Special Issue: Innovations

ALCOHOLISM & DRUG ABUSE WEEKLY

News for policy and program decision-makers

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In This Issue...

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Missouri set to recruit high-cost Medicaid recipients with untreated SUDs

Missouri is embarking on a program that will expand substance use disorder (SUD) treatment for high utilizers of medical services with average Medicaid costs of $20,000 a year each. Previously successful for high Medicaid utilizers with serious mental illness, the diagnoses are now being expanded to include SUDs, explained Mark Stringer, director of the Division of Behavioral Health in the state's Department of Mental Health. The targeted patients are not currently in SUD treatment, are already enrolled in Medicaid and have a chronic medical condition.

Bottom Line...
Targeting Medicaid patients with $20,000 a year or more in medical bills who have untreated substance use disorders is hoped to save Missouri millions of dollars a year while improving care.

"The purpose is to engage them in clinical services," Stringer told *ADAW* in an October 21 interview. "These people are pretty sick, and many are not interested in traditional services, so there will be a lot of

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The Business of Treatment

A focus on service has allowed N.Y. provider alliance to flourish

B$T

At its peak, an alliance of community-based substance use treatment providers mainly in western New York had 12 members — it is now down to 9. But rather than that being a sign of concern, a longtime leader in the group brings this fact up in the context of describing a key element of RecoveryNet's success.

Bottom Line...
Staying mindful of the collective good and maintaining a client focus are being cited as key components to the longstanding success of a coalition of community-based substance use service providers in western New York.

"We agreed from the beginning that our collaboration was not to be created to make sure that Huther Doyle would continue to exist," Bob Lebman, president and CEO of said Monroe County treatment facility and founding member of RecoveryNet, told *ADAW*. "This was about making sure that community-based services would remain an option for people not comfortable with receiving care from an institutional entity."

Made possible originally out of a planning grant in 2000 from the Substance Abuse and Mental Health Services Administration (SAMHSA), RecoveryNet and its provider orga-

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outreach involved." What was learned on the mental health side of this project, called Disease Management 3700, is that many of the people are homeless and have medical problems that are "out of control," said Stringer. "We'll need to hook them into some form of treatment, which for many will include medication-assisted treatment, and we will work with them on their medical condition."

Care coordination

One requirement for SUD providers to participate is that they must have medical staff on board, said Stringer. Most of the state-funded SUD providers have nursing staff, he said. If there are services the patient needs that the SUD treatment provider can't give, that provider will need to make sure the patient has access to these services and must coordinate with other providers under this program. Asked whether SUD providers shouldn't already be doing this anyway, Stringer noted that traditionally the providers have "treated the substance use disorder all by itself." That's partly because of the way the state pays providers, he conceded. "Right now we pay our providers according to a certain allocation, and that puts a limit on how much revenue they can get from the state," he said. But the disease management program will be different, because all of the services will be paid not by Stringer's department, but by the state Medicaid agency. "This is a way for the providers to increase their revenue," said Stringer. "There's a financial incentive" for providers to be coordinating care.

"This is the future of healthcare," said Stringer. On the mental health side, the annual savings in Medicaid costs for the state — even after the extra mental health services were paid for — was $8.3 million on average a year, for about 3,000 patients who met the criteria.

> **'You almost can't help but save money.'**
>
> Mark Stringer

"You're not treating just one component, but you're looking at the person wholistically, from a case management perspective," explained Nora Bock, director of treatment services for the Division of Behavioral Health. "You're going to be evaluating all life domains, coordinate housing services, with medical providers, with substance abuse treatment providers." This not only makes for better healthcare, but reduces medical costs, she said.

Medicaid partnership

For recovery supports that are not funded by Medicaid, "we'll use the block grant," said Stringer. "We're just lucky in a variety of ways in Missouri, because we're building on an existing relationship between the Department of Mental Health and the state Medicaid agency." And Missouri has the legendary Joseph (Joe) Parks, M.D., clinical director of the Office of Mental Health, who launched the disease management program, noted Stringer, adding that Bock had the idea to expand it to from mental illness to SUDs.

"It was a natural next step," said Bock. "We are the Department of Behavioral Health; we've seen success on the psychiatric side, a lot of the providers offer both addiction and psychiatric services and our folks with addictive disorders have just as many co-occurring health problems as people with mental illness."

