Interagency Demand Reduction Working Group

Briefing Book on Subcommittee Reports

Friday, July 24, 1998

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

July 21, 1998

MEMORANDUM

TO: Interagency Demand Reduction Working Group

FROM: Donald R. Vereen, Jr., M.D., M.P.H.

SUBJECT: Briefing Book

Enclosed for your review is the Interagency Demand Reduction Working Group Briefing Book. This is a summary of each of the IDRWG's subcommittees work and accomplishments. Due to time constraints, all of the subcommittees will not have a chance to present their work at the July 24 meeting. It is suggested that you take the time to read these summaries, as your agency has been well represented in this endeavor.

Look forward to seeing you on July 24.

Treatment Gap

TREATMENT GAP SUBCOMMITTEE REPORT

Committee Members: Steve Wing, HHS/SAMHSA, Co-Chair; John Gregrich ,ONDCP, Co-Chair; Elena Carr, DOL; Herman Diesenhaus, HHS/CSAT; Bennett Fletcher, HHS/NIDA; Charlene Lewis, HHS/OAS; Richard Suchinsky, VA; Pat Tarr, DOJ; Jane Taylor, HHS/CSAT; Tom Vischi, HHS/OPHS.

The Treatment Gap Subcommittee has met as a full committee and as a technical working group. The following analysis of the treatment gap was developed by Drs. Diesenhaus, Fletcher and Lewis and Messrs. Gregrich and Wing; the general framework and the recommendations for closing the treatment gap are based on the discussions of the entire subcommittee. Various ONDCP staff attended several subcommittee meetings and the subcommittee is grateful for their contributions.

The Subcommittee took as its charge (1) learning about how the size of the treatment gap is determined, (2) analyzing the causes of the gap and the barriers to treatment, and (3) developing policies for reducing the size of the gap and increasing access to treatment.

THE COMPOSITION OF THE TREATMENT GAP

The treatment gap has been defined in the National Drug Control Strategy as the difference between the estimated number of persons needing treatment[1] and the number of clients treated in a given year[2]. In the 1998 document, these estimates are contained in Appendix Table 17, Treatment Need and Percent Treated. Since the need for treatment varies according to the severity of the problem, HHS divided those needing treatment into two categories, termed Level 1 and 2, based on intensity of drug use, symptoms, and consequences. The more severe category of need is Level 2. Level 2 users correspond to chronic, "hardcore" users discussed in the Strategy. The 1998 Strategy emphasizes the need to provide drug treatment for chronic users who are inside and outside the criminal justice system. About 3.6 million Level 2 drug users were identified as needing help to overcome their addiction in 1994 while only approximately 1.8 million (52 percent) received treatment in that year.

Some caveats to these basic numbers should be stated. The items comprising the National Household Survey on Drug Abuse's measure of chronic drug users and the estimates of dependence are currently undergoing review and may be revised. The sampling frame for the NHSDA, while appropriate for capturing national prevalence rates of drug use, is not the best for estimating the number of chronic, "hardcore" drug users and probably does not give a comprehensive picture of drug abuse treatment utilization by chronic users. Finally, the amount of overlap between those eligible to be interviewed in the NHSDA and those in the UFDS sample is unknown. Given that these methodological issues have an important impact on the estimated treatment gap, activities are already underway at HHS to improve the quality of the available data and the methods for estimation. Additionally, ONDCP has funded another large-scale feasibility study to determine whether other methods can improve these estimates.[3]

Thus, despite the widely acknowledged seriousness of the problem of drug abuse in the United

States, a widely accepted estimate of the number of persons who need and receive treatment for use of illicit drugs in either the public or private sectors is not available. It is known that not all who wish to receive treatment for drug problems are able to receive the treatment of their choice and that there is a wide variability among jurisdictions in total treatment capacity as well as how capacity is distributed among settings and modalities. The exact size of the gap between services available and needed for persons experiencing clinical problems with illicit drugs is not yet well defined and stable baselines need to be determined.

Consistent with this subcommittee's mandate, our report identifies conceptual issues which are involved in defining the treatment gap, identifies barriers to closing the gap, and proposes a strategy for addressing those barriers. Proposing a specific methodology for calculating the gap is outside the scope of this subcommittee.

Two Treatment Gaps

The current estimate of the number of chronic, "hardcore" drug users was taken as the number in need of treatment on the presumption that frequent users and those who meet dependence criteria (or indicators of dependence as in the NHSDA) have a need for and would benefit from treatment.

The estimate of the gap in the National Drug Control Strategy collapses what is effectively two treatment gaps into one:

- the gap between the number of individuals who have a severe illicit drug disorder (drug addiction or dependence) that would require treatment for resolution, and the number who demand treatment, and

- the gap between the number who demand treatment and the capacity of the treatment system to deliver it.

The concept of demand for treatment was introduced early on in the subcommittee's discussions to differentiate between persons who would seek treatment if it were readily available and those, although determined to be in need of treatment, who would not. This distinction is already in use in many of the States that have developed their own methodologies for determining the size of the treatment gap in order to re-allocate funds among different substate planning areas or to seek new funds. The distinction enables planners to determine more readily what budgetary expectations are reasonable. In addition, the subcommittee wished to understand the barriers that inhibited those individuals in need of treatment from seeking it when available as well as those barriers that blocked treatment for those seeking it.

Gap between number with severe disorder and number seeking treatment. A gap exists between the number of individuals with a severe illicit drug use disorder (e.g., addiction or dependence) and the number who seek drug abuse treatment.[4] While a number of factors contribute to this gap, it is not necessary to identify the specific reasons for the gap between the need and for demand for treatment in order to estimate it. All that is needed is an estimate of the number who need drug abuse treatment and the proportion of these who have not sought treatment.

It is necessary, however, to understand why some who need treatment do not seek it in order to intervene to close the gap between need for treatment and demand for it. Therefore, the subcommittee undertook a review of the factors known about individuals who use drugs and the characteristics of the drug abuse treatment system that are known or are hypothesized to affect the size and nature of the treatment gap. Some factors are primarily rooted in the individual. For example, the perception that drug abuse treatment is ineffective may cause some to disregard it as an option. The stigma attached to drug abuse treatment, even by chronic addicts, prevents treatment from being sought by many who could benefit from it. Although some individuals who would be identified by clinicians as in need of treatment seek it on their own, many enter treatment only under threat of external coercion from family, employers, or the criminal justice system. Other factors are rooted in the general social perception of the effectiveness of drug treatment and the image of the drug abuser.[5]

Factors influencing whether a person seeks drug abuse treatment are listed below. (This is not intended to be a comprehensive list.)

- recognition of existence of a drug problem
- readiness to change (internal or external pressure)
- readiness to seek professional help
- existence of other problems (may be drug related or not), such as medical, psychological, legal/criminal justice, family/social, vocational/employment
- need for treatment because of relapse
- ability to pay

While the number of persons in this category remains to be determined, the subcommittee concluded that the gap between need for treatment and demand for it should be smaller than it is, and that interventions should be undertaken to reduce this gap.

Gap between number seeking treatment and capacity of treatment system. Many who want drug abuse treatment cannot get into treatment when they need to and cannot get the type of treatment that is best for them. This second gap is the gap between demand for treatment and the ability of the drug abuse treatment system to accommodate this demand. If the demand for treatment were known, the size of this gap could be estimated based on current data on static capacity (from UFDS) and utilization (from TEDS and/or UFDS).

It should be noted that estimation of capacity is usually a static estimate, such as number of treatment slots, admissions, or beds. However, treatment is dynamic and a more accurate picture of capacity would need to reflect the dynamic nature of treatment availability. One dimension of this dynamism is the fact that more than one person may occupy a treatment 'slot' in any given year. That is, varying lengths of stay in different modalities need to be considered in estimating the capacity of

each modality to deliver treatment across a given period of time.

In addition, the appropriate modality and level of care (setting in which treatment takes place), based on client need, must be factored into the estimation. For example, brief interventions, long-term residential care, and intensive outpatient care are all appropriate modalities for different segments of the treatment population. Expectations about the length of the treatment episode vary in accordance with both the modality and the level of client need. Thus, individuals with a lengthy addiction career and attendant medical problems may need a long term medically supervised residential rehabilitation program; whereas, other individuals with less severe problems may be treated effectively in an outpatient setting. To propose to increase the absolute capacity of treatment to close the gap between demand and current capacity, the interaction of both client and modality characteristics must be considered.

Similarly, demand for treatment may also be considered as a dynamic variable, rather than a static number. Environmental changes (e.g., stricter enforcement of DUI laws, drug sweeps, changes in the price, purity and/or availability of certain drugs) influence demand, as do seasonal factors (e.g., demand for in-patient or residential care often increases in the winter), local and state policy changes, and availability of appropriate care (e.g., specialized programs for pregnant women, HIV-infected individuals, opiate addicts, etc.).

The following is a listing of some systemic aspects of the drug abuse treatment system affecting the treatment gap:

- Capacity to treat

- Availability of treatment, and access to treatment
  - Logistical, practical barriers
  - Financial
  - Cultural, language

- Suitability of treatment
  - Setting (inpatient vs outpatient)
  - Modality / type of treatment
  - Continuity of care / maintenance
  - Special population / special problems (adolescent, HIV risk, women, dual diagnosis, etc.)

- Treatment Services
  - Assessment of need
  - Match to need for modality, wrap around services, and setting
  - Case management
  - Provision of wrap around services in-treatment or by referral out

- Linkages to other social systems
  - Criminal justice system
  - Family / social services
  - Health (medical, psychological)
  - Welfare
  - School

Interventions to reduce the gap include increasing access, capacity, utilization, efficiency, and effectiveness. Barriers to increasing static capacity include the levels of public and private funding for drug abuse treatment, and the impact that state health care financing reform (especially moving to managed care systems) has on treatment systems. One example of the impact of managed care is in the area of capitalization of treatment. Since many managed care companies pay for treatment after the fact and slowly, and often at negotiated rates which barely cover costs, thinly capitalized substance abuse programs have been placed at risk financially, limiting their ability to expand quickly in response to increased demand for services.[6]

Financial barriers, lack of suitability, and problems of accessibility constitute barriers to utilization of drug abuse treatment. Financial barriers include insurance coverage (what is covered; parity issues). Suitability questions include the availability and quality of services needed by the patient (e.g., inpatient vs. outpatient; level or intensity of service; type of service -- medical, psychological, child care, female, adolescent, vocational/employment, family/social). Accessibility includes the physical location, security of facility, transportation, hours of operation, and setting of treatment. Availability of low cost maintenance and relapse prevention services such as methadone/LAAM treatment programs, transitional and follow-up support in drug-free living environments for those in recovery could free up more expensive active treatment slots.

Subdividing the treatment gap.

It is important to note that substance abuse treatment is supported by a variety of public and private sources, including private insurers, HMOs, the Substance Abuse Prevention and Treatment Block Grant, State general funds, the Department of Veterans Affairs, the Indian Health Service, Medicaid, Medicare, and the criminal justice system. Since the gap between the number of persons seeking treatment (including those who are coerced by employers and the criminal justice system) and the availability of such treatment may vary by sector or by payment source, it is possible to conceive of the "treatment gap" as the total of a series of " individual treatment gaps". While the subcommittee recognizes the methodological problems involved in quantifying individual gaps, it should be noted that a breakdown by payee and sector would greatly assist in the development of policies and strategies for closing the gap.

CLOSING THE TREATMENT GAP AND INCREASING ACCESS

Specific actions will be necessary on at least five fronts to close the treatment gap, regardless of how it is measured or described. Reducing the size of the overall gap will be enhanced by creating policies and defining implementation strategies that attack the specific components. For those who

need and will seek treatment, those who can be reached, those who must be coerced, and those who will resist all efforts, the following interrelated actions are recommended for consideration:

1. Increased block grant funding;

   Increased funding to maintain sufficient progress toward targets for closing the treatment gap.

   Expanded support for low-cost treatment and for self-help transitional and follow-up support (e.g., drug-free living environment for those in recovery).

2. Targeted Funding

   Increased funding for SAMHSA's Targeted Capacity Expansion Program, which requires the use of best practices and concrete outcome measures in addressing existing and emerging treatment needs.

