





May 6, 2005

Nora D. Volkow, M.D., Director  
National Institute on Drug Abuse  
6001 Executive Boulevard  
Bethesda, MD 20892

Dear Dr. Volkow:

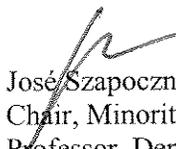
I am pleased to transmit the report and recommendations of the Minority Health Disparities (MHD) Work Group that was created at your request by the National Advisory Council on Drug Abuse in May 2004. The report and recommendations reflect the unanimous view of the Work Group members. We take full responsibility for the contents. We remain available to meet with you and/or members of your staff to discuss our conclusions and recommendations.

The Work Group is impressed with the commitment of the Institute's leadership toward minority health disparity research as well as by the breadth and depth of the minority relevant research conducted throughout the Institute. The Work Group recommends: an initiative to address minority health disparities within the framework of the NIH Roadmap; that minority health disparities be more fully integrated into NIDA's Strategic Plan; that increased Institute-wide collaboration and coordination is required to quicken the rate of discovery on minority health disparities, their prevention and treatment; that novel training mechanisms are needed to increase the number of minority researchers; that incentives are needed to encourage the generation of knowledge about specific minority subgroups in present and future minority-relevant research; and finally identifies specific programmatic priorities.

The members of the Work Group and I would like to thank Denise Pintello of NIDA for her support throughout the process. She helped immensely by providing guidance to the Work Group and, along with Jennifer Elcano, played a major role in editing the report.

Thank you for this opportunity to support NIDA's mission to reduce minority health disparities. As you well know, minorities suffer disproportionately from the consequences of drug abuse.

Sincerely,

  
José Szapocznik, Ph.D.  
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**Report**

***Of the Racial/Ethnic  
Minority Health Disparities Work Group  
of the  
National Advisory Council  
on Drug Abuse***

**National Institute on Drug Abuse**

**May 2005**

# Table of Contents

EXECUTIVE SUMMARY .....	1
INTRODUCTION .....	3
BACKGROUND .....	4
<i>Overview of Urgent Public Health Needs</i> .....	4
<i>Scientific Opportunities</i> .....	5
NIDA’S INSTITUTE-WIDE EFFORTS TO PROMOTE RESEARCH ON MINORITIES .....	7
<i>Special Populations Office</i> .....	7
<i>Minority Workgroups</i> .....	7
<i>NIDA’s Strategic Plan on Reducing Health Disparities</i> .....	7
<i>Definitions of Minority Health Disparities</i> .....	8
<i>NIDA’s Minority Health Disparities Research Portfolio</i> .....	8
<i>Work Group Analysis of NIDA’s Research Within the Divisions and Centers</i> .....	9
WORK GROUP METHODOLOGY AND REVIEW PROCESS .....	10
WORK GROUP FINDINGS AND RECOMMENDATIONS .....	11
<i>Recommendation 1. Utilize the Scientific Opportunities of the NIH Roadmap</i> .....	11
<i>Recommendation 2. Ensure Alignment of the NIDA Strategic Plan and the NIDA Strategic Plan on Reducing Health Disparities</i> .....	12
<i>Recommendation 3. Enhance NIDA Organization and Collaboration</i> .....	13
<i>Recommendation 4. Training Minority Researchers</i> .....	16
<i>Recommendation 5. NIH Policies on Minority Inclusion</i> .....	18
<i>Recommendation 6. Research Needs and Priorities</i> .....	19
CONCLUSION .....	20
REFERENCES .....	21
APPENDIX A: MINORITY HEALTH DISPARITIES WORK GROUP .....	A-1
APPENDIX B: MEETING AGENDAS .....	B-1

## EXECUTIVE SUMMARY

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To develop a better understanding of the drug abuse and addiction research needs of racial and ethnic populations, its consequences, their prevention and treatment, the National Institute on Drug Abuse (NIDA) established a Special Populations Office (SPO) in 1993. In May of 2004, the NIDA Director, Nora D. Volkow, M.D., created the NIDA Minority Health Disparities Work Group (the Work Group). The charge to the Work Group was to review the Institute's current racial/ethnic minority health disparities research portfolio and to produce a written Report to advise the Institute on strategies to best address racial/ethnic minority health disparities, including research needs and priorities, research training, collaborations, and organization and management of the minority health disparities program. This Report identifies six recommendations, summarized below, that were unanimously supported by the Work Group:

1. **Utilize the NIH Roadmap Approach to Address Minority Health Disparities.** A NIDA-wide effort is needed to encourage the development of interdisciplinary research teams to address urgent public health disparities impacting racial/ethnic minorities. For example, phenotyping racial/ethnic minority environments is critical to understanding resilience and vulnerability in gene-environment interactions among racial/ethnic minorities. Moreover, NIDA's currently funded clinical research in community settings offers an excellent opportunity to develop an interdisciplinary clinical research workforce with scientific, clinical, and cultural competence.
2. **Ensure Alignment of the NIDA Strategic Plan with the *NIDA Strategic Plan on Reducing Health Disparities*.** The pursuit of reductions in health disparities in drug abuse should be a NIDA-wide priority. As such, both the NIDA-wide Strategic Plan and the *NIDA Strategic Plan on Reducing Health Disparities* should be carefully harmonized. To achieve this goal, the 2005 Health Disparities Strategic Plan should be developed in close collaboration with Division and Center Directors and should incorporate the bold vision of the National Institutes of Health (NIH) Roadmap. To ensure input from scientific experts on drug abuse and minority health disparities, the 2005 Health Disparities Strategic Plan should also be developed in close collaboration with the four racial/ethnic minority workgroups.
3. **Enhance NIDA Organization and Collaboration.** There is considerable minority health disparities research at NIDA. However, the lack of teamwork across Divisions, Offices, and Centers hinders their considerable scientific and public health potential. A mechanism should be established to systematically review and integrate the wealth of NIDA's racial/ethnic minority research on an ongoing basis. Such an effort should, in the spirit of the NIH Roadmap, be broadly integrative across NIDA Divisions, Offices, and Centers. This function could be conducted by SPO staff with interdisciplinary research expertise, or by a NIDA-wide coordinator for minority health disparities research.

NIDA has established four racial/ethnic minority workgroups to support the Institute's efforts to reduce minority health disparities. To enhance collaboration between NIDA and the workgroups, a review should be conducted of the composition, mission, and mechanisms of action for each of the four workgroups to ensure their alignment with NIDA's mission. Achieving this alignment may require the disbanding and reconstituting of the workgroups.

4. **Increase Training Opportunities for Minority Researchers.** Targeted efforts are needed to increase the number of minority investigators in the field of drug abuse. Recommendations include:
  - Continued support of the Research Supplement for Underrepresented Minorities and the Minority Institutions' Drug Abuse Research Development Program.
  - Additional efforts, including some that are national in scope, are needed to make use of research-rich environments for the training of minority researchers, such as: a national drug abuse research minority mentorship program; a visiting minority scholars program; career development/K01 awards for minority faculty; a national minority research scholar's program to bring minority clinicians into research careers; and "Minority Research Training Centers" in research-rich and minority-rich environments. Training efforts involving minority faculty and mentors will require faculty and infrastructure support.
  - Tracking: Mechanisms should be developed for tracking NIDA-funded minority trainees to determine whether NIDA is successful in helping minority researchers progress along the research career pipeline.
  
5. **Create Incentives to Promote Valid Analyses on Minorities.** NIDA can maximize the impact on minority health disparities of non-minority specific studies by providing incentives for these studies to include sufficient minorities of a single racial/ethnic subgroup. Doing so would permit valid analyses of data from that subgroup, even if small group analytic strategies must be used. Therefore, rather than attempting to be broadly representative, studies could focus on minority participation from one minority subgroup. Incentives might take the form of providing research supplements to augment specific minority subgroup sample size, developing new analytic strategies specific to small population samples, or increasing priority rankings for studies that will yield findings on specific racial/ethnic subgroups.
  