Recruitment challenges

The state hopes to qualify 1,600 patients to participate in the SUD disease management program, said Debbie McBaine, who is heading up the disease management pilot. "I

ALCOHOLISM & DRUG ABUSE WEEKLY
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don't know that we could expect half that number — that would be on the optimistic side." Even though the state will attempt to contact 1,600 patients, the program is voluntary — if they don't want treatment for their SUD, they don't have to have it, she said.

In addition, sometimes it's hard to fine people, said Bock. The Medicaid system may have bad addresses — people may have moved. "And also, there are issues associated with someone representing the government," she said. Providers who have been involved with the mental health project already have dealt with this — "going onto someone's porch and having the patient threaten to call the sheriff, dealing with people who are very sick in a variety of ways who don't want help but who also feel horrible."

Bringing these patients into the disease management system will help them and will help the state's finances, according to Stringer. "You almost can't help but save money" with this program, he said, adding that he is confident that it will continue to grow.

The target implementation date is January 1. •

Buprenorphine by telemedicine: Reaching rural W.V. patients

Patrick J. Marshalek, M.D., oversees the buprenorphine telemedicine program run out of West Virginia University (WVU), where he is an assistant professor of behavioral medicine and psychiatry. By partnering with community mental health agencies across this state, which is hard-hit by opioid addiction, he is able to make sure buprenorphine medication and adjunct counseling are accessible to patients who are in rural areas.

The community mental health infrastructure is essential, because there are offices in every county, with catchment areas that must be served. "This has allowed us to build upon services," said Marshalek. By pairing the academic resources of WVU with the proximity of the mental health centers, more patients can get buprenorphine, he said. "We have a lot of M.D.'s, and most community mental health centers don't have even one, much less one trained in addiction," he said. Prescribing buprenorphine also requires a federal waiver.

Assessing withdrawal

Inductions — the most difficult aspect of buprenorphine treatment for many primary care physicians — are not a problem, said Marshalek. He can easily assess withdrawal via telemedicine, he said. Drug screens are performed at the community mental health center. "We manage inductions a great deal, via telemedicine and face-to-face," he said. "It's not that different from starting someone on Prozac or Lexapro."

Induction with buprenorphine can't be done unless patients are in some withdrawal, but most opioid-dependent people know this and have "let themselves get to that point" by the time they come in for the initial assessment, said Marshalek. That way they can get the buprenorphine right away, rather than being sent away and told to come back when they are in withdrawal — something that distresses treatment providers because they know there is a good chance the person won't come back.

'We have a lot of M.D.'s, and most community mental health centers don't have even one, much less one trained in addiction.'

Patrick J. Marshalek, M.D.

In many cases, the patient will be given the induction dose of buprenorphine to take at home. "The induction can be managed without the amount of observation that has been dictated," said Marshalek. "They come in somewhere between intoxicated and withdrawal," said Marshalek. "I say to take it right after they get home."

Tech upgrades

Marshalek sees telemedicine patients on a group basis once a week, and assesses their recovery at each visit. Based on their progress, he then sees them every other week, and then monthly. After a year in recovery, he sees them once a month.

The groups last 30 minutes and include education about buprenorphine and recovery. Marshalek also reviews comorbid psychiatric and medical problems, and intravenous drug use histories. At WVU there is a coordinator of telepsychiatry, with point contacts at the mental health centers.

Grants and state funding help pay for the program, including updating the equipment at the community mental health centers, which historically have been at the forefront of telemedicine and behavioral healthcare in the state, said Marshalek. Not only has the hardware improved, but the software has been upgraded as well, he said. "We use web-based software that allows use of devices like iPads," he said. "I'm on a television, and my patients are on a television so I can see them —

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it's the equivalent of a webcam." But it's all HIPAA-compliant, so it's private and "not like Skype," he said.

Psychosocial interventions

Marshalek stresses that his program is more than just medication. Most of the patients in rural locations are on Medicaid, said Marshalek. "I'm reminded of this when I see the struggle patients have to go somewhere once a day" to get methadone or buprenorphine without naloxone, he said. "And I see how poorly patients do when they don't get proper treatment, whether it's methadone or Subutex or Suboxone — unless the psychosocial interventions are there, then you are basically trading one drug for another." Buprenorphine has "fallen into the hands of providers" who often do not provide the psychosocial interventions, he said. "Look at the providers who just want 400 bucks for the induction and then a couple hundred at every subsequent treatment — that isn't the best treatment," he said. "Some of them have the idea that therapy means giving the patient a list of therapists in the area."

