Methamphetamine

The National Summit to Promote Public Health, Partnerships, and Safety for Critically Affected Populations

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The National Summit to Promote Public Health, Partnerships, and Safety for Critically Affected Populations

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Acknowledgments

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Executive Summary

Background

The *National Summit to Promote Public Health, Partnerships, and Safety for Critically Affected Populations* (*The Summit*) was held November 16–19, 2008, in Washington, DC. The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Federal partners for *The Summit* included the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH), the HHS Office on Women's Health (OWH), the Indian Health Service (HIS), the National Institute on Drug Abuse (NIDA), the Office of Community Oriented Policing Services (COPS), the Bureau of Justice Assistance (BJA), and the Drug Enforcement Administration (DEA). Strategic Applications International, a SAMHSA partner in conducting State Governors' summits on methamphetamine, facilitated *The Summit*.

Planning for *The Summit* began in June 2007 when the Center for Substance Abuse Treatment (CSAT) convened a planning group to provide input into the design of a national summit focused on methamphetamine use in the lesbian, gay, bisexual, and transgender (LGBT) communities and strategies for addressing it at national, State, and community levels. Input from that original group was used as the foundation for a summit design. Based on additional input and guidance from SAMHSA, the critically affected populations selected for the focus of this national summit were expanded to include justice-involved populations and women. SAMHSA served as the host agency, inviting all 50 State Governors as well as representatives from all U.S. Territories to submit a letter of interest to participate. An expanded Steering Committee of 70 participants was convened in July 2008, with representation from all Federal sponsors and representative of all three critical populations.

The selection of the three critically affected populations was based on a number of factors; one factor was data that indicate that methamphetamine use has a disproportionate impact on certain populations including incarcerated populations, LGBT individuals, women of childbearing years, American Indians/Alaska Natives, Latinos/Latinas, and Asian/Pacific Islander populations. Issues of funding and complexity focused the discussion on three critically affected populations.

The justification for focusing on justice-involved populations, LGBT individuals, and women can be found in the anecdotal and quantitative data and research on these populations, though some statistics demonstrating the striking impact of methamphetamine use on these populations are provided here:

- Fifteen percent of State and 13 percent of Federal prisoners reported using methamphetamine regularly before their conviction in 2004 (Mumola & Karberg, 2004).
- Twenty-four percent of State and 18 percent of Federal prisoners reported using methamphetamine at some point in their lives in 2004 (Mumola & Karberg, 2004).
- The San Francisco Department of Health (2004) recently estimated that from 17 percent to 22 percent of gay men had used methamphetamine in the past 12 months. The danger inherent to the drastic increases in methamphetamine use currently underway among gay and bisexual men is twofold and shines the spotlight on what Halkitis and colleagues (2001) refer to as the "Double Epidemic," the devastating physiological and psychological consequences of methamphetamine use and its contribution to the increasing risk for HIV transmission.
- Hser and colleagues (2005) studied gender difference among people who use methamphetamine in a sample of treatment programs in California. The researchers conclude, "Women in our sample, most of whom were of child bearing age or had children, demonstrated more severe problems than did men." They added, "Many were unemployed, relied on public assistance, and suffered from severe psychiatric problems."

The Summit Design, Structure, and Goals

Design

The Summit was designed to integrate public health and public safety through improved partnerships, collaboration, and outcomes using integrated strategies:

- *The Summit* targeted three populations critically affected by methamphetamine use: justice-involved populations, LGBT individuals, and women.
- Within the three critical populations were six domains: criminal justice, HIV/AIDS and other sexually transmitted diseases, mental health services, prevention/public awareness, rural issues and treatment, and continuing care/recovery management and support services.
- There were four strategic focus areas for policy and program recommendations: data collection and research, cultural competency, access to substance abuse services, and best practices.

The Summit participants included 20 State and Territory Action Teams[1]—comprising a comprehensive representation of key State stakeholders—and representatives from Federal partners, national organizations, and the methamphetamine grantees of CSAT, the Center for Substance Abuse Prevention (CSAP), COPS, and BJA.

[1] State and Territory Action Teams: American Samoa, Arizona, California, Colorado, District of Columbia, Florida, Guam, Hawaii, Idaho, Indiana, Iowa, Minnesota, Montana, New Mexico, New York, Nevada, Northern Mariana Islands, Ohio, Oklahoma, and Texas.

Structure

The Summit was structured with five components: plenary sessions, springboard sessions, small group discussions, policy and program recommendations, and Action Team planning. All participants attended the four plenary sessions, which set the stage for discussion and work on each of the four strategic focus areas. These plenary sessions served to build a bridge across the three critically affected populations in each focus area and to explore the commonalities and differences among them. Following each plenary session were concurrent springboard sessions broken out by the three critically affected populations. These sessions explored the specific needs of each population as they relate to the strategic focus areas and stimulated thinking and discussions. Following these sessions, small group discussions were organized by the six domains with the goal of brainstorming policy and program recommendations in each strategic focus area. Each day of *The Summit* started and ended with Action Team planning leading to a final State/Territorial Action Plan to be submitted by each Action Team at the end of *The Summit*.

Goals

The three goals of *The Summit* were:

1. Synthesize local successes, move States to action, and promote the development of national strategies that participants can use to strengthen and expand efforts back home.
2. Identify culturally and linguistically appropriate and relevant products that reflect promising areas of research and evidence-based practices in prevention, intervention, treatment, and recovery management to assist communities in their response to methamphetamine use in critically affected populations.
3. Forge collaborations across Federal, State, Tribal, and local government agencies and with community partners and establish a mechanism for the creation of collaborative plans with all Federal sponsors similar to that which currently exists between SAMHSA and CDC.

The Summit was not intended to be a traditional conference on methamphetamine use. Rather, it was intended to convene key stakeholders from committed States to inform a national agenda as well as create State-/Territory-specific Action Plans with strategies to address systemic issues focusing on the impact of methamphetamine use on the most critically affected populations from a public health and public safety perspective. There was recognition from the beginning that, though methamphetamine was the convening topic, solutions must be systemic and address the broader challenges of integrating public health and public safety responses to substance abuse.

Prioritized Recommendations

The Summit recommendations were developed through small group discussions in each track targeting the three critically affected populations: justice-involved populations, LGBT individuals, and women. Each track was broken into six domains, and a small group discussion occurred in each during which two to three key questions were addressed on the needs of the target population in the context of the domain and the strategic focus area being addressed in that session. During the final session, the small groups reviewed the collective recommendations for their population and domain and prioritized and refined their top five recommendations for each strategic focus area.

This document presents the crosscutting recommendations (common among populations and domains) in each of the four strategic focus areas and the unique issues that emerged, either for each critically affected population or by domain. These unique issues were specific to a particular critically affected population and/or domain, but they are equally important as recommendations to address the needs of all three targeted populations. No cookie-cutter policy or program solution fits all populations; thus, unique issues emerged in the spirit of *The Summit*. This Executive Summary does not present all key ideas generated. Rather, it gives an overview of the recommendations that emerged from *The Summit* and the basis for State-specific Action Plans that will form the strategic planning at the national level in each focus area.

The prioritized recommendations for each domain and for each strategic focus area will serve as the foundation for the four working groups organized by the Federal partners to follow up on implementing *The Summit* recommendations. All the work of the small group discussions has been recorded and is posted to the Web site on Methpedia.org for use by *The Summit* participants, Federal partners, and working groups. Listed below is a small snapshot of the extensive recommendations made over the course of *The Summit*'s 3 days.

A. Data Collection and Research

Discussions should focus on expanding and refining data collection and research efforts to better answer key questions that address the unique needs of justice-involved populations, LGBT individuals, and women. National, State, and local surveys need to find out how methamphetamine use differs from other drug use, explore the interaction between methamphetamine use and multiple drug use, and ask questions about gender and sexual orientation, identity, and behavior.

1. Increase local, State, and national funding for substance abuse research that will facilitate data collection, generate data analysis, and target substance abuse issues related to underreported and underserved populations, particularly research related to ethnicity, gender identity, sexual orientation/behavior/attraction, and the unique challenges of Tribal, rural, and frontier areas.

2. Coordinate data systems across local, State, Tribal, and Federal jurisdictions and across agencies/sectors such as criminal justice, treatment, social services, public health, and child protection.
3. Strengthen the collation, analysis, and dissemination of substance abuse-related data sets across sectors and jurisdictions to support and encourage data-driven substance abuse program and policy decisions.
4. Measure and document resiliency and protective factors in addition to risk factors, particularly for critical populations.

B. Cultural Competency

Cultural competency should focus on both skills and systemic barriers and should include ethnicity, gender, LGBT, HIV/AIDS, and rural issues. The question of using the term cultural sensitivity versus cultural competency was also raised.

1. Require government-funded programs to demonstrate cultural competency in all areas of program and policy development.
2. Provide cultural competency training for policymakers, providers, professionals, students, administrators, and line staff.
3. Develop a trauma-informed licensure community by providing additional resources to the Addiction Technology Transfer Centers and other technology transfer centers to raise competencies of current and future workforces.
4. Ensure that service provider organizations and individual providers reflect the cultural aspects of the community needing services.

C. Access to Substance Abuse Treatment Services

Equitable, skilled, affordable, and welcoming access to substance abuse treatment services remains a challenge for Tribal, rural, and frontier areas and for specific populations including the critically affected populations.

1. Address the unique barriers for women, LGBT individuals, rural and Tribal communities, youth, people of color, and criminal justice reentry clients.
2. Increase integration and coordination of systems and services—for example, mental health, substance abuse, criminal justice, public health, case management, HIV/AIDS, and veterans.
3. Ensure that a comprehensive continuum of substance abuse treatment services includes pretreatment services in funding and policy infrastructure.
4. Develop government and provider policies to promote offender-, LGBT-, and women-friendly substance abuse treatment services.

D. Best Practices

Examples of best practices that have met the test of a variety of standards are available in the substance abuse treatment services arena though they have not necessarily been tested for efficacy across the unique needs of a wide range of clients such as the critically affected populations. More should be done to encourage research and innovation to demonstrate efficacy and to better meet the substance abuse treatment needs of all clients.

1. Fund promising practices or evidence-informed programs for underserved populations where data are lacking; promote innovative, dynamic, and creative models; and develop evaluation tools to measure impact.
2. Develop venues and collaborations for connecting research to practice and practice to research.
3. Develop cross-agency strategies for dissemination of data and information about programs and projects.
4. Allow for flexibility in all Federal grants. Many States have implemented promising strategies that have not gone through a rigorous evaluation process but that have shown positive outcomes. Identify mandatory components of best practices, allowing evaluated best practices to be used as a guide and requiring States to demonstrate evaluation results regardless of which strategies are implemented.

E. Unique Issues

Several unique issues were identified across the three target populations and the six domains.

1. Address the issue of trauma as a cause or contributing factor to substance abuse, particularly for women and LGBT individuals.
2. Address the issues of social stigma, discrimination, and homophobia as contributing factors to substance abuse for LGBT individuals.
3. Develop a Treat America model using a student loan forgiveness incentive to increase the number of treatment providers in rural areas.

Conclusion

Several essential outputs and products emerged from *The Summit;* these products are the beginning of a coordinated and comprehensive approach to treating methamphetamine and other substance use among critically affected populations. By the conclusion of *The Summit,* each Action Team had produced an Action Plan for addressing the health and safety of the critically affected populations in its State or Territory—an appropriate and relevant plan that addressed the four strategic focus areas in a macro-policy sense and that could be implemented with collaborative partnerships.

The policy and program recommendations that emerged for each critically affected population will shape Federal policies and programs. As the partnerships that helped create and implement *The Summit* continue to be enhanced and expanded, these recommendations will be evaluated in four working groups—one for each strategic focus area. *The Summit*'s participants, their recommendations, and their work will continue to have an impact on the critically affected populations not just in reducing methamphetamine use, but in a comprehensive approach to substance abuse treatment services.

Background

SAMHSA has a long history of addressing the unique challenges presented by the manufacturing, distribution, and use of methamphetamine. Under the leadership of Dr. H. Westley Clark, CSAT has supported Governors' summits on methamphetamine in 15 States since 2002 in partnership with the Drug Enforcement Administration (DEA), the Office of Community Oriented Policing Services (COPS), and Strategic Applications International (SAI).

State Governors' summits use facilitated strategic planning and mobilization processes that involve comprehensive teams from local jurisdictions (e.g., counties) and representatives from statewide agencies and organizations. The facilitation process uses the "social reconnaissance" model to identify and prioritize problems, barriers, and solutions. Day One produces statewide recommendations across several domains (e.g., law enforcement, prosecution/courts, treatment, prevention, child protection, first responders, precursor chemicals, clandestine labs, public awareness/media, mobilization) that serve as the foundation for a statewide Action Plan. Day Two produces local Action Plans using the same process. The social reconnaissance model focuses discussions on barriers to solving the prioritized problems. Targeted and pragmatic Action Plans move the agenda quickly toward producing breakthroughs that have real outcomes.

Over the last 9 years, SAI (the principal facilitator for *Methamphetamine: The National Summit to Promote Public Health, Partnerships, and Safety for Critically Affected Populations [The Summit]*) has conducted more than 22 summits (organizing and mobilization events) specifically related to methamphetamine. Over the course of working with many States, SAI has seen the aggressive response to methamphetamine use yield exciting results in the reduction of clandestine methamphetamine labs, increased drug arrests and seizures, and other measurable outcomes. Treatment practices have improved, and access to effective treatment for methamphetamine use is well documented. SAMHSA and SAI have seen prevalence rates decrease or stabilize in several categories. Although progress has been made, serious gaps remain in the nature of the response and the disproportionate impact of methamphetamine on certain groups.

As the methamphetamine problem spread across the country, States have engaged in proactive efforts using trainings, conferences, summits, statewide methamphetamine task forces, clandestine lab teams, and other strategies. Much has been done to reduce access to precursor chemicals, protect drug endangered children, expand prevention efforts, and improve the use of evidence-based treatment models. However, methamphetamine use continues to have a disproportionate impact on specific populations.

Organizers for *The Summit* saw a strategic opportunity to respond to methamphetamine use and to strengthen the public health and public safety systems' responses to not only this drug but all drugs. Addressing the needs of justice-involved individuals; LGBT individuals; and women—focusing on data collection and research, cultural competency, access to substance abuse treatment services, and best practices can expand and or enhance outcomes for individuals, families, and communities. This is an exciting time in treatment as recovery-oriented systems of care are developing and entire sectors are rethinking their long-term responses to addiction. SAMHSA appreciates the commitment of the Federal partners that saw the need for and supported *The Summit* and are providing necessary follow up to implement the recommendations that emerged.

Dr. Edwin Craft, the CSAT Government Project Officer, and James and Colleen Copple of SAI, the principal facilitators of the Governors' methamphetamine summits and *The Summit*, recognized the opportunity to address a number of unique needs identified over the course of each Governor's summit. The goal was to convene key stakeholders to inform a national agenda and develop State-/Territory-specific strategies to address systemic issues focusing on the impact of methamphetamine on the most critically affected populations. *The Summit* would examine and promote emerging partnerships across both the public health and the public safety sectors to create an integrated, comprehensive approach to reducing methamphetamine use.

CSAT convened a planning group in June 2007 to provide input into the design of a national summit that would focus on methamphetamine use in the LGBT community and strategies to address this issue at national, State, and community levels. Input from that original group was used as the foundation for *The Summit* design.

An expanded Steering Committee of 70 participants was convened in July 2008 with representation from all the Federal agency sponsors for the event and additional participation from women and justice-involved stakeholders. This Steering Committee reviewed the issues surrounding methamphetamine use and the three critically affected populations, *The Summit* goals, the original design of *The Summit*, the strategic focus areas, the six domains, the composition of the State/Territorial teams, the participant and State/Territorial team outreach and selection processes, potential speakers, and resources, research, and tools that could be made available through a clearinghouse on methamphetamine.

Based on the Steering Committee's input, *The Summit* agenda was finalized. With the support of Federal partners, planning continued during early fall 2008. These efforts culminated in *Methamphetamine: The National Summit to Promote Public Health, Partnerships, and Safety for Critically Affected Populations,* held in November 2008. *The Summit* participants numbered 400 and included members of 20 State and Territory Action Teams and representatives from Federal partner agencies, national organizations, and the methamphetamine grantees of several Federal agencies.

Federal Partners

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Federal partners for this event included the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH), the HHS Office on Women's Health (OWH), the Indian Health Service (HIS), the National Institute on Drug Abuse (NIDA), the Office of Community Oriented Policing Services (COPS), the Bureau of Justice Assistance (BJA), and the Drug Enforcement Administration (DEA). Strategic Applications International (SAI) facilitated *The Summit*.

Why These Three Critically Affected Populations?

Data indicate that methamphetamine use has a disproportionate impact on a number of populations. Through its work with its discretionary programs, CSAT data shows that incarcerated populations, LGBT individuals, women of childbearing years, American Indians/Alaska Natives, Latinos/Latinas, and Asian/Pacific Islander populations are particularly affected (Services Accountability and Improvement System [SAIS], SAMHSA, 2008; Halkitis, 2009; Bull et al., 2002; Frosch, Shoptaw, Huber, Rawson, & Ling, 1996; Halkitis, Fischgrund, et al., 2005; Halkitis, Parson, & Wilton, 2003; Halkitis, Shrem, & Martin, 2005; Kurtz, 2005; Halkits et al., 2001; Mansergh, Shouse, et al., 2006; Nina, 2007; Paul, Stall, & Davis, 1993; Plankey et al., 2007; Reback, 1997).

Funding for *The Summit* did not accommodate six different tracks. Complexity was also a consideration. The decision was made to focus on three, rather than six, critically affected populations. Because a strong focus on American Indian populations and methamphetamine already exists, including Federal funding and national working groups, it was determined that the Tribal aspect would include participation of Tribes in State/Territorial Action Teams, Tribal methamphetamine grantees, and invitations to Tribal representatives of the HHS/SAMHSA-sponsored National Indian Country Methamphetamine Initiative. The goal was to avoid duplication of effort and to ensure that the national recommendations and State/Territorial Action Teams included interaction and integration of Tribal issues.

The needs of Latino/Latina and Asian/Pacific Islanders as specific groups were also addressed by focusing on State and Territory Action Teams that represented high percentages of these populations. Rather than addressing minority groups in isolation, it was determined that the better course would be to integrate them into the Action Teams and to address those needs locally. The justification for focusing on justice-involved populations, LGBT individuals, and women can be found in the anecdotal and quantitative data and research on these three populations.

Meth and Critically Affected Populations

Research supporting efforts to respond to methamphetamine use among the three critically involved populations is both emerging and diverse. It is impossible in a proceedings document to provide a comprehensive review of all the literature related to *The Summit* or its themes. However, below is a snapshot of research topics and themes that reinforce the need to develop prevention, treatment, and intervention strategies for the selected populations.

Justice-Involved and Incarcerated Populations

- Fifteen percent of State and 13 percent of Federal prisoners reported using methamphetamine regularly before their conviction in 2004 (Mumola & Karberg, 2004).
- Twenty-four percent of State and 18 percent of Federal prisoners reported using methamphetamine at some point in their lives in 2004 (Mumola & Karberg, 2004).
- Six percent of State and 7 percent of Federal prisoners reported using methamphetamine at the time of their offense (Mumola & Karberg, 2004).
- Thirty-nine percent of local and State agencies reported that methamphetamine use is the greatest drug threat in their regions. When asked to compare the threat of all drugs, law enforcement agencies rated methamphetamine number one, with cocaine coming in second (National Drug Intelligence Center, 2006).
- Forty-eight percent of counties reported that methamphetamine use is the primary drug problem in their communities (National Drug Intelligence Center, 2006).
- Minnesota has strong data collection resources that document the specific impact of methamphetamine use as separate from other drug offenses. Its data provide a clear indication of the impact of methamphetamine on the criminal justice system. Even in a State with a dramatic decrease in methamphetamine labs, the impact of methamphetamine continues. Methamphetamine use in Minnesota peaked in 2005 in terms of crime data, but the drug continues to have a disproportionate impact on the criminal justice system (Office of the State Drug Policy and Meth Coordinator, 2008).
  - Minnesota saw a decline in methamphetamine labs from a high of almost 500 in 2005 to 49 in 2008.
  - Between 2006 and 2007, drug task force methamphetamine seizures decreased 46 percent and methamphetamine arrests declined by 12 percent. Meth still accounted for 43 percent of all drug task force arrests in 2007.
  - In 2005, 4,709 adult methamphetamine court cases were filed, constituting 46 percent of all felony drug cases and more than 14 percent of all felony cases filed throughout Minnesota.
  - Although the number of adult methamphetamine court cases dropped by 26 percent in 2006, methamphetamine cases still constituted 38 percent of all felony drug cases filed in Minnesota and 11 percent of all adult felony cases filed.

— By 2005, methamphetamine offenders made up more than half of all the drug offenders in Minnesota's prison system (Office of the State Drug Policy and Meth Coordinator, 2008).

- Methamphetamine offenders constituted 10.5 percent of the entire prison population in 2008, down from a high of 12.8 percent in 2005–2006 (Shrem & Halkitis, 2008).

LGBT Individuals

- Methamphetamine use is not confined to gay and bisexual men; however, the majority of literature supports the increasing trend of methamphetamine use in this segment of the population. Much of the research over the last decade focused on the connection of methamphetamine use and HIV in gay men (Halkitis et al., 2003, 2005b; Hall, 1996; Mendelson & Harrison, 1996).
- Current investigations, including the Seropositive Urban Men's Study (a study of HIV-positive men who have sex with men), estimate the rate of methamphetamine use to be 11 percent, with rates of 17 percent and 7 percent in San Francisco and New York, respectively (Purcell, Parsons, Halkitis, Mizuno & Woods, 2001).
- In a sample of gay and bisexual men frequenting gay social venues, Halkitis and Parsons (2002) estimated that 10 percent of their sample were using methamphetamine and that 25 percent of the people reporting using methamphetamine first used the substance within 3 months before their participation in the study; this confirms the timeframe of methamphetamine's emergence in New York City to be in the middle to late 1990s. In addition, a more recent longitudinal investigation found that among a sample of 450 gay and bisexual men who use club drugs, 64.6 percent reported using methamphetamine in 4 months before assessment with a mean use of 11.76 days (Halkitis et al., 2005b).
- The San Francisco Department of Health (2004) recently estimated that from 17 percent to 22 percent of gay men had used methamphetamine in the past 12 months. The danger inherent to the drastic increases in methamphetamine use currently underway among gay and bisexual men is twofold and shines the spotlight on what Halkitis and colleagues (2001) refer to as a "Double Epidemic," the devastating physiological and psychological consequences of methamphetamine use and its contribution to the increasing risk for HIV transmission.
- Although research demonstrates that methamphetamine use is linked with high-risk sex practices among gay and bisexual men (Frosch et al., 1996; Halkitis et al., 2003, 2005b; Parsons & Halkitis, 2002; Paul, Stall, & Davis, 1993; Reback & Ditman, 1997; Stall, McKusick, Wiley, Coates, & Ostrow, 1986; Stall & Wiley, 1988, Woody et al., 1999), this behavior appears to be layered with complex behaviorally and psychologically driven motivations that vary depending on the contextual factors and the personality traits of those who use the drug (Halkitis et al., 2006).

Women

- Researchers are exploring gender differences and methamphetamine use. For example, Brecht and colleagues (2004) and Covey (2007) found several gender differences in selected aspects of methamphetamine involvement:
  - Females were more likely to be introduced and gain access to methamphetamine from husbands or boyfriends than males were from wives and girlfriends. Men were more likely to be introduced and gain access to the drug through friends and coworkers.
  - Males were more likely to inject drugs than were females.
  - Males were more likely to sell drugs than were females.
  - Females were more likely to report skin and high blood pressure problems than were males.
  - Females had longer first-time treatment episodes than males did.
  - Males used a wider variety of drugs than did females.
- Hser and colleagues (2005) studied gender difference of people who use methamphetamine in California. The researchers conclude, "Women in our sample, most of whom were of child bearing age or had children, demonstrated more severe problems than did men." They added, "Many [women] were unemployed, relied on public assistance, and suffered from severe psychiatric problems." Hser and colleagues (2005) specifically found:
  - Women reported methamphetamine use at an earlier age (19.2 years) than males did (20.6 years) (UCLA Integrated Substance Abuse Programs, 2006–2009).
  - Women reported significantly more prior treatments for drug use than men did (National Drug Intelligence Center, 2006).
  - Women were significantly more likely to be living with their children than were men (National Drug Intelligence Center, 2006).
  - Women in treatment tended to have more psychological symptoms, lower self-esteem, heightened anxiety and depression, and higher rates of childhood sexual abuse than men did (National Drug Intelligence Center, 2006).
  - Women had greater issues regarding employment, children, job skills, and incomes than men did (National Drug Intelligence Center, 2006).

Women use methamphetamine at rates roughly equal to those of men. (UCLA Integrated Substance Abuse Programs, 2006–2009) Surveys of women suggest that they are more likely than men to use methamphetamine to lose weight and to control symptoms of depression. (UCLA Integrated Substance Abuse Programs, 2006–2009) Among women, methamphetamine-related drug disorders may present different challenges to their health, may progress differently, and may require different treatment approaches. More than 70 percent of women dependent on methamphetamine report histories of physical and sexual abuse, and women are more likely than men to present for treatment with greater psychological distress. (UCLA Integrated Substance Abuse Programs, 2006–2009) Many women with young children do not seek treatment or drop out

early from treatment because of the pervasive fear of not being able to care for or keep their children, as well as fear of punishment from authorities in the community. Consequently, women may require treatment that both identifies her specific needs and responds to them.

Overview of *The Summit* Goals and Design

The Summit Goals

The Summit goals define the expected outcomes or deliverables from *The Summit*. The Steering Committee sought to ensure that *The Summit* would have local, State, Tribal, and Federal impacts. Although *The Summit* would focus on methamphetamine and the three critically affected populations, ***there was recognition from the beginning that methamphetamine was the convening topic but that the solutions must be systemic and address the broader challenges of integrating public health and public safety responses to substance abuse***.

The Summit goals are:

1. Synthesize local successes, move States to action, and promote the development of national strategies that participants can use to strengthen and expand existing efforts back home.

2. Identify culturally and linguistically appropriate and relevant products that reflect promising areas of research and evidence-based practices in prevention, intervention, treatment, and recovery management to assist communities in their responses to methamphetamine use in critically affected populations.

3. Forge collaborations across Federal, State, Tribal, and local government agencies and with community partners and establish a mechanism for the creation of collaborative plans with all Federal partners.

The Summit Design

Integrating Public Health and Public Safety

- Partnerships
- Collaboration
- Better outcomes through integrated strategies

Three Target Populations Critically Affected by Methamphetamine

- Justice-involved populations
- LGBT individuals
- Women

Four Strategic Focus Areas for Policy and Program Recommendations

- Data collection and research
- Cultural competency
- Access to substance abuse services
- Best practices

Six Domains in Each Critically Affected Population

- Criminal justice
- HIV/AIDS and other sexually transmitted diseases (STDs)
- Mental health services
- Prevention/public awareness
- Rural issues
- Treatment and continuing care/recovery management and support services

Participants

- 20 State and Territory Action Teams made up of a comprehensive representation of key stakeholders
- Federal partners
- National organizations
- Methamphetamine grantees: CSAT, CSAP, COPS, BJA, Access to Recovery (ATR), and Tribal grantees throughout HHS and the Department of Justice (DOJ)

Summit Structure

A. Plenary Sessions

- All participants
- Four sessions—setting the stage for each strategic focus area
- Data collection and research
- Cultural competency
- Access to substance abuse treatment services
- Best practices
- Build a bridge across the three critically affected populations in each focus area
- Explore commonalities and differences of the three critically affected populations

B. Springboard Sessions

- Break out into the three critically affected populations: justice-involved populations, LGBT individuals, women
- Hold immediately following each strategic focus area plenary session
- Explore the specific needs of the critically affected population as they relate to the strategic focus area
- Stimulate thinking and discussions in follow up small group discussions to generate policy and program recommendations

C. Small Group Discussions

- Purpose—generate policy and program recommendations
- Immediately following the Springboard Sessions
- Small groups organized by domains within each critically affected population
- Discussion of key questions
- Brainstorming policy and program recommendations by domain in each strategic focus area

D. Policy and Program Recommendations

- Refine and prioritize top five recommendations for each strategic focus area
- Make recommendations by domain and critically affected population

E. Action Team Planning at the beginning and end of each day

State/Territorial Action Teams

- All State and Territorial Governors were invited to apply to send an Action Team
- 20 States/Territories were selected based on their applications to participate
- Each Governor identified a State Team Leader
- Each State Team Leader participated in briefings before *The Summit* about the selection of the Team, preparation before *The Summit,* planning time available during *The Summit,* and followup plans for ongoing support and technical assistance as States implement Action Plans.
- Followup reporting of Action Team activities

Action Planning by Other Participants in The Summit

- Federal partners
- National organizations
- Grantees
- Tribal representatives

Federal Policy Recommendations

- Proceedings document
- Ongoing Federal partners' working group to address recommendations
- Four working groups organized on strategic focus areas
- Presentation of findings to stakeholders

Ongoing Access to Resources and Technical Assistance

- http://www.methpedia.org/summit/—site for information about *The Summit*
- Technical assistance available through SAMHSA and its Federal partners
- Monthly conference calls with Action Teams

Summary of *The Summit* Recommendations

The Summit recommendations were developed through small group discussions in each of the three tracks targeting the critically affected populations.

The small group discussions began by discussing two or three questions that explored challenges or barriers to addressing the needs of the target population within the context of the domain and the strategic focus area. Participants then brainstormed solutions to the challenges they identified. Their discussions were recorded on worksheets that were compiled for refinement during the final session of *The Summit*.

During the final session, the small groups received all recommendations developed within their domain and critical population for each strategic focus area. They then reviewed the combined recommendations, prioritized their top five recommendations for each question, and refined language for the recommendations. Recommendations were submitted by each small group organized by domain within each critically affected population.

The prioritized recommendations for each critically affected population and strategic focus area are provided in their entirety here and serve as the foundation for the three working groups organized by SAMHSA to follow up on implementing *The Summit* recommendations. All the work of the small group discussions have been recorded, including the brainstorming, and are posted to *The Summit* Web site on Methpedia.org for *The Summit* participants and use by the Federal partners and working groups.

This section summarizes the crosscutting recommendations in each strategic focus area. In addition, unique areas that emerged, either for each critically affected population or by domain, are included. This analysis does not represent all key ideas generated but rather gives an overview of the recommendations that emerged from *The Summit* and that form the basis of the Action Plans for each strategic focus area.

Data Collection and Research

1. Increase local, State, and national funding for substance abuse research that will facilitate data collection, generate data analysis, and target substance abuse issues related to underreported and underserved populations, particularly research related to ethnicity, gender identity, sexual orientation/behavior/attraction, and the unique challenges of Tribal, rural, and frontier areas.

   ### Action Steps

   a. Include sexual orientation/behavior/attraction and gender identity questions in all standardized Federal agency data collection tools such as the National Survey on Drug Use and Health (NSDUH), National Outcome Measures (NOMs), Government Performance and Results Act (GPRA) forms, Monitoring the Future Survey, and the National Health Interview Survey (NHIS).

   b. Seek institutionalization of sexual orientation/behavior/attraction and gender identity questions in all State and local surveys including Youth Risk Behavior Survey Study, Behavior Risk Factor Survey, and community health indicators.

   c. Continue to fund and support the work and development of Statewide Community Epidemiology Work Groups (CEWGs) and drive the process into local community coalitions.

   d. Examine the viability of replicating CEWGs and develop standardized protocols that will allow for data collection across communities and States.

   e. Ensure that data collection efforts across populations monitor emerging trends in substance abuse both in modality and in composition of drug.

   f. Review and modify Federal statutes to require common data elements to be collected and shared across systems (e.g., change regulations in Title 42 of the Code of Federal Regulations and the Health Insurance Portability and Accountability Act).

2. Coordinate data systems across local, State, Tribal, and Federal jurisdictions and across agencies/sectors such as criminal justice, treatment, social services, public health, and child protection.

   ### Action Steps

   a. Develop common definitions to ensure that data sets are consistent and compare appropriate populations and subsections of those populations.

   b. Add requirements to funding that insist on culturally responsive and inclusive questions that speak to women, gender identity, and sexual orientation and address gaps in rural data collection.

c. Identify data and research topic areas such as recidivism, homeless populations, and correlation of violence to substance abuse to explore unique data collection challenges and the impact of these areas on substance abuse in communities.

3. Strengthen the collation, analysis, and dissemination of substance abuse-related data sets across sectors and jurisdictions to support and encourage data-driven substance abuse program and policy decisions.

Action Steps

a. Survey existing CEWGs to determine the level and skill sets of data analysis used in survey review.

b. Identify relevant organizations and systems to engage in data analysis.

c. Set up quarterly reviews of cross-system data collection and disseminate analysis of diverse sectors in justice, health and human services, and education.

d. Review Federal, State, and local policy decisions for data-driven or evidence-based practices.

4. Measure and document resiliency and protective factors in addition to risk factors, particularly for critical populations.

Cultural Competency

Cultural competency should focus on skills and systemic barriers, not skills alone. Cultural competency is needed to address ethnicity, gender, LGBT, HIV/AIDS, and rural issues. The question of using the term *cultural sensitivity* versus *cultural competency* was also raised.

Action Steps

1. Require government-funded programs to demonstrate that staff is culturally competent.

2. Provide cultural competency training for policymakers as well as line staff.

3. Ensure that organizations providing services and providers reflect the cultural aspects of the community that is seeking services.

4. Link consistent and sustained cultural competency training with professional/facility credentialing/licensing and include training in professional schools.

Access to Substance Abuse Treatment Services

1. Address the unique barriers for women, LGBT individuals, rural and Tribal populations, youth, people of color, and criminal justice clients.

   ### Action Steps

   a. Create and implement policies and materials that support inclusivity and diversity.

   b. Include access to transportation and child care for individuals receiving substance abuse treatment services.

   c. For rural areas and Territories, assess efficacy and leverage technologies differently, recognizing the limited number of providers (e.g., tele-health programs, e-learning for providers, government grants) that allow treatment of persons across jurisdictions.

   d. Remove requirements that clients must be HIV positive to access substance abuse treatment services.

