Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

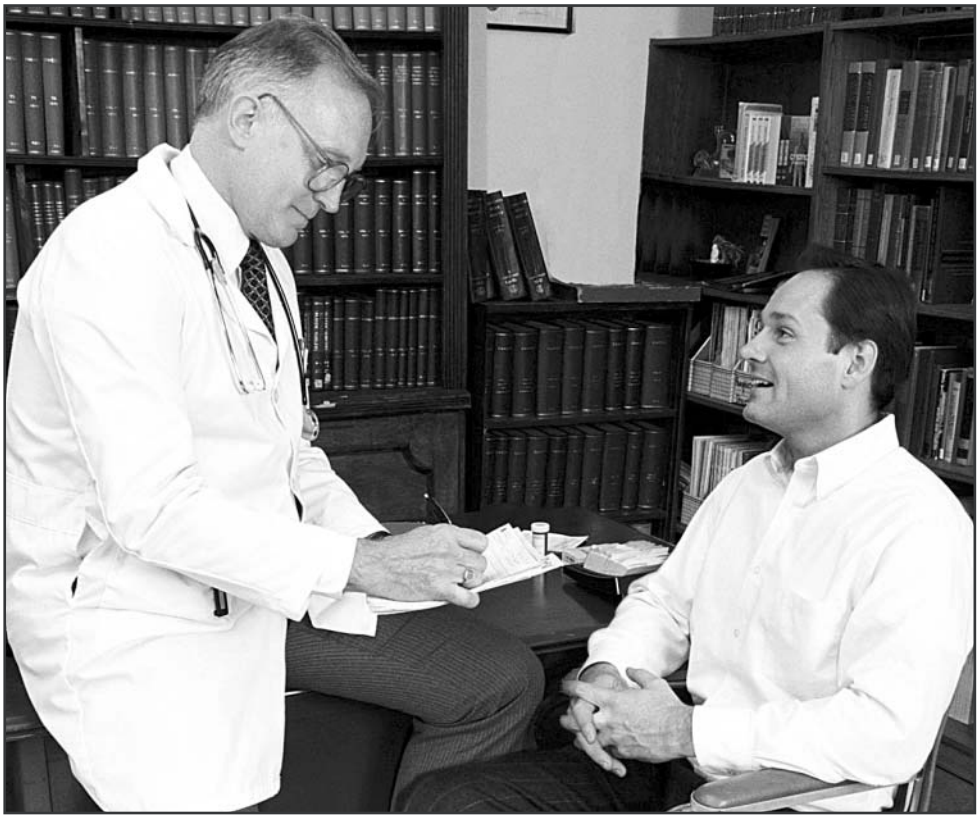
March/April 2004, Volume 12, Number 2

SAMHSA Helps Bring Buprenorphine to the Field

Ask Anthony H. Dekker, D.O., about the ideal candidate for buprenorphine-based opioid dependence treatment, and he'll tell you the story of a patient who started injecting heroin again right after finishing a long prison sentence. Intent on turning his life around, the man came to the Indian Health Service facility where Dr. Dekker works and asked for help. Dr. Dekker's new patient had never heard of buprenorphine—a recently approved medication that alleviates drug cravings and eases the withdrawal of patients addicted to heroin, prescription narcotics, or other opioid drugs.

"Since this patient works 12 hours a day, the convenience of going to a local doctor's office for his medication was a big plus," said Dr. Dekker, Associate Director of the Phoenix Indian Medical Center in Phoenix, AZ. "Getting this man on buprenorphine means he has time to be involved in our support groups, sweat lodge, and a lot of other things. It's a way to help him get his life back."

Dr. Dekker is just one of many physicians around the country who are putting this new medication to use. Approved by the Food and Drug Administration (FDA) in 2002 and available in pharmacies in 2003, buprenorphine allows opioid-dependent patients to bypass specialized methadone clinics and—for the first time—seek treatment in the privacy of their own doctor's office.



To increase the number of physicians prescribing buprenorphine and thus increase patients' access to care, SAMHSA's Center for Substance Abuse Treatment (CSAT) is helping physicians get the training they need to prescribe the medication. The Center is studying how the new drug is actually being used in the field. And, the Center is developing resources to help physicians

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curriculum focuses on the logistical aspects of buprenorphine treatment, including sections on protecting a patient's privacy, establishing appropriate office policies and procedures, and keeping good medical records. The curriculum concludes with several case studies.

Estimating that trainers use about 80 percent of the curriculum's slides in their current form, Dr. Fiellin noted that he and other trainers are already modifying the slides or adding slides of their own. When Dr. Fiellin gives trainings, for example, he adds information about incorporating psychosocial treatment into an office-based setting. Dr. Dekker's trainings feature more detailed information about prescription drug abuse than the basic curriculum offers.

Using the Curriculum

In addition to funding the curriculum's development, CSAT is providing support for the trainings where Dr. Fiellin, Dr. Dekker, and other experts use the curriculum. Buprenorphine's manufacturer recently decided to provide additional funding for training. Sponsored by the three medical societies involved in the curriculum's development as well as the American Psychiatric Association (APA), these ongoing training events are taking place nationwide. AAAP and APA also offer Web-based instruction that allows physicians to get their training online.

As of February, 3,722 physicians had been trained in the use of buprenorphine.

So far, the trainings have attracted addiction specialists who technically don't need the training but who want to learn more about buprenorphine. Trainings also attract primary care physicians. "Most physicians are not addiction specialists. The more we can get primary care physicians interested in taking a course, the greater the likelihood they will become interested in treating this population," stated H. Westley Clark, M.D., J.D., M.P.H., CSAT Director.

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From the Administrator

Buprenorphine Treatment: How Is It Working?

When the medication buprenorphine was approved by the Food and Drug Administration for clinical use in 2002, it was hailed as a milestone in the treatment of addiction to illicit opiates such as heroin and certain prescription painkillers such as codeine and oxycodone.

Buprenorphine is said to be long-lasting, with minimal side effects and a low potential for abuse. It is also the only controlled substance approved for the treatment of opioid addiction that may be prescribed by physicians in an office-based setting as opposed to a specialty clinic.

With these advantages, buprenorphine increases the number of tools service providers can use to treat addiction. This medication also expands the availability and accessibility of substance abuse treatment—a priority for the Bush Administration, the U.S. Department of Health and Human Services, and SAMHSA.

