

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration (SAMHSA)**

**Minutes  
41st Meeting of the  
Center for Substance Abuse Treatment National Advisory Council  
Rockville, Maryland  
January 26-27, 2005**

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met on Wednesday, January 26, 2005, at the SAMHSA Building, 1 Choke Cherry Road, Rockville, Maryland.

CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the open session at 9:15 a.m. Members present included Anita B. Bertrand, M.S.W., Bettye Ward Fletcher, Ph.D., Kenneth A. DeCerchio, M.S.W., David P. Donaldson, M.A., Melody M. Heaps, M.A., Valera Jackson, M.S., Chilo L. Madrid, Ph.D., Francis A. McCorry, Ph.D., Gregory E. Skipper, M.D., Richard T. Suchinsky, M.D. (ex officio), and Judge Eugene White-Fish. Also present were Richard Kopanda, M.A., Deputy Director, CSAT, and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

**Welcome and Introductions**

Dr. Clark welcomed participants to the meeting, and introduced new Council members Anita Bertrand, M.S.W., Bettye Ward Fletcher, Ph.D., Francis A. McCorry, Ph.D., and Judge Eugene White-Fish.

**Minutes, September 1-2, 2004**

Council members voted unanimously to accept the minutes of the September 1-2, 2004, CSAT Council meeting as presented.

**Director's Report**

Dr. Clark noted that as a new Secretary joins the U.S. Department of Health and Human Services (HHS), new policies and issues may emerge. President Bush is expected to submit a tight FY2006 budget to Congress in February 2005.

Dr. Clark referred Council members to the printed "Director's Report" for a more detailed account of CSAT's recent activities. He highlighted the imminent release of the new TIP 42, Substance Abuse and Co-Occurring Disorders; the E-therapy, Telehealth, and Telepsychiatry Summit held in December 2004; and the involvement of SAMHSA/CSAT staff in both domestic and international disaster relief efforts, including the Asian tsunami.

Dr. Clark stated that SAMHSA's focus on performance has earned "green status" from the Office of Management and Budget in a number of areas. He noted that the nation's major treatment problem is fueled partly by denial. Household Survey data show that large percentages of people who meet the criteria for needing substance abuse or alcohol

treatment services do not perceive a need. Community and faith-based organizations can reinforce the message that recovery is possible and that communities welcome people in recovery. NIMBYism (not in my backyard) is a barrier; stigma distorts recovery and discourages people from pursuing recovery efforts. Recovery support services, as part of a continuum of treatment and community support, protect against relapse. Dr. Clark noted that private insurance has retreated from a major role in paying for services. He asked for input from Council members about community recovery activities and about co-occurring disorders. Dr. Clark stated that the largest group of substance abusers is comprised of those who are in denial, which indicates a need for screening initiatives in settings beyond treatment programs, including community health centers, schools, churches, and places of employment, in order to make early interventions available.

**Discussion.** Dr. Clark stated that the steering committee for Partners for Recovery is expanding to represent all SAMHSA. Multistakeholder. Multidisciplinary efforts are underway to derive an operational definition for recovery. Dr. McCorry discussed SAMHSA's data strategy and outcome domains, questioning whether outreach efforts with other care-giving systems on data exist. Dr. Clark noted that CSAT is engaged in facilitating relationships to obtain collateral data from such systems as child welfare and criminal justice. Dr. McCorry stated his interest in cross-disciplinary measures to provide care for people with alcohol and substance abuse.

Ms. Jackson pointed out the importance of promoting positive messages for recovery to counteract negative perceptions of addiction. Dr. Clark stated that only 7 percent of people who perceive a need for treatment are *not* in treatment and that Recovery Month offers an opportunity for communities to become invested in the recovery construct. Ms. Jackson called for year-round broadcast of recovery-oriented public service announcements (PSAs). Dr. Clark responded that CSAT produces PSAs, but local communities decide when to run them.

Dr. Suchinsky suggested adding involuntary treatment to the agenda and placing greater emphasis on involuntary treatment in the civil justice system prior to entering the criminal justice system. Dr. Skipper stated that he works with physicians and other professionals to induce them to face their problems early on, and is investigating a study of professional health programs to demonstrate their effectiveness. Ms. Heaps expressed concern about the impact on the civil justice system if it were to become the repository of failures in health or other social service systems. Judge White-Fish stated that courts often find that no funds from the jurisdiction are available to pay for treatment. His tribe fully insures 100 percent of its members, but if the court orders treatment, insurance does not apply and members are not treated. Mr. DeCerchio stated his view that incarceration over a civil process is a development to avoid. Dr. McCorry expressed interest in looking at inducement into treatment. Ms. Heaps stated that research shows that the sanctioning process is effective in breaking down denial and moving a person into treatment with successful outcomes, but cautioned against moving to a civil commitment process. Dr. Skipper stated that families, employers, and the community may promote involuntary treatment outside the judicial realm.

### **Remarks from SAMHSA Administrator Charles Curie**

The Administrator, Mr. Curie was called to a meeting downtown and was unable to attend the meeting. Dr. Clark read the Administrator's report. Mr. Curie's remarks included his expectation that SAMHSA's new building will facilitate cross-center communication and create a sense of community; acknowledgement of the leadership of outgoing Secretary Tommy Thompson, and his anticipation of support from Secretary designate Mike Leavitt; expectation of several major themes to emerge—increasing efficiencies, focus on outcomes, pushing science to new heights, containing health care costs, increasing access to health care services, and advances in information technology.

Mr. Curie's remarks also focused on substance abuse treatment capacity, Access to Recovery (ATR), and the Strategic Prevention Framework (SPF). ATR provides grants for states to increase the number and types of providers, including faith-based providers who deliver clinical treatment and/or recovery support services; to allow choice of pathway to pursue recovery; and to require grantees to manage performance based on outcomes. Congress appropriated \$100 million for both FY2004 and FY2005. Initial ATR grantees include 14 states and one tribal organization. The SPF focuses on substance abuse prevention and the emerging area of mental health promotion and prevention of mental illnesses. It holds that these health problems should be treated with the same concern and urgency as diabetes or cancer. In FY2004 SAMHSA awarded \$45 million in grants to 19 states and two territories. SAMHSA plans to continue to build a national commitment to the community-based risk and protective factor approach to prevention.