2. Increase integration and coordination of systems and services (e.g., mental health, substance abuse, criminal justice, public health, case management, HIV/AIDS, veterans).

   ### Action Steps

   a. Create a funding mechanism to research and document cost benefits related to prevention in urban, Tribal, border, rural, and frontier areas. Use the findings to prioritize efforts, make funding decisions, and distribute funding effectively.

   b. Evaluate the current structure and priorities of prevention and treatment funding with the goal of equalizing efforts.

3. Ensure a comprehensive continuum of substance abuse treatment services, including pretreatment services, in funding and policy infrastructures.

   ### Action Steps

   a. Focus on distinct access needs of transgender people—make no assumptions about their provision of care.

   b. Develop a pool of funding from multiple Federal agencies that can be invested in family-centered treatment for those who are incarcerated and those in the community.

   c. Clearly identify potential coordination components within various Federal agencies and organize strategies for cross-site collaboration.

4. Develop government and provider policies to promote offender-, LGBT-, and women-friendly substance abuse treatment services.

   ### Action Steps

   a. Promote funding for open access support and paraprofessional services. Support funding for technological strategies to improve access for people isolated because of stigma, health/mobility, and geographical locations.

   b. Help build infrastructure in rural areas, including such agencies as the Centers for Medicare & Medicaid Services (CMS), IHS, Department of Veterans Affairs (VA), and rural health/community centers.

   c. Develop and implement cost-effective student loan forgiveness programs that will promote substance abuse treatment services workforce development and assist with recruiting qualified people who are representatives of the vulnerable populations.

Best Practices

1. Allow for flexibility in all Federal grants. Many State and community-based programs that reach underserved populations have implemented promising strategies that have shown positive outcomes, but the programs have not gone through a rigorous evaluation process. Identify mandatory components of best practices, allowing evaluated best practices to be used as a guide and requiring States to demonstrate evaluation results regardless of the strategies implemented. Develop evaluation tools where none exist.

2. Develop venues and collaborations for connecting research to practice and practice to research.

   ### Action Steps

   a. Use local evaluators and universities and colleges affiliated with a research center to evaluate grassroots efforts, including possible funding and stipends. Once a working relationship with the evaluator has been established, expand the content area to include trauma and perinatal components.

   b. Build infrastructure for primary behavioral health interventions across the multiple systems (e.g., child welfare system), implementing best practices and using technologically sophisticated dissemination practices in rural/frontier communities.

3. Develop cross-agency strategies for dissemination of data and information about programs and projects.

Action Steps

a. Develop a clearinghouse/database of emerging interventions, including adaptations.

b. Increase support for building the evidence base of emerging interventions.

c. Build on existing efforts to document and disseminate best practices through agencies/systems such as the Addiction Technology Transfer Centers (ATTCs), NIDA, SAMHSA, and CDC.

Unique Issues

1. Address the issue of trauma as a cause or contributing factor to substance abuse, particularly for women and LGBT populations.
2. Address the issues of social stigma, discrimination, and homophobia as contributing factors to substance abuse for LGBT individuals.
3. Develop a Treat America model to increase the number of treatment providers in rural areas using a student loan forgiveness incentive.
4. Make sure that all of the work of *The Summit* does not go to waste—ensure an ongoing mechanism to respond to the recommendations and to demonstrate results or implementation of the recommendations.

The Summit Agenda-At-A-Glance

Sunday, November 16, 2008

Time	Session
12:00 p.m.–6:00 p.m.	Registration Opens
1:00 p.m.–4:30 p.m.	LGBT Training
5:30 p.m.–6:30 p.m.	Reception
6:30 p.m.–7:00 p.m.	Welcome and Introduction
7:00 p.m.–7:15 p.m.	Plenary Keynote
7:15 p.m.–8:15 p.m.	Plenary Respondent Panel (one respondent for each population)

Monday, November 17, 2008

Time	Session
7:00 a.m.–5:00 p.m.	Registration
8:30 a.m.–9:15 a.m.	Plenary: Welcome and Overview of Agenda
9:15 a.m.–9:30 a.m.	Break—Transition to Tracks
9:30 a.m.–10:15 a.m.	Concurrent Springboard Presentations: Data Collection
10:15 a.m.–11:15 a.m.	Group Facilitation by Domain
11:15 a.m.–11:30 a.m.	Report Out from Domain within Critical Population Groups
11:30 a.m.–12:30 p.m.	Break—Action Team Meetings Over Lunch
12:30 p.m.–1:15 p.m.	Critical Populations: Their Needs, Their Rights, and Their Access to Services
1:15 p.m.–2:30 p.m.	Defining Innovations and Emerging Responses Related to Cultural Competency Plenary Respondent Panel
2:30 p.m.–2:45 p.m.	Break—Transition to Tracks
2:45 p.m.–3:30 p.m.	Concurrent Springboard Presentations: Cultural Competency and Demographic Sensitivities
3:30 p.m.–4:30 p.m.	Group Facilitation by Domain

Time	Session
4:30 p.m.–4:45 p.m.	Report Out from Domains within Critical Populations
4:45 p.m.–5:00 p.m.	Break—Transition to Plenary Session
5:00 p.m.–5:30 p.m.	Plenary Keynote: Access to Treatment and Recovery—Issues, Challenges, and Opportunities
5:30 p.m.	Action Team Meetings

Tuesday, November 18, 2008

Time	Session
7:00 a.m.–5:00 p.m.	Registration
8:30 a.m.–9:15 a.m.	Concurrent Springboard Presentations: Substance Abuse Services and the Barriers to Access
9:15 a.m.–10:15 a.m.	Group Facilitation by Domain: Services and Access
10:15 a.m.–10:30 a.m.	Report Out from Domains within Critical Populations
10:30 a.m.–10:45 a.m.	Break—Transition to Larger Group
10:45 a.m.–11:45 a.m.	Plenary: Considerations in Identifying and Replicating Best Practices—Turning "Promising" Practices into "Evidence- Based" Practices
11:45 a.m.–12:45 p.m.	Break—Action Team Meetings Over Lunch
12:45 p.m.–1:30 p.m.	Plenary: Current Best Practices to Address Critical Populations
1:30 p.m.–1:45 p.m.	Break—Transition to Tracks
1:45 p.m.–2:30 p.m.	Concurrent Springboard Presentations: The Challenges and Opportunities of Implementing Best Practices and Effective Programs
2:30 p.m.–3:30 p.m.	Group Facilitation by Domain: Implementing Best Practices
3:30 p.m.–3:45 p.m.	Report Out from Domains within Critical Populations
3:45 p.m.–4:00 p.m.	Break—Transition to Plenary Session
4:00 p.m.–5:00 p.m.	Plenary: Future Funding and Support for Activities Related to this Initiative—Panel Discussion
5:00 p.m.	Action Team Meetings to Discuss Key Lessons Learned (Meetings can move to dinner meetings)

Wednesday, November 19, 2008

Time	Session
8:30 a.m.–9:15 a.m.	Concurrent Springboard Presentations: Recommendations
9:15 a.m.–10:15 a.m.	Group Facilitation by Domain
10:15 a.m.–10:30 a.m.	Report Out from Domains within Critical Populations
10:15 a.m.–10:30 a.m.	Transition to Plenary Session
10:45 a.m.–11:15 a.m.	Process Wrap-Up and Summary Report Out for all Critical Populations Results and Recommendations
11:45 a.m.	Call to Action Appreciation for Participants' Effort Closing Remarks

Summary of *The Summit* Presentations: Plenary and Springboard Sessions

The following descriptions are based on information provided in the original presentations given by the referenced speakers. For information on references in or pertaining to these presentations, please contact the speakers directly. For contact information, refer to the Participant List at the end of this document.

Sunday, November 16, 2008 (evening session)

Greetings from Federal Partners

- **Kana Enomoto**, MA, Acting Deputy Administrator
  SAMHSA
- **Richard Kopanda**, MA, Acting Deputy Director
  CSAP
  SAMHSA
- **Laura W. Cheever**, MD, ScM, Deputy Associate Administrator/Chief Medical Officer
  HIV/AIDS Bureau
  HRSA
- **David Purcell**, PhD, Acting Chief, Prevention Research Branch
  Division of HIV/AIDS Prevention
  CDC
- **Lucinda Miner**, PhD, Deputy Director
  Office of Science Policy and Communications
  NIDA
- **Lorenzo Olivas**, MPH, Regional Minority Health Consultant
  OMH, Region VIII
  HHS
- **Wanda K. Jones**, DrPH, Deputy Assistant Secretary for Health (Women's Health)
  OWH
  HHS
- **Andrew Kessler**, Advocacy for Substance Abuse Mental Health Consultant, Friends of SAMHSA

Federal partners welcomed attendees and thanked Dr. Edwin Craft (*The Summit* Project Officer with CSAT), SAI, and DB Consulting Group, Inc. for their roles in organizing the meeting. Speakers highlighted the need to make the most of limited spending during tight budget times, focus on prevention strategies to curtail future methamphetamine abuse, and collaborate across agencies and constituencies. They further noted that, contrary to a once widely held belief, methamphetamine addiction is indeed treatable.

Statement of Purpose and Overview of the Agenda

James E. Copple, Principal Event Facilitator, SAI, *The Summit* Facilitator

Following the Federal partners panel, Mr. Copple outlined the purpose and overview of *The Summit* agenda. He noted that methamphetamine abuse began as a "Hawaii and California problem" that moved East over the past 12 years. *The Summit* was designed to determine what Federal, State, and local agencies can do to address this problem.

The Summit Goals

- Learn from State innovations and local successes.
- Understand the different responses required by the different critically affected populations.
- Foster collaboration among Federal, State, and local agencies.

Four Strategic Focus Areas

- Gaps in data and research
- Cultural competency
- Barriers to access to substance abuse services
- Best practices

The Summit was designed "to get to outcomes" and concrete recommendations in four strategic focus areas. Following *The Summit*, Action Teams will determine next steps and CSAT will host followup conference calls. Action Teams from 20 States/Territories attended *The Summit*.

Plenary Keynote Session: 7:00 p.m.

Commonalities–Intersections Between Public Health and Safety Challenges in Critical Populations Affected by Methamphetamine

Edwin Craft, PhD, MEd, LCPC, Lead Government Project Officer and Activities Coordinator for Methamphetamine, CSAT, SAMHSA, introduced Dr. Clark.

H. Westley Clark, MD, JD, MPH, CAS, FASAM, Director, CSAT, SAMHSA

Dr. Clark welcomed participants via videotape to *The Summit*. The background data Dr. Clark cited included information from the Treatment Episode Data Set (TEDS) that showed a 127-percent increase in use among admissions to drug abuse treatment between 1995 and 2005 (SAMHSA, 2007). Although methamphetamine use in the United States has recently shown signs of decreasing in some sectors (e.g., lifetime use between 2002 and 2007 decreased from 8.1 to 6.3 percent for men and from 5.1 to 4.3 percent for women), its use among individuals ages 12 and older remains relatively stable (SAMHSA, Office of Applied Studies [OAS], 2008). Over this time, age of first use fluctuated, indicating that the indices of community availability continue to need an emphasis on prevention, treatment, and supply reduction (Mumola & Karberg, 2004).

The reason for focusing on the three critical populations is that methamphetamine use has disproportionate impact on these groups. Law enforcement identifies methamphetamine as one of the most difficult drug issues it faces. The LGBT community faces psychosocial pressures that increase susceptibility to methamphetamine use. More than seventy-five percent of women dependent on methamphetamine report histories of physical and sexual abuse (Cohen, Dickow, Horner, Zweben, Balabis, Vandersloot, & Reiber, 2003). Women with young children do not seek treatment or do not stay in treatment for fear that they may lose their children (UCLA Integrated Substance Abuse Programs, 2006–2009). We face challenges meeting the needs of all three of these populations from both criminal justice/public safety and public health perspectives.

CSAT has invested significant resources in effective treatment strategies through such programs as Access to Recovery (ATR); Screening, Brief Intervention, and Referral to Treatment (SBIRT); and Targeted Capacity Expansion (TCE)—Methamphetamine. Dr. Clark noted that CSAT efforts are all about outcomes: Do our programs make a difference? He reminded participants that we know treatment can work. For those in treatment, outcomes data from CSAT programs show a 41-percent decrease in use; we see improvements in employment, housing, and social connectedness and decreases in criminal activity. The TCE—Methamphetamine projects have seen even more robust reductions in use (Services Accountability and Improvement System, SAMHSA, 2008).

We are seeing a major paradigm shift in the treatment field. The focus is shifting to recovery. Recovery is a process of change. The Recovery-Oriented Systems of Care (ROSC) approach is person centered. We know that most people experience multiple treatment episodes and that it

can take an average of 9 years before they experience 1 year free of substance use. Addiction is a chronic disease not an acute disease—a disease treated only when symptoms are severe. The shift to ROSC focuses on a self-managed, person-centered, self-directed approach to care that builds up the strength and resiliency of individuals, families, and communities with a comprehensive menu of services and supports.

A system that focuses on a continuous treatment response and self-care will help people move into a recovery zone, as will early intervention and support for sustained recovery efforts. Adopting the person-centered, self-directed approach to care does not mean people will not have relapses, but that relapses are managed as temporary episodes.

There are many different pathways to recovery for different people, and that is why various supports must work together in harmony with the person in recovery and why an integrated outcomes-driven response to safety and health treatment is needed. Dr. Clark concluded his remarks by thanking the numerous Federal partners that had made *The Summit* possible. He also thanked the Tribal representatives, State/Territorial Action Teams, national organizations, and grantees for their participation in *The Summit*. Dr. Clark indicated his interest in the results of their thinking together, working together, and providing input and guidance to the Federal Government. He noted that SAMHSA is considering a number of followup activities to *The Summit*, including supporting the State/Territorial Action Teams with the development and implementation of their Action Plans.

Plenary Respondent Panel: 7:15 p.m.

Commonalities–Intersections Between Public Health and Safety Challenges in Critical Populations Affected by Methamphetamine

Kathryn Jett, Undersecretary of Adult Programs, California Department of Corrections and Rehabilitation

There has been a basic disconnect between the public health perspective on addiction and the criminal justice perspective. One of *The Summit*'s goals is for the public health and criminal justice systems to collaborate on remedies to successfully address the methamphetamine use problem.

Looking back, we see that the criminal justice system was years ahead of the public health system in its recognition of the methamphetamine crisis. Criminal justice's involvement came through its discovery of methamphetamine labs and its response to the effects these labs had on children and other related issues. The criminal justice system was aware of the consequences of methamphetamine addiction but was too busy dealing with prison overcrowding to address the issue, and parole agents had no choice but to incarcerate offenders for their methamphetamine use.

California has one of the worst recidivism rates in the country. When Ms. Jett assumed her job as California's undersecretary for corrections and rehabilitation, she learned that:

- The age of first use for methamphetamine of inmates in treatment programs in California was 20 (California Department of Alcohol and Drug Programs, 2007). Although the age of first use is substantially older than for many other drugs, the State's drug prevention funding was targeted at youth rather than at young adults.
- By 2004, methamphetamine had overtaken alcohol and heroin as the most commonly reported drug problem in California. (California Department of Alcohol and Drug Problems, 2001). Until then, it had been assumed that alcohol would remain the most problematic. Most participants (78.5 percent) met *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for having an alcohol and/or drug-related disorder (i.e., abuse or dependence) (Office of Substance Abuse Programs, 2003).
- In California, 24 percent of parolees who returned to prison were returned by the courts and 76 percent of parolees who returned to prison were returned by their parole board. For all other States except California, 35 percent of parolees who returned to prison were returned by the courts and 65 percent of parolees who returned to prison were returned by their parole board (Bureau of Justice Statistics, 2008).

The individuals who are addicted and who come out of corrections need the most help and are the hardest to treat. For information on relevant evidence-based practices, Ms. Jett referred *The*

Summit attendees to the National Institute of Corrections Web site (http://nicic.gov). She also cited http://www.adp.ca.gov/ for treatment data on LGBT and other populations in California. Additional information is available from the California Department of Alcohol and Drug Programs via email (askadp@adp.ca.gov) and the California Department of Corrections at http://www.cdcr.ca.gov/.

Perry N. Halkitis, PhD, Professor of Applied Psychology and Public Health, Associate Dean for Research and Doctoral Studies, New York University

Dr. Halkitis discussed methamphetamine use among the male gay and bisexual community, particularly with respect to HIV/AIDS and health and financial implications. He also identified issues that need to be addressed in working with this population.

Methamphetamine addiction is not just a gay problem. A true understanding of this problem drug cannot be ascertained by focusing solely on this population. The diversity of people who use methamphetamine speaks to the need to understand this drug addiction from holistic and biopsychosocial perspectives. As examples, he pointed to a 35-year-old single working mother in Des Moines with three jobs and four children; an 18-year-old who has just emerged in the gay community of New York City; and a 60-year-old truck driver—all addicted to methamphetamine.

Although no population-based data for methamphetamine use among gay and bisexual men and other men who have sex with men (MSM) are available, estimates have ranged from 7.4 to 62.0 percent. Data collection for MSM is seriously hindered because sexual orientation is not measured in most large-scale studies.

Use Patterns

- Methamphetamine use in Los Angeles, Miami, and San Francisco is spread across ethnic groups; it is not just a gay White man's drug. (Choi, Operario, Gregorich, McFarland, MacKellar, & Valleroy, 2005; Fernandez, Bowen, Varga, Collazo, Hernandez, & Perrino, 2005; Halkitis, Moeller, Siconolfi, Jerome, Rogers, & Schillinger, 2008)
- Many gay and bisexual men who use methamphetamine engage in multiple drug use. Patterns of multiple drug use cross ethnic and racial lines (Halkitis, Green, & Mourgues, 2005; Halkitis, Palamar, & Pandey, 2007; Lee, Galanter, Dermatis, & McDowell, 2003).
- Use has been noted in Latino, Black, and Asian/Pacific Islander MSM and among gay and bisexual high school students (Lampinen, McGhee, & Martin, 2006).
- Methamphetamine use among 18- to 29-year-olds is not as prevalent as it is in older gay men, according to a recent study. Men become initiated into this drug as they get older (Halkitis, Moeller, & Siconolfi, 2009).
- Some men use methamphetamine only on weekends—the effects can last all week (Halkitis, Parsons, & Wilton, 2003; Halkitis & Shrem, 2006).
- Snorting, inhaling, and smoking are the main forms of intake.

Questions to Address

- How do gay and bisexual men actually use methamphetamine?
- What are the national trends?
- How do we encourage legislators to measure sexual orientation in large-scale, national surveys such as the NSDUH?
- How can we combat methamphetamine addiction when clubs are not the main social venues in which the substance is used?
- How do we encourage gay and bisexual men to seek treatment when many see their "weekend" use as non-problematic?

Health Implications

Dr. Halkitis reviewed the long-term health effects of methamphetamine abuse, including heart attack, stroke, depression, and brain damage.

Financial Toll

The monthly cost of methamphetamine is about $159, compared with $775 per month for other substances. More than 65 percent of the men who use these drugs have an average monthly income of $1,600 or less. (Jerome & Halkitis, 2009)

Methamphetamine and HIV

Dr. Halkitis discussed methamphetamine, sex, sexuality, and sexual risk-taking behaviors among gay and bisexual men. The interconnectedness between methamphetamine use and the potential perpetuation of HIV through sexual risk-taking behaviors aggravates a dual epidemic. Methamphetamine has aphrodisiac qualities. The drug reinforces the sexual identity of the user, although not every man who uses methamphetamine is going to have unprotected anal sex.

The negative effects of methamphetamine are more pronounced in those who are HIV positive. Methamphetamine use has increased significantly among people living with HIV/AIDS because of immune systems already ravaged by the virus. The drug may increase HIV replication and mutation in the brain and can have negative interactions with certain HIV medications. Death could result from the rupture of brain blood vessels, cardiac failure, or hypothermia.

Issues to Address

- How do we work with gay and bisexual men to enhance their self-identity so that they do not rely on drugs such as methamphetamine to alleviate feelings from gay-related stigma?
- How do we give men the tools they need to engage in less risky sexual behaviors when they are under the influence?
- How do clinicians and other healthcare providers empower gay and bisexual men to care for their own health at a time when some may not perceive the sexual risk that leads to HIV as dangerous or problematic?
- How should HIV prevention and methamphetamine prevention function synergistically in the gay community?
- How do multiple drug use combinations affect the physical, emotional, and social well-being of gay and bisexual men and their social circles?
- How do we intervene to prevent drugs such as cocaine and Ecstasy from acting as gateways to methamphetamine use?
- How can addiction treatments be tailored to address the multiple addictions that often extend beyond methamphetamine?

Linda Tippins, Executive Vice President, San Antonio Fighting Back

Ms. Tippins was passionate about the need for collaboration among those working in the fields of prevention, continuing care, and recovery. She stated that people "need to lay egos aside" and that "we are all in this [fight] together." Many strategies are needed to address the illness of addiction, and it is up to the States to develop Action Plans and implement them effectively.

Ms. Tippins discussed the far-reaching societal implications of methamphetamine addiction. For instance, as more women with addictions continue to be sent to prison, more children will lose their mothers. That means they will either be uncared for or will have to be taken in by relatives.

Prevention has become a "stepchild" in the area of methamphetamine addiction. She called for a greater emphasis on prevention practices because prevention works for every age group—from the very young to the very old.

Ms. Tippins noted that CSAP funds 12 grants across the Nation to address methamphetamine prevention. This funding helps communities intervene with evidence-based prevention strategies and expand substance abuse prevention programs and systems to stop abuse of methamphetamine. A list of these grants is on page 97.

Monday, November 17, 2008, Plenary Session: 8:30 a.m.

SAMHSA's National Surveys Addressing Methamphetamine: Overview of Data Collection and Challenges

Jack Stein, PhD, LCSW, Director, Division of Services Improvement, CSAT, SAMHSA, introduced Dr. Delany.

Peter J. Delany, PhD, LCSW-C, OAS/SAMHSA

Dr. Delany discussed what SAMHSA data sets do and do not tell us about methamphetamine and how they can be updated. He said he was committed to opening data sets in a number of new ways; SAMHSA wants to know the best way to disseminate data to attendees. Dr. Delany said SAMHSA obviously has more work to do because only about a third of the attendees queried in the audience said they were familiar with SAMHSA's three databases.

National Survey on Drug Use and Health

- The 2007 NSDUH received information from 67,870 respondents.
- Figures for methamphetamine have not declined since 2002. It is a stubborn drug.
- Most people using methamphetamine take multiple drugs. They are listed as methamphetamine users because methamphetamine was their primary drug at the time they were surveyed.
- 4.1 percent of the population takes stimulants.
- 2.0 percent of people who begin taking a stimulant drug in a particular year will begin taking methamphetamine.

Treatment Episode Data Set

Smoking methamphetamine has grown over time. Sixty-four percent of TEDS respondents report this method as their primary route of administration. Injection and inhalation as routes of administration are declining. These are important data for designing treatment.

About 1.1 million people are in substance abuse treatment, but most people who use methamphetamine do not make it into treatment. They end up in jail.

National Survey of Substance Abuse Treatment Services (N-SSATS)

N-SSATS provides facility-level data on who are in treatment facilities on any given day and their age, race, and income. It also provides demographic and drug use data.

Attendees at *The Summit* can get more information on these three surveys and questionnaires from the SAMHSA Web site (http://www.samhsa.gov/). Attendees should think about what kinds of information they need. SAMHSA reports on survey data every other week. It will start looking at methamphetamine more deeply, but attendees also can get the data online at

http://www.oas.samhsa.gov/ or through the public use files on the Substance Abuse and Mental Health Data Archive Web site at http://www.icpsr.umich.edu/icpsrweb/samhsa. Anyone can get specific information by contacting the OAS data request line at http://www.oas.samhsa.gov/Mail/email.cfm.

To address cultural competency in the data collection, field staff members are trained in culturally competent strategies. SAMHSA wants to move into the area of private practitioners to capture different data. Dr. Delany told attendees to think about the kinds of data they need to drive policy. Possibly SAMHSA already has the data it needed but just has not publicized them.

Dr. Delany urged attendees to think about the policy issues related to national data collection that need to be addressed and identify the gaps in research or data that need to be closed.

Springboard Sessions: 9:30 am

Data Collection and Needs: What Do We Know and How Do We Know It?

JUSTICE-INVOLVED SPRINGBOARD PRESENTATIONS ON DATA COLLECTION

Barry Zack, MPH, Chief Executive Officer, Corrections & Health, The Bridging Group

People who enter prison have higher rates of infectious diseases, such as HIV, hepatitis C, and tuberculosis, than do those in the general community. Chronic conditions, such as hypertension and diabetes, are also more pronounced among methamphetamine users who are incarcerated (Wilper, Woolhandler, Boyd, et. al., 2009). Although people in correctional facilities who use methamphetamine suffer from significantly more health problems than does the general population, these facilities are also legally required to provide treatment. After release, their medical treatment is interrupted and their medical conditions tend to go untreated.

Mr. Zack cited a number of statistics that underscore the problem in correctional facilities:

- About 25 percent of people living with HIV/AIDS in the United States spend time in a correctional facility in any given year (Maruschak, 2009).
- Rates of sexually transmitted infections (STIs), hepatitis, and tuberculosis are significantly higher for these populations (Hammett, Harmon, & Rhodes, 2002).
- Prevalence of mental illness is from 45 to 64 percent (James & Glaze, 2006).
- Substance use is as high as 75 percent (Zack & Kramer, 2009).
- Chronic conditions (e.g., hypertension, diabetes) are common (Wilper, Woolhandler, Boyd, et. al., 2009).

Mr. Zack delineated the professional cultural "disconnect" between public health and corrections; they have different missions with different approaches.

Public Health	Correctional Setting
Mission: change oriented	Mission: order oriented
Humanitarian	Paramilitary
Dress: informal	Dress: uniform
Prevention/care/diagnosis	Punishment (rehabilitation)
Client centered	Institution centered
Flexibility	Rules
Creative	Standard operating procedure

Data collection for health research and program evaluation in criminal justice typically pertains to:

- Criminal behavior
- Health status
- Health behavior
- Risk behavior
- Prevalence and incidence rates
- Program intervention outcomes
- Treatment outcomes
- Recidivism

Mr. Zack said *recidivism,* as an outcome measure, is defined differently by various jurisdictions or research investigators. Is recidivism "return to custody" for a new conviction (only) or does it include parole violators? Does any interaction with law enforcement constitute recidivism? Conceptual issues to review include:

- What should be the timeframe for defining recidivism—3 months, 6 months, 1 year, or longer?
- If there was a treatment outcome, did the client stop using, use less, or turn to a less risky drug?
- Is a treatment/intervention for injecting methamphetamine considered a failure if, after being released from prison, the person is re-incarcerated for smoking marijuana?

Mr. Zack urged attendees to look for evidence-based programs to replicate and indicated that the Project START research study illustrates the effectiveness of interventions for incarcerated populations. (Wolitski, R.; the Project START Writing Group, 2005; Grinstead, Eldridge, MacGowan, Morrow, Seal, & Sosman, 2008) This multisession intervention program focused on the sexual risk behavior of 561 young men between ages 18 and 29 who were leaving prison. The comprehensive and single-session interventions were based on extensive formative research with incarcerated men inside and outside prison. A key finding was that fewer men involved in the multisession intervention program reported that they were having unprotected anal or vaginal sex 6 months after their release.

Priscilla Lisicich, PhD, Executive Director, Safe Streets Campaign, National Methamphetamine Training and Technical Assistance Center

Safe Streets is a nonprofit organization that was founded as a grassroots community organizing campaign to impact illegal drug trafficking and gang activity. Founded through a partnership of government, enforcement, and community members, Safe Streets has mobilized a critical mass of the Pierce County population in Washington State. Safe Streets brings together strategic partners, including corrections and enforcement agencies, community-based organizations, businesses, schools, and local government, to reduce risk factors such as low neighborhood attachment and community disorganization for combating methamphetamine addiction, youth substance abuse,

and gangs. Safe Streets develops effective data-driven strategies and multidisciplinary coalitions for families and communities to reduce problem behaviors, build neighborhood attachments, and contribute to community cohesiveness.

One key strategy to addressing the methamphetamine problem has been to form methamphetamine Action Teams that bring together people from all disciplines in the community. Safe Streets has adopted the Communities that Care operating system, a model mobilization program that assesses community needs and uses qualitative/quantitative data sources to guide strategies to address problem behaviors. The community mobilization plan has reduced substance abuse and crime-related problem behaviors and heightened healthy social norms, including neighborhood attachment and community cohesiveness, by working with individuals, peers, schools, and families.

Safe Streets has had a dramatic impact on the community. Specific accomplishments include:

- Parent and youth programs found 27 percent less drug use in grades five to seven.
- Crime data from an organized neighborhood show that, in the aggregate, assaults are down 71 percent.
- Data are accessible through the program's Web site (http://ncadi.samhsa.gov/features/ctc/resources.aspx) to help community members learn from their neighborhood and others.
- Drug use is down.

Recently, an expert panel led discussions on drug use among high school students and the latest developments in methamphetamine trafficking. Although the number of local methamphetamine labs has gone down, the highly addictive and damaging drug remains a serious problem in Pierce County (Safe Streets Campaign, National Methamphetamine Training and Technical Assistance Center, 2008).

The objective of community-based models is to organize neighborhoods and communities for action. Support is provided for broad-based coalitions in each focus area to drive area impact plans and ensure adults and youth are involved. The Larchmont block group, 1 of more than 75 organized block groups, helps young people and parents learn about alcohol, marijuana, and methamphetamine use and meets every Thursday at a local church. It has organized a neighborhood patrol, and interested parties can be trained to work with it. Safe Streets collects attitudinal and involvement data, and Larchmont neighbors have demonstrated mutual concern for one another at the 75-percent level (Safe Streets Campaign, National Methamphetamine Training and Technical Assistance Center, 2008).

In addition to linking with law enforcement to prevent crime, Safe Streets also works with corrections so that neighbors can make people feel welcome when people move from the criminal justice system and back into the community. Neighbors work actively to integrate others into their

block groups. Six months before a prisoner is scheduled to return to the neighborhood, the group works with the Department of Corrections to get the prisoner into a reentry program. Family groups are formed to orient incarcerated persons, who are required to participate. If a prisoner does not have a family, an organized group may provide support and help with the reentry process.

LGBT SPRINGBOARD PRESENTATIONS ON DATA COLLECTION

Steven Shoptaw, PhD, Professor of Family Medicine, Dave Geffen School of Medicine, University of California, Los Angeles

With trends showing that methamphetamine use is higher among gay men and other MSM than in the general population, it becomes a necessity to learn why there is such a high preponderance of use in this population. Special consideration must be given to populations whose drug-related sexual practices place them at high risk for HIV. Data indicate that treatment providers need to ask different types of clinically relevant questions so that effective intervention strategies are developed for specific subgroups. Although there is no research to show that culturally competent treatment decreases methamphetamine use, there are data that show people are more likely to stay in treatment when they are in a culturally sensitive environment (Cochran et al. 2007).

Methamphetamine Usage Trends

As a group, LGBT individuals use substances differently than do other groups. According to national household survey data, gays and lesbians are twice as likely to use stimulants (Cochran et al., 2004). Data also show that MSM were twice as likely to use methamphetamine as were straight men, (California Department of Alcohol and Drug Problems, 2008) and reports indicate that up to 13 percent of MSM used methamphetamine in the previous 6 months (Stall et al., 2007).

A survey of gay men showed that 11 percent of those in Los Angeles and 13 percent in San Francisco acknowledged methamphetamine use in the previous 6 months (Stall et al., 2001). Among MSM and MSM and men who have sex with women, Latinos and Whites in these groups indicated they were twice as likely as Black men or other men of color to use methamphetamines, whereas Black men and other men of color used cocaine and were twice as likely to be bisexual (Shoptaw and Reback, 2006).

Intervention Strategies

Tailored interventions to reduce methamphetamine use among LGBT individuals address cultural factors unique to this community and focus on how feelings of stigma and negative personal attributions, internalized or otherwise, are experienced by this group and affect experiences in treatment. Locally funded agencies are unlikely to provide unique services, and mainstream clinic counselors often exhibit neutral or negative attitudes about LGBT individuals, particularly about the connection between methamphetamine and the extreme kinds of sex experienced under its influence. Prevention and treatment programs must address practices unique among this population, such as hormone trading that can lead to the injection of known and unknown substances increasing the risk of contracting HIV and other diseases.

In four separate samples of MSM in Los Angeles whose intensity of methamphetamine use ranged from recreational use to chronic use and included those individuals seeking drug abuse treatment, the association between methamphetamine use and HIV infection increased as the frequency of methamphetamine use increased (Shoptaw & Reback, 2006). These and other data suggest that not all MSM who abuse methamphetamine need residential treatment to recover (Shoptaw, Reback, et al., 2005; 2008). Those who infrequently use methamphetamine may respond well to lower-intensity/lower-cost prevention and early intervention programs, whereas those who use the drug at dependence levels may benefit from high intensity treatment.

The five A's of methamphetamine use treatment (ask, advise, assess, assist, arrange) is a tried-and-true low-cost intervention that can be implemented at each point of contact in health systems that provide care to gay and bisexual men.

Other approaches include contingency management (CM) and culturally tailored cognitive therapy that show efficacy for reducing methamphetamine use and concomitant high-risk sexual behaviors. Four publicly funded CM programs for methamphetamine use are in the west coast: Los Angeles, San Diego, San Francisco, and Seattle. The public health officials in these communities recognize the cost efficiency in using CM as a method to reduce methamphetamine use and as a primary HIV prevention strategy.

Findings (Shoptaw, Reback, et al., 2005) have shown that CM, compared to standard drug treatments, has produced:

- Significantly longer retention in treatment
- Significantly more drug-free urine drug test results
- Significantly longer stretches between consecutive drug-free urine drug test results.

Getting Off, a behavioral treatment intervention for gay and bisexual men who use methamphetamine, is showing positive outcomes with a combination of cognitive-behavioral therapy (CBT) and CM and can be downloaded for free at http://www.uclaisap.org/ (UCLA, 1984–2008).

Key Insights for Providing Treatment

- It often is better to refer transgender individuals to treatment providers who have specific experience working with the transgender population.
- All gay men should be screened for methamphetamine use at each point of contact for primary and mental health care, with referrals to appropriate levels of treatment for those who are ready to reduce or quit methamphetamine use.
- By knowing what fails at the lower levels of methamphetamine use treatment, individuals can learn what they need to do to increase the intensity of treatment to reach their goals.

