United States and Mexico
High Level Contact Group

Proceedings
of the
Third Bi-National
Drug Demand Reduction Conference

co-sponsored by
the U.S. Office of National Drug Control Policy
and
Mexico National Council on Addictions

May 31 - June 2, 2000
Phoenix, Arizona

FOREWORD

For the third time in as many years, Mexican and American officials and experts gathered at a bi-national conference to collaborate in reducing drug use in both countries. The understanding, goodwill, cooperation and work products generated during and in preparation for these conferences demonstrate what can result when suspicion and blame are set aside for the common good. With each successive conference, bi-national relationships and tools were created that can continue to effectively serve the people of the United States and Mexico throughout the normal periodic changes in leadership that take place in both countries.

While Mexico and the United States have worked together on drug issues for many years, our collaboration took dramatic steps forward under the leadership of Presidents Zedillo and Clinton, prompted in part by the greater economic interdependency fostered during their administrations by the creation and implementation of the North American Free Trade Agreement. In March 1996 the U.S.-Mexico High Level Contact Group for Drug Control (HLCG) was created. In May 1997 at the Mexico City Summit, the two presidents signed a 16-point Alliance against Drugs designed to strengthen our nations' joint commitment to reducing drug use. Then in February 1998 the two countries produced a Bi-National Drug Strategy that committed both nations to specific measures in the fight against illegal drugs. Both documents reinforce our commitment to reduce the availability of drugs through aggressive interdiction, tough law enforcement and sound judicial processes, but their first priority is together meeting the challenge of eliminating the demand for drugs in both countries.

One of the demand reduction measures in the Bi-National Drug Strategy was to convene a bi-national conference on demand reduction. The first conference, held in El Paso, Texas, USA, in March 1998, was exploratory in nature. Over 250 researchers, practitioners, and treatment and prevention experts in both countries gathered to share their expertise, exchange ideas, and strengthen our shared ability to reduce drug use. From the conference came the beginnings of a framework for joint efforts in demand reduction. Working groups generated explicit strategies in eight areas including research cooperation and the exchange of technical information, public awareness, community participation, youth, special populations, the workplace, HIV/AIDS, and violence and drug-related problems.

Between the first and second conferences, the bi-national demand reduction working group formed by the HLCG developed Performance Measures of Effectiveness (PMEs) to implement the strategies conceived at the first conference. The group identified 108 target actions, 22 of which were bi-national in nature. Before the second conference, 19 of those bi-national target actions were accomplished.

Over 300 people attended the second Bi-National Conference on Demand Reduction June 1999 in Tijuana, Baja California, Mexico. The PMEs developed between conferences to implement the first year's workgroup strategies were reviewed, adjusted, and supplemented by the second year's workgroups (reduced to five from eight: research, treatment, prevention, public awareness, and the workplace). Participants were encouraged and excited by all that had been accomplished between conferences and were anxious to build on that momentum.

In addition to plenary sessions and work groups, this second conference featured pre-conference professional development workshops and guided tours to Tijuana research and treatment and prevention centers. Also, special sessions were held for representatives of non-governmental organizations (NGOs) involved in prevention and treatment and for youth participants. Among

other actions, the youth agreed to work toward the creation of a Bi-National Youth Organization Coalition for the Prevention and Control of Addictions.

The third Bi-National Demand Reduction Conference, which is described in these proceedings, met in Phoenix, Arizona, USA, in May 2000. Building on the accomplishments of the prior two conferences, this conference's objectives were:

- To identify future needs within drug control policy and ways the U.S. and Mexico can work domestically and bi-nationally, benefiting from one another's ideas and experiences;

- To bring together key policy makers, researchers, community members, and others from both countries to encourage networking, information sharing, and long-term relationships;

- To develop a bi-national research agenda;

- To expand bi-national youth-oriented substance abuse treatment and prevention efforts;

- To expand bi-national linkages and exchange of technical expertise in the field of substance abuse treatment, especially within the criminal justice system.

The 2000 conference brought together 426 participants for 2 ½ days of meetings. It was preceded by a research symposium and by three concurrent sessions for non-researchers: Advancements in Prevention Interventions; Advancements in Treatment Interventions; and Initiating and Evaluating Public Awareness Campaigns. Throughout the conference, workshops were organized along three tracks: Prevention, Treatment, and a new emphasis: Linking the Public Health and Public Safety Systems. While these were going on, youth participants convened the first annual meeting of the Bi-National Youth Organization Coalition for the Prevention and Control of Addictions that had been organized the year before. A fourth bi-national conference is scheduled for September 2001 in Mexico.

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THE WHITE HOUSE

WASHINGTON

May 26, 2000

Warm greetings to everyone gathered in Phoenix to participate in the third U.S.-Mexico Bi-National Drug Demand Reduction Conference. This conference culminates another year of effective partnership between our two nations in the struggle to combat illegal drugs.

Since President Zedillo and I signed the Declaration of Alliance Against Drugs in 1997, the United States and Mexico have closely cooperated to achieve a comprehensive, balanced approach to reducing the demand for and supply of illegal drugs. In the area of law enforcement, we have seen the arrest of some major traffickers and cooperated with mutual respect on important cases. We have improved interdiction and cracked down on money laundering. We have also worked together to reduce demand for illegal drugs in both countries.

I am confident that this third Bi-National Drug Demand Reduction Conference will build on the achievements of your earlier gatherings. I applaud each participant for your commitment to protecting a new generation of youth on both sides of the border from destructive drug use. As we stand at the dawn of a new century, we must reaffirm our obligation to ensure a safer, healthier future for all our citizens.

Best wishes for a successful conference.

United Nations Office
for Drug Control
and Crime Prevention

Vienna International Center
P.O. Box 500, A-1400, Vienna, Austria
Telephone: +43-1- 26060-0 Telefax +43-1-26060-5866
E-Mail: undcp_hq@undcp.un.or.at

THE EXECUTIVE DIRECTOR

Message to the Third U.S./Mexico Bi-National Drug Demand Reduction Conference Phoenix, Arizona, 31 May 2 June 2000

As you know, the work of the United Nations International Drug Control Programme is guided by agreements reached by the international community in inter-governmental bodies. In March this year, the Commission on Narcotic Drugs continued to devote special attention to drug demand reduction, particularly regarding follow-up to the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction.

During the debate the Commission identified four substantive priority areas for U7NDCP's activities:

Firstly, drug abuse among children and youth and the globalization of youth culture and associated patterns of drug abuse, with special attention to young people's involvement and participation in the design and implementation of drug prevention programmes.

Secondly, the growing problem of ATS abuse, and the need to develop effective responses in this area. The abuse of ATS increased dramatically throughout the 1 990s and diffused to regions where it was previously unknown. There is a need to identify and develop culturally appropriate approaches to prevention and treatment.

Thirdly, the health consequences of drug abuse and particularly drug injection, such as HIV infection, hepatitis C and other communicable diseases, as well as overdoses. In many countries, and in developing countries in particular, the increase in heroin abuse has been accompanied by the introduction of drug injecting. Furthermore, the number of countries reporting HIV infection among drug injectors is increasing.

Fourthly, cutting across all the three above-mentioned areas, the need for improved data collçction to provide a sound knowledge base for the development of effective responses, and in particular the important role UNDCP should play in supporting the development of capacity for data collection and analysis in countries where this is absent or deficient.

Concentrating on these four priority areas in drug demand reduction constitutes plenty of work for us all in the coming year. I wish you fruitful deliberations and a successful conference.

Pino Arlacchi

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

May 31, 2000

Dear colleague:

The Office of National Drug Control Policy welcomes participants in the Third U.S.-Mexico Bi-National Drug Demand Reduction Conference. This conference marks an important milestone in the evolving cooperation between our two countries in reducing the demand for illegal drugs.

The United States and Mexico are two dynamic societies whose present and futures are intertwined. We share a 1,800-mile border, the world's busiest. We are major trading partners. We share a common culture, with the U.S. now possessing the world's fifth largest Hispanic population. Although we share much that is positive, we also face a common threat to the health and safety of our citizens: the use of illegal drugs. That is why our presidents signed, in May 1997, the Declaration of the U.S.-Mexico Alliance Against Drugs, outlining 16 principles under which cooperation would be carried out. Reducing drug demand was the first of these principles, and this conference – the third such conference – is a fundamental vehicle for advancing collaborative efforts.

Like those that preceded it, this is a working conference. It brings together experts, scholars, program administrators and practitioners from the U.S. and Mexico to exchange information, highlight effective approaches, and work together on issues that require a cross-border solution. Our cooperation is already showing tangible results. Community anti-drug coalitions on both sides of the border are working together as never, before. Researchers are developing a common framework for future studies. Regional conferences have been held on drug and violence prevention approaches. A special website has been developed to facilitate binational information exchange. And our countries are mounting unprecedented drug prevention media campaigns in cooperation, not in isolation.

Our partnership must continue and be strengthened in the years ahead if we are to succeed in reducing the devastating impact of drug abuse on our societies. We look forward to working with each of you on this long-term approach to ensuring a healthier, safer future for our. children and our families.

Best wishes,

Barry R. McCaffrey
Director

THE SECRETARY OF EDUCATION
WASHINGTON, D.C. 20202

THIRD U.S./MEXICO BI-NATIONAL
DEMAND REDUCTION CONFERENCE
Phoenix, Arizona
May31 —June 2, 2000

I wish to extend my warmest greetings to all of you who are participating in the Third U.S ./Mexico Bi-National Demand Reduction Conference.

This conference provides an important opportunity for our countries to share information about promising and effective strategies to prevent drug use and violence. The Department of Education is engaged in a number of new initiatives to ensure that our children have access to safe, disciplined, and drug-free schools.

One approach the Department of Education is taking is to collaborate with other Federal agencies on initiatives that support comprehensive, multidisciplinary drug and violence prevention strategies involving the whole community. An example is the Safe Schools/Healthy Students Initiative, a joint effort of the U.S. Departments of Education, Health and Human Services, and Justice that awards grants to school districts to implement comprehensive, community-wide strategies for safe, drug-free learning environments and healthy childhood development. The initiative draws on the best practices of the education, justice, social service, and mental health systems to help children avoid drug use and violent behavior.

We look forward to sharing information about our current initiatives and learning about similar prevention initiatives in Mexico. We are committed to our continuing partnership in this bi-national effort. Best wishes for a successful and productive conference.

Richard W. Riley

THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

May 16, 2000

Dear Colleague,

I am pleased once again to have the opportunity to extend my greetings to the participants in the third Bi-National Drug Demand Reduction Conference, this year in Phoenix, Arizona.

Safety is President Clinton and Vice President Gore's highest transportation priority and the North Star by which the Department of Transportation is guided and willing to be judged. Safety is a partnership in commitment. Each of us - government, industry, and private citizens alike - must take personal responsibility for reducing crashes on our highways and ensuring that those who are entrusted with the safety of our public are drug and alcohol free.

The bi-national meetings focus on developing and expanding the partnership between our two countries in the vital interest of reducing the demand for drugs. This vision continues within each of you this year. Nowhere is it more important to send a signal to the public that we are committed to reducing drug and alcohol usage than in our workplaces. Together we should expect nothing less than workplaces that are completely drug and alcohol-free, making for even safer workplaces for our employees, their families, and the traveling public.

Transportation is more than concrete, asphalt, and steel, it is about people and providing them the security of being able to enjoy safe travel. Together we can make this happen and this conference will go a long way to ensuring that the people of our countries working collaboratively can reduce the demand for drugs. I applaud all of your efforts in achieving our mutual goals.

Sincerely,

Rodney E. Slater

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

May 26 2000

Dear Colleagues:

Welcome to the third annual High Level Contact Group U.S.-Mexico Demand Reduction Conference – the first in this new millennium. This key meeting – "Strengthening the Bi-National Partnership in the New Century" – will give still further concrete structure and form to the blueprints for action that we have crafted together in past meetings.

There is no better time for us to get down to the work of training and education, sharing what "works" in prevention, in treatment, and in linking public health and public safety. The issues on which we will work transcend nationality, transcend politics and ideology. They are at the very heart of our purpose: reducing substance abuse for our people today, and eliminating it for those who will come tomorrow.

This meeting most assuredly will set the tone and direction for the new century of collaborations and individual demand reduction efforts within and across our borders. The commitment, dedication and, above all, collaboration of the leaders in substance abuse prevention and treatment at this key meeting can and, I am certain, will serve as the springboard to meaningful and targeted substance abuse-related programs for both the Mexican and American people.

It has been said that "progress occurs when courageous, skillful leaders seize the opportunity to change things for the better." Let us work together to live up to those words. We have already seized the opportunity; let us now demonstrate once again, that capacity to change things for the better not just for our nations, but for all the Americas.

Sincerely yours,

Nelba Chavez, Ph.D.
Administrator

CONFERENCE OVERVIEW

CONFERENCE OVERVIEW

The Third Bi-national Drug Demand Reduction Conference in Phoenix featured sharing of innovations and best practices in the area of substance abuse prevention and treatment, training for Mexican officials on advances in heroin and amphetamine treatment, and expert presentations on ways to better integrate the public health and public safety systems.

Concurrent pre-conference sessions were held on advances in prevention and treatment, and in initiating and evaluating public awareness campaigns. Both Mexican and US programs were featured, such as SAMHSA's media campaign, *Hablemos En Confianza*, as well as Mexico's prevention program, *Construye Tu Vida Sin Addiciones*. Officials from Baja, California, Mexico and San Diego jointly presented an innovative school curriculum to prevent drug-related border crime. Treatment professionals discussed faith-based and social models of recovery, and participants shared best practices in crafting and evaluating public awareness campaigns and heard from experts in social marketing.

The conference featured several plenary sessions covering a range of topics and was divided into three tracks: Prevention, Treatment, and Linking Public Health and Public Safety. Plenary sessions included opening remarks, challenges and opportunities in drug demand reduction, mobilizing parents, youth, and program evaluation — for prevention, treatment, and public health-public safety programs.

The prevention track featured prevention experts from both Mexico and the US on topics such as family strengthening and community mobilization, while the treatment track consisted of two training sessions — one on opiate treatment, and a shorter training on amphetamine treatment. The track on linking public health and public safety featured presentations on the dually-diagnosed, relapse prevention, recovery, diversion and community corrections, and drug courts.

ORGANIZATION OF THIS BOOK

These *Proceedings* are organized thematically rather than chronologically. All plenary sessions across the three days are presented first. Then materials are grouped for each track: prevention, treatment, public media campaigns, and public health-public safety. Each grouping contains speech transcripts, papers provided by the speaker, or slides presented at the conference. Those materials are followed by the NIDA pre-conference session overview. The final components are lists of attendees.

PLENARY SESSIONS

PLENARY SESSIONS
Opening Remarks

Daniel Schecter
Deputy Director for Demand Reduction (Acting)
Office of National Drug Control Policy
United States

Good Morning. Welcome to the third Bi-National U.S.- Mexico Drug Demand Reduction Conference.

Many of you will remember two years ago when we held the first bi-national conference in El Paso, Texas. This kind of gathering had never been done before. There were no examples in history of two contiguous nations convening their experts together to jointly hold a conversation on how to cooperatively reduce the use of illegal drugs. Well, that conference was a tremendous success.

In fact, those of you who were there would remember that on the final day of the conference, on a Friday afternoon, in the final moments of the final plenary session, the room was packed; nobody had left. I think that speaks to the interest and the commitment on both sides of the border to find common solutions to common problems.

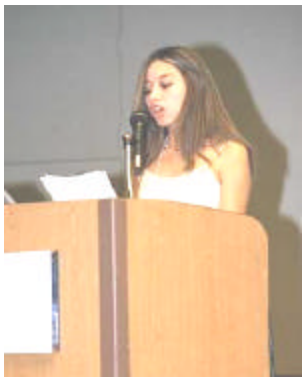
A second conference was hosted by Mexico last year in Tijuana, again, a highly successful conference. Now, here we are; a third U.S.-Mexico conference which we hope will be the most successful of all. And it will be followed, I am sure, by a fourth, a fifth, and a sixth. The reason I am so confident of this is because of the many relationships that have been formed, collegial relationships among experts from both countries, working together outside of these conferences throughout the year in many, many different settings. You will be hearing about those collaborations over the next two days.

Although this is the official opening of the conference many of us have already been meeting for two days. On Tuesday, we had a very successful day-long meeting of bi-national researchers, hosted by the National Institute on Drug Abuse. Yesterday, we held pre-conference sessions on prevention, treatment and on communicating anti-drug messages.

Before we get to our distinguished panel of speakers, I would like to call upon a very special young lady to say a few words to us. Her name is Sofia Magaly Camorlinga; she is twenty years old, from the State of Colima, and attends the University of Colima, majoring in Public Administration. She was a participant in our first youth forum last year in Tijuana and we are continuing that youth forum here. As a result of this conversation, Sofia and others in Mexico formed a national youth coalition organization for the prevention of addictions ? yet another tangible example of the benefits of this collaboration.

Sofia Magaly Camorlinga
Youth Representative
Mexico

Good Morning. First of all I would like to thank everyone for the opportunity provided us, as part of the young people of the world, to come to a forum such as this to express ourselves. I would like to convey a message that was collectively drafted by youth organizations here present as well as those who have been working in their communities. I'm going to be reading the message in order not to omit any details.



We are here speaking the different views of the coalition of youth organizations for the

prevention of addiction and critical conditions associated with it. This is from the organization, the neighborhood, the rock band, the dance group, the football team or just the boys and girls out in the field; in the cities, in the schools, on the corner of the street; those of us who undertake different actions to prevent the use and dependence on psychoactive drugs and substances. This coalition is comprised of young people of different ages, ways of thinking, identities, political affiliations and even with different beliefs, religious beliefs and sexual preferences. We have interests as diverse as the cultural economic and political conditions that we find in Chiapas or Quintana Roo, in Mexico City or Morelos, in Tijuana or Ciudad Juarez.

In spite of our differences, which we assume with joy in order to enrich each other, we have been working together, so that in our own small way we might transcend our local living conditions. We are a hundred and twenty youth organizations working throughout almost all of the states of Mexico. We are most willing to take action and we have the desire to achieve much in our coalition.

Today our youth, both in the United States and Mexico, are here to talk about our concerns and proposals for continuing the work. We want to share this with government agencies and non-government organizations that are also concerned about the conditions of youth in order to jointly build public policies that will take into account our contributions.

We know that the phenomenon of production, trafficking, distribution and consumption of drugs is increasingly complex and growing in both countries. This is related to poverty, violence, insecurity, delinquency and social exclusion. It is not merely a legal issue or a national security issue. The consequences of drug use concerns youth, the family, the priest, teachers, police, community leaders and officials. With their support we strive to put in place the promotion of prevention programs that address these issues and the critical related consequences. We feel that is very important to promote the distinct efforts and models that take place at the local level in youth organizations that are based on the prevailing local conditions. We know that this can take place at different levels, but we hope that efforts will be undertaken jointly so that governments, institutions, youth organization and young people can go forward together.

We presented our desires at the second bi-national conference in Tijuana and you have been working for us and with us. We want you to continue working with us. It is our proposal that we continue working collectively with the young people of both Mexico and the United States. We want to build this coalition further. What we have done thus far has been hard work and we have run into certain obstacles, but we realize that we have progressed to the point where our efforts can transcend any border.

After our participation in the second bi-national conference where 50 young people attended in order to build a coalition, we in Mexico decided to invite other youth organizations so that they could join our fight. We met at a national camp that was held in the State of Morelos, and we also had two regional meetings, one in Ciudad Juarez, Chihuahua and the other in Tuxtla Gutierrez, Chiapas. In December we held our first national meeting in Mexico City with 120 organizations participating.

There we decided on an action plan for this year. A communication structure was also created so that we could all keep in touch with the work that each organization is doing. It would take a very long time for me to tell you what every organization has done, but on the second floor of this hotel, we have a display that shows the work being done by each organization.

We youth agree that the drug demand reduction work requires political, social and economic support in order to reduce drug use. And we must not forget the commitment of the last bi-national conference to create a fund that will support the projects of youth organizations.

For a long time young people have been considered as passive role players in the phenomenon of drug use and abuse. And now we enthusiastically see that the governments of both of our countries, Mexico and the United States, are again demonstrating that they're

quite open to us by inviting us and supporting our participation in this event.

Together with the experts and those responsible for programs, we are capable of collaborating in this program as well as many others that impact our young people. The message of irresponsibility or lack of social awareness that has for many years been the weight upon the shoulders of our youth, is now being reversed through the dynamics and creativity of our young people.

Together with government organizations, social organizations, as well as with the help of researchers and others, we wish to no longer be part of the problem. We want to become an essential component for its solution. We know that our contribution will add up and that this third bi-national conference will end with commitments and agreements that the associations will undertake and live up to.

We invite you to join forces with us and to commit to working together with us so that we can reduce the demand for drugs in our countries. Thank you.

Barry R. McCaffrey
Director
Office of National Drug Control Policy
Executive Office of the President
United States

Thank you for that introduction. You know, each year there's one part of the introduction that becomes more and more important for me to hear— the youngest four-star General. I cling to it, and I thank you Dan for including that. Let me, if I may, very briefly make some remarks.

To begin, I want to tell you our corporate sense of pride, satisfaction and optimism for the future to see all of you here. The most senior, engaged, and experienced officials in both of these huge democracies are here, charged with the important responsibility of the reduction of drug abuse in our societies. We have enormous expectations that what we are doing here is more of a process than a snapshot in time. We have committed ourselves to partnership on this very essential issue of reduction in drug consumption.

I really thank all of you for the gift of your most precious personal asset, your time, to come here from all over these two great nations. Let me also thank the Mexican delegation leadership. Quite specifically, we've become not only partners, but also friends. We had a breakfast among thirty of us this morning; it's an unusual relationship. We have some very strong partnerships in the international community, but I would suggest that there is almost nothing like the growing sense of very continuous contact between our two governments at the most senior levels.

I thank Attorney General Jorge Madrazo for his own leadership, for his integrity, for his courage in facing one of the most violent, corrupting international criminal threats history has ever seen. It's unfortunate Mariano Herrán could not be here, but he has his representatives here. We thank them for their commitment to responding to President Zedillo's instructions to see this as a most significant threat facing Mexico.

We also welcome the Minister of Health of Mexico, José Antonio González Fernández; we thank him for the tremendous experience he brings to this public policy position. He is a great partner in the last months of our administrations.

Haydée Rosovsky, who as you know, is the head of CONADIC, and Dr. Roberto Tapia Conyer— we thank them for their continuing support. The heavy lifting of this relationship is really done by those two in many ways.

And congratulations to Jesús Cabrera Solís, the Director of the Juvenile Integration Institute, on their 30th anniversary for all they do.

And to the many other Mexican partners we have come to know, we thank you for the ability to work with you for three days here in Phoenix.

In the U.S. delegation, there are too many here to identify specifically, but, Ambassador Jeff Davidow, our U.S. Ambassador to Mexico, thank you for your presence here, underscoring that in the world of diplomacy we understand that the 21st Century has very different concerns than the 19th Century. And so his own involvement and indeed that of Secretary Madeline Albright has been crucial to try and build a new sense of multinational partnership.

The most important person in our government in the drug issue is Dr. Nelba Chavez. She's here, fortunately, with both Dr. Westley Clark, who is in charge of our Center for Substance Abuse Treatment, as well as Dr. Ruth Sanchez-Way, who monitors our Substance Abuse Prevention programs, and I thank the two of them. They're making spectacular progress in our own internal domestic challenges.
John Wilson, the Acting Director of the Office of Juvenile Justice and Delinquency Prevention in the Department of Justice, is here. You should make sure you get to know him. They've been a very important part in our U.S. effort of bringing together these two worlds of the criminal justice system and the chronic offender, without which, there can be no progress in dealing with the chronic addict, so we thank him for being here.

There are many other people. Mr. Dan Schecter is my principal permanent civilian official in charge of Demand Reduction. We thank him for his leadership. He will be here in the next three U.S.-Mexico Demand Reduction conferences.

I notice we have Art Dean, right over here, retired general officer, one of the reasons he looks so good. We thank you, Art, for your leadership with Community Anti-Drug Coalitions of America (CADCA). He started with 4,000 community anti-drug coalitions around America; we're now up to 5,000.

We're also working on funding some new innovative approaches, and both Henry Lozano and Mary Ann Solberg are here from our Advisory Commission on Drug-Free Communities. I thank you for your leadership. They're really involved in helping us establish what have been to date more than 200 new funded community coalitions. They've had modest amounts of money, a hundred thousand dollars or less, to let communities begin to pull together the leadership that counts in this country.

We often say that our nation doesn't have a national drug problem; it has a series of community drug epidemics. So you can't possibly hope to confront these issues unless data is collected locally. Organizations are local — parents coalitions, the health community, the educators, the local law enforcement — that's really what CADCA is doing, as well as the thousands of anti-drug coalitions.

I hope Sunna Rasch is here. Last night it was a great treat and a privilege for many of us to see The Periwinkle Theatre production "Halfway There." This group of young people puts on what is probably the best acted and the most creative anti-drug play that I've seen. They are trying to communicate with young people the notion of the terrible destructive potential of drug abuse in their lives. We thank them for their involvement.

Let me also, if I may, pay note to two letters that we are very proud to have. The first is from my own President Bill Clinton. He has provided his greetings to this assembly and takes note of the enormous personal cooperation between these two Presidents over the last five-plus years. You know, I am a non-political officer of government by law and I helped change the law to make it that way. But, I personally have to articulate my own gratitude and respect for these two Presidents to step beyond domestic politics and to keep us on track working this common solution. We thank both of them.

We also have a letter from the United Nations Drug Control Program Secretary, Mr. Pino Arlacchi. I hope all of you know about his work and of him personally. They're based in Vienna,

of course, and just last week I was very proud to lead a delegation to New York, to the United Nations, and to spend some time, first with our Secretary General Kofi Annan and also with Pino Arlacchi. We talked about how we will continue to stress multi-national cooperation.

Now, at every one of these conferences, one thing I can always count on is Mexican civility. And so, with your permission let me read a few words in Spanish**.** *Creo que es importante subrayar el éxito que se está logrando con la estrategia nacional para el control de drogas en los Estados Unidos. En los últimos 20 años, por ejemplo, el consumo general en los Estados Unidos representa una reducción del 50 por ciento, mientras que el consumo de cocaína representa una reducción del 70 por ciento. En los últimos dos años nuestros jovenes norte-americanos han empezado a rechazar las drogas. Hemos lanzado una campaña de prevención historica. No se puede dudar nuestra determinación para reducir la demanda.* It's a miracle what three years of West Point Spanish thirty years ago can produce.

With your permission, a few continuing comments in English. Some of them perhaps underscore the general idea that the older I get, the more that I believe the most important things in life are obvious and need to be stated. One of those is that the U.S. and Mexico have no option but to cooperate. We are sitting in the same lifeboat. There is almost no frontier between these two nations. 350 million people a year cross that two thousand mile border. In most places, the border is barely marked. This is not North Korea next to another nation. These two nations have huge common cultural, economic, and political interests. We also have a history of ignorance and animosity toward one another on an official level, but not on a personal level. Because when you look at the impact of these two societies on one another in food, in art, in music, in religion, in cooperation, there has always been a tremendous sense of people-to-people cooperation and warmth over 200-plus years. But now, fortunately, what we've begun to do is to understand that only through the success of the three of us, Canada, the United States and Mexico, will our grandchildren's futures be preserved.

And so, I would just underscore, it would be simply remiss for officials in these two nations to not also recognize that an issue of such tremendous consequence to our societies such as drug abuse also deserves to have a response which is crafted in respectful, cooperative partnership. That's why we're here. Because we are serving our own self interests by extending a hand of dialogue, friendship, and partnership across that border. I think it's an easy message to make, given the fact that our senior leadership, the Presidents and their senior officials, have publicly continued to say that.

Now the second observation is that bi-national drug cooperation is really key to either society hoping to confront the issue. I do not believe it is possible for the United States standing alone, nor Bolivia, nor Thailand, nor other nations which are fundamentally threatened by this issue, to confront the problem without mechanisms of cooperation. This extends even to the most obvious and arguably best orchestrated part of international cooperation which is law enforcement. The law enforcement people do pretty well, almost naturally. Our two Attorneys General, thank God, have telephones that go to each other's direct line communications. So, in accordance with their own laws, the police, the intelligence, there is a continuing dialogue. How could we address drugs without money laundering, precursor chemical control, guns going from the United States into Mexico, the kind of system problems of crime that we address? It's a requirement, we would argue, to have a sense of cooperation. Clearly, that cooperation also extends into the 21st century. The most important aspect, I would argue, the most important institutions, are the legislative bodies. How can we cooperate on money laundering issues if there aren't 21st century laws that allow multiple systems in the hemisphere to share evidence, to do extradition, to have wire-tapping authority, where a Mexican wire tap can be used in a San Diego trial and vice versa? So I would just argue again, that any of us who hope to successfully confront the issue have to understand that we no longer live in a world of national concerns; we're in a global community.

The third point I would underscore is the dynamic nature of drug abuse. We talked of this at breakfast. Ambassador Davidow asked the question, "Now wait a minute, I understand

the past, I hear your programs. What is the future? Where is this drug problem moving?" Many of us are still holding old stereotypes of the problem, both in the national community and the international community. There's a danger that we will continue to work on past problems. This is a dynamic situation. It has taken me years to get U.S. officials to stop saying in their public speeches that the United States consumes half the drugs in the world. It's a curious kind of statement. It's not only completely wrong, but it produces an impact in which policy won't address the problems that we face.

Drug data is the worst aspect of this issue; it's too soft. If we were dealing with international economic questions, if we're dealing with highway construction problems, you never argue about facts. You find out what the facts are, you argue about conclusions.

But in the drug issue we have difficulty with data; addressing this is another aspect of our cooperation. I think that's very encouraging that Mexico and Argentina and other nations are now getting in front of the problem in collecting data. I would clearly suggest, straight out, that when I talk to the international community I say the United States has a huge drug consumption problem, around 6% of the population in the past month used drugs. In 1979, it was 14% of the population; in 2007, it will be below 3% of the population. It'll be the lowest recorded in modern American history. That's where we're going.

Meanwhile, Mexico is fortunate to be in a situation where the culture, the family, the Catholicism all combined to make your nation resistant to adolescent drug use. But times are changing. All of us are being immersed in the same modern communications and change in family values, change in how women relate to the work force. We are converging in many ways, which is largely good.

And the worldwide plague, the nature of the drug threat is changing. It's not just heroin; the world is submerged in heroin. The increase in production in the last ten years is unbelievable. In Afghanistan, now the number one producer of heroin on the face of the earth, it's the only aspect of that society that works. In Myanmar, we have huge rates of production of heroin. And then we come to Mexico. Fortunately, it has reduced heroin production. Thanks to the Mexican armed forces' courage, integrity and dedication, it has gone down by 25%. And yet the United States, we believe, consumes 3% of the world's heroin, so almost the entire consumption in the U.S. can come from Colombia and Mexico. It's a global problem. What we really fear and what many of us are looking at is that ten years from now—when my daughter who is an intensive care unit nurse is here as the U.S. Drug Policy Director— she will not be talking about cocaine as the number one addiction problem. But instead she will talk about methamphetamines, MDMA, ecstasy, and GHB and PCP, chemically manufactured psychoactive substances.

We need to understand this is a global problem. Mexico has a tremendous opportunity to ensure that what happened to the United States in the 1970's will not occur in Mexico. Demand reduction must be central to our partnership. It's great fun to work with Secretary Rosario Green, Minister Cervantes, and Attorney General Madrazo. We all have vital national federal responsibilities and we'll do them. But at the end of the day, the people who count are those who work with youth, and those who deal with the treatment of the chronically addicted. In many cases, these are either private non-profit organizations, or they deal with organizations that don't necessarily have governmental standing. We need to find ways for these groups to talk to each other, in particular along that border region. I think that is, of course, the central purpose of what we are doing here in the next two plus days.

Finally, let me point to the future. You know none of us are quite sure how the two political processes will work out in these two democracies. But clearly, by next year at this time, we'll have two very new political sets of leaders in place, and what we are making a very strong argument for is that regardless who has the honor of temporarily serving as officials in these two democratic governments, they must continue cooperation on the drug issue. And we're going to make that argument very strongly. We think we have heavily imbued in

the permanent bureaucracy a commitment to scientific, medical educational cooperation in drug treatment communities in the coming years. I hope that's the case. I believe, probably in August, you'll see us have another meeting of our High Level Contact Group, and by then the Mexican election will be over, and the U.S. system will be in the final weeks of our election. It'll be a good statement, I would hope, that on both sides of the border we see the problems as continuing and the requirement to cooperate as continuing.

Again, if you will, let me just share the sense of pride all of us at the head table, the ministers of government from both nations, feel in being privileged to provide a forum in which the serious professionals in this room can build concrete cooperation.

Thank you for who you are, and what you stand for, and God bless you in your work. Thank you.

Jeffrey Davidow
United States Ambassador to Mexico

Good Morning. Last week I was in Washington, at the meeting of the Bi-National commission of the United States and Mexico. And at that meeting, 16 sub-commissions, led by members of the cabinets of both countries, dealt with problems relating to health and education in the whole range of topics that unite and sometimes divide our two countries. What became apparent to me at that meeting, and I think we will see again at the meeting that will be taking place just one week from today in Washington between President Zedillo and Clinton, is that there are various components that have to be in place to deal with problems. They are, it seems to me, procedures, systems mechanisms and people with dedication and vision.

The fact that this is the third meeting of this group is immensely important. It means that it is now a tradition and it will continue. It will continue because it's a good idea and it's productive. And the people who will be running the government of Mexico next year and the people who will be running the government of the United States next year will understand that. It will recognize that this mechanism must continue to give you, the experts, the dedicated people, the opportunity to come together at least once a year and hopefully more to deal with this important problem.

But mechanisms, procedures, systems don't mean anything without dedicated people. You know, President Kennedy had a favorite story, which I'm going to repeat to you because it's one of my favorite stories. It's about a very old man, even older than me, a man in his 90's ? very wealthy, with a great estate. And one day he called his gardener, and he said to his gardener, "Tomorrow, I want you to go to town, to the little pueblo, to the garden place, the nursery and buy some seedlings ? seedlings of oak trees. And I want you to plant them over there."

And of course the gardener said, "Of course sir, I will. I will do that. I will go and buy the seedlings, but let me ask you a question. These oak trees will take 20 or 30 or 40 years to grow, and uh, with all due respect, I don't think you'll be here to see them, because you're already 90 years old. "

And the old man thought for a minute and he said, " you're absolutely right. I don't want you to go to town tomorrow to buy those little oak trees. I want you to go this afternoon."

And this is what I mean about people. Because what is necessary and what that old man had, is dedication and vision. So governments can help put together the mechanisms, mechanisms such as this meeting. But without the dedication and vision of you people, the mechanisms mean nothing.

And I am very honored to have been invited to come and meet you. I am very honored and

very encouraged to see the work that you're doing, and I wish you every success.

Thank you.

Nelba Chavez, Ph.D.
Administrator, Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Thank you for that gracious introduction. Once again, I am honored to be here.

And once again, I bring greetings from Donna Shalala, Secretary of the U.S. Department of Health and Human Services, whose support for programs to address drug abuse has been unwavering during her service to the Nation.

President John F. Kennedy said, "when people come together for a common cause, good things start to happen." Well, since our countries came together to develop and implement the U.S.-Mexico Binational Drug Strategy, we have been able to speak about drug demand reduction as a common cause.

Over the past years together, we've translated the theory and reality of drug abuse into a language we all understand. It's the language of family and home, the language of law and safe community, the language of forthright national leadership.

And that shared language has allowed us to create new knowledge, goals, and strategies to address drug abuse within our countries and across our borders.

Our shared language has been heard and read in our agreements to work together, our tenacity to get over the ticking spots of disagreement and dissent, and our shared commitment to do what is right for the people of both the Unites States and Mexico.

And as a result, those "good things" that President Kennedy spoke about, indeed, have started to happen.

We have moved from words to action. The words contained in Alliance Point 1, to "reduce demand through information, education and rehabilitation" have been actualized in a comprehensive set of performance measures of effectiveness for demand reduction – PMEs.

The PMEs capture successes in research, public education and the advance of effective prevention and treatment programs. And from the framework of the PMEs have come recommendations - recommendations that are the very soul of our work together – the collective wisdom of our insights, ideas and mutual respect.

Those recommendations affirm, above all, that substance abuse demand is a public health problem – a problem not dissimilar from insect-borne diseases or natural disasters such as earthquakes and floods. After all, when a disaster strikes, nations come together in shared purpose – to be of aid to suffering people, suffering nations.

So, too, it is with substance abuse demand. We – the United States and Mexico – come together to be of aid to suffering people – from children to elders – caught in the web of substance abuse.

More concretely, those recommendations span everything from research cooperation and technical information exchange to community participation, from public information and awareness to workplaces and education. And that's the public health model in action; that's the Bi-lateral Commission in action.

Now it is time to move these recommendations into our communities, as we promote an underlying base of self-worth, safety, and economic security for all.

We know the message must be unified; we know the message must be ongoing; we know the message must come from schoolroom and pulpit, from the circle of family to the camaraderie of the workplace.

To take that step ? as other steps we have taken together ? we need shared understandings, harmonized data, and awareness of what works for people at home where they live.

And today we're sharing just that knowledge. What you have found works; what we have found works - in treatment, in prevention; in schools, in the workplace, in communities; for adults, for youth; and across the health, and justice, and safety systems.

When we close this meeting, we'll all have more than take-away messages. We'll take-away knowledge that we can apply at home.

We will have the measuring sticks to tell if we're doing a good job of it. And we will have the opportunity for continued collaborations ? at the level of nations and at the level of programs.

I'm reminded of a story from Eastern Europe before the turn of the last century. Right after young couples married in the village church, the old women of the village would hustle them out of the town and into a forest.

There, the couple was handed a bocksaw – that's the kind log cutters use, with two handles and a blade in-between. The old women pointed to a good-sized tree and demanded that the new couple cut it down.

So, the couple is struggling to cut down the designated tree in the woods and they're surrounded by a group of village elders.

When the tree finally falls, the old women go into a huddle. Based on what they have seen, they will make a prediction on how long this marriage will likely last.

How do they make their judgment? Not on whether the couple exchanged loving looks and hugs and kisses. No. Rather, based on how well they worked together at a common task.

And what does this tale tell us? What does it suggest for our future together? Well, from what I've seen, we've met the test.

And, as I mentioned earlier, it's been said that good things start to happen when people come together in a common cause.

But, we've got to admit, these are challenging times. At the start of this new century, it's a time of transition in so very many ways.

Someone once said that the best way to predict the future is to create it. And with this conference, most certainly we're sharing the tools to help create a safer, drug-free environment for the people of both Mexico and the United States.

Thank you.

Jorge Madrazo Cuellar
Attorney General
Mexico

Very distinguished Secretary of Health, Jose Antonio Gonzalez Fernandez; my dear friend General McCaffrey; dear friends from the United States and Mexico.

I would like to thank for the invitation to participate in this Third Bi-National Conference on Demand Reduction, whose main topic is the strengthening of the bi-national relationship in the fight against drugs in the new century.

The relationship between the United States and Mexico on the subject of drugs is one of the most ample and varied in the world. The first attempt made by our countries to develop a joint outlook regarding the issue began in May 1997 with the presentation by Presidents Zedillo and Clinton of the report entitled "U.S.-Mexico

Bi-National Drug Threat Assessment", a joint study and diagnosis which gives a comprehensive outlook on the joint phenomenon of drug abuse, drug trafficking, and related crimes.

The U.S.-Mexico Bi-National Drug Threat Assessment comprises an acknowledgement of the challenge posed by drugs for the majority of modern people and societies, independently of what their level of development might be and how this issue has been recognized in most international *forums,* such as the United Nations and the Organization of American States. The assessment established that the fight against drugs has to be approached from a comprehensive standpoint. In other words, measures to control drug supply will only bear fruit if we simultaneously set up the necessary measures that will control demand. It established the commitment made by both countries in order to comprehensively fight against the problem of drugs and posited that measures to control drug supply will only succeed if we simultaneously set up the necessary measures to control the demand of drugs.

In view of the commitment made by both countries to comprehensively combat the problems of drugs, May 1997, Presidents Zedillo and Clinton signed the Declaration of Mexico/United States Alliance Against Drugs, agreeing to establish a bi-national drug strategy for cooperation. The bi-national drug strategy signed in February 1998 to complement the national strategies of both countries has contributed to direct our efforts towards the reduction of illicit drug demand. The strengthening of our cooperation in the different areas affected by the drug phenomenon has reached the highest priority in the agenda of both countries. Bilateral efforts towards demand reduction are evident. This conference precisely, is an example and reflection of the way in which international cooperation with regards to this subject must operate.

Because of all of this and with the holding of this third bilateral conference, our two countries reiterate their commitment to continue strengthening their collaboration and cooperation in the fight against drug abuse in both countries, especially today when the new century is beginning. As the international community acknowledged during the extraordinary meeting of the United Nations General Assembly, held in order to face the world problem of drugs, drugs destroy lives as well as communities and impact all sectors of society. Above all, the abuse of drugs has an impact upon the freedom and development of youth that are, undoubtedly, the most valuable asset of humanity.

There is no doubt that the problem of illicit drug use and abuse means a complex challenge for those of us who are responsible for fighting against this scourge. The last National Addiction Survey that was done in 1998 has allowed the Mexican government to analyze what the trends of consumption have been, as compared with similar studies that were done in 1988 and 1993. Drug use rates in Mexico are still rather low when compared to those of other countries. Nevertheless, there have been increases in use trends that are cause for concern, particularly in urban centers and the northern region of our country. Marijuana continues to be one of the main drugs used by different population groups. Inhalable solvents tend to be reduced, but the consumption of cocaine, which is a drug that traditionally had been used by reduced population groups, has now become popular among the young people and lower income groups. The use of heroin, although low at the national level, has also gone up in the northern cities of Mexico. Methamphetamine use is not yet a problem that affects a large sector of our population; however, among some young people its use is now a reason for concern.

As I pointed out in the Meeting of Hemisphere Leaders on Drug Policy that was held in Washington, from November 3 to 5, 1999, since illicit drugs are one of our most sensitive challenges, policies at the national level, regional level, and global level must be based upon humanist principles that will inspire us to face the challenge. In this regard, a humanist policy concerning illicit drug use is nothing else but the expression of a general state policy that has its foundation on a social consensus directed towards that specific challenge. A humanist policy against this phenomenon must have as its

base, the conviction of there having to be a pact between government and society, a collaboration among the different levels of government and population, a pact expressed through concrete actions within the family, in the school, through the media, and in our national as well as international society.

Therefore, the Mexican government has decided to enter into a social pact that will destroy ideological type barriers and allow us to make progress in the fight against drug abuse. In this regard, the General Attorney's Office has undertaken enormous efforts to create a network with the different civilian organizations and agencies. We have also set up coordinating mechanisms with the different agencies of the federal and local governments, such as the Ministry of Health, the Ministry of Public Education, and the General Attorney's Office of Mexico City.

Among the most relevant activities within this framework of collaboration has been the presentation of talks regarding crime prevention and drug use and abuse, addressed to those population groups considered to be at high risk. That is, talks addressed to our young people and children. We also have tried to see to it that parents, teachers, social workers, law enforcement and public security officials, etc, assume the commitment of communicating preventive messages in their homes, school, work centers and communities with the purpose of presenting a common front against addictions and crime.

Since a humanist policy must be based upon the acknowledgment and defense of human dignity, we have proposed to care for drug users and not to treat them as delinquents. Because of this, together with the Ministry of Health and the General Attorney's Office of Mexico City, we have set up a Unit for Assistance for Drug Users. The objective of this unit is to channel those individuals with addiction problems who have been detained and put before the Federal Public Prosecutor, towards rehabilitation and treatment centers.

Our efforts must also have a policy basis for mass media to convey to the population the consequences of illicit drugs. In this regard, our Institution has had the support of outstanding personalities in the world of arts, sports and also of the very diverse media that have their own messages and policies to communicate to large numbers of our population.

Ladies and gentlemen, drug use and abuse is a problem that presents us with severe challenges at the beginning of this century. We cannot consider the possibility of doing away with the supply of drugs if we do not do away with the demand. It is among the children and young people that we must gear our efforts. We cannot allow for their future to be overshadowed by the possibility of their becoming dependent upon drugs. We cannot hope to have a better stage of development for our people if we allow for the cancer of drug addiction and violence that goes hand in hand with it, to contaminate our youth and our children. We must share our experiences once again. We must keep these forums open as one of the main paths for us to exchange ideas, projects, and programs regarding how to prevent the use of drugs, as well as the treatment for drug users in order to protect the human dignity and health of our youth.

I would like to comment that one of the greatest satisfactions I have had in this joint fight that we have taken up between Mexico and United States has been the friendship and affection of General McCaffrey. The Mexican delegation has been able to share and learn so much from this valuable citizen of the United States, this extraordinary fighter against drugs, who has participated perhaps, in one of the greatest wars that humanity has ever fought towards the end of last century and the beginning of this century. General McCaffrey, I would like to say that as a public servant of the Mexican government and as an individual, it has been a great honor and an enormous privilege to have worked with you.

José Antonio González Fernández
Secretary of Health
Mexico

It's almost afternoon, so I think that I must say, "Good afternoon." After these very weighty contributions, so full of content, so purposeful and concise, I would like to say that when you have to speak after so many others who are so intelligent, you are at a disadvantage, but maybe also at an advantage. The main disadvantage is that everything has been said, and it has been said very well. One runs into the problem of what to say in order not to repeat concepts, to not overtire people. The main advantage on the other hand is if one is very brief, people will say he was the one who spoke the best. I don't intend for you to say that I was the one that spoke the best, but I do hope to be the briefest because everything has been said.

Thank you very much on behalf of the Mexican government and President Zedillo, who sent you a most cordial greeting through me. I would like to show President Clinton our gratitude for his letter, his comments, and his solidarity with this meeting. I want to thank also the host authorities, headed by General McCaffrey, Donna Shalala, Nelba, Daniel, Jeffrey, all of you. I thank you for having welcomed us to this third conference.

With respect to what General McCaffrey said about how times change, it is a pleasure for me to see how in fact times have changed ? at times for the better, but unfortunately in certain things, for the worst. I had the privilege of working in this great country as part of the Mexican government some years ago. In 1987 I came here entrusted by the Attorney General to open a new office in our embassy in the United States. I was to open what has become a reality today, not only in the United States, but also around other parts of the world. It's a liaison office between the Attorney General of Mexico and our own embassy in each of the countries in which we have an embassy including the United States, to analyze the issue of drug trafficking and drugs. I had the privilege of not only working in this great country as a representative of my own government, but in working with an equally committed and honorable person, a strict fighter as is Attorney General Jorge Madrazo today, who at that time was our Attorney General Sergio Ramirez, a great man that we all love and acknowledge.

In 1987 there was a great deal of talk about drug traffic. In 1987 there was an exchange of many different adjectives between our two countries. We sort of blamed each other. We said we produce because you consume; if you didn't consume, we wouldn't produce but today I find it very encouraging that these types of comments are not being put before the table. Times have changed and we all understand that only together can we hope to fight these types of problems. It is a pleasure for me to realize that not only do we stress, as we did then, the problem of drug traffic, but that today through the political will of our two Presidents, President Clinton and President Zedillo, it has been possible to hold special meetings intended to reduce demand in our two countries. It's really a source of pleasure that times have changed in that direction. It is also excellent that the practices in both countries have changed ? not only towards joining our efforts in fighting drug traffic and reducing drug demand. But it is excellent that today we can talk about this subject in an organized way, that coordinates efforts at an institutional level. For this I thank the great efforts and tenacity of public officials in our two governments and I am very grateful to General McCaffrey, Nelba, Daniel and to Jeffrey for what they have said. And with all of the role players at various levels present at this meeting, we have not only those that can implement government policies. We also have those who, because of their personal conviction, because of their political vocation, because of their social concern, because of their love for the families in our two countries, have engaged

in this daily fight in an unpretentious manner. They have done this for the benefit of our countries, the families, and the people of our two countries in order to avoid further drug use.

Fourteen years ago when I worked in the United States, I never would have imagined that in a meeting like this we would have youngsters present. It is a pleasure to know that a girl from my country, such as Sofia, has come here to speak. She speaks not because she has made use of drugs, not because she is a part of a rehabilitation program, but because she is so sold on the value of our youth: the young people of Mexico and other young people who wish to put forth their efforts on both sides of our border in order to avoid the use of drugs among them. And it is also wonderful that throughout these years we have been able to witness how people of non-government organizations, from families, and from private enterprise have formed groups at the regional, state, or local level. And people from different levels of society, no matter what their economic income or condition might be, have all come here to try to find new methods to better coordinate improved and newer strategies so that those strategies, actions and shared points of view can bear better fruits. This is the good news of the time that has elapsed.

The bad news is also there. One item is that after so many years of dealing with the subject, in our own country as well as in the United States, it's a pity that an increase in drug use has taken place in my country in these last few years. Certainly, as Attorney General Madrazo has said, we don't have usage levels as high as prevailing levels in other countries, but in 1987 we practically had no use of drugs in Mexico. Back then, the Attorney General at the time insisted that we had to clearly understand that the drug traffic and drug use phenomenon would lead to a situation where in the future we would all be consumers and producers.

General McCaffrey has been so kind in his comments and in conversations with him, and I'm very grateful to him. This morning at the breakfast sponsored by the Border Health Foundation whose members we had the pleasure of meeting, we were saying that today the United States is a great producer of drugs; back then it was not. And the good news is that in the United States they have reduced drug consumption and use. It's excellent that they have been able to invest more in new and better programs, all of this the result of the efforts, tenaciousness, imagination, greater resources, and of course people at the governmental level and at the level of society who are greatly committed. I am referring here especially to the Secretary of Health, President Clinton, Nelba, and General McCaffrey. All their efforts have helped to truly reduce drug abuse, which has been so high.

But in Mexico, as the Attorney General said in the figures and numbers that he has given us, drug use has been on the rise in recent years. The trend is a rising one, not a downward one. That is the bad news resulting from these last few years. If we don't undertake all these efforts to clearly understand the phenomenon taking place in Mexico and to clearly understand the situation along the border and that of the United States; if we don't take advantage of this potential and resources which are so unique (and our dear friend Jeffrey Davidow said this very clearly); if we do not take advantage of this excellent relationship, this great joint effort being undertaken by these two magnificent countries and people, I really don't see clearly how we might achieve successful results and outcomes.

I am altogether convinced that with the will and with the effort that we have witnessed here, we will truly be able to do things that will have results. For the United States these efforts are resulting in reduced consumption and use. Also in Mexico, the use will drop, and in the years to come we will make this social scourge only a memory.

Another piece of bad news I am sorry to acknowledge is something I didn't know before today ? that when we have meetings such as this we come to agreements and commitments and sometimes our side doesn't live up to them. It's a pity that Sofia has said that last year it was agreed that we would work with them, with our youth, and that we would have to create a fund to help our youth with the community work. I offer that this month of June, you will have that fund and that we will be working with

youth. As to the future, if we are convinced, if we have the will, then the future winds blowing will be most favorable. We certainly have six months to work jointly under this administration headed by President Zedillo and which has done so much in favor of health in Mexico. We have only a few months left of witnessing what this government does, where such distinguished United States citizens have worked such as Nelba, General McCaffrey, Daniel and many others. But what really matters is that this conviction prevails in our people and in our government so that we can continue moving ahead at the highest level possible. It's important that we share information and that we work together.

I am most pleased then to be able to announce that President Zedillo together with the Attorney General, who has done such excellent work in his position, will announce an extensive program and strategy, not only to fight drug traffic but also in developing programs to reduce the demand for drugs. And I'm very pleased that Jorge Madrazo and I are here together today. In any case, the President of Mexico will announce a program through an official standard that will compile the different standpoints and views in a way similar to that taken up in the United States. President Zedillo will announce a creation of a higher level office entrusted with fighting drugs. I think truly there must be a commitment to assign greater resources, not greater bureaucracy, a greater amount of will and greater resources so that practices will be taken up that will truly convince and encourage our society, so that whatever the government does will truly permeate the different levels of our community.

The United States has already done this. They have created this special office. General McCaffrey has presided over it, and we hope to do the same in order to have greater possibilities in our fight against the traffic and the reduction of demand. So Mexico will also have a high commissioner that will do everything possible to reduce drug demand in the forthcoming months. This is the reason I share Jorge's vision. Together we can do a great deal in these few months and together we will be able to do much more in coming years.

Finally, I would like to say, that on behalf of the Mexican delegation where we have young people, men and women, working daily in various organizations to reduce drug demand; the director of Social Security Institute Maria Luis Fuentes; Attorney General Jose Madrazo, myself and many other people with us from Mexico, that it's a privilege for us today to leave a testimonial. We would like to present to General McCaffrey this parchment to remind him of the acknowledgment expressed by the President of Mexico for his great talent and great vision in the fight against drug traffic and reduction of drug demand in the United States. Thank you very much.

Challenges and Opportunities in Drug Demand Reduction

John W. Wilson

Acting Administrator, Office of Juvenile Justice and Delinquency Prevention Department of Justice United States

I want to thank the planning committee for asking me to speak briefly this morning and to serve as moderator for this plenary session. I'm honored to be here today on behalf of the U.S. Department of Justice, Attorney General Janet Reno, and the Office of Juvenile Justice and Delinquency Prevention. I'm here, along with Mark Morgan from our Anti-drug Program Unit, and I'm excited to have the opportunity to introduce the plenary session on the subject, "Challenges and Opportunities in Drug Demand Reduction." Fortunately, we've been hearing some encouraging news about youth attitudes towards drug use lately. Forty percent of teens in a recent survey responded that they strongly agree that really cool teens do not use drugs. And along with changes in attitude, we're seeing

positive changes in behavior. Youth drug use has been generally decreasing since the mid-1990's and in 1999 the level of drug use among American adolescents held steady from the previous year. We hope that this is a pause and that the downward trend will continue into the new millennium.

Yet, even with these gains in the battle against youth substance abuse, many challenges lie ahead. For even as youth substance abuse was declining in 1998, more than half of American high school seniors said they used an illicit drug, at least once. And even more admitted to consuming alcohol. Moreover, it is estimated that 3000 youth, those under the age of 18, started smoking every single day in 1997. We also know that youth who have used or sold drugs are more likely to engage in other delinquent behaviors. Think about this. Youth who have used marijuana are much more likely to have sold marijuana – about four times more likely, three times more likely to have carried a gun, and seven times more likely to have been in a gang. This all happens at some point during adolescence. That is why it is so important for us to focus on prevention and early intervention of substance abuse. I'm talking about intervention at the first sign of trouble. Time and again, our experiences and research have shown that the most effective and successful approach to juvenile crime is prevention, including youth development programs that target at-risk youth, and early intervention programs for youth engaged in high-risk behaviors including drug use.

Our communities pay a high price when we allow even one youth to leave high school for a life of crime and drug abuse: a bill that is estimated to cost over $1.7 million per lost youth. Based on decades of research in the fields of criminal and juvenile justice, public health and youth development, our office, the Office of Juvenile Justice and Delinquency Prevention, has developed a comprehensive system-wide approach to delinquency prevention, early intervention and improvement of the juvenile justice system's response to juvenile offenders. Our comprehensive strategy for serious violent and chronic juvenile offenders is a framework that is built on strengthening families and communities so that they can better provide guidance and support for their children in developing capable, mature and responsible youth.

Another key component of the comprehensive strategy is multi-disciplinary coordination. To succeed, we must have the support of key leaders and the involvement of a strong network of community based programs and services public and private ? system and non-system, state and local ? collaborating on prevention, intervention, supervision and the provision of effective services. We have committed to such collaboration at the Federal level with initiatives like the Drug Free Communities Support Program. Together, OJJDP, the Office of National Drug Control Policy, and the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Prevention, with private partners such as CADCA are helping coalitions across this country to bring communities together, we support drug prevention programs by providing funding, resources and tools needed to support at-risk youth, provide services to drug-involved youth, and make neighborhoods safe and drug free for families. And this program has received strong financial support. The U.S. Congress appropriated an additional $30 million in fiscal year 2000, the program's third year, to ensure that no child, family or community is left behind in the prevention of substance abuse. Just within the border states of Arizona, California, New Mexico and Texas there are currently 43 operational Drug-Free Community support programs. And if you don't have one in your community, or if you're a visitor from Mexico, I suggest that you go and see these programs at work and work to put a coalition together in your community.

We know that if we can reduce substance abuse among our children, we will be laying the foundation that gives them a better opportunity to become drug free and productive adults. By coordinating these efforts across agencies and disciplines and through collaboration between juvenile justice system officials, schools, law enforcement, child and family services, and community based organizations, we can succeed in creating a community wide network of care for our children. We have a special challenge and a unique opportunity to reach out further

and establish a strong collaborative effort between the United States and Mexico. Forming local, state, Federal and global partnerships, and using a system-wide approach, a comprehensive strategic approach, that incorporates the latest research into prevention and treatment programming, we can successfully reduce substance abuse by reducing drug demand.

I think the global nature of the problem has been illustrated recently by a number of articles and stories that I've read about in papers about the use of the Internet for drug sales. We have children now who are going on the Internet and buying drugs for delivery to their homes. Think of the implications of that and the need for all of us to work together nationally and nternationally to address this issue. One of the things that we pride ourselves on in our office is providing information resources. We have at the back table here, a sample of publications from our office. And they include publications about how youth can be a bit more involved in reducing crime and delinquency and drug prevention. We work closely with a national youth network to help youth to become involved as part of the solution. And I applaud you for having the youth representation here at this conference because that's critical to our success. These publications deal with issues of gangs, guns and drugs. They're all inter-related problems. You can't look at one without looking at the others. And they cover issues including research, evaluation, programs, effective programs that you can adopt in your community. How to involve youth, families in the communities, in comprehensive efforts on how to involve the juvenile justice system as a player in these efforts.

In this plenary, our speakers will present some of the components of system wide services that span the continuum of prevention and treatment. This plenary challenges the opportunities in drug demand reduction. It was designed to stimulate continuing discussion and thought on the roles of prevention, treatment and multi-sector, multi-strategy collaborative efforts and what role they can play in achieving demand reduction on the U.S.-Mexico border. I thank you for your attention. We have seven speakers, so we're going to be moving very quickly. Our first speaker is H. Westley Clark. Dr. Clark is the Director of the Center for Substance Abuse Treatment in the Department of Health and Human Services. He leads the nation's effort to provide effective and accessible treatment to all Americans with addictive disorders. Dr. Clark's areas of expertise include substance abuse treatment, methadone maintenance, pain management, dual diagnosis, psycho-pharmacology, anger management, and medical and legal issues. Ladies and gentlemen, it is my pleasure to introduce Dr. Clark.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director Center for Substance Abuse Treatment Department of Health and Human Services Unites States

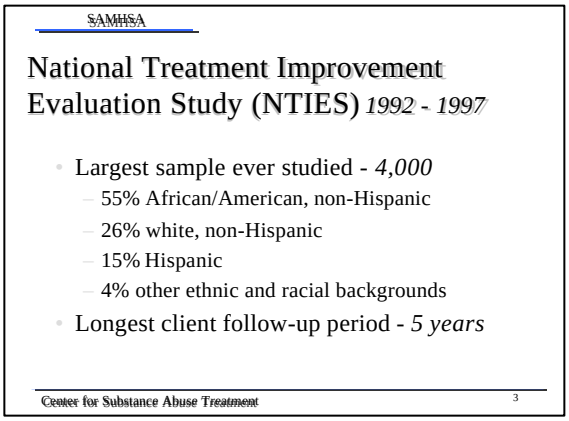
Estoy muy contento de estar aqui nuevamente con ustedes. I am very pleased to join you again to continue the dialogue between the U.S. and Mexico on Drug Demand Reduction. I have been asked to focus my comments on providing effective treatment.

For the Center for Substance Abuse Treatment known as CSAT, effective treatment means scientifically based, culturally relevant treatment that can be replicated in different settings and adjusted for use among various ethnic groups. I would also like to note that effective treatment improves the lives of individuals and families affected by alcohol and drug abuse and reduces the health and social costs to our communities and the nation.

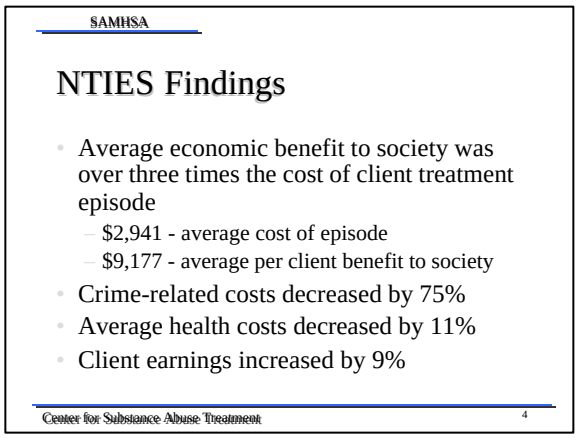
To collect scientific base data, CSAT conducted the National Treatment Improvement Evaluation Study, known as NTIES from 1992-1997. This was the largest sample ever studied, with one of the longest client follow-up periods in the substance abuse treatment field.

