

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

**Minutes of the
57th Meeting of the
CSAT National Advisory Council**

**December 11, 2008
1 Choke Cherry Road
Rockville, MD**

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Center for Substance Abuse Treatment National Advisory Council

December 11, 2008
Rockville, Maryland

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met in open session on December 11, 2008, at the SAMHSA Building in Rockville, Maryland. Cynthia A. Graham, M.S., Designated Federal Official, CSAT National Advisory Council, called the Council meeting to order at 8:35 a.m. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., chaired the meeting. Members present included Abdelwahhab Alawneh, M.A.; Anita B. Bertrand, M.S.W.; Rev. John D. Castellani; Kenneth A. DeCerchio, M.S.W.; Elizabeth Howell, M.D.; Francis A. McCorry, Ph.D.; and Gilbert Sudbeck, M.A. Also present were Ted Searle, M.B.A., CSAT Acting Deputy Director, and George R. Gilbert, J.D., Director, CSAT's Office of Program Analysis and Coordination.

Welcome

Dr. Westley Clark welcomed participants to the Council's 57th meeting.

Consideration of Minutes

Council members voted unanimously to adopt the minutes of the March 20, 2008, CSAT National Advisory Council meeting. The minutes had been certified in accordance with the Federal Advisory Committee Act regulations, and members had been given an opportunity to review and comment on the draft minutes.

Opening Remarks and Introductions

Dr. Clark acknowledged members' contributions to the Council and acknowledged the service of Ms. Melody Heaps and Mr. Kenneth DeCerchio, whose tenure on the Council was ending. Dr. Clark reported that SAMHSA has undergone a transition since the Council last met. SAMHSA Administrator Terry Cline accepted a position as the health attaché at the U.S. Embassy in Baghdad. Dr. Eric Broderick now serves as Acting SAMHSA Administrator, and Ms. Kana Enomoto serves as Acting Deputy Administrator.

Council members introduced themselves and described their recent activities. Mr. Gilbert Sudbeck, Director of South Dakota's Division of Alcohol and Drug Abuse, reported that his State, which has just completed its substance abuse block grant application, has maintained stable funding and services for both prevention and treatment. Mr. Ken DeCerchio stated that Children and Family Futures, under a CSAT contract to operate the National Center for Substance Abuse and Child Welfare, continues its work to strengthen collaboration between the two fields. In addition, his organization works with the Children's Bureau of the Administration on Children and Families' regional partnership grant program in support of families in the child welfare system who are affected by substance abuse disorders; 53 grantees were poised to submit initial, joint-system outcome data. Dr. Beth Howell has continued her work as a

psychiatrist with an addiction specialty and has been named director of the new American Board of Addiction Medicine. Ms. Anita Bertrand serves as executive director of the Northern Ohio Recovery Association in Cleveland. Her organization recently increased treatment capacity for adult males for whom a long-standing waiting list had existed. The association participated in September's National Recovery Month and was preparing to implement a CSAT HIV grant. Dr. Frank McCorry, director of the Commissioner's office in New York City for the State Office of Alcoholism and Substance Abuse Services and chair of the Washington Circle Group, stated that New York State faces a \$12 billion deficit, which may have implications for substance abuse services. For Recovery Month, New York State launched a Stories Campaign, whereby people posted their stories on a Web site to promote and celebrate the possibility of recovery. The State's Office of Mental Health has established a partnership with the New York State Health Foundation to create an integrated setting for outpatient mental health and substance abuse treatment. Dr. McCorry leads an initiative to integrate medication-assisted treatment as a recovery option, and his agency will host the international methadone conference in April. In the criminal justice arena, the Office of Mental Health now operates a semi-inpatient program for persons who have violated parole for drug use, with treatment provided by addiction experts and facilities and security provided by the Department of Corrections. To inform its work on a performance measure for medication-assisted treatment, the Washington Circle plans to convene an expert panel. Rev. John Castellani, who has been involved with Teen Challenge's faith-based alcohol recovery program, stated that Teen Challenge presented a program with the Red Ribbon and Henry Lazano. Mr. Abdelwahhab "Abe" Alawneh explained that the nonprofit Arab American and Chaldean Council provides substance abuse and mental health services. Most of its clients, members of Arab-American and Iraqi populations, have post-traumatic stress disorder. Mr. Alawneh explained that his agency hosted SAMHSA-sponsored trainings and visits on mental health topics for Iraqi physicians and participated in Recovery Month.

Mr. Ted Searle, CSAT Acting Deputy Director and former Deputy Director for the Center for Mental Health Services for more than five years, introduced himself. He explained that all SAMHSA deputy directors are rotating around SAMHSA's centers to get an opportunity to see how things are working in each center.

In addition to being deputy directors, they are also chief operating officers, and learning how the operations work within each of the centers, and taking some of that information on to the next center and utilizing some of that.

Director's Report

Dr. Clark noted that the change in Administration provides opportunities for CSAT to communicate how its programs benefit the treatment community and the Nation. CSAT emphasizes the importance of grantees using evidence-based practices wherever possible as well as outcome data to assess program effectiveness in meeting goals and objectives and to guide necessary adjustments. The economic downturn highlights the need for grantees to demonstrate quantitatively that CSAT programs reduce substance abuse disorders in the community.

