

TCE NEWS

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MARCH 2002

T A R G E T E D C A P A C I T Y E X P A N S I O N

CLUSTERS ARE WHERE THE ACTION IS!

Are you a member of a cluster? If you are, you already know the benefits of membership. If you are not, this article provides some compelling reasons why you should join a cluster today. The purpose of a cluster is to promote sharing and collaboration around common interests. A cluster consists of grantees serving similar populations and addressing similar issues. A cluster coordinator once stated, "The clusters are where it's happening." Clusters provide the following benefits:

- ✍ Networking opportunities
- ✍ Similar group values
- ✍ Opportunities to form subclusters and spinoff interest groups
- ✍ Uniformity of outcomes for external reporting
- ✍ A cross-section of data available for analysis
- ✍ Services offered by other cluster members through referrals
- ✍ Shared cluster tool information
- ✍ Group unity resolving issues and addressing grantee needs
- ✍ A non-threatening environment for voicing issues
- ✍ Help with sustainability issues; cluster membership can lead to additional funding
- ✍ Exchange of information and lessons learned
- ✍ Open exchange between grantees and CSAT
- ✍ Opportunities for members to tell their stories
- ✍ A LISTSERV to communicate with other members
- ✍ An interagency quality assurance system
- ✍ Promotes grantee success
- ✍ Pooled resources, such as funding and staff
- ✍ A forum for discussion and resolution of:
 - ✍ Environmental issues
 - ✍ New legislative issues
 - ✍ New treatment initiatives
 - ✍ Brainstorming ideas
- ✍ Enhancement of treatment skills
- ✍ Shared treatment strategies
- ✍ Cross-site comparisons
- ✍ Data collection and analysis across multiple sites
- ✍ Technical assistance support
- ✍ Assistance in producing outcomes:
 - ✍ Data
 - ✍ Publications
- ✍ Opportunities for members to present and be featured at national conferences
- ✍ No cost to join

WHAT ARE YOU WAITING FOR? JOIN A CLUSTER TODAY AND ENHANCE YOUR EFFECTIVENESS!

Adolescent
Co-Occurring and Other Functional Disorders
Criminal Justice
Methadone/IVDUs
Native American
Women
Women's Subgroup on Children
TCE HIV
HIV Outreach

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CALL (703) 575-4775 FOR AN APPLICATION TODAY.**

TREATMENT METHODS FOR WOMEN

Addiction to drugs is a serious, chronic, and relapsing health problem for both women and men of all ages and backgrounds. Among women, however, drug abuse may present different challenges to health, may progress differently, and may require different treatment approaches.

Understanding Women Who Use Drugs

It is possible for drug-dependent women, of any age, to overcome the illness of drug addiction. Those that have been most successful have had the help and support of significant others, family members, friends, treatment providers, and the community. Women of all races and socioeconomic status suffer from the serious illness of drug addiction. And women of all races, income groups, levels of education, and types of communities need treatment for drug addiction, as they do for any other problem affecting their physical or mental health.

Many women who use drugs have faced serious challenges to their well-being. For example, research indicates that up to 70 percent of drug abusing women report histories of being victims of physical and sexual abuse. Data also indicate that women are far more likely than men to report a parental history of alcohol and drug abuse. Women who use drugs often have low self-

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esteem and little self-confidence and may feel powerless. In addition, minority women may face additional cultural and language barriers that can affect or hinder their treatment and recovery.

Many drug-using women do not seek treatment because they are afraid. They fear not being able to take care of or keep their children, they fear reprisal from their spouses or boyfriends, and they fear punishment from authorities in the community. Many women report that their drug-using male sex partners initiated them into drug abuse. In addition, research indicates that drug-dependent women have great difficulty abstaining from drugs, when the lifestyle of their male partner is one that supports drug use.

Consequences of Drug Use for Women

Research suggests that women may become more quickly addicted than men to certain drugs, such as crack cocaine, even after casual or experimental use. Therefore, by the time a woman enters treatment, she may be severely addicted and consequently may require treatment that both identifies her specific needs and responds to them.

These needs will likely include addressing other serious health problems, for example, sexually transmitted diseases (STDs) and mental health problems. More specifically, health risks associated with drug abuse in women include:

- /// Poor nutrition and below-average weight
- /// Low self-esteem
- /// Depression
- /// Physical abuse
- /// If pregnant, pre-term labor or early delivery
- /// Serious medical and infectious diseases (e.g., increased blood pressure and heart rate, STDs, HIV/AIDS)

Drug Abuse and HIV/AIDS

AIDS is now the fourth leading cause of death among women of childbearing age in the United States. Substance abuse compounds the risk of AIDS for women, especially for women who are injecting drug users and who share drug paraphernalia, because HIV/AIDS often is transmitted through shared needles and other shared items such as syringes, cotton swabs, rinse water, and cookers. In addition, under the influence of illicit drugs and alcohol, women may engage in unprotected sex, which also increases their risk for contracting or transmitting HIV/AIDS.

From 1993 to 1994, the number of new AIDS cases among women decreased 17 percent. Still, as of January 1997, the Centers for Disease Control and Prevention had documented almost 85,500 cases of AIDS among adolescent and adult

women in the United States. Of these cases,

- /// About 62 percent were related either to the woman's own injecting drug use or to her having sex with an injecting drug user.
- /// About 37 percent were related to heterosexual contact, and almost half of these women acquired HIV/AIDS by having sex with an injecting drug user.

Treatment for Women

Research shows that women receive the most benefit from drug treatment programs that provide comprehensive services for meeting their basic needs, including access to the following:

- /// Food, clothing, and shelter
- /// Transportation
- /// Job counseling and training
- /// Legal assistance
- /// Literacy training and educational opportunities
- /// Parenting training
- /// Family therapy
- /// Couples counseling
- /// Medical care
- /// Child care
- /// Social services
- /// Social support
- /// Psychological assessment and mental health care
- /// Assertiveness training
- /// Family planning services

Traditional drug treatment programs may not be appropriate for women because those programs may not provide these services. Research also indicates that, for women in particular, a continuing relationship with a treatment provider is an important factor throughout treatment. Any individual may experience lapses and relapses as expected steps of the treatment and recovery process. However, during these periods, women particularly need the support of the community and the encouragement of those closest to them. After completing a drug treatment program, women also need services to assist them in sustaining their recovery and in rejoining the community.