- For most individuals seeking treatment for the first time, there is no need to start at the most intensive levels. Brief interventions and assessment and community-based programs, such as Crystal Methamphetamine Anonymous (CMA), can help many individuals.
- A concomitant focus on sexual and drug behaviors can reduce HIV risk.

Steve Lee, MD, Assistant Clinical Professor of Psychiatry, Columbia University

Methamphetamine use among MSM is frequently intertwined with sex and Internet use. These three activities, each with its own addictive potential, combine powerfully in a way that increases the risk of addiction, unsafe sexual practices, and contracting HIV. The interrelationship among the three activities needs to be studied to develop effective strategies for prevention, outreach, and treatment.

Negative consequences of methamphetamine use are profound and potentially deadly. They include cardiovascular, neurological, and psychiatric problems, including depression, anxiety and panic attacks, aggression, and impulse dyscontrol (NIDA, 2006).

Chronic exposure to methamphetamine causes significant cognitive deficits that may last for weeks to months after cessation of drug use. One commonly seen example is impairment of executive functioning, in which weighing information and making complex decisions becomes more difficult. Executive functioning is one of the key thought processes used when comparing the negative consequences of methamphetamine use against the positive effects of the drug high. This is of particular concern because this mode of reasoning is the cornerstone of traditional relapse prevention therapy. The high level of cognitive impairment has implications for modifying treatment specifically for individuals addicted to methamphetamine, such as breaking down addiction learning concepts into small, bite-sized pieces; using few complex logical steps; repeating information during the early stages of abstinence; putting more emphasis on non-logic-based strategies, such as CM; employing emotion-based strategies (e.g., visualizing negative consequences with high emotional value) to use limbic brain centers; and considering pharmacologic strategies, such as modafinil, that may enhance cortical activity and cognition immediately after cessation of methamphetamine use, when cognitive deficits are most pronounced.

Association Between Methamphetamine Use and Sex

Methamphetamine use and sexual behavior are deeply intertwined, particularly in the MSM community. Both sexual activity and methamphetamine cause a release of dopamine in the brain that is associated with pleasure, and this chemical release causes a powerful physiological response that reinforces the need to repeat the original behaviors. However, the amount of dopamine released by methamphetamine is approximately 16 times stronger than that released during sex. When sex is paired with methamphetamine, the tremendous release of dopamine is so much stronger that the pleasure of sex without methamphetamines pales in comparison. Every time sex is experienced, it stimulates the same brain pathway that creates a reminder of previous

pleasure with methamphetamine sex but also brings disappointment in not experiencing the same intense degree of pleasure. Therefore, sex becomes one of the most powerful triggers for some individuals addicted to methamphetamine; for many MSMs, sex is the most common cause of relapse. In recovery work, sex must be specifically addressed, with strategies to address this inevitable trigger and to gradually restore satisfaction in sex without methamphetamine.

Data supporting the strong association between sex and methamphetamine use include:

- Chicago 2004: MSM using methamphetamine report twice as many sex partners as MSM who do not use methamphetamine. (Chicago Department of Public Health, 2005)
- Boston: MSM using multiple substances were nine times more likely to have sex without a condom (Mimiaga, Reisner, Vanderwarker, Gaucher, O'Connor, & Medeiros, 2008).
- MSM with STIs were four times more likely to use methamphetamine than MSM without STIs (Hirshfield, Remien, Walavalkar, & Chiasson, 2004)
- UCLA Methamphetamine Treatment Project findings suggested that treatment of methamphetamine dependence is promising for reducing behaviors that have been shown to transmit HIV. In Los Angeles, 61 percent of MSM seeking treatment for methamphetamine dependence had a three to four times higher incidence of being HIV seropositive (Rawson, Gonzales, Pearce, Ang, Marinelli-Casey, & Brummer, 2008).
- Community reactions to campaigns addressing crystal methamphetamine use among gay and bisexual men in New York City are at http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1885400/.

Sex and Internet use can be both compulsive and addictive activities. When combined with the strong, physiologically reinforcing effect of methamphetamine, the combination of the Internet, sex, and methamphetamine create a perfect storm, each contributing to the compulsive repetition of the others. A sample of Internet advertisements on gay sex Web sites illustrate a dramatic difference in the degree of sexual intensity exhibited by those using methamphetamine compared with those not using. Both the types of activities requested and the types of language used clearly demonstrate the hypersexual effects of methamphetamine. For example, there is a higher prevalence of unprotected anal intercourse and "extreme sex."

Effects of Methamphetamine on the Body, HIV, and the Immune System

Methamphetamine significantly impacts the body's interaction with HIV (Liang, Wang, Chen, Song, Ye, & Wang, 2008; Nair, Saiyed, Nair, Gandhi, Rodriguez, & Boukli; Carrico, Johnson, Morin, Remien, Riley, & Hecht, 2008; Maragos, 2002; Theodore, Cass, Nath, & Maragos, 2007; Mahajan, Aalinkeel, Sykes, Reynolds, Bindukumar, & Adal, 2008). It increases the ability of the virus to enter human cells more efficiently and to replicate. It also impairs the immune system in various ways, such as decreasing CD8 cells and B lymphocytes. Methamphetamine has also been found to affect immune cells in a manner similar to HIV, which exhausts immune cells over time, possibly leading

to an even faster decline in immune function in those people already infected with HIV. In addition to methamphetamine's association with unsafe sexual practices (Peck, Shoptaw, Rotheram-Fuller, Reback, & Bierman, 2005; Amphetamine use is associated with increased HIV incidence among men who have sex with men in San Francisco, 2005; Shoptaw & Reback, 2007; Thiede, Jenkins, Carey, Hutcheson, Thomas, & Stall, 2008; Carey, Mejia, Bingham, Ciesielski, Gelaude, & Herbst, 2008; Hirshfield, Remien, Walavalkar, & Chiasson, 2004; Shoptaw & Reback, 2007), the debilitating effect on the immune system may also decrease the body's limited ability to fight initial HIV infection; once HIV infection has occurred, continued methamphetamine use likely adds to the development of subsequent serious and life-threatening infections.

Changing Environment of Methamphetamine Use

Around the year 2000, two major events contributed to the rapid escalation of methamphetamine use on the east coast: the popularization of smoking methamphetamine and the growing number of Internet sex sites. Smoking is a fast and potent method of methamphetamine delivery to the brain. The speed of this particular delivery is associated with more rapid development of addiction, as seen in the rise of cocaine addiction with the advent of smoking crack cocaine.

Internet use in general has the potential for addictive use, and, when paired with sexual gratification, the development of compulsive behavior is even more common. In particular, the method of cruising for Internet sex neatly fits the behavioral model of random intermittent reinforcement. The process of Internet cruising involves logging onto a Web site, searching through potential sex partners, sending out emails, and waiting for responses. The cycle of behaviors that fits the model of random intermittent reinforcement consists of sending out requests, checking emails, receiving negative responses, sending out more requests, checking emails again, until randomly one of the responses is positive. It is common to hear of men who become obsessively engrossed in this process, feeling victorious when they receive a positive response and sometimes enjoying this victory even more than actually following through with the sexual hookup.

Manhunt, a gay male Web site started in 2003 with an initial investment of $800,000, has expanded to a company earning millions of dollars. At one time it was rated the second "stickiest" Web site, meaning that, unlike Web sites that attract initial attention but are unable to sustain it, Manhunt visitors are loyal, returning to the Web site frequently. The sheer popularity, the amount of money that people are willing to spend, and the documented pattern of frequent returns to the site are indicators of the compulsive potential of Internet sex.

The community of MSM who use methamphetamine has evolved over time. The effectiveness of media campaigns to educate the gay community about the dangers of methamphetamine has moved methamphetamine use out of the mainstream, which no longer accepts methamphetamine use as the cultural norm. The community of people who use methamphetamine was driven underground, and the Internet served as one way for this community to stay connected. People who use methamphetamine are now more likely to be found in their homes and at private sex

parties rather than at more traditional MSM venues, such as bars and clubs. This has made finding these individuals for outreach efforts and to conduct research much more difficult. Current estimates of methamphetamine use in the gay community are likely underreporting actual prevalence of use because of inability to reach these individuals.

Dr. Lee conducted an informal study in which he created a fictitious profile on an Internet sex site. The profile contained several words known by people who use methamphetamine as code words for those seeking to inject methamphetamine. Code words are a common method for people who use methamphetamine to identify one another easily from within a large online group of MSM, most of whom do not use methamphetamine. The profile was left online overnight; with more than 1,500 people logged on at any one time, the profile was found by several men seeking sex with methamphetamine. Search engines in sex sites facilitate searching through hundreds or thousands of profiles easily for code words to readily identify others in the methamphetamine-using community; this enables the underground community to stay connected while remaining effectively hidden. Over time, as code words become discovered by those who do not use methamphetamine, old codes are abandoned, and new words slowly emerge.

The frequency of code words for injecting methamphetamine in Internet profiles concurs with anecdotal reports that injection use is now the norm within the methamphetamine-using culture. Many individuals report that injecting has become eroticized and is often the focal activity at sex parties, rather than sex itself.

A notable new phenomenon is the appearance of Internet videos of people injecting themselves with methamphetamine. One of the responses to the Internet profile in Dr. Lee's informal study was an email with an invitation to sex and a link to a video of the emailer injecting methamphetamine. The entire process of injection was clearly shown while the person was narrating, describing his feelings, and showing his facial reaction to the high. The use of visual cues to trigger potential sex partners to want to use methamphetamine with sex is a powerful tool for those looking to compel another individual to agree to have sex and get high.

Dr. Lee showed a second video found on YouTube of a young gay man injecting himself with methamphetamine. Over the 5 months that the video was posted, it was viewed more than 9,000 times. In the past, viewing injections was considered repulsive, but in recent years injecting is attracting more fascination and curiosity, as it is becoming increasingly accepted by the methamphetamine-using community. Among the 9,000 viewers, only a handful posted comments. Notably, none of them condemned the behavior. Rather, comments demonstrated fascination, envy of the experience, and curiosity for what injecting feels like.

Another change in the community of MSM who use methamphetamine is the younger age of new users. Anecdotally, many people report seeing men in their early 20s appearing at sex parties, smoking and injecting methamphetamine, and engaging in unprotected anal intercourse. This new

age group had never been significantly involved in the crystal methamphetamine scene, and it presents new challenges in developing effective outreach and treatment strategies.

The community of people who use methamphetamine has evolved into a new underground, which is more difficult to find, involves younger MSM, and includes individuals who participate in more risky drug use and sexual behavior. We must refine our understanding of this changing community to have a better understanding of the prevalence of methamphetamine use and to develop more effective outreach and treatment interventions.

WOMEN SPRINGBOARD PRESENTATIONS ON DATA COLLECTION

Sheigla Murphy, PhD, Director, Center for Substance Abuse Studies, Institute for Scientific Analysis

Methamphetamine has long been associated with women. Whether it is used to lose weight quickly, manage the demands of family and work, or stave off the "blues," methamphetamine is a very useful drug. To maintain the demands and desires of their daily lives, some women seek help from methamphetamine, often with devastating consequences to themselves and their families.

Admissions to treatment facilities for methamphetamine abuse have increased in the past decade, from 21,000 treatment admissions in 1993 to 121,000 in 2003 (Bureau of Justice Statistics, 2006). Of the 151,649 individuals who entered treatment for methamphetamine abuse in 2006, 45 percent were women (SAMHSA, 2006). In many cities women make up almost 50 percent of arrestees for methamphetamine-related offenses. Among State (17 percent) and Federal (15 percent) prisoners, women were more likely than men to report methamphetamine use in the month before their offense (Bureau of Justice Statistics, 2006).

Methamphetamine use is not a new phenomenon. The United States has a long history with speed. Its use has been endemic for the past 70 years. Factors that contribute to methamphetamine's resurgence have implications for strategies to contain it. For example, efforts to reduce supply by suppressing domestic production and restricting access to the ingredients to make methamphetamine have been generally successful, but they have done little to reduce the demand for methamphetamine. In the long run, this approach has reduced the harms associated with local methamphetamine production at the cost of strengthening drug cartels and expanding the market for more expensive methamphetamine smuggled into the country. Women are often adversely affected as many are driven to engage in crime to obtain money to meet the higher cost of maintaining their habit.

Women's attraction to methamphetamine should not be surprising. Strong cultural and marketing forces encourage women to seek products that will help them lose weight, feel better, and do more. Methamphetamine meets those needs. Many women who currently use methamphetamine are the daughters of women who were prescribed methamphetamine in a previous generation to lose weight, combat depression, or treat bronchial or asthmatic conditions (Uretsky, n.d.). An effective response to women's methamphetamine use must take into account these longstanding

cultural influences and promote strategies that affirm and support women, not merely malign them for their problematic choices.

There is a growing body of research regarding the effectiveness of women-centered treatment programs in assisting women to overcome methamphetamine addiction and the importance of including family preservation as a central component of treatment interventions. The ideal program is comprehensive and integrated, coordinating the various services women need to both maintain abstinence and build successful lives. Our problem is less a lack of information than it is a lack of political and social will. Most women in need of treatment for methamphetamine addiction are still unable to access it. Although there is much to learn about women and methamphetamine, we need to use the knowledge that we have about what works. There is still an inadequate number of treatment programs specifically for women as well as a paucity of programs that treat special populations (e.g., pregnant women, women with infants, women with mental illness, adolescents, lesbians, transgender women).

Why Do Women Use Methamphetamine?

Methamphetamine has always been strongly associated with women. In the 1950s and 1960s, methamphetamine was frequently prescribed as a diet aid. Taken as prescribed, it is an effective weight loss and antidepressant medication. For years, amphetamines were the mainstay of weight-loss therapy. They reduce appetite making dieting much easier and increase energy making functioning without food possible. (Uretsky) For example, during the trial of Jean Harris,[2] it was revealed that her lover and physician, Dr. Tarnower, regularly prescribed Desoxyn (a form of methamphetamine) for her to treat chronic depression (Ferron, 1981).

Today, women use methamphetamine for many of the same reasons they used it in the past: increased energy and self-confidence and decreased appetite to lose weight. The stimulant effect of methamphetamine suppresses appetite, and, because the effect lasts for a long time, women using methamphetamine find it easy to lose weight because they have no desire to eat.

In a country where obesity is a worsening problem, losing weight is often not associated with fitness; it is associated with looking good. The social pressure to be thin, as opposed to becoming fit, has led to a desire for quick and painless fixes that do not require people to change their lifestyles. Methamphetamine provides women who have limited time and resources an alternative to rigorous diet programs and committing to an exercise routine. In addition, methamphetamine gives women who may feel tired, overwhelmed, and unattractive the ability to feel good about themselves even if only temporarily:

- Methamphetamine appeals to women because it gives them energy to take care of their children, maintain their homes, and feel more efficient in everything they do (Uretsky, 2009).

[2] Former headmistress of the exclusive Madeira School for Girls, she was convicted of killing her paramour, Dr. Stanley Tarnower, the Scarsdale Diet Doctor.

- Reducing fatigue, sustaining work, and reducing weight are not only socially acceptable; they are socially rewarded functions of methamphetamine (Rawson, Anglin, & Ling, 2001).
- Most women who use methamphetamine use other drugs to counteract the "wired" feeling that results from prolonged use and lack of sleep (Department of Justice, 1999).

According to a report by the National Institute of Justice, methamphetamine does not produce the type of "physical manifestations of withdrawal associated with other drugs" (e.g., caffeine, nicotine, heroin); however, "some women may experience an intense desire for the drug when coming down, along with depression, decline in energy and the inability to feel pleasure or interest in life. [T]he drastic drop in mood can also make the potential for suicide a serious concern." (National Institute of Justice, 1999) After a prolonged period of use or "run," people who use methamphetamine will fall into a deep sleep that can last for several days. They may also feel nervous, anxious, depressed, and irritable. Although methamphetamine may start out as a miracle drug, over time it has the potential to cause women severe health and social problems.

Dr. Murphy presented some myths about methamphetamine and the facts that challenge them.

Myth: Methamphetamine addiction is voluntary behavior.

Fact: Unlike other drugs people seek for their euphoric effects, many people start using methamphetamine for very practical reasons. What starts out as occasional use becomes compulsive. Why? Because over time, continued use of methamphetamine changes the brain in ways that result in compulsive and even uncontrollable drug use (Leshner, 2005).

Methamphetamine assists users in staying awake, increasing physical stamina, losing weight, and enhancing focus. The initial use of methamphetamine is accompanied by a tremendous feeling of pleasure and euphoria. Over time women often find they need more and more of the drug to achieve the desired effect and to avoid the crash that comes when the effects wear off. With prolonged use women go from using methamphetamine to accomplish something to just using methamphetamine.

Myth: Substance abuse treatment does not work with methamphetamine addiction.

Fact: A growing body of evidence shows that substance abuse treatment programs are effective in treating methamphetamine addiction.

We know treatment works, and treatment programs for methamphetamine users can and do succeed (Luchansky, 2006; Rawson, Marinelli-Casey, Anglin, Dickow, Frazier, & Gallagher, 2004). As with treatment for any other drug, methamphetamine treatment is not a one-size-fits-all process, and effective treatment addresses different populations at different stages of their use. Researchers and treatment specialists are adapting existing programs to meet the needs of people who use methamphetamine and discovering new approaches that address the unique challenges

of methamphetamine use. A comprehensive treatment system should offer a range of options from low-intensity outpatient treatment to more intensive and prolonged treatment.

> **Myth:** Providing specialized treatment for women who use methamphetamine requires expensive new programs.
>
> **Fact:** Existing treatment programs can be adapted to meet the needs of people who use methamphetamine including the special needs of women.

Treatment providers all over the country have been adapting existing programs to address the particular effects that methamphetamine abuse has on women. One example of a successful treatment program is in Salt Lake City, Utah. Valley Mental Health (VMH) has adapted a substance abuse treatment program to meet the needs of a growing number of women seeking help for methamphetamine abuse. Recognizing that not all women need the same level of treatment, VMH offers women a variety of options, ranging from low-intensity outpatient treatment to a full residential program for women and their children. The program allows women to move between systems as they more fully identify their needs and capabilities (Mitchell, 2006).

Summary

Communities have different kinds of methamphetamine problems requiring different solutions. These variations necessitate locally based responses in which health, law enforcement, criminal justice, drug treatment, and social service agencies along with other relevant stakeholders are informed about and sensitive to the unique and shifting traits of the local community and its methamphetamine issues. In the long run, these responses will do better to serve the needs of women.

There are multiple starting points for communities to begin to create or enhance a coordinated, effective prevention, intervention, and treatment system. Success can come from relatively simple steps that make the most of existing services, are sensitive to women's needs, and address the underlying and related problems of methamphetamine abuse.

Linda Tippins, Executive Vice President, San Antonio Fighting Back

The purpose of the Methamphetamine Prevention Partnership is to prevent, reduce, and delay the use and/or spread of methamphetamine. In the United States, treatment admissions for methamphetamine abuse have increased substantially. In 1992, approximately 21,000 people were admitted to methamphetamine-related treatment representing more than 1 percent of all treatment admissions during the year (Bureau of Justice, 2006). By 2004, the number of methamphetamine treatment admissions increased to more than 150,000, representing 8 percent of all admissions. (Bureau of Justice, 2006)

In Texas, the female-friendly meth stereotype holds true—more women are addicted to methamphetamine than men are. In 2008, 59 percent of those admitted for meth addiction were women. There were 3,677 total people admitted to treatment facilities for meth in Texas (All

Treatment, Inc., 2008). It is alarming to the uninformed person to think that over 3,000 people are addicted to meth. That is more people than everyone you know; more people than your immediate family, extended family, and even friends. As such, meth should not be taken lightly.

The criminal justice system's method for capturing methamphetamine data differs from the health system's method. This difference poses problems and makes obtaining methamphetamine data difficult.

Methamphetamine abuse can cause reproductive disorders and birth defects. About 16 percent of people reporting methamphetamine use had their children living with them. Exposure to parents on methamphetamine may compromise child safety. When high on methamphetamine, people often exhibit poor judgment, confusion, irritability, paranoia, and aggression. Children may be at increased risk for violence and sexual abuse. Often, grandparents or other relatives or caregivers must step in to care for the children, especially if the mothers become incarcerated.

Methamphetamine increases sexual activity, sexual pleasure, and extreme kinds of high-risk behavior that lead to contracting HIV and other sexually transmitted diseases (STDs), regardless of how the drug is taken (NIDA, 2006). Evidence suggests the use of methamphetamine (not injected) by heterosexual men and women is associated with unprotected vaginal sex and a higher number of sex partners during the past 12 months. (Molitor, Truax, Ruiz, & Sun, 1998)

Plenary Session: 12:30 p.m.

Critical Populations: Their Needs, Their Rights, and Their Access to Services

Barbara Warren, PsyD, Director, Planning, Research, and Government Relations, The Lesbian, Gay, Bisexual, and Transgender Community Center of New York City

Recent data indicate that at least 15 million Americans identify as lesbian, gay, bisexual, or transgender, with almost 30 percent also identifying as people of color and/or immigrants. These data put the estimate of the LGBT population in the United States at 5 percent of the total population (Mosher, Chandra, & Jones, 2005). The LGBT population is an extremely diverse group crossing every line of class, gender, education, income, religious creed, and background. These data belie the sometimes cultural stereotype of the LGBT community as predominantly White, rich, and male.

The great challenge for the LGBT population in the United States is the achievement of equity: both civil rights equity and health equity. Civil rights equity would include equal rights to marry, to foster and adopt children, to serve unhidden in the military, to be free from discrimination in the workplace and in housing, and so on.

Health equity, as understood in public health literature and practice, is achieved when all people have the opportunity to "attain their full health potential" and no one is disadvantaged from achieving this potential because of his or her social position or other socially determined circumstance including sexual orientation and gender identity and expression.

LGBT individuals in the United States are still routinely denied equal protection under law and are stigmatized by sexual orientation and gender expression identities. As a result, LGBT persons and their families experience health disparities and suffer the effects of social trauma—the result of persistent and often intense hostility toward these identities that is still prevalent in American, and global, society.

But change is coming, and this historic meeting under the auspices of SAMHSA is exemplary of that change. Three charges of *The Summit* are to ensure that that we begin to work on health equity for LGBT persons when addressing the impact of substance abuse and addiction, particularly the challenge of methamphetamine, in a way that is culturally competent; to recognize the need for relevant and sensitive access to prevention, treatment, and recovery support; and to set the example for such efforts across all agencies of government and all aspects of our healthcare system.

Judith Bradford, PhD, Director, Community Health Research Initiative, Virginia Commonwealth University

Women become addicted to methamphetamine at lower levels of use than men (Califano, 2006). They also face stigmas that keep them from seeking help (Haseltine, 2000).

Treatment Strengths for Women

- Women like groups better than men do.
- Women are more likely than men to seek help.
- Women deal more effectively with uncomfortable emotions.
- In some ways, women have an easier time accepting treatment if it is tailored to meet their needs.

Personal Barriers to Treatment

- Acceptability
- Language
- Culture
- Education
- Income
- Attitudes

Women who are addicted to substances are unlikely to get well on their own. It is important to understand women's needs in devising treatment—child care; their interpersonal relationships with family, friends, and peers that constitute their social identity; and the full range of social, cultural, and environmental factors that influence their personal and interpersonal behaviors.

James Copple, Principal Event Facilitator, SAI

About 2.5 million people are incarcerated each year. (Department of Justice, Bureau of Justice Statistics, 2008) Seventy-five percent of the 550,000 people coming out of the criminal justice system have a drug problem (Rounds, 2005). If they are not treated, they create more problems when they are out. We need to respond holistically and inclusively to this problem.

We cannot afford to leave this population behind in our response to the methamphetamine problem in this country. Each population demands a specific and unique approach. Those who are incarcerated come to that experience from a variety of backgrounds that demand examination. For too long, we have taken a punitive approach to people who are incarcerated and are also addicted. If we have any hope or expectation that these individuals will return to the general population without the fear or threat of recidivism, it is necessary that we create access to treatment and treatment management after release.

We have to examine the budgetary impact of methamphetamine use among the incarcerated. In South Dakota, 67 percent of incarcerated women are imprisoned because of methamphetamine

use (Rubinstein & Mukamal, 2002). This percentage has an enormous impact on the State's budget and capacities.

We need better data collection, we need better communication, and we need to better equip and train those who work in the criminal justice system to respond holistically to this population.

Plenary Session: 1:15 p.m.

Defining Innovations and Emerging Responses Related to Cultural Competency

Joseph Amico, President, National Association of Lesbian and Gay Addiction Professionals, Vice President for Program Development and Community Educator, Alternatives, Inc., and Rainbow Bridge Community Services

Some clinics say they deal with methamphetamine treatment and have knowledge of LGBT issues, but there are no clear standards or requirements for having competency in these areas.

More freedom is needed to talk about LGBT issues without judgment. In addition, new curricula will build competence in addressing LGBT issues in methamphetamine addiction treatment.

Mr. Amico commented that methamphetamine is the most insidious drug ever encountered. A lot of programs say they specialize in methamphetamine, but they don't really. No clear standards of competency for treating methamphetamine addiction exist; therefore, this is an issue *The Summit* should address. Attendees at this summit may visit the Pacific Southwest ATTC Web site to download an LGBT training curriculum. The site is http://www.attcnetwork.org/regcenters/index_pacificsouthwest.asp.

Research bears out the effectiveness of culturally specific treatment. Women do better in women-only programs, and ethnic- and cultural-specific programs have successful outcomes. LGBT-specific program for individuals who may question their identity and sexuality have also been successful.

Culturally specific programs can provide a safe environment for people who have been abused and are fearful of their own families and of what people will say. Treatment providers cannot deal with methamphetamine use without discussing sex. They need to help individuals understand methamphetamine use and its relationship to sexual behavior, adjust to sex without drugs, and avoid triggers that may cause a return to drug use.

In Los Angeles the Office of AIDS Program and Policies held crystal methamphetamine town hall meetings, and task forces were created for each of the seven regions of Los Angeles County.

In his 25 years as a substance abuse treatment provider, Mr. Amico said he had never been a proponent of prevention. Now, he thinks prevention is the best way to combat methamphetamine use.

Mr. Amico asked, if the attendees' States have specific standards for cultural competencies for LGBT and crystal methamphetamine treatment? If they do not, why not and when will they get them? Cultural competency in LGBT issues should be required for licensure to treat people addicted to methamphetamine.

Alison Hamilton, PhD, Assistant Research Anthropologist, Integrated Substance Abuse Programs, University of California, Los Angeles

Dr. Hamilton conducted a study of 30 females who use methamphetamine in Los Angeles County. The average age of the women was 28.5 years. Ten were White, 15 were Latina, and two were American Indian. All but one received public assistance. Twenty were using other drugs in addition to methamphetamine. Most were not married. Twelve described early sexual abuse. Nineteen reported same-sex experiences in their lifetimes, though not all of these women self-identified as bisexual or lesbian.

In terms of the relationship between methamphetamine use and sexuality, frequency of sexual encounters does not necessarily equate with enjoyment of sexual encounters. Some women indicated that they would not engage in some sexual activities if they were not using methamphetamine.

The study exposes some familiar characteristics: the women were economically disadvantaged (although three-quarters indicated they had not been economically disadvantaged before their addiction), and they were involved with the justice system, with 30 percent on probation.

Methamphetamine is different from other drugs because of its impact on violence and sexuality. People worry about what is going to happen to their sexuality once they become clean; consequently, sexuality has to be part of a program's cultural competency.

Lt. Brett A. Parson, Acting Lieutenant/Commanding Officer, Special Liaison Unit, District of Columbia Metropolitan Police Department

By the time people who use methamphetamine get involved with law enforcement, they have reached a point of no return—the result will be incarceration or death. Availability of wraparound services could help many people who use methamphetamine avoid numerous tragedies.

In the past, the Washington, DC, police did not routinely test for methamphetamine––testing had to be requested. Police started asking for testing as use of the drug moved east.

In June 2000, the police department became aware that it was not gathering hate crime statistics on gay men. It looked at why hate crimes were not being reported and trained its officers to recognize when such crimes occurred. The fact that the rate of hate crimes is going up indicates that the community has recognized the work the police department has done and is willing to report them. This relates to the difficulty the police department has detecting and combating methamphetamine use in the highly secretive and closed gay community. Officers need to be aware of the problem and have an effective strategy to improve reporting and response.

The Gay and Lesbian Liaison Committee started in Washington, DC, because the Committee wanted to educate officers that sometimes law enforcement is not the best answer. If officers learn to recognize methamphetamine addiction and they know about support services in the gay community, they can use different approaches such as emergency committals and referrals to

treatment programs. Who better to make an arrest than someone who knows the community, and who better than the gay community to make its members responsible for their behavior.

JoAnne Keatley, MSW, Minority Programs Manager, Pacific AIDS Education and Training Center, University of California, San Francisco

Trans is an abbreviated term that includes transgender, transsexual, and other kinds of trans-identified people. A lot of transgender people get erroneously classified as MSM. Various studies have found that trans people use methamphetamine at higher rates than other high-risk groups (Cochran, Peavy, & Santa, 2007; Song, Sevelius, Guzman, & Colfax, 2008).

Incarceration rates for transgender people range from 37 to 65 percent depending on the study (Clements-Nolle, Marx, Guzman, & Katz, 2001; Xavier, Bobbin, Singer, & Budd, 2005; Reback, Simon, Bemis, & Gatson, 2001). Regardless of their location, transgender people are disproportionately arrested and affected by the criminal justice system in this country (Brown & McDuffie, 2009).

Transphobia has been shown to be a barrier to employment, and it may push transgender individuals to engage in sex work (survival sex) and drug use, which often leads to incarceration. Trans teens can end up on the street with no support systems and/or services available.

Trans people often use drugs to cope with the rejection and the societal stigma that come from being transgender. Transphobia in health care is unhealthy! We need a concerted effort to engage and understand populations affected by insidious epidemics such as HIV/AIDS, hepatitis C, and/or other sexually transmitted diseases (STDs).

Harlan Pruden, Council Member, NorthEast Two-Spirit Society3

Native Americans and two-spirit people are often overlooked. The concept of two-spirit does not make sense unless it is embedded in the Native American culture. An estimated 4.5 million American Indians and Alaska Natives live in the United States, and 65 to 70 percent live in urban settings and not on reservations (Pruden) (Ogunwole, 2000). The population of Native Americans is small; that is precisely why they must receive priority status. Once they are gone, they are gone. An estimated 13 percent of the indigenous peoples use methamphetamine (SAIS, 2008).

We know that making healthy decisions comes with the development of self-esteem. Low self-esteem for Native peoples, including the two-spirit community, result from colonization, oppression, racism, loss of identity, and a disconnect among social support structures that reservation life offers. For example, a generation of Native children had their culture beaten out of them at schools like the Carlisle Industrial School, where the philosophy was to "kill the Indian to save the man." Today, social determinants such as poverty, lack of education, and few economic opportunities

[3] The NorthEast Two-Spirit Society (http://ne2ss.typepad.com; also http://www.ne2ss.org/) works to increase the visibility of an advocate for the two-spirit people that call New York City and the surrounding metro area home and to provide social, traditional, and recreational opportunities that are culturally appropriate. At the heart of this effort is community development for our people.

lead to alcohol and drug abuse. Alcohol and illicit drug use among Native peoples is higher than in any other ethnicity (OAS, 2007), and Natives have the highest teen suicide rate.

Community building is a healing process. By using the ancient principles of responsibility to one's community, it has been observed that ending the isolation and healing intergenerational trauma bring Native peoples a powerful antidote.

When working, or attempting to work with Natives, a good place to start is to meet with and get to know community members and leaders—work to win their trust and respect. Success at these efforts could take years and may NEVER happen because of the more than 500 years of broken and empty treaty promises. Hire members of the community to do the work. However, the person who is hired should not be a token hire; he or she should be viewed as an expert who is compensated and treated accordingly regardless of their "paper" education. Partner with community-based organizations and empower and support their work. Finally, resist "colonizing" the process. Given the proper support, a community can tap into the wisdom and knowledge of Native elders. All too often, outsiders think they know better and have dictated what needs to be done.

Cheryl Reese, MHS, LPC, Executive Board Member, NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies

We need to make cultural competency a priority as policies, programs, and treatment interventions are retooled. Addiction providers are having the same conversation they have had for 25 years. After 10 years of offering the same course at Rutgers, the policy and programs improved minimally and the results reported by people attending these classes were unchanged. The pertinent government agencies have not made this a priority.

In the early 1980s, Peter Bell wrote the blueprint for clinical guidelines for cultural diversity. These guidelines were published in 1990 and again in 2002, showing that the profession is spinning in a circle with cultural diversity issues and no plan. This begs the question: Do providers really not know the next right thing to do?

I was asked to address some special populations. Young military men and women do not enter civilian treatment programs. The military has no tolerance for drugs, and people who use them are discharged; consequently, behavior out of the norm is seldom seen in that environment. Tetrahydrocannabinol (THC) is routinely tested for along with cocaine and heroin. Other drugs like steroids, lysergic acid diethylamide (LSD), and methamphetamine are not tested for through random screening because money is not targeted for testing for those drugs. The military has a zero-tolerance policy for drugs. I believe there are thousands of people in the military who use drugs and who end up on our streets.

Today, clinicians treating addiction face many clients with dual diagnoses; the dilemma is whether to address the individual's addiction or trauma first. In the initial stages of treatment, individuals

will not reveal their traumatic past. Following the revelation, the practitioner must decide when to address trauma. In my work, the consumer gradually reduces his/her dependence on the drug of choice as a coping mechanism and slowly tackles the trauma. In those cases, consumers developed new coping strategies and became substance free.

Middle-age Black women who use methamphetamine are at risk for preventable diseases. This population is an invisible group in the treatment setting. Many of these women have not learned how to ask specific questions related to health. These consumers have taken care of others for years and have never prioritized themselves. Addiction recovery is not a priority for them. Health promotion such as nutrition, physical activity, and stress reduction may be a good entry point for building trust and authenticity with these women and would enhance the quality of their recovery.

LGBT individuals yearn for identity, family, connections, and hope. Providers, agencies, and staff need to examine their attitudes and address the fears they have relative to working with this population. These same fears and attitudes can extend from top managers, throughout the staff, and among other agency consumers. LGBT kids are future users of methamphetamine if appropriate services are not inclusive and available.