SAMHSA's 2007 National Survey on Drug Use and Health (NSDUH) reported a significant decrease in cocaine and methamphetamine use among young adults over the past year, but also a rise in prescription drug abuse. In addition, drug use among people ages 50–59 has spiked. These findings are important in light of Census Bureau projections that by 2030 one in five U.S. residents will be age 65 or older; by 2042 minority populations will become the majority; and by 2050 the Hispanic and Asian populations will double from 2008 levels. Dr. Clark highlighted CSAT's need to tailor its programs and focus to meet the needs of these changing populations.

Dr. Clark stated that alcohol disorders are rising in transitional youth ages 18–25, who thus warrant increased attention. CSAT will explore the potential benefit of engaging transitional youth in treatment before their substance abuse becomes more entrenched. CSAT's Targeted Capacity Expansion (TCE) Campus Screening and Brief Intervention (SBI) Program has demonstrated the success of early intervention with this population, and CSAT will continue to analyze program data for lessons learned applicable to other grants or programs, including programs for young adults who do not attend college.

CSAT's Recovery Month in September 2008 promoted the message of "Real People, Real Recovery." SAMHSA sponsored 50 community events, one in each State, and usage of the official Web site increased 9% over the same period in 2007. The Entertainment Industries Council's PRISM awards permitted CSAT to increase public awareness of substance abuse and its impacts in recognizing the entertainment industry's commitment to accuracy in depictions of addiction and health issues in a variety of entertainment media. Some television programs have relied on SAMHSA's technical assistance, including "Grey's Anatomy." CSAT sponsored or played a significant role in the recent State Systems Development Program Conference; Third Annual Conference on Women, Addiction, and Recovery; National Methamphetamine Summit; and the Returning Veterans Conference.

Recognizing that social determinants of health affect many populations, CSAT's grant awards have focused on providing services to persons in criminal justice systems, underserved racial and ethnic populations, and persons who are homeless. In September, CSAT awarded 20 new Treatment Drug Court grants, 10 Adult Criminal Justice Treatment grants, and 23 TCE grant awards to address gaps in substance abuse treatment and recovery support services in communities with serious, emerging drug problems. One TCE grantee category includes specific minority populations, while the other includes community, faith-based, and recovery community organizations that aim to create recovery oriented systems of care (ROSC), which support individuals and help communities use resources more effectively. CSAT also made awards to 25 community service organizations that offer substance abuse treatment and mental health services to persons who are homeless.

In fiscal 2008, CSAT awarded a total of 189 new discretionary grants amounting to \$77.1 million. New grants were funded to support accreditation for opioid treatment programs and to provide clinical support for treating pain and opioid addiction with

methadone. CSAT funded four new Screening, Brief Intervention, and Referral to Treatment (SBIRT) grants, plus 11 grants to implement SBIRT training in medical residency programs. Endorsement of SBIRT by Congress and the Administration has allowed CSAT to engage the medical community in addressing addiction. In addition, CSAT made 49 new TCE awards to address substance abuse and HIV/AIDS in minority communities and 16 new Pregnant and Postpartum Women Treatment grants. CSAT supported the development and implementation of National Outcome Measures (NOMs) with States and workforce development activities with Historically Black Colleges and Universities. Dr. Clark pointed to his written "Director's Report" for additional details on CSAT activities.

Regarding the FY 2009 budget, Dr. Clark noted that CSAT has been operating under a continuing resolution (CR) that provides funding at the FY 2008 levels, with congressional action not expected until January 2009. Both the House and Senate have tentatively approved increases over the CR level, but their priorities differ, and resolution of differences is difficult to predict.

Dr. Clark asserted that while a difficult economy has complicated the transition to a new Administration, it is important to recognize that CSAT funding has an economic impact on the communities it serves. Preliminary analysis of data associated with CSAT's discretionary grant program reveals that CSAT's portfolio is responsible for \$100 million in salaries and benefits at the local level, accounting for approximately 20,000 jobs in States, tribes, counties, cities, and towns. In addition, \$100 million investment and 20,000 jobs leverage additional economic benefits by returning people to work, decreasing the public cost of illness, and decreasing crime. Dr. Clark stated that CSAT's portfolio should be considered a complement to any economic stimulus package. By providing direct services to local communities that endure the burden of substance abuse disorders, CSAT's portfolio directly supports jobs and helps people return to work, thus decreasing the burden on the local economy and restoring the availability of workers. This analysis serves as a reminder of SAMHSA's important role in improving public health and public well-being.

Council Discussion. In response to Dr. McCorry's request, Dr. Clark agreed to provide Council members with his presentation on the economic benefits associated with funding of substance abuse treatment services in communities. Dr. Howell suggested that CSAT consider educating drug court judges about decisions related to medications. Dr. Clark stated that he will engage senior staff to address the effectiveness of drug courts and DWI courts. Mr. DeCerchio inquired about a possible line-by-line review by the incoming Administration of the budget and findings from PART reviews. Dr. Clark stated that CSAT recognizes the importance of program effectiveness and described several systems that help evaluate the grant portfolio.