6. **Address Research Needs and Priorities.** The Work Group found gaps in NIDA's current minority health and health disparities research portfolio and encourages the Institute to conduct priority research in the areas described below:
  - Native Americans (American Indians, Alaskan Natives, and Native Hawaiians) were selected as a research priority, given that they have the greatest number of unmet needs.
  - HIV infection and criminal justice system involvement are consequences of drug abuse that disproportionately impact racial/ethnic minority populations but are particularly urgent for African Americans, who have the highest rates of HIV infection associated with drug use, followed by Hispanic Americans and Native Americans.
  - Given the dire consequences of drug use for minorities and the dearth of minority-specific prevention and treatment research, an initiative is urgently needed to encourage intervention research on prevention and treatment of drug abuse for specific minority subgroups. Priority should be given to research on interventions with potential application across a diversity of populations and contexts.
  - Much health services research has targeted the failures of the health delivery system with minorities. More research is needed on effective models of health services delivery to specific racial/ethnic minority subgroups.

The implementation of these recommendations will quicken the rate of scientific discoveries having the potential to reduce minority health disparities.

## INTRODUCTION

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Since its inception, the National Institute on Drug Abuse (NIDA) has supported research on racial/ethnic minorities. To ensure that NIDA continues to take full advantage of available scientific opportunities, NIDA's Director, Nora D. Volkow, M.D., established the NIDA Minority Health Disparities Work Group (the Work Group) in May of 2004, composed of members from the National Advisory Council on Drug Abuse (the Council) and prominent experts from the drug abuse and addiction fields.

Dr. Volkow's charge to the Work Group was to produce a written Report that includes the following:

1. A background review of the current minority health disparities program portfolio.
2. Recommendations to fortify the current minority health disparities program research mission.
3. Development of a 5-year plan for NIDA's minority health disparities program to:
  - Ensure that minority issues in drug abuse research are adequately represented in the work supported by NIDA;
  - Promote research training and career development needs of underrepresented minorities and others (women, individuals with disabilities, etc.) in drug abuse research; and
  - Examine the organization and management of the minority health disparities program and the interactions with other NIDA Divisions/Centers.

The Work Group convened in person and by telephone on several occasions between July and November 2004 and heard detailed presentations on many facets of these issues from NIDA and other National Institutes of Health (NIH) staff, and from representatives of NIDA's four racial/ethnic minority workgroups. In response to Dr. Volkow's charge, the Work Group has prepared this Report intended to quicken the advance of scientific discovery having the potential to protect and improve the health of people from all races and ethnicities.

## BACKGROUND

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### Overview of Urgent Public Health Needs

During the past several decades, extraordinary scientific advances in biomedical research have led to remarkable improvements in public health. Despite these substantial gains, racial and ethnic minorities have not benefited equally from our nation's progress in scientific discovery. The 2003 Institute of Medicine (IOM) Report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith & Nelson, 2003) found significant variation in health care services by race. In addition to unequal consequences from drug use and unequal access to services, drug addiction's stigma has also disproportionately affected racial/ethnic minorities.

According to data from the 2003 National Survey of Drug Use and Health: "Lifetime illicit drug use among persons aged 12 and older was reported to be highest among American Indians/Alaskan Natives at 62.4 percent, followed by Whites at 49.2 percent, African Americans at 44.6 percent, Hispanic Americans<sup>1</sup> at 37 percent, and Asian Americans at 25.6 percent" (Substance Abuse and Mental Health Services Administration, 2004). For all four racial/ethnic groups there is considerable variability in subgroup use. While lifetime prevalence is highest for Native Americans/Alaskan Natives, consequences of drug use are highest for African Americans and second highest for Hispanic Americans:

- African Americans represent 11 percent of the population, yet represent 50 percent of HIV cases. Among women, African American women represent 75 percent of the HIV seropositive population.<sup>2</sup> Similarly, while Hispanic Americans account for 12 percent of the population, they account for 23 percent of HIV/AIDS cases.
- Incarceration is another severe consequence of drug use among African Americans and Hispanic Americans.<sup>3</sup> Even more striking, however, is the racial disparity among these drug offenders and its impact on overall rates of disproportion. Between 1983 and 1998, drug admissions increased 26-fold among African Americans and 18-fold among Hispanic Americans compared to a 7-fold increase among Caucasian prisoners (Iguchi, London, Forge, Hickman, Fain & Riehman, 2002).
- A third important consequence of drug use for Hispanic Americans in particular is the high rate of school dropout, which affects approximately 26 percent of Hispanic American youth, followed by 11 percent of African American and 7 percent of Caucasian youth (Child Trends, 2003).

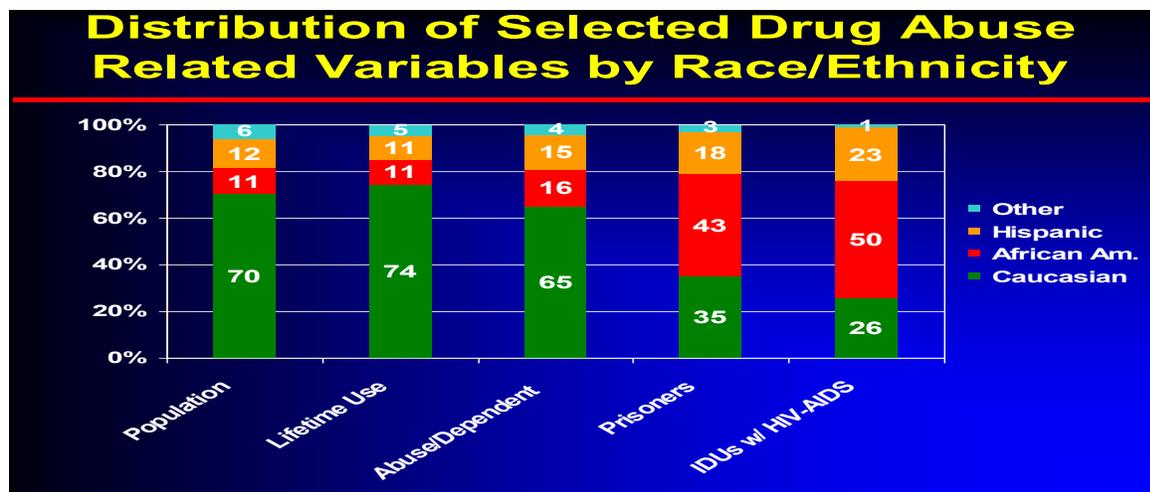
Figure 1 depicts the interaction between disparities in drug abuse, incarceration, and HIV status among African Americans, Hispanic Americans, and Caucasians (Substance Abuse and Mental Health Services Administration, 2003; Centers for Disease Control and Prevention, 2002).

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<sup>1</sup> For the large number of undocumented Hispanic Americans, participation in surveys tends to be sufficiently low to cause an undercount for burden of illness.

<sup>2</sup> Sanders-Phillips K. Public Health Rep. 2002; 117 Suppl. 1:S151-6.

<sup>3</sup> Peters, R. H., Greenbaum, P. E., & Edens, J. F. Prevalence of DSM-IV substance abuse and dependence disorders among prison inmates. *American Journal of Drug and Alcohol Abuse*. 1998 Nov; 24(4):573-87.



**Figure 1. Disparities in Drug Abuse Variables Across Populations**

Although NIDA leads the nation in bringing the strength of science to bear on the problem of drug abuse and addiction, our understanding of these problems and their solutions among racial/ethnic minorities is limited. While epidemiological data show that racial/ethnic minority populations are consistently over-represented in this country when it comes to suffering disproportionately the consequences of drug abuse and addiction, little is known about effective strategies for reducing disparities in drug abuse consequences. As a result, our understanding of these consequences (e.g., health comorbidity, disability, incarceration) and of strategies for drug treatment and prevention, particularly among racial/ethnic minorities, is almost non-existent. Existing health services delivery research suggests that in general, minorities—particularly African Americans, Hispanic Americans,<sup>4</sup> and Native Americans—are less likely to receive services because they are less likely to be engaged and retained in prevention and treatment services and that when engaged in services, these minorities find them to be less satisfactory than do mainstream populations. However, little is known about effective service delivery systems relative to minority populations.