Extent of Use

The National Household Survey on Drug Abuse (NHSDA)* provides yearly estimates of drug use prevalence among various demographic groups in the United States. Data are derived from a nationwide sample of household members aged 12 and older.

- /// In 1996, 29.9 percent of U.S. women (females over age 12) had used an illicit drug at least once in their lives (33.3 million out of 111.1 million women). More than 4.7 million women had used an illicit drug at least once in the month preceding the survey.

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- ✂ The survey showed 30.5 million women had used marijuana at least once in their lifetimes. About 603,000 women had used cocaine in the preceding month; 241,000 had used crack cocaine. About 547,000 women had used hallucinogens (including LSD and PCP) in the preceding month.
- ✂ In 1996, 56,000 women used a needle to inject drugs, and 856,000 had done so at some point in their lives.
- ✂ In 1996, nearly 1.2 million women had taken prescription drugs (sedatives, tranquilizers, or analgesics) for a non-medical purpose during the preceding month.
- ✂ In the month preceding the survey, more than 26 million women had smoked cigarettes and more than 48.5 million had consumed alcohol.

Source: National Institute on Drug Abuse, National Institutes of Health

* *NHSDA is an annual survey conducted by the Substance Abuse and Mental Health Services Administration. Copies of the latest survey are available from the National Clearinghouse for Alcohol and Drug Information at 1-800-729-6686.*

MYTHS, FACTS, AND ILLICIT DRUGS: WHAT YOU SHOULD KNOW

The Substance Abuse and Mental Health Services Administrations (SAMHSA) has joined with the Office of National Drug Control Policy, the Community Anti-Drug Coalitions of America, the National Institute on Drug Abuse, and the National Guard to sponsor a series of Webcasts on illicit drugs currently gaining popularity in American life.

In each Webcast, a panel of experts discusses the facts and misinformation about these drugs and responds to the concerns of community coalitions, community leaders, drug prevention and treatment providers, law enforcement officials, parents, caregivers and educators.

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Go to SAMHSA's Webcasts for information on meth, ecstasy, heroin, and marijuana at:

http://www.samhsa.gov/news/clickframe_fourdrugs.html

COLLABORATORY RESEARCH CENTER FOR SERVICE OPTIMIZATION

Instead of relying solely on research ideas generated by traditional academic researchers, drug and alcohol (D&A) programs need to take leadership in generating research topics that will be useful for optimizing service quality and effectiveness. Working in isolation, academic and research institutions are limited in generating questions that will induce greatest benefits to the D&A clients. These institutions will be inclined to produce "academic" and "scholarly" research reports that are largely useless for direct practice personnel and program administrators.

Traditional academic researchers are well-known for repeatedly committing two major errors: Type III (asking wrong questions and generating useless answers) and Type IV (over-emphasizing tribal findings while neglecting focus on meaningful findings.) Thus, genuine collaboration between D&A service providers and research institutions is essential for selection of relevant research questions and production of useful reports that will produce direct benefits to D&A clients and their family members.

In response to the above need, the Tadiso-University of Pittsburgh School of Social Work D&A Collaboratory Research Center was created to generate new knowledge and techniques that can be readily applied in services to D&A clients. To achieve continual improvement in service quality and effectiveness, the Research Center is responsible for conducting empirical assessments designed to optimize clinical and counseling effectiveness and maximize client outcomes. The Targeted Capacity Expansion (TCE) clients of Tadiso are direct beneficiaries of this research-based insight regarding client needs, empowerment, cultural competence, and service satisfaction.

Preliminary Assessment

Based on preliminary assessment, the collaborative research center has generated five assessment areas that are directly relevant to the organization's counselors and medical staff members.

A. Enhancement of Client Engagement Process

Historically, drug and alcohol counselors are trained to conduct a comprehensive intake assessment, determine client needs, provide counseling, assess client progress, and conduct client follow-up after service termination. However, too few counselors are trained adequately in the client engagement process, which may directly promote the client-counselor trust, commitment to intervention, and their reliance on the counseling services. Thus, research

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studies are needed in order to identify critical factors associated with successful client engagement, a constructive process that promotes client retention and explanatory information regarding client disengagement with counseling services against medical advice.

B. Recruitment and Retention of Addicted African American Women

Addicted African American Women (often with young children) are one of most vulnerable populations in our region, with noticeably low participation in D&A services. Although drug and alcohol researchers have documented disparities in health outcomes for ethnic and racial minority groups, knowledge of these disparities in itself has not led to significant improvements in reducing the disparities in racial and ethnic health service access. This is due in part to the fact that the causes of and contributing factors to these inequalities are not well understood. For instance, little is known about the role that various aspects of effective prevention programs play in contributing to racial and ethnic health disparities, such as the quality of communication between a provider and a patient, the quality of screening, the timeliness of follow-up, and the appropriateness and effectiveness of interventions (U.S. Department of Health and Human Services, 2000).

C. Development of Specialized Treatment Track

As noted above, the disparity in health outcome calls for more empirically based information. Thus, developmental research is needed in order to generate specialized treatment tracks (for example, based on gender and race of client, dual diagnosis, and history of addiction, etc.). To improve the health status of racial and ethnic minority populations, interventions need to acknowledge and incorporate the culture of the people they serve. The extent to which individuals and organizations who design and deliver health interventions respect the cultural values, traditions, and customs of their target audience and successfully affirm these values will determine the appropriateness and acceptability of the health care services in the eyes of the recipients (Gaston et al., 1997). Lack of understanding regarding interaction effects between contextual/cultural and intervention strategies, which contribute to disparities in minority health indicators, constitute a continuum of opportunity for development of specialized intervention tracks for uniquely different D&A client groups.

D. Enhancement of Access to Other Supportive Services

No single organization can meet all of the needs of D&A clients. All human service organizations need an interagency collaboration system with shared vision, formal and informal agreement, adequate communication and coordination, and established

ground rules. This notion is well supported by significant number of D&A clients who are in need of auxiliary services, including housing, childcare, job training, primary health care, transportation, and other services. Research studies are needed in order to specify a collaboration system that will work with efficiency and effectiveness. Such an arrangement should not only transform the current independent and isolated human service system to a more comprehensive, holistic, and well-coordinated service system that can provide numerous services to D&A clients and their family members in an organized and timely manner. A refined collaboration system should also reduce duplication of services and contribute directly toward successful client outcomes.

