

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

**Minutes of the
48th Meeting of the
CSAT National Advisory Council**

September 20, 2006

Rockville, Maryland

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The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met in open session on September 30, 2006, at 9:12 a.m. at SAMHSA's headquarters in Rockville, Maryland. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the meeting at 9:12 a.m. Members present included Anita B. Bertrand, M.S.W.; David Donaldson, M.A., Bettye Ward Fletcher, Ph.D.; Melody M. Heaps, M.A.; Valera Jackson, M.S.; Francis A. McCorry, Ph.D.; and Gregory E. Skipper, M.D., FASAM. Also present were George Gilbert, J.D., Acting Deputy Director, CSAT, and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

Welcome and Opening Remarks

Dr. Clark welcomed participants to the meeting and emphasized the value of Council members' contributions to SAMHSA. He explained that following Charles Curie's resignation effective on August 5, Dr. Eric Broderick has served as SAMHSA Acting Deputy Administrator.

Members introduced themselves and identified activities in which they have been involved. Ms. Bertrand continues her work with Recovery Month. Dr. Skipper has been involved in a national study of the efficacy of physician health programs and in consulting on the ethyl glucuronide (EtG) issue. Mr. Donaldson has engaged in relief and development work in Africa and the Middle East. Ms. Jackson has been involved with the privatization of services in Florida. Dr. McCorry attended SAMHSA/CMS's Medicaid invitational conference, which highlighted the need for sustained dialogue on the lack of a financing model for substance abuse services. The Washington Circle is working on performance measures for adult screening for alcohol abuse in primary and other settings. Dr. Fletcher's organization is co-sponsoring a training event for pastoral leaders and clergy on substance abuse treatment in collaboration with the National Association of Children of Alcoholics. In teaching a graduate course in substance abuse intervention, Dr. Fletcher finds the Treatment Improvement Protocols (TIPs) highly valued by her students. Ms. Heaps and her organization have helped the Drug Enforcement Agency's (DEA) new museum in Illinois develop its local treatment and prevention story, have contracted with NIDA to train judges, and are involved in building networks of treatment and partnership. She anticipates participating in a major prevention initiative to defer and deflect individuals from the justice system, and is involved in developing research projects for buprenorphine and the criminal justice system, and for community systems and medication support.

SAMHSA Update: Acting Deputy Administrator's Report

SAMHSA Acting Deputy Administrator Eric B. Broderick, D.D.S., M.P.H., greeted Council members and described his background. A dentist by training and a member of the Commissioned Corps of the United States Public Health Service, he served as a clinician and public health program manager in the Indian Health Service. More recently has worked on tribal policy for the HHS Secretary. Dr. Broderick stated that the selection process for a new SAMHSA administrator is underway and assured that SAMHSA will continue to pursue the goals enumerated in the SAMHSA Matrix.

Dr. Broderick expressed personal interest in improving access to care for substance abuse problems in locations where resources are insufficient to meet the burden of disease, particularly in communities with disparate amounts of substance abuse. Other interests include the related issues of suicide prevention, co-occurring disorders, substance abuse prevention, and developing ways to involve public health and primary care providers as points of first contact—and more contact—with people with substance abuse needs. Dr. Broderick invited Council members to communicate with him about their concerns.

Discussion. Dr. Broderick discussed a geographical information systems approach: using epidemiological data on substance abuse, mental health problems, and multiple other indicators to map areas of greatest need for services. Ms. Jackson supported this strategy, which has implications for prevention.

Recognition Ceremony for Retiring Members

Dr. Clark recognized the contributions of Drs. Madrid, Skipper, and Voth, and Ms. Jackson and Mr. Donaldson during their terms on the National Advisory Council, which end in November.