### Scientific Opportunities

NIH is charged with developing knowledge to improve the health of the public. Relatively little is known about effective strategies for prevention of drug use, prevention of drug use progression, prevention of drug use consequences (health and social), prevention of comorbidity, and prevention of disability resulting from drug use among racial/ethnic minorities. Even less is known about the treatment of drug use, abuse, and dependence in these populations. Although the failure of current health service delivery systems in effectively preventing and treating racial ethnic minorities is relatively well documented, little is known about effective models of service delivery for minorities. Of great concern is the lack of basic or applied models of behavioral and biological/biomedical research that can both attend to and take

<sup>4</sup> Different terms are preferred by individuals of Hispanic ancestry who live in different parts of the United States. Many individuals of Hispanic ancestry prefer to refer to themselves as Latino(a)s or Chicano(a)s; others as Latin Americans or Central Americans. The use of the term Hispanic Americans in this document is intended generically to include all Hispanics living in the United States, whether U.S.-born or foreign-born, and whether Latino(a)s, Chicano(a)s, Mexican Americans, Central Americans, or Latin Americans.

scientific advantage of the considerable variability in social, cultural, and biological processes that not only exist within a single racial/ethnic minority group, but across minority and mainstream racial/ethnic groups.

Given the greater burden of negative health effects (HIV, cancer, violence) and social consequences (incarceration, school dropouts) experienced by drug using racial/ethnic minorities, NIDA has a unique opportunity to contribute to improving the health of the nation by developing knowledge about risk and protective processes, prevention and treatment services, and about how drugs may affect specific racial/ethnic subgroups differentially as a function of many factors including genetics, metabolism, culturally specific environmental conditions, or nutrition.

Variability is an essential element in research. The variability that exists between and within major racial/ethnic groups and even between and within their subgroups represents an opportunity to learn about structures and processes that are fundamental and thus common across the human condition (e.g., the existence and function of dopamine receptors; the role of the family in human development). Variability across and within subgroups also presents opportunities to learn about the range of factors that influences risk and protection (e.g., specific gene-environment interactions that predict brain structure and function; specific family conditions within particular social, cultural, and physical contexts that create protection and risk).

Efforts to develop knowledge in these areas are essential to NIDA's mission to lead the nation in bringing the power of science to bear on drug abuse and addiction by providing strategic support to interdisciplinary research that ranges from molecular biology to cultural competence. This range includes complex proximal and distal interacting environmental (social, cultural, physical) conditions that affect the individual; prevention and treatment; and the specific social, cultural, organizational, and community contexts in which prevention and treatment services are delivered. Clearly, nowhere are the NIH Roadmap's "Research Teams of the Future" more urgently needed than in research to improve the health of minorities.

Minorities represent a unique opportunity to study variability across many domains, as well as the complexity of the inter-relationships. Although several of these aspects require clinical and epidemiological approaches, animal models can also provide valuable information on the relationship of social conditions to vulnerability to drug addiction. Further scientific inquiry using animal models of social conditions experienced by racial/ethnic minority populations can add considerably to our scientific understanding of minority health disparities. Given that certain social conditions, which are not readily changed, have the potential to increase vulnerability, research may also be needed to identify social, behavioral, or biological interventions to increase resilience or reduce vulnerability in individuals exposed to deleterious social conditions.

## NIDA'S INSTITUTE-WIDE EFFORTS TO PROMOTE RESEARCH ON MINORITIES

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This section briefly discusses NIDA's Special Populations Office (SPO) and two activities of this Office—the four minority workgroups and the *NIDA Strategic Plan on Reducing Health Disparities*. It also presents NIH's definitions of health disparities and discusses the minority health disparities research portfolio of NIDA's Divisions and Centers.

### Special Populations Office

To increase scientific understanding of the drug abuse and addiction research needs of racial/ethnic populations, NIDA established the Special Populations Office in 1993. Located within the Office of the Director, the SPO was intended to serve as the cornerstone of NIDA's minority health disparities research efforts. Its mission is to address the training and career development needs of under-represented minorities in drug abuse research and to ensure that minority issues are appropriately represented in NIDA-supported research. The SPO supports 10 major programs, including the Research Supplements for Underrepresented Minorities, Research Development Seminar Series, the Minority Institutions' Drug Abuse Research Programs (MIDARP), and the Historically Black Colleges and Universities (HBCU) Initiative.

### Minority Workgroups

The SPO also coordinates four external minority workgroups organized to identify and address drug abuse research issues and needs among various populations. (Note: for the purposes of this Report, we have differentiated the present Minority Health Disparities "Work Group" from the four NIDA minority "workgroups"). These four minority workgroups are:

- The Researchers and Scholars Workgroup for African Americans
- The Researchers and Scholars Workgroup for Asian Americans/Pacific Islanders
- The Researchers and Scholars Workgroup for Native American/Alaskan Natives; and
- The National Hispanic Science Network on Drug Abuse.

### NIDA's Strategic Plan on Reducing Health Disparities

The SPO developed the first *NIDA Strategic Plan on Reducing Health Disparities* in 2000. The second plan, referred to as the 2005 Health Disparities Strategic Plan, is currently under development. The *NIDA Strategic Plan on Reducing Health Disparities* (2000) addressed four main topic areas:

- Epidemiology of drug abuse, health consequences, and infectious diseases among minority populations—focuses on understanding the incidence, patterns, and causes of drug abuse and HIV/HCV in minority populations.
- Prevention of drug abuse and addictions—focuses on the need for more culturally specific prevention programs to reach minority populations in high-risk settings and neglected, hard-to-reach areas of communities.
- Disparities in treatment and health services research—focuses on the full inclusion of minority populations in treatment research and clinical trials and examines the medical, social, and cultural factors that may influence treatment outcomes and adherence to treatment.

- Racial/ethnic disparities in basic and clinical neurosciences—focuses on research to better understand the racial/ethnic differences in genetic vulnerability and resilience to drug abuse and addiction.

### Definitions of Minority Health Disparities

Currently NIDA utilizes the following definitions of “health disparities research” and “minority health disparities–related research”:

- **Health Disparities Research:** Basic, clinical and behavioral research that addresses the magnitude and/or the impact of drug use within racial/ethnic minority populations, where the goal of the study is to determine the differential *use and/or effects of drugs on the racial/ethnic minority groups included in the study*. Health disparities research addresses issues related to epidemiology, prevention, services, and treatment outcomes within and across racial and ethnic populations.
- **Minority Health Disparities-Related Research:** Research that includes racial/ethnic minorities as participants but where the *goals, aims, and hypotheses of the study do not specifically address drug use and/or its effects as they are experienced by racial/ethnic minority populations*.

### NIDA’s Minority Health Disparities Research Portfolio

The Work Group met with NIDA Division and Center Directors and was pleased to learn about the scope of relevant minority-focused research that had already been conducted or was currently under way. These specific NIDA research activities include the following:

**NIDA’s Center for the Clinical Trials Network (CCTN):** The CCTN is conducting multisite trials in 120 community treatment programs across the country; approximately 44 percent of the treatment population is composed of racial/ethnic minority groups. The CCTN Minority Special Interest Group is composed of researchers and treatment providers to advocate for minority participation at all levels of the CCTN and to review completed studies to ensure analysis and publication of information regarding minorities.

**The Division of Pharmacotherapies and Medical Consequences of Drug Abuse (DPMCD):** DPMCD has conducted research on nicotine metabolism among African American and Hispanic American populations and has recently funded multiple studies to examine the medical consequences of HIV occurrence in drug abusing minority populations.