E. Enhanced Client Orientation to Methadone Treatment

Misconceptions regarding methadone treatment are not prevalent only among traditional D&A service providers but also among drug dependent clients. Research-based information regarding how methadone interacts with other drugs and nutritional food intake are scarcely available and understood among D&A counselors and their clients. Understanding what health care providers communicate with patients regarding how to maximize positive effectiveness of methadone treatment is critical to making progress in the reduction of D&A relapse and promotion of effective healthy recovery. The dialogue that occurs between the physician and the patient has been shown to have an impact on patient satisfaction and patient compliance with physician recommendations as well as on health outcomes (Roter and Hall, 1992). However, very little is understood about the potential relationship between knowledge of the best ways to maximize benefits of methadone treatment and actual treatment outcomes.

Summary

Reciprocal resource sharing and collaboration between Tadiso and the University of Pittsburgh School of Social Work create a synergistic learning opportunity that promises production of useful research products. The Research Center's major mission is to generate new knowledge and techniques that can be readily applied in services to D&A clients. To achieve continual improvement in service quality and effectiveness, the Research Center is responsible for conducting empirical assessments designed to optimize clinical and counseling effectiveness and to analyze client outcomes. The Research Center is headed by Marlene Burks (CEO, Tadiso, Inc.) and Hide Yamatani, (Interim Associate Dean for Research, School of Social Work, University of Pittsburgh). This unique research system provides the University an opportunity to exercise its social responsibility through collaborative production of locally and nationally relevant research products. Tadiso also welcomes an opportunity to continually access the latest empirical information that is directly

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relevant to the optimization of D&A services. Such benefits cannot be realized without a research system that is configured to start by asking the right questions.

*Written by Hide Yamatani, PhD
Dr. Yamatani is a CSAT Evaluator currently working with TADISO, Inc. and the PBA Inc. Braddock Hospital Collaboration in Pittsburgh, PA.*

PROGRAM SPOTLIGHT

Adult Treatment for Methamphetamine

Methamphetamine use is an epidemic sweeping from west to east across the United States, according to Alan Leschner, PhD, Director of the National Institute on Drug Abuse (NIDA). As stated at the October 1998 Iowa Town Meeting on Drug Abuse, use of methamphetamine (also called “meth”) has been especially prevalent in the midwest. Iowa, for example, has seen a tremendous increase in arrests, treatment admissions, seizure of laboratories, and drug convictions related to methamphetamine abuse.

In response to the alarming statistics presented at the Town Meeting, the Iowa Department of Public Health, using Targeted Capacity Expansion grants awarded in October 1999, contracted with the Gateway Center, House of Mercy, Powell III, and Bernie Lorenz to provide residential, halfway house, outpatient, and other services to methamphetamine abusers in central Iowa. This effort became commonly known as the Adult Treatment for Methamphetamine Project. This article provides an overview of the project and its accomplishments.

The Emerging Need and Its Impact

The effects of methamphetamine on its users are numerous. Central nervous system side effects from even small amounts of methamphetamine may include initial euphoria, increased alertness, paranoia, decreased appetite, and increased physical activity. It can also lead to athetosis (slow involuntary writhing movements of the hands), irritability, nervousness, insomnia, confusion, tremors, anxiety, aggression, incessant talking, hypothermia, and convulsions that sometimes can result in death.

Cardiovascular side effects of methamphetamine use may include chest pain, accelerated heartbeat, elevated blood pressure, and irreversible damage to blood vessels in the brain. Psychological effects of prolonged methamphetamine use may include anger, panic, paranoia, auditory and visual hallucinations, repetitive behavior patterns, and formication (sensation of something small crawling over the skin).

Sometimes called “the poor man’s cocaine,” methamphetamine is being used by a growing number of Iowa men and women. The NIDA says methamphetamine users are typically white, male, high school graduates, and 20 to 35 years of age. The Iowa Department of Public Health, Division of Substance Abuse and Health Promotion, reports a growing number of women are using methamphetamine in the State’s cities and rural areas. Central Iowa has the most significant need, with 24.4 percent of current treatment admissions being treated for methamphetamine abuse. Moreover, Des Moines (Iowa’s capital) was designated as one of eight “Methamphetamine Model Cities” in the United States in 2000.

When methamphetamine began invading Iowa, it hit with practically no advance warning. This is unlike most trends in drug use that start on one United States coast or the other and takes months or even years to work their way to the midwest. However, abuse accelerated in Iowa because methamphetamine traffickers discovered that rural Iowa was a relatively new market where they would not face a lot of competition.

In spite of its devastating impact on so many people, many factors appear to contribute to its popularity. It is inexpensive, provides a long-lasting high (compared to cocaine), readily accessible for purchase, and can be made at home. Being uninformed may also be a factor, especially among teenagers. During a focus group, an Iowa high school senior said “Teens have heard of methamphetamine, but we still don’t know what it is.”

The 1997 Governor’s Alliance on Substance Abuse survey of recovering Iowa methamphetamine users highlights the importance of drug education in home, schools, and the community. The top two reasons survey respondents gave for using methamphetamine are (1) friends using methamphetamine, and (2) curiosity.

The Iowa Medical Classification Center, the substance abuse assessment checkpoint for all incoming inmates into the Iowa prison system, reports a rise in methamphetamine use. In fact, methamphetamine has surpassed marijuana as the number two primary drug of choice (behind alcohol) for incoming inmates; 20.6 percent reported methamphetamine to be their primary drug of choice. This represents a 30 percent increase in methamphetamine as the primary drug over prior years.