Finally, Mr. Curie's remarks updated Council members on SAMHSA's data strategy, a cross-cutting principle on the matrix. The tighter the measurements, the better the proof of effectiveness; the greater SAMHSA's effectiveness, the greater the number of people served and the greater the chances for a life in the community for everyone. Development of a data strategy has begun with a meeting of substance abuse prevention and treatment leaders; a similar meeting is anticipated with mental health leaders in the future. Key outcome measures can help SAMHSA to know how well its grant programs are building resiliency and facilitating recovery; eventually the measures will extend across all SAMSHA grant programs. SAMHSA currently is implementing selected measures through ATR and SPF; they will minimize reporting burdens on states and other grantees, and will promote better monitoring of client outcomes and system improvements.

### **Engaging Faith-and Community-Based Organizations in Recovery**

*Council member David P. Donaldson, M.A.*, explained that a revolution is occurring as it relates to the faith community partnering with the government. The goal of the revolution is not to publicly fund proselytizing, but to ensure that both faith-based and community-based groups can compete on a level playing field, whether they are religious or non-religious. The initiative was signed into law by President Clinton under charitable choice, and in January 2001 President Bush signed an executive order.

**Jocelyn Whitfield, Senior Public Health Advisor, CSAT; Co-chair, SAMHSA Community and Faith-Based Initiative Work Group**, discussed CSAT's outreach efforts to the faith community, including a successful technical assistance program in grant writing in 2003. In 2004 emphasis expanded to licensure and certification, best practices, and several organizations achieved certification and licensure. In 2005 efforts shifted to organizational development and readiness to provide services. To date 6,500 representatives of community and faith-based organizations have participated in trainings, and more than \$18 million has been awarded in foundation, state, and federal funds. Outcomes include increased access to private funding, treatment and recovery options and services, and faith-based organizations and single state agencies engaging in partnerships. CSAT has produced a compendium of state requirements for certification and licensure, and "Successful Strategies for Recruiting, Training, and Utilizing Volunteers."

Mr. Donaldson commended the SAMHSA report "Core Competencies for Clergy and Other Pastoral Ministers." The strategy to engage the faith-based community involves developing relationships; representation in multi-sector coalitions that have increased involvement in the review process, in submitting applications, and in mobilizing for Recovery Month; mentoring and train-the-trainer activities; resource leveraging, including adjustments to the review process that rewards leveraging with private resources; replication of effective models; and establishing standards for recovery models. Mr. Donaldson invited Council members to participate on a subcommittee on faith-based activities.

**Clifton Mitchell, Coordinator, Faith- and Community-Based Initiative CSAT**, urged Council members to increase their activities in communities to help change attitudes. He explained that around 15 city coalitions are developing to expand treatment capacity and the supports that faith and community-based organizations have provided for decades, including case management, job training, parenting and GED classes. The faith and community-based organization can provide continuing care following treatment. Budget constraints have limited large training conferences, but CSAT is helping the existing coalitions improve their infrastructure to improve their capacity.

**Discussion.** Dr. Fletcher suggested the need to establish community mentoring programs (for example, at colleges and universities) to help build the capacity of small faith-and community-based organizations. She volunteered to serve on the faith-and community-based subcommittee. Mr. DeCerchio stated that the promise of ATR is that linkages between faith-and community-based organizations and public-sector funding agencies will remain when ATR dollars expire. A number of faith- and community-based organizations have participated in training in Orlando, and a network of faith- and community-based organizations that provide a variety of services has developed. Mr. Mitchell explained that CSAT contacts state faith-and community-based offices to offer technical assistance, including workshops and conferences, and help in developing ATR plans. Ms. Heaps volunteered to focus on ATR activities to facilitate coalition development.

Dr. Clark noted that while ATR is not a faith-based program, faith-and community-based organizations can play critical roles. ATR was created to leverage the contributions of traditional providers by faith and community-based organizations facilitating the recovery process by providing recovery management services. Dr. Clark explained that there are multiple pathways to recovery, and choice is enabled by mobilizing the community in positive relationships. Ms. Bertrand stated that Ohio is looking at ways to help faith-based organizations work more efficiently with other community-based organizations, including cross-training, sharing staff competencies, and training clergy on regulations and barriers. She volunteered to work on the subcommittee. Dr. Madrid described El Paso's successful first faith-based conference. Dr. McCorry expressed support for attention to the continuum of care and for the term *recovery management services*, which may diffuse providers' concerns about how their treatment work might change. He questioned what faith-based organizations fear in working with the public sector. Mr. Donaldson responded that the faith community has fears that accepting federal funds might lead to a slippery slope, but he stated that organizations need not compromise their values or methods. Mr. DeCerchio stated that faith partners assert the importance of not "chasing the money" and of focusing on their mission. Mr. Donaldson highlighted the importance of resisting dependence on public funds. Dr. Clark stated that CSAT is working to improve recovery management services in the states and to identify issues and dispel mythology and fears associated with ATR.

### **Treatment in Ethnic Communities**

*Council member Chilo Madrid, Ph.D.*, described his small Texas community, where heroin is cheaper and more convenient than methadone, NIMBYism is an issue, criminal justice involvement is rampant, and nicknames for drug use are different from those typically used.

CSAT's Services Accountability Improvement System data show that persons of color occupy 66.8 percent of treatment slots. By contrast, most clinicians are white, 45 years old or older, and women—characteristics that impede provision of the racially concordant health care recommended by the National Institute of Medicine (IOM). Pay for substance abuse workers is low, with few fringe benefits, which contributes to major workforce problems.

Dr. Madrid urged sensitivity to the preferences and perceptions of all minorities concerning drugs, noting that Treatment Episode Data Sets (TEDS) data reveal that opiates affect Hispanics in great numbers. Eighty-seven percent of intravenous drug users in the El Paso area are hepatitis C-positive; CSAT has developed training on hepatitis C. For 29 percent of non-Hispanic blacks, cocaine is the drug of choice.