Of course, the 100-patient limit still applies, so Marshalek can only have that many on his caseload, telemedicine or not. He thinks that he could probably take on more patients, because he does specialize in addiction treatment and focuses on recovery. Not many primary care physicians would see a patient every week to check on recovery, he noted. "Case management is really important for successful buprenorphine maintenance programs," said Marshalek. "We stress that with the community mental health centers." •

NYC expands peer counseling services to include SUDs

The New York City Health and Hospitals Corporation (HHC) is in the middle of expanding its peer counseling services from persons with mental illness and co-occurring disorders to persons with substance use disorders (SUDs). Under the guidance of Marylee Burns, senior director of HHC's Division of Medical and Professional Affairs in the Office of Behavioral Health, there is now a specific project in which part-time peer counselors are paid to lead groups for patients with SUDs.

"For many years, HHC has employed peer counselors in mental health services," Burns told *ADAW*. "Now HHC is expanding peer counseling services to work within chemical dependency services."

Peer counselors have been using HHC's *Guide to Keeping Healthy after the Hospital*, which is a workbook-style tool that addresses patients' health, mental health and substance use conditions and treatment needs. Peer counselors who are in recovery from SUDs run groups using a new guide, the *Recovery and Wellness Handbook*, created by peer counselors with guidance from HHC chemical dependency staff, said Burns. Most of the patients in these groups are in either ambulatory or inpatient settings.

Burns said the peer counselors are cost-effective — they are less costly than psychologists or social workers — and provide motivation and hope in recovery. "Patients identify with peer counselors and connect by sharing mutual experiences," she said. Peer counselors are enhancing HHC's treatment teams and in fact help patients engage in treatment. In some cases, states are beginning to utilize Medicaid 1115B waivers to cover peer services. Managed care organizations also have been more receptive to provide reimbursement for peer services, she said.

> **'Patients identify with peer counselors and connect by sharing mutual experiences.'**
>
> Marylee Burns

For peer counselors, in addition to lived experience, relevant training is required. There is a growing effort to credential peers in New York, and some limited training programs exist. HHC recruits peer counselors through a variety of resources, including graduates of training programs and individuals who have reached points in their recovery where they are able and interested in helping others, while also soliciting through advertisements. HHC has developed a training manual and a supervision guide and recognizes the need for intensive support and supervision of the peer counselors.

Groups are customized to the patients' needs by matching them with peer counselors' lived experience and backgrounds. The patients, who enthusiastically participate in groups, respond well to the groups led by these peer counselors, she said.

HHC is the largest municipal healthcare system in the country, serving 1.4 million New Yorkers annually, more than 475,000 of whom are uninsured, through 11 hospitals and more than 70 community-based clinics. •

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Abstinence-only provider won over by buprenorphine

Over the past 10 years, Rocky Hill, owner of Hill Alcohol and Drug Treatment in Temecula, California, has gone through a sea change when it came to medication-assisted treatment. Originally a staunch advocate of drug-free treatment, Hill had to change his mind when patients started coming into his outpatient program, directly from detoxification, either under the influence because they couldn't deal with withdrawal or in withdrawal. What had changed was the drug of choice — instead of alcoholics or methamphetamine addicts, people who had been addicted to prescription opioids, benzodiazepines or heroin were coming in for treatment. "They were unable to concentrate, and this made treatment very difficult," he told *ADAW*.

When buprenorphine came along, Hill was initially "reluctant and skeptical," he said. "We've always been abstinence-based and still consider ourselves as such." But, he said, patients who had been addicted to opioids or benzodiazepines weren't doing well, either in terms of retention or in the ability to avoid relapse. There was no medication to treat benzodiazepine addiction, but for opioids, buprenorphine seemed to offer hope. So Hill switched from drug-free to Suboxone for these patients, and kept them on the medication for six to eight weeks. "We wanted them to be able to work in treatment, have a core of recovery, get their family involved, have them stop the racing brain and the lack of energy," said Hill. "We could deal with them, they were present, they could emote," he said of patients on buprenorphine.

Then, in many cases, after the patients had been on buprenorphine for six to eight weeks, they were tapered off the medications. Older patients with chronic pain issues who had gotten into opioid addiction due to prescription opioids were kept on buprenorphine, because it worked as an analgesic, said Hill. "For those patients, anecdotally, they said they could tolerate their pain better on the buprenorphine than they could on the full agonist," he said.

