Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

November/December 2004, Volume 12, Number 6

SAMHSA Launches *Rapid HIV Testing Initiative*

SAMHSA has launched a Rapid HIV Testing Initiative, which will make available a "rapid results" HIV test and related support services to thousands of people who receive help from SAMHSA's programs.

Inside This Issue

In August 2004, the U.S. Department of Health and Human Services provided $4.8 million to SAMHSA to purchase rapid HIV test kits and to train eligible service providers on the fundamentals of rapid HIV testing, HIV prevention counseling, and related data collection activities. Preliminary efforts are now underway.

With this Initiative, SAMHSA has the potential to revolutionize prevention and treatment services for HIV/AIDS—and ultimately reduce the incidence of the disease.

The Test

The Food and Drug Administration (FDA) recently approved the OraQuick® ADVANCE Rapid HIV-1/2 Antibody Test, which provides results in just 20 minutes, for use in non-clinical settings. (For more on the test, see page 2.) These settings may include a doctor's office, a local clinic, or a community-based outreach organization, among others. However, each testing site must receive a waiver under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). To qualify for a CLIA waiver, a facility must establish quality standards

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for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results.

Traditional HIV testing requires two visits: one visit to take the test sample and then a second visit—often 2 weeks later—to receive the results. According to the Centers for Disease Control and Prevention (CDC), however, many people do not complete this sequence. Nearly one-third (31 percent) of those who test positive for HIV at CDC-funded sites never return to receive these results—and so do not access counseling, treatment, and other supportive services. Nationwide, CDC estimates that between 180,000 and 280,000 people do not know that they are HIV positive.

In contrast, rapid HIV testing provides results in one visit. An added benefit is that clients with a confirmed HIV-positive result can be referred immediately to appropriate treatment, counseling, and other vital assistance.

"People need to know that . . . if they test positive for HIV, we can connect them to treatment and other supportive care services to maintain their health . . ."

—Beverly Watts Davis, Director Center for Substance Abuse Prevention and SAMHSA's HIV/AIDS & Hepatitis Matrix Lead

Furthermore, because rapid HIV testing can be conducted in both clinical and non-clinical settings, access to people served through SAMHSA's program site venues—especially outreach programs—is expected to increase.

SAMHSA's Role

Currently, SAMHSA is supporting many mental health, substance abuse, and community-related HIV programs across the Nation. "The relationship between substance abuse and the transmission of HIV/AIDS has been well established since the beginning of the HIV/AIDS epidemic," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Injection drug use alone has accounted for 36 percent of AIDS cases in the United States."

Facts about Rapid HIV Testing

SAMHSA's new Rapid HIV Testing Initiative uses the OraQuick® ADVANCE Rapid HIV-1/2 Antibody Test.

The test kit consists of a single-use test device and a single-use test developer solution. Additional items provided include a reusable test stand and disposable specimen collection loop.

Test results are provided with greater than 99-percent accuracy in as little as 20 minutes.

Other facts about this product include:

- The OraQuick® ADVANCE Rapid HIV-1/2 Antibody Test is the first and only rapid, point-of-care test approved by the U.S. Food and Drug Administration (FDA).
- In June 2004, the FDA approved a waiver under the Clinical Laboratory Improvements Amendments of 1988 (CLIA) for the OraQuick® ADVANCE test.
- The test is available for use by more than 180,000 sites registered under CLIA in the United States, including hospitals, physicians' offices, health clinics, outreach clinics, HIV counseling centers, and community-based organizations.
- Unlike other antibody tests for HIV, OraQuick® ADVANCE can be stored at room temperature and requires no specialized equipment.

How the Oral Test Works

The "lateral-flow" technology behind OraQuick® ADVANCE is similar to that used in a home pregnancy test. For the oral rapid test, oral fluid is collected by gently swabbing completely around the outer gums, both upper and lower, one time around, using the flat pad of the device. Then, the device is inserted into the vial of special solution provided. The result appears on the device as a prominent line, which becomes evident in about 20 minutes.

The national rate of HIV transmission continues to grow, especially in low-income, minority populations, with 40,000 new cases reported each year. Currently, at least 1 million Americans are living with HIV/AIDS.

Helping to increase the number of people who learn their HIV status will ultimately help prevent the spread of HIV and ensure more timely treatment for those infected.

For additional background information on rapid HIV tests visit **www.cdc.gov/hiv/rapid_testing.**

For more information about the test, call 1 (800) 869-3538.

Impaired judgment and lack of inhibitions associated with alcohol and drug use, as well as with some serious mental illnesses, can also lead to behaviors that put people at risk of contracting or transmitting HIV.

"The capacity to provide referral and access to treatment immediately is as important as the new testing technology," said Beverly Watts Davis, Director of SAMHSA's Center for Substance Abuse Prevention, who also serves as SAMHSA's HIV/AIDS & Hepatitis Matrix Lead. "People need to know that treatment for substance abuse and mental illness is an integral part of reducing their HIV risk, and that, if they test positive for HIV, we can connect them to treatment and other supportive care services to maintain their health and prolong their lives."

How the Program Works

To provide rapid HIV testing, an eligible service provider must have the capacity to provide rapid HIV tests and counseling, make referrals, and collect required data.

SAMHSA has developed four criteria to determine site eligibility. A site must:

- Be located in metropolitan and rural areas with high HIV prevalence that are currently interested in providing traditional HIV/AIDS counseling, testing, and referrals.
- Serve high-risk clients (e.g., injection drug users, persons with co-occurring substance use and/or mental disorders, men who have sex with men, college students, previously incarcerated reentry populations).
- Have a rapid HIV testing infrastructure that will expedite CLIA waiver certification, and have few state or local barriers to rapid HIV testing.
- Have established linkages to HIV/AIDS treatment, counseling, and other supportive services.

Eligible sites must also meet SAMHSA's mandatory readiness requirements, including the completion of required trainings; a CLIA waiver; an established referral network

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From the Administrator

HIV/AIDS: *A New Effort Offers Hope*

While HIV/AIDS, increasingly, has become a treatable illness, it remains incurable and life threatening. Prevention and early intervention remain critical.

The availability of a new test that yields rapid results presents a unique opportunity for early detection and treatment of the virus. That's why the U.S. Department of Health and Human Services has made rapid HIV testing—coupled with prevention, counseling, and referral—a priority in countering this disease.

SAMHSA is overseeing the Department's $4.8 million Rapid HIV Testing Initiative—a promising effort that allows the Agency to assist people in immediate and tangible ways.

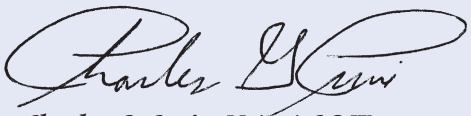
The Initiative will reach many people at high risk for acquiring HIV, particularly individuals with a mental or addictive disorder. In addition to offering a quick and easy test, service providers participating in this Initiative will offer counseling and referral to treatment and supportive care services.

As part of this process, we're educating America by demonstrating that mental illnesses, substance abuse, and HIV are chronic, long-term illnesses that can be treated successfully. We are teaching that, with appropriate supportive services, people with these illnesses can lead long, productive, and fulfilling lives in our Nation's communities.

We're also focusing attention on the interrelationships among mental illnesses, substance use, and HIV/AIDS. Today, we know that co-occurring disorders—addictive, mental, and physical—are more the expectation than the exception.

We are also combating the misunderstanding and stigma associated with these illnesses. Too many people avoid seeking diagnosis and therefore do not benefit from treatment and other services that could help them.

As with all SAMHSA efforts, this Initiative reflects a commitment to the Nation's health. The rapid HIV test, combined with the proper interventions, has the potential to transform the prevention and treatment of HIV/AIDS—and ultimately, reduce the incidence of the disease.



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

21 States, 2 Territories Awarded Strategic Prevention Framework Grants

SAMHSA has awarded its first Strategic Prevention Framework State Incentive Grants to advance community-based programs for substance abuse prevention, mental health promotion, and mental illness prevention. The grants, to 21 states, total $230 million over 5 years.