But the availability of a new medication is only one part of the story; its adoption into clinical practice is another. Incorporating buprenorphine into treatment raises many questions. For example:

- What special training do physicians need to prescribe or dispense buprenorphine and how do they obtain this training? How do physicians coordinate buprenorphine treatment with addiction treatment counselors and what kind of training do these counselors need?
- What are some of the challenges and barriers to the use of buprenorphine in clinical practice, and how can SAMHSA help surmount these?
- How do addiction treatment providers see buprenorphine affecting their clinical practices? How can lessons learned from using buprenorphine in clinical practice increase acceptance and enhance the overall use of medical approaches in the treatment of addiction?

These kinds of questions are of particular concern to us at SAMHSA. Our Agency seeks to serve as the conduit between the information gained from research and the knowledge gleaned from clinical practice; the synapse between science and service. We view the constant interchange between the two as a catalyst that fuels the advancement and enhancement of recovery.

This issue of *SAMHSA News* explores some of the emerging developments as buprenorphine is integrated into treatment. Articles also describe SAMHSA-funded efforts to train service providers to administer the medication and grassroots efforts that include buprenorphine to combat opioid use and addiction in the community.

Medications such as buprenorphine, along with psychosocial supports, can help people addicted to opiates stop craving their drugs and re-establish productive and fulfilling lives in the community. Buprenorphine alone is not a silver bullet for opioid addiction, but it can open the door to recovery and provide the opportunity to regain lost lives.

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

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Now CSAT is reaching out to other organizations that can help bring in more physicians. The Health Resources and Services Administration's HIV/AIDS Bureau, for instance, is working to convince physicians that treating opioid addiction can enhance prevention as well as adherence to HIV treatment regimens. CSAT is also working with ASAM and other organizations to educate physicians involved in pain management about buprenorphine's role in treating patients addicted to prescription narcotics.

Overcoming Barriers

More than 2,500 physicians have received their waivers so far. And, approximately 1,700 are listed on CSAT's Buprenorphine Physician Locator (see "Resources" on page 2).

Buprenorphine is proving to be beneficial in rural areas, which often lack alternative treatment options. "Mostly jail" is how Art Van Zee, M.D., a general internist at the St. Charles Clinic described the pre-buprenorphine treatment options when prescription drug abuse first hit his tiny coal-mining town in southwestern Virginia. The nearest methadone clinic is more than an hour away. As far as Dr. Van Zee knows, he is the only physician within 60 miles qualified to prescribe buprenorphine.

However, buprenorphine is no magic bullet. For one thing, some physicians just aren't interested in treating patients with opioid dependence. "This is not a group of patients who are appealing to some physicians," said George Kolodner, M.D., Director of Chemical Dependence at Georgetown University Hospital and Medical School. "They have a history of antisocial behavior and a reputation of being difficult to manage."

The intensive patient management that buprenorphine requires at the beginning of the treatment process seems to be an additional deterrent, especially for physicians in solo private practices. The Drug Addiction Treatment Act limits individual and group physicians from having more than 30 patients on buprenorphine at one time. Because many patients may remain on buprenorphine long term, this patient limit means that some practices are already at capacity. It also means that some physicians—especially those in primary care practice—are deciding that buprenorphine treatment is not for them.

"Primary care doctors are swamped as it is," said Dr. Dekker. "Why would they want to jump through these hoops to take care of such a small number of drug-addicted patients rather than just refer them to someone else?"

"Buprenorphine allows physicians to treat opioid addiction just like they treat diabetes, hypertension, or any other chronic disease."

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

The prospect of Drug Enforcement Administration (DEA) inspections also generates concern among some physicians, even though the purpose of most visits is to assess compliance with the 30-patient limit.

According to an official from the DEA, "Physicians should not view these visits negatively but as an opportunity to identify any areas of concern." The DEA estimates that only about 3 percent of the waived physicians will be inspected in 2004.

The high cost of the medication and related treatment and, to date, limited third-party insurance coverage are other potential barriers to expanding buprenorphine treatment. Furthermore, in practices lacking Federal funding, physicians cite cost when asked why patients reject the buprenorphine option, fail to adhere to the treatment regimen, or drop out of treatment altogether.

Evaluating the Program

To address any potential concerns, the Drug Addiction Treatment Act requires the Secretary of Health and Human Services to evaluate the buprenorphine waiver program.

The evaluation has three primary objectives: to determine whether buprenorphine treatment provided through the program has been effective, whether treatment availability has increased, and whether there have been any adverse public health consequences.

According to Robert Lubran, M.S., M.P.A., Director of CSAT's Division of Pharmacologic Therapies, "CSAT is carrying out this evaluation by conducting three specific surveys." One survey will assess addiction specialists' views of buprenorphine. A second will provide a longitudinal look at patients' perceptions. A third will focus on physicians who are actively prescribing the medication. Results will be used to see if the waiver program's rules—such as the 30-patient limit—need adjustment.

"At SAMHSA, we're looking at how the medication—and the waiver program—are working for people in the real world."

—H. Westley Clark, M.D., J.D., M.P.H.
CSAT Director

"At SAMHSA, we are looking at how the medication—and the waiver program—are working for people in the real world," Dr. Clark said.

Although the evaluation's results won't be available until late 2005, SAMHSA is already making use of preliminary feedback. The Agency has created a special area on SAMHSA's buprenorphine Web site where physicians can get answers to their questions and share information.

For example, the password-protected Buprenorphine Clinical Discussion WebBoard allows physicians with waivers to ask and answer questions, share their experiences, and obtain advice from expert guest moderators.

Another project under consideration is a clinical support network that would match physicians concerned about prescribing buprenorphine for the first time with experienced addiction specialists who can guide them through the process.

These developments should be good news for trainers like Dr. Dekker and Dr. Fiellin.

"The doctors involved with us in the training get many, many calls every day," said Mr. Lubran. "Everybody's always asking them, 'What do I do with this patient?' "

Now, the doctors have a source for some answers.

—By Rebecca A. Clay

Visit **www.buprenorphine.samhsa.gov** for information.

Buprenorphine Training Available for Counselors

Only physicians with SAMHSA waivers can prescribe buprenorphine. But physicians aren't the only ones who need to learn about this new option for treating opioid addiction.