Components for successful treatment include the following:

- A friendly environment and a diverse staff allow clients to see themselves reflected in the treatment community—these efforts can build a relationship among agencies, counselors, and programs.
- Authenticity can tear down barriers and allow consumers to reach out fully for assistance and become involved in treatment outcomes.
- Commitment to clients and their family is important. Is there a willingness to redefine family?

Springboard Sessions: 2:45 p.m.

Cultural Competency and Demographic Sensitivities in Critical Populations

JUSTICE-INVOLVED SPRINGBOARD PRESENTATIONS ON CULTURAL COMPETENCY

Capt. Kyle Jones, LGBT Liaison, Salt Lake City Police Department

The Salt Lake Valley Gay, Lesbian, Bisexual, Transgender, and Questioning (GLBTQ) Public Safety Liaison Committee began in 2000. The law enforcement community's acceptance of GLBTQ officers is better now than it has ever been. It is particularly good in Salt Lake Valley agencies, but a problem in rural agencies still exists.

The Liaison Committee has brought the department's recognition of GLBTQ issues to the forefront and created a more accepting work environment. Active membership consists of the Utah AIDS Foundation (UAF), City Prosecutor's Office, Utah Pride Center, mental health professionals, community members, law enforcement and fire department representatives, and seven law enforcement agencies representing three counties in Salt Lake City.

Similarly, the Law Enforcement Cultural Awareness Training Program has brought awareness of same-sex domestic violence to three agencies and cultural competency to all Salt Lake City officers.

The Healthy Self Expressions training program for Salt Lake City police officers was launched in 2000 when therapists, vice detectives, prosecutors, and the gay community decided to address the problem of cruising. The program helps men understand why they seek out sexual encounters with other men in public (often without condoms) and encourages them to practice safe sex.

In groups, participants discuss sexual orientation and learn about HIV prevention and the impact of public sex. The charges of public lewdness or disorderly conduct are dismissed for offenders who successfully complete the program and are not arrested for 12 months. Capt. Jones said that, since his involvement began, the recidivism rate has been less than 5 percent for about 350 program participants.

GLBTQ Community Training

- Personal safety
- Hate crimes
- Dangers of cyber dating
- Safety in the workplace
- Bullying of GLBTQ youth
- Club and bartender vice regulation

Community Presence

The program's first booth at the Pride Festival was set up in 2000; since then attendance at the festival has grown to approximately 20,000 in 2008. In 2006, there was a major recruiting effort by all liaison member agencies.

Youth are always challenging for law enforcement. Liaison members, along with several different agencies and police officers, volunteer to work the Queer Prom. Officers at this event insist on being in uniform.

Capt. Jones has been writing a public safety column in *Q*, Salt Lake City's GLBTQ newspaper, for the last several months.

No hard data address the level of methamphetamine use by gay men in Salt Lake City, but methamphetamine use is considered a serious problem. Methamphetamine is the drug of choice for party and play. That is where public safety and public health intersect.

Grant efforts: The Salt Lake City Committee applied for a COPS grant in 2003. The Utah Department of Health was moving toward a methamphetamine grant, but the employee who was pushing it quit. Securing a grant is still a viable goal if the law enforcement community can get the GLBTQ community behind it.

Lessons Learned

- The GLBTQ community can get things done when it puts its mind to it.
- It has been hard to get the GLBTQ community to work with the committee.
- Utah law enforcement has a long way to go in cultural competency.
- The Liaison Community can be a good vehicle for change with local law enforcement.
- Lack of funding makes it hard to do everything that is needed.

The Liaison Committee's Next Steps

- Offer the Liaison Committee's help to all Salt Lake Valley chiefs of police.
- Persuade the Utah State Police Academy to include information about the Liaison Committee in its curriculum.
- Build a Web page with links to the police department, the Pride Center, and UAF Web pages.
- Launch a formal methamphetamine effort involving the GLBTQ community.

Lori Moriarty, Executive Director, National Alliance for Drug Endangered Children (NADEC)

Developing a State drug endangered children (DEC) alliance requires the collaboration of local resources such as law enforcement; medical, emergency and hazardous materials services; the treatment community; and the legal system.

History and timeline of DEC alliance:

- **1993:** Butte County, California, established the first DEC alliance that was initiated across the country.
- **1998:** COPS funded the DEC alliance through methamphetamine initiatives in several States.
- **2004:** COPS funded the first national DEC conference and COPS and the Office for Victims of Crime (OVC) funded the NADEC training program.
- **2006:** NADEC became a nonprofit. OVC funded the NADEC Resource Center and BJA State DEC development, training, and TA.

Ms. Moriarty showed slides of children living in homes that were methamphetamine labs. In one photo, clothes, toys, and bikes were strewn around a room. In another shot, an empty waffle box was seen on a bed alongside drug paraphernalia and methamphetamine manufacturing equipment.

Creating a State DEC alliance that supports and connects with local DEC initiatives requires interactions of multiple disciplines and communities to develop a national network from the bottom up. In working together, groups must overcome fears and focus on motivation. Ms. Moriarty said that children give us a reason to work together. There is a shared common outcome of protecting and serving children. Each discipline needs to assume a role and responsibility in a comprehensive response.

Ms. Moriarty said that "breaking out of our silos" leads to shared knowledge and evidence-based practice for identifying which people need to work together to get the job done. A comprehensive community response means determining how to break the cycle for the next generation and achieve sustainability.

The strategic planning process requires community-based planning:

- Where are we now? Identify and analyze problems.
- Where do we want to be? Set mission, goals, and objectives.
- How are we going to get there? Develop strategies and programs.
- What must we do to get there? Who will do it? Implement action plans and assign tasks.
- How are we doing? Assess results.

Each discipline needs to understand how it fits into the comprehensive response:

- Whom does your agency serve?
- What needs do those you serve have?
- What roles and responsibilities does your agency have?
- What does your agency do to address these roles and responsibilities?

- What outcomes is your agency trying to achieve?
- What is the primary expertise/knowledge used to perform your role?
- What tools are used to support this work?
- What types of training are required to perform your role?
- What other agencies/groups do you work with in performing these roles?
- What information do you receive and share with other agencies/groups?
- Are there formal protocols to coordinate your work with other agencies/groups?

Ms. Moriarty gave an example of how a local DEC initiative collected data to determine the impact of its collaborations. Data were collected from January 4, 2005, to December 29, 2005. Eighty-eight DEC forms were completed:

- Of 137 children who were identified, 50 percent had a Department of Social Services (DSS) history, but only 12 percent of those had an open DSS file. Follow up on these cases revealed that the other 38 percent were not open cases because DSS did not know whether there were indicators of substance abuse or violence in the home. Ms. Moriarty advised that law enforcement would be able to answer these questions and reinforced the need for collaboration.
- The children clearly lived in homes that were methamphetamine labs or other types of dangerous drug environments. One case involved an 8-year-old boy who returned from school on two occasions to a vacant home that had been condemned. He broke into the house and was alone until a family member bonded out of jail.

LGBT SPRINGBOARD PRESENTATIONS ON CULTURAL COMPETENCY

Harlan Pruden, Councilmember NorthEast Two-Spirit Society

The NorthEast Two-Spirit Society was established in 2004 to educate the LGBT and non-LGBT communities about indigenous and two-spirit histories and traditions; to ensure community cohesion among people through the promotion of health and spiritual well-being by sharing traditions with one another; and to build alliances and coalitions with other community-based organizations to increase the visibility of the two-spirit community and ensure its needs and concerns are addressed. At the heart of this effort is community development. All programs and activities build community and connectivity, instill greater cultural awareness, and enhance the overall wellness of the community through the ability of one to express pride in his/her distinct heritage.

On the land known as North America, there were approximately 400 distinct Indigenous Nations. Of that number, 155 have documented multiple-gender traditions. The term two spirit came into existence in 1989 at the third Annual International Gathering. “Two-Spirit” is a contemporary term that refers to those traditions in which some individuals’ spirits are a blending of male and female spirits. The two-spirit tradition is primarily a question of *gender, not sexual orientation.* Sexual orientation describes the relationship a person has with another person. Gender describes an

individual's expected role within a community. When an individual claimed the role of two-spirit, it was a position that could not be fulfilled by any other gender.

Within traditional American Indian communities, there was an expectation that women farmed/gathered and cooked food and men hunted big game. Although there was division of labor along gender lines, there was no gender-role hierarchy. Within the American Indian social construct of gender, a community could not survive without both equal halves of a whole. This commitment to gender equality opened the door for the possibility of multiple genders. Because there was no stigma for a man to take on a "lesser" gender by placing himself in a woman's role, the hierarchy simply did not exist.

People of two-spirit gender functioned as craftspeople, shamans, medicine givers, mediators, and/or social workers. So two-spirit people were honored with gifts at gatherings. They did not keep the gifts but passed them on to spread the wealth. In this respect, two-spirit people were similar to contemporary social workers.

Few people realize that the majority of Native Peoples in the United States are now living in urban areas and not on reservations (Harvard Project on American Indian Economic Development, 2007). Even fewer people realize that New York City has the largest number of Natives living in an urban setting (Forquera, 2001; Ogunwole, 2000). According to the 2000 Census, 106, 444 New Yorkers were American Indians, Alaska Natives, or Native Hawaiians. If New York City were a reservation it would be the second largest reservation in the country. Urban Indians are "invisible" peoples.

The same tools that are used to engage the two-spirit community can be used to work with a host of other minorities.

The first step toward making healthful decisions comes with the development of self-esteem. Community pride is a critical component in the development of self-esteem. All of our programs and activities are designed to break the sense of isolation that many of our people experience, especially in urban areas that may be far from their ancestral territories, families, and communities. The programs build community, instill greater cultural awareness, and enhance the overall wellness of our participants through their ability to express pride in their distinct heritage.

Our programs are targeted but not limited to the two-spirit community. Members of the larger Native community are always welcome to attend and participate, and some do. The concepts of coming together and mutual support are the basis of the programs.

Cultural components are the basis of all of our work. However, we are not simply a two-spirit organization. First and foremost, we serve everyone within our Indigenous communities.

JoAnne Keatley, MSW, Minority Programs Manager, Pacific AIDS Education and Training Center, University of California, San Francisco

The Center of Excellence (CoE) for Transgender HIV Prevention focuses on developing and implementing best practices for working with transgender people. It provides leadership, capacity building, professional training, policy advocacy, research development, and resources to increase access to culturally competent HIV prevention services for transgender people in California.

The transgender community comprises individuals with hundreds of identities, so no single approach addresses all racial, ethnic, and cultural affiliations. HIV prevalence among the transgender population in California is estimated to be 6 percent (29 percent among Black trans women) (Herbst, et. al., 2007); among transgender men it is estimated at 2 percent (this may be because sex work is less prevalent among trans men) (Clements-Nolle, Marx, Guzman, & Katz, 2001). California prison medical facilities report that 1 prisoner in 50 identifies as transgender (Brown & McDuffie, 2009).

Transphobia adversely impacts transgenders in all areas—from housing (homelessness), health services, and law enforcement to victims of violence, harassment, and family rejection.

Health services and messages that focus on gay men do not work with transgender people. Tailored messages need to be developed for this population.

Intake forms, the office environment, and insensitivity along with a lack of insurance coverage discourage transgender people from seeking medical treatment. In addition, some providers have a high level of personal discomfort working with transgender people and may refuse to deliver treatment.

Many transgender people cannot continue in their careers for fear of disclosure; consequently, they often resort to sex work as a survival tactic.

Machismo and marianismo stereotypes in the Latin culture can lead to extreme preoccupation with notions of masculinity and femininity and create gender confusion. The perception that gay men or lesbians are failed men or women, combined with the importance of family, causes many Latino/Latina transgender people to leave their home of origin for fear they will shame their family.

The following eight practices are designed to help providers, clinicians, consumers, researchers, and others involved in the care and treatment of transgender persons living with HIV:

1. **Ground Your Work in the Community.** Develop partnerships with transgender people and organizations to create and grow programs, services, and research with, by, and for trans people. Hiring transgender people and getting them involved on advisory boards are effective because these people know the best ways to reach and deliver services to their peers. Community involvement ensures acceptability, appropriateness, and relevance of your interventions, programs, and services to the transgender people.

2. **Race and Ethnicity: Be Aware That One Size Does Not Fit All.** Interventions and programs are most effective when they incorporate racial and ethnic issues that contribute to HIV risk and issues of stigma and discrimination that are specific to transgender people.

3. **Use Multidisciplinary Approaches to HIV Prevention.** Educate and provide services and care through a broader context of health and wellness. Consider approaches that focus not only on the individual, but also on families, social networks, schools, communities, and organizations that transgender people live, work, and play in. Creative interventions are often the result of employing multidisciplinary approaches. For example, because many trans women in California are undocumented and cannot earn a living without resorting to sex work, the CoE bought sewing machines and brought in a gay man who was an experienced tailor and spoke Spanish to teach them how to sew, cut patterns, and create clothing they could sell. By acquiring this skill, the transgender women had a source of income other than sex work.

4. **Get the Facts! Assess, Evaluate, and Enhance.** Conduct thorough needs assessments and evaluations, use the data in program planning and improvement, and disseminate what you learn. Acquiring information on transgender persons depends on looking in all the right places and asking the right questions. In addition, expanded gender categories are necessary to capture accurate, relevant data.

5. **Look in All the Right Places.** Recruitment and retention strategies should consider the unique needs and circumstances of priority populations. Go beyond what is convenient, and bring education and services to transgender people in their neighborhoods and communities.

6. **Increase Access to Health Care for Trans People.** Have a central location or multiple locations with easy access to public transportation and provide services in multiple languages. Health educators use outreach approaches that include conducting skills-building workshops and job training; mentoring; and providing services for legalization and documentation, health care, hormone therapy, and HIV risk reduction education.

7. **Invest in Developing and Supporting Your Staff.** Prioritizing staff development, ongoing training and education, and creating opportunities for advancement are key to building capacity and healthy work environments for staff members and their clients and patients. Hiring transgender people facilitates the development of HIV prevention information, provides employment, and establishes peer relationships that minimize relapse.

8. **Advocate for Structural and Systemic Change on Behalf of Trans People.** Collaborate with community partners to advocate for policy development and social change to identify and address how HIV among transgender people is affected by housing, employment, transphobia, racism, violence, lack of health insurance, provider education, and legalized discrimination.

Assessing Progress, Advancing Excellence: Serving Transgender People in California is available at http://www.transhealth.ucsf.edu/.

WOMEN SPRINGBOARD PRESENTATIONS ON CULTURAL COMPETENCY

Dionne Jones, PhD, Deputy Branch Chief, Services Research Branch, Division of Epidemiology, Services, and Prevention Research, NIDA

Methamphetamine use in the United States is increasing, especially among 18- to 25-year-olds. The rates of alcohol and methamphetamine use for rural youth are higher than those for urban youth. Use is widespread among those with low socioeconomic status (OAS, 2007).

The prevalence of illicit drug use, including reported methamphetamine use, by geographic area in 2006 for ages 12 and older were:

- Northeast, 8.9 percent
- Midwest, 7.9 percent
- South, 7.4 percent
- West, 9.5 percent (OAS, 2007)

In 2006, 8.1 percent of 12th graders used amphetamines. Also in 2006, illicit drug use, including reported methamphetamine use, among persons aged 12 years and older during the past year was:

- 13.7 percent among American Indian/Alaska Natives
- 3.6 percent among Asians
- 9.8 percent among Blacks
- 6.9 percent among Hispanics
- 7.5 percent among Native Hawaiian and other Pacific Islanders
- 8.5 percent among Whites (OAS, 2007)

People who use methamphetamine report positive associations with sexual functioning, compared with users of other drugs of abuse (OAS, 2007).

Methamphetamine use among pregnant women can cause growth retardation, premature birth, and developmental disorders in neonates (Sexton, Carlson, Leukefeld, & Booth, 2006). The number of women who use methamphetamine is equal to the number of men who use methamphetamine; however, for every two men who use cocaine there is one woman who uses cocaine and for every three men who use heroin there is one woman who uses heroin (Yih-Ing, Evans, & Huang, 2005).

Dr. Jones discussed the adverse consequences of methamphetamine use and the reasons women use methamphetamine. She said family characteristics are more predictive of drug use in women than in men (Hans, 1999).

Family Characteristics Predictive of Drug Use in Women

- Maternal substance abuse
- Low parental attachment, monitoring, and concern
- Dysfunctional family
- Unstructured home environment
- Childhood sexual abuse (Hans, 1999; NIDA, 2007)

A major reason people take a drug is they like what it does to their brains. Abused substances enhance the dopamine pathway (Mumola & Karberg, 2004).

Facts Related to Methamphetamine Use and Incarceration

- Between 1980 and 1995, drug offenders in State prisons increased 1,000 percent, or 1 out of 4.
- Drug offenders account for more than 80 percent of the total growth in the Federal inmate population.
- Forty-two percent of Federal inmates in prison for drug offenses are Black.
- Thirty percent of people on probation in the United States are Black (drug offenses account for 25 percent of probation offenses).
- Forty-one percent of people on parole are Black (Blankenship, Smoyer, Bray, & Matocks, 2005).

HIV/AIDS Link to Drug Abuse

Drug abuse is more than twice as likely to be directly or indirectly related to AIDS in women (57 percent) than it is in men (23 percent) (CDC, 2006). A woman infected with HIV with half the amount of virus circulating as in an infected man will progress to a diagnosis of AIDS in about the same time.

Interventions are more effective when they are tailored to a target audience, for example, when they:

- Are woman focused
- Are drug specific
- Address mental health needs (Needle, Coyle, Normand, Lambert, & Cesari, 1998).

Effective Interventions

- Improve coping skills
- Improve self-esteem
- Are empowering (OAS, 2007).

Culturally Competent Interventions

- Provide quality care

- Create a culturally sensitive climate and culture
- Include provider/patient interaction free of stereotyping, stigma, and bias
- Provide testing and counseling (Grills, 2000).

Access to Quality Care

- A high proportion of women and minorities who are HIV positive are likely to be uninsured and have a higher risk of misdiagnosis (Shapiro, Morton, McCaffrey, Senterfitt, Fleishman, & Perlman, 1999; Roberts, McNair, & Smith, 2004).
- Minorities are less likely than Whites to receive evidence-based treatment or proper medication when first diagnosed.
- Minority populations tend to seek care in public, not private, settings.
- Many tend to postpone medical care because of a lack of transportation or other competing needs.
- Women with young children often do not seek treatment or drop out early for fear of having their children taken from them (UCLA, 2006–2009).

Treatment and Care Needs

- Prevention education for youth
- Training in screening and assessment for emergency department staff
- Treatment staff's ability to identify women's specific needs and respond to them
- Increased levels of care for pregnant women
- The monitoring and promotion of proper prenatal care while in treatment
- Empathetic staff for pregnant women who relapse
- The recognition that women present for treatment with greater psychological distress than do men
- Screening for psychological problems, abuse, and violence
- Comprehensive, trauma-related services
- An integrated treatment model and multidisciplinary team
- Coordination among substance abuse treatment, mental health, and medical facilities
- Enhanced HIV and STD prevention and treatment programs to include methamphetamine use assessment with referrals to methamphetamine treatment, primary testing, and sexual health promotion
- A broader array of services connecting women to housing, job training, and so forth
- Ancillary services such as transportation and case management (Mumola & Karberg, 2004; UCLA Integrated Substance Abuse Programs, 2006–2009).

Women present for treatment with greater psychological distress than men, which is why screening for psychological problems, abuse, and depression is important (Mumola & Karberg, 2004).

Judith Bradford, PhD, Director, Community Health Research Initiative, Virginia Commonwealth University, Co-Chair, The Fenway Institute (Boston)

Health is not just an individual matter—it also involves public policy, community, institutional, and organizational involvement as well as interpersonal relationships.

Much about substance abuse is really about behavior––a woman cannot be extracted from her environment. Providers often act as if the environmental component does not count. Providers need to determine whether a woman's family and community are supportive and subsequently help her understand that she cannot do anything about these things if they are not.

An effective behavioral model for understanding the impact of contextual and individual characteristics on health behaviors and outcomes was reported in 2008. Contextual characteristics are predisposing (demographic, social, and beliefs), enabling (health policy, financing, and organization), and need (environmental and population health indicators). Individual characteristics include the same predisposing and enabling measures as well as perceived and evaluated needs. Health behaviors include personal health practices, the process of medical care, and use of personal health services. Outcomes are perceived health, evaluated health, and consumer satisfaction (Andersen, 2008).

Women must be taught how to adjust and take responsibility for personal health behaviors that are not health promoting.

Providers and agencies need to be aware of biases toward women and determine whether they can conduct an assessment in a nonjudgmental manner. Congruent behaviors, attitudes, and policies come together as a system, agency-wide, or among professionals to enable effective work in cross-cultural situations. This approach requires a defined set of values and principles; demonstrates effective behaviors, attitudes, policies, and structures; and has knowledge-based skills to provide effective care for specific ethnic or racial groups. Some approaches emphasize knowledge and skills needed to interact with people of different cultures; others focus on attitudes.

Acquiring cultural competency is a developmental process over an extended time. Individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competency continuum:

- **Cultural awareness:** The process of conducting self-examination of one's biases toward other cultures and the in-depth exploration of one's cultural and professional background. Also involves being aware of the existence of documented racism and other "isms" in healthcare delivery.
- **Cultural skill:** The ability to conduct a cultural assessment to collect relevant cultural data regarding the client's presenting problem as well as accurately conduct a culturally based physical assessment.

- **Cultural knowledge:** Process in which the healthcare professional seeks and obtains a sound information base regarding the worldviews of different cultural and ethnic groups as well as biological variations, diseases, health conditions, and variations in drug metabolism found among ethnic groups (biocultural ecology).
- **Cultural encounter:** Process that encourages direct engagement in face-to-face cultural interactions and other types of encounters with persons from culturally diverse backgrounds to modify existing beliefs about a cultural group and to prevent possible stereotyping.
- **Cultural desire:** Motivation to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, and culturally skillful and to seek cultural encounters, rather than the "have to."

Have I asked myself the right questions?

- **Awareness:** Am I aware of my biases and assumptions about women? Do I think, "Their needs are the same as men's"?
- **Skill:** Do I have the skill to conduct a women's health assessment in a sensitive, nonjudgmental manner? Do I really listen?
- **Knowledge:** Am I knowledgeable about the specific addiction-related issues women have? Do I understand what barriers they face in getting care? Am I aware and do I acknowledge their unique strengths?
- **Encounters:** Do I seek out opportunities to work with women as colleagues, as clients?
- **Desire:** Truthfully, do I really want to learn how women's needs are different and develop my capabilities to provide culturally competent care to them?

Plenary Session: 5:00 p.m.

Access to Treatment and Recovery: Issues, Challenges, and Opportunities

Kathryn P. Jett, Undersecretary of Adult Programs, California Department of Corrections and Rehabilitation

Ms. Jett commented that many positive things have occurred in *The Summit* workshops and that during the past 18 months things have gotten better because more attention is being given to the needs and challenges of women and children affected by methamphetamine addiction. Because of the dynamic changes that are the result of growing awareness that the draconian measures used to deal with illegal drug use must end, it is an exciting time to be involved in corrections.

California's budget to run corrections is $10 billion and growing. Two years ago it was $7 billion. The California system is the most cost-effective system in the United States, but it is not a productive environment. California's openness to change and willingness to get to the cause of problems in communities make for an opportune time to work in corrections.

Those involved in methamphetamine addiction treatment have little awareness of what goes on in prisons. Inmates are forgotten in the discussions agencies and providers have on how to intervene in the cycle of addiction. Psychotic offenders are often left out of the mental health system and only gain access to medications, clothing, and shelter through the parole agent.

The prison environment can effect change in those who are incarcerated. For instance, a women's correctional facility that addresses the needs of women with drug problems was developed after a lot of research. Experts were brought in to help women who were incarcerated because of trauma in their lives. If the trauma is addressed, the system may never see the offender again.

Most correction services have core substance abuse treatment. Because prison has become home, inmates are not necessarily afraid of returning; consequently, the parole system cycles many of them back into prison every 30 to 90 days. What can agencies provide to offenders coming out? Some intervention options include working with parole agents and teaching them about alternative programs and connecting offenders with treatment opportunities in their community.

Changing how offenders think and knowing how well agency and provider staffs understand their jobs are vital when working with this population.

Alternative sanctions can help the community by moving the $20 million spent on prison programs into other programs for drug offenders. Partnerships with public and private programs can address the multiple problems afflicting many offenders who are disabled, unable to communicate, and suffer from brain damage or mental illness.

The inmates, who are the very people agencies and providers are trained to assist, have no way to access the services being delivered in the community. Identifying points of access for getting offenders into treatment and educating the correctional system about the needs of offenders are topics that need to be discussed.

Arizona has a wonderful correctional environment; offenders live as they would on the outside, but they do it in custody.

Another area that is cause for excitement is the open discussion taking place with law enforcement and public health officials about gender differences and LGBT individuals who have been isolated.

More effort is being devoted to understanding perspectives based on race and culture. What service providers see as a problem, the correctional system sees as a problem indicator for something else. Special tools that are gender specific and special assessments that are gender sensitive are needed so that women and LGBT individuals get tailored services. There also needs to be an environment where women can openly talk about rapes, abuse, and degradation.

Ninety percent of inmates come "home" to prison. If there is a way to break the recidivism cycle, there is no better time to talk to people than when they are reintegrating into society.

Released offenders who have received job training are not hired. Often the best trained, most highly motivated substance abuse counselors come out of the prison system; however, the substance abuse treatment community will not hire felons their first year out.

The first 72 hours makes or breaks offenders' successful reentry into the community. If most prisoners run into problems in the first 72 hours of their release, why do States not provide transitional living environments?

Reentry can be eased by bringing programs into the prisons for inmates serving their last year and then sponsoring the offenders when they are released to the community. A number of counties are investing in reentry programs and use a case management approach to provide assistance with housing and connect newly released offenders with mental health services and support groups to reduce the risk of reoffending. (Visit http://www.cdcr.ca.gov/ for more information.)

In April 2008, Congress passed Second Chance legislation designed to aid former prisoners coping with the challenges of reentry. Modest funding is available for communities to access.

Substance Abuse Services and the Barriers to Access

JUSTICE-INVOLVED SPRINGBOARD PRESENTATIONS ON ACCESS TO SERVICES

Kimberly O'Connor, PhD, Director, Arizona Division of Substance Abuse Policy

In 2007, the Arizona Department of Corrections launched the Legacy Project, a pilot program in south Phoenix that is a cross-agency collaboration of the Department of Corrections; the Department of Economic Security; the Governor's Office for Children, Youth, and Families; the Division for Substance Abuse Policy; and community groups. Specialized programs involve family intervention teams and children of incarcerated parents. The purpose of the project is to change the way newly released prisoners are supervised and to move community supervision away from the zero-tolerance approach, under which missed parole meetings, poor work habits, or socializing with other former inmates could put a person back behind bars.

Under the comprehensive Legacy Project approach, officers now seek to address the underlying socioeconomic and health problems that released prisoners often confront, such as poverty, unemployment, substance abuse, and mental illness.

Addressing the methamphetamine crisis in Arizona begins with the Governor's Methamphetamine Task Force Report, *A Plan for Action,* which contains 10 specific, action-oriented priority recommendations for law enforcement, prevention, and treatment. They provide a framework for policymakers, substance abuse specialists, law enforcement, and community members to work together to combat the methamphetamine problem.

The recommendations and action steps identified in the plan are data-driven strategies and focus on the general themes of prevention, treatment, and law enforcement, with additional recommendations specific to environmental cleanup and the workplace. They are designed to reduce the production, distribution, and use of methamphetamine and its impact on law enforcement, schools, healthcare providers, businesses, and families.

The Priority Recommendations in the Arizona Plan

1. Create a single point of contact to orchestrate the statewide planning and delivery of services specific to methamphetamine.
2. Fund site-based prevention specialists to enhance the capacity of school districts to engage in prevention efforts.
3. Promote the use of evidence-based media campaigns to reduce the production and use of methamphetamine.
4. Identify and implement evidence-based prevention strategies to prevent high-risk populations from using methamphetamine.

5. Expand treatment services for adult and juvenile methamphetamine-related offenders.
6. Develop a framework to improve access to substance abuse treatment statewide.
7. Reduce trafficking of methamphetamine and its precursor chemicals.
8. Implement and support continuous data collection methods to track pseudoephedrine sales and methamphetamine-related arrest information through multisystem approaches.
9. Expand the reach of DEC protocols to all communities and Tribal governments.
10. Implement an immediate response system to clandestine methamphetamine labs and other methamphetamine-affected properties to reduce the negative environmental impact of methamphetamine.

SAMHSA has awarded Arizona an $8.3 million ATR grant to support the expansion and enhancement of methamphetamine treatment and recovery services targeted to adult drug courts, children, youth, and families.

Daniel G. Ronay, Chief of Staff, Indiana Department of Corrections (IDOC)

Methamphetamine production costs Indiana nearly $100 million a year. From 1994 to 2004, methamphetamine lab seizures rose by 3,500 percent. From 2000 to 2004, there were 68 fires and methamphetamine laboratory-associated explosions. Indiana ranks second in the Nation for the number of methamphetamine labs. More than 1,500 labs were seized in 2004. (de Martinez, Perera & McCarthy-Jean, 2005) From 2002 to 2004, Indiana police reported 620 cases of children who were affected by methamphetamine (Indiana State Police reports). The Office of National Drug Control Policy ranked Indiana fourth in the Nation for children affected by methamphetamine. Anywhere from 2 to 5 percent of all Indiana residents between ages 18 and 25 had used methamphetamine, according to 2002–2004 data, compared with only 1.6 percent of youth between ages 18 and 25 nationwide (Vance & Schoenradt, n.d.)

In 2005, Governor Daniels implemented the Methamphetamine Free Indiana Coalition and the Clean Lifestyle is Freedom Forever (CLIFF) program. On December 1, 2005, CLIFF opened a 50-person facility for juveniles (Thornton-Copeland & Garner).

The Methamphetamine Free Indiana Coalition kicked off Methamphetamine Watch, a statewide campaign to educate citizens and communities.

Incarceration Statistics: Texas Christian University Drug Screen (TCUDS) entries show that 79 percent of offenders have relatively severe drug problems (Knight, Holcom, & Simpson).

Diane Williams, MSW, LCSW, Assistant Deputy Director of Substance Abuse Treatment, Indiana Department of Mental Health and Addictions

The CLIFF Therapeutic Communities (TCs) program calls for intensive treatment, high accountability, privacy and respect that need to be earned, a 6- to 12-month core program, a relapse prevention program for the length of stay, and the availability of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and CMA meetings.

CLIFF TCs

- TC model
- 6- to 9-month offender involvement
- Cognitive interventions
- Matrix Model programs in curriculum (NIDA Essential Drugs Program)
- Samenow's *Commitment to Change: Overcoming Errors in Thinking* series
- Methamphetamine recovery support groups with behavioral interventions that lead to long-term recovery

To be admitted to the 6- to 9-month program, people who abuse substances must meet the following criteria:

- Methamphetamine-specific charges
- A significant history of methamphetamine abuse
- Admission within 14–36 months of release
- No violent history within the past year
- Sentence modification for treatment considered
- 6 months without security threat group activity
- The total recidivism rate for all IDOC facilities is 37.8 percent within 3 years of release.

Offender Structure and Responsibilities

- Dorm coordinator
- Peer group leaders
- Committee structure
- Peers become agents for change, and offenders help in the accountability process.

Selection, Utilization, and Training

- Dedicated correctional officers are selected according to their interest, motivation, and attitudes.
- Officers provide education and life-skill training, participate in the intervention, and conduct committee meetings.
- All dedicated officers must successfully complete a training module on the principles, structure, and function of a TC.

Client Responsibility—Techniques for Staff- and Offender-Led Groups

- Peer groups
- Leadership training
- Positions of responsibility
- Interventions with staff involvement
- Experiential groups that make the client a participant, not a spectator, and provide a platform for reflection

Techniques for staff- and offender-led groups provide for education groups, life skills, interventions, and process groups.

The essential staff and the offender structure ensure that all staff are trained in TC concepts. Officers receive specific TC concept training. All staff members follow TC concepts. Counselors and officers work as a treatment team to convey lifestyle information to offenders on a consistent basis.

It is critical to reduce contamination of the TC participants:

- They should be maintained separately from general population offenders.
- Activities such as recreation, meals, and commissary visits should be separate from the activities of other population.

The American Correctional Association (ACA) has notified the Indiana State DOC that its CLIFF program was selected as the 2009 ACA International Offender Program of the Year.

LGBT SPRINGBOARD PRESENTATIONS ON ACCESS TO SERVICES

Bryan Cochran, PhD, Associate Professor of Clinical Psychology, University of Montana

Data collection regarding sex and gender is inconsistent. Many studies do not provide options for gender identity, which makes it difficult to compare data across networks and observe on differences based on sex or gender. It also makes it virtually impossible to know what unique medical challenges transgender people face. Treatment programs often do not appropriately offer services that they report to have for LGBT individuals. State Action Teams need to think about how to better identify populations and bring their recommendations to SAMHSA and other agencies administering the data.

LGBT individuals use multiple terms (LGBT, MSM, gay, etc.) and may identify themselves by behavior, attraction, or in other ways. Self-reported data have ramifications on the findings from samplings from different venues. The shifts in survey data collected by identity and on populations in treatment are significant and make comparing surveys difficult. Ideally, collecting data about orientation involves measures of attraction, behavior, and identity.

Currently, Washington is the only State that collects data on LGBT identity for its database of clients in substance abuse treatment. This has largely resulted from Washington's Division of Alcohol and Substance Abuse (DASA) fostering collaboration with the LGBT community and having LGBT individuals on its advisory board. Other States could use Washington as a model for collecting such data.

A barrier to treatment for LGBT individuals is that the services that are reported to be offered actually do not exist or are not as advertised. One study by Cochran, Peavy, and Robohm in 2007 found that of the 911 treatment programs that reported offering specialized programs or groups for gay or lesbian individuals in the N-SSATS database, only 7.4 percent could identify a specific service offered.

Assessing for drug use is also difficult because individuals often do not self-identify as using drugs. Their illusion of control and competence leads them to denying having a problem; consequently, most come into treatment because of external influences.

