Includes Key Role for SAMHSA
- Majority of Youth Obtain Marijuana from People They Know
- SAMHSA Releases Guide for Clergy
- 5 Million Parents Have Alcohol Problems
- Rules Proposed for Workplace Drug Testing
- SAMHSA Launches Two Major Efforts on Underage Drinking
- Kit Links Service Providers to Resources for Older Adults
- Disaster Assistance Center Offers Resources for Service Providers
- SAMHSA Announces Funding Opportunities
- Center Assists People with Substance Abuse and Child Welfare Issues
- Recovery Month Celebrates 15th Year
- I visited [SAMHSA News](http://www.samhsa.gov/SAMHSA_News) online at [www.samhsa.gov/SAMHSA\\_News](http://www.samhsa.gov/SAMHSA_News)

Other comments: \_\_\_\_\_

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\_\_\_\_\_

I'd like to see an article about: \_\_\_\_\_

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\_\_\_\_\_

Name and title: \_\_\_\_\_

Address and affiliation: \_\_\_\_\_

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

Mail, phone, fax, or e-mail your response to:

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E-mail: [dgoodman@samhsa.gov](mailto:dgoodman@samhsa.gov)

***Thank you for your comments.***

# Recovery Month Celebrates 15th Year

Individuals, organizations, and communities nationwide are already planning their participation in the 15th annual National Alcohol and Drug Addiction Recovery Month this September.

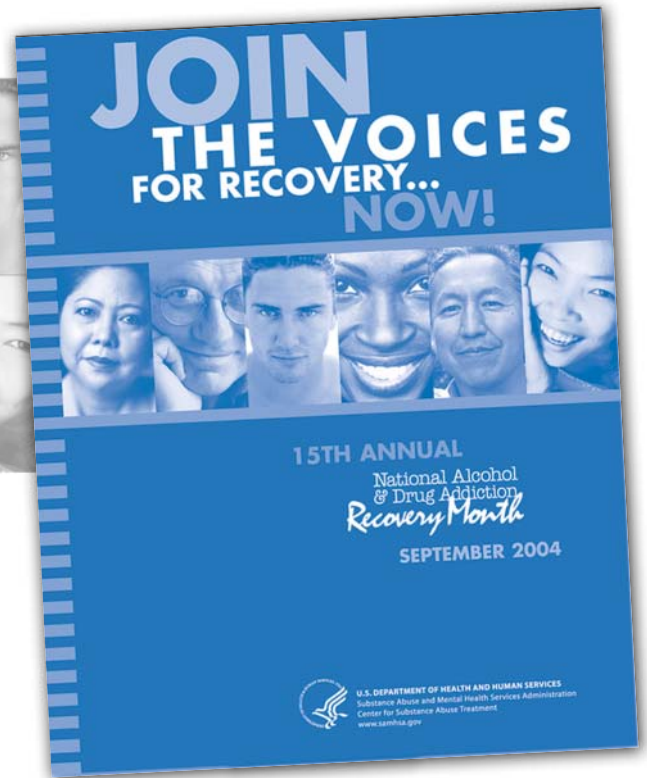
The 2004 theme is "Join the Voices for Recovery . . . NOW!" It underscores the need to educate communities nationwide about the value and significance of alcohol and drug addiction treatment and the kinds of services that are available.

The celebration, coordinated by SAMHSA's Center for Substance Abuse Treatment (CSAT), highlights the benefits of substance abuse treatment and promotes the message that recovery from substance abuse in all its forms is possible.

"Today, addiction is the number one health problem in America," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Treatment is the best tool we have to address this problem. And, the public awareness generated by Recovery Month is essential to reducing stigma and improving services and supports for people coping with alcohol or drug addiction."

Activities and materials in support of the Recovery Month campaign include a toolkit with comprehensive resource information, the Recovery Month home page on SAMHSA's Web site, TV and radio public service announcements, community forums, and community-sponsored events. All of these materials provide comprehensive options for developing tailored Recovery Month events and activities in every community.

Central to outreach efforts for the month-long celebration is the Recovery Month toolkit, which provides ideas for planning and tools for creating a variety of successful events. The kit features important resources for both treatment providers and consumers, event ideas, and sample materials on how to reach local media. The kit also includes detailed fact sheets for state and



local agencies, key constituency groups, and other special audiences.


SAMHSA also hosts an award-winning, interactive Web site for Recovery Month at [www.recoverymonth.gov](http://www.recoverymonth.gov). Additional planning resources, news and updates, articles, and a schedule of events throughout the country are listed in a state-by-state interactive registry. Visitors to the site can also sign up to receive ongoing updates about Recovery Month events.

The Recovery Month Web site also hosts a series of Webcasts that provide information about Recovery Month activities and discuss key issues relevant to individuals in recovery. The first, Road to Recovery 2004, aired in February. Additional Webcasts are scheduled for the first Wednesday of each month and will be archived on the Recovery Month Web site for viewing at any time.

As lead coordinator for Recovery Month, CSAT partners each year with other

public sector entities and national and local coalitions to develop materials and host events.

Events will include community forums across the country, inviting experts and legislators to come together to discuss local addiction treatment and recovery issues. Other local events include rallies at state capitals; panel discussions and conferences hosted by local universities, faith groups, and other organizations; proclamations; health and information fairs; run/walk events; and more.

For 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). Also available is Recovery Month's virtual toolkit, online at [www.recoverymonth.gov](http://www.recoverymonth.gov). 

**SAMHSA News**

Substance Abuse and  
Mental Health Services  
Administration

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