Treatment Strategies and Community Support: A Cooperative State Effort

Several new and enhanced initiatives to fight methamphetamine abuse were put in place in 1998. Legislative efforts included the following:

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- ✍ Drug-free workplace law to expand drug-testing options in the private sector
- ✍ Drugged-driving law that applies drunken-driving penalties to methamphetamine and other illicit drugs
- ✍ Denial of appeal bonds for convicted methamphetamine offenders
- ✍ Mandatory sentencing for convicted methamphetamine dealers, unless they cooperate with prosecutors
- ✍ Stiffer prison sentences for possession of illegal drugs, making a third offense a felony
- ✍ Judicial authority to deny State and Federal benefits to convicted drug users and dealers

In 1999, legislative efforts aimed at curbing methamphetamine abuse included the following:

Expansion of methamphetamine prevention efforts

- ✍ Methamphetamine education program for Women, Infants, and Children (WIC) Program
- ✍ Expansion of Strengthening the Families Program
- ✍ Increase the length of time in treatment
- ✍ Tougher sentences
- ✍ Increased narcotics enforcement efforts
- ✍ Development of youth leadership model programs
- ✍ Drug court pilot programs
- ✍ Treatment for juvenile delinquents in the State training school

Polk County, which has the highest concentration of methamphetamine use in the State, established a drug court that combines intensive supervision and substance abuse treatment services for drug-affected offenders. Treatment Alternatives to Street Crime (TASC) liaisons monitor offender's adherence to treatment plans, and frequent drug tests are administered to detect any drug use so that the court can quickly intervene. The third and fourth judicial districts have received drug court planning grants from the United States Department of Justice.

However, there is still concern among public health and other health care officials, law enforcement officials, treatment providers, and researchers that capacity and average lengths of stay for methamphetamine abusers are inadequate in the region. The following barriers continue to impede treatment to methamphetamine abusers:

- ✍ Waiting lists
- ✍ Program staff who are unaware of referral sources
- ✍ Lack of a seamless transition from drug court and other corrections programs to admission
- ✍ Mandatory sentences for some offenders
- ✍ A reluctance of some clinicians to try new strategies in working with methamphetamine clients
- ✍ Childcare

- ✍ Funding
- ✍ Staffing shortages
- ✍ Transportation

The Adult Treatment of Methamphetamine Project was established to either resolve or reduce the impact of these issues on methamphetamine abusers in Iowa.

***Project Goal:** To increase the overall period of treatment and provide residential, extended residential, intensive outpatient, extended outpatient, halfway house, and continuing care to Iowa residents. In addition, to provide case coordination between clients and local agencies as well as accept referrals from other agencies.*

In order to successfully accomplish this goal, members of the Adult Treatment for Methamphetamine Project developed the following treatment program:

- ✍ **Step One.** The methamphetamine client is assessed to determine if treatment is needed. If so, the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPCII) is used to determine the appropriate level of care.
- ✍ **Step Two.** The client is then assigned a counselor or case manager who will transition with the client through all levels of care. Treatment for the client is tailored to individual needs.
- ✍ **Step Three.** For the first few days to two weeks, treatment is geared towards immediate health and safety needs whether the client is in an inpatient or outpatient environment. Most clients start the program with residential care. The program is getting away from traditional treatment as recommended in TIPS Series Number 33 guidelines.
- ✍ **Step Four.** After those immediate needs are met, the client is placed in more intense treatment if appropriate. Assessment is continuous to determine the correct level of treatment intensity for the client.

Program Strengths

Some of the program's strengths include the following:

- ✍ The amount of data available in addition to the GPR data (Government Performance and Results Act)
- ✍ The 80-item questionnaire related specifically to the Criminal Justice Cluster Group
- ✍ The Substance Abuse Reporting System, a State data collection instrument
- ✍ The "Mini" (Mini International Neuro-psychiatric Interview), a mental health program used as a screener for clients at admission and sixty days post admission.

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Program Challenges

Currently, the Adult Treatment for Methamphetamine Project does not have any challenges that have not been addressed. However, there was a problem obtaining a replacement for a provider that went out of business after one year with the project. The other providers stepped in to pick up additional clients as it took six months to get a qualified replacement.

A Measurement of Success

From all indications, the Adult Methamphetamine Project has been a success. Methamphetamine use in central Iowa has decreased over the past year. To date, the Project has treated approximately 250 clients since 1999. These clients have received enhanced case management services, stimulant specific treatment curriculum, and longer than average lengths of stay. Over 50 percent of these clients are women (this is consistent with the national average) and the average age is 32 years. Some of the success stories produced by the Project are:

- ✍ Darla is making \$9 an hour as a construction worker and has been reunited with her son.
- ✍ Tammi has been sober for more than two years and is a full-time student. She now works at a treatment program to help others. Tammi was in prison prior to this treatment.
- ✍ Kim relocated to Des Moines to complete treatment and has remained there to continue building a sober support system. She is working full-time. Kim has been sober for over a year.
- ✍ Tracy is still involved in Aftercare and has been sober five months. She is an assistant manager at a restaurant. She is paying off her fines and fulfilling terms of her probation.

As the Project begins the third and final year, it is anticipated that there will be many more success stories.

(Submitted by Mark Mahon, MPA, ACADC, Project Coordinator)

QUICK, SIMPLE TEST COULD REDUCE HIV DRUG RESISTANCE

Method Accurately Predicts Treatment Failure in Less Than a Week

By Salynn Boyles, WebMD Medical News

Knowing whether HIV drugs are working can ultimately mean the difference between life and death. Assessing drugs' effectiveness currently takes as long as two months, but findings reported this week by researchers from two Federal health agencies suggest the process can be shortened to as little as a week. Researchers from the National Institute of Allergy and Infectious Diseases (NIAID) and the National Cancer Institute (NCI) found

that the rate at which the AIDS virus disappears from the blood during the first week of treatment is a highly accurate measure of whether the drugs will fail. The report was published in the November 24, 2001 issue of the medical journal *The Lancet*.

The preliminary research indicates that people who do not experience a five fold, or 80 percent, drop in viral load by the sixth day of treatment will almost certainly have a poor long-term response to the chosen drugs.

“We found that if we didn't see a rapid drop in viral load during the first week, then there was a good chance that the drug regimen was not going to be effective,” lead author Michael A. Polis, MD, of NIAID, tells WebMD. “If we don't see a big drop, then it could mean that a patient isn't taking the drugs appropriately or it could mean resistance. Either way, the earlier we know this the better.”

If confirmed and widely adopted, the simple measure could reduce drug resistance among people on HIV drugs. Side effects of treatment might also be minimized if doctors can more rapidly identify drug treatments that don't work.