Dr. Madrid highlighted the need to attract diverse representation among treatment providers and to focus on the specific needs of minorities. He cited the need for a universal toolbox, plus customized toolboxes for various drugs and ethnicities, and for a workforce recruitment strategy that might include loan forgiveness, repayment programs, and internships. Collaboration is called for with the various federal incentive programs that support ethnic minorities. In addition, it is important to examine how managed care,

Medicaid, children's insurance programs, and other payers view various ethnic groups and how the groups are affected. Dr. Madrid encouraged CSAT to revisit its publications on cultural competence and to promote evidence-based practices with culture and ethnicity in mind.

**Discussion.** Dr. Madrid stated that he is unaware of the existence of customized toolboxes, and noted demand among counselors for this type of support. Ms. Jackson suggested that evidence-based practices be tweaked to accommodate the needs of certain populations. Dr. Fletcher identified the need to look at how training related to ethnic groups is incorporated into curricula. Dr. McCorry concurred that attracting and retaining minority workers are important issues. Dr. Madrid identified the need for the field to offer competitive salaries and to develop incentive systems. Drs. McCorry and Fletcher suggested working with minority institutions to create and promote value in the field. Dr. Fletcher observed that credentialing bodies play a role in the effort. Dr. Clark noted that workforce issues appear on SAMHSA's matrix.

#### **Public Comment**

**Arthur T. Dean, Chairman and CEO, Community Anti-Drug Coalitions of America (CADCA)**, explained that CADCA aims to strengthen the capacity of community anti-drug coalitions to help build safe, healthy, and drug-free communities. Its training institute is scheduled for July 2005, and its next National Leadership Forum will be held in February 2006.

**Katherine Fornili, International Nurses Society on Addictions**, stated that IntNSA works to promote certification of addictions nurses and to recruit nurses to the addictions field. She urged SAMHSA to consider allowing advanced practice nurses to prescribe buprenorphine and other pharmacological therapies. IntNSA has the only national credentialing for addictions registered nurses, works with nurses with past and present addiction problems, and publishes a peer-reviewed professional journal.

#### **NIDA: Translating Science-Based Treatment Interventions into Service**

**Timothy P. Condon, Ph.D., Deputy Director, National Institute on Drug Abuse**

Dr. Condon stated that NIDA aims to make its research useful and used. While scientific advances have created new understandings of drug abuse and addiction, which has enabled development of more targeted prevention and treatment strategies, translational bottlenecks exist in the pipeline from the research lab to the community. In a study of standard practice of care for various medical conditions, for example, just 10 percent of individuals in treatment for alcohol dependence received recommended care, far below rates for certain other conditions.

NIDA focuses attention on barriers to implementing evidence-based practices with NIAAA, NIMH, SAMHSA, and AHRQ. NIDA co-funds CSAT's ATTCs. Blending teams work to disseminate materials from NIDA's research portfolio and the Clinical Trials Network (CTN). NIDA advises CSAT staff on the research base for the National Registry of Effective Programs and Practices (NREPP). NIDA has conducted technical assistance for SAMHSA grantees in grant writing and, together with SAMHSA, conducts

projects in criminal justice drug abuse treatment (CJ-DATS), primary care, and state research capacity building.

NIDA's clinical research focuses on medication and behavioral treatment research development, clinical trials research in community-based settings, and health services research to apply evidence-based practices in real-life applications. Medications have been developed for opiate use and alcoholism, but not yet for cocaine or methamphetamine, although new targets have been identified for cocaine, opiate, and methamphetamine addiction. NIDA also has developed behavioral therapies for marijuana use and smoking, many of which are ready for prime time. NIDA works to make evidence-based practices user friendly and transferable, to maintain fidelity, and to identify and retain interventions' "active ingredients." In addition, NIDA operates portfolios in organizational structure and climate, environment, stigma, financing, provider knowledge and behavior, and access and engagement. NIDA's efforts to make research more relevant include collaborations involving CTN and CJ-DATS. CJ-DATS seek to improve outcomes for offenders with substance abuse disorders. The CTN program conducts clinical trials to determine the effectiveness of drug abuse treatment interventions in diverse community-based treatment settings and among diverse patient populations, to transfer research results to treatment programs, and for clinicians and patients to improve drug abuse treatment quality. All studies completed have revealed positive findings. NIDA is coordinating dissemination efforts with SAMHSA's ATTCs.

Data show that untreated ADHD is a significant risk factor for substance abuse disorders in adolescence. NIDA plans to conduct randomized controlled trials on long-acting methylphenidate among adolescents with co-occurring ADHD and substance abuse disorders and among adult smokers with ADHD. Another study will address buprenorphine as a treatment for opiate analgesic dependence. NIDA's services research includes a buprenorphine liver study done in the CTN by another division, and NIDA plans to use the CTN infrastructure as a platform for doing all kinds of research, including research on health services and genetics. The Primary Care Initiative, co-funded with SAMHSA, aims to encourage primary care physicians to do interventions, to assess, and to do referrals. Another activity undertaken with SAMHSA is to help states build research infrastructure to enhance their capacity to foster adoption of science-based practices.

Dr. Condon noted that NIDA and SAMHSA have developed an informal dissemination methodology that has involved researchers and others in discussing research results, barriers, and possible findings to disseminate. "Blending teams" of ATTC and NIDA staff members have developed dissemination plans, for example, for a tool to facilitate buprenorphine awareness for nonphysicians, an addiction severity index, motivational interviewing, buprenorphine detox, and motivational incentives. Dr. Condon stated that NIDA's future directions involve focus on interventions that reach large numbers of people and that can be adopted broadly in different settings, implemented consistently by staff with moderate training, produce reliable and long-lasting effects, and be reimbursed at reasonable cost.