**The Division of Epidemiology, Services and Prevention Research (DESPR):** DESPR takes a population-based approach aimed at understanding and addressing interactions between individuals and environments, which would include issues of health disparities. Key research findings for African Americans include higher risk of HIV/AIDS exposure and increasing rates of marijuana use disorders. Additional study results found an increase in comorbidity among Hispanic Americans, owing to acculturation effects; high rates of drug use among American Indians/Alaskan Natives; and lower overall drug use among Asian Americans/Pacific Islanders, coupled with a wide variation among subgroups.

**The Division of Basic Neurosciences and Behavior Research (DBNBR):** DBNBR is examining common mechanisms of drug addiction that cut across all racial/ethnic groups, including differences in the etiology, neurobiology, and genetics of drug addiction. DBNBR is investigating the role of menthol

in maintaining drug addiction among African American smokers and is conducting genetics research in an attempt to discover the basic underlying variables that protect people from or expose them to drug abuse consequences.

### **Work Group Analysis of NIDA's Research Within the Divisions and Centers**

The Work Group acknowledges all Divisions and Centers within NIDA for their considerable minority research efforts. In particular, the Work Group commends the substantive breadth and depth of minority and minority-relevant research carried out by the Division of Epidemiology, Services and Prevention Research (DESPR), and the thoughtfulness of the research conducted by the Division of Basic Neurosciences and Behavioral Research (DBNBR). These two Divisions exemplify the pursuit of scientific opportunities in areas of great racial/ethnic minority public health need.

The Work Group also commends the CCTN for the high proportion and absolute number of racial/ethnic minorities in their studies and for conducting a protocol for Spanish-monolingual Hispanics. Without a doubt, the samples of African American and Hispanic drug abusers in some of the CCTN protocols will constitute the largest samples ever of a single racial/ethnic minority in a drug abuse treatment clinical trial. NIH guidelines direct that Phase III/Stage III protocols conduct *valid analyses of racial/ethnic minority groups or subgroups*, the Work Group recommends that all future CCTN protocols incorporate research designs that will increase the validity of analyses of one specific racial/ethnic subgroup, even if small group statistics are used.

## WORK GROUP METHODOLOGY AND REVIEW PROCESS

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The Minorities Health Disparities Work Group convened in person and by telephone on several occasions between July and November 2004 to develop its Report. The Work Group heard detailed presentations on many facets of the issues from NIDA and other NIH staff (including the National Institute of Mental Health [NIMH] and the National Center on Minority Health and Health Disparities), engaged in discussion and question-and-answer sessions with each presenter, and met several times in executive session.

At the first meeting in July 2004, Work Group members identified the difficulty in evaluating the breadth and depth of NIDA-wide minority activities given the lack of a centralized mechanism to compile and track information on minority research and minority research trainees. Informational requests were made of NIDA staff for the following:

- The *NIDA Strategic Plan on Reducing Health Disparities* for 2000 and 2005
- Data from all NIDA grants (1993 – 2004) awarded since the SPO was established
- Descriptive data on Principal Investigator (PI) characteristics from all NIDA grants (1990 – 2004)
- Ongoing research projects addressing minority health research
- Research training of minorities through mechanisms such as Ts, Fs, and minority research supplements
- Composition, mission, outcome, and recommendations from the four NIDA minority workgroups
- Mechanisms in place for interactions between NIDA and the National Center on Minority Health and Health Disparities
- Proportion of minority staff NIDA-wide

At the September meeting, the Work Group sought to learn more about how each Division and Center approached minority research in the following areas: to identify the gaps in scientific knowledge, to identify available mechanisms to summarize and integrate research findings, and to develop strategies for how best to integrate the complex matrix of minority research and other minority research-related activities at NIDA.

Work Group members also heard from representatives of each of the four racial/ethnic minority workgroups. At the November meeting, the Work Group met with the NIDA Director and specifically focused on identifying its primary recommendations.

Because the urgency of the public health needs of racial/ethnic minorities appears to be well understood by NIDA leadership, the Work Group's recommendations focus on strategies for optimizing the scientific opportunities in racial/ethnic minority research. In addition, organizational challenges to achieving the alignment of science and racial/ethnic minority public health needs are addressed.

## WORK GROUP FINDINGS AND RECOMMENDATIONS

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The Minority Health Disparities Work Group was impressed by the richness of the minority-focused and relevant research already conducted or under way as described by the NIDA Division and Center Directors. It is clear that the NIDA leadership, from the Institute Director to the Division and Center Directors, is committed to racial/ethnic minority health disparities research. However, to improve our knowledge of racial/ethnic minorities, we must advance our understanding of variability in the human condition. This will require NIDA to develop and test multidimensional theoretical models that can take advantage of the complexity and variability inherent in the human condition.

The Work Group identified the following six priority areas that require further attention: the NIH Roadmap, the *NIDA Strategic Plan on Reducing Health Disparities*, NIDA organization and collaboration, training of minority researchers, NIH policies on minority inclusion, and research areas of emphasis. From these priority areas emerged particular Report findings and recommendations unanimously supported by Work Group members. These are described in detail below.

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### **Recommendation 1. Utilize the Scientific Opportunities of the NIH Roadmap**

The NIH Roadmap provides an extraordinary opportunity to accelerate the scientific discovery and translation of biomedical research from the bench to the bedside. The Roadmap Initiative, launched in 2004 and scheduled to continue through 2009, offers unique scientific opportunities to move research to new levels in addressing the public health needs of racial/ethnic minorities. The Roadmap also challenges NIDA to translate basic research into clinically relevant solutions. Nowhere is this challenge more important than in reducing minority health disparities.

***Research Teams of the Future:*** Research Teams of the Future are needed to address urgent public health disparities impacting racial/ethnic minorities. A NIDA-wide effort is needed to encourage development of these interdisciplinary research teams. These teams form the infrastructure required to capitalize on opportunities to translate findings from bench to bedside, with relevance for reducing health disparities. They also provide the perspective necessary to direct science from critical health disparities to clinical and psychosocial research on to the bench. For example, the study of gene-environment interactions requires teams with expertise in molecular biology (e.g., genetics and genomics); neuroscience and behavior; and in phenotyping of the cultural (e.g., anthropology, cross-cultural psychology, sociology), social (e.g., education, family psychology, political science, sociology), and physical (e.g., architecture and town planning, environmental psychology) environments that may affect minority populations.

***New Pathways to Discovery:*** New Pathways are expected to result from the forging of ties between complementary fields that may be critical to understanding health disparities. Research using animal models has demonstrated the role of social processes in effecting changes in brain structure that increase vulnerability to addiction. Research in these arenas has the potential to increase our understanding of minority health disparities.

***Re-engineering the Clinical Research Enterprise:*** Much of the prevention and treatment of drug abuse occurs in primary care, community-based organizations, and criminal justice settings. NIDA already

funds a great deal of clinical research in these settings, which offers an excellent opportunity for NIDA to establish a sustained research training effort and to develop an interdisciplinary workforce with scientific, clinical, and cultural competence. It is of concern, however, that NIDA's best example of a re-engineered clinical research enterprise, the CTN, is in danger of being converted into a pre-NIH Roadmap, traditional clinical research enterprise. One of the advantages of the kind of clinical research enterprise encouraged by the NIH Roadmap is that it expedites the movement of research findings to the front lines of practice. In drug abuse treatment, the frontline of practice overwhelmingly occurs in drug abuse community treatment programs, which throughout the country receive billions of service dollars.

NIDA has the unique opportunity to redirect the considerable service funding already in place toward science-based research practice, but it is quickly losing that opportunity as it moves the CTN away from the kind of collaborative research-practice model recommended by the IOM report titled: "*Bridging the Gap Between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment*" (Lamb, Greenlick & McCarty, 1998). This is of concern to the Work Group because the Clinical Trials Network, with its large samples of minority drug using clients, offers a unique setting to train culturally competent clinical researchers.