The Food and Drug Administration has approved 17 different HIV drugs. They are given in a variety of combinations because the fast-mutating virus quickly develops resistance to single drugs. Because many of the drugs are similar, resistance to one drug may mean resistance to several.

The most common way to test how well HIV drugs are working is by measuring the amount of virus in the blood after four to eight weeks of therapy. Using data from three previously reported trials, Polis and colleagues found that the five fold or less drop in viral load at Day 6 of therapy predicted treatment failure more than 99 percent of the time.

“This method is far better at identifying bad regimens than good ones,” Polis says, adding that treatment response is not certain for those whose drop in viral load is more than six fold but less than 50.

Coauthor Dimiter S. Dimitrov, PhD, ScD, says the research team is in the process of analyzing ways to spot suboptimal treatments even earlier. He says he hopes that measurements of drug concentrations in the blood will prove effective in identifying failing drug regimens in just a few days. Dimitrov is a computational biologist at the NCI.

Medically Reviewed
By Michael Smith, MD
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WHAT'S NEW

Antipsychotic Drug Risperidone Reduces Euphoric Effects of Cocaine

Repeated dosing with risperidone, an antipsychotic drug used to treat disorganized or psychotic thinking, was effective in blunting the euphoric highs associated with cocaine use in nine human volunteers.

The subjects treated with low doses of risperidone for five days prior to receiving intravenous (IV) cocaine reported perceiving less of a high than they did from the same amount of IV cocaine received prior to the risperidone pretreatment. The scientists from the University of California, Los Angeles (UCLA) School of Medicine who conducted the study say that risperidone reduced the high by a significant but modest degree, about 15 percent. Previous studies using a single dose of dopamine antagonists failed to reduce the perceived effects of cocaine. The UCLA scientists concluded that repeated dosing, rather than a single treatment, may be necessary. Medications such as risperidone block specific dopamine and serotonin receptors, elements of the brain circuitry that are thought to play a role in the perception of pleasure and in craving.

WHAT IT MEANS: Although risperidone effectively blocked dopamine receptors, there was only a modest reduction in cocaine-induced euphoria, suggesting that mechanisms other than those receptors may be important in drug-induced euphoria. A better understanding of the neurochemical basis for stimulant-based euphoria is critical to the development of better treatments for stimulant addiction.

Lead investigator Dr. Thomas F. Newton published the study in issue 102:3 of *Psychiatry Research*.

Personality, Family Characteristics Differentiate Adolescent Substance Abusers

Contrary to previously held views that adolescent substance abuse is exclusively an “externalizing” disorder, investigators from the University of Miami School of Medicine found that teens who abuse drugs include “internalizers,” “externalizers,” and some who are a combination of the two personality types. Teens who externalize problems tend to exhibit a general lack of control or tend to “act out” distress, while those who internalize tend to over-control or to direct their stress inward.

The researchers found that the 236 adolescents in the study—largely inner-city, economically disadvantaged males involved with the juvenile justice system—did not represent a homogenous group. Rather, there appeared to be subtypes. The investigators

concluded that treatment approaches would be most effective when tailored to the various subgroups, not to the stereotypical adolescent drug user.

The majority of the youth in the study tended to be externalizers. These adolescents were more likely to come from homes with high conflict, disorganization, and low levels of cohesion. For teens in this situation, a primary goal of therapy may be to repair strained parent-adolescent relations and to resolve conflicts that are the product of years of family dysfunction. A smaller group in the study manifested coexisting externalizing problems and internalizing problems. They experienced many of the problems noted in the externalizing group but were marked by greater parental psychopathology. For this group, engaging the parents in the child’s treatment may be a primary concern, given that these parents may be even more disorganized, conflicted, and overwhelmed with their own problems than parents of externalizing adolescents.

A third group in the study experienced normative levels of both externalizing and internalizing problems. These adolescents were likely to use marijuana heavily but reported less alcohol use and experienced less preoccupation with substance abuse than the other two groups. Their substance abuse may be more socially motivated than driven by the need to relieve psychological stress. These teens probably have the best prognosis.

WHAT IT MEANS: Adolescent substance abusers’ personality types and family characteristics need to guide decisions regarding treatment approaches.

Lead investigator Dr. Cynthia Rowe reported the study in the December 2001 issue of the *Journal of Child and Adolescent Substance Abuse*.

Study Finds That Beliefs About Health Effects of Cigarette Smoking Change with Age

Surveys of more than 7,000 individuals questioned, periodically from middle school through their mid-30’s about their beliefs concerning the risks from smoking cigarettes and the value they place on health, reveal that these attitudes change with age.

A research team from Arizona State University and Indiana University drew participants for the study from a large, midwestern community. At the most recent assessment, 26 percent smoked cigarettes.

The researchers found that:

Between the ages of 11 and 14 year, the perception that smoking would harm one’s own health decreased. However, between the ages of 15 years and 18 years and continuing to

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age 24 years, there was an increased belief that smoking can be harmful to one's personal health.

- ⚡ Throughout adolescence and young adulthood, there was a small but statistically significant increase in the belief that cigarette smoking is harmful to people's health in general.
- ⚡ Between the ages of 15 years and 18 years, the value that adolescents placed on health decreased. However, the value placed on health increased starting at age 19 years and continued to increase up to age 29 years.
- ⚡ Between ages 11 years and 14 years, belief in the positive psychological consequences of smoking increased; however, this trend reversed between ages 15 years and 18 years.
- ⚡ Between 11 years and 14 years, the belief that cigarettes are addicting decreased, but between the ages of 15 years and 18 years and between ages 19 years and 24 years, both smokers and nonsmokers increased their belief that cigarettes are addicting.
- ⚡ Across all age groups, those who smoked were significantly less likely to believe that smoking is harmful to either health in general or to their own personal health, and smokers placed significantly less value on health than did nonsmokers.

⚡ **WHAT IT MEANS:** Smoking interventions aimed at adolescents must counter the perception among middle school students that cigarette smoking does not pose a risk of addiction or a risk to one's own health, and must counter the declining values placed on health by high school students.

The research team led by Dr. Laurie Chassin and Dr. Clark Presson from Arizona State University and Dr. Steven J. Sherman from Indiana University published the study in the September 2001 issue of *Health Psychology*.