Director's Report

Dr. Clark announced staff changes at CSAT, including the retirement of Terry Schomburg, Nita Fleagle, and Lonn Aussicker. In addition, Rick Dulin has moved from the Division of State and Community Assistance (DSCA) to the Division of Pharmacologic Therapies (DPT), and Rasheda Stevenson has moved to the Center for Mental Health Services (CMHS). DSCA has gained Alejandro Arias, Juli Harkins, and Bryant Goodine. Ting Mei Chau has joined as an emerging leader intern. The Division of Services Improvement's (DSI) new director is Jack Stein, joined by Natalie Lu and Dawn Levinson. Paulette Waiters has left SAMHSA. Danielle Johnson and Shavonne Reed have joined the Office of Program Analysis and Coordination. Changes in the Office of the Director include the detail of Stephen LeBlanc to the National Institutes of Health and his replacement by Hardy Stone, detailed from CMHS. Millie Nevels now serves as Rich Kopanda's staff assistant. Dr. Clark's new staff assistant is Dee Encarnacion, who replaces Elsie Fisher. Dr. Clark acknowledged the contributions of Anne Herron and John Campbell, who recently served as DSI Acting Director and DSCA Acting Director, respectively.

Dr. Clark presented highlights of SAMHSA's 2005 National Survey on Drug Use and Health (the full report appears on CSAT's website), which found that slightly more than half of all Americans age 12 and older reported being current drinkers of alcohol—126 million, up from 121 million in 2004. More than one fifth of persons age 12 and older participated in binge drinking—55 million, about the same as in 2004. Heavy drinking was reported by 6.6 percent, or 16 million, similar to the previous year. Among young adults ages 18–25, the binge drinking rate was 42 percent and heavy drinking was 15.3 percent, similar to rates in 2002 and 2003. Current use among youth ages 12–17 has declined significantly to 16.5 percent from 17.6 percent in 2004, but current use in the 12–20 age range remains the same. Binge drinking among youth ages 12–17 declined from 11.1 to 9.9 percent, but heavy drinking, at 2.4 percent, did not change significantly. Overall, drinking for ages 12–20 remained unchanged; in 2005 about 10.8 million persons reported drinking alcohol in the past month.

Among persons ages 12–20, past month alcohol use was 12 percent among Native Hawaiians or other Pacific Islanders, 15.5 percent among Asian Americans, 19 percent among African Americans, 21.7 percent among American Indians/Alaskan Natives, 24 percent among persons reporting two or more races, 25.9 percent among Hispanics, and 32.3 percent among whites. In 2005, about 13 percent of persons age 12 or older, 31.7 million people, drove under the influence at least once in the past year, a significant drop from 2002. Across age groups, drinking under the influence peaks at 21–25 and does not decline significantly until age 55.

An estimated 19.7 million Americans age 12 and older were current illicit drug users, about 8.1 percent; the group ages 12–17 showed a statistically significant drop since 2002, due probably to the confluence of such factors as parental involvement, media message, prevention efforts, and the faith community. The main drug of choice is marijuana, but nonmedical use of prescription medications is the second most prevalent area at 6.4 million; cocaine, hallucinogens, and inhalants follow at rates similar to, or not statistically different from, the previous year. Past-month use of methamphetamine declined slightly for persons age 12 and older, but its use continues to move from the West Coast to East Coast. Although rate of use shows a decline, people who use tend ultimately to present for treatment; the delivery system must be prepared.

Past-month nonmedical use of prescription drugs among persons age 12 and older increased from 2.5 to 2.6 percent; 50–60 percent of survey respondents obtain their drugs free from friends or relatives. This is a key issue in terms of how physicians can educate their patients that prescription drugs should be treated like guns in the house: Lock them up and don't share. Internet purchase is less of a problem than once thought, but it remains an issue. The lower the age of beginning use, the earlier greater problems arise. The mean age of use of pain relievers is 21 and for heroin, 22; for PCP, inhalants, and marijuana, first use is much earlier. Dr. Clark asserted that many pathways exist to communicate about the dangers of substance abuse.

In 2005 an estimated 22.2 million persons, 9.1 percent of the population age 12 or older, were classified with either substance abuse or dependence. Specific illicit drugs at highest levels of past-year dependence in 2005 continued to be marijuana, at 22.0 million, followed by cocaine and then prescription drugs, both around 1.5 million. Dr. Clark noted that although Household Survey estimates of the problem's magnitude may be challenged, it documents dependence or abuse related to decrements in function. Although rates for males of abuse and dependence are higher than for females in all age groups, they are similar for persons ages 12–17.