   Expanded outreach programs for chronic injectors, crack and cocaine addicts, and other treatment resistant populations in order to foster increased treatment readiness and treatment entrance.

   Expanded use of criminal justice sanctions and review of state and local experience with civil commitment as a means to get priority populations into treatment.

3. Regulatory change - to make proven modalities more readily accessible

   Provide adequate resources to reform regulation of methadone/LAAM treatment programs, maintaining and improving program quality.

   Provide training to treatment programs and to physicians on the proper administration of opiate agonists and emerging pharmacotherapies.

   Conduct demonstrations of physician administration of opiate agonists (e.g., referral of stable patients from treatment programs to physician office settings).

   Conduct outreach and education programs with medical and health professional organizations; state legislators; regulators; and administrators regarding the administration of pharmacotherapies for drug dependence.

Provide incentives for states to develop common approaches to regulation, monitoring, and financial and technical assistance.

Provide for comprehensive evaluation of the impact of regulatory reform on treatment access, quality, and cost.

4. Policy Changes

Provide parity insurance coverage (i.e. coverage for substance abuse services that is on a par with coverage for other medical and surgical services)

Provide sufficient resources for parity coverage for substance abuse services under all plans offered to Federal employees.

Support Federal legislation to establish parity coverage nationwide.

Conduct outreach and education programs with businesses, health care funds, other purchasers of health care, and providers regarding parity.

5. Priority Research, Evaluation, and Dissemination

Development of by-state estimates of drug treatment need, demand, and treatment services resources, including the identification of priority populations (coordinated implementation of the state-based needs assessment initiative with the expansion of national data sets like the National Household Survey of Drug Abuse and data collected by CDC.)

Initiate improvements in the validation and dissemination of best treatment practices.

Conduct research and publish guidance on ways to increase retention in treatment; ways to reduce relapse; ways to conduct treatments that foster progress from external coercion to internal motivation.

Conduct, and publish guidance in accordance with comprehensive research on the impact of parity coverage.

Conduct research and demonstrations on the development and application of pharmacotherapies and behavioral therapies for the treatment of dependence on or abuse of cocaine/crack, opiates, marijuana, and stimulants, including methamphetamine.

Conduct evaluations and disseminate guidance regarding low-cost treatment and self-help transitional and follow-up support to reduce relapse (e.g., social model programs, safe and sober, drug-free housing).

Notes

1. Estimated by HHS from the National Household Survey on Drug Abuse (NHSDA) augmented with data from the National Drug and Alcohol Treatment Unit Survey (NDATUS), now known as the Uniform Facility Data Set, or UFDS; the Drug Services Research Survey (DSRS); and the Uniform Crime Report (UCR). The NHSDA underestimates drug use prevalence because the sampling frame may not completely enumerate drug abusers (undercoverage) and because respondents may not always report drug use and other stigmatized or illegal behaviors (underreporting). To correct these problems in part, an estimation procedure is used to modify analysis weights applied to the NHSDA sample. To adjust partially for undercoverage and underreporting in the NHSDA, the three subsidiary data sources are used in ratio estimation. None of these three data sources are as comprehensive as the NHSDA and therefore cannot replace the NHSDA. Two of these, the National Drug and Alcohol Treatment Unit Survey (NDATUS) and the Drug Services Research Survey (DSRS), provide an independent estimate for the number of people receiving specialty drug abuse treatment. The third source, the Uniform Crime Report (UCR), provides an independent estimate for the number of persons arrested.

2. Estimated from the National Drug and Alcohol Treatment Unit Survey (NDATUS), now known as the Uniform Facility Data Set, or UFDS. The NDATUS is an annual, one day census of all the known specialty drug abuse and alcoholism treatment units in the nation. Fifty-six states and other jurisdictions plus several federal agencies, working with SAMHSA, identify the NDATUS universe of treatment units or providers. Approximately 11,500 public (government) and private (both for profit and not for profit)treatment providers in the United States were surveyed each year. The complete list or universe of specialty treatment providers is maintained and continuously updated by SAMHSA as an automated data base. The NDATUS collects data mainly on clients in treatment as of one day at the end of September or early October. Data are collected in this way to minimize the reporting burden. NDATUS one-day census counts by eight types of treatment are inflated into annual estimates of persons treated based upon DSRS estimates for "length of stay" in treatment and for the number of treatment episodes per year per client.

3. Simeone, R., et al. 1997. **A Plan for Estimating the Number of Hardcore Drug Users in the United States**. Washington, DC: ONDCP.

4. Demand for treatment is not strictly a subset of those having a severe illicit drug use disorder defined as above because demand will also include some with an identified but less severe drug abuse problem who also enter treatment (i.e., Level 1 users). These admissions may include, for example, adolescents taken to treatment by parents upon discovery of experimental drug use, or non-dependent criminal justice offenders offered treatment in lieu of incarceration.

5. See particularly the chapter, Ideas Governing Drug Policy, in Gerstein D.R. and H.J. Harwood. (eds.) 1990. Institute of Medicine: **Treating Drug Problems**, Vol 1. Washington DC: National Academy Press.

6. See Edmunds, M. et al. (eds). Institute of Medicine: **Managing Managed Care: Quality Improvement in Behavioral Health**. Washington DC: National Academy Press. 1997.

DRAFT--7/17/98

INTERAGENCY DEMAND REDUCTION WORKING GROUP
Subcommittee Report: Treatment in the Criminal Justice System

Report prepared by: Patrick Tarr, co-chair; Steve Wing, co-chair; Christine Quinn; Stephen Amos

The work of the Subcommittee on Treatment in the Criminal Justice System has been focused primarily on the Consensus Meeting sponsored by ONDCP in March 1998. Up to this point the subcommittee has been process-oriented, helping to shape the agenda of the Consensus Meeting and to deliberate on follow-up activities to that conference.

Key Principles for Drug Treatment in the Criminal Justice System

Based upon the reports from the six workgroups held at the Consensus Meeting, we can summarize several key principles related to drug treatment in the criminal justice system.

- Effective drug and alcohol treatment requires ongoing assessment of the drug using behavior of the offenders in order to match appropriate types of drug treatment, transitional, and follow-up supervision and support social services to the individual's needs

- A combination of drug testing, graduated sanctions, and incentives for getting drug free are crucial elements of any comprehensive drug treatment program for drug and alcohol abusing offenders

- Testing, sanctions, and incentives may also be effective in treating drug and alcohol abusing behavior of juveniles who are not yet seriously addicted to controlled substances

- Although the therapeutic community (TC) model is the most researched type of drug and alcohol treatment for incarcerated individuals, cognitive restructuring models (compare the TRIAD studies) and other models should also be explored.

- To be effective, drug and alcohol treatment of offenders often needs to be supplemented by other

services such as mental health and physical health care.

- To be effective drug and alcohol treatment protocols must be faithfully implemented, and implementation should be closely monitored.
- Treatment of drug and alcohol using offenders in the criminal justice system requires a continuum of care and accountability.
- Early intervention of testing, sanctions, and treatment improves the effectiveness of the programs

Gaps in Research

- We need more information about the relative effectiveness of different types of treatment modalities, especially concerning residential alternatives to the TC approach
- We need more information about the use of therapeutic drugs to restore brain functioning to the extent possible
- We need a better knowledge of how to motivate people to enter and remain in treatment

Next Steps

The subcommittee held a meeting three weeks ago to discuss the next ONDCP-sponsored conference to follow up on the Consensus Meeting. We continue to be involved in helping to shape the agendas and purposes of these conferences. At that time we also reviewed the upcoming conference being sponsored by the Office of Justice Programs. The National Corrections Conference on Enhancing Public Safety by Reducing Substance Abuse will be held in Los Angeles October 19-21, 1998. This conference will provide "a forum to exchange state-of-the-art information with the goal of promoting informed decision-making on effective implementation and management of substance abuse control, testing, and intervention efforts in institutional and community correctional settings." Ten state and local officials from each state will be invited to participate in this conference.

The subcommittee notes that there has been a number of conferences over the last year or so where the effectiveness of drug treatment, or drug treatment in the criminal justice system, has been the primary focus. [Insert list of conferences at this point] We are convinced that drug treatment has a consistent, significant, positive impact on criminal behavior, drug and alcohol use, employment, and disease transmission, and that it is cost-effective. We now need to focus on how to implement some of the many good programs, and how to convince federal, state, and local legislators that such programs are worth funding. To that end we make the following suggestions:

(1) Conference workshops should concentrate on system integration to provide a "continuum of care and accountability" for substance abusing criminal offenders. Systems integration implies both improved continuity from arrest through probation and parole, as well as information-sharing between the criminal justice system and the health care community.

(2) A wide spectrum of correctional and substance abuse (illicit drugs and alcohol) professionals and researchers have participated in recent conferences to ascertain many of the key principles of drug treatment articulated above. The next ONDCP-sponsored conference should focus on governors, mayors, and key legislators from state and local governments who can influence policy and resources related to drug and alcohol treatment.

(3) Consistent with ONDCP's responsibility to forge a national strategy to control drug abuse, subsequent conferences should target audiences who can set policy and appropriate funding for drug treatment.

The subcommittee will continue to participate with conference planners. We need to build and sustain momentum by using each subsequent conference to increase the awareness that treatment is effective, to improve the system integration of treatment programs, and to gain federal, state, and local support for treatment programs.

Workplace

INTERAGENCY DEMAND REDUCTION WORKING GROUP
SUBCOMMITTEE ON DRUGS IN THE WORKPLACE
Report on Accomplishments
July 24, 1998

Chairpersons:
Mary Bernstein, *Office of Drug and Alcohol Policy and Compliance, Office of the Secretary, U.S. Department of Transportation (DOT)*
Elena Carr, *Office of the Assistant Secretary for Policy, U.S. Department of Labor (DOL)*
Bob Stephenson, *Division of Workplace Programs, Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS)*

Participating Members: Bob Dey, *Drug Enforcement Agency, Department of Justice (DEA,DOJ)* ; Hal Holzman, *U.S. Department of Housing and Urban Development*; John Jemionek, *U.S. Department of Defense*; Jim Lipari, *Division of Workplace Programs, CSAP, SAMHSA, HHS*; James Van Wert, *Small Business Administration (SBA)*

Recommendations

Since 73% of drug users are in the workplace, it presents an ideal setting for prevention, intervention, referral to treatment, and support in recovery. However, the workplace remains vastly underutilized due to lack of Federal resources to encourage private sector and non-federal public sector drug-free workplace efforts. In addition, there is no substantive data to determine how many workplaces have programs in place -- let alone to measure their impact. The subcommittee recommends the following:

1. ***Stronger, more visible leadership from the executive branch on workplace substance abuse prevention and intervention initiatives and opportunities.***

2. ***Increased funding levels to support workplace activities including the necessary data collection to meet our obligations as specified in the Performance Measurements of Effectiveness (PME) document.***

Subcommittee Objectives

The activities of the subcommittee are intended to make the best use of the resources currently available by increased collaboration and better coordination and to highlight the need for additional attention and resources in this area. The Subcommittee discussed the need for members to participate in other subcommittee meetings to ensure that workplace issues were addressed. The Drugs in the Workplace subcommittee identified the following five key objectives:

1. ***To increase the visibility of workplace strategies and to highlight the inherent opportunities for effective prevention, intervention and treatment which it provides;***

2. ***To identify data collection needs and recommend strategies to satisfy the Performance Measures of Effectiveness system;***

3. ***To identify emerging issues of relevance to the workplace;***

4. ***To identify gaps and duplication in agency program activity; and***

5. ***To develop and implement coordinated, interagency responses to identified needs and issues.***

A description of the subcommittee's accomplishments relevant to each objective are organized accordingly and summarized below.

Summary of Accomplishments

1. ***To increase the visibility of workplace strategies and to highlight the inherent opportunities for effective prevention, intervention and treatment which it provides.***

The Subcommittee identified the need for a high level event to highlight Federal workplace prevention and intervention initiatives and to create interest in and support for these programs. ONDCP staff is planning a ***White House Event*** for September 16th which will include participation by the relevant Department Secretaries and corporate CEOs.