To ensure that counselors and other health care providers have the information they need, SAMHSA's Central East Addiction Technology Transfer Center (ATTC) offers an online course called *Buprenorphine Treatment of Opioid Addiction: A Counselor's Guide.* Available at the Central East ATTC Web site, this free, self-paced training prepares counselors to advise patients and families, and to work with physicians who provide buprenorphine-based treatment. The course covers buprenorphine's effects, efficacy, and safety as well as the counselor's role in treatment.

Soon a curriculum for use in on-site trainings will also be available. An adaptation of the online course, this curriculum is being developed by representatives from SAMHSA's ATTCs and the National Institute on Drug Abuse (NIDA). Working together to increase awareness of buprenorphine among health care providers, this "Blending Team" is an outgrowth of a 2001 agreement between SAMHSA and NIDA designed to speed up the process of bringing research findings into actual practice. (See *SAMHSA News,* Volume 10, Number 4.)

"There are plenty of resources for physicians interested in buprenorphine," said Suman Rao, Ph.D., a health scientist administrator in NIDA's Office of Science Policy and Communication. "But we recognized that there was a gap in terms of resources for other health care providers."

When the new curriculum is finished this spring, the Blending Team will distribute it to the ATTCs for use in their local areas.

"On-site training will be available in the 14 regions of the ATTC Network, which covers all states and U.S. territories," said Karl D. White, Ed.D., ATTC project officer at CSAT. In addition to the curriculum, the training package will include a brochure, fact sheets, a bibliography, and a CD-ROM.

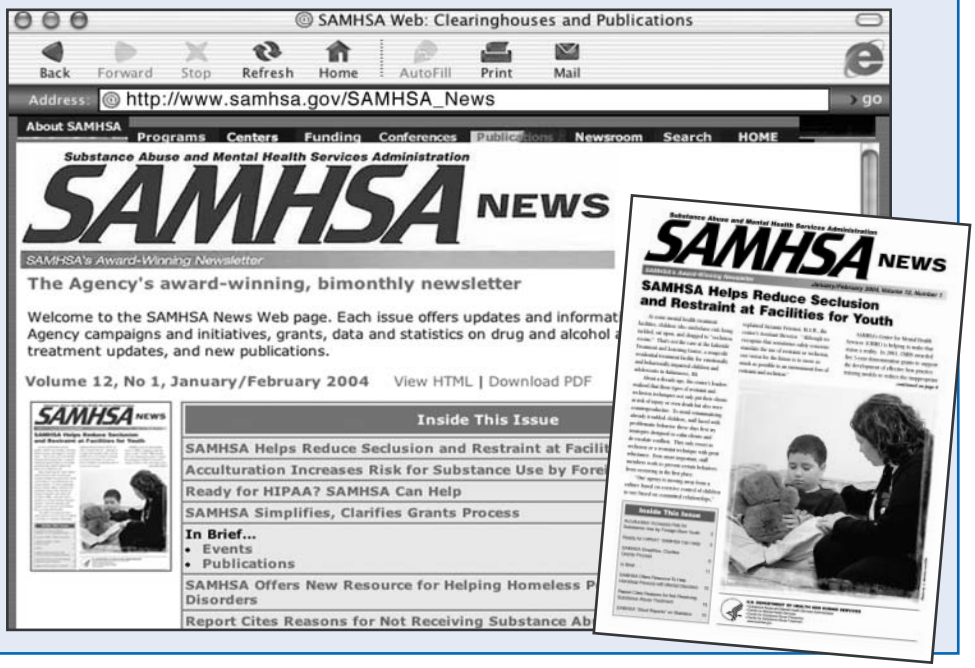
"We want to offer as many opportunities as possible to provide an effective introduction to this new treatment opportunity," said Team Leader Thomas E. Freese, Ph.D., director of the Pacific Southwest ATTC in Los Angeles, CA. "For buprenorphine to be effective, counselors must have information about the medication itself and its use in the treatment process. Only then can a coordinated system of care be developed that addresses a client's medical, behavioral, and psychological issues comprehensively."

To learn more about SAMHSA's ATTCs, visit **www.nattc.org.** To access the online buprenorphine training course, visit **www.ceattc.org.** To learn more, 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).

SAMHSA News Gets a New Web Address

A new Web address for *SAMHSA News* online at SAMHSA's Web site makes access quick and convenient. The newsletter is available in a fully linked HTML format.

SAMHSA News is published bimonthly in January, March, May, July, September, and November. Visit *SAMHSA News* online at **www.samhsa.gov/SAMHSA_News.**



Buprenorphine in Action: One Community's Story

Nestled in central Pennsylvania, Lewistown used to be the kind of place where people didn't lock their doors. That changed when gangs brought heroin to town a couple of years ago. This rural area was faced with a violent crime wave and a surge in addiction among teenagers and young adults.

Lewistown started a grassroots effort to solve this problem. Working as a team, a local hospital, a family health practice, and a substance abuse treatment center developed an innovative protocol for providing buprenorphine treatment. The team announced the new option's availability during a "community day." Members held a press conference at the local hospital and immediately started accepting patients.

While law enforcement targeted the gangs, local health care providers tackled the addictions. Local physicians received special buprenorphine training sponsored by the American Society of Addiction Medicine and funded by SAMHSA's Center for Substance Abuse Treatment (CSAT) as part of an initiative to educate physicians throughout the Nation (see *SAMHSA News,* p. 2).

The Lewistown program proved so successful, according to CSAT senior public health analyst Nick Reuter, M.P.H., that CSAT sent a team to Lewistown in November to see how the program operated, visit with doctors and patients, and hear about local law enforcement efforts and treatment options. The team included Arlene Stanton, Ph.D., a social science analyst, and Ruth Hurtado, a public health advisor.

What's special about the Lewistown approach, said Mr. Reuter, is its use of a coordinator—a psychologist, in this instance—to handle much of the time-intensive interaction and followup required during the treatment's early phase.

"This model addresses two major concerns related to providing buprenorphine treatment," added Dr. Stanton, "First, it allows medical doctors to 'do business as usual.' That means it relieves doctors of time-consuming startup procedures for their patients on this treatment. Second, it ensures these patients receive integrated care—both medical and psychosocial."

In Lewistown, the psychologist meets with patients and their families to educate them about buprenorphine and do some preliminary assessments before they see a physician. After a patient's initial dose of the medication, she checks in to offer reassurance and see if dose adjustments are needed. Later she makes sure patients are going to counseling appointments and complying with the treatment regimens.

Without this kind of help, these physicians admit that taking on more than a few patients at a time would be impossible.