Hill started his career in 1981 working in a methadone maintenance program, and he wasn't happy with what he saw — "I didn't see anybody getting clean and sober," he said. But he saw his patients on buprenorphine "relieved of the negative consequences" of their addiction. "Our job is to enhance their quality of life," he said.

> **'We wanted them to be able to work in treatment, have a core of recovery, get their family involved, have them stop the racing brain and the lack of energy.'**
>
> Rocky Hill

The taper is done very gradually, based on patient symptoms, with no preset dates, said Hill. "They need to go to meetings," he said. "It's very likely that once the buprenorphine is removed, they will experience the symptoms of full-on withdrawal again." And there is a real problem with patients who were formerly addicted to opioids switching to benzodiazepines, said Hill. Benzodiazepine withdrawal, unlike opioid withdrawal, can be life-threatening, and the taper must be managed by physicians, said Hill. "We work with the patient and the family, and create a safety zone," he said. •

Alliance from page 1

nization members are now reaping the benefits of more than a decade of joint strategizing. These agencies will continue to play a pivotal role in implementation of health home models of treatment (already under way in New York) and public-sector managed behavioral health services (expected to be launched in 2014).

In a far-ranging interview with *ADAW*, Lebman emphasized how important it has been for RecoveryNet's members to discard a competitive mentality among themselves. "Only 10 percent of the people who need treatment are getting it. Why are we fighting over that when nobody is engaging the other 90 percent?" he said.

Significant milestones

RecoveryNet grew out of a meeting about 13 years ago involving several Monroe County substance use service agencies and the county mental health director. Lebman says the provider participants left that gathering with this assumption: "If we continue the way we are, hospital systems will be the sole providers [of substance use treatment in the county] and there won't be community-based services."

Four agencies in the county that includes the city of Rochester took the lead in organizing initial joint activity, with one of the agencies securing the SAMHSA planning grant. A consultant was brought on to conduct a walk-through of the business and operational practices of each provider organization, and Lebman said the primary goal in this effort was to establish a "no wrong door" approach for client services among the agencies.

"If a woman with two small children comes through the door of my agency and needs residential treatment, we need to be able to

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place her in one of our partner agencies without having her go through another assessment process," said Lebman.

The group therefore had to standardize assessment forms across member organizations, an effort that involved synthesizing the best elements from each separate assessment that had been used traditionally.

A key step after that involved getting each member on an electronic health record. A vendor product from Sequest Technologies was selected in this process, but only the largest members of RecoveryNet directly bought licenses for their own organization. Funds were pooled among the agencies in order to allow smaller members that could not finance this on their own to acquire the electronic record capability.

Lebman adds that through all these stages of the alliance's development, cooperation has been easier to come by than what one might have assumed going in.

For example, he said, "When the idea of a uniform assessment first came up, one of the directors said, 'Oh no, we can't do that.' Five to six months later, the same idea was raised by the same person who had objected — he had seen the light."

RecoveryNet's members also worked on approving a common set of outcome measures among the respective agencies, and Lebman says these ended up looking very similar to the national measures that have since been advanced out of Washington.

He said the common approaches have resulted in numerous benefits for the member organizations. "Since we all adopted the electronic record, every member's re-licensing review has resulted in receiving the maximum license term," he said.

The state Office of Alcoholism and Substance Abuse Services (OASAS) is also supportive of the collaboration. "The RecoveryNet alliance providers view each other as partners, and share a comprehensive assessment which allows clients to be assessed and admitted quicker as well as transferred to different levels of care more efficiently throughout the greater Finger Lakes region of New York state," said Jannette M. Rondo, spokeswoman for OASAS. "OASAS encourages such partnerships, which promote administrative efficiencies and improve patient care within the emerging behavioral healthcare system."

'All of the partners in RecoveryNet became network members for the health home.'

Bob Lebman

RecoveryNet also has been largely responsible for the member organizations' ability to adjust to shifting payment winds, as members now tend to receive about two-thirds of their revenue from insurance payment as opposed to being primarily dependent on state and federal funds.

As predicted, though, the alliance has not had a static membership roster since its inception. A couple of members exited the substance use treatment business altogether in recent years, others have experienced organizational mergers and two of the current members are actually located outside of Monroe County. However, the existence of RecoveryNet has meant that some services from closing agencies have been easily incorporated into another member agency, as was the case when Huther Doyle assumed control of a Spanish-language and -culture addiction services program that had been run by a former member that now does not deliver behavioral healthcare.