In 2005 3.9 million persons, 1.6 percent of the population age 12 and older, received treatment for a problem related to alcohol or illicit drugs, more than half in self-help groups. That year 20.9 million people classified as needing substance abuse treatment received no treatment in a specialty facility; the vast majority of these people felt they did not need treatment, highlighting the need to identify people in need of treatment—in physicians' offices, emergency rooms, houses of worship, for example—and then to have adequate treatment capacity. From a public safety point of view, drug dealing problems go unaddressed because people depend on their dealers to get their drugs. Of the 1.2 million people who felt they needed treatment, only 296,000 made an effort to get treatment. Reasons that a minority of people who made the effort to get treatment did not receive it included cost, insurance, stigma, and other access barriers, while

some were not ready to stop using. Dr. Clark emphasized CSAT's role in early intervention: changing people's attitudes about the misuse of psychoactive substances.

Dr. Clark noted that the House and Senate full budget committees have met on the FY 2007 budget. The President's budget included \$375 million in discretionary funds, with \$1.76 billion for the block grant, totaling \$2.134 billion. The House gave CSAT about \$26 million more than President's budget, while the Senate mark is \$3 million less. Although funding for the Access to Recovery Program (ATR) is not included in these budgets, the House reallocated ATR funds to the block grant and the Senate increased the block grant by \$30 million. A continuing budget resolution is expected. Both houses have agreed on a \$25 million methamphetamine program that would leave voucher decisions to states. Planning has begun for FY 2008 funding. SAMHSA has submitted a budget to the Office of Management and Budget; the request will be announced in February 2007.

Discussion. To a question from Ms. Jackson, Dr. Andrea Kopstein replied that the Household Survey is conducted in Spanish as well as English. Ms. Rita Vandivort replied to Dr. McGorry that SAMHSA reports on all public and private spending on mental health and substance abuse; an upcoming report will cover 1993 to 2003 and will project major public and private payers to 2014. Specialized studies provide additional details on major payers such as Medicare, Medicaid, and others. SAMHSA is seeking good criminal justice data. Ms. Heaps suggested getting such data from corrections departments; Ms. Vandivort replied that the available datasets are problematical, and she welcomed suggestions. She noted that state and local governments are the largest payer for substance abuse at 40 percent of all spending.

Mr. Donaldson noted that the ATR program assisted 48 percent more clients than originally targeted and questioned the congressional committees' motivation to discontinue the program. Dr. Clark responded that the rationale is not clear, but that the Administration continues to work toward its inclusion in the final bill. Ms. Heaps suggested that NASADAD's opposition to ATR as it stands vis-à-vis the block grant may have influenced Congress's direction. Dr. Clark pointed out that rural providers in particular need a core financial stream; if they go out of business, a whole community is without a provider.

Minutes, June 23, 2006

Council members voted unanimously to accept, as presented, the minutes of the June 23, 2006, CSAT Council meeting.

CSAT's Alcohol Dependence Treatment Initiatives

Dr. Clark stated that the Household Survey demonstrates that alcohol remains a major issue in society. The FDA has approved acamprosate and naltrexone for extended-release injectable suspension, the first new medications available for treatment of alcoholism in more than a decade. An updated TIP on naltrexone will include the newer medications, including oral naltrexone and disulfiram. Dr. Clark noted that experimental biochemical measurements to assess objectively patients' current or past alcohol use hold promise for measuring acute alcohol consumption and relapse. These biomarkers, if used appropriately, can be good indicators of alcohol use, presupposing no other illnesses or problems. CSAT is developing an advisory about

the role of biomarkers in treatment that covers indirect (for example, liver functions) and direct (for example, alcohol and EtG) measures of alcohol exposure.

Biomarkers complement self-report measures and represent an objective laboratory test to assist in outcome measures for treatment and studies, to screen to detect problems, and to provide some evidence of abstinence. Limitations exist for these strategies in clinical and, especially, forensic contexts, where biomarkers must be more rigorous. In treatment biomarkers can be used to screen for alcohol use problems, using feedback to motivate change in drinking behavior, to identify relapse, and to evaluate interventions. Forensic use of biomarkers to document abstinence (for example, in child custody cases and for impaired professionals) requires close attention in terms of outcomes.

