

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES  
SUBSTANCE ABUSE and MENTAL HEALTH SERVICES ADMINISTRATION

**45th Meeting  
of the  
Center for Substance Abuse Treatment (CSAT)  
National Advisory Council (NAC)**

+ + +

Thursday  
February 2, 2006

**VOLUME I**

+ + +

1 Choke Cherry Road  
1st Floor Conference Room  
Rockville, Maryland

+ + +

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**Valera Jackson, M.S.**

**Chilo L. Madrid, Ph.D.**

**Gregory E. Skipper, M.D., FASAM**

**Frank McCorry, Ph.D.**

**Eugene White-Fish**

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Administrator, SAMHSA

**Richard T. Suchinsky, M.D.**

### Guest Speaker

**Charles G. Curie, M.A., A.C.S.W.**

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### Presenters

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1 PROCEEDINGS

2 [9:15 a.m.]

3 Welcome/Opening Remarks

4 H. Westley Clark, M.D., J.D., M.P.H.

5 DR. CLARK: Good morning. I'm delighted to  
6 welcome each of you to the 45th meeting of the CSAT  
7 National Advisory Council. I'm trying to be upbeat  
8 today. I hope you find the discussions fruitful. We  
9 have taken into consideration council members'  
10 suggestions and looked at what we should be doing.

11 Since we met last, CSAT has experienced two  
12 very sad events. On Christmas Eve, Dr. Sheila Harmison,  
13 who served as my special assistant for a long time, more  
14 than five years, passed away. In addition, our council  
15 member, David Peterson, who is unable to join us today,  
16 lost his daughter, Christine Peterson Braverton [ph] on  
17 October 12th.

18 So before we proceed with this meeting, I would  
19 like to ask you to join me in a moment of silence because  
20 they are two grave events.

21 [Moment of silence observed.]

22 DR. CLARK: Thank you. The loss of anyone is a

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1 very painful event, and that of a long-time staff person  
2 and the loss of a child, even though it is an adult  
3 child, is still very disturbing.

4 **Adoption of May 19-20 Meeting Minutes**

5 With that, our very first item of business on  
6 the agenda is to vote on the minutes from the May 14th  
7 and 15th, 2005, meeting. Hopefully, you've had an  
8 opportunity to review the minutes again, since we did not  
9 have a September meeting last year.

10 I will entertain a motion to adopt the minutes.

11 [Motion moved.]

12 [Motion seconded.]

13 DR. CLARK: We have had a motion and a second.

14 Is there any discussion?

15 [No response.]

16 DR. CLARK: May I get a vote? All those who  
17 move to approve the minutes?

18 [Chorus of ayes.]

19 DR. CLARK: Opposed?

20 [No response.]

21 DR. CLARK: The minutes are adopted. Thank  
22 you.

1 [Motion carried.]

2 DR. CLARK: I really can't overemphasize the  
3 importance of your role as members of CSAT's National  
4 Advisory Council. You play a critical role in helping us  
5 advise the Administrator about courses of action and  
6 policies that SAMHSA should be taking in the area of  
7 substance abuse treatment. So I want to thank you for  
8 adjusting your schedules to attend this meeting and for  
9 the advice that you provide and for the activity in which  
10 you have been engaged.

11 We are here because we are familiar with the  
12 problem of substance abuse and substance use disorders  
13 and its many complications. The expertise you bring with  
14 you enriches our discussions and facilitates the way for  
15 CSAT to reach its goals. Your contributions therefore  
16 are very much appreciated.

17 Some of you are doing quite a lot, and I don't  
18 want to enumerate them, but in case some of you have not  
19 had an opportunity to meet all the members of the  
20 council, I want to take a couple minutes to allow the  
21 members to introduce themselves so that staff and others  
22 in attendance from the public can make sure that they

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1 know who the CSAT council members are who are in  
2 attendance. Let us know whether you have been working on  
3 any new projects since we last met.

4 Why don't we begin with Melody Heaps.

5 **Council Member Introductions**

6 MS. HEAPS: Melody Heaps. I'm with TASC in  
7 Illinois.

8 DR. CLARK: Any new activities that you have  
9 been working on?

10 MS. HEAPS: I suppose I can say this. We're  
11 trying to pass an alcopops [ph] tax in Illinois, and  
12 that's hot and heavy on the agenda and would be one of  
13 the few states that has taken after that issue, which is  
14 exciting for us.

15 We also have been significantly involved in  
16 Illinois in the largest corrections treatment center,  
17 called the Sheridan Unit. That has gotten press in The  
18 New York Times and all that. Our governor has now  
19 decided to expand that model to two or three other  
20 institutions, and that includes a good deal of money for  
21 community-based treatment.

22 I remain an active member of the CSAT Advisory

1 Council and a part of Partners for Recovery.

2 DR. MADRID: Chilo Madrid, El Paso, Texas. As  
3 the legislative liaison for our state association, I have  
4 been very busy in developing our legislative agenda for  
5 next January. So we are starting 11 months early.  
6 Hopefully we will be successful when the session  
7 convenes.

8 The other thing that we have done is, last  
9 weekend, we sponsored a faith-based conference for about  
10 300 teenagers and 100 parents. It was very, very  
11 successful. We got a chance to do a lot of counseling  
12 and a lot of interventions with the young people.