According to SAMHSA Center for Substance Abuse Prevention Director Beverly Watts Davis, who serves as the Agency's Strategic Prevention Framework Matrix Lead, "The funds will support a five-step process known to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors." The five steps are: (1) conduct needs assessments; (2) build state and local capacity; (3) develop a comprehensive strategic plan; (4) implement evidence-based prevention policies, programs, and practices; and (5) monitor and evaluate program effectiveness, sustaining what has worked well.

Funding by State

- The **Arizona** Governor's Office for Children, Youth, and Families will work with other state agencies to develop a statewide substance abuse prevention framework that results in data-driven, community-based activities targeting high-risk youth and families.
- The **Colorado** Prevention Partners for Sustainable Change project will promote interagency cooperation, launch new prevention systems, fill service and policy gaps, and build a state and community infrastructure that increases efficiency and maximizes resources.
- **Connecticut** will create a strategy for delivering and implementing substance abuse prevention and mental health promotion services that can be used by state and community partners.
- The **Florida** Strategic Prevention Alliance will use its grant to ensure that state and community strategic plans are supported by multiple resources for evidence-based programming.
- **Illinois** will encourage state and community leaders to work in tandem to remove barriers and build capacity for substance abuse prevention efforts.
- **Kentucky** will build a data-driven, interagency prevention service system. The state also will expand its use of geographic information system technology to guide community goal-setting and resource allocation.
- **Louisiana** will develop a system that coordinates the planning and evaluation of evidence-based, culturally appropriate, and cost-effective prevention activities.
- **Maine** will build a statewide, data-driven prevention infrastructure that provides common tools for prevention programs.
- **Michigan** will use its grant to enhance the effectiveness of prevention services by increasing the use of evidence-based strategic planning models.
- **Missouri** will build on the efforts begun under the Governor's Prevention Initiative to establish a sustainable substance abuse prevention infrastructure, which is data-driven, culturally competent, and evidence-based.
- **Nevada** will use its funds to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking. The program will also improve state and community prevention capacity and infrastructure.
- **New Hampshire** will transform the state's prevention system.
- **New Mexico** will conduct a statewide needs assessment, create a comprehensive strategic plan for prevention, and launch new activities to reduce substance abuse.
- The **Rhode Island** program is a broad public/private initiative designed to enhance infrastructure and focus on childhood and underage drinking.
- **Tennessee** will provide the framework and resources for state government and communities to target scarce resources and build capacity more effectively.
- **Texas** will develop and coordinate a statewide strategy to prevent substance abuse and related problems by building on the existing infrastructure of the Drug Demand Reduction Advisory Committee.
- **Washington** will use its grant to implement and evaluate evidence-based strategies, and to establish reporting procedures that track progress toward preventing substance abuse and related problems, including mental illness, delinquency, and violence.
- **West Virginia** will work to coordinate prevention funding, improve program quality, and increase service availability.
- **Wyoming** will establish a state epidemiological work group and a regional community coordinator system. It also will implement evidence-based prevention programs in communities; modify programs, policies, and strategic plans based on annual data collection; and develop a data-driven decision-making framework.

Funding by Territory

- **Guam** will develop a substance abuse prevention network that links a state-level advisory committee with community-based prevention mentors.
- **Palau** will engage communities in developing a strategic prevention framework based on sound prevention principles and Palauan culture and strengths.

More information about SAMHSA's Strategic Prevention Framework is available at **www.samhsa.gov.**

WORKFORCE DEVELOPMENT

The Workforce Crisis: SAMHSA's Response

The shortage of adequately trained personnel to provide services for substance abuse and mental health—also known as behavioral health care—is of major concern within the field. For SAMHSA, creating strategies to solve this problem is a top priority.

This article is the first of two that will examine the nature of the workforce crisis and discuss SAMHSA efforts to address the problem. This article focuses primarily on mental health; the next will focus more on substance abuse.

Prestigious organizations across the field—including the Institute of Medicine (IOM), the President's New Freedom Commission on Mental Health, and the U.S. Surgeon General—all agree that the health care system needs to do a much better job applying evidence-based practices, serving rural areas, including consumers and families in decision-making, eliminating racial and ethnic disparities, and more. But none of these goals can be achieved without solving one underlying problem: the need for a bigger, better workforce.

"Some people don't have access to any services at all," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Others don't have access to the right services—services provided by workers who are knowledgeable about evidence-based practices, experienced in the latest treatment methods, and sensitive to cultural nuances and issues."

How bad is the workforce crisis? The IOM's definitive report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* cites workforce preparation as one of four critical areas demanding immediate action.

One problem is the simple shortage of providers. "We don't have a workforce that's adequate in terms of numbers, much less a workforce that's adequate in terms of training," emphasized SAMHSA Chief of Staff Gail P. Hutchings, M.P.A. "We have big hurdles to face in terms of recruitment and retention." These hurdles include low salaries, poor benefits, and the hassles of third-party reimbursement.

Simply put, there aren't enough providers to meet the Nation's needs. Take graduate-level personnel, for example. An influential study, *Can the National Addiction Treatment Infrastructure Support the Public's Demand for Quality Care?,* co-authored by A. Thomas McLellan, Ph.D., University of Pennsylvania Center for Studies of Addiction, found that few addiction treatment programs employ psychiatrists, psychologists, social workers, or nurses. This shortage of key clinical personnel compromises the field's ability to adopt effective new therapies and medications, the study warned.

In rural areas, shortages of behavioral health providers are critical. Consider psychiatrists, for instance. According to a report from SAMHSA's Center for Mental Health Services (CMHS), *Mental Health, United States, 2002,* Idaho and Mississippi have only 6 active psychiatrists per 100,000 residents compared to 57 per 100,000 in Washington, DC.

In addition, service providers and administrators need training in areas other than clinical skills, said Ronald W. Manderscheid, Ph.D., chief of the Survey and Analysis Branch at CMHS. For example, the behavioral health workforce especially needs training in information technology and data analysis.

Persuading people to stay in the behavioral health field is another problem, fueled by the same concerns that make it difficult to recruit people in the first place. "Turnover is a key issue in both the substance abuse treatment and prevention system and in the mental health delivery system," said SAMHSA Center for Substance Abuse Treatment (CSAT) Director H. Westley Clark, M.D., J.D., M.P.H. "Just when I get you trained, you leave."

The McLellan study found that more than half of the substance abuse treatment program directors and a similar proportion of counselors surveyed were in their current jobs less than a year.

"We have a huge succession problem," said Dr. Manderscheid. He noted that the

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Workforce development is one of the cross-cutting principles in SAMHSA's Matrix of Priority Programs.

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current generation of leaders is approaching retirement age, and their replacements aren't being recruited or retained.

Karl White, Ed.D., CSAT's Team Leader for Workforce Development, cited another problem. "There is a dire need for more clinical supervision," he said. "Supervisors carrying full caseloads of clients don't have time to oversee and mentor the people working under them or supervise the implementation of evidence-based practices."

CMHS Director A. Kathryn Power, M.Ed., emphasized the connection between improving the workforce and SAMHSA's initiative for Mental Health Transformation. "SAMHSA is seeking to introduce a fundamental change in the way mental health services are perceived, accessed, delivered, and financed," she explained. "Care should focus on facilitating recovery and building resilience—not just managing symptoms. To do this, we must ensure that service providers are taught the skills they need to facilitate change."

The Director of SAMHSA's Center for Substance Abuse Prevention, Beverly Watts Davis, sees a place for prevention in educating the workforce also. "Prevention is a continuum that extends from deterring diseases and behaviors, to changing community conditions to support a healthy and safe community and support recovery, to slowing the onset and severity of illnesses after they occur," she said. "Furthermore, after treatment, efforts are still needed to prevent relapse. We want to encourage service providers to include prevention in their thinking and planning and in all of their health promotion initiatives."

Change Is Underway

Currently, SAMHSA is taking action to increase the number of behavioral health care providers and improve their training.

The SAMHSA-funded Annapolis Coalition is one of the Agency's most recent efforts in this regard. Founded by the American College of Mental Health Administration and the Academic Behavioral Health Consortium, the coalition and participants in SAMHSA's Partners for Recovery workforce initiative are building a national consensus on the nature of the workforce crisis and promoting improvements in both education and training.

At the 2001 conference in Annapolis that gave the group its name, the coalition began by identifying and describing some major problems.