**Discussion.** Mr. DeCerchio observed the important results in NIDA and CSAT's work to take relevant research to states and providers in a positive way, and to enable creation of a culture change around the adoption of good science and practice where it is available. Dr. McCorry noted that New York State and NIDA are looking at delivery mechanisms, including motivational interviewing, to promote adoption and sustaining of evidence-based practices. He suggested that NIDA proactively solicit input from such stakeholders as state policy makers, practitioners, researchers, and consumers to develop a research agenda that resolves competing priorities. Dr. Condon noted that NIDA has conducted periodic constituent conferences over the past decade; another is planned for 2005.

### **National Survey on Drug Use and Health (NSDUH): Recent Findings**

#### ***Joe Gfroerer, Office of Applied Studies, SAMHSA***

Mr. Gfroerer presented data from the 2003 NSDUH survey, which is representative nationally and in each state. The computer-assisted, self-administered interviews are conducted face-to-face. More than 67,000 respondents participated in 2003. The 2003 data are comparable only to 2002 data, not to data from prior years.

Data showed that about 30 percent of respondents used some tobacco within the past 30 days, similar to 2002. No significant change in the usage rate of 13 percent occurred for youth age 12-17, but usage ranged from 2 percent to 26 percent from age 12 to 17. A significant decline in tobacco use was found only for persons age 13, and a decline in cigarette use occurred among females age 12 to 17. About half the population age 12 and over are current alcohol users; 23 percent report binge drinking; and 7 percent are heavy drinkers. The numbers are identical to those for 2002. Underage current drinking ranges from 4.5 percent up to 51 percent in persons age 18-20; a majority of drinkers in this age group are binge or heavy drinkers.

Prevalence of current illicit drug use is unchanged from 2002 at about 8.2 percent, mostly marijuana use at 6.2 percent. Significant usage drops were registered for such hallucinogens as ecstasy and LSD. A significant increasing trend, however, appears to be non-medical use of pain relievers. In rural areas, overall illicit drug use declined. Among youth, marijuana use showed no change, but lifetime use and heavy use declined significantly. Data showed an increase in the percentage of youth who said that smoking marijuana is risky. Dependence and treatment data showed that 22 million people in 2003 had dependence or abuse, primarily for alcohol, with no change from 2002. Marijuana dependence or abuse was experienced by 4.2 million people.

New data show that northern states, plus Arizona and New Mexico, have the highest rates of alcohol dependence or abuse in past year, and southern states have the lowest. In illicit drug use, northern states are the lowest category, while New England, Louisiana, Washington, Arizona, and New Mexico have the highest rates. A study of substance use by older adults, projecting a population increase in 2020 of 50 percent, predicted a 70 percent increase in dependence or abuse, and 150 percent the number of persons age 50+ with dependence on alcohol or drugs.

Treatment data showed no change in need for treatment, a significant decline in the number of people who received specialty treatment, and no decrease in treatment for persons age 25 and under. Of the 1.9 million persons who reported symptoms that can be classified as dependence or abuse, 87 percent stated that they did not need treatment. About 1 million people reported a need for treatment, but did not get it, including 26 percent who tried unsuccessfully to get treatment. Some respondents offered reasons why they did not get treatment: not ready to stop using drugs, cost and insurance barriers, and stigma. For the people who received treatment, the substances reported were consistent with TEDS data, about 65 percent for alcohol and 35 percent for marijuana. Almost half paid for treatment with savings or earnings, and only one third used private health insurance. The balance relied on public assistance.

The survey found that 9 percent of adults in 2003 had a serious mental illness and that 21 percent of persons with a serious mental illness had co-occurring substance abuse or dependence. This compares with 8 percent of persons with a drug or alcohol disorder and no serious mental illness. About half of the 4.2 million persons with co-occurring disorders received no treatment; 40 percent received mental health but no substance abuse treatment; 7.5 percent received mental health and substance abuse treatment; and 3.7 percent received only substance abuse treatment.

Mr. Gfroerer identified plans for other analyses and reports, including sub-state estimates, immigrants and substance use (compared to the non-foreign-born population), national 2004 survey findings, and assessment of and improvements to survey methodologies.

*Discussion.* Ms. Heaps questioned whether efforts were underway to examine the decrease in access to treatment. Mr. Gfroerer stated that analysis produced an explanation only for older adults, but that 2004 data may shed more light on the issue; this issue might be a sampling problem. Mr. Gfroerer stated that in the formulation of the mental health questions, responses were calibrated to the results of clinical interviews. The questions, not diagnosis specific, refer to any disorder plus functional impairment within the past 12 months. The definition of non-medical substance use is prescription drugs not prescribed by one's own doctor.

### **Residential Treatment by the Drug and Alcohol Services Information System (DASIS): Recent Findings**

*Deborah Trunzo, Office of Applied Studies, SAMHSA*

Ms. Trunzo explained that two kinds of data compose the DASIS data sets, facility data from the National Survey of Substance Abuse Treatment Services (N-SSATS) and client-level data from the Treatment Episode Data Set (TEDS). N-SSATS presents a census snapshot of all known substance abuse treatment facilities. The most recent survey was conducted on March 31, 2004, to which 13,454 facilities responded. Eighty-one percent of facilities provided outpatient care, 27 percent non-hospital residential treatment, and 8 percent hospital inpatient care, a stable trend since 1997. Clients in treatment numbered 1,080,000.

Residential services were provided to 102,000 clients by 3,680 facilities, 80 percent of which offered programs lasting 30 days or more. Half as many offered short-term treatment, and one-quarter offered detox services. Three quarters reported that they were private not-for-profit organizations; private nonprofit, 12 percent; and government owned, fewer. Eight percent of facilities reported affiliation with a religious organization. Most facilities focused primarily on substance abuse treatment alone (80 percent); substance abuse and mental health services, 14 percent; and mental health services, 3 percent. Facilities reported a total of about 125,000 beds, with a utilization rate of 77 percent on the date of survey.

