

# **DASIS STATE DATA ADVISORY GROUP MEETING**

November 14–15, 2000

Nashville, Tennessee

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## **DASIS STATE DATA ADVISORY GROUP MEETING**

November 14–15, 2000

Nashville, Tennessee

This meeting is the eighth in a series of regional meetings. Representatives from Alabama, Arkansas, Kentucky, Maryland, Mississippi, Tennessee, and Virginia attended along with staff from the SAMHSA Office of Applied Studies, Mathematica for Policy Research, and Synectics for Management Decisions.

### **Opening and Overview**

Dr. Donald Goldstone of the Office of Applied Studies (OAS) gave the opening remarks. He emphasized the importance of these face-to-face meetings between OAS staff and the State people who produce the data. The one-and-a-half-day meetings provide a forum for OAS staff to inform the States about current activities and to give States an opportunity to share with OAS and each other their solutions to common problems in data collection and management of information.

Dr. Goldstone stressed the importance OAS attaches to State feedback from these meetings and the importance previous comments have already played in developing the N-SSATS questionnaire and other aspects of the DASIS programs.

This meeting, like the others, combined presentations and demonstrations with considerable discussion by participants. Discussed at the meeting were plans for the 2000 N-SSATS (formerly called UFDS), highlighting changes in the questionnaire; the I-SATS (formerly the NMFI), a master list of all facilities, and the need for State support to keep the I-SATS current; and issues related to submissions of TEDS data. Three demonstrations were given: one on the Substance Abuse Treatment Facility Locator, a second on the I-SATS ON-LINE updating system, and a third on the Substance Abuse and Mental Health Data Archive (SAMHDA), a system for producing tables on line. Bill Rusinko of Maryland gave a presentation about the Maryland management information system. Dr. Goldstone discussed the National Household Survey on Drug Abuse (NHSDA), highlighting some significant findings from the survey.

### **Demonstration of Substance Abuse Treatment Facility Locator**

Synectics has developed a system that displays the National Directory on the Web, allows users to query the directory for substance abuse providers, and shows provider locations on a map. The Locator has its own Web site address: <http://findtreatment.samhsa.gov>. It became operational in November 1999. Since then the hits on the Locator have gone from approximately 600 hits a week to 2,000 a week. The Locator is used by family members, substance abuse programs, individuals seeking treatment, and by professionals who do referrals. The listings include only state-approved facilities, and the information is based on the facilities' answers to the 1999 N-SSATS survey.

Deborah Trunzo of OAS demonstrated the three search features of the locator. Users can do a Quick Search, a Detailed Search, or a List Search. In the Quick Search, the user clicks on a State on a map, and then enters a starting point (a street address, city, or zip code). The system searches the file for the closest substance abuse facilities to the starting point, displays the results on a map, and generates a list

with all the current directory information. The search area is a radius of 99 miles from the starting point. Users can also use Detailed Search, which allows users to specify several of the directory variables as an aid in focusing the search. An example of a Detailed Search is: give me all the providers in and around Nashville, Tennessee, that are in a residential setting, have a treatment program for dually diagnosed clients, and take private insurance.

The third feature, List Search, allows users to generate a list of facilities for a geo-political area using search capabilities similar to the Detailed Search. The list contains all the treatment facilities meeting the criteria for a geographic area such as a city or a State. The area of the search can be one or more zip codes, cities, States, or the entire United States.

Many of the States attending have used the system and find it useful. Some States have added a link from their site to the Locator.

### **The 2000 N-SSATS**

Geraldine Mooney of Mathematica for Policy Research (MPR) discussed the changes being made to the questionnaire for this year's survey and had handouts showing the 1999 survey results for the new items. The tables gave the U.S. totals and the results for the States attending the meeting.

Because of the difficulty facilities had in answering some types of questions and the questionable quality of the responses, some major data items have been deleted from the upcoming survey; namely, facility setting, revenue, and counts of clients by sex, race, and age. Some items that were tested in the 1999 telephone survey are being added to the mail survey—primary focus, separate intake telephone number, Web site address, and questions on accreditation, the availability of a sliding fee scale and other payment assistance—and several questions have been revised.