Members of the Buprenorphine Model Program at Lewistown Hospital's Family Health Associates include (top left) Sally Wooten, M.D., prescribing physician; (top right) Cheryl Stayton, Ph.D., Buprenorphine Program Coordinator and psychologist; and (bottom) Brad Miller, D.O., prescribing physician.

With the nearest methadone clinic located hours away, the use of buprenorphine has been a boon for this rural community, and it offers the same potential for other underserved areas.

In Lewistown today, four physicians are prescribing buprenorphine to their patients. Joe,* 25, is one of these patients. Trying to get his heroin and other addictions under control has not been easy, but after years of addiction, he found his cravings began to subside when he started buprenorphine medication. "By the time the psychologist called him the night after his first pill, he was already thinking more clearly," said Dr. Stanton, who sat in on the young man's induction. "Now he is eager to begin his new life."

—By Rebecca A. Clay

*Pseudonym

President's 2005 Budget Proposes Increase for SAMHSA Services

President George W. Bush's Fiscal Year 2005 budget for SAMHSA proposes increases for the President's Access to Recovery Initiative for drug treatment and bold new investments to transform mental health care across the Nation as recommended by the President's Commission on Mental Health. The budget also calls for a new Strategic Prevention Framework.

Overall, the proposal calls for a 6-percent increase in both mental health and substance abuse services, expanding SAMHSA's budget to $3.6 billion in Fiscal Year 2005—a net increase of $199 million over Fiscal Year 2004.

"This budget request underscores the support SAMHSA is receiving from both President Bush and Health and Human Services Secretary Tommy Thompson," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "At SAMHSA, we structure our work around the vision of a life in the community for everyone, and our mission is to build resilience and facilitate recovery." He added, "The Administration's actions clearly support SAMHSA's efforts."

Substance Abuse

The President's budget seeks to expand treatment and recovery support services to people with drug and alcohol problems. It includes $2.5 billion, a net increase of $148 million—or 6 percent, for substance abuse treatment and prevention activities.

Expanding Access to Treatment. The budget represents the fourth year of the President's commitment to expand drug treatment and recovery support services over 5 years. The request proposes to double funding for the "Access to Recovery" State Voucher program to $200 million. The initiative allows individuals seeking treatment and recovery support services to exercise choice among qualified community provider organizations, including those that are faith-based. The program places strong emphasis on results measured by specific outcomes. These outcomes include no substance use, no involvement with the criminal justice system, becoming employed or enrolling in school, improved family and living conditions, social support, access to care, treatment capacity, and retention in services. The Access to Recovery program is expected to serve approximately 100,000 people in Fiscal Year 2005.

Promoting Effective Prevention. The budget proposal includes $196 million to implement SAMHSA's new Strategic Prevention Framework, which is designed to promote the use of performance measures and evaluation tools by substance abuse prevention providers. It also is intended to support the implementation of effective prevention programs in states and communities across the Nation. Through the Strategic Prevention Framework, SAMHSA builds and strengthens the capacity within states and the prevention field to promote resiliency and decrease risk factors in individuals, families, and communities. In Fiscal Year 2005, this program will focus on promoting the replication of effective

Substance Abuse and Mental Health Services Administration
Budget Authority by Activity (Dollars in Millions)

	2003	2004	2005	2005 +/- 2004
Substance Abuse:				
Substance Abuse Block Grant	$1,754	$1,779	$1,832	+$53
Programs of Regional and National Significance:				
Treatment	317	419	517	+98
Prevention	197	199	196	-3
Subtotal, Substance Abuse	**$2,268**	**$2,397**	**$2,545**	**+$148**
Mental Health:				
Mental Health Block Grant	$437	$434	$436	+$2
PATH Homeless Formula Grant	43	50	55	+5
Programs of Regional and National Significance	245	241	271	+30
Children's Mental Health Services	98	102	106	+4
Protection and Advocacy	34	35	35	0
Samaritan Initiative	0	0	10	+10
Subtotal, Mental Health	**$857**	**$862**	**$913**	**+$51**
Program Management	$87	$92	$92	$0
Total, Program Level	**$3,212**	**$3,351**	**$3,550**	**+$199**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-74	-117	-121	-4
Total, Discretionary BA	**$3,138**	**$3,234**	**$3,429**	**+$195**
FTE	534	546	546	0

Source: U.S. Department of Health and Human Services Web site, "Budget in Brief," at www.hhs.gov/budget/05budget/fy2005bibfinal.pdf (page 40, PDF format).

"The Administration's actions clearly support SAMHSA's efforts."

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

programs at the community level, with an emphasis on preventing underage drinking.

Substance Abuse Block Grant. The proposal requests $1.8 billion for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, an increase of $53 million over Fiscal Year 2004. The SAPT Block Grant provides treatment services to more than 425,000 individuals. It also supports more than 10,500 community-based organizations and accounts for at least 40 percent of each state's prevention and treatment funding.

Mental Health

The President's budget also calls for bold new investments in mental health services. The Fiscal Year 2005 budget for mental health—$913 million—represents a net increase of $51 million over Fiscal Year 2004.

Transforming the Nation's Mental Health System. Specifically, the budget earmarks $44 million for State Incentive Grants for Transformation. These funds are being proposed in response to the recommendations and the final report of the President's New Freedom Commission on Mental Health, which called for a fundamental overhaul of how mental health care is delivered in the United States. These new grants will support the development of comprehensive state mental health plans to reduce system fragmentation and to increase services and support available to people with mental illness.

In the first year, states will establish a planning dialogue across multiple service systems and agencies such as criminal justice, housing, child welfare, labor, and education. In subsequent years, 85 percent of grant funds may be used to support community-based programs identified in the state plan, while the remaining 15 percent will support state planning and coordination activities.

Homeless Services. The President's request includes a $10 million contribution for the Samaritan Initiative, a Presidential priority designed to reduce chronic homelessness. The program is jointly administered by the U.S. Department of Health and Human Services, the Department of Housing and Urban Development, and the Department of Veterans Affairs. The initiative is intended to help service providers increase access to the full range of services that chronically homeless people need, including housing, outreach and support services, mental health services, substance abuse treatment, and primary health care.

The budget request also includes $55 million for the Projects for Assistance in Transition from Homelessness (PATH), a $5 million increase over Fiscal Year 2004. The funds will allow grantees to reach out to 154,000 homeless individuals and to help these individuals obtain mental health, substance abuse treatment, and housing services.