States collect TEDS data, which describe client-level information on treatment admissions, from facilities that receive public funds. About 1.9 million records are received annually and aggregated for analysis. In 2002, inpatient admissions accounted for 34 percent of all admissions, a stable rate since 1992. Residential admissions are more likely to report alcohol and opiates as primary substances of abuse than outpatient admissions, but less likely than hospital inpatient admissions. Marijuana is less likely to be primary drug abuse for inpatient admissions than for outpatient admissions. Only slight gender differences exist in types of services. Residential admissions are older than outpatient, but younger than hospital admissions, and tend more to be African American or Hispanic than outpatient admissions. American Indian/Alaska Natives (AI/AN) represent 4 percent of all residential admissions, and Asian American/Pacific Islander (AA/PI) 1 percent.

Slightly more than half of 2002 residential admissions sought detox services, equally divided between long and short term, with little change since 1992. Residential detox services have a much higher proportion of alcohol and opiate admissions, while short- and long-term rehabilitation have higher proportions of marijuana, cocaine, and stimulant admissions. Detox services have a higher proportion of males, and long-term treatment a slightly higher proportion of females. Detox has older admissions; few are under age 18, and about one quarter are age 45 and older. Long-term admissions are less likely to be white and more likely to be African American or Hispanic than other residential admissions. Ms. Trunzo stated that demographics appear to be driven by primary drug. For residential admissions by substance, each race/ethnic group has a different pattern. More than 70 percent of AI/AN admissions are for primary alcohol abuse, compared to 35 percent for AA/PI. AA/PI admissions are most likely to report stimulants as primary drug, while Hispanic admissions are most likely to report opiates.

Ms. Trunzo presented a preview of the 2002 TEDS discharge dataset. Of total discharges from all treatment services, 42 percent completed treatment, 8 percent transferred to another level of treatment, accounting for a combined 50 percent positive end to a treatment episode. The remaining 50 percent represented dropouts, treatment terminated by the facility, and death, incarceration, or other reasons. Residential short-term treatment results in the highest completion rate at 65 percent, and long-term residential treatment reports a 33 percent completion rate.

**Discussion.** Ms. Jackson suggested moving the “death, incarceration, or other” category in the presentation closer to “completed treatment.” Ms. Trunzo volunteered to separate the categories. In response to questions from Council members, Ms. Trunzo stated that not all data has unique client identifiers, which would facilitate knowledge about numbers of individuals; 2003 N-SSATS data gives utilization rates; and no data is available on success at follow-up for treatment completions versus dropouts. Dr. McCorry noted that when detox beds are aggregated with other treatment, utilization rates appear deceptively low. Ms. Trunzo responded that detox beds cannot be distinguished in the data from other residential beds, but that the comment will be considered in the 2006 redesign. Ms. Heaps strongly urged redesign to avoid possible political impact from misleading statistics that indicate that treatment beds are underutilized and that long-term treatment does not work. Ms. Trunzo stated that completion data comes from state-submitted TEDS data. Data that provides a more balanced picture will be published soon.

### **Residential Treatment: CSAT’s Discretionary Services Portfolio**

***Joan Dilonardo, Ph.D., Branch Chief, Organization and Financing Branch, CSAT/SAMHSA***

Dr. Dilonardo stated that CSAT’s discretionary services portfolio (DSP) represents a variety of grant programs, but insufficient data exists to look at trends and differences over time. On a live, interactive Web-based system, grantees report GPRA data on their 508 grants, most of which target underserved and vulnerable populations for a variety of services. Two CSAT programs currently require provision of residential treatment services, to substance-abusing adolescents and to pregnant, postpartum, and parenting women. About 9 percent of all DSP grantees provide solely residential services. Additional programs provide residential treatment plus other services, which account for about 23 percent of DSP grantees. Other services include outpatient treatment, intensive outpatient treatment, and also outreach and then residential.

Only 12.2 percent of patients served by discretionary grants have received residential services. Data show duration of residential services, but data on treatment completion is not collected. Only 30 percent of clients exit residential treatment within one to five weeks. Few applicants for funding propose to provide detox services. Dr. Dilonardo offered to provide outcome data to Council members. Slightly more than 70 percent of clients who receive residential services also receive case management services; 20 percent also receive outpatient services; and 10 percent receive outreach in addition to residential services.

More men than women receive residential services within the DSP portfolio, and race/ethnicity data show general concordance with the ethnic profile of the portfolio—but different from national benchmarks. Adolescents account for 15 percent of those who receive residential treatment. A comparison of demographic characteristics in DSP programs of persons who receive some residential services shows few differences from those who receive nonresidential treatment, although a larger proportion of AI/AN and a slightly smaller proportion of African Americans are served. Demographic characteristics of persons served by DSP programs are significantly different from the population

described in TEDS and ADSS data. Clients in residential treatment most frequently mentioned alcohol, cocaine, and marijuana as primary drug, compared to alcohol, marijuana, and cocaine cited in nonresidential settings. People with cocaine problems are more likely to be in residential treatment in the DSP portfolio. The residential DSP serves a more diverse population and more women than the population seen in TEDS or ADSS.

In the future as data become better, CSAT wants to develop a predictive model for residential treatment that focuses on, for example, factors most likely to result in residential treatment and the relationship between treatment completion and outcomes.

**Discussion.** Ms. Heaps and Dr. Clark commended Dr. Dilonardo on the work, and Dr. Dilonardo recognized the grantees' contribution in the data collection process.

### **Legislative Update**

#### ***Joe Faha, Legislative Director, Office of the Administrator, SAMHSA***

Mr. Faha described changes in leadership and structure of the 109th Congress following the 2004 election. Sen. Stevens has resigned as chair of the Senate Appropriations Committee, to be succeeded by Mr. Cochran. The seat formerly held by Mr. Young will go to Mr. Lewis. In the House, Mr. DeLay proposed to reduce the number of subcommittees from 13 to 10, and Mr. Lewis has agreed to reorganization—but the Senate has declined to conform. Mr. Faha predicts that a political-process problem will emerge in resolving the incongruence. Mr. Regula is expected to chair the Labor-HHS-Education subcommittee, and in the Senate, Sens. Specter and Harkin are expected to continue as chair and ranking member, respectively, on SAMHSA's subcommittee on appropriations; they have been generous to SAMHSA. Hearings occur only on the House side, and for FY2005 Mr. Curie appeared in hearings with the directors of NIH, NIAAA, and NIDA, a process likely to be repeated this year in late March or early April.