13 DR. MCCORRY: Good morning. I'm Frank McCorry.  
14 I'm with the New York State Office of Alcoholism and  
15 Substance Abuse Services in the performance improvement  
16 area. Since we met, New York is rolling out or trying to  
17 encourage the adoption of a mental health screen in its  
18 substance abuse programs. The modified mini screen is a  
19 22-item tool that has been validated.

20 We validated it in New York substance abuse  
21 treatment settings as well as in jails and in shelters,  
22 and it was found to be fairly effective in screening.

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1 Screening is only a kind of red flag. It is not an  
2 assessment, but it is an indication of a need for further  
3 inquiry.

4 We have been having some success in rolling  
5 that out statewide. We are very excited about it as part  
6 of this initiative to adopt a no-wrong-door policy in New  
7 York for co-occurring disorders. We are also trying to  
8 roll it out in a way that is consistent with our current  
9 understanding of what is the best way for a state to  
10 support the adoption of an evidence-based practice.

11 So we are kind of using two tracks, both the  
12 content and the process, grounded in research, and  
13 looking at the state's role in how to do these things.  
14 Thank you.

15 DR. CLARK: Frank didn't mention the 11 percent  
16 increase in the governor's budget for substance abuse.

17 DR. McCORRY: We have been getting some funding  
18 for co-occurring disorder demonstration grants, yes. So  
19 it is a very good budget in New York this year. Thank  
20 you.

21 MS. JACKSON: Thank you. My name is Valera  
22 Jackson. I'm from Miami, Florida. I started on the

1 council as a CEO for The Village, which is a longstanding  
2 comprehensive agency in south Florida. We have since  
3 become part of a family of WestCare Foundation,  
4 Incorporation, which has services in seven states, Puerto  
5 Rico, and the Virgin Islands. So we are a very large  
6 organization, however we try to maintain a very  
7 community-based approach and have been successful in  
8 doing that.

9           One thing I would like to mention is that I am  
10 also the chair of South Florida Provider Coalition.  
11 Florida, in its progressive wisdom, has chosen to move  
12 forward in some alternative kinds of funding, allowing  
13 managing entities that have a lot more provider input, a  
14 lot more provider authority in terms of how they fund  
15 their local communities. So, in a sense, they are  
16 turning it over more to the local folks.

17           We have 31 members and 25 contracts and, right  
18 now, something like \$25 million to manage. This is just  
19 in Miami and the Keys. One of the things that that does  
20 is allow the providers and the stakeholders to be able to  
21 really look at their own issues, to also combine some of  
22 the areas of substance abuse and mental health that are

1 very important, and also to speak -- which I think is  
2 something that has been missing over the years in many  
3 areas of Florida -- with a united voice to the state, to  
4 the governor, and to allow us to really look at the past.

5 "What was the contract last year? We will give you  
6 another contract this year." How do we really need to  
7 face the problems and what are the problems, and to move  
8 those things.

9 So I'm very proud to be a part of that. I have  
10 done a lot of work on it and appreciate the opportunity.

11 DR. SUCHINSKY: I'm Richard Suchinsky from  
12 Department of Veterans Affairs. We have been involved in  
13 a number of things lately, but probably the most  
14 important has been the implementation of the Mental  
15 Health Strategic Plan for the Department of Veterans  
16 Affairs, one aspect of which is an increase in funding  
17 for substance abuse, a significant portion of which is  
18 being targeted towards expansion of buprenorphine  
19 availability in the VA system.

20 DR. CLARK: Rock and roll.

21 DR. SUCHINSKY: One of the things that we will  
22 be doing over the next several months is implementing

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1 four regional training programs for physicians in the VA  
2 to become certified in their ability to provide  
3 buprenorphine. This will have a significant impact.

4 DR. CLARK: Thank you.

5 JUDGE WHITE-FISH: Good morning, everyone. Dr.  
6 Clark, thank you for giving me all this information that  
7 I now have to share with the Native American community.  
8 There have been a lot of questions.

9 I'm Eugene White-Fish. I'm the chief judge for  
10 the Forest County Pottawattamie located in Crandon,  
11 Wisconsin. I also serve as the president of the National  
12 American Indian Court Judges Association, which is judges  
13 throughout the United States and Alaska, all tribal  
14 judges.

15 One of the things that all the judges  
16 identified when I brought this issue to them is, there is  
17 a meth problem in all Native American communities. It is  
18 a great concern. Our tribal chairmen at the National  
19 Congress of American Indians are also addressing the same  
20 concern.

21 So, I mean, it is not only from our level. We  
22 work closely with the National Congress of American

1 Indians as well. Our president, Joe Garcia of the  
2 National Congress, is also cooperating with the National  
3 Tribal Court Judges Association. The concern is the meth  
4 problem as well.

5           The thing that also is coming to light now;  
6 because Native nations are sovereign nations, we always  
7 run into the problem of jurisdiction. But when it comes  
8 to problems like the meth problem and the alcohol  
9 problem, that is pertinent in both jurisdictions. I  
10 think it is time, and the state courts and federal courts  
11 are looking at coming together with their issues. We  
12 have been dealing with it on a national level. It is no  
13 longer a question of sovereignty; it is a question of  
14 what we can do to work together to address issues like  
15 the meth problem, the alcohol problem, and drug problems  
16 in our communities.

17           The great thing about that is exactly that,  
18 that move forward. However, there seems to be sometimes  
19 a lack of information. They look