Study Sheds New Light on the Age Most at Risk for Drug Use and Transition from First Drug Use to Dependence

Researchers from the Johns Hopkins University report on data from the National Comorbidity Survey, which investigated the age at which individuals are at greater risk for starting to use marijuana, alcohol, and cocaine and when dependence on these drugs is likely to occur. More than 8,000 individuals ages 15 to 54 answered questions regarding the age at which they first used these drugs, and at what age they became dependent. Of this sample, almost half (3,940) had used marijuana; the majority (7,485) had used alcohol; and fewer than 20 percent (1,337) had used cocaine. There were 354 cases of marijuana dependence, 220 cases of cocaine dependence, and 212 cases of alcohol dependence.

The survey indicated that the ages at which individuals are more at risk for starting to use alcohol and marijuana are 17 to 18 years, about 2 years earlier than for cocaine. However, once use of

cocaine begins, cocaine dependence occurs earlier and more rapidly, with more than 5 percent of cocaine users becoming dependent on the drug during the first year of use. Within 10 years of their first use, more than 15 percent of those who used cocaine were dependent, versus 8 percent of marijuana users and approximately 12 percent of individuals who used alcohol. The data also indicated that the risk of developing alcohol dependence extends through middle age, whereas for marijuana and cocaine users, the period of developing dependence generally has ended by ages 30 and 35 years, respectively.

⚡ **WHAT IT MEANS:** The periods of risk for developing dependence on alcohol, marijuana, and cocaine are not the same. Cocaine dependence almost always develops within the first several years after initial use, while alcohol dependence develops more insidiously, often many years after starting to drink. Interventions seeking to prevent or delay development of cocaine dependence among cocaine users should be timed to occur soon after the start of cocaine use, since cocaine dependence may occur within the first few years of use.

This study was authored by Dr. Fernando Wagner and Dr. James C. Anthony, and was published in the electronic online journal, *Neuropsychopharmacology* (the official journal of the American College of Neuropsychopharmacology); it is due to appear in a hard-copy issue of *Neuropsychopharmacology* early in 2002.

Alcohol Use Prior to Smoking Marijuana Results in Increased THC Absorption

Scientists at McLean Hospital/Harvard Medical School observed that male volunteers who drank alcohol (vodka mixed with orange juice) prior to smoking marijuana detected the effects of marijuana more quickly, reported more episodes of euphoria, and had higher levels of THC (tetrahydrocannabinol) in their blood than did subjects who smoked marijuana without first ingesting alcohol.

The investigators concluded that alcohol might increase the absorption of THC, the active ingredient of marijuana, into the body, resulting in a higher "high" than is experienced when using marijuana alone.

⚡ **WHAT IT MEANS:** Marijuana and alcohol are often used together, but little is known about why they are combined. The results of this experiment suggest that these two drugs are used to maximize the desired effects of the drug experience and so may explain the popularity of this combination.

The study was published by lead investigator Dr. Scott E. Lukas in Volume (issue): 64 (2) 2001 of the journal *Drug and Alcohol Dependence*.

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ECSTASY FACTS

An Emerging Drug of Abuse in Maryland

Drug Early Warning System (DEWS) researchers have been tracking ecstasy use since mid-1999. Ecstasy is no longer just a club drug. It has now been reported as an emerging drug in 19 jurisdictions, and it is spreading to the general teen and young adult population. The Maryland State Police reports that ecstasy cases increased more than four-fold from 13 in 1998 to 59 in 1999. As of January 29, 2001, 121 cases were recorded for 2000. The National Drug Abuse Warning Network (DAWN) reports for the Baltimore metro area show a sharp jump in ecstasy-related emergency room episodes, from 6 in 1998 to 35 in 1999.

What is Ecstasy?

Ecstasy, or MDMA (methylenedioxymethamphetamine), is a stimulant that combines the properties of methamphetamine ("speed") with those of hallucinogens. It is also known as X-Files, Mitsubishi, Triple Stacks, 007, and the Love Drug. It is usually taken in tablet or capsule form. Some pills sold as ecstasy actually contain little or no MDMA; pills may contain other drugs such as PMA or another MDMA analogue, DXM, household chemicals such as Ajax or rat poison, or other (sometimes lethal) byproducts of the drug manufacturing process. Pills sell for between \$7 and \$30 each. According to DEA reports, a majority of the ecstasy sold in the United States is manufactured in the Netherlands and smuggled to local dealers by couriers. Items associated with ecstasy use include pacifiers, eye droppers, painter's masks, and bottled water.

What Are the Effects of Ecstasy Use?

Ecstasy causes the brain to release serotonin, a neurotransmitter that helps control mood. Users often experience euphoria, enhanced mental and emotional clarity, and heightened sensory perceptions. When the drug wears off, in three to six hours, the user's brain has been depleted of serotonin. This can contribute to depression and harm parts of the brain responsible for thought and memory. Because users feel energetic, many dance until they are dehydrated. This has led to deaths from heat exhaustion and kidney and cardiovascular system failure. It has also led to heart attacks, strokes, and seizures in some users. Recent studies with humans and baboons (NIDA Notes Vol. 114, No. 4) revealed that repeated ecstasy use has an adverse effect on serotonin levels in the brain. Brain damage was still present in monkeys seven years after drug use stopped. A human study comparing 24 users to 24 non-users shows significant impairment in visual and verbal memory more than two weeks after use.

For more information on ecstasy and other drugs, please call

toll free: 1-877-234-DEWS (3397)

Source: Center for Substance Abuse Research, University of Maryland (November 2001)

NEED TECHNICAL ASSISTANCE
BUT DON'T KNOW WHAT TO DO?

There are four steps in requesting technical assistance (TA):

1. Identify your TA needs
 - a. Grantees may identify TA needs within their program or TA may be recommended by your Government Project Officer (GPO).
 - b. ACS/Birch & Davis staff can assist you with outlining and defining your TA needs or you can contact your GPO. Contact Lou Podrasky-Mattia, Deputy Project Director, CSAT TCE Project, at (703) 575-4765 or Louis.Mattia@acs-inc.com.
2. Complete a TA request form and forward it to your GPO. TA forms are available from ACS/Birch & Davis staff or your GPO.
3. Upon approval of the TA request, the information is sent to ACS/Birch & Davis by the GPO.
4. ACS/Birch & Davis staff will work directly with the grantee and CSAT to plan and execute the requested TA.