First, the training offered in many graduate programs doesn't reflect the dramatic changes that occurred in behavioral health care in recent years. Despite the fact that the majority of behavioral health care is delivered through managed care arrangements, for example, students typically receive little formal training about how to work in such systems.

Second, nearly all continuing education programs use a passive, didactic model of instruction that has proven ineffective in influencing the way practitioners provide services or in improving health care outcomes.

Related Resources

- The Addiction Technology Transfer Center (ATTC) Network, funded by SAMHSA's Center for Substance Abuse Treatment, relies on 14 regional centers and an ATTC national office to upgrade the skills of current substance abuse treatment providers and get them the latest research findings. Visit **www.nattc.org.** The Network has also created a guide to certification requirements in all states and territories and a list of current opportunities for face-to-face educational activities at over 300 colleges and universities as well as an online guide to distance education opportunities called AddictionED.org, available at **www.nattc.org/addictionEd/index.asp.**
- The national Centers for the Application of Prevention Technologies, funded by SAMHSA's Center for Substance Abuse Prevention, helps prevention practitioners put knowledge gained from research into everyday practice. Visit **www.captus.org.**
- The National Technical Assistance Center for State Mental Health Planning (NTAC), run by the National Association of State Mental Health Program Directors and funded in part by SAMHSA's Center for Mental Health Services, provides technical assistance to help ensure that the best practices and most up-to-date information are translated into action at the state and local levels. Visit **www.nasmhpd.org/ntac.cfm.**
- Information on the Annapolis Coalition on Behavioral Health Workforce Education is available at **www.annapoliscoalition.org.**
- SAMHSA's Minority Fellowship Program supports racial and ethnic minority students in doctoral and postdoctoral programs in mental health and substance abuse, in partnership with the professional associations. (See *SAMHSA News,* Volume XI, Number 3, "Minority Fellowship Program Extends Training, Expands Treatment" online at **http://alt.samhsa.gov/samhsa_news/VolumeXI_3/article4.htm.**) Visit **www.mentalhealth.samhsa.gov/publications/allpubs/NMH02-0143/default.asp.**
- TAP 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice,* published by CSAT, is available online at **http://tie.samhsa.gov/Taps/tap21/TAP21Toc.html.**

Third, people working in this field with a bachelor's degree or no degree at all receive very little training. These care providers are the ones that consumers are likely to have the most contact with in public sector systems of care.

"We know that a large proportion of care is delivered by people who have very little information about mental illness and very little formal training in treatment," said Michael A. Hoge, Ph.D., a professor of psychology in the department of psychiatry at Yale University School of Medicine and Co-Chair of the Annapolis Coalition.

And fourth, consumers of services and family members who provide the bulk of support to individuals with behavioral health problems usually receive no training at all. "Particularly on the mental health side, there's been a very heavy emphasis on professional training and professional care," said Dr. Hoge. "We need to build much better educational support to teach individuals and families about disorders and how to navigate systems of care. We also need to engage them as educators of the workforce, teaching about the lived experience of illness, treatment, and recovery."

A National Strategy

The CSAT publication, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice,* Technical Assistance Publication 21 (TAP 21) has been endorsed and is currently being used by several professional organizations as the basis for developing certification requirements for addiction counselors.

In addition, CSAT has been working for 3 years on a national workforce plan to guide SAMHSA in providing leadership on workforce issues in the substance abuse field. The internal guidance document draws on input from a series of focus groups with representatives from training programs, accrediting bodies, managed care plans, and others as well as currently available research and data from addiction workforce surveys conducted by CSAT's Addiction Technology Transfer Centers Network and others.

Currently, SAMHSA is taking action to increase the number of behavioral health care providers and improve their training.

The Annapolis Coalition is also helping SAMHSA put together a national strategic plan for behavioral health workforce development. In May 2004, the coalition came together at a CMHS-funded conference to promote the use of core competencies as a foundation for training and education in behavioral health.

While SAMHSA staff members expect to craft a coordinated response to the workforce crisis, there are significant differences between the substance abuse and mental health service provider workforces. For example, the mental health field tends to emphasize providers with graduate-level training, whereas the substance abuse field embraces the use of peers who draw on their own experience of addiction and recovery to help others in addition to graduate-level professionals.

"SAMHSA is adamant about respecting the separate identities of the two fields, but we need to learn from each other and share resources," Ms. Hutchings said. "Especially given the number of people with co-occurring disorders, it's imperative that we put out a strategy that integrates both fields."

CSAT Division of Services Improvement Director Mady Chalk, Ph.D., further noted the importance of integrating behavioral health services with primary care medicine. "Much of what we do in the substance abuse treatment field depends on having health care providers with adequate education in addiction in primary care settings, clinics, and emergency rooms," she said.

In September 2004, several members of the Annapolis Coalition and nationally recognized substance abuse provider associates testified on their recommendations before the IOM. The Institute is producing a companion piece to its *Crossing the Quality Chasm* report that will focus specifically on mental health and substance abuse disorders. SAMHSA is helping to fund this IOM project.

The expert panel suggested that the IOM identify "levers of change" that could spur workforce development, such as regulation, accreditation processes, or financing. The panel also recommended the launch of a major recruitment and retention initiative that would involve such strategies as increased recruitment of culturally and linguistically diverse individuals, greater use of student loan repayment programs, and the enhancement of salary-and-benefit packages. Another suggestion outlines steps for building a more consumer- and family-centered workforce in the mental health field, recognizing the tradition of peer support that has characterized the substance abuse field.

For SAMHSA resources on workforce development, see the accompanying box on page 6.

—By Rebecca A. Clay

SAMHSA Heads Drug-Free Communities Program

SAMHSA is expanding its leadership role in substance abuse prevention by assuming responsibility for management of the Drug-Free Communities (DFC) program. A broad initiative, the program currently funds more than 600 community coalitions and 200 mentoring programs across the country.

On October 1, the Office of National Drug Control Policy (ONDCP) transferred the grant administration of the program from the Department of Justice Office of Juvenile Justice and Delinquency Prevention to the U.S. Department of Health and Human Services—specifically, SAMHSA's Center for Substance Abuse Prevention (CSAP).

"For SAMHSA, this program will become an integral part of our prevention work," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "The Agency's commitment and dedication to grassroots efforts in communities nationwide will serve this program well."

The Drug-Free Communities program provides grants of up to $100,000 to community coalitions that mobilize their communities to prevent or reduce alcohol, tobacco, illicit drug, and inhalant abuse by youth.

The grants support local coalitions that comprise diverse populations—youth, parents, the media, law enforcement, school officials, faith-based and fraternal organizations, health care professionals, and state, local, and tribal government agencies, as well as other community representatives.

"Giving community coalitions the resources and tools they need to strengthen their coordination and prevention efforts is critical," said CSAP Director Beverly Watts Davis. "The Drug-Free Communities program encourages people of all ages to join in reducing substance abuse in their communities," she added. Information about current effective programs is also provided to community leaders.

Moving the DFC program to SAMHSA follows recommendations made by the Advisory Commission for Drug-Free Communities. ONDCP solicited proposals from multiple Federal agencies to administer the Drug-Free Communities program grants. After careful review, ONDCP officials asked SAMHSA to assume control of the program.

On SAMHSA's new role, ONDCP Director John Walters said, "I am confident this leadership change will allow our anti-drug coalitions to become even more successful in preventing drug use."

On September 27, the same day Mr. Walters announced that SAMHSA would assume control of the DFC grants program, he awarded $21.9 million in new Drug-Free Communities matching grants to 227 communities in 46 states. An additional $41 million will support the continuation of grant awards to 487 existing community coalition projects operating in all 50 states, the District of Columbia, and the U.S. Virgin Islands.

Upcoming Drug-Free Communities grants will be announced by SAMHSA.

The DFC program was created under the Drug-Free Communities Act of 1997. In December 2001, Congress passed and the President signed into law a 5-year extension of the Drug-Free Communities Act, authorizing $399 million in funds through Fiscal Year 2007.

For more information, visit SAMHSA's Web site at **www.drugfreecommunities.samhsa.gov** or e-mail dfc@samhsa.hhs.gov.