Ms. Bertrand asserted the need for the Council to inform the new Administration of CSAT's priorities. Dr. Clark responded that the Council can express its sentiments to SAMHSA's Acting Administrator and share information with local communities. Ms. Bertrand volunteered to lead the effort to move CSAT's agenda forward. Mr. DeCerchio clarified that the Council had sent a letter to Dr. Cline articulating its views on the

budget and its recommendations for 2010 budget priorities. Mr. DeCerchio volunteered to join in this effort. In response to Dr. McCorry's request, Dr. Clark stated that CSAT will provide the Council with the name of the transition team member assigned to SAMHSA. Dr. McCorry congratulated CSAT/SAMHSA on its Returning Veterans Summit and its international summit on methamphetamine use in critically affected populations. Dr. Clark highlighted the importance of a bi-directional policy academy approach that enables community representatives to translate information into change in their respective jurisdictions with SAMHSA serving as a resource to facilitate those changes.

Public Comment

No comments.

State of the Agency: Planning for Transition to the New Administration

Eric B. Broderick, D.D.S., M.P.H., Acting Administrator, SAMHSA, and Assistant Surgeon General, announced that President-elect Barack Obama officially announced his intent to nominate Sen. Tom Daschle as HHS Secretary.

Dr. Broderick explained HHS's transition activities prior to the election in response to the Office of Management and Budget's (OMB) memo directing facilitation of a smooth transition. In July 2008, HHS convened a team of agency and division leaders to compile information and attend regular meetings. SAMHSA prepared a briefing book to assist the transition team, and the new SAMHSA Administrator, to help them understand and get a feel for the agency. Former HHS chief-of-staff William Core has led the HHS team to learn about changes that have occurred over the past 8 years, "hot" issues, and what the new Administration must know to succeed in its first 90 days.

Two transition team members at SAMHSA interviewed the administrator and other top leaders and prepared a report. Their next tasks were to seek input from constituent organizations and develop lists of potential political appointees. The President-elect hopes to have top appointees confirmed by the Senate by April 2009, among them the HHS Secretary and Deputy Secretary. The web site <http://change.gov> posts information about the transition.

Dr. Broderick described his responses to transition team questions. Changes at SAMHSA over the past 8 years include a new building, increased programmatic emphasis on recovery and recovery support services, mental health parity legislation, and the importance of associated regulations. In the first 90 days, SAMHSA must respond to the Office of National Drug Control Policy's (ONDCP) proposed budget. He expects increased systematic integration of mental health and substance abuse treatment into the overall health system and integration of public health principles and practice into the substance abuse and mental health fields using a public health model. Dr. Broderick noted that the transition team's Dr. Nicole Luria inquired what the HHS Secretary might do immediately to push integration of mental health and substance abuse services into the overall medical system. He emphasized the necessity to focus

on the needs of underserved persons and returning veterans, and on increasing suicide rates among youth.

Dr. Broderick stated that SAMHSA has begun to develop recommendations regarding NSDUH data that reveal an intractable treatment gap as well as static rates of substance abuse for individuals ages 18–24. Ongoing internal discussions will be followed by eliciting ideas from constituent groups on how to address that population.

Council Discussion. In response to Mr. DeCerchio's question on possible appointees for the position of ONDCP director, Dr. Broderick replied that he had not heard a lot of names. That the one that was in the press recently was Congressman Ramsted. Dr. Broderick also stated that a parity celebration Congressman Kennedy put his name forward as an administrator of SAMHSA..

Dr. Broderick concurred with Ms. Bertrand on the desirability of the Council's developing a work plan to provide advice on CSAT's agenda. He noted that political appointees determine the policies and staff implement them. Dr. McCorry noted that the idea of addiction services as integral to community-based services might resonate with a President who was a community organizer. He requested Council access the documents HHS submitted to the transition team. Dr. Broderick stated that he will make available public materials submitted on behalf of SAMHSA. SAMHSA's information is destined for posting online in a database to be updated over time. Dr. McCorry suggested inviting transition team members to discuss their experiences and emerging priorities. Ms. Bertrand noted that Cleveland plans to host a town hall meeting on health care. Dr. Broderick suggested that the organization invite him.

In response to a question from Mr. Sudbeck about the transition's influence on timing of grant awards, Dr. Broderick explained that issuing requests for applications depends on budget status, whether a new budget supersedes the FY 2009 CR and the associated availability and amount of funding. SAMHSA expects to receive guidance from OMB shortly after the inauguration, and the new President is expected to release his budget in April.

Mr. DeCerchio inquired about discussion of outcomes and effectiveness with the transition team. Dr. Broderick responded that while that topic was marginally relevant to the 90-day-priority discussion, the outgoing Administration's upcoming Performance Summit will feature a case study and lessons learned from CSAT's ATR program. SAMHSA's focus on NOMs, grantee performance, and data collection will likely continue.