Elena Carr participated in meetings of the interagency subcommittee tasked with Increasing Public Understanding of Addictions, Treatment, Prevention and Recovery (IPU) which identified the business community as a target audience for conveying its message. As a result, a joint meeting was held to determine ways to augment the work that is being done in this area. As a first step, an annotated bibliography will be compiled listing the resources available from various federal agencies to encourage and assist businesses in developing substance abuse prevention, intervention and treatment programs. The Drugs in the Workplace subcommittee will continue to work in collaboration with the IPU subcommittee.

2. ***To identify data collection needs and recommend strategies to satisfy the Performance Measures of Effectiveness system.***

The May 20th meeting was dedicated to a discussion of data requirements for measuring progress towards the workplace targets identified in the Performance Measures of Effectiveness (PME) document and instruments needed to collect this data. ONDCP staff from the Office of Programs, Budget and Evaluation participated and encouraged the subcommittee to submit recommendations to ONDCP's Data, Evaluation and Interagency Coordination Committee.

Mike Horrigan of the DOL/Bureau of Labor Statistics (BLS) and Janet Greenblatt the Substance Abuse and Mental Health Services Administration (SAMHSA) described surveys that have provided data relevant to the PME. These include the Survey of Employer Anti-Drug Programs conducted by Bureau of Labor Statistics in 1988, with a follow-up in 1990. This survey has not been repeated since -- and whether it gets done again is largely a funding issue. Horrigan also described the National Longitudinal Survey which BLS conducts and which includes questions about drug-use behavior and could inform the PME.

Greenblatt reported on the status of the household survey workplace questions. Additional workplace questions were added in 1994, but not in 1995, with a smaller set repeated in 1996. SAMHSA was finalizing the workplace questions for 1998 survey and Greenblatt requested input from the subcommittee. One issue under consideration was whether to drop the occupational/industry codes analysis. DOL representatives voiced grave concern about such a change and the subcommittee recommended keeping occupational/industry codes.

The Subcommittee agreed that there is insufficient data to establish the PME baselines related to the workplace targets (Goal 3 Impact target and Goal 3, Objective 3 target). Although the National Household Survey on Drug Abuse (NHSDA) provides a measure of drug users in the workforce rather than drug use in the workplace, it is the instrument identified in the PME and could serve as a proxy measure for actual prevalence of drug use in the workplace. However, since the BLS Survey has not been repeated and there are no plans to do so, there is not any current data that provides a baseline for the percentage of workplaces with the various components of drug-free workplace programs (EAPs, policies, drug testing and education).

It was agreed that the Workplace subcommittee would develop a consensus document describing what data is needed to satisfy the PME and forward these recommendations to the ONDCP Data Committee which will be prioritizing all PME data needs and making associated budget requests. A draft document which delineates the data needed to measure progress towards the specific targets and objectives related to the workplace has been compiled and will be finalized and forwarded to the appropriate working group of the Data Committee

3. To identify emerging issues of relevance to the workplace.

Welfare Reform. The June 30th meeting was dedicated to issues arising from welfare reform. Specifically, the purpose of the meeting was to 1) identify the needs of those administering Temporary Assistance to Needy Families (TANF) and Welfare-to-Work (WtW) programs for information and/or technical assistance on applicable workplace substance abuse technologies (e.g., EAPs and drug testing); and 2) to explore what resources are available, or can be made available, to meet these needs.

Additional Participants included: Cathy Keiter, DO*L/Employment and Training Administration, Welfare-to-Work*; Laura Feig, *HHS/Office of the Assistant Secretary for Planning and Evaluation*; Yvonne Howard, *HHS/Administration for Children and Families (ACF)*; Ulonda

Shamwell, *HHS/SAMHSA*; Sharon Amatetti, *HHS/CSAT*; Ed Morris, *DOT/Office of Civil Rights*; Dora Teimouri, *Dept. of Education, Office of Special Education and Rehabilitative Services*; Hal Holzman, *HUD/Office of Policy Development and Research.*

The meeting included brief, informal presentations intended to increase understanding of workplace drug representatives (Subcommittee members) from various Federal agencies about welfare reform specifically highlighting Temporary Assistance to Needy Families (TANF) and the Welfare-to-Work grants. There was concern expressed that very few (if any) of the WtW grants awarded specifically address substance abuse. There was speculation as to whether those from the substance abuse treatment community who submitted proposals had information and resources required to compete favorably. The group identified the need to get more information to the substance abuse prevention and treatment community about welfare reform and the job training activities and how they can work with those implementing these programs.

Several participants from the lead agencies directly involved in administering welfare and job training programs have been participating on interagency meetings to address substance abuse issues. However, those agency divisions with expertise in workplace substance abuse strategies have generally not been included in these discussions. Because there are already ongoing meetings among the agencies, the sense of the group was that it is not necessary at this time to create another subcommittee under auspices of ONDCP. However, the meeting served to highlight the fact that those agencies with drug-free workplace initiatives have information and expertise to offer in this area. Members of the subcommittee will continue to work with those responsible for administering welfare reform and Welfare-to-Work grants to increase information flow and collaboration.

Drug-Free Workplace Act of 1998. This bill has passed in the House (H.R. 3853) and was introduced in the Senate (S2203) as part of Gingrich's set of 15 anti-drug bills. The bill 1) encourages states to provide incentives to businesses for implementing drug-free workplace programs; 2) provides $10 M funding for demonstration grants to go to non-profit organizations to provide outreach and assistance to businesses; and 3) identifies the Small business Development Centers (SBDCs) as providers of technical assistance. Concern was expressed that agencies should work together to avoid "recreating the wheel" since technical assistance/ expertise and informational materials already exist and both CSAP and DOL currently providing assistance to small businesses in this arena. Several amendments were made to the House bill including expanding the qualifications of the intermediary organizations eligible to receive to include those whose primary purpose is other than drug-free workplace programming; including an evaluation process; etc. The bill is reportedly due for mark-up in the Senate shortly.

4. To identify gaps and duplication in agency program activity.

Members agreed to compile an inventory of current Federal workplace initiatives and to query agencies about perceived needs in this arena. This inventory builds on an existing document produced by a previous interagency group which proposed specific federal initiatives to encourage workplace substance abuse efforts but which were never funded. Few responses were received,

but the subcommittee will proceed with compiling an inventory based on the knowledge of the participants.

5. To develop and implement coordinated, interagency responses to identified needs and issues.

Although the exchange of information that occurs at the subcommittee meetings has enhanced our ability to collaborate, a more comprehensive and coordinated approach is needed. The subcommittee will provide leadership in developing a unified plan for proceeding based on the findings from the inventory.

Other Issues Addressed

Drugs Don't Work reorganization. DEA and CSAP have both been supporting efforts by local business substance abuse prevention coalitions which encourage and assist businesses to implement drug-free workplace programs to reconstitute the disbanded national Drugs Don't Work organization. A steering committee has met on several occasions for strategic planning and has renamed the group the National Drug-Free Workplace Alliance (NDWA). NDWA is also entering a partnership with the U.S. Chamber to create a national presence for the 35+ local business coalitions. Representatives from NDWA met with ONDCP staff and plans are underway for ONDCP and the Drugs in the Workplace Subcommittee to participate in a NDWA national conference in March 1999.

Substance Abuse Treatment parity. The subcommittee discussed the importance of the business community in achieving parity in benefits covering substance abuse treatment, and decided that the Treatment Gap subcommittee was better suited to address issues of parity. Elena Carr has participated in some of the treatment gap subcommittee meetings in order to ensure consideration of workplace issues as appropriate.

International efforts. Mary Bernstein participated in the Workplace group at the U.S./Mexico Demand Reduction Conference in El Paso. Although the group focused on workplace issues, participants generally lacked knowledge or experience in workplace prevention. A suggestion was made that the U.S. could facilitate information/technology transfer regarding workplace prevention and intervention services by pairing Mexican and American companies. Although the subcommittee generally concurred that it would make sense to create an integrated task force to deal with both supply and demand with other countries, it was generally agreed that getting involved to a significant degree on the international level may be beyond the capacity of many subcommittee members.

Expert system on the Drug-Free Workplace Act of 1988. The U.S. Department of Labor (DOL) is developing a web-based interactive expert system on the Drug-Free Workplace (DFWP) Act of 1988. Because this common rule was developed by the Office of Management and Budget (OMB) but is enforced by individual Federal agencies, this project demands exactly the kind of ONDCP leadership and interagency coordination that the IDRWG provides. ONDCP is

supporting DOL in securing cooperation from OMB and the other federal agencies necessary to develop this expert system.

Products In Process

PME Data Requirements and Recommendations (to submit to Data Committee Working Group)

Inventory of Federal Initiatives to Encourage Drug-Free Workplace Programs (Information Request form attached)

Budget Guidance Recommendations (attached, submitted to ONDCP)

H:\WORK\WP61\ELENA\ONDCP\IDRWGWP\WPACTRPT.WPD

Information Request

AGENCY: _____

CONTACT NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

E-MAIL: _____

Please complete and return to:
Elena Carr, DOL ASP
202-219-9216 (fax)
202-219-6197 (phone)
carr-elena@dol.gov
RETURN BY APRIL 10, 1998

The agency contact identified above **will/will not** ***(choose one)*** participate in the Drugs in the Workplace Subcommittee and **will/will not** *(choose one)* attend the April 14, 1998 meeting at 10:00 a.m. at the Department of Labor, Room S-2312.

Please answer the following questions:

1. What workplace substance abuse initiatives (other than your own agency's Federal drug-free workplace program) does your agency currently have underway? Please include a description of who your "customers" are and how you communicate with them?

2. Are you aware of any duplication of efforts among agencies in the area of workplace substance abuse initiatives and/or other opportunities for collaboration. Please specify.

3. Identify desirable federal initiatives currently NOT being implemented--and what is needed to fill these gaps. ***(You may find it helpful to refer to the attached chart of previously proposed federal initiatives.)***

4. The Performance Measures of Effectiveness for National Drug Control Strategy include targets for *reducing the prevalence of drug use in the workplace* and for *increasing the number of work organizations that have policies and programs in place to address drug use* (e.g., training/education, Employee Assistance Programs and drug testing). Does your agency collect data related to these performance measures. _____YES _____NO If YES, please specify.

FEDERAL INITIATIVE TO ENCOURAGE PRIVATE SECTOR AND NONFEDERAL PUBLIC SECTOR SUBSTANCE ABUSE WORKPLACE EFFORTS

RECOMMENDATION		PROPOSED LEAD/COLLABORATING AGENCIES									
	COST	ONDCP	DOL	DOT	DOJ	HHS	SBA	HUD	NIOSH	DEA	OTHER
A. LEADERSHIP AND COORDINATION											
A1. Provide official attention to the Substance Abuse-Free Workplace goal and consistent message delivery from Administration leaders.	1	L	C	C	C	C	C	C		C	C - Federal Drug-Free Workplace Advisory Group
A2. Integrate substance abuse issues into health care and welfare reform packages, into crime and criminal justice initiatives and into economic development and job training programs.	2	L	C		C	L		C			
A3. Establish tri-partite partnership of government, labor/employees, and employers.	2	L	C	C	C	C	C	C	C	C	
A4. Maintain currency of Federal standards for laboratory certification and testing guidelines; expand to include alcohol; extend use into private and non-Federal public sectors where employers choose to include testing in a comprehensive workplace program.	2	L	C	C		L					C - Dept. of Energy
A5. Standardize and integrate Federal testing regulations; clarify inter-relationships with other State and Federal laws and regulatory practices.	0	L	C	C		L	C				C - Dept. of Energy C - Dept. of Defense C - NRC, NASA, EEOC, OMB
A.6 Support efforts to encourage the development and implementation of Substance Abuse-Free Workplace programs in international and foreign companies that do business in the United States.	1	L	C	C		C				C	L - Dept. of State C - DOC, ITC

KEY: L = Lead; C = Collaborating
O = $0-20K; 1 = $20,001-$300K; 2 = $300,001K-$1.5M; 3 = >$1,500,001