Other Mental Health Programs. A total of $436 million is requested for the Community Mental Health Services Block Grant Program, which provides community-based mental health services for adults with serious mental illness and children with serious emotional disturbances. The budget also supports assistance to states in developing programs for people with co-occurring mental health and substance abuse disorders, as well as efforts to continue support for Federal partnerships focusing on youth violence.

Program Management

The President's budget provides $92 million to maintain SAMHSA staffing levels and to support effective administration of the Agency. As part of the President's Management Agenda, SAMHSA has revamped its grant announcement process to make the application process easier and simpler for potential grantees.

For more information, visit the SAMHSA Web site at **www.samhsa.gov/budget/budget.html,** which includes the Fiscal Year 2005 Justification of Estimates for Appropriations Committees as well as information on the Government Performance and Results Act. In addition, a "Budget in Brief" is available at the HHS Web site at **www.hhs.gov.**

Overall, the proposal calls for a 6-percent increase in both mental health and substance abuse services, expanding SAMHSA's budget to $3.6 billion in Fiscal Year 2005.

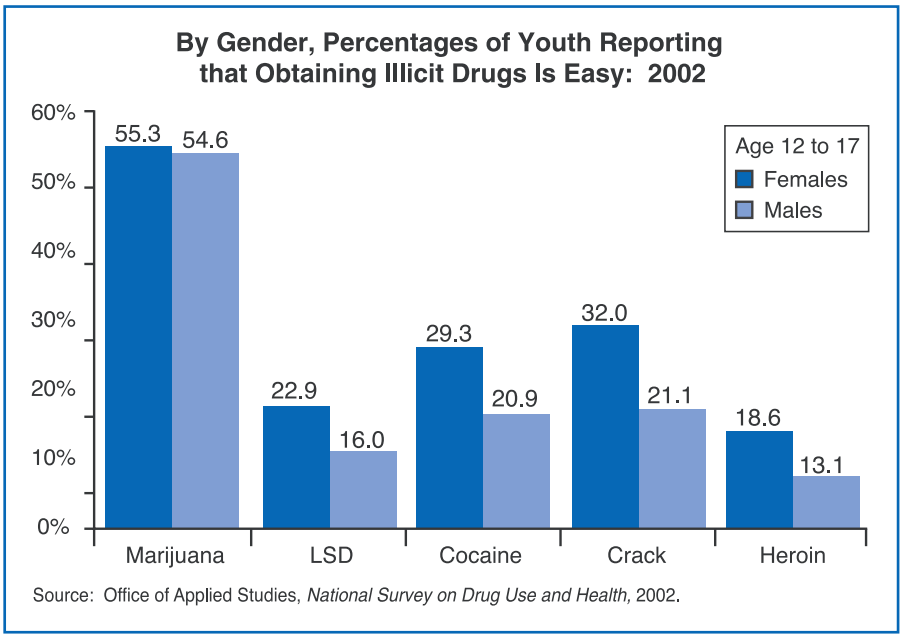
Majority of Youth Say Marijuana Easy To Obtain

How easy is it for young people to get marijuana and other illicit drugs?

In 2002, more than half of youth age 12 to 17 felt that marijuana was easy to obtain. And almost 17 percent of all youth reported being approached by someone selling drugs in the past month. These statistics are included in a new report from the 2002 National Survey on Drug Use and Health (NSDUH), formerly the National Household Survey on Drug Abuse.

From across the Nation, the survey gathered responses from more than 23,000 youth to a series of questions about their use and perceptions of availability of illicit drugs.

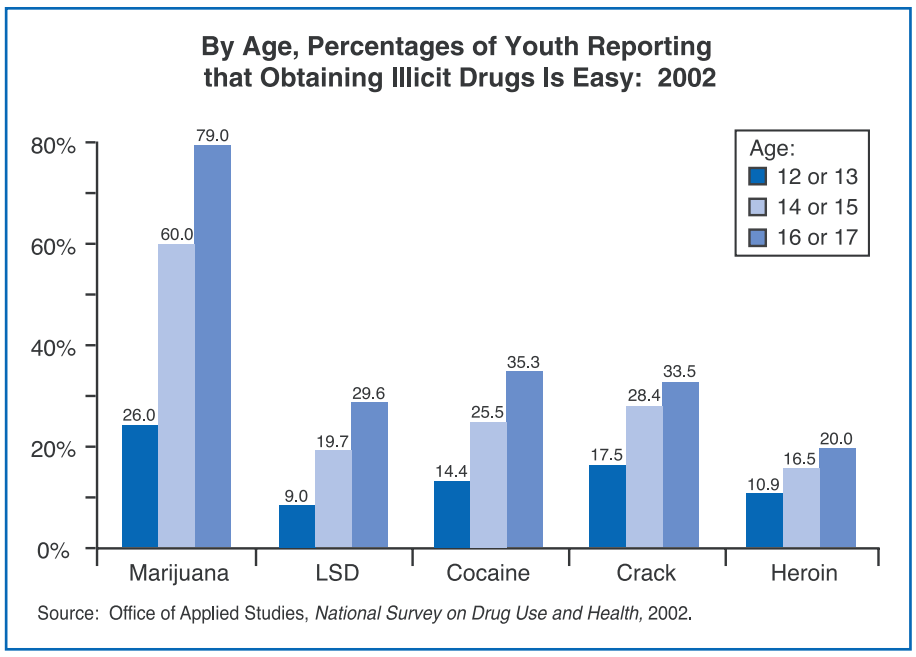
First, young people were asked to give a tally of their illicit drug use in the month prior to the interview. Illicit drugs included marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, and prescription drugs for non-medical use. Youth were then asked how easy or difficult it was to obtain drugs. In addition, they were asked about being approached in the past month by someone selling drugs. Responses were analyzed by gender, age, and residence by the type of county (metropolitan versus non-metropolitan) in which the respondents lived.



The survey estimated that 3 million youth (12 percent) age 12 to 17 used an illicit drug in the past month. Marijuana was the most frequently used drug; 8 percent reported using it within the last month. Four percent reported using prescription drugs non-medically in the past month; 1 percent used inhalants; and 1 percent used hallucinogens, including LSD. Cocaine (including crack) and heroin were used by less than 1 percent of the respondents.