—By Jon Bowen

Buprenorphine Update:

Mentoring Program Supports Physicians Treating Opioid Addiction

SAMHSA and the American Society of Addiction Medicine (ASAM) are joining forces through a cooperative agreement to develop a mentoring program for physicians treating opioid dependence with the medication buprenorphine.

Funded by a 3-year cooperative agreement grant from SAMHSA, ASAM—a specialty organization of addiction medicine physicians—will create a clinical support system for internists, family medicine specialists, primary care physicians, pain specialists, psychiatrists, and other physicians. The system will provide a national network of 50 trained physician mentors with expertise in treating dependence on opioids—such as narcotic pain medications and heroin—with buprenorphine.

"The Agency's goal is to have 6,000 trained and approved physicians treating patients by the end of 2006," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. Currently, 3,558 physicians are certified to prescribe or dispense the medication; nearly 350 more physicians have applied, and their notification is under review at SAMHSA or pending approval.

"The more doctors we have trained to administer the medication buprenorphine in their offices, the better off we are," said H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment (CSAT). "According to the 2003 National Survey on Drug Use and Health, non-medical use of prescription painkillers is on the rise, especially among older adults, so there's a real need for office-based treatment services for opioid abuse. There's no stigma attached to going to the doctor for help."

DATA and Doctors

Approved by the Food and Drug Administration (FDA) in 2002 and made available to pharmacies in 2003, buprenorphine is a medication that allows patients addicted to opioids to seek treatment in the privacy of their own doctor's office (see *SAMHSA News,* March/April 2004).

"Our goal is to train as many physicians as possible in the United States who are able to treat substance abuse disorders in the many individuals who are dependent on heroin and prescription pain medications containing opiates such as oxycodone and meperidine," said project officer Anton Bizzell, M.D., a medical officer with SAMHSA's CSAT.

Besides ASAM, mentors in the national network will include representatives from four other medical specialty training organizations—the American Academy of Addiction Psychiatry, the American Psychiatric Association, the American Osteopathic Association, and the American Medical Association. These entities are permitted by law to provide training to physicians on the use of buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA). This law allows experts from these organizations—which are referred to as DATA groups—to provide the required 8 hours of training to physicians to become certified to prescribe or dispense formulations of buprenorphine.

Some early evaluation work by SAMHSA staff emphasized the need to encourage more primary care doctors to provide buprenorphine treatment. This was one of the Agency's motivations to offer this grant. "We've seen some reports suggesting that physicians were slow to adopt this practice, so we thought that one of the approaches that might help was to bring together addiction treatment experts with the physicians who are less experienced in order to bridge that gap," said Robert Lubran, M.S., M.P.A., Director of CSAT's Division of Pharmacologic Therapies.

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Early buprenorphine evaluations revealed approximately 35 percent of individuals receiving buprenorphine treatment were first-time patients to substance abuse treatment. These patients have never tried any type of substance abuse treatment such as self-help groups or other forms of medication-assisted treatment for their addiction. "Nearly 55 percent of patients in the survey were new to medication-assisted treatment, which shows that buprenorphine is opening doors in substance abuse treatment," said Dr. Bizzell.

"The survey showed that 13 percent of the patients had been treated previously with methadone prior to buprenorphine treatment, so we're not disrupting an existing treatment model," said Mr. Lubran. "People aren't leaving in droves to go from methadone to buprenorphine. What we're finding is that these people are new—never in treatment before. That's a very good sign."

Hands-On Support

Under DATA's provisions, SAMHSA has assisted in the training of more than 5,000 physicians in the use of buprenorphine. While the 8-hour training is comprehensive and provides the appropriate amount of information needed to provide quality care, there are physicians—even addiction specialists—who feel more confident having a local colleague with expertise in the care of opioid-dependent patients and the use of this medication, according to David A. Fiellin, M.D., an associate professor of medicine at the Yale University School of Medicine and Chair of the ASAM Buprenorphine Training Subcommittee.

To provide this support through the ASAM/SAMHSA partnership, mentors will not only serve as national experts on buprenorphine treatment, but will also be accessible one-on-one at the local level for physicians who need additional help once their training is complete. For instance, during a training session, the DATA groups may make available the contact information for these mentors so the physicians can call on them for "hands-on" support, Mr. Lubran explained.

"Physicians who are beginning to provide this treatment indicate that they would like to receive either telephone or e-mail contacts. In some cases, they are invited to observe another physician's practice," said Dr. Fiellin. "There, they can see the medication, meet the patients, and observe some of the procedures that relate to induction and initiation of treatment for opioid-dependent patients."

For more information on buprenorphine or to access the Physician Locator, visit **http://buprenorphine.samhsa.gov.**

—By Julie McDowell

Rapid HIV Testing Initiative
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for clients who need counseling, treatment, and support services; copies of rapid HIV testing policies and procedures; and data collection capabilities.

Currently, SAMHSA is collaborating with CDC to finalize the Initiative's data collection activities. Sites are required to collect and report on client- and site-level data, and other data specific to the use of the OraQuick® ADVANCE test.

The Initiative has two phases. The first phase will include SAMHSA's current Substance Abuse Prevention, Treatment, and Mental Health Minority AIDS Initiative grantees, SAMHSA's Opioid Treatment pilot sites, and grantees from states and territories with Substance Abuse Prevention and Treatment Block Grants that include HIV set-asides.

The second phase is open to service providers from other programs funded by SAMHSA discretionary and Block Grants, and other Federal agencies that fund HIV/AIDS-related services. Physicians who are providing buprenorphine treatment for opioid addiction are also eligible to participate during phase 2 (see *SAMHSA News,* March/April 2004).

Training

SAMHSA has been working extensively with CDC on training activities for this Initiative.

In July, SAMHSA identified 22 trainers instructed by CDC on the fundamentals of rapid HIV testing. In September, these trainers trained more than 40 service providers from SAMHSA's regulated opioid treatment centers and more than 90 grantees from SAMHSA's Minority AIDS Initiative.

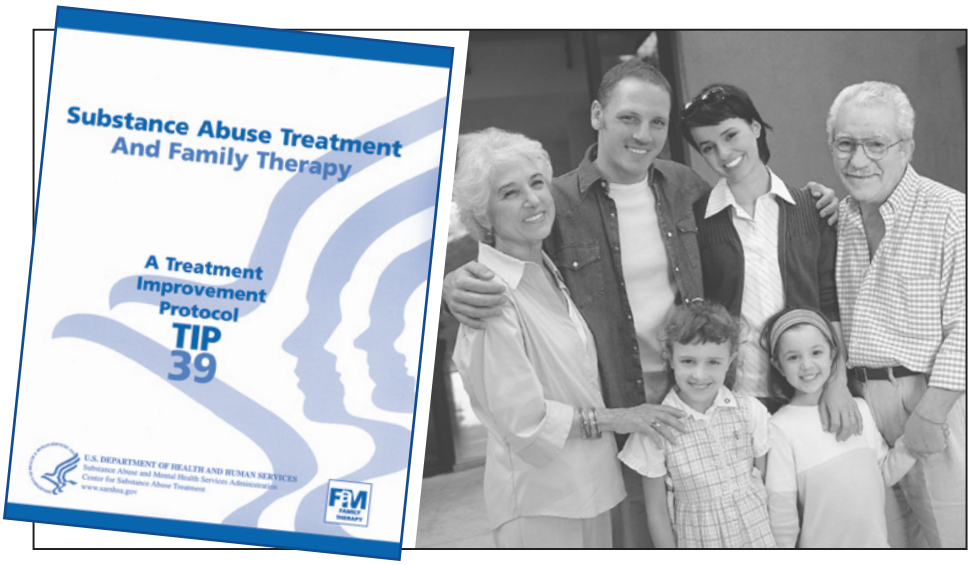
For more information about SAMHSA's Rapid HIV Testing Initiative, contact 1 (877) 219-6953 or e-mail rhti@samhsa.hhs.gov. For a fact sheet on SAMHSA's Rapid HIV Testing Initiative, visit **www.samhsa.gov/Matrix/matrix_HIV.aspx**.

—By Melissa Capers

Integrating Substance Abuse Treatment and Family Therapy

A new practical guide from SAMHSA offers advice on how substance abuse treatment counselors and family therapists can understand and incorporate each other's methods and theories.