Issues in biomarker testing, discussed in an upcoming advisory, involve understanding sensitivity, specificity, and positive predictive value; estimating the prevalence of a problem; and understanding the relationship among sensitivity, specificity, prevalence, and positive predictive value. Reliance on a test as evidence of alcohol consumption ignores exposure to such products as aging juice, foods cooked with alcohol, over-the-counter or prescribed medications, the propellant in nasal inhalers, and household products—all of which produce low-level positives. Dr. Clark stated that the difference between breathalyzers, which require considerable alcohol to produce a reasonable positive, and biomarkers, some of which can detect alcohol at 50 nanograms, is substantial—but 50 nanograms in the body bears no relationship to intoxication.

Dr. Clark asserted that further research is critically necessary to determine cutoff levels that clearly distinguish consumption of beverage alcohol from exposure to alcohol in other products, factors that influence an individual's biomarker response to alcohol, the window of assessment associated with various levels of alcohol use, the reliability of laboratory testing procedures, and products that can give a positive test result at specific cutoffs. Issues involved in establishing a good cutoff value include the risk/benefit of a correct label or of an incorrect label to the patient, the cost of working up or of missing a false positive case, and a test-only alcohol detection program that requires 100 percent specificity for no false positives. The advisory advocates that people focus not on the absolute nature of biomarkers, but instead on their utility in general clinical assessment. Dr. Clark noted that CSAT is developing a TIP on medications for treatment of alcohol dependence to ensure that primary care physicians and students have the latest information. He observed that if abstinent people are accused of using on the basis of biomarkers, recovery efforts are vulnerable. He urged scientific honesty and recognition of biomarkers' limitations.

Dr. Skipper commented on the regulatory aspect of biomarkers from the perspective of his work with health and other professionals with substance abuse problems and in introducing EtG and EtS testing into the United States. More than a dozen laboratories conduct 20,000–30,000 tests monthly, mainly to monitor people who have agreed to be abstinent. EtG testing is highly effective in terms of negatives, but problematic in terms of positives, particularly in forensic settings where incontrovertible evidence is wanted. Biomarker tests pose the dilemma of substance abuse as crime or illness, warranting punishment or treatment. Dr. Skipper expressed concern about the rigid and sometimes punitive manner in which some agencies use the tests, and the limited role medical review officers (MROs) take in these issues.

Dr. Skipper stated that he personally issued advisories in 2004 and 2005 warning agencies that positive EtG tests could result from incidental exposure, but the field virtually ignored them. He hears from a dozen or so people a day who claim they are falsely accused of drinking, many of whom are returned to prison, lose custody, or lose their licenses. He expressed hope that SAMHSA's upcoming advisory will influence persons in positions of authority to use care in using the potentially valuable tests.

Dr. Skipper recommended that SAMHSA convene a meeting of regulatory licensing boards, criminal justice representatives, and others who use the tests to help them understand advisory and how to use the tests properly. He noted that clinicians can use low positives in clinical settings to detect early relapse. Dr. Clark added that the test might be useful to advise about environmental exposure to alcohol in prevention of relapse. Dr. Skipper stated that he is studying Purell; breathalyzers register up to 0.2, while blood levels show 0.01 or 0.02. He cautioned that alcohol without liquid (AWOL), sold in Europe, may become a problem in the United States.

Public Comment

Lorie Garlick, Nancy Clark, and Tina Schroeder recounted their devastating experiences with EtG testing that resulted in loss of their respective professional licenses. Ms. Garlick pointed out that no literature supports EtG cutoff levels, and no studies have been published on the effect on EtG levels of medications, gender, endogenous alcohol production, or individual variations in metabolism. She urged CSAT to communicate the test's limitations to all licensing boards, third-party administrators, MROs, and criminal justice programs; to require, not suggest, clinical correlation; to issue warnings to laboratories against unethical marketing practices and remind them of their duty to educate and inform clients about both good and bad effects; and to urge the National Institute on Alcohol Abuse and Alcoholism to add the issue to its research portfolio. Ms. Clark noted the lack of clinical correlation following positive EtG tests and pointed out that although boards and monitoring agencies are responsible for test interpretation, lab statements about cutoff levels leave little room for interpretation; agencies are victims, also, because labs give them bad information. Although the issue was raised with the American Society of Addiction Medicine, the situation has not changed.