Dr. McCorry inquired about the team's interest in interagency approaches to addiction treatment. Dr. Broderick responded that a better opportunity to discuss cooperative efforts will arise in briefings with new departmental and agency leaders. He noted the need to induce departments to work more collaboratively. Mr. DeCerchio concurred, noting the desirability of SAMHSA's leading that discussion. Dr. Broderick stated that creating opportunities to increase levels of understanding among other service-providing systems represents a first step. Dr. McCorry commended CSAT's leadership

in educating public health, public safety, and public welfare systems about addiction prevention and providing treatment within their purview. Mr. DeCerchio stated that SAMHSA's stories about SBIRT in medical settings, along with its work in child welfare and homelessness, can inform the educational process.

Recognition Ceremony for Retiring Council Member Kenneth DeCerchio and Melody Heaps (who was unable to attend the meeting).

Dr. Clark thanked Mr. DeCerchio for his outstanding service on the CSAT National Advisory Council and presented him with a plaque.

Dr. Clark emphasized the value of input from leaders in the field to help give direction to the new and existing administration by advocating for a robust substance abuse prevention and treatment strategy that takes an ROSC approach. He expressed his commitment to such a multi-systemic approach as essential for addressing the social determinants of health and dealing with health inequities. He invited others to work with CSAT on these issues.

National Expenditures for Mental Health Services and Substance Abuse Treatment

Ms. Rita Vandivort-Warren, M.S.W., Public Health Analyst, CSAT's Division of Services Improvement, presented findings of a recent SAMHSA report on national expenditures for mental health services and substance abuse treatment projected from 2003 to 2014. The report from the SAMHSA Spending Estimates details spending by provider, payment source, and cost of a disorder treatment, but not the expenditures on prevention, comorbidities, dementia, tobacco dependence, developmental delays, mental retardation or societal costs. The report identifies treatment spending by primary diagnosis and includes prescription drug spending for products used mainly to treat psychiatric and addiction conditions. Ms. Vandivort described the range of data sources used to inform the methodology and noted that parity is not accounted for since it passed after the study was completed.

By 2014 overall mental health and substance abuse treatment spending is expected to grow to \$239 million, but mental health and substance abuse as a share of all health spending is declining, estimated to be just under 7% by 2014. Mental health spending will be about 85% of total combined mental health/substance abuse treatment spending, and substance abuse treatment is 15%. Medicaid is the largest payer for mental health services and a significant payer for substance abuse treatment. State and local jurisdictions are the largest payers for substance abuse treatment. By 2014, it is projected that private insurance will account for 26% of mental health services spending but only 7% of substance abuse treatment expenditures. Thirty percent of all mental health dollars will go toward prescription drugs, while less than 1% of all substance abuse treatment spending will go towards substance abuse medications. The report also notes differences between mental health and substance abuse spending for physicians and other providers.

Ms. Vandivort noted that by 2014, substance abuse treatment spending as a portion of all health spending will have declined by half since 1986, estimated at about 1% in 2014. Private insurance spending on substance abuse treatment has declined from 2% of all private insurance spending to less than 0.2%, while Medicare expenditures on substance abuse treatment will be under 1% of all Medicare spending. Only the public payers have significant portions of expenditures toward substance abuse treatment. Medicaid substance abuse spending is estimated to decline to 1% of all Medicaid spending in 2014, while all other Federal expenditures on substance abuse treatment represent 3–4% of all Other Federal spending. Other State and local payers contribute the largest portion of their spending on substance abuse treatment, accounted for almost 8% of all their health spending by 2014. The decline share of substance abuse treatment spending in most payers is a result of not keeping pace with the growth rate in spending on all health.

The substance abuse treatment spending is increasingly dominated by public, rather than private, dollars. Public and private payers equally shared in the spending for substance use disorders, each accounting for half of substance abuse treatment spending in 1986. But by 2014, the portion of all private spending, which includes private insurance, out-of-pocket, and charitable, is estimated to decline compared to all public sector spending accounting for about 17% whereas public expenditures will account for 83%. Ms. Vandivort explained that private health insurance spending on substance abuse treatment will have dropped from 30% in 1986 to 7% by 2014. These estimates were critical to demonstrate the need for parity because of declining spending in group health insurance plans.

Spending for mental health services by private payers has held steady since 1986, supported by spending on prescription drugs. If medication-assisted treatment for substance use disorders expands, private spending should rise. Ms. Vandivort stated that private spending on substance abuse treatment is anticipated to grow more rapidly in the future than it has over the past 15 years, although still at only half the rate of public spending growth. Medicaid spending, which accounted for about 10% of treatment spending in 1986, is projected to double by 2014. Other Federal spending, which includes the block grant as well as the Veterans Affairs and military spending, is expected to double from 7% in 1986 to 14% in 2014. Other State and local payers remain as the largest portion of spending, projected at be 45 % by 2014, a reliance that raises concerns given the budget crises in most States.

In 2003, SAMHSA's block grant accounted for almost half of the other Federal spending category, 8% of all public expenditures and 6% of total substance abuse treatment spending. Substance abuse treatment spending is shifting from hospital to specialty substance abuse centers; from 2003 onward, hospitals are expected to account for around 25% of spending, about half of their share in the late 1980s. Growth areas include residential and outpatient specialty treatment centers, for which spending will grow from 19% in 1986 to a projected 42% in 2014, while spending for physicians and other providers has been constant.