Substance Abuse Treatment and Family Therapy, SAMHSA's Treatment Improvement Protocol 39 (TIP 39), addresses how substance abuse affects the entire family and how treatment providers can use family therapy principles to improve communications and interactions among family members. The TIP series is produced by SAMHSA's Center for Substance Abuse Treatment.



Although family therapy has a solid history within the mental health field, substance abuse treatment developed in isolation. Prior to the 1970s, many alcoholism counselors rejected the widely held view among mental health experts that alcohol abuse was a symptom of some underlying disorder rather than a primary disorder of its own account. Over the years, however, practitioners in both fields have developed an understanding of the synergy between the services provided by substance abuse treatment providers and family therapists.

TIP 39 presents models, techniques, and principles of family therapy, along with special attention to stages of motivation and to treatment and recovery. Discussion also focuses on clinical decision-making and training, supervision, cultural considerations, specific populations, funding, and science-based research. This TIP also identifies future directions for both research and clinical practice.

Six chapters are included in the publication. **Chapter 1, Substance Abuse Treatment and Family Therapy,** introduces the changing definition of "family," explores the evolution of the field of family therapy and the primary models of family therapy, presents concepts from the substance abuse treatment field, and discusses the effectiveness and cost benefits of family therapy.

Chapter 2, Impact of Substance Abuse on Families, describes social issues that coexist with substance abuse in families and offers recommendations for ways to address these issues.

Chapter 3, Approaches to Therapy, examines differences in family therapy and substance abuse treatment services. One section, directed at substance abuse treatment counselors, provides basic information about the models, approaches, and concepts in family therapy. Another section, for family therapists, provides basic information about theory, treatment modalities, and the role of 12-step programs in substance abuse treatment.

Chapter 4, Integrated Models for Treating Family Members, discusses conjoined treatment approaches as well as matching therapeutic techniques to recovery levels.

Chapter 5, Specific Populations, provides background information about substance abuse treatment for various populations, based on characteristics such as age, gender, race and ethnicity, sexual orientation, and the presence of physical or cognitive disabilities or co-occurring disorders. This chapter also describes applications to family therapy for each population.

Chapter 6, Policy and Program Issues, presents information for administrators and trainers about the importance of improving services to families and some policy implications to consider for effectively joining family therapy and substance abuse treatment. In addition, this final chapter discusses program planning models that provide a framework for including family therapy in substance abuse treatment.

Appendices to TIP 39 include resources, guidelines for assessing violence, a bibliography, a glossary, and lists of panelists and field reviewers involved in producing the TIP.

For a copy of TIP 39, *Substance Abuse Treatment and Family Therapy,* 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). For an electronic version of this TIP, visit SAMHSA's Web site at **www.samhsa.gov.**

2003 Survey: Marijuana Use Drops Among Youth, Risk Perceptions Climb

Marijuana use among American youth age 12 to 17 is on the decline, while perception of risk associated with this drug has increased, according to findings from SAMHSA's 2003 National Survey on Drug Use and Health (NSDUH). These and other survey findings, presented at the launch of the Agency's 15th annual Recovery Month activities, were released in early September.

"While most of the findings from the 2003 National Survey are moving in the right direction, they show how much work still remains to be done to stop drug use before it starts and to heal America's drug users," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

The survey shows that while there was not a statistically significant change in overall current illicit drug use or in current use of any specific drugs, there were important shifts in some measures for youth. For example, in addition to a decline in lifetime marijuana use among youth age 12 to 17, from 20.6 percent in 2002 to 19.6 percent in 2003, past-year use of ecstasy dropped by 41 percent and past-year use of LSD dropped by 54 percent.

Overall, 19.5 million Americans age 12 and older—8 percent of this population—currently use illicit drugs.

Workplace Statistics

The 2003 survey findings show that more than three-quarters of adults who have a serious substance abuse problem are employed, which challenges the stereotype that the typical drug user is poor and unemployed. More specifically, of the 19 million adults age 18 and older characterized with a serious alcohol or drug problem in 2003, 77 percent—or 14.9 million people—were employed either part time or full time.

"Amazingly, 90 percent of these workers didn't recognize they had a problem," Mr. Curie said. "Employers who think alcohol and drug abuse will never be a problem in their workplace need to consider the facts. With these new data, it is clear why the workplace is a focus of our efforts."

Marijuana

According to data from the 2003 survey, marijuana continues to be the most commonly used illicit drug, with 14.6 million current users, which represents 6.2 percent of the population—the same as in 2002. The survey also shows an estimated 2.6 million people who tried marijuana for the first time in 2002—two-thirds of these new users were under age 18. About half were female.

Both youth and young adults reported a significant increase in their awareness of the risks of smoking marijuana. Consistent with this shift, there was a 20-percent decline between 2002 and 2003 in the number of youth who were "heavy users" of marijuana (those smoking either daily or 20 or more days per month).

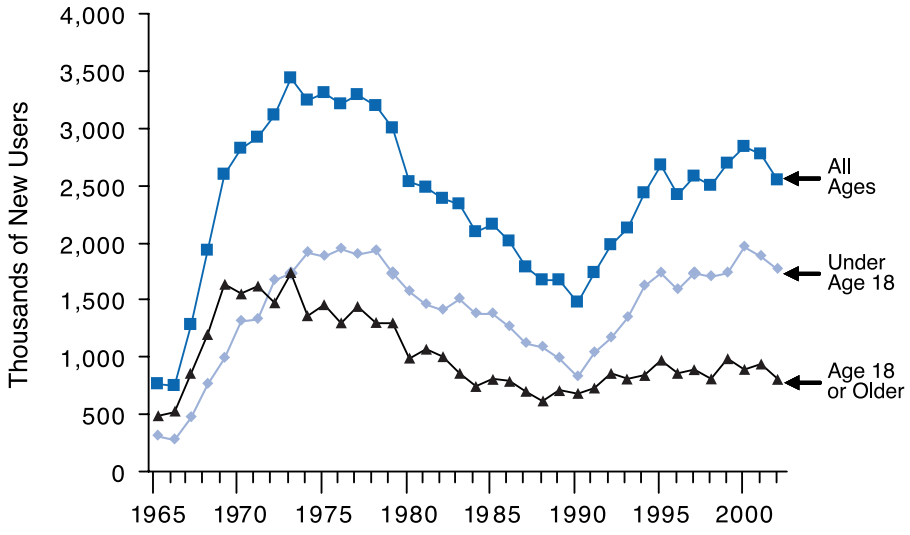
Despite an increase in perceptions of great risk of once-a-month marijuana use among youth age 12 to 17, there was no significant change from 2002 to 2003 in past-month use among youth (8.2 percent to 7.9 percent).

Perceived availability of marijuana also declined significantly among youth.

Youth who believed that their parents would "strongly disapprove" of marijuana reported rates of use 80 percent lower than those who reported that their parents would not "strongly disapprove" (5.4 percent vs. 28.7 percent).

"Young people are getting the message that marijuana, which is substantially more potent today than it was 20 years ago, is a dangerous drug, and they are staying away from it," said John Walters, Director of the White House Office of National Drug Control Policy, a featured speaker at the Recovery Month launch.

Annual Numbers of New Users of Marijuana: 1965-2002



Source: Office of Applied Studies, *Overview of Findings From the 2003 National Survey on Drug Use and Health,* page 19.