RECOMMENDATION	PROPOSED LEAD/COLLABORATING AGENCIES										
	COST	ONDCP	DOL	DOT	DOJ	HHS	SBA	HUD	NIOSH	DEA	OTHER
B. INCENTIVES											
B1. Support development of employer, labor, and employee incentives for workplace program participation, e.g., family employee assistance coverage; premium reductions for: property, casualty, and liability insurance; health/medical insurance; workers' compensation insurance/claims denial.	1	L	C			C	C				
B2. Identify methods and disseminate exemplary programs and best practices of State and local level workplace substance abuse programs and consortia; finance replication through cooperative agreements with State or locally sponsored programs and consortia, targeting small- and medium-sized employers.	2	L	C			C	C			C	
C. DATA, INFORMATION AND MATERIALS DEVELOPMENT											
C1. Conduct cost-offset/return-on-investment studies/reviews to establish credible numbers about bottom line and other impacts; support applied research in the private sector and at State/local levels.	3	C	L			L	C		C	C	
C2. Conduct assessment of the value and impact of the Drug-Free Workplace Act in extending the Federal goals into grantee and contractor workplaces.	2	L		C		C					C - DOD C - OMB
C3. Expand employer, labor, and employee access to Substance Abuse-Free Workplace information sources and databases; assure quality, accuracy, and appropriateness of information; model potential for State/local level coordination, collection, and integration of information.	2	C	L	C	C	L	C	C	C	C	C - DOD, DOE, DoEd, DOC, NRC, NASA
C4. Develop process for and institutionalize the conduct and analysis of periodic studies of current employer and union/employee Substance Abuse-Free Workplace policies and practices.	3	L	C	C		C	C		C		
C5. Develop and disseminate tailored materials and provide strategic support for specialized sectors.	2		L	C		C	C			C	C - DoEd, BOP

KEY: L = Lead; C = Collaborating
O = $0-20K; 1 = $20,001-$300K; 2 = $300,001K-$1.5M; 3 = >$1,500,001

BUDGET GUIDANCE RECOMMENDATIONS
(submitted to ONDCP on May 20, 1998)

Increase funding levels are needed to:

Conduct outreach and education to businesses, health funds and other purchasers/ providers of health insurance on the effectiveness of substance abuse treatment in order to encourage support for parity and truly comprehensive coverage of substance abuse treatment services. (Also suggested as one of Treatment Committee recommendations.)

Support the formation of coalitions/consortia which provide EAPs, drug testing, education, training and other intervention services (e.g., wellness programs) to small businesses.

Provide incentives to businesses to implement drug-free workplace programs and to provide specific education and training to parents that will complement the drug prevention messages that youth receive in the schools and communities and provide skills training in how to communicate effectively about these issues, and other life-style decisions.

Encourage and evaluate the application of workplace intervention technologies (e.g., policies, EAPs, drug testing, education, supervisory training, wellness programs etc.) to programs designed to transition individuals from dependency (welfare, criminal justice system, public housing etc.) to self-sufficiency (employment).

Conduct research into the economic and social costs of drug abuse to the workplace and the effectiveness and resultant savings accrued by implementing drug-free workplace programs --especially among small businesses. (Including measuring impact of incentive programs, e.g., worker's comp discount programs.)

Conduct targeted outreach to small businesses about the costs of drug abuse and the value of implementing drug-free workplace programs.

Conduct establishment surveys to measure the number of workplaces with various components of drug-free workplaces programs and the prevalence of drug use in the workplace in order to meet obligations imposed by the Performance Measures of Effectiveness (PME) document. [Added per 7/24/98 recommendations.]

Research, Data and Evaluation

ONDCP'S SUBCOMMITTEE ON DATA, EVALUATION AND INTERAGENCY COORDINATION

BACKGROUND AND PURPOSE: The Subcommittee on Data, Evaluation and Interagency Coordination (the Data Subcommittee), is one of three Subcommittees of the larger ONDCP advisory committee, the Drug Control Research, Data, and Evaluation Committee (DCRDE). The legislative mandate that established the DCRDE advisory committee and its subcommittees is the 1994 Violent Crime Control and Law Enforcement Act. The Data Subcommittee is composed of an external committee of outside advisors as well as representatives from Federal departments and agencies that have legislative mandates to pursue drug-related initiatives. Upon its establishment, the Data Subcommittee's charge was to accomplish the following tasks:

- Develop an inventory of drug-related information systems and their report generation capabilities;
- Evaluate the adequacy and ability of drug-related data systems to inform the drug policy planning process;
- Integrate Federal efforts related to drug data collection, data processing, and data sharing; and
- Develop a drug data strategy for the Federal Government to improve the quality and efficacy of drug-related data systems.

ACCOMPLISHMENTS: The Data Subcommittee has produced the following documents: 1) an *Inventory of Federal Drug-Related Data Sources*, 2) a concept paper for participants attending the "*Forum on Integrating Information and National Drug Policy*," and 3) a Report entitled "*Integrating Information and National Drug Control Policy*." The most recent meeting of the Data Subcommittee was 18 June 1998. (Please see attached copies: June 18 meeting agenda, and a Federal Data Set Inventory Form.)

Future Directions: Over the next several months, the Data Subcommittee will focus its efforts primarily on assisting ONDCP in conducting a "data gap analysis" in the context of linkages to the performance measures of effectiveness. This analysis will utilize the Inventory of Federal Drug-Related Data Sources, and the National Performance Measures of Effectiveness Report. The next meeting of the Data Committee is scheduled for late summer.

OPBRE
7/20/98

AGENDA

OFFICE OF NATIONAL DRUG CONTROL POLICY
750 17th Street, N.W., 5th Floor

Subcommittee on Data, Evaluation & Interagency Coordination

June 18, 1998

9:00 To 9:15a.m.	**Welcome and Introductions**
9:15 To 10:30a.m.	**Subcommittee Discussion:**
•	**Comments Regarding Meeting Summary Reports from ONDCP's Drug Control Research, Data, and Evaluation Committee and Subcommittee on Data, Evaluation & Interagency Coordination**
•	**Subcommittee linkages to ONDCP's Performance Measures of Effectiveness**
10:30 To 10:45 a.m.	
•	**Other ONDCP Drug Control Initiatives**
10:45 To 11:00 a.m.	**Summary/Next Steps: Open Discussion**

TITLE OF DATA SET:

Drug and Alcohol Services Information System (DASIS)

The DASIS has three components: (1) the *National Master Facility Inventory (NMFI)*, a master list of organized substance abuse treatment and prevention programs known to SAMHSA; the subset of NMFI based providers that are licensed, certified, or otherwise recognized by individual State Substance Abuse Agencies is referred to as the National Facility Register (NFR); (2) the *Uniform Facility Data Set (UFDS)*, a periodic, annual survey of the providers in the NMFI; and, (3) the *Treatment Episode Data Set (TEDS)*, a minimum data set of information about individuals admitted to treatment, primarily by providers receiving public funding.

FREQUENCY OF DATA COLLECTION:

NMFI and TEDS, continuous; UFDS, annual

SPONSORING AGENCY(IES):

Substance Abuse and Mental Health Services Administration

POINT(S) OF CONTACT:

Deborah Trunzo
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
Telephone No.: (301)-443-0525
Fax No.: (301)-443-9847

PURPOSE OF THE DATA SET:

DASIS provides information on the substance abuse treatment delivery system in the United States and on patients receiving treatment in that system. The NMFI provides a sampling frame for special studies. UFDS and TEDS contain information on the characteristics of services and admissions to treatment facilities.

HOW AND TO WHOM THE DATA ARE DISSEMINATED:

Reports include (1) annual reports for UFDS and TEDS that present summary data for that year as well as trend data; both State-level and national data are included; (2) State Feedback Reports that present summary data in tablular form and data on individual facilities within that State are sent to each State; (3) the *National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs*, published annually; (4) special ad hoc analyses.

AVAILABLE FORMATS:	SAMPLE SIZE OF DATA SET:
Data reports and the *National Directory* are distributed in printed form and can be accessed through the SAMHSA home page on the Internet. UFDS and TEDS public use data files can also be accessed through the SAMHSA home page.	The universe for the NMFI and UFDS is all known publicly and privately funded drug abuse and alcoholism treatment and prevention facilities. There are approximately 19,500 facilities in the NMFI; of the approximately 16,900 NFR facilities, about 14,100 offer treatment and 2,100 are prevention only. The TEDS universe is all substance abuse treatment facilities that receive funding from State Substance Abuse Agencies; TEDS includes patient level data on all admissions to these facilities and contains data on approximately 1.5 million admissions per year from 1992 to the present.

METHODOLOGY (SAMPLE DESIGN, TIME FRAME, CRITERIA FOR SAMPLE SELECTION, SOURCES OF DATA, METHOD OF DATA COLLECTION, VALIDITY AND RELIABILITY CHECKS, AND TYPE OF DATA COLLECTED):

The NMFI is updated by periodic enhancements that employ listings of potential substance abuse treatment providers and by updates of NFR facilities from the States. UFDS is a point-prevalence survey of all facilities on the NMFI; more limited data are collected from prevention programs. UFDS data are collected by mail questionnaire; a telephone non-response follow-up is conducted among facilities that do not respond to the mailed questionnaire. The TEDS minimum data set on patient admissions is transferred electronically from States to SAMHSA. Some States also maintain a minimum discharge data set. Future plans call for development of linked admissions and discharge data.

DRUG-RELATED VARIABLES:	OTHER VARIABLES:
UFDS contains treatment and prevention facility location, treatment facility characteristics, services provided, financial data, and aggregate patient counts. TEDS contains patient drug use history, clinical data, and treatment data.	Patient demographics.

STRENGTHS AND LIMITATIONS OF THE DATA SET:

Strengths: DASIS contains the only ongoing national census-based data set on substance abuse clients admitted to facilities that receive public funds. It also contains the only longitudinal national prevention and treatment program level data set. These data sets provide a foundation for analysis and research on the cost, organization, structure, and effectiveness of the national treatment system. The NMFI provides a national sampling frame for special studies, including studies of treatment outcomes. The longitudinal nature of these data permit monitoring of trends.

Limitations: DASIS is known to omit some treatment units, particulary privately funded units, and some clients. Attempts to address these gaps are through periodic frame enhancements. DASIS covers speciality substance abuse providers. It does not include some mental health facilities and omits all treatment provided by doctors' offices and other settings.

IMPLICATIONS FOR DRUG POLICY:

DASIS provides the only longitudinal national-census-based data on the substance abuse treatment system and clients in treatment in that system. It is the only data source available to measure and monitor multiple dimensions of interest to policymakers charged with substance abuse treatment and prevention responsibilities. TEDS person-level data permit study of the history and correlates of substance abuse clients in treatment. The data are also useful as the basis for special studies of clinical effectiveness and treatment, organization, structure, and financing.

Prevention Strategies

Following is the abstract for a Dissemination panel to be held on Thursday, June 4, from 10:30 a.m. to 12 noon. Attached for your consideration prior to the panel is a copy of the latest iteration of the "Working Paper on Science-Based Substance Abuse Prevention" which is being prepared at the request of the Secretary of the Federal Department of Health and Human Services (DHHS). This panel will devote the majority of its session to questions from the floor and to discussion of the substance of this document.

DISCUSSION PANEL ON SECRETARY'S "WORKING PAPER ON SCIENCE-BASED SUBSTANCE ABUSE PREVENTION"

This panel will discuss this working paper on the science base for effective substance abuse prevention interventions, which is being developed at the direction of the Secretary, DHHS. The paper presents the key characteristics of effective substance abuse prevention interventions, drawing on various reviews of the literature, including the 1997 research-based guide on *Preventing Drug Use Among Children and Adolescents*, published by the National Institute on Drug Abuse. This working paper has already gone through a number of revisions, and the panel will be inviting audience comment at its presentation at the annual meeting of the Society for Prevention Research. The Working Group responsible for this paper includes senior officials and scientists from the Deparatment of Health and Human Services, the Department of Education, the Department of Justice, and the Office of National Drug Control Policy. Conference participants are invited to suggest ways in which this paper could be further improved and perhaps later adapted for use by Federal, State, and local researchers, practitioners, and policymakers. ***Persons planning on attending this panel are invited to read the attached paper and to participate in discussion.***

Panel Chair:

➔ **VERONICA M. FRIEL, Ph.D.**
Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS

Panelists:

➔ **ROBERT W. DENNISTON**
Director, Secretary's Initiative on Youth Substance Abuse Prevention, DHHS

➔ **WILLIAM J. BUKOSKI, Ph.D.**
Associate Director for Prevention Coordination, National Institute on Drug Abuse, DHHS

➔ **WILLIAM MODZELESKI**
Director, Safe and Drug-Free Schools Program, Department of Education

➔ **SHAY BILCHIK**
Administrator, Office of Juvenile Justice and Delinquency Prevention, Department of Justice

➔ **THOMAS R. VISCHI**
Senior Advisor for Drug Policy, Office of Disease Prevention and Health Promotion, DHHS

➔ **JUNE S. SIVILLI**
Senior Policy Analyst, Executive Office of the President, White House Office of National Drug Control Policy

A WORKING PAPER ON

SCIENCE-BASED SUBSTANCE ABUSE PREVENTION

DRAFT

May 27, 1998

INTRODUCTION

This working paper focuses on the characteristics of effective substance abuse prevention interventions, primarily for youth.