The representatives at the meeting had many comments about the questionnaire. The year 2000 questionnaire has replaced the setting question with one on primary focus with a shortened list of settings. Representatives reviewing the data from the 1999 survey felt the results looked reasonable for their State. They also commented that selecting the primary focus for a substance abuse program within a general hospital might still leave the respondent wondering whether to select the setting of the program (substance abuse) or the setting for the hospital facility (general health).

Another new question that generated considerable discussion asked about providing substance abuse treatment in a language other than English. It is the OAS intention to capture those programs that provide a specialized program that is culturally sensitive to a special ethnic group and goes beyond having a bilingual person available. Several of the States indicated that they often contract for these services. It is not clear if the question as worded includes contract services since it uses the word "provided" rather than a more inclusive phrase such as "made available." There was considerable discussion about alternative approaches but none were agreed upon.

Each year facilities are asked if they provide intensive outpatient, which is defined in our surveys as a minimum of 6 hours a week. The definition varies in the field; for example, the American Society of

Addiction Medicine (ASAM) advocates a minimum of 9 hours a 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, so the distinction between outpatient and intensive outpatient does not seem realistic. The data for Mississippi showed that all facilities answering the 1999 questionnaire answered 9 or more hours. Maryland indicated that it uses the definition of 9+ hours and 70 percent of the facilities reported 9 or more hours. Tennessee indicated standards are coming but not in place now (75 percent reported 9+ hours) and Virginia indicated it does not differentiate.

Gerry Mooney reminded the States that they will be asked if they would like to assist in following up with non-respondents. States participation is strictly voluntary. The next N-SSATS will have a new point prevalence date of March 1 instead of the current October 1. This will change the annual schedule somewhat. The pretest will take place in August to September, 2001, the survey will be sent out in February, and the results will be available for State review in the late fall of 2002.

### **Updating the I-SATS**

The I-SATS is a listing of all substance abuse providers in the country. Keeping this listing current and accurate is important. Information from the N-SSATS combined with the latest information on approved facilities from each State provides the data needed to produce the National Directory and the Facility Locator. The information from the States on State approval is critical to the validity of these listings.

In order to lessen the burden on States, OAS and Synectics are advocating the use of the I-SATS ON-LINE system to update the I-SATS. In addition, Synectics is now sending out lists to the States to review on a flow basis, thereby spreading out the State burden over the year, because many States report that reviewing comprehensive lists once a year is a very labor-intensive job. Rapid turnaround of these lists is important in maintaining the integrity of the Facility Locator and our file.

### **Demonstration of I-SATS ON-LINE**

The I-SATS ON-LINE system is a convenient way to enter new providers in the I-SATS and to change the status of existing facilities. The system is on the Web and can be accessed at the DASIS home page (<http://www.dasis.samhsa.gov>), but it requires an ID and password. Qualified State people can obtain IDs and passwords by calling Alicia McCoy, the I-SATS administrator, at 703-807-2329. Once a user has an ID and password, the home page allows access to a variety of information and utilities. By clicking on I-SATS ON-LINE, the user can a) enter a new facility, b) enter a new facility based on an existing one, and c) select a facility to update. Entering a new facility and updating a facility's choices were demonstrated at the meeting. On the "new facility" form, users enter required information in the top part and optional information in the lower part. The "update" form, which a user can access by entering a State ID or the NFRID, displays the current information for the facility on the left-hand side of the form. The right-hand side is where the user can then enter the changes in the appropriate fields.

### **Analysis of National TEDS Data**

States often wonder what happens to the TEDS data at the national level. Deborah Trunzo of OAS gave a slide presentation demonstrating the strength of TEDS data aggregated to the national level. The information on the slides has been presented to SAMHSA officials, the Secretary of the Department of Health and Human Services, officials at OMB, and staff of ONDCP. The slides featured trend maps for 1993–1998 for heroin, amphetamines, cocaine, and marijuana admissions. Also featured were density plots showing admissions by age at first use and duration of use for various primary substances. These visual presentations of the data have been very effective in gaining the attention of important program officials and in increasing the funding for substance abuse treatment.