Substance abuse treatment spending is projected to continue financing mainly specialty care, with only 17 % paid to primary care and other non-specialty providers. By comparison, in the mental health field, one third of care is offered in non-specialty settings. As substance abuse treatment becomes more integrated with primary care delivery systems, models such as SBIRT are expected to help grow substance abuse treatment.

Ms. Vandivort highlighted key issues in substance abuse treatment spending: (1) hospital-based treatment is falling and center-based treatment is rising as a share of substance abuse spending; (2) center-based facilities capture the largest share; (3) medications currently play no significant role in substance abuse treatment as they are less than 1% of all substance abuse treatment spending; (4) public spending is projected to reach 83% of all spending by 2014; (5) State and local spending will account for 45% of spending in 2014; and (6) private insurance is shrinking as a share of substance abuse funding.

As a share of gross domestic product, mental health services spending is projected to rise slowly, while substance abuse treatment spending will remain relatively flat. Factors that might influence substance abuse treatment spending in the future include the 2008 Parity Act, returning combat veterans with high prevalence of substance abuse disorders, State budget constraints and serious economic hardship, adoption of new treatment modalities such as SBIRT and recovery-support models, advances in the use of medications in substance abuse treatment, and the impact of Medicare and Medicaid payment policies regarding the location of care.

Ms. Vandivort noted that the growing burden of mental health and substance abuse treatment financing on Medicaid and State and local governments raises concerns, and she pointed out that the declining share of substance abuse treatment spending from private insurance requires renewed focus on making the case for substance abuse treatment to that sector. The SAMHSA Spending Estimates is currently exploring the possibility of estimating States' spending levels. In addition, SAMHSA is now conducting a study of cost and revenue data for mental health and substance abuse facilities that should provide new insights.

Council Discussion. Ms. Vandivort responded to a question from Dr. Howell about how the use of primary diagnosis to determine spending patterns may under report substance abuse treatment spending, especially for those with co-occurring mental health problems that are usually coded with mental health diagnosis as primary. Ms. Vandivort agreed that substance abuse treatment spending is probably understated but special studies have generally followed this accepted practice of primary diagnoses in health services research. She did note that new SAMHSA facility survey is expected to inquire about numbers of persons who have diagnoses for mental health, substance abuse, and co-occurring disorders so she expects to derive better data to guide spending allocations in the future. Mr. DeCerchio inquired about whether the \$239 billion in substance abuse treatment spending included correctional and juvenile justice facilities or prevention. Ms. Vandivort stated that prevention dollars are excluded. Correctional dollars that pay for community facilities are included but correctional

spending inside correctional facilities are excluded because of lack of data sources. She responded to a question by Dr. McCorry, stating that spending for detoxification services is included. Dr. Clark pointed out that the spending estimates represent a substantial contribution to the field.

SAMHSA's Household Survey: Update/Results from the 2007 National Survey on Drug Use and Health (NSDUH)

Peter Delany, Ph.D., LCSW-C, CAPT USPHS, Director, SAMHSA's Office of Applied Studies, updated the Council on national trends in drug and alcohol use as revealed in the latest NSDUH survey, whose data guide resource allocation. NSDUH is a nationally and statewide representative survey of civilian, non-institutionalized individuals ages 12 and older. In 2007, 68,000 people responded to the survey, and data are comparable since 2002.

Dr. Delaney described findings related to the use of illicit drugs, alcohol, and tobacco. The overall risk of illicit drug use, as well as risk for marijuana, psychotherapeutics, pain relievers, cocaine, and methamphetamine use among people 12 years and older has been relatively stable since 2002. The risk for use of pain relievers has grown a bit since 2004, an area that warrants special attention. Among people ages 12–17, overall illicit drug use shows a statistically significant decrease from 2002 to 2007, while from 2005 to 2007 the trend has been merely stable. These data are important guides for programming and planning. Marijuana, psychotherapeutics, inhalants, and hallucinogens have shown similar flat trends since 2005, with use of the latter two substances stable since 2002. The school-based study Monitoring the Future and the population-based Youth Risk Behavior Survey show parallel trends, thus lending strength to the data.

NSDUH looks at lifetime use, past year use, and past month use, with past month data used to identify trends over time. SAMHSA recently has increased attention to the 18–25 age group because of, for example, greater increases over time in nonmedical use of pain relievers. NSDUH revealed important information on sources of pain relievers—56.5% of users got them free from a relative. By contrast, methamphetamine use showed a significant drop among people ages 12–17 and also among people ages 18–25 after a rise in 2005. Past month heavy illicit drug use has risen among adults ages 50–59, as baby boomers who earlier were heavy users age into the category. Additional analysis is expected to explore this trend.

NSDUH showed that 51% of people use alcohol, 23% (58 million people) binge drink, and 7% (17 million) use alcohol heavily. People with long-term, ongoing heavy alcohol use experience considerable co-occurring medical conditions in addition to auto accidents, serious injuries, and behaviors that lead to pregnancy and other health problems. Underage drinking remains high among 18- to 20-year-olds, although younger people show significant declines in use. Surveys of alcohol use among persons in the criminal justice system were discontinued because of the near universality of drinking behaviors.