Alcohol

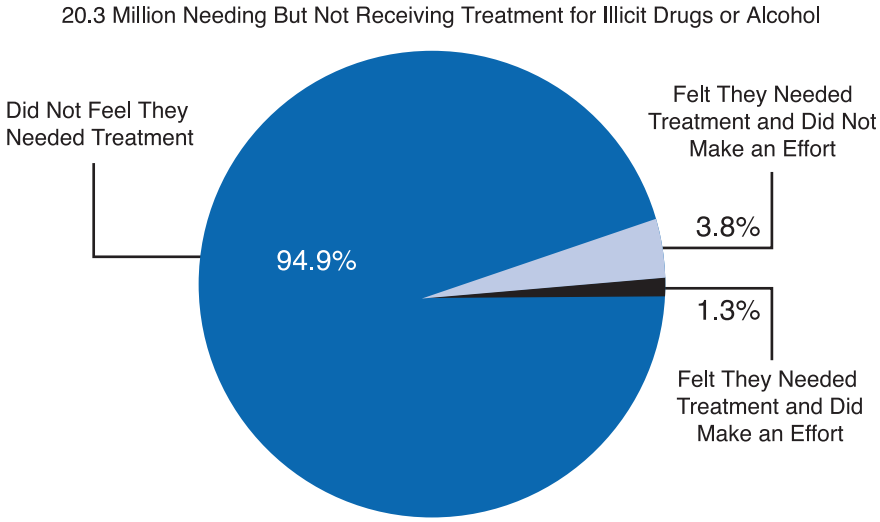
The numbers of binge drinkers and heavy drinkers did not change between 2002 and 2003. About 54 million Americans age 12 and older participated in binge drinking at least once in the 30 days prior to being surveyed. The highest prevalence of binge and heavy drinking in 2003 was reported among young adults age 18 to 25, with both binge and heavy drinking at their peak at age 21.

Underage drinking remains a "stubborn and destructive problem," said Mr. Curie.

There were 10.9 million drinkers under legal age (age 12 to 20) in the month prior to the survey interview in 2003. This number represents 29 percent of this age group. Of these, nearly 7.2 million (19.2 percent) were binge drinkers and 2.3 million (6.1 percent) were heavy drinkers.

In terms of alcohol initiation rates, reports from 2001 (the most recent year for which estimates are available) indicate that 5.3 million Americans used alcohol for the first time. "Most of these new alcohol users—88 percent—were under the legal drinking age of 21," Mr. Curie said.

Past-Year Perceived Need and Effort Made To Receive Specialty Treatment among Persons Age 12 or Older Needing But Not Receiving Treatment for Illicit Drugs or Alcohol: 2003



Source: Office of Applied Studies, *Overview of Findings From the 2003 National Survey on Drug Use and Health,* page 26.

Photo by Martin Castillo

SAMHSA Administrator Charles G. Curie introduced the* 2003 National Survey on Drug Use and Health *at the launch of the Agency's 15th annual Recovery Month activities at the National Press Club in September. Seated are H. Westley Clark, M.D., J.D., M.P.H., Director of SAMHSA's Center for Substance Abuse Treatment, and Deni Carise, Ph.D., Director of Treatment Systems, Treatment Research Institute, and Clinical Professor, University of Pennsylvania.

Prescription Drugs

The 2003 NSDUH results also reported on non-medical use of prescription pain relievers. Overall, current non-medical use of prescription pain relievers remained stable from 2002 to 2003; however, a 5-percent increase in lifetime use was reported for the population age 12 and older, with young adults (age 18 to 25) experiencing a 15-percent increase in lifetime use as well as current use.

This 2003 NSDUH report is based on interviews with 67,784 respondents age 12 and older surveyed in home settings, which includes people residing in dormitories or homeless shelters. Not included in the survey are persons on active military duty and in prisons.

For a copy of the survey, contact SAMHSA's National Clearinghouse for Alcohol and Drug Information at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD). Online, the publication is available at **www.oas.samhsa.gov.**

SAMHSA Announces Grant Awards

For Fiscal Year 2004, SAMHSA awarded grants totaling $300 million over 3 years as part of an innovative new initiative, Access to Recovery, announced by President George W. Bush in August to provide people seeking drug and alcohol treatment with vouchers for needed services (see *SAMHSA News,* September/October 2004, page 18). SAMHSA also awarded its first Strategic Prevention Framework State Incentive grants to 21 states for a total $230 million over 5 years (see *SAMHSA News,* page 4).

Other grant awards continue to reflect the Agency's commitment to build resilience and facilitate recovery for people with or at risk for substance abuse and mental illness. With these grants, SAMHSA assists a wide range of populations from homeless persons to pregnant and postpartum women and their children. The Agency also awarded grants to fund peer-to-peer recovery support services, prevention services to fight the spread of ecstasy and other club drugs, and fellowships to minorities to encourage workforce development in the field.

Selected grant awards include:

- **Ecstasy and Other Club Drugs Prevention Services. $23 million.** 17 cooperative agreement grant awards over 5 years to fight the spread of ecstasy and other club drugs through culturally appropriate prevention services at the state and local level. The funds, awarded to programs in 11 states and the Jamul Indian Village in California, foster development of prevention projects through schools, local health departments, and community-based organizations. This year's grant award totals $4.9 million. [SP 04-004]
- **State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders. $19.3 million.** 4 grant awards over 5 years to Arizona, New Mexico, Oklahoma, and Virginia 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 disorders. This year's grant award totals $3.8 million. [SM 04-012]
- **Young Offender Reentry Program. $23.3 million.** 12 grant awards over 4 years to expand and enhance substance abuse treatment and reentry services for juveniles and young adult offenders returning to the community from the correctional system, including prisons, jails, or juvenile detention centers. This year's grant award totals $6 million. [TI 04-002]
- **Peer-to-Peer Recovery Support Program. $11.2 million.** 8 grant awards over 4 years to deliver and evaluate peer-to-peer recovery support services to help prevent relapse and promote sustained recovery from alcohol and drug use. The program helps people seeking to recover from an alcohol or drug problem along with their family members and significant others who will be both the providers and recipients of recovery support services. Services will be developed and delivered under SAMHSA's Recovery Community Services Program. This year's grant award totals $2.8 million. [TI 04-008]

First Funding Opportunities for Fiscal Year 2005 Announced

SAMHSA recently released two Notices of Funding Availability (NOFAs).

- **$7.1 Million Available for State Adolescent Substance Abuse Treatment Coordination:** To help states build capacity to provide effective, accessible, and affordable substance abuse treatment for adolescents. These grants will fund a new staff position in state government with sole responsibility to ensure effective adolescent substance abuse treatment. In addition, funding will support a process to access, facilitate, and coordinate planning for adolescent substance abuse treatment statewide. **Application Due Date:** January 12, 2005. [TI 05-006]
- **$16 Million for Targeted Capacity Expansion Grants:** To improve a community's ability to provide a comprehensive response to a well-documented substance abuse treatment capacity problem or to improve the quality and intensity of services in a local area. Funding will be available across three target areas including treatment for American Indians and Alaska Natives or Asian Americans/Pacific Islanders, treatment related to methamphetamine and other emerging drug use use among rural populations, and college campus screening to combat underage drinking. **Application Due Date:** January 12, 2005. [TI-05-003]

Notices of Funding Availability are updated on a regular basis on the SAMHSA Web site at www.samhsa.gov/grants. Please visit the site often for the latest information. For an application, call the National Clearinghouse for Alcohol and Drug Information at 1 (800) 729-6686.

• **State Incentive Grants To Build Capacity for Alternatives to Seclusion and Restraint. $5.3 million.** 8 grant awards over 3 years to support state efforts to adopt best practices to reduce and eliminate the use of restraint and seclusion in institutional and community-based settings that provide mental health services. People receiving services include those with co-occurring substance use and mental disorders. Grantees: Hawaii, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Missouri, and Washington. This year's grant award totals $1.9 million. [SM 04-007]

• **Child and Adolescent Mental Health and Substance Abuse State Infrastructure Development. $26 million.** 7 grant awards over 5 years to expand and strengthen the capacity of states, territories, and American Indian tribal governments to support coordinated treatment services for children, adolescents, and youth in transition with serious emotional disturbances, substance abuse disorders, or co-occurring disorders, and their families. This year's grant award totals $5.1 million. [SM 04-006]

• **Drug/Alcohol/Mental Health Treatment Services for Homeless Persons. $67.6 million.** 34 grant awards over 5 years to expand and strengthen treatment services for homeless individuals with substance use disorders, mental illness, or co-occurring disorders. This year's grant award totals $13.5 million. [TI 04-001]

• **Targeted Capacity Expansion Grants. $35 million.** 24 grant awards over 3 years to expand or enhance the ability of states, local governments, and tribal organizations to provide comprehensive, integrated, and community-based substance abuse treatment services in communities facing serious, emerging substance abuse problems. Funds are awarded in four categories: minority populations, rural areas, methamphetamine treatment, and innovative approaches to treatment capacity expansion. This year's grant award totals $12 million. [TI 04-003]

