DASIS STATE DATA ADVISORY GROUP MEETING

April 12-13, 2000
Charleston, South Carolina

Summary	**Page 2**
Agenda	**Page 11**
Participant list	**Page 12**

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This meeting is the sixth in a series of regional meetings. Representatives from Georgia, Florida, North Carolina, South Carolina, West Virginia, the District of Columbia and the Virgin Islands attended. Staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions were also present.

Opening and Overview

Dr. Donald Goldstone of OAS gave the opening remarks. He explained that the purposes of these meetings are: (1) to promote a mutual understanding of the data needs of OAS, (2) to inform the States about current activities of OAS, and (3) to give States an opportunity to share with OAS and with each other their solutions to common problems in data collection and information management.

OAS is continually examining its data programs, looking for ways to improve the quality of the data collected to increase its use by State and national policy makers and researchers. Dr. Goldstone stressed the importance OAS attaches to State feedback on its programs and his interest in sharing data with the States.

This meeting, like the others, combined presentations and demonstrations with considerable discussion by participants. The meeting provided the latest information from the 1999 Uniform Facility Data Set (UFDS) survey, reviewed plans for the 2000 UFDS, and provided discussion of the role of the National Master Facility Inventory (NMFI). It emphasized the need for State support in keeping the NMFI up-to-date, and in helping to evaluate possible out-of-range responses to the UFDS. Three demonstrations were given: 1) the Substance Abuse Facility Locator System, 2) the NMFI on-line updating system, and 3) the Substance Abuse and Mental Health Data Archive (SAMHDA). Sam Korper of OAS gave a presentation on substance abuse among the aged and Jane Maxwell of Texas gave one on the use of Texas data for program planning and evaluation. Donald Goldstone discussed the National Household Survey on Drug Abuse (NHSDA) and recent significant findings from the survey.

1998 UFDS and State Feedback Process

Data collection for the 1998 UFDS concluded in May 1999, with a response rate of 93% for State-approved facilities and 87% for non-State-approved treatment facilities. The universe consisted of 21,377 facilities. More than 25% of the facilities surveyed were first-time reporters to UFDS, although not necessarily new providers. Seventy-five percent indicated they were providing treatment, 12% were prevention only, and 10% were closed at the time of the survey. Considerable efforts were made to identify facilities linked by administrative arrangements, and 43% indicated that they were affiliated with at least one other place.

The 1998 survey showed a dramatic increase in the client counts over 1997. The increase was largely because of facilities reporting in 1998 that did not exist (or did not participate) in the 1997 survey. The largest increase occurred in providers not approved by the States.

The client count is an important figure because it is used in producing SAMHSA s estimate of the treatment gap. Last year, there was a $250 million increase in the Block Grant for States because of the increase in the treatment gap estimate. Although the one-day census count does not vary much from year to year nationally, the State-by-State variation is considerable.

In an effort to get States help in evaluating unusual (and possibly incorrect) responses to the UFDS survey, each State was sent provider-level data representing outliers for key variables and asked for its evaluation of the reported numbers. OAS received a mixed response to the request. A few States provided detailed feedback; some States could comment on only some of the data because of lack of comparable data in the State system; and some States did not respond. States at the meeting were given handouts for their States comparing 1998 and 1997 client counts and enumerating outliers, similar to the reports sent last year. OAS staff asked for feedback about this approach to evaluating unusual client counts collected in the UFDS. Staff urged States to send them any suggestions or insights they have that would help the feedback process.

Early results from the 1999 UFDS

The 1999 UFDS is a telephone survey concentrating on the information needed for the National Directory of Substance Abuse Treatment Facilities. Data on client counts were not collected in 1999. Several new items were tested in the 1999 survey. Among the items tested were:

Facility affiliation. When MPR first conducted the survey in 1997, it encountered a number of facilities that were contacted for the survey more than once. MPR realized that many facilities were associated with multiple sites. Therefore, special efforts were made to identify these associations. More than one-half of the facilities are part of a network. This proportion has been increasing over the last few years, possibly because of better detection and enumeration of networks. However, there is a lot of State variation.

Setting. Setting is a confusing term. Some respondents interpret it as the physical structure that houses the program; others interpret it as the programs that are available. Consequently, many facilities report multiple settings. The question was changed in 1999 to ask about the primary focus of the facility?68% had substance abuse as the main focus, but mental health was the primary focus for more than 13%. Again, there was State variation. In non-State-approved facilities, a higher percentage of facilities were focused on mental health.