This study found that the average economic benefit to society was over three times the average cost of a client treatment episode. The average cost of a treatment episode was

$2,941, while the average per client benefit to society in the year after treatment was $9,177.



Comparing the year before treatment with the year after treatment, crime-related costs decreased by 75 percent, average health costs decreased by 11 percent, and client earnings increased by 9 percent.



In our continuing data analysis we looked at four large scale studies of community-based treatment programs – NTIES, the CALDATA study from California, the CSAT-sponsored Services Research Outcomes Study and the Drug Abuse Treatment Outcomes Study. All four of these studies showed that marijuana use, powdered cocaine use, and heroin use declined significantly after treatment. Based on these outcomes, we know that treatment is effective and that effective treatment is not buying blindly into unproven theories, but utilizing proven methods.

Effective treatment also means looking for new ways to distribute available medications. CSAT's Office of Pharmacologic and Alternative Therapies has a priority to develop new guidelines that can be used to take patients that have been stabilized on methadone maintenance from a clinic setting to a private physician's offices for their continued treatment.

CSAT is also addressing the use of partial agonists in office-based treatment. There are two new narcotic treatment medications, buprenorphine and buprenorphine/naloxone, that are being reviewed by our Food and Drug Administration (FDA).

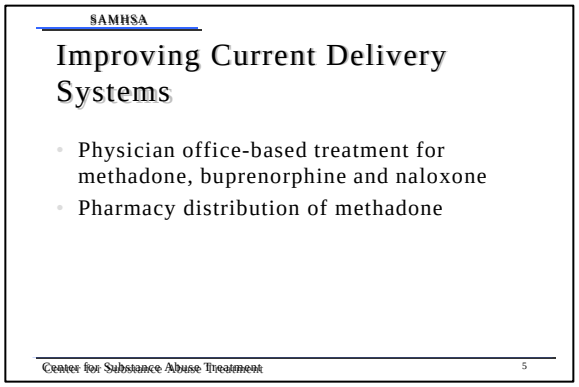
We are also developing proposals for standards, procedures and training of physicians who would prescribe these new medications to patients in treatment for illicit opioid use.

On May 4, CSAT published a notice of intent in the *Federal Register* to develop regulations that would allow physicians to provide partial agonist treatment medications, upon approval by the FDA, in office-based settings to patients addicted to heroin.

Since partial or mixed agonist medications are different than full agonist medications, such as methadone, and have different risks associated with their use, the Department of Health and Human Services has designated CSAT as the appropriate agency to tailor federal opioid treatment standards to the specific characteristics of these future medications.

These standards could include limits on the number of patients that any one physician may treat. The standards may also determine the requirements for medical and psychosocial services follow-up, such as substance abuse counseling, that must be identified by the attending physician. The proposed rule could include standards affecting the quantities of medications that could be prescribed, dispensed or administered to patients for unsupervised use.

CSAT envisions that the new rule, when proposed, will allow office-based physicians to prescribe partial agonist treatment medications for opiate addiction when these new pharmaceuticals become available. This is prohibited under current law in the United States.



To deal with the problem of methamphetamine, the fastest growing drug problem here in Arizona, and a major problem in many other states in the southwest, northwest and midwest, CSAT is sponsoring a study to determine the most effective and cost-effective methods of treating methamphetamine addiction.

The CSAT program is designed to test a 16 week psychosocial intervention approach developed by the MATRIX Center in Los Angeles and existing treatment models at seven treatment sites in California, Hawaii and Montana. An eighth site, the UCLA Drug Abuse Research Center in Los Angeles, will coordinate the research and analyze the cross-site data. This is a three year program to determine what methods can be successfully used to treat those addicted to this very dangerous substance that is particularly appealing to women, since it does affect weight loss.

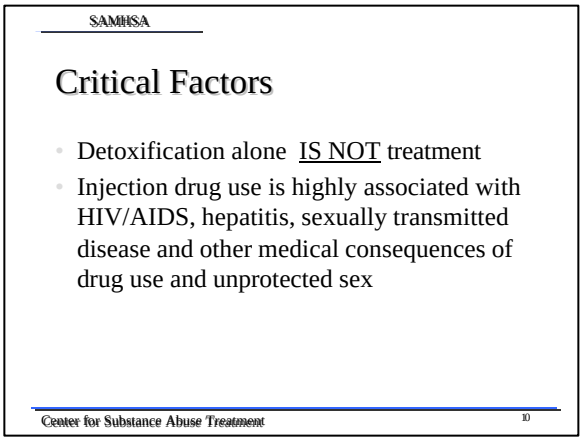
The study has been designed to see if results can be replicated in different user populations such as Latino women, pregnant women and women with children, and Asian Pacific Islanders or Native Americans, or in the gay community in Los Angeles.

The study is looking at adolescent and adult white males, Hispanic males, and white women. The site in Hawaii is looking at effective treatment of younger, less-educated users whose parents are using marijuana or cocaine.

Specifically, the principles of drug addiction treatment include common-sense approaches towards service delivery. Effective substance abuse treatment programs have:

- tailored treatment approaches, treatment settings and services to each individual's particular problems and needs
- availability to treatment services at the time that the individual needs help (which means clients will not have to be placed on a waiting list to receive services)
- the program options address the full spectrum of the individual's needs including: medical, psychological, social, vocational and legal problems
- the individual's treatment plans allows for flexibility in the course of treatment and recovery and addresses appropriate treatment approaches based on age, gender, ethnic and cultural needs
- degree to which individuals in the program are allowed to remain in treatment for an acceptable length of time based on the client's needs
- degree to which individuals in treatment are offered individual or group counseling and other behavioral therapies as part of their treatment protocol
- degree to which programs offer or have access to pharmacologic alternative options as part of the treatment services
- degree to which programs offer or have access to psychological, psychiatric or mental health services for individuals demonstrating a coexisting mental disorders
- degree to which individuals in recovery are monitored once the leave formal treatment and degree to which individuals have the option to participate in long term treatment and to join self-help groups once they leave treatment
- degree to which individuals are provided with counseling to help them avoid high-risk behavior and degree to which treatment program provides assessments for HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases.

Beyond these factors, what is important to underscore is the undeniable fact that detoxification should not be confused with treatment. Medical detoxification is meant to overcome acute symptoms of withdrawal. It is not designed to deal with the underlying problems that lead to drug use or to motivate the patient to work toward long-term abstinence.



Another critical factor is that injection drug use is highly associated with medical problems that include HIV/AIDS, hepatitis, sexually transmitted diseases, and other medical consequences of drug use and unprotected sex.

Just last month, CSAT released a new Treatment Improvement Protocol, "Substance Abuse Treatment for Persons With HIV/AIDS" – or TIP #37. This new TIP volume provides the latest information on what is known about the intersection or interrelatedness of HIV/AIDS and substance abuse.

The TIP includes chapters on demographic trends, identifies the information that is important for conducting medical assessments, identifies ways to determine mental health needs, and discusses issues that might come up for substance abuse counselors, including dealing with their own prejudices when treating HIV/AIDS-positive clients.

The TIP also offers information on how to integrate other necessary services for these patients including the use of case management techniques, ways of managing pain, ethical and privacy issues and funding and policy considerations in the delivery of services.

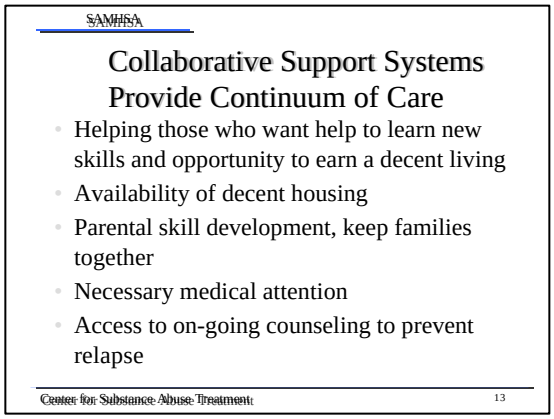
CSAT is working to develop comprehensive treatment models that programs can replicate to provide the highest quality of substance abuse treatment available anywhere. This should be the strongest component of every demand reduction effort. Given the complexities and different variables that influence society as a result of substance abuse among its population, we need to continue our call for increased levels of funding for substance abuse treatment programs.

My last point is perhaps the most telling point. In the U.S. we are spending an inordinate amount of the Federal tax resources to cover the costs associated with drug related crimes. These crimes include the use or trafficking of illegal substances, domestic violence incidents related to substance use, and a cyclical pattern to recidivism related to substance use.

CSAT is working diligently with other sectors of the Federal government ? the Department of Justice, Department of Labor, Department of Education, Department of Housing and Urban Development, Department of Transportation – and with states and local governments to try to better coordinate substance abuse treatment programs at all levels.

Increasingly, these systems realize that we must work together to create continuum of care for individuals that have a substance abuse problem. The continuum of care means that once we have an individual that wants help, he or she will not be turned away from learning a new skill to sustain their recovery and to offer them an opportunity to earn a decent living.

He or she will not be turned away from finding a decent place to live. He or she will be provided with the necessary information and parental skills development so they can attempt to keep their families intact and prevent them from losing custody of their children.



He or she will be given the necessary medical attention to deal with their diabetes, their HIV/AIDS and any other medical condition that can adversely impact the road to recovery.

And, most importantly, he or she will have access to on-going counseling to prevent an irreversible relapse episode from clouding the road to recovery.

At CSAT, our mission is to determine how we can best support the coordination of substance abuse treatment services and to help facilitate the development and implementation of a integrated service delivery systems.

Both of our countries need the commitment of our governments, the health insurance sector, the private sector, the foundations and the dedicated throngs of substance abuse service providers and practitioners to work together to continue to minimize the adverse effects of substance abuse within our borders.

Together, we will all make a difference as we strive for productive societies unburdened by the current weight of addictive behavior.

Timothy P. Condon, Ph.D.
Associate Director
National Institute on Drug Abuse
Department of Health and Human Services
United States

There are many reasons people take drugs. One is to feel good. And that's often the people who are sensation seeking and want to feel better. Those are people who are taking drugs to help to get through the day. They may be depressed, have anxiety disorder. They may, in fact, be victims of socio-economic problems.

They may be victims of family abuse, spousal abuse, or parental abuse. They take drugs to just get through the day. And in many cases they are self-medicated. But the bottom line is, people take drugs because they like what drugs do to their brain.

And here's your neuro-science lesson. I am a neuro-scientist and I couldn't leave you today without a little bit of the neuro-science of what we've learned in the last five or ten years. And this is, and if I had my pointer, I could show you that this is the reward pathway for the brain, or the pleasure centers in the brain if you will.

What drugs and abuse do is, they hijack this. You can see here, alcohol, cocaine, heroin, all work in the various areas of the reward pathway, and they work at the level of the neuron or the brain cell itself.

This is one of the terminals of the brain cell. They work on many neuro-transmitter systems, seretonin, norepinephrine, gabba. But they all seem to work. There's some commonality there. And they all work on the dopamine system. And what happens here is that a nerve impulse comes down into the neuron and it causes the release of the dopamine. It crosses that space there and binds to those dopamine receptors and stimulates that next cell. You like that. And in fact, if a lot of dopamine comes down and stimulates that, you get a very euphoric feeling. But Mother Nature, in her wisdom, decided there needed to be a mechanism to turn this system off because this is the normal way you experience pleasure. So, there is in fact, as you see here in the red, mechanisms that really scoops up or transports back the dopamine back into that cell.

That's where drugs of abuse like cocaine work. They block the reuptake of that dopamine.

If you measure the amount of dopamine in that space with drugs of abuse as you can see here, cocaine, methamphetamine, nicotine, THC, they all cause a dramatic release of dopamine into that space. You love that release. That's part of what causes this euphoric feeling or this high associated with drugs of abuse.

But this doesn't happen in the long-term. In fact, long-term changes occur in the brain after you stimulate this system over and over again.

So, we know that prolonged drug use changes the brain in long-lasting and fundamental ways. And it's as if there's a switch in the brain that flips. Something changes. And we don't have very much research at this point about what that transition is, from somebody who goes from voluntary drug use to addiction. They're different states. There is something that happens in the brain and we don't actually know all about it. That's one of the areas of research for the future.

But here's an example of that change. Those long-lasting and fundamental changes that occur in the brain. As Dr. Clark pointed out, methamphetamine is a very big problem in many countries, many communities around the United States.

This is the front of the brain. The top is the front of the brain. The back of the brain, the left and the right. The area there is the striadum. And what that is showing you is that dopamine transporter or that scooper molecule, and the first one is a control. The second one is a methamphetamine addict three years after his last methamphetamine. Three years. There's a dramatic reduction in the amount of that molecule that's in this individual's brain, in his striadum.

Methadone addict. Same thing. Three years after his last drug. And the last panel is for comparison, is a Parkinson's Disease patient who has a dramatic deficit in the dopamine system in his brain.

People often ask me what that means. And this is very new data that just came out. Again, top is normal controls. The bottom is individuals and there are about 13 people in this study. Individuals who are chronic methamphetamine abusers. And you can see on the bottom a dramatic reduction in the amount of dopamine. This is actually dopamine transporter in methamphetamine abusers as it was in the last slide. But what does that mean? Well, they tested the meth abusers compared to the controls and this is the first time there have been data on the functionality changes associated with those long-term changes in the brain. They found two simple things: motor tasks and memory tasks. It took longer for them to walk from here to there for the methamphetamine addicts. And their memory was not as good in terms of a word recall. So, they've got cognitive problems and they've got some motor problems associated with that long-term change in the brain.

So, as they say then, addiction results from long-term effects of drugs on the brain. And the brains of addicts are different from the brains of non-addicts. And those differences are really the essential element of addiction. So addiction is fundamentally a brain disease, but it's not just a brain disease. That would be a little bit easier for the scientists to discover how to fix that. It's in fact, the quintessential bio-behavioral disorder. What I mean by that is in fact that the biology, the behavior and the social context all become intertwined in this disease. And if, in fact, you go to make some progress in treating people with addiction, you need to attend to all of those things. It's as if the challenge for treatment is to flip the switch back in the brain by behavioral therapy, counseling, medications, job placement, a number of different things from biology, behavior and social context. The most effective treatments will, in fact, attend to all of these. And we have a number of things in our clinical toolbox that can help us do those things. These are just some therapy manuals that the Institute published last year. One on cognitive behavioral approaches and one on community reinforcement. You can order those at the NIDA exhibit. And there's also, of course, a number of medications, as Dr. Clark said**.** Methadone, nicotine replacement, are coming on line in the coming year and we hope buprenorphine.

Dr. Clark did a really eloquent and comprehensive job of listing a lot of the

principles of effective treatment that we published in the NIDA Principles of Drug Addiction Treatment last year.

So, as I said, the most effective treatment strategies will in fact attend to all those things. Treatment, pharmacology, or counseling are very important but they're not the only things that have to be part of the comprehensive successful and effective treatment program. There needs to be childcare services and vocational services as well as a whole host of other things.

And as we have a variety of effective treatment options in the toolbox, we need to do better. In fact this is just a list to show you what's in the pipeline for the future. We have a whole host of behavioral therapies that are in various stages of research that we hope will be available in the clinic and in the community in the not-too-distant future. So too do we have a host of medications as anti-cocaine agents that are in various stages of development. This is all part of NIDA's Future Treatment initiative to move treatment from the lab into the community, into real life settings for new treatment components as well as improvement of existing treatment components.

One of the ways we're doing that is we've launched the clinical trial network; the National Drug Abuse Clinical Trial Network will test effectiveness in real life settings, behavioral and medication treatment. We envision there will be nodes of research, regional research training centers, partnered with community treatment programs. Five to ten community treatment programs that will test various therapies – behavioral, pharmacological, in various real life settings with diverse populations, as Dr. Clark said. And in fact, we've established the first six of these through NIDA grandiosity. So, we envision this to be a national program in the next few years. We've made the first six awards. We're going to make another six awards this coming year. And in the following year we hope to make an additional five or six. So, with a national clinical trial network, not only to test therapies in real life settings and to get them incorporated into the community treatment programs, but also to use it as a vehicle to disseminate other areas of research, whether it be neuro-science or genetics. Science is available to replace ideology at the local and community level as well as the national level. Thank you.

Slide presentation follows.

Challenges and Opportunities in Drug Demand Reduction: What We Have Learned From Research

Timothy P. Condon, Ph.D.
Associate Director,
National Institute on Drug Abuse
6001 Executive Boulevard
Room 5263 MSC 9591
Bethesda, Maryland 20852
(301) 443-6480 (301) 443-9127 Fax

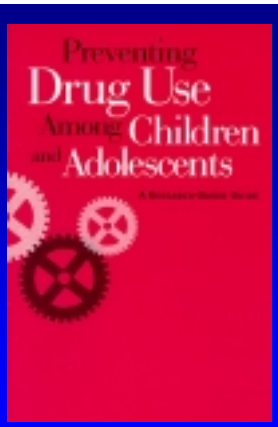
U.S. - Mexico High Level Contact Group
Third Bi-National Drug Demand Reduction Conference
Phoenix, Arizona
June 1, 2000

Advances in Science Have Revolutionized Our Fundamental Views of Drug Abuse and Addiction

Drug Abuse is a Preventable Behavior
Drug Addiction is a Treatable Disease

Partnership for a Drug Free America

Why Do People Take Drugs In The First Place?



NIDA www.drugabuse.gov

Prevention Programs Should . . .
Reduce Risk Factors

- ✓ ineffective parenting
- ✓ chaotic home environment
- ✓ lack of mutual attachments/nurturing
- ✓ inappropriate behavior in the classroom
- ✓ failure in school performance
- ✓ poor social coping skills
- ✓ affiliations with deviant peers
- ✓ perceptions of approval of drug-using behaviors in the school, peer, and community environments

NIDA www.drugabuse.gov

Prevention Programs Should . . . .

Enhance Protective Factors

- ✓ strong family bonds
- ✓ parental monitoring
- ✓ parental involvement
- ✓ success in school performance
- ✓ prosocial institutions (e.g. such as family, school, and religious organizations)
- ✓ conventional norms about drug use

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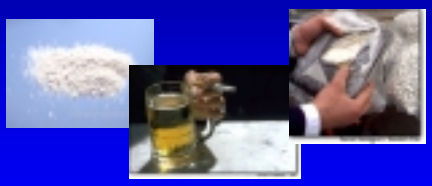
Prevention Programs Should . . . .

Target all Forms of Drug Use



. . . and be Culturally Sensitive

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Prevention Programs Should . . . .

Include Interactive Skills-Based Training

- ✓ Resist drugs
- ✓ Strengthen personal commitments against drug use
- ✓ Increase social competency
- ✓ Reinforce attitudes against drug use

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Prevention Programs Should be . . . .

Family-Focused

- ✓ Provides greater impact than parent-only or child-only programs
- ✓ Include at each stage of development
- ✓ Involve effective parenting skills

NIDA www.drugabuse.gov

Prevention Programs Should . . . .

Involve Communities and Schools

- ✓ Media campaigns and policy changes
- ✓ Strengthen norms against drug use
- ✓ Address specific nature of local drug problem

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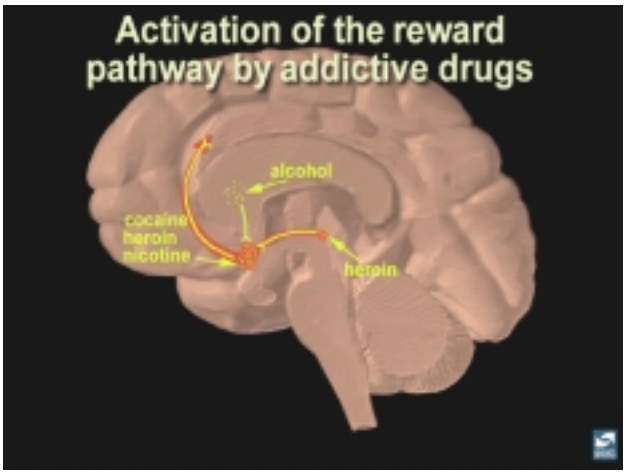
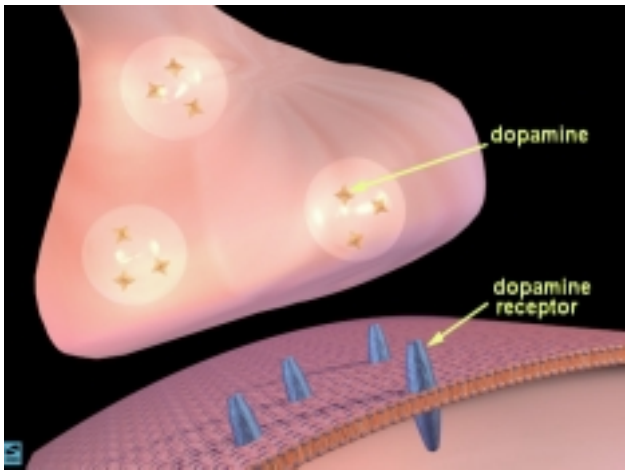
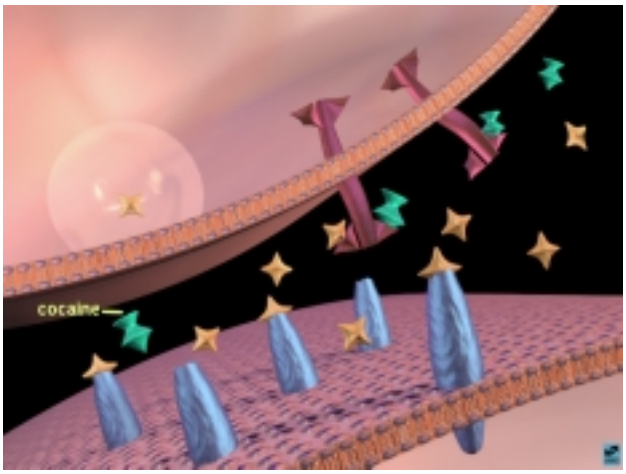
People Take Drugs To:

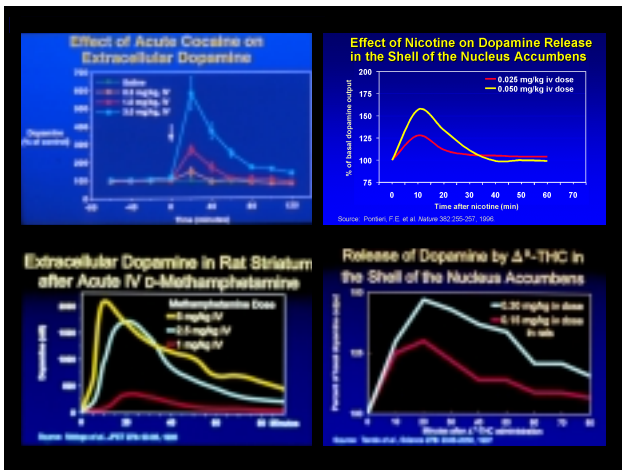
- Feel good (sensation seeking)
- Feel better (self-medication)

A Major Reason People Take a Drug is They Like What it Does to Their Brains



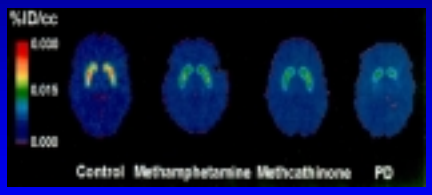




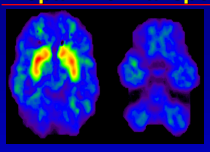


Prolonged Drug Use Changes The Brain In Fundamental and Long-Lasting Ways

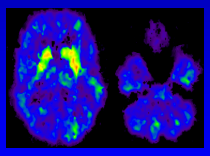
Methamphetamine Neurotoxicity



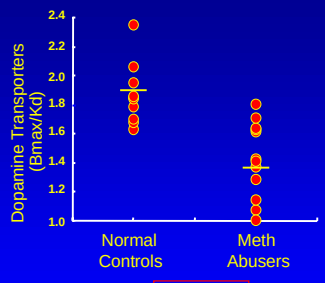
Dopamine Transporters in Methamphetamine Abusers



Normal Control



Methamphetamine Abuser



$p < 0.0002$

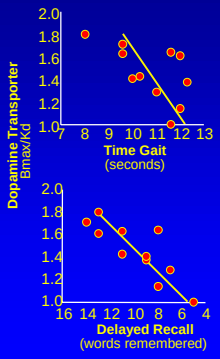
Methamphetamine abusers have significant reductions in dopamine transporters.

BNL - UCLA - SUNY
NIDA - ONDCP - DOE

What We Have Learned From Research

Timothy P. Condon
Associate Director
National Institute on Drug Abuse
6001 Executive Boulevard
Room 5263 MSC 9591
Bethesda, Maryland 20852
(301) 443-6480

Dopamine Transporters in Methamphetamine Abusers



Motor Task

Loss of dopamine transporters in the meth abusers may result in slowing of motor reactions

Memory Task

Loss of dopamine transporters in the meth abusers may result in memory impairment.

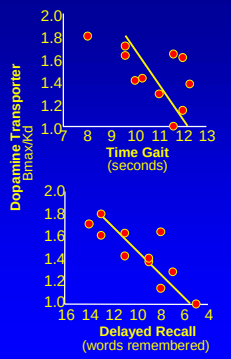
BNL/UCLA/SUNY
NIDA, ONDCP, DOE

Addiction Results from Long-Term Effects of Drugs on the Brain

The Brains of Addicts Are Different From the Brains of Non-Addicts

…And Those Differences Are An Essential Element of Addiction

Dopamine Transporters in Methamphetamine Abusers



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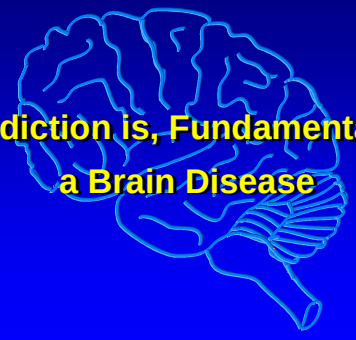
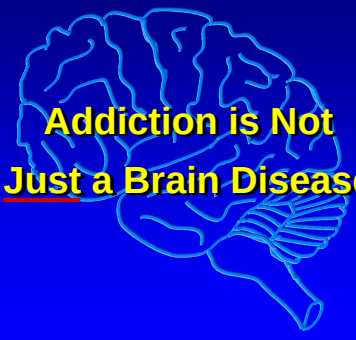
BNL/UCLA/SUNY
NIDA, ONDCP, DOE

Addiction Results from Long-Term Effects of Drugs on the Brain

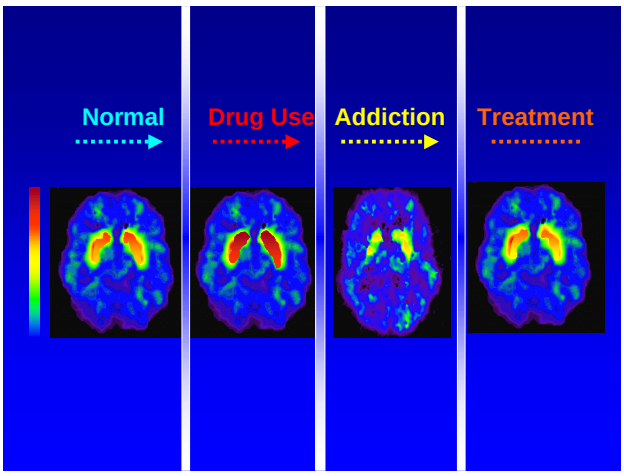
Addiction is, Fundamentally, a Brain Disease



Addiction is Not Just a Brain Disease



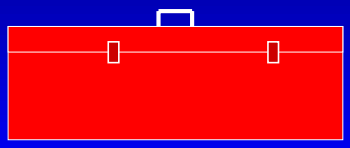
Addiction is the Quintessential Biobehavioral Disorder



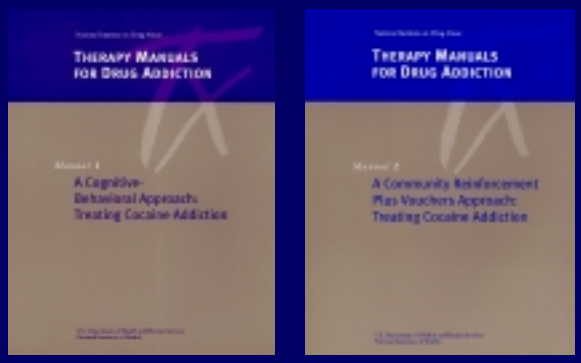
The Most Effective Treatment Strategies Will Attend to All Aspects of Addiction:

- Biology
- Behavior
- Social Context

We Have A Variety Of Effective Treatment Options In The Clinical Toolbox



NIDA THERAPY MANUALS



Tx Medications for Drug Addiction

- ✓ Methadone
- ✓ LAAM
- ✓ Naltrexone
- ✓ Nicotine Replacement
  - patches
  - gum
  - buproprion

NIDA www.drugabuse.gov

NIDA www.drugabuse.gov

The Most Effective Treatment Strategies Will Attend to All Aspects of Addiction:

- Biology
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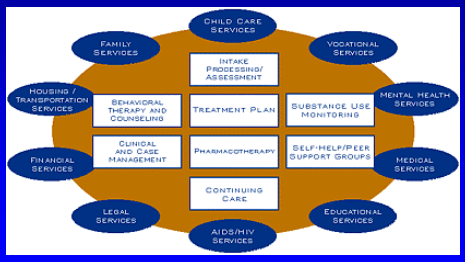
- Social Context

Components of Comprehensive Drug Addiction Treatment



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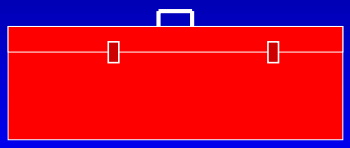
We Have A Variety Of Effective Treatment Options In The Clinical Toolbox

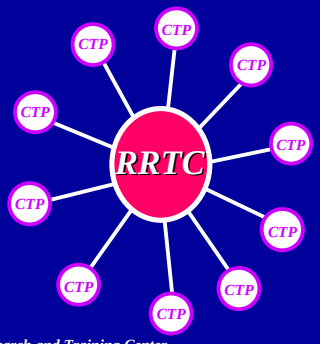


…But We Need To And Can Do Better

Clinical Trials Network

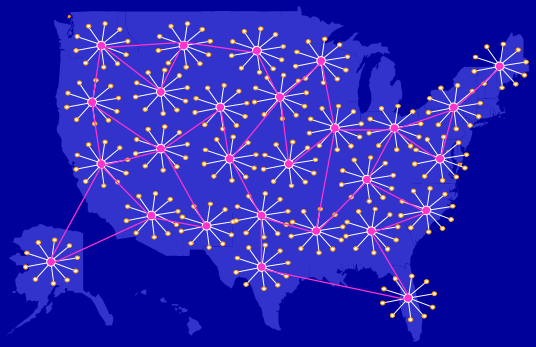
- Infrastructure based on NIH model
- Test effectiveness in real-life settings
- Behavioral and medications treatment
- Diverse populations
- Partnership with community treatment programs

National Drug Abuse Treatment Clinical Trials Network Node



RRTC -- Regional Research and Training Center
CTP -- Community-Based Treatment Program

National Drug Abuse Treatment Clinical Trials Network



We've Come A Long Way in Replacing

with SCIENCE

Haydée Rosovsky
Technical Secretary
National Council on Addictions
Ministry of Health
Mexico

I am very happy and I am very proud to participate in this plenary session together with outstanding professionals in this field. I'm going to make some remarks that have to do with the challenges we have to face whenever we do prevention that is targeted to the youth. I'm referring to drug use prevention among youth. First of all, I would like to say that prevention is the best possible strategy for our programs. This is where we would like to invest all of our resources and we would like to have abundant resources for this purpose. Unfortunately, prevention at present in Mexico has to go hand-in-hand with various important treatment actions because we already have an important proportion of the population who started to use drugs a few years ago and that are now presenting problems that require therapy.

From the standpoint of the youth, what I've been able to observe and what my colleagues at National Institute of Psychiatry have read in international literature is that the most, let's say, universal, recommendation is that prevention should start as early as possible. Preventive programs that expect to achieve a very important impact when targeted to youngsters after puberty or in middle school or in high school do not seem to be as effective as programs that begin from the time the child begins to develop. What's the reason for this? Well, the concept of prevention that seems to be the most successful one is the one dealing not only with substance abuse but also with an environment that promotes positive behaviors and lifestyles that are created from the earliest childhood. In these models, the use of drugs makes us feel better and as we heard a moment ago from the presentation of our NIDA colleague, there is a search for relieving pain or looking for pleasure. All of these behaviors would not necessarily be sought when there are other sources of satisfaction in individual's lives.

Another important element of this education for life, as we call it, is a proper management of emotions: growing up in environments where freedom goes hand-in-hand with responsibility, and one in which individuals learn to grow up feeling self-assured and having a realistic judgment about their self-esteem.

In certain environments, prevention among the youth is more successful. And this is, these are the ones we should focus on. Let me mention some of these sites where we should reinforce our actions. And I think this is important because many prevention efforts do not reach their target population. Let me give you an example. Let's say we want to do a lot of prevention in the setting of health care, the primary health care setting for instance. In the case of the young people, we're not going to be very successful because youngsters seldom go to primary health care centers. We see mainly young children, or adults that go for immunization or for a specific problem. But teenagers do not represent the most frequent clients of primary health care centers. Therefore, the type of educational and information materials that we use are not going to reach our youngsters. But where are they? They are at schools, and this is something that is universally recognized. However, I would like to state that basic science is more universal, because in the end, biologically speaking we have more commonalties among us humans. Whenever we refer to behaviors and to our preventive work, we find many reservations about international recommendations.

There are some recommendations, for instance, that stem from the experience of institutions in the United States like SAMHSA. And these recommendations cannot necessarily be successfully taken to Mexico. We need to do a translation or an adaptation and take some aspects that are applicable, but exclude others that are not. For instance at schools you know that unfortunately, in Mexico, the mean schooling level of the education, of the population continues to be quite low. An important proportion of our youth, especially women, quit school at a very early age. Fortunately, this situation is changing. We are making progress, but we are still very far from having all of our youngsters completing high

school, or graduating from high school, let alone giving to all of them the opportunity of going to college. This is only available for a minority. Therefore, although the school is a very important setting for prevention, we cannot expect that the young population that we want to reach with preventive actions are all going to be at schools.

It's precisely the young people who are at risk for drug use, those who quit school probably because of their personal life situations that make them be very vulnerable, and expose them to drug use. Another setting where we would have to work is the community. You were given an example of this today and you will hear about many more later, those who approach the younger coalitions or coalitions of the young, many of which are represented here, but also at the community at the neighborhood level, in small towns. The young people are moving, are there, and they are very active. They are not necessarily at home. They are out in parks, out in the street. They are playing. They are having fun. Some of them are even working in the streets. That's why we should approach them wherever they are. And as I already said, there are many young people who are part of the labor force, of the working force. Some work under very poor conditions that further expose them to drug use. For example, those working in certain areas of big cities where there is prostitution or where one finds adult centers like nightclubs where one can easily have access to drugs, or sell to your economic need see the need for working in prostitution or as beggars. There is another group of young people who work, but they are not necessarily so much exposed to drug use. They may work in supermarkets and self-service stores and maybe they combine work with school.

Another very important setting is that of recreation centers. These are meeting places for the young people. And here we may include those who play sports. Young people like bars, discos, going to places to listen to rock bands. And probably in every country and in the different regions of our countries, we may find different habits of the young people in doing this type of activity. But I think that each one of us, in our own country need to define these different settings, to determine what our target population is. In working for the youth, in doing prevention efforts, we think that there are certain actions that we are trying to undertake in Mexico that may have a very important impact. And that they be carried out only under the condition of having a very good coordination with other sectors. It's a fact that the government alone cannot take care of this problem. And the government cannot and should not take care of this problem alone.

We are becoming more and more aware of the need to work jointly with equality, without one of the parties being submissive to another one, and with a different group of youth. Preventive programs, as I said, cannot be universal for the reasons that I already mentioned, but there are other reasons, for example, cultural aspects, different values, gender aspects. And there are risk factors and protective factors that pertain to the different groups, cultures, regions, even inside one single country. Yesterday we heard some experiences about research. And let me say that this is the reason why research is so important for prevention purposes. Prevention needs to be research-based. Research can guide us as to what's going on, what's the status of the problem in different population groups so that prevention and treatment resources can be more successfully allocated. As I said, we heard yesterday about the construction of the gender idea, and the different perspectives one finds in different cultures. We heard about self-esteem, assertiveness, and in two neighbor countries like Mexico and the U.S., something might mean something totally different. For example, for a young Mexican woman, being assertive may sound like being too aggressive or a behavior that will make her unaccepted vis-a-vis the boys of her community. So these are aspects that in my view should be based on research.

I also think that drug use prevention cannot lie within community and government programs as if it were something separate for resource utilization purposes. We would like to undertake comprehensive action. Drug use prevention needs to be part of many other health programs. Why? Because we know that substance use and abuse is an extremely important risk factor. For example, for HIV AIDS transmission, for unwanted pregnancies, accidents, violence and dropping out of school.

All of these are important challenges, but there are other important challenges we face in our prevention efforts. We frequently see that different organizations use different conceptual frameworks for prevention. And often, they are not only not complementary, they are opposed. And this unfortunately, leads to confusion among the population, and efforts are neutralized or there is suspicion about what's being done.

We also see quite frequently preventive actions that are not permanent enough and that are not consistent with other actions that are undertaken by a different group. That's why, in order to reach our young population, in the case of mass media campaigns, we need to see that whenever they are broadcast, it must be a time when the young people can hear them or watch them. This is something we need to think about and we have with us some examples of the work we have been doing. Part of this we have done for a few years. Other actions are more recent. And we're working in the setting of families and communities. To do prevention among the youth, we also need to work with their parents, with their religious leaders. This is something that has to do with the cultures and traditions of every country. You heard Sofia this morning telling us about the youth coalition. We have great hopes for what is being done. And the youth have told us that they are suspicious about adults and they don't trust either adults or governments or institutions. At least this is the case in Mexico. So, we need to take this to account and ask the young people of our country to become the most active agents of prevention. Let's ask them to be, with ourselves as facilitators, and give them the tools that they need.

The educational setting is very important as well for us. We have started to organize student organizations against addiction under the model of building a drug-free life. This is a model that we have used with other institutions. We have a crusade with teachers. We know that the preventive experiences at the school setting should be part of the school's educational programs. These should not be actions that are isolated or that are done intermittently. They should be part of the material that teachers use and be part of the internal school regulations.

In the work setting it is important to develop ad hoc programs that consider the socio-economic stratum of individuals and that facilitate a timely provision of preventive treatments. In the recreational setting, one of the things we're doing now is to work with owners of discos, bars and nightclubs. They want to get together on this because it's not good for them to have accidents or drug problems in their centers or discos. So, we have found a possibility to work together with them and we will have the specifics quite soon.

Finally, actions towards responsible alcoholic drinking. In Mexico the age at which one can drink is 18 years. This is younger than in the United States. We know there are certain individuals that should not drink because they are prone to addiction or dependency. But there are many other individuals who may have drinking problems. There are very interesting programs aimed at changing this and promoting responsible drinking. We also have actions in cultural and sports centers. This is based on what we have learned from our young people.

Mary Bernstein
Director
Office of Drug and Alcohol Policy and Compliance
Department of Transportation
United States

Slide presentation follows.

THIRD U.S./MEXICO BI-NATIONAL DRUG DEMAND REDUCTION CONFERENCE
Phoenix, AZ
May 31 – June 2, 2000

Drug Free Workplaces
A Critical Prevention Component

Mary Bernstein
Department of Transportation
Office of Drug and Alcohol Policy and Compliance

KEY MESSAGES

- Drug and alcohol abuse are a major problem. Its consequences are felt in all segments of society, including the workplace.
- Employers want to provide their employees with a safe and healthful work environment.

2

KEY MESSAGES

- Drug and alcohol abuse impairs lifestyle, work productivity and shortens life span.
- Drug and alcohol abuse may destroy normal family life, cause financial difficulties and may lead to spouse and child abuse.
- Drug and alcohol abuse places an extra burden on friends, coworkers and associates.

3

KEY MESSAGES

- Companies encourage employees having drug or alcohol abuse problems to seek help before work performance is affected. Through the Employee Assistance Program employees can avail themselves of drug and alcohol counseling and rehabilitation.
- Drug testing is an effective intervention to identify and deter drug users.

4

SUBSTANCE ABUSE IN THE WORKPLACE

What Is It?

- Alcohol
- Drugs
- Prescription Drugs

5

SUBSTANCE ABUSE IN THE WORKPLACE

Why Does Business Care?

- Cost to Industry
- Liability
- Social Conscience
- Legislation (United States)

6

DRUG-FREE WORKPLACE INTIATIVES

DRUG-FREE WORKPLACE ACT OF 1988

- Shot heard throughout United States Industry

OMNIBUS TRANSPORTATION EMPLOYEE TESTING ACT OF 1991

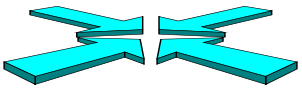
- Required mandatory testing for safety sensitive transportation workers

7

PUZZLE PIECES

Training and Education are used to create an environment that stresses "No tolerance."

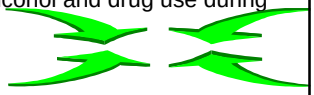
- Supervisory Training
- Employee Education
- Employee & Family Communications
- Hosting



8

PUZZLE PIECES

Policies and Procedures which spell out the companies position on alcohol and drug use during working hours.



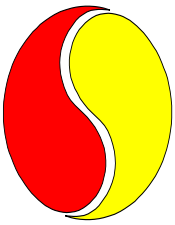
- Use of alcohol
- Position on illicit drugs
- Position on licit drugs
- Procedures to be followed after a violation
- Consequences of violation
- How employees can seek help

9

PUZZLE PIECES

The Employee Assistance Program is the companies vehicle for employees and family members to seek help for alcohol and drug problems. It is a proactive program whose goal is education early intervention and follow-up.

- Job Performance Based
- Education
- Prevention Programs
- Supervisory Training
- Management Consultation
- Intervention
- Short Term Problem Resolution
- Referral
- Follow-up

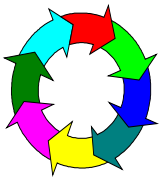


10

PUZZLE PIECES

Drug and Alcohol Testing is a safety program that has become an important tool in identifying and deterring substance abuse in the workplace.

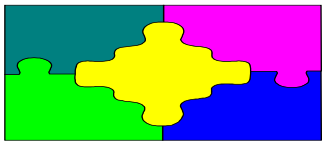
- Pre-employment Testing
- Random Testing
- For Cause Testing
- Post Accident Testing
- Return-to–Duty Testing
- Follow-up Testing



11

WHEN THE PUZZLE FITS TOGETHER

IT IS IN BOTH THE EMPLOYERS AND THE EMPLOYEE'S BEST INTEREST TO HAVE A DRUG-FREE WORKPLACE.



12

Agustin Vélez
General Director
Trusteeship for the Institute for Street Kids and Addictions
Mexico

Gracias, John. There is no doubt that the workplace is an important place for preventing the use of substances irrespective of which they are. Our research project that is being changed once again shows that drug use is a preventable behavior. Prevention of this behavior without doubt, has as a purpose, a goal: that a larger number of individuals at a given point in time in a society would prefer to promote their interest for health rather than have a brain disorder. So, the questions we must answer with preventive actions or activities are not only in children and young people or in adults. We must be at schools and the workplace. That is where we must put in place prevention programs. Intervention is quite broad and leads us to intervene with preventive activities at any time in the life of individuals and at any place where they can meet. They can be intervened with prevention.

In recent years, we have made great efforts to guide our interventions towards children and teenagers that find themselves studying and going to school through many information activities. We tell them about their risks, and strengthening those factors that protect them. However, at schools where our children attend, there are also adults – both the teachers and those who have other duties in the field of education. And these adult individuals in this workplace called school express their attitudes, and with their words, concepts that would not necessarily be favorable to avoid the use of substances. Quite the contrary, some how concepts that can lead people to think that substance use is a behavior that is allowable. And this is in most workplaces, including schools.

For those of us who are between 20 and 50 years of age, this age of life is of our greatest work productivity. This is also the age where more substances of any type are used. Clearly, we can say that a large number of workers at schools where our children attend, are using some type of substance – alcohol, tobacco and some other type of substance. School must be seen as a place for intervention to tell all the students about the risks involved in using these substances, but to we must also consider it as a workplace under a care modality that I will mention later. So, this workplace will be a priority place for preventive intervention.

Research is pointing out that at any point in time in life, we must do prevention activities and we must not consider all substances as risky. They can lead to addiction. We must not neglect actions addressed to avoid the use of alcohol and tobacco as we address the use of other basically illegal drugs.

Every year in the world, billions of dollars are lost due to the use of alcohol and of other drugs also in the workplace. And this is due to the fact that substance use is behind absenteeism, injuries, and low productivity in companies. There are many studies that try to measure the cost. Many of them fall short because cost due to the loss of days of work and the loss due to cost in injuries does not take into account the impact within a social network: the use of alcohol on the rest of the family. Because they don't go to work, there's no income and there are other repercussions in the family setting. A prevention program on the use of alcohol and other drugs in the workplace must consider at least this space where people work together as a simulation of what happens at home or a simulation of what happens in the community. For a long period of time, different types of people are together. Values, traditions, standards and laws regarding the use of substances are at stake every day. This is why this type of program should consider the creation of an infrastructure inside the company that will take into account the owners, senior management, the employees through their union organizations, and health and manpower offices who are the ones that will carry out a preventive action in the workplace. Of course, it's necessary to put in place any value with a model that includes all substances and includes all the ways in which these substances are used. The major components of this type of program must develop the necessary human resources for this end, must strengthen primary health care, and must include the component of the

family and the community within the same workplace. A program of this type must be part of a more comprehensive one that ensures quality in the company and can be reinforced with health, safety and well-being policies included in the organization's documents and made available to any worker, manager, or anybody who's in the workplace.

This way, top management and unions must reach an agreement about the various aspects and objectives of the type of program. You become committed to the project. If the heads and senior management agree that this is a very important subject, the workers will understand that senior management is worried for them and they will have greater interest to follow a program. There are two basic strategies in the programs for workplaces – those programs that address the existing problems and those that address prevention. For problem-oriented programs, the strength of the concept is also their greatest weakness. They are focused on the individual that is already sick and is already a problem. Most people feel that this approach is stigmatizing, and makes it difficult to seek or accept help when it's needed the most. It's more effective to offer prevention before workers have developed any type of dependence and have infringed upon the work bylaws repeatedly. The highest losses in the worker's performance may not come from addicts that have been identified as such, but rather of the rest of the workers of the organization. The most acute risks are related to sporadic incidents like drinking too much, or being under the influence of alcohol or drugs at the wrong time and the wrong place.

All this affects the mechanisms that individuals have to face in a given situation. The risk, the critical task now is to go beyond the care of individuals in order to face broader social issues through prevention methods that will be part of the structure. They must be a part of the company. Programs must focus on prevention. The major goal is prevention while less emphasis is made on treatment and rehabilitation. If we use the metaphor of a traffic light, green is primary prevention and its concept would be that those who are free of drugs and alcohol. A yellow light tells us about the risk and we must create possibilities to go back to the green light. A red light is when a worker has very severe health problems due to addiction. This requires constant treatment.

In a culture that accepts the use of alcohol, primary prevention must be pragmatic rather than dogmatic. Instead of intending to avoid drinking, we should focus people on how to face alcohol and how to do it in their daily life and on special occasions. Union leaders and managers are also exposed to the same risks. Thus, they should also be part of a comprehensive policy of any company.

And finally, it's important to recall that in a workplace where workers have problems, such use of substances also indicates problems in the social network, basically within the family setting. So, the support of the family is a fundamental part of a program that begins in the workplace. Thank you very much.

Melody Heaps
President and Founder
Illinois Treatment Assessment Screening Center, Inc.
United States

Let me just very briefly talk to you about what I think are some elemental principles having to do with this issue. You will have a track that indeed all afternoon and tomorrow will go through some of the programs that have attempted to be the bridge between public health and public safety within the United States and with the government of Mexico.

Let me begin by suggesting to you, that as we in the United States have faced an increasing illegal drug usage, and in fact even legal drug usage, we have put the burden of handling that problem on the criminal justice system to the point where the justice system itself has almost failed. It is groaning with the weight of having to process cases in our courts, of incarcerating individuals. If we take my state of Illinois alone, in 1990 there were maybe 800 individuals who were incarcerated because of drug offenses. In the year 2000, there are almost 11,000 individuals. My state is not unique. And indeed,

we focus on those numbers only of drug offenses but the other offenses related to drug use which happen to be property crime offenses have also escalated. So that the whole justice system, that which has become a foundation for our democracy is struggling to deal with the issue of substance abuse. And it is therefore, very critical that we begin to look at how we can intervene with the justice system to bring people out of that system into community treatment. Particularly because we know that there is a never ending cycle of arrest, addiction, incarceration, release, arrest. And so the opportunity to intervene in that cycle in a constructive way is very important.

At the last conference, the speaker from the government of Mexico talked about the public safety and public health systems as interlocking and that metaphor, I thought, was an excellent metaphor. And what it brought to mind was how our spaceships have space stations and shuttles to connect. And they've had to connect often between the Soviet Union and the United States where we've had different technologies. If we can apply that metaphor to public health and public safety, the first principle is to understand that both systems have not only different technologies, but very, very different cultures. And in order to bridge the gap, in order to connect those systems, there has to be a docking mechanism. At points along the system, we need something very specific which allows, as the Attorney General of Mexico spoke of this morning, channeling of individuals whom we don't want to continue to prosecute or to continue to allow to penetrate further into the justice system and further criminalize. And so a docking mechanism like a TASC program, or a more recent iteration, the drug court movement, is a mechanism which the United States has used to move people from the justice system at all phases, from courts to corrections, into the community-based treatment system.

The other thing you must understand is that the justice system provides a unique opportunity as a catchment area to really go to what is perhaps a hot bed of what I consider a communicable disease. If we are not intervening and looking at ways to treat substance abuse, individuals within the justice system will move into the community and that disease will spread.

The importance that the justice system can offer the public health system is sanctions, a way to overcome what we know to be one of the hallmarks of our substance abuse disease model – denial. The importance of sanctions in stimulating recovery in an individual can be met and melded with the treatment process in such a way as to encourage recovery as individuals move along. I think if we begin, and if, for instance the government of Mexico is beginning to look at the issue of bridging both systems, it is really critical that we understand that if we are going to put mechanisms in the justice system, we had better be ready with treatment programs. For instances in our corrections centers if we get the justice system ready to identify drug users, we'd better have community treatment. There ought to be dedicated community treatment that is rich in resources. That is obviously culturally sensitive but we must get ready to handle the vast numbers that seem to move from justice into treatment.

It is also important and a lesson we've learned in the United States that we need to take a strategic macro approach when we look at forming programs and developing this bridge. That macro approach is not by finding the latest trick or silver bullet or program that may solve our problem within six months. But we look at the total justice system. We look at the problems of usage in a community and we decide to target areas, cases, individuals, to help set up a systemic movement from justice into treatment. It is critical that there be cross-cultural training because, again, we are dealing with individuals in each system that are used to doing different things, thinking different ways, and using different languages. People in the justice system think enforcement, think punishment. People in the treatment system think rehabilitation. So, I suggest that these are very, very obvious principles, but General McCaffrey gave me permission to be obvious today. That will help us at least conceptualize and focus on the need to develop this new bridge or interlocking system. And again, I would stress to you the need to specifically look at designing the function that will help dock, and bring together both the public health and public safety systems in both Mexico and The United States. Thank you.

Bridging Public Health and Public Safety

Bridging the Public Health and Public Safety Systems

Presented by Melody M. Heaps
President, Illinois TASC, Inc.
1500 N. Halsted St.
Chicago, IL 60622
(312)787-0208 Fax: (312)787-9663

1

Bridging Public Health and Public Safety

Evolution of System Linkage

- **Explosion of drug use in 1970's**
- **Communities not equipped to respond**
- **Justice system became catchment for clients slipping through public welfare system**

2

Bridging Public Health and Public Safety

Evolution of System Linkage

- **Justice system had no faith in treatment**
- **Justice system saw no need for treatment**
- **Justice system is compromised**
- **Community safety is compromised**

3

Bridging Public Health and Public Safety

Evolution of System Linkage

- **Federal Approaches - TASC Model**
  - **bridge criminal justice and social welfare**
  - **move clients from justice system to community social services**
  - **accountability - balance treatment need with justice mandates**

4

Bridging Public Health and Public Safety

The TASC Linkage System

- **Identify drug-involved offenders**
- **Diagnostic assessment of drug use**
- **Treatment planning**
- **Identify community resources**
- **Referral to treatment**
- **Monitoring for justice system**
- **Case management through care continuum**

5

Bridging Public Health and Public Safety

What has changed?

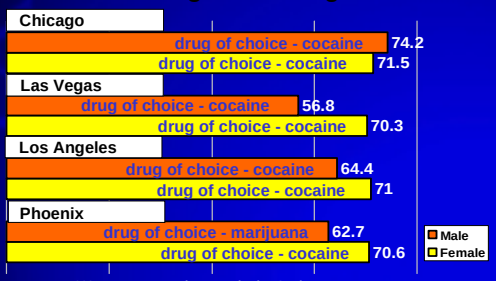
- **Escalating numbers of drug offenders**

6

Bridging Public Health and Public Safety

What has changed?

- Increased drug use among arrestees



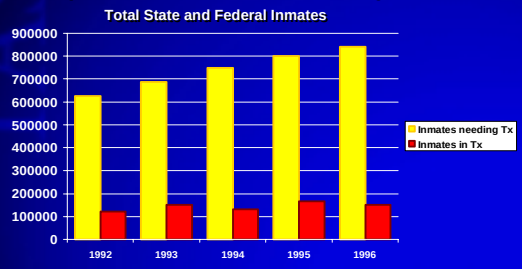
From NIJ's 1998 Arrestee Drug Abuse Monitoring Study

7

Bridging Public Health and Public Safety

What has changed?

- Gap between need and availability of treatment



Based on estimates from GAO, CASA and the Federal Bureau of Prisons

8

Bridging Public Health and Public Safety

What has changed?

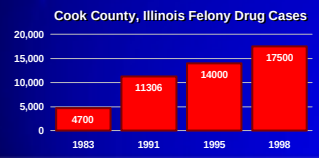
- Client profile
  - Mix of substance abuse and criminality
  - Economic & social dysfunction
  - Mental illness
  - Compromised/vulnerable health status
  - Impulsivity & aggression

9

Bridging Public Health and Public Safety

What has changed?

- Justice system recognizes need for community resources
  - Federal overcrowding lawsuits
- Justice system more compromised



There are now more felony drug cases in Cook County than total felony cases in any year before 1988

10

Bridging Public Health and Public Safety

What is still needed?

- Federal and local policy that moves from program-level response to system-level response
- Federal policies that respond to all phases of justice system:
  - pre-trial
  - sentencing
  - corrections
  - parole

11

Bridging Public Health and Public Safety

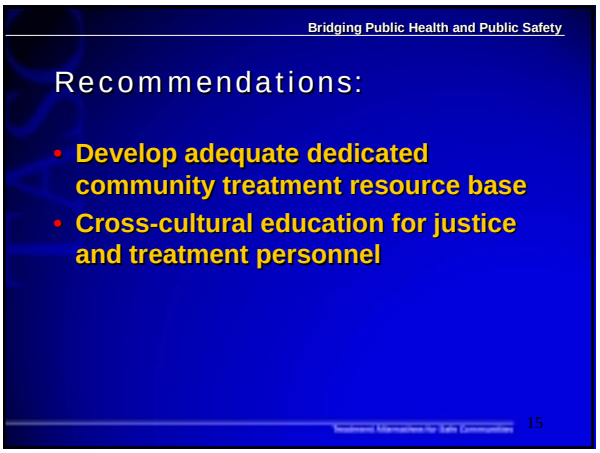
What is still needed?

- Funding that mandates system linkage infrastructure
- Increased, dedicated treatment base
- Funding for and focus on community re-entry

12


Bridging Public Health and Public Safety
What is still needed?
• Funding responsive to client treatment issues
– culture
– gender
– co-occurring mental illness
– cognitive and behavioral problems
13


Bridging Public Health and Public Safety
Recommendations:
• Macro approach
– addresses drug use impact on justice populations
– addresses treatment accessibility
• Target priority justice populations
• Develop linkage infrastructure programs like TASC
14


Bridging Public Health and Public Safety
Recommendations:
• Develop adequate dedicated community treatment resource base
• Cross-cultural education for justice and treatment personnel
15

Rafael Velasco Fernández
President, Center in Studies on Alcohol and Alcoholism, A.C. Mexico

The first thing I want to say is that I feel very fortunate and surely so do you of having been here, listening to people who know what they're talking about. They are conveying their experience and in some point, really update us of things on which we all want to know. If you will allow me, I would just like to stress on the basis of my own criteria, which I hope you find useful, something of what was said here by each of those who spoke before me. Especially as regards those things that have a certain impact on our own country.

Mr. Wilson gave us a good and bad piece of news initially. This has become customary whenever we speak of drugs. Almost always when we have piece of good news regarding some reduction in use and so on, it comes hand in hand with something which is not all that good. Mr. Wilson was telling us, and this is excellent, that adolescents in the United States and juveniles are consuming less drugs now. Less illegal drug use. This seems to me to be excellent news and it has already happened in other areas, stages of time. And then it goes up again. But it seems that the reduction now is a sustained one, which is good news. And we have to begin to ask ourselves whether it is because of programs that they have underway or are providing very good results or whether there are other factors involved. Probably there's a bit of everything that is responsible, but we would have to research more in depth to know what is helping to improve things.

The bad news is that more and more young people are initiating the use of alcohol and tobacco. So this leads to other questions. All of the fruitful research that is done brings up new questions. It provides answers to certain questions, previous questions, but it opens up other questions not yet answered. He also said something that was of great interest to me regarding the youth groups in the United States, along the U.S.-Mexico border. He asked that we have an exchange so that the groups on our side, on the Mexican side, can get in touch with them. Well, probably, the funding of our groups, in spite of what we've heard here with our Secretary of Health giving them the financial support, is not very similar to the 30 million dollars being devoted to such programs in the U.S.

Nevertheless, I believe that establishing links doesn't necessarily mean that they have to lend us some of those 30 million dollars. It means that we must work together and do things that will really help to improve the programs that we have along the border. Mr. Wilson has worked a great deal in the field of drug-related delinquency. And it is an excellent thing for me to have had the opportunity of hearing him today. Dr. Clark told us about the end product of treatment as he called it. What happens at the end of these prevention programs and the treatment of drug addictions and use. He reminded us of something that we often forget, that the treatment of episodes must be cost effective. And if we don't do it appropriately, it will be more costly later on.

Although perhaps not specifically, but Dr. Clark did speak in favor of assessments and evaluations. And I'm very pleased because that's one of the problems that we have in our Mexican programs. We have to work towards assessment. Not a quantitative type of assessment or evaluation, not the one that has to do with how many took the courses, how many supervisors we have to train. But rather the qualitative assessment of what we have done. Whether the goals of our programs have been met, what we expected to do was actually being done. So, a qualitative type of assessment is fundamental. And it is being done on the U.S. side and it's producing good results and I'm glad that he stressed this.

He also announced a study to be done on the best treatment adapted to specific high-risk groups. He ended by saying that, this is very interesting because it will provide us with further news in future that could be useful. What I'm saying is that luckily we are now undergoing moments during which programs are being assessed after 20 or more years that they have been underway. This discovery which seems to be a very basic one ? that we have to discover what are the protecting factors and the risk

factors ? could seem like a truism, something very logical that everybody should be aware of. But if we really don't know what those risk factors are and if we don't identify what the protective factors are, we cannot really put out very many protective programs and effective ones. And here they are undertaking an effort to continue to assess programs.

He also said something very interesting. He said detoxification is not treatment. At least not the comprehensive treatment against addictions and drug use. Nevertheless it is a very important part of it. And it must be done.

Fine. I think I should go on to talk about Dr. Condon. His expression that science is international is an excellent one, and we all know it, but we don't always remember this. Modern imaging and the images that we have of drug use and abuse and addictions are something which is relatively modern and is increasing in importance to all of us. But it's very important that in meetings such as this, and that's why I'm saying that we're fortunate in having heard so many points of view, it's very important that we're told about basic sciences and the research that leads to other things, in terms of prevention for example. And his expression that drug use is preventable, and addictions are treatable, is something that we all have to learn. When we first give a conference or lecture on subjects such as this, its very important that everybody listening understand this, especially in the field of health.