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## **Recommendation 2. Ensure Alignment of the NIDA Strategic Plan and the NIDA Strategic Plan on Reducing Health Disparities**

The first *NIDA Strategic Plan on Reducing Minority Health Disparities* was completed in 2000. The SPO is currently preparing the second Health Disparities Strategic Plan, scheduled for completion in 2005. During the Work Group meetings, it was learned that the NIDA Division and Center Directors did not know about the 2005 Health Disparities Strategic Plan nor had they provided input or reviewed the 2000 Health Disparities Strategic Plan, even though there were specific items identified for particular NIDA Divisions/Centers. (It appears that while staff are assigned to work with the SPO on the Strategic Plan, no mechanism is in place for ongoing review and consultation with Directors about the Strategic Plan). Similarly, Work Group members were surprised that none of the four NIDA-established racial/ethnic minority workgroups were aware of the 2005 Health Disparities Strategic Plan, nor had they provided input or reviewed the 2000 Health Disparities Strategic Plan.

Finally, while the mission of NIDA's National Advisory Council includes providing input to the Institute's policy and programmatic matters, the *2000 NIDA Strategic Plan on Reducing Health Disparities* has not been reported to the Council since September 2001, nor has the 2005 Health Disparities Strategic Plan been presented or discussed by the National Council on Drug Abuse. This raises questions about who provided input into the 2005 Health Disparities Strategic Plan, how the Plan is implemented, and who monitors the implementation of the Plan. There needs to be a strategy for routine and ongoing monitoring of the Health Disparities Strategic Plan's implementation, such as by an annual Council review.

During the Work Group review, it was clear that the 2000 and 2005 *Strategic Plan on Reducing Health Disparities* had been developed without input from NIDA Division and Center Directors. The Work Group recommends that the Health Disparities Strategic Plan be an integrated product of NIDA leadership. Much more than isolated activities, the Health Disparities Strategic Plan, building on the "bold vision" of the NIH Roadmap philosophy, should be integrative in several ways: (1) it should

include a strategy for fostering integrated drug abuse research on health disparities; (2) it should create opportunities for collaboration and synergy across Divisions and Centers, identifying scientific opportunities from findings in one part of NIDA that when moved to another NIDA component can quicken the rate of discovery of strategies for reducing health disparities; and (3) given the large burden of drug abuse consequences suffered by minorities, the NIDA Health Disparities Strategic Plan should be fully harmonized with NIDA's Strategic Plan. The Work Group suggests that the pursuit of reductions in minority drug abuse health disparities is, in the larger picture, the pursuit of knowledge about drug abuse. It is therefore not possible to conduct research on minority health disparities divorced from the larger NIDA mission. Nor is it possible for NIDA to pursue its larger mission without conducting research that will have implications for the reduction of minority health disparities.

NIDA's Health Disparities Strategic Plan should also be developed in close collaboration with NIDA's four racial/ethnic minority workgroups, which, when properly constituted, can provide considerable scientific expertise on minority health disparities broadly to NIDA and, more specifically, to its Health Disparities Strategic Plan. In addition, the Health Disparities Strategic Plan should identify commonalities with the strategic plans of other agencies, which present fertile areas for collaboration (e.g., NIH Institutes and Centers and other Health and Human Services [HHS] agencies). Both the overall NIDA Strategic Plan and the Health Disparities Strategic Plan should have wide distribution throughout NIDA and the field.

The Work Group also recommends that the Health Disparities Strategic Plan specify implementation milestones, measurable outcomes, and methods for achieving them. Some thought must be given to the method for allocating funding to each area in the Plan, and minority research supplements should be used in the service of the Health Disparities Strategic Plan. In addition to the recommended annual review by NIDA Council, NIDA leadership should conduct more frequent reviews to assess progress, identify obstacles to implementation, and develop solutions.

The *NIDA Strategic Plan on Reducing Minority Health Disparities* is the mechanism by which NIDA collaborates with the National Center on Minority Health Disparities (NCMHD). Having an integrated Strategic Plan empowers the NCMHD Director, Dr. John Ruffin, to support NIDA's health disparity goals. Once NIDA's 2005 Health Disparities Strategic Plan is developed, close collaboration with NCMHD should be sought to assist in its implementation.

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### **Recommendation 3. Enhance NIDA Organization and Collaboration**

Two very important findings emerged from the discussions with Division and Center Directors. The first finding is that because Divisions, Centers, the Intramural Research Program, and the SPO function as silos with regard to research portfolios and findings, there is little opportunity for Institute-wide planning around minority health disparities. Moreover, one program may have important findings that could be used to spur research in another part of the Institute, but there is no systematic method for communicating findings and encouraging research across the Institute. The Work Group has determined that an urgent need exists to establish a NIDA-wide mechanism to coordinate and integrate research findings on minority health disparities in order to quicken the rate of discovery with potential to reduce health disparities.

The second important finding from this discussion is that there may not be sufficient minority expertise within NIDA to recognize the importance of particular research findings to minorities. One specific

example had to do with the role of menthol in increasing nicotine levels in the body. This finding emerged from research in two Divisions (neither of which appeared to know about the research of the other in this regard). Work Group members familiar with customs in the African American community recognized the finding's considerable potential impact on and importance for African American smokers who tend to prefer mentholated cigarettes. This finding could explain why African Americans suffer disproportionately high rates of lung cancer. This example suggests that more interaction is needed between NIDA Divisions, Centers, the Intramural Research Program, and minority scientists who can help identify research with significant implications for minority health disparities. NIDA's racial/ethnic minority workgroups, properly constituted, could play such a role. Further, NIDA currently has in place a bi-annual conference on minority health disparities, which, if properly conceptualized as a discussion among NIDA Divisions, Centers, the Intramural Research Program, and minority scientists, could also play a distinguishing role. These are only examples of the kinds of mechanisms that may be needed to ensure that promising public health findings are identified.

To accelerate the pace of advancement in knowledge, NIDA leadership must actively identify and creatively integrate research findings having potential for high impact on minority health. The application of the NIH Roadmap vision to the reduction of minority health disparities begins with NIDA leadership. NIDA leadership can only accomplish the bold vision of the NIH Roadmap by organizing itself as a "research team of the future" comprised of different areas of expertise. Integrated, interdisciplinary leadership is needed to bring about integrated, interdisciplinary research throughout the field and not just in small pockets of research. More specifically, with regard to minority health disparities, the Institute must put into place organizational and quality assurance features that will support a collaborative minority health disparities planning process, common definitions, and well-specified short-, medium-, and long-range objectives designed to map onto the larger NIH Roadmap, the Institute-wide Strategic Plan, and NIDA's *Strategic Plan on Reducing Health Disparities*. The process must be as transparent as possible, with inputs, alterations in direction, and implementation occurring within clearly defined lines of authority. NIDA Division and Center Directors, the Intramural Research Director, the SPO, and the racial ethnic minority workgroups were identified as key collaborators.

***Special Populations Office (SPO) – Structure and Communication:*** Currently there exists within NIDA a systemic lack of communication and the needed structure to promote it. A review of NIDA's minority health disparities portfolio and interviews with Division Directors revealed systemic weaknesses that appear to stem from the isolation of the SPO and from stove-piped Division, Center, and Intramural communications. This compromises NIDA's ability to organize, plan, and implement a coordinated set of activities in support of a comprehensive and effective minority health disparities portfolio. Evidence of this problem includes: (1) a lack of knowledge and no apparent involvement in the Health Disparities Strategic Plan development by Division and Center Directors; (2) an unfamiliarity with the current definition of minority health disparities across NIDA; and (3) an absence of communication across Divisions regarding minority health disparities. The isolation of the SPO is apparent in all aspects of program development, in funding mechanisms to encourage minority health disparities research, in incentives for research addressing minority health disparities issues, and in tracking mechanisms to monitor the progress of minority health disparities research. Involvement with NIDA's research portfolio on racial/ethnic minority research has not before been an implemented goal within the mission of the SPO. Strong scientific leadership is needed to convene other Directors to work together on scientific minority health disparities issues and to develop a new synergistic approach to addressing them. This is a

role that an office like the SPO or a NIDA-wide Coordinator of Minority Health Disparities could and should have.