Intensive outpatient. Each year, the UFDS asks whether a facility provides intensive outpatient treatment. The definition varies in the field, with the American Society of Addiction Medicine (ASAM) advocating a minimum of 9 hours per week. Past UFDS surveys specify 6 hours per week. In 1999, facilities were asked for their definition of intensive outpatient. A considerable proportion did not meet even the less stringent

definition of 6 hours per week. The distinction made in the UFDS between outpatient and intensive outpatient care may not be realistic.

Subsidized care. Twenty-three percent of the facilities did not provide any subsidized care. This question was added because people who use the National Directory often want this information. There was some concern expressed as to whether or not this information can be collected reliably.

Sliding fee scale. The results of this question are similar to the ones for subsidized care. However, there was a general feeling that the answers to this question were probably more accurate.

Updating the NMFI

The NMFI is a listing of all substance abuse providers in the country. Keeping this listing current and accurate is important. Information from the UFDS, combined with the latest information on approved facilities from each State, provides the data needed to produce the National Directory each year and to maintain the on-line Facility Locator. The information from the States on State approval is critical to the validity of the National Directory.

A handout was distributed to each State containing a list of its non-approved facilities and their answers to questions on the 1999 survey about other forms of accreditation and whether the facility was State-approved. Each State was asked to review the list and notify Synectics if facilities on the list were State-approved. Donald Goldstone emphasized that OAS does not want to be seen as certifying the legitimacy of facilities for treatment; this is the role of the States. If the State does not approve the facility, the facility does not get into the National Directory.

There was considerable discussion about the problems associated with keeping the list updated and the burden on the State. To lessen the burden on States, OAS and Synectics advocate the use of the NMFI on-line system to update the NMFI. In addition, Synectics is no longer sending out comprehensive lists to the States to review once a year because many States reported that this was a very labor-intensive job. Instead, Synectics is sending out lists on a flow basis, thereby spreading out the State burden over the year.

The question of whether Synectics could use States electronic databases, rather than sending out a list, was raised. A major impediment to this effort is the variation in requirements among States and the differences between State requirements and practices and those of OAS. Synectics will get electronic databases from Florida and Kansas to test the feasibility of the idea.

A practice among some States that needs to be addressed is that of listing or licensing a main provider but not its satellite locations. For the purposes of the National Directory, OAS/Synectics propose an agreement by States that if the main facility is approved, all subsidiaries can be considered as approved.

Demonstration of National Facility Locator

Synectics has developed a Web-based National Facility Locator that allows users to query the National Directory on-line and displays the results on a map. The Locator became operational in November, 1999. Since then, the Locator has had at least 1,000 hits a month and has generated considerable e-mail. It is used by family members, substance abuse programs, individuals seeking treatment, and people not directly involved in substance abuse treatment, but who make referrals to treatment.

The Locator has its own Web site address: http://findtreatment.samhsa.gov. This link goes to the DASIS Web page, which in turn has a link to the Locator. Search options include a simple search and a more complicated search of treatment facility characteristics. In *Simple Search*, a user specifies a city and State or zip code, and can optionally include a street address. The system then identifies the substance abuse treatment providers closest to the starting point, showing a map and generating a list with all the current directory information (updated monthly). The search area is a radius of 99 miles from the starting point. Users can also use *Advanced Search*, which allows specification of several directory variables as an aid in focusing the search. An example of an advanced search is:

? Show all the providers in and around Charleston S.C. that provide residential treatment, that have a treatment program for dually diagnosed clients, and that accept private insurance as the form of payment

A *Browse* feature allows users to generate a list of facilities for a geopolitical area (one or more zip codes, city and State, one or more States, or the entire United States). It has search capabilities similar to *Advanced Search*. The list generated contains all the treatment facilities meeting the criteria for an area.

Demonstration of the NMFI On-line

The NMFI on-line system was demonstrated. This system is used by many States as a convenient way to enter new providers in the NMFI and to change the status of existing facilities. Several improvements to the system were suggested. One was to revise the existing form so that the important information was first, followed by the optional information. OAS and Synectics agreed to review the form and to remove extraneous items. There was also a suggestion that the system be redesigned to walk a user through the data entry by a series of branching questions similar to a CATI questionnaire. A final suggestion was that States that have a large number of updates be able to submit an electronic database to avoid re-keying of data.