Mr. Condon spoke about risk reduction and strengthening protective factors, and the idea of introducing these into the very effective programs. He also said a very basic truth that we must all remember: that young people take drugs in order to feel better and to feel good about themselves. This is something we must not neglect or forget when we talk to our young people about the problems that they have to face and the reasons why drugs are consumed. He also clearly told to us about activating the pleasure circuit as it has been called lately. He talked about the dopamine effects or dopamine-like effects. What happens with certain neuro-transmitters and so on. And I would like to tell our colleagues who are not physicians or biologists or bio-chemists, but who view this problem from the field of social psychology, anthropology, and who collaborate with other specialists in the field of drug use and prevention, to also read this. They also realize that in principle, addiction is a relationship between a substance and a living biological being. It's fundamental that we know about this, at least as has to do with the general guidelines of it, the basics of this relationship.

That's why his statement that addiction is a disease of the brain, seems to me an excellent way of viewing things because in fact the brain does become ill when it has become used to consuming these substances. The expression of this problem goes beyond the purely biological realm. It has to be something more than just a brain pathology, although basically that is what it is. Therefore, treatment must be comprehensive, and that's why I think that if we are talking about a multi-factorial problem, then the treatment must be comprehensive. And include all of the factors that have an impact on the problem when treating.

Haydée Rosovsky stressed the idea of leading more healthy lifestyles. She led us from the basic sciences to the psycho-social sciences. We also must take note of. There are other factors that we have to research for our young population, not only those that will lead them to deviations in behavior. She mentions self-esteem and other things. She said that in school and in the community and in the work place and recreation centers, we must work towards the self-esteem. And this goes hand in hand with the idea that is in the minds of many teachers who view the use of drugs and the appearance of this use of drugs in the streets. They view this, not only as an educational challenge but as a universal failure of education. Many of these outstanding teachers have said that we have forgotten and neglected to shape personalities and have devoted more time to providing information. It's a necessary supplement of the basic sciences of course, this view. And we are reminded to consider cultural diversity. That which is implemented in one place is not always as successful elsewhere. It is true that there are certain aspects of basic sciences that are valid without any borders or obstacles anywhere, but she marked differences between our young people, their habits and those of other latitudes.

And she almost closed by saying something which was of great interest to me, which is to point out that every preventive effort should be based upon research first and foremost. Research, not only basic research, but also social and other types of research that will provide support is truly useful for our programs.

Dr. Augustine Velez reminds us that we mustn't only ask ourselves about our children and adolescents vis-a-vis drugs, but we should also wonder about all individuals at all ages, especially in the workplace. This is extremely important and he reminded us not all young people are students. In countries such as ours, much less so. And, on the other hand, adult teachers at school, at the workplace, are sometimes consumers both of legal and illegal, or licit or illicit, drugs. It's hazardous for teachers to take a mistaken approach to that problem at the schools. And that's one of the issues that we have in our country which is that of truly and really training our teachers appropriately. This must be said. They are not being truly well-trained to face up to this problem. Truly in developing countries we demand a great deal from teachers. If there's an ecological problem, we tell them to talk about the ecology. If there's a problem in sexual education, we introduce sexual education in the curriculum. If there's a drug problem, we also ask them to approach that. And in general terms, they are not appropriately trained to do it. I'm pleased that this was brought up here.

We were told about the money that is lost. Absenteeism. The drop in productivity. And I would yet add something else that was somewhat expressed, but cannot be measured. The moral suffering of the worker, of his or her family and his co-workers. There's also a political issue here at stake, because we have to try and involve entrepreneurs and businessmen more, as well as the unions. Dr. Velez talked about the two strategies: the one that attacks the already existing problems and the other policy to prevent problems.

Dr. Bernstein told us that in the United States many young people work part-time and also full-time. And that it's quite fair that we should try and make sure that their workplace be free of drugs. We have to sit down and think in Mexico about the great differences that still separate us from what is being done in the United States. I think we still have a long road to cover in terms of knowledge, of training, and of revision of laws and regulations. This is what I was taught by what Mary Bernstein said here about the efforts undertaken in the United States on this issue. Drug users, she told us, get ill more often. And this is a cost that we normally don't take into account. They get ill, not only of the things directly related to their drug use, but they simply are generally weaker and can therefore contract illnesses more frequently. And since they generally are less responsible, they have more accidents, both in the workplace and outside the workplace.

She also told us about the law. I hadn't an opportunity to jot it all down, but I do remember that she stressed the aspect of training, education, policies of zero tolerance. She said, this is something we really have to ponder. And timely care. She also mentioned testing here which is something we have to work a great deal on in Mexico. I'm not saying it's not done. It is done. But the test and the comparisons of laboratories is a matter that we have to really study in-depth.

Dr. Melody Heaps stressed the need of linking the justice system to the health care system or treatment system. Here again we in Mexico have a great deal to be done. And what she said was useful to me: more than anything we should reflect upon the fact that our preventive programs should be linked with many other things and activities. In Mexico we are still not establishing those links. So, this meeting, I think, leaves behind good experiences and learning. Each of those that has spoken, has spoken on the basis of their own excellent personal expertise. What they have said must be translated to each of our countries so that those of us who work in the areas of prevention and treatment can really become enriched with this knowledge here presented. And I repeat, it was a pleasure to be here today.

Mobilizing Parents for Prevention

Jesús Cabrera Solís
Director
Centers for Youth Integration (CIJ)
Mexico

Today, we have two outstanding people from our two countries whose contributions will undoubtedly be of great interest to everyone here today. The first to take the floor shall be Mr. Bautista, who is President of the National Parents Association in my country. He has a BA in business management and specializes in business direction. Prior to being President of the National Parents Association, he was President of his State Association for the parents. I briefly would like to tell you how important this parents' association is by first of all pointing out that in our country we have 19 million parents with children in school. There are a total of 194,500 committees of parents throughout the country, one per school. There also are 32 state parents associations, one per state. And grouped in this national association are parents whose children are in different types of schools, such as the special education children, preschool children, grade school, middle school and secondary school children. This association groups together all of the parents with children in private and public schools.

L.A. Jose Luis Perez Bautista
President
National Association of Parents
Mexico

Mobilizing parents is a very important goal. We should strive in workshops, training sessions, exhibits, conferences, preventative meetings, and at sports events to talk with parents with the common objective of preventing drug use and addiction. Parent associations have been important sources for sharing information in schools as well as in the home. Parents can attend the school where their children study, and schools can offer workshops that deal with a great many subjects that benefit the relationships between the home and the school. It is in the schools where subjects of prevention and drug use are delved into and information can be brought to all parents. If we consider that the school, the community and the parents as well as participating institutions are all working towards a common end, then we will agree that our joint work toward these objectives will produce better and greater results than the isolated efforts of only one of the parties. Many experiences have shown this.

Experiences that link the school with the community are vital and can be achieved by devoting an hour per month or every fortnight to holding meetings with parents and children and youths. Subjects can be approached in a basic and simple way, for example, entering into agreements to talk with their family members about specific topics of importance to the work of prevention.

It is important to consider that today education is not to be given in an isolated way. Rather, it often involves a comprehensive effort by many institutions working together. These institutions can form a comprehensive development system where the family, the National Education Institute for Adults, the Social Security Institute, state workers, Social Services, the Department of Health, Youth Integration Centers, General Attorney's Office, and representatives from Mexico City and the country participate together constantly in the area of education. Such collaboration allows these agencies and institutions to focus their specialized knowledge of prevention and their experienced prevention staff to work with teachers in their schools in order to provide broad knowledge about preventing youth substance use. Also, school curricula contain information regarding delinquency prevention, lack of safety, preventing drug use and addiction, smoking, and alcoholism. It is important to remember that many times these subjects are also important to discuss with parents.

The right to protect the health of children, of young people and of all Mexican citizens is set forth in our Constitution and its provisions. To fully comply with this, all institutions and parents

need to work together. Institutions must offer those services required for the well-being of the population. And parents in the community at large should accept the commitment individually and collectively, of developing and implementing a prevention culture, self-care, and safety. We know that health, safety and education are a shared responsibility. Parents who have organized in our country ratify our commitment to continue contributing in these areas. The government of our country must continue forward with firm public health policies, policies of safety and education that are congruent with the needs of most Mexicans. Organized parents in the country and our organization, through me, have firmly requested that the health and education sectors, as well as those institutions and agencies in charge of law and safety enforcement, establish closer coordination links to reinforce the training and education of our youth in order to prevent violence and delinquency. To this end, undoubtedly, the joint responsibility of everyone is required. In the area of health and prevention, we and our children require constant orientation campaigns that will allow our community to reduce the risks and diseases as well as addictions and violence that they produce.

It is timely to repeat that the National Parents' Association finds it necessary to reinforce guidance programs and information programs in the areas of drug use, violence and crime, both for our parents as well as for our children. We need to strengthen the mechanisms that will allow for us to more rigorously inform our children and our youth throughout the school system, so that we can truly, more efficiently prevent and alert them regarding the brutal risk that drugs represent for their own health and the eventual health of their families. That is why we must speak to our children objectively and truthfully with the greatest respect that all families and sectors of the population deserve, but also clearly enough so that all of our programs and campaigns will have the impact we want. We know of no father wishing evil for his or her children. We know of no teacher that wishes to shape a poor citizen, but I also know of no other way of guiding parents and families if it is not through the help of everyone that takes part in the educational process and in our institutions.

The government, headed by President Zedillo and his distinguished wife as well as the parents of our country have joined efforts. We must acknowledge that we have a good stretch to cover, but only through the will and organized work of institutions and the community, can we forge ahead. Parents will make this effort in favor of our children, for our schools where they go to receive knowledge, and for Mexico. Thank you very much.

Henry Lozano
President
Californians for Drug Free Youth
United States

It's an honor to be here today. It's an honor to address you. As my esteemed colleagues have already mentioned, the basic principle of our discussion this afternoon is to think about the implications of the family. How many of you know that across this country, and across other countries, when you mention things like prevention, and then connect the logical connector, in my mind – the family, that somehow there's a bridge that still has to be built to understand the importance, the value and the implication of families and parents coming together in communities to address the issue of substance abuse and illicit drug prevention?

How many of you know that there's still a bridge out there that has to be crossed? There's still a vast lack of understanding about the value of community. I'm proud to be part of a number of institutions and agencies across this country that have forged bridges into communities, that have forged alliances with different agencies, and have gone the extra mile in their efforts to consider how they might approach bringing together agencies, communities, resources, and most importantly, family. Parents. La familia. The center. The core of every institution within every city. You know how we always draw the case that we have to move to the cities. We've got to move to the communities. We've got to impact the legislatures. We've got to impact the local civil governments and the institutions that

reside out there. But more at heart, we have to impact the family.

I compliment the previous speaker in his points about understanding specifically that there isn't a family anywhere, not one family, that would look upon their children without heart and not want the best for their child, the best in that child's development, education, welfare, growth, environment, status, and achieving. The one thing I do know, that this morning, as this conference was started, we had a wonderful communicator. A speaker before the dignitaries, a dignitary in her own right. A young lady who advanced the charge, a charge about her nation, a charge about her people and a charge about the declaration of the value of young people in their incorporated necessity in what we call prevention and family dynamics. I would say to you that the reason we continue to call parents and family the hardest domain to reach is because we haven't understood what they're listening for. We continue to frighten our families. The moment we use the word drugs, we have families across this nation and across Mexico that instantly are perplexed by the dilemma of what it would mean to associate with a drug prevention organization. Would somebody actually think that my family was involved in that kind of a lifestyle? If I went to help and support, would somebody perceive that what I was there for was help? Across this nation and across Mexico, we have a common thread, a common theme to involve and incorporate people. One of the campaigns that I've been honored to be involved with was this campaign that was under SAMHSA's direction and The Center for Substance Abuse Prevention (CSAP). Our administrator, Dr. Nelba Chavez, founded this program, moved it across this country with the Association of Collaborative Agencies, and important individuals in this room who advanced it. The project had a primary focus. The focus was to deliver to parents, both English and Spanish, a tool-kit, a digest of suggestions and possibilities of programs dialogue forums to encourage communities to start talking at the family level. And the question has always been: what can this do?

Let me give you a quick brief of what this can do. I stand here a proud and honored son of two incredible people — two individuals who gave me my life, who gave me an understanding of what it is to work everyday. My father's side came from Chihuahua, Mexico. My mother's side are Apache from southwestern New Mexico. These two people gave me what I understand today to be an honorable son. They gave me the facility to understand what it is to be a son of integrity, a son who responded to his father's name, a son who respected his mother. Now you smile at that because in this gathering, that understanding is imperative. I had a father who worked seven days a week and a mother who carried a broom seven days a week, not to sweep the floor but to crack it on our backs if we didn't respond the way we should have while Daddy wasn't there. I understood at an early age. From the early days of my upbringing the one thing inside of me, the one thing that held me true to course, the one thing that advanced me forward, was the understanding that my mother and father cared about who I was as a child, that my father understood the value of complimenting me as a son, that my mother understood the value of always being my public relations expert.

Every time mother got up and introduced me, she would tell everybody 50% of a non-truth by telling them how wonderful I was. And she would tell 50% of the truth. All of those things that I did do. But my mother continued to advance the prospect that her firstborn son was a man of honor and integrity like her husband was.

Why did my mother do that? Why did my mother continue to advance a son in such a spectacular way? And then subsequently, my brothers and sisters? Because my mother understood that the man she married, Enrique Lozano, was a man of integrity, a man of honor, a man of value. And to inspire that in me, she had to continue to reinforce in the community's public eye, that I was also a man of integrity. And what did that mean in our family? What did that say about us? What impression did that give about us locally? It gave other people the impression that this firstborn was a man who was going to carry out his father's ways.

I want to tell you that that was the most important lesson my family could have ever given me. All of the curriculum, of the

institutions, of the programs that were assembled could never have taught me what my mother and father gave me in my principles of life. And I'm proud of that. I'm proud of where my dad, proud of where my mother's people come from. On this side of the border I'm proud of who I am. And to understand that pride in me is what I gave to my children. It's what I hope to give when I'm a grandfather. I hope to see that respect come back to me. I'm going to tell you why. I'm going to tell you that we must come to that conclusion as a country.

I'm proud to be of another campaign – The National Media Campaign. The Anti-Drug Campaign that is moving across this country to bring a baseline value of understanding and clarity to this nation on how it goes about investing in its children. In my mind it's the most important campaign of value that could happen in the United States. I'm proud of the leadership, the director, General Barry McCaffrey, and the Office of National Drug Control Policy, and the strategy that's been implemented to move a campaign across this nation, to send this country a message: that our young people are not tomorrow's future. Please hear this. That our young people are not tomorrow's hope. That our young people are not tomorrow's future. They are today's future. Our young people happen to be the pride of today. My mother never said to anybody in public, when this young man finally grows up, then he'll have some value. When this young man finally gets his degree and five years experience, then he'll be worth something. When this man finally gets to be, well, as tall as my father, when this young man can fill my father's shoes, or my husband's shoes, as my mother would say, and walk in them in a manly way, then he will be of value. My mother understood intrinsically that the value was placed within me coming from her, from her very words, from her heart. My familia, my family, is a family that's intact today. A family of brothers and sisters that wait for our annual reunions, that have a better time when we're together than when we're not. And it's all because of two people who championed that the common thread, the common voice in both our countries. We have to speak with confidence, with integrity and dignity to our young people. But not about what they're doing wrong, but about what they're doing right.

We have to move and advance throughout both of our countries. The honor and respect of the family as it is today. The common theme that both of our countries understand is that we have something of value, imperative value, that exists today. It's our young people, working alongside us. Now. Not tomorrow. Not after they go to school. Today. It's moving our young people in such a primary form that that young woman who spoke this morning would be the champion of every other young voice in both of our countries, if they would speak with the dedication and honor, knowing that someday their mother and father are going to hear those same words, those same suggestions, that any mother or father that would sit right there and listen to their son.

If it wouldn't have been that today was the day and my mother and father were otherwise engaged, my hope was to have my father and my mother sitting right there right now. My hope would have been that with these eyes, I could have looked at my father and I could have looked at my mother at this luncheon and I could have said "Salute" to them. I could have been with honor to understand that my people gave me a destiny. A proud destiny.

Toolkits. I'm proud of this one. Probably because I sit on the steering committee and because I get to work with a wonderful group of people. I want you to know that this is a wonderful product that would work in Mexico as well as the United States. And I know the administrator and the local dignitaries here from SAMHSA would love to move this to both countries. I would love to be invited to advance this product because it's a product that has an ethic to it. That has a moral support to it.

Another opportunity I'd like to share with you is that within this nation, there's a network of people who are working together to advance the issues of alcohol and substance abuse across our people's venues. And there's a conference that's going to happen. I'm sounding like a hawker now. It's for the millennium. It's going to happen October 18-20 in Albuquerque, New Mexico. That conference will bring together the finest in research, the finest in researchers, and leadership across this nation to look at our

issues and to consequently forge together the bridge to the communities, the bridge to the leadership within communities. I would invite those of you from Mexico who sit here today to know that we invite you to that conference. We would like to forge that bridge with the wonderful work that's going on. We have begun a bridge to connect to our families. The day is today. Today is the day to continue to advance.

I would also like to thank our Department of Education. I would like to thank Mr. William Modzeleski who is here today, because of the schools and the imperative projects that have gone on with our Safe and Drug Free Schools and Communities Act, the projects that have ventured across this nation to reach young people. The caretakers who usually become the formal providers for our young people happen to be those educators across this country who act as surrogate parents in incredible ways. The tools that are needed are there. The instruments that are needed are there. The collaboration mechanisms for these two countries coming together are there. I am proud that there are young people here today. Without these young people, without the people right there with us, our wholeness, our young people, young men and young women who are the leadership here, without them, we the fathers and mothers do not have a future.

My closing comment: When I'm a grandfather, it will be in my honor and dignity to have grandchildren who want to come and see me. Just like I want to see my mother and father. It will be an honor for those little kids to sit in my lap. To sit and look up at grandpa and to say I love you. It will be an honor for this grandfather to tell his grandchildren that, just as my father and mother gave me that gift, I love you back. Do you know what? I will never understand that privilege unless I create the respect and the tradition of that love and honor within my own children's lives. Because they will be the ones that will convey that thought to my grandchildren. They will be the ones that tell my grandchildren in their homes that Grandpa's a good man. Grandma's a good woman. We need to go see Grandma and Grandpa.

What does this have to do with prevention? Prevention in its heart and soul, is the fabric of this nation's mind and the nation's mind in Mexico. It was us remembering that the prize and the goal that we always had, was to raise children of honor, dignity and purpose.

Program Evaluation

José Vila del Castillo
Moderator
Representative for Mexico and Central America
United Nations International Drug Control Program (PNUFID)

Thank you very much for inviting me to moderate this section on program evaluation. I am sure you will agree that we have chosen speakers who are very highly qualified and highly respected authorities in the prevention and treatment of drug abuse.

Evaluation of Prevention Programs

Abraham Wandersman, Ph.D.
University of South Carolina
United States

Dr. Wandersman's session described how evaluation can be helpful in achieving substance abuse prevention, program improvement and program outcomes. The session highlighted:

- Empowerment and Evaluation
- Getting to Program Outcomes: A results-based approach to accountability.

Dr. Wandersman pointed out that the goal of Empowerment Evaluation is to improve overall program success. It provides program developers with tools for assessing the planning, implementation and results of programs. Thus

program practitioners have the opportunity to make significant adjustments and contributions to the effectiveness of their program.

Empowerment Evaluation encourages:

- Improved planning
- Improved quality of program implementation
- Utilization program outcomes with which to evaluate the program
- Development of a continuous quality improvement system and
- The net result of increased probability of achieving results.

Dr. Wandersman also presented a model he referred to as "Getting To Outcomes: A results-based approach to accountability." This model identified ten key questions. By answering his "10 accountability questions" listed in the following chart, preventionists in the audience were told that they could achieve results-based accountability in the substance abuse prevention programs.

Ten Accountability Questions follow with the steps needed for strategic planning and evaluation focus.

10 Accountability Questions	**Steps Needed for Strategic Planning and Evaluation Focus**
1. What are the underlying needs and conditions that must be addressed?	Needs, assets/resources assessment
2. What are the goals, target populations, and objectives, i.e., desired outcomes?	Goal setting
3. Which science (evidence) based models and best practice programs can be useful in reaching the goals?	Consult literature & promising practice programs
4. What actions need to be taken so the selected program "fits" the community context?	Feedback on comprehensiveness and fit of program
5. What is the plan for this program?	Planning
6. What organizational capacities are needed to implement the plan?	Organization capacities
7. Is the program being implemented with quality?	Process evaluation
8. How well is the program working?	Outcome and impact evaluation
9. How will continuous quality improvement strategies be included?	Lessons learned
10. If the program is successful, how will it be sustained?	Sustainability plans

Evaluation of Treatment Programs

D. Dwayne Simpson, Ph.D.
Texas Christian University
United States

Numerous studies based on almost 300 drug abuse treatment programs and 70,000 patients over the past 30 years have shown that treatment can be highly effective in reducing or eliminating drug use, criminality and related problems. However, all patients do not have the same needs and all programs are not equally effective, so treatment evaluation research has expanded in recent years to focus on how to maximize treatment effectiveness and efficiency. General findings show that —

- Problem severity dictates the appropriate type and intensity of treatment needed.
- Patients with moderate-to-high problem severity levels usually need at least three months of treatment (and for chronic opiate addiction, this increases to a year or longer) before significant benefits can be documented following release. As problem severity increases, the need for and benefits of intensive residential care rises. Good assessments of patient needs and progress are therefore essential.
- Cognitive stages of treatment readiness (or motivation) influence the chances that patients will engage and benefit from treatment. Special cognitive-based "induction" strategies for poorly motivated patients can be effective antidotes, especially in correctional settings.
- Several distinct, sequential phases of treatment (e.g., referral, induction, engagement, early recovery and continuing care) are related to addiction recovery outcomes of patients. Establishment of therapeutic rapport is particularly important.
- Specialized interventions have been developed that can improve each of these crucial steps of the therapeutic continuum.

Jesús Cabrera Solís
Director
Centers for Youth Integration
Mexico

Optimizing valuable resources is an overarching principle in selecting effective drug abuse and addiction treatment. Mr. Cabrera, underscored the following points:

Network of Service Providers

At CIJ privileged rights are granted to:

- mixed operating units that offer prevention programs, community mobilization, and treatment,
- ambulatory therapeutic service units, which are promoted in areas of high demand for services, and
- residential therapeutic units, strategically located across our country for the purpose of providing specialized services to complex cases.

Financial justification

The financial justification is based on the following example:

- At CIJ, residential service is offered through 3 month programs; 122 cases are seen, of which 70 cases or 57% go through recovery and are released.
- The annual operational cost for this type of service is approximately U.S. $356,000.
- Through the ambulatory service system, and for a similar line of cost, effective treatment can be offered to 1,284 cases annually, of which 449 or 35% can be treated and released.

- At centers with mixed operating units, preventive programs are offered to 70,500 persons, services are provided to 512 cases with addiction problems, of which 130 cases or 25% are treated and released.

Based on these concepts, the 54 operating units that form the institutional network for service providers offer prevention, treatment, and community mobilization programs; 4 units provide ambulatory treatment services; and 3 units provide residential services.

Behavioral Training

The institutional training for modality programs is composed of the following:

- Therapists are trained in basic, intermediate, and advanced levels,
- Instructors are trained in individual, family, and group therapy,
- Specialized training is offered to address specific modalities, such as cognitive behavioral therapy for treating persons addicted to cocaine and are registered and using ambulatory services, and
- Training in supportive therapy modality, such as acupuncture.

Productivity of networking service provider

- On average, at each therapeutic unit in CIJ services are provided to 300 patients per year, of which 70 are treated and released;
- If these figures are obtained in the 3000 and 9000 treatment centers registered in Mexico and in the United States, the projected result would indicate that 900,000 and 2,700,000 persons would be treated for drug addictions, of which 108,000 and 324,000 persons would treated and released.

Recommendation: To favor and support ambulatory services over the residential ones in the design of the networking for service providers and training programs for therapists.

Evaluation of Prison-Based Therapeutic Communities: Current Status and Future Steps

George De Leon, Ph.D.
Center for Therapeutic Community Research
United States

Summary of Key Findings:

- Over 80% of admissions to community based TC's have criminal histories.
- TC treatment for CJS clients is effective in community based programs in showing reductions in drug use and crime. Improvements are related to length of stay.
- Estimates of the percentage of inmates in state correctional facilities with serious substance abuse histories range from 50-80%.
- Modified TC programs in prison and jail settings are effective in reducing recidivism and relapse to drug use.
- Modified TC programs in prisons plus post release aftercare produce the largest and most consistent reductions in recidivism to crime and in drug use.
- Aftercare programs which are "continuous" with the prison-based primary treatment programs appear to be particularly effective.
- The large majority of inmates with substance abuse problems do not elect treatment in prison. Among those who do enter prison TC treatment, most do not voluntarily elect to continue their treatment in post release after care settings.
- Individual motivation appears to be a critical factor in completing prison-based treatment as well as post release aftercare.

Conclusion:

Prison-based treatment is highly effective in reducing relapse to drug use and recidivism to crime when it is followed by aftercare treatment in the community after release from prison. However, only a minority of substance abusers in prison enter treatment in prison or go on to aftercare.

The implication for treatment, policy and research: Based upon the science to date, the impact, effectiveness and cost effectiveness of prison-based treatment can be significantly improved.

Four specific recommendations are briefly outlined.

- Establish continuity of care initiatives: Treatment initiated in prisons must be extended after release from prison. Moreover, aftercare programs should be continuous with the philosophy and approach implemented in prison-based treatment.

- Enhance Treatment Utilization Initiatives: Strategies are needed to increase the proportion of inmate substance abusers who will enter and complete prison-based treatment and who will continue in post release aftercare treatment.

- Implement Quality Assurance And Training Initiatives:

  Efforts are needed for guiding the conduct of prison-based treatment and aftercare treatment programs. These include standards for accreditation of treatment programs within prisons to assure the fidelity of treatment delivery. Such efforts should be accompanied by uniform training initiatives for criminal justice and treatment personnel.

- Define Research and Evaluation Priorities

  Evaluation and research studies should address the above stated broad recommendations:

  (1) evaluations of the effectiveness of integrated vs. non integrated treatment system

  (2) research on motivational and other strategies to increase treatment utilization

  (3) research on models of training

  (4) studies of treatment matching e.g., clarifying the subgroups of inmate substance abusers who require prison treatment plus aftercare, prison treatment only or post release treatment only.

Focus on Youth

Ruth Sanchez-Way, Ph.D.
Acting Director
Center for Substance Abuse Prevention
Department of Health and Human Services
United States

The reason why most of us are in the business of substance abuse prevention and treatment is because of our young people. We're in this because we love our young people. We know that they have great potential and that we want to give them all the opportunities that we've had in life and maybe even more. So, our focus this afternoon, while it is the closing session, is on youth, I think that they are really primary in our concerns and in our hearts. The youth component of this conference has been meeting the past two days and they have broken up into four discussion groups and are going to present to us their discussion points, their ideas, and their recommendations. We have four youth representatives who will present the information. And the presenters are: from Mexico, Maria Christina Diaz Jimenez and Carlos Espinoza. From the U.S., we have Carla Perez and Ricardo Hernandez.

Report from the Youth

Maria Christina Diaz Jimenez
Carlos Alejandro Espinoza Dominguez
Mexico

Carla Perez
Ricardo Hernandez
United States

Today, fifty youth participants from the U.S. and Mexico are here. Their ages vary from 13 to 30 years. Youth from different social groups, like students, professionals, artists, indigenous people and street boys. Youth from across the Arizona border and from 32 Mexican states.

Topic of discussion: popular culture and artistic expression, sports and recreation, communication, education and social movement, and community work.

Recommendations. Establish a pilot youth coalition between Arizona and Sonora to develop activities and projects. Expand the pilot to a national level coalition.

We would like to establish a pilot youth coalition between Arizona and Sonora as a pilot project. Mexico, as you know, already has a youth coalition across their country. As a means to expand into the United States, we would like to establish a pilot project within the borders of Arizona and Sonora, form connections and form a similar national coalition within the country. By expanding the pilot to a national level, we would like to create a bi-national youth coalition where connections between all 32 Mexican states, and if possible, all 50 American states, are created. We'd also like to establish a planning committee with youths, adults, United States and Mexican officials to gather the opinions of youths for whom these projects were created, as well as adult feedback. We would like to get their opinions and suggestions on ways that we can move around within our government, our community and non-profit organizations, and U.S.-Mexican officials to make this coalition happen. We would be able to establish a bi-national youth camp. This bi-national youth camp would allow the exchange of ideas to explore prevention. One way to exchange addiction prevention strategies is to create planning committees. Another way is the exchange of cultural traditions. Among border towns within Arizona and Sonora, in religious, social and economic of Mexico and the United States are very similar. They are inter-dependent because, this is the border. We learn from each other, we live with each other, so we have to learn how to work with each other.

We want to establish a bi-national youth camp, we want to establish discussion groups in the four main areas that were discussed previously: sports, recreation, popular culture, artistic expression, communication, education, social movement and community work. By having the exchange of ideas and traditions within these areas, we have the best of both worlds. We need strategies that the United States youth groups have been using, along with strategies that the Mexican youth groups have been using, and that may be implemented bi-nationally. One thing that we, as the American delegation wish to commit to is the free flow of ideas by letting Mexican youth travel within the United States freely, without any reservation, without any form of denials. We should be able to work together to form communities and coalitions and establish good ideas. As a means of doing this, we would also like American students to go to Mexico and to form an exchange of cultural traditions as well.

The themes that we want to expand on for the bi-national youth camp are, as she said, *Manos Jóvenes a través de la frontera,* United Against Drugs; a mixture of English and Spanish; Spanglish as we call it. We are a global community. We are a community engaged in a society where nobody is just alone. Nobody stands alone any more. Everybody exchanges, everybody's connected in one form or another. Within Mexico, the local youth groups have connected with each other, linked with each other, and exchanged ideas with each other. Among themselves, among their governments, among their leaders and adults. That is something that we, the United States, wish to commit the United States government to. We would like to know if the Mexican government has committed to its youth, will the United States commit to theirs?

Slide presentation follows.

Binational Youth Forum

May 31- June 2
Phoenix, Arizona

Participants

- 50 youth from the US and Mexico
- Coed ages vary from 13 to 30
- Youth from different social groups: students, professionals, artists, indigenous people; street boys
- Youth from across the Arizona border in Nogales, Douglas and Somerton and from 29 of 32 Mexican states.

2

Topics of Discussion

- Popular Culture and Artistic Expression
- Sports and Recreation
- Communication, Education, and Social Movement
- Community Work

3

Recommendations

- Establish a pilot youth coalition between Arizona and Sonora to develop activities and projects.
- Expand the pilot to a national level coalition.

4

Recommendations

- Establish a planning committee with youth adults, and US/Mexico officials
- Establish a binational youth camp
- Exchange of cultural traditions
- Discussion group in the 4 areas (sports and recreation, popular culture and artistic expression, communication, education, social movement, community work)

5

Themes for the Binational Youth Camp

- Manos jovenes a traves de la frontera, united against drugs
- Coalicion Juvenil: Trabajo local con metas de impacto global
- Youth coalitions: Local work with goals of global impact

6

Adolescent Treatment

Jorge Sánchez Mejorada
Researcher
Veracruzana University
Mexico

I want to welcome you to this closing plenary session of this bi-national meeting. It is an honor to be with you this evening, talking to you, very briefly about the topic which, for me, is a core issue. The participation of the youth, I think, is fundamental and I use their participation as a very successful event to say that from the viewpoint of treatment of adolescents we will also require their participation. I think this is a core, or a key, participation. I would like to tell you why when I identify a specific point. One of the things, and you youngsters know this very well, you who are working on a daily basis with the other young persons, you who have an impact on the activities and mindset and lifestyles and fashions and styles and mores. You who have also an impact on treatment and recovery and have to be aware of how important your role is. Fortunately, those youngsters who have addictions can enter into a recovery program and link to other young persons who can understand their problems and move forward along this process.

I will briefly share with you a couple of experiences, one of them linked with the testimony of our young persons who have had an impact upon my professional life. This happened about 12 or 13 years ago when I had the opportunity to listen to an alcoholic 16 year-old boy. That broke away with many paradigms because I have to confess that for me specifically, alcoholism was a problem of older persons. That was the medical model I had been working on. And that addiction as such was especially alcohol, it was something which was never seen in early ages. The testimony of this young boy really hit me. It moved me. And I have to tell you that once in a while I have the pleasure of seeing him again. He's around 28-29 years of age. And he's been able to take control of his life and career. The great teaching was that I could clearly understand that addiction is a very complex problem. It is a disease if we use the disease model, which I think is the one to better understand addictions. The model can be present at any age and much more so now that at an early age many persons are using drugs that have a high addictive potential. As you have heard, the proliferation of the use of cocaine is something that we more often see amongst very young teenagers or young persons. And this is something we have to be aware of.

About 10 or 11 years ago, I was invited to go to a treatment center in Minneapolis, Minnesota, called St. Mary's Chemical Dependence Services. It was quite a novelty to me and highly stimulating. To find a place that had the characteristics this center had. The young addict and the adult addict were treated with a broad range of strategies with a comprehensive approach. Different needs were present there, but everything was done with full respect for the dignity of individuals. I thought that to be fundamental. And since then, I had this dream, a dream I have tried to make a reality throughout this year. And I can tell you now, that some steps have been taken in Mexico, although much has yet to be done. And the dream is that any addicted person, youth or adult, can receive professional treatment, with ethics, where dignity and an individual's integrity are respected. So, we have a lot of work to do. Although I have acknowledged that things have been done in my country, and that we have the necessary foundations, it is now time to move forward at a greater pace.

I would like to share some thoughts specifically with the young representatives here. Treating and working with professionals or volunteer personnel, young persons, parents, persons in recovery, what I have been able to realize is that if you require passion and commitment in many occupations, in this one much more. When treating, when working in the prevention and treatment of addictions, you're required to love your activity. If you believe in healthy lifestyles, you have to truly believe so that you can truly convey the message. Otherwise, our words will be empty and will be left hanging out in the air. So, we have to be passionate and fully committed. And, I'm very pleased to see that there are young persons from Mexico and the U.S. that are getting involved in all of this, because this had been the missing link. I hope

you continue moving forward with this enthusiasm because adults and professionals, by themselves, won't be able to cope with the task. It's evident we need your participation.

I'm going to present to you some ideas here which relate to treatment of adolescents. This is a proposal based on literature reviews as well as on direct observations made at treatment centers in the U.S. and in other places including Mexico, for example, the ones existing in Colombia. Within this field, there's a lot of work to be done, such as creating different but specific alternatives of treatment for adolescents. With adolescents' treatment for problems of drug dependence and drug addiction diagnostic difficulties sometimes make it difficult to differentiate between abuse and dependence. Young persons have to provide us the guidelines to follow as to the degree of intervention we should undertake. Going from interventions which can use tools, the most traditional ones, for example, individual psychotherapy, family psychotherapy, or group psychotherapy which is a very good approach to be used with adolescents. As to the other side, more intensive treatment: outpatient care, home care, or maybe hospitalizations, with times that may vary according to the characteristics of those persons affected. The truth is, addiction amongst adolescents as well as within adults requires us to resort to strategies that require home care. And this is, more or less, what I'll be talking about in the forthcoming minutes.

This is a specific characteristic in the case of adolescents and which we have to address. There are different needs, which I would categorize into three groups: those needs related to the development stage. In adolescence, aside from any additional problems they may be experiencing, we need to solve specific issues. Certain things that pertain to that specific development stage of their life. Some authors call these developmental tasks. You have to answer a set of questions and arrive at a set of conclusions. Throughout this process of growing up and in defining one's self in many senses, and getting to know one's self. And appreciating one's self and learning about our own individual potentials. This is a set of needs that have to be undertaken and considered within any treatment scheme. Other needs are linked to the addictive process and recovery itself. And the third group are the specific problems like the case of the psychiatric morbidity or dual diseases or parallel diseases to addiction.

Here, we have some of the points I had mentioned that pertain to that developmental stage. The first one, the personal identity responding to the question, "Who Am I?". Fundamentally, who am I? The definition of sexual orientation, which is also a task to be done during adolescence. Understanding the definition and acceptance of the sexual orientation. The definition of personal values. Moral values. Ethical values. Spiritual values. Religious values. Values relating to daily life. That which is important for each individual. That which each individual believes in. And evidently, if you live in accordance with all that, there will be a sense of well-being and be a feeling of being a comprehensive person. Communicating to others. Getting close to others and living with others. Vocational choice. The sense of belonging. All of us need to belong. But this is fundamental during adolescence. To belong to a group of peers, that's very important. You have to be a member of a peer group. One of the characteristics of addiction is that it provides individuals with a sense of belonging to a group of peers that identify themselves through their different behaviors. Well, in addiction recovery, at a certain point in time, you can experience that same feeling when the links are established in a lifestyle which implies sobriety.

And lastly, to define a life project. The understanding, the vision, that each individual has as to life in terms of defining one's self mission. This is closely linked to values and vocation. And it is also linked to all the other areas of life. So, these are the things that have to be considered within any treatment in the long run when we treat addicted young persons. And we have to walk along as individuals with these adolescents in trying to identify answers to these questions. The needs which are inherent to recovery, that is to recovery of those damages caused by addiction. Starting with detox, through some drugs, this poses no problem, but with other drugs it poses problems, even within the medical and physical fields, specifically, when we talk about opiates.

It is not common to see withdrawal syndromes amongst adolescents because of the type of substances used – at least in Mexico. However, we are not exempt from having problems and from having to address the situation. We have to confront denial, because you know that part of the characteristic of this addiction is denial. When an individual says, no, I have no problem, nothing is wrong with me; this is denial. And we have to address the post-acute withdrawal syndrome with a different characteristic. The mental field, in the emotional arena, and even in the physical arena. Emergencies, due to the use of drugs such as cocaine, even after some time after consumption has been suspended. We have to support and foster healthy behaviors. We have to rediscover or restructure cognitive structures, a new way of thinking, a new way of visualizing oneself, and visualizing life in the environment, and the individual's problems.

We also have to look at background information, having to do with badgering or abuse, psychological or physical. And also, we have to consider HIV and early pregnancy. We have to emphasize sports activity in contexts that will allow socializing to take place. This is something very important that has been somewhat lost. Sport is an element of coming to know each other and sharing with others in contrast with the current trends towards this lonely kind of sport where the only thing being done is heeding one's body, personal development and self-pride. The recovery of values has to be taken, values that have been somewhat lost along the way. It enables those people to provide a meaning to life through this interaction and through this range of possibilities and of interactions that are developed.

It is also a fact, as it happens within the adult population, that some adolescents, aside from having the drug addiction problem, they have other psychiatric problems. And we could also talk about other medical problems, but here we're just referring to the psychiatrists. And these are some of the most often-seen problems amongst adolescents, may they be drug addicts or not. But when we're at a certain point in time treating addicted adolescents, we would have to identify and/or discard the presence of any of the aforementioned diseases to be able to treat these diseases in an efficacious way. So, we have schizophrenia which is a disease that usually has its onset during adolescence or early adulthood. We also have personality disorders before 18 years of age. However, there are certain traits that could somehow point towards this direction and if we see these traits early, we will then be able to identify specific needs that have to be considered within treatment. And also, it is important to know them in terms of prognosis. The activity disorders, hyperactivity disorders that have their onset during early childhood, or anxiety disorders or learning problems or disorders, these are the most meaningful ones. This is a broad range of disorders that can be associated with drug addictions. And if they're not detected and specifically addressed, then the adolescent will be at a disadvantage to use the recovery tools available, and to be able make this cognitive change and behavioral change being proposed to that person.

Now, in trying to respond to all these needs that I've mentioned already, here are some considerations which can be used within a broad range of therapies. First, we have self-help and mutual help and these are main axes, and many times they are confused but it's quite clear here that self-help is the help that one can render him or herself, and mutual help is the help patients provide each other. By now, you'll see how I help myself and how I help you. And this, in turn, does help me. And another alternative in these therapies is only you can do it, but you cannot do it alone. This emphasizes personal liability but also the need for help, an atmosphere which promotes confidence and self-esteem in the environment of the teenagers. Many of these needs can be covered and can be found within this atmosphere. It's not an atmosphere that fosters fear or terror. But, obviously, what you need is discipline. You need clearly cut standards and rules. These rules should be established, especially in dysfunctional families, and we try to deal with them in the centers to make them as functional as possible. This is difficult and sometimes we become more dysfunctional than the families that we have diagnosed as such.

Now, on education, recovery and new lifestyles and abilities for being able to play recreation and athletic activities and also occupational

activities. Service to the community – this is fundamental. And therefore, I restate here the efforts and the participation and involvement of these young people that are here today. To serve is something very important. From many viewpoints, the one who serves, gives and the one who gives also serves because you feel useful. So, within the communities, service to the community itself plays a very important role, and group therapies play a central role. They are opportunities for confrontation for knowledge and also feedback.

The involvement of the family is also fundamental. It's decisive. We know that in Mexico there are places in which the addicts are often teenagers. The family deposits them as if they're dropping off a package somewhere. So, if we speak of family involvement as being fundamental and always very important in order to help in this change process and to make the necessary changes, this is one way in which the family can be part of the solution to the problem. We have to work intensely with them. This is also a matter of convincing the family that they must be involved in this fashion.

We're also dealing with multi-faceted programs based upon goals or objectives in which the reinsertion which comes later is something that happens gradually. The social and family reinsertion. And, obviously, something that has been said in many conferences these last few days, is the importance of post-treatment, that is, follow-up in which the prognosis improves greatly if there is post-treatment that also is long-term and continuous. I think this is fundamental.

We also have much to do. In Mexico we know this because the profile of the consumers of drugs has changed considerably in the last few years. Young people begin taking drugs younger and younger and this is a problem, not just in the major cities, but rather in many communities. I have data in populations where I never would have imagined that it takes place.

In rural areas they use controlled substances and alcohol, but at younger and younger ages, 10 and 11 years of age, in fact. How can we face this challenge? I think training is the golden key. In order to be able to multiply the options of treatment throughout the country, training professionals must also train those who have been empirically trained, along with volunteer personnel who are more than willing to work and may already work in this field. However, many require the necessary training. Therefore, we'd be able to work on models in which there is intensive inter-disciplinary work taking place where the gulf exists between the theories and the professionals.

And also, there's work on research. That is, research on the impacts that we've seen in the conferences and in the U.S. I think they're light years ahead of us here. But we can learn a lot and we need to do it urgently. It behooves us to do so. We also have to know that in Mexico very good things are being done, but we don't have the necessary elements to say "yes, here's the data." And the data supports this. This can lead to the right path. We need to do it. There's an urgent need for this. And obviously, we need funding. We need the funding from different sources. From governments, Federal, state, from civil society. Unfortunately, in Mexico, we do not have a very altruistic culture in this sense – that is, with regards to donating money. We have it in other senses, ironically, so we have to knock on these doors and we have to seek out other options. In the case of state or municipal governments, I see more and more examples of situations in which they donate a house or a piece of land, a property, or they are being loaned. So, we have to knock on these doors. We have to open them up and therefore, see the participation of government agencies. They are quite useful and obviously the participation of professionals and of volunteer personnel working together to respond to the problem and to evaluate the measures so that in a few years, we'll be able to say we've done this. And we have all this data, and we have a series of studies which at a given moment will indicate that we're on the right path or we have to change our path. And therefore, be able to continue heading towards something we can no longer delay.

I think the need has been created and the response is already within us and around us. So we have to start working. Thank you so much for your attention.

Prevention for High-Risk Youth

Susan Kunz
Director
U.S.-Mexico Border Center for the Application of Prevention Technologies
United States

We have a mechanism that some of you in the room are also involved in. We have an advisory group. This is to keep us honest, to keep us focused, for you to tell us what you need for us to do as representatives of the border community that we're trying to serve. We have a meeting coming up very soon. There are representatives from each border state and several Federal agencies and some other local groups. So, I encourage you to find out who the representative is from your area, and use that person as a conduit of information. They will really be guiding the direction of our project. If you don't contact us, chances are we will not fulfill our mission. These are the people that can help you. They can help provide these resources. They've very responsive. They're really nice. And they're very helpful. And, please take advantage of the U.S.-Mexico Border CAPT, so we can help youth through good prevention programs. Thank you.

Slide presentation follows.

Effective Prevention Programs for Border Youth

Programas Efectivos de Prevención para la Juventud de la Frontera

Susan Kunz, MPH
U.S. Mexico Border CAPT
Border Health Foundation
2501 East Elm St.
Tucson, AZ 85716
(520) 795-9756 fax 795-1365
skunz@ambhf.org

1

Basic Premise

- Involve representative youth
- Reach youth in need

Premísa Básica

Involucrar a jóvenes representados
Alcanzar las necesidades de los jovenes

2

How do we know what is effective?

¿Cómo sabemos que es efectivo?

3

Science-Based Framework

Clear target population
Program design based on needs

Estructura Basada en la Ciencia

- Población definida
- Programa díseñado en base a las necesidades

4

Science-Based Framework

Interventions tied to outcomes
Design is culturally appropriate

Estructura Basada en la Ciencia

- Intervenciones relacionadas con los resultados
- El diseño es culturalmente apropiado

5

Science-Based Framework

Integrated evaluation

Estructura Basada en la Ciencia

- Evaluación integrada

6

Basic Principles

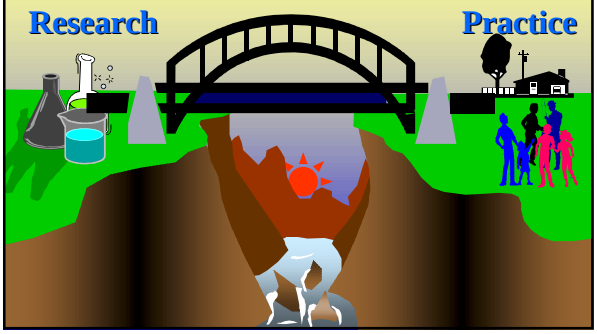
Address multiple domains
Utilize multiple strategies

Principios Básicos

- Dirigirse a múltiples áreas
- Utilizar múltiples estrategias

7

CSAP's Vision for the Future



What is science-based practice?

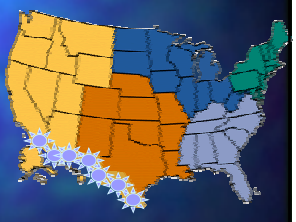
Que es la practica basada en la ciencia?

- Model Program
- Best Practice
- Promising approach
- Programa Modelo
- Mejores Practicas
- Enfoques Prometedores

9

CAPTs at a Glance

- Border CAPT: Tucson, AZ, 520-795-9756
- Central CAPT: Anoka, MN, 800-782-1878
- Northeast CAPT: Newton, MA, 617-969-7100
- Southeast CAPT: Jackson, MS, 800-233-7326
- Southwest CAPT: Norman, Oklahoma, 405-325-1454
- Western CAPT: Reno, NV, 888-734-7476



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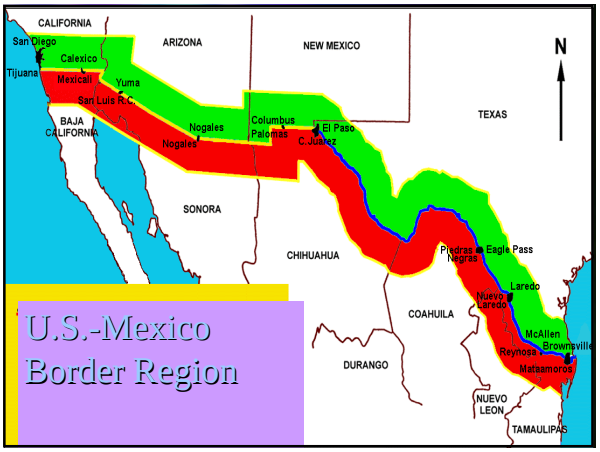

Mission

- Increase availability and application of science-based substance abuse prevention knowledge that is responsive to US-Mexico border dynamics

Aumentar la disponibilidad y aplicacion del conocimiento sobre la prevencion del abuso de sustancias basada en la ciencia que responda bien a la dinamica de la frontera Mexico-Estados Unidos

12

Border Context

CAPT de la Frontera Mexico-Estados Unidos

- Community conditions
- Drug availability
- Migration
- Transculturation

- Las condiciones de la comunidad
- La disponibilidad de las drogas
- La imigracion
- La transculturizacion

13

Goals of Border CAPT

Metas del CAPT Fronterizo

- Identify culturally appropriate programs
- Help customers apply programs
- Sustain border prevention efforts

Identificar programas culturalmente apropriados
Ayudar a clientes con aplicacion de programas
Sostener esfuerzos preventivo fronterizos

14

How? Como?

- Integrate US-Mexican research to adapt models suited to residents of the border region

Integrar las investigaciones mexicanas y estadounidenses para adaptar los modelos que sean mas apropiados para los residentes de la region fronteriza

15

Services

- Electronic
- Technical Assistance
- Skill Building

Servicios

- Electronicos
- Asistencia tecnica
- Formacion de habilidades

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Electronic Electonico

- Website
- English/Spanish resources
- Links

Sitio web
recursos en ingles y espanol
enlaces

WWW.BorderCAPT.org

17

Technical assistance

- Expert Network...
  - ...we want you

Asistencia tecnica

- Red de Expertos...
  - lo(a) queremos

18

Skill building

- Group training...
  - what are your needs?

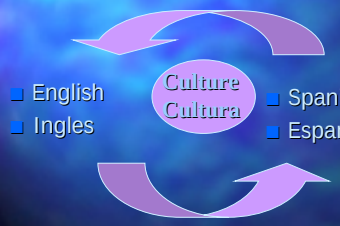
Formacion de habilidades

- Entrenamiento de grupo...
  - Cuales son sus necesidades?

19

Adaptation/Translation

Adaptacion/
Traduccion



- English
- Ingles
- Spanish
- Espanol

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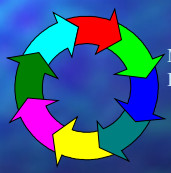
Research Work Group

Grupo de Trabajo de Investigacion

- U.S. researchers
- Investigadores estadounidenses



Mexican researchers
Investigadores mexicanos

21

Research Work Group

Grupo de Trabajo de Investigacion

- Review, adapt and recommend best practices for border populations
- Revisar, adaptar y recomendar las mejores practicas para las poblaciónes fronterizas

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Advisory Group

- Mexico & U.S.
- State and Federal

Grupo de Asesoria

- Mexico y Estados Unidos
- Estatal y Federal

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Contact Us

Nos puede contactar en nuestra pagína electronica

www.bordercapt.org

Courtney Coffey, BHF
(520)795-9756

Lorenza Mena, USMBHA
(915)833-6450

24

Addressing the Needs of Youth in Criminal Justice / Substance Abuse-Public Health Programs

Eugenia Ortega
Superintendent
Karl Holton Youth Correctional Drug and Alcohol Treatment Facility
California Youth Authority
United States

Ok, thank you very much. And muchas gracias. I am very honored to be here. I am very impressed with this collaboration. Quite frankly, I wasn't aware that Mexico and the United States were making such a conscientious effort to work and address these problems. I would like to also make an observation. Last year I was also part of the panel for ONDCP in Washington, DC when they were addressing drug issues throughout the country. And, of course, I was at the end of the session because it dealt with youth. And, today again, we're at the end of the session. And, actually it makes it a lot easier to do a presentation to half of a crowd, but I want to challenge both Mr. Schecter and Mr. Cordova, if we continue with these kinds of conferences, we talk about our youth being our primary focus. We talk about our youth being the most important reason we're here. We talk about these programs and the efforts being made so we can address the youth of not tomorrow – as Henry said – but of our youth today, and we leave them to the end. So, I challenge you to take an observation of that. I would like to see this ballroom full with all our dignitaries here, with all our panel members here. To listen to what they're doing. I'm so impressed, and I just compliment you all.
Let me just give you a quick overview of what the California Youth Authority is doing. We are an institution, we are a department that houses 7,500 juvenile offenders. These juvenile offenders come to us through the courts. They are sentenced by the courts and they end up in the Youth Authority. We have 11 institutions statewide, and four camps, which allow these young men to establish, develop additional skills. When these young men come to the Youth Authority, obviously they're here involuntarily. And I'm going to address that, because as you have heard throughout the conference and the literature clearly speaks to, is that providing substance abuse treatment. whether it's voluntary or involuntary, has proven to have an impact. It has been proven to show a change, even if the person is attending these different services on an involuntary basis.

Our population in the Youth Authority, is 49% Hispanic. Personally, that saddens me. Twenty-nine percent are African-American, 14% are White, 5% Asian, and 2% "other". The Hispanic population has increased from 33% in 1990 to 49% in 1999. That's quite a change, quite a difference in our population. And right now, we're looking at different treatment modalities. They're more culturally related, so that we can introduce that element to our programs. About, 85% of our young men, come to us with substance abuse, either drug related offenses or drug related history. As a result, in 1994, the Youth Authority decided that they needed to look at an institution and totally dedicate the services provided to substance abuse treatment. So, in 1994, in Karl Holton, which is located in Stockton, California, we housed approximately 410 wards. All the wards there address substance abuse.

I'm going to talk a little bit about what we do. First of all, the mission of Karl Holton is to provide these young men the training, the education and the treatment necessary to establish a substance abuse free lifestyle once they go out into the community, once they get out on parole. Karl's program is from 8 to 12 months. The literature clearly speaks to the longer the stay in treatment the better the success rate. So, we have an established 8 month program, but it can go up to 12 months, depending on the particular needs of the young men. It's a transitional program. The literature also states that if you provide these services upon the end of their stay, while incarcerated, you have a better success rate. In other words, if the young men have a sentence of three to four years, they will come to Karl approximately one year before their release on parole.

Karl has an established therapeutic community. Karl was established in 1966 with that modality. Since then, obviously, many years have gone by. We still have some elements and some components of therapeutic community, but they're not as strong as were presented earlier by Dr. De Leon. As a matter of fact, I took his card because I want him to give us some additional training and update our staff in the therapeutic community. But we still have some of the same concepts and elements that were presented.

Karl is a three-phase program. When the young men arrive, they arrive during an orientation period. During the orientation period, they are taught what we term social thinking skills. It's a cognitive method for these young men to learn how to deal with their issues, resolve programs and deal with their daily living while at the Youth Authority. Upon completion of the orientation, there is a 12-step Hazelton Program that's called *Design for Living.* It's a modified 12-step program, that is used for correctional settings. So, the young men go to school. In addition to working towards their high school diploma, their GED, they are also working in school to learn the 12-step program. Once they learn the concepts, in school, they have to take a test. It's all cognitive. Then once they go into the living units, then the youth counselors are supporting the treatment modality by doing small groups, individual counseling with the same 12-step program.

There's an aftercare program which provides relapse prevention and helps the young men get ready for parole. They work on establishing, what we call a personal life plan. I'm going to address that in a little bit. They're a number of things that our institution does. We do have statistics, of course. You always have to be careful when quoting statistics because it's all relative. Karl's success rate is: 64% of the young men are able to maintain free from incarceration within the first 12 months upon release from the Youth Authority, greater than the Youth Authority norm at 49%. So, we're doing a little better than some of the other institutions because of the intensity of our program.

They're all kinds of components. I'm not even going to elaborate any more on the different services that we provide. What I mainly wanted to focus on in today's session was on the needs of our juvenile offenders and the needs of the youth in the criminal justice system. Dr. Sanchez earlier talked about adolescent treatment. He already elaborated on all the key components that we have that have been recognized as different areas that need attention. So, I'm just going to highlight a few of them. Number One: there is a mental health concern. Twenty-five percent of the young men sentenced to the Youth Authority, or sentenced to Karl, are dually diagnosed, which means that they have other, maybe mood disorders, and anxiety disorders. Some of them are schizophrenic and paranoid. Some of them come to us with very extensive histories of physical abuse or sexual abuse. So, those needs must be addressed, needs that are above and beyond the substance abuse issues and concerns.

We talked about some of the other areas that were highlighted, such as a sense of self-identity, developing a sense of who they are. Mind you, these young men come to the Youth Authority at a prime age during their adolescence. Their sense of seeking their self-identity is no greater or no less than any other adolescent. When you couple that with having to deal with incarceration, it exacerbates the situation. Particularly with self-identity, there's a concern of gang involvement. Most of our young men have some form of gang affiliation. We have extensive programs at Karl that help these young men break away to denounce their gang affiliation. And we have modeled a couple of programs by using some of the 12-step components and adapting them to gang related issues. We've looked at using sponsors as mentors. We also have a group called Independent Status. These young men meet on a regular basis to look at how they can support each other to break away from the gangs. As you well know, gang involvement comes with a lot of peer pressure, so I think we need to enhance the peer pressure on a positive note just as well to help them overcome their gang involvement, gang affiliation.

Family involvement is so crucial. Unfortunately, that's probably one of the most difficult areas. A lot of times, and I have to say that particularly my experience has been in working with the

Hispanic community, it's very difficult to involve the family. I know personally, my parents are very private, very humble and have the "keep it in your household" mentality. It's just very difficult to enlist the family in the treatment, in the development. So, we're trying to educate them by showing them what kind of progress is being made by getting the family involved. And these young men are returning back to their communities, it's so important that they understand the changes that the young men have made and accomplished. But that's very difficult, I have to admit, very difficult to do.

One of the needs that is crucial upon preparing these young men is to ensure that their plans for parole, their plans upon release, are realistic. These young men have made some very positive changes while incarcerated. But, they start establishing these very grandiose goals. I'm never going to get involved in gangs. I'm never going to do this. And some of that may not be realistic. So, we need to establish and assist these young men in establishing a realistic, what we call a personal life plan. You can establish nice, grandiose goals, but they have to be coupled with very specific, concrete objectives. That's very important. And so we work with these young men. What are they going to do about school? What are they going to do about work? In what areas are they going to hang out? Are they going to be in the same communities, in the same neighborhoods? What are they going to do if temptation hits them? What are they going to do if relapse occurs? So, the personal life plan is very, very concrete.

In addressing today's topic, which spoke to the needs of the youth, I was reflecting upon our work in the Youth Authority, reflecting upon my experience in working with juveniles. And in essence, it really comes down to the fact that these youth have no different needs than you and I. They really don't. These young men or women who are dealing with substance abuse, want to feel important. They want to feel love, and they want to feel cared for. Just like you. Just like me. They want to have this love and this care demonstrated to them. How many of us are parents or children or spouses? And, we know our parents love us. We know our children love us. We know our spouses love us. But we want to hear it. We want to hear it. I love you. Honey, you did great today. We need that positive reinforcement. The needs of these youth that are in criminal justice have the same needs in that regard. They want to feel recognized. They want to feel important. And they want to feel part of a bigger good. You and I want to feel accepted by our families, by our loved ones, by our communities. These young youth also want to feel the same. They want to feel that they are accepted by the bigger community, by the bigger good, so, it's very difficult. It may appear simplistic, as I present it in that fashion and in someways it is. It's pretty simple. But I know it's much more difficult to implement and to create processes and methods and treatment programs to help them overcome this desire that probably they've been neglected by their upbringing, their communities, their schools. Everybody has turned away from them.

So, it's really important that we ensure that as we deal with these youth, that we recognize that the essence of their needs are very similar to yours and mine. So, I challenge you all. I empower you all to go back to your work sites, go back to your communities and respond to your youth, to our youth, that they are accepted in our community and that we truly care for them and we're going to do whatever we can to salvage this generation to come.

Thank you very much.

Closing Remarks

Daniel Schecter
Deputy Director for Demand Reduction (Acting)
Office of National Drug Control Policy, United States

This conference really began four days ago with NIDA's research conference. On Wednesday were the pre-conference sessions, the reception, and the play "Halfway There," followed by two days of plenary and breakout sessions, which were really like conferences within conferences. So, it's been a very, very intense four days. Our heads are filled with information and ideas.

Think about how different the first U.S./Mexico conference two years ago was from this conference. In El Paso, Americans and Mexicans working on drug abuse problems didn't really know each other. They weren't familiar with what each other was doing. They weren't familiar with the problems in the others' country. They certainly weren't working together very much. We didn't have Susan Kunz's Border Center for the Application of Prevention Technology. None of those things existed. It was a very different kind of meeting.

But look at this conference. The whole atmosphere was different. It was much more collegial, much more businesslike. We got together and talked about ongoing projects, areas in which we were already working together. And we discussed what we were going to do next together. So, I think we've come a tremendously long way in two years. And we should give ourselves a lot of credit for that.