### **Submitting TEDS Data**

TEDS data are being used more and more at the national level and as a result the coverage and quality of TEDS data are receiving more attention. Therefore OAS is undertaking an extensive review of all the TEDS data that has been submitted since 1993. Synectics developed two sets of tables, one showing the percent of valid records for each year between 1993 and 1999 for each of the TEDS variables and a second set of tables showing the distribution of all TEDS admissions by year and TEDS variables. The tables, with questionable data patterns highlighted, were sent to each State that attended this meeting. These States were asked to review the data and report on the reason for the problems. Once the reason for the anomaly has been identified, the data will either be corrected or be documented with the deficiency. Ultimately this information will be available to users and will aid in the proper analysis of the data. After reviewing the results of this first effort, the program will be extended to include all States.

Another problem with TEDS data is the timeliness of reporting. The OAS goal is to have a complete file available for publishing and analysis 12 months after the end of the calendar year, but each year several States do not meet that deadline. States are being urged to keep their reporting current. Cutoff date for 1999 TEDS data is December 30.

### **Update on National Household Survey on Drug Abuse (NHSDA)**

Donald Goldstone presented an update on the household survey. The survey universe is the civilian population 12 years and older; however, it excludes people in prison and the homeless, both populations with serious substance abuse problems. The survey is in the field continuously. In 1999, the survey data were collected by computerized questionnaire, the sample was selected so both national and State estimates can be produced, and there were 67,000 respondents. The sample was split in thirds among 12- to 17-year-olds, 18- to 25-year-olds, and those 26 and over.

Some highlighted findings are:

The use of illicit drugs has been stable since 1991.

In 1999, among those respondents reporting illegal drug use, 57 percent used marijuana only, 18 percent used marijuana and another drug, and 25 percent used some drug other than marijuana.

*Illicit drug use by age, 1979–99.* Use among 12- to 17-year-olds bottomed out in 1992, then rose a bit, and has been more or less stable the last 5 years. Use among 18- to 25-year-olds showed a slight

increasing trend: the increase is real, reflecting an increase in use. This may be a cohort effect: we saw an increase in 1992–95 among 12- to 17-year-olds, and that group is now older, moving forward in the age span categories.

*Illicit drug use by age, 1999.* The highest rate among those reporting use in the past month is 20.5 percent among 18- to 20-year-olds. Next is 16.5 percent among 16- to 17-year-olds and 14.6 percent among 21- to 25-year-olds.

*Illicit drug use among youth age 12–15, 1999.* Marijuana is the predominant drug among 15-year-olds and inhalants among 12-year-olds.

*Illicit drug use among 12- to 25-year-olds by gender and age, 1999.* Usage is the same by gender up to age 16 and then, although usage rates drop for both by the time they are in their 20s, male rates remain higher.

*Illicit drug use by race/ethnicity, age 12 and older, 1999.* The highest rate was among American Indians/Alaska Natives.

*Alcohol use among youth age 12–17, 1994–99.* There was very little change in rates between 1994 and 1999.

*Cigarette use in past month by age, 1999.* The rate of use increases between the ages of 12 and 19 and starts leveling off at approximately 45 percent.

State estimates of illicit drug use, tobacco use, and alcohol use were produced for the first time using a method that combined use of a direct estimate with a regression estimate. State prevalence rates were presented for 7 measures: past month use of any illicit drug, ages 12 and older; past month use of any illicit drug, ages 12–17; past year dependence on illicit drugs, ages 12 and older; past month binge alcohol use, ages 12–17; past month use of cigarettes, ages 12 and older; past month use of cigarettes, ages 12–17; and past month use of cigarettes, ages 18–25. The quintile categories for these prevalence rates were displayed in state maps.

The 10 States with the highest prevalence rates for illicit drug use among persons 12 and over are (in alphabetical order) Alaska, California, Colorado, Delaware, Massachusetts, Michigan, Nevada, New Mexico, Rhode Island, and Washington.

A comparison of states across substances found that Delaware was in the top group for all 7 measures and that there was a 0.63 correlation between marijuana use and other illicit drug use, but found no correlation between cigarette use and illicit drug use. Three findings from a comparison across age groups were that Massachusetts was in the top group for any illicit drug, all age groups; that five Midwestern States were in the top group for binge drinking, all age groups; and that Kentucky and North Carolina were in the top group for cigarette use, all age groups.