State Presentation by Jane Maxwell (Texas)

Texas has been collecting TEDS data since 1973 and has a rich longitudinal database. Dr. Maxwell showed a series of tables and graphs illustrating the State   use of data. She also distributed a series of program management reports that Texas regularly produces.

Summarized below are some findings presented:

Adult admissions to treatment by primary substance 1983-99. Important to the proper analysis of data is having an understanding of the data system. A graph showing primary substance abuse over time illustrated this point. The graph showed a drop in 1999 in the use of heroin. However, there were changes in the treatment system in the Dallas area (where there is a lot of heroin abuse) beginning July 1, 1999. Because there was no mandate to report the data, data from Dallas has been missing since 1999.

Heroin injection vs. inhalation. Heroin is moving into new markets, e.g., peddling of heroin outside nightclubs to yuppies. Users are told that if they snort heroin, it is not addictive. However, data indicate that snorters appear in treatment on average 6 years earlier than do injectors. Injectors in Texas are one-third each black, Anglo, and Hispanic. Inhalers are predominantly Anglo or Hispanic. The increase in Anglo and Hispanic heroin users indicates that the focus on where treatment is delivered may need to change. In Texas, 90% inject and 10% inhale. This is in stark contrast to Delaware, where it is approximately half-and-half.

Ninety day assessment of clients finishing treatment. Texas reports to the legislature on adult and child treatment effectiveness. Measures include percent completing treatment, percent abstinent at follow-up, and percent who gained employment. The measurement is done by a 90-day follow up survey. The 90-day follow-up is used because people are most likely to relapse in the first 3 months post-treatment. A flaw in these statistics is that these measures include only persons who completed treatment, not those who received any treatment.

Analysis of National TEDS Data

Dr. Goldstone showed a series of slides using national TEDS data based on rates of admissions by State between 1992 and 1997. These yearly state maps documented some interesting geographic trends in drug usage. One series clearly shows the movement of amphetamine use from west to east over time. A second showed heroin use between 1992 and 1997, indicating that high heroin use is associated with the east and west coasts. Cocaine is mainly an East Coast problem.

On-line Substance Abuse and Mental Health Data Archive (SAMHDA)

Charlene Lewis of OAS demonstrated the Substance Abuse and Mental Health Data Archive (SAMHDA). The goal of SAMHDA is to provide researchers, academics, policymakers, service providers, and others with ready access to substance abuse and mental health data. Data and accompanying documentation can be downloaded from the Internet (http:// www.icpsr.umich.edu/ SAMHDA/ index.html). Data sets are in SAS and SPSS format, and documentation is in PDF format.

This site has now been in operation for 18 months and is registering 20,000 hits per month. There are 65 datasets in the data warehouse. The system uses a Data Analysis System (DAS) developed by the University of California at Berkeley. DAS was developed specifically for use on the Internet. It computes frequencies, cross tabulations, means, and correlations; data subsets can be extracted for downloading. Customized data sets and codebooks can be downloaded. The documentation includes a title page,

cookbook notes, weighting information, bibliographic citation and data disclaimer, and description of imputations, data anomalies, and data problems.

Among the data sets available are TEDS (1992-97), the National Household Survey on Drug Abuse, and data from the Drug Abuse Warning Network (DAWN).

The demonstration focused on the TEDS data. The system allows the user to generate a query and build a table to answer the query on-line. To protect confidentiality, the TEDS data undergoes a disclosure analysis and the public use file is a one in four sample of the original file.

Update on the National Household Survey on Drug Abuse (NHSDA)

Dr. Goldstone showed slides that described the NHSDA and highlighted some findings from the 1998 survey. NHSDA covers use of drugs, alcohol, and tobacco. The survey universe is the civilian population aged years and older. The NHSDA excludes people in prison and the homeless, two populations with serious substance abuse problems. In 1998, the sample was 18,000 nationally, with expanded samples in California and Arizona to monitor their new laws legalizing medical marijuana use (Arizona later rescinded its law). The survey is in the field continuously.

Some highlighted findings are:

Trends in illicit drug use 1979-98. The use of illicit drugs has been stable since 1991.

Use by drug 1998. In the past month, 60% of those surveyed used marijuana, 21% used marijuana and another drug, and 20% used a drug other than marijuana.