A final thought. We were asked by Eugenia Ortega to focus these conferences on youth. I think that's a wonderful suggestion, the right suggestion. A few moments ago, Sofia gave me this shirt with the name of the Mexico youth coalition on it. When you're in the drug prevention field, you often come home from meetings of this sort with at least one T-shirt. But this is a special shirt. In fact, I think I will put it on the wall in my office, to remind me of the good and important things that come out of the work that we're doing together. It's not just another shirt with a slogan on it. This is a real tangible example of a coalition of Mexican youth committed to drug prevention that didn't exist before we began this bi-national cooperation in El Paso two years ago. So, I'm going to be very proud of having this shirt on my office wall.

With that thought, let's bring this conference to a close and let's give ourselves a great big hand for what we've accomplished together.

PREVENTION

PREVENTION PRE-CONFERENCE SESSIONS

Successful Intervention Programs

Ruth Sanchez-Way
Moderator
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
United States

FAMILIES AND COMMUNITIES

Hablemos En Confianza

Mark Weber and Luisa Pollard
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
United States

Luisa Pollard, of SAMHSA's Center for Substance Abuse Prevention, told participants that the *"Hablemos en Confianza"* campaign, under the leadership of Dr. Chavez, was launched on September 4, 1999, after careful work with a 17-member group representing the largest Hispanic groups in the U.S. ? researchers, providers, parents, and kids. Stating that "this is about communications skills," Pollard told participants that the family ? in all its extensions ? was the key focus and tool of the campaign. Products include various materials for 3-6 year olds, and "soap operas" in pictures of three families (Lopez, Ruiz, and Castro) to portray the reality of family-life and the way in which prevention messages can be given to children by all adult family members. More important than the well-developed press component, Pollard maintained, was developing the campaign based on meetings with parents who asked for practical information about drugs (street names, symptoms of use, etc.) as well as for prevention messages. Coming soon will be additional materials for girls ages 9-14, and materials for their mothers. Pollard said that the key messages for parents in the campaign were:

- First talk and give clear rules
- Then listen/watch/observe
- Then speak.

Mark Weber, SAMHSA Associate Administrator for Communications, noted that it is clear that direct translations are not enough; we need to start with the target group and design materials with and for them.

Supporting and Financing Prevention Projects Focused on Youth

Jesus Garcia
Director
Mexican Institute for Youth
Mexico

Mexico Institute for Youth Prevention Program: Jesus Garcia of Mexico's Institute for Youth talked about the steps the Institute took in reaching the broad-based, youth-oriented prevention effort it coordinates today. Initially, school officials had asked the Institute to provide drug information to youth, which wasn't effective (as confirmed by a survey of youth). The Institute then developed a lecture series for schools, which they didn't have time to incorporate into their curricula. So the Institute turned to youth organizations, where "there was time to do the lectures." However, the youth told the Institute that they had enough information – what they needed was someone to "tell us how to deal with our families, the media, and peer pressure. As a result, the Institute totally revised the prevention program, keeping the information part (primarily for rural areas), and letting the youth take the lead. The Institute brought in health care professionals to help the youth develop activities such as festivals, dramas, youth weeks against smoking, etc. with resources and skills identified by the youth in their own communities. In 1995, recognizing that the Institute could not reach into every community that requested this kind of help, it started to identify youth-oriented non-governmental organizations (NGOs), and now works with 350 NGOs and individuals to develop and support such prevention activities throughout Mexico. The Institute provides small

grants (often matching) to communities and NGOs; the resulting programs are evaluated and their results are shared.

CHILD DEVELOPMENT PROGRAMS: A SCHOOL AND FAMILY MODEL

Building Me

Aimee Graves
Director of Community Based Services
CODAC
Tucson, Arizona
United States

Aimee Graves gave an overview of a highly successful early childhood prevention program for Hispanic populations in public housing in Tucson, Arizona. This five-year program consisted of a "Building Me" curriculum featuring 70 activities to build resiliency, short sessions for 3-4 year olds, with transportation, parenting classes, home visits, support groups, and treatment services for both mental health and substance abuse needs. Parental involvement was key - and was achieved by a Parent Advisory Council, and special Family Weekend activities. The program's success was due to a true collaboration of all segments of the community, in-service and cross-training of staff, and resource integration. She ended by stating the challenges remaining in conducting such a broad-based program - defining roles of each player, learning collaboration and valuing individuals as resources.

Raul Zapata
Youth Integration Centers (CIJ)
Mexico

Through risk assessments, CIJ identified communities at risk in Mexico, and found that 1.3 million persons received some type of prevention services. Stating that prevention should be based in the community so that it can take root, and that "precarious life conditions" are key risk factors, Garcia noted that CIJ-funded activities target youth ages 10-18. CIJ promotes healthy lifestyles by strengthening resiliency factors such as assertiveness, stress management, socialization, and commitment to school. CIJ funds "training of trainers" to help different communities address their different needs. In general, Garcia concluded, such prevention programs achieved "highly favorable" results, with respondents saying that the information was useful and that they were very interested in participating in prevention activities. Difficulties encountered in implementing such programs were lack of time and various restrictions. Regarding drug-using students, Garcia noted that teachers had reported they felt helpless to help such students with their obvious anti-social and psychological problems. Garcia concluded that by training teachers in prevention, they would see the benefit to their students in improved academic performance → increased self-esteem → no more drug use.

Drug Prevention in the Workplace

Bernie McCann
Office of National Drug Control Policy
United States

DRUG-FREE WORKPLACE DATA SUMMARY

Drug Abuse & Workforce Demographics

- According to the most recent Household Survey in 1998, almost 75% of adults (age 18 and up) who reported current illicit drug use (at least once in the past month) are employed, either full or part-time. This number represents more than 8.5 million individuals. *Unpublished Results from the 1998 National Household Survey on Drug Abuse,* U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies, Rockville, MD, August, 1999.
- The 8.5+ million workers reporting current illicit drug use represent 6.4% of the 1998 adult workforce. Similarly, 7.8% of the adult workforce reported heavy drinking (5 or more drinks on 5 or more occasions in the past month). *Preliminary Results from the 1998 National Household Survey on Drug Abuse,* U.S. Department of Health and Human Services, SAMHSA, Office of Applied

Studies, Rockville, MD, August, 1999. [Table 19, Page 82; Table 24, Page 87]

- Among employed adults, the highest rates of current drug use and heavy drinking are reported by white, non-Hispanic males, 18-25 years old, with less than a high school education. By occupation, significantly higher rates of current drug use and heavy drinking were reported by those employed as food preparation workers, waiters, waitresses and bartenders (19%), construction workers (14%), other service occupations (13%) and transportation and material moving workers (10%). *Worker Drug Use and Workplace Policies and Programs: Results from the National Household Survey on Drug Abuse* [1997], U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies, Rockville, MD, September, 1999.

- A 1999 SAMSHA study reveals workers reporting current drug use were more likely to have worked for three or more employers, to have voluntarily left an employer in the past year, and skipped one or more days of work in the past month. Employees in three of four occupations reporting significantly lower rates of current drug use and heavy drinking (protective services; extraction and precision productions; electronic equipment assemblers; and administrative support) were employed in those occupations identified with the highest rates of drug information and policies in the workplace. *An Analysis of Worker Drug Use and Workplace Policies and Programs, 1997.* U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies. Rockville, MD, September 1999.

- About one-half of young adults ages 16-17, work during the year. Those working more than 20 hours per week are at high risk for substance abuse and injury. *Protecting Youth at Work: Health, Safety, and Development of Working Children and Adolescents in the US.* Committee on Health & Safety Implications of Child Labor, Washington DC: National Academy Press, 1998, [pp. 2-5]. ONDCP Director Barry McCaffrey, cautioned that employers will need to be vigilant regarding the next generation of workers. There are signs that youth aged 12 to 17 years use gateway substances ? a predictor of future substance abuse ? at disturbingly high rates. Remarks by Director McCaffrey at the Recovery Month Kick-off, Washington, DC September 8, 1999.

- The number of workers ages 16 - 24 will increase by more than 3 million between 1998 and 2008, making this group the largest it has been in 20 years. U*.S. Department of Labor, Bureau of Labor Statistics, 1998-2008 Employment Projections*. Nov. 30, 1999. [Table 5]

- In 1998, 18.2% of unemployed adults (18 and over) reported current drug use a substantial increase over the 1997 rate of 13.8%. 10.8% reported heavy drinking, slightly higher than the 10.1% rate reported in 1997. *Preliminary Results from the 1998 National Household Survey on Drug Abuse,* U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies, Rockville, MD, August, 1999. [Table 19, Page 82; Table 24, Page 87]

Alcohol Abuse in the Workforce

- Alcohol is the most widely abused drug among adults, especially among young adults. According to the 1998 National Household Survey on Drug Abuse, 85% of heavy drinkers in the United States are employed ? about 10 million people. One in three adults aged 18 to 25 are binge drinkers (at least 5 drinks at a time). Rates of binge drinking and heavy drinking (binging at least 5 times a month) are consistently higher among men than women ? 43% of men aged 18 to 25 are binge drinkers, compared to 21% of women. *Preliminary Results from the 1998 National Household Survey on Drug Abuse,* U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies, Rockville, MD, August, 1999

- Many more employees drink to a lesser degree. A common misconception among employers is that alcoholics are responsible for most workplace problems related to alcohol. Casual drinkers, in aggregate, account for far more incidents of

absenteeism, tardiness, and poor quality of work than those regarded as alcohol dependent. *The Worksite Alcohol Study,* National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism and the Robert Wood Johnson Foundation. Rockville, MD, 1998.

- According to the 1998 Harvard School of Public Health Corporate Alcohol Study, light and moderate drinkers cause 60% of alcohol-related incidents of absenteeism, tardiness and poor quality of work, while dependent drinkers cause 40%. *New Perspectives for Worksite Alcohol Strategies: Results from a Corporate Drinking Study.* Thomas W. Mangione, Jonathan Howland and Marianne Lee, funded by the Robert Wood Johnson Foundation and the National Institute on Alcohol Abuse and Alcoholism, December 1998.

- Alcohol-related job performance problems are caused not only by on-the-job drinking but also by heavy drinking outside of work. Ames and colleagues found a positive relationship between being "hungover" at work and feeling sick at work, sleeping on the job, and having problems with job tasks or co-workers. Among pilots whose performance was tested in flight simulators, researchers found evidence of impairment 14 hours after pilots reached blood alcohol concentrations of between 0.10 and 0.12 BAC, and significant impairment 8 hours after reaching a BAC of 0.10. Drinking at work, problem drinking, and frequency of getting "drunk" in the past 30 days are positively associated with frequency of absenteeism, arriving late or leaving early, doing poor work, doing less work, and arguing with co-workers. *Hangover Effects on Aircraft Pilots 14 Hours After Alcohol Ingestion: A Preliminary Report.* Yesavage, J.A., and Leirer, V.O. American Journal of Psychiatry 143(12):1546-1550, 1986.; *Employee Drinking Practices and Work Performance.* Mangione, T.W.; Howland, J.; Amick, B.; Cote, J.; Lee, M.; Bell, N.; and Levine, S.Journal of Studies on Alcohol 60(2) :261-270, 1999; *The Influence of Alcohol and Aging on Radio Communication During Flight.* Morrow, D.; Leirer, V.; and Yesavage, J. Aviation, Space, and Environmental Medicine 61(1):12-20, 1990.

- Productivity losses attributed to alcohol were estimated at $119 billion for 1995. *Economic Costs of Alcohol and Drug Abuse in the United States,* National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, May 1998. Alcoholism accounts for 500 million lost workdays each year. *Treatment is the Answer: Cost-Effectiveness of Alcoholism and Drug Dependency Treatment.* National Association of Treatment Providers, Laguna Hills, CA. March 1991.

- One in 5 workers report being injured, having to cover for a co-worker, or working harder due to other employees' drinking. Nearly 1/3 of workers who consider their jobs to be dangerous report experiencing "secondhand" alcohol effects; ½ of employees surveyed supported random alcohol testing at work; nearly ¾ of employees in manufacturing or transportation supported testing. *New Perspectives for Worksite Alcohol Strategies: Results from a Corporate Drinking Study.* Thomas W. Mangione, Jonathan Howland and Marianne Lee, Robert Wood Johnson Foundation and National Institute on Alcohol Abuse and Alcoholism, December 1998.

- Many employers (an estimated 20,000 nationwide) offer employee assistance programs (EAPs) designed to promote healthy lifestyles for workers. According to the U.S. Department of Labor, for every dollar invested in an EAP, employers can save $5-$16. Many companies do not have alcohol policies; those that do may not enforce them effectively. Nearly 60% of managers and supervisors say their companies are "tough" on illicit drugs but "soft" on alcohol; 80% say they have inadequate training in how to address employee performance problems. More managers (23%) and supervisors (11%) actually report drinking during the workday and at company functions than do other employees (8%), which may contribute to a corporate culture that encourages drinking. *Perspectives for Worksite Alcohol Strategies:*

Results from a Corporate Drinking Study. Thomas W. Mangione, Jonathan Howland and Marianne Lee, funded by the Robert Wood Johnson Foundation and the National Institute on Alcohol Abuse and Alcoholism, December 1998.

- In a 1998 Peter Hart poll, employers often encounter denial (75%) and anger (42%) when they approach workers about alcohol problems. However, mandatory referral to treatment and the risk of job loss are strong motivations for treatment compliance. *Coerced Treatment for Substance Abuse Problems Detected Through Workplace Urine Surveillance: Is it Effective?* Eli Lewantal et al., Journal of Substance Abuse, 8(1): 115-128, 1996.

- A 1996 study by the Pennsylvania Veterans Administration Center for Studies of Addiction found employees required to enter alcohol treatment programs tend to perform as well in treatment as employees who voluntarily seek it. Drinking dropped 74% after 6 months of "coerced" treatment and 78% after 6 months of "self-referral." Even when alcohol programs are available, many employees do not take advantage of them. *Survey Shows Alcohol/Drug Use Has Strong Impact on Workplace.* Hazelden Foundation, Center City, MN Oct. 22, 1996.

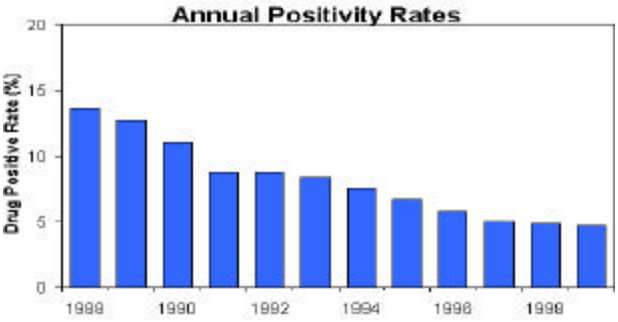
- Employers can encourage participation by informing employees about the confidentiality of programs to help deal with alcohol and other drug problems. Increased public education focused on treatment successes may encourage more participation in alcohol interventions among both employers and employees. *The Road to Recovery: A National Study on Public Perceptions of Alcoholism and Barriers to Treatment.* San Francisco, CA: The Recovery Institute, 1998.

Drug-free Workplace Programs: Successes and Future Challenges

- Available research demonstrates that comprehensive workplace prevention programs which include: 1) education for workers and training for supervisors; 2) equitable, reliable drug testing; and 3) access to assistance and treatment services can successfully reduce worker substance abuse and improve health, safety, and worksite productivity. Workplaces provide an ideal opportunity to influence individual behavior and community norms. Clear and consistent substance abuse policies and drug education efforts create an aware and informed workforce, can significantly reduce drug and alcohol abuse in workplaces, and reach the families of employees and the communities where they live. *Selected Findings in Prevention: A Decade of Results from the Center for Substance Abuse Prevention,* Department of Health and Human Services, SAMHSA, Center for Substance Abuse Prevention, Rockville, MD, 1997.

- Since 1986, the Federal government has mandated a comprehensive drug-free workplace program for all Federal workers. Implemented in 120 agencies, this model program covers approximately 1.8 million employees. In 1997, the most recent positive drug test rates available, the rate of positive test results for Federal job applicants and employees in designated testing positions (numbering approximately 80,000), was 0.5%; or one-tenth of the 5% positive rate of approximately 4 million tests conducted in 1997 by the largest private sector workplace testing laboratory in the US. As the nation's largest employer, the Federal government continues to provide leadership by example. In June 1999, President Clinton took another historic step forward to ensuring a drug-free federal workforce by issuing an Executive Order directing the Federal Employees Health Benefit Program, the nation's largest health insurance plan, to provide full coverage for substance abuse treatment, equal to any other medical condition, by the year 2001. *Annual Survey of Federal Agency Drug Free Workplace - 1997*, U.S. Department of Health and Human Services, SAMHSA, Center for Substance Abuse Prevention, Division of Workplace Programs, Rockville, MD, March 1999; *Quest Drug Testing Index©,* Quest Diagnostics, inc., Teterboro, NJ, October 19, 1999

- According to the semi-annual Drug Test Index©, the national rate of positive drug test results among private-sector workers has declined 65% over the past decade, from a high of 13.6% in 1988 to a low of 4.7% for the first 6 months of 1999. *Quest Drug Testing Index© (Press Release),* Quest Diagnostics, inc., Teterboro, NJ, October 19, 1999. (see chart on the following page)



- Further data from the 1999 Drug Testing Index© illustrates drug test positivity trends rates among three major testing populations: federally mandated, safety-sensitive workers; the general workforce; and the combined U.S. workforce. Rates of use for cocaine and opiates, showed declines as a percentage of all positive test results. Cocaine use made up 16% of all positive results in the first half of 1999, down from 18% for 1998. The opiate positive test rate declined by almost half from 1998, as predicted following a raise in the federally mandated opiate cut-off level, from 300 to 2000 nanograms per milliliter in December, 1998. This change reduced the number of "false positive" test results due to certain prescription and over-the-counter medications or certain foods, such as poppy seeds. Positive marijuana test results increased nearly 4% as a percentage of all positive results to 63%. *Quest Drug Testing Index© (Press Release),* Quest Diagnostics, inc., Teterboro, NJ, October 19, 1999.

- Nearly 2% of positive results in the 1999 Drug Testing Index© showed clear evidence of substances used to adulterate or compromise specimen test results. More specimens tested positive for adulterants and substituted specimens than for either opiates or amphetamines. After initiating adulterant and substituted-specimen testing in April, 1998, the following year Quest expanded adulterant testing to include the oxidizing adulterants, bleach and pyridinium chlorochromate. Oxidizing adulterants, which include nitrites, are used as masking agents in an attempt to defeat the process of detecting drug use. *Quest Drug Testing Index© (Press Release),* Quest Diagnostics, inc., Teterboro, NJ, October 19, 1999.

- A 1999 SAMHSA study of workplace substance abuse revealed that the percentage of workers who said they had been provided information, who were aware of written policies regarding drug and alcohol use, or whose workplace provided access to an Employee Assistance Program (EAP) increased with establishment size. Only 27% of workers in small businesses reported having access to an EAP, compared to 61% of workers in mid-size and 75% of workers in large establishments reported that their workplace had EAP programs. Larger workforces were far more likely to have incorporated a comprehensive drug-free workplace program (including a formal policy, employee education, access to an EAP and drug testing) which has resulted in approximately 50% lower positive drug test rates, and 75% fewer self-reports of current drug use among workers compared to smaller worksites (1-24 employees). Workers in small establishments reporting current illicit drug use were less likely to be employed in workplaces with a written policy. *An Analysis of Worker Drug Use and Workplace Policies and Programs, 1997.* U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies. Rockville, MD, September 1999.

- A scientific study completed in December, 1995, conducted by Houston's Drug-Free Business Initiative in collaboration with the University of

Houston, reinforced the belief by many employers that drug testing reduces injuries and workers' compensation claims in the workplace. The study found that companies engaged in random drug testing in combination with pre-employment testing reduced their mean workers' compensation claims per 100 employees per year by 63.7% over a 4-year period while the control group of employers (employers not conducting drug testing), experienced a 19% increase during that same time period. The study also found that well over half of the responding employers believed that the benefits of drug testing outweighed the cost and just under half felt that the benefits of an EAP outweighed the cost. When asked to select one strategy over the other, 40.6% of the respondents stated that it was more important to conduct drug testing than have an EAP, while only 7.8% thought it was more important to have an EAP than to test. However, 51.6% thought drug testing and EAPs were of equal importance. *A Report on Employer Attitudes and the Impact of Drug Control Strategies on Workplace Productivity* Fay, Calvina L., Harlow, Kirk C. , and Durand, Roger. Houston's Drug-Free Business Initiative and the University of Houston - Clear Lake December, 1995.

- In 1990, problems resulting from alcohol and other drugs use cost American businesses an estimated $81.6 billion in lost productivity due to premature death (37 billion) and illness (44 billion); 86% of these combined costs were attributed to drinking. *Substance Abuse and Mental Health Statistics Sourcebook*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Rockville, MD. 5/95, p.3. In 1991, the reported cost of drug abuse to the United States business community was $75 billion annually. Address delivered to President Bush and the President's Drug Advisory Council by Frank T. Tasco, Chairman, Marsh & McLennan Companies. [November 15, 1991]

- Workplace safety is the most common reason employers give for drug testing. In 1997, approximately 25% of workers reported having a drug testing policy in their workplaces. Of employers implementing testing, the majority have adopted urine drug screening as the preferred methodology. In 1997, pre-employment testing was the most common type of testing reported by workers (39%), followed by reasonable suspicion testing (30%), post-accident (29%) and random testing (25%). Current drug users indicate they are far less likely to apply for a job where they know that pre-employment or random drug testing is used. *An Analysis of Worker Drug Use and Workplace Policies and Programs, 1997.* U.S. Department of Health and Human Services, SAMHSA, Office of Applied Studies Rockville, MD, September 1999.

- Results of an extensive U.S. Postal Service study indicate that employees who tested positive on their pre-employment drug test were 77% more likely to be discharged within the first three years of employment, and were absent from work 66% more often than those who tested negative. Had the U.S. Postal Service screened out all drug positive postal service applicants in 1987, the authors estimated this would have saved approximately $52 million by 1989. *An Evaluation of Pre-employment Drug Testing.* Normand, J., Salyards, S. & Maloney, J. Journal of Applied Psychology. Vol. 75, No. 6, 1990. [pp. 629-639]

- According to the American Management Association's annual Survey on Workplace Drug Testing and Drug Abuse Policies, workplace drug testing has increased by more than 1,200% since 1987. More than 81% of businesses surveyed in 1996 were conducting some form of applicant or employee drug testing. Likewise, the perceived effectiveness of drug testing,

as assessed by human resources managers, has increased from 50% in 1987 to 90% in 1996. *AMA Survey on Workplace Drug Testing and Drug Abuse Policies. American Management Association. New York, NY. 1996.*

- Testing for the right reasons has the support of most employees and there is some evidence that drug testing helps prevent illicit drug use. A 1995 Gallup poll of employees found 97% in agreement that workplace drug testing is appropriate under certain circumstances; 85% believed that urine testing might deter illicit drug use. *The Gallup Organization, Princeton, NJ, October 1995, commissioned by The Institute for a Drug-Free Workplace, Washington, DC.*

- Referrals to treatment for drug and alcohol abuse and support for employees to change drug use behavior are key. Employee Assistance Programs (EAPs) are increasingly being used by employers to provide a gateway to substance abuse treatment, and reflect cost differences related to the quantity and qualities of services, the size and type of industry and region of the United States. (1995 mean cost per employee $22.19). *Cost of Employee Assistance Programs: Comparison of National Estimates from 1993 and 1995. French, M.T., Zarkin, G.A., Bray, J.W., Hartwell, T.D., Journal of Behavioral Health services Research, February 1999.*

- Employee assistance programs (EAPs) are growing in popularity in all types of U.S. worksites, according to a 1996 study. In 1993, 1/3 of private, nonagricultural worksites with 50 or more employees had an EAP, a significant increase over the numbers shown in similar studies in 1988 and 1990. Most employers surveyed, especially those with 50 to 99 employees, had implemented an EAP in the 5 years preceding the study. Compared to 1988 results, most of this growth was in external programs: 81% of EAP services in 1993 were provided by external contractors, and 83% at a location outside the workplace. Larger worksites (more than 1000 workers) and certain industries (communications, transportation, finance, realty) were more likely to have an EAP. Demographic findings revealed a greater likelihood of an EAP in workplaces where employees were unionized and relatively more educated, and where there were relatively low numbers of visible minority workers. Geography had no impact on the existence of a program, but program costs did vary regionally, with a median annual cost per employee of just under $22 for internal programs and of $18 for external programs. Based on their survey results, the authors conclude that EAPs will continue to grow in importance, and that health care professionals working in the areas of substance abuse and emotional health will continue to get numerous referrals of clients who have passed through the EAP process. Consequently, research into the costs, characteristics, and results of EAPs will continue to be important. *Aiding troubled employees: prevalence, cost, and characteristics of employee assistance programs in the United States. Hartwell, Tyler D. American Journal of Public Health, 86(6): 804-808, 1996*

CURRENT TRENDS AND RESEARCH IN DRUG-FREE WORKPLACE EFFORTS

Office of National Drug Control Policy
Washington, DC
Bernie McCann, CEAP
Workplace Policy Analyst

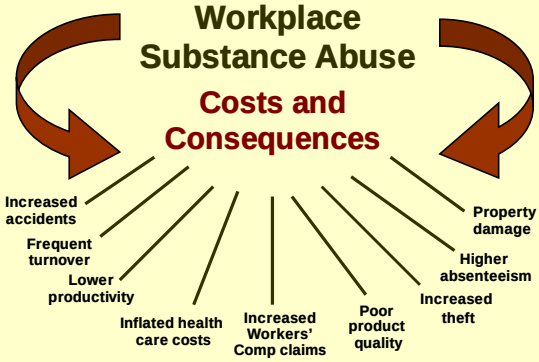
Office of National Drug Control Policy
The White House
Washington, DC 20503
202-395-3096, fax: 202-305-6744
Bernard_A._McCann@ondcp.eop.gov

Workplace Drug Use

- 13.6 million Americans report 'current drug use'
- Estimated cost to economy = $276 billion in 1995*
  (*Does not include employer costs)
- Almost 75% of 'current drug users' are employed
  (Full or part-time)
- 8.3 million American workers report drug use
  (or 6.5% of employed adults)
- 11.2 million American workers report heavy drinking
  (or 14% of employed adults)

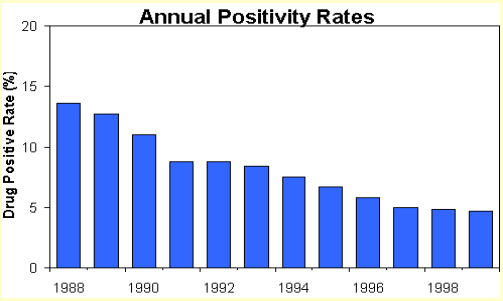
2

Workplace Substance Abuse Costs and Consequences



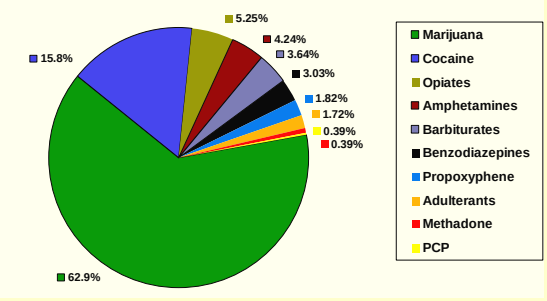
3

Workplace Drug Test Results 1988-99



Source: Quest/SmithKline Drug Testing Index - 1999

Positive Drug Test Results by Type -1999



Source: Quest/SmithKline Drug Testing Index - 10/99

National Drug Control Strategy

Goal #3 - Reduce Health and Social Costs of Illegal Drug Use

Objective #3 - Promote national adoption of comprehensive drug-free workplace programs that include: drug testing, education, prevention and intervention.

Targets - Increase number of workplaces with:

- Drug-free workplace policies
- Substance abuse education (1 hr/year)
- Employee Assistance Programs
- Drug Testing

6

Role and Objectives of Drug Prevention

- Deter experimentation and new drug use
- Deter existing users progression into more serious use
- Break intergenerational cycle of substance abuse
- Reduce risk factors and increase protective factors
- Improve knowledge and attitudes
- Reduce drug and alcohol problem behaviors

7

Workplace Prevention Efforts

- The workplace provides an ideal venue and opportunity to influence both individual adult behavior and community norms.
- Clear, consistent workplace substance abuse policies and employee drug education can:
  1) create an aware and informed workforce;
  2) significantly reduce drug and alcohol abuse problems in the workplace; and
  3) reach employees, their families, and into their communities with prevention messages.

8

Drug-free Workplace Programs Historical Development

- 1940s - Occupational Alcoholism Programs
- 1960s - Employee Assistance Programs
- 1986 - Executive Order 12564
- 1988 - Drug-Free Federal Workplace established
- Drug-free Workplace Act of 1988
  (covers Federal contractors and grantees)
- 1989-94 Transportation (DOT) Regulations
  (covers safety-sensitive transport employees)
- Drug-free Workplace Act of 1998
  (provides drug-free workplace assistance to small business)
- National Drug Control Strategy: Workplace

9

Why would Employers Implement a DFWP?

- Triggering event
- Regulations
- Safety of:
  - Public
  - Employees
- Productivity
- Cost savings
- Community and/or Industry norms
- Labor market influences
- Liability exposure
- Tax incentives
- Health insurance

10

Components of a Drug-Free Workplace Programs

- Policy Statement and Procedures
- Employee Education
- Supervisory Training
- Employee Assistance Program (EAP)
- Drug Testing

11

Workplace Policy Elements

- Rationale (specific to worksite)
- Prohibited behaviors (and substances)
- Employees affected
- Detection of policy violation
- Consequences of prohibited behavior
- Availability of assistance

12

DFW Policy Considerations

- Why implement a DFW policy?
- Who or what groups decide?
- Who should be covered by policy?
- What substances are prohibited?
- To test or not to test?
- Consequences of policy violations
  - Treatment options?
  - Suspension, termination, etc?
  - Worker's comp and unemployment claims?
  - Return to work procedures?

13

Employee Education - Learning Objectives

- Clearly communicate policy
- Inform about the dangers of drug use
- Identify signs of drug abuse and effects on job performance and safety
- Describe when, if and how to approach co-workers and/or family members
- Additional resources for help and info

14

Supervisory Training - Learning Objectives

- Identify signs of drug abuse and effects on job performance and worksite safety
- Clarify supervisors' role and responsibility in policy enforcement
  - Recognize
  - Document
  - Intervention
  - Referral to EAP and/or drug testing
  - Follow-up job performance monitoring

15

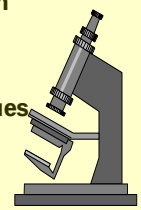
Employee Assistance Programs

- Workplace-based services to assist in problem identification and resolution
- *Confidential* service to employees
- Assess, refer to help and follow-up
- Education and training services
- Consultation and training for organization
- Often available to family members

16

To Test or Not to Test?

- Worksite safety - internal
- Public Safety - external
- Privacy - legal and ethical
- Legitimacy of business concern
  - Job performance indicators
  - Off-duty v.s on-duty use
  - Non-workplace drug convictions
- Risk reduction and liability issues
- Business Climate
- Organizational culture



17

What Substances are Covered?

- Illicit drugs
- Alcohol
- Prescription drugs
  - Used with or against medical advise
- Over-the-counter medications
- Non-medical intoxicants

18

To Treat or Not To Treat?

- Zero tolerance or .....?
- Treatment opportunities
  - Type and number
- Who pays?
- Return to duty restrictions
- Last Chance Agreements
- Expectations from treatment

19

"Carrying the Message"
-about Workers and Treatment

Those who participate in drug treatment:

- ↓ Decrease their drug use
- ↓ Decrease their criminal activity
- ↑ Increase their employment
- ↑ Improve their social functioning
- ↑ Improve their physical health

Drug use and criminal activity decrease for virtually all who enter treatment, with better results the longer they stay in treatment

20

Easy Access DFW Resources - US

Federally-funded services

- ☎ Drug-Free Workplace Helpline -
  - ☛ Employers, Labor Unions, Supervisors, & Associations
- 💻 National Clearinghouse (NCADI) -
- 💻 Department of Labor (Working Partners) -
- ☽ Drug Enforcement Administration -
  - ☛ Regional Demand Reduction Coordinators
- ☽ Department of Transportation -
  - ☛ Assists with FAA, FHWA, USCG, FTA, FRA, RSPA regs
- ☽ Small Business Administration -
  - ☛ 50+ Small Business Development Centers

21

Easy Access DFW Resources, cont.

- ✔ State Substance Abuse and related Workforce Development Agencies
- ✔ Private Sector Resources
  - Regional and Community groups, i.e., "Drugs don't Work" Coalitions, etc.
- ✔ Professional and Trade Associations - National, State and local, e.g.,
  - Employee Assistance Professionals Association
  - National Drug-free Workplace Alliance
  - Chambers of Commerce
  - Substance Abuse Professionals Association
  - Natl. Assn. of State Alcohol & Drug Abuse Directors

22

Opportunities/Challenges

- Creating demand among small employers
- Delivering services cost-effectively
- Program standards and procedures
  - Federal or State issue?
  - Uniformity and standardization
  - Employee protections
  - Enforcement authority
- Certification of professionals and others delivering DFW products and services

23

Drug Testing Elements

- Established policy and procedures
- Illicit Drugs (or additional substances)
  Marijuana, Cocaine, PCP, Opiates, Amphetamines
- Alcohol
- Testing Methodology
  Screening and Confirmation
- Types of Testing
- Consequences of Positive Tests
- Due Process and Appeals

24

Types of Workplace Testing

- Pre-employment
- Random
- Reasonable Suspicion
- Post accident/incident
- Return-to-duty
- Follow-up
- Voluntary
- Pre-Promotion
- Periodic

25

Who Should be Covered?

- Large and/or small businesses?
- All workplaces and all workers?
- Safety-sensitive workers?
- Certain industries?
- Certain professions?

26

Juan Roman Uriarte Galvan
Secretary of Communications
and Transportation
Mexico

The Secretary first noted that the U.S. experience with drug-free workplace programming has been invaluable to Mexico. He agreed with the list of costs and consequences presented by the previous speaker, Mr. McCann. He also noted that Mexican labor laws clearly prohibit alcohol and other drug use in the workplace by public sector workers.

The main drug prevention activities of the Ministry of Communication and Transportation in the workplace have been:

- Performing comprehensive occupational physicals and medical examinations, including pre-employment and subsequent random urine drug testing for drugs of abuse; and
- Conducting a massive educational campaign to prevent alcohol and drug abuse and thus reduce accidents associated with substance abuse.

In the post-NAFTA environment, Ministry-sponsored programs have, in effect, adopted U.S. Department of Transportation guidelines to achieve common protocols necessary to aid cross-border commerce. These activities extend to all modes of transportation: air, land, sea, etc.

Given research revealing that traffic crashes are the fourth leading cause of death in Mexico (many in which alcohol use is implicated or suspected) the Transportation Ministry has undertaken prevention and detection efforts with both public and private sector. To this end, the National Council for Accident Prevention has been established. The National Council provides the coordinating role for state councils that will advise and help states to reduce incidents and fatalities. Another agency, CONADIC has been conducting research regarding transportation accidents as well as exchanging information with others and working to implement proven programs.

In recognition of the key importance of transportation safety, the Ministry of Transportation was given the lead in developing programs in this area, and has recently signed a Memorandum of Understanding with Mexico City to cooperate on programs geared to youth and accident prevention. He also noted that recently legislation was passed to regulate toxicology tests and involve more private employers in prevention programs.

One of the Ministry's priorities is to develop closer working relationships with employers and to increase prevention efforts around holiday times, which typically see a rise in accidents attributable to substance abuse.

As Mr. McCann stated, it is important to realize that our efforts here and elsewhere have indeed caused people to become more aware and interested in making changes to reduce accidents and other costs of substance abuse. It is even more important to have the political will to address the plague of substance abuse among those who are most vulnerable, who in turn endanger the lives of others. An excellent example would be efforts to increase education and substance abuse assistance for vehicle operators.

DRUGS AND VIOLENCE: OVERVIEW OF BORDER CRIME PREVENTION PROGRAM IN BAJA, CALIFORNIA & SAN DIEGO

Developing a Culture of Lawfulness

Edward Brand
Superintendent of Sweetwater Union School District
Chula Vista, California
United States

Rosalia Salinas
Director of Curricula
Sweetwater Union School District
Chula Vista, California
United States

Carlos Franco
Director of Curricula
Baja School District
Mexico

Luciana Ramos
Mexican Institute of Psychiatry
Mexico

Dr. Brand, Ms. Salinas, and Sr. Franco spoke about a middle school curriculum jointly developed by Ms. Salinas, Sr. Franco, and a group of U.S. and Mexican teachers, to teach students about the rule of law and the way organized crime can infiltrate a community. It is based on an approach developed in Hong Kong and Sicily by the National Strategy Information Center that focuses on personal and social ethical decision making, the rationale for the rule of law, the temptations of crime and materialism, and techniques for resisting involvement in criminality and corruption.

The curriculum in Baja and San Diego was developed as part of a social studies course and is meant to address the problem of drug violence along the border. According to Dr. Brand, the keys to this program's effectiveness include:

- Commitment by senior political leadership in the communities
- School administrations' support (i.e., county boards of education)
- Teacher training and assistance, and a good fit with current social studies curricula.

Ms. Salinas noted the importance of bringing in curriculum experts from both the U.S. and Mexico who could develop a course that could be integrated into current curricula determining, for example, where such a course could fit into the schedule and who could teach it. Student results from the pilot effort jointly conducted by Sweetwater and Baja show the following:

- Increased knowledge about drug-related crime and how to resist it
- Improved interpersonal competency, self esteem, and problem solving ability
- Improved ability to resist temptation and increased awareness of life choices and importance of planning.

She stressed the importance of teacher-to-teacher collaboration and recommended that the program be extended to all of Southern California.

Sr. Carlos Franco stated that the teachers' common concerns about drug related violence along the border has really led to the curriculum's development and support. He described the U.S.-Mexican collaboration in curriculum development:

- Agreement to and specification of a pilot (set period of time, evaluation according to objectives)
- Formed a task force of teachers representing both poor and better-off schools, that developed a curriculum to explain why society has laws and why they are important; to show how crime operates counter to those laws; and to increase the students' sense of self-worth and competence to support a society of laws.

The teachers are now adding a program on values and citizenship training.

He explained that the project has continued for two six-month segments and reiterated the results described by Ms. Salinas, noting the "enormous difference between pilot and non-pilot schools" in terms of student understanding and self esteem. He concluded that the next step is to bring the parents into the program.

Dr. Luciana Ramos
Mexican Institute of Psychiatry
Mexico

Dr. Ramos spoke on drugs and violence from the perspective of a researcher on family and domestic violence. She noted that in Mexico the role of substance abuse (mainly alcohol) is rarely acknowledged in domestic violence cases. She called for a clearer understanding by the public and by policy makers of this connection, stating that each could be a risk factor for the other. She then reviewed her research on this issue, which has revealed the following:

- One in every three women in Mexico have experienced some sort of abuse

- Between 30-60% of women in the Americas report some sort of "gender violence"

- Of the women reporting incidents of domestic violence, there was more tranquilizer and marijuana use (but no significant difference in alcohol use from women who reported no such incidents).

She described results of a survey conducted in two Mexico City high schools which revealed sexual abuse against both sexes and increased use of cocaine and marijuana by these young people. Dr. Ramos concluded by calling for studies of young people of both countries.

PREVENTION TRAINING SESSIONS

COMPREHENSIVE SCHOOL-BASED PROGRAMS INVOLVING THE FAMILY

Introduction to Programs on Schools and Families

Carmen Mille
National Council on Addictions (CONADIC)
Ministry of Health
Mexico

"Construye tu Vida sin Adicciones" (Build your Life without Addictions" Program in Schools

Carmen Mille,
Maria Teresa Sanchez Fragoso,
Fernando Bilbao Norma Merena
Council on Addictions (CONADIC)
Ministry of Health
Mexico

Bi-national Implementation of "Construye tu Vida sin Addiciones"

Dr. Ignacio Benedicto Reyes
Baja, California
Mexico

In a prevention track session on school and family-based programs, CONADIC staff provided an overview of Mexico's wide-ranging prevention effort, "*Construye Tu Vida Sin Addiciones,*" (build your life without addictions) followed by a presentation by Dr. Ignacio Benedicto Reyes about a cross-border implementation of *Construye* in Baja California in both Mexico and the U.S.. *Construye* programs have many elements including role-plays for young people on decision making, community work in which facilitators form groups of community prevention workers, and projects specifically planned by and for young people. Materials include posters, bulletins, flyers, four books and three videos. The biggest problem in getting prevention programs in schools is that school officials think they have no time for such activities. Presenters noted, however, that the students find time and even work on Saturdays on tournaments, parties, fairs, basketball games ? all drug-free and promoting healthy lifestyles. At this time, process evaluations are being done on *Construye* programs, and Carmen Mille of CONADIC stated that a follow-up study will be conducted that will enable measurement of program impact. Other CONADIC staff noted the need for improved dissemination systems.

Noting that Baja is a "third culture," Dr. Reyes, of Baja California, described bi-national implementation of *Construye* programs there. Baja, Mexico's activities were coordinated with those of Imperial, California's, and these communities jointly chose *Construye* as their prevention model. A youth committee and an adult prevention committee were formed, and bi-national training was conducted. *Construye* went through its entire process, from the identification of small groups of students to lead the effort in particular schools, to their identification of activities. In this case, under the theme "Baja Fighting Drugs Together," the community held prevention fairs and art shows, and a youth-operated hotline has been started. At this point, *Construye* is at the community level but some training has begun in the schools. In some schools, *Construye* lessons have become part of the curriculum; in others, it is an after school activity. Sometimes teachers invite parent participation and provide training for both students and parents. Reyes concluded that all models have to be adapted to the specific culture, be easily understood, and have direct relevance to the target population.

EFFECTIVE COMMUNITY MOBILIZATION APPROACHES

Drug-Free Communities Support Program: Community Mobilization in the Border States to Reduce Substance Abuse

Mary Ann Solberg, Moderator
Advisory Commission on Drug-Free Communities
United States

Panel:

Harry Montoya
Hands Across Cultures, Inc.
Espanola, New Mexico
United States

Luz Arriola
West Texas Council on Alcoholism and Drug Abuse
El Paso, Texas
United States

Lorenzo Merritt
Project HEAVY West
Los Angeles, California
United States

Luis Navarro
Chimalli System for the Integral Development of the Family (DIF)
Mexico

Grantees from the Drug-Free Communities Support Program (DFCSP) facilitated this training session. This program is a collaborative program of ONDCP, OJJDP and SAMHSA/CSAP created by the Drug-Free Act of 1997 (Public Law 105-20). This act funds community coalitions (collaboratives) to reduce substance abuse among youth, and over time among adults; and increase collaboration among Federal, State, local, and private non-profit community based organizations.

The DFCSP projects all serve a diverse bi-national target community on the U.S. side of the border.

Harry Montoya, presented cultural relevance, vision and principals of community mobilization. Luz Arriola, WTCADA, provided a step-by-step guide to plan and form a community coalition to mobilize the community to reduce substance abuse. Dr. Lorenzo Merritt, PHW, presented the developmental stages of community mobilization, the challenges and opportunities, and the outcomes of community mobilization. Luis Navarro, Chimalli-DIF, Mexico, presented the results of a Mexican research project on homeless children living in the streets in 100 cities in Mexico. Mr. Navarro's presentation provided the many risk factors that these children are exposed to, including a higher incidence of substance abuse and substance abuse related violence.

The main points of this training were:

- Assess the community that you are trying to mobilize in order to establish baseline data.
- Balance inter-cultural issues in community mobilization process.
- Determine steps and developmental stages relating to community mobilization for the target community.
- Impact negative social norms by using the proven Community Mobilization training model.
- Utilize community challenges and opportunities for community mobilization to design, provide ongoing review of effectiveness, and revise, if necessary, evaluation of mobilization efforts.

BUILDING EFFECTIVE PARTNERSHIPS FOR DRUG PREVENTION IN THE WORKPLACE

Robert Stephenson, Acting Director,
Division of Workplace Programs
Center for Substance Abuse Prevention,
Substance Abuse and Mental Health Services Administration
United States

Building Partnerships for Drug Prevention in the Workplace

Elizabeth Edwards, Gabriela Garcia,
Arizonans for a Drug-Free Workplace
United States

Model Program on Alcohol and Drug Use Prevention between Workers and Their Families

Agustin Vélez, Director,
Trusteeship for the Institute for Street Kids and Addictions
Mexico

Slide presentations follow.

Building Effective Partnerships for Drug Prevention in the Workplace Bob Stephenson

- **2nd Year of Workplace focus**
- **From 1999, the Working Guidelines and Action Plan included: *No Tolerance* policy, developing data, and organize business leaders (including small businesses)**

1

- **This 3rd Year of Workplace focus**
- **Focus on Training examples for Mexico and the United States of programs that address substance abuse in the workplace.**
- **First-Elizabeth Edwards and Gabriela Garcia, Arizonans for a Drug-Free Workplace;**
- **Second-Agustin Velez, Director FINCA, Mexico**

2

- **Importance** of Drug-Free Workplace Program and Products…some resources
- **Broad Objectives**: Comprehensive Programs, Employer/Health System Partnerships, and Incentives to Invest
- Youth transition into the workforce
- Workplace Bi-National Collaboration

3

U.S. Federal Drug-Free Workplace

"The Federal Government, as the largest employer in the nation, can and should show the way towards achieving drug-free workplaces through a program designed to offer drug users a helping hand...."

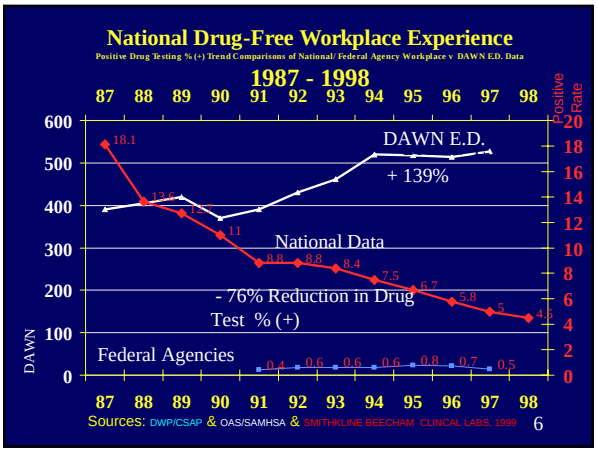
--Executive Order 12564
September 15, 1986

4

DHHS Has Oversight Responsibility of Federal Agency Drug-Free Workplace Programs

- **About 1.8 million Federal civilian employees**
- **About 400,000 of these are in Testing Positions**
- **About 8.3 million DOT Regulated Industry Employees are subject to testing under standards**
- **About 600,000 Nuclear Regulatory Commission employees are also covered by most of DHHS testing standards**

5



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Testing Designated Positions (TDPs)

- Safety and Security Sensitive Positions -- includes, but is not limited to:
  - motor vehicle drivers (those that carry passengers)
  - aviation positions -- pilots, mechanics, flight crew, ATCs and others
  - Law enforcement
  - National, chemical or nuclear security
  - Protection of property or persons from harm

7

Components of a Comprehensive Drug-Free Workplace Program

- Formal Written Policy
- Employee Assistance Program
- Supervisor Training
- Employee Education
- Methods for Detecting Illicit Drug Users (i.e., drug testing)

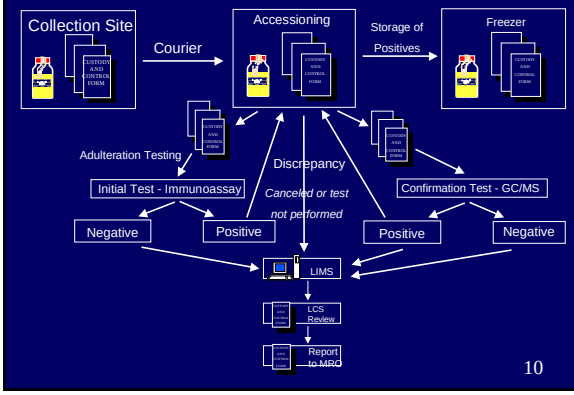
8

Types of Drug Testing

Applicant Testing
Accident/Unsafe Practice Testing
Reasonable Suspicion Testing
Follow-up to Treatment Testing
Random Testing
Voluntary Testing

9

Forensic Urine Drug Testing



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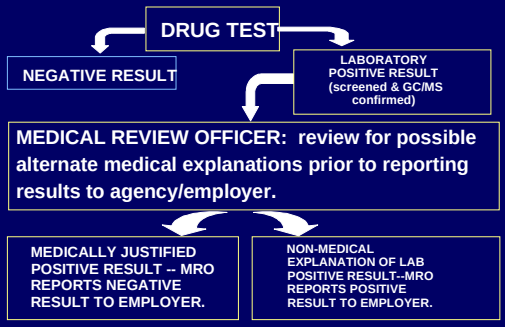
The Medical Review Officer (MRO) - I

- Must be a physician with knowledge of substance abuse disorders.
- Must afford an opportunity for the tested individual to discuss the test results prior to making a final decision to verify a test as positive.
- Must review all medical records made available by a tested individual when a confirmed positive could have resulted from a legally prescribed drug.

11

THE MRO CHAIN



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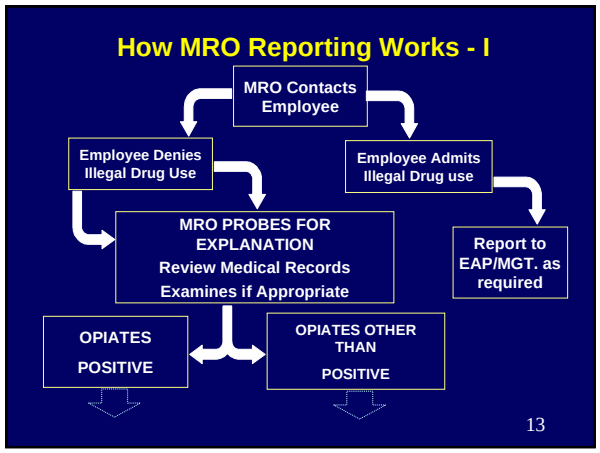
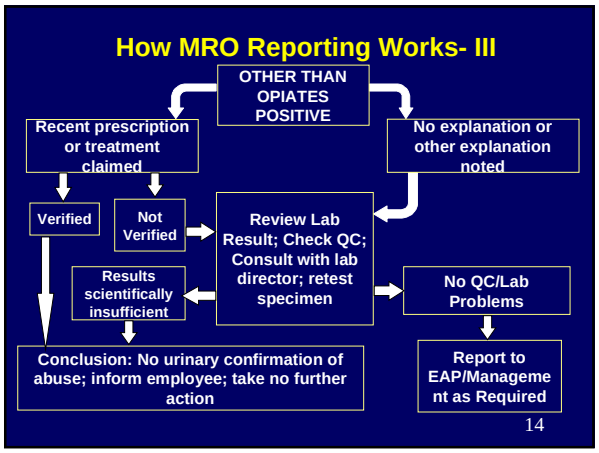




Non-Testing Activites - 1

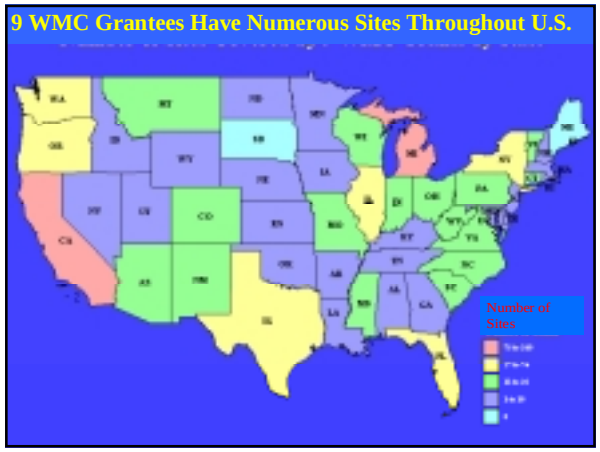
- DWP administers a drug-free workplace Helpline for businesses, that receives over 700 inquiries per month, and may be reached at **1 800-WORKPLACE,** or on the Internet at **helpline@samhsa.gov**.
- The"**Workplace Resource Center**" is coming to the Internet soon, and was demonstrated on the evening of May 10, at the SAMHSA Joint Council Meeting. workplace.samhsa.gov
- **Workplace Managed Care KDA,** exploring the health care provisions of private sector employers to identify effective and cost efficient models that provide substance abuse prevention and early identification and intervention components. Nine (9) Three year Cooperative Agreements

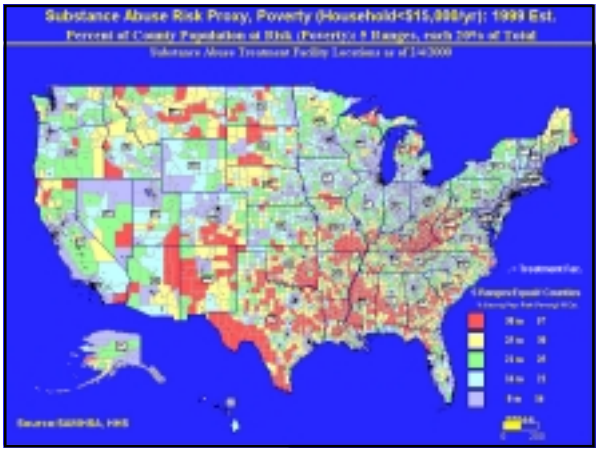
15

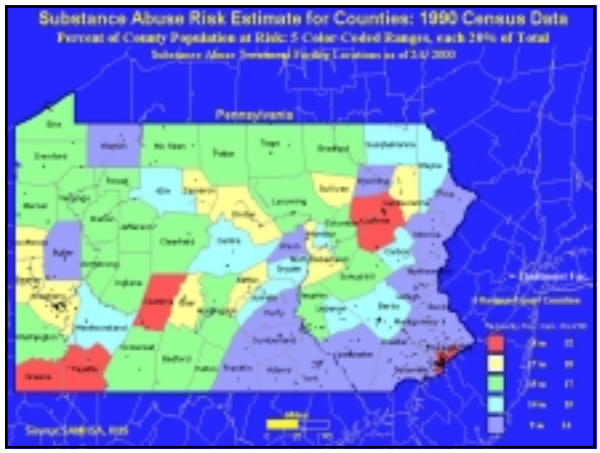
Non-Testing Activites - 2

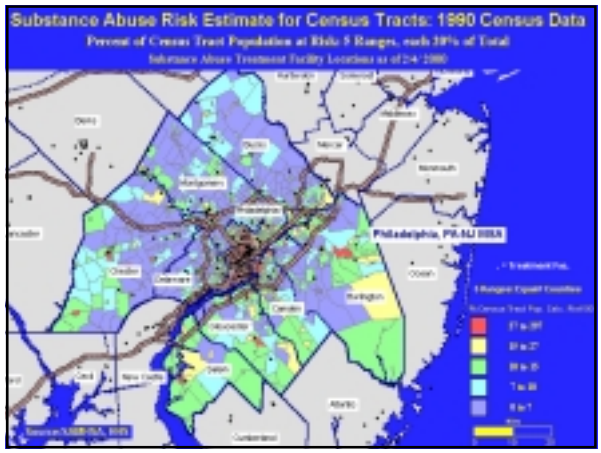
- **Geographic Information System (GIS)** applications for workplace and community substance abuse and violence reduction. These resources have been used by SAMHSA in the Congressional Budget Hearings in 1999 and this year. These GIS resources are being incorporated into the CSAP Decision Support System (DSS), currently under development, and will also be available through the Internet in the next few months.

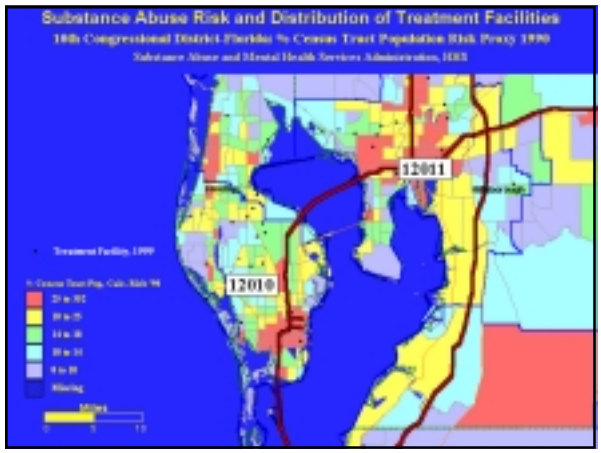
16







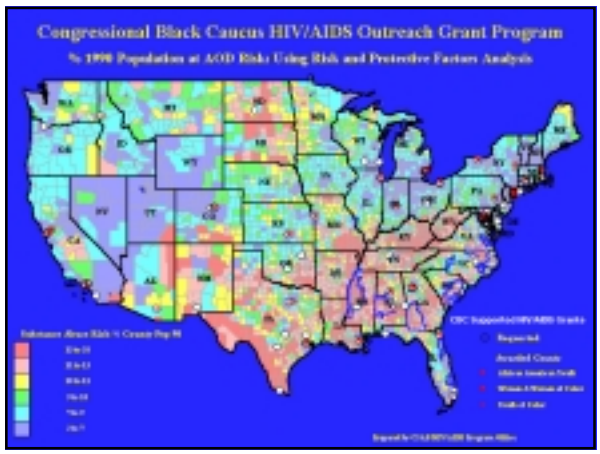


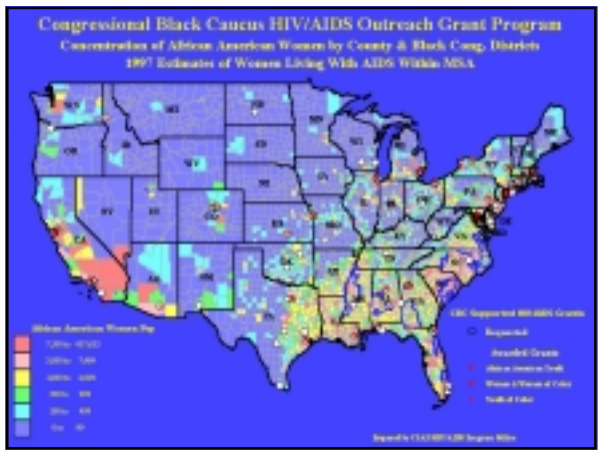


Example: CONGRESSIONAL BLACK CAUCUS HIV/AIDS Outreach Grants Program (November 10, 1999)

- **Assisted CSAP HIV/AIDS Program Office and the Surgeon General in presenting to the Congressional Black and Hispanic Caucuses the distribution of funds targeted for the African American Community by analyzing:**
  - **Concentration of the Population at Risk, African American Population and Target Groups (African American Women, Women of Color, Children & Youth)**
  - **Correlated the spread of HIV/AIDS within these community (CDC Data)**
  - **Location of CSAP HIV/AIDS Grants Requested & Approved within CBC Member Districts - HHS-wide data to follow**

22





US/MEXICO DEMAND REDUCTION MEETING

PHOENIX, AZ MAY 31-JUNE 2, 2000

Arizonans For A Drug-Free Workplace
P. O. Box 13223
Tucson, AZ 85732
C. E. Edwards, Executive Director
520-295-5962
800-592-3339
fax: 520-295-5979

1

WHY BUSINESSES ESTABLISH DRUG-FREE WORKPLACES

- **Provide safe & healthy workplace for employees**
- **Increase profits, thereby increasing jobs & wages**
- **Help company to grow and create jobs**
- **Reduce liability exposure**

2

LOS NEGOCIOS ESTABLECEN LUGARES DE EMPLEO LIBRES DE DROGAS PARA:

- **Proveer a su personal lugares de empleo sanos y seguros**
- **Maximizar ganáncias, las cuales aumentan empleos y salarios**
- **Ayuda a crecer a las compañias y ayuda a crear más empleos**
- **Reduce obligaciones legales**

3

DRUG USERS ARE:

- **3 times more likely to be late for work**
- **3.6 times more likely to be injured or injure co-workers**
- **1/3 less productive**

4

LOS USUSARIOS DE DROGAS SON:

- **3 veces más propenso a llegar tarde al trabajo**
- **3.6 veces más propenso a herirse o herir a compañeros de trabajo**
- **33% menos productivo**

5

THE PROGRAM SERVES. . .

- **Primarily small businesses**
- **Businesses of all sizes**
- **Federally regulated companies**
- **Public/federal employers**
- **Tribal employers**

6

EL PROGRAMA ASISTE A . .