Among persons age 12 and older, past month tobacco use, mostly cigarettes, has slowly and steadily declined, while the 12–17 age group showed a sharper decline. Smokeless tobacco use has slightly increased, although it is currently a major issue in the armed services. Other tobacco use trends have remained stable. Mr. Alawneh identified emerging hookah use, particularly on college campuses. Dr. Delany will pass the information on to the NSDUH team.

NSDUH reports age at initiation of specific illicit drug, tobacco, and alcohol use. Findings indicate that of the 2.7 million individuals 12 years and older who initiated illicit drug use in 2007, the greatest percentage (56.2 percent) used marijuana followed by pain relievers (19 percent). Mr. Joseph Gfroerer clarified that the slightly more than 2.14 million individuals 12 and older initiated illicit use of pain relievers followed closely by marijuana (2.09 million) but that many of these individuals had prior histories of illicit drug use. Dr. Delany explained that data on average age of initiation helps inform programming for prevention and treatment. Initiation of PCP use occurs most commonly at age 16, followed by inhalants, marijuana, and LSD.

NSDUH's youth prevention-related measures—perceived great risk of marijuana use among youths ages 12–17, and whether those individuals saw that it was a great risk to use marijuana either once or twice a week or once a month—have been flat for several years, but it is possible that a lag time in certain behaviors may be a factor. Seeing or hearing substance abuse prevention messages and programs has declined in the past year among youth 12–17. Perceived availability of marijuana has declined significantly, while risk of cocaine use spiked in 2006 but dropped to previous levels. This measure for LSD and heroin has been flat for several years.

An important measure is the need for and receipt of specialty treatment in the past year for illicit drug or alcohol use among persons age 12 and older. About 7.5% of the population met the criteria for abuse or dependence in 2007, of whom only 18% got treatment for illicit drug use and 6.2% did not get specialty treatment. Only about 8% received treatment for an alcohol problem, and about 10% received treatment for a drug and/or alcohol problem. Of the 19.5 million people who met criteria for substance abuse and did not get treatment, 94% did not see the need for treatment; 4.6% felt they needed treatment and did not make an effort to get it; and 1.8% felt they needed treatment and made an effort to get it. The challenge is to motivate people to the point where they think they might need help, an area that would benefit from working with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) to determine the utility, for example, of the SBIRT program.

Mr. Alawneh suggested that usage is increasing among young people because less prevention education takes place in schools, for example, in Michigan. Dr. Delany explained that messages are also decreasing outside of school. He asserted that data must be placed in context, for example, by looking at national, State, and local data together. Dr. McCorry inquired about the usefulness of abuse or dependence criteria met by 94% of people. Dr. Delany noted that NIDA and NIAAA discussions have focused on moving away from categorical definitions based on the *DSM-IV*. Dr. Clark stated that meeting criteria for needing treatment represents an opportunity for early

intervention. Insurance reimbursement and the amount of additional burden for that insurance are small, because there is no demand for it. In cases of accidents due to drinking, emergency rooms often do not chart the alcohol because, under UPL laws, insurance companies may not reimburse for services. Dr. Delany highlighted the opportunity to rethink how to address the problem. Of the population who felt they needed treatment, 36% had no health insurance and could not afford the cost. Some stated they were not ready to stop using, and others cited transportation difficulties, inconvenience, and stigma.

Dr. Delany and Mr. Gfroerer reported findings regarding substance dependence or abuse among adults age 18 and older by major depression episode in the past year. Having depression offers more than twice the risk of having drug or alcohol, just drug, or just alcohol dependence or abuse. Ms. Bertrand inquired whether people who did not use substances for 6 months would still be considered depressed. Dr. Delany replied that clinical evidence shows that that strategy works for some but not for others. He stated that a large proportion of youth ages 12–17 have had a major depressive episode within the past years, especially girls, setting the stage for great difficulties when combined with substance abuse problems.

In summary, Dr. Delany pointed out that (1) widespread decreases in use are encouraging, but the number of initiators and the increase in nonmedical drug use is of great concern; (2) stability in the number of people needing, but not receiving, treatment calls for SAMHSA to think more broadly about prevention and early intervention; (3) rates of illicit drug use among youths have decreased significantly and then flat lined, prompting questions about underlying factors; (4) progress has been achieved in decreased alcohol and tobacco use rates among youth, but not for smokeless tobacco and hookah use; (5) increased nonmedical prescription use calls for more attention to working with physicians and for more analysis; and (6) NSDUH's compatibility with other data sources is good news. Continuing efforts are needed to support service delivery at each point in the continuum of care.

SAMHSA's Grants Process Improvement

Bruce Waltuck, M.A., SAMHSA's Senior Advisor for Process Improvement, described SAMHSA's process improvement initiative. He pointed out that awarding and managing grants are SAMHSA's core business processes, and he identified general principles that guide process improvement.

Mr. Waltuck stated that SAMHSA has adopted the NIATx model of process improvement, which focuses on understanding the customers of the process (grantees and employees), focusing on key problems important to senior leadership, and conducting short test cycles of promising ideas to accelerate learning. Basic principles include articulating the goal to be accomplished, focusing on the customer, relying on data, and determining whether a change is an improvement. Mr. Waltuck stated that SAMHSA's 17th process improvement team has been convened, toward a goal of 20 by the end of 2008; the goal is to at least double the number of teams in 2009.