Council Discussion

Council members agreed that additional research on biomarker tests (EtG) for alcohol consumption is needed and suggested draft language to add the advisory (see Council Roundtable, below). In addition, Council members unanimously recommended that CSAT Council members and staff take a leadership role in creating a strong educational campaign for criminal justice agents and professional regulatory bodies nationwide on the limitations and properties of the biomarker test and its potential for negative effects. A dissemination plan would be an important component of the campaign, with emphasis, for example, on physician assistants, clinical boards, lawyers, and anyone with potential to make punitive decisions. CSAT should convene a meeting to be attended by an appropriate representative of each state.

Proposition 36 Cost Study

Larry Carr, Deputy Director, Office of Applied Research and Analysis, California Department of Alcohol and Drug Programs, UCLA, introduced an overview of his agency's cost/benefit

analysis of the Proposition 36 initiative. California voters passed Prop 36 in 2000 as the Substance Abuse and Crime Prevention Act (SACPA), whereby adults convicted of nonviolent drug-related offenses may be sentenced to probation with community drug treatment.

Angela Hawken, Ph.D., Policy Analyst, Integrated Substance Abuse Programs, UCLA, an author of the study, enumerated key findings: Prop 36 substantially reduced incarceration costs (about \$800 million over the first five years), created more savings for certain eligible offenders than others, and can be improved for increased efficiency. The analysis incorporated three studies. The first found a savings of \$2.50 for each dollar invested in the program when cost outcomes of all SACPA-eligible offenders are compared to a comparison group. The second study, which compares costs outcomes among those referred to SACPA based on degree of treatment participation, found cost outcomes better for treatment completers, a savings of \$4.00 for each dollar invested. In comparing cohorts, the final study found that cost outcomes for years 1 and 2 were stable. All estimates are based on administrative data on many outcome domains obtained from state agencies. Conducted using a difference-in-differences design from the perspective of the taxpayer, the study includes only costs and benefits that affect state- and local-government budgets. Data on welfare and mental health did not lend themselves to inclusion in this study.

Dr. Hawken summarized Study 1 findings: Significant savings due to Prop 36 per offender were realized in prison costs (\$3,500 on average) and (\$1,500) jail costs. Probation costs rose slightly, while costs for parole declined with fewer individuals in prison. Arrest and conviction costs rose an average \$1,300 per person, an issue of concern; but compared with the comparison group, more persons stayed on the street and had more opportunity to be arrested for a new crime. Further study found that most Prop 36 offenders were significantly less costly, but a tiny group drives up these costs; the best predictor of a high-cost offender was five or more prior convictions in the 30 months preceding arrest. An increase in costs for treatment programs was expectable. Health care costs spiked upon entering treatment, but then settled down, thus demonstrating the value of longer-term evaluations. Finally, Prop 36 offenders paid more in taxes and more people were employed than in the comparison group, a factor important for its social implications. The study found a total savings of \$2,800 per offender across domains.

Study 2 found much greater savings for offenders who complete treatment. Treatment completers add less arrest and conviction costs than individuals who do not complete treatment. Noncompleters are more costly in terms of criminal recidivism. Individuals who never enter treatment fall into two groups: those with clean histories and those who find themselves re-incarcerated. Cost of treatment is more costly for completers.

Study authors recommended continued funding of SACPA, improved treatment entry and treatment retention in the program, and exclusion of offenders with five or more prior convictions or increased offender and agency accountability. Additional recommendations include improved treatment matching, increased residential placement for high addiction-severity offenders, expanded use of narcotic replacement therapy, cultural issues addressed to enhance treatment completion, and improved assessment and treatment show rates by locating assessment at or near the court, incorporating drug-court approaches where possible, allowing walk-in assessments, and completing assessment in one visit. Other research evidence findings and recommendations include expanded use of graduated sanctions/rewards to help offenders comply

with terms of their treatment, and an ongoing evaluation cycle of the program. The study concluded that Prop 36 has saved California taxpayers significant money.