NHSDA data were compared with other state surveys. When the NHSDA data were compared to the 1997 BRFSS (adults) data, there was a 0.80 correlation on cigarette use and a 0.74 correlation on binge alcohol use. Comparison with 1999 YRBS (youth) data showed a 0.74 correlation on cigarette use and a 0.53 correlation on marijuana use.

NHSDA is an extraordinarily valuable data set and the State data will be made available as soon as there are sufficient numbers for each State and when the privacy problems have been worked out. OAS is investigating the possibility of using a licensing arrangement to facilitate the use of the data by States and still protect confidentiality.

Since the survey has built in edits, and data transmission occurs daily, more timely data will be available.

### **On-Line Substance Abuse and Mental Health Data Archive (SAMHDA)**

The OAS has a policy of making their national data sets available as public use files (PUF) approximately 6–7 months after the end of the data collection period. The PUF are made available on SAMHDA, an on-line data analysis system <http://www.icpsr.umich.edu/SAMHDA>). The SAMHDA goal is to provide researchers, academics, policymakers, service providers, and others with ready access to substance abuse and mental health data. Visitors to the Web site can download data and documentation as well as use the on-line data analysis system to perform cross-tabulations, comparisons of means, comparisons of correlations, and to subset records and variables. Among the data sets available are TEDS, the National Household Survey on Drug Abuse, and data from the Drug Abuse Warning Network (DAWN). The documentation available includes a title page, codebook notes, weighting information, bibliographic citation and data disclaimer, and descriptions of imputations, data anomalies, and data problems. Charlene Lewis demonstrated a cross-tabulation of TEDS data. The system allows the user to generate a query and build a table to answer the query on line.

In order 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. A State representative expressed concern that this system allows users not familiar with the nuances of the data to do analysis that may be harmful to States. Donald Goldstone responded that this is one of the problems of a decentralized system and this is why they centralized the data collection of N-SSATS. Although there is a protocol for TEDS, not all States follow the protocol. The current initiative of sending TEDS data to the States for their review in order to get corrections or explanations is critical to proper documentation and will help minimize any data interpretation problems.

A discussion ensued about the relevance of the TEDS episode model in the current treatment environment of managed care. Virginia and Kentucky mentioned that the TEDS model of admission and discharge was at odds with the rest of their internal systems. It was also mentioned that the standards being proposed for HIPPO may be helpful in generating common datasets.

### **State of Maryland Presentation**

Bill Rusinko presented a series of slides showing admission and discharge data from Maryland. Maryland is one of a few States that gets reports from almost all the providers in the State. All clinics

certified by the Maryland Department of Health and Mental Hygiene or the JCAHO as alcohol and drug abuse treatment clinics are required to report. Maryland recently revised their system. The new system is called SAMIS (Substance Abuse Management Information System) 2000. Maryland also uses unique identifiers. There are 350 reporting programs in Maryland, 125 of them are State funded and approximately 60,000 admissions and discharges are reported in a year.

Some of the findings reported were:

Approximately 47 percent of the discharges reported that they completed treatment.

The highest rate for successfully completing treatment, by leading substance abuse mention, was for alcohol (47 percent). The rate for the other leading substance abuse mentions—heroin, crack, other cocaine, and marijuana—ranged from 30 to 40 percent.

Approximately 65 percent of the discharges classified as having completed treatment achieved their substance problem objective.

Maryland is in the midst of a study of post-discharge outcomes. The primary question is: How do individuals who successfully complete drug treatment differ from individuals who do not complete treatment? They plan to use available administrative data, including criminal justice data, DWI assessment database, employment data, Medicaid data, mortality and drug treatment data.

Preliminary Findings from Baltimore City (1998 data):

The universe is predominately male and Black; two-thirds are heroin users.

Seventy-six percent stayed in treatment 90 days or less.

Slightly less than 10 percent successfully completed treatment, and an additional 20 percent completed treatment and were referred.

Approximately 50 percent of the discharges who had some wages prior to admission and successfully completed treatment had increased wages at discharge.