The federal government has declared budget deficits of \$412 billion for FY2004 and \$427 billion for FY2005. Mr. Faha anticipates monumental funding barriers for FY2006.

Mr. Faha explained the reauthorization process, by which Congress gives agencies the authority to do what Congress thinks they ought to do. The Senate's Health, Education, Labor, and Pension Committee and the House Committee on Energy and Commerce have jurisdiction over SAMHSA's programs. Sen. Enzi (Wyoming) will lead a reorganized Senate committee that no longer includes a Subcommittee on Substance Abuse and Mental Health. All public health issues are expected to reside in full committee, and substance abuse and mental health are not mentioned on the list of priorities. The House also may undergo reorganization. SAMHSA historically receives a three-year authorization every ten years. Mr. Faha explained that reauthorization is not necessary from a budgetary/appropriations standpoint to continue SAMSHA's work. It is unknown whether members of Congress will move to reauthorize the agency in this Congress.

Mr. Ramstead and Mr. Patrick Kennedy have created a caucus of House members interested in substance abuse issues. An issue that remains unresolved is eliminating the barrier in group medical practices that limits prescribing buprenorphine. An electronic

prescription monitoring bill is expected to reappear. Senators Talent and Feinstein are expected to introduce a methamphetamine bill that changes criminal statutes to reflect treatment and prevention.

**Discussion.** In response to members' questions, Mr. Faha stated that legislation on child welfare and substance abuse has not been reintroduced, and that any NIH reauthorization would not merge NIDA and NIAAA. Mr. Donaldson stated that a faith-based caucus called Community Solutions focuses on legislation related to community-based efforts.

### **Council Roundtable**

Dr. Skipper observed difficulties in identifying physicians on the website willing to prescribe buprenorphine. Robert Lubran, M.P.H., Director, Division of Pharmacologic Therapies, CSAT, explained that only 70 percent of eligible physicians are listed on the locator and that too few physicians are authorized to meet demand. To help expand capacity, more than 60 trainings are planned for 2005. Approximately 4,000 physicians now have a SAMHSA waiver; an increase of 70-80 percent is expected by year-end. Some patients are interested only in detox, and others want long-term treatment; obtaining the right mix of physicians for clients in a community is a challenge. In 2004 CSAT, the American Society on Addiction Medicine, and other medical groups funded the Clinical Support Network to educate and provide assistance to primary care physicians in administering buprenorphine. Mr. Lubran solicited input from Council members. Mr. Lubran stated that a series of physician satisfaction surveys is underway. A new survey will identify geographical gaps, and outreach efforts are planned. Dr. Skipper suggested adding details to the website on the specific services provided by authorized physicians.

Mr. DeCerchio suggested a presentation to update the status of performance domains and indicator development as a future Council agenda item, and Ms. Jackson suggested a presentation about development of topics for RFAs for discretionary funds.

The meeting adjourned at 4:15 p.m. and reconvened the next day.

### **Thursday, January 27, 2005**

#### ***Closed Session***

CSAT's Council met in closed session on January 27, 2005, at 9:00 a.m. to review grant applications.

#### ***Open Session***

The Council reconvened in open session at 10:35 a.m.

### **SAMHSA's Disaster Readiness and Response Activities**

***Daniel Dodgen, Ph.D., Emergency Coordinator, Office of the Administrator, SAMHSA***

Dr. Dodgen described SAMHSA-wide disaster readiness and response activities. SAMHSA has worked with the National Research Council and the IOM on a report on psychological consequences of terrorism; it proposes a public health model for preparing

and responding. Expert panels, co-funded with NIH, are considering assessment of population needs to determine how to gauge a federal response. SAMHSA has compiled all-hazards planning guidance, for which an appendix for substance abuse is under consideration; cultural competence guidelines specific to disaster response for behavioral health; and risk communication guidance. To promote infrastructure development, SAMHSA's All Hazards Emergency Capacity Development Grant Program has made awards to 35 states for plan development. The new SAMHSA Disaster Technical Assistance Center (DTAC) provides guidance to states in applying for grants and learning about the knowledge base, and regional state training meetings have been held related to the state planning grants. SAMHSA's disaster and terrorism response includes the FEMA Crisis Counseling Assistance and Training Program. The program focuses on mental health, but substance abuse-related activities are eligible, and SAMHSA is helping states with both mental health and substance abuse services. Congress provided supplemental assistance through CSAT for post-September 11 activities and the aftermath of Florida's hurricanes.

Dr. Dodgen described the emergency response process. In anticipation of Hurricane Ivan, for example, CSAP used GIS mapping to reach SAMHSA grantees before landfall. The response included updating the website, extending DTAC's hours, and alerting grantees. During hurricane season SAMHSA collaborated with CDC, HRSA, FDA, and the Departments of Defense, Veterans Affairs, and Agriculture; a behavioral health person participated in all emergency calls.

Following the Asian tsunami, SAMHSA for the first time participated in an international response. The National Child Traumatic Stress Network created information sheets on how children might be affected and others for persons working in areas where children were affected. SAMHSA collaborates with the Department of State on international matters.

Current activities have included in-service training for all staff, development of a formal protocol to guide response activities, a multijurisdictional public/behavioral health tabletop drill, involvement in top officials' terrorism planning exercises, and establishment of an operations center at SAMHSA headquarters to coordinate emergency responses.

### **Disasters and the Substance Abuse Treatment Field**

***Sheila Harmison, D.S.W., Special Assistant to the Director, SAMHSA***

Dr. Harmison defined trauma as an event that involves actual or threatened death, serious injury, or threat to one's physical integrity, and stated that trauma can develop into post-traumatic stress disorder (PTSD), depending on duration, proximity, severity of event, social supports, and other factors. Clinical symptoms of PTSD include numbing, detachment, being in a daze, marked avoidance of stimuli that arouse recollections, anxiety or increased arousal, irritability, difficulty sleeping, poor concentration, and exaggerated emotions.