Overall, 55 percent of youth age 12 to 17 said it would be easy to obtain marijuana. More than one in four young people felt it would be easy to obtain crack, compared to 25 percent for cocaine, 19 percent for LSD, and 16 percent for heroin. By gender, females were more likely than males to report that LSD, cocaine, crack, and heroin were easy to obtain. By age, 16- and 17-year-olds were more likely than younger children age 12 to 15 to report marijuana, LSD, cocaine, crack, and heroin as easy to obtain.

Data show that many young people don't have to go looking for illicit drugs; sellers bring the drugs to them. Males were more likely to be approached by a drug



seller than females, and youth age 16 or 17 were more likely to be approached than youth age 15 or younger.

The report reveals some discrepancies between youth who live in metropolitan areas and those who live in non-metropolitan areas. Youth in metropolitan areas were more likely than youth in non-metropolitan areas to report that LSD or cocaine was easy to obtain. In large metropolitan areas, youth reported more frequently that heroin was easy to obtain than those living in small metropolitan or non-metropolitan areas. Youth living in metropolitan areas were more likely to be approached by someone selling drugs.

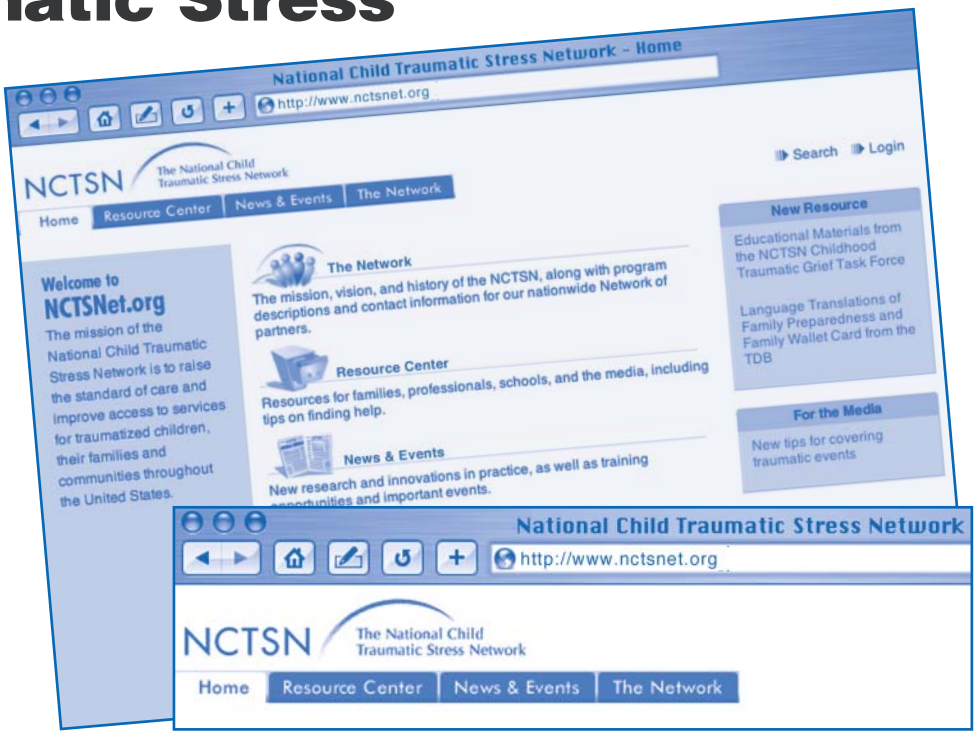
Clearly, young people who reported that illicit drugs were easy to obtain were more likely to report past-month use of marijuana, LSD, cocaine, or crack than were those who viewed illicit drugs as hard to obtain. Furthermore, youth who were approached by someone selling drugs during the past month were also more likely to report using drugs than were youth not approached by a drug seller.

An electronic copy of this NSDUH report, *Availability of Illicit Drugs among Youths,* is available from SAMHSA's Office of Applied Studies at **www.drugabusestatistics.samhsa.gov.**

On the Web: A New Resource for Child Traumatic Stress

The National Resource Center for Child Traumatic Stress, funded by SAMHSA, has developed a comprehensive and easy-to-navigate Web site with information and resources for counselors, families, and others seeking to understand and treat child traumatic stress.

Developed to support the National Child Traumatic Stress Network (See *SAMHSA News,* Volume XI, Number 1), the Resource Center's Web site provides families, school personnel, and health professionals access to the developing body of knowledge on the effects of domestic, school, and community violence; traumatic bereavement; natural disasters; medical procedures; and other traumas experienced by children from infancy through adolescence.



Resources include:

- Links for mental health professionals including the PILOTS database—a catalogue of professional literature on post-traumatic stress disorder—and articles and presentations by Network members.
- Articles and fact sheets on child traumatic stress, resilience and recovery factors, and evidence-based approaches to service and treatment in a variety of settings.
- A guide to family preparedness to help a family develop an emergency plan, a communication plan, and an emergency supply kit.
- A downloadable wallet card to keep contact information of family members, schools, local authorities, and others.
- Disaster preparedness information specific to bioterrorism, epidemics, earthquakes, floods, and hurricanes.
- A checklist to evaluate the mental health component of the school crisis and emergency plan for school personnel.
- Contact information for Network member organizations.

Expansion of the Resource Center's Web site continues as Network member organizations develop and publish new findings and strategies. For example, a resource area added recently focuses on child traumatic grief. Fact sheets for parents and professionals, as well as information specifically designed for the media, parents, pediatricians and pediatric nurses, and school personnel, are included.

For more information, visit the National Resource Center for Child Traumatic Stress Web site at **www.nctsnet.org.** Additional links to information on children and disasters are available on SAMHSA's Web site at **www.samhsa.gov.**

Methadone from Clinics Is Not the Culprit

Methadone-associated deaths are not being caused primarily by methadone diverted from methadone treatment programs, according to a panel of experts convened by SAMHSA.

"While deaths involving methadone increased, experiences in several states show that addiction treatment programs are not the culprits," said SAMHSA Center for Substance Abuse Treatment (CSAT) Director H. Westley Clark, M.D., J.D., M.P.H. He cited the expert panel consensus report at the Sixth International Conference on Pain and Chemical Dependency in New York City in early February.

Methadone-Associated Mortality, Report of a National Assessment concludes that "although the data remain incomplete, National Assessment meeting participants concurred that methadone tablets and/or diskettes distributed through channels other than opioid treatment programs most likely are the central factor in methadone-associated mortality."