The current lack of a mechanism for ensuring a formal working relationship between the SPO and NIDA Division Directors points to a structural problem within NIDA. The degree of communication between the SPO and NIDA leadership through both formal and informal channels (i.e., an executive committee) is not clearly established. Although some Division Directors report a good relationship with the SPO, the MHD Work Group found that Division Directors within NIDA were not aware of the *2000 NIDA Strategic Plan on Reducing Health Disparities* nor were they involved in developing the 2005 Health Disparities Strategic Plan. The Health Disparities Strategic Plan must be a meaningful document used to guide NIDA's work across Divisions to ensure coherent development of research initiatives. Currently, NIDA Divisions operating in silos lack the interaction required to meet the NIH Roadmap expectations.

At the National Institute of Mental Health (NIMH), the Director of the Office for Special Populations (OSP) is a member of the NIMH's executive committee and sits at the table on a monthly basis with Division Directors and the Institute Director. The Work Group acknowledges that for an SPO representative to sit at the table with Division Directors, that SPO representative must be recognized as a scientist capable of collaborating with individual Division Directors in reviews of their research portfolios so as to provide guidance on integrating racial/ethnic minority issues into the Division's program of research and across Divisions, Centers, and the Intramural Research Program.

Finally, the Work Group learned that there are no clear NIDA-wide guidelines about whether grants should be coded as minority-focused or -related, in addition to the NIH-wide definitions of health disparities-focused and -related. There should also be a NIDA-wide guideline for when and by whom grants should be coded as minority-focused or minority-related.<sup>5</sup> It appeared from conversations with NIDA Division Directors and their staff that definitions of health disparities relatedness may not be well known across the Institute. Further, it appears that coding for minority/health disparities-relatedness may be completed after the grant is identified for funding and that coding currently takes place within Divisions. The Work Group recommends that NIDA establish an Institute-wide mechanism to code for minority/health disparities-relatedness prior to the time grants are identified for funding.

In summary, an Institute-wide scientific coordinating role is needed for minority health disparities.

**Minority Workgroups at NIDA:** Currently, each of the four NIDA minority workgroups (Researchers and Scholars Workgroups for African Americans, Asian Americans/Pacific Islanders, Native American/Alaskan Natives, and the National Hispanic Science Network on Drug Abuse) appear to be pursuing their own trajectories. In general, workgroups expressed frustration about their inability to make a difference at NIDA. It is not clear to the workgroups what mechanisms are available to achieve their goals. All workgroups are clearly interested in training minority researchers (See Recommendation 4); this may be the single most important common thread among all the workgroups. A review should be conducted of the composition, mission, and mechanisms of action for each of the four workgroups to ensure their alignment with NIDA's mission. Once objectives/goals are defined, specific operational criteria will need to be developed (benchmarks) in order to monitor accomplishments. A system of performance measures, developed with input from constituent and minority workgroups, should be put

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<sup>5</sup> Note that there has been an NIH-wide directive to change the term "minority" to "health disparities," which will apply to all future research.

into place to assess yearly progress. It is important that the workgroups be comprised of scientific leadership that can provide NIDA with recommendations within its field of action. Similarly, it is important that the workgroups have a research mission that is consistent with that of NIDA and, in fact, that they help to further NIDA's research mission in reducing minority health disparities. Achieving this alignment may require the disbanding and reconstituting of workgroups.

To ensure that workgroups are able to assist NIDA in implementing its mission, we recommend an annual meeting of workgroups where NIDA leadership will discuss the scientific opportunities with which workgroups can be of greatest assistance. A strategy of taking the message to the most interested audience has three purposes: (1) it elicits immediate scientific response from an interested audience and results in new research applications, (2) it encourages dissemination from an audience well connected with minority populations, and (3) it provides an opportunity for brainstorming on findings with immediate applicability for reducing health disparities.

- The NIDA Strategic Plan should be shared with the workgroups to allow them to provide feedback to ensure alignment with their own strategic direction. This addresses the issue of how to ensure that the workgroups' recommendations are heard and implemented at NIDA.
- The role of the workgroups should be as scientific partners and consultants to NIDA/SPO in formulating and providing feedback on the *NIDA Strategic Plan on Reducing Health Disparities*.
- The Work Group members noted that the Hispanic workgroup and the National Hispanic Science Network on Drug Abuse represent a model for other workgroups to emulate. Specifically, the Hispanic workgroup's focus on concepts with considerable valence at NIDA were recommended for all workgroups, such as public health need/urgency, scientific opportunities to address identified needs, and interdisciplinary research. It is recommended that NIDA provide the technical assistance needed to share this model with the other workgroups.

In summary, NIDA is encouraged to establish a new direction for the four NIDA racial/ethnic minority workgroups. Again, the role of the workgroups should be to serve as scientific partners and consultants providing a minority health disparities scientific infrastructure to NIDA and the SPO. A review should be conducted of the composition, mission, and mechanisms of action for each of the four workgroups to ensure alignment with NIDA's mission. Achieving this alignment may require the disbanding and reconstituting of the workgroups.

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#### **Recommendation 4. Training Minority Researchers**

Since its inception, the mission of the SPO was to increase the number of drug abuse researchers from racial/ethnic minority populations. This objective has been approached by awarding minority supplements to ongoing grants held by majority researchers, summer research programs aimed at student populations, Minority Institutions' Drug Abuse Research Programs (MIDARP) grants and cooperative agreements aimed at building research infrastructure at institutions serving minority populations, and funding of meetings to encourage students and faculty at minority institutions to enter research careers. The success of this mission has been difficult to assess due to the inability to track and evaluate the career progress of individual awardees and the lack of defined career success for award recipients. Future efforts to address minority health disparities research questions may be facilitated by utilizing funding mechanisms that NIDA already has in place and by expanding training opportunities that encourage alternative mechanisms successfully used by other Institutes. For example, the Work Group recommends

the inclusion of the Diversity T32 and the U54 mechanisms already in use at other Institutes. These mechanisms are important because they provide the infrastructure support that minority scientists need to purchase the effort required to run training programs.

The Work Group believes that systematic improvements are needed in four key areas to increase the number of minority investigators:

1. **Mentorship.** NIDA should establish a national drug abuse research mentorship program devoted to training racial/ethnic minority investigators. Senior minority scientists often rely on research funding to cover their salaries and are already over-burdened with minority mentoring responsibilities. For this reason, senior minority scientists will require significant coverage of effort to allow them to devote additional time to mentoring.
2. **Research Environment.** The Work Group commends and supports NIDA's funding of research infrastructure development for minority institutions and recommends developing strategies for making research-rich environments available to racial/ethnic minorities at all stages of career development.
3. **Trainee Career Development.** Attention should be given to all stages of the career development pipeline. The Work Group recommends continued support of the Research Supplements for Underrepresented Minorities program as well as development of the following new programs:
  - A visiting scholars program to permit racial/ethnic minority researchers to visit or be visited by outstanding drug abuse researchers.
  - A career development award or K01 for minority faculty interested in all areas of drug abuse research.
  - A national minority research scholar's program to bring minority clinicians into research careers, with an emphasis on clinical and community research.
  - New mechanisms such as a "Training Center Grant" that permit development of comprehensive training programs attending to several levels along the training pipeline at the same time, facilitating the continued support of trainees across multiple levels of career development (e.g., undergraduate, graduate, post-doctoral, and new assistant professor).
4. **Tracking.** Mechanisms should be developed for tracking NIDA-funded minority trainees to determine whether NIDA is being successful in helping minority researchers move along the research career pipeline. For any minority-specific research training mechanism, tracking of career development outcomes should be required. A report recently developed by the NIMH National Advisory Council's Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparities Research identifies impediments (e.g., Privacy Act limitations) and strategies to overcome them to successfully track minority scientists: *An Investment in America's Future: Racial/Ethnic Diversity in Mental Health Careers* ([http://www.nimh.nih.gov/publicat/nimh\\_diversity.pdf](http://www.nimh.nih.gov/publicat/nimh_diversity.pdf)). In this report (pages 33-34), a limited analysis of NIMH minority recipient outcomes is presented. We encourage the NIDA SPO to join its counterpart at NIMH and to seek support from the NCMHD in planning and implementing a training career management system.