• **Statewide Consumer Network Grants. $3.9 million.** 19 grant awards over 3 years to facilitate involvement of consumers of mental health services in the development of mental health programs. The focus is on adults with serious mental illness. This year's grant award totals $1.3 million. [SM04-003]

Statewide Family Network Grants. $8.5 million. 43 grant awards over 3 years to facilitate involvement of families in mental health policies and programs affecting their children. The focus is on families of children and adolescents with serious emotional disturbances. This year's grant award totals $2.8 million. [SM04-004]

• **Networking and Certifying Suicide Prevention Hotlines. $6.6 million.** 1 grant award over 3 years to the Mental Health Association of New York to manage a toll-free national suicide prevention hotline network of local crisis centers linking callers to local emergency, mental health, and social services resources. The funds also will be used to increase the number of crisis centers certified in suicide prevention services. This year's grant award totals $2.2 million. [SM 04-013]

• **Youth Transition into the Workplace. $4 million.** 13 grant awards over 2 years to provide substance abuse prevention programs for youth age 16 to 24 who are transitioning into the workplace. Recipients will document and evaluate innovative practices that address critical substance abuse and mental health service gaps not yet evaluated formally. This year's grant award totals $2.2 million. [SP 04-006]

• **Residential Substance Abuse Treatment for Pregnant and Postpartum Women and Their Children. $21 million.** 14 grant awards over 3 years in 9 states to provide or expand the availability of comprehensive, high-quality, residential substance abuse treatment services to low-income pregnant and postpartum women, as well as other mothers with minor children. Services also will be provided to children suffering from the effects of maternal alcohol and drug use while their mothers receive care. This year's grant award totals $7 million. [TI 04-004]

• **Minority Fellowship Program. $3 million.** 4 grant awards to facilitate entry of minority students into careers in mental health and substance abuse services. Grantees are the American Nurses Association, American Psychological Association, American Psychiatric Association, and the Council on Social Work Education. [SM 04-001]

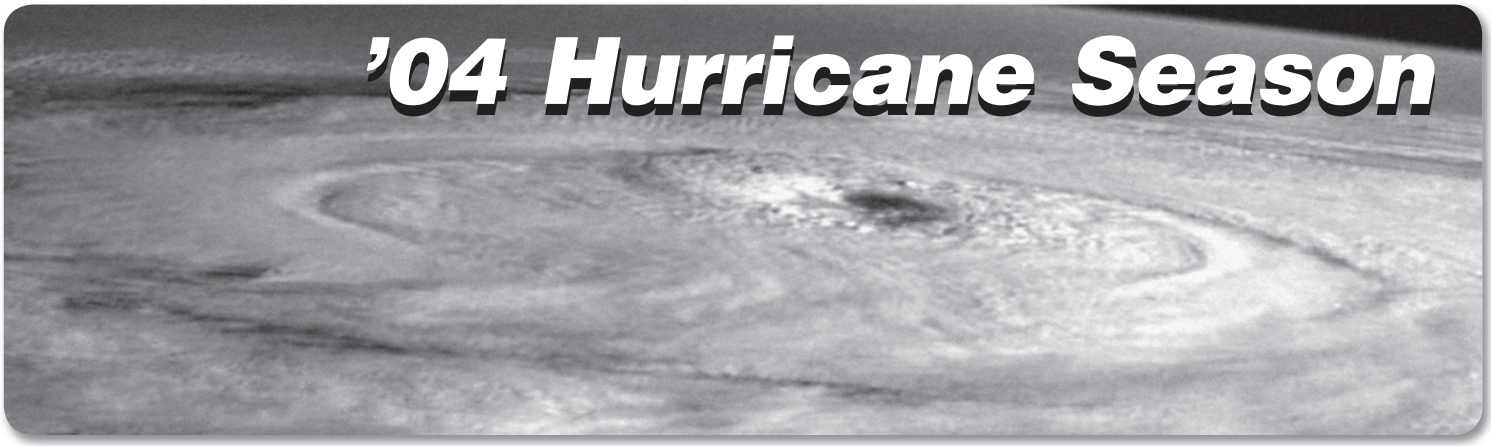
• **National Technical Assistance Centers on Consumer/Peer-Run Programs. $1.9 million.** 5 grant awards to fund 5 National Technical Assistance Centers to assist in the transformation of the mental health system by providing consumers with the necessary skills to foster self-determination and recovery, and help people with severe mental illness decrease their dependence on expensive social services and avoid psychiatric hospitalization. [SM 04-011]

• **Intervention and Evaluation Centers for the Child Traumatic Stress Initiative. $3 million.** 5 cooperative agreement grant awards to refine specialized treatment approaches to child traumatic stress, tailor practice manuals for new service settings, and update procedures to disseminate related products. [SM 04-009]

• **Community Treatment and Services Centers of the National Child Traumatic Stress Initiative. $4.7 million.** 12 cooperative agreement grant awards to improve treatment and services for children and adolescents who have experienced traumatic events and to increase access to effective trauma treatment and services. [SM 04-010]

For ongoing updates on SAMHSA grant awards or funding opportunities, visit the SAMHSA Web site at **www.samhsa.gov/grants.**

Helping State Agencies Weather '04 Hurricane Season



As a relentless track of hurricanes pounded the Nation's Gulf Coast and triggered tornados and flooding throughout the Southeast region in August and September, SAMHSA mobilized its Emergency Services Team to ensure that substance abuse and mental health agencies would have the resources they needed to weather these storms and sustain public services.

"There's the initial impact, and then there's the longer process of recovery," said Seth Hassett, M.S.W., Chief of the Emergency Mental Health and Traumatic Stress Services Branch at SAMHSA's Center for Mental Health Services (CMHS). "Right from the start, we know that this is going be a several-month effort."

State agencies and local service providers have access to technical assistance, publications, funding opportunities, and sample emergency plans through the SAMHSA Web site. The site provides ongoing alerts regarding disaster readiness and response. Services available in the aftermath of the season's four major hurricanes—Charley, Frances, Ivan, and Jeanne—are posted on the site.

Port Charlotte, FL, after Hurricane Charley. In response to the growing need for aid in Florida, SAMHSA is awarding an additional $11 million to help those in need of substance abuse and mental health clinic services, interventions, and treatment.

In response to the growing need for aid in Florida, SAMHSA is awarding an additional $11 million to help those in need of substance abuse and mental health clinic services, interventions, and treatment. SAMHSA joins the Administration on Aging, the Administration for Children and Families, and the Health Resources and Services Administration in this effort.

SAMHSA's Team in Action

Just before Hurricane Ivan roared ashore in mid-September, teams of SAMHSA personnel prepared for the storm's landfall. Officials from all three SAMHSA Centers reached out to grantees across the Gulf Coast to solidify a broad network of support.

"A hurricane is a disaster that crosses a lot of geographical boundaries," said Mr. Hassett. "Our goal is to help get the communities back on the path to recovery."

Officers from the SAMHSA Disaster Technical Assistance Center (SAMHSA DTAC) called all state mental health and substance abuse disaster coordinators in the storm's path to offer assistance. Through SAMHSA DTAC, state officials and local service providers were able to request help with grant applications, emergency plans, and other procedures.

"They [SAMHSA DTAC] went to extended hours to be more available," said SAMHSA Emergency Management Coordinator Dan

Dodgen, Ph.D. "They pulled together vital information and provided consultation."

With Ivan looming, the Center for Substance Abuse Prevention's Division of Workplace Programs used a special software program to produce a list of SAMHSA grantees situated in the path of the storm. Using this information, SAMHSA staff members were able to contact grantees, help them prepare, gauge the damage sustained during the storms, and offer assistance.

At the same time, SAMHSA developed a list of deployable civilian personnel for responding to the hurricanes. Simultaneously, through the Commissioned Corps Readiness Force of the U.S. Public Health Service, SAMHSA staffers arrived in various locations to help, including CAPT Carol Rest-Minchberg, CAPT Peter Delany, LCDR Wanda Finch, LCDR David Morrissette, and LT Christine Guthrie.