It is being developed in response to a request by the Secretary of the U.S. Department of Health and Human Services for a short statement on what is known about effective substance abuse prevention interventions, based on the science.

In this paper, the terms "drug" use or abuse and "substance" use or abuse are variously used to refer to the use and abuse of illicit substances (such as marijuana, cocaine, and heroin), the use by youth of alcohol and tobacco, and the unsafe use of other substances (such as inhalants).

It is clear that there are significant differences in the social, cultural, legal, and pharmacological aspects of alcohol, tobacco, and the various illicit drugs. No single term or approach may fit all of these substances, and satisfy all audiences, in all uses and contexts. Nevertheless, the Federal contributors to this working draft believed that an effort should be made to identify and discuss the key characteristics of prevention interventions that address alcohol, tobacco, and the illicit drugs, and to try to identify the major commonalities and make the necessary distinctions.

The paper is being put together and will be further refined by senior officials and scientists from the Department of Health and Human Services, the Department of Education, the Department of Justice, and the Office of National Drug Control Policy, with additional suggestions from officials in other departments. It draws upon reviews of the literature, including the National Institute on Drug Abuse's 1997 research-based guide on *Preventing Drug Use Among Children and Adolescents*, a similar internal review prepared by the National Institute on Alcohol Abuse and Alcoholism, literature reviews compiled by the Substance Abuse and Mental Health Services Administration, and other literature reviews.

The paper is organized around the following questions:

What do we know about the characteristics of effective substance abuse prevention interventions?
How do we know what we know?
What should we do next?

The paper will continue to be revised, based on comments from researchers and practitioners. When it is complete, the paper will be submitted to the Secretary of Health and Human Services. It will also be used to guide the development of other documents and activities to advance the science and practice of effective substance abuse prevention interventions.

I. WHAT DO WE KNOW ABOUT THE CHARACTERISTICS OF EFFECTIVE SUBSTANCE ABUSE PREVENTION INTERVENTIONS?

What do we know, based on the science, about the characteristics of effective substance abuse prevention interventions across the full range of kinds of such interventions?

While the characteristics discussed below have been documented (in various ways) by science, our understanding of them can benefit from additional research and by scholarly literature reviews that focus on the characteristics of effective interventions. For example, we need to know more precisely the extent to which, and the conditions under which, various characteristics contribute to the effectiveness of substance abuse prevention interventions, in general and for particular interventions and particular target populations. Also, we need to clarify whether there are subsets of characteristics that must be present for certain interventions to be effective.

The characteristics are organized in response to the classic journalistic questions of: Who? What? When? Where? How? and Why?

WHO?

Focus on Clearly Defined Individuals and Groups

Substance abuse prevention interventions seem to work well when they focus on individuals and groups of individuals that are clearly defined by age, sex, race/ethnicity/nationality/culture, income, and geographic location. Clearly defining the target population allows interventions and policies to address the major risk and protective factors and the major drugs of abuse for the target population, in ways that are appropriate, understandable, and effective. A statement that holds true in many arenas certainly holds true for substance abuse prevention: One size does not fit all. Interventions need to be tailored to specific populations. A target population can also be defined as universal (the whole population, without regard to problem severity), selective (a subgroup at high risk of substance use and abuse), and indicated (a subgroup that is already using but not yet abusing substances). The use of these three categories has been recommended by the Institute of Medicine.

Focus on Peers, Parents, and Other Adults

Substance abuse prevention interventions seem to work well when they also address the peers, family members (especially parents), and other significant adults that are important for these target populations. For their continuing viability in communities, prevention interventions also

need to be acceptable to community leaders, who control and manage resources.

Peers. Peer group beliefs and behaviors, for example, can be potent for youth. Peer pressure to use drugs can be difficult for youth to resist. Encouraging association with non-drug-using schoolmates, teammates, siblings, and friends can make it easier for youth to not use drugs.

Parents. Research has compellingly documented the effectiveness of strong, supportive, and skillful parents and families in helping youth to not use alcohol, tobacco, illicit drugs. A variety of parent and family interventions have been demonstrated to be effective, such as behavioral parent training, family skills training, and family therapy.

Other Adults. Many youth who have successfully made it through high-risk families and communities later attributed their success to the presence and support of one or more caring adults outside their immediate families. Such adults, whether they are coaches, teachers, neighbors, relatives, or Big Brothers and Big Sisters, can offer youth the vision and conviction that there are alternative, drug-free ways to live a life and succeed.

WHAT?

Address the Major Risk and Protective Factors

Substance abuse prevention interventions are more likely to be effective when they address the major risk factors (that contribute to drug use and abuse) and the major protective factors (that protect against drug use and abuse) than if they focus on less salient factors. Such interventions are more likely to be effective, whether they focus on universal, selective, or indicated populations. The major domains of risk and protective factors are family climate, school climate, school attachment, peer influence, attitudes about substances, individual behavioral and affective disorders, and drug use. Longer lists of risk and protective factors include the following:

Risk factors include:

widespread availability and aggressive marketing of drugs,
early use of drugs (including alcohol and tobacco),
maternal smoking,
pro-drug-use attitudes and social norms,
peer pressure to use drugs,
peer drug abuse,
parental drug abuse,
physical abuse,
sexual abuse,
family conflict,
sensation seeking,
peer rejection,

poor school performance,
early and persistent behavior problems,
perception that drug use is harmless,
perception of approval of drug use,
perception that drugs are used more widely than they are actually used,
bonding to drug using adults and peers,
impulsivity, and
affective disorders (such as persistent depression or anxiety), and so on.

Protective factors, many of which are suggested by the risk factors, include:

limited availability of drugs,
late onset of any use of drugs,
parental non-drug use,
anti-drug-use attitudes and norms,
non-drug-using peers,
close and supportive family relationships,
perception that drug use is harmful,
perception that drug use is not approved by others,
perception that drugs are not widely used,
bonding to non-drug-using adults and peers,
life skills and drug refusal skills,
sufficient monitoring of children, and so on.

Address the Expectancies About Drug Use and Abuse

Also relevant, although there is less research on this, is a focus on the role that individual needs, motivations, and expectancies may play in contributing to the use and abuse of various drugs.

For example, individuals may turn to different drugs with the expectation of reducing undesirable feelings or conditions, such as:

tension,
anxiety,
loneliness,
boredom,
depression,
fear,
impotence,
appetite, or
weight.

They may turn to drugs with the expectation of increasing desired states, such as:

sociability,
alertness,
excitement,
concentration,
strength,
creativity,
the flow of ideas, or
a sense of belonging.

More simply, they may turn to drugs to:

defy rules or
satisfy curiosity.

Such needs, motivations, and expectancies undoubtedly interact complexly with the risk and protective factors.

Substance abuse prevention interventions often emphasize the adverse consequences of substance use and abuse. Their effectiveness may be further enhanced when they address the needs and motivations behind the substance use and abuse of a target population, when they address cognition related to substance use, and when they encourage or provide safe and healthy alternatives to substance use.

Address the Major Forms of Substance Abuse

Substance abuse prevention interventions may be more effective when they target all the major substances of abuse, including the illicit use of alcohol and tobacco by youth.. This is plausible in view of the increase in polydrug abuse and the ease of switching from one drug to another. More narrowly targeted efforts (for example, on marijuana alone) may be effective in reducing marijuana use, but they probably should be supplemented by interventions that focus on the wider variety of substances that are being abused in a particular population. Drugs to be addressed in many communities include tobacco and alcohol (for those who are underage), marijuana, inhalants, cocaine (both powder and crack), and heroin.

Foster More Comprehensive, Multi-Modal Approaches

Substance abuse prevention efforts are more likely to be effective when they are multi-modal, using a variety of strategies such as didactic, discussion, video, cd-rom, and the like, rather than using only single approaches. A strong focus on behavior, and not just on knowledge or attitudes, is probably important in every community. A community may wish to select, from among the characteristics of effective prevention efforts, those intervention characteristics that seem to best fit the needs of that community. There is no single best way of combining the characteristics of effective efforts into a comprehensive effort.

WHEN?

Start Early Enough

Early problems. The scientific literature is making it more and more clear that the failure to prevent early childhood aggression or drug use increases the likelihood of more serious negative behaviors, including delinquency and drug abuse, later. Some studies have found a progression from the early use of tobacco and alcohol to the later use of other drugs such as marijuana, cocaine, and heroin. However, no causality has been established, the sequencing varies, and most individuals who try alcohol and tobacco do not go on to use these other drugs. Nevertheless, those who use alcohol and tobacco at very early ages do seem to be at higher risk for the later use and abuse of other drugs.

Early interventions. Substance abuse prevention interventions are more likely to be effective when they start early enough to prevent the use and abuse of substances later on. Depending on the target population, this can mean that the intervention should start extremely early (for example, pre-natal care for pregnant drug users), very early (for example, early childhood interventions for those in high-risk families or communities or for those who manifest early childhood aggression), or less early (for example, junior high school interventions for those in more stable and lower-risk situations). Children in drug-using or abusive families are particularly vulnerable to the use and abuse of drugs.

Reinforce Appropriately and Often Enough

Substance abuse prevention interventions seem to work well when they are reinforced in booster sessions that are age-appropriate. One-time-only efforts may contribute to the prevention of drug use in the short term, but they cannot guarantee that youth will be "inoculated" against drug use over the longer haul. Drug use can be encouraged by environmental factors (such as the availability of drugs, the marketing of drugs, and the use of drugs by friends and family) and individual developmental factors (such as the proclivity of many adolescents to engage in defiant and risk-taking behaviors that test the boundaries that have been set for them), and these factors can make it difficult for youth to resist offers to use drugs, despite lessons learned in earlier years. As children grow older, substance abuse prevention interventions are likely to be needed to reinforce earlier efforts in ways that are age-appropriate.

WHERE?

Focus on Key Environmental Factors in the Community

Substance abuse prevention interventions can be effective if they address a variety of environmental factors. For example, environmental factors (such as limitations on the physical and economic availability of substances) and community-wide policies can reduce the initiation of substance use and the progression to substance abuse.

Especially for alcohol and tobacco, policy research has documented the effectiveness of such strategies and interventions. For tobacco, effective strategies to reduce availability include increasing the cost of tobacco products and decreasing minors' access to tobacco products. For alcohol, effective community-wide policies include constraining the availability of beverage alcohol (including State control of alcohol sale, as opposed to privatization), lowering the legal level of blood alcohol concentration, penalties that are swift and certain and severe (such as license revocation for driving while intoxicated or driving under the influence of alcohol), mass media prevention messages, and community mobilization and activation.

Focus on Key Community Settings

Safe and supervised activities and settings can help youth not to use illicit drugs. Activities can be with parents, other adults, or peers. Such activities seem more likely to be effective substance abuse prevention interventions if they take place in settings (such as homes, schools, workplaces, recreational settings, and community-wide settings) that are free of illicit drugs. Efforts that help these settings to be drug-free and supportive reduce the likelihood that youth will use drugs in those settings. Such efforts include Clean Sweeps of public housing (which remove drug dealers illegally residing in public housing), drug-free school zones and school climate change approaches (plus student assistance programs and comprehensive school health clinics), drug-free workplaces (with anti-drug-use policies, drug testing, drug education, supervisory training, and employee assistance programs), drug-free recreational activities and settings (such as in Boys and Girls Clubs, dances, and athletics), and neighborhood watches and community policing (to strive to remove drug dealers from neighborhoods). Although more research is needed on these kinds of setting-specific prevention interventions, it is plausible that the more extensive the range of drug-free, safe, and supportive settings there are in a community, the greater is the likelihood that drug-free behaviors will be encouraged, reinforced, and realized.