Discussion. Dr. Hawken explained that treatment was defined by California's 58 counties, each with a different model. Ms. Jackson suggested that knowing more about the criteria and assessment tools could be helpful to look at outcomes. Dr. Hawken responded that the next round of evaluation will look at best practices. She noted that some offenders with co-occurring disorders received mental health treatment, although not under Prop 36. Her group is working with alcohol and drug programs to define a study to understand that aspect better, and a mental health report on Prop 36 offenders is forthcoming. Ms. Heaps inquired how states fund the extra costs of recidivism and noted the effectiveness of a treatment continuum under case management in reducing the costs of residential care. Dr. Hawken responded that state and county costs are taken into consideration and analyzed in the report, as is the issue that jail overcrowding is so severe that jails do not experience cost savings as a significant reduction. California is working to increase treatment capacity along the continuum of care.

E-Therapy Update

Ms. Jackson, the Council's E-therapy Subcommittee chair, explained that the e-therapy work group has held several meetings and identified a group of e-therapy experts. The work group defines e-therapy for substance abuse treatment as the use of electronic media and information technologies (e.g., the Internet, PDAs, text messaging, telephone, videoconference) to provide services for participants in different locations. It is used by skilled and knowledgeable professionals (e.g., counselors, therapists) to address a variety of individual, familial, and social issues. E-therapy can include a range of services to engage persons in therapy, to treat as a standalone modality, and to treat in continuing care and relapse. The challenge is to identify the services and find practices to make them work at a comfortable cost.

E-therapy's key components include community resources, state and other regulations and legislation, cultural and linguistic competence, efficient administration, rigorous evaluation, and targeted outreach. Regulation and legislation involve mandated reporting and confidentiality requirements, informed consent, insurance liability, and legal protections against malpractice. Elements of cultural and linguistic competence apply to most interventions. Administrative challenges include insurance, electronic billing, and client record keeping. Targeted outreach is a controversial issue that appears to have relevance in isolated rural areas and in urban areas where transportation to therapy is an issue; underserved and hard-to-reach populations warrant more consideration. Ms. Jackson and Ms. Heaps urged SAMHSA to develop guidance to the field on issues related to e-therapy, with a view to future evaluation, demonstration, or pilot programs.

Council Discussion. Capt. Stella Jones, Federal Project Officer for the initiative, responded to Dr. Fletcher's question that the literature does not cite research on the effectiveness of e-therapy. The guidance in preparation will identify some practitioners who have enjoyed success with various modes of technology and certain populations. Ms. Heaps asserted that CSAT has responsibility to caution the field about the current lack of science and also to inform about proven methods and best practices. Ms. Jackson noted that e-therapy currently is being practiced, and that CSAT should apply parameters on what might be a service-to-science focus. Mr. Donaldson urged progress on this modality, which is valuable for its anonymity. Dr. Skipper

urged investigating existing technology for e-therapy management and volunteered to share information about a system that notifies and reports on drug testing through an online mechanism. Ms. Bertrand suggested researching the ways in which Weight Watchers and 12-step support programs have overcome barriers to e-therapy. Dr. Fletcher identified the need for knowledge transfer mechanisms for professional development in e-therapy.

Public Comment

Thelma King Thiel, Chief Executive Officer, Hepatitis Foundation International, noted the lack of information provided in schools about liver health and described the unique approach of using humor and analogies to help assess and change behaviors risky for liver damage. She looks forward to increased collaboration with CSAT and enumerated activities undertaken on behalf of CSAP grantees, methadone counselors, and others. The foundation has produced 14 videos on hepatitis and substance abuse prevention, used, for example, in STD clinics. A new video geared to adolescents has been released.

Substance Abuse Treatment Services for Individuals with Disabilities

Ruby V. Neville, M.S.W., L.G.S.W., Public Health Advisor, CSAT, explained that the focus on treatment services for individuals with disabilities originated with the 2001 President's New Freedom Initiative to promote full access to community life through efforts to implement the Supreme Court's *Olmstead* decision. A subsequent executive order directed Federal agencies to remove barriers to community living, and the 2005 Deficit Reduction Act directs states to engage fully in the workplace individuals with disabilities.

Ms. Neville explained that the Americans with Disabilities Act (ADA) provides civil rights protections to persons with disabilities. But drug and alcohol addictions alone do not count as a disability; only if a drug or alcohol addiction is a contributing factor material to a finding of disability would addiction count as a disqualifier. The fundamental question is whether the disability would remain in the absence of drugs or alcohol.