Many individuals who seek substance abuse treatment exhibit the symptoms of depression and anxiety. A high percentage of individuals have experienced an adverse event or trauma and have a pervasive loss of self-esteem. These factors are often compounded for LGBT individuals because of multiple discrimination and victimization experiences. Providing appropriate services for LGBT individuals begins with targeting the LGBT community, providing appropriate services, and addressing the multiple ways in which sexual/gender identity and substance use interact.

Michael D. Siever, PhD, Director of Behavioral Health Services, San Francisco AIDS Foundation; Co-Chair, Mayor's Task Force on Crystal Meth, San Francisco; Director, The Stonewall Project

To dismantle barriers to services for LGBT individuals, we need services that:

1. Are culturally proficient
2. Are integrated
3. Are effective
4. Use a range of approaches including harm reduction
5. Are accountable

Culturally proficient means going beyond culturally competent to real proficiency. This includes not only issues of race/ethnicity, gender, sexual orientation, and gender identity, but also issues that address specific drug cultures, class, language, disability, and more. Integrated services mean services are not divided by funding streams. Human beings should not be turned away at substance use treatment facilities and sent to a mental health agency because they have mental health issues along with a methamphetamine problem, or vice versa. There are programs and agencies that are not effective but continue to get funded. We need a range of services that include alternatives to abstinence-based programs. Not everyone wants or needs total abstinence.

We need programs that help those who want to stop using methamphetamine but do not have a problem with having a glass of wine with dinner.

We need to accord people the dignity and respect of choosing their own goals and offer strategies to reduce the harms created by alcohol and drugs when these people are not ready, able, or willing to stop using any and all substances. We also need to be accountable to the communities in which we work; to the people to whom we provide services; and to the families (both families of origin and chosen families), friends, lovers, and partners of people struggling with their methamphetamine use.

Another huge barrier is the "us–them" dichotomy. The people to whom we are providing services, whom we are researching, or for whom we are setting policy are not fundamentally any different from those of us who are providing these services, conducting the research, or creating the policies. We often fall into the trap that "we" are the professionals, the therapists, the counselors, the researchers, the bureaucrats; "we" are in recovery; "we" have got it together. "They" are the addicts and the users; "their" lives are out of control and chaotic. In the particular arena of gay men and crystal methamphetamine, this view even becomes statements or thoughts that "they" are out-of-control "freaks" who engage in unsafe sexual activities, behaviors that no one with any sense would engage in. That "they" stubbornly refuse to listen to "our" opinions about how "they" should stop doing crystal methamphetamine, how "they" should have sex, how "they" should live their lives. This is not the message most of us are seeking when we ask for help.

- We all want to be treated with dignity and respect.
- None of us want to be judged or condemned.
- We all want to fit in.
- We all want to be accepted.
- We all want to belong.
- We all want to be listened to, to be truly heard and understood.
- None of us want to be labeled or boxed into categories.
- If I am a trans man asking for help, if I am a trans woman, if I am a bi woman or man, if I am a gay man or a lesbian, I want to be seen as a whole human being who is not defined by the fact that I do crystal methamphetamine. I do not want to be labeled as an "addict," a "user," a "junkie," a "dope fiend," or something else.
- If I come to you for help, will I feel comfortable? Wanted? Cared about?
- Will you see my good points? My strengths?
- Will I feel comfortable talking about sex? About my sexual desires and fantasies?
- Will I feel safe talking about the abuse and trauma that I have experience in my life?

- Are you going to lump me together with all the other letters of the alphabet in the LGBTQQI, etc., and not look at the differences among those letters?
- If I am a person of color, will you understand how my multiple identities play out?
- If I am a trans man, will I be met with incredulity? Shock? Confusion?
- If I am gay, will I be judged as a sex addict just because I have a lot of sex?
- What if I am still in the closet?
- Can I talk about my body image issues?
- Can I talk about my fear of aging?
- Will you tell me that I am wrong? That I cannot have a glass of wine when all I am coming to you for help with is my crystal methamphetamine use? Or that my goal cannot be to use crystal methamphetamine once in a while? I may not be able to but at least let me try.

Stigma is huge—stigma about being trans, about being bi, about being queer; stigma about being a drug user; even worse, an injection drug user. In our society, I think that being someone who shoots any type of dope is considered to be among the lowest of the low. I want to return to the bottom line—this is not about "us" and "them." We cannot treat the folks who come to us for help, the folks we are studying, the folks for whom we are setting policy as the "other" if we really want to be effective. I am not "other." I am a human being.

Now let me move on to more mundane but equally important issues such as:

- Do I know where I can go to get help? Are there advertisements that tell me where I can get help?
- How do I get there? How far away is it? Is there public transit to get there?
- What will I have to pay? What will I have to do to get help? Call in every day? Demonstrate somehow that I really want help? Is it not enough that I am asking for help?
- Even more important, will anyone return my phone call? I cannot tell you how many times I have heard folks say that they tried to get help but could not get anyone to return a phone call.

All of these function as barriers to care for LGBT folks.

Patricia Hawkins, PhD, Associate Executive Director for Planning and External Affairs, Whitman-Walker Clinic

Welcome to Washington, DC, the last colony in the developed world. And welcome to the epicenter of the AIDS epidemic, with the highest AIDS rate in the United States—10 times the national average. (District of Columbia Department of Health, 2007) But the numbers are even more appalling when you break them down by subpopulations. Using CDC's methodology for estimating diagnosed and undiagnosed positive individuals, I did an analysis for Whitman-Walker Clinic of the District's 2003 AIDS epidemiology data and found that in this city:

- 1 in 20 adults (older than age 18) is estimated to be HIV positive.
- 1 in 10 men between ages 30 and 44 is estimated to be HIV positive.
- 1 in 5 Black men between ages 30 and 44 is estimated to be HIV positive.

Unfortunately, the most recent 2007 Washington, DC, data indicate that the rate of infection among MSMs is now on the rise. This can be attributed in part to a growing increase in methamphetamine use and what many of us see as a related increase in the visibility and availability of "bare backing" (intercourse without using condoms). Although numerous individual personality and psychological factors contribute to these increases, I would like to focus on the psychocultural factors that disproportionately impact the gay, bisexual, and transgender (GBT) male community. As you know, the LGBT community has long-faced high degrees of stress, discrimination, and violence related to its marginalized and stigmatized sexual orientation, and this has led to increased levels of depression, posttraumatic stress disorder (PTSD), and substance abuse (Center for Substance Abuse Treatment, 2001). In addition to these underlying vulnerabilities, it is my contention that the primary cause of the new explosion in high-risk behaviors in the GBT community is increasing attempts of GBT men to use substance abuse and sex to self-medicate the symptoms of three separate but intersecting mental health disorders related to HIV/AIDS. First, depression related to years of community pain, grief, and loss; second, PTSD as people attempt to cope with a horrifying and devastating trauma for which we had no prior collective coping strategies; and third, individual burnout syndromes among caregivers, partners, friends, and the community at large. In reality, the symptoms of all these disorders overlap and exacerbate one another and lead to the typical "fight vs. flight" defenses. Unfortunately, crystal methamphetamine, a stimulant and a chemical insulant from fear and shame, can fill the role as both an active and an escape defense.

Most of you are familiar with the symptoms of depression and PTSD, but you may be less aware of the behavioral and emotional correlates of burnout. According to the work of Herbert Freudenberger (1974), burnout occurs when people are deeply committed to a job/mission and find themselves increasingly incapable of meeting their own expectations. This situation was particularly true for LGBT health professionals, volunteers, and community members confronting the AIDS epidemic. Largely ignored by the mainstream for many years, AIDS invaded every aspect of our lives, not just our working hours, as we cared for and buried partners, friends, colleagues,

and strangers abandoned by their families. Among the burnout symptoms Freudenberger described the following: (1) a sense of failing at something extremely important; (2) moving from over-commitment of time and energy to avoiding work; (3) moving from strong idealism to pervasive cynicism and negativism; (4) moving from indifference to minor job details to constant complaints about space, salary, benefits, and so forth; (5) moving from feelings of energy and commitment to despair, hopelessness, anger, and irritability toward clients and coworkers.

Confronting the enormity of a communitywide devastation, unheard of since the Holocaust, it should not be surprising that many affected people found refuge in substance use and sex and that, for many of them, crystal methamphetamine became the drug of choice, because it did the following: enhanced sexual drive and acting out opportunities, particularly when combined with new erectile dysfunction drugs; allowed GBT men to reaffirm a sex-positive identity and to capture and/or recapture the excitement and carefree sex of the legendary pre-AIDS world; and allowed GBT men to forget/overcome infection fears, internalized homophobia, heterosexually normed social constraints, and survivor guilt and to have sex without connection, concentrate on the moment, deny depression/anxiety, and avoid conflicted feelings related to sexual activity.

If we are to successfully treat crystal methamphetamine dependence, we must address these underlying psychocultural conditions that make it so powerful and addictive: (1) we must recognize that it is still risky to come out and face legal and social discrimination, homophobia, and increasing attacks from the Right; (2) we must acknowledge the lack of adequate resources, particularly LGBT-specific treatment; (3) we must improve data collection by including sexual orientation in all client-level data; (4) we must use tools such as the 18 minute Client Diagnostic Questionnaire (Aidala, 2004); (5) we must screen all clients for drug use, depression, anxiety, and PTSD and provide integrated mental health and substance abuse treatment; and (6) we must recognize and address the impact of burnout on our clients and ourselves and learn to inoculate ourselves from its effects. Research indicates that positive burnout-mitigating strategies include dining out, 3-day weekends vs. longer vacations, escapist reading, walks and structured exercise, time with friends, and coping support groups (Hawkins & Halprin, 1989). Most important, we must remember that burnout is temporary and treatable. Above all else, we need your continued commitment and energy if we are to successfully treat the twin epidemics of HIV/AIDS and substance abuse that have brought so much loss and devastation to our community.

Malika Saada Saar, JD, Director, The Rebecca Project for Human Rights

Treatment for women with methamphetamine addiction must be delivered from the family and child welfare perspectives. There are shortcomings in traditional treatment programs for families, and it is vital that other family treatment models are considered and discussions on how to fund them take place.

America's families, especially in rural areas, continue to suffer from the methamphetamine scourge. Although many States have successfully dismantled homemade methamphetamine labs, addiction rates remain unchanged. Most States impacted by methamphetamine and other drugs either lack family-based treatment programs or possess very limited family-treatment capacity. As a result, mothers and their children are turned away from treatment, children are placed in foster care, and States' costs of family addiction continue to skyrocket.

State Facts and Figures

Iowa: Despite Iowa's crackdown on methamphetamine labs, the percentage of child welfare cases involving parental methamphetamine use remains steady at 49 percent in the State's southwest region (Lorentzen, 2005).

Kansas: Women with children had to wait an average of 18 days before entering a treatment program (Kansas Department of Social and Rehabilitation Services, 2005).

Missouri: Of the State's more than 11,000 children placed in foster care in 2004, 29 percent were removed from their homes as a result of methamphetamine and other drug use (Generations United, 2006).

Montana: Fifty-two percent of the parents of children in foster care have lost custody of their children because of methamphetamine-related abuse. The cost to the State is estimated at more than $12 million annually (McGrath, 2007).

North Dakota: Mothers with children seeking treatment must wait an average of 2 months to enter treatment with their children (Magsamen).

South Dakota: A minimum of 110 children were placed in foster care because of parental addiction to methamphetamine. The average length of stay for children discharged from foster care in fiscal year 2005 was 12.8 months. The estimated cost of foster care for the 110 children for 1 year would be at least $2.3 million ($21,092 per child) (Leonardson, 2005).

Wyoming: More than 1 in 20 pregnant women suffer from methamphetamine addiction. Fewer than 1 in 10 Wyoming residents who needed drug treatment received it (Bureau of Justice Statistics, 2001).

Treatment Programs

- Ninety-day, drive-by programs: The name refers to the amount of time traditional treatment programs allow to address the issues that need to be addressed.
- Most traditional treatment programs do not allow mothers to bring their children.
- Women often are unable to address their histories of sexual violence in traditional treatment programs.
- People do not understand why a woman would use, which is why it is important to educate people about the history of sexual violence.

Most women who abuse drugs have histories of sexual abuse and violence (U.S. Department of Justice, 2006). Their children are both a source of shame and hope. Children are part of the healing process and need treatment. The best family treatment models are 12 to 18 months long. In reality, less than 10 percent of treatment programs are family based (CSAT, 2004).

How can the number of family treatment programs be increased? The Rebecca Project looks at child welfare funding as an opportunity to expand family treatment. Family treatment is a critical way to prevent drug use.

Criminal Justice System

In California, 30 percent of women behind bars are addicted to drugs and two-thirds are mothers to children under age 18 (Public Policy Institute of California, 2006).

The Second Chance Act (P.L. 110-199), signed into law by President Bush in 2008, was designed to improve outcomes for people returning to communities from prisons and jails. This first-of-its-kind legislation authorizes federal grants to government agencies and nonprofit organizations to provide employment assistance, substance abuse treatment, housing, family programming, mentoring, victims support, and other services that can help reduce

Sharon Amatetti, MPH, Senior Public Health Analyst, CSAT, SAMHSA

There are many barriers to treatment for both men and women and many reasons women give for not seeking treatment. Women-focused services in treatment programs remove some barriers to treatment. Although a SAMHSA/CSAT initiative to improve treatment access and retention through State-level process improvement methods is underway, the majority of people who need treatment do not receive it.

According to the 2007 NSDUH, 91 percent of the approximately 7.63 million women who needed substance abuse treatment did not receive it. The majority of these women, nearly 94 percent, felt they did not need treatment. Only 6.3 percent of the women who needed treatment but did not receive treatment felt they needed it.

Barriers to Access Can Be Conceptualized

- Intrapersonal: not motivated, not ready, health status, psychological issues, etc.
- Interpersonal: family dynamics, support systems, childcare issues, etc.
- Sociocultural: stigma surrounding addiction, healthcare disparities, etc.
- Structural: program characteristics, treatment policies or restrictions, inconvenient, etc.
- Systemic: public policy and laws, drug use patterns, etc.

Reasons for Not Receiving Treatment by Gender, Annual Averages 2004 to 2006

Among those classified as needing but not receiving treatment at a specialty facility and who felt a need for treatment (responses not mutually exclusive), the top reasons for not seeking treatment vary somewhat but are similar for men and women, as reported in a special data run of SAMHSA's NSDUH (previously known as the Household Survey) to ascertain gender breakouts (NSDUH, 2007):

Stated Reason	Women (Percentage)	Men (Percentage)
Not ready to stop using	34.5	27.8
No health coverage, could not afford cost	27.6	35.5
Did not know where to go for treatment	12.9	12.2
Felt they could handle the problem without treatment	12.1	10.3
Neighbors/community might have negative opinion	11.7	9.9
Might have negative effect on job	10.7	13.1
Did not feel the need for treatment	8.8	5.5
No transportation/inconvenient	8.1	7.4
Did not want others to find out	7.5	3.4
Health coverage did not cover treatment costs	6.4	5.9
Did not have time	5.2	3.6
Treatment would not help	3.1	2.6
No opening in program	1.6	3.1

Women's Treatment Services: Summary of Women-Specific Programs in 2004

SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS; 2006) reflected that although the majority of treatment facilities accept women (87 percent), far fewer have specific programs or groups for women (32.2 percent) and/or pregnant and postpartum women (14.2 percent) (OAS, 2006).

Of those programs that are identified in the 2006 N-SSATS as specialty programs that serve women, nearly all (90 percent or more) provided:

- Individual and group therapy
- Relapse prevention therapy
- Discharge plan (SAMHSA, OAS, 2006)

The majority (more than 50 percent) provided:

- Family counseling
- Continuing care counseling
- Other outcome followup
- Assistance with social services
- Housing assistance
- Case management
- HIV/AIDS education (SAMHSA, OAS, 2006)

The minority (less than 50 percent) provided:

- Mental health assessments
- Assistance with employment
- Child care (20 percent)
- Domestic violence services
- Transportation assistance
- Beds for clients' children (10 percent) (SAMHSA, OAS, 2006)

These services, provided by a minority of providers, are typically included in services that are truly gender specific for women.

Strengthening Treatment Access and Retention to Address Structural Barriers to Treatment

Strengthening Treatment Access and Retention (STAR) is a SAMHSA/CSAT initiative to improve treatment access and retention through State-level process improvement methods and customer-service orientation to access to treatment:

- Streamline client intake, assessment, and appointment scheduling procedures
- Eliminate paperwork duplication
- Extend clinic hours
- Contact client no-shows
- Elicit and incorporate customer feedback
- Use clinical protocols (motivational interviewing, motivational incentives, etc.) to engage clients in treatment

Treatment Engagement Strategies to Address Other Barriers to Treatment

- Outreach
- Identification of most pressing concerns first
- Empathy for fears
- Assistance with negotiating the service system
- Pretreatment intervention groups
- Orientation to treatment
- Enhanced motivation
- Case management
- Improvements in retention for women with complex needs

Plenary Session: 10:45 a.m.

Considerations in Identifying and Replicating Best Practices: Turning Promising Practices into Evidence-Based Practices

David W. Purcell, JD, PhD, Acting Chief, Prevention Research Branch (PRB), CDC

The talk focused on translating research into public health action, using the model from CDC's Division of HIV/AIDS Prevention (DHAP). Evidence-based interventions and prevention strategies are requested and need to be adopted by the field. Adopting evidence-based initiatives involves many steps; scientific publication is not enough.

DHAP's Research-to-Practice Model

This research-to-practice model involves three steps: (1) identifying efficacious interventions (Prevention Research Synthesis [PRS] project), (2) translating interventions into user friendly packages (Replicating Effective Programs [REP]), and (3) disseminating interventions and providing technical assistance and training (Diffusion of Effective Behavioral Interventions [DEBI] project).

1. Prevention Research Synthesis Project
   (http://www.cdc.gov/hiv/topics/research/prs/index.htm)

   - Identify evidence-based interventions (EBIs) for inclusion in CDC's *Compendium* of HIV prevention interventions.
   - Review scientific literature.
   - Review interventions that have evidence to warrant dissemination using specified criteria developed through internal and external consultation.

   The *Updated Compendium* of HIV behavioral interventions was released in 2007 and covered studies published through 2005. The criteria for EBIs were made more stringent in the *Updated Compendium,* and the total number of identified interventions increased from 24 to 49 interventions. Other topics discussed related to the *Updated Compendium*:

   - Only individual and group-level interventions are included; community interventions will be added in 2009.
   - CDC packages some interventions, and some are packaged by companies and sold.
   - Fourteen EBIs are for adult women; 12 are for youth; 5 are for HIV-positive persons; and 4 are for MSM.
   - EBIs for people who use drugs are listed.
   - Four individual-level interventions are listed.
   - Five group-level EBIs for people who use drugs are listed.
   - A fact sheet for each intervention in the *Updated Compendium* is available on the PRS Web site.

2. Replicating Effective Programs Project
   (http://www.cdc.gov/hiv/topics/prev_prog/rep/index.htm)
   - REP converts EBIs into user-friendly packages.
   - Packages are tested for feasibility and usability in real-world settings.
   - Packages include an implementation manual, a facilitator guide, a technical assistance guide, a monitoring and evaluation guide, videos and handouts related to the intervention, and a training curriculum for facilitators.

3. Diffusion of Evidence-Based Interventions
   (http://www.effectiveinterventions.org/en/home.aspx)
   - Develop a national dissemination model for each intervention.
   - Develop train-the-trainer materials that provide training and ongoing technical assistance for delivering the intervention.
   - Discuss core elements and key characteristics for each intervention.
   - Discuss adaptation models: core elements cannot be changed; key characteristics can be changed to accommodate different populations or settings.

Betty Tai, PhD, Director, Center for Clinical Trials Network (CTN), NIDA

In the past 10 years, the methamphetamine epidemic has spread from the west coast to the east coast of the United States.

Treatment approaches include the Matrix Model; Cognitive Behavioral Therapy (CBT); and Contingency Management (CM), which provides motivational incentives. NIDA has made progress in treatment research over the past 10 years, but more research is needed. New medications are in various stages of development, but they are not yet approved by the Food and Drug Administration for this purpose.

Evidence-Based Practices

Evidence-based medicine involves the conscientious use of the best evidence in making decisions about the care of each patient. It is widely applied across all therapeutic areas by professional associations in the development of treatment guidelines, oversight agencies for quality measurement and improvement, treatment facilities for organizational management decisions, and health insurance companies for benefits and coverage.

Evidence from randomized clinical trials (gold standard) and from observational studies is used. More recently, epidemiology surveys and medical records are included as sources that may provide supporting evidence.

The CTN conducts many different types of clinical trials in different settings. Adherence to good scientific and clinical practices is considered essential to the research process and enhances the value of the studies conducted. The balance between internal and external validity is vigilantly

maintained. The CTN also considers the potential for translation of the study results into real-world practice.

CTN Approach

- Randomized controlled trials
- Joint efforts between researchers and practitioners
- Broad patient inclusion
- Real-world treatment settings
- Adherence to good clinical practices
- Balanced internal and external treatment

A Successful CTN Research Effort

In the past 10 years, NIDA has awarded 200 grants for CM in the treatment of drug addiction. The body of research is robust, and NIDA published a treatment manual in 1998. Despite these well-documented studies, this technique was not embraced in community treatment centers. Providers were concerned about how counselors and patients would respond to the intervention and unforeseen issues that might arise.

A CTN clinical trial for CM was developed with extensive input from practitioners to accommodate the practice environment and address practitioner concerns. This modified intervention was tested in two different settings with demonstrated effectiveness. The data showed decreased use of methamphetamine, and the cost analysis established that motivational incentives can be cost effective.

NIDA is a research organization that works diligently with other agencies to ensure the diffusion of innovative therapies and trial results into the community. NIDA and SAMHSA partner on the development of an ongoing dissemination effort to provide resources for practitioners to implement motivational incentives and other research findings in the community setting. Partnerships such as this are essential in advancing the science of addiction.

NIDA and other agencies work to reduce other barriers to the adoption of science into practice. To alleviate concerns, the HHS Office of Inspector General developed an advisory opinion to confirm that motivational incentives were not in violation of the Medicaid regulations of the Social Security Act.

Kevin Hennessy, PhD, Science to Service Coordinator, Office of Policy, Program, and Budget, SAMHSA

The National Registry of Evidence-Based Practices and Programs (NREPP) is 18 months old. Independent reviewers evaluate and rate interventions, and a summary is posted for every intervention reviewed. Lists of studies and resources submitted for review are also included.

NREPP, which used to be called the Model Programs Initiative, is trying to disseminate information about what works in delivering interventions in real-world settings. State-of-the-art techniques along with strategies, tools, and systems are available through http://www.NREPP.SAMHSA.gov/—a site that assists in identifying scientifically tested and readily distributable field interventions.

A summary and rating on different dimensions are listed for every intervention. The ratings provide measures of confidence in the studies' current key outcomes based on the quality of the research, availability, quality of materials, and readiness for dissemination. These factors are important when determining whether an intervention is a good fit for an organization.

A list of studies with links to abstracts of articles is available. Program developers can be contacted directly, and intervention developers can be asked questions about the cost, nature, and availability of a particular intervention.

In 2003, SAMHSA decided to increase its efforts in regard to mental health and substance abuse. People wanted more interventions to choose from and wanted to know how interventions were chosen for the registry (transparency); they also wanted the elimination of mandates for use of systems.

Some 125 interventions were reviewed as of November 2008. A keyword search produced four methamphetamine-specific interventions. NREPP interventions must meet the following three requirements:

- The intervention demonstrates one or more positive outcomes in mental health and/or substance use behavior among individuals, communities, or populations.
- Intervention results have been published in a peer-reviewed publication or documented in a comprehensive evaluation report.
- Documentation of the intervention and its proper implementation (e.g., manuals, process guides, tools, training materials) is available to the public to facilitate dissemination.

Plenary Session: 12:45 p.m.

Current Best Practices To Address Critical Populations

Thomas E. Freese, PhD, Director, Pacific Southwest ATTC

Evidence-based practice (EBP) is important to providers, funders, and consumers because it shows consistency, accountability, quality, and cost effectiveness of services. There is still a question about what constitutes best practices. SAMHSA uses EBP as one of the ten indicators of quality of care.

Evidence comes from randomized, state-of-the-art clinical trials. EBP lists can be found on a variety of sites: NREPP, American Psychology Association, American Psychiatric Association, and University of Washington Alcohol and Drug Abuse Institute. Analytic studies are also available. The lists are useful because they summarize the evidence available and provide a quick guide to available treatments that meet standards of EBP.

These lists also have limitations. They have different standards. EBP may be implemented without fidelity to the context of the research, and there is no information showing whether the adaptation worked. Care must be taken, however, not to exclude interventions that, although they have not shown an evidence base, show positive outcomes. Some interventions may not be researched fully because of a lack of funding. However, if only interventions that were part of a double-blind study were included, the list would be very small.

For some centers it may be better to teach EBP skills instead of training staff in the entire program. For instance, trained staff could help patients learn how to improve impulse control and reduce cravings, which would reduce substance abuse.

Matrix Model of Outpatient Treatment

- Was developed in 1994 for people using cocaine
- Creates explicit structure and expectations
- Teaches cognitive-behavioral concepts and reinforces them
- Provides ongoing feedback about what works and what does not work

Defining Features of Matrix Model

- Is manual driven but is not cookbook medicine.
- Is empirically based.
- Provides handouts for participants.
- Comprises individual sessions, early recovery group, relapse prevention groups, family education group, and 12-Step program.
- Focuses on positive behavior and ongoing feedback to move participants close to their goal.
- Does not use urinalysis as a punitive measure but as a tool.

It is not possible to say that any one piece is critical, but the Matrix Model as a whole is effective (California Department of Alcohol and Drug Problems, 2007; SAMHSA, 2006). The CSAT Methamphetamine Treatment Project was a study of more than 1,000 participants who on average used methamphetamine about 7.5 years; they also used marijuana and alcohol. Critical elements in the Matrix Model were shown to work well in seven of eight sites. People stayed in treatment longer and had more drug-free urine specimens than those who received treatment as usual.

It is important to look at a particular intervention's results when a project is moved from concept to completion.

MSM

NIDA conducted a study of four behavioral interventions in the Los Angeles area to determine whether behavioral treatment affected MSM methamphetamine use and high-risk activities for HIV exposure:

- CM—reward for drug-free urine sample
- CBT
- Combined CM and CBT
- Gay-specific CBT—took out drug information and replaced it with identity information. The treatment period was followed by another intervention. Gay-specific outcomes were the same as CM.

Elements of the study:

- Active treatment period was 16 weeks.
- Treatment response was good.
- Combination (CM and CBT) helped those in treatment for a long period.
- Depression rates were reduced dramatically.
- High-risk sex behavior was reduced in first 4 weeks with CM.
- Follow up had a positive mental health impact.

Behavioral Treatment Approaches for Methamphetamine Dependence and HIV-Related Sexual Risk Behaviors Among Urban Gay and Bisexual Men is available free of charge on the UCLA Integrated Substance Abuse Programs—Methamphetamine—Special Populations Web site. The manual can be downloaded from http://www.methamphetamine.org/html/special-pops-MSM.html.

Sanctions in some circumstances can work as well as cognitive treatment.

Women

Early trauma has a very negative impact on treatment. Women who are dependent on drugs have a greater risk of exposure to childhood adverse effects (CAEs)—such as childhood emotional, sexual, and physical abuse—than men do, and 60 percent report frequently witnessing domestic violence. (Brecht, O'Brien, Von Mayrhauser, & Anglin, 2004)

Women who use drugs are four times more likely to have been sexually abused as children than men were, and approximately 80 percent report continued physical/sexual abuse in adolescent and adult relationships. (Cohen, Dickow, Horner, Zweben, Balabis, Vandersloot, & Reiber, 2003) There is a cumulative effect; the more trauma that is experienced, the greater the likelihood that there will be negative outcomes. Increased exposure to CAEs increases health problems; consequently, there is a critical need for comprehensive programs for wellness along with addiction treatment.

Justice-Involved Individuals

Incarcerated people are not receiving treatment. Without treatment, they end up back in prison. In a 5-year period, almost half of offenders who continued treatment after release did not return to jail. Those who receive continuing care are more likely to stay off drugs (Martin, Butzin, Saum, & Inciardi, 1999).

Women offenders who have more severe psychological problems than their male counterparts were also less like to return to custody if they received continuing care. Gender-specific curriculum that focuses on women's issues and treatment needs is needed.

The Matrix Model was adapted for a program that connected treatment in incarceration to treatment in the community. Community providers who delivered post institutional care were trained in Matrix Model methods to facilitate offenders' transfer from a 400-bed in-prison treatment unit that also followed the Matrix Model. Outcome data are being collected.

Process Improvements

Good programs that are not on the EBP lists need to be identified. Effective dissemination strategies for getting information out to the populations that need them are also needed. The Network for the Improvement of Addiction Treatment allows treatment providers to share successes in process improvement. (For more information, see http://www.niatx.net.)

The NIDA/SAMHSA Blending Initiative encompasses several components. One component is the NIDA Blending Conference (http://www.seiservices.com/nida/blendingcinci/) that provides unique opportunities for teams of clinicians and researchers to co-present innovative scientific findings about drug abuse and addiction. Another key component is the creation of Blending Teams. These Teams create innovative "products" for the substance abuse treatment and research community. These products are being made available at nearly the same time that the research results are published in peer-reviewed journals, substantially reducing the gap between research and practice. More information is at http://www.nida.nih.gov/Blending/.

Springboard Sessions: 1:45 p.m.

The Challenges and Opportunities of Implementing Best Practices and Effective Programs

JUSTICE-INVOLVED SPRINGBOARD PRESENTATIONS ON BEST PRACTICES

Jeanne L. Obert MFT, MSM, Executive Director, Matrix Institute on Addictions, UCLA Integrated Substance Abuse Programs

The Matrix Model of Intensive Treatment is a guideline developed for the Behavioral Health Recovery Management project and is included in SAMHSA's NREPP (http://www.nrepp.samhsa.gov/).

What Is Evidence-Based Practice?

- EBP generally refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence.
- Controlled clinical studies are the most scientific. Other methods are also used.

EBP has three minimum requirements:

1. The intervention must demonstrate one or more positive outcomes in mental health and/or substance use behavior among individuals, communities, or populations.

   An example of an EBP is the Multi-site Trial of a Manualized Psychosocial Protocol for the Treatment of Methamphetamine by Richard Rawson, PhD. Dr. Rawson also is the associate director of UCLA's Integrated Substance Abuse Programs at the UCLA Research Center.

   The multi-site trial compared the Matrix Model with treatment as usual (TAU) (Rawson, Marinelli-Casey, Anglin, Dickow, Frazier, & Gallagher, 2004):

   - 978 people who use methamphetamine were seeking treatment.
   - CSAT multisite study; 1998–2002 (Costa Mesa, San Diego, Hayward, Concord, San Mateo, Billings, Honolulu).
   - Participants were randomly assigned to Matrix Model or TAU.

   Weeks in treatment: During the 9-week program, Matrix patients averaged an 8.2-week stay of treatment compared with 5 weeks for the TAU patients. The Matrix group were abstinent an average of 6 weeks, compared with 3 weeks for the TAU group.

2. Intervention results have been published in a peer-reviewed publication or documented in a comprehensive evaluation report. In this case, findings were published in the journal *Addiction* (Rawson, Marinelli-Casey, Anglin, Dickow, Frazier, & Gallagher, 2004).

3. Documentation of the intervention and its proper implementation (e.g., manuals, process guides, tools, training materials) must be available to the public to facilitate dissemination.

References for Understanding the Implementation of Best Practices and Effective Programs

NIDA published Principles of Drug Abuse Treatment: A Research Based Guide (Second Edition) (http://www.drugabuse.gov/drugpages/treatment.html).

Hazelden and CSAT published the following Matrix treatment manuals:

1. *The Matrix Model: Intensive Alcohol & Drug Treatment Program*
2. *The Matrix Model: Intensive Alcohol & Drug Treatment; Counselor's Treatment Manual*
3. *Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.*

Matrix Model Dissemination

- Matrix Institute contracts for 2-day core trainings that are conducted by Matrix trainers with clinical experience using the model.
- In the past 3 years, more than 240 of these trainings have been conducted nationally and internationally (7000+ individuals).
- The Matrix Key Supervisor is the in-house trainer, the change agent, and the Matrix advocate and ensures fidelity.
- An established program with a Key Supervisor may apply for Matrix Institute certification.
- Tuition is provided for two people to attend the 2.5-day Key Supervisor training.
- The training is conducted by Matrix trainers with clinical experience using the model.

The Matrix Model

- Cognitive-based treatment
- Motivational interviewing
- 12-Step facilitation
- Family therapy
- CM

The Matrix Model Treatment Components

- Individual sessions
- Early recovery groups
- Relapse prevention
- Family education
- 12-Step meetings
- Social support groups
- Relapse analysis
- Urine drug testing

Triggers and Cravings, The Progression of Addiction Information, Roadmap for Recovery

- Withdrawal
- Early abstinence, honeymoon
- Protracted abstinence, the wall
- Adjustment/resolution

Defining Features of Matrix Model

- A comprehensive manual-driven program with simple, well-organized instructions
- A clinical program with empirically based interventions
- A series of patient handouts for each session in a patient workbook that contains written and illustrated concepts

Marjean Searcy, SSW, Project Coordinator, Salt Lake City Police Department, COPS Methamphetamine Initiative

Established in 1998, the Salt Lake City COPS Methamphetamine Initiative is one of seven Department of Justice COPS Methamphetamine Initiative grantees. The Salt Lake Methamphetamine Initiative involves more than 30 local, State, and Federal agencies and uses a comprehensive approach to confront the problem of methamphetamine use.

The COPS Innovations Promising Strategies from the Field

A national overview includes:

- Drug endangered children
- Chemically contaminated properties cleanup
- Public awareness and training campaign
- Comprehensive multiagency collaboration

Continued evaluation encompasses baseline data, trend review, and an adjusted approach by:

- Institute of Law and Justice/COPS: An evaluation for the COPS Office Methamphetamine Initiative at http://www.cops.usdoj.gov/files/RIC/Publications/meth_initiative.pdf
- Local evaluation, Bach Harrison LLC
- Local longitudinal study effort (Primary Children's Medical Center, South Main Clinic)
- Interagency study

Utah's Governor implemented the Meth Task Force in 2006. This effort involved a public awareness campaign that focuses on hope in recovery. It leveraged the work of the Salt Lake COPS Meth Initiative and provided the next step for women with methamphetamine addiction to receive substance abuse treatment services. The public awareness campaign involved the Women Methamphetamine Use Survey, media campaign literature review, and the local media in the End Methamphetamine Now Campaign (Bach Harrison, LLC, 2008).