CONFERENCE CALENDAR CORNER

APRIL**April 2, 2002 - Ypsilanti, Michigan****734-973-7892**

Teens Using Drugs: How To Know and What To Do. (Part 1: How To Know) Dawn Farn, the Livingston/Washtenaw Safe and Drug Free Schools and Communities Act (SDFSCA) Consortium, and the Saint Joseph Mercy Health System "Healthy Communities" Program.

Jess Antanaitis

jessa@umich.edu

April 4, 2002 - Baltimore, Maryland**404-756-5745**

Lonnie E. Mitchell HBCU Substance Abuse Conference The National HBCU Substance Abuse Consortium, CSAT, NIDA, Morehouse School of Medicine Cork Institute ATTC, and Danya International, Inc.

Jackie Johnson

johnsoj@msm.edu

April 5, 2002 - Fort Wayne, Indiana**219-481-2700, ext. 2019**

Shelter From the Storm: Clinical Assessment & Intervention with Young Children Who Witness Violence Park Center, Inc.

Fran Howard

gmoore@parkcenter.org

CONTINUED...

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April 6, 2002 - Raleigh, North Carolina 919-420-7968
 BreakOut VII: A National Conference of PSR and Deafness.
 Community Interventions: Preserving Our Roots
 Greensboro Area Health Education Center (AHEC)
 Brad Trotter
brad.trotter@ncmail.net

April 10, 2002 - Cincinnati, Ohio 1-800-668-9277
 PRIDE2002 World Drug Prevention Conference
 PRIDE Youth Programs
 Kim Johnson
prideyouth@ncats.net

April 11, 2002 - Bethesda, Maryland 301-443-3860
 Comparison of Mechanisms of Tolerance and Dependence Among Alcohol,
 Opiates, and Other Psychoactive Drugs
 National Institute of Health
 Nancy Colladay
ncolla@willco.niaaa.nih.gov

April 11-12, 2002 - Fort Lauderdale, Florida 301-897-7400(f)
 All Things Are Connected: Blending Science, Technology,
 and Culture to Improve HIV/AIDS and Substance Abuse Health Practices
 American Indian and Alaska Native HIV/AIDS and Substance Abuse Conference
 Abbe Smith
 Online registration at
<http://www.tech-res-intl.com/nativeconference/registration.asp>

MAY

May 6, 2002 - Anchorage Alaska 907- 770-2927
 Annual School on Addictions
 Substance Abuse Directors Association of Alaska
 Mary Rosenzweig
mrosenzw@pobox.mtaonline.net

May 7 & 14, 2002 - Ypsilanti, Michigan 734-973-7892
 Teens Using Drugs: How To Know and What To Do (Part 1 & Part 2)
 Dawn Farm, the Livingston/Washtenaw Safe and Drug Free Schools
 and Communities Act (SDFSCA) Consortium, and the Saint Joseph
 Mercy Health System "Healthy Communities" Program
 Jess Antanaitis
jessa@umich.edu

JUNE

June 5-8, 2002 800-969-6642
 2002 Annual Conference - Prevention, Resilience, and Recovery:
 United for Mental Health National Mental Health Association
<http://www.nmba.org>

June 9-11, 2002 - Baltimore, Maryland 410-706-3449
 National Conference on Children & Adolescents
 University of Maryland School of Nursing
 Sally Raphael
raphel@son.umaryland.edu

June 24-26, 2002 - Washington, DC 703-575-4775
 Targeted Capacity Expansion National Evaluation Meeting
 Center for Substance Abuse Treatment
 Louis Podrasky-Mattia
louis.mattia@acs-inc.com

June 26-28, 2002 - Washington, DC 703-575-4775
 Targeted Capacity Expansion HIV and HIV Outreach
 National Evaluation Meeting, Center for Substance Abuse Treatment
 Miriam Phields, PhD
miriam.phields@acs-inc.com

June 28, 2002 - New York, New York 800-245-3333
 What Mental Health Professionals Need to know About
 HIPAA's Privacy Rules
 The Center for Mental Health Services
 Cindy Smith
csmith@prms.com

R E M I N D E R

QUARTERLY REPORTS should be submitted on time.
 Any delays must be cleared with your CSAT Project
 Officer. We look forward to receiving your reports by
 April 30, 2002. If you need assistance in any way, please
 call Kraig Marable at (703) 575-6630.

Thank You.
ACS/Birch & Davis
CSAT Team

DATA BYTES

***Ecstasy Use Stabilizes Among High School Seniors
 as Perceived Harmfulness Increases; Drug Continues
 to Be Widely Available***

For the first time since 1999, ecstasy (MDMA) use among U.S.
 12th grade students has not increased significantly, according
 to data from the national Monitoring the Future survey. In 2001,
 9 percent of high school seniors reported that they had used
 ecstasy in the past year, compared to 8 percent in 2000 (a
 statistically non-significant difference). At the same time, the
 percentage of seniors that perceived a "great risk" of harm from
 using ecstasy once or twice increased significantly, from 38
 percent in 2000 to 46 percent in 2001. Past research has shown
 that as perceived harmfulness of a drug rises, use falls (see
 CESAR FAX, Volume 6, Issue 14).

While these findings suggest that ecstasy use may decline in
 future years, there has been a continued increase in the perceived
 availability of the drug. In 2001, 62 percent of seniors reported
 that ecstasy was "fairly easy" or "very easy" to obtain, compared
 to 22 percent when this question was first asked in 1989. Study
 director Lloyd D. Johnston suggests that this increase in perceived
 availability may be "due in part to the fact that this drug is still

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TEEN NEWS

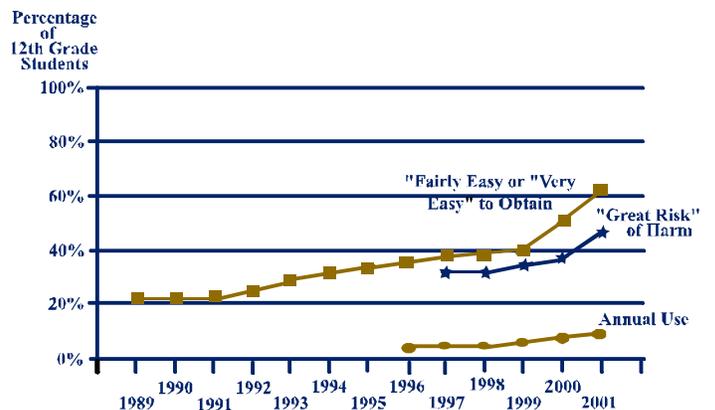
T A R G E T E D C A P A C I T Y E X P A N S I O N

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reaching new communities” (p. 2-3). The percentage of schools in the 12th grade national sample that had any survey respondent who had used ecstasy increased from 53 percent in 1998 to 72 percent in 2001 (data not shown). According to Johnston, “even if fewer students are willing to use ecstasy in the schools where it has been present, that decline very likely has been more than offset by the continuing rapid diffusion of the drug to additional areas” (p. 3).