- Pequeñas industrias
- Industrias de todo tamaño
- Compañias bajo reglamentos del gobierno federal
- Personal público/ federal
- Personal de Naciones Indígenas Norteamericanas

7

ARIZONANS FOR A DRUG-FREE WORKPLACE

COMPANIES/ORGANIZATIONS SERVED 1990-2000

Arizona: 4,643

National: 953

8

ARIZONANS FOR A DRUG-FREE WORKPLACE

COMPAÑIAS/ ORGANIZACIONES ASESORADAS: 1990-2000

En Arizona: 4,643

En la nación: 953

9

ARIZONANS FOR A DRUG-FREE WORKPLACE

SERVICES PROVIDED

Technical Assistance

Training

Education

Resources

10

ARIZONANS FOR A DRUG-FREE WORKPLACE

SERVICIOS BRINDADOS

Asistencia técnica

Instrucción

Educación

Recursos

11

HOW BUSINESSES ARE REACHED

Business networks & professional organizations

Referrals

Business conferences

Media and direct mail for training programs

12

COMO SE ATRAEN A LOS NEGOCIOS

Asociaciones de negocios y otras asociaciones profesionales

Recomendaciones

Conferencias relacionadas con el sector privado

Medios de comunicación y folletos sobre cursos enviados directamente a negocios

13

REACHING RURAL AND SMALL BUSINESSES

Increased number of training programs from 8 to 19

5 regions established in Arizona for centers

Arizona zoned for convenient access to training programs

Provide toll-free telephone service and internet site

Provide listing of rural community test collection sites

14

COMO SE ATRAE A REGIONES RURALES Y PEQUEÑAS INDUSTRIAS

Incrementación de cursos de 8 anuales a 19

5 centros de recursos regionales en Arizona

Cursos impartidos en zonas accessibles para regiones rurales en Arizona

Acceso a numero telefónico con lada gratuita y presencia en el internet

Acceso a una lista de localidades para centros de colección de muestras en las regiones rurales

15

HOW THE PROGRAM EXISTS

- **Partnerships with drug demand reduction agencies**
- **Fees from training programs, products, other materials**
- **Memberships, donations, sponsorships**
- **Fund-raising activities**

16

COMO EXISTE Y SE SOSTIENE EL PROGRAMA DE AFDFW

- **Vínculos con agencias de reducción de demanda**
- **Honorarios por impartición de cursos, productos, y la venta de otros materiales**
- **Asociación a AFDFW, donativos, patrocinadores**
- **Actividades de capturación de fondos**

17

BARRIERS ENCOUNTERED

- **No funds for advertising to reach rural businesses**
- **Continual budget shortages**
- **Demand for services exceeds resources and available staff levels**

18

OBSTACULOS ECONTRADOS

- **Falta de fondos para promoción del programa a negocios en zonas rurales**
- **Déficit continuo en los presupuestos**
- **La necesidad y demanda por los servicios excede los recursos y el personal disponible**

19

TRENDS OBSERVED

- **More small businesses working with employee treatment**
- **Insurance costs, injuries down - safety improved**
- **Product or job quality improved**
- **Business belief in drug-free workplace benefits**

20

OBSERVACIONES

- **Aumento de pequeñas industrias que emplean a trabajadores con problemas de addiciones**
- **Reduccíon en costos de seguros, el numero de accidentes – seguridad aumentada**
- **Mejoramiento a la calidad del producto y /o servico**
- **Negocios confian en los beneficios de un lugar de trabajo libre de drogas**

21

Programa Modelo de Prevención del Abuso Alcohol y Drogas en Trabajadores y sus Familias

RESULTADOS DE INVESTIGACIÓN

Adaptaciones al Contexto Mexicano

Dr. Agustín Vélez Barajas

Objetivos de la Investigación

- Identificar los elementos que favorecen o restringen la prevención de abuso de sustancias en los ámbitos laboral y familiar
- Obtener la información necesaria del proceso y resultados de la instrumentación del programa
- Realizar recomendaciones para la adaptación del programa a contextos mexicanos
- Realizar la extensión del programa a la familia

Metodología

FASE I: Evaluación de necesidades

Prioridades

- 44% Alcohol
- 7% programas de adiccion a drogas
- 81% Tienen programas de salud y seguridad
- 48% Incluyen un componente de drogas

FASE II. Introducción del programa a las empresas

- Contacto con el departamento de recursos humanos
- Política de recursos humanos
- Asistencia al seminario
- Acuerdo con el marco conceptual
- Visitas clave del coordinador internacional

Metodología

FASE III. Desarrollo de instrumentos y diagnóstico

- Tabaco, alcohol (AUDIT), otras drogas y problemas relacionados
- Lugares para beber
- Razones para beber
- Conocimientos y actitudes acerca del alcohol
- Información sociodemgráfica
- Formas de enfrentamiento y apoyo social
- Estrés laboral y familiar

FASE IV. Desarrollo y evaluación de materiales para la intervención

Desarrollo

- Nececidades de información
- Normas y valores
- Necesidad de asociación de colores usados
- Simbolos y Palabras
- Comprensión del texto

Evaluación

- Tiempo de exposición
- Opinión de expertos, gerentes y médicos
- Grupos Focales
- Aplicación del cuestionario a través de entrevistas con los trabajadores

Metodología

FASE V. Intervención

Sensibilización

- Video: política de la empresa, conceptos básicos de programa, autoevaluación y ubicación en zona verde, ámbar o roja
- Carteles: con los colores asociados al alcohol y calidad de la producción

Intervención

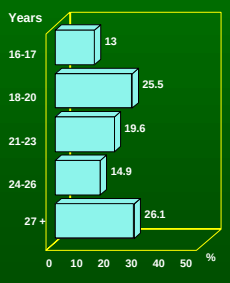
- Carteles: "aprenda a contar"
- Folleto: "¿Te estás pasando el alto?"
- Folleto: "Guía para la familia de los trabajadores"

FASE VI. Evaluación de la Intervención

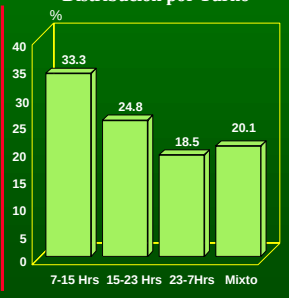
- Asociación de los colores
- Cambios en creencias y conocimientos acerca de los efectos del alcohol
- Variaciones en la conducta
- Impacto en los problemas relacionados con el alcohol
- Percepción de las fuentes de apoyo
- Conocimientos acerca de estrategias de enfrentamiento en la familia

CARACTERÍSTICAS GENERALES DE LA MUESTRA DE TRABAJADORES DE LA EMPRESA "A"

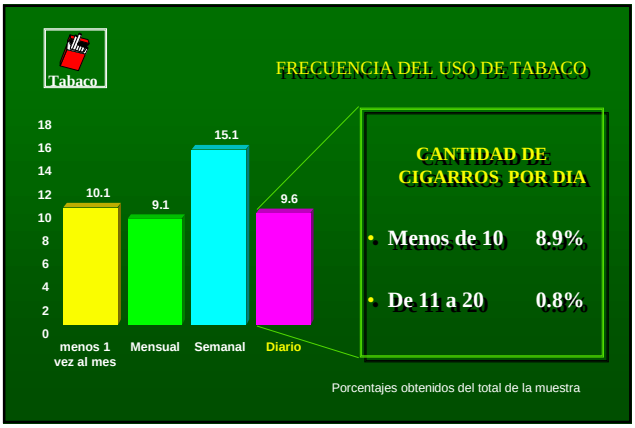
Distribución de Edad

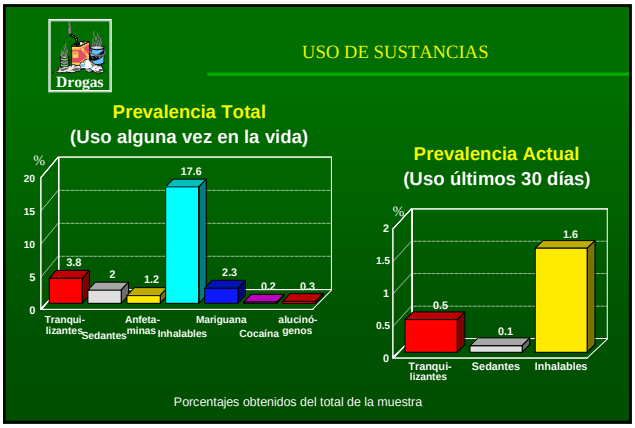


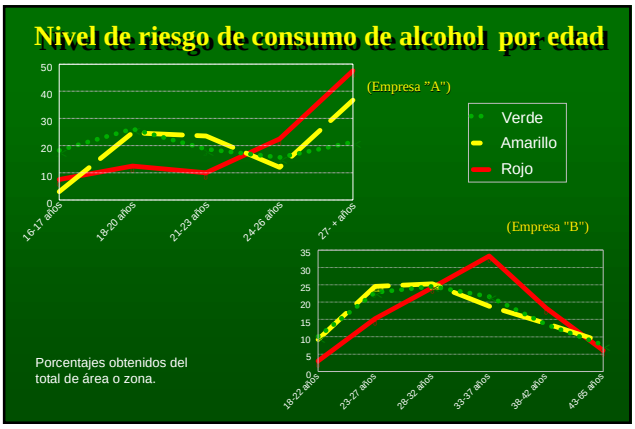
Distribución por Turno

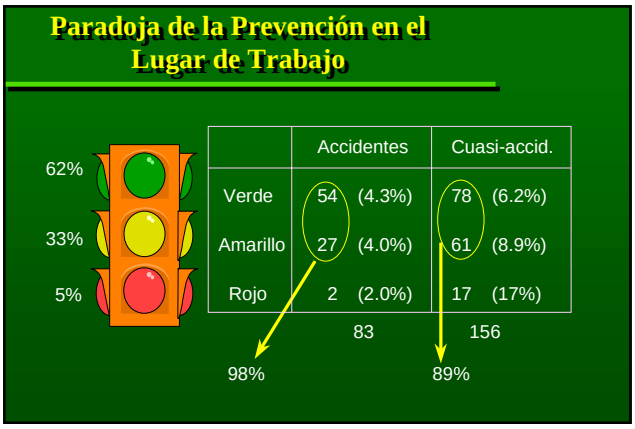


8% no asistieron a la escuela, 59% 1 - 8 años

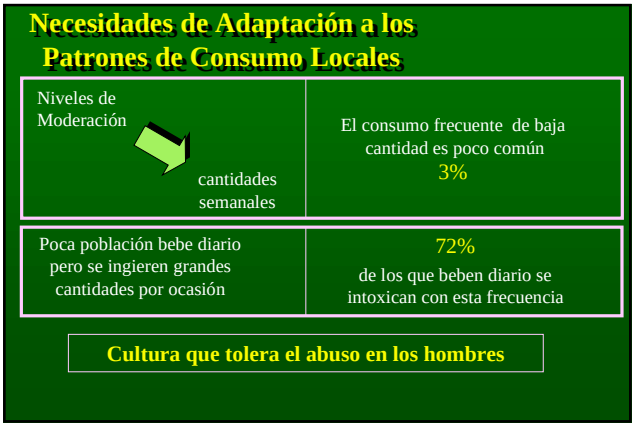

Tabaco
FRECUENCIA DEL USO DE TABACO
18
16
14
12
10
8
6
4
2
0
10.1
9.1
15.1
9.6
menos 1 vez al mes
Mensual
Semanal
Diario
CANTIDAD DE CIGARROS POR DIA
• Menos de 10 8.9%
• De 11 a 20 0.8%
Porcentajes obtenidos del total de la muestra


Drogas
USO DE SUSTANCIAS
Prevalencia Total
(Uso alguna vez en la vida)
%
20
15
10
5
0
3.8
2
1.2
17.6
2.3
0.2
0.3
Tranqui-lizantes
Sedantes
Anfeta-minas
Inhalables
Mariguana
Cocaína
alucinó-genos
Prevalencia Actual
(Uso últimos 30 días)
%
2
1.5
1
0.5
0
0.5
0.1
1.6
Tranqui-lizantes
Sedantes
Inhalables
Porcentajes obtenidos del total de la muestra


Nivel de riesgo de consumo de alcohol por edad
50
40
30
20
10
0
16-17 años
18-20 años
21-23 años
24-26 años
27- + años
(Empresa "A")
Verde
Amarillo
Rojo
(Empresa "B")
35
30
25
20
15
10
5
0
18-22 años
23-27 años
28-32 años
33-37 años
38-42 años
43-65 años
Porcentajes obtenidos del total de área o zona.


Paradoja de la Prevención en el Lugar de Trabajo
62%
33%
5%
Accidentes
Cuasi-accid.
Verde
54 (4.3%)
78 (6.2%)
Amarillo
27 (4.0%)
61 (8.9%)
Rojo
2 (2.0%)
17 (17%)
83
156
98%
89%


Resultados de el Diagnóstico
Componente de Familia
➢ En la familia de los trabajadores en zona ámbar y roja el consumo de alcohol es una práctica común
➢ Los principales usuarios de alcohol en las familias son el padre y los hermanos
➢ Es muy frecuentes que en reuniones familiares se sirvan y consuman bebidas alcohólicas
➢ Se consume alcohol en su propia casa o en la de los amigos
➢ La familia es la mejor fuente de apoyo social


Necesidades de Adaptación a los Patrones de Consumo Locales
Niveles de Moderación
cantidades semanales
El consumo frecuente de baja cantidad es poco común
3%
Poca población bebe diario pero se ingieren grandes cantidades por ocasión
72%
de los que beben diario se intoxican con esta frecuencia
Cultura que tolera el abuso en los hombres

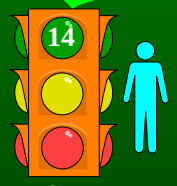
Consumo Moderado

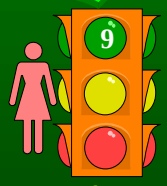
- 1-2 COPAS POR DÍA
- NO MÁS DE 14 POR SEMANA
- NO MÁS DE 4 POR OCASIÓN
- NO MÁS DE 2 POR HORA.

HOMBRES

MENOS CONSUMO PARA UNA VIDA MEJOR

Unidades por semana





Máximo
4 copas por ocasión

Máximo
3 copas por ocasión

¿Por qué la familia debe ser incluida?

- La familia es la principal fuente de apoyo social
- La cultura es principalmente "colectivista"
- La mujer es una vía esencial para prevención y tratamiento

De esta manera la familia es un ambiente clave para el desarrollo de políticas sociales

Estrategias por Área

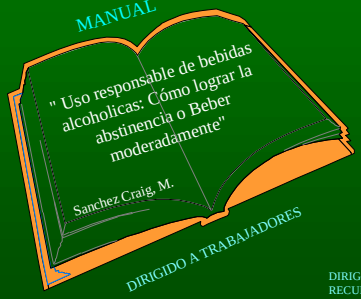
	CONSEJO	ESTRATEGIA
VERDE	Manténgase en VERDE	Campaña de Sensibilización Carteles Folletos Videos
AMARILLO	Cuente sus Copas	Manual Naranja del Trabajador Manual de Familia Entrenamiento de Supervisores
ROJO	Busque Ayuda	Manual de Familia Referir a Centros de tratamiento

Ejemplos de Carteles de Sensibilización

Ejemplos de Carteles de Intervención

Estrategias para la zona naranja

MANUAL



DIRIGIDO A TRABAJADORES

INSTRUCTIVO

"Detección, evaluación y orientación de personas con problemas de alcohol en el ambiente laboral"

Romero, M.; Rivera, E.

DIRIGIDO AL PERSONAL ENCARGADO DE RECURSOS HUMANOS, TRABAJADORES DE LA SALUD, CAPACITADORES.

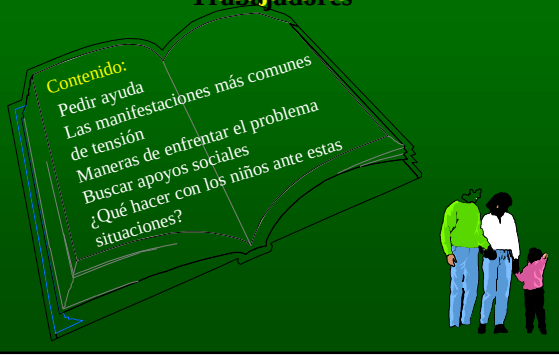
Como lograr la abstinencia o consumir moderadamente

- DECIDASE A CAMBIAR
- EXAMINE SUS HÁBITOS
- ESTABLEZCA SUS LIMITES
- **MANTENGASE EN LOS LÍMITES.**
  - Aprenda a sobreponerse a las tentaciones
  - Anote diariamente cuánto bebe
  - **Evite Emborracharse**
    - Mida cada copa
    - Diluya o rebaje
    - Espere una hora para beber otra copa
    - Beba Lentamente
    - Alterne con bebidas no alcohólicas
    - Coma antes y mientras bebe
  - Preparese para situaciones peligrosas
  - Desarrolle hábitos más saludables
  - Aprenda de sus errores, no se desanime

Procedimientos de detección temprana y de intervención breve

- Paso I. PREGUNTE E INVESTIGUE acerca del consumo de alcohol
- Paso II. EVALUE los problemas relacionados con el alcohol
- Paso III. ACONSEJE la acción apropiada a tomar (instrucciones del manual)
- Paso IV. SIGA el progreso del sujeto

"Orientación para las Familias de los Trabajadores"



Acciones Preventivas que Pueden Extenderse a las Familias

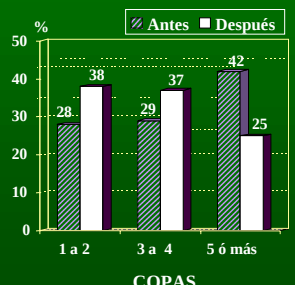
- Audiovisual
- Carteles
- Manual para el Orientador "Prevención del Consumo de Alcohol y Drogas en el Trabajador y sus Familiares".
- Folleto "Orientación para las Familias de los Trabajadores"
- Manual "Uso Responsable de Bebidas Alcohólicas. Como Lograr la Abstinencia o Beber Moderado"

Efecto de la Intervención en la Frecuencia/ Cantidad Consumo de Alcohol

Prueba Rápida

	Antes	Después
X	3.2	2.5
S	(1.86)	2.1

t = 4.15 p >= 0.0001



Evaluación de Resultados

- Adaptación de la metáfora y una fácil introducción del concepto de riesgo asociado a los niveles de consumo de alcohol
- Adaptación del material, lugares y tiempo de exposición
- Bajo impacto en la estrategia de zona verde en conocimientos y creencias
- Cambio satisfactorio en la conducta o al menos sensibilización en la asociación del nivel de riesgo con el consumo de alcohol (76% permanecen en verde o se mueven de ámbar a verde)

Conclusiones

- Necesidad hablar de la prevención del uso de substancias
- Prueba del programa en otros ambientes (con más riesgo en el abuso de substancias, orientación a la producción comparado con orientación al desarrollo humano)
- Enfatizar las diferencias en los niveles de consumo de alcohol y problemas relacionados en cada empresa
- Precaución en el uso del concepto “moderación”

Conclusiones

- El trabajador es un medio para dar información a la familia
- Resaltar la interacción del lugar de trabajo-familia-comunidad
- Altamente recomendable evaluar el uso de alcohol y problemas relacionados en la familia y la actitud hacia la participación de la familia
- Identificación de caminos más directos para llegar a la familia
- Estrategias para evaluar los cambios en la conducta
- Evaluación continua del impacto

PREVENTION ACROSS THE LIFE CYCLE

Ruth Sanchez-Way

Introductory Remarks

Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
United States

Prevention in Early Childhood

Rosa Bonifaz, Carmen Mille
National Council on Addictions
Ministry of Health
Mexico

U.S. Efforts – Prevention in Early Childhood

Eileen O'Brien
Casey Family Program
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
United States

Dr. Ruth Sanchez-Way, Acting Director of SAMHSA's Center for Substance Abuse Prevention (CSAP), opened the session by underscoring the need to view prevention as a life-long process, not just one or two interventions.

Ms. Mille described *Mexico's "Construye Tu Vida sin Addiciones"* a comprehensive prevention effort covering physical, mental, spiritual, social, and cultural aspects of prevention. She noted that the health promotion aspects of *Construye* are based on elements of "care" and a healthy environment. Ms. Mille then described the public awareness features of the effort, including the use of television, radio (with specific targets), written guides, and hotlines.

Ms. Rosa Bonifas, also of CONADIC, described *Construye*'s media campaign, which targets youth ages 9-14, older adolescents, and adults 20+ years of age. Materials for the youth include activity guides, self-surveys, and discussion guides. For older adolescents, self-help manuals have been developed, along with self-evaluations. For adults, self-help manuals and facilitator guides have been developed, along with specific guides for parents and teachers.

Ms. Eileen O'Brien, of SAMHSA's CSAP, then described an early childhood prevention program developed by CSAP called Starting Early/Starting Smart (SESS). Describing brain research that shows early experiences (i.e., positive or negative interactions) shape neural pathways, she then recounted the various elements of SESS as listed below. In general, she noted that SESS provides integrated substance abuse and mental health services in early childhood setting, and SESS services may include: case management, pediatric primary care, language development, reading readiness, and family services including parenting education and support groups. Ms. O'Brien stressed that SESS is based on acknowledging and building family strengths with a direct focus on both substance abuse and mental health, and is implemented through collaborations and partnerships.

Pre-natal:

- improving attachment and parenting skills for expectant parents
- nutrition support for the future mothers
- general support and encouragement for future fathers.

Infants and toddlers:

- health care, child care
- links with Healthy Start, and well-baby care.

Children ages 3-5:

- Access to primary care clinics, child care, pre-school and early reading programs.

PREVENTION IN YOUNG ADULTHOOD

Higher Education Programs

John Clapp
Research Director
College of Health & Human Services,
School of Social Work
San Diego State University
United States

Dr. John Clapp described a college prevention program called CAPP, the Collegiate Community Alcohol Prevention Partnership. From 1989-1999, individual colleges in the U.S. conducted prevention programs based on raising awareness and peer education, with modest success. Now, according to Clapp, colleges are funding "environmental prevention" programs that involve all sectors of a community, from recognizing the role of the social environment in preventing alcohol and other drug abuse by college students, to developing prevention programs that target real needs.

The strategy used to develop these realistic prevention efforts starts with data collection, then goes to strategy identification (e.g., media advocacy, server training, party penalty programs), and finally to strategy selection. Clapp stressed the importance of starting with community assessment of problems and needs, in order for communities to identify desired outcomes (reduce binge drinking or reduce alcohol-related injuries, etc.).

Parent Prevention Education in the Workplace

Bernie McCann
Office of National Drug Control Policy
United States

The National Youth Anti-Drug Media Campaign Workplace Program Objective is to use the workplace to communicate Media Campaign messages and strategies to parents, grandparents and others involved with youth.

The Media Campaign's workplace component is designed in conjunction with National Drug Control Strategy's Goal Number 1: to educate and enable America's youth to reject illicit drugs as well as alcohol and tobacco.

Business Case
America's workplaces offer an efficient, effective and, at this time, an underutilized channel to reach parents and guardians with drug prevention information, solutions, and resources to help raise drug-free children. And research demonstrates there is a need for these resources in the workplace:

- A recent poll conducted in conjunction with the Society for Human Resource Management (SHRM) showed that most human resource professionals believe an employee's concerns over their child's possible drug use could lead to decreased morale and productivity, and a concomitant increase in turnover, and healthcare costs. The Media Campaign workplace program is designed to reduce youth drug use while assisting with a company's efforts to find solutions for critical performance issues.

How the program will work
The Media Campaign will recruit employers to work in partnership to incorporate Media Campaign messages and in the internal communications vehicles employees know and trust – employee newsletters, company intranets and e-mail systems, posters, benefit and employee assistance program kits, workplace seminars, etc.

Media Campaign will accomplish recruiting efforts by:

- A nationwide publicity and promotion effort emphasizing the importance and organizational benefits of providing youth-focused drug prevention information to employees who are parents, grandparents and guardians of teens and tweens. Materials and resources will be easily adaptable to a company's existing employee communications program.

- Reaching out to business leaders and professional, business, labor and government organizations willing to serve as

Media Campaign messengers and as influential conduits into employer organizations.

- Contacting and offering Media Campaign information directly to employer organizations.

What materials will be distributed?
Print and electronic media will be made available to employers for their employees. Print materials will consist of a collection of items from nationally recognized drug prevention programs. Each company participating in the workplace program will have the option of ordering materials directly from the publisher. Materials will be available in either print or electronic formats (downloadable files via the World Wide Web). Items include:

- Pamphlets, posters, etc., appropriate to the parent target audience

- Media Campaign-created newsletter articles for use in employee magazines, newsletters, human resource benefit kits and employee mailers

- Electronic communications including Media Campaign-generated e-mails, down-loadable PSAs, screen savers, banner ads for use on corporate Web pages, and electronic links for drug prevention resources available for parents/guardians on the World Wide Web.

Screening and Brief Alcohol Interventions with Older Adults

Kristen Barry
Senior Associate Research Scientist
University of Michigan
United States

The purpose of Dr. Barry's presentation was to provide state-of-the-art information and techniques regarding alcohol screening and brief alcohol interventions targeted to adults age 60 and over. Dr. Barry pointed out the fact that a growing number of people reach later life, and that the promotion of healthy lifestyles and primary disease prevention among these older adults is becoming a critical issue. She presented information regarding how many aging adults are seeking costly health care for acute and chronic conditions and how because of the increased incidence of health care problems, elderly adults are more likely to seek health care on a regular or semi-regular basis than are younger adults. In addition, Dr. Barry identified older adults as being more vulnerable to the effects of alcohol and, this combined with the increases in co-morbid diseases and their use of prescription and over-the-counter medications, may cause them to seek health care for a variety of conditions that are not immediately associated with increased alcohol consumption.

She stressed the importance of systematic alcohol screening and intervention methods and tools, and said that they can help insure relevant and high quality health care to older adults. Older adults with alcohol problems are a special and vulnerable population who require elder-specific screening and intervention procedures focused on the unique issues associated with drinking in later life. She stressed the following important points to consider when working with these older adults, including:

- The prevalence of at-risk drinking in community samples of older adults has been estimated to be between 1-15%, depending on the group studied.

- Randomized controlled clinical trials indicate that older adults whose alcohol use exceeds the National Institute on Alcoholism and Alcohol Abuse (NIAAA) guidelines will significantly decrease alcohol use in response to brief structured workbook-driven interventions.

- Implementing alcohol screening and brief intervention strategies for older adults in clinical settings will require the development of systematized protocols that provide easy service delivery.

DRUG AND VIOLENCE PREVENTION PRESENTATIONS ON SAFE-SCHOOLS

Healthy Students Initiative

William Modzeleski, Moderator
Director, Safe and Drug-Free Schools Program
U.S. Department of Education
United States

Presenters:
Ann Clark
Supervisor, Safe and Drug-Free Schools
Houston Independent School District
Houston, Texas
United States

Philmer Bluehouse
Pinon Unified School District #4
Pinon, Arizona
United States

Forrest Van Camp
Leon County Schools
Tallahassee, Florida
United States

Martha Fletcher
Leon County School District
Tallahassee, Florida
United States

Dra. Marisa Oceguera
Latin American Institute for Family Studies
Mexico

Overview

The drug and violence prevention session began with an introduction by the moderator, followed by presentations on three Safe Schools/Healthy Students projects in the United States, and a presentation on the Latin American Institute for Family Studies program in Mexico.

Introduction

Bill Modzeleski opened the session with an overview of issues and data regarding school safety in the United States. For the most part, U.S. schools are safe. Recent data indicate that 43 percent of schools experience no crime, and 90 percent experience no serious violent crime. The most common crimes that occur in schools are theft and fighting. Serious violent crimes against students at school or going to and from school have been decreasing since 1992, and remain much lower than the same types of crimes committed in communities. With regard to weapon carrying, based on data from 1993-1999, the general trend in weapon carrying on school grounds has been decreasing.

With regard to the frequently asked question of how many homicides there are in schools, according to a study by the Centers for Disease Control (CDC) over a two-year period between 1992-1994, there were 105 school associated violent deaths, of which 85 were homicides. From 1997-1998, there were 58 violent deaths, representing a slight increase from the previous period studied. Today, there is a lower incidence of homicides in schools, but more victims, due to an increase in multiple homicides. Much attention is being directed to homicides; however, not enough attention is given to more basic, prevention-related issues such as discipline, truancy, and bullying. Prevention of violence needs to start with a strong foundation of clear standards of behavior.

How are we addressing the problem of violence in schools? Through the following broad approaches: 1) improving physical conditions at schools; 2) targeting high-risk youth; 3) implementing drug and violence prevention programs and 4) increasing security and establishing strong discipline policies. It is important to use comprehensive strategies that involve many partners, including schools, law enforcement, health services, community organizations, families, and many others.

The following recent publications of the U.S. Department of Education and the U.S. Department of Justice can be ordered free of

charge by contacting ED Pubs at 1-800-877-433-7827.

- *Safeguarding Our Children: An Action Guide*
- *1999 Annual Report on School Safety*
- *Early Warning/Timely Response: A Guide to Safe Schools*

Safe Schools/Healthy Students Initiative

Houston Independent School District, Houston, Texas

Ann Clark, Safe and Drug-Free Schools Coordinator, Houston Independent School District (I.S.D.) presented information on Houston's Safe Schools/Healthy Students Initiative. The purpose of the program is to provide students, schools, and communities in the feeder schools to Houston's secondary schools with enhanced comprehensive educational, mental health, social, law enforcement, and juvenile justice services that promote healthy childhood development and prevent violence, drug and alcohol abuse. The Houston I.S.D. serves a diverse population which speaks 87 different languages. The program has six goals:

- Establish a safe school environment by reducing the levels of violence, aggression, and substance abuse among children and youth in the community.
- Improve mental health and increase pro-social behavior through an integrated, coordinated continuum of programs and services.
- Ensure that children at risk of emotional and behavioral problems receive appropriate school and community mental health preventive and treatment intervention services.
- Assist high risk families to build resilience to adversity so that children enter school with the necessary pro-social and academic skills to succeed.
- Support educational reform efforts that increase academic achievement through development of school climate.
- Improve integration and coordination of services among Houston I.S.D. and various community agencies.

Activities for accomplishing these goals include strategies for increasing parent involvement; improving the availability of after-school programs; providing ongoing training to students, parents, and teachers on accessing resources and services; providing mental health treatment services for children at risk for emotional and behavioral problems; providing intensive early prevention and therapeutic services to high-risk families of children ages 0-5; and many other strategies.

Pinon Unified School District, Pinon, Arizona

Philmer Bluehouse, Director of the Safe Schools/Healthy Students Initiative for Pinon Unified School District, began his presentation with the Navajo greeting "Ya'a'te", which means "I come to you with the universe" and "It is perfect." As he introduced himself as a full-blooded Navajo of the Many Goats Clan, he explained that it is critical to teach children who they are, and that it is Navajo custom to introduce oneself through one's clan. One must start from one's clan to understand where one fits in. The Many Goats Clan has a "humble" side and a "warrior" side. We are all designed in the same way, in that we have a linear side and a cultural side, or a peace side and a warrior side. This creates balance.

Pinon School District is very rural, with a population of 8,000. Children are bused to school, leaving their homes at 6:00 a.m. and not returning until late afternoon. Services are stretched thin, meaning that the community must play an important role. The Safe Schools/ Healthy Students initiative is looking at a strategy of re-empowering the community to decide what services to provide, and how the services should be provided, including education, health, and law enforcement. There are Federal, State, and Tribal laws that apply.

The community must be involved, and all parts of the community must work together.

The goal is to achieve a state of harmony or "hosanosnin." How can harmony be achieved? How can the process make things better? How do we allow the process to heal rather than destroy? The overall objective is to allow people to be involved in making decisions at the community level rather than being acted on by outside forces, and to encourage traditional ways to flourish. The problems and the solutions are local.

Leon County School District, Tallahassee, Florida

Forrest Van Camp, Executive Director, Leon County School District, provided an overview of the Safe Schools/Healthy Students Initiative in Leon County School District.

The initiative places an emphasis on early childhood, providing early intervention for at-risk children. Five elementary schools are being targeted. Objectives are to build student resiliency and increase access to mental health and prevention services. Strategies include increasing alternative after school programs and recreational activities for students. School security strategies include increasing surveillance cameras and radios in schools.

Martha Fletcher, Program Specialist, Early Childhood Programs, provided further information about the Leon County initiative. Leon County is unique in that all funding for early childhood services is under one umbrella. This blending of funds for early childhood services enables more children to be served. Services include programs for teen parents, and mental health programs for young children. Many children are coming to school from chaotic home environments. Mental health intervention services need to be provided early, rather than waiting until children are older. Children need to be taught how not to become victims. Teachers are being trained through a problem solving approach. Leon County has produced a training curriculum for parents and a video entitled "Discipline with Love." The Safe Schools/ Healthy Students initiative will provide an "active parenting" parent education curriculum.

Latin American Institute for Family Studies

Marisa Oceguera presented information on the Latin American Institute for Family Studies and its family therapy services. The focus is on prevention among families. One must consider the family in various contexts, such as social and economic environments, as part of an ecosystem. Legislation related to family violence in Mexico has been recent. According to a 1999 study, family violence occurs in one out of three homes in Mexico. In fact, family violence is sometimes seen as normal behavior. Another study found that 38.4% of women had suffered some type of violence. Family violence is often associated with alcohol abuse by men. Violence against women is a significant social problem. Its impact often extends to children, resulting in behavioral problems and problems at school. One of the main reasons that girls leave home is due to sexual abuse. One must have an ecological outlook when considering family violence, such as personal history, distribution of power within the family, lack of equality, gender roles, stereotypes, and a certain way of looking at men in relation to women. Many studies on alcoholic men show a close relationship between alcohol use and violence. Women with drug and alcohol problems often come from families where there is a lack of care and support. To be a female addict is worse than to be a male addict. Women are prey to violence. According to one study, two-thirds of people on controlled substances had been subjected to violence. There is a "social silence" on the subject of family violence. It is hushed up, reinforcing the negative effects, and creating difficulties in seeking help. The ecosystem approach is recent. It is an approach that must involve all parts of many complex systems in addressing the problem.

TREATMENT

TREATMENT PRE-CONFERENCE SESSIONS

Arturo Ongay Pérez
Moderator
National Council on Addictions (CONADIC)
Ministry of Health
Mexico

COMPREHENSIVE TREATMENT PLANS
Comprehensive Treatment Approaches for Women
Robin Hoskins
Women's Treatment Network
Phoenix, Arizona
United States

THERAPEUTIC COMMUNITIES
Standards for Prison-Based Therapeutic Communities
George DeLeon
Center for Therapeutic Research, National Development and Research Institute, Inc.
United States

Treatment Program for Heroin Use
María Elena Ramos
Programa Compañeros, A.C.
Mexico

RECOVERY PROGRAMS: FAITH-BASED MODELS
Christianity Interventions
Roberto Bital Pineda
Alcance Victoria
Mexico

RECOVERY PROGRAMS: SOCIAL MODELS
EVAC and PREHAB of Arizona: Successful Multi-Systemic Approaches Within a Community Context
Tom Hutchinson
Prehab of Arizona
United States

HIV Prevention, Addictions and Social Reintegration of Street Kids
Martín Pérez
El Caracol
Mexico

COMPREHENSIVE TREATMENT PLANS
Comprehensive Treatment Approaches for Women
Robin Hoskins
Women's Treatment Network

I want to welcome those of you who are here today. We were expecting about 70 people today, so we're happy that you all are here. My name is Robin Hoskins and I work here in Phoenix, Arizona for the Adult Probation Department. I am a Director, and I oversee a program that supervises female substance abusers in the criminal justice system. I was asked to talk about our comprehensive treatment approach for female offenders. So what I'm going to do is spend a little bit of time telling you what we do here locally, and my hope is that some of the things that I tell you today are things that you can apply to where you're from.

I want to make sure that I have something to share that's of value. And so, what you'll find in my presentation today is that it's very simple. When we do our comprehensive treatment planning for our women in our program, we use a very, very simple basic concept. What we do at the "Women's Treatment Network," which is the name of the program I oversee in adult probation, is we treat each individual client as an individual client. And that's really important. What's traditionally done in criminal justice is that our clients are not seen as offenders or defendants. A lot of times our clients are defined as either just being a substance abuser or maybe a violent offender. But what we try to do

is to take a look at that client as an individual. In doing that we take a holistic approach in our treatment planning. But what's most important to tell you in our approach to treatment planning is that it all starts with a comprehensive assessment. And I don't really know where you all are from or what your backgrounds are, so if this seems very basic and simple, I apologize. I'm not trying to make it too basic or boring for you. I found in my job in working in our department is that it's hard for people to keep it basic. It's hard for people to continue to look at our clients as whole people rather than just criminals.

When we develop our comprehensive treatment plan for our clients, we focus on seven life areas. And those life areas are mental health, family, employment, education, social, medical and legal. When we develop our treatment plan we assess the need of the client in each of those 7 life areas. That's critical to the success of our program. Also important in what we do, is that we put the time and energy at the front end of our assessment, development of our treatment plan which is the assessment. What I mean by that is that we employ Master's level, certified counselors to do our assessments. Other programs will have assessments done by maybe Bachelor's level folks or people that are not certified in counseling. And we have chosen to spend the time and energy and resources up front so that we can get a comprehensive assessment and that will pave the way for a better treatment plan.

What we also know is not every woman that we see has needs in every life area. But what we do consistently is we approach each life area to make sure that the woman is being addressed as a whole, like I said, as a whole person. I keep saying this, but I would imagine that most of you know what I mean when I talk about the traditional criminal justice system identifying the clients as just defendants rather than people.

One of the exciting things about what we're doing in the Women's Network is, we're one of seven programs across the nation that is supported by Washington, DC in our efforts. And our plan is to take our approach with women ? this comprehensive approach ? and apply it to other populations. For example, we're in the process now of developing the same type of approach for our juvenile offenders.

What makes our approach unique, and I think one of the reasons why I was asked to be here today as a resource for you all, is that we have the same kind of approach, systems delivery and supervision for our clients whether they come from jail and they're pre-sentenced or pre-trial or if they're coming out of prison on parole. So the whole continuum is covered and we have a consistent approach with these clients. One of the main things that we teach our staff when they deal with our clients is called a strengths-based approach. This means that we focus on solutions rather than problems. Our clients, the women that we see, are very used to being unsuccessful and not completing things. And what we do is we focus on their strengths. We involve the client in her treatment planning. We believe that the client has the energy within herself to propel her towards success. It's not really our energy, it's hers. We really focus on the client and her strengths. We try to mobilize the client's attributes so that she can move forward. And this really gives us the greatest potential to produce positive outcomes we believe.

One of the other things that's important to do when you're trying to develop a comprehensive treatment plan is that it's important that everybody's on the same page. So what we've done here at The Women's Network, is that we have a treatment team that includes the client, the probation officer, a case manager, and a clinical director. Any agency in the community that's providing services to that client is welcome to be a part of the treatment team. And these folks meet every month to discuss the progress of the client.

By approaching the client in a holistic manner, using a treatment team and sharing the comprehensive assessment and treatment plan, we're able to better address the needs of the client. We save money, we save resources, we save time. And that's a key element. I've been in the criminal justice system for a very long time and my experience has been that it's a very fragmented system. Probation usually doesn't communicate well with parole. City governments don't usually communicate with local or state

governments and it's very fragmented. And the people that are suffering the most from that are the clients, ultimately.

One of the things I will share with you as some of our outcomes because everyone's interested in tangible outcomes. The clients that we see are probably not very different from the clients that you see in your communities. The majority of the women that we serve choose methamphetamine as their drug of choice. And the second drug of choice is cocaine. And for us the third drug is alcohol. The majority of our clients, about 75%, are in their late 30s. And the majority of our clients, again about 75%, have children. Also the majority of our clients are unemployed and under-educated. As a result of our comprehensive approach to taking a look at the whole person addressing those 7 life areas, I'll give you some statistics of the women that we have in our program.

Eighty percent of our clients are in stable housing which is key for our clients. When I say stable housing, I mean they're in a home on their own. They're not relying on family or a husband or a boyfriend. It's a stable home that they have control of. And that's a key issue for a lot of our clients. Seventy percent of our clients are employed either part-time or full-time. And 62% of our clients are enrolled in education or vocational programs. When we talk about demand reduction, reducing the demand for illegal drugs, what we know we have to do is reduce the barriers that prevent our clients from succeeding in their recovery. And some of those barriers are housing, childcare, employment, education, health, legal issues ? those life areas that I talked about – and mental health problems. So as the Women's Treatment Network, what we do is try to break down those barriers. I talked about making a commitment at the assessment level where we hire a qualified, certified counselor to do the assessment. Another thing that we do as part of our comprehensive treatment plan is we have funds set aside that we can spend on housing and childcare and parenting classes. We pay for rent for the first couple of months on some of these homes for these women until they can get on their feet. By doing that, we break down the barriers, ultimately resulting in demand reduction. These women are able to take care of business and they're not relying on drugs.

You know, you're going to leave here today and you probably in a year and one-half or a week, or maybe even six months from now, you won't remember me. And that's ok. I don't take that personally. But I do hope that you remember a statement that I want to read from a client, a graduate. She wrote a statement that I'd just like to read to you all. Again, this is a tangible result. "I'm a Black, 46 year old woman who's had a problem with drug addiction and self-esteem. As a child, I aspired for great things: being an Olympic track star, being the fastest jump-roper in the world, or a lawyer. But I never imagined I would be a drug addict. I have a Bachelor's degree in business and three beautiful daughters who depend on me for everything. I've overcome many obstacles, but drug addiction is done on a day-to-day basis. What turned my life around was going to jail and losing custody of my baby. There are so many things that I've been blessed with ? where do I begin? I went from living in a shelter after being released from jail to living in a mansion." She actually owned her first home which was a two-bedroom home, but it felt like a mansion after jail. "I found a new career with St. Mary's Community Kitchen as a chef trainer, and make money, up to $30,000 a year. I can't believe it. I'm planning on purchasing my own home in a year, a larger home, and a decent car for the first time. I'm on the Board of Advisors for the Probation Department. I'm a motivational speaker for The Women's Network, and I've been asked to meet the Drug Czar from Washington, DC. Some days I question myself. Am I worthy? Do I deserve this? You're DAMN right I do. I've worked hard to achieve this dream, and I don't see myself going to a life of drugs and crime again with God's love and grace. Today I'm successful because I choose to be."

It's these kinds of things that keep me going as far as developing new programs and changing policies and procedures, not only locally but nationally. I hope that your experience here this week provides you with some information, some guidance and resources where you can do some things in your own communities that will make a difference to your clients. My number is in the

workbook that was given to you all. And please feel free to call me if you have any questions.

THERAPEUTIC COMMUNITIES
Standards for Prison-Based Therapeutic Communities

George DeLeon
Center for Therapeutic Research, National Development and Research Institute, Inc.
United States

Good afternoon. I was asked to speak on therapeutic communities, in particular, recent developments for therapeutic communities. We now have standards in the United States for delivering therapeutic community programs, both in the general community and particularly in correctional settings. I don't know how much this audience knows about the therapeutic community approach. That term therapeutic community is used very generally, but the approach is actually a very specific one. And so, before I talk with you about the standards themselves, let me take a few moments and review with you the basic theoretical approach of the therapeutic community.

As some of you may know, this particular treatment approach is very well researched. There are some 30 years of research on therapeutic communities documenting the effectiveness of this treatment. This treatment has been demonstrated to actually serve the most serious of substance abusers: usually anti-social, with many other psychological problems in addition to their substance abuse. So therapeutic communities have been serving the most serious of the addicts over the years. And the research has shown, of course, that the treatment is effective. The basic findings of that research, for those of you that may not be aware of it, is that the longer clients stay in residential treatment, the greater the likelihood of their long-term success. The treatment approach has been modified and adapted for numbers of populations including adolescents, mentally ill, chemical abusers, those in homeless shelters, those in mental hospitals, and of course, those in prisons.

The approach that the therapeutic community has that governs everything that it does, is straightforward. This perspective views the disorder one of the whole person, so substance abuse essentially is only one component of what has to change in the treatment.

Secondly, the persons themselves can be understood in terms of a variety of characteristics. Many of them may be seen as character disorder features, along with other psychological dysfunction like depression, anxiety and low self-esteem.

Recovery of the individual requires a multi-dimensional and a multi-interventional approach to change the individual. The goals of the therapeutic community are to transform lifestyles and identities. So, the goal is much beyond the issue of using drugs.

And finally, the fourth view that constitutes the perspective is that this approach teaches right living. The assumption here is that individuals cannot sustain their recovery, cannot change their lifestyles unless they actually have learned certain values to govern them. And so, much of what goes on in the therapeutic community involves teaching those values and teaching individuals how to live.

That's the perspective, admittedly very briefly said to you, that governs and guides everything that is done in a therapeutic community. These treatment programs are generally long-term residential settings, self-contained, primarily managed by recovering people themselves. It's a self-help approach, a mutual self-help approach, with relatively few staff compared to the number of residents. And that of course ultimately has been shown to be very cost-effective. But, if you actually want to understand the treatment, the active treatment ingredient in the therapeutic community, it is the use of the community, which is peers and staff, and all of the activities that go on in that community as the method. So, unlike traditional treatment approaches, there is less emphasis on traditional counseling, traditional psychotherapy, traditional psychiatric approaches, and relatively few programs with medication. In the therapeutic community, the primary treatment change agent

is the community itself. And that's why, over the years, I have used the term "community as method" to indicate what is the primary active treatment ingredient.

When we actually spell out community as method, it can be summarized in four points: the context, which means all of the influences in a contained environment; the people; the relationships; and the daily regimen of activities which is groups, meetings, seminars, recreation, dining, eating together, personal time. All of those activities are defined as the context, and it is assumed in the theory that every one of those activities is potentially an intervention for changing the individual.

So, it is not only whether the individuals go to groups, or whether they attend meetings, but it's everything that they do. Work, meetings, groups, recreation, informal time together, dining together. Every element of the social life in the therapeutic community is an intervention to produce change. Every element is used to teach the individual or to train the individual. And the theory says, in order to bring about multi-dimensional change, you have to have a multi-interventional environment. That's context.

But there is more to community as method. It says that the community is not only the context for learning and changing, but it also sets the expectations for individuals' participation in that community. This is a very critical feature to understand this method. The community itself establishes explicit requirements in terms of how the individual should participate and how much they should participate. So, there is a basic demand characteristic in the community. Not only is this the place where you can change, but there is expectation about how you should use this place to change.

The third assumption in community as method is that the community is also continually assessing, observing, whether you are in fact participating. So, it is a requirement of the community to continually confront, support, provide feedback to the individual as to whether they are participating in the community. And the fourth element is that the community, peers and staff provide responses, both positive and negative, concerning whether the individual is participating. So again, to understand community as method, the community ? all of its people, its relationships and its daily activities ? provide the social learning setting for producing change in the individual. The community sets the expectations for how you should participate. The community will assess, continually observe through challenging you, testing you and exposing you as to whether you are participating and using the community to change yourself.

And finally, the community will provide the responses, the affirmations, the supportive responses as well as the negative ones and the corrective responses. Now, while this may seem obvious to you, what needs to be emphasized is that all of this method essentially describes individuals living together and carrying out the process of recovery. So it's very unlike traditional treatment.

And now, just a word about how the community produces change. What I've just described in the previous slide is what we mean by community as method. And this slide tries to communicate briefly to you how community produces change. Again, everything that is done in the therapeutic community is addressing a behavior, attitude, value or emotional management issue in the individual: how they work, how they relate to people in the dining room, how they participate in the meeting, how they participate in groups. All of those activities essentially surface individual behavioral, attitudinal, emotional characteristics which can then be changed. And that's what we mean by everything can be an intervention.

In order for change to occur, the individual has to have some relationship to the community. That's why I've used the words "affiliation, participation and change." What that means is that in order for individuals to use the community to change themselves, they have to have some affiliation with the community, some connection with the community. So much that goes on in the therapeutic community is designed to strengthen affiliation. If I am affiliated with the community, I listen. If I listen, I change.

The process of change is a gradual, gradual gradient path of learning that leads to internalized change. There are really four levels of internalization, people changing. First, they can change initially through compliance. I do what the community says I have to do because I don't want to be thrown out and go to jail or go to the street, or go back home. So one reason I do what I'm supposed to do is "I'm complying," with very little internalization. Initially, in the therapeutic community, the first changes that we see in most clients are compliance.

The second stage is conformity. They gradually now begin to do the behaviors and attitudes that the community is expecting them to do, based upon their increasing affiliation with others. They do not want to lose the relationships in the community. It's still a form of compliance, but it has shifted now to relationships with the community. They don't want to lose those.

The third stage of learning is one in which the individuals now are making a commitment, and the commitment stage of internalization. They will make the commitment that they want to finish the program. These are the first changes, learning and changing in recovery, that are actually related to the experience of the individual. I keep my room clean, because now I feel better about myself and clearer in my head. When I first came into the program I kept my room clean because I didn't want them to throw me out. As I stayed on, I kept my room clean because I didn't want my peers to in some way to discourage me. The third stage is, I keep my room clean because when I keep my room clean, my head is clean. That's based on my experience. You're now entering internalization.

And the last stage of internalization is a commitment to the change process. The individuals now learn that for them to continue to change, they have to literally "remain in the change process even though I may leave treatment."

And the fourth point that you see in terms of how the process occurs has to do with emphasis on motivation and readiness. Most of the change that comes about in an individual requires a continuous sustaining of motivation ? I want to change ? and readiness ? I take action to change. That must be, those two characteristics must be sustained throughout, and much of what goes on in the community is designed to sustain motivation and readiness. And we say, in the therapeutic community that individuals of course bring about their own recovery but they do that by using the community to change themselves. To continually use the community, they have to remain motivated and ready.

Again, the reason why they wanted me to speak about program standards of therapeutic communities is that it is a recent development. And it was a very big step forward in the evolution of this treatment approach. As I mentioned earlier, the treatment approach is well documented in the research literature. But until recently we did many, many treatment activities that would actually call themselves therapeutic communities because that phrase is a general phrase, therapeutic community. What you have been hearing from me is that it is actually a very, very specific methodology that has a very sound theory to it and a set of prescribed practices and a research base. So the need for standards has been to address the issue of quality assurance, making certain that programs that call themselves therapeutic communities were in fact treatment programs that were adhering to the basic theory, method and model of the therapeutic community. This is a great step forward.

Therapeutic communities have been here for about 40 years. We now have a significant body of research, a theoretical framework that is well described in the literature, and now we have a set of standards which will help to prescribe best practices. We're not going to go through those standards here, but what I want to make sure that you learn today about these is that the standards themselves apply to community based therapeutic communities as well as special adapted therapeutic communities such as those in prison. These were developed for prisons and they're very detailed, therefore very educational for those of you who want to learn more about the therapeutic community and how actually to implement properly implement therapeutic community programs.

But the other very important feature about these standards is that they are grounded in both the theory and the research. So I will give you some examples of that, just quickly. The entire theoretical framework of the therapeutic community and what I've called the theory ? the program model and various methods which we call community as method ? can be organized into 11 domains. There are some 121 item standards across all those domains.

If there's a therapeutic community in the prison ? and there are many of them now in the United States ? the field reviewer has a review document and can spend two or three days in the prison therapeutic community, and review exactly how all of these domains are actually functioning and whether the program is actually delivering the treatment in accordance with these standards. Let's look at one or two examples of these domains.

For example, there are standards which strictly reflect the theoretical basis of the therapeutic community. It says in the standards manual that it's essential that they have a program grounded in the theory. And then it simply resummarizes some of the key theoretical points. And then it present some sample items of exactly how I would walk into your program and check whether you are meeting this particular standard. There are more items than these three, but this is an example. So that was the theoretical domain.

Similarly a very critical domain in the standards is the general clinical principles. I'll just give you one example. It is essential that program participants identify with the therapeutic community and feel a sense of belonging in order to change their patterns of criminality and substance use. Remember I mentioned the issues of affiliation. There must be a continuous 24 hour atmosphere of constructive confrontation and feedback ? 24 hours a day ? to the individuals in the community as a whole, in order to raise personal awareness of the individual behaviors and attitudes. Now that's the principle that governs the standards which are very explicit items. And then there's the rationale for this principle and then some examples.

It's much better that you actually look at the standards, but what I want to get across to you is the relationship between the basic theory of the therapeutic community, the elements that therefore essentially should flow from that theory and then the basic assessment method through the standards themselves.

Let's try one more area. Even on the administrative level a standard is necessary. Here's the general principle. It is necessary that key administrative and management staff interface with a particular agency. This happens to be a prison therapeutic community. So that in a prison, the therapeutic community is in the prison and may be provided by an outside agency for the prison. And this standard says that the individual agency, the prison itself and the treatment provider have to be in a very close interface. They have to be closely related to the success of the program. And then there are some standards to essentially assess whether that relationship between the prison and the treatment provider exists. I'll take one more and then we'll stop.

It is essential that the entire staff function in a manner consistent with the philosophy and the practice of the therapeutic community. Let me make a point about this because in my general introductory comments I didn't have the time to detail the roll of staff in a therapeutic community model which is largely a peer, self-help, mutual self-help model. Staff have very, very critical roles in therapeutic communities. Their key role is as a community member. That is, they have to role model what the program itself is teaching. But they have other roles. Staff are rational authorities making assessments about individuals in the therapeutic community. But they are not conventional therapists and they are not conventional counselors although counseling and therapy actually go on all day at all times in the therapeutic community. I call that informal. There's much informal counseling and therapy. It may be for two minutes at a time, three minutes at a time. So that the traditional view of counseling and therapy where the client comes in to a counselor's office for 50 minutes or one hour is relatively infrequent in a therapeutic community. Because the primary treatment agent is the community itself, not the individual therapist. So that the role of staff,

when they are in a counseling situation, or in a therapeutic situation, are always directing the client to in fact go back to the community to deal with what they have to deal with. So the role of staff is really as facilitator and guide, not really as traditional therapists. Even though therapeutic moments go on all the time.

So this notion of the standards is very difficult to get across because traditional professionals, psychologists, social workers, psychiatrists, have their own tendencies and want to essentially carry out that role as they have learned it. The traditional approaches in the therapeutic community are not effective. There has to be a change in the whole staff mindset when they work in therapeutic communities. That's been a lot of my work over the years to try and teach staff this model and method ? how to move from a primary provider to a primary facilitator. Of course the therapeutic community is not a provider-consumer model. It is a self-help model. And the role of staff is to facilitate self-help. So the standard becomes very important, particularly as you move into prisons and you move into mental hospitals. As you use more and more of the traditional staff, this standard becomes a very important standard and there is an entire training initiative that essentially follows this standard. How to get staff well trained in this very powerful self-help model.

There are seven or eight other domains. I'm going to not talk about those. You'll look at those in the monograph if you're interested. But let me stop and take some questions.

The question was, "How difficult was it to move from the general statements, the general level of the theoretical statements of the therapeutic community to the very specific?" In reality, it was for many years impossible to do that. But once we were able to write a clear theoretical basis for the therapeutic community, once we were able to make that theoretical writing very clear about what we do and why we do it in the therapeutic community, then it was much less difficult to move from the general statements to the specific standard items. We needed an explicit theory to do that. That was the difficult part ? the years of making that theory explicit and clear. That was the difficult part. This part, beginning to write the specific items for the standards, this was much easier once we had the theory.

Can we consider a little clinic? The answer is yes, we can consider any clinic or any particular environment as a therapeutic community if it adheres to the perspective and the method. That's the important part of your question. And I'll answer it, if you allow me, in another way. I have developed programs in many settings now, prison settings, shelters for the homeless, in day treatment settings for methadone clients. The idea is that once we had a theory and a model and a method, then you can use it to guide the transformation of the environment into a therapeutic community. Even if it's day treatment, or if you like, outpatient ? even if they don't live there ? you can, in fact, incorporate the essential elements of the therapeutic community. But you have to have those essential elements and you have to understand the theory behind those essential elements. So the answer is yes, you can have small clinics, schools, shelters, hospital wards, and whole sections of prisons, which we have in the United States now serving almost 12 thousand inmates in therapeutic communities in prisons. So the answer is yes, but it takes training and you need to know the elements and you need to know the theory.

EVAC and PREHAB of Arizona: Successful Multi-Systemic Approaches Within a Community Context

Tom Hutchinson
Prehab of Arizona
United States

Thank you. I appreciate the opportunity to be here this afternoon. My name is Tom Hutchinson, and I'm Director of Community Services for Prehab of Arizona. A colleague of mine, Dr. Frank Scarpatti, is sitting to my left and he works for the organization, East Valley Addiction Council. These are two separate organizations. Today, we are going to talk about those two organizations. We are featuring one program that deals mainly with adults and one program that deals mainly with teens.

We're going to talk about general concepts used in the social model as well as characteristics of two successful programs, the one being East Valley Addiction Council, the other being Prehab of Arizona. We want to talk a little bit about client experiences within those programs, and then we have time for questions and answers.

When Dr. Scarpatti and I were speaking the other day, it was interesting because we found things in common that our programs had. And the word "caring" came up ? that we have caring, dedicated and committed staff who work with our clients. Often these people are forgotten, the people who work directly with our clients. They show much love to the clients with whom they are dealing. We also favored small program size, feeling that clients feel cared for. There's a certain level of intimacy that develops and also it helps with retaining staff members over time.

Flexibility to meet client needs. We both are from Arizona. We're from the East Valley of Maricopa County, and there is a variety of people who reside there. So, our programs are both flexible, in terms of language, in terms of transportation, in terms of different services that clients need at various levels. In both of our programs there's integrated treatment that happens. EVAC features a medical detoxification and yet there are other elements of treatment that are involved – in particular, across a continuum of care. Our youth programs which we will talk more of in a few minutes, are very comprehensive. Both organizations work with a continuum. And we have a cooperative, collaborative mindset which we practice in our community, among organizations. One key aspect was to protect the length of stay for the client. Both of our programs are publicly funded and therefore there is pressure around dollars and moving people quickly and we felt that it is very important to protect the length of stay of the client in order for the client to be successful.

Our idea of the social model had to do with the idea that substance abuse and addictions operate in a context. They are simply not something that can be described from a biological or medical point of view or solely from an environmental point of view. They grow out of a person's environment and also, they have very serious repercussions across society. Therefore, it's important that for a person in treatment, a person in recovery, that the professionals work with all the client's social systems. We speak mainly of families, but also of peer groups, neighborhoods. I would also say that we need to deal with the various systems that the clients find themselves in, whether it be the public health system in our state, whether it be the corrections system, whatever kind of system that person is in. Our programs seek to help that person understand how to best utilize the resources available to them. Families are crucial to success and failure. Peer groups and neighborhoods and communities make a tremendous difference in the recovery of individuals.

The East Valley Addiction Council is located in Mesa, Arizona. It's located in the south central part of the city and it is a gem. It is a very well-kept physical plant. It's essentially a small hospital in the neighborhood. Dr. Scarpetti is to be complimented for the great work he's done with building that facility in the last five years. It has a budget of about 1.5 million dollars from various sources. Most of that comes from the state of Arizona, but the East Valley cities support the program as well as does The United Way. There is a continuum of care. It is licensed by the Department of Health Services. It is accredited by the Council on the Accreditation of Rehabilitation Facilities, and 80% of the patients that were seen in 1999 ? and there were 4000 patients that went through the program ? are homeless. A good percentage of the remaining 20% are low income individuals. So, these are people in tremendous need of assistance. EVAC provides some prevention services mainly through the schools, provides training for staff, presentations to youth, and various other activities in the community. They are very involved with presenting literally hundreds of different presentations to different organizations, to educate those people about substance abuse.

The core service, SORT, stands for Stabilization, Observation, Referral and Treatment. And when an individual is referred to the detoxification center, the first day or so is spent in that part of the process. Some individuals leave after a day of treatment. If they are severely affected and

toxified they will go into the medical detox. The slogan is "detox with dignity," and the program prides itself on its staff. The medical director is a toxicologist. All the staff members are either registered nurses or trained as emergency medical technicians. After the detox period the program refers them to halfway homes and residential treatment centers with emphasis on relapse prevention for these individuals.

When we think of detoxification centers there's sometimes a problem with the idea that they're revolving doors in the sense that we see the same people, time and time again. The vision of EVAC is to stop that revolving door. They've been working at it for about 5 years.

In the old model, there would be a crisis and there would be a crisis team response, including transportation and then the individual would end up in the detoxification center and spend anywhere from 0 to 5 days getting various levels of care. Then they would often be released back to their same circumstances. What EVAC has done is included the SORT time, which is an intensive assessment time, as well as a stabilization period for the individual, and then he or she moves into the detoxification phase. The counselors who are on the staff are known as transition counselors and they're more interested in transition management than they are in actual process of giving clients therapy. So, they work with our local healthcare enrollment, social services assessment, family reconnection, medication management and case management referral. As the person moves through the system, they're given services around relapse prevention. There is an aftercare Naltrexone treatment program that saw about 400 people last year. And some individuals are going into residential treatment environments.