Trends in use by age 1979-98. Use among 12-17 year-olds reached a low in 1992, then rose a bit, and has been stable the last 4 years. Use among 18-25 year-olds indicates a reason to be concerned. The increase is real, reflecting an increase in use. This is a probably a cohort effect, reflecting the increase in drug use in 1992-95 among 12-17 year-olds. That group is now older, moving forward in the age span.

Illicit drug use by age 1998. The age-group 35-39 was a heavy-using group 15 years age and remains a heavy-using group. Increases in teen use indicate a problem that will persist throughout the lifetime of the cohort.

Trends in marijuana use by frequency in past month, age 12-17, 1992-98. There are more users and heavier use. This graph does not reflect that marijuana is now a different and stronger product.

Marijuana use by grades, age 12-17, 1998. Marijuana use is associated with getting Cs and Ds, although this is not a causal association in cross-sectional data.

Underage alcohol use, age 12-20, 1994-98. The flat lines indicate that publicity and efforts to change youth alcohol use have not been effective.

Stealing by alcohol use, age 12-17, 1994-96. There is a relationship between heavy alcohol use and the rate of stealing.

Past month cigarette use 1998. Figures of 28% of the population and 18% of youth are the lowest rates ever measured.

Trends in cigarette use by age. Age 12-17 is stable, age 18-25 is beginning to go up, and age 26 and over is decreasing.

Inhalant use, age 12-17, 1994-98. There was a decrease between 1997-98 in both past month and past year use.

Youth substance dependence. Estimated numbers: alcohol 389,000; illicit drugs 464,000; 525,000 alcohol and drug, for a total of 1.4 million aged 12-17 who are substance dependent. Dependence is measured using a series of 7 characteristics (the physiological DSM-IV criteria). These include withdrawal, inability to stop using, increased use, life changes because of drug use, etc. There is a clinical basis for reaching the conclusion of dependence. In 1998, if a person responded positively to 5 of 7 questions, he or she was classed as dependent.

The NHSDA also measures incidence; that is the rate of new users (i.e., persons who have never tried a drug before). Some results are:

Marijuana incidence rates 1965-97. Incidence among 12-17 year-olds shows a decline in 1996-97. No association was found with the new media campaign introduced in some parts of the country in the fall of 1998. There is also a decline in incidence among 18-25 year-olds. Of all those who try the drug, only a small proportion will continue its use. However, if the number of new users goes up, the number of continuing users will also go up.

Cocaine incidence rates 1965-97. Rates have been up among 12-17 and 18-25 year-olds since about 1990. The rate for 12-17 year-olds was level in 1996-97, but increased for 18-25 year-olds in that period. There are a greater number of regular users.

Rates of new use, age 12-17, per 1000 person-years. The rate for marijuana increased from 38 in 1991 to 64 in 1997, for heroin from .3 to 1.1, and for cocaine from 4 to 11. This suggests that the future may hold more of a problem than is seen currently.

For 1999 several changes were made to the sample, the mode, and the content. These include a provision for State estimates. The new design includes 7,200 segments, 230,000 screened households, and 70,000 completed interviews. 20,000 paper and pencil interviews were conducted (in 1999 only) for comparison.

The segments were based on the 1990 Census, and the sample is 5 times bigger than the sample for the 1998 survey. The screening rate is driven by the rarest sample, in this case ages 12-17. There will be 25,000 aged 12-17, and 22,500 each ages 18-25 and 26 and over.

The 8 largest States (California, Florida, Illinois, Michigan, New York, Ohio, Pennsylvania, and Texas), with 50% of the population, will be sampled directly (3,700 respondents each). There will be 900 interviews in smaller States. For large States, OAS will make direct estimates. For the smaller States, a composite estimator will be used. This will combine direct survey estimators and regression-derived indirect estimators. These model estimators will be evaluated by comparing direct estimates with modeled estimates for the large States.

The mode of collection will be computer-assisted personal interview (CAPI) and audio computer-assisted self-interview (ACASI). An automated survey helps to standardize the questionnaire and aids in guiding respondents and interviewers through the skip patterns in the questionnaire. These methods have been tested in some 2,000 cases. Results indicate an increased reporting of substance use over the paper version.

Since the CAPI and ACASI have built-in edits and data transmission occurs daily, more timely data will be available. National estimates from the expanded survey are expected to be released in August 2000. Estimates for individual States will follow.

Expansion of the survey for the year 2000 will include the addition of question modules. In 2000, these are the Diagnostic Interview Schedule for children, and the use of mental health services by adults and children. In 2001, questions will be included on the market for drugs: what, where, what interferes with getting drugs. The mental health instrument has never been used this widely or this way; it is in the field now. For services, data collection includes where, when, costs, and insurance coverage.