Successes to date include a substantial decrease in response time to both constituent correspondence and follow-up letters to grantees after site visits.

In working to improve SAMHSA's grants process, senior leaders generated a list of their most significant current issues. Staff teams then gathered data to help distinguish fact from opinion. Changes must be legal, ethical, and in accord with existing policy, law, and regulation. SAMHSA leaders divided the grants process into three phases: from point of concept to issuance of the Request for Application(s) (RFA), from issuance of the RFA to award, and from date of award to closeout of the grant. The top issue in the first phase relates to RFA development; in the second phase, quality of peer reviews and reviewers; and in the third phase, earlier identification of grantee performance problems. Mr. Waltuck described the teams' process and problem-solving dynamics, noting that they hope to submit deliverables by the end of the year.

The first-phase team on RFA development has developed a template for both program staff who author the RFAs, and for Policy, Planning, and Budget staff who review and approve the RFAs. The Process Improvement team has also developed performance measures regarding time necessary to do certain tasks, and the number of people who must handle the document before it is published. Regarding peer reviews, the second-phase team developed ideas for recruiting more appropriate and experienced reviewers at professional events and establishing standing review committees. The third-phase team is addressing ways for SAMHSA to make earlier determinations of grantee performance problems. The Phase Two Process Improvement team (peer reviews) has discussed where reviewers come from, the current process for, reviewer dialogue and consensus-building, and options for recruiting peer reviewers. SAMHSA currently is exploring best practices for peer review in other disciplines.

Council Discussion. Mr. DeCerchio raised the issues of inter-rater reliability and limited personal interaction among reviewers. Mr. Waltuck responded that a new review management contract incorporates use of webinar technology to address the issue of interpersonal reviewer contact. Mr. DeCerchio suggested that SAMHSA elicit feedback on the review process from more experienced reviewers and former grant recipients. Mr. Waltuck stated that a request to survey grantees has been submitted and that he will follow up on the suggestion to elicit feedback from grant reviewers.

Center for Substance Abuse Prevention: Overview and Update

Frances Harding, Director, Center for Substance Abuse Prevention (CSAP), joined SAMHSA in June 2008 after having served as associate commissioner of the Division of Prevention and Recovery at the New York State Office of Alcoholism and Substance Abuse Services. She stated that her vision for CSAP revolves around health and wellness and bringing prevention services into the public health arena. CSAP will develop a strategic plan following the transition.

Ms. Harding expects to focus CSAP's grant programs on building the prevention workforce and strengthening States' prevention leadership by developing a common understanding of prevention and by helping States bring the talents and skill sets of

their prevention workers to a consistent level. CSAP will help States connect with community-based programming as the most effective way to create the normative change necessary to set the stage for a public health approach based on risk factors and personal responsibility for addressing problem behaviors. The success of the tobacco prevention movement serves as a model for this approach.

At the same time, CSAP will continue its focus on prevention in its HIV/AIDS, fetal alcohol spectrum disorder (FASD), and returning veterans initiatives, and increase its programming to combat underage drinking, especially on college campuses. Ms. Harding stated that the *Federal Register* has published the final notice of revisions to regulations pertinent to mandatory Federal workplace drug-testing programs, which will take effect on May 1, 2010. Having made headway in decreasing drug use among youth ages 12–17, CSAP and CSAT are addressing increasing prescription drug misuse in the 18–25 age group. CSAP will continue to work with its Strategic Prevention Framework State Incentive Grants (SPF-SIG). To date CSAP has awarded 42 SPF-SIGs to 34 States, three territories, and five tribal organizations, which funnel 85% of their money directly to community-based programs. Ms. Harding noted her expectation that SAMHSA's Centers will work together in the future on jointly funded programs. She welcomed suggestions to make CSAP a household word.

Council Discussion. Mr. Alawneh urged increased investment in school-based substance abuse prevention to capture certain populations that might not be receptive to a prevention focus in other settings. Ms. Harding responded that CSAP uses the SPF-SIG process to teach communities how to assess their own needs. If a community finds a need for more school-based programming, such programming should become a top priority, with schools involved in developing a strategy. This process empowers communities to develop solutions, change the environment, and become better advocates to achieve what they need.

Dr. McCorry suggested that SAMHSA highlight prevention successes in decreasing young people's use of marijuana. Ms. Harding stated that CSAP is addressing the challenge to package positive prevention data for use by families, businesses, and communities. CSAP faces the challenge of underage drinking by working within communities to link risk factors with programs that reduce them in order to change environmental conditions. The goal is to achieve sustained declines in substance abuse, not merely a leveling off. Mr. DeCerchio urged targeted prevention for the high-risk populations that drive later drug use, for example, youth ages 13–14 in the child welfare system with family histories of drug use and abuse, older youth with serious emotional disturbance, youth aging out of foster care, and youth transitioning into young adulthood. Ms. Harding noted that two SPF-SIGs work with child welfare offices and stated her intent to collaborate with CMHS on addressing these populations, along with prescription drug misuse among older adults. Mr. Sudbeck cautioned against refocusing resources away from prevention for youth ages 12–17 for fear of losing the gains made to date. Ms. Harding responded that CSAP is expanding its awareness of the needs of the 18–25 age group, including adding questions to survey instruments. She expressed faith that the SPF-SIG process will guide community priorities and

enable them to sustain their efforts in prevention of alcohol and drug abuse, as has occurred in the prevention movements for tobacco, heart disease, and cancer.