SOURCE: Adapted by CESAR from data from University of Michigan, Monitoring the Future Study Press Release, “Rise In Ecstasy Use Among American Teens Begins to Slow,” December 19, 2001. Available online at www.monitoringthefuture.org. For more information, contact Lloyd Johnston at 734-763-5043.

Percentage of U.S. 12th Grade Students Reporting Annual Use, Perceived Availability, and Perceived Harmfulness of Ecstasy (MDMA), 1989-2001



CSAT

Center for Substance Abuse Treatment
SAMHSA
 Produced under a contract funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
 Center for Substance Abuse Treatment, 5600 Fishers Lane
 Rockwall II, Suite 616, Rockville, Maryland 20857, 301.443.5052



Substance Abuse and Mental Health Services Administration
 Center for Substance Abuse Treatment

RESEARCH FILE

Methamphetamine, Cocaine Abusers Have Different Patterns of Drug Use, Suffer Different Cognitive Impairments

National Institute on Drug Abuse (NIDA) -supported research has found that methamphetamine abusers typically use the drug throughout the day in a pattern that resembles taking medication, while cocaine abusers often exhibit a binge pattern, using the drug continuously over a period of several evening and nighttime hours. According to the researchers at the University of California, Los Angeles (UCLA), the drugs also appear to cause different types of deficits in reasoning and concentration.

Patterns of Use

Dr. Sara Simon and her UCLA colleagues interviewed 120 methamphetamine abusers and 63 cocaine abusers to determine patterns of drug use. Ninety-seven of the methamphetamine abusers and 56 cocaine abusers were recruited from treatment programs; the others were using the drug and not seeking treatment.

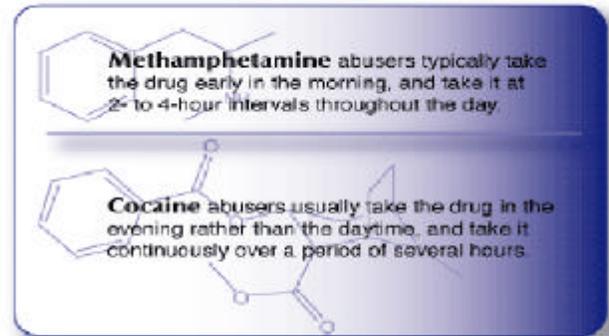
Continuous use, more than 20 times per month, was more common for both cocaine abusers (52 percent) and methamphetamine abusers (70 percent) than was any other pattern of drug use. Among those who used either drug fewer than 20 times per month, methamphetamine abusers were four times as likely as cocaine abusers (48 percent compared with 12 percent) to use the drug at least once per week in a regular cycle.

“The typical methamphetamine abuser reported using the drug when he or she first got up in the morning, then using approximately every two to four hours during their waking day. Most of the descriptions of use more closely resembled taking a medication than using a drug for pleasure,” Dr. Simon says. “Cocaine abusers reported patterns that fit a picture of recreational use: They began in the evening and continued until all the cocaine on hand had been used.”

The different patterns of use may in part be a result of the drugs’ different effects in the body, the researchers say: Methamphetamine triggers the release of large amounts of the neurotransmitter dopamine into areas of the brain that regulate feelings of pleasure, whereas cocaine blocks the removal of dopamine, resulting in an accumulation that causes continuous pleasurable stimulation of brain cells. The effects of methamphetamine typically last more than 10 hours, and the half-life (the time it takes for the body to remove 50 percent of the drug) of methamphetamine is 12 hours. Cocaine’s half-life is roughly one hour, and the drug’s high lasts about 20 to 30 minutes.

Understanding the patterns of methamphetamine and cocaine use will help treatment providers and drug users identify circumstances that may lead to relapse to drug use. “Differences in use patterns

indicate different triggers and different times and places when the recovering abuser is particularly vulnerable,” says Dr. Simon.



Effects on Reasoning and Memory

In another study, Dr. Simon and her colleagues evaluated the effects of methamphetamine and cocaine on learning and memory in 40 methamphetamine abusers and 40 cocaine abusers who were not in treatment and 80 individuals who had never used either stimulant drug. The researchers administered tests to evaluate memory; perceptual speed and ability to manipulate information; ability to ignore irrelevant information; general intelligence; verbal fluency; and executive function (abstract reasoning, reactive flexibility, and ability to use feedback).

Methamphetamine abusers performed more poorly than nonusers of stimulants in tests of word recall, perceptual speed, ability to manipulate information, and abstract thinking. Cocaine abusers scored more poorly than nonusers of stimulants in tests measuring ability to recall words and pictures and working memory. “Methamphetamine abusers displayed impairments on the tests of perceptual speed and manipulation of information that were not seen in the cocaine group. Moreover, in tests that require both speed and manipulation, there was even more difference between the groups than on tests of either skill separately,” Dr. Simon says.

“Overall, both drugs are associated with similar cognitive deficits,” Dr. Simon says. “The most striking difference is that methamphetamine abusers have more trouble than cocaine abusers at tasks requiring attention and the ability to organize information.”

Written By Patrick Zickler (December 2001).

NIDA NOTES: Research Findings, Volume 16, Number 5

Sources

Simon, S.L., et al. A comparison of patterns of methamphetamine and cocaine use. *Journal of Addictive Diseases*, in press.

Simon, S.L., et al. Cognitive performance of current methamphetamine and cocaine users. *Journal of Addictive Diseases*, in press.

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