HOW?

Share Appropriate Information

Substance abuse prevention interventions can help individuals make the right decision not to use drugs, by providing them with information that is accurate, relevant, credible, culturally appropriate, age-appropriate, and sensitive to their needs and motivations. Information can be shared with targeted individuals and also with their peers and family members, especially parents.
Various techniques can be used to share such information, including posters, brochures, school curricula, interactive discussions, computer websites, workplace education and training, payroll stuffer messages, and public service announcements on radio and television.

Helpful information. Research suggests that it can be helpful to share information about the harmfulness of drug use, the social disapproval of drug use, the actual (as opposed to perceived) extent of drug use, and alternatives to drug use.

Potentially harmful information. Some information, such as explicit descriptions about how to use various drugs (including information about household products that can be used for their drug effects), has been found at times to be associated with increases in drug use.

Credibility. Information needs to be credible. Scare tactics which exaggerate the adverse effects of drugs, for example, may reduce the credibility of other anti-drug use messages, making it easier for youth to ignore such messages and also, possibly, increasing their willingness to use drugs.

Strengthen and Enforce Non-Drug-Using Attitudes and Norms

Information by itself is often not enough to reduce drug abuse. Communities, peer groups, and families that articulate and enforce beliefs and expectations about the non-use of illicit drugs can influence the beliefs, expectations, and behaviors of youth, both individually and in groups. For example, youth who perceive drug use to be socially acceptable, and who overestimate the prevalence of drug use among their family members and peers, report higher levels of drug use themselves, whereas youth who perceive drug use to be socially unacceptable report lower levels of use.

Cautionary note. These relationships need not be causal; they may be non-causal correlations. For example, those who use drugs are more likely to report that drug use is acceptable; and those who perceive drug use to be socially acceptable are more likely to report truthfully on their own drug use. Nevertheless, these research results seem likely to be not solely correlational, and may indeed indicate the efficacy of non-drug-using attitudes and norms for preventing drug use, especially when supported by non-drug-using behaviors among peers and family members.

Tobacco and alcohol. Tobacco research has shown the effectiveness of deglamorizing the use of tobacco and restricting tobacco advertising. Alcohol research has shown the effectiveness of some mass media campaigns in promoting greater awareness of the personal risks of violating laws against alcohol (for example, via sobriety check points) and greater support for such policies.

Drug testing. Clear expectations can also be set and enforced through, for example, drug testing, which is associated with lower rates of drug use, at least in controlled settings such as workplaces or the military. Again, the correlation may in part reflect self-selection: drug users may choose not to participate in those settings. However, it seems plausible that drug testing also contributes to changes in attitudes and behaviors about drug use and abuse, reducing the willingness to use drugs because of the penalties associated with being caught.

Strengthen Life Skills and Drug-Refusal Skills

Non-drug-using attitudes and norms are also, by themselves, not necessarily enough to prevent drug use. One of the best-documented approaches to preventing substance abuse is to teach and reinforce life skills (related to impulse control, communications, problem solving, conflict

resolution, and resiliency) and drug refusal skills. These skills go beyond the acquisition of information about drug use and abuse and beyond the reinforcement offered by anti-drug-using attitudes and norms. They are tools that youth can use to shape their behaviors, especially as they make their way through their developmental years and encounter opportunities to use and sell illicit drugs. Learning and practicing these skills in situations that mimic real-life situations can strengthen the ability of youth to make non-drug-using decisions and engage in drug-free activities in the real world, and not just in the classroom.

Emphasize Interactive Approaches That Encourage Bonding

Strictly didactic approaches are less likely to be effective than approaches that emphasize participation and interaction. Youth are more likely to learn, accept what they learn, and act on what they learn if they can ask questions and interact extensively with the teachers, parents, coaches, police officers, doctors, other adults, or peers who are trying to instill and reinforce anti-drug-using knowledge, attitudes, and behaviors. Youth, in this way, can become more satisfied with and committed to the meaning and applications in their own lives of the anti-drug-use efforts. By interacting extensively with adults and peers in substance abuse prevention interventions, youth can become bonded to non-drug-using peers and adults, in ways that can carry over into their current and future lives. Scientific studies have demonstrated the protective effects of bonding to pro-social peers and adults. When youth work or play well with non-drug-using peers and adults, and when they learn to respect and trust them, the likelihood of substance use and abuse is significantly diminished.

Implement Community-Wide Anti-Drug-Use Policies

The use and abuse of alcohol and tobacco have been demonstrated to be effectively prevented or reduced by a variety of anti-drug policies, including laws, regulations, sanctions, formal and informal norms, and their enforcement, that take effect in the community as a whole. Research on such environmentally focused interventions, sometimes as "natural experiments" (which nevertheless can be rigorously designed and implemented) rather than as controlled experiments, has been more extensive for alcohol and tobacco than for the illicit drugs such as marijuana, cocaine, and heroin, where researchers have focused more on individual interventions. This is the case largely because the purchase and use of alcohol and tobacco are legal in this country for persons 21 years old and older, and, consequently, States have enacted and implemented diverse laws and regulations governing the sale, distribution, and taxation of alcohol and tobacco, that have provided extensive opportunities for research on the effects of these different policies on the purchase, use, and abuse of alcohol and tobacco.

For tobacco, effective strategies (some of which were previously cited under environmental strategies, above) include increasing the cost of tobacco products, decreasing minors' access to tobacco products, reducing exposure to environmental tobacco smoke, deglamorizing and denormalizing the use of tobacco products, and reducing the appeal of tobacco via advertising restrictions.

For alcohol, effective strategies (also, in part previously noted above) include constraining the availability of beverage alcohol (including State control of alcohol sales, as opposed to privatization), lowering the legal level of blood alcohol concentration, penalties that are swift and certain and severe (such as license revocation for driving while intoxicated or driving under the influence of alcohol), mass media prevention messages, and community mobilization and activation.

WHY?

Reduce Substance Abuse and Related Problem Behaviors

The primary purpose of a substance abuse prevention intervention is to prevent and reduce the use and abuse of substances, and measures of substance use and abuse should be used as the measures of success of these interventions. Process and other interim measures can be useful, but they are not by themselves enough to prove that an intervention is effective in preventing or reducing substance use and abuse. Nor is it enough to document a change in attitudes only. Reductions in casual or experimental drug use may be significant, but reductions in more serious drug abuse should also be documented. It is likely that reductions in drug abuse will be associated with reductions in other problem behaviors or situations as well - such as unemployment, incarceration, physical or sexual abuse, dropping out of school - and these can be measured and used as additional indicators of success.

II. HOW DO WE KNOW WHAT WE KNOW?

Based on more than twenty years of rigorous research, a science of substance abuse prevention is now emerging. This science is increasingly characterized by sound theories and significant program findings from basic and applied research studies. The studies have focused on the systematic and objective study of the efficacy and effectiveness of theory-based and empirically-based substance abuse prevention intervention programs and policies. The studies have used observational and controlled experimental and quasi-experimental research designs that meet high standards for rigorous research.

Substance abuse prevention science has been following a model that was defined and has been used in cancer research. In this model, studies are conducted across five phases of research: (1) hypothesis development and exploratory studies, (2) methods development, (3) controlled efficacy trials, (4) defined population and effectiveness studies, and (5) implementation studies. (See chart at end of this paper.) The model is now being modified to accommodate the special requirements of alcohol and drug abuse research, to document substance abuse prevention principles, practices, and policies that are statistically, clinically, and socially significant in preventing substance abuse. Research into the effectiveness of substance abuse prevention interventions needs to be made more and more rigorous, consistent with the five phases of the above model.

This research collects outcome data that are systematically identified, assessed (or evaluated), synthesized, and reported in studies that guard against bias and misinterpretation. Research designs must control against a variety of threats to the validity and scientific integrity of studies, including poorly defined theories, measurement errors, low statistical power, flaws in sampling, differential attrition, the inappropriate use of statistical analysis techniques, inadequate follow-up procedures, and other limitations in research designs.

A key tool in this process is the "hierarchy of evidence," used by the U.S. Preventive Services Task Force in developing its "Guide to Clinical Preventive Services." In this analytic model, a claim of preventive efficacy and effectiveness (as reported in the peer-refereed prevention research literature) is assessed, with careful attention to the type of study design used to measure health outcomes after exposure to a prevention intervention. This approach gives more weight to study designs that are less subject to bias and misinterpretation. The hierarchy of evidence ranks study designs in descending order of importance, as follows: (1) randomized controlled trials, (2) non-randomized controlled trials, (3) cohort studies, (4) case-control studies, (5) comparisons of events between different times and places, (6) natural experiments, and (7) descriptive studies.

Prevention studies can also be compiled and rated for the quality of their science and for their significance in reducing morbidity and mortality from substance abuse. A number of techniques can be used, including meta-analyses, consensus reviews, Cochrane Collaborations, expert opinions, and clinical experience. When prevention research is carefully scrutinized, using the best available evidence-based scientific review procedures, the results can be shared with the prevention community to improve the practice of substance abuse prevention. The peer-reviewed research literature constitutes a continually evolving knowledge base that can help increase the effectiveness of substance abuse prevention interventions.

III. WHAT SHOULD WE DO NEXT?

This working paper on science-based characteristics of effective substance abuse prevention interventions can be helpful in a variety of ways to support the development of substance abuse prevention interventions that work, including the following:

Research and Research Reviews

Guide the conduct of literature reviews. The characteristics presented above are known to be grounded, to some extent at least, in the scientific literature. However, some are more strongly supported by the science than are others, and some are more broadly applicable to a wide variety of circumstances than are others. Thorough reviews of the scientific literature, that focus on these characteristics one at a time, would clarify the conditions under which each of the characteristics apply. For example, starting substance abuse prevention interventions early may be important, especially for youth who are at high risk of using illicit substances early in their lives, but less important for youth in communities where such early starting of substance abuse is

less of a problem. Also, starting prevention interventions early may be important even at the pre-natal stage, for substance abusing women who are pregnant. But in workplace programs, starting prevention interventions early may mean starting them early in the employment of adults, but not necessarily early in their lives. Thus, the characteristic of "starting early" can be seen to play out differently under a variety of different circumstances, and yet it remains a key characteristic of effective substance abuse prevention interventions that needs to be addressed.

Identify key areas needing additional research. The discussions of characteristics in this paper, especially when buttressed by literature reviews, will point to the need for additional research in key areas. For example, while it is known that children who begin smoking cigarettes at young ages are at higher risk of using other substances at older ages, it is less well documented that existing prevention interventions are able to prevent these early starters from starting. Also needed is further research documentation of the degree of effectiveness of school, media, and environmental interventions (for example, that reduce the availability of substances) in reducing the use of illicit drugs. The effectiveness of environmental interventions for reducing youth use and abuse of alcohol and tobacco has been well documented in the scientific literature.

Strengthen current prevention research methods. Prevention research could be more targeted on key unanswered questions, and specifically on candidate characteristics that may, under some circumstances, be key for the effectiveness of certain prevention interventions.

Program Planning and Design

Strengthen the science-based design of Federal program and budget proposals. Federal substance abuse prevention program and budget proposals should be required to address the emerging science base. For example, they could be required to address the characteristics in this paper and indicate how these characteristics are being incorporated in the basic program design and application requirements.

Increase the readiness of States and localities to use science-based prevention practices. Program planners and designers in States and localities, in the public and private sectors both, could be informed by these characteristics and the literature reviews about what works and what is not proven to be effective. Such information could contribute to more rational decisions about which interventions to select or to design for implementation.

Target programs at general populations, populations at high risk, or populations with the early signs of disorders. The characteristics of effective substance abuse prevention interventions can be used to help planners and administrators target their resources and tailor their program efforts at populations with varying degrees of susceptibility to substance abuse. For example, populations at greater risk or further along in the progression of substance abuse are likely to require interventions that are more intensive, more multi-pronged, in a wider variety of settings, and with more booster sessions.