Health homes, managed care

Lebman said RecoveryNet members are presently at the forefront of two major service transformations in the state: the emergence of health home initiatives for the Medicaid-covered and the impending arrival of public-sector managed behavioral healthcare services.

"My agency was approached by the Monroe County mental health director to serve as the lead for one of two health homes," said Lebman. By virtue of the existence of the provider alliance, "All of the partners in RecoveryNet became network members for the health home," he said.

Huther Doyle recently opened its own primary care clinic as part of the effort to integrate addiction and general health services, and all individuals who receive substance use services from any RecoveryNet member organization are eligible to receive primary care at that clinic.

Participation in the health home model in general is voluntary for patients; they must have a severe and persistent mental illness, be HIV-positive, or have two chronic illnesses (substance abuse can be one), or have one and be at risk for the second. Facilities generally have three months to engage an individual client in the health home concept. "If it's explained to them properly, they're interested," said Lebman.

Another coalition-building effort over the years in western New York took the form of the New York Care Coordination Program, governed by area behavioral health providers (including some RecoveryNet mem-

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bers) and county government behavioral health agency directors in the region. When the state issued its request for proposals for behavioral healthcare organizations (BHOs) to oversee implementation of managed care in five designated regions of the state, the New York Care Coordination Program applied to be the BHO for the area encompassing 21 western New York counties. It is now the only region with a BHO that is not a managed care entity, Lebman said.

So in western New York, the managed care company that will manage services beginning in late 2014 is a contractor to the BHO, not the reverse, Lebman said.

He said that SAMHSA officials have told him that to this day, few examples of this level of cooperation among providers in a region exist across the country. He said that as a result of members' not seeing themselves first as competitors, "We're able to be at the table and have input."

He urges providers in other communities simply to "get up, get out of bed and get out there" to establish similar partnerships. •

The latest in EHRs: Moving the technology to where the patient is

Addiction treatment is starting to move away from the "desktop" and into the community, armed with "untethered devices" — smartphones or iPhones or iPads. And the applications are following, explained Bill Connors, senior vice president and general manager of Netsmart.

Netsmart now has a division called "Points of View," which involves a small application — not a complete electronic medical record — to help the consumer at the point of care.

"The traditional inpatient detox still exists, but the market, whether because of legislation or insurance, is changing with treatment provided more in the outpatient environment," said Connors. "We're going out and providing solutions in the field."

For example, in New York one Netsmart client, a program for war veterans, signed up for a smartphone app that allows patients who feel at risk for relapse to connect with the treatment provider. "People who are thinking of picking up a drink or a drug can register this on their iPhone, and it gets dropped right into the care record," said Connors. "The smart electronic medical record at the site alerts the case manager, the clinician on call, or the medical director if it is that serious," he said. In this program the veterans were given special phones to use, said Connors.

"All sorts of alerts can be fired off, saying someone is contemplating a drink or drug use, and then the clinician is added with decision-making — 'Do I call them, do I do a mobile outreach, how do I help them?'"said Connors.

The project was initially funded by the Substance Abuse and Mental Health Services Administration.

Briefly Noted

Son's death leads father to raise money for synthetic marijuana detection

New technology is making it easier for law enforcement to test for synthetic marijuana in the field, WSB-TV in Atlanta, Georgia reported October 15. Instead of having to wait for the product to be tested at the crime lab at the Georgia Bureau of Investigation, officers can now seize the product from a convenience store or smoke shop and test it right away. These tools were discussed at a synthetic drug summit in Bremen this month, where drug investigators, counselors and testing companies gathered to share information. The event was organized by Lance Dyer, whose 14-year-old son Dakota died after smoking synthetic marijuana. The father raised money to purchase a Ford Interceptor that will be equipped as a synthetic drug response vehicle, said Dyer. "It will have state-of-the-art synthetic drug testing equipment," he said. "We're trying to shrink the time it takes to prosecute someone and get these things off the street."One device, called "True Narc," is a handheld narcotics analyzer that can detect more than 100 different narcotic and synthetic drug compounds. Another, called the "Nark II," can speed up investigations of synthetic marijuana in particular. "They suspect they have a synthetic cannabinoid, and they can confirm it so they can make arrests and proceed with their case," said Nark II representative Jack Thornick. And Georgia Tech and the Hall County School system use a dipstick test, called "K-2, D-2" to see if athletes are using synthetic marijuana. "All they have to do is collect a urine sample in a cup, dip this in, and in three to five minutes you have a result for K-2. We test for 16 different types of synthetic compounds" said Affinto Company CEO Sherry Bender.