Dr. McCorry urged attention to window-of-opportunity activities that can prevent co-occurring substance abuse in young people with a mental health disorder, perhaps linked to work under SPF-SIGs or COSIGs. Ms. Harding stated that she will raise the issue with Ms. Power. Dr. Howell suggested using the NESARC study data on patterns of alcoholism among young adults to focus prevention efforts. Dr. Clark noted that a White House press release on its meeting on drug abuse held that day highlighted the ATR program as a performing and productive program.

Council Roundtable

Mr. DeCerchio stated that the National Center for Substance Abuse and Child Welfare plans to convene grantees in January 2009 at a conference to advance clinical practice in family-centered methamphetamine treatment for families in child welfare systems. In addition, the center has submitted a paper to SAMHSA on drug testing in child welfare settings.

Mr. Sudbeck inquired about information gathering during the transition. Dr. Clark characterized the conversation as more fact-finding on the part of the transition team than a consideration of priorities. An appropriate strategy for influencing the new agency rests with community-based organizations' advocacy and education efforts. Dr. Clark stated his expectation that the new Administration will support drug courts, but other priorities remain unknown.

Dr. McCorry suggested that CSAT invite a Health Resources and Services Administration (HRSA) representative to speak to the Council about data relevant to addiction treatment services in community health centers, particularly medication-assisted treatment. He suggested collaboration in this area by SAMHSA, HRSA, and the Centers for Disease Control and Prevention (CDC). Dr. Clark welcomed input on this issue.

Mr. Sudbeck inquired about the status of co-occurring disorders in CSAT's portfolio. Dr. Clark responded that CSAT continues its priority status for co-occurring disorders by awarding COSIG grants and has established a new requirement for discretionary portfolio grantees to screen for co-occurring disorders. CSAT is working with the Center for Mental Health Services (CMHS) to promote an integrated approach among grantees to address co-occurring disorders' early level of severity. Mr. Sudbeck stated that States need assistance in defining practice issues related to co-occurring disorders.

Mr. DeCerchio recalled States' early difficulties in adopting the ATR initiative and credited Dr. Clark and CSAT for efforts critical to its success. Dr. Clark recognized the contributions to ATR's successes by his staff, faith- and community-based organizations, State agencies, and tribal organizations. He stated that, in considering the social determinants of health, mental health, and recovery, CSAT's ROSC approach addresses multiple factors, returns people to work, deals with child abuse

and neglect and domestic violence, ensures that all appropriate services are accessed, and recognizes that an entire community must focus on the individual, the family, and the community in recovery.

Mr. DeCerchio inquired about the issue of potential matching requirements for discretionary programs. Mr. George Gilbert stated that during the formal comment period, CSAT received a large number of mostly negative comments but also guidance on administering a program, should it be adopted. Discussion on the issue likely will be linked to the FY 2010 budget cycle.

Dr. Howell raised the issue of a perceived disconnect between an Office of Applied Studies report that adolescents use drugs at an earlier age and are more likely to develop substance dependence or abuse, and a Healthy People 2010 goal of preventing or delaying substance abuse among this population, a policy with which the American Society of Addiction Medicine takes issue. She offered to send details on the colloquy. Dr. Clark responded that he appreciated being made aware of the concerns. He stated that although evidence of causality might be lacking, neurobiological, animal, and human study data from NIDA and NIAAA suggest benefits in delaying substance use. Based on knowledge of brain maturity, a delay or prevention of substance use and abuse at an early age may enable individuals to make better decisions later on the use of substances, particularly alcohol, and enable better treatment earlier if necessary. Dr. Howell stated that she teaches that it is unknown whether people are so genetically loaded that they want to start to use early, or whether earlier use leads to brain changes and the brain becomes more likely to be addicted. Dr. Clark concurred, but stated that epidemiological data show that 7–10% of children ages 12–15 become drunk, many of whom are trauma victims and live in socially stressful environments, suggesting the need for attention to those issues. Delay of substance abuse can create an environment where children in this age group can learn how to be students, learn to think, and learn social skills. He acknowledged the need for healthy debate.

Ms. Bertrand encouraged Council members to work with community-based organizations and local SSAs to host town hall meetings on health care. Mr. Sudbeck commented on progress made within the past 7 to 8 years, despite the barriers, and commended SAMHSA for its contributions in advancing the addiction treatment field.

Adjournment

The meeting adjourned at 5:00 p.m.

Proposed NAC Meetings

March 18, 2009 (new member orientation)

March 19, 2009

June 25, 2009 (teleconference)

August 20, 2009 (teleconference)

September 10, 2009

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

March 4, 2009
Date

/s/
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Chair
CSAT National Advisory Council
Director
SAMHSA/Center for Substance Abuse Treatment