However, in the state of Arizona, there are not many residential beds, so most of the people are referred to some kind of therapeutic community. In the city of Mesa, there were some 80 or so halfway houses. EVAC studied those and came up with a list of 12 facilities they felt were adequate to deal with the individuals that were placed there. They audited each site for the proper environment of care for cleanliness, for training of staff, for staffing patterns. When it came right down to it, there were 12 facilities that met their standards, and many of the individuals who go into the detox part, go into the halfway homes. Of those, 75% have not returned in need of detoxification. So that effort at stopping the revolving door, seems to be working with a significant number of individuals in our community.

By the way, the most frequently occurring circumstances that bring people to EVAC are difficulties with heroin, alcohol, and meth-amphetamine, and various combinations of those drugs. The fact that most of the people are homeless also leaves them in very physically incapacitated, and often, there are 9-1-1 calls, just to assist those people through their detox phase. These people are suffering a great deal and are given the kinds of comfort at EVAC that they need. The model is based on the American addiction medicine treatment model. And all those standards are applied and monitored by their accrediting body.

I appreciate the opportunity to provide two presentations today.

I am an employee of Prehab of Arizona. We are also located in Mesa. And we have a budget of about $11 million from a wide variety of sources. We have monies from the court, monies from the Department of Health, from our local Department of Economic Securities, as well as various grants and foundations. In order to survive, we have 2.5 individuals who simply write grants and obtain various monies in order to keep our programs going. We have 13 programs. We are private, non-profit, licensed by the state, and we are accredited by the Joint Commission on the Accreditation of Health Care Organizations. We serve children, youth, adults and families. We have an out-patient counseling service, with about 1500 open files. We have domestic violence and family homeless shelters. We have training employment for hard to serve individuals. We have alternative crisis centers for youth. Then we have long-term residential treatment with the school.

When people come to us, all medical services are provided including psychiatric care and psychological services. We have two doctors that we use for psychiatric care as well as a psychologist. The children receive mental health

counseling ? group, individual, and family. We have 20 kids, and there are about 20 staff. There are 4 or 5 clinical staff and then other support people. Our philosophy is to support and promote abstinence, and we do that and monitor individuals on a daily basis. We also have support groups using the 12-step model generally speaking with youth: Narcotics Anonymous. And we also have our own school. So we try and have an integrated program that involves the mental health and t social aspects of treatment as well as the recovery program. We feel very fortunate that we have been able to keep the length of stay at a level where we feel it needs to be.

We also support aftercare. Family involvement starts early. In fact, in the interview process the family is involved. And if the family is unwilling to support the teen who's in treatment, we will not accept that teen. There needs to be a level of support for the treatment process or we will not accept that individual. We start within 2-4 weeks family counseling on an individual family level. We do work with extended families. We do work with Spanish speaking people in particular and have staff that can provide that service.

Also on a weekly basis we have multi-family groups, most weeks of the year. We have onsite visitation on a weekly basis on Sundays. And we have home and neighborhood visits as the youth start to become ready to return to their environment. If the family is unsupportive and there are active addictions going on within the family setting, we will seek alternative placements, whether that be the extended family, other people within that environment, or through any other means that we find necessary.

In terms of the accreditation, we are considered a Level One facility. We are not a locked facility. The elopement rate is quite low because the screening is pretty rigorous. We screen people to make sure that they are willing to do work and to stay in treatment. The elopement rate is not high. Our environments are more homelike than they are institutional. We believe in creating a healthy milieu for the youth and really focus on doing that in a thoughtful way.

And of course the idea of having individuals and having leaders and having followers who are committed to the long-term. Who are willing to stay on a task such as their careers, we feel is very, very important organizationally and programmatically. And it's important to express to the community around us that we care about and respond to their needs. And in doing so, we gain community support. And that is not only on a formal level through the United Way or through the city councils, but also on an informal level. For example, in Frank's neighborhood, there is a community garden. And individuals from the neighborhood itself come onsite, tend that garden, reap the fruits of that effort and feel connected to their institution. So, those kinds of activities we feel are very important to create success, not only for the organization, but for the clients involved. In our youth centers we have celebrations. We have graduations from school, graduation from programs. We have holiday events, birthday events. We bring in service groups to support the environment in which they live and try and keep that environment really appropriate for their stays.

We also believe that people need to always learn. That is the staff. We continue to professionalize staff. I can speak for our organization – it being mainly publically funded, but we make every effort to train staff through events like this, or through supporting their education, because much of the work is done by direct care people who maybe are not degreed in some functions. We really promote that and promote lots of training and education.

Also the need to collaborate and network with other organizations creates strength. It's not so long ago that people competed with each other organizationally, and they competed for the dollars. That atmosphere is changing on the program level to a great extent, and that allows for more healthy environments overall. In terms of client support, there were times when the doors were closed to different people who were interested. I can speak for our organizations that all supportive people who were involved with the client are invited to become involved with those individuals in the treatment process. We consider it very important within our settings to do that with immediate families, even families

who are struggling with their own issues and their own addictions, and also extended families in particular.

I appreciate your time and your attention.

TREATMENT TRAINING SESSIONS

New Developments in Oversight and Treatment of Opiate Addiction: Pharmacology and Behavioral Therapies

Mark W. Parrino, M.P.A.
President
American Methadone Treatment Association
United States

Good morning. It's a pleasure to be here.

Part of my remarks will focus on research and policy: Why methadone maintenance treatment is so widely used in the United States and other countries. The presentation will also focus on community education – the need to inform the public about the value of methadone maintenance treatment. Some additional issues of clinical management include pregnancy, treating, and comorbidity, such as HIV infection and other infectious diseases with people on methadone maintenance. And in addition, I will come back after Dr. Barthwell has concluded to finish some administrative concepts about program design, how best to operate methadone maintenance treatment programs, and so that you don't run into the flaws in Mexico the way we did in the United States in the early part of methadone maintenance treatment. So, I thank you for your gracious introduction, for inviting me to speak and hopefully this will help all of you in other parts of the country and in Mexico.

So, with that, I'm the President of the American Methadone Treatment Association, which was founded in 1984. The association represents approximately 650 methadone treatment programs in the United States and we're organized through statewide methadone program association chapters. Some of the largest chapters are from the states of California, New York, Illinois and Texas. In fact, in addition to Dr. Barthwell being the President elect of the American Society of Addiction Medicine, she also represents the Illinois Methadone Provider Association to our Board of Directors, which is not atypical of Dr. Barthwell. She represents many different organizations at once.

The focus here will be three major issues effecting the future of opiate addition in the United States. The first is a change in program oversight in the Federal government from the Food and Drug Administration to the Center for Substance Abuse Treatment. These are two Federal agencies in the United States. For the past 25 years, since 1974, the Food and Drug Administration has provided Federal oversight to methadone treatment. This made sense at the beginning of the major change in methadone treatment in the early 1970s, but lost its applicability over the course of the last 5 years. The plan is to use accreditation standards, which are outcome oriented standards as a way to evaluate the success of methadone maintenance treatment, to measure the improvement of the well-being of the patients who are in treatment. It's a very serious and major shift in how methadone maintenance treatment will be evaluated in the United States, and our association has supported such a practice.

The second major issue is having stabilized methadone maintained patients who have been in treatment in methadone programs in the United States, have the ability to transfer out of the clinics, into private physician office practices. This is called medical maintenance. The idea behind this is to free up needed places for new patients to come into methadone maintenance treatment and to give the successfully stabilized patients an opportunity to gain access to a different kind of treatment experience once they've successfully demonstrated stability in the treatment system.

The third major policy issue is the development and use of new medications to treat opioid dependency. Methadone maintenance treatment has been the most evaluated, studied and used treatment for opiate dependence that we have

in the history of any medicine. No other medicine has been scrutinized and evaluated so carefully to treat a disease. No other form of cancer treatment, or any other disease, has been so carefully evaluated. So methadone maintenance treatment is the most studied care. And according to our Federal agencies and the National Institute on Drug Abuse and the National Institute of Alcoholism and Alcohol Abuse, methadone maintenance treatment has been found to be the most effective medical treatment available to treat opiate dependence.

Of the new medications, the most current one is called buprenorphine. It's certainly to be found effective. The question becomes effective for what patient, during what part of the addiction cycle? From our perspective and what we've known in reviewing the research, it is probably best geared to the younger, or more naive opiate dependent person. The individual who has not been using opiates for a very long period of time. In the United States, if I were to give you a sketch of the most typical opiate dependent person, it would be as follows. The individual began using heroin at the age of 17, after using alcohol and some other drugs including marijuana. The young person doesn't complete high school in most cases. Rarely gets to college. Generally gets involved with the criminal justice system. Is arrested. Spends some time in jail. The individual rarely gets training for an employable skill. Most times the individual, as they get into their 20s, because of using dirty needles, becomes susceptible to hepatitis C or to HIV infection. The person generally enters a methadone treatment program somewhere around the age of 27 to 29 years old. As a result, the patient has been exposed to a lot of other illnesses, to the criminal justice system and presents the program with many challenges in terms of providing rehabilitation or in some cases, habilitation. So, keep in mind that treating this disease is extremely complex. And all of my remarks should be put in the context that while methadone is effective, you need more than medication to treat the complexity of opiate addiction. It is not simple to treat and it will take some time. It is also important to show at the outset that while some people will be able to be free and will not use methadone very long, history shows that the majority of people who do best in methadone treatment will remain in methadone treatment for 5 years or for many cases, for the rest of their natural lifetime.

This is not a setback. This is not a problem. This is just the treatment they require.

As I said, the Association was founded in 1984. We represent about 650 of the programs in the United States. This slide demonstrates from the National Household Drug Abuse Survey, the increasing trend of using heroin in the United States. I know that in Mexico, you're also having a very serious problem with people using heroin, including young people. This trend has been mirrored in other countries. This is not new. And the reason is that heroin is becoming more available. It's more available at purer levels, and it's less expensive.

Now, understand that when you look from the left side to the right side of this graph, in 1995, you have 140 thousand brand new heroin users in the United States. This was for one year. You notice the increase from 1993 to 1995. I would argue that Mexico and other countries are having the same problem. To let you know that this is not just a problem between the United States and Mexico, internationally renowned researchers, Dr. Jerry Stimson and Dr. Don Dejoulas, did a worldwide study of the number of countries using heroin. In 1991, 80 countries were reporting heroin use intravenously. In 1995, 121 countries were reporting intravenous heroin use. HIV infection follows the pattern. In 1991, 50 countries are reporting HIV infection as a result of intravenous heroin use. But by 1995, 81 countries are reporting HIV infection as a result of intravenous drug use.

In Mexico, I don't know if you've seen HIV infection and AIDS or hepatitis C. And I don't know to what degree you see dramatic percentages. But I can guarantee you, that if you do not treat intravenous heroin use effectively, and if you don't provide access to treatment, you will see an increase in HIV infection, of AIDS, of other infectious diseases, hepatitis B, C and Delta, to say nothing of the kind of opportunistic infections that untreated heroin users get. What this slide does not show is the number of young people using heroin. It tells you that 140 thousand people in the United

States used heroin for the first time in 1995. But of this group, 2½ percent of 8th grade students used heroin in the United States. This is a dramatic difference. It is also striking to note that in the last nine years, the average age of the heroin user was about 22-24 years old. The average age of the heroin user in 1998 dropped to 16½ years old. This may not seem dramatic at first blush, but I can tell you that that drop in the average age in so short a period of time is alarming. It's exactly why health officials in the United States are trying to increase access to treatment.

What you're going to be receiving now is the Association's news report from December 1999. In that news report, you will see the breakdown of all the methadone treatment patients and programs in the United States. It's in the middle of that booklet and it's in a purple background and it's short. Our association conducted the survey to demonstrate the number of patients in treatment. This is not an estimate. This is an actual count. So, once again, this gives you a breakdown of where the treatment programs are, what states and what number. According to the White House Office of National Drug Control Policy, the estimate of untreated heroin users is about 800 thousand. It probably is more, but the number has increased over the course of the last several years. So, if I could recommend that the Mexican government do anything, my recommendation is capture good information at the very beginning. The value of what the United States government has done is, it has the National Institute on Drug Abuse which really funds 85% of the world's research on drug abuse. The only reason we have such good information about methadone treatment and why it works is because of the National Institute on Drug Abuse. More recently the Center for Substance Abuse Treatment is a relatively newer agency that's really been in existence for about 10 years or so, and this is a much more critical agency in terms of treatment and treatment effectiveness. In fact, one of the first treatment approved protocol statements that CSAT developed was on methadone treatment. And one of the slides that I will show you comes from this book.

I would recommend that if you have an interest, please access this document. It took about 18 months to develop and given the quality of the document and the material it covers, it is actually remarkable. It is as useful today as it was 8 years ago when it was first published. So, I really recommend it to you. It's a basic guidelines of the most effective treatment practices.

Now, what we have to do in the United States, when we go to Congress and to state legislatures, is we have to demonstrate in hard terms what the costs are of dealing with drug abuse. So, here this came from the California Drug and Alcohol Treatment Assessment of 1994. Dr. Gerstein and his colleagues conducted the survey. If you look to the right of the chart, in the pie, the cost to society for the impact of drug and alcohol abuse in the year before entering treatment is $4.4 billion each year. This is the cost to society. The reason I show you this slide first is to demonstrate the reality that like it or not, every country has an economic impact. If the politicians, or government agencies wish to ignore it, you're going to pay for this, one way or another. I will also demonstrate how inexpensive treatment is compared to this kind of number.

The average cost per year for one heroin addict is based on a study in 1991 by Dr. Vincent Doyle and Dr. Don Dejolais. While the slide represents a study of nine years ago, and this is based on New York State, the average, the relative cost, between the category is pretty much the same. On the left side of the graph, you will notice that the cost of untreated heroin is about $45,000 per person, per year. And look at how the cost is calculated. Security, theft and heroin use.

To incarcerate the person is about $35,000 per inmate per year. For residential treatment, $14,000. For methadone maintenance treatment, about $4,500 per patient per year. If the society or the government, does not want to treat the patient, you pay $45,000 per year. If you want to treat the patient with methadone, you pay $4,500 to $5,000 per year. Which costs more? We also have to demonstrate to Congress and state legislatures, the value of methadone maintenance treatment even compared to other forms of treatment. So, here, you look at clients who reduce costs to taxpaying citizens by 50% in the year following treatment. Look all the way

to the right. If patients continue, not end, but continue methadone treatment, society gets 55% savings for the person staying in methadone treatment. Look at the bar next to it. The discharged methadone. You notice how that goes down to 19.5%, which means if the patient remains in treatment, and the longer the patient remains in treatment, not only is it better for the patient, but it's better for the country. It's better for the culture. So, any policy, any directive about methadone maintenance treatment should also include the fact that treatment should be open-ended. What that means is that you leave the patient in treatment as long as they're doing well. You do not create artificial barriers to end treatment at any particular point in time as long as the patient continues to do well.

This slide shows the strategies for improving methadone treatment process and outcome. As I indicated at the beginning of these remarks, what's most important is that you follow what's happening to the patient. The hallmark of methadone maintenance treatment is that the patient improves. That's its hallmark. That's its value. You will notice that was in the Journal of Drug Abuse in 1997, and you probably saw the slide if you were in the morning lecture, because this comes from Dr. Dwayne Simpson and his colleagues. In the first bar, to the far left of the graph, the injection frequency drops from 94% in the patient before treatment, to 35% as the patient is in methadone treatment. The opiate use, from 100% to 48%. And this is all within the first year. If you look at cocaine use, you don't see as dramatic a change. You see from 43% to 31% because methadone maintenance treatment is not necessarily going to prevent cocaine use. If the patient is at the right methadone dosage it will decrease the drug seeking behavior and the use of cocaine, but it will not eliminate it. Methadone maintenance treatment at the right dosage level eliminates the use of heroin. We know that from research. You will also notice the change in alcohol abuse, from 31% before to 18% during treatment, and crime or jail decreases dramatically.

One of the true hallmarks of methadone maintenance treatment is a decrease in crime. You'll notice this comes from Dr. John Ball's study in 1989, published in 1991. The red bars show crime in the untreated heroin user before they enter methadone treatment. The yellow bars show crime during methadone treatment. You notice the dramatic change. Now, the following slides represent a history. When methadone maintenance treatment was expanded in the United States, it was in the early 1970s, during the Nixon Administration. You would not think that the Nixon Administration might expand access to methadone treatment, but they did so because crime would be reduced. It became clear that as the methadone maintenance patient continues and as people leave using heroin to get into methadone treatment, crime decreases sharply and the reduction continues. This slide demonstrates it.

This slide is shown to break the myth that the untreated heroin user is a predatory criminal. Dr. John Ball, who did this study, wanted to know what kind of crime the untreated heroin user would commit. Society has the myth that the untreated heroin user commits predatory crime so that people will be hit on the head, will be held up at gunpoint, or at knifepoint. This is not true. This study looked at 6 clinics in New York, Philadelphia and Baltimore. Go from the left side to the right side of the graph, and look at the kind of crime that's committed. In the New York City clinics, and Philadelphia and Baltimore, all the way to the left, in the yellow color, that's theft. The blue is drug business. Green is organized crime. And then to the far right is organized crime, but look at violent crime, all the way to the right. In New York programs, 1.1% of untreated heroin users would commit violent crime: in Philadelphia, 1.6%; in Baltimore, .7%. The reason I show this slide is to remind you that the untreated heroin user commits crime to support an illicit addiction. They are not looking to harm people. I'm not forgiving the fact that crime is committed. I'm just trying to demonstrate the kind of crime that is committed. These are people who are sick, these are people who have a disease; these are human beings who need access to treatment; they are not criminals; they should not be put in jail. They should be treated. And as you saw from one of the earlier graphs, it's also less expensive.

To bring you back to the 1970's ? and I show you this as a piece of history in the United

States ? this slide was developed by Drs. Doyle, Dejolais and Joseph. Between 1971 and 1973, 19,900 untreated heroin users entered methadone treatment in New York City. This is the largest single expansion of any methadone system in the country. It never happened again. In one city, 20,000 people enter methadone treatment during a 24 month period. Look at what happens in the same period of time: decreases in complaints to the police department for burglary; robbery and grand larceny decreased by 77,000. So, 20,000 people enter methadone treatment, and there are 77,000 fewer complaints of burglary in the same 24 month period. In terms of drug arrests, you see 25,000 fewer drug arrests. This means that fewer police are chasing after untreated heroin users. This means that courts are not filled with this kind of case. This means that police are able to do other kinds of work rather than lock up people because they're buying heroin illegally on the streets. This saves taxpayers all the money you saw in the first graph. This is part of the cost of untreated addiction and $45,000. This is part of that cost.

Now, this is also before HIV infection and AIDS. It's the same period: 1971-1973, New York. But as those 20,000 entered treatment, you see a reduction of contagious serum hepatitis by 1,500 cases. The reason methadone maintenance treatment became much more supported by public health officials in the United States is because of HIV infection and AIDS. This is from New York State Department of Health, 1996. Compare New York City with the rest of the United States, looking at only one reason of transmission for AIDS through intravenous drug use. In New York City, 45% of people with AIDS get it as a result of untreated intravenous drug use. If you look throughout the United States, 25% of people with AIDS get that AIDS as a result of untreated intravenous drug use. Treating AIDS is extremely expensive to say nothing of the human torment that people with AIDS go through. You can prevent this by getting into methadone treatment, as I will demonstrate in the subsequent slides.

This was in 1989-1990: HIV seropositivity among new and established methadone maintenance treatment patients. For those people who had been newly admitted to methadone treatment, you had 45% of the patients entering treatment who were HIV positive. Compare that to patients who were already in methadone treatment, who had not been exposed to HIV infection. Look at the difference. It's 27.2%, a major difference. This is another value to methadone treatment. Not only is it less expensive than untreated, not only does it reduce crime, but it reduces AIDS and HIV infection. If you look at the effect of methadone treatment on HIV positivity rates in a different way, you see the value of keeping a patient in treatment. In the first bar to the left, the person who's not in treatment is 47% HIV positive. If you're currently in treatment but were not infected at the time of entering treatment, the percentage drops to 23%. If you've been in methadone maintenance treatment for five years, the percentage drops to 17%. If you've been in treatment without needle use, the percentage of HIV infection drops to 12%. And if you've been in treatment for five years or more without needle use, the percentage of HIV infection drops to 6%. Once again, this demonstrates the value of retention and treatment as opposed to discharging the patient. As the patient remains in treatment, you continue to see the benefit.

This slide is related to methadone dose. Most patients do well with between 80 and 100 mg of methadone. It is true that some patients will do well on lower dosages, but on average, the patient should be receiving a dosage between 80-100 mg per day. Look at the frequency of heroin use and methadone dose. You will notice that the percentage of patients using intravenous heroin decreases steadily as the dose of methadone increases. Ultimately, the most effective dosage range, as you will see, is above 70 mg. So, for all programs, it's instructive to remember this lesson. There are a number of programs in the United States that have used 50 and 60 mg for the majority of their patients. These patients are not getting the appropriate dosage of methadone. As a result, these patients are using heroin, cocaine, continuing to drink and are using other drugs as well. The most basic issue for methadone is its effective pharmacology. Methadone is effective at the appropriate dosage level, and will extinguish the use of heroin as this slide demonstrates.

This shows, in another way, as the patient enters and stays in methadone treatment, how the patient's use of heroin steadily decreases. This also comes from the John Ball study. And I would argue that if the programs in this study used 80-100 mg of methadone, you would see a much sharper decline in the number of people using heroin. This slide demonstrates that beyond treating heroin, we're also treating an extremely complex disease. This shows the lifetime and recent prevalence of psychiatric symptoms among the patients in the John Ball Study. Just look at the first two lines. The incidents' prevalence of serious depression and serious anxiety among the people in treatment: 48% of the patients have a lifetime prevalence of serious depression and 51% have a lifetime prevalence of serious anxiety. So, while you're treating heroin, you're also treating other diseases as well. And a major component of methadone treatment has to be counseling, individual counseling and group counseling, because after the patient is stabilized on a dose of methadone, you must deal with the fact that so many of the patients have underlying problems of mental health. I don't know if this is the case also in Mexico, but I would assume that the cultures are not that dissimilar. Because this is also the case in Switzerland, in Italy, in Australia, in England and in France.

This study that was conducted in the early 1990's, with Dr. Thomas McLellan and his associates. Dr. McLellan wanted to study the different levels of methadone maintenance treatment. How much treatment should you give a patient? And how valuable will it be? What's the difference? There were three different patient groups in the study. In minimum methadone maintenance, you have a minimum daily dose of 60 mg per day, but no regular counseling and no extra service. In the standard methadone service, which is mostly the kind of methadone treatment that's provided in the United States, you have a minimum daily dose of 60 mg plus regular counseling but no additional service. In the last study group, enhanced methadone treatment, you have the same dose of 60 mg but regular counseling, on-site medical and psychiatric care, family therapy and employment counseling. Which means this is a very comprehensive treatment. It's also more expensive. The first group, it's about $1,500 per patient per year. The second group is about $4,500 per patient per year. The third group is about $7,500 per patient, per year. So, the more treatment is, the more it costs.

Look at the number of patients who actually seek additional care when they're in the methadone program. Remember there are three different study groups. They're all at the same dosage level, everyone of them. Some people improperly suggest that the patient will not access treatment services, even if it's given to them. This slide shows that's not true. If you look at other drug use, family care and psychiatric care, when those services are provided to the patients, the patients will use the care. This slide demonstrates this.

This slide, from the same study, also shows the difference in the use of opiates. What's most interesting about this slide however, is that while you see a difference in how the patient is responding, the top group is showing a very high use of heroin. Fifty to sixty percent of the patients are using heroin while they're on their dose of 60 mg of methadone. In the middle group, the standard, they're using a little less heroin. But it's still there. And in the lower group, which is the enhanced methadone treatment in yellow, you have the least amount of heroin being used. Why is this slide interesting? Because all groups are maintained on the same dose of 60 mg. So, even though opiate addiction is a brain disease, it also responds to behavioral changes, too. If you provide the patient with adequate counseling, adequate medical care, adequate services to respond to their needs, psychiatric, comordibity, in addition to the other medical problems of HIV infection and AIDS, what you have are patients doing better in the methadone treatment programs.

This comes from Dr. Vincent Doyle who is the co-founder of methadone maintenance treatment with his wife, Dr. Marie Neiswander. And I'm going to read the statement for you. "The problem was one of rehabilitating people with a very complicated mixture of social problems on top of a specific medical problem, and that practitioners ought to tailor their programs to the kind of problems they were dealing with." The strength of the early

programs, as designed by Marie Neiswander was their sensitivity to individual human problems. What I have demonstrated in the slides is that you cannot treat a complicated disease just with simple solutions like a dose of methadone alone.

This slide comes from Dr. Ball and Ross and his associates. They found that the program characteristics that were associated with success in methadone treatment are the ones listed here. If the programs provide comprehensive services the patients get better. If the programs have integrated medical, counseling and administrative services, once again, the patient's health will improve. If the patient's getting individualized care where the staff of the treatment facility responds to the patient, the patient gets better. If the clinic has adequate dosing policies, the patient will get better. If there is sufficient and stable staff, patients will get better. If there is sufficient staff training, the patients will get a better quality of care and will ultimately improve.

This is the staffing pattern that's used in the United States for most of the treatment programs. Nurses comprise 27%, physicians 13%, and counselors and social workers make up the majority. Look at this for a few minutes. It demonstrates the relapse to heroin use at the end of methadone maintenance treatment. Eighty-two percent of people on methadone will relapse to using heroin within 12 months of ending methadone maintenance treatment. 82%. This has been replicated mostly in Switzerland, in Hong Kong and in Australia. This is a geo-political and national and international problem. What you have here is the same thing replicated in other countries. What this demonstrates is as the patient enters and remains in treatment, it's best to leave them in treatment.

Next, we need to educate the public about methadone. In spite of what I have just shown you, most people don't support methadone maintenance treatment. I understand that there's even a medical society in Mexico – psychiatrists – that don't support methadone treatment.

This is not philosophy. This is medicine. This is medicine treating a disease the way doctors treat heart disease. Or the way doctors treat diabetes. So, why is it that we get into a debate about how to treat heroin users? The reason I suggest to you is because heroin use is not seen as a disease by most people in the public. The people who use heroin are seen as criminals. They are seen as very strange human beings that may not be seen as human at all. It's seen as a criminal problem, and that people should be locked up, rather than treated. So what our association decided to do, was fund the development of a brief video tape, which I'm going to show to you now. It's the story of successful methadone patients and their families. It only lasts seven minutes, and I know that you will have the text of it interpreted but this is most instructive for you to understand. This is going to be our association's campaign to educate the public.

This tells you the narrative story. This is the new kit ? with stripes in it. This is designed for the community, for legislators, for judges. This is designed for people who know nothing about methadone maintenance treatment. This kit goes with this video.

The point of this is to put a human face to heroin addiction. It's to demonstrate that methadone maintenance is a human treatment and it helps people. The idea is to break down the barrier that most people have about the person using heroin, which is pretty similar to the person who's using methadone. It's to break through the stigma. The value of this is to remind people who don't use drugs and have no understanding of methadone, that the people that we're treating are pretty much just like they are. This video is from the person's perspective, not from my perspective as the President of the Association, not from the perspective of the research scientists who did the graphs. It's to remind people that we're all in the same boat, that we're all dealing with people just like ourselves. Someone who had seen this tape said to me, why are you making this so emotional? My answer was, because a lot of people don't want to listen to the science those who take the point of view that methadone doesn't work.

This community education kit, this video is a method of trying to break through a lot of the

cultural barriers. We were told this is the same in many countries – in European countries and the same thing happened in Germany. In Germany, only until the last five to six years did methadone treatment expand. At the beginning of the 1990's, the only way a person using heroin could get on methadone treatment in Germany was if the person had HIV infection. That was the criteria for admission.

Slides are an effective way to explain to legislators to policy makers, to people who don't like methadone treatment, that this is the story of methadone treatment in facts. This is not philosophy. Do I think it works? These slides, this book, ? absolutely. What this does is tell you our associations, policies and positions ? about everything I've talked about: about accreditation, about policies for new medications. This tells you where our association stands on every major policy initiative about methadone treatment in the United States. The community education book tells you how to educate people in the community. For those of you who operate methadone treatment programs in Mexico, for those of you who are in government positions, to try and influence other people, you need to use this kind of community education book because it tells you a great deal about methadone maintenance treatment.

You always will have to educate the public. It never ends. I operated a methadone treatment program for 15 years in New York City. I always, every single week, had to educate someone about methadone maintenance treatment. Always.

Andrea G. Barthwell, M.D.

President, Encounter Medical Group
United States

Question and Answer Session

I want to make sure we're all on equal footing relative to the biological rationale for methadone therapy, which then sets out the reason for the chronic care of a patient who needs methadone replacement therapy in a medical context. We, at this point in the United States have very few people receiving office-based opioid therapy in the doctor's office, and there is no established rate for that. Some physicians who are doing it provide self-payment option for those patients receiving it in that way. And if they are seeing the patient once a month with the standard cost of a medical visit and the patient's insurance is picking up the cost of the methadone, it would be expected to average between $40-60 or $80 a month. In the least funded publicly funded clinics, clinics receive anywhere from $38 to up to $80 per week for services, and that would be chronic and lifelong. In those settings where patients, or clinics, are subsidized to provide the care, patients might pay on a sliding fee scale anywhere between $1 and $50 a week in addition to what the clinic gets. And clearly, the larger the clinic, the lower you can get your costs. One of the things that artificially inflates the cost in the clinic is an arbitrary determination of the kinds of services that people receive. So the cost of providing care to individuals who need less group therapy is transferred over to providing care to those individuals who need more. We have an average cost that the clinic receives. For some patients it takes more money to treat, some patients less.

Q. Who is going to continue to pay for clients' methadone treatment?

A. I want to comment that the necessity for that level of treatment with daily medical visits, daily psychiatric visits and so forth, drops down dramatically as people are restored to more normal functions. And, we have to consider that the treatment in an ideal or perfect world would be phased. And phasing of treatment early on would provide more intensive support and structure. But as the person is normalized and cured of the addictive behaviors while on methadone, the need for those supportive services could conceivably drop off. The person could begin to engage in therapeutic activities in a self-directed way where they're going to 12-step meetings and they don't have to have a therapist encouraging or supporting their participation in that. They're doing that on a voluntary basis, in the same way that long-term recovered and recovering alcoholics continue to go to their 12-step meetings to support their continued growth and change across their life. So, I appreciate your question about who's going to pay for this, and what does it cost long-term, looking at a cost of $40 per week every

week for the rest of your life seems like a difficult proposition. And we really need to encourage the development of other ways of delivering the medication when the medication replacement therapy is all that's needed and developing phases to allow for that.

Q: My question to you doctor is, earlier we heard that there's a rising number of adolescents using heroin, and in fact it is so immense of a problem that the average heroin user now, I believe, is 16 or so? And so that really presents a whole different treatment, a whole milieu of different treatment strategies because it seems that up until this point we've been talking about dealing with heroin addicts in terms of adults. This really changes a lot. I'd be interested in any comments that you may have in terms of dealing with adolescent heroin addicts in the future.

A: The adolescent drug user who is using heroin is more typically using it within a pattern of poly-substance abuse and using it within a pattern of emotional behavioral problems that are not necessarily specifically drug addiction. We know from all of the studies of the onset of this disorder, it is more likely to be a primary disease without greater underlying psycho-pathology if the age of onset is delayed. When we see individuals who start with early drug involvement, their drug involvement is a part of a complex of psycho-behavioral problems, and it is more likely to be a symptom of a greater underlying problem than when you see onset of addiction in an adult. So you cannot talk about adolescent drug abuse in the same way that you talk about adult, or adolescent addiction in the same way that you talk about adult addiction. The earlier the age of onset, the more likely you are going to find psycho-behavioral problems underlying that disorder and that behavior.

Your treatments therefore cannot be as directed at the primary disorder as they are in the adult, and they have to take in to account the developmental stages of the adolescent and be appropriate to that adolescent's developmental stage. They also have to take into account whether another psycho-behavioral disorder exists along with the addiction, where you're more likely to be dealing with dual diagnosis or if the addiction is one of the criteria for a greater psychological disorder. And that's one of the ways in which that psychological disorder is being expressed in the adolescent. So, you're not going to be able to treat it as simply, with a biological intervention, as you are adult addiction. And again, we're going to have to encourage treatments directed at the psycho-behavioral disorders for the adolescent and less focused on the biological. The adolescent may need the biological support if repeated treatments fail to turn their behavior around. But the adult is going to be more easily responsive to a biological support, a replacement therapy, when placed on a platform of talk therapy. In the adolescent, the platform of talk therapy is going to be critical to have established and you may or may not be able to treat them without the biological therapy.
I had a question yesterday about other medical conditions and the management of this disorder in hospitalized patients, pregnant patients and patients with pain.

This set of slides was developed by this group of people – Dr. Flowers, from Wisconsin, Dr. Maxwell from Chicago, and Dr. Samosa from Ohio. They came together and developed this workshop for the Addiction Technology Transfer Center that's funded by SAMHSA through CSAT which exists in the Chicago area. The Great Lakes Addiction Technology Transfer Center. These slides will be available to you online through the CSAT website by the end of the summer for individuals who would want to use them in presentations. We have developed this lecture, and I'm giving you an abbreviated version of it, for use in the hospital setting for a medical grand rounds. It can be delivered in less than an hour, allowing time for questions and answers. I'm using it because it illustrates some of those points you discussed yesterday.

We start out by making the point that addiction is a chronic disease of the brain. It's a primary, chronic disease with genetic, psycho-social, and environmental factors that influence its development and manifestation. And again, across the life cycle, each of those aspects may weigh in more than another depending upon the age of initiation and the person's basic condition when they make their first contact with the chemical. The disease is often progressive and it is fatal. When you look at addiction you don't

diagnose it by the nature of the drug. It matters not what drug is being used, addiction is not diagnosed by physical dependence alone. Clearly methadone addresses the physical dependence. I said that because it's a drug to which the addict is cross-tolerant, it blocks the withdrawal syndrome and the withdrawal syndrome is the external evidence, that physical dependence has occurred. Physical dependence can be defined as one having an experience of adverse physical consequences when drug use stops. So it's a cyclical kind of definition. You know it exists because when you're not using, you're sick. And when you're sick and you can relieve that by using again, you know it exists.

It is also not diagnosed by the dosage, how much the person is taking, how often they take it, or how long they've been taking it. Individuals have different characteristics to their dependence. So it's much broader than what was taken, how often, and how much. Addiction is similar to other chronic diseases. It has features in common with insulin dependent diabetes mellitus. It has features in common with hypertension. It has features in common with coronary artery disease. Those features include that there is both a biology and an environmental contribution to its cause. People who are genetically predisposed to coronary artery disease can have the chance that genetic predisposition will become expressed if they grow up in an impoverished area and eat inferior food that's high in fat content. People can have a genetic predisposition to insulin-dependent diabetes mellitus that may never get expressed if they have grown up in an environment where exercise is valued and they exercise and maintain a very slim figure throughout their life. So biology and environment contribute to the disease.

Chronic diseases often have a poor response to behavior interventions alone. Have you ever tried to treat a diabetic with diet alone and seen how unsuccessful you are? Chronic disorders typically require both biological and behavioral interventions in order to get a more idea management of them. Pharmacological management is usually necessary for the control of high blood pressure. Someone can make a decision that they're going to eliminate stress, change their diet, workout and do a number of things. Reduce the salt in their diet to help bring their blood pressure within a normal range. But even with a strict adherence to a behavioral management program, some individuals will not get their high blood pressure under complete control and will have to have that behavioral program supplemented with a biologically directed program, pharmacological management in other words.

The chronic course of these diseases is characterized by remissions, where the disease gets worse or it appears to be worse with an aggressive deterioration over time. All of those things characterize chronic medical conditions and characterize addictions, particularly opiate addiction. But addiction is different from other chronic diseases because there's a stigma attached to it. The behaviors which support getting the drugs are criminalized so that the disease is put in a criminal context. And over time we have had very limited pharmacological interventions available to us. There is not a lot of incentive for the pharmaceutical industry to develop treatments for these disorders. And when we have had pharmacological treatments developed, there has been a lot of misunderstanding and misinterpretation of them. For example, methadone.

There are over 900 peer reviewed publications over the last 30 years which talk about the safety and efficacy of methadone. There are only 237 about the oral hypoglycemic, and there are only about 426 about a drug for an antidepressant; yet there is generally more public acceptance of these other drugs. We look at the evidence on these other drugs and accept that they are an important component that physicians can use in the managing high blood sugar, depression, and other mood disorders. The number of studies which support the safety and efficacy of them are small and insignificant in comparison to the literature and the data available in high quality, peer reviewed journals about methadone. Yet, we find methadone not achieving the same level of acceptability as Prozac. Within 6 months of Prozac's being released for use by physicians of a specialized nature, many general practitioners were using it readily in their personal practices. And patients were going to their physicians asking for the

drug for a variety of things for which it hadn't been approved, including weight control.

On the other hand, we see no outpouring of support or adoption of this medication, methadone, for a variety of reasons that we've been struggling with over the last two days. Empirical studies have proven that methadone is effective. More than 900 studies over more than 30 years document that methadone is effective in the treatment of heroin addiction, and they prove that methadone is extremely safe. No organ pathology has ever been associated with either acute or chronic methadone treatment. There are more deaths annually from the use of non-steroidal anti-inflammatory drugs than from illegal drug use. Yet, when you hear methadone discussed, you hear a lot of concern about methadone overdose and methadone deaths. And they typically have nothing to do with the fact that the person was on methadone. In fact, methadone has been life-sustaining and life-giving to more people than not.

We do know that methadone is not safe for non-addicts, just as insulin is not safe for non-diabetes. Individuals should not take a medication for which they don't have a medical disorder. There will be some problem with safety in that instance. Empirical studies have proven that methadone is life prolonging, and I think I'm not going to dwell on this because Mark dealt with that. But, you can see that for individuals in methadone maintenance treatment, the ratio of observed deaths to expected, based upon the patient population is 8.4. For those who are not in treatment, the death rate ratio of observed to expected is seven times that. For those who are involuntarily discharged from treatment, it's about six times that. It's surprising to see how much of the administrative policy governing the treatment of narcotics addicts has been based upon theoretical opinions, political pressures and wishful thinking. And there's a tremendous body of scientific evidence that we have accumulated over the last 33 years.

Some people are concerned about providing methadone because they think they're going to create addicts by giving them methadone. Remember, we said yesterday that methadone works because the heroin addict is cross-dependent to it. It therefore maintains the underlying dependence on heroin but it suppresses all the other behavioral effects that an untreated heroin addict would present with. And the incidents of iatric, iatrogenic, meaning physician-caused opioide addiction is clinically insignificant. We just do not see people becoming heroin addicts because someone treated their heroin addiction with methadone. We are careful in our review of who needs to go on methadone, as Mark pointed out. And typically people have had multiple failures at other forms of treatment before we will initiate methadone. Methadone treatment is a sound medical practice. For individuals who are admitted to the hospital with an untreated heroin addiction, it can ensure a continuation of the medical-surgical stay. Without treatment, the individual will experience withdrawal and leave treatment prematurely. It decreases the physiological stress on the patient who's presenting for another medical condition. It ensures that the management, the staff will have fewer management problems with a patient. If the person is in the hospital experiencing heroin withdrawal, they are going to push the nurses' buttons regularly and frequently, trying to get some relief from withdrawal. And it increases patient compliance with prescribed medication regimens during the hospital stay and afterwards because the person isn't having their life interfered with because they need to go get heroin to relieve withdrawal.

We recommend that when patients present to physicians for medical care, that the physician continue existing methadone maintenance if a person is in a program. What we find frequently, however, is that when patients get admitted to the hospital, the admitting physician, who may not be knowledgeable about methadone, will try and do us a favor by reducing or eliminating that person's dependence upon methadone. And they'll seize the opportunity of the patient being in the hospital to reduce or eliminate their dose for us. And while the person may be able to tolerate a reduction in dose while they're in the hospital and not in that complex environment where they use their heroin, as soon as they return to the street, they'll resume heroin use.

What we try to teach people about individuals on methadone, is that when patients present in medical settings they don't routinely report an inflated methadone dose. They tell their hospital-based doctor what they're getting at the clinic. They don't increase their dose. Unless they're receiving treatment in a clinic that uses inadequate methadone doses. We advise the physician to call the clinic to coordinate care and follow-up. But we also recommend that for treating physicians, or if you're going to work with a patient who's in your clinic to get them hospitalized, that you advise the admitting physician to maybe increase their dose by up to 20% to cover them during the hospital stay because, there are additional stressors on our patients when they get admitted to the hospital. So, if I have someone on 100 mg, when they present to the hospital, if I have a chance to work with the doctor before them going in, I'll ask the doctor to cover them with 120 mg while they're there to cover the additional stress. To allow them to be adequately covered from what's associated with being in the hospital, the fear, the anxiety, the pain, the personal intrusions that occur when a person is hospitalized.

If a person presents to a medical care with heroin addiction who is not on methadone, we recommend that methadone replacement be initiated. And our clinics make ourselves readily available to our hospital system to admit those patients at discharge. We have found that the reluctance among physicians to treat with methadone while the patient is in the hospital can be reduced or eliminated if the physician knows that the patient can enter a clinic when being discharged. Otherwise, they feel kind of like they have been put on the spot by the patient's addiction, and they feel helpless in terms of managing it long-term. So, we make ourselves available to them.

Methadone in that setting is prescribed not as a definitive addiction treatment because again, we want the other services to be provided to the person, but as an acute replacement to the heroin which is lost to the patient upon being admitted to the hospital. Opioide withdrawal syndrome will not increase the chance of abstinence after discharge, so by letting somebody go through withdrawal in the hospital, they're not more likely not to return to heroin once they've been discharged. And a person having a good experience with replacement therapy while in the hospital may seek treatment for their heroin addiction after they're discharged. We want people to know that there is no medical indication to withdraw methadone in the hospital setting.

In our country we have some Federal regulations and there is a quote out of the regulation which states, "This section is not intended to impose any limitations on a physician or authorize hospital staff to administer or dispense narcotic drugs in a hospital, to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction." While we have a Federal regulation that keeps us from treating addiction with a narcotic drug, except under a methadone program sponsor, that regulation does not keep the physician from treating an addiction, as long as the finding of addiction is incident to admission to a hospital for another reason. So, in order to complete treatment for the primary reason for which the person's admitted to the hospital, if you have to provide methadone under that situation, you can. There's nothing in the law that keeps you from doing that.

Now, in order to treat this disease, you have to recognize opioide addiction is a disease and have to understand that patients don't always volunteer that they're heroin dependent or on methadone. Patients have to be asked specifically. But they don't generally give a false report of being addicted to heroin if they're not. So people won't tell you I'm a heroin addict just to get methadone from you in the hospital. We have found no incidents of that. But how you ask the patient as to whether they're an addict or not will certainly influence how they respond. So, if the question sounds like "You don't use drugs do you?" You don't encourage the patient to report it appropriately. You need to say, "In my experience, when treating people with hepatitis C, there is a chance that they have used heroin in the past, or are currently using heroin. I see this enough in my practice to know that this happens, and we've developed a way of helping the person deal with their heroin addiction while they're in the hospital for their

hepatitis C. And we use methadone to treat that while you're in the hospital. So tell me, are you currently using heroin, and how much? Are you on a methadone program? Have you ever been on a methadone program? When you were on methadone in the past, what was your dose?" So, asking the questions in a way that communicates to the patient that you're concerned about them, and that you have some solutions for the problems that they're going to face. Some familiarity with those problems, encourages the patient to disclose.

In order to initiate methadone for someone who's not on it, you have to assess the degree of opioide dependence. And I never, ever recommend that you do a narcane challenge test in order to determine how addicted the person is. What you will do in a narcane challenge test is precipitate withdrawal in the heroin dependent person and make them very sick, and rupture the therapeutic relationship you're trying to establish. So I encourage you to use the clinical history and understand that using $10 worth of heroin is approximately equivalent to 10 mg of methadone. You can go up to 30 mg for the initial dose, and add 10 mg every four hours until the person is comfortable. And at the end of the first 24 hours, add up how much you've given and you've established the daily dose that will be required.

You want to look for signs and symptoms of withdrawal. We've talked about them yesterday and they're on your handout. And also look for signs and symptoms of intoxication. If you see signs and symptoms of withdrawal, the patient needs more. If you see signs and symptoms of intoxication, you can stop increasing the dose. And administer the dose that it took to get to that point the next day.

Understand that if, at a very low dose, you can eliminate the objective signs of withdrawal. At a low dose, you may eliminate subjective symptoms of withdrawal. Remember grade 0 compared to grade 1 through 4 from yesterday. And you want to exceed both the very low and the low dose and get them into a therapeutic range where there are no signs of symptoms of withdraw or intoxication, and the patient reports being comfortable. You cannot base where you stop dosing on what you see alone. The patient has to report being comfortable. If the patient continues to report not being comfortable but they're exhibiting signs of intoxication, you'll want to watch them.

Now the pain management. Often you will see people who are on a methadone program and they'll go into the hospital for surgery and they'll have post-operative pain. And the doctor will say well, they're on methadone. That should be taking care of their pain. So the one take home message for you here is that the maintenance dose from a methadone program does not provide any analgesia. In order to get analgesia, you have to add to the maintenance dose a short acting opioide. Something that you're going to give every 3-6 hours for pain. Now, when the person is on an opioide blockade dose of methadone, it's going to create a higher dose requirement for the medication that you give them for pain. So if you were someone that I was going to give 100 mg of Demerol to, I'd have to give you 125 mg in order to bring about adequate pain relief. So the rule of thumb is a 25% higher dose. If I were going to give you Demerol every 4 hours for pain, I have to give it in shorter intervals, 25% shorter interval, so I'd start to give it to you every 3 hours. So if a standard dose is 100 mg every four hours for pain, in the individual on methadone maintenance, I want to give 125 mg every 3 hours for pain. A 25% higher dose with a 25% smaller interval. And I also want to review the nursing notes as to the person's level of comfort from pain following the dose and at the end of that interval because I might have to shorten it even more. I might have to increase the dosage even more. I also want to see whether I'm getting significant sedation. Because if I'm getting significant sedation, I might want to back off on the dose or back off on the interval. And lengthen the interval.

Never, ever use the mix antagonist agonist, or an antagonist for pain relief. You will precipitate withdrawal with mixed agonis antagonist. And a patient controlled analgesia is extremely appropriate in the population. Since the person has a greater tolerance for and a greater need for pain relief, something that they can manage themselves, by pushing the button and delivering the dose will reduce the management problems associated with inadequate relief in

the population. And if your patient controlled analgesia is turned off at 10 mg every four hours you want to set it at a 25% higher ceiling, understanding that the patient will require more.

Sometimes physicians and nurse practitioners and other health professionals will see a person who is addicted and mis-attribute inadequately treated pain as addiction. This pseudo addiction is an iatrogenically caused disorder. Physicians and nurse practitioners who write inadequate pain management regimens bring this disease about. It's caused by the poor management of acute pain in addicted and non-addicted populations. And it's characterized by a drug-seeking behavior exhibited on the part of the patient. The patient is pushing the nursing button at shorter and shorter intervals, asking for more and more pain relief. And it gets labeled as drug-seeking behavior, which it is. They're seeking adequate medication to relieve pain. So it's medication-seeking behavior that gets mislabeled as drug-seeking behavior. And it results in a terrible, terrible misunderstanding between the patient and the physician, or the healthcare provider and the patient. That person misperceives the patient as an addict and the patient misperceives their healthcare provider as uncaring. So it needs to be diagnosed where it exists.

Pregnancy: I said yesterday that opioid withdrawal is not life-threatening to the adult. It is life-threatening to the fetus. Fetal withdrawal is well-established before the mother becomes symptomatic. Before the mother feels withdrawal, the fetus is in withdrawal. And the fetus is suffering from withdrawal before the mother knows that she's in withdrawal. Opiates are extremely benign to fetal tissue when given in a way that is supportive in a medical environment. There are no known terradigenic effects of opioide like drugs. Opium, heroin and methadone are not known to cause birth defects. We see negative outcomes from pregnancy in the heroin addict because of repeated withdrawal for the fetus and because of the lifestyle associated with heroin using. But all of that can be normalized by putting the mother on an adequate dose of methadone throughout her pregnancy. What we see in terms of the neo-natal withdrawal once the child has been delivered has no known direct relationship to the dose of methadone that the mother required to maintain her during the pregnancy. So you may have a mother who's on 10 mg of methadone whose child experiences some neo-natal withdrawal. You may have another on 80 mg whose child does not demonstrate any visible neo-natal withdrawal. We do not establish the dose for the mother based upon what we predict the child will experience. We provide the dose to the mother based upon what the mother needs in order to achieve the goals of methadone maintenance during the pregnancy, which is to eliminate the target symptom, heroin use. If we put the mother on too low a dose of methadone, thinking we're doing the child a favor, we will see continued heroin use on the part of the mother, continued fetal withdrawal, continued risk of infection, continued premature rupture of the membranes, continued early delivery and all of the other complications associated with heroin use during pregnancy.

Multiple dependencies: Methadone does not cover withdrawal from alcohol or sedative hypnotics. So additional treatment will be necessary. If you have a person who is dependent upon heroin and valium and alcohol and cocaine, and you start them on methadone, it will address the heroin addiction, but not the other dependencies. Remember in that setting that if they stop the valium and the alcohol, it poses a life-threatening withdrawal risk to the adult. You are obligated to treat and address the sedative withdrawal and the alcohol withdrawal with medication assisted detoxification. It would be recommended in that instance to sequence the coming off of the alcohol and the sedative hypnotics with a taper of benzyoldiazepines, and a maintenance dose of methadone. If your goal is to detox from all drugs, you don't have someone who is a candidate for methadone maintenance, for example, you withdraw from the benzylodiazepines, and then withdraw from the methadone. Otherwise, you withdraw from the benzylodiazepines and leave the methadone dose unchanged and initiate psycho-social therapies to address the cocaine, alcohol and Valium dependence.

Frequently in a methadone program you'll see individuals whose heroin use stops and their use of alcohol or sedatives or cocaine continues, or

they initiate on methadone. Those individuals again will require psycho-social therapies to address their other dependencies. Methadone cannot be held responsible for stopping those other dependencies. It is very specific biologically to the receptors that respond to heroin.

Drug interactions: Certain medications that will be prescribed by the patient's physician can lower the methadone level in the blood, creating for the patient a crisis of methadone withdrawal. And if it is not anticipated and then addressed, the individual may resume heroin taking to self-medicate the withdrawal they're experiencing. We recommend that if there is a choice that can be made for another medication, that that medication be selected. Avoid those medications that lower the methadone dose unless they are medically necessary. And if they are, if there's not a good alternative medication to use in the population, the fact that the person is going on these medications be anticipated and the physician putting this patient on those medications coordinate with the methadone prescriber, to have the methadone dose increased in response to it, as needed. There are also medications that can raise the methadone level, and the patient may complain of sedation after these medications are started. If it is going to be transient, the person may accommodate to the increased effective dose. And you may leave them alone. You may want to reduce it and when they stop taking these other medications, make sure that you increase their methadone level again. But again, you raise or lower the methadone level as needed, based upon both your physical findings and the patients' subjective reports of comfort.

If methadone is initiated when the patient is in the hospital or continued when they're in the hospital, we recommend that a simple phone call to the clinic will do when the person's admitted to verify the dose and to let the clinic know that the person won't be showing up there for the next few days. And then on the day of discharge, call the clinic to let them know what the last dose was and when it was administered. If you've increased the dose during the hospital stay from 100 to 120 mg. you'll want to inform the clinic that the person will probably be comfortable back at 100 but that they should watch them in the event that their body has adjusted to the increased dose, depending upon how long the increased dose was in place. If the person wasn't at a clinic at the point where they were admitted to the hospital, you look for a clinic to transfer them to if the patient has agreed to that. But if the clinic cannot take the patient immediately and they're saying we need three days to run them through the admission process, in the United States methadone can be continued up to three days after discharge where it is dispensed daily at the hospital. They cannot be given medication to cover them for three days. They have to go back to the hospital every day for three days.

What are the take home messages? That addiction is a brain disease. That over 900 studies over 30 years have shown that methadone works. Withdrawing someone from methadone when they go into another medical setting is bad medicine. And withdrawing someone from methadone when they go to jail is bad medicine. There is no indication to withdraw the person from the medication in the same way that there is no indication to withdraw someone from insulin when they become insulin dependent. When you see a stable person on methadone, there is no indication to withdraw the methadone. You are doing them no favor. You have to understand that they're stable because they're on methadone. When you see a stable diabetic on insulin, you don't think to discontinue the insulin. You're not doing them any favor and you will precipitate a crisis in their life. Likewise, you will precipitate a crisis in the person's life who is stable on a dose of methadone.

Methadone maintenance is separate from pain management. The methadone dose that they're taking on a daily basis is addressing the addiction. The pain management has to be addressed separately. There are no real legal barriers to the proper care of the heroin addict within the medical context. There should be no real legal barriers to the proper care of heroin addiction in the prison context. People don't go from needing this medication on one day for its life-sustaining, life-giving and life-restoring properties, to not needing it the next day just because their life situation changed.

Dr. Parrino: With that, there are several pieces of information that both of us have not covered yet. First, to follow on some of Dr. Barthwell's remarks. The importance of treating the patient who's pregnant and treating the patient properly is truly important. I'll give you one example when I was an administrative director of a clinic in New York. It was on a Friday afternoon, at about 3:00. Our admissions were closed for the day. The clinical supervisor of the facility approached me and said, "We have a 41 year old woman who has just seen the doctor and she has found that she is six months pregnant. She has just been withdrawn from methadone from another methadone treatment program. We believe that it is important to admit her immediately and try to restore her methadone dose." Obviously we were concerned about the mother and the fetus. We admitted the patient. We tried to increase her dose over the course of the weekend, and I called the administrator of the clinic that the patient had been maintained on and inquired why this patient had been withdrawn. The answer was, first, they did not know she was pregnant. Secondly, she was an alcoholic and she refused treatment for alcohol. I explained that the patient had been pregnant more than 6 months, which was determined through medical exam. Unfortunately, within five days, the patient had a spontaneous abortion and the child was lost. So, what Dr. Barthwell presented to you is not only critical, but it's critical to the child that you don't see.

Ultimately, everything that we do has been so carefully studied, that we're giving you the benefit of these 30 years of research and information. In terms of prison facilities, it's unfortunate that the only prison system in the United States that dispenses methadone, is Rikers Island in New York City. Our association has tried to work to increase access to methadone treatment in prison systems throughout the United States. But, most prison officials simply do not want to provide access to methadone treatment services. Again, the prison officials take the position that most of society takes: that methadone is not really a medication and that the heroin user is not really suffering with a disease, that the heroin users brought this disease on themselves. As one warden in a prison said to me, "He created the disease, let him suffer without it in jail." So Rikers Island has demonstrated there is a significant cost savings from giving methadone treatment.

We have found through research that for certain patients, there is an irreversible change in the brain structure. In the neuro-chemistry. And for those people, they are going to need a replacement, pharmaco-therapy as you suggest, for an indefinite period of time, or for the rest of their lives. NIDA is still doing research using some of the new computer temography studies, and in certain cases you'll also find that for different people there may be some reversibility. It depends on the individual. It depends on the length of time the person has used heroin. It depends on the individual's brain chemistry. Dr. Barthwell will talk more about that particular aspect. In terms of other kinds of treatment intervention, methadone maintenance treatment is effective. But it's not necessarily the treatment of choice for all heroin users. Some heroin users, again depending on length of time in treatment, may not need a pharmaco-therapy like methadone, or even others, like buprenorphine. Some patients do well with drug free, in-patient, therapeutic communities. But we have found that many of the patients who are in methadone treatment have tried to discontinue their use of heroin, whether they've been in residential drug-free treatment or they've been through self-help groups. So, the clear majority of the people on methadone treatment have tried this already. And have not succeeded. Ultimately, for most people, methadone is the last treatment choice – not the first. So, in this regard we have found that the replacement pharmaco-therapy is really the most effective for the majority of the people because of the length of time using, their history, and most of those patients have really tried using and stopping on their own many times over, even in jail, in psychiatric facilities and withdrawal wards.

Víctor Manuel Guisa

Centers for Youth Integration (CIJ)
Mexico

Dr Guisa's presentation focused in the clinical research for treatment. The psychological, sociological, and environmental factors related to drug abuse were emphasized. His

presentation-included discussion of a study entitled "*Imagen del Padre en pacientes adictos,"* (English translation: The Father's image of patients with addictions). Research projects that were suggested included:

- Bicultural aspects in migrant populations
- The impact of drug abuse on children of addicts
- Drugs and violence
- Drug abuse among adolescents and young adults
- Effectiveness of drug treatment
- Drug abuse with comorbid conditions
- Clinical research in LAAM and Methadone treatment
- Vaccines for cocaine addicts
- Epidemiology

In conclusion, Dr Guisa stressed the effectiveness of treatment of opiate addiction such as the use of LAAM and methadone. He underscored the need to incorporate methadone treatment methods at Centers for Youth Integration.

Program Accreditation

Stephen Shearer
Health Care Consultant
United States

The topics of the workshop that Mr. Schearer led included:

- Presenting the benefits of accreditation of programs by a recognized accreditation body

- Describing the program accreditation processes of the Joint Commission and CARF

- Discussing the new CSAT guidelines for opioid replacement therapy

- Discussing the concepts in the Patient Rights, Assessment and Care standards of the Joint Commission

- Question and Answers session

Nora Gallegos
National Council on Addictions (CONADIC),
Ministry of Health
Mexico

Slide presentation follows.

Nora Gallegos
National Council on Addictions
(CONADIC)
Ministry of Health
Mexico

¿Donde están los jóvenes?
¿Where are the the youngsters?

- En escuelas
- En comunidades
- En ámbitos laborales
- En centros de diversión

- In schoools
- In the communtiy
- In the workplace
- In recreational centers

High - impact actions

- Families and Communities

I. Working with parents and families
II. Working with religious leachers
III. National Coalition of Juvenile Organisations for the Prevention of addictions

Education

I. Network of Student. Associations Build jour without addictions
II. Crusade with teachers
III. National Universities Network against addictions

Acciones de alto impacto

- Familias y comunidades
- Cruzada con padres de familia
- Líderes religiosos
- Coalición Nacional de Organizaciones Juveniles para la Prevenciónde las Adicciones

Ambito Educativo

- Red de Asociaciones Estudiantiles *Construye tu Vida sin Adicciones*
- Cruzada con maestros
- Red Universitaria Nacional contra las Adicciones (REUNA)

Acciones de alto impacto

Ambitos Laborales

- Prevenci[on, Detecci[on y Atenci[on de los problemas asociados al uso y abuso de sustancias adictivas

Ambitos recreacional

- Acciones en discotecas, bares y otros centros de diversión
- Programa de consumo responsible de alcohol
- Acciones en centros culturales y deportivos

High - Impact actions

Workplace

- Prevention, detection and attention problems associated use and abuse drugs adictives.

Recreational settings

- I. Actions in discos, bars and other recreation centers
- Responsible consumption program
- Actions in cultural and sports centers

Innovations in the Treatment of Stimulant Use Disorders

Jeanne Obert
Executive Director
Matrix Institute on Addictions
University of California at Los Angeles
United States

The cocaine epidemic that began in the United States in the 1980's and the present widespread methamphetamine problem have presented treatment providers with tremendous challenges. Patients dependent on stimulants have been particularly unresponsive to traditional psychosocial treatments and no effective pharmacologic interventions have been discovered. The lack of medical necessity for hospitalization during the withdrawal and the treatment phases argues against inpatient treatment as an option. The most effective interventions presently available to treatment providers working with stimulant abusers are the structured, outpatient, psychosocial interventions. This presentation will present an overview of those models of psychosocial treatment that have documented efficacy. One of the models, the Matrix Model, will be presented in detail. Participants will be made aware of specific interventions that have proven effective for the different stages of recovery from stimulant dependence.

Slide presentation follows.

MATRIX MODEL
OF
OUTPATIENT CHEMICAL
DEPENDENCY TREATMENT

Matrix Center, Inc.
Matrix Institute On Addictions
UCLA Alcoholism and Addiction Medicine Service

Matrix Model of Outpatient Treatment

Organizing Principles of Matrix Treatment

- Create explicit structure and expectations
- Establish positive, collaborative relationship with patient
- Teach information and cognitive-behavioral concepts
- Positively reinforce positive behavior change

Matrix Model of Outpatient Treatment

Organizing Principles of Matrix Treatment (cont.)