Reckitt Benckiser may sell off pharmaceutical unit

Now that Suboxone has lost its patent protection, with declining sales as a result, manufacturer Reckitt Benckiser is thinking of selling the pharmaceutical unit, Reuters reported October 22. According to financial analysts, that part of the business might have international

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appeal, and is worth more than $3.2 billion. Shares rose 5 percent; analysts have been uncertain about how less expensive generics of buprenorphine-naloxone would affect the market. United States sales of Suboxone fell 14 percent in the third quarter.

State News

Rolling admissions increases capacity at Alaska teen program

Raven's Way, a residential adventure-based treatment program in Sitka, Alaska, is changing its enrollment structure from one with preset enrollment dates to rolling admissions, allowing patients to be admitted at any time. In addition, the program length will change from six to eight weeks. Raven's Way, run by the SouthEast Alaska Regional Health Consortium, the *Juneau Empire* reported October 18. The program calls its patients students "because we really feel like they're here to learn," said program manager Rebecca Howe. "They're here to learn new ways of thinking about substances, new ways of communicating with the people around them, just a lot of new skills to help them choose a new lifestyle." Both the rolling admissions and the increase in length of stay are important, she said. For example, if a student leaves early, the bed can immediately be used for another teen, instead of staying empty until the next enrollment period. In addition, if teens need an extra week or two, they can stay longer instead of having to leave. According to Howe, the program has a 50-percent success rate, meaning that 50 percent of the teens achieve abstinence. Of the other 50 percent, half significantly reduce their use of drugs. The goal, said Howe, is to get the success rate up to 60 percent. "Just the amount of recovery talk that they're engaging in, it seems like they're really getting it," Howe said. "I really feel that we're going to be able to meet our students' needs in a better fashion and help set them up for success." For more information, go to www.searhc.org/services/behavioral-health/yeil-jeeyax-ravens-way.

Coming up...

The conference of the **American Association for the Treatment of Opioid Dependence (AATOD)** will be held **November 9–13** in **Philadelphia**. For more information, go to **www.aatod.org**.

In case you haven't heard...

A group of Mormon mothers in Utah is getting help from a lawmaker in the state in obtaining marijuana extracts for their children, who have severe epilepsy, the *Salt Lake Tribune* reported October 11. Rep. Gage Froerer, a Republican state legislator, says the extract is "not a drug" and not medical marijuana. But it does come from the cannabis plant, and it's cultivated by the nonprofit Realm of Caring in Colorado Springs — in a state where marijuana is legal. This plant is high in cannabidiol (CBD) but low in tetrahydrocannabinol (THC), the psychoactive component that makes users high. One child went from having 300 seizures a week to having only on at the most. Froerer wants the Utah Substance Abuse Advisory Council to recognize the extract, which he calls "Alepsia," as different from a controlled substance, so that it can be imported into Utah. "Utah has an opportunity to be innovative," said Annette Maughan, whose 6-year-old son also has untreatable epilepsy.

Resources

NIDA announces smartphone updates for drug information

Aimed mainly at teenagers and their parents and teachers, new applications allowing people to get information on drugs in English and Spanish are now available from the National Institute on Drug Abuse (NIDA). As part of this initiative, which was timed to coincide with National Substance Abuse Prevention Month (coordinated by the Office of National Drug Control Policy) events in October, NIDA has upgraded its teen website to be responsive to screen size, allowing easier viewing through smartphones and tablets. The teen site has free, interactive resources. There is also a parents and educators page for scientifically based prevention and education materials. "By using improved Web and handheld device strategies to distribute research findings, we can reach a broader audience," said NIDA Director Nora D. Volkow, M.D., in announcing the new apps October 21. "NIDA is launching these tools during National Substance Abuse Prevention Month and will continue to translate the science to guide effective prevention and education efforts in homes and communities." For the teen site, go to http://teens.drugabuse.gov. For more information on drug prevention, see NIDA's Preventing Drug Abuse among Children and Adolescents at www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents. To find out how to get involved in National Substance Abuse Prevention Month, visit www.whitehouse.gov/ondcp/prevention-intro/prevention-month.