### **Closing Remarks**

Donald Goldstone thanked the group for their participation in the meeting, and complimented them for their interesting and insightful comments. The remarks that they made over the last day and one half would be noted and taken into consideration in future OAS plans. Several of the State representatives commented that it was a unique experience to be together with so many knowledgeable State people and that they found this exchange very helpful.

*AGENDA*  
**DASIS REGIONAL MEETING**  
**Alabama, Arkansas, Kentucky, Maryland, Mississippi, Tennessee, Virginia**

**November 14 – 15, 2000**  
**Sheraton Downtown Nashville**  
**Nashville, Tennessee**

**Tuesday**

- 8:30 a.m. Continental Breakfast
- 9:00 a.m. Welcome and Introduction.....*Donald Goldstone, OAS*
- 9:15 a.m. Demonstration of Substance Abuse Treatment Facility Locator .....*Deborah Trunzo, OAS*
- 9:45 a.m. National Survey of Substance Abuse Treatment Services.....*Geri Mooney, MPR*
- Status and schedule for 2000 N-SSATS survey
  - New items in 2000
  - State assistance with non-respondents
  - State review of data
- 10:30 a.m. BREAK
- 10:45 a.m. Inventory of Substance Abuse Treatment Services .....*Peter Hurley, Synectics*
- Demonstration of I-SATS On-Line D
  - The I-SATS and State licensing/approval practices T
  - Keeping the I-SATS up to date
- 12:00 p.m. LUNCH
- 1:00 p.m. Treatment Episode Data Set
- Importance and applications of the data.....*Deborah Trunzo, OAS*
  - TEDS Improvement Program.....*Peter Hurley, Synectics*
  - Data submission and quality control process.....*Jim DeLozier, Synectics*
- 2:45 p.m. BREAK
- 3:00 p.m. National Household Survey on Drug Abuse.....*Donald Goldstone, OAS*
- New design and data collection methods
  - State estimates
- 4:30 p.m. Adjourn

**Wednesday**

- 8:30 a.m. Continental breakfast
- 9:00 a.m. Demonstration of the SAMHDA On-Line Data Analysis System..... *Charlene Lewis, OAS*

9:45 a.m. Processing and Analysis of Maryland Discharge Data.....*Bill Rusinko, Maryland*  
10:30 a.m. BREAK  
10:45 a.m. Open discussion.....*Donald Goldstone, OAS*  
11:30 a.m. Wrap up  
12:00 noon Adjourn

**PARTICIPANT LIST**  
(Revised 12/00)  
**DASIS State Data Advisory Group Meeting**  
**Nashville, Tennessee**  
**November 14 - 15, 2000**

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**SAMHSA STATE REPRESENTATIVES**

Robert Chaffin  
Systems Development Manager  
Department of MH, MR & SAS  
P.O. Box 1797  
Richmond, VA 23218-1797  
Phone: 804.786.4148  
Fax: 804.786.2029  
bchaffin@dmhmrsas.state.va.us

Lynn Graham  
Information Systems Analyst  
Department of Health  
Bureau of Alcohol & Drug Abuse Service  
425 5th Avenue North  
Cordell Hull Building 3rd Floor  
Nashville, TN 37247-4401  
Phone: 615.532.7788  
Fax: 615.532.2419  
lgraham@mail.state.tn.us

Joe Drop  
REI Chief  
Office of Research, Evaluation & Information  
Substance Abuse Services Division  
AL DMH/MR  
100 N. Union Street  
P.O. Box 301410  
Montgomery, AL 36130-1410  
Phone: 334.242.3966  
Fax: 334.242.0759  
jdrop@mh.state.al.us

Phillip Johnson  
Information Center Supervisor  
Data Management Bureau  
AL DMH/MR  
100 N. Union Street  
P.O. Box 301410  
Montgomery, AL 36130-1410  
Phone: 334.242.3392  
Fax: 334.242.0759  
pjohnson@mh.state.al.us

Katherine Fornili  
HIV/Aids Services Program Specialist  
Office of Substance Abuse Services  
Department of MH, MR & SAS  
P.O. Box 1797  
Richmond, VA 23218-1797  
Phone: 804.786.4301  
Fax: 804.786.4320  
kfornili@dmhmrsas.state.va.us