Dr. Harmison stated that the substance abuse treatment system can intervene in preventive interventions, after trauma but before stress symptoms appear, prior to onset of delayed or acute PTSD, and prior to the onset of chronic PTSD. Trauma can trigger excessive use of alcohol or drugs and also can result in increased demand for services from people in recovery from substance-related disorders as well as people with current disorders who had not realized they had a problem prior to the trauma. Staff and program administrators must be trained and ready for disasters. Administrators now are developing plans to handle clientele and to enable staff members themselves to deal properly with disasters.

Research shows that substance use and substance abuse disorders can be problems in the wake of disaster. For example, Vlahov et al. found that after September 11 3.3 percent of New York survey respondents started using cigarettes, 19.3 percent started drinking alcohol, and 2.5 percent started marijuana use. Smith et al. found that after Hurricane Hugo, beer consumption rose 25 percent; in the year after the Oklahoma City bombing, alcohol consumption rose 200 percent.

It is important for substance abuse treatment providers to recognize that traumatic events leave imprints on patients. Disasters and trauma may reactivate pre-existing PTSD, and substance abuse treatment programs should routinely assess patients for histories and be prepared to address disasters and terrorist attacks. The public health system response to trauma requires focus on administrative and clinical components, and on determining needed research and training. CSAT has developed a substance abuse treatment state all-hazards plan document; conducts oversight of the opioid treatment program accreditation standards for emergency and disaster planning; prepared a template for developing disaster plans by methadone clinics; awarded September 11 CSAT supplemental grants to nine states; and funds DTAC.

**Discussion.** Dr. McCorry raised the issue of critical incident debriefing as a post-disaster intervention. Dr. Dodgen stated that the intervention to address potential stress problems with first responders is controversial. Some research identifies potential for harm when the model is used inappropriately, but if the model is adhered to strictly, little potential exists for harm and significant potential for benefit.

Mr. Donaldson identified for follow-up several implementation activities discussed at a national summit to facilitate faith-**and community**-based activities in disaster response, including collection of needs assessment data, delineation of roles and duties, plans for continuation of services, and guidelines for handling medication stockpiles. Dr. Dodgen responded that SAMHSA's plan has been first to determine what is known and then to proceed to the implementation phase, including bringing technical assistance providers up to speed, which is currently underway. The Strategic National Stockpile is a larger HHS/Homeland Security issue, with the ability to manage and the ability to deploy in different places. People are looking at the contents of the stockpile regarding the need for medications beyond vaccination and emergency medical response. Mr. Donaldson pointed out that following the events of September 11, more than 700 clergy and chaplains were turned away because of lack of a certification process. Dr. Dodgen noted

that certification and credentialing is a complicated, controversial issue, and that such organizations as the Red Cross and Department of Defense, and aviation disaster response, have spiritual care components. Mr. Donaldson suggested that an HHS initiative would be a good strategy to help professionalize the role of clergy in disaster response, and Dr. Dodgen agreed to convey that idea to HHS leadership. Mr. DeCerchio stated that Florida works with the Florida Interfaith Network. There is no need for certification, and a process is in place to engage clergy. Chaplains trained in disaster work are part of the team. Mr. DeCerchio stressed the importance of permitting an area to assess its needs and to get people ready to move. He acknowledged SAMHSA's support during Florida's recent hurricane season.

Dr. Dodgen stated that SAMHSA is looking increasingly at the needs of special populations, including persons who are homeless, HIV-positive, and not ambulatory. Guidance regarding special needs now is being incorporated into emergency plans.

**Drug Enforcement Administration's (DEA) Supply and Demand Reduction Efforts**  
*Michele Leonhart, Deputy Administrator, Drug Enforcement Administration*

Ms. Leonhart explained that treatment professionals and teachers inform law enforcement about community drug trends. She attributed Chicago's successes in reduced crime to combined enforcement, prevention, treatment, and community attack. Ms. Leonhart acknowledged the contributions of Ms. Heaps and Dr. Voth.

DEA allocates resources to pursuing major illegal drug trafficking organizations, frequently with international links. A major strategy is to seize assets and destroy organizations' financial base, not simply to seize drugs and incarcerate criminals. DEA coordinates intelligence gathering with other agencies and jurisdictions to build the best, hardest-hitting cases.

Methamphetamine, a recent problem that originated in the West but that has spread nationwide, exists largely in rural areas. The greatest impediment to solving the problem is the fact that the primary ingredient is a nasal decongestant, pseudoephedrine, with widespread availability and easily processed. DEA and its partners aggressively targeted methamphetamine superlabs that had accounted for about 80 percent of the drug found in the country. Through enforcement operations, decreased availability is evident, based on cutting off flows of bulk pseudoephedrine and ephedrine that had been crossing the Canadian border. Several states have enacted legislation to limit availability of the ingredients, and the U.S. Senate is expected to act on this issue.

Targeting and putting the right criminals out of business, and closing their labs, has resulted in dramatically reduced rates of LSD availability. Law enforcement, prevention, and treatment work together on community awareness about ecstasy. DEA's ecstasy case, Candy Box, eliminated 15 percent of the country's supply. An impact study has shown that in cities where enforcement operations combine with treatment, prevention, and education of the public, price has gone up and availability is down, with effects sustained for six months.

Ms. Leonhart reported that since 2001, 600,000 fewer teenagers are using drugs; current marijuana use by teens dropped by 11 percent in 2004 and 17 percent to date. The South American coca harvest is at its lowest level in 20 years, down 21 percent in Colombia. By summer availability of cocaine is expected to decline. DEA has indicted 89 percent of individuals supplying drugs to the U.S. Cocaine use has dropped more than 70 percent over the last 20 years. DEA has almost doubled the seizure of drug proceeds in the last year. More than \$5 billion in drug control funds was allocated for prevention, treatment, and research in 2004. Communities in 42 states received more than \$18 million to establish or continue drug courts.