Hospital emergency department visits involving methadone rose 176 percent from 1995 to 2002. The rise from 2000 to 2002 was 50 percent, according to SAMHSA's Drug Abuse Warning Network.

SAMHSA convened the panel in May 2003 to determine whether its methadone regulations were allowing diversion of methadone from clinics or whether the rise of methadone mentions in hospital emergency rooms and reports of deaths were due to methadone coming from other sources.

The panel—state and Federal experts, researchers, epidemiologists, pathologists, toxicologists, medical examiners, coroners, pain management specialists, addiction medicine specialists, and others—concluded that the methadone from reported deaths came from sources other than opioid treatment programs.

"The participants in the meeting reviewed data on methadone formulation, distribution, patterns of prescribing and dispensing, as well as relevant data on drug toxicology and drug-associated morbidity and mortality, before concluding that the cases of overdosing individuals were not generally linked to methadone derived from opioid treatment programs," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

The panel based its conclusion that methadone is coming from other sources on data showing that the greatest growth in methadone distribution in recent years is associated with its use as a prescription analgesic prescribed for pain, primarily in solid tablet or diskette form, and not in the liquid formulations that are the mainstay of opioid treatment programs that treat patients with methadone for abuse of heroin or prescription painkillers.

The experts surmise that current reports of methadone deaths involve one of three scenarios: illicitly obtained methadone used in excessive or repetitive doses in an attempt to achieve euphoric effects; methadone, either licitly or illicitly obtained, used in combination with other prescription medications such as benzodiazepines (anti-anxiety medications), alcohol, or other opioids; or an accumulation of methadone to harmful serum levels in the first few days of treatment for addiction or pain, before tolerance is developed.

"SAMHSA will continue to monitor the situation to ensure that SAMHSA's supervision of opioid treatment programs is always in the public interest," Mr. Curie emphasized.

SAMHSA Adds Sixth Accreditation Body for Methadone Programs

SAMHSA recently approved the National Commission for Correctional Health Care to conduct accreditation surveys for initiation, renewal, and continued accreditation of opioid treatment programs in jails and corrections facilities that provide methadone for patients with opioid addiction.

Oversight of opioid treatment programs was transferred to SAMHSA from the Food and Drug Administration in May 2001. At that time, the SAMHSA accreditation process was created to require all treatment facilities that use methadone to withdraw or maintain patients addicted to opiates to become accredited.

Other approved accreditation bodies include: Commission on Accreditation of Rehabilitation Facilities; Council on Accreditation for Children and Family Services; Joint Commission on Accreditation of Healthcare Organizations; Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services; and Division of Alcohol and Drug Abuse, State of Missouri Department of Mental Health.

SAMHSA regulations mandate that a SAMHSA-recognized accreditation body accredit all methadone treatment centers at least every 3 years. Accreditation bodies are required to notify SAMHSA within 48 hours after becoming aware of any practice or condition in an opioid treatment program that may pose a serious risk to public health and safety or patient care.

For more information, go to **http://dpt.samhsa.gov/accreditation.htm.**

Retailers Reduce Cigarette Sales to Youth

Recent data from SAMHSA show that retailers continue to reduce sales of tobacco to children under age 18. Overall, the national retailer violation rate dropped to 14.1 percent in 2002—from 16.3 percent in 2001 and 40.1 percent in 1996. SAMHSA released these data in December at the 2003 National Conference on Tobacco or Health in Boston.

The 2002 survey shows that 41 states and the District of Columbia achieved a retailer violation rate of no more than 15 percent.

Survey findings are based on reports submitted by states in response to a Federal law established in 1992 that restricts access to tobacco by youth under age 18. The law, known as the Synar Amendment, was named for the late Representative Mike Synar of Oklahoma. It includes implementing regulations that require states and U.S. territories to enact and enforce youth tobacco access laws; conduct annual, random unannounced inspections of tobacco outlets; achieve negotiated annual retailer violation targets; and attain a final goal of 20 percent or below for retailer non-compliance.

The new survey shows that seven states reported achieving a retailer violation rate of 20 percent or less for the first time in 2002. These states include Indiana, Maryland, Nevada, New Jersey, Ohio, Oklahoma, and Pennsylvania.

States with a low retailer violation rate have a number of common characteristics, according to SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W. "Generally, these states employ a comprehensive strategy that combines vigorous enforcement efforts, political support from the state government, and a climate of active social norms that discourage youth tobacco use," he explained. "Tobacco control programs in these states also tend to be well coordinated and include targeted merchant and community education, media advocacy, and use of community coalitions to mobilize support for restricting minors' access to tobacco."

Alaska was the only state that failed to meet its negotiated retailer violation target in 2002. As specified in the law, Alaska is committing additional state funds for tobacco enforcement as an alternative to losing part of its SAMHSA block grant funding.

For more information, visit **http://prevention.samhsa.gov/tobacco.** Or, 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).

Retailer Violation Rates Reported for 2002

State Name	Target	Reported	State Name	Target	Reported	State Name	Target	Reported
Alabama	20.0	9.1	Kentucky	20.0	9.7	North Dakota	20.0	6.5
Alaska	20.0	30.2	Louisiana	20.0	5.7	Ohio	20.0	16.6
Arizona	20.0	12.8	Maine	20.0	7.3	Oklahoma	20.0	20.1
Arkansas	20.0	11.5	Maryland	20.0	10.4	Oregon	20.0	17.5
California	20.0	19.3	Massachusetts	20.0	8.9	Pennsylvania	20.0	14.5
Colorado	20.0	5.4	Michigan	20.0	15.7	Rhode Island	20.0	10.2
Connecticut	20.0	12.0	Minnesota	20.0	15.5	South Carolina	20.0	15.5
Delaware	20.0	5.7	Mississippi	20.0	7.7	South Dakota	20.0	7.6
District of Columbia	20.0	15.7	Missouri	20.0	11.0	Tennessee	20.0	22.3
Florida	20.0	7.1	Montana	20.0	23.3	Texas	20.0	15.7
Georgia	20.0	10.6	Nebraska	20.0	19.0	Utah	20.0	12.4
Hawaii	20.0	6.0	Nevada	20.0	18.3	Vermont	20.0	14.6
Idaho	20.0	10.5	New Hampshire	20.0	9.6	Virginia	20.0	11.7
Illinois	20.0	13.9	New Jersey	20.0	15.9	Washington	20.0	13.8
Indiana	20.0	19.4	New Mexico	20.0	9.8	West Virginia	20.0	10.1
Iowa	20.0	11.0	New York	20.0	11.6	Wisconsin	20.0	20.7
Kansas	20.0	20.6	North Carolina	20.0	18.0	Wyoming	20.0	8.2

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:

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- ❑ From the Administrator

Buprenorphine:

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- ❑ Training Available for Counselors
- ❑ In Action: One Community's Story

- ❑ *SAMHSA News* Gets a New Web Address
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- ❑ Majority of Youth Say Marijuana Easy To Obtain
- ❑ On the Web: A New Resource for Child Traumatic Stress
- ❑ Methadone From Clinics Is Not the Culprit
- ❑ SAMHSA Adds Sixth Accreditation Body for Methadone Programs
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Room 13C-05
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-8956
Fax: (301) 443-9050
E-mail: *dgoodman@samhsa.gov*

Thank you for your comments.