The research study underway includes cases involving drug endangered child (children located at drug environments in Salt Lake County including all drugs of abuse). Data were collected from the Salt Lake County District Attorney's Office, State of Utah Third District Court, Salt Lake and West Valley City Police Departments, Utah Division of Child and Family Services (DCFS), Salt Lake County Substance Abuse Treatment Services, and Utah Division of Substance Abuse and Mental Health.

Ms. Searcy presented slides showing evidence that children were living in close proximity to methamphetamine labs and other drug environments. Stuffed animals and other toys were interspersed with drug paraphernalia in the homes where drugs apparently were being manufactured, distributed, or used. In one slide, a small girl crouches inside a makeshift playpen in a bedroom; above her, a box of toys sits on a wood plank that covers the playpen.

Utah's Child Endangerment Statute states that a defendant who knowingly or intentionally causes or permits a child (or elder adult) to be exposed to, ingest, inhale, or have contact with a controlled substance, chemical substance, or drug paraphernalia is guilty of a third-degree felony.

Ms. Searcy cited a number of criteria that are used in police and DCFS data: Was a guardian on the scene? Was intent to distribute found? Was the location a high traffic area? Was the victim removed? Was the location filthy? Were weapons found? Were bodily fluids found? Were syringes found? Was stolen property found? Was rotten food found? Was a clandestine lab found? Was pornography found? Was the residence closed? Were roaches found? Were vermin found?

As noted earlier, the public awareness campaign involved the Women Methamphetamine Use Survey, media campaign literature review, and the local media in the End Methamphetamine Now Campaign (Bach Harrison, LLC, 2008).

Main Referral Resources in Order of Frequency

- DCFS
- Adult court
- Probation
- Individual
- Alcohol/drug abuse care provider
- Other community providers
- Juvenile court
- Parole/prison
- Driving under the influence/driving while intoxicated referrals
- Other healthcare providers in school/workforce (Nelson, Prince, & Searcy, 2009, 2010)

Methamphetamines were overwhelmingly the substance of choice for females: 40 percent for females and 11.8 percent for males. Marijuana (35 percent) was females' second choice. Alcohol and marijuana (29.4 percent) were the leading substances of choice for males.

About 11.7 percent were living in a private residence and did not require support.

The vast majority of cases were treated on an outpatient basis. From 45 to 70 percent were outpatient cases, regardless of whether the person had been in treatment once or 10 times. The most severe cases, which represented 10 to 30 percent of the total cases, were in residential detox or residential facilities. Individuals who had been in treatment seven times ended up in residential detox or residential facilities 30 percent of the time, but those percentages dropped off if the person underwent treatment 8 to 10 times (Nelson, Prince, & Searcy, 2009, 2010).

LGBT SPRINGBOARD PRESENTATIONS ON BEST PRACTICES

Perry N. Halkitis, PhD, MS, Professor of Applied Psychology and Public Health Associate Dean for Research and Doctoral Studies, New York University, Director, CHIBPS

Interventions based on CBT and social learning theory appear to work successfully with the LGBT community. The goals are to help individuals develop coping strategies and to better understand how methamphetamine use plays a role in their lives. Within the context of community-based programs, CBT is the most effective because individuals are asked to think about their behavior.

Therapy Approaches

The Matrix Model is the most widely acclaimed approach for working with people who use methamphetamine because it extends beyond CBT principles and has demonstrated effectiveness (SAMHSA, 2006). Based on CBT and motivational interviewing, the Matrix Model helps people think about and change their behavior.

CM has been successfully applied to treat people who use heroin as well as to improve children's learning. Studies show a longer mean period of abstinence than with other treatment, but questions remain about what happens to individuals when vouchers rewarding their behavior are no longer available.

The 12-Step approach based on the AA model is the standard of care and easily available. In New York, most gay men get support from Methamphetamine Anonymous programs because that is what they know about. These programs are somewhat controversial because they center on religion. Although the 12-Step programs seem to show success, there are no data on the long-term effectiveness for people who use methamphetamine (California Department of Alcohol and Drug Programs, 2007). People finishing treatment commonly use a 12-Step program as continuing care.

Several studies have tried to quantify the effectiveness of behavioral therapy combined with medication to determine whether this is a good treatment approach for methamphetamine use. Some individuals who were on antidepressants and received talk therapy had more cravings than those who were not on antidepressants (Miller, 2007; Shoptaw, et. al., 2006). There is a belief that psychological and social processes have a biological manifestation in people who use methamphetamine. In addition, the link between methamphetamine use and sex needs to be examined.

Strategies

The role that sex plays in the lives of people who use methamphetamine must not be overlooked. Determining what comes first, the need for drugs or the need for sex, is a vital piece of the puzzle, and knowing the answer can affect how programs address the stigma of being an LGBT individual who uses methamphetamine.

Programs that focus on the strengths of the individual and deliver the message that LGBT people are strong, powerful, and resilient do not make drug use the centerpiece of their efforts. Individuals' social supports should be identified and fortified to counter the drug addiction.

Executive functioning and decision making processes for people who use methamphetamine are different from those of people who do not use methamphetamine and affect how the person who uses methamphetamine interacts with the world. Talk therapies need to be tailored to address the individual's limited capacity.

Joseph Amico, Vice President for Program Development, Alternatives, Inc.; Community Educator, Alternatives, Inc., and Rainbow Bridge Community Services; President, NALGAP: The National Association of Lesbian and Gay Addiction Professionals

When policies are put into effect, often they do not reflect the needs of the people in the field who are doing the work. Better communication is needed among counselors, therapists, researchers, and others involved in providing services to LGBT individuals who use methamphetamine and the national partners. This will help policymakers develop better national policies and provide them with greater understanding of where funding goes.

Treatment providers can adapt EBPs to a diverse LGBT population, and national partners such as SAMHSA can address the need for universal standards and definitions for culturally specific treatment. In addition, accrediting organizations such as The Joint Commission (JCAHO) and nonprofits can begin to require sexual orientation data as part of their intake process and psychosocial evaluations.

Challenges

Inpatient program data show that many gay men have two or more diagnoses and use more than one drug, with methamphetamine as their drug of choice, and 85 percent are on Medicare and Medicaid for HIV disability (Alternatives, 2008). However, Medicare and Medicaid do not cover substance abuse treatment, which presents a problem in devising a treatment plan.

In the development of a treatment plan, it is unclear who defines best practices for LGBT individuals. Psychologists, social workers, and substance abuse counselors have roles in treating LGBT individuals. There is no research organization, however, that defines best practices, and there is no consensus about who decides what they are.

Some programs think they are LGBT sensitive, have identified staff members as specialists, and think that is enough.

Faith-based programs are funded to do reparative therapy. If the goal of best treatment practices is to do no harm, where are the voices against this?

Most States have licensure requirements for culturally specific training; however, LGBT issues are not included. A few hospital programs require staff to take in-service LGBT sensitivity training. This training is not designed to change religious or moral beliefs, but it sends the message that it is not good clinical practice for individuals who cannot overcome their beliefs to work with LGBT patients.

Some providers are uncomfortable with discussing sex.

Funding for research does not require the inclusion of sexual minorities. In the last decade, research has focused on MSM and not on gay men.

The literature on addiction treatment shows that more consistent and frequent interactions have greater effect. This brings up the question of why treatment facilities are not open on weekends.

People who are addicted to substances are often not heard from in the development or evaluation of programs, making it difficult to measure the success of a program. In addition, a new generation of LGBT individuals who are addicted does not have a voice in the creation of new programs and needs to be brought into the discussion.

Opportunities

CM that uses rewards remains controversial because of the issues involved in funding it. Some research shows positive outcomes from relatively small rewards such as when working on smoking cessation for HIV patients. It has been found that, when patients were rewarded for their initial engagement and retention in treatment, they did not need rewards by the end of the program because they found intrinsic rewards from their treatment.

There is a real ability of many people to engage in long-term motivation and the incremental processes to change their behavior.

Residential programs that run mostly substance abuse treatment programs focus on consequences and judgment. Programs can be revamped to reflect a tier system by rewarding individuals for their progression in learning the rules. The area of the brain stimulated by crystal methamphetamine is the same area as that stimulated by rewards. A reward system in the first 30 to 60 days is a positive trigger for individuals who do not have the capacity to fully function because the frontal lobe of the brain is affected, causing people who use methamphetamine to experience impulsivity and have difficulty making decisions. However, over time, the brain appears to return to normal.

Transitional housing and residential treatment appear to be incentives because many people who use methamphetamine are homeless. However, no data show what the success rates are for residential programs that also employ transitional housing and continuing care.

Alison Hamilton, PhD, Assistant Research Anthropologist, Integrated Substance Abuse Programs, UCLA

The Matrix Model—enhancing CBT—is a standardized model of treatment and has been shown to be effective for treating people who use methamphetamine.

The Matrix Model was implemented as a standard treatment model in California, Hawaii, and Montana. The Model has some individualized components, but it is mostly a group model. It can be modified to address the specific needs of the target population; for example, a culturally adapted version of cognitive behavioral treatment worked well for men who have sex with men in Los Angeles (Shoptaw, et. al., 2005).

Women are often a concern for providers. Their issues/needs are complicated and frequently pose a challenge to traditional treatment approaches.

Unfortunately, little attention has been given to intergenerational drug use; some people are exposed to methamphetamine by their parents or grandparents. This cycle of intergenerational methamphetamine use is initiated at an early age and becomes a mechanism for dealing with weight loss, issues of sexual abuse, and low self-esteem. (SAMHSA, 2007) Methamphetamine also plays a role in issues of violence against women by partners and other family members. This aspect is often overlooked and may play a critical role in the cyclical nature of methamphetamine use between generations.

People who inject methamphetamine fare more poorly than people who use other forms of intake. People who inject had the poorest treatment prognosis. Some generalized findings include the following:

- Women may do better in groups; they like the socialization.
- People who use methamphetamine may need longer treatment. Multiple drug use adds to their length of treatment (California Department of Alcohol and Drug Programs, 2007).

Sharon Amatetti, MPH, Senior Public Health Analyst, CSAT, SAMHSA

Histories of Violence Among Clients Treated for Methamphetamine

Eighty-five percent of women and 69 percent of men in treatment for methamphetamine reported high rates of violence. For 80 percent of the women, the most common source of violence was a partner; for 43 percent of men, it was strangers. Fifty-seven percent of women and 16 percent of men reported a history of sexual abuse and violence (Brecht, O'Brien, Von Mayrhauser, & Anglin, 2004).

Best Practices: CSAT's Methamphetamine Treatment Project—Matrix Model

- Largest randomized clinical trial of treatment for methamphetamine dependence (Obert, McCann, Marinelli-Casey, Weiner, Minksy, & Brethen, 2000)
- Intensive outpatient setting
- Three to five visits per week of comprehensive counseling for at least the first 3 months
- Cognitive-behavioral approach
- CM
- Fairly good outcomes for this model of treatment
- Treatment outcomes do not differ from those of other drugs of abuse
- Treatment outcomes have more to do with the quantity and quality of treatment than the type of drug abused

Gender Differences and Implications for Treatment

- Co-occurring mental disorders complicate treatment and require longer duration of treatment. Women bring more co-occurring mental disorders to treatment than men do (Stromwall & Larson, 2004).
- Sexual behavior linked to methamphetamine use is a significant clinical issue that needs to be addressed in women-only groups (Rawson, 2008).
- Violence linked to methamphetamine use is related to trauma and safety needs, which must be addressed in treatment.
- Body image and nutrition need to be addressed (Rawson & Anglin, 1999).
- Trauma needs to be addressed.
- Primary parenting role is often an issue.

Predictors of Longer Abstinence

- Longer time in treatment (e.g., those with 4 or more months of treatment have more than double the abstinence rate at 24 and 48 months after completion) (Obert, McCann, Marinelli-Casey, Weiner, Minksy, & Brethen, 2000)
- More sessions per month of individual counseling (Obert, McCann, Marinelli-Casey, Weiner, Minksy, & Brethen, 2000)
- Treatment, intervention, and case planning need to account for short-term effects, especially cognitive deficits and verbal communication
- Drug court involvement
- Family involvement

Child Welfare Best Practice: Sacramento County's Comprehensive Reform

- Sacramento County population is 1.5 million.
- In 2004, there were about 7,000 substantial child abuse/neglect referrals in Sacramento.
- An estimated 70 to 80 percent of child welfare cases involve families affected by substance abuse.

- More than half of court-ordered cases involved methamphetamine (Boles, Young, Moore, & DiPirro-Beard, 2007).

Sacramento County before reform:

- Reunification rate was about 20 to 25 percent.
- Parents were unable to access Alcohol and Chemical Dependence (ACD) treatment.
- Social workers, attorneys, and courts were often uninformed on parent progress.
- Drug testing was not uniform, and results were delayed.

Five components of Sacramento County's comprehensive reform:

- Comprehensive cross-system joint training
- Substance abuse treatment system of care
- Early intervention specialists
- Recovery management specialists
- Dependency drug court

Sacramento County after reforms:

- Reunification rates are at 40 to 45 percent.
- Reunification is occurring faster.
- Parents truly have "treatment on demand."
- All parties involved in the case are informed at every stage of treatment.

Trauma-informed treatment approaches for women: (Moses, Reed, Mazelis, & D'Ambrosio, 2003)

- "Trauma-informed" = treatment adaptations to accommodate pervasiveness of trauma experience (program characteristics, treatment policies or restrictions, etc.)
- "Trauma-specific" = treatment practices and program components to directly manage trauma experience and symptoms

Plenary Session: 4:00 p.m.

Future Funding and Support for Activities Related to This Initiative

Note: Funding levels discussed in all presentations in this section were as of November 17, 2008 and *are not current.*

Edwin Craft, DrPH, MEd, LCPC, Lead Government Project Officer and Activities Coordinator for Methamphetamine, CSAT, SAMHSA

Dr. Craft presented an overview of CSAT grant funding and methamphetamine-related products.

- 2009 continuing resolution and programs are funded.
- Level of funding for Substance Abuse Block Grants is $1.76 billion.
- Level of funding for ATR is $96.8 million and includes $25 million for methamphetamine activities.
- Level of funding for drug courts is $10.1 million, which includes approximately $3.1 million for new drug court grants.
- Minority HIV/AIDS funding is $63.1 million.
- Level of funding for SBIRT is $29.1 million.
- Level of funding for Pregnant and Postpartum Women is $11.8 million.
- Funding for Targeted Capacity Expansion (TCE) General is $35.2 million, which includes approximately $11.3 million for new TCE General grants.
- Level of funding for Children and Families is $23.9 million, which includes approximately $8.0 million for new treatment grants for adolescents and their families.
- Level of funding for Homeless is $42.5 million, which includes approximately $11.3 million for new Homeless grants.
- CSAT has several products available related to methamphetamine treatment. These include Treatment Improvement Protocol (TIP) 33, *Treatment for Stimulant Use Disorders*; a two-DVD set from the Pacific Southwest ATTC that covers the etiology and physiology of methamphetamine and an introduction to evidence-based methamphetamine treatments; the set of manuals for the *Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders* (*Counselor's Treatment Manual, Counselor's Family Education Manual, Client's Handbook, Client's Treatment Companion)*; and a new SAMHSA/CSAT methamphetamine video: *Intensive Outpatient Treatment: Family Education Video* will address triggers and craving, a roadmap for recovery, and families in recovery (scheduled for release in 2010).

- SAMHSA/CSAT also has products available for development of culturally relevant services for LGBT populations: *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* and the accompanying training curriculum help providers create culturally relevant treatment environments and treatment protocols. The training curriculum is available in Spanish. A substance abuse training curriculum targeting minority MSMs is also under development by the ATTCs.
- TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women,* helps providers create gender-specific treatment environments and protocols. In addition, a new SAMHSA/CSAT gender-specific adaptation of the Matrix Model will address the treatment needs of women (in concept development stage).

Claudia Richards, MSW, LICSW, Chief, Community Grants and Program Development Branch, Center for Substance Abuse Prevention (CSAP), SAMHSA

Ms. Richards provided an overview of CSAP grant funding opportunities.

CSAP has provided grants to various States and communities to create an effective prevention infrastructure. CSAP has developed several resources for organizations, schools, professionals, and others involved in prevention efforts. These resources may be accessed at: http://www.prevention.samhsa.gov/capacity/prevedutools.aspx.

In 2006, SAMHSA/CSAP awarded 10 grants to support expansion of methamphetamine prevention interventions and/or infrastructure development. This program addresses the growing problem of methamphetamine abuse and addiction by assisting localities in expanding prevention interventions that are effective and evidence based and/or increasing capacity through infrastructure development. The goal is to intervene effectively to prevent, reduce, or delay the use and/or spread of methamphetamine abuse. In 2007, SAMHSA awarded two additional grants to prevent methamphetamine abuse.

Information about these 12 CSAP methamphetamine grantees is at http://www.prevention.samhsa.gov/grants/methamphetamine.aspx. These 12 grantees are listed here.

Grant #	Grant Name	Location
14008	University of Washington School of Medicine Fetal Alcohol and Drug Unit	Seattle, WA
14018	Colorado State Judicial Branch	Denver, CO
14033	Association for the Advancement of Mexican Americans, Inc. (AAMA)	San Antonio, TX
14042	Centerstone Community Mental Health	Tullahoma, TN
14050	Cherokee Nation Behavioral Health Services	Tahlequah, OK

Grant #	Grant Name	Location
14085	Native American Rehab Association	Portland, OR
14088	Ridgeview Center, Inc.	Oak Ridge, TN
14100	Oklahoma State Department of Mental Health	Oklahoma City, OK
14113	Crawford-Wabash-Lawrence (CRA-WA-LA) Volunteers in Probation	Lawrenceville, IL
14133	California Recovery Clinics	Corona, CA
14142	Fenway Community Health Center	Boston, MA
14156	San Antonio Fighting Back, Inc.	San Antonio, TX

CSAP has a methamphetamine use prevention grant program that funded $19.6 million from FY 2002 through 2008 for approximately 30 programs in 16 States. Information about the CSAP HIV grant program is at http://www.prevention.samhsa.gov/grants/hiv.aspx.

In 2004, SAMHSA invested more than $111 million to develop local capacity to provide mental health and substance abuse treatment and prevention services for individuals living with and affected by HIV/AIDS. These funds assist States with outreach and training, addressing the special needs of racial and ethnic minorities and studying the costs associated with delivering integrated care.

The Drug-Free Communities Grant Program has earned strong bipartisan support. This program provides grants up to $100,000 to community coalitions to reduce drug/alcohol abuse among youth. Information about this program is available at: http://www.prevention.samhsa.gov/grants/drugfree.aspx. The Drug Free Communities Act has been extended for 5 years, through FY 2013.

The White House Office of National Drug Control Policy (ONDCP) directs the Drug-Free Communities Support Program in partnership with SAMHSA. This anti-drug program provides grants of up to $125,000 to community coalitions that mobilize their communities to prevent youth alcohol, tobacco, illicit drug, and inhalant abuse. Information is available at http://www.ondcp.gov/dfc/overview.html.

Information on grant opportunities available at CSAP can be found at: http://grants.gov/ or http://prevention.samhsa.gov/whatsnew/default.aspx.

CSAP's role is to create healthy communities that are free of drugs. The role of prevention is to create healthy communities in which people have:

- Healthy environments at work and in school.
- Supportive communities and neighborhoods.

- Connections with families and friends.
- Communities that are drug and crime free.

CSAP also promotes a structured, community-based approach to substance abuse prevention through the Strategic Prevention Framework (SPF). The SPF approach provides information and tools that can be used by States and communities to build an effective and sustainable prevention infrastructure. SPF aims to promote youth development, reduce risk-taking behaviors, build assets and resiliency, and prevent problem behaviors across the individual's lifespan. SPF uses a five-step process to achieve these goals, which can be found at http://www.prevention.samhsa.gov/about/default.aspx.

Eva Margolies, Associate Director for Planning and Policy Coordination, National Center for HIV/AIDS, STD, TB Prevention, and Viral Hepatitis, CDC

Ms. Margolies presented an overview of CDC grant funding opportunities and some of the current work related to methamphetamine and substance abuse:

- The Center has a budget of approximately $1 billion for domestic programs, two-thirds of which is for HIV/AIDS (domestic).
- Most funding goes to State health departments—where local providers may find funding opportunities.
- The Center funds more than 100 community-based organizations for HIV prevention directly.
- MSM of all races and African-Americans are priority populations for all funding.
- Methamphetamine research at CDC is conducted through cooperative agreements that focus on methamphetamine use by MSMs.
- These programs are adapted for African-American MSM who use methamphetamine.
- One intervention focuses on MSM in small towns.
- Project Mix includes interventions with MSM who abuse substances.
- Adapt 2 includes interventions with episodic substance use by MSMs.

Kristen Martinsen, Public Health Analyst, Office of Rural Health Policy, HRSA

Ms. Martinsen provided an overview of HRSA grant funding opportunities:

- No initiative specifically targets methamphetamine; community health centers provide primary care services including mental health and substance abuse treatment services to underserved populations.
- Screening and Brief Intervention Initiative establishes protocols for screening and brief intervention as part of routine health services.

- Several community-based grants (Rural Health Outreach and Rural Health Network Development Grants) support community consortia on specific healthcare needs such as substance or methamphetamine abuse. More information can be found at http://www.hrsa.gov/ruralhealth/.
- Rural Assistance Center provides information about funding opportunities, research, and methamphetamine. More information can be found at http://www.raconline.org.
- Rural Health Research Gateway provides summaries of current and completed research projects and related publications funded through HRSA's Office of Rural Health Policy. More information can be found at http:/www.ruralhealthresearch.org.
- New funding for prescription drug and methamphetamine abuse in the Appalachian region is scheduled for next year.
- More information is at http://www.hrsa.gov.

Susan Weiss, PhD, Chief, Science Policy Branch, Office of Science Policy and Communications, NIDA

NIDA supports a broad portfolio of research on methamphetamine aimed at determining who is using and why; identifying risk factors for addiction and other adverse health consequences (e.g., HIV/AIDS); developing medications and behavioral treatments; and broadening our knowledge of how methamphetamine affects the brain and whether its deleterious effects can be reversed. Dr. Weiss provided an overview of NIDA funding opportunities.

Methamphetamine Research

- Prevention: school and family programs
- Basic mechanisms: to understand how methamphetamine alters brain structure and function (including epigenetic research)
- Genetics: why some people are more vulnerable than others
- Treatment
- Medications development: vaccines to prevent relapse by blocking methamphetamine's entry into the brain
- Behavioral therapies: CBT, Matrix Model, motivational incentives
- Recovery: whether brain and behavioral abnormalities reverse with abstinence
- Impact on other diseases: HIV/AIDS transmission and course of illness

General Research in Drug Abuse/Addiction

- Treatment in community settings: the Clinical Trials Drug Abuse Treatment Network
- Criminal Justice Drug Abuse Treatment Studies (CJ-DATS): covers treatment and implementation research within criminal justice settings and during transition back to communities; includes juvenile justice
- Health services research involving States, communities, and academic institutions
- Screening and brief interventions to improve early detection of drug problems in medical settings
- Roadmap: National Institutes of Health funding initiatives, including clinical and translational service awards (CTSAs)—research centers that conduct studies involving community practice and community input); eventually there will be 60 sites across the country
- Community participation research: involve community and researchers, with community participation at every level, including developing and disseminating research

The NIDA Networking Project provides information on NIDA Web site to facilitate interactions between NIDA's clinical and basic research networks and other stakeholders. It is organized geographically so that people can find out what is going on in their States. (More information can be found at https://nnp.drugabuse.gov/.)

Drug abuse information, including research funding opportunities, is available at: http://www.drugabuse.gov/nidahome.html.

Calvin K. Hodnett, Management Analyst, COPS

Mr. Hodnett provided an overview of COPS grant funding opportunities and tools for fighting methamphetamine:

- COPS has funded $500 million of methamphetamine-related grants over the last decade.
- COPS collaborates with the Drug Enforcement Administration and CSAT on the Governors' summits on methamphetamine.
- COPS information on drugs and crime is on a CD in the registration packets of attendees at these summits.
- COPS encourages grantees to increase collaboration and information sharing about methamphetamine and related issues.
- Future funding levels are uncertain.
- Tools for combating methamphetamine may be found at http://www.cops.usdoj.gov/default.asp.

Tim Jeffries, Policy Advisor, BJA Substance Abuse and Mental Health Team

Mr. Jeffries provided an overview of BJA grant funding opportunities:

- The Web site for grant-funding information is http://www.ojp.usdoj.gov/ovc/fund/welcome.html.
- Discretionary funding is for nonviolent offenders (drug courts) and allows offenders to get treatment in communities.
- Methamphetamine is a priority for drug court grants.
- The Department of Justice is partnering with the National Drug Court Institute to develop a comprehensive drug court training series for practitioners. More information can be found at http://www.ndci.org/trainings.
- Edward Byrne Block Grant funding can be used to support methamphetamine task forces and drug courts.
- Community presentations have reached more than 12,000 people. More information can be found at http://www.drugfree.org.

Mark Krawczyk, Deputy Director, Advertising, National Youth Anti-Drug Media Campaign, ONDCP

Mr. Krawczyk provided an overview of ONDCP resources on methamphetamine:

- Campaign materials have been tested in focus groups before target audiences. Many print and radio ads can be tailored for local use. Prevention-focused print ads and Web banner ads are available at http://www.methresources.gov/free-psa.html.
- For every dollar spent on drug treatment, $12 are saved in healthcare and drug enforcement arenas.
- National Congress of American Indians and Partnership for Drug-Free America have developed anti-methamphetamine print ads.
- More information is available at http://www.ncai.org and http://www.methresources.gov.

Wednesday, November 19, 2008 | Plenary Session: 10:45 a.m.

Wrap-Up and Summary Report Out for All Critical Populations

The closing plenary session provided an overview of *The Summit* recommendations by Mr. Copple, *The Summit* facilitator. Each critical population discussion group presented one key recommendation for each domain (18 in all) as a snapshot of its work over the 3 days. The various groups participating in *The Summit* then worked on their Action Plans.

Overview of *The Summit* Recommendations

Mr. Copple provided an overview of crosscutting recommendations in each of the four strategic focus areas and unique issues that emerged from the work of the breakout groups:

Data Collection and Research

- Increased funding for research, especially for underrepresented populations.
- Measure and document resiliency factors as well as risk factors: What are the tools for underrepresented populations?
- Add sexual orientation, behavior, gender identity, and expression questions to National, State, and local surveys.
- Coordinated data systems
  - Across systems
  - Local, State, Federal
  - Common definitions
  - User friendly
  - Culturally inclusive/culturally competent
  - Consumer input
  - Public and private

Cultural Competency

- Require funded programs to demonstrate cultural competency.
- Train policymakers and administrators as well as line staff.
- Ensure organizations providing services reflect their communities.
- Link cultural competency with professional and facility credentialing.

Access to Substance Abuse Services

- Address the unique barriers of LGBT individuals, women, youth, rural and Tribal communities, and people of color to improve access and services:
  - Policies and materials that support inclusivity and diversity
  - Transportation and childcare for women
  - Rural and territory needs
    a. Efficacy of services for context
    b. Limited number of providers.
- Integrate and coordinate systems and services: mental health, substance abuse, criminal justice, public health, HIV/AIDS, domestic violence, and child protection.
- Provide comprehensive continuum of services including pretreatment.
- Initiate policies/practices to promote LGBT and women-friendly services.

Best Practices

- Fund programs with promising practices or evidence-informed practices for underserved populations.
- Data are lacking to validate EBPs in underserved populations or settings.
- Increase research to practice and practice to research.
- Disseminate best practices through clearinghouses, using existing resources.

Unique Issues

- Address trauma
  - Women
  - LGBT individuals
  - Incarcerated populations
  - Military
- Address youth and child protection issues.
- Ensure accountability for all of the above.

The overview of crosscutting issues was followed by individual presentations from each critical population identifying its top recommendations in each of the six domains. Following the presentations from each critical population on top recommendations, Action Teams, grantees, and national organizations met to identify next steps and complete the Report Out forms for SAMHSA.

Call To Action

Mr. Copple closed *The Summit* with a call to action. He began by talking about the lessons of United Flight #93, the plane that went down in Pennsylvania on September 11, 2001. The flight began normally, in a controlled, predictable environment with expected procedures and outcomes. There were no identifiable signals of change or disruption. Then the repetitive cycle was broken, terrorists seized the cockpit, killing individuals in control and creating a climate of fear and chaos. All things were now unpredictable. The passengers responded by trying to create a reasoned, patterned response out of chaos. They gathered at the back of the plane and began assessing "what do we know." Based on cell phone calls, they knew they were part of a larger attack on the United States and that the plane was being used as a weapon. They asked, What skills do we have? What are our assets? Who can execute those skills? Then they did the quintessentially American thing we all do as early as kindergarten, they voted. The feasibility of success was not a variable. They did not ask what their chances were. They acted without a guarantee of success.

The leadership lessons learned from United Flight #93 reinforce the following principles:

- Gather information
  - — Use the resources you possess
  - — Do not blame the tools.
- Assess skills (What do we have?)
  - — Always an asset
  - — Remember Apollo XIII: What **do** we have to work with?
- Build consensus around a goal
  - — What do we have in common?
  - — What can we live without?
- Execute with abandonment.

Moving from Understanding to Action

Ms. Anne Herron congratulated *The Summit* participants on their hard work and reiterated the Federal partners' commitment to making *The Summit* possible and supporting follow up on *The Summit* recommendations. She gave special recognition to the Action Team Leaders who convened the State/Territorial Teams, especially the Single State Authorities that played a leadership role in organizing the teams, including representatives of the three critical populations and the six domains.

Adjournment

Dr. Craft provided the final closing remarks for *The Summit* by expressing his appreciation for everyone who had made *The Summit* a success. He also provided instruction to the Action Teams on following up on their Action Plans and information about technical assistance resources available from SAMHSA to support their efforts.

Appendix A: References

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Appendix B:
Expanded Summary of
The Summit Recommendations

Expanded Summary of *The Summit* Recommendations

Justice-Involved Populations

Data Collection

1. Develop universal statewide accessible, centralized data warehouses/repository with uniform data collection systems that can share information across agencies, systems, and States and address needs of both rural and urban localities.

   Action Steps

   a. Begin with standardized definitions of terms, data elements, and units of measurement to be used for cultural sensitivity. In conjunction, create one centralized data collection tool for States to input data across all SAMHSA grants.

   b. Integrate public and private sectors and link public health, public safety, and other systems. Provide access to outcome data at all levels: provider, local, Tribal, State, and Federal. Establish a task force to address jurisdictional problems that often result in a lack of uniform system data collection.

   c. Develop a connected data system using the Strategic Prevention Framework State Incentive Grant (SPFSIG) data system as a model and enhance the skills and number of community anti-drug coalitions to address methamphetamine issues including families, communities, or others.

   d. Look at "shared assessment" models for client intakes in community services that promote better data collection across systems, resulting in reduced paperwork and administration.

   e. Enhance the capacity for establishing privacy policies that ensure the confidentiality of individuals and allow for agreements among agencies to facilitate data sharing and case management.

   f. Identify States where clients get "unique" identifiers, research this practice, and, if it is found to be an evidence-based practice, implement and replicate it.

2. Convene a task force to conduct a needs assessment of the juvenile justice system, focusing on youth addicted to methamphetamine, needs of their siblings, information from family-based assessments, and criminal justice-involved families in general.

3. Advocate for legislation that supports data collection and research. Align funding opportunities with funding sources. Allow flexibility for local needs. Establish a mechanism for grantees to inform Federal agencies in a timely manner and a realistic expectation of a timely response. Establish non-drug-specific discretionary Block Grants to meet local needs.

   Action Steps

   a. Advocate for Federal statutes to require that common data elements be collected and shared across systems (i.e., change regulations in Title 42 of the Code of Federal Regulations and Health Insurance Portability and Accountability Act).

   b. Develop long-term studies of the treatment, health, and social outcomes of people who are addicted to substances and drug-endangered children by drug classification to assist future policy changes and funding streams.

   c. Expand data collection and research opportunities focused on outcomes related to courts—standardized data collection, reporting, and outcome measurements and evaluation data.

4. Capture comprehensive data components such as health consequences and mortality of those who use substances, including homeless populations, families and children, and those people with histories of violence/witnessing violence and drug/alcohol influences contributing to school dropout.

   Action Steps

   a. Develop programmatic, process-driven data collection systems to identify root causes, existing community needs, community awareness, and effective support strategies; replicate best practices; and define lessons from recovery—how individuals and families got there and what worked for them. Provide access to prevalence/incidence rates for specific populations that may identify triggers that contribute to substance abuse.

   b. Reinstitute the Arrestee Drug Abuse Monitoring (ADAM) system to document whether perpetrators of crimes have methamphetamine in their systems at the time of their offenses. Add specific substances, including methamphetamine and alcohol, to police department tracking systems.

5. Fund prospective research projects that compare outcomes for different cultures and demographic groups. Ensure that these projects address clinical care of the justice-involved population, recovery-oriented research focused on "continuous care" in the community versus "episodic care," and NOMs-based research to identify factors that enhance recovery and reduce recidivism or measure the impact of alternatives to incarceration on recovery and treatment adherence.

6. Analyze all aspects of recidivism. Clearly define recidivism at the national level through a task force approach that involves individuals from nongovernmental organizations/community

coalitions and that allows for comparison and aggregation across States. (Three groups prioritized this.)

Cultural Competency

1. Prepare a model State policy encouraging agencies and organizations to conduct a needs assessment of the status of an organization regarding cultural inclusion and competency. Set a baseline from which States and organizations can compare themselves with others. Document the unique aspects of a State's cultures.

   Action Steps

   a. Convene a taskforce to target and work on cultural competency issues in the criminal justice, public safety, and public health arenas. Task Force members will conduct annual visits to appropriate organizations in these arenas to make sure everyone is up to date and fulfilling mandates.

   b. Ensure organizational competency by developing an organizational standards toolkit to address barriers to cultural competency throughout the processes of hiring, training, staff development, and volunteerism. Ensure that resources in the toolkit enable cross-systems collaboration to increase access to the full spectrum of services and build on shared outcomes.

   c. Expand and standardize a consensus on a criminal justice definition of cultural competency that is beyond gender/race and creates a common language for programmatic application.