Barriers in accessing substance abuse services include providers' lack of information in determining the level of service for disorders. Access to services depends on the type of coexisting disability; for example, persons with cognitive and physical disabilities are at higher risk for substance abuse disorders, but less likely to receive effective treatment than persons without the coexisting disability, and persons with traumatic brain injury may be unable to benefit from didactic training or group interventions, and a lack of abstract reasoning abilities and reduced ability to solve problems may be undetected by providers. Persons who are blind/visually impaired, deaf/hard of hearing, or non-English speakers have their own unique access challenges, including lack of formalized assessment tools and training for rehabilitation professionals. These professionals often focus on the disability and miss signs of substance abuse, which makes clear the need to develop plans and training to conduct accurate assessment and develop treatment plans.

CSAT's activities include support for treatment at the Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing, a study at Ohio State University of methods to improve the ability to engage persons with traumatic brain injury in treatment for coexisting disorders, Wright State University's Substance Abuse Resources and Disability Issues program, Chestnut

Health Systems' Exemplary Treatment Model Program, and Anixter Center. CSAT also provides technical assistance to states to target the coexisting disability population. The Surgeon General's 2005 Call to Action to Improve the Health and Wellness of Persons with Disabilities aims to increase understanding nationwide that people with disabilities can lead long, healthy, and productive lives; increase knowledge among health care professionals and provide them with the tools to screen, diagnose, and treat the whole person with a disability with dignity; increase awareness among people with disabilities of steps they can take to develop and maintain a healthy lifestyle; and increase accessible health care and support services to promote independence for people with disabilities.

CSAT's next steps are to promote increased access to substance abuse treatment for individuals with disabilities; encourage inclusion of members of all disability groups in treatment programs; provide support to programs to engage in cross-agency activities; encourage grantees to target services to coexisting populations; encourage linkages among substance abuse treatment providers and other providers; initiate inclusion of coexisting populations within CSAT activities that focus on criminal and juvenile justice, workforce development, cultural competence, children and families, and suicide prevention; support the *Olmstead* decision; encourage and expect CSAT-funded providers to include in their strategic plans efforts to extend treatment to persons with coexisting disabilities; provide training; and explore additional publications.

Discussion. Dr. McCorry stated that New York State has implemented a traumatic brain injury screen, but in many places no psychologists are available to do neuropsychological assessment. In addition, he noted, many providers have no knowledge of how to modify their treatment services to incorporate people with cognitive impairments. Ms. Neville replied that some states have promising practices, and solving these issues will take collaboration, idea sharing, and replication of what works. In addition, technical assistance through ATTCs or the SARDI program is available to providers.

Screening, Brief Intervention, Referral, and Treatment (SBIRT), and Access to Recovery: Update

Jack B. Stein, L.C.S.W., Ph.D., Director, DSI, CSAT, explained that SBIRT, launched in 2003 as a paradigm shift in treatment for substance use and abuse, screens individuals with, or at risk for, nondependent substance abuse within communities and/or specialty settings in order to triage them to appropriate services. SBIRT's screening process uses specific instruments to engage individuals in a brief intervention, brief treatment, or referral to more comprehensive treatment. Promising results have emerged to date.

Seven state agencies and one tribal organization, each with a unique model, received the original grants. In 2005 SBIRT awarded grants to 12 colleges. Many programs serve Latino/Hispanic communities. Ongoing data collection reveals 165,000-plus cumulative screenings; the number of screenings exceeded the 2006 target. New state grants have been awarded to Colorado, Wisconsin, Florida, and Massachusetts. With the American College of Surgeons, National Highway and Traffic Safety Administration, and Centers for Disease Control and Prevention (CDC), CSAT is developing a Web-based toolkit to target the medical arena, including primary care physicians; a quick guide for trauma surgeons and coordinators aims to provide tools to conduct screening and brief interventions; and training modules are under development.