Screen existing prevention interventions. The characteristics in this paper can be used to help program planners and funders screen existing prevention interventions for science-based characteristics that are incorporated (or not incorporated) in their program designs, and then help them select the interventions they want to try in their own communities, based on the science.

Design and test new interventions. Program planners and developers could use the science-based characteristics of effective interventions as the elementary building blocks to help them design new substance abuse prevention interventions. To help them work their way through the many characteristics and the many possible combinations of characteristics in specific interventions, they should first focus on a population, a substance, and a setting. For example, adolescent use of marijuana, with interventions in schools, would be a plausible target for intervention design in many communities. Next, they should work their way through the list of characteristics, preferably with the assistance of literature reviews or other technical assistance materials that help them think about the applicability of each key characteristic to their community situation. In this way, an intervention could be designed that targets, for example, the adolescent use of marijuana with an intervention that is launched in school settings, and with the intervention characterized by many of the key characteristics of effective substance abuse prevention interventions. Similarly, other interventions (with many of the key characteristics) could be designed to address other targets, such as the use of methamphetamine by adults who drive trucks, the snorting of heroin by teenagers who are in school, the use of tobacco by children in or out of the home, binge consumption of alcohol by youth in high school or college, or the use of crack cocaine by the homeless in the inner city.

Develop prevention report cards. The characteristics can be used to design techniques for assessing (based on the science) the likely effectiveness of prevention strategies, programs, and interventions. Developing formal report cards that are fair and science-based, however, may well require further developments in the science underlying prevention interventions, to ensure fairness and consistency.

Training

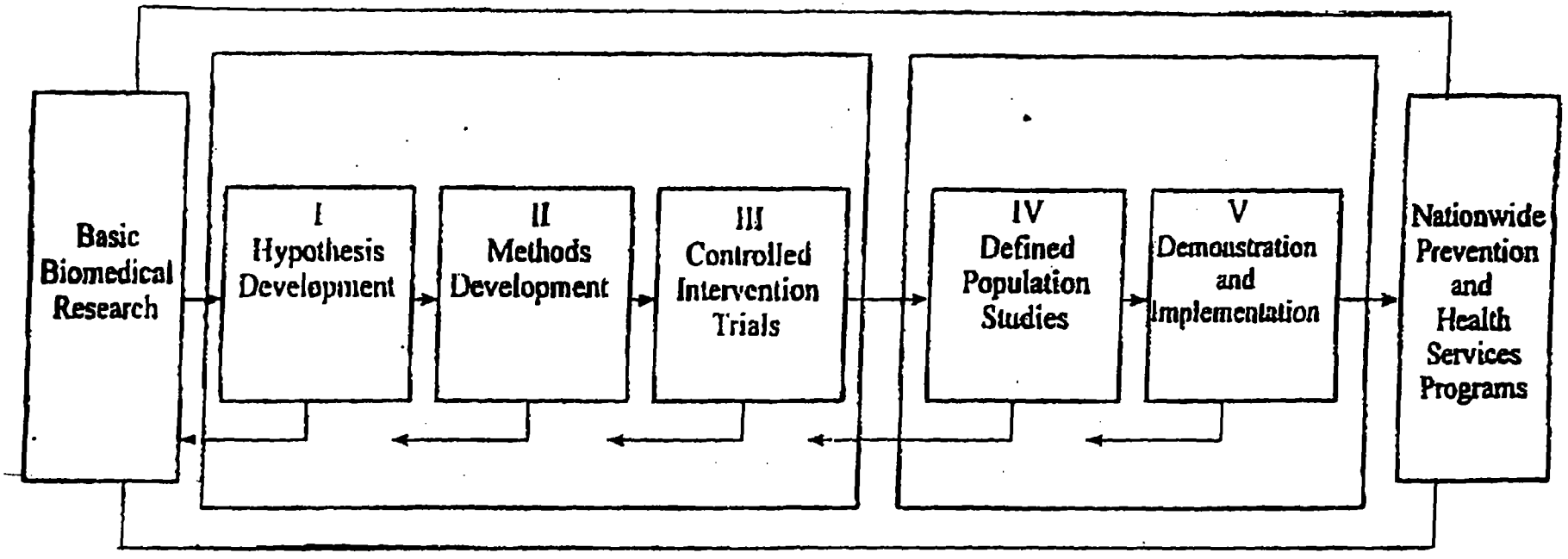
Federal policy, budget, and Congressional staff. Training could be provided to key Federal staff and officials about the grounding in science of some substance abuse prevention initiatives. Such training could help them design or review program proposals with a greater sense of the underlying science and how it supports certain kinds of interventions.

Grant application writers and reviewers. Training and technical assistance could be provided to grant application writers and reviewers for specific programs, to help them focus on how the characteristics should or may be addressed by funding applications for specific programs with specific goals and objectives.

State and community decision-makers. State and local decision-makers could become more widely and deeply informed about the characteristics and the underlying science, so that they

may be in a better position to design and implement prevention interventions that are likely to be effective.

NIH: NIDA/NIAAA/NIMH CSAP/DOE STATES



Research on Applications | Applied Research | Applications of Research

Figure 1: Continuum of Substance Abuse Prevention Research (Jansen, Glynn, & Howard, 1996; Greenwald and Cullen, 1985)

INCREASING PUBLIC UNDERSTANDING OF ADDICTION, TREATMENT, PREVENTION AND RECOVERY

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Mission statement

To increase public understanding of drug addiction, treatment, prevention and recovery through the more efficient and effective use of existing information, materials and resources.

Meetings summary

February 25, March 18, April 22, and July 15, 1998

There is a considerable amount of good information and messages on drug addiction that have already been developed by various federal agencies. Therefore, rather than duplicate efforts and develop new messages or vehicles for information and dissemination, the Increasing Public Understanding (IPU) of Addiction, Treatment, Prevention and Recovery working group is focusing on better managing the messages and information that already exist, with an emphasis on ensuring that the messages are based in scientific research. Its mission is to increase public understanding through the more efficient and effective use of information, materials and resources already available.

Recent scientific advances have revolutionized our understanding of drug abuse and addiction, addressing it's most fundamental and essential questions. Over the past two decades, research has firmly established that drug abuse is a preventable behavior and that drug addiction is, fundamentally, a chronic, relapsing disease of the brain. This knowledge will enable us to reduce

drug abuse, develop effective treatment and prevention programs, reduce transmission of infectious diseases such as HIV and hepatitis among drug abusers, and to develop anti-drug medications. However, this information is not useful if it is not disseminated and then applied.

Prior to focusing on specific tasks, the IPU working group gathered general information on each agency's public information dissemination programs. For example, SAMHSA is the lead agency in sponsoring National Alcohol and Drug Addiction Treatment Recovery Month in September 1998. This year's theme is "Addiction Treatment: Investing in Communities." In addition, NIDA has been sponsoring a series of "Town Meetings" across the United States, in which practitioners, scientists and the general public convene to address state-of-the-art research findings in drug abuse and addiction relevant to local communities. All of the agencies represented on the working group have exhibits programs, web pages, and work with constituent organizations to disseminate their information.

After examining currently available information and materials, the IPU working group then identified what could be done with them including:

- share with other agencies and organizations for maximum utilization
- identify a common message from the ones that are already being used by various agencies
- identify the materials and messages that are resonating with the public
- build a consistent message
- review materials for adaptability for use by difference audiences (for example, how can information targeted to children be adapted for use by businesses)
- identify target audiences within the business community: CEOs, small businesses, employees
- explore ways to use employees' status as parents to bring drug addiction messages to their children

While reviewing the available materials, the IPU working group identified the gaps in the information and found that, while children and adolescents were a target audience for much of the material, information for businesses and the criminal justice community were lacking. Based on this review and discussions with the Department of Labor representative on the IPU working group, it was determined that the group would target the small business community in its initial efforts. If the effort toward the business community was successful, the group would then work

on information for the criminal justice community.

Workplace-specific issues discussed included:

(1) What is already available?
- CSAP's information kit on creating a drug free workplace for small businesses.
- Industry-specific materials developed by DOL for distribution by trade associations
- Web-based searchable database of workplace-related substance abuse information

(2) How should this information be presented?
- Message to businesses should reflect practicality rather than altruism, i.e. reducing drug use by workers will reduce workplace accidents, which in turn will reduce insurance premiums

(3) How can the information be disseminated?
- Through unions (information provided by an employer may be viewed with suspicion by some employees)
- With paychecks (associating the information with something pleasant)
- Through employee assistance program (EAP) counselors

Other issues to be discussed further include:
- Addressing the needs of small businesses that do not have the money to fund extensive drug abuse prevention and treatment programs
- Using the workplace as a vehicle to reach employees who are parents with children who may need drug abuse information
- Using labor unions and local drug-free workplace coalitions effectively

Future Actions

The IPU working group had a joint meeting with the Drugs in the Workplace working group, and made plans to engage in a joint effort to work toward mutual goals, including the development of information for a November ONDCP workplace summit. Several of the goals of the Drugs in Workplace working group parallel those of the IPU group, including increasing the visibility of workplace strategies and highlighting the inherent opportunities for effective prevention,

intervention and treatment it provides, identifying gaps and duplication in agency program activity, identifying emerging issues of relevance to the workplace, and developing and implementing coordinated, interagency responses to identified needs and issues.

Many employers, particularly among small businesses, choose to fire employees with substance abuse problems, rather than promote treatment. The major focus of the joint workgroups effort will be to increase awareness that the workplace can play a significant role in increasing understanding of drug addiction, treatment, prevention, and recovery. Many drug abuse-focused initiatives for the workplace already exist, so the first task would be to identify any gaps in existing efforts and any opportunities to fill those gaps. The working groups identified several needs, and then discussed preliminary actions to address those needs:

(1) Need: to "create excitement" among businesses and the workplace community about the effort to address drug addiction

Action: Representatives from CSAT/SAMHSA discussed September's "National Alcohol & Drug Addiction Recovery Month" activities, under this year's theme: "Addiction Treatment: Investing in Communities." The focus of this year's activities is to promote the importance and effectiveness of substance abuse treatment among communities. This year's kit contains a targeted section for business leaders. It was suggested that perhaps next year's treatment month activities could focus on the business community and the workplace. Possible partners for this initiative include the Chamber of Commerce and the Drugs Don't Work Initiative to help support activities.

(2) Need: to get available information to the right people

Action: A substantial amount of information is available on the web. The working group will ask that the Small Business Association and the Chamber of Commerce put links to CSAP and DOL drug addiction web pages in the workplace section of their web pages.

ONDCP will be sponsoring a drugs in the workplace seminar for CEOs of Fortune 500 companies in September. The working groups will develop an annotated bibliography of all available federal materials on understanding drug addiction in the workplace for dissemination to

seminar participants. The bibliography will also be available to all federal agencies for their own uses.

(3) Need: DOT identified their most frequently asked drug abuse question as being "Where do I get information on local treatment resources?"

Action: SAMHSA reps pointed them to SAMHSA's website, which contains a list of all of the local treatment and prevention programs in the US, updated annually.

(4) Need: Current research-based statistics on drug addiction in the workplace. DOL and other agencies would like to update their materials, replacing old statistics with new ones. However, they are finding it difficult to find current, research-based information of the use of drugs in the workplace.

Action: NIDA reps will review their research portfolio to identify studies that may provide useful workplace information and statistics.

(5) Need: To link the workplace effort with ONDCP/federal initiatives to increase drug abuse efforts aimed at children and youth.

Action: Identify ways to use the workplace effort as a vehicle for parents in the working community to bring drug addiction information and awareness to their children.

(6) Need: An assessment of whether these activities are actually increasing public understanding.

Action: No resolution; further discussion is necessary.

Medical Marijuana

Marijuana Subcommittee

At the marijuana subcommittee's first meeting, held March 17 at ONDCP, the representatives present decided that the subcommittee's mission would be to educate both the public and government officials by disseminating information on marijuana. Consensus was that we have an obligation to get science-based facts about marijuana to the public and counter any misinformation currently being circulated.