Finally, the Work Group recognizes an interesting opportunity presented by an untapped source of personnel that could be utilized to perform minority health disparities research in NIDA-funded research laboratories. There is a pool of minority faculty who are employed by traditional teaching institutions, including Historically Black Colleges and Universities (HBCUs) and Tribal Colleges. These faculty at

traditional teaching institutions are not provided the time, facilities, or intellectual support to initiate or sustain programs of research. Moreover, the Work Group recognized that many promising minority faculty at both minority and majority institutions are, as young faculty, tapped for committees and administrative responsibilities before their research is fully developed. Thus, we find that there is a substantial number of worthy minority faculty whose scholarly activities are not sufficient to move up the ranks to full professorship or to major research institutions.

Utilizing this pool of mid-career professionals would require the creative expansion of NIDA's funding mechanisms to move beyond "training" and into "mid-career collaborations" during summer months and for a limited percent of release time effort during the academic year. The expectations of this collaboration would not be that training would result in these researchers seeking individual R01 funding, which would be unrealistic at teaching institutions. Rather, the measure of success would be establishment of racial/ethnic diversity within NIDA-funded research teams that can include both faculty and students. Additional benefits would include continued minority faculty participation at a part-time level (e.g., during summers) in ongoing research secured by NIDA funding, regular authorship on publications, and an enhanced understanding of current research directions that can be incorporated into the teaching programs of HBCUs and Tribal Colleges. Such collaborations have the potential to secure a two-way relationship between NIDA-funded investigators and cooperating non-research institutions, for which the Work Group finds no precedent, particularly with Tribal Colleges.

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### **Recommendation 5. NIH Policies on Minority Inclusion**

The NIH Policy and Guidelines on the Inclusion of Women and Minorities (NIH Revitalization Act of 1993, PL 103-43) states that "In conducting or supporting clinical research ... the Director of the NIH shall...ensure that...members of minority groups are included in such research." This well-intentioned policy, amended in 2001, fails to promote the development of knowledge on specific racial/ethnic minority subgroups. As a consequence, many studies include a small number of minorities, possibly a smattering from each of several subgroups. The benefit of this policy is that at least *some* minorities receive the direct benefits of participation in research; of particular benefit is participation in prevention and treatment research. Unfortunately, however, the policy fails to add to our body of knowledge on racial/ethnic minorities. A more useful policy would offer incentives for studies to include a sufficient number of a somewhat homogeneous group of minority subgroup participants (e.g., Navajo Indian adolescents) to permit at least some meaningful small group analysis (e.g., effect size). Such a policy would achieve a scientific goal—that is, to increase our knowledge about racial/ethnic minority subgroups. In time, across many studies, a body of knowledge would emerge that would point to the need for larger studies with a specific minority subgroup capable of effecting the greatest yield (i.e., the most useful, most urgent information).

Beyond mere inclusion of minorities, when appropriate, investigators should be encouraged to plan valid analyses that will directly impact our understanding of minority populations. Incentives might include offering research supplements to augment specific minority subgroup sample sizes, developing new analytic strategies specific to small population samples, or increasing priority rankings for including defined minority subgroups.

The Work Group would like to clarify that this recommendation is intended to encourage subgroups that can be defined with some specificity. Research that includes Native Americans in general, for example,

is not nearly as informative as research that includes a specific subgrouping such as “reservation-dwelling Navajo Indian women,” “Vietnamese Asian American emerging adults,” or “Mexican American recent immigrants.” An analysis of a small sample of “Asian Americans” in a treatment sample yields relatively little information because of the heterogeneity of the group. We therefore conclude that while the policy of racial/ethnic minority inclusion is well intended, it is not helpful to furthering the knowledge base on racial/ethnic minorities. Again, a much more effective policy would be to encourage and incentivize inclusion (over-sampling) of a single subgroup within a racial/ethnic minority group.

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### **Recommendation 6. Research Needs and Priorities**

After reviewing NIDA’s current minority health disparities research portfolio, the Work Group identified three areas that require further scientific attention: Native Americans; HIV and criminal justice; and drug abuse treatment, prevention, and health services.

***Native American/Alaskan Natives Drug Abuse Research:*** The Work Group concluded that “neediest among the needy” are Native Americans. Native Americans (including American Indians, Alaskan Natives, and Native Hawaiians) were selected as a focus because Work Group members believe that this population had the greatest unmet needs and the greatest research challenges. This selection does not imply any diminished concern for the needs of other minority groups, and although special knowledge of and working relationships with populations are needed for all racial/ethnic groups, substantial additional challenges and unique complexities apply to conducting research with Native American populations, Nations, and tribes. Native Americans have additional challenges in the conduct of reservation-based research, with few successful models to emulate. In addition, the small number of Native American researchers, as well as the particularly difficult cultural issues relating to research in this population, make this group one that requires special attention. A further recommendation urges scientific interaction between the Native American/Alaskan Native Researchers and Scholars Workgroup and the other minority workgroups (e.g., Asian American/Pacific Islanders) to stimulate the development of research tools and approaches of potential mutual benefit, particularly with regard to the need for small population methodologies.

***Consequences of Drug Use Significantly Impacting Minorities:*** Two critical consequences of drug abuse that disproportionately impact racial/ethnic minorities include HIV infection and criminal justice involvement. HIV infection is of particular health concern for African Americans, who have the highest rates of HIV infection associated with drug use, followed by Hispanic Americans and Native Americans. African Americans account for 50 percent of all HIV infections, and African American women account for 75 percent of all new HIV infections among women. Another consequence of drug abuse that significantly affects minority populations is involvement with the criminal justice system. African Americans and Hispanic Americans are incarcerated at substantially higher rates and “...approximately 1 out of every 113 black adult males entered prison on a drug offense [in 1988] as compared to approximately 1 out of every 1,500 white adult males. The disproportions are striking, and the cumulative effects are obvious. Recently, the Bureau of Justice Statistics (BJS) estimated that nearly one in every three black males will serve time in a state or federal prison in their lifetime” (BJS, 2003).

Overwhelmingly, these HIV and incarceration rates are consequences of drug use. Further research is needed to study the consequences disproportionately impacting minorities and to examine effective prevention and treatment approaches.

***Treatment, Prevention, and Health Services Research for Diverse Minority Populations and Contexts.***

*Treatment.* Given the dire consequences of drug abuse for racial/ethnic minorities, it is urgent to develop and adapt behavioral treatments that may be optimally applied to specific racial/ethnic minority subgroups. Efforts should also be directed at treatments that may have potential for application across a diversity of populations and contexts.

- Theoretical, methodological, and clinical advances are needed in the study of context (e.g., culture, faith, family/kinship, networks/tribes, discrimination, stigma, broader community contexts, and criminal justice) and its role in treatment.
- Only a handful of treatments have been tested at the efficacy level, and no effectiveness studies have been reported with findings specific to a particular racial/ethnic minority group. Because of the large number of minorities involved or at risk for involvement with the criminal justice system, particular attention should be given to treatment research focusing on criminal justice involvement with minorities.

*Prevention.* While more work has been done in prevention with minority populations, it has not yet encompassed all minority groups and the range of contexts. Research is needed on prevention interventions for populations outside the mainstream school settings, such as primary care settings, families, churches, shelters, juvenile justice, alternative schools, etc.

*Health Services Research.* Considerable research has focused on the failures of health service delivery systems. More research is needed on effective models of health services delivery to specific minority groups. It has been suggested that such research should incorporate an understanding of the community and cultural contexts in which the services are delivered (Alegria, Page, Hansen et al., 2003).

## **CONCLUSION**

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The application of the recommendations highlighted in this Report will allow NIDA to take a leadership role in reformulating minority health disparities research as research occurring at the cutting edge of science.