Substance Abuse and Aging

Sam Korper of OAS made a presentation of work OAS is conducting with other Federal agencies on forecasting the impact of an aging cohort of drug users on the health and substance abuse treatment system. The task force is focusing on estimates of health care need in the years 2010 and 2030. The baby boom generation, born 1946-64, has historically the highest rates of drug use and will be reaching retirement age in this period. What will this mean to the health care system? SAMHSA has launched, with other Federal agencies, an initiative to address these questions.

This is an area that has been largely overlooked by the substance abuse community. Studies by CSAT of substance abuse in the elderly show increases in co-morbidity and premature death. Studies also show an increase in sensitivity to drugs as people age. All of this portends an increase in treatment need in the future.

As part of this effort, 17 interested Federal agencies have begun a series of meetings. Phase 1 focused on identifying available data, formulating the key assumptions, and describing the data gap. Currently the agencies are in Phase 2, where they are beginning initial analyses and making preliminary estimates. This

information will form the basis for moving into Phase 3. Phase 3 will focus on engaging Federal agencies, the private sector, and States to put together a well-grounded policy piece to stimulate debate.

1997 UFDS Survey of Correctional Facilities

In 1997, OAS conducted a survey of correctional facilities. The survey identified 3,000 additional sites and 173,000 additional clients. This is a baseline for future studies. The next round of this survey will be in 2001. Some findings were:

Drug offenders make up 65% of the Federal prison system. However, only 40% of correctional facilities provided treatment. This varied by ownership: 93% of the Federal prisons provided treatment, 60% of the State prisons, and 33% of the jails.

70% of facilities offered treatment in the general prison facility population, 28% had special units, and 2% had hospital/psychiatric units.

An outside contractor often handles inside-the-facility treatment. Outside contractors provide half the treatment in juvenile facilities, 20% in State correctional facilities, and none in Federal prisons.

The ratio of patients to staff is 3:1 for juvenile facilities and 25:1 for State facilities.

Closing Remarks

Dr. Goldstone ended the meeting by thanking the participants for their participation and urging them to feel free to contact OAS staff with any suggestions or problems they may have. He reiterated that the feedback OAS receives is extremely useful and hoped that the State representatives find the exchange equally beneficial. Dr. Goldstone reiterated the importance of the partnership with the States and how important it is to the proper operation of the DASIS system.

Agenda

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Wednesday

9:00 a.m. — Welcome and Introduction .... *Donald Goldstone, OAS*

9:30 a.m. — UFDS Survey

- ? Client counts from 1998 .... *Deborah Trunzo, OAS*
- ? Process for getting State feedback .... *Trish Royston, OAS*
- ? Current status of 1999 survey .... *Geri Mooney, MPR*
- ? Early results from 1999 – new items
- ? Plans for 2000

10:30 a.m. — BREAK

10:45 a.m. — Demonstration of Substance Abuse Treatment Facility Locator .... *Deborah Trunzo, OAS*

11:00 a.m. — National Master Facility Inventory (NMFI) Discussion .... *Peter Hurley, Synectics*

- The NMFI and State licensing/approval practices
- Keeping the NMFI up to date
- Demonstration of NMFI On-Line

12:15 p.m. — LUNCH

1:15 p.m. — State presentation .... *Jane Maxwell, Texas Commission on Alcohol and Drug Abuse*

1:45 p.m. — Applications of TEDS data and discussion of TEDS-related issues .... *Donald Goldstone,OAS*; *Peter Hurley, Synectics*

2:45 p.m. — BREAK

3:00 p.m. — Demonstration of the SAMHDA on-line data analysis system .... *Charlene Lewis, OAS*

3:45 p.m. — National Household Survey on Drug Abuse (NHDSA) .... *Donald Goldstone, OAS*

5:00 p.m. — Adjourn

Thursday

9:00 a.m. — Open discussion of data-related issued .... *Donald Goldstone, OAS*

10:00 a.m. — Substance abuse and the elderly .... *Sam Korper, OAS*

10:45 a.m. — BREAK

11:00 a.m. — Results from the 1997 UFDS Survey of Correctional Facilities .... *Donald Goldstone,OAS*

11:30 a.m. — Wrap up .... *Donald Goldstone, OAS*

12:00 noon — Adjourn

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