Representatives prepared an annotated list of their agency's public domain material regarding marijuana, and the material was subsequently consolidated into an Interagency Resource Guide to Marijuana. *(Copy attached)* In addition to describing the material available, the guide gives implicit instructions on how to order material, and includes a list of related websites. After much discussion on whether to send this guide to governors, mayors, police chiefs, members of the civic alliance and each agency's "Friends of" list, it was decided that sending such unsolicited material would not be productive. Instead, subcommittee members agreed to post the list on their individual websites. The subcommittee is considering other ways to educate the public about marijuana.

ONDCP has had suggestions that it should provide a Speakers Bureau of highly articulate persons qualified to speak out against the medical use of marijuana, especially medical doctors. The suggestion was brought to the subcommittee, where it was recommended that such requests be forwarded to non-government organizations such as the Partnership for a Drug-Free America and the Community Anti-Drug Coalitions of America, who already maintain local speakers lists.

A secondary objective of the marijuana subcommittee is to ensure that all federal-level policy makers are in agreement when they make public comments about the medical use of marijuana. The subcommittee discussed several "sound-byte" phrases that might be sent to cabinet secretaries for approval and possible inclusion in their speeches. In addition, subcommittee members will assist ONDCP prepare a briefing for agency speechwriters by providing information that falls within their agency's area of expertise.

Interagency Marijuana Resource Guide

The following list was compiled by the Office of National Drug Control Policy in collaboration with the following federal agencies: Department of Health and Human Services, Department of Justice, Drug Enforcement Administration, National Institutes of Health, Substance Abuse and Mental Health Services Administration, Department of Education, and Food and Drug Administration.

A Police Chief's Guide to the Legalization Issue, an 11-page publication that gives a brief overview of drug legalization and helps local Police Chiefs respond to the issue in their communities. To receive copies, contact DEA's Demand Reduction Section at 202-307-7936.

Drugs of Abuse, a 54-page publication that provides an overview (origin , use, and affects) of illicit and prescription drugs. Limited copies are available by contacting DEA's Information Services Section at 202-307-7967, or visit DEA's website at www.usdoj.gov/dea.

Get It Straight! The Facts About Drugs, a 42-page publication for youth (aged 12-15) that provides the facts about illicit and prescription drugs. To receive copies, contact DEA's Demand Reduction Section at 202-307-7936, or visit the website at www.usdoj.gov/dea.

Keeping Youth Drug Free, a 44-page booklet that provides guidance for parents, guardians, and other role models about preventing alcohol, tobacco, or illicit drug use among youth they care for and care about. It is divided into five sections based on the five reasons that young people give for using alcohol and drugs: to feel grown up; to fit in and belong; to relax and feel good; to take risks and rebel; and, to satisfy curiosity. It includes action steps and exercises, as well as a list of resources. Also contains responses for parents who used drugs in the past if they are questioned by their children about having used drugs. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686.

Marijuana, a tri-fold pamphlet that outlines what marijuana is, how it affects the mind and body, a discussion on teens and marijuana, as well as the use of marijuana as medicine. To receive copies, contact DEA's Demand Reduction Section at 202-307-7936.

Marijuana: Facts for Teens. Booklet providing the basic facts on marijuana in question and answer form: What is marijuana? How is it used? Why do young people use it? What happens if you smoke it? Available in English and in Spanish. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686; or, visit the National Institute on Drug Abuse's website at www.nida.nih.gov.

Marijuana: Facts Parents Need to Know. Booklet providing the basics facts on marijuana in question and answer form: What is marijuana? How can I tell if my child has been using marijuana? What are the effects of marijuana? Available in English and in Spanish. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686; or, visit the National Institute on Drug Abuse's website at www.nida.nih.gov.

Mind Over Matter-The Brain's Response to Marijuana. A large color poster explaining to middle school age children how marijuana affects the brain and other parts of the body. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686.

National Conference on Marijuana Use: Prevention, Treatment, and Research: Conference Highlights. Summary of the proceedings of a national conference on the prevention, treatment, and research on the use of marijuana, sponsored by NIDA July 19 and 20, 1995. Topics included: Changing trends, patterns, and nature of marijuana use, the national marijuana media campaign, Marijuana: What it is and what it does, effects of marijuana on the body, consequences of marijuana use, patterns of use, what do teens and parents think about marijuana, screening for marijuana use in adolescents, the science of marijuana testing, community prevention strategies, and perinatal and developmental effects of marijuana. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686; or, visit the National Institute on Drug Abuse's website at www.nida.nih.gov

NIDA Capsule -Marijuana Update. Regularly updated synopsis of the latest facts and figures on marijuana use, including Monitoring the Future study data, information on the effects of marijuana of various parts of the body and information on neuroscience research as it relates to marijuana. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686; or, visit the National Institute on Drug Abuse's website at www.nida.nih.gov

NIDA Infofax-Marijuana. Regularly updated fact sheet presenting the latest science-based facts about marijuana abuse and addiction. They are available by dialing 1-888-644-6432 and, for the hearing impaired, 1-888-889-6432. The system will send the fact sheet via fax or mail. The fact sheets and audio portion of NIDA Infofax are available in English and in Spanish.

Reality Check is a community kit for parents, educators and community service groups of youth ages 9-14. Reality Check is a multimedia campaign designed to prevent use and reduce existing use of marijuana by 9 to 14-year olds. Includes ready-to-use materials, camera-ready artwork, print PSAs, list of national resource organizations, and practical information on conducting media outreach and local community campaigns. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686.

Speaking Out Against Drug Legalization, a 42-page resource guide that addresses the arguments against legalization. This publication can be accessed from DEA's website at www.usdoj.gov/dea. Copies are currently unavailable.

Substance Abuse Resource Guide: Marijuana. A list of materials and programs compiled from a variety of publications and data bases. Provides information on marijuana that will assist professionals in the prevention, education, criminal justice and health care fields. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686.

Tips for Teens About Marijuana is a tri-fold brochure that lists some short and long-term effects of marijuana. To receive copies, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847, 1-800-729-6686.

Websites with Drug Information

ACDE (American Council for Drug Education):
http://www.acde.org

CADCA (Community Anti-Drug Coalitions of America):
http://www.cadca.org

CASA (Center on Addictions & Substance Abuse):
http://www.casacolumbia.org

Corporation for National Service
Drug Alliance Office:
http://www.cns.gov

CSAP (Center for Substance Abuse Prevention):
http://www.samhsa.gov/csap/

CSAT (Center for Substance Abuse Treatment):
http://www.samhsa.gov/csat/csat.htm

DEA (Drug Enforcement Agency):
http://www.usdoj.gov/dea/

Drug Watch International:
http://www.drugwatch.org

Drug Strategies:
http://www.drugstrategies.org

Family Research Council:
http://www.frc.org

Higher Education Center for
Alcohol and Other Drug Prevention:
http://www.cdc.org/hec

Join Together:
http://www.jointogether.org

National Clearinghouse for Alcohol & Drug Information:
http://www.health.org

National Families in Action:
http://www.emory.edu/NFIA

National Inhalant Prevention
Coalition:
http://www.inhalants.org

NIAAA (National Institute on Alcohol Abuse and Alcoholism):
http://www.niaaa.nih.gov

NIDA (National Institute on Drug Abuse):
http://www.nida.nih.gov

NIH (National Institutes of Health):
http://www.nih.gov

ONDCP (Office of National Drug Control Policy):
http://www.whitehousedrugpolicy.gov

Partnership for a Drug-Free America:
http://www.drugfreeamerica.org

PRIDE (Parents Resource Institute for Drug Education):
http://prideusa.org

Reader's Digest and Parent Soup (co-hosted):
http://www.drugfreekids.com

Robert Wood Johnson Foundation:
http://www.rwjf.org

SAMHSA (Substance Abuse and Mental Health Services Administration):
http:// www.samhsa.gov

Managed Care

Hemp Oil / Drug Testing

INTERAGENCY DEMAND REDUCTION WORKING GROUP
Subcommittee Report: Hemp and Drug Testing

Issue: The proliferation of hemp products has the potential to create a problem for drug testing. The use of products containing hemp/THC at detectable levels which cause a positive urinalysis and their implications on workplace drug testing programs. Report on research by Research Triangle Institute (RTI) revealed that (1) hemp seed, hemp oil and other hemp products are widely available. (2) Hemp oil is pressed from hemp seed at least two sites in the United States; also, hemp oil is imported from Canada and South America. (3) Analysis of cannabinoids in hemp seed and hemp seed oil have found Δ^9-THC at concentrations capable of producing a positive urinalysis.

The Hemp and Drug Testing Subcommittee has met on three dates (Jan 15, Feb. 13 and June 3, 1998). It comprises representatives from ten federal agencies (ONDCP, DoD, DOJ, DEA, DOT, DOL, USCS, HHS/SAMHSA, FDA and ATF).

Discussion has centered on the following topics:

- Where is the source of the THC? Is the THC content in these products due to the presence of THC in hemp oil, or a result of the crude harvesting of the seeds?
    - Research being conducted by Dr. ElSohly seems to indicate that THC is not only present as a contaminate, but may actually be present in the seed, depending on the variety of seed.
- Would a requirement to remove leafy material in order to avoid contaminants or to add an alkaline wash prior to shipment be helpful?
    - Research on whether THC is an integral component of hemp seed or hemp oil, or whether it is a contaminant to the seed coat that is introduced into the oil during seed processing revealed that since a brief chloroform wash removed over 90% of original THC, it appears that a large amount of the THC is a contaminant.
- Will it be necessary to require an analysis after a positive urinalysis (or hair test) to determine origin of THC as is being currently done with opiate positives?
    - Currently there is no scientifically documented metabolite or by-product to determine the origin of THC is body fluids (i.e. smoking vs. ingestion of hemp)

- Can manufacturers be persuaded to voluntarily comply in making products that do not produce positive urinalyses, that is, will they voluntarily de-THC their products?

    - Some of the companies contacted for information were very helpful and concerned about this issue others have a legal opinion that presently their is a conflict of law which may allow products made from seeds an exemption from the Controlled Substances Act.

    - Voluntary compliance would be preferable to legal pressure in gaining compliance by manufacturers.

- Is there a need to set standards for acceptable levels of THC in products, as we now have standards setting acceptable levels of lead in paint?

    - Currently if a product contains THC in any detectable amount then it is a controlled substance and prohibited from sale.

    - Consensus was that human tests were needed to evaluate levels of THC in hemp products.

- Should we enforce, or even promulgate, the existing law, which says a product containing THC is technically a controlled substance?

    DOJ

    - Has reviewed case law and found no cases in which the courts have addressed the issue of whether a product must be THC-free.

    DEA

    - Will notify each DEA registrant who imports and processes cannabis seed that any material which contains or is contaminated with THC or marijuana particulate is a Schedule I controlled substance and should be treated as such.

    - Will solicit registrants who handle cannabis seed to invoke procedures such as solvent washing or other means in an effort to eliminate the presence of marijuana particulate matter and THC

    - Will visit each registrant to determine the purchasers and uses of the seed.

    - As requests to import or manufacture hemp seed oil or products made from hemp seed oil come to DEA's attention, will notify the importer or manufacturer that any material containing or contaminated with THC or marijuana particulate matter is a

Schedule I controlled substance and should be treated as such.

DOD

- Considering a basis for advising service members subject to drug testing that ingestion of THC through hemp oil/seed-containing products is not a defense for a positive test result.

DOT

- DOT's current policy is that ingestion of hemp oil products is not an acceptable excuse for a positive urinalysis test for marijuana.

ALL

- Agreement that any policy statement or agency interpretations of current law be consistent with the interpretation that THC in any amount is prohibited by the CSA. Therefore, 1) it is illegal to import, sell or manufacture a THC-containing product without the proper registration;
  2) it is illegal to have THC in the body fluids.
- Voluntary compliance should be encouraged.
- Communicating this interpretation of law give incentives to importers to ensure their products are THC-free.

Actions to be taken:

FDA

- Provide list of hemp oil importers

DEA

- Provide list of hemp seed importers

ONDCP

- Interpret CSA with respect to THC
- Send interpretation for interagency review and comment

HHS/DoD Study means of removing THC (DEA will assign a scientist to this project); future discussions with hemp seed and hemp oil manufacturers/importers

HHS/NIDA Conduct human subject research of hemp products containing THC

Media