2. Develop and organize mandatory cultural competency training for staff across multiple agencies and disciplines such as law enforcement, State Attorneys, community leaders, and educators.

   Action Steps

   a. Allow for honest discussion and disagreement during formulation of training using a tolerance rather than acceptance model.

   b. Use treatment cultural awareness and cultural respect rather than competency.

   c. Use nontraditional partners through special projects or programs to model diversity (Tribal, LGBT, faith based).

   d. Provide training materials and facilitators to assist all disciplines in developing a culturally competent workforce.

3. Identify strategies to increase funding that targets cultural competency.

Action Steps

a. Increase funding to identified critical populations with the intent to establish new or maintain and expand current cultural competency programs and intervention models. Support translational research efforts.

b. Increase funding for NIDA and SAMHSA research to identify effective prevention approaches that impact specific populations. Use Federal agency collaboration to leverage resources to support effective evaluation of current prevention practices for these populations.

c. Provide joint funding of mandatory set-asides to transition people leaving incarcerated settings.

d. Implement family drug courts and healing-to-wellness courts for unification of families and to avoid foster care, incarceration, and other costly followups.

4. Develop and fund a process for vetting key practices, normed testing, and evaluations among diverse populations with myriad key activities: engagement, evaluation, evidence-based culturally adaptive practices, and outcomes.

Action Steps

a. Research cultural adaptations of evidence-based best practices for application in various groups and communities such as Latino/Latina, rural communities, recovery culture, and individuals with a history of incarceration.

b. Create consistent and predictable program and agency quality assurance that pays attention to cultural and demographic issues regarding assessment, intervention, prevention, and treatment and that is case based and population based.

c. Educate family members, lawmakers, judges, law enforcement personnel, the general public, and other providers about the impact of methamphetamine and other drug addiction and the characteristics of the people who are addicted, including the medical and psychological aspects of addiction.

5. Implement creative workforce development strategies such as building paraprofessional tracks or career ladders for certain populations (Spanish-speaking; deaf/hard-of-hearing, etc.)

Action Steps

a. Provide funding for individuals entering the field to assist them in education/training expenses. For example, provide incentives for professionals such as lawyers and doctors who practice in rural/poor areas or provide public service. Incentives may include forgiveness of part of their student loans.

b. Develop, fund, and implement a program titled Treat America modeled after the Teach America program.

Access to Substance Abuse Treatment Services

1. Draft and implement a Federal policy that mandates States to connect services between State departments of corrections and human services professionals. Disseminate draft or sample memorandum of understanding/memorandum of agreement documents, demonstrating successful working partnerships among law enforcement agencies, correctional institutions, and treatment facilities. Provide funding and incentives to prisons, treatment providers, and other community resources to assist one another and enhance continuity of communication among systems.

   Action Steps

   a. Promote collaboration among Federal agencies, focusing on treatment across other agencies, including the Department of Justice and State judiciary. Loosen restrictions on Federal funding for residential substance abuse treatment programs, and for treating violent offenders.

   b. Establish policies and practices that authorize Medicare and Medicaid to pay for community-based services and work with legislators/policymakers to negotiate a Medicaid rate for substance abuse treatment of inmates.

2. Develop and implement a specific plan for targeting services to areas and populations most in need by including broader representation in decision making about where funding is allocated. Develop and use mapping tools to implement and promote mapping strategies to assist in determining service needs and gaps.

   Action Steps

   a. Eliminate Federal regulations that prohibit use of Federal funds for community-based incarcerated individuals so that more drug treatment alternatives can be developed.

   b. Facilitate collaborative efforts among all local and State agencies involved in the spectrum of service delivery. Form formal partnerships focused on addressing barriers to early access, full continuum of evidence-based core, cultural sensitivity, and ancillary services.

   c. Analyze the spectrum of services and link treatment providers and services such as transitional care, access to employment services, child care, and transportation. Implement programs that prepare the prison and jail population for assimilation back into the community. Continue treatment from jail, to prison, to release, and through recovery, including application for benefits.

   d. Develop and expand funding opportunities for “problem focused” courts, modeled after the success of the drug court program but expanded to meet the needs of the clientele.

e. Fund and implement increased, effective, and sustained longstanding community-based services.

3. Require patients to sign a consent form to be drug tested before being prescribed pain medication.

4. Provide an economic stimulus package, including direct resources to increase provider services and infrastructure development through:

   - Increased capacity by training staff and developing infrastructure instead of funding for planning, including workforce development
   - Additional resources for training clinicians
   - Additional resources incentives (e.g., scholarships, stipends, tuition forgiveness) to talented laid-off professionals.

5. Develop early detection and intervention strategies in the criminal justice field to be implemented before a felony or "prisonable" offense is committed. Use the current drug court model as a foundation for development.

6. Increase opportunities for training and technical assistance.

Action Steps

a. Provide joint training for correctional, treatment, and prevention staffs to improve understanding of roles and responsibilities.

b. Increase and expand available training opportunities on topics such as Health Insurance Portability and Accountability Act requirements.

c. Institute training for parole/probation on addiction-related issues, not only science of addiction (addiction as health condition) but also evidence-based practices such as motivational interviewing.

d. Mandate that medical personnel receive substance abuse continuing education training and substance abuse and addictions training in medical school.

Best Practices

1. Develop a Practice to Research forum that allows practitioners to work with developers of culturally appropriate adaptations (as well as other best practices) and researchers to quickly turn around data to support or refute these adaptations. Consider use of the Centers for the Application of Prevention Technologies.

Action Steps

a. Support innovation for measuring outcomes including funding research to build a best-practices inventory and moving from practice to policy and program.

b. Require participation across the disciplines, including Medicaid, in continuing education opportunities.

c. Build the capacity of the ATTCs to disseminate information and implementation strategies related to best practices.

d. Create statewide interdisciplinary coordinators to oversee best practices and evidence-based certification.

e. Use the Strategic Prevention Framework to assist with community mobilization to support diverse populations.

2. Build the capacity, fiscally and programmatically, for a statewide collaboration or state-level methamphetamine task force and a clearinghouse for information. Charge this group with using the media, public service advertising, video products, and the Web to promote evidence-based best practices (public/private partnerships).

Action Steps

a. Increase support and technical assistance to establish increased applied studies and research that demonstrates creative and new evidence-based practices and prevention application technologies, such as environmental strategies and the use of national media campaigns. Identify the level of flexibility or "must have" components related to evidence-based practice implementation.

b. Charge national associations (National Association of State Mental Health Program Directors, Substance Abuse and Mental Health Program Directive, National Association of State Alcohol/Drug Abuse Directors, Child Welfare) with providing technical assistance to States to maximize Medicaid support of evidence-based practices.

c. Develop an online system, modeled after Google, to increase access to information related to best practices.

d. Hold public forums to openly discuss issues involving methamphetamine problems and possible best practices. Include a mechanism for receiving input from community participants.

3. Mandate professional standards for staff of in-service programs.

Action Steps

a. Involve PhD/PsyD programs in dissertation/research, including internships, in the development of professional standards related to development and implementation of best practices (centralized database of needed research and partnerships with American Psychological Association and local universities). (Two groups prioritized this.)

b. Bring together stakeholders to develop guidelines for practice and strategies for dissemination.

4. Develop legislation that provides incentives for outcomes to encourage agencies to use best practices.

Action Steps

a. Build the capacity for SAMHSA, through increased collaborations with key presidential cabinet-level staff, to influence State policymakers to increase emphasis on prevention best practices through the National Governors Association, National Conference of State Legislatures, and the like. (Two groups prioritized this.)

b. Require evidence-based programs and the use of best practices and outcome-based results when developing an application or request for proposals at the State/local level.

LGBT POPULATIONS

Data Collection

1. Expand and improve data collection regarding methamphetamine and other substance use among LGBT populations.

Action Steps

a. Include and standardize sexual orientation, behavior, and attraction and gender identity questions in all Federal agency data collection (e.g., NSDUH, TEDS,, NOMs, GPRA, and the NHIS).

b. Institutionalize similar measures for State and local data collection efforts and in surveys such as Youth Risk Behavior Study, Behavior Risk Factor Survey, community health indicators, corrections, law enforcement data collection and surveys, and outcome and performance measures.

c. Ensure that data about the LGBT community is incorporated into the health disparities data component of Healthy People 2020 and all relevant chapters, including HIV and substance abuse.

d. Use universal language and definitions so that different instruments, which address the needs of local/specific populations, can be rolled into a bigger set and that data collection is uniform.

e. Develop more user-friendly data formats for analysis, allowing for limited resources to be spent most efficiently.

f. Use community epidemiologic approaches at the local level to assess community risk, including the LGBT community, and inform providers, law enforcement, community health services, local government, and community members of the responses.

g. Include diverse LGBT populations in needs assessments and gap analyses to allocate resources such as Block Grants funding and State tax dollars to address unmet prevention needs and to determine the adequacy of existing prevention services for LGBT populations.

h. Fund data collection and information gathering in multiple locations. Fund efforts beyond quantitative methods to include multiple approaches in addition to population samples, such as cultural ethnography, community-based surveys, and research studies. Ensure that data collection reflects emerging needs in LGBT populations. Ensure that risk and protective factors, including mental health indicators, are included (e.g., the impact of anti-LGBT stigma and discrimination on risk and the effect of LGBT-relevant and LGBT-affirmative services on protection).

i. Fund longitudinal and natural history data collection, including rates of administration, levels of use, and characteristics of those who have achieved recovery.

j. Develop a standardized fidelity measure to assess cultural competency of funded providers.

k. Conduct formative and evaluative research to inform prevention and education campaigns and materials to ensure they are effective and rooted in the target LGBT community and do not reinforce stigma. Require Federal agencies to collect LGBT evaluation data from grantees to assess effectiveness of programs.

2. Improve coordination and dissemination of data regarding methamphetamine and other substance abuse among LGBT populations.

Action Steps

a. Increase effective dissemination of data, information, and results in prevention, intervention, and treatment services through a clearinghouse, monographs on important research in all domains, and applying research to practice.

b. Reinvigorate the Community Epidemiology Work Groups (e.g., mental health, treatment, prevention, dental).

c. Develop funding opportunities with broader inclusion of treatment for methamphetamine use across agencies and disciplines that include community-based participatory action research as well as general population samples.

d. Establish a system through which State agencies aggregate, share, and disseminate data on LGBT populations regarding substance use and specify crystal methamphetamine use and other health determinants of risk and protection.

Cultural Competency

1. Embed cultural competency in Federal, State, and local regulations, policies, and funding requirements.

   Action Steps

   a. Ensure all SAMHSA and other Federal agency activities or publications are inclusive of sexual orientation and gender identity (and included in the required data variables).

   b. Establish an Office of LGBT Health Affairs in HHS to ensure equity and coordination.

   c. Issue executive orders through the offices of the Governors to support LGBT inclusivity/diversity.

   d. Promote interdisciplinary dialog (particularly among Federal agencies).

   e. Develop and implement a 3-year Federal plan to better define cultural competency. Ensure that the plan defines cultural competency, including such factors as region, race, gender, sexual identity, and ethnicity.

   f. Develop tools to measure LGBT cultural competency.

   g. Require HIV-focused grants to meet cultural competency standards for LGBT populations.

   h. Require agencies and publicly funded educational institutions to include affected communities in planning, policy development, implementation, and evaluation.

   i. Implement a program in which States that certify programs can require support of LGBT competencies, modeled after The Joint Commission and Commission on Accreditation of Rehabilitation Facilities. These LGBT competencies should be required for addiction treatment providers.

2. Expand training and information dissemination to increase the number of addiction professionals who are competent in providing services to LGBT populations.

   Action Steps

   a. Link cultural competency skill development to licensure/credentialing over time. Measure to determine whether systems change as a result of the training.

   b. Recruit addiction professionals for rural areas through increased incentives, such as waiving some loan repayment for students.

   c. Fund and require education for first responders (e.g., law enforcement, hospitals/emergency rooms).

   d. Support tele-health opportunities for rural/isolated populations that maximize linkages and referrals.

   e. Fund creation of cultural competency standards. Develop a training curriculum on LGBT issues and crystal methamphetamine for mental health counseling professional programs.

f. Fund development and broad dissemination of LGBT-competent best practices.

g. Fund and train organizations and educational institutions working with LGBT communities to develop cultural competency standards and materials.

h. Develop and implement a core curriculum that includes education of all human sexuality.

i. Provide resources to colleges and universities to enhance cultural competency of curricula. Provide better education opportunities for addiction professionals.

Access to Substance Abuse Treatment Services

1. Strengthen the Federal and State grant application process to cast a wider net for LGBT grant applications and increase access to substance abuse treatment services for LGBT populations.

Action Steps

a. Increase the number of funding opportunities for LGBT services.

b. Provide technical assistance for potential SAMHSA grant applicants to improve competitiveness of LGBT applicants.

c. Emphasize cultural competency as a scoring category for grant applications with a minimum requirement to be considered for funding.

d. Fund open access support and paraprofessional services.

e. Fund technological strategies to improve access for people who are isolated because of stigma, health/mobility, and geographical locations (e.g., Web cams, text messaging, blogging, email, telephone).

f. Support funding to address the unique needs of frontier and rural populations, including development of infrastructure in rural areas with CMS, IHS, VA, rural health/community health centers, and so forth.

g. Provide funding and technical support to allow providers to treat persons across jurisdictions in areas with limited treatment resources and to create community consortiums of treatment, prevention, and psychiatric emergency agencies.

h. Expand and incentivize opportunities for peer-led support groups, wellness groups, and so forth through grants.

2. Develop and implement guidelines, definitions, and standards at national, State, and local levels to increase access to substance abuse treatment services by LGBT populations.

Action Steps

a. Recognize distinct access needs of transgender people; do not assume these needs are met under the LGBT umbrella.

b. Create and implement clear national guidelines for how substance abuse treatment provider organizations can identify themselves as LGBT sensitive.

c. Remove requirement that clients must be HIV positive to access services.

d. Review and adopt or replicate the Massachusetts LGBT Healthcare Access Project Community Standards of Practice. Concurrently, engage CMS leadership to write regulations that better serve LGBT clients under the new mental health parity provisions in the stimulus bill.

e. Be more specific about what is meant by LGBT services in SAMHSA's N-SSATS; services should be based on established best practices for cultural competency in serving LGBT clients. Standardize and increase rigor applied to those who self-designate as LGBT-friendly providers.

3. Implement and revise LGBT-sensitive Federal, State, and local policies and initiatives to increase access to substance abuse treatment services for LGBT populations.

Action Steps

a. Offer methamphetamine treatment in HIV/sexually transmitted disease programs (e.g., prevention, treatment, testing).

b. Enact antidiscrimination legislation to allow rejected clients the ability to hold service providers accountable in a court; repeal discriminatory policies such as Don't Ask, Don't Tell that sanction unequal access to services and benefits.

c. Undertake a Federal-level review of all Federal and State programs affecting rural populations to develop a coherent national strategy with respect to methamphetamine-driven rural health challenges. Establish a strategy and timelines for implementation.

d. Remove barriers to funding reimbursement for substance abuse treatment (i.e., insurance/payment reimbursement) and include services for clients that may not be ready to enter treatment and/or completely abstain from methamphetamine use. Require draft LGBT public information and outreach campaigns to be reviewed by members of the target communities.

e. Implement intervention matching based on assessment and stages of change (e.g., nutritional counseling, depression/anxiety, housing).

f. Provide information regarding available services and prevention via nontraditional outlets such as bath houses and niche media.

4. Provide training, technical assistance, and other support to promote providers' ability to ensure access to substance abuse treatment services for LGBT populations.

Action Steps

a. Provide technical assistance, capacity-building, and funding for community-based LGBT-friendly agencies.

b. Increase the ability and proficiency of substance abuse treatment professionals to engage clients in nonshaming, honest discussions about sexual orientation, gender identity, and sexual behavior.

c. Expand training in alternatives to an abstinence-based model and recovery readiness to move clients toward the changes they are ready to make and to develop a more competent and compassionate workforce.

Best Practices

1. Improve Federal, State, and local government efforts to consider, review, evaluate, and promote LGBT best practices in substance abuse treatment services.

Action Steps

a. Establish LGBT committees in Federal agencies to review and evaluate LGBT-specific practices and programs (such as SAMHSA's Sexual and Gender Minority Interest Group).

b. Mandate representation of LGBT individuals on SAMHSA, NIDA, CDC, and CSAT advisory boards.

c. Update SAMHSA's *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* and develop a companion document for mental health.

d. Build Federal, State, and local capacity for evaluation beyond quantitative methods to collect evidence of efficacy for innovative and nontraditional approaches for LGBT populations.

e. Expand availability and dissemination of LGBT training and technical assistance.

f. Fund expanded LGBT-friendly social marketing campaigns targeting rural populations including media venues that advertise treatment services broadly and raise visibility. Work with the ONDCP and the Partnership for Drug Free America to demonstrate and increase LGBT presence.

g. Fund and support structural interventions to promote community connectedness, including posttraumatic stress disorder support programs, positive outlets/venues for meeting, and social marketing campaigns.

h. Fund and support homegrown programs to demonstrate their effectiveness.

i. Disseminate LGBT information through SAMHSA's Web site and publications.

j. Mandate and fund a State clearinghouse of promising and evidence-based prevention strategies to include all six substance abuse prevention strategies for LGBT populations and create State initiatives to offer training and technical assistance to all providers on best practices.

k. Undertake a Federal review of all programs affecting rural populations with respect to methamphetamine-driven rural health initiatives. Establish a timeline and strategy for implementation.

l. Fund research related to best practices on an ongoing basis, taking feedback into account through a system that creates the ability to revise, revisit, and re-evaluate rapidly with minimal bureaucracy.

m. Ensure that the NIH provides more funding for pharmacological interventions to continue best practice development.

2. Identify and promote policies that strengthen the LGBT community and increase protective factors (e.g., Federal support for State marriage/equal benefits).

3. Provide training, technical assistance, and other support to disseminate and promote best practices in addressing substance abuse among LGBT populations.

Action Steps

a. Use and publicize e-learning for community providers throughout the nation.

b. Offer continuing education units for LGBT trainers.

c. Increase technology transfer grants. Improve technology transfer by requiring sites that conduct randomized controlled trials to partner with a rural site to collect data, train staff, and so forth.

d. Support collaboration between providers and research universities to connect research to practice and vice versa and build support in clinical settings to disseminate best practices.

e. Support replication of the Hopi and Navajo Nations' model for presenting intergenerational substance abuse information.

f. Support establishment of prelapse centers for a limited stay (e.g., 2–3 days) if a person is at risk for relapse.

WOMEN

Data Collection

1. Improve protocols and language related to the National Data Strategy:

Action Steps

a. Create a longitudinal data set that tracks women through continuing care and allows for the provision of ancillary and support services focused on geographic and cultural components. Identify the unique antecedents of initiation of various drugs (methamphetamine) to get at root causes.

b. Fund the OWH as a primary center of information to disseminate data across domains related to health care, substance abuse, and criminal justice and to create accessible and empirically informed policy support.

c. Mandate the integration of prevention, treatment, and testing protocols.

d. Require Federal agencies to provide technical assistance to the States in the development of State survey systems.

e. Require Block Grants to capture and report family/household data to promote and facilitate family-centered treatment.

f. Introduce a universal identifier of methamphetamine for data, data collection, and data analysis that would allow for ease of cross-system/cross-agency data coordination and information sharing to inform and shape future prevention efforts at local, State, and Federal levels and include identification of drug-related deaths and the substances involved.

g. Examine the viability and tools necessary for the implementation of electronic health records. Implement an electronic health records system:
   - Support provider adaption to collect data across sectors.
   - Support development of a national health information network to facilitate collection of national morbidity and mortality data at all levels.
   - Track death-root causes related to substance abuse overdoses.

h. Develop a national electronic prescription drug monitoring system for all drug programs, coordinating data sets across local and State jurisdictions.

i. Standardize prevention data collection sets using consistent protocols (i.e., questions) across all sectors and populations to include rural/frontier populations, women, and subsets like child welfare, treatment, prevention, and criminal justice. Include family-focused, gender, and culture-specific data on women, including common data elements and outcome measures based on national guidelines for women's treatment. Create data reports tailored to community/Tribal organizations needs. For example, allow professionals

to track women and their families involved in the criminal justice system from arrest to re-entry into the community.

2. Promote family-centered services across the spectrum from prevention through recovery.

Action Steps

a. Implement family-centered treatment of alcohol and drug use. Include mental health services that address intergenerational trauma and comprehensive treatment.

b. Increase the utilization of SAMHSA's SBIRT program in healthcare settings to improve outcomes for women and their families involved with the juvenile justice or criminal justice system.

c. Require States to review all children's deaths to identify any related to substance abuse.

d. Conduct university research related to the effects of maternal substance abuse on the brain of infants and toddlers, including a cost-analysis comparison of babies born with methamphetamine in their systems and those without.

e. Develop and implement a medical home model of service delivery to enhance service integration and health service delivery to women and their families.

3. Focus resources and strategic technical assistance on building rural health service capacity.

Action Steps

a. Support the development of a committee to critically review poverty and its link to behavioral health in rural communities, as well as the rate of service delivery as a function of geography and socioeconomic status. Disseminate these findings at the State and national levels.

b. Prioritize the need to develop rural data components related to access, strategies, and data analysis.

Cultural Competency

1. Make a cadre of prevention trainers available to local and States systems.

Action Steps

a. Include crosscutting trauma-informed training in SAMHSA's SBIRT program.

b. Implement training strategies that empower and engage communities to identify effective prevention approaches. Review the community-driven decision-making process model implemented by the COPS.

c. Use current nongovernment sectors to assist in implementing prevention training e.g., Community Anti-Drug Coalitions of America, The National Association of Drug Court Professionals, and Pacific Institute for Research and Evaluation.

d. Train “preventionists” to develop programs that address gender needs in contextual environments.

e. Promote policies, practices, and funding to focus ATTC activities on women.

2. Mandate and fund support services, such as childcare assistance and transportation, for programs engaging women in treatment.

3. Enhance professional development across multiple fields of study (e.g., social workers, rural track training programs, education) resulting in increased competencies among future professionals to identify the targeted needs of the population.

Action Steps

a. Analyze the feasibility of a public rating scale for healthcare providers, with a training component required for those with a low rating.

b. Develop and implement women-specific and trauma-informed training for the licensure and certification of all mental health, medical, and community health professionals.

c. Increase and enhance the capacity of prevention, treatment, and support services in rural/frontier areas focusing on increasing the economic base through differential pay for professionals with cultural expertise.

d. Develop national loan forgiveness set-asides and incentives for rural/frontier populations.

4. Institute at the Federal, State, and county levels a continuous spectrum of integrated medical/behavioral health and HIV services, using existing service delivery systems (e.g., community health centers and community mental health services).

Action Steps

a. Establish linkages to community and social support programs to reduce the burden of limited resources on staff and increase the quality of holistic care supporters through direct funding.

b. Prioritize the use of this integrated team model with the rollout of changes related to legislative healthcare parity and reform.

c. Develop strategies and partnerships that enhance the opportunity for education and awareness through faith communities.

d. Implement a law enforcement critical incident model as the foundation of social services promoting better self-care.

5. Establish a registry of best policy practices and sample policy documents, specific to rural/frontier populations, to be accessed by service providers, elected officials, and policymakers.

Action Steps

a. Identify or create a model education curriculum for women and girls in media literacy to provide information related to sexuality in the mainstream media, social media, and Web links and information related to alternative sexuality.

b. Create trauma-informed training with a cultural sensitivity component to be implemented at the Federal level and then train State trainers to increase awareness of the broad impact of trauma on the three critical populations with regard to:

   - Access to services
   - Retention
   - Relapse service
   - Prevention

6. Analyze the current healthcare recordkeeping system and expand the infrastructure to address confidentiality needs while allowing cross-agency sharing of information to expedite individual interaction with the healthcare system.

Action Steps

a. Develop strategies to engage physicians and workforce experts on behavioral health in the screening and referral process.

b. Increase opportunities for information sharing among providers, such as development of health information sharing networks or electronic health records. The use will help . engage, educate, and inform the needs of rural women who may be affected by methamphetamine use and may become involved in using.

Access to Substance Abuse Treatment Services

1. Fund programs and services that demonstrate positive and effective outcomes, are tied to client satisfaction, and attempt to address community norms.

Action Steps

a. Align outcome measures, consistent implementation of evidence-based practices, and flexibility to meet population needs and allow for the consistent implementation of evidence-based programs that drive the funding.

b. Allocate targeted funding specific to State and local demographics.

c. Support multidisciplinary team building (networking) strategies, including e-communications, consultation for small or isolated communities, and face-to-face regional training.

d. Mandate that funded programs provide outreach intake, use treatment readiness groups and services, and use appropriate technology and case management effectively through an extensive community network.

- Require service providers to use existing, nontraditional partners such as the agricultural extension; Women, Infants, and Children Nutrition Program; Children First; and Shots for Tots as an entrée into homes with families in need of treatment services.
- Increase collaboration among service providers, with an understanding that any access into services provides an entrée for all services.

2. Review and consider removal of the diagnosis of borderline posttraumatic stress disorder from the *Diagnostic and Statistical Manual of Mental Disorders*.

3. Braid funding at the local and Federal levels from CSAT, Center for Mental Health Services (CMHS), CMS, and other agencies to integrate technical assistance and training into States and communities.

Action Steps

a. Develop policy recommendations at the Federal and State levels to loosen the Maternal and Child Health (MCH) Block Grant's 85/15 requirements for rural areas with limited infrastructure and programs to use case management in the framework of best practices. (The Block Grants funds are provided to States to support health care for mothers and children. According to statute, 85 percent of appropriated funds up to $600,000,000 are distributed to States and 15 percent are set aside for special projects of regional and national significance [SPRANS]. Also according to statute, 12.75 percent of funds over $600,000,000 are to be used for community-integrated service systems [CISS] programs. The remaining funds over $600,000,000 are distributed on the same 85/15 percent split as the basic Block Grant.)

b. Develop a consistent definition of the use of family across Federal funding sectors.

4. Mandate Federal agencies such as SAMHSA's Health Information Network, NIDA, and the National Institute on Alcohol Abuse and Alcoholism to develop and disseminate a cadre of gender-appropriate materials through the Internet. Ensure that materials reflect subculture categories such as race, ethnicity, age, region, and religion.

Action Steps

a. Train correctional staff on mental health and substance use disorders, including the use of appropriate screening and referral tools and procedures.

5. Develop an incentive-based funding system for the expansion of the workforce at the employment program level and for the adoption of best practices, using an evaluation framework.

Action Steps

b. Increase funding for and access to vocational services at the secondary and postsecondary level.

c. Use AmeriCorps to increase workforce development, enhance professional development, and expand existing service areas.

d. Develop and implement cost-effective student loan forgiveness programs to promote substance abuse treatment services workforce development and assist with recruiting qualified staff representatives of the vulnerable populations.

e. Use the ATTCs and existing training systems to develop, implement, and deliver workforce development materials related to evidence-based practices and cross-train students to deliver trauma-informed services. Include the development of a guide to educate practitioners in self-care.

6. Develop an infrastructure for women's health and issues at every level (Federal, State, local) beginning with the option of a cabinet position that responds to and receives direction from local groups/committees and submits recommendations from the grassroots level.

a. Partner with the nontraditional Federal agencies to support and encourage family-centered treatment services and services for rural women (e.g., returning veterans) and their families. Expand the role of the child welfare treatment system to include family units engaged in treatment services.

b. Inform upcoming national healthcare reform discussions with policies that include parity of benefits for both medical and behavioral health interventions without placing arbitrary limits on health visits.

c. Encourage policymakers to explore the consequences of implementing a policy and strategy that requires the Substance Abuse Prevention and Treatment Block Grants funding to be divided equally for treatment and primary prevention.

d. Educate leaders and community participants about the kinship funding and the potential support for enhanced prevention programs.

Best Practices

1. Identify and adopt adaptive, dynamic, flexible strategies that support the implementation of best practices or innovative homegrown programs with demonstrated effectiveness, allowing for efficient identification of appropriate programs at the community level.

   Action Steps

   a. Build on the strengths of the existing regional infrastructure and establish cross-system priorities for dissemination of efforts across the full spectrum of services including services for women.

   b. Develop a girl-specific life skills development approach, focusing on the basics of positive self-identity, trauma, recovery, family resources, and basic prevention. Promote a comprehensive approach to healthy living coupled with a comprehensive approach to treatment and continuing care as a best practice.

   c. Build an infrastructure for primary behavioral health interventions across the multiple systems (e.g., the child welfare system), implementing best practices and using technologically sophisticated dissemination practices in rural/frontier communities.

   d. Encourage a multifaceted approach to include, but not be limited to, women, brain trauma, LGBT individuals, justice-involved communities, Native Americans, veterans, and other diverse subgroups.

2. Pool technical assistance resources at the Federal level and across multiple Federal departments to build a strong infrastructure in each region that will engage multiple stakeholders and departments rather than isolate technical assistance and training to one aspect of the system or population.

   Action Steps

   a. Increase funding to ATTCs.

   b. Explore the feasibility of developing and implementing statewide anti-stigma media efforts to assist in reframing addiction as a public health issue with far-reaching impact on healthcare systems and budgets.

   c. Create a coalition at the Federal and State levels of diverse stakeholders who advocate for best practices, are willing to develop curricula and educational materials that are evidence-based, are culturally competent, and can address the areas of women, LGBT individuals, and justice-involved communities.