ATR, a three-year, \$300 million discretionary voucher-based grant program that ends in August 2007, aims to expand treatment capacity, support client choice in accessing treatment, and increase the array of faith- and community-based providers for clinical treatment and/or recovery support services. ATR's goal is to serve 125,000 clients over three years; preliminary data indicate that the target of screening individuals who perhaps would not have been screened through other mechanisms is within reach. Grantees include 14 states and one tribal organization. Data show that more than 63 percent of clients have received recovery support services; 48 percent of expenditures paid for recovery support services; 25 percent of dollars were paid to faith-based organizations; and faith-based organizations provided 23 percent of recovery support services and 35 percent of clinical treatment services. Early outcome data show a 64 percent increase in abstinence rates, 28 percent increase in stable housing, 30 percent increase in employment, 57 percent increase in social connectedness, and 82 reduction in involvement in the criminal justice system.

Dr. Clark added that SBIRT identifies dependent, as well as nondependent, users in settings where they seek health care, an advantage beyond the program's initial conceptualization, and that SBIRT is welcomed by the community. ATR reaches a broader population, involves alternative practitioners, and, with its satisfactory results, ATR is a justifiable strategy.

Fentanyl: Update

Ms. Heaps explained that last fall and early winter, the State of Illinois, the press, and providers noticed increasing overdose deaths and admissions with a new compound substance of heroin and fentanyl, which when combined, results in immediate suppression of cardiopulmonary effects—but on the streets of Chicago, the combination produced a “fabulous high.” Within five to six months, more than 100 deaths occurred. Illinois' administrator convened state and county public health officials and treatment agency leaders to discuss action steps. The effect continues, but indicators show declines. Ms. Heaps contacted Rep. Danny Davis, who called a press conference; the Illinois congressional delegation requested increased funding for treatment, in view of long methadone wait lists; the DEA investigated the source of the fentanyl (Mexico).

Ms. Heaps recommended that CSAT invite DEA to make an annual presentation on latest trends in drugs of choice to help communities plan for upcoming problems. Mr. Robert Lubran stated that SAMHSA, charged with responsibility for an integrated Federal response, has engaged DEA, Justice, Office of National Drug Control Policy, CDC, and more than 50 state and local public health/law enforcement officials in weekly conference calls. Dr. Ken Hoffman shared details about CDC's initial detection of the problem and noted that representatives from the National Institute on Drug Abuse's Community Epidemiology Work Group and the Food and Drug Administration have joined in the effort. ONDCP conducted a forum in July 2006 that focused on looking at the problem in terms of an early warning, detection, and response system.

Discussion. Dr. Clark stated that CSAT is working to develop practicable solutions, including fostering increased awareness among substance abuse public health authorities and among users. Dr. Clark stated that a report from DEA coupled with information from the National Survey on Drug Use and Health and TEDS data would be useful. He noted that DEA's Web site includes state-specific information on popular drugs.

Council Roundtable

Dr. Donna Bush, CSAT, reported on the new language that will introduce the advisory on EtG: “Currently the use of an EtG test in determining abstinence lacks sufficient proven specificity for use as primary or sole evidence that an individual, prohibited from drinking in a regulatory compliance context, has truly been drinking. Legal or disciplinary action based solely on a positive EtG or similar unproven test is inappropriate and legally and scientifically unsupported at this time. These tests should currently be considered as potential valuable clinical tools, but their use in forensic settings is premature.” Ms. Heaps suggested adding the “criminal justice” context to the statement. She also urged convening a conference call to suggest revenue-neutral mechanisms to get the word out. Dr. Clark agreed to follow up on development of the public information campaign.

Ms. Jackson noted the passing of Marilyn Culp, and Dr. Clark noted the loss of CSAP’s Steve McElray, both important contributors to the substance abuse field.

Ms. Jackson urged addressing the large percentage of the population that acknowledges the need for substance abuse treatment but does not access it; an initial approach might be to determine specific target populations, such as people who have experienced trauma or disabilities. In addition, she expressed her strong belief in the need for discretionary grants.

Regarding the ATR initiative, Mr. Donaldson and Ms. Heaps urged continuing attention to provision of recovery support services along the continuum of care and use of the voucher approach. Mr. Donaldson endorsed the value of the faith community in providing the continuum. Dr. Clark responded that the Administration is considering how to inform Congress of ATR’s utility. He added that community-based organizations are important in this initiative that promotes personal empowerment rather than professional paternalism. CSAT has an ancillary program for community recovery support services program that is subject to charitable choice.

Adjournment. The meeting adjourned at 4:25 p.m.

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

5/31/2007
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