Vickie Kaneko  
Analysis Unit Director  
Alcohol and Drug Abuse Administration  
201 West Preston Street, Room 409  
Baltimore, MD 21201  
Phone: 410.767.6890  
Fax: 410.333.7946  
kanekov@dnhm.state.md.us

## SAMHSA STATE REPRESENTATIVES (Con't)

Donna Langlais

Director

Division of Financial and Data Management

Department of Mental Health, Alcohol and  
Drug Abuse

5800 West 10th Street, Suite 907

Freeway Medical Center

Little Rock, AR 72204

Phone: 501.280.4521

Fax: 501.280.4519

dlanglais@healthyarkansas.com

Bill Rusinko

MIS Chief

Alcohol and Drug Abuse Administration

201 West Preston Street, Room 409

Baltimore, MD 21201

Phone: 410.767.6887

Fax: 410.333.7965

rusinko@erols.com

Fred Wesley Smith

Planning Specialist II

Division of Financial and Data Management

Department of Mental Health, Alcohol and  
Drug Abuse

5800 West 10th Street, Suite 907

Freeway Medical Center

Little Rock, AR 72204

Phone: 501.280.4510

Fax: 501.280.4519

fwsmith@healthyarkansas.com

Julie Smith

Director of Fiscal Services

Department of Health

Bureau of Alcohol & Drug Abuse Service

425 5th Avenue North

Cordell Hull Building 3rd Floor

Nashville, TN 37247-4401

Phone: 615.741.8519

Fax: 615.532.2419

jsmith10@mail.state.tn.us

Eze Uzodinma

Senior Programmer Analyst

Division of Alcohol & Drug Abuse

Department of Mental Health

Robert E. Lee Office Building, 11th Floor

239 North Lamar Street

Jackson, MS 39201

Phone: 601.359.6275

Fax: 601.359.6295

euzodinma@msdmh.org

Robert Walker

Assistant Professor

University of Kentucky

Center on Drug & Alcohol Research

Bowman Hall Room 333

Lexington, KY 40506-0059

Phone: 859.257.6623

Fax: 859.257.9070

jrwalk0@pop.uky.edu

Dusty Wright

Programmer/Systems Analyst

University of Kentucky

Research and Data Management Center

2355 Huguenard Drive, Suite 100

Lexington, KY 40503

Phone: 859.260.1960 x35

Fax: 859.260.1682

dusty.wright@rdmc.org

## SAMHSA REPRESENTATIVES

**Substance Abuse and Mental Health Services Administration (SAMHSA)  
Office of Applied Studies (OAS)  
5600 Fishers Lane, Parklawn Building, Room 16-105  
Rockville, MD 20857  
Fax: 301.443.9847**

**Cathie Alderks**  
Statistician  
301.443.9846  
calderks@samhsa.gov

**Donald Goldstone, MD**  
Director  
301.443.1038  
dgoldsto@samhsa.gov

**Charlene Lewis**  
Public Health Analyst  
301.443.2543  
clewis@samhsa.gov

**Gerri Scott-Pinkney**  
Statistician  
Div. Of Operations  
301.443.5185  
gscott@samhsa.gov

**Deborah Trunzo**  
Dasis Team Leader  
301.443.0525  
dtrunzo@samhsa.gov

---

## CONTRACTOR STAFF

**Synectics for Management Decisions, Inc.**  
3030 Clarendon Blvd. Suite 305  
Arlington, VA 22201  
Fax: (703) 528-2857

**Jim DeLozier**  
Senior Consultant  
703.807.2331  
jimd@smdi.com

**Peter Hurley**  
Project Manager  
703.807.2347  
peterh@smdi.com

**Heidi J. Kral**  
Conference Manager  
703.807.2323  
heidik@smdi.com

**Mathematica Policy Research, Inc.**  
P. O. Box 2393  
Princeton, NJ 08543-2393  
Fax: (609) 799-0005  
**Geri Mooney**  
Vice President  
609.275.2359  
gmooney@mathematica-mpr.com