While the Gulf Coast bore the brunt of the storms, states in the Southeast and Mid-Atlantic regions suffered through hurricane-related tornados and flooding. SAMHSA worked with officials in Alabama, Florida, Georgia, Louisiana, Mississippi, New Jersey, North Carolina, Ohio, Pennsylvania, West Virginia, and Puerto Rico to offer support and assist with counseling.

David Morrissette, D.S.W., of the SAMHSA Community Support Program at the Center for Mental Health Services was deployed to Florida after Hurricane Charley as part of the Commissioned Corps Readiness Force.

U.S. Public Health Service officers sent to Port Charlotte and Punta Gorda, FL, after Hurricane Charley included members of the Mental Health Team: (left to right) Front row: CDR Paul Andreason, LCDR Mike Murray, Judy Farrar, Iris Crane, and LT Doug Mowell. Back row: LT Mike Tillus and LCDR Dave Morrissette. Ms. Farrar and Ms. Crane served as Mental Health Coordinators.

"When we have a large multi-state disaster, we need to have the capacity to work with several states at one time," said Mr. Hassett.

In Florida, SAMHSA is working with the U.S. Department of Homeland Security and the Federal Emergency Management Agency (FEMA) on Project Hope, a crisis counseling and training assistance program grant designed to help Florida agencies recover and rebuild. Project Hope, operated through the Florida Department of Children and Families, offers a toll-free information and referral hotline.

"We've been doing a whole variety of things to strengthen state planning," said Mr. Hassett. "We've had a particular emphasis on joint planning to foster our all-hazards work."

For most of the mental health and substance abuse agencies and local service providers in Florida and other states affected during this hurricane season, responding to disasters is not their usual line of business. And yet, when a hurricane or some other disaster suddenly strikes, these agencies need immediate resources to help them sustain services.

"Their usual job isn't disaster response," said Dr. Dodgen, "but now here they are in a disaster. So what do they do?"

SAMHSA offers help through personnel, the Agency's Web site, the SAMHSA DTAC, and collaborative programs like Project Hope.

"It's been an incredible challenge," said Mr. Hassett, "but it's also a chance for us to learn and refine our system. We'll learn more as we go along to improve our efforts."

The SAMHSA Web site continues to post alerts of the Agency's activities before, during, and after disasters, and to provide links to important Federal information at FEMA.

For more information about SAMHSA's disaster readiness & response, visit the SAMHSA Web site at **www.samhsa.gov.**

—By Jon Bowen

SAMHSA's Disaster Technical Assistance Center

For more information about SAMHSA DTAC, visit SAMHSA's Web site at **www.mentalhealth.samhsa.gov/dtac** or call 1 (800) 308-3515.

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:

- ❑ SAMHSA Launches Rapid HIV Testing Initiative
- ❑ From the Administrator: HIV/AIDS: A New Effort Offers Hope
- ❑ 21 States, 2 Territories Awarded Strategic Prevention Framework Grants
- ❑ The Workforce Crisis: SAMHSA's Response
- ❑ Policy Academy Strives To Improve Services for Older Adults (online version only)
- ❑ SAMHSA Heads Drug-Free Communities Program
- ❑ Buprenorphine Update: Mentoring Program Supports Physicians Treating Opioid Addiction
- ❑ Integrating Substance Abuse Treatment and Family Therapy
- ❑ 2003 Survey: Marijuana Use Drops Among Youth, Risk Perceptions Climb
- ❑ SAMHSA Announces Grant Awards
- ❑ Helping State Agencies Weather '04 Hurricane Season
- ❑ In Brief . . .
- ❑ *SAMHSA News* Index 2004—Volume 12
- ❑ ***SAMHSA News*** online at **www.samhsa.gov/SAMHSA_News**

Other comments: _____

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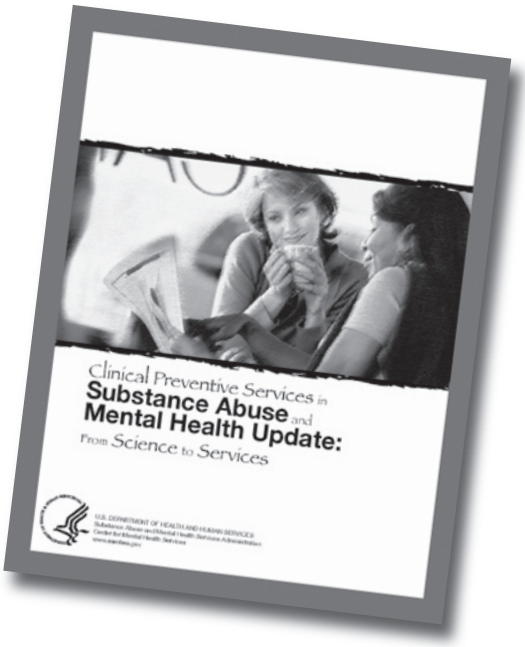
E-mail: *deborah.goodman@samhsa.hhs.gov*

Thank you for your comments!

Preventive Services Publication Released

SAMHSA's Center for Mental Health Services recently published *Clinical Preventive Services in Substance Abuse and Mental Health Update: From Science to Services.* The 178-page resource summarizes the most promising preventive interventions in the behavioral health field. This review focuses on interventions that are primarily delivered by health care systems; therefore, interventions provided in schools, worksites, communities, and criminal justice systems were excluded from this resource.

The publication includes 16 chapters. The introduction contains information on models of preventive services, the differences between clinical and community services, and the health care delivery system



provision of preventive behavioral services. Other chapters provide information on preventive services for pregnant women, including high-risk pregnant women, and information on screening children and adolescents (age 5 to 18) for evidence of a behavioral disorder. The publication also discusses tobacco, alcohol, illicit drug use, and depression.

This publication can be ordered through SAMHSA's National Mental Health Information Center at P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Online, the publication can be accessed at **http://www.mentalhealth.samhsa.gov/publications/allpubs/sma04-3906.**

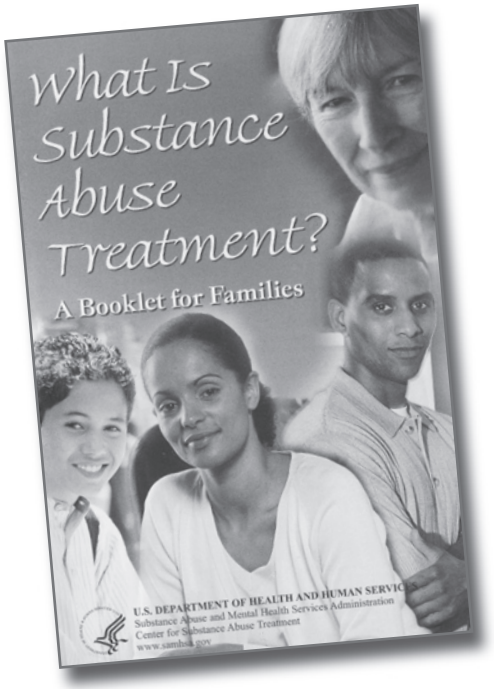
Corrections & Clarifications

The photo of Dr. Alan Pincus on page 14 of the September/October issue of *SAMHSA News,* Volume 12, Number 5, is incorrect. A new photo of Dr. Pincus is posted online on the SAMHSA Web site at **http://alt.samhsa.gov/samhsa_news/VolumeXII_5/article4_6.htm.**

Booklet Explains Treatment to Families

SAMHSA's Center for Substance Abuse Treatment recently published *What Is Substance Abuse Treatment? A Booklet for Families.* This 31-page resource answers questions often asked by families of people entering treatment. The booklet includes chapters on substance abuse treatment and information for young people. The "Resources" section at the back of the booklet lists a selection of sources for more information, including support group information.

This publication can be ordered through 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).



SAMHSA News *Index 2004 – Volume 12*

This index includes entries for all six issues of *SAMHSA News* for 2004. Each issue is numbered: January/February (1), March/April (2), May/June (3), July/August (4), September/October (5), and November/December (6). Specific pages follow. Entries in **boldface type** are SAMHSA's Matrix of Priority Programs described in detail on SAMHSA's homepage at **www.samhsa.gov.** Entries in *italics* are publications.

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SAMHSA NEWS

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