Treatment Admissions Rise for Narcotic Painkillers

According to a new report from SAMHSA's Drug and Alcohol Services Information System (DASIS), treatment admission rates for abuse of narcotic painkillers more than doubled between 1992 and 2000.

The proportion of new users of narcotic painkillers (those entering treatment within 3 years of beginning use) increased from 30 percent in 1997 to 41 percent in 2000. In addition, between 1997 and 2000, the number of treatment admissions involving narcotic painkillers increased for all ages, especially among people age 20 to 30.

In 1992, five states had an admission rate for narcotic painkillers of 24 per 100,000 (age 12 and older). By 1997, 11 states had admission rates that high. By 2000, 21 states had narcotic painkiller admission rates of 24 or more per 100,000. Rates were particularly high in New England, where they ranged from 12 per 100,000 people in New Hampshire, to 63 per 100,000 in Connecticut, to 120 per 100,000 in Maine.

The characteristics of admissions for abuse of narcotic painkillers changed very little between 1997 and 2000. More than half of these admissions (56 percent) were male, and more than 80 percent were white.

Narcotic painkiller admissions include all admissions reporting primary, secondary, or tertiary abuse of substances such as oxycodone, codeine, dilaudid, morphine, demerol, and any other drug with morphine-like effects.

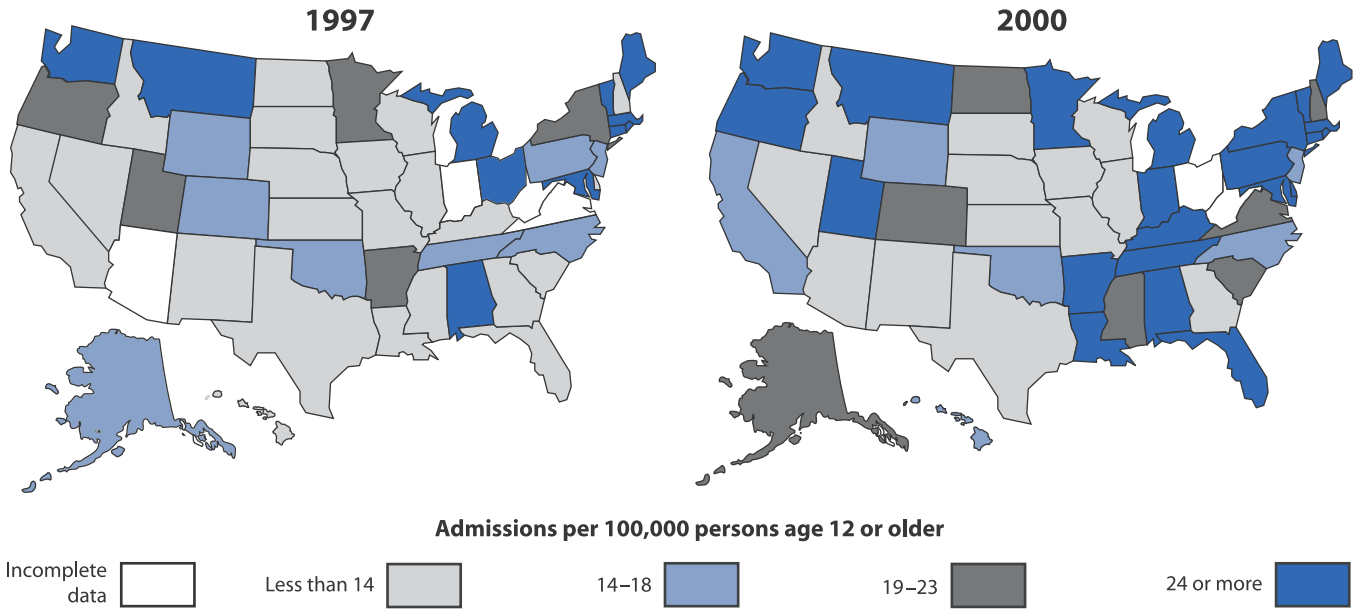
To obtain a copy of the DASIS report, *Treatment Admissions Involving Narcotic Painkillers,* contact SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686 (English and Spanish) or 1 (800) 487-4889 (TDD).

SAMHSA's Office of Applied Studies recently released another short report on treatment admissions for narcotic painkillers based on data gathered in a range of localities. These data show that between 1992 and 2000 the greatest increases in treatment admissions involving these drugs occurred in areas outside large central metropolitan areas.

Treatment Admissions in Urban and Rural Areas Involving Abuse of Narcotic Painkillers Treatment is also available from NCADI.

Both reports can be downloaded from the SAMHSA Web site at **www.drugabusestatistics.samhsa.gov.**

Rates of Narcotic Painkiller Admissions by State



Source: Office of Applied Studies, *Drug and Alcohol Services Information System, Treatment Episode Data Set,* 2000.

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Substance Abuse and Mental Health Services Administration

ADMINISTRATOR
Charles G. Curie, M.A., A.C.S.W.

CENTER FOR MENTAL HEALTH SERVICES
A. Kathryn Power, M.Ed., Director

CENTER FOR SUBSTANCE ABUSE PREVENTION
Beverly Watts Davis, Director

CENTER FOR SUBSTANCE ABUSE TREATMENT
H. Westley Clark, M.D., J.D., M.P.H., Director

EDITOR
Deborah Goodman

Comments are invited.
Phone: (301) 443-8956
Fax: (301) 443-9050
E-mail: *dgoodman@samhsa.gov*
Mail: Editor, *SAMHSA News*
Room 13C-05
5600 Fishers Lane
Rockville, MD 20857

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