Appendix C:
State/Territorial Action Team Rosters

State/Territorial Action Team Rosters

Team Rosters Submitted by Team Leaders

American Samoa			
Name	**Position**	**Agency/Organization**	**Population**
Oreta Togafau (Team Leader)	Territorial Senior Policy Analyst	Governor's Office	Lesbian, Gay, Bisexual, and Transgender (LBGT)
Ofeira Nuusolia	Executive Director	Tafuna Family Health Center	Women
Tusi Suiaunoa	State Drug Free Coordinator	Governor's Office Drug Free Coordinator	Justice-Involved
Lisa Teesch-Maguire	Assistant Attorney General	American Samoa Office of Attorney General	Justice-Involved
Benjamin Tili	Director, Prevention Program	Safe and Drug Free Schools, American Samoa Department of Education	Justice-Involved
Tuumafua Maiava	Prevention Specialist	Department of Human and Social Services	Justice-Involved
Lima Togia	Supervisor, Narcotics Division	American Samoa Department of Public Safety	Justice-Involved

Arizona			
Name	**Position**	**Agency/Organization**	**Population**
Kimberly O'Connor (Team Leader)	Director	Governor's Office for Children, Youth and Families	Justice-Involved
Rodgers Wilson	Acting Chief Medical Officer and Substance Abuse Authority	Arizona Department of Health	Justice-Involved
Lisa Shumaker	State Prevention Director (National Prevention Network)	Arizona Department of Health	LGBT
Karen Zeigler	Deputy Director	Arizona Criminal Justice Commission	Justice-Involved
Karen Hellman	Administrator, Addiction Treatment Services	Arizona Department of Corrections	Women

Arizona			
Name	**Position**	**Agency/Organization**	**Population**
Mary Specio-Boyer	Community Health Director	COPE Behavioral Services, Inc./Pima County Meth Free Alliance	Women
Phil Stevenson	Director	Arizona Statistical Analysis Center	Justice-Involved
Michelle Skurka	Coordinator, Women's Treatment, State Methadone Authority	Arizona Department of Health	Women
Anthony Coulson	Assistant Special Agent in Charge	Drug Enforcement Administration	Justice-Involved
Briana Kreibich	Administrator, Anti-Meth Program	Governor's Office for Children, Youth and Families	Women
Ralph Ogden	Sheriff	Yuma County Sheriff's Office	Justice-Involved
Morgan Hester	Administrator, Arizona Substance Abuse Partnership Program	Governor's Office for Children, Youth and Families	LGBT

California			
Name	**Position**	**Agency/Organization**	**Population**
Dave Neilsen (Team Leader)	Director	Program Services Division, California Department of Alcohol and Drug Programs	Women
Peggy Bean	Coordinator, Women's Treatment	California Department of Alcohol and Drug Programs	Women
Mary Skorka	Team Member	California Department of Alcohol and Drug Programs	Justice-Involved
Mike Gorman	Associate Professor	San Jose State University	LGBT
Virginia Rondero Hernandez	Academic Representative	California State University	Women
Alessandra Ross	Program Coordinator Manager	State Office of AIDS	LGBT
Lionel Chatman	County Probation Officer Coordinator	County of San Diego	Justice-Involved

California			
Name	**Position**	**Agency/Organization**	**Population**
Angela Goldberg	Member/Coordinator	County of San Diego Methamphetamine Strike Force	Justice-Involved
Mark LeBeau	Health Policy Analyst	Tribal Health Programs	Justice-Involved
Jan Ryan	Prevention Consultant	Riverside County Substance Abuse Prevention Services	LGBT
Cynthia Jaynes	Prevention Program Analyst	Department of Alcohol and Drug Programs, Child Health and Disability Prevention Program	Justice-Involved
West Irvin	Program Manager	Department of Social Services Liaison	Justice-Involved
Kathryn P. Jeff	Undersecretary of Adult Programs	Department of Corrections and Rehabilitation	Justice-Involved
Sheigla Murphy	Director	Center for Substance Abuse Studies	Women

Colorado			
Name	**Position**	**Agency/Organization**	**Population**
Janet Wood (Team Leader)	Director, Division of Behavioral Health/SSA	Colorado Department of Human Services	Women
Leslie Herod	Policy Analyst	Governor's Office of Policy and Initiatives	Women
Stan Paprocki	Director, Prevention Services/NPN	Colorado Department of Human Services	LGBT
Dennis Dahlke	Program Director, Peaceful Spirit Southern Ute Indian Tribe	Peaceful Spirit Southern Ute Indian Tribe	Justice-Involved
Jeanne Smith	Director, Division of Criminal Justice	Colorado Department of Public Safety	Justice-Involved
Ralph Wilmoth	Director, Sexually Transmitted Infection(STI)/HIV	Colorado Department of Public Health and Environment	LGBT
Mark Thrun	Director, HIV Prevention	Denver Public Health Department	LGBT
Tonya Wheeler	Addiction Counselor	Advocates for Recovery	Women

Colorado			
Name	**Position**	**Agency/Organization**	**Population**
Carmelita Muniz	Director	Colorado Alcohol and Drug Services Providers	Women
Steve Holloway	Director, Primary Care Office	Colorado Department of Public Health and Environment	Women
Nicolas Taylor	Delta Project Clinical Director, Treatment Specialist	State Meth Task Force	Justice-Involved
Jade Thomas	Program Manager	Colorado Alliance for Drug Endangered Children	Women

District of Columbia			
Name	**Position**	**Agency/Organization**	**Population**
Tori Fernandez Whitney (Team Leader)	Senior Deputy Director	Addiction Prevention and Recovery Administration	Women
Valerie Robinson	Director	DC CORE Access To Recovery (ATR) Program	Women
Judith Donovan	Director, Prevention Services	Addiction Prevention and Recovery Administration Department of Health	Women
Susan Shaffer	Director, DC Pretrial Services Agency	Court Services and Offender Supervision Agency	Justice-Involved
Jasper Ormond	Interim Director	Court Services and Offender Supervision Agency	Justice-Involved
Christopher Dyer	Director	Office of LGBT Affairs	LGBT
Shannon Hader	Senior Deputy Director, HIV/AIDS Administration	DC Department of Health	Women
Carlos Cano	Senior Deputy Director, Community Health Administration	DC Department of Health	Women
Steve Geishecker	Director	Behavioral Health Whitman-Walker Clinic	LGBT

District of Columbia			
Name	**Position**	**Agency/Organization**	**Population**
Kristen Degan	Director of Operations	DC Crystal Methamphetamine Working Group	LGBT
David Schwartz	Licensed Clinical Psychologist	DC Crystal Methamphetamine Working Group	LGBT
Isaiah Webster	Program Coordinator	DC Crystal Methamphetamine Working Group	LGBT

Florida			
Name	**Position**	**Agency/Organization**	**Population**
Stephenie Colston (Team Leader)	Director/SSA	Florida Department of Children and Families	Women
Sue Ross	Assistant Director	Department of Corrections	Justice-Involved
Pam Denmark	Deputy Assistant Secretary	Department of Corrections	Justice-Involved
Senta Goudy	Director, National Prevention Network (NPN) Prevention Services	Substance Abuse Program Office	Justice-Involved
Ed Hudson	Special Agent Supervisor	Florida Department of Law Enforcement	Justice-Involved
Dano Beck	HIV Behavioral Surveillance Coordinator	Division of Disease Control Florida Department of Health	LGBT
Peggy Scheuermann	Deputy Division Director	Department of Health Women/Children Services	Women
Libbie Combee	Founder/Executive Director	Meth Free Project	Justice-Involved
Gerri Goldman	Special Project Coordinator	Women's Services	Women
Joel Kaufman	Executive Director/Vice President of United Way of Broward County Commission on Substance Abuse	State Meth Task Force & Drug Free Coalition	LGBT
Jeff Beasley	Inspector	State Law Enforcement	Justice-Involved

Florida			
Name	**Position**	**Agency/Organization**	**Population**
Chad Johns	Assistant Chief, Counter Drug Law Enforcement	Florida Office of Drug Control	Justice-Involved

Guam			
Name	**Position**	**Agency/Organization**	**Population**
Don P. Sabang (Team Leader)	Supervisor, Substance Abuse Program	Department of Mental Health and Substance Abuse	Justice-Involved
Mary-Grace Rosadino	Supervisor, Research and Statistical Analyst II	Department of Mental Health and Substance Abuse	Justice-Involved
Franklin S. Sablan	Board President	Guam's Alternative Lifestyle Association	LGBT
Anna Marie Kenny	Certified Substance Abuse Counselor	Oasis Empowerment Center	Women
Arthur R. Barcinas	Judge	Guam's Superior Court of Guam/Criminal Justice	Justice-Involved
Manuel Babuata	Officer in Charge, Criminal Investigation/Lab	Guam Criminal Justice Agency/Guam Police Department	Justice-Involved
Barbara Benavente	Supervisor, Prevention and Training	Department of Mental Health and Substance Abuse	Justice-Involved
Doris Crisostomo	Governor's Drug Policy Advisor	Office of the Governor	Justice-Involved
Josephine O'Mallan	State Director, HIV/AIDS Services	Department of Health	Justice-Involved
James Cruz	Chief Investigator Representative of Guam Attorney General	Guam Attorney General's Office	Justice-Involved

Hawaii			
Name	**Position**	**Agency/Organization**	**Population**
Karl Espaldon, Esq (Team Leader)	State Drug Control Liaison	Office of the Lieutenant Governor	Justice-Involved
Michelle R. Hill	Deputy Director	Behavioral Health Administration Department	Justice-involved

Hawaii			
Name	**Position**	**Agency/Organization**	**Population**
Larry Hales	Manager, Substance Abuse Program	State Department of Public Safety	Justice-Involved
Shackley F. Raffetto	Judge	Maui Drug Court	Justice-Involved
Darrin Kawazoe	Chief Development Officer	Care Hawaii, Inc.	LGBT
Joao Paolo Wright	Projector Director	Kulia NA Mamo	LGBT
Ms. Leslie Moody	Program Manager	Salvation Army	Women
Lorraine Robinson	Executive Director	T.J. Mahoney and Associates, Inc.	Women
Ed Gomes	Regional Coordinator	National Methamphetamine Training & Technical Assistance Center	Justice-Involved

Idaho			
Name	**Position**	**Agency/Organization**	**Population**
Debbie Field (Team Leader)	Director, Drug Policy	Idaho Office of Drug Policy	Justice-Involved
Kim Toryanski	Administrator	Idaho Commission on Aging	Justice-Involved
Terry Pappin	Director, State Prevention	Department of Health and Welfare	Women
Shane Evans	Deputy Director, Education and Treatment Division	Idaho Department of Correction	Justice-Involved
Sharon Harrigfeld	Administrator, Community Operations and Programs Services	Idaho Department of Juvenile Corrections	Justice-Involved
Megan Ronk	Executive Director	Idaho Meth Project	Women
Shelby Kerns	Executive Director	Idaho Rural Partnership	Rural
Matt McCarter	Coordinator	Safe and Drug Free Schools	Justice-Involved
Jeff Lavey	Chief of Police	Drug Coalition Task Force	Justice-Involved
Norma Jaeger	Director, Problem Solving Courts and Community Sentencing and Coordinator, Statewide Drug Court	Idaho Supreme Court	Justice-Involved

Idaho			
Name	**Position**	**Agency/Organization**	**Population**
Bethany Gadzinski	Program Director, Idaho Division of Behavioral Health	Department of Health and Welfare	Women

Indiana			
Name	**Position**	**Agency/Organization**	**Population**
T. Neil Moore (Team Leader)	Executive Director	Indiana Criminal Justice Institute	Justice-Involved
Sonya Cleveland	Director, Substance Abuse Services Division	Governor's Commission for Drug Free Indiana	Justice-Involved
Cole Crawford	Sergeant	Indiana State Police	Justice-Involved
Diana Williams	Assistant Deputy Director, Substance Abuse Treatment	Division of Mental Health Services Administration	Women
Dan Ronay	Chief of Staff	Indiana Department of. Corrections	Justice-Involved
Stephen P. Luce	Sheriff of Knox County	Indiana Sheriff's Association	Justice-Involved
Michael J. Kramer	Judge	Noble Superior Court, Division 2	Justice-Involved
David Judkins	Deputy Director	Indiana Department of Child Services	Justice-Involved

Iowa			
Name	**Position**	**Agency/Organization**	**Population**
Gary Kendell (Team Leader)	Director	Governor's Office of Drug Control Policy	Justice-Involved
Kathy Stone	Director, Behavioral Health	Single State Authority	Women
DeAnn Decker	Bureau Chief, Substance Abuse Prevention and Treatment	Iowa Department of Public Health	LGBT
Kevin Frampton	Director	Iowa Division of Narcotics Enforcement	Justice-Involved
Joby Holcomb	Counselor	Unity Community Services	LGBT
Mary O'Neill	Director, Behavioral Health	Heartland Family Services	Women

Iowa			
Name	**Position**	**Agency/Organization**	**Population**
Judy Murphy	Founder	Moms Off Meth	Women
Randy Mayer	Manager, HIV/AIDS/Hepatitis Program	State HIV/AIDS and Viral Hepatitis	LGBT
Gloria Vermie	Director	State Office of Rural Health Director	Women
Robert Mahan	Judge	Iowa Court of Appeals	Justice-Involved

Maryland			
Name	**Position**	**Agency/Organization**	**Population**
Kip Castner	Deputy Chief, Center for HIV Prevention	Maryland AIDS Administration	General
Peter Cohen	Medical Director	Maryland Department of Health and Mental Hygiene	General
Christina Lentz	Director	Maryland Stastical Analysis Center	Justice- Involved

Minnesota			
Name	**Position**	**Agency/Organization**	**Population**
Rick Moldenhauer (Team Leader)	Treatment Services Consultant	Minnesota State Drug Policy	Justice-Involved
Robert Kacheroski	Insurance Specialist	HIV/AIDS Division	LGBT
Carol Ackley	Owner	River Ridge Treatment Center	Women
Chuck Noerenberg	Coordinator	Minnesota State Drug Policy	Women
Richard Terzick	Director, Business Development and Marketing	Private Treatment Provider	LGBT
Cynthia Godin	Project Manager	State Mental Health Services	Women
Al Fredrickson	Principal Planner	Department of Human Services, Chemical Health Division	LGBT
Steve Branco	Program Director	Latitude at Twin	LGBT

Montana			
Name	**Position**	**Agency/Organization**	**Population**
Joan Cassidy (Team Leader)	Montana's SSA/Chief, Chemical Dependency Bureau	Addictive and Mental Disorders Division	Women
Deb Matteucci	Program Facilitator, Behavioral Health	Department of Corrections	Justice-Involved
Bob Runkel	Assistant Superintendent	Office of Public Instruction	Women
Joshua Hemsath	Student and President of Montana State University's Queer-Straight Alliance	Montana State University	LGBT
Margaret (Peg) Shea	Executive Director	Montana Meth Project	Justice-Involved
Jeffrey Kushner	Statewide Administrator	Montana's Drug Court	Justice-Involved
Gary Hamel	Administrator, Health, Planning and Information Services	Montana Department of Corrections	Justice-Involved
Kristin Juliar	Director	Montana Office of Rural Health	Women
Vicki Turner	Director	Montana Prevention Resource Center	Women
Mona L. Sumner	Chief Executive Officer	Rimrock Foundation	Women

Nevada			
Name	**Position**	**Agency/Organization**	**Population**
Deborah McBride (Team Leader)	Agency Director	Substance Abuse Prevention and Treatment Agency	Women
Linda Kreeger	Prevention Analyst/ Health Program Specialist I	Substance Abuse Prevention and Treatment Agency	Women
Sheila Leslie	Coordinator, Specialty Courts	Second Judicial District Court	Justice-Involved
Antioco Carrillo	Program Director	Clark County Community Counseling Center	LGBT
Scott Jackson	Chief	Nevada Department of Public Safety	Justice-Involved
Tom Ruble	Counselor	A Rainbow Place	LGBT

Nevada			
Name	**Position**	**Agency/Organization**	**Population**
Charlene Herst	Manager, Service Assurance and Systems Development Group/Health Program Manager	Nevada State Health Division	Women
Mary Pennington	Manager, Communicable Disease Program	Nevada State Health Division	LGBT
Kevin Quint	Executive Director	Join Together, Northern Nevada	Justice-Involved
Patrick Conmay	Inspector General	Department of Corrections	Justice-Involved

New Mexico			
Name	**Position**	**Agency/Organization**	**Population**
Harrison Kinney (Team Leader)	Executive Manager	Behavioral Health and Substance Department	Women
Scott Wallace	Regional Director	Managed Behavioral Health Care	Women
Susan Bosarge	Program Manager, NPN (Acting)	Office of Substance Abuse Prevention Public Health	Women
Michael Estrada	Program Manager	New Mexico Corrections Department	Justice
Patricia Rael	Special Projects Coordinator	Office of the Secretary of State	Justice-Involved
Reena Szczepanski	Director	Drug Policy Alliance New Mexico (Women's Services)	Women
LeeAnn Roberts	Program Manager, Rural Health	Department of Health/Office of Primary Care and Rural Health	Women
Robert V. Mitchell	Administrator	San Juan County Alternative Sentencing Division	Justice-Involved
Justin Hunt	President	Time & Tide Productions, Inc.	Justice-Involved
Scott Ford	Inspector	New Mexico Department of Public Safety	Justice-Involved

New York			
Name	**Position**	**Agency/Organization**	**Population**
Maria Pasceri (Team Leader)	Director	Manhattan Addiction Treatment Center	LGBT
Ivan Garcia	Regional Coordinator, Upper Manhattan	Office of Alcoholism and Substance Abuse Services	LGBT
Daliah Heller	Assistant Commissioner	Bureau of Alcohol and Drug Use Prevention, Care and Treatment	LGBT
Rafael Ponce	Coordinator, Special Populations	Bureau of HIV Prevention and Control, New York City Department of Health and Mental Hygiene	LGBT
Barbara E. Warren	Director, Planning, Research, and Government Relations	The Lesbian, Gay, Bisexual & Transgender Community Center	LGBT
Joseph Ruggiero	Assistant Clinical Director	Addiction Institute of New York St. Luke's Roosevelt Hospital	LGBT
Alma R. Candelas	Director, Division of HIV Prevention	New York State AIDS Institute	LGBT
Mark Hammer	Coordinator, Special Projects Division, HIV Prevention AIDS Institute	State Department of Health/HIV Prevention	LGBT
Loretta Parsons-Poole	State Prevention Director, NPN	New York City Office of Community Affairs	LGBT
Debra Hall-Martin	Project Director	Manhattan Treatment Court Project	Justice-Involved
Carrie Davis	Director of Adult Services	LGBT Center	LGBT
Daniel Siconolfi	Project Director	CHIBPBS, NYU	LGBT

Northern Mariana Islands			
Name	**Position**	**Agency/Organization**	**Population**
Joseph Kevin Villagomez (Team Leader)	Secretary of Public Health	Department of Public Health	Justice-Involved
Jose Saures	Manager, Crime Prevention Program	Department of Public Health	Justice-Involved
Reyna Malone	Manager, Prevention Services	Department of Public Health	Women
Andrea Ozawa	Police Officer II/Detective	Department of Public Safety, Criminal Investigation Division, Domestic Violence Unit	Justice-Involved

Ohio			
Name	**Position**	**Agency/Organization**	**Population**
Joyce Starr (Team Leader)	Chief, Division of Treatment and Recovery Services	Ohio Department of Alcohol and Drug Addiction Services	Justice-Involved
Ruth Satterfield	Chief, Division of Prevention Services	Ohio Department of Alcohol and Drug Addiction Services	Women
Jackie McCarey	Women's Coordinator	Ohio Department of Alcohol and Drug Addiction Services	Justice-Involved
Debbie Nixon-Hughes	Deputy Director	Ohio Department of Mental Health	Justice-Involved
Theodore Zeigler	Chief Executive Officer	Community Health Center	LGBT
Bradley DeCamp	Assistant Chief	Ohio Department of Alcohol and Drug Addiction Services	Justice-Involved
Tim Leonard	Trainer, HIV Care Services	Ohio Department of Health	LBGT
Hylton E. Baker	Captain/ Commander	Summit County Sheriff's Office/Narcotics	Justice-Involved
Rodney Woods	Chief, Bureau of Recovery Services	Ohio's Department of Rehabilitation and Corrections	Justice-Involved
Jane Forrest Redfern	Coordinator of Rural Policy	Ohio Department of Jobs and Family Services	Justice-Involved

Oklahoma			
Name	**Position**	**Agency/Organization**	**Population**
Caletta McPherson Team Leader)	Deputy Commissioner, Substance Abuse Services	Oklahoma Department of Mental Health and Substance Abuse Services	Justice-Involved
Steve Buck	Deputy Commissioner, Communications and Prevention	Oklahoma Department of Mental Health and Substance Abuse Services	LGBT
Carrie Slatton-Hodges	Deputy Commissioner, Mental Health Services	Oklahoma Department of Mental Health and Substance Abuse Services	Justice-Involved
June Elkins-Baker	Director, Provider Support Services	Oklahoma Department of Mental Health and Substance Abuse Services	Women
Laura Pitman, Ph.D.	Deputy Chief, Mental Health Officer	Oklahoma Department of Corrections	Justice-Involved
Connie Motley	Director, LGBT/HIV Programs	Red Rock	LGBT
Jeri Sue Robertson	Coordinator, Child Health Program	Oklahoma Health Care Authority	LGBT
Jan Fox	Chief, HIV/STD Service	Oklahoma State Department of Health	Women
Amanda Barron	Indian Country Methamphetamine Initiative Coordinator and Chi Hullo Li Case Manager	Choctaw Nation	Women
William (Scott) Cannon	Lieutenant	Oklahoma County	Justice-Involved
(Ronald) Darrell Weaver	Director	Oklahoma Bureau of Narcotics and Dangerous Drugs	Justice-Involved
Terri White	Commissioner	Oklahoma Department of Mental Health and Substance Abuse Services	General

Texas			
Name	**Position**	**Agency/Organization**	**Population**
Mimi Martinez McKay (Team Leader)	Chief, Staff/Legislative Liaison	Department of State Health Services/ Mental Health and Substance Abuse Services	Justice-Involved
Michael Maples	Assistant Commissioner	Department of State Health Services/ Mental Health and Substance Abuse Services	Justice-Involved
Madeline Ortiz	Division Director	Texas Department of Criminal Justice	Justice-Involved
Debbie Meripolski	Executive Director	Greater Dallas Council on Alcohol and Drug Abuse	Justice-Involved
Judy (Catherine) Brow	Coordinator, Specialized Female Services	Department of State Health Services/ Mental Health and Substance Abuse Services	Women
Esther Betts	Representative, National Prevention Network	Department of State Health Services/ Mental Health and Substance Abuse Services	Justice-Involved
Carey Welebob	Deputy Director	Texas Department of Criminal Justice, Community Justice Assistance Division	Justice-Involved
Theresa K. Cruz	Director	Texas State Office of Rural Health	Justice-Involved
Julie Stagg, MSN, RN	Nurse Consultant	Montrose Counseling Center	Women
Keville Ware	Coordinator, HIV/AIDS Counseling Program	Montrose Counseling Center	LGBT
Ann Robbins	Manager, HIV/STD Comprehensive Services Branch	Department of State Health Services/ Mental Health and Substance Abuse Services	LGBT
Doug Denton	Executive Director	Homeward Bound, Inc.	Justice-Involved
Karen Eells	Director, Access To Recovery Project	Texas Department of State Health Services	Justice-Involved

Texas			
Name	**Position**	**Agency/Organization**	**Population**
Cynthia Humphrey	Executive Director	Association for Substance Abuse Programs	Women
Patrick Clancey	Executive Director	The Patrician Movement	General

Appendix D:
Steering Committee Membership

Steering Committee Membership

Steering Committee Lead: Edwin Craft, DrPH, MEd, LCPC

Full contact information for Steering Committee members can be found in Appendix E: Participant's List.

Steering Committee Membership	
Sharon Amatetti, MPH Senior Public Health Analyst SAMHSA/CSAT	**Joseph Amico** President National Association of Lesbian and Gay Addiction Professionals Vice President for Program Development and Community Educator, Alternatives Inc. and Rainbow Bridge Community Services
CAPT Carolyn Aoyama Women's Health Advanced Practice Indian Health Service	**Gigi Belanger** Public Health Advisor HHS/SAMHSA/CMHS/DKDSDInternet
Sean Cahill, PhD Managing Director Public Policy, Research and Community Health Gay Men's Health Crisis	**Kip Castner, MPS** Deputy Chief, Center for Prevention Maryland AIDS Administration
Laura W. Cheever, MD, ScM Deputy Associate Administrator Chief Medical Officer, HIV/AIDS Bureau Health Resources and Services Administration	**Bryan Cochran, PhD** Associate Professor of Clinical Psychology University of Montana
Grant Colfax, MD Co-Director, HIV Epidemiology Section Director, Interventions Unit San Francisco Department of Public Health	**Edwin Craft, DrPH, MEd, LCPC** Lead GPO/Activities Coordinator for Methamphetamine Health Systems Branch Division of Services Improvement SAMHSA/CSAT
Miguel A. Cruz-Feliciano, MS Project Evaluator Caribbean Basin and Hispanic ATTC Universidad Central del Caribe School of Medicine Institute of Research, Education, and Services in Addiction	**Carrie Davis** Director of Adult Services The Lesbian, Gay, Bisexual & Transgender Community Center

Steering Committee Membership (continued)	
Alicia DeLeon-Torres National Director National Asian Pacific American Families Against Substance Abuse	**Robert W. Denniston** Director National Youth Anti-Drug Media Campaign Office of National Drug Control Policy
Alexa Eggleston, JD Director of Public Policy National Council for Community Behavioral Healthcare	**Judith Ellis** Lead Public Health Advisor HIV, Hepatitis & Meth Team Leader SAMHSA/CSAP
Love Foster-Horton Public Health Advisor SAMHSA/CSAT	**Thomas E. Freese, PhD** Director Pacific Southwest Addiction Technology Transfer Center UCLA Integrated Substance Abuse Programs
Cheryl J. Gallagher Public Health Advisor SAMHSA/CSAT/DPSD/CIOMB	**Rob Garofalo, MD, MPH** Deputy Director Howard Brown Health Center Immediate Past President The Gay and Lesbian Medical Association
Gregory Goldstein Senior Public Health Advisor HHS/OS/OPHS	**Tonia F. Gray, MPH, CPS** Public Health Advisor SAMHSA/CSAP
Christine Hager, PhD Social Science Analyst SAMHSA/OAS	**Perry N. Halkitis, PhD, MS** Associate Dean Professor of Applied Psychology & Public Health Director, CHIBPS NYU Steinhardt School of Culture, Education and Human Development
Steven Harlow, MA, MFT Clinical Director New Leaf: Services for Our Community	**Patricia Hawkins, PhD** Associate Executive Director for Policy and External Affairs, Whitman-Walker Clinic
Ravinia Hayes-Cozier Director of Government Relations & Public Policy National Minority AIDS Council	**Calvin K. Hodnett** Management Analyst COPS Office US Department of Justice
Kirk James, MD Medical Officer Health Systems Branch Division of Services Improvement SAMHSA/CSAT	**Terry L. Jenkins** Director Adult and Juvenile Programs Indiana Department of Corrections Indiana Government Center South

Steering Committee Membership (continued)	
Kathryn P. Jett Undersecretary of Adult Programs California Department of Corrections and Rehabilitation	**Wanda K. Jones, DrPH** Deputy Assistant Secretary for Health (Women's Health) U.S. Department of Health and Human Services
JoAnne Keatley, MSW Minority Programs Manager Pacific AIDS Education and Training Center, UCSF	**Aleisha A. Langhorne, MPH, MHSA** Health Scientist Office on Women's Health Department of Health and Human Services
Steven J. Lee, MD Assistant Clinical Professor of Psychiatry Columbia University	**Eva Margolies** Associate Director for Policy and Planning Centers for Disease Control and Prevention (CDC)
Harriet McCombs Administration/Bureau of Primary Health Care/ODQ Health Resources and Services Administration	**Kristen Martinsen, MPM** Public Health Analyst Office of Rural Health Policy Health Resources and Services Administration
Lucinda L. Miner, PhD (Cindy) Deputy Director Office of Science Policy and Communications National Institute on Drug Abuse	**Alan Moghul, PhD** Director Prevention Services National Association of State Alcohol & Drug Abuse Directors, Inc. (NASADAD)
Lori Moriarty Executive Director National Alliance for Drug Endangered Children	**Robert Morrison** Director of Public Policy National Association of State Alcohol & Drug Abuse Directors, Inc. (NASADAD)
Lisa Neel, MPH Indian Country Methamphetamine Initiative (ICMI) Coordinator Kauffman & Associates, Inc.	**Lorenzo Olivas, MPH** Regional Minority Health Consultant US Public Health Service, Region VIII
Brett A. Parson Acting Lieutenant/Commanding Officer Special Liaison Unit Executive Office of the Chief Metropolitan Police Department Washington, DC	**Murray C. Penner** Deputy Executive Director, Domestic Programs National Alliance of State & Territorial AIDS Directors (NASTAD)
Wilma A. Pinnock, MPA, CPP Public Health Advisor Behavioral Health Branch Division of Community Programs SAMHSA/CSAP	**Harlan Pruden** Council Member NorthEast Two-Spirit Society

Steering Committee Membership (continued)	
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Michael Sessa Chair DC Crystal Meth Work Group President Metro DC Lesbian, Gay, Bisexual, and Transgender Community Center	**Michael D. Siever, PhD** Director The Stonewall Project San Francisco AIDS Foundation
Marvena Simmonds Public Health Advisor PPGSB Division of State and Community Assistance SAMHSA/CSAT	**Amy Bullock Smith** Behavioral Site Director Whitman-Walker Addiction Services Whitman-Walker Clinic
Kim Thomas, MEd CAC Public Health Advisor Health Systems Branch Division of Services Improvement SAMHSA/CSAT	**David Thompson** HIV Team Leader Systems Improvement Branch Division of Services Improvement SAMHSA/CSAT
Willie Tompkins, PhD Public Health Advisor SAMHSA/CSAT	**Danny Ukestine** Public Health Advisor SAMHSA/CSAP
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Barbara Warren, PsyD Director, Planning, Research, and Government Relations The Lesbian, Gay, Bisexual & Transgender Community Center	**Lynn R. Wegman, MPA** Chief, HIV Education Branch HIV AIDS Bureau Health Resources and Services Administration
Linda White-Young Public Health Advisor Division of Services Improvement SAMHSA/CSAT	**Ludmilla F. Wikkeling-Scott** Women of Color Policy Associate Government Relations and Public Policy Division National Minority AIDS Council (NMAC)

Steering Committee Membership (continued)	
Wilbur Woodis, MA (Navajo) Special Assistant on Native American Affairs Office of Minority Health OPHS/OS/HHS	**Jessica M. Xavier, MPH** Public Health Analyst Special Projects of National Significance Project Demonstration & Evaluation Branch Division of Science and Policy HIV-AIDS Bureau HRSA

Appendix E:
Participant List

Participant List

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Clinton Anderson Director Lesbian, Gay, Bisexual, & Transgender Concerns Office The American Psychological Association 750 1st Street NE Washington, DC 20002 Phone: 202-336-6037 Email: canderson@apa.org	**John Anderson** Senior Director, Office on AIDS The American Psychological Association 750 First Street NE Washington, DC 20002-4242 Phone: 202-336-6051 Email: janderson@apa.org
Matthew Aumen Prevention Associate National Association of State Alcohol and Drug Abuse Directors (NASADAD) 1025 Connecticut Avenue NW Washington, DC 20036 Phone: 202-293-0090 Email: maumen@nasadad.org	**Manuel Babauta** Officer in Charge, Criminal Investigation/Lab Guam Police Department Building, No. 233, Central Avenue Tiyan, GU 96913 Phone: 671-475-8404 Email: manuel.babauta@gpd.guam.gov
Wendy Bailie Director Substance Abuse Services 1307 W Main, PO Box 365 Marion, IL 62959 Phone: 618-997-5336 Email: wendy.bailie@fwhs.org (TCE Meth Grantee)	**Hylton Baker** Captain/Commander Summit County Sheriff's Office, Narcotics 53 University Avenue Akron, OH 44308 Phone: 330-643-2170 Email: Hebaker57@hotmail.com (Ohio Action Team Member)
Arthur Barcinas Superior Court of Guam Judge 120 W O'Brien Drive Hagatna, GU 96910 Email: arbarcinas@mail.justice.gov.gu	**Jed Barnum** Project Manager New Champions Crystal Meth Prevention Project, Fenway Community Health 7 Haviland Street Boston, MA 02115 Phone: 617-927-6384 Email: jbarnum@fenwayhealth.org (Fenway Community Health Grantee)

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Peggy Bean Women's Treatment Coordinator 1700 K Street Sacramento, CA 95843 Phone: 916-203-3406 Email: pbean@adp.ca.gov (California Action Team Member)	**Jeff Beasley** Inspector Florida Department of Law Enforcement 2331 Phillips Road Tallahassee, FL 32308 Phone: 850-251-6033 Email: jeffbeasley@fdle.state.fl.us (Florida Action Team Member)
Dano Beck Behavioral Surveillance Coordinator Florida Department of Health 4052 Bald Cypress Way, Bin #A09 Tallahassee, FL 32399 Phone: 850-245-4444 Ext. 2631 Email: Dano_Beck@doh.state.fl.us (Florida Action Team Member)	**Gigi Belanger** Public Health Advisor Division of Systems and Services Improvement, Homeless Programs Branch SAMHSA/CMHS 1 Choke Cherry Road, Room 6-1026 Rockville, MD 20857 Email: gigi.belanger@samhsa.hhs.gov
Barbara Benavente Supervisor Prevention and Training Branch with the Department of Mental Health and Substance Abuse 790 Governor Carlos G. Camacho Road Tamuning, GU 96913 Phone: 671-477-9081 Email: bbena@guamcell.net (Guam Action Team Member)	**Esther Betts** Mental Health & Substance Abuse Prevention Lead & NPN Representative Texas Department of State Health Services 1100 W 49th Street Austin, TX 78756-0529 Phone: 512-206-5865 Email: esther.betts@dshs.state.tx.us (Texas Action Team Member)
Tammy Boose Project Director Cra-Wa-La 2nd Circuit Methamphetamine Prevention Program PO Box 635 Lawrenceville, IL 62439 Phone: 618-943-5326 Email: tboose@crawalavip.org	**Susan Bosarge** NPN (Acting) 1190 Saint Francis Drive, Room 1051 Santa Fe, NM 87502 Phone: 505-231-7057 Email: susan.bosarge@state.nm.us

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Appendix F:
Acronym List

Acronym List

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SAMHSA—Substance Abuse and Mental Health Services Administration
BJA—Bureau of Justice Assistance
COPS—Office of Community Oriented Policing Services
CDC—Centers for Disease Control and Prevention
HHS—U.S. Department of Health and Human Services
OMH—HHS Office of Minority Health
OWH—HHS Office on Women's Health
IHS—Indian Health Service
NIDA—National Institute on Drug Abuse
HRSA—Health Resources and Services Administration
LGBT—lesbian, gay, bisexual, and transgender
DEA—Drug Enforcement Administration
SAI—Strategic Applications International
CSAP—Center for Substance Abuse Prevention
HIV/AIDS—Human immunodeficiency virus/acquired immunodeficiency syndrome
DOJ—Department of Justice
STD—sexually transmitted disease
CEWG—Community Epidemiology Work Group
NSDUH—national survey on drug use and health
NOMs—national outcomes measures
GPRA—Government Performance and Results Act
NHIS—national health interview survey
CMS—Centers for Medicare & Medicaid Services
VA—Department of Veterans Affairs
ATTC—Addiction Technology Transfer Center
TEDS—treatment episode data set
ATR—access to recovery
SBIRT—screening, brief intervention, and referral to treatment
TCE—targeted capacity expansion
ROSC—recovery-oriented systems of care
DSM—*Diagnostic and Statistical Manual of Mental Disorders*
MSM—men who have sex with men
OAS—Office of Applied Studies
STI—sexually transmitted infections

CM—contingency management
CJ-DATS—National criminal justice drug abuse treatment studies
N-SSATS—National survey of substance abuse treatment services
ADAM—arrestee drug abuse monitoring
NASADAD—National Association of State Alcohol & Drug Abuse Directors, Inc.
NMI—Northern Mariana Islands
STDs—sexually transmitted diseases
NALGAP—The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies
CTSA—clinical and translational service awards
THC—tetrahydrocannabinol
LSD—lysergic acid diethylamide
UAF—Utah AIDS Foundation
GLBTQ—Gay, Lesbian, Bisexual, Transgender, and Questioning
NADEC—National Alliance for Drug Endangered Children
DEC—drug endangered children
OVC—Office for Victims of Crime
DSS—Department of Social Services
CoE—center of excellence
IDOC—Indiana Department of Corrections
CLIFF—Clean Lifestyle is Freedom Forever
TCUDS—Texas Christian University drug screen
AA—Alcoholics Anonymous
NA—Narcotics Anonymous
CMA—Crystal Meth Anonymous
TC—therapeutic communities
ACA—American Correctional Association
DASA—Division of Alcohol and Substance Abuse
CBT—cognitive-behavioral therapy
PTSD—posttraumatic stress disorder
STAR—Strengthening Treatment Access and Retention
PRB—Prevention Research Branch
DHAP—Division of HIV/AIDS Prevention
PRS—prevention research synthesis
REP—replicating effective programs
DEBI—diffusion of effective behavioral interventions
EBI—evidence-based interventions
CTN—clinical trials network
NREPP—National Registry of Evidence-Based Practices and Programs
EBP—evidence-based practice

CAE—childhood adverse effects
TAU—treatment as usual
DCFS—Division of Child and Family Services
CHIBPS—Center for Health, Identity, Behavior & Prevention Studies
ACD—alcohol and chemical dependence
TIP—treatment improvement protocol
AAMA—Association for the Advancement of Mexican Americans, Inc.
CRA-WA-LA—Crawford-Wabash-Lawrence
SPF—strategic prevention framework
ONDCP—White House Office of National Drug Control Policy
DSCA—CSAT Division of State and Community Assistance
SPFSIG—strategic prevention framework State incentive grant
BG—Block Grants
NIH—National Institutes of Health
CMHS—Center for Mental Health Services
MCH—maternal and child health
SPRANS—special projects of regional and national significance
NPN—National Prevention Network
SSA—Single State Authority or Single State Agency
OPHS—Office of Public Health and Science
OS—Office of the Secretary
ICMI—Indian Country Methamphetamine Initiative
UCSF—University of California at San Francisco
NASTAD—National Alliance of State & Territorial AIDS Directors
NMAC—National Minority AIDS Council
DSSI—Division of Services and Systems Improvement
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STEPP—State Education and Prevention Partnership
PEPFAR—President's Emergency Plan for AIDS Relief
REMOTE—rural enhanced model for opioid treatment expansion
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