- Provide corrective feedback when necessary
- Educate family regarding stimulant abuse recovery
- Introduce and encourage self-help participation
- Use urinalysis to monitor drug use

MATRIX TREATMENT MODEL
Different from General Therapy

1. Focus on behavior vs. feelings
2. Visit frequency results in strong transference
3. Transference is encouraged
4. Transference is utilized
5. Goal is stability (vs. comfort)

MATRIX TREATMENT MODEL
Different from General Therapy

6. Focus is abstinence
7. Bottom-line is always continued abstinence
8. Therapist frequently pursues less motivated clients
9. The behavior is more important than the reason behind it

MATRIX TREATMENT MODEL
Different from General Therapy

10. Family system support is encouraged
11. Therapist functions in coach/advocate role
12. More directive
13. Therapeutic team approach is utilized

MATRIX TREATMENT MODEL
Different from Inpatient Programs

1. Less confrontational
2. Progresses slower
3. Focus is on present
4. "Core issues" not immediately addressed
5. Allegiance is to therapist (vs. group)

MATRIX TREATMENT MODEL
Different from Inpatient Programs

6. Non-judgmental attitude is basis of client-therapist bond
7. Change recommendations based on scientific data
8. Changes incorporated immediately into lifestyle

Outpatient Recovery Issues
Structure - Ways to Create

- Time scheduling
- Attending 12-step meetings
- Going to treatment
- Exercising
- Attending school
- Going to work
- Performing athletic activities
- Attending church

Outpatient Recovery Issues
Information - What

- Substance abuse and the brain
- Triggers and cravings
- Stages of recovery
- Relationships and recovery
- Sex and recovery
- Relapse prevention issues
- Emotional readjustment
- Medical effects
- Alcohol/marijuana

Outpatient Recovery Issues

Stimulant Craving Response Sequence

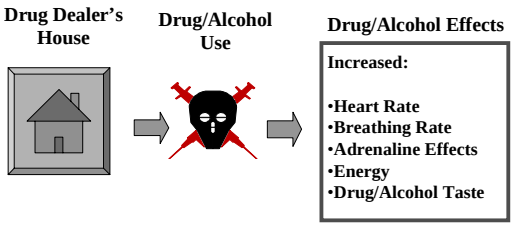
Trigger → Thought → Craving → Use

Phases of Addiction

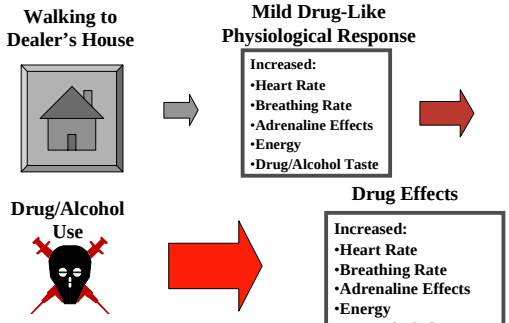
and

Stages of Recovery

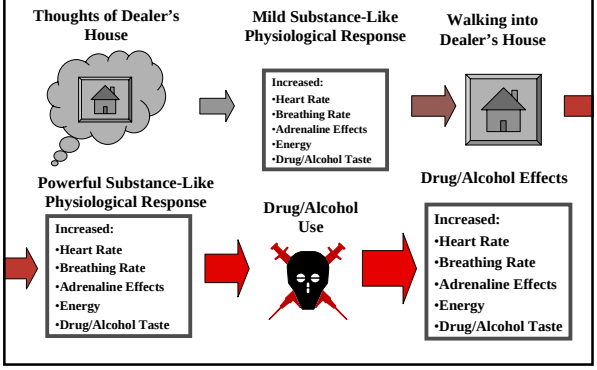
Development Of Craving Response
INTRODUCTORY PHASE



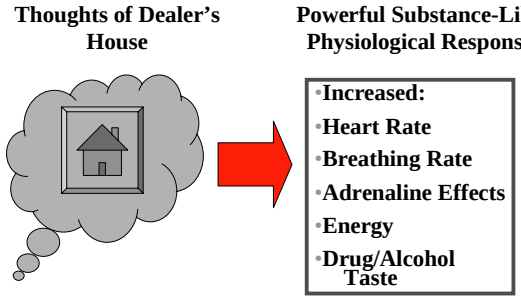
Development Of Craving Response
MAINTENANCE PHASE



Development of Craving Response
DISENCHANTMENT PHASE



Development of Craving Response
DISASTER PHASE



Outpatient Recovery Issues
Relapse Factors - Withdrawal Stage

- Unstructured time
- Proximity of triggers
- Secondary alcohol or other drug use
- Powerful cravings
- Paranoia
- Depression
- Disordered sleep patterns

Outpatient Recovery Issues
Relapse Factors - Honeymoon Stage

- Overconfidence
- Secondary alcohol or other drug use
- Discontinuation of structure
- Resistance to behavior change
- Return to addict lifestyle
- Inability to prioritize
- Periodic paranoia

Outpatient Recovery Issues
Relapse Factors - The Wall Stage

- Increased emotionality
- Interpersonal conflict
- Relapse justification
- Anhedonia/loss of motivation
- Resistance to exercise
- Insomnia/low energy/fatigue
- Dissolution of structure
- Behavioral drift
- Secondary alcohol or other drug use
- Paranoia

Outpatient Recovery Issues
Relapse Factors - Adjustment Stage

- Secondary alcohol or other drug use
- Relaxation of structure
- Struggle over acceptance of addiction
- Maintenance of recovery momentum/commitment
- Six-month syndrome
- Re-emergence of underlying pathology

Matrix Intensive Outpatient Program (4 Month)

INTENSIVE OUTPATIENT PROGRAM SCHEDULE

Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday & Sunday
Weeks 1 Through 4	6-7 pm Early Recovery Skills 7-8:30 pm Relapse Prevention		7-8:30 pm Family Education Group		6-7 pm Early Recovery Skills 7-8:30 pm Relapse Prevention	12-Step Meetings and Other Recovery Activities
Weeks 5 Through 16	7-8:30 pm Relapse Prevention Group	12-Step Meeting	7-8:30 pm Family Education Group Or Transition Group	12-Step Meeting	7-8:30 pm Relapse Prevention Group	
Weeks 17 Through 52			7-8:30 pm Social Support			

Urine testing and breath-alcohol testing conducted weekly
One individual session is included in each of the program phases

PUBLIC AWARENESS CAMPAIGNS

INITIATING AND EVALUATING PUBLIC AWARENESS CAMPAIGNS

***Introduction*:**
Jennifer Bishop
Office of National Drug Control Policy
United States

Crafting Effective Messages for Behavioral Changes
Amelie G. Ramirez, Dr. P.H.
Associate Professor
Department of Medicine
Baylor College of Medicine
United States
Telephone: (210) 348-0255
Fax: (210) 348-0554
armirez@bcm.tmc.edu

Dr. Ramirez gave an overview of the ONDCP National Youth Anti-Drug Media Campaign's behavioral change guidelines that are used for its outreach to Hispanic communities.

Main points:

- Increasing drug use among youth in the early 1990's poses a significant public health threat that is best reduced using a Social-Cognitive theory approach to offset psychosocial influences.

- Acculturated Hispanics in the United States show higher rates of drug abuse compared to immigrants. Thus, the Media Campaign is focusing specifically on reaching first generation teens.

- To reach Hispanic audiences in the US, the Media Campaign will emphasize cultural sensitivity, instill importance of traditional values, model positive behavior and increase familial communication.

Developing and Implementing Community Awareness
Antonieta Martin, Ph.D.
Researcher
Johns Hopkins University

Dr. Martin presented an overview of a youth drug prevention campaign underway in Mexico, that is produce though the assistance from John Hopkins School of Hygiene and Public Health.

Main points:

- Campaign focuses on the emotions associated with drug use, and seeks to find ways to determine one's intent to use drugs.

- Behavioral modification based on social marketing follows a distinct pathway:

  - awareness of preventive message
  - approval of prevention message
  - intention to change behavior
  - practicing the new behavior
  - advocating new behavior.

- Strategic communication models or initiatives need to address the cognitive, social and emotional motivations for performing a drug use behavior.

Developing and Implementing Community Awareness
Isabel Gomez-Bassols, Ph.D.
Radio Unica Network
United States
Telephone: (305) 463-5045
Fax: (305) 463-5001

Dr. Bessols hosts a radio program that helps families deal with drug abuse. Her presentation shares her experiences using radio as a prevention medium.

Main points:

- To get a drug prevention message out to the community, you need an attention grabbing mechanism, a radio

talk show on drug use in the context of familial effect, has been successful.

- To be successful you must provide resources to empower individuals and families to overcome their drug problems. This can be facilitated through creating partnerships with organizations that can provide the information, and by using methods that will initiate dialogs within families.

- Family development is necessary in prevention and the radio can play a role.

Mario Bejos
Liber addictus
Mexico

This session focused on Liber Addictus a Mexican magazine designed to discuss the use of mass media in the prevention of drug use and addiction treatment.

Main points:
- Liber Addictus has transformed itself from a small scientific paper/publication into a large publication that addresses the issue of all addictions.

- The greatest challenge to reducing addiction and its prevention, is a growing "toxic culture" which normalizes and promotes drug use and other disruptive behaviors. Toxic cultures portray addictive behaviors as cool while labels healthy habits as anti-social.

- The media plays an important role in promulgating addiction as it adds to the creation of this toxic culture.

Evaluating Media Campaigns

Terry Zobeck, Ph.D.
Office of National Drug Control Policy
United States
Telephone: (202) 395-5503
Fax : (202)395-6729

Dr. Zobeck gave an overview of the methodology currently in use to evaluate the National Youth Anti-Drug Media Campaign.

Main Points:
- ONDCP is doing an externally contracted impact evaluation of the campaign which will determine the campaign's overall effectiveness. Additionally the agency has already created internal performance measures/goals that are used to evaluate the campaign's efforts.

- The campaign initially collected base line behavioral data from in school surveys. With time its become increasingly difficult to conduct survey's in school and have since began using household surveys which use hour long in person interviews using youth and parent dyads.

- Continual evaluation during the life of the Media Campaign will initiate change in the campaign during its lifetime.

Jaime Quintanilla
Mexico's Central Institute of Justice (CIJ)
Mexico

Mr. Quintanilla discussed the methods presently used by (CIJ) to evaluate its mass media drug prevention initiatives.

Main Points:
- A majority of data that was collected was derived from television advertising that featured an 800 number to receive information on treatment and to order materials. Once the CIJ began using television advertising, call volume to the 800 number increased by 500%. Respondents had a number of questions that were not directly related to treatment. A Gallup poll was later used to gauge national attitudes towards drugs.

- CIJ established a number of public and private partnerships to increase the reach of their messages, especially with children.

- The feedback received via the phone lines gave them solid qualitative data by which to revise their future efforts.

Building Private Public Partnership for Social Marketing

Beverly Schwartz
Senior Vice President
Fleishman Hillard International Communications
United States

Ms. Schwartz gave an overview of Fleishman-Hillard's work with the National Youth Anti-Drug Media Campaign to disseminate drug prevention messages in local arenas.

Main Points:

- Social marketing is voluntary behavior change for the benefit of society, which is distinct from consumer product marketing. It works because it offers benefits that people want.

- To promote drug prevention messages; you must extend these themes into communities by using non-traditional methods, and public/private partnerships.

- To facilitate these partnerships, you must know what you want from you partner, and know what you can do to help them. Together you must work to what resources are available through the venture to reach your goal.

The Azteca Foundation

Eduardo Chacón Vizcaino
Mexico

Described their efforts to use a social marketing approach to develop traditional and non-traditional partnerships to prevent drug use among youth.

Main points:

- Campaign messages need to extend into the community.

- Partnerships are developed around what they can do for you and what you can do for them.

- Campaigns need to give their audiences more than just information, skills and support are necessary. You must tell them how, not only why.

PUBLIC HEALTH AND PUBLIC SAFETY

LINKING PUBLIC HEALTH AND PUBLIC SAFETY

Moderators
Steve Wing
Senior Advisor for Drug Policy
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
United States

Oscar Fuentes Fierro
Attorney General's Special Office for Crimes against Health (FEADS/PGR)
Mexico

Introduction
Allen Ault
National Institute of Corrections
Department of Justice
United States

Special Populations: Adolescents
Wilfred Rios Sánchez
Attorney General's Special Office for Crimes against Health (FEADS/PGR)
Mexico

Duane McBride
Andrews University
United States

Richard Dembo
University of South Florida
United States

Mario Alva Rodriguez
National Institute of Sciences of Penal Investigations (INACIPE)
Mexico

Special Populations: Dually-Diagnosed
David M. Wertheimer, M.S.W.
King County Department of Community & Human Services
United States

Mark Simpson
Lexington Federal Penitentiary
Department of Justice
United States

Engagement into Treatment and Retention
Tom McLellan
Treatment Research Institute
University of Pennsylvania
United States

Relapse Prevention and Recovery Support
D. Dwayne Simpson
Texas Christian University
United States

A System-Based Approach
Steve Wing, United States
Oscar Fuentes Fierro, Mexico

Diversion and Community Corrections: Pre-trial Diversion, Drug Courts, and Pre-Trial Diversion
Barbara Zugor
Executive Director
Treatment Assessment Screening Center (TASC)-Arizona
United States

Drug Courts
Tim Murray
Office of Justice Assistance
Department of Justice
United States

Incarceration: Adult Populations
Allen Ault
National Institute of Corrections
Department of Justice
United States

Parole and Community Corrections
Dave Gaspar
Arizona Department of Juvenile Corrections
United States

Jennifer Mankey
Denver Juvenile Justice Integrated Treatment Network
United States

Hiram Suárez Villa
Office of the Secretary of Government
Mexico

Lilia Vasquez Portales
Office of the Attorney General (PGR)
Mexico

Introduction
Allen Ault
National Institute of Corrections
Department of Justice
United States

In the United States, substance abuse leads hundreds of thousands of people into the criminal justice system each year – many of them in need of treatment. This represents a problem for both the public health and public safety systems.

There have been numerous creative responses to this challenge. An ongoing dialogue sponsored by the U.S. Department of Justice, U.S. Department of Health and Human Services, and the Office of National Drug Control Policy has focused on how system-wide approaches are needed, including approaches to:

- Prevent entry into the criminal justice system for those who can be safely diverted to community social service systems
- Limit penetration into the criminal justice system for nonviolent offenders through community justice interventions
- Intervene with those who must be incarcerated, through treatment and supervision, both during and after confinement.

The ONDCP policy paper *Drugs, Alcohol Abuse, and Adult and Juvenile Offenders: Breaking the Cycle—Breaking Free of the Cycle: Policy for Community and Institutional Interventions to Safeguard Public Safety and Restore Public Health* outlines the elements of an integrated system. Communities employing these approaches can reduce recidivism and drug-related crime.

Oscar Fuentes
Attorney General's Special Office for Crimes against Health (FEADS/PGR)
Mexico

It is a pleasure to participate in this important conference. In Mexico there are a number of institutions involved with the processing and rehabilitation of persons within the criminal justice system.

Many speakers from Mexico will address the roles that various government institutions play in reducing drug use and related crime. Lilia Vázquez, representing Procuraduría General of the Republic (PGR), will address drug treatment in the criminal justice systems. Addressing system-wide challenges will be Wilfred Rios Sánchez (FEADS/PGR), Mario Alva Rodriguez (INACIPE), Hiram Suárez (Secretrariat of Government), and Licenciada Vázquez Portales (PGR).

This session examining the linkage between public health and public safety offers great opportunity for sharing knowledge and expertise between Mexico and the United States. It also offers a unique opportunity to build a continuing dialogue on this issue of mutual concern.

Special Populations: Adolescents and Dually-Diagnosed Adolescents

Wilfred Rios Sánchez
Attorney General's Special Office for Crimes against Health (FEADS/PGR)
Mexico

Mr. Rios discussed the role that the Attorney General's Office for Crimes against Health takes in Mexico's anti-drug prevention campaigns and its efforts to discourage criminal behavior and the social consequences of drug related crime and violence.

Drug consumption is given special attention so that appropriate measures with specific targets can be applied to attack the supply and the demand of illicit substances. Information is a fundamental mechanism for all social sectors vulnerable to this phenomenon. Therefore, the diffusion of legal disposition applicable to the commission for crimes against health is vital, as well as the diffusion of organic damages brought by the use and abuse of drugs.

To accomplish these tasks, the Special Office for Crimes against Health is engaged in the following activities:

- Organizing, developing, and implementing conferences, including training the trainer courses for the formation of leaders in drug prevention

- Sponsoring diverse activities include anti-drug messages with special emphasis on school age youth.

An important concept to understand is that under Mexican legislation, addicts are not considered delinquents, but rather sick persons who should be treated in a special manner. Cases are reviewed and diagnosed by a competent authority in the field and in accordance with the federal penal code system. Diagnosed cases are referred to the appropriate health sector for treatment and rehabilitation.

Mexico deems a crime committed against health to be one where any responsible person is engaged in the production, transportation, commercialization, and trafficking, including the provision of drugs as a gift. Sanctions can reach up to 25 years in prison.

In training provided to the community the areas described above are discussed, placing special emphasis on the effect that trained drug detecting canines have contributed to the success of anti-drug operations. This tool has been used successfully in preventing drugs from infiltrating schools.

Special Populations: Adolescents

Duane McBride
Andrews University
United States

For more than two decades, researchers, clinicians, and juvenile justice program administrators have been aware of the consistent relationship between alcohol and other drug (AOD) use and juvenile crime. Poly-drug use in this population is prevalent and most commonly includes alcohol, marijuana, amphetamines, LSD, and crack.

The consequences of the juvenile drug-crime cycle are severe. AOD use among juvenile delinquents appears to be strongly related to other social and psychological problems, including lowered school performance, poor family relationships, arrested social emotional development, increased interactions with AOD-using peers, and adult unemployment. AOD use also appears to be associated with a number of delinquent behaviors including recurring, chronic, and violent delinquency that continues into adulthood.

The juvenile justice system is a viable point of entry for a comprehensive collaborative service designed to break the juvenile drug-crime cycle. Very few juvenile justice jurisdictions provide appropriate substance abuse treatment services for youth. In the U.S. treatment for adolescent substance offenders has be found to been available in less than 40 percent of the 3,000 public and private juvenile detention, correctional, and shelter facilities.

The following model program employing research-based components can be used to guide improvements within the system.

- ***Intake.*** There should be a single point of entry into the system, an immediate comprehensive and culturally competent assessment, and a special emphasis on evaluating possible co-occurring mental illnesses and conditions.

- ***Cross Systems Case Management.*** Each case should be ensured a continuum of care provided by coordinating needed services from various systems.

- ***Collaborative Systems.*** In order to protect the public safety and ensure integration of relevant community and social services, a judge within the Juvenile Justice System should administer the system. Examples of such systems include Drug Courts and Treatment Alternatives to Street Crime (TASC) programs.

- ***Treatment Interventions within Graduated Sanctions.*** Graduated sanctions coupled with careful monitoring of treatment progress can be successful in reducing both drug use and delinquent behavior.

- ***Evaluation.*** The system should have an evaluation system in place that provides ongoing feedback to the entire system.

Presentation based on:

McBride, D.C., VanDerWaal, Terry, Y.M., VanBuren, H. *Breaking the Juvenile Drug Crime Cycle*. National Institute of Justice Research Web Monograph, www.ncjrs.org/jjsa.htm 1999.

McBride, D.C., Terry, Y.M., & Inciardi, J.A. *Alternative Perspectives on the Drug Policy Debate* in The Drug Legalization Debate (second edition) Sage Publications, Newbury Park, California, (pp:9-54), 1999.

McBride, D.C., Pacula, R.L., VanderWaal, C.V., Chriqui J. & Terry, Y.M.. *Conceptual Framework Report* to ImpacTeen, April 2000.

Terry, Y.M., VanderWaal, C.J., McBride, D.C., & VanBuren H. *Provision of Drug Treatment Services in the Juvenile Justice System: A System Reform*. Journal of Behavioral Health Services and Research, 27 #2: 194-214, May 2000.

Richard Dembo

University of South Florida
United States

Over the last few years there has been an increase in juvenile crime. There is a high correlation between juvenile drug use and crime. In Florida, arrests for drug offenses have increased 300% in the last 10 years. Increasingly younger people are entering the criminal system, bringing with them ever more serious problems.

Juvenile offenders are in special need of holistic approaches that address mental health, education, substance use, and other psychosocial problems. Communities require more effective programs for children and families who have not been able to access services.

Much of what we know has been derived from working with adults. However, there is a growing knowledge base about alcohol and drug problems in youth, and how to handle them more effectively. Challenges faced by the system include:

- Developing consistent evaluation systems to assess the impact of treatment and identify candidates for early intervention

- Determining the cost effectiveness of treatment interventions

- Ascertaining approaches for increasing entry into and retention in treatment programs (especially challenging for an adolescent population)

- Improving community support services to increase post treatment retention

- Developing integrative systems of care that follow clients through their entire time within the criminal justice system.

Systems can address these challenges by incorporating interrelated activities into their efforts by:

- Establishing preliminary screening and triage to identify problem areas that could be targeted during a more in-depth assessment, including the severity and scope of problems

- Involving clients in quality treatment programs at the residential and community levels

- Developing collaborative systems of care

- Providing aftercare services, including the post-sanctions period (this is a major problem throughout the country, where long-term investments in treatment are needed.)

Model programs have been developed in Florida where assessment centers provide centralized intake facilities for youngsters who are at high risk. The target population includes juveniles who: (1) have been taken into custody; (2) are truant from school; (3) have not been taken into the justice system, but are at high risk, and (4) have undergone screening process, and are referred to the program.

Assessment centers provide opportunities and challenges. The centers can gather comprehensive information on youngsters that help inform referrals, court disposition, and program placement. (Before centers were established juveniles cases went through the court system and youngsters were followed 3 weeks later, thereby providing little information to the court about how best to serve the juvenile.)

The centers provide an opportunity to employ early intervention and diversion programs. Centers can serve as focal point for coordinating and evaluating services for families and individuals. Routine drug testing can be used to identify new drug use trends in a community.

Assessment centers also face challenges. For example, it is important that programs limit their catchment population so as not to pull in youngsters not truly in need of treatment (i.e., minor misdemeanors.) Screening instruments should be as culturally sensitive as possible. Maintaining a strong infrastructure and the support of key stakeholders is important for program success. And finally, collecting data on treatment outcomes system-wide is critical for evaluating and creating cost-effective programs.

Mario Alba Rodriguez

National Institute of Sciences of Penal Investigations (INACIPE)
Mexico

In Mexico, 75 percent of drug users are between the ages of 12 and 34. Drug use in this population has been on the rise since 1980. Marijuana and inhalers are the drugs of choice with heroin being the least consumed drug. Drugs are available on the street, schools, bars, and discos. The consequences of addiction are crimes, accidents, and absenteeism.

Prevention is crucial to combat addiction, with education being a priority. Prevention studies in Mexico have focused on one of the most vulnerable populations – males between the ages of 10 and 20.

Studies have shown significant tobacco and alcohol in the younger populations, with alcohol being the most abused drug. Usage is greater in tourist and U.S. border areas, which might indicate that location is a factor in increased usage. Also, areas close to metropolitan areas are more extensively affected.

Of 6,374 violent deaths analyzed in Mexico City's Coroner's Office, over half of the bodies had excessive alcohol levels in the blood. Illegal substances accounted for a much smaller amount.

Special Populations: Dually Diagnosed

David M. Wertheimer
King County Dept. of Community and Human Services
United States

Dual diagnosis is the co-occurrence of mental illness and substance use disorders. A wide spectrum is possible. Mental health problems can be a situational crisis or a persistent mental disorder. Substance abuse problems can range from use to abuse to dependence.

Persons with co-occurring disorders represent a significant proportion of the prison and jail populations. Sixty-three percent of jail detainees have a mental illness or a substance abuse disorder. The rate of serious mental illness in jails is 3-5 times the rate in the community. Ninety percent of inmates with schizophrenia, major affective disorders, or anti-social personality disorders have co-occurring substance abuse problems.

Behaviors that result in incarceration are often byproducts of mental illness and chemical dependency rather than true sociopathy. Incarceration provides neither a disincentive to criminal behavior nor a setting for rehabilitation. Rates of recidivism are extremely high.

Integrated treatment (i.e., where a client's mental health and substance abuse disorders are treated simultaneously) provides the most effective results. Achieving integration requires collaboration among the mental health, chemical dependency, and criminal justice systems – at all entry and exit points in each system.

In a structure with a "No Wrong Door" approach, every entry point into the system is the "right" door leading to appropriate care regardless of the presenting problem. Major mental health, substance abuse, and criminal justice linkage points include pre-booking, post-booking, and post-release services.

By focusing on appropriate placement, provision of quality treatment services, and community transition, states and localities can experience reduced recidivism in this population.

Mark Simpson
Lexington Federal Penitentiary
Department of Justice
United States

Criminal offenders with co-occurring addictive disorders and psychiatric illnesses pose a special problem for the criminal justice system. If untreated, these offenders are often among the most difficult to manage within an institution. Their behaviors are often disruptive to the general inmate population and require increased staff supervision. These inmates are at greater risk of relapse in substance use and criminal behavior following their release back to the community. One reason for this is the likelihood such individuals use illicit substances to medicate their psychiatric symptoms.

In the United States, the criminal justice system is being increasingly tasked with the responsibility of providing drug abuse treatment to its offender population. When done right, drug abuse treatment can effectively reduce relapse in drug use and recidivism in criminal behavior among offenders following their release back to the community. However, dually diagnosed criminal offenders often do not respond as favorably to more traditional forms of substance abuse treatment. There are a variety of reasons for this. Substance abuse counselors often lack the training necessary to assess mental illness. Many programs lack the psychiatric help needed to treat mental illness. Involvement and retention of dually diagnosed criminal offenders in treatment are often difficult, due to rationalization and blaming others for their difficulties, distrust of treatment providers, and sudden changes in their psychiatric symptoms.

In response to the unique challenges posed by dually diagnosed offenders, the U.S. Bureau of Prisons, Department of Justice created a specialized drug abuse treatment program in 1997 for dually diagnosed male inmates at the Federal Medical Center (FMC) in Lexington, Kentucky. The 16-bed dual–diagnosis program is a 9-month intensive residential program that operates within a larger residential program for general population inmates.

The experience of the dual diagnosis program at FMC, Lexington has helped to identify critical elements that significantly impact the success of such treatment initiatives. These elements include:

- accurate assessment of an offender's psychiatric illness
- skilled drug abuse treatment personnel who are trained and experienced in working with mentally ill offenders
- long-term and intensive treatment that integrates substance abuse treatment and management of psychiatric symptoms
- transitional treatment in the community that assists dually-diagnosed offenders in successfully reintegrating back into society
- the transfer of information between institution-based treatment staff and community treatment providers to assist in the offender's transition back to the community.

Engagement into Treatment and Retention

Tom McLellan
Treatment Research Institute
University of Pennsylvania
United States

Evidence suggests that drug dependence is a chronic medical illness with biological, psychological, and social components. For treatment to be as effective as possible it should address these aspects of illness with medication, therapy and counseling, and skill building.

A study looking at treatment for opiate addiction in pregnant women found that addressing their addiction in holistic manner with medication, counseling, job and family therapy and psychiatric care yielded the best outcomes.

Disorders have a genetic, metabolic, and behavioral influence. The nature of an individual's addictive disorder depends on both inherent tendencies and vulnerabilities in addition to behavior and environmental influences.

Factors that predict poor outcomes for conditions such as asthma, diabetes, and hypertension treatment are the same as for addiction, specifically: non-adherence to a physician's orders, low socioeconomic status, low family support for change; and psychiatric comorbidity. Medication adherence and relapse rates are similar across these illnesses.

Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Drug dependence generally has been treated as if it were an acute illness. However, research suggests that long-term care strategies of medication management coupled with behavioral interventions and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

Relapse Prevention and Recovery Support

D. Dwayne Simpson
Texas Christian University
United States

Numerous studies based on almost 300 drug abuse treatment programs and 70,000 patients over the past 30 years have shown that treatment can be highly effective in reducing or eliminating drug use, criminality, and related problems. However, all patients do not have the same needs and all programs are not equally effective, so treatment evaluation research has been expanded in recent years to focus maximizing treatment effectiveness and efficiency. General findings show that

- *Problem severity* dictates the appropriate type and intensity of treatment needed.
- Patients with moderate-to-high problem severity levels usually need at least *3 months of treatment* (and for chronic opiate addiction, this increases to a year or longer)

before significant benefits can be documented following release. As problem severity increases the need for and benefits of intensive residential care rises. Good assessments of patient needs and progress are therefore essential.

- Cognitive stages of *treatment readiness* (or motivation) influence the chances that patients will engage and benefit from treatment. Special cognitive-based "induction" strategies for poorly motivated patients can be effective antidotes, especially in correctional settings.

- Several distinct, sequential *phases of treatment* (e.g., referral, induction, engagement, early recovery, and continuing care) are related to addiction recovery outcomes of patients. Establishment of therapeutic rapport is particularly important.

- *Specialized interventions* have been developed that can improve each of these crucial steps of the therapeutic continuum.

- Research now being supported by several federal agencies emphasizes the need to understand and improve the manner in which treatment innovations can be effectively introduced and used in treatment programs for community-based and correctional populations.

A System-Based Approach

Steve Wing
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
United States

Working in concert, justice and public health agencies can establish a continuum of accountability and treatment for juvenile and adult offenders with substance use disorders. The criminal and juvenile justice systems should operate in concert with other service systems as a series of opportunities for intervention with offenders experiencing substance use disorders. Interventions should be carried out in a systematic manner and at the earliest possible opportunity.

Improving public safety and public health requires systematic interventions to bring about long-term change in the substance abusing and criminal behaviors of offenders. Treatment must be a priority of the justice system and incorporated into the routine practices and decisions of justice officials. More than simple coordination is required for the justice system to work effectively with public health service providers, largely because the primary focus of the former is public safety, while the latter focuses primarily on improving the lives of individual clients.

Policies and operational procedures must cross organizational boundaries to make treatment decisions a critical element of justice decisions. Nine key elements have been identified to help communities move beyond coordination of programs to full collaboration among community agencies with integrated decisions and services, specifically:

1. Set the stage.
Recognize substance abuse as a public health and public safety problem that requires the collective efforts of the health and justice communities working in an integrated fashion.

2. First things first.
Identify areas where collaboration will result in long-term benefits.

3. Treatment's contribution.
Recognize treatment as a key element in crime control. Treatment is not an ancillary service. Rather, treatment is important to the reduction of recidivism and substance seeking and abusing behaviors.

4. The importance of assessment.
Employ assessment protocols that address both substance use and juvenile/criminal justice factors.

5. Rational placement.
Adhere strictly to placement based on an assessment of safety risk and the severity of substance use disorders.

6. Individual treatment plans.
Employ the assessment to develop an individual treatment plan for each offender.

7. Rigorous case management.
Manage offenders in treatment with testing, supervision, sanctions, and incentives. Adult and juvenile offenders in treatment must be closely supervised and their cases tightly managed.

8. Structured accountability.
Be fair and predictable in delivering sanctions and incentives. Offenders respond to situations that they believe are fair and just, and to sanctions and incentives that are uniformly applied.

9. Follow through.
Extend the impact of treatment by providing a continuum of supervision and support.

Oscar Fuentes Fierro
Attorney General's Special Office for Crimes against Health (FEADS/PGR)
Mexico

In Mexico, the public health and public safety systems are linked in several ways. The Government of Mexico has a national program to combat illegal drugs, of which the main objective is to combat drugs in its entire dimension including programs in drug demand reduction.

Mexico's fundamental judiciary framework, the Constitution of Politics, sets forth several important principles. Public safety is embodied in Article 21 of the basic rule of the Mexican penal system, which establishes the authority and rights of the Public Ministry for prosecuting criminal acts. Article 73 describes coordinated activities that must be established among the federation, the federal district, municipalities, and States, in matters of public safety. Article 73 also establishes the organization, duties, selection, and promotion of members in public safety institutions.

Public health is considered a judiciary right of the people. The law, however, defines the basis and actions for access to public health services that must be coordinated by the federation and the States.

Diversion and Community Corrections: Pre-trial Diversion and Drug Courts

Pre-Trial Diversion

Barbara Zugor
Executive Director
Treatment Assessment Screening Center (TASC)-Arizona
United States

Collaboration between the criminal justice and treatment systems is essential in assuring that all available resources are most appropriately utilized. Such services should based on a thorough evaluation of the needs of the offender.

System success depends on an objective, comprehensive needs assessment. The initial assessment of substance abuse involved offenders should be administered at a centralized location and can take place while the offender is either in or out of custody. The assessment process must respect the offender's constitutional and statutory rights and follow guidelines regarding confidentiality. A comprehensive treatment plan should be completed at the earliest possible juncture after entry into the criminal justice system.

Because no single factor causes substance abuse disorders, and because the effects of substance abuse extend to multiple areas of a person's life, it necessary to evaluate a wide range of individual and environmental factors. A comprehensive treatment plan should be holistic in nature, covering, key components in treatment plan development also include the participation and active input of the offender, the knowledge of the treatment provider, and referring or supervisory criminal justice personnel.

The Women's Treatment Network was developed to put these concepts into practice. At the time of the program's inception there was little coordination between criminal justice and the client service delivery systems for women entering the system. TASC believed that for the program to be successful it must provide early intervention to the client on the individual, community, and criminal justice levels. Comprehensive treatment plans should take into account the strengths and needs of the offender, set realistic goals and objectives, and be flexible to allow for unplanned or unforeseeable events. Establishing a coordinated service delivery system will help clients get from treatment to success.

Drug Courts

Tim Murray
Office of Justice Assistance
Department of Justice
United States

Drug courts in the United States have experienced an evolutionary development. In the mid-1980's, many states and local criminal justice systems were inundated with felony drug cases. Drug courts began in 1989 as an experiment by the Dade, Florida County Florida Circuit Court to call upon the authority of a sitting judge to devise – and proactively oversee – an intensive, community-based, treatment, rehabilitation, and supervision program for drug defendants.

The goal of the drug courts was to halt rapidly increasing recidivism rates and reduce drug usage. The program is now underway in 48 states as well as in the District of Columbia, Puerto Rico, Guam, a number of native American tribal courts, and one federal district court.

The appeal of the drug court lies in many sectors: more effective supervision of offenders in the community; more credibility to the law enforcement function (where arrests of drug offenders are taken seriously, even by court systems overwhelmed by cases); greater accountability of defendants for complying with conditions of release and/or probation; greater coordination and accountability of public services provided; and more efficiency for the court system by removing a class of cases that places significant resources demands for processing on the courts.

Since the program's inception, close to 100,000 drug dependent offenders have drug court programs with over 70% either still enrolled or graduated. Drug court participants reflect all segments of the community. Approximately 66% are parents of minor children. Approximately 15% are veterans. Men participate at twice the rate of women although the percent of female participants is rising. Many drug court participants have been using drugs for many years and most are poly-drug users. A large proportion of participants has never been exposed to treatment previously although many have served jail or prison time for drug-related offenses.

The original goals of drug courts of reducing drug use and recidivism have largely been achieved. Challenges however remain. Improving the system to address the repeat offender remains an area for further work. However, with continued support from federal, state, and local jurisdictions, the advances achieved under this program can be extended even further.

Incarceration: Adult Populations

Allen Ault
National Institute of Corrections
Department of Justice
United States

In the United States, 60% of adult male arrestees tested positive for drugs. Eighty percent of men and women behind bars (1.4 million) in the United States are seriously involved with alcohol and other drug use. It costs the United States $30 billion per year to incarcerate this population, with an average length of stay of 27 months.

Moreover, non-drug users in drug using households are 11 times more likely to be killed

compared to those in a drug free household. Drug abuse in a home increases a woman's risk of being killed 28 times.

Treatment is essential to breaking the cycle of drug use and crime. It is important to note that Sanctions without treatment actually increase recidivism. Inappropriate interventions also increase recidivism.

The length of time in treatment is positively correlated with treatment success. Treatment assessment and matching inmates to necessary services yields better treatment outcomes. Programs that adopt combinations of treatment components that are suited to individual client's problems and needs are more successful than "one size fits all" inflexible programs.

Programs must provide a significant level of structure throughout assessment, treatment planning, supervision, and swift and certain sanctions. Rewards must be a part of the correctional treatment program. A segregated treatment unit is found to increase the likelihood for success. Segregation provides more treatment accountability and structure. Transitional services provide significantly better outcomes than programs without transitional services.

There is a need for better information dissemination to public and legislative groups regarding what we know about treatment programs that work and how these efforts reduce costs and recidivism. Treatment outcomes could improve if there were more options for matching inmates with the necessary treatment and service needs, including inmates with co-occurring illnesses. There is also a need for more evaluation data that is useful to correction managers.

Substance abuse treatment coupled with post-release follow-up and support are highly successful in reducing recidivism. Programs require both components for success.

Parole and Community Corrections

Dave Gaspar
Arizona Department of Juvenile Corrections
United States

The Arizona Department of Juvenile Corrections (ADJC) is the state agency responsible for juveniles adjudicated delinquent and committed to its jurisdiction by the county juvenile courts. ADJC is accountable to the citizens of Arizona for the promotion of public safety through the management of the state's secure juvenile facilities and the development and provision of a continuum of services to juvenile offenders, including rehabilitation, treatment and education.

The Department is 10 years old, having separated from adult corrections in 1990. It has two responsibilities -- the first responsibility is to keep the public safe and the second is to change an adolescent's life. ADJC's efforts are based on seven basic values:

- A good future requires a good foundation
- Valuing the safety of youth in our care and the citizens of Arizona
- Believing that all individuals should have the opportunity to engage in continuous improvement and learning
- Believing that all people, including the youth in our care, have the right to live productive lives
- Valuing all people regardless of where they are in their development and who they are as individuals
- Valuing instilling hope in our youth and families
- Valuing data and research-based decision making.

The program begins with a 28-day assessment period. Here, staff conduct a thorough evaluation, including job skills and interests, and focus on the key issues to be addressed for the

individual. A number of secure housing facilities are available to provide a continuum of care based on the severity of the problems presented. Sixteen hours per day are dedicated to programmed activities with six of those hours spent in a learning environment. A major goal of the program is to penetrate delinquent thinking and catalyze personal change.

Through this approach of getting young people involved in education and changing delinquent thinking and behavior, the program gives the program participants an opportunity to see new life paths and hopefully provide a chance at a better life.

Jennifer Mankey

Denver Juvenile Justice Integrated Treatment Network
United States

The Denver Juvenile Justice Integrated Treatment Network was founded in 1995. Its purpose is to bring a variety of juvenile offender, substance abuse intervention and treatment as well as other community agencies to one table to identify ways to assist in interrupting the cycle of delinquency and substance abuse. It is funded by the Center for Substance Abuse Treatment, U.S. Department of Mental Health and Substance Abuse Services Administration.

Comprised of every state and local juvenile justice agency with responsibility for Denver's juvenile offenders, in addition to a wide variety of other youth and family serving programs, the Network has made significant progress in expanding access not only to substance abuse treatment but to other needed services in the community for this population. In addition, the Network believes that one of the keys to long term innovation and change within the youth services community is an investment in current and future generations of youth workers through establishment of a higher education link.

Ms. Mankey related the story of a child, David, which illustrated the juvenile justice system's ability to fail when interventions are not done early enough. In his case opportunities for services were missed, multiple systems and services were involved but with no single entity with lead responsibility, and there was no role for or engagement of his family.

In addressing the needs of juvenile offenders it is important that collaborative treatment network be organized to serve their particular needs. Members of the treatment network should include law enforcement (including parole), state and city agencies, public schools, family members and family advocacy groups, social service agencies, and substance abuse and mental health service agencies and providers. Members should collectively identify barriers and options for resolution. There should be cross training for the purpose of knowledge and skills development. Information systems should be integrated and the data used to evaluate Network efforts.

In Denver this approach has resulted in more youth receiving more services and staying in treatment longer. Participants are showing an increased ability to abstain from alcohol and drug use, handle life problems, and stay in school. There is a 23% decrease in the conviction rate one year after release on parole.

The system is also working more collaboratively. There is a more comprehensive intake assessment conducted, an increase in referrals within the system, more family involvement, improved case management, and enhanced communication and information sharing. The changes brought about by the Network have a positive impact on the system, youth, community, and families.

Dr. Hiram Suárez Villa

Office of Secretary of the Government
Mexico

The Mexican Government agencies that address prevention and social rehabilitation are

- Prevention and Social Rehabilitation
- Prevention and Treatment for Adolescent

- Adolescent Council
- Patronage for Employment Social Rehabilitation
- Executive Coordination of Penitentiary Infrastructure

We will only address two of these organizations, specifically:

- **Prevention and Education** which formulates, coordinates, and evaluates social programs dealing with prevention and social rehabilitation of delinquent adults.

- **Prevention and Treatment for Adolescents** which runs all programs that addresses preventing antisocial conduct among adolescents.

The administrative federation to support these programs manages five adult federal Institutions and six for adolescents. Federal prisons for adults in Mexico include Guadalajara, Jalisco, and Matamoros (Tamaulipas), a penal colony in the Marias Islands, and a Federal Center of Psychological Rehabilitation.

The adolescent institutions, which are complemented with prevention programs for orientating and supporting the adolescent and their parents, are:

- The Diagnostic Center for Boys
- The Diagnostic and Treatment Center for Women
- The Treatment Center for Men
- The Special Needs Center
- The Interdisciplinary Center for Walk-in Treatment

Prevention programs are of utmost importance and should be a fundamental part of treatment programs; this is because it is a sad reality that drug usage is high among adults and adolescents during the commission of a crime. The Mexican Government promotes the fight for eradication of this ill that equally affects, institutionalized adolescents and adults through the coordination of strategies and programs of the various Government's administrative entities.

In Mexico pharmaco-dependent prevention programs are a public health issue. Their implementation is of public and social interest. The Health Department is in charge of implementing these programs which, in coordination with State Governments, promote and support:

- Prevention and treatment of drug dependency – the rehabilitation of drug dependent users.

- Education on the effects of drugs, psychotropic substances, and other substances of probable addiction, as well as their social consequences.

- Education and instruction of the families and the community on how to recognize the symptoms of drug dependency in order to provide timely prevention and treatment.

The Mexican Government has special interest in involving all of the essential health factions with the penal authorities in charge of the institutionalized adult and adolescent population through:

- the design of novel drug prevention program within the institution

- the development of lines of communication with society as a whole in order to develop new strategies that would reduce and eradicate this terrible epidemic that threatens the security and the health of our citizens.

Lilia Vasquez Portales

Office of the Attorney General (PGR)
Mexico

Drug usage in Mexico has increased in recent years due to several factors. A major reason is the availability of drugs derived from cash transactions. The usage index has increased primarily in urban centers, tourist areas, and northern frontier towns. Linking drug usage with the attorney's office is difficult in cases where the usage of drugs is perceived during the commission of a crime and when cases

involving possession of a controlled substance are transferred to the Public Ministry.

To solve this problem the Mexican institutions that comprise the public safety and public health systems address the following:

- Substance abuse prevention and crime prevention.
- Rehabilitation of drug addicts through:
  - rehabilitation as an alternative to penal punishment
  - rehabilitation as part of social readaptation of the criminal.

The coordination of the public health and public safety institutions is addressed in the National Program for Drug Control 1995-2000 (PNCD), which defines the objectives, strategies, and actions to be developed by the Mexican Government to confront drug issues. The national policy plan has as an objective to develop complementary programs to reduce drug demand as well as availability. To achieve this goal coordination between twelve Government institutions is promoted.

In the area of drug consumption affecting public safety, an effort is being made to promote the coordination between the public health and justice departments, in order to prevent drug consumption and to promote rehabilitation of substance abusers, including those whose are on trial or incarcerated. This effort is being supported to facilitate the transition of the delinquent into society.

Important advances have been made in substance abuse prevention, the rehabilitation of addicts, and treatment as part of social readaptation. The Public Health Ministry, the State Department, as well as the Attorney General's Office have played a fundamental role. There are specific procedures in place that require the coordinated involvement of the respective authorities in concrete cases. For example, when a drug addict's case has been transferred to the Public Ministry, during the initial stages of an existing investigation, or when a penal process is being referred to the corresponding judicial jurisdiction.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) PRE-CONFERENCE SUMMARY

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) PRE-CONFERENCE SUMMARY

Developing a Bi-national Research Agenda
U.S. – Mexico Cooperation on Drug Abuse Research

Phoenix, Arizona
May 30, 2000

At a one-day meeting preceding the (*Third U.S. – Mexico Bi-national Demand Reduction Conference)*, Mexican and U.S. drug abuse researchers and officials met to discuss the recommendations of the work groups from the two previous bi-national conferences and to identify several potential collaborative research projects. Fifty-six participants from both Mexico and the United States came together for a daylong series of presentations, discussions and working group sessions. The meeting was organized by the National Institute on Drug Abuse International Program in cooperation with the U.S. Office of National Drug Control Policy.

Welcoming participants, Dr. M. Patricia Needle, International Program Director, NIDA Office of Science Policy and Communications, opened the meeting and encouraged attendees to network and exchange information regarding research about drug abuse and health consequences, as well as to establish future collaborative research initiatives. She added that the comments, suggestions and ideas that emerged from this meeting would help structure the agenda for the next U.S.-Mexico conference.

Ms. Haydee Rosovsky, Mexican National Council Against Addictions, opened the morning presentations with her discussion of the benefits of exchanging data, instruments and information as steps toward building bi-national research cooperation. She also reviewed some of the important achievements in research cooperation between Mexico and the United States over the past three years.

Dr. Richard H. Needle, U.S. Department of Health and Human Services, Office of HIV/AIDS Policy, presented preliminary results from Rapid Assessment, Response and Evaluation (RARE) projects in three U.S. cities. The RARE methodology will be implemented in racial and ethnic minority communities around the country disproportionately impacted by HIV/AIDS to better understand the changing dynamics of HIV/AIDS and to implement feasible, science-based best practices to respond to the epidemics of HIV/AIDS and drug abuse in their communities.

Dr. Mary Jeanne Kreek, Rockefeller University, discussed from her extensive experience in drug abuse science as a basic scientist and clinical researcher the important contribution of basic neuroscience for understanding addiction and the translation of this knowledge into science-based best practices for prevention and treatment of drug abuse and the health consequences of abuse. Dr. Silvia Cruz, Cinvestav, served as a discussant

and raised issues of importance for practitioners in implementing programs built on scientific research.

Dr. Judith Brook, Mt. Sinai School of Medicine, described the U.S. National Institutes of Health (NIH) grant application process and the advantages of collaboration between Mexican and U.S. partners, especially NIDA-supported researchers, to secure research funding for joint projects. Dr. Brook also provided a list of current topics of special relevance in drug abuse research, based on priorities of NIDA and NIDA researchers.

Dr. Luciana Ramos, Mexican Institute of Psychiatry, and Dr. M. Patricia Needle discussed funding mechanisms available in their respective countries for building research cooperation between Mexico and the United States. NIDA promotes international scientific collaboration in drug abuse through fellowships and grant mechanisms. Other NIH programs were also described.

Research information sessions featured presentations by Mexican and U.S. drug abuse scientists, followed by work groups that explored issues on epidemiology and prevention, drug abuse treatment, and basic science. The work group participants developed goals and objectives for future U.S.-Mexico research collaboration and presented them at the closing plenary session. These recommendations are listed below.

Recommendations

1. Binational website and/or listserv to facilitate development of research cooperation.

2. Second research pre-conference in 2001 (or next U.S.-Mexico Bi-national Demand Reduction Conference) with scientific presentations that feature bi-national (U.S.-Mexico) research collaborations.

3. Formalize a program of bi-national research cooperation. Topics of importance for this group include: perception of risk in relation to drug abuse prevalence; program evaluation; HIV prevention interventions for drug abusers; implementation of rapid assessment, response and evaluation on U.S.-Mexico border; adolescent drug use, violence and HIV; gender differences, family influences, women, social and cultural factors; patient-treatment matching; and cooperation in the basic science of drug abuse.

OTHER CONFERENCE INFORMATION

ACKNOWLEDGEMENTS

The Office of National Drug Control Policy (ONDCP) acknowledges the cooperation and support given by the following organizations and individuals of those sponsoring the event:

In the United States:

The Substance Abuse and Mental Health Services Administration (SAMHSA)
The National Institute on Drug Abuse (NIDA)
The U.S. Department of Education (ED)
The U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs (INL)
The U.S. Department of Justice, Drug Enforcement Administration (DEA) and Office of Juvenile Justice and Delinquency Prevention (OJJDP)
The U.S. Department of Transportation
The Arizona National Guard

In Mexico:

The Under-Secretariat for Disease Prevention and Control, Ministry of Health
The National Council on Addictions (CONADIC), Ministry of Health
The Directorate of Epidemiology, Ministry of Health
The Mexican Institute of Psychiatry

The Conference Committee would also like to thank Periwinkle National Theatre and their Executive Director Sunna Rasch for their outstanding production of "Halfway There."

Program Committee for the U. S. and Mexico

In the United States:

Ana Anders
Public Health Analyst
Office for Special Populations
National Institutes of Health
National Institute on Drug Abuse

Gail Beaumont
Senior Education Program Specialist
Safe and Drug-Free Schools Program
US Department of Education

John Campbell
Public Health Advisor
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Javier M. Córdova (Conference Manager)
Policy Analyst
Office of Demand Reduction
Office of National Drug Control Policy

Darlind Davis
Chief, Prevention Branch
Office of Demand Reduction
Office of National Drug Control Policy

Lorinda Daniel
Special Assistant to the Administrator
Substance Abuse and Mental Health Services Administration

Kenneth Edgell
Drug Enforcement and Program Compliance
U.S. Department of Transportation

Dan Fletcher
Special Assistant to the Director
Division of State and Community Systems Development
Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Sandra Lawson
Policy Analyst
Office of Demand Reduction
Office of National Drug Control Policy

Winnifred Mitchell
Public Health Analyst
Office of Policy and Program Coordination
Substance Abuse and Mental Health Services Administration

Bernard McCann
Policy Analyst
Office of Demand Reduction
Office of National Drug Control Policy

Mark Morgan
Program Manager
Office of Juvenile Justice and Delinquency Prevention

M. Patricia Needle
Director, International Program
Office of Science Policy and Communication
National Institute on Drug Abuse

Barbara Roberts
Senior Policy Analyst
Office of Demand Reduction
Office of National Drug Control Policy

Jane Sanville
Policy Analyst
Office of Demand Reduction
Office of national Drug Control Policy

Daniel Schecter
Deputy Director for Demand Reduction (Acting)
Office of National Drug Control Policy

Barbara Wetherell
Senior Prevention Programs Manager
Demand Reduction Section
Office of Congressional and Public Affairs
Drug Enforcement Administration

In Mexico:

Mtra. Haydée Rosovsky
Secretaría Técnica
Consejo Nacional contra las Adicciones (CONADIC)

Lic. Nora Gallegos Vázquez
Directora de Normatividad
CONADIC

Lic. José Castrejón Vacio
Director de Programas
CONADIC

Mtra. Carmen Millé Moyano
Directora de Capacitación e Información
CONADIC

Lic. Alejandro Arroyo Domínguez
Coordinador Administrativo
CONADIC

Lic. Juan Nuñez Guadarrama
Subdirector de Apoyo a la Descentralización
CONADIC

Lic. Patricia Reyes del Olmo
Subdirectora de Coordinación Sectorial
CONADIC

Lic. Rosa Bonifaz Pedrero
Subdirectora de Documentación y Difusión
CONADIC

Lic. Teresa Sánchez Fragoso
Subdirectora de Capacitación
CONADIC

Dr. Arturo Ongay
Subdirector de Desarrollo Técnico
CONADIC

Lic. Karen Aspuru Juárez
Jefa del Departamento de Normatividad
CONADIC

Sra. Eda González Richmond
Secretaria Particular de la C. Secretaría Técnica
CONADIC

Dra. Ma. Elena Medina Mora
Jefa de la División de Investigaciones Epidemiológicas y Sociales
Instituto Mexicano de Psiquiatría (IMP)

Lic. Luis Ignacio Sánchez Gómez
Director General
Instituto Mexicano de la Juventud (IMJ)

EXHIBITORS

Arizona National Guard Demand Reduction
1614 West Roosevelt
Phoenix, Arizona 85007
(602)267-2901 Fax: (602)267-2474
storma@az.ngb.army.mil

California Department of Justice
4949 Broadway, Room #E-131
Sacramento, California 95820
(916)227-3220 Fax: (916)227-3198

Centros de Integracion Juvenil A.C.
La Tlaxcala 208 - Col. Hipodromo Condesa
Mexico D.F. 06300
(525)286-9597 Fax: (525)286-9597
promoci3@cij.gob.mx

Coalicion de Organizaciones Juveniles Para Prevencion de Adicciones
2a. Retorno Boulevard Jacarandas
No. 22, Col. Lomas de Teopanzol
nodocoalicion@yahoo.com
(527)316-2576 Fax: (527)216-2575

Consejo Nacional Contra Las Adicciones
Aniceto Ortega 1321 1st Piso Col. Del Valle
Mexico D.F. 03100
Washington D.C. 20503
(525)524-5600 Fax: (525)534-9024
cdoc@supernet.com.mx

Counterdrug Technology
Assessment Center – (CTAC)
ONDCP
750 17th Street, N.W., Suite 731
Washington D.C.
(202)395-6761 Fax: (202)395-6775
james_a._petrovsky@ondcp.eop.gov

D.A.R.E. Southwest Regional Training Center
3110 North 19th Avenue, Suite 290
Phoenix, Arizona 85015
(602)223-2544 Fax: (602)279-0853

El Caracol A.C.
Rafael Helidoro Valle No. 337
Col. Lorenzo Boturini
Mexico, D.F. Distrito Federal 15820
(525)768-1204 Fax: (525)674-2121
caracol@supernet.com.mx

Fiscalia Especializada Para La Atencion de Delitos Contra La Salud, PGR
Plaza de la Republica No. 43, 2o. Piso, Col. Tabacalera
Deleg. Cuauhtemoc D.F. 06030
comis@pgr.gob.mx

Fundacion Azteca
Vereda No. 80 Col. Jardines del Pedregal
Mexico D.F. 01900
(015)568-9303 Fax: (015)568-9309
echacon@tvazteca.com.mx

Instituto Mexicano de La Juventud
Serapio Rendon No. 76 Col. San Rafael
Mexico D.F. 06470
(525)536-1605 Fax: (525)535-9235

Narcotics Anonymous World.
Services, Inc
19737 Nordhoff Place
Chatsworth, California 91311
(818)773-9999 Fax: (818)700-0700
bob@na.org

National Institute on Drug Abuse (NIDA)
1375 Piccard Drive, Suite 360
Rockville, Maryland 20850
(240)632-5624 Fax: (240)632-0519
tbrown@masimax.com

Office of National Drug Control
Policy (ONDCP)
P.O. Box 6000
Rockville, Maryland 20850
(301)519-5520 Fax: (301)519-5212
lflaim@ncjrs.org

Operadora Oceanica Internacional, S.A. de C.V.
Porfiro Diaz No. 102 P.H. 01 Col. Nochebuena
Mexico D.F. 03720
(525)615-3001 Fax: (525)611-2207
oceanica(arroba).spin.com.mx

Organizacion Panamericana de La
Salud
5400 Suncrest C-4
El Paso Texas 79912
(915)845-5950 Fax: (915)845-4361
decosiog@usmbha.org

Substance Abuse and Mental Health Services
Administration(SAMHSA)
P.O. Box 2345, Suite 200
Rockville, Maryland 20847-2345
(800)729-6686 Fax: (301)468-6433
jventurini@health.org

U.S. - Mexico Border Center
for the Application of Prevention
Technologies
2501 East Elm Street
(520)545-2970 Fax(520)795-1365
skunz@ambhf.org

U.S. Department of Education
400 Maryland Avenue, S.W.
Washington D.C. 20202-6123
(202)260-2673 Fax(202)260-7767
gail_beaumont@ed.gov

United Nations International Drug
Control Programme
Masarik #29, Col. Chapultepek
Morales
Mexico D.F. 11570
(525)545-2970 Fax:(525) 545-2970
lucero.gudino@un.org.mx

SPEAKERS FROM THE UNITED STATES

Luz Arriola
Program Director
West Texas Council on Alcoholism and Drug Abuse
3210 Dyer Street
El Paso, Texas 79930
(915)577-0791 Fax: (915)577-0799
wtcadacmt@msn.com

Allen Ault
Chief
U.S. Department of Justice
Washington, D.C. 20534
(202)307-3995 Fax: (202)305-2185
aault@bop.gov

Kristen Barry
University of Michigan
(734)930-5127 Fax: (734)930-5150
barry@umich.edu

Andrea G. Barthwell
President
Encounter Medical Group
1010 Lake Street, Suite 210
Oak Park, Illinois 60301
(708)383-2700 Fax: (708)383-2959
agbmd@aol.com

Mary Bernstein
Director, Office of Drug and Alcohol Policy and Compliance
U.S. Department of Transportation
400 7th Street, S.W., Room 1403
Washington, D.C. 20590
(202)366-3784 Fax: (202)366-3897

Jennifer Bishop
Office of National Drug Control Policy
Washington, D.C.

Philmer Bluehouse
Safe Schools Director
Pinon United School District #4
P.O. Box 839
Pinon, Arizona 86510
(520)725-3450 Fax: (520)725-3278

Edward Brand
Superintendent
Sweetwater Union District
1130 5th Avenue
Chula Vista, California 91911
(619)691-5555 Fax: (619)498-1997

Alejandra Castillo
Office of National Drug Control Policy
The White House
Washington, D.C. 20503

Nelba Chavez
Administrator, SAMSHA
5600 Fishers Lane, 12-105
Rockville, Maryland 20857
(301)443-4795 Fax: (301)443-0284
nchavez@SAMHSA.gov

John D. Clapp
Research Director
College of Health & Human Svcs
San Diego State University
San Diego, California 92182-4119
(619)594-6859 Fax: (619)594-5991
jclapp@mail.sdsu.edu

Ann Clark
Supervisor
Houston Independent School District
3830 Richmond Avenue
Houston, Texas
(713)892-6690 Fax: (713)892-7494

H. Westley Clark
Director
Substance Abuse&Mental Health Svcs. Admin.
6001 Executive Boulevard, Room 5263 MSC 9591
Bethesda, Maryland 20852
(301)443-6480 Fax: (301)443-9127

Timothy P. Condon
Associate Director
National Institute on Drug Abuse
U.S. Department of Health & Human Svcs
Rockville, Maryland 20857
(301)443-5700 Fax: (301)443-8751
TC52X@NIH.GOV

Jeffrey Davidow
Ambassador to Mexico

George De Leon
Director
National Development and Research Institutes, Inc.
World Trade Center
New York, New York 10048
(212)845-4417 Fax: (212)845-4698
george.deleon@ndri.org

Richard Dembo
Professor
University of South Florida
4202 East Fowler Avenue
Tampa, Florida 22620-8100
(813)931-3345 Fax: (813)933-1146
jac@gate.net

Elizabeth Edwards
Executive Director
Arizonans for a Drug-Free Workplace
P.O. Box 13223
Tucson, Arizona 85732-3223
(520)295-5962 Fax: (520)295-5979
afdfw@azstarnet.com

Martha Fletcher
Program Specialist
Leon County School District
500 North Appleyard Drive
Tallahassee, Florida 32304
(850)487-7598 Fax: (850)487-7614
fletcherm@mail.lively.leon.k12.fl.us

Gabriela Garcia
Administrator
Arizonans for a Drug-Free Workplace
P.O. Box 13223
Tucson, Arizona 85713
(520)295-5962 Fax: (520)295-5979
afdfw@azstunret.com

David Gaspar
Arizona Department of Juvenile Corrections
United States

Isabel Gomez-Bassols
Radio Unica Network
(305)463-5045 Fax: (305)463-5001

Aimee Graves
Director of Community Based Services
CODAC Behavioral Health Services, Inc.
Tucson, Arizona

Melody M. Heaps
President
TASC, Inc.
1500 North Halsted Street
Chicago, Illinois 60622
(312)787-0208 Fax: (312)787-9663
mheaps@tasc-il.org

Robin Hoskins
Executive Director
Women's Treatment Network
Phoenix, Arizona
(602)506-6456 Fax: (602)506-5381

Tom Hutchinson
Prehab of Arizona
(480)464-9669 Fax: (480)969-1509

Susan Kunz
Director
U.S. - Mexico Border Center for the Application of Prevention Technologies
2501 East Elm Street
Tucson, Arizona 85716
(520)795-9756 Fax: (520)795-1365
skunz@ambhf.org

Sandra Owens Lawson
Office of National Drug Control Policy
Washington DC
202)395-6750 Fax: (202)395-6744

Henry Lozano
President
Californians for Drug Free Youth
333 West Colfax Avenue, Suite 400

Jennifer Mankey
Director
Denver Juvenile Justice Treatment Network
Denver, Colorado 80204
(303)893-6898 Fax: (303)893-6848
jmankey@djjitn.state.co.us

Antonieta Martin
Researcher
John Hopkins University

Duane McBride
Professor and Chair
Andrews University
Berrien Springs, Michigan 49104
(616)471-3576 Fax: (616)471-3108
mcbride@andrews.edu

Barry R. McCaffrey
Director
Office of National Drug Control Policy
Washington D.C.