A major challenge is to disseminate the message of the effects drug use has on nonusers, including drug-related auto accidents, illegal drug use that leads to crime, and broad prevalence of drug-related AIDS cases and child abuse and neglect. Ms. Leonhart anticipates problems with Paladone, a more potent type of OxyContin released in January, once it is diverted and hits the streets. The prescription drug problem is serious and growing, and traditional enforcement techniques do not work to curb availability over the Internet. Ms. Leonhart encouraged the Council to invite DEA to present regular updates.

**Discussion.** Ms. Leonhart explained that until recently, Afghanistan supplied 75 percent of the heroin in the United States. DEA's Operation Containment focuses on containing heroin production in that region and on not letting it affect the U.S. drug market. Mr. Donaldson questioned the data that show significant decreases in drug use in rural areas. DEA's Catherine Harnett responded that arrest data no longer is available, which may lead to missing some rural users. Monitoring the Future shows some reductions in methamphetamine, but DEA's demand-reduction people in rural areas continue to say that the drug is a big problem. Ms. Harnett stated that DEA works with the faith community in prevention and treatment in various ways in different places, including particularly strong partnerships in the Baltimore and St. Louis areas. Ms. Leonhart explained DEA strategies to deal with prescription misuse, including piloting the Medical Examiners Database, which will enable faster response to changing trends than does DAWN data, and which is anticipated to be important regarding trends for Paladone. DEA agents are learning Internet techniques, including using a WebCrawler that will look at patterns among Internet pharmacies for use in prosecution. Release of a new nasal decongestant called phenylephrine, which cannot be used in methamphetamine labs, is expected to impact methamphetamine availability and use. Ms. Leonhart stated that DEA depends on ADAM data and is concerned about its discontinuance, even temporarily. She noted that the 22 states with prescription monitoring programs have the lowest rates of OxyContin abuse.

### **E-Therapy Update**

***Sheila Harmison, D.S.W., Special Assistant to the Director, SAMHSA***

Dr. Harmison explained that SAMHSA is seeking to harness information technology innovatively, in particular to support e-therapy as a vehicle for delivering counseling and treatment services through the Internet. Many underserved clients—for example, those who may be vulnerable to stigma, have disabilities, or live in remote areas—can benefit

from increased access to services. Challenges include restricted reimbursement codes, licensing for in-state treatment only, no generally accepted minimum standards of care, limited measurements of effectiveness, and privacy issues. E-therapy currently is offered on Internet sites.

CSAT held an interagency conference on e-therapy in 2002 in which NIMH, NIDA, NIAAA, HRSA, and the Department of Veterans Affairs participated. Since then an HHS Interagency Workgroup on E-Therapy has met and a conference held in December 2004 at which participants discussed definitions, clinical applications, technology, financing, and other issues. Practitioners demonstrated electronic substance abuse and mental health applications.

Dr. Harmison showed a variety of examples of Internet advertisements for online therapy. She described online communications patterns and types of wireless applications, including remote patient monitoring and visiting nurse services. The hospital environment uses patient trackers, patient bar coding, wireless medical glossary, and notification and alert. Practitioners use e-prescriptions, billing/chargebacks, electronic patient medical records, and computerized physician order entry. Pharmaceutical applications include customer relationship management, call reporting, sample tracking, and the *Physician's Desk Reference*, among others.

Dr. Harmison described several network technologies for telepsychiatry. Join Together supports AlcoholScreening.org, for example, a screening and brief intervention for drinkers. Twenty-one percent of respondents with possible alcohol use or dependence click on the "learn more" or "get help" areas, as do 15.8 percent of heavy or binge drinkers and 9.4 percent of nonhazardous drinkers. HealthSim, Inc., conducts research with computer-based interventions. eGetgoing, an accredited provider of services to adults and adolescents, delivers live online substance abuse treatment in a group setting.

HHS has been working toward electronic health records, computer-assisted clinical decision support, computerized provider order entry, and secure, private, interoperable, electronic health information exchange. It has developed a plan to deliver consumer-centric and information-rich health care that discusses informing clinical practice, interconnecting clinicians, personalizing care, and improving population health. Critical issues include defining the terms of e-therapy, licensing/credentialing, regulations, creating controls on technology to ensure secure sites and to protect clients, training counselors in technology use, confidentiality, information security, cultural issues, and cost. Evaluations from the December 2004 conference support moving in this direction, and CSAT is constituting an expert panel chaired by Ms. Jackson.

**Discussion.** Dr. Harmison stated that research shows e-therapy to be as effective as seeing someone face-to-face. Concerns include supports for the client in an emergency and comfort with the technology to understand body language. Dr. Clark asserted the need to explore this cost-effective modality, which allows more access, particularly to special populations. Ms. Jackson expressed excitement about leading the workgroup to

explore issues related to e-therapy, a good adjunct to treatment and continuation of recovery. Dr. Clark added that technology can facilitate recovery management services.

Dr. McCorry noted that CMHS is working on computerized decision support and suggested that CSAT explore doing so in the future. Judge White-Fish identified cultural differences in computer usage and expressed concerns about licensing and about the importance of eye contact. Dr. Clark explained that technology is not a substitute for therapy, but that it can reduce the cost of services. He asserted that it is important to consider appropriate uses of technology and to contribute to thinking and dialogue. Dr. Fletcher expressed support for the approach and encouraged a continuing dialogue regarding how technology impacts subpopulation groups. Ms. Bertrand noted that the recovery community uses the Internet as a support tool and observed the need for attention to securing appropriate counselors and therapists online. She expressed support for a variety of levels of care and for looking at out-of-the-box ways to reach people.

### **Council Roundtable**

Dr. Madrid suggested discussing workforce issues related to Partners for Recovery at a future Council meeting. Dr. Fletcher suggested a briefing on women's treatment issues. Judge White-Fish volunteered to work on cultural competence issues. Mr. Donaldson suggested allocating time during Council meetings subcommittees meetings. Dr. McCorry expressed interest in a presentation on performance measures and data.

### **Adjournment**

The meeting adjourned at 1:00 p.m.

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

\_\_\_\_\_  
6/30/05  
Date

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