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# Appendices

## Appendix A:

### APPENDIX A: MINORITY HEALTH DISPARITIES WORK GROUP

**Chair: Jose Szapocznik, Ph.D.**

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# Appendix B:

## APPENDIX B: MEETING AGENDAS

**National Institute on Drug Abuse  
Minority Health Disparities Work Group**

**July 26-27, 2004**

**Jurys Washington Hotel  
1500 New Hampshire Avenue, N.W.  
Washington D.C. 20036  
(202) 483-6000**

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### Day 1 – July 26, 2004

9:00 – 9:20 am      **NIDA’s Strategic Plan: Minority Health Disparities**

*Timothy P. Condon, Ph.D., Deputy Director, NIDA*

9:20 – 9:45 am      **Opening Remarks; Workgroup Questions**

*Jose Szapocznik, Ph.D., Work Group Chair*

9:45 – 10:30 am      **Overview of NIDA’s Special Populations Office**

*Lula Beatty, Ph.D., Chief*

10:30 – 10:45 am      BREAK

**--- 10:45 - 5:00 pm ----- EXECUTIVE SESSION -----**

10:45 – 11:45 am      **NIDA Research Related to Minority Health and Health Disparities**

*Yonette Thomas, Ph.D., Division of Epidemiology, Services and Prevention Research; Chief, Epidemiology Research Branch*

*Paul Schnur, Ph.D., Division of Basic Neuroscience and Behavioral Research; Acting Deputy Director*

11:45 – 1:00 pm      LUNCH (On your Own)

1:00 – 1:45 pm      **Workgroup Discussion**  
- Additional Information Needs

1:45 – 2:30 pm      **NIMH: Office for Special Populations**

*Robert A. Mays, Jr., Ph.D., Program Director, Research Training/Infrastructure*

- 2:30 – 2:45 pm            BREAK
- 2:45 – 3:45 pm            **NIDA Research Related to Minority Health and Health Disparities**  
*Carmen Rosa, M.S., Center for Clinical Trials Network, Program Operations Branch*  
*Jamie Biswas, Ph.D., Division of Pharmacotherapies and Medical Consequences of Drug Abuse, Chief, Medications Research Grants Branch*
- 3:45 – 5:00 pm            **Workgroup Discussion**  
                                 - Review the Day
- 

**Day 2 – July 27, 2004**

**--- 9:00 – 12:00 noon ----- EXECUTIVE SESSION -----**

- 9:00 – 9:45 am            **Workgroup Discussion**  
                                 - Additional Information Needs  
*Jose Szapocznik, Ph.D., Work Group Chair*
- 9:45 – 10:30 am            **NIH: National Center on Minority Health and Health Disparities**  
*John Ruffin, Ph.D., Director, National Center on Minority Health and Health Disparities*
- 10:30 – 10:45 am            BREAK
- 10:45 – 12:00 noon        **Addressing Minority Health Disparities Work Group Objectives**  
                                 - Timeline  
                                 - Next Steps  
                                 - Workgroup Assignments  
*Jose Szapocznik, Ph.D., Work Group Chair*
- 12:00 – 1:00 pm            LUNCH (On your Own)
- 1:00 pm                      ADJOURN

**National Institute on Drug Abuse  
Minority Health Disparities Work Group**

**September 13-14, 2004**

**Wyndham City Center  
1143 New Hampshire Avenue, NW  
Washington, DC. 20037  
202-775-0800**

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**Day 1 – September 13, 2004**

9:00 – 9:15 am      **Opening Remarks; Workgroup Questions**

*Jose Szapocznik, Ph.D., Work Group Chair*

9:15 – 10:30 am    **NIDA’s Special Populations Office**

- Review of Work Group Request for Information
- Discussion

*Lula Beatty, Ph.D., Chief*

10:30 – 10:45 am    BREAK

**--- 10:45 - 5:00 pm ----- EXECUTIVE SESSION -----**

10:45 – 11:15 am    **Workgroup Discussion**

11:15 – 11:45 am    **Feedback from NIDA Expert Racial/Ethnic Minority Workgroups**

*Raymond Daw, Native American & Alaskan Native Researchers & Scholars Workgroup*

11:45 – 1:00 pm      WORKING LUNCH (On your own per diem)

12:15 – 12:45 pm    **Feedback from NIDA Expert Racial/Ethnic Minority Workgroups**

*Hortensia Amaro, Ph.D., National Hispanic Science Network*

1:00 – 1:30 pm      **Workgroup Discussion**

- Additional Information Needs

1:30 – 2:00 pm      **NIDA Minority Health Disparities Research**

*Frank Vocci, Ph.D., Director, Division of Pharmacotherapies & Medical Consequences of Drug Abuse*

2:00 – 2:30 pm      *Wilson Compton, M.D., Director, Div. of Epidemiology, Services & Prevention Research*

*Jack Stein, Ph.D., Deputy Director*

2:30 – 2:45 pm      BREAK

2:45 – 3:15 pm *David Shurtleff, Ph.D., Director, Division of Basic Neurosciences & Behavior Research*

3:15 – 3:45 pm *Betty Tai, Ph.D., Director, Center for Clinical Trials Network*

3:45 – 5:00 pm **Workgroup Discussion**  
- Review the Day; Needs for Second Day

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**Day 2 – September 14, 2004**

**--- 9:00 – 12:00 noon ----- EXECUTIVE SESSION -----**

9:00 – 10:00 am **Workgroup Discussion**  
- Additional Information Needs  
*Jose Szapocznik, Ph.D., Work Group Chair*

10:00 – 10:30 am **Feedback from NIDA Expert Racial/Ethnic Minority Workgroups**  
*Daniel Sarpong, Ph.D., African American Researchers & Scholars Workgroup*

10:30 – 11:00 am *Tooru Nemoto, Ph.D., Asian American/Pacific Islander Researchers & Scholars Workgroup*

11:00 – 11:15 am BREAK

11:15 – 1:00 pm **Addressing Minority Health Disparities Work Group Objectives**  
- Goals of Final Report  
- Timeline  
- Next Steps  
- Workgroup Assignments  
*Jose Szapocznik, Ph.D., Work Group Chair*

12:00 – 1:00 pm WORKING LUNCH (On your own per diem)

1:00 pm ADJOURN

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**National Institute on Drug Abuse  
Minority Health Disparities Work Group**

**November 18-19, 2004**

**Hyatt Regency Bethesda  
7400 Wisconsin Avenue  
Bethesda, Maryland 20814  
(301) 657-1234**

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**Day 1 – November 18, 2004**

**--- 9:00 – 9:30 am ----- OPEN SESSION -----**

9:00 – 9:30 am            **Opening Remarks; Status of Current Report**  
*Jose Szapocznik, Ph.D., Work Group Chair*

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**--- 9:30 – 5:00 pm ----- EXECUTIVE SESSION -----**

9:30 – 10:15 am        **Work Group Discussion**  
                              - Key Recommendations

10:15 – 10:30 am        BREAK

10:30 – 11:15 am        Discussion of Work Group Recommendations and Report  
*Nora D. Volkow, M.D., Director, NIDA*

11:15 – 12:00 noon      Work Group Discussion  
                              - Key Recommendations (continued)

12:00 – 1:15 pm        WORKING LUNCH (on your own per diem)

1:15 – 3:00 pm            **Work Group Discussion**  
                              - Key Recommendations (continued)

3:00 – 3:15 pm            BREAK

3:30 – 5:00 pm            **Work Group Discussion**  
                              - Executive Summary  
                              - Next Steps

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**Day 2 – November 19, 2004**

**--- 9:00 – 12:00 noon ----- EXECUTIVE SESSION -----**

9:00 – 10:30 am	<b>Work Group Discussion</b> - Next Steps (continued)
10:30 – 10:45 am	BREAK
10:45 – 12:00 noon	<b>Finalizing NIDA’s Minority Health Disparities Report</b> - Impact of Report on NIDA, NIH and the Field
12:00 noon	ADJOURN

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