Bernard McCann
Office of National Drug Control Policy
Washington D.C.
(202)395-3096 Fax: (202)395-6744
bernard_mccann@ondcp.eop.gov

Tom McLellan
Treatment Research Institute
150 South Independence Mall
Philadelphia, Pennsylvania 19106-3475
(215)399-0980 Fax: (215)399-0987

Lorenzo Merritt
Project Heavy West
1600 Sawtelle Boulevard, Suite 300
Los Angeles, California 90025
(310)477-1291 Fax: (310)477-1373

William Modzeleski
Director, Safe and Drug Free Schools Program
U.S. Department of Education
400 Maryland Avenue, S.W., Room 3E314
Washington, D.C. 20202-6123
(202)260-3954 Fax: (202)260-7767
bill_modzeleski@ed.gov

Harry Montoya
President/CEO
Hands Across Cultures, Inc.
P. O. Box 2215
Espanola, New Mexico 87532
(505)747-1889 Fax: (505)747-1623
hmontoya@aol.com

Tim Murray
Bureau of Justice Assistance
Department. of Justice
Washington, DC
(202)616-8933 Fax: (202)307-0036

Eileen O'Brien
Senior Enterprise Development
Office on Early Childhood
5600 Fishers Lane
Rockville, Maryland 20857
(301)443-7762 Fax: (301)443-7878
eobrien@samhsa.gov

Jeanne Obert
Executive Director, Matrix Institute on Addictions
University of California at Los Angeles
12304 Santa Monica Boulevard, Suite 200
Los Angeles, California 90025
(310)207-4322 Fax: (310)207-6511
jlobert@aol.com

Eugenia Ortega
Superintendent
California Youth Authority
7650 South New Castle Road
Spockton, California 952139002
(209)944-6331 Fax: (209)465-4164
eortega@cya.ca.gov

Mark W. Parrino
President
American Methadone Treatment Association
217 Broadway, Suite 304
New York, New York 10007
(212)566-5555 Fax: (212)349-2944
amermeth@aol.com

Luisa Del Pollard
SAMHSA
5600 Fishers Lane
Rockville, Maryland 20857
(301)443-6728
lpollard@SAMHSA.gov

Amelie Ramirez
Assoc. Professor, Department of Medicine
Baylor College of Medicine
8207 Callaghan Road, Suite 110
San Antonio, Texas 78230
(210)348-0255 Fax: (210)348-0554
armirez@bcm.tmc.edu

Rosalia Salinas
Director, Curriculum Instruction and Assessment
6401 Linda Vista Road
San Diego, California 92111
(858)292-3522 Fax: (858)571-4750
rsalinas@sdcoe.k12.ca.us

Ruth Sanchez-Way
Acting Center Director
SAMHSA
5600 Fishers Lane
Rockville, Maryland 20857
(301)443-0365 Fax: (301)443-5447
rsanchez@SAMHSA.gov

Dan Schecter
Acting Deputy Director
Office of National Drug Control Policy
Washington, DC 20503
(202)395-6733 Fax: (202)395-6744
daniel_schechter@oa.eop.gov

Beverly Schwartz
Senior Vice President
Fleishman Hillard, Inc.
1615 L Street, N.W., #1000
Washington, D.C. 20036
(202)828-8820 Fax: (202)223-8199

Stephen Shearer
Consultant
Stephen Shearer, Inc.
446 Upland Road
Redwood City, California 94062
(650)599-9007 Fax: (650)599-9008

D. Dwayne Simpson
Director
Texas Christian University
TCU Box 298740
Fort Worth, Texas 76129
(817)257-7226 Fax: (817)257-7290
dds@tcu.edu msimpson@bop.gov

Mark Simpson
FMC Lexington
3301 Leestown Road
Drug-Free Communities Support Program
Lexington, Kentucky 40511
(606)253-8839 Fax: (606)253-8839

Mary Ann Solberg
Chair
Drug-Free Communities Support Program

Robert Stephenson
Acting Director
SAMHSA/CSAP

Forrest Van Camp
Executive Director, Area 3
Leon County Schools
2757 West Pensacola Street
Tallahassee, Florida 32304
(850)487-7525 Fax: (850)414-5106
vancamps@mail.leon.k12.fl.us

Abraham Wandersman
University of South Carolina
Barnwell College
Columbia, South Carolina 29208
(803)777-7671 Fax: (803)777-9558

Mark Weber
Director
SAMHSA
5600 Fishers Lane
Rockville, Maryland 20857
(301)443-8956 Fax: (301)443-9050
mweber@SAMHSA.gov

David Wertheimer
Service and Systems Integration
King County Department of Community
and Human Services
Seattle, Washington 98104zz
(206)205-1354
david.wertheimer@metrokc.gov

John W. Wilson
Acting Administrator
U.S. Department of Justice
810 Seventh Street, N.W.
Washington, D.C. 20531
(202)307-5911 Fax: (202)307-2093

Steve Wing
Senior Advisor for Drug Policy
SAMHSA
5600 Fishers Lane
Rockville, Maryland 20857
(301)443-0593 Fax: (301)443-7590
swing@samhsa.gov

Terry Zobeck
Office of National Drug Control Policy
Washington, D.C. 20503
(202)395-5503 Fax: (202)395-6729

Barbara Zugor
Executive Director
TASC – Arizona
2234 North 7th Street
Phoenix, Arizona 85006
(602)254-7328 Fax: (602)255-0851

SPEAKERS FROM MEXICO

Norma Amerena
CONADIC

Jose Luis Perez Bautista
Presidente
Asociación Nacional de Padres de Familia

Mario Bejos
Liber-Addictus

Fernando Bilbao
CONADIC

Rosa Bonifaz
CONADIC

Roberto Canto
Juventud, Luz y Esperanza

Jose Vila del Castillo
Representative for Mexico and Central America
Director de Operacion y Comunicacion
United Nations International Drug Control Programme (UNDCP)

José Castrejon
CONADIC

Eduardo Chacon
Fundacion Azteca
Vereda No. 80 Jardines del Pedrega

José Antonio Gonzalez Fernandez
Secretary of Health

Rafael Velasco Fernandez
President
Center in Studies on Alcohol and Alcoholism (CESAAL)

Oscar Fuentes Fierro
Fiscalia Espcializada Para La de Delitos
Contra La Salud, PGR

Carlos Franco
Baja School District

Maria Teresa Sanchez Fragoso
CONADIC

Nora Gallegos
CONADIC

Juan Roman Uriarte Galvan
Secretariat of Communications and Transportation (SCT)

Jesus Garcia
Instituto Mexicano de la Juventud

Juan Rebolledo Gout

Victor Manuel Guisa
Centros de Integracion Juvenil

Jorge Machado
Funadacion Azteca

Jorge Madrazo
Attorney General

Jorge Sanchez Mejorada
Researcher
Veracruzana University

Carmen Mille
CONADIC
California

Juan Nuñez
CONADIC

Jose Luis Navarro Padilla
DIF
Martin Perez
El Caracol

Elizabeth Preciado
FEADS

Jaime Quintanilla
Centros de Integracio Juvenil

Maria Elena Ramos
Programa Companeros, A.C.

Mario Alva Rodriguez
INACIPE

Manuel Carbajal Ruiz
CESAD

Wilfred Rios Sanchez
FEADS, PGR

Agustin Velez
General Director
Trusteeship for the Institute for Street Kids and Addictions (FINCA)

Mr. Raul Zapata
Youth Integration Centers

Norma Merena
Council of Addictions CONADIC
Mexican Ministry of Health

Lorenzo Morin
Secretario de Educacion, Baja

Marisa Ocequera
Latin American Institute for Family Studies

Arturo Ongay Perez
CONADIC
Roberton Bital Pineda
Mexico

Ignacio Carrillo Prieto
Ministry of Interior

Luciano Ramos
Mexican Institute of Psychiatry

Ignacio Benedicto Reyes
Baja California

Haydee Rosovsky
CONADIC

Ninfa Sada
Fundación Azteca
Mexico

Jesus Cabrera Solis
Center for Youth Integration

Hiram Juarez Villa
SEGOB

ATTENDEES FROM THE UNITED STATES

Ms. Ana Anders
NIDA-NIH
6001 Executive Boulevard
Bethesda, Maryland 20892
(301) 443-0441 Fax: (301) 480-8179
aa96o@nih.gov

Dr. Rudy Arredondo
Texas Tech University-Health Science Center
3601 4th Street
Lubbock, Texas 79430
(806) 743-2800 Fax: (806) 743-4250
psyrma@ttuhsc.edu

Mr. Luz Arriola
WTCADA
3210 Dyer Street
El Paso, Texas 79930
(915) 577-0791 Fax: (915) 577-0799
wtcadacmt@msn.com

Ms. Linda J. Augenstein
Tucson Unified School District #1
2025 E. Winsett
Tucson, Arizona 85719
(520) 617-7174 Fax: (520) 617-7094
laugenst@tusd.k12.az.us

Dr. Allen Ault
National Institute of Corrections
320 First Street, NW
Washington, D.C. 20534
(203) 307-3106 Fax: (202) 305-2185
aault@bop.gov

Dr. Kristen Barry
University of Michigan
400 E. Eisenhower Parkway
Ann Arbor, Michigan 48108
(734) 930-5127 Fax: (734) 930-5150
barry@umich.edu

Mr. Carl Battistone
Lions Clubs International
1260 Delfield Drive
Bethel Park, Pennsylvania 15102-2454
(412) 831-0540 Fax: (412) 831-0227
battruth@aol.com

Ms. Gail Beaumont
U.S. Department of Education
400 Maryland Avenue, S.W.
Room 3E310
Washington, D.C. 20202-6123
(202) 260-2673 Fax: (202) 260-7767

Ms. Mary Bernstein
U.S. Department of Transportation
400-7th Street, SW, Suite 10403
Washington, D.C. 20590
(202) 366-3784 Fax: (202) 366-3897
marybernstein@ost.dot.gov

Mr. Jeffrey Billings
Border Health Initiative
148 E. 30th Street, Suite Up-South
National City, California 91950
(619) 791-2610 Fax: (619) 791-2600
billings@pciborderregion.com

Ms. Jennifer Bishop
Office of National Drug Control Policy
Washington D.C.

Mr. John Blackburn
Maricopa County Attorney's Office
301 W. Jefferson
8th Floor
Phoenix, Arizona 85003-2151
(602) 506-3411 Fax: (602) 506-8102

Mr. Philmer Bluehouse
Pinon Unified School District #4
P.O. Box 839
Pinon, Arizona 86510
(520) 725-3450 Fax: (520) 725-3278

Ms. Kimberley Bonnington Kouri
Greater Detroit Area Health Council
333 West Fort Street, Suite 1500
Detroit, Michigan 48226
(313) 965-4115 Fax: (313) 965-2031
kbonnington@msms.org

Ms. Madeline Duran Bosma
Oracle Board of Education
65820 E. Rocky Trail Drive
Tucson, Arizona 85739
(520) 825-5270 Fax: (520) 825-5271
bosma@ispchannel.com

Ms. Joan Boughton
Rotary International
1333 Camino Lorado
Lake San Marcos, California 92069
(760) 736-4700 Fax: (760) 736-4800
boughtonj@aol.com

Mr. Michael Branham
Arizona Criminal Justice Commission
3737 North 7th Street
Suite 260
Phoenix, Arizona 85014
(602) 728-0752 Fax: (602) 728-0752

Mr. John Campbell
HHS
Rockwall II, Suite 619
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-9299 Fax: (301) 480-6077
jcampbel@samhsa.gov

Ms. Linda Carrier
Governor's Community Policy Office
3800 North Central Avenue, Suite 1500
Phoenix, Arizona 85012
(602) 280-1365 Fax: (602) 280-1470
lindac@azcommerce.com

Ms. Gail Chadwick
Arizona State University
641 East Van Buren, Suite B-2
Phoenix, Arizona 85004
(480) 727-2772 Fax: (480) 727-5400
gchadwick@asu.edu

Ms. Anna Chisman
CICAD/OAS
1889 F. Street, NW
Washington, D.C. 20006
(202) 458-6221 Fax: (202) 458-3658
achisman@oas.org

Ms. Joanne Cisneros
U.S. DOT/FMCSA
22690 Cactus Avenue
Suite 250
Moreno Valley, California 92553
(909) 653-2299 Fax: (909) 653-6969

Dr. John D. Clapp
San Diego State University
5500 Campanile Drive
San Diego, California 92182
(619) 594-6359 Fax: (619) 594-5991
jdclapp@mail.sdsu.edu

Ms. Ann B. Clark
Houston Independent School District
3830 Richmond Avenue
Houston, Texas 77027
(713) 892-6690 Fax: (713) 892-7494
baylor@tenet.edu

Dr. H. Westley Clark
Health and Human Services
5600 Fishers Lane
Rockwall II, Suite 619
Rockville, Maryland 20857
(301) 443-5700 Fax: (301) 443-8751
wclark@samhsa.gov

Mr. Timothy P. Condon
National Institute on Drug Abuse
6001 Executive Blvd
Room 5263, MSC 9591
Bethesda, Maryland 20852
(301) 443-6036 Fax: (301) 443-6277
tc52x@nih.gov

Mr. Javier Cordova
ONDCP
Washington D.C. 20503
(202) 395-3000
javier_m._cordova@ondcp.eop.gov

Mr. Gerardo De Cosio
Pan American Health Organization
5400 Suncrest Drive C-4
El Paso, Texas 79912
(915) 845-5950 Fax: (915) 845-4361
decosio@usmbha.org

Ms. Margaret Cossey
California Department of Alcohol and Drug Programs
1700 K Street, 2nd Floor
Sacramento, California 95814-4037
(916) 324-4468 Fax: (916) 323-0633
mcossey@adp.state.ca.us

Mr. Bill Crane
Alcohol and Drug Services
Health and Human Services Agency
P.O. Box 85222
California 92186-5222
(619) 692-5762 Fax: (619) 692-5604
bcranehe@co.san-diego.ca.us

Ms. Laura Cummings
STCADA
1502 Laredo, Suite 2
Laredo, Texas 28040
(800) 487-7752 Fax: (956) 725-0236

Ms. Lorinda Daniel
SAMHSA
5600 Fishers Lane
Parklawn Building, Room 12-105
Rockville, Maryland
(301) 443-5337 Fax: (301) 442-0284

Major General (Ret.) Arthur T. Dean
Community Anti-Drug Coalitions of America
901 North Pitt, Suite 300
Alexandria, Virginia 22314
(703) 535-8530 Fax: (703) 706-8088
adean@cadca.org

Mr. George DeLeon
Center for Therapeutic Community Research
2 World Trade Center
16th Floor
New York, New York 10048
(212) 845-4417 Fax: (212) 845-4698
george.deleon@indri.org

Dr. Richard Dembo
University of South Florida
4202 E. Fawler Avenue
Tampa, Florida 33620
(813) 931-3345 Fax: (813) 933-1146
jac@gate.net

Mr. Mark F. Demers
National Drug Intelligence Center
319 Washington Street
5th Floor
Johnstown, Pennsylvania 15901
(814) 532-4028 Fax: (814) 532-4690
mfd@ndic.osis.gov

Mr. Paul J. DeWispelaere
PRIDE Youth Programs
4684 S. Evergreen
Newayso, Michigan 49337
(800) 668-9277 Fax: (231) 652-2461
jay@ncats.net

Mr. Alejandro Duran
DEA
3010 North 2nd Street
Phoenix, Arizona 85012
(602) 664-5600

Mr. Kenneth Edgell
Department of Transportation
400 7th Street, SW
Room 9404
Washington, D.C. 20590
(202) 366-3784 Fax: (202) 366-3897
kenneth.edgell@ost.dot.gov

Ms. Elizabeth Edwards
Arizonans for a Drug-Free Workplace
P.O. Box 13223
Tucson, Arizona 85732
(520) 295-5962 Fax: (520) 295-5979

Mr. A.J. Ernst
ATCMHMR
909 W. 45th Street
P.O. Box 12668
Austin, Texas 78711
(512) 206-4763 Fax: (512) 206-4784
aj.ernst@mhmr.staff.tx.us

Ms. Calvina Fay
Drug Free America Foundation
P.O. Box 11298
St. Petersburg, Florida 33733
(727) 893-2616 Fax: (727) 893-2563
cfay@dfaf.org

Mr. Joáo Ferreora-Pinto
University of Texas, Houston
1100 North Stanton # 110
El Paso, Texas
(915) 747-8507 Fax: (915) 747-8512
joáo@utep.edu

Mr. Dan Fletcher
Division of State and Community
Systems Development
Center for Substance Abuse Prevention
5515 Security Lane
Rockville, Maryland 20875
(301) 443-5660 Fax: (301) 443-0526

Ms. Martha Fletcher
Leon Co. Schools
500 N. Appleyard Drive
Tallahassee, Florida 32304
(850) 922-2099 Fax: (850) 487-7614

Ms. Gabriela Garcia-Head
Arizonans for a Drug-Free Workplace
P.O. Box 13223
Tucson, Arizona 85713
(520) 295-5962 Fax: (520) 295-5979

Mr. Jose Gonzalez
Department of Alcohol and Drug Programs
1700 K Street
Sacramento, California 95814
(916) 445-0860 Fax: (916) 323-0633
jgonzalez@adp.state.ca.us

Ms. Aimee Graves
CODAC Behavioral Services, Inc.
Tucson, Arizona
(520) 327-4505 Fax: (520) 792-0033

Ms. Melody Heaps
TASC, Inc.
1500 N. Halsted St.
Chicago, Illinois 60622
(312) 573-8203 Fax: (312) 787-8214
mheaps@tasc.il.org

Ms. Brenda Henderson
Governor's Office
1700 West Washington
Phoenix, Arizona 85007
(602) 542-6003 Fax: (602) 542-3643
bhenderson@az.gov

Mr. Eduardo Hernandez
Cal Partners Coalition
909 12th Street
Suite 205
Sacramento, California 95814
(916) 442-3760 Fax: (916) 447-7052
ehernandez@calpartners.org

Ms. Sally Holcomb
Southeastern Arizona Behavioral Services
382 E. Wilcox
Sierra Vista, Arizona 85635
(520) 459-6377 Fax: (520) 458-0237
newturf@primenet.com

Mr. Charles E. Holzer
University of Texas- Medical Branch
301 University Boulevard
Galveston, Texas 77555-0189
(409) 747-8362 Fax: (409) 747-8364
cholzer@utmb.edu

Ms. Sheila Hoppe
Governor's Division of Drug Policy
1700 W. Washington
Room 101
Phoenix, Arizona 85007
(602) 542-3406 Fax: (602) 542-3643
shoppe@az.gov

Ms. Sonja J. Hoppe
Southwest Laboratories, Inc.
2727 W. Baseline Suite #1
Tempe, Arizona 85283
(602) 438-8507 Fax: (602) 438-2737
sshoppe@home.com

Mr. Pedro Janer
Drug Enforcement Administration
1880 Regal Row
Dallas, Texas 75235
(972) 574-2111 Fax: (974) 574-2050
zorrdpj@hotmail.com

Mr. Ricardo Jasso
Luz Social Services
345 E. Toole
Suite 101
Tucson, Arizona 85701
(520) 882-6216
rjasso@luzsocialservices.org

Ms. Mary Ann Jaurequi
Border Area Mental Health
P.O. Box 1349
Silver City, New Mexico 88062
(505) 388-4497 Fax: (505) 534-1150

Ms. Susan Jones
Drugs Don't Work in Arizona
3010 N. 2nd Suite, Suite 301
Phoenix, Arizona 85012
(602) 248-8453 Fax: (602) 664-5627
ddwa@psn.net

Mr. Kaare Kjos
San Diego Joint Border Initiative
2838 Granada Avenue
San Diego, California 92104
(619) 285-1725 Fax: (619) 285-9432
kaarek@aol.com

Mr. Thomas C. Kring
USDHHS/HRSA
50 United Nations Plaza Suite #349
San Francisco, California 94102
(415) 437-8090 Fax: (415) 437-7664
tkring@hrsa.gov

Ms. Susan Kunz
Border Health Foundation
2501 East Elm Street
Tucson, Arizona 85716
(520) 795-9756 Fax: (520) 795-1365
skunz@ambhf.org

Ms. Janet Lander
Arizona Department of Education
1535 West Jefferson
Phoenix, Arizona 85007
(602) 542-8717 Fax: (602) 542-3818

Mr. Ronald Lard
D.A.R.E. International
4916 Lincoln Avenue
Alexandria, Virginia 22362
(703) 750-3321 Fax: (703) 750-7844
dareintrel@

Ms. Cheri Levenson
Arizona Department of Education
1535 West Jefferson, Mail Bin 6
Phoenix, Arizona 85007
(602) 542-5045 Fax: (602) 542-5467
clevens@ade.az.gov

Mr. John Lewis
Alberta Tippecconnic
2214 N. Central Avenue
Suite 100
Phoenix, Arizona 85004
(602) 258-4822 Fax: (602) 258-4825
john.lewis@itcaonline.com

Dr. Don Livingston
Croft Workplace Drug Programs
4659 S.Lakeshore Drive
Suite B
Tempe, Arizona 85282
(480) 496-9116

Mr. Henry Lozano
Californians for Drug-Free Youth, Inc.
P.O. Box 826
Big Bear City, California 92314-0826
(909) 584-1170 Fax: (909) 584-4485
HL4DFY@aol.com

Mr. Matthew G. Maggio
National Drug Intelligence Center
319 Washington Street
5th Floor
Johnstown, Pennsylvania 15901
(814) 532-4989 Fax: (814) 532-4690
mgm@ndic.osis.gov

Ms. Jennifer Mankey
Denver Juvenile Justice Network
333 W.Colfax Ave. .
#400
Denver, Colorado 80204
(303) 893-6898 Fax: (303) 893-6848

Mr. Ricardo Martinez
STCADA
207 Fal St
Heldoronville, Texas 78361
(361) 527-5132 Fax: (361) 527-4311

Mr. Alberto Mata
University of Oklahoma
601 Elm Avenue
Room 728
Norman, Oklahoma 73019
(405) 325-1756 Fax: (405) 325-4402
agmata@ou.edu

Ms. Pastora C. Maytorena
San Diego Health Alliance
234 North Magnolia Avenue
El Cajon, California 92020
(619) 579-8373

Mr. Bernie McCann
ONDCP
Washington, D.C. 20503
(202) 395-3096 Fax: (202) 395-6744
bernard_a._mccann@ondcp.eop.gov

Ms. Lorenza Mena
U.S.-Mexico Border Health Association
5400 Suncrest Drive
Suite C5
El Paso, Texas 79912
(915) 833-6450 Fax: (915) 883-7840
menal@usmbha.org

Ms. Adriana Mendiolea
U.S. Consulate Tijuana
P.O. Box 439039
San Diego, California 92143-9039
(6) 681-7400 Fax: (6) 681-8592
ammex@pd.state.gov

Mr. Julio Mercado
Drug Enforcement Administration
700 Army Navy Drive
Arlington, Virginia 22202
(202) 307-7345 Fax: (202) 307-4540

Mr. Lorenzo Merritt
Project Heavy-West
1600 Sawtelle Blvd
Los Angeles, California 90019
(310) 477-1291 Fax: (310) 477-1373

Mr. Dennis Metrick
Arizona Supreme Court
1501 West Washington
Room 410
Phoenix, Arizona 85007
(602) 542-9453 Fax: (602) 542-9480
dmetrick@supreme.sp.state.az.ys

Mr. John Miles
CDC
1600 Clifton Road, NE
Mail Stop E-07
Atlanta, Georgia 30333
(404) 639-8011 Fax: (404) 639-8629
jmiles@cdc.gov

Ms. Winnifred Mitchell
SAMHSA-HHS
5600 Fishers Lane
Parklawn Building, Room 12C-105
Rockville, Maryland 20857
(301) 443-2324 Fax: (301) 443-1450
wmitchel@samhsa.gov

Mr. David Monnette
Drug Enforcement Administration
660 N. Mesa Hills, Suite 2000
El Paso, Texas 79912
(915) 832-6000 Fax: (915) 832-6001

Mr. Harry Montoya
Hands Across Cultures
P.O. Box 2215
Espanola, New Mexico 87532
(505) 747-1889 Fax: (505) 747-1623
hmontoya@aol.com

Mr. Jack G. Moortel
Paradise Valley School District
15002 North 32nd Street
Phoenix, Arizona 85032
(602) 867-5124 Fax: (602) 867-5251
jmoortel@pvusd.k12.az.us

Mr. David Morales
Texas Commission on Alcohol and Drug Abuse
P.O. Box 80529
Austin, Texas 78708-5233
(512) 349-6721 Fax: (512) 837-8624
David_Morales@tcada.state.tx.us

Mr. Mark Morgan
OJJDP-SED
810 7th Street, NW
Room 3307
Washington, D.C. 20531
(202) 353-9243 Fax: (202) 353-9095
morganm@osp.usdoj.gov

Dr. M. Patricia Needle
NIDA
9000 Rockville Pike
Building 31, Room 1B59
Bethesda, Maryland 20892
(301) 594-1928 Fax: (301) 402-5687
pn28@nih.gov

Dr. Andrew Nichols
Border Health Foundation
2501 East Elm Street
Tucson, Arizona 85716
(520) 626-7862 Fax: (520) 321-7763

Dr. Eileen O'Brien
The Casey Family Program
5515 Security Lane
Rockwall II, Suite 950
Rockville, Maryland 21144
(301) 443-6323 Fax: (301) 443-7878
eobrien@samhsa.gov

Ms. Laura O'Neil
Sunnyslope Village Alliance
8827 N. Central
Phoenix, Arizona 85021
(602) 395-9847 Fax: (602) 749-0618
proflvo@aol.com

Ms. Stephania O'Neill
Scottsdale Prevention Institute
7428 East Stetson, Suite 215
Scottsdale, Arizona 85251
(480) 994-0004 Fax: (480) 994-3922
scotprev@uswest.net

Mr. Dee Ogle
Texas Commission on Alcohol and Drug Abuse
P.O. Box 80529
Austin, Texas 78708-5233
(512) 349-6655 Fax: (512) 837-8624

Mr. Eduardo Olivarez
Rio Grande Valley Council on AlDA
3511 West Alberta
Edinburg, Texas 78539
(956) 928-1996 Fax: (956) 928-0004
rgv@council.vt.com

Mr. Ranaldo Ollie
Drug Enforcement Administration
1433 West Loop South
Suite 600
Houston, Texas 77027-9506
(713) 693-3354 Fax: (713) 693-3153

Ms. Eugenia Ortega
California Youth Authority
P.O. Box 213002
Stockton, California 95213
(209) 944-6331 Fax: (209) 465-4164
eortega@cya.ca.gov

Dr. Luis S. Ortega
Arizona Department of Health Services
3815 North Black Canyon Highway
Phoenix, Arizona 85015
(602) 230-5880 Fax: (602) 230-5959
lortega@hs.state.az.us

Ms. Rosa Ortega
Compañeros
Douglas, Arizona P.O. Box 1008
(520) 364-8200 Fax: (520)364-5617
compa@theriver.com

Mr. Vincent Ortega
Southern New Mexico Inc
P.O. Box 2285
Las Cruces, New Mexico 88004
(505)882-5101 FaxL (505) 882-2858

Ms. Enid Osborne
State of New Mexico Department of Health
1190 Saint Francis Drive
Santa Fe, New Mexico 87502
(505) 827-1643
eosborne@health.state.nh.us

Ms. Sylvia Parra
Tohono O'odham Nation
P.O. Box 837
Sells, Arizona 85634
(520) 383-2221

Mr. Mark W. Parrino
American Methadone Treatment Association
217 Broadway, Suite 304
New York, New York 10007
(212) 566-5555 Fax: (212) 349-2944

Mr. Roger Pisani
33 Harding Road
Old Greenwich, Connecticut 6870
(203) 698-0433 Fax: (203) 698-0433
Plunck@ct2.nai.net

Ms. Luisa Pollard
SAMHSA/CSAP
Rockwall II, Room 800
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-6728
lpollard@samhsa.gov

Mr. Richard Ramirez
Tohono O'odham Nation
P.O. Box 837
Sells, Arizona 85634
(520) 383-2221

Special Agent Ricardo Ramos
Drug Enforcement Administration
8400 NW 53rd Street
Miami, Florida 33166
(305) 590-4804 Fax: (305) 590-4437

Ms. Kathy Rice
Arizona Department of Education
1535 West Jefferson, Bin 7
Phoenix, Arizona 85007
(602) 542-8713 Fax: (602) 542-3818
krice@mail1.ade.az.us

Mr. Kenneth Rodgers
FMCSA
400 7th Street, SW
Washington, D.C. 20590
(202) 316-4016
kennethrodgers@fmcsa.dot.gov

Mr. Ambrose Rodriguez
Department of Mental Health
3333 Wilshire Boulevard
Suite 820
Los Angeles, California 90010
(213) 738-2882 Fax: (213) 384-0729
arodriguez@dmh.co.la.ca.us

Mr. Galen E. Rogers
San Diego Health Alliance
234 N. Magnolia
El Cajon, California 92020
(619) 579-8373 Fax: (619) 579-8155

Ms. Cecilia Rosales
Arizona Department of Health
4949 E. Fifth Street
Tucson, Arizona 85716
(520) 795-1531 Fax: (520) 795-1816
crosule@hs.state.az.us

Ms. Lucy Rosario
Juntos Unidos
P.O. Box 310
Nogales, Arizona
(520) 761-4412 Fax: (520) 761-4413
junidos@dakotacom.net

Mr. Jacob L. Rueda
HRSA- Border Health
3815 No. Black Canyon Highway
Phoenix, AZ 85015
(602)230-5949 Fax: (602) 230-5959
jrueda@hs.state.az.us

Mr. Rene T. Salgado
Arizona Mexico Border Health Foundation
2501 East Elm
Tucson, Arizona 85716
(520) 795-9756 Fax: (520) 795-1365
rsalgado@ambf.org

Ms. Rosalia Salinas
Learning Resources and Educational
Technology Division
San Diego County Office of Education
6401 Linda Vista Road
San Diego, California 92111-7399
(619) 292-3522 Fax: (619) 571-4750

Ms. Dubia Sanchez
Puentes de Amistad
P.O. Box 646
Somerton, Arizona 85350
(520) 627-4280 Fax: (520) 627-4277
pda1@primenet.com

Ms. Ruth Sanchez-Way
CSAP
5600 Fishers Lane, Rockwall II
Room 9-30
Rockville, Maryland 20857
(301)443-0369 Fax: (301)443-0526
rsanchez@samhsa.gov

Ms. Mary Sandy-Neville
Drug Enforcement Administration
3010 North Second Street, Suite 301
Phoenix, Arizona 85012
(602) 664-5630 Fax: (602) 664-5612

Ms. Sylvia J. Sapien
LCDF
P.O. Box 3420
Anthony, New Mexico 88021
(505) 882-7370 Fax: (505) 882-7373
sapien@zianet.com

Mr. Daniel Schecter
ONDCP
Washington, D.C. 20503
(202) 395-6733 Fax: (202) 395-6744
daniel_schecter@ondcp.eop.gov

Dr. D. Dwayne Simpson
Texas Christian University
TCU Box 298740
Fort Worth, Texas
(817) 257-7226 Fax: (817) 257-7290
ibr.tcu.edu

Mr. Mark Simpson
U.S. Bureau of Prisons
3301 Leestown Road
Lexington, Kentucky 40511
(859) 253-8839 Fax: (859) 253-8839
msimpson@bop.gov

Mr. Shepherd Smith
The Institute for Youth Development
P.O. Box 16560
Washington, D.C. 20041
(703) 471-8750 Fax: (703) 471-8409
jjones@youthdevelopment.org

Ms. Mary Ann Solberg
Troy Community Coalition for the
Prevention of Drug and Alcohol Abuse
4420 Livernois
Troy, Michigan 48098
(248) 823-5088 Fax: (248) 823-5051
mas1otry@moa.net

Mr. Harry Steed
Arizona Elks Association
37 South 82nd Way
Mesa, Arizona 85208
(480) 984-1219 Fax: (480) 832-9503
csteed@uswest.net

Mr. Robert Stephenson
SAMHSA/CSAP
5600 Fishers Lane, Rockwall II Room 815
Rockville, Maryland 20857
(301) 443-6780 Fax: (301) 443-3031

Ms. Linda Sturdivant
Employee Assistance Professionals
Association
200 Lothrup Street
Pittsburgh, Pennsylvania 15213
(412) 647-3296 Fax: (412) 647-9484
sturdivant11@msx.upmc.edu

Ms. Emma Torres
Puentes de Amistad
P.O. Box 646
Yuma, Arizona 85350
(520) 627-4280 Fax: (520) 627-4277
pda1@primenet.com

Mr. Avelardo Valdez
University of Texas at San Antonio
1222 N. Main Avenue #650A
San Antonio, Texas 78212-5709
(210) 458-2370 Fax: (210) 458-2372
avaldez@ustsa.edu

Dr. Elizabeth Valdez
Concilio Latino de Salud, Inc.
546 East Osborn Road, #22
Phoenix, Arizona 85012
(602) 285-0970 Fax: (602) 285-0980
concilio@netzone.com

Mr. Forrest Van Camp
Leon Co. Schools
2757 W. Pensacola Street
Tallahassee, Florida 32304
(850) 487-7525 Fax: (850) 414-5106
vancampf@mail.leon

Mr. Luis E. Vazquez
Puentes de Amistad
143 N. State Avenue
Somerton, Arizona 85350
(520) 627-4280 Fax: (520) 627-4277
pda1@primenet.com

Mr. Moises Venegas
The Albuquerque Partners
801 Encino Place, NE
Suite F21
Albuquerque, New Mexico 87102
(505) 244-9770 Fax: (505) 244-9771
apart5@swcp.com

Mr. Ray Vinsik
Arizona HIDTA
1750 E. Benson Highway
Tucson, Arizona 85714
(520) 746-4426 Fax: (520) 746-4405
vinsiki@azstarnet.com

Mr. Ricky Wascher
Juntos Unidos
P.O. Box 310
Nogales, Arizona
(520) 761-4412 Fax: (520) 761-4413
junidos@dakotacom.net

Mr. Harvey Weiss
National Inhalant Prevention Coalition
2904 Kerbey Lane
Austin, Texas 78703
(800) 269-4237 Fax: (512) 477-3932
nipe@io.com

Major Larry W. Wilbanks
National Guard Bureau
Jefferson Plaza 1, Suite 6500
1411 Jefferson Davis Highway
Arlington, Virginia 22202
(703) 607-5772 Fax: (703) 601-2733
wilbanksl@

ATTENDEES FROM MEXICO

Dr. Enrique de Jesus Aceves Arce
Centros de Integración Juvenil

Lic. Evangelina Aguilar Soto
Responsible del Pp y Ca de Sinaloa

Dr. Mario Alva Rodriguez
De la Direccion General

Lic. Norma Amerena Casao
Secretaria de Educacion Publica

Dr. Benito Antón Palma
Instituto Mexicano de Psiquiatría

Jose Angel Arce Gonzalez

Jose Arellano Lopez
Casa Juvenil de Villahermosa

Lic. Alejandro Arroyo Domínguez
Consejo Nacional Contra lass Adicciones

Edith Gabriela Arroyo Tinoco
De Promotores Juveniles de Irapuato

Lic. Karen Aspuru Juárez
Departamento de Normas CONADIC

Dr. Carlos Astorga Othón
Director General de Salud en el
Estado de Baja California

Dr. Hector E. Ayala Velazquez
Facutad de Psicologia Unam

Lic. Adrian Badillo Martinez
Centros de Integración Juvenil

Arnulfo Banuelos

Dr. Mario Cesar Bejos Lucero
Liber-Adictus

Lic. Fernando Beltran Aguirre
Direccion General de Salud Reproductiva

Lic. Ruth Noemí del Pilar Beltrán Ojeda
Comunidad Terapéutica Para Mujeres

Dr. Fernando de J. Bilbao Marcos
Universidad Autonoma de Morelos

Lic. Rosa del Carmen Aglae Bonifaz Pedrero
CONADIC

Lic. Jaime Luis Brito Vazquez
Cultura Joven

Lic. Jesús Cabrera Solís
Centros de Integración Juvenil

Dr. Luis Calderón Rodríguez
Federación Médica de Baja California, A.C

Jose Camarografo

Sofia Magaly Camorlinga Camacho
De Programas de Adicciones y Sexualidad

Juan Carlos Camul Cu
Boys Scouts

Dr. P. Roberto Canto Aguilar
Juventud "Luz y Esperanza" I.A.P.

Lic. Mónica Cantú de Ainslie
Fundación Ama la Vida, I. A. P.

C. Veronica Eulalia Caporal Perez
Casa Dar y Amar Daya

Dr. Manuel Carbajal Ruiz
Clínica Especializada en Solucionar
Alcoholismo y Dependencias

Ismael Carreto Iglesias

Pablo Carrillo

Lic. Ignacio Carrillo Prieto
Director General de Prevención y
Readaptación Social

Cónsul Salvador Casián
Cónsul de México en Phoenix

Amada Castanon

Dr. Javier Castellanos Countiño
Subsecretario de Regulación y
Fomento Sanitario, SSA

Lic. Claudia Angélica Castillo Aldana
Tec. de Monterrey

Lic. Jose Castrejon Vacio
CONADIC

Dr. Mario Castro Rochel
Responsible del Pp y Ca en Durango

Lic. Sergio Tadeo Cervantes Gallegos
De Jovenes

Lic. Jesús Cevallos Copel
Oceánica

Eduardo Chacon

C. Alma Rosa Colin Colin
Anica

Lic. Roberto Cordova Contreras
Servicios de Salud en el Estado de Chihuahua

Dr. Francisco Humberto Cordova Cordero
Secretariade Salud en el Estado de Chiapas

Luis Alberto Cordova Gonzales

C. Miguel Angel Coria Valdez
CIRAD

Lic. Adriana Cortes Jimenez
Fundación Comunitaria Bajio A.C.

Lic. Maribel Cuellar Ramirez
Radio Neta

Dra. Christine de Agostini
PNUFID

Maria de la Paz

Arturo de la Paz Vega

Martin de la Rosa

Dr. Hector de Leo Tovalina
Secretaria de Salud de Veracruz

Lic. Claudia de Mendieta Ortega
Universidad del Valle de Mexico

Lic. Lino Diaz Barriga Salgado
Centros de Integración Juvenil

C. Maria Cristina Diaz Jimenez
Juventud Progresista Chiapaneca

Lic. David Bruno Diaz Negrete
Centros de Integración Juvenil

Roberto Duran

C. Carlos Alejandro Espinoza Dominguez
Instituto Mexicano de la Juventud

Dra. Emilia Figueroa Guillén
Clínica Integral de Tratamiento Contra
lass Adicciones

Lic. Karina Flores Carmelo
Centros de Integraciòn Juvenil

Lic. Oscar Fuentes Fierro
Procuraduria, General de la Republica

Lic. Nora Gallegos Vázquez
Dirección de Normatividad CONADIC

Dr. Jose Luis García Aguirre
Coordinación de Salud Mental

Lic. Monica García Murrieta
Oceanica

Lic. Israel Arturo Gomez Daniel
De Atención a la Juventud

Ana Maria Gonzales Medina
Lic. José Antonio González Fernández
Secretario de Salud

C. Eda González Richmond
Dirección General CONADIC

Dr. Victor Manuel Guisa Cruz
Centros de Integración Juvenil (CIJ)

Dra. Gladys Guzon Jover
Genesis de Sinaloa

C. yomara Dominguez Contreras
CONALEP

Lic. Ernesto Enriquez Rubio
Centros de Integración Juvenil

Lic. Fanny Feldman
Grupo Retorno

Luis Manuel Flores

Carlos Franco

Lic. Laura Elena Gaither Jiménez
Responsible del Pp y Ca en Tamaulipas

Dr. Jesus García
Salud, Equidad y Servicios a Jovenes

L.P. Erendira García Alcantar
Pp y Ca en Michoacan

C. Roberto García Salgado
Instituto Mexicano de la Juventud

Maria Idalia Gomez Silva

Acuna Gonzalez
Dra. Ma. de Los Angeles González
Terapeutica

Sra. Martha Granados
AMAAR de Chihuahua

Lic. Maria de Lourdes Velez
FIPADIC

Leo Hernandez

Victor Miguel Hernandez

Sr. Jorge Hernandez Villareal
Los Brazos de Dios

Lic. Mariano Herrán Salvatti
Fiscal Especial-PGR

Miguel Inguanzo Blanco

Sr. Jose Israel Jimenez Calvillo
Presidencia Municipal de Leon

Dr. Alvaro Jurado Alonso
AMAAR de Chihuahua

Dr. Philippe Leff Gelman
Instituto Nacional de Psiquiatría

Marta Lohr
Secretariat de Salud de Sonora

Dr. Joaquín López Bárcena
Director General de Servicios
Médicos, Unam

Dr. Hèctor López González
Servicios de Salud en Tamaulipas

Lic. Juan Pablo Lopez Montano
CIRAD

Lic. Alejandro Lopez Sanchez
DGPMP

Jorge Machado

Lic. Claudia Yanet Machi German
Causa Joven

Ing. Juan Machin Ramirez
Instituto Mexicano de la Juventud

Lic. Eduardo Maciel del Valle
Club Juventud Siglo XXI

Lic. Jorge Madrazo Cuéllar
Procurador General de la República

Dr. Carlos Leonardo Magis Rodriguez

Raul Marquez Albujar
Conasida

Dr. Hector Marroquin Segura
Servicios de Salud en El Estado San
Luis Potosi

C. Imelda Marrufo Nava
Casa

Dra. Silvia Cruz Martín del Campo
Centro ce Investigación y Estudios
Avanzados Cinvestav

Mtra. Antonieta Martín Gómez
Universidad de Johns Hopkins

Jorge Alejandro Medellin Vazquez

Lic. Ana Maria Mercadal Martinez
Fiscalia Especializada Para la
Atencion de Delitos Contra la Salud

Lic. Mauricio Meza Barrera
Del Grupo de Pacificadores

Mtra. Maria Carmen Rosa Millé Moyano
Dirección de Capacitación y Informacion

Lic. Dina Nohami Molina Gomez
Causa Joven

Lic. Carlos Oswaldo Morales Buelna
Instituto Sonorense del Deporte y la Juventud

Gregorio Moreno Contreras

Lic. María Jesús Muñoz Avila
Responsible del Pp y Ca en Campeche

Humberto Munoz Grande

Lic. Gustavo Ignacio Muñoz Manzo
de Organizaciòn Juvenil

Dr. Armando Muñoz Valencia
Servicios de Salud en el Estado de Mexico

Lic. Fernando Murguia Orozco
Oceanica

Lic. Alejandro Narvaez Higuera
Asociacion Dips Por un Consumo Responsible

Dr. Jose Luis Navarro Paredes
Prevencion de Riesgos Sociales en la Infancia

Lic. Yvette Nuñez Bravo
Instituto Nacional Para la Educación
de Los Adultos

Lic. Juan Nuñez Guadarrama
CONADIC

C. Luis Antonio Obregón Contreras
Responsible del Pp yY Ca e en Chihuahua

Lic. Francisco Ojeda Quesney
Causa Joven

Dr. Arturo Ongay Pérez
CONADIC

Alfredo Ortega Sanchez

Lic. Rosa Maria Ortiz Encinas
Centros de Integración Juvenil

C. Ricardo Ortiz Longoria
Instituto Mexicano de la Juventud

Ernesto Ortiz Maldonado

Lic. Marisa Oseguera Garcia
ILEF-CAVIDA

Lic. Sandra Paola Otalora de Gre
Genesis de Sinaloa

Lic. Amir Efren Padilla Espadas
Consejo Quintanarroense de la Juventud

Lic. Mario Padilla Ramos
Secretaria de Salud de Sonora

C. Jose Edgar Palma Carrillo
Consejo Quintanarroense de la Juventud

Maria Eugenia Parra

Lic. Andrea Pastor Padilla
Centro de Estudios Superiores
Monte Fenix

Lic. Leonel Penagos Flores
Servicios Especiales, PGR

Jose Luis Perez Bautista

Maria Rosalia Perez Garcia

Lic. Juan Martín Pérez García
Centro "El Caracol"

Dr. Jose Luis David Peterson Beltrán
Salud Mental en Sonora

C. Yazmin Elizabeth Piña Alfaro

C. Jose Luis Pino Guerrero

Opcion Mexico

Dr. Jaime Ponce Alcocer
Estatal para el Control de Drogas en Queretaro

Lic. Adriana Porter Mejia
Atencion A la Delincuencia Ciudadana

Lic. Maria Teresa Puebla de Carreño
Centros de Integración Juvenil

Lic. Jaime Quintanilla Bendek
Centros de Integración Juvenil

Lic. Alba Rabling
PNUFID

M.C. Martha Ramirez Rambao
Clinica Integral de Tratamiento

Lic. Luciana Ramos Lira
Instituto Mexicano de Psiquiatría
Guillermo Rangel

Dr. Ignacio Benedicto Reyes Aguila
Servicios de Salud en Baja California

Lic. Claudia Rigalt Gonzalez
Universidad del Valle de Mexico

Sr. Ruben Rivera Peña
AMAAR de Chihuahua

Dr. Manuel Robles Linares Negrete
Secretaria de Salud de Sonora

Sr. Pedro Rodriguez Garcia
El Caracol

Dr. Juan José Roque Segovia
Responsible del Pp y Ca en el Estado
de Nuevo León

Drogadictos Anonimos

Lic. Manuel Ponce Bernal
Centros de Integración Juvenil

Psic. Gloria Estela Portillo García
Centros de Integración Juvenil

Lic. Gabriela Quiñones Cervantes
Centros de Integraciòn Juvenil

Lic. Ana Maria Quintanilla Enciso
Centros de Integración Juvenil

Dr. Miguel Angel Ramirez Almanza
Servicios de Salud de Oxaca

Oscar Ramos

Mtra. Ma. Elena Ramos Rodriguez
Programa Compañeros
Enriquez Reyes

Lic. Patricia Ines Reyes del Olmo
CONADIC

Lic. Wilfred Rios Sanchez
Procuraduria General de la Republica

Lic. Yasmin Rivera Perez
Secretaria de Desarrollo Social
Queretaro

Dra. Rosalía Rodriguez Cuevas
Clinica de Tabaquismo IPN

Sr. Gerardo Rodriguez Rivera
El Caracol

Lic. Galia Rosemberg
PNUFID

Mtra. Haydée Rosovsky
Secretaría de Salud

Cesar Rubio Garcia

Sra. Ninfa Sada de Salinas
Directora de Fundación Azteca

Lic. Epifanio Salido Pavlovich
Secretaria de Salud de Sonora

C.P. Alfonso Salinas Corral
Secretaria de Comunicaciones y Transporte

Lic. Teresa Sanchéz Fragoso
CONADIC

Dr. José Sánchez Ortega
Ceca en el Estado de Baja California

Lic. Mario C. Sánchez Tapia
Presidencia Municipal de Leon, GTO

Dr. Jorge Sánchez-Mejorada Fdez.
Universidad Veracruzana

Dr. Hector Sandoval Martinez
CETyS

C.P. Irene Sandoval Mejia
Instituto Mexicano de la Juventud

Dr. Mauro Santiago Pedro
CONADIC

Dr. Jorge Santibañez
Director del Colegio de la Frontera Norte

Lic. Ma. Cristina Santoscoy Gutierrez
Consejo Estatal Contra las Adicciones
en Jalisco

Lic. Toffie Sasson Hamui
Centro Monte Fenix

Lic. Marta Serafin Moreno
FEADS

C. Engelbert Serna Barraza
Del Secretario General

Dr. Fred Sipe
Oceanica

Lic. Sonja Skarstol
Oceanica

Dr. Luis Solis Rojas
Instituto Nacional ee Psiquiatría

Dr. Ivan Suarez Villa
Secretaria de Gobernacion

Dr. Roberto Tapia-Conyer
Subsecretario de Prevención y
Control de Enfermedades

Lic. Pedro Tonella Trelles
Pp y Ca en Sonora

C. Andrés Tovilla Saenz
Narcóticos Anónimos

C. Luz del Carmen Trejo Fernandez de Castro
Fundación "Dr. Sergio Berumen"

Sra. Socorro Trespalacios Guerrero
AMAAR de Chihuahua

Sr. Eduardo Trespalacios Lozano
AMAAR de Chihuahua

Lic. Luis Amador Treviño Peña
Instituto Mexicano de la Juventud

Dr. Manuel Urbina Fuentes
Subsecretario de Coordinación Sectorial, SSA

Lic. Juan Ramón Uriarte Galván
Director General de Promoción y Medicina del Transporte, SCT

Lic. Blas Urquidez Jr.
Transportación Maritima Mexico S.A. de C.V.

Lic. José Vallejo Flores
Fundación Renacimiento

Lic. Lilia Vazquez Portales
PGR Cendro

Aida Velasco

Dr. Rafael Velasco Fernández
Centro de Estudios Sobre Alcohol y Alcoholismo, A.C. (CESSAL)

Dr. Agustín Vélez Barajas
Fideicomiso para los Institutos para los Niños de la Calle

Lic. Araceli Vergara Sabbagh
Clinica Nazaret

Lic. Cesar de Jesus Vergara Sabbagh
Clinica Nazaret

Dr. José Vila del Castillo
Representante del PNUFID en México

Cesar Viruega

Ing. Roberto Vital Pineda
Casa de Rehabilitación "Alcance Victoria"

Margarita Ybarra

Lic. Joaquin Zamora Ortega
Del Proyecto y Educador de Calle

Lic. Raul Zapata Aguilar
Centros de Integración Juvenil

NIDA PRE-CONFERENCE PARTICIPANTS

Dr. Jaime Ponce Alcocer
Coordinator
Estado de Queretaro
Secretría de Gobierno
Conse Jo Estatal para el Control de Drogas

Mr. Mario Alva
Instituto Nacional de Ciencial Penales
Apartado Postal 10830

Dr. Benito Antón
Investigatador Titular AB@
División de Investigaciones Clínicas
Instituto Mexicano de Psiquiatría

Ms. Esther Arellano
Prevention Application Management Coordinator
Center for the Application of Prevention Technology
Arizona Department of Health Services
Division of Behavioral Health

Mr. Hector Ayala
Coordinador de Enseñanza Profesional
Facultad de Psicología
Universidad Nacional Autonoma de Mexico

Ms. Judith Brook, Ph.D.
Professor
Department of Community and Prevention
Mount Sinai School of Medicine

Dr. Luis Calderón
Director del centro de la Conducta S.C.

Dr. Felipe Gonazalez Castro, M.S.W.
Department of Psychology
Arizona State University

Patricia Chavez-Anaya
Value Options Investigador Titular

Anna Chisman
Chief of Demand Control
Inter-American Drug Abuse Control Commission
Organization of American States
1889 F Stree NW Washington DC 20006 USA
Phone: (202) 458-6119
Fax: (202) 458-3658
achisman@oas.org

Dr. Francisco H. Córdova
Secretario de Salud
Hospital General, María Ignacia gandulfo
Estado de Chiapas, Mexico
Phone: (529) 613-7688
Fax: (529) 613-1309

Mr. Javier Córdova
Policy Analyst
Prevention Branch
Office of Demand Reduction
Office of National Drug Control Policy
750 17th St., N.W., St. 612, Washington D.C
20503 USA
Phone: (202) 395-6166
Fax: (202) 395-6744
javier_.m._cordova@oa.eop.gov

Dr. Silvia Cruz
CINVESTAV, IPN

Dr. Bruno Diaz
Centros de Integración Juvenil
Calle Vicente Suárez 149
Col. Hipódroma Condesa
C.P. 06100 Mexico, D.F.
Phone: (525) 211-4186
Fax: (525) 286-5955
investigación@cij.gob.mx

Dr. Gerardo DeCosio
Coordinator Binacional
Programa Binacional Colabrorativo de Diabetes
Frontera Mexico-Estados Unidos
Organización Pan Americana de la Salud
Organización Mondial de la Salud
5400 Suncrest Drive, St. El Paso, TX 79912
Phone: (915) 845-5950
Fax: (915) 845-4361
decosiog@fep.paho.org

Mr. Leonel Penagon Flores
PGR FEMOS
Mexico, D.F

Mr. Oscar Fuentes
PGR
Mexico D.R.

Lic Nora Gallegos
Directora de Normatividad
Consejo Nacional Contra las Adicciones, SSA
Aniceto Ortega 1321, Piso 5
Col. Del Valle
03100, Mexico, D.F.
Phone: (525) 534-6690
Fax: (525) 534-6690
ggallegos @supernet.mx

Ms. Elsa Garcia
Chihuahua

Dr. Victor Guisa
Director de Tratamiento y Rehabilitación del
Centro de Integración Juvenil
Calle Vicente Suárez No. 149
Col. Hipó dromo Condesa
06100 Mexico D.F.
Phone: (525) 534-6690 Tijuana, Mexico
Fax: (525) 286-5995
guisav@usa.net

Dr. Mary Jeanne Kreek
The Laboratory of the Biology of Addictive Diseases
Rockefeller University Hospital
1230 York Avenue
New York, NY 10021-6399 USA
Phone: (202) 327-8247
Fax: (202) 327-8574
kreek@rodkvax..rockfeller.edu

Ms. Susan Kuntz
Director
Border Health Foundation
2501 East Elm Street
Tucson, AZ 85716 USA
Phone: (520) 795-9756
Fax: (520) 795-1365
skuntz@ambhf.ort

Dr. Sandra Owens Lawson, Ph.D.
Senior Policy Analyst
White House Office of Drug Control Policy
750 17th St. N.W. Washington DC 20503 USA
Phone: (202) 395-6750
Fax: (202) 395-6744
sandra_o._lawson@oa.eop.gov

Dr. Phillip Leff
Investigados Asociate
División de Investigaciones Clinicas
Calzado, Mexico D.F.
pleff@neuroserver.imp-nuero.edu.mx

Dr. Remedios Lozada
Coordinadora del Programa HIV/SIDA
Enfermedades de Transmisión Sexual
Comite Municipal Contra el SIDA
Av. ConstituciónEntre call 8 y 9
Zona Centro 22000, Baja California
Phone: (526) 668-3804
Fax: (526) 685-1338

Dr. Carlos Magis
Director de investigación
Consejo Nacional para la Prevención y Control del SIDA (CONASIDA), SSA
Calzado de Tlalpan, No. 4585 Piso 2
Col. Torilello Guerra
C.P. 14050 Mexico D.F.
Phone: (525) 528-1949 / (528)1887
Fax: (525) 528-1949
magis@cenids.na.gob.mx

Mr. Alberto Mata. Jr.
Associate Professor
Division of Human Relations
University of Oklahoma
601 Elm Ave., Room 728, Norman, OK 73019 USA
Phone: (405) 325-1756
Fax: (405) 325-4402
agmata@ou.edu

Ms. Adriana Mendiolea
Border Affairs Coordinator
U.S. Consulate Tijuana
Office of Public Affairs Tijuana, Mexico
Phone: (526)-681-7400 ext. 261
Fax: (526)-681-8592
ammex@pd.state.gov

Dr. M. Patricia Needle, Ph. D.
Director, International Program
Abuse National Institute on Drug Abuse
Room 1B59 Building 31, 9000 Rockville Pk.
Bethesda, MD 20892 US
Phone: (301) 594-1928
Fax: (301) 402-5687
pn28@nh.gov

Dr. M. Richard H. Needle, Ph. D., M.P.H.
Senior Policy Advisor for HIV/AIDS & Drug
U.S. Department of Health and Human Services
Room 733-E, 200 Independence Ave, S.W.
Washington DC 20201
Phone: (202) 205-0290
Fax: (202) 690-7560
rneedle@osophs.dhhs.gov

Luis Antonio Obregón
Director General
Coordinador de Atención a las Adicciones y
Responsible del Programa de Prevención y
Control de Adicccciones
Niños Heroes 1103-B
Col. Centro 31000 Chihuahua, Mexico
Phone: (521) 415-3059
Fax: (521) 410-7980 / (521)-410-7856

Lic. Andrea Pastor
Directora
Centro de Estudios Superiores Monte Fenix
Las Flores No 439, Col. San angel Inn
01060 Mexico D.F.
Phone: (525) 681-3011 ext. 249
Fax: (525) 595-3349
admon@supernet.com.mx

Mr. Juan Paz
Associate professor
School of Social Work
Arizona State University
2648 east 6th Street
Tucson, AZ 85716 USA
Phone: (520) 884-5507
Fax: (520) 881-0678
juan.pax@asu.edu

Dr. Luciana Ramos
Jefe del Departamento de Investigaciones Especiales
Instituto Mexicano de Psiquiatría, SSA
Calzada Mexico-Xochimilco, No. 101
Delegación Tlalpan
14370 Mexico D.F.
Phone: (525) 655-21811 ext. 201
Fax: (525) 534-1346
ramosl@imp.edu.mx

Ms. Rebecca Ramos
U.S. – Mexico Border Health Association
Asociación Fronteriza
5400 Suncrest Dr., St. C-a5
El Paso, TX 79912 USA
Phone: (915) 833-6450
Fax (915) 833-7840
rebecca@utep.edu

Mtra. Haydée Rosovsky
Secretaría Tecnica
Consejo Nacional Contra las Adicciones
Aniceto Ortega 1321 Piso 2
Colonia del Balle
03100 Mexico City, Mexico
Phone: (525) 534-7891 ext. 204
Fax: (525) 554-7851
rosovsky@mail.internet.com.mx

Wilford Rios Sanchez
PGR FEDPS
Investigador del Instituto de Investigaciones Psicológicos
Universidad de Veracruz
Km 3.5 de la Carretera Jalap-Las Trancas
91100, Jalapa, Veracruz, Mexico
Phone: (522) 812-5740
Fax: (522) 812-8683
josame@infosel.net.mx

Dr. Jorge Santibañez
Presidente
Colegio de la Frontera Norte, A.C.
Blvd. Abelardo L. Rodriguez No. 2925
Zona del Rio
22320, Baja California, Tijuana Mexico
Phone: (520) 631-3300
Fax: (520) 631-5266 / (520) 631-3555
santj@colef.mx

Lic Toffie Sasson
Director Clinico Del Centro Monte Fenix
Las Flores No. 439
Col. San Angel Inn
01060 Mexico, D.F.
(525) 681-3011 ext. 249
(525) 595-3349
admon@supernet.com.mx

Dr. Steven Shoptaw, Ph.D.
Senior Behavioral Scientist
Friends Research Institute, Inc.
11075 Santa Monica Blvd., St. 225
Las Angeles, CA 90025 USA
Phone: (310)479-9330 ext. 239
Fax: (310)479-9601
shoptaw@friendsresearch.org

Dr. Luis Solís
Jefe del Centro de Ayuda al Alcohólico y sus Familiares (CAAF)
Instituto Mexicana de Psiquiatría
Calle Rebública de Venezuela esq. Rodriguez Puebla
Col. Morelos Centro, 06020 Mesico, D.F.
Phone: (525) 702-7568
Fax (525) 702-7538
solisr@impledu.mx

Mr. Robert L. Stephenson II
Director (Acting)
Center for Substance Abuse Prevention/SAMHSA
Division of Workplace Programs
5600 Fishers Lane Rockwall II, Room 815
Rockville, Maryland USA
Phone: (301) 443-6780
Fax: (301) 443-3031
rstephenson@samhsa.gov

Ms. Claire E. Sterk
Rollins School of Public Health
Emory University
1518 Clifton Road, N.E. Room 516
Atlanta, GA 30329-4218 USA
Phone: (404) 727-9124
Fax: (404) 727-1369
csterk@sph.emory.edu

Mr. Avelardo Valdez
Director
Hispanic Research Center
University of Texas, San Antonio
6900 North Loop 1604 West
San Antonio, TX 78249-0650 USA
Phone: (210) 458-5154
Fax (210) 458-5155
avaldez@utsa.edu

Mr. Fernando Wagner-Echeagaray
Johns Hopkins University
624 North Broadway, 8th Floor
Baltimore, MD 21209 USA
Phone: (410) 415-6055
Fax: (410) 955-5155
fwagner@jhsph.edu

Mr. Harvey Weiss
Executive Director
National Inhalant Prevention Coalition
2904 Kerbey Lane
Austin, TX 78703
Phone: (800) 269-4237
Fax: (512) 477-3932
nipe@io.com

Dr. Raúl Zapata
Director de Prevención
Centros de Integración Juvenil
Vicente Suárez 149
Col. Hipódromo Condesa
Mexico, D.F.
Phone: (525) 286-9230
Fax: (525) 286-8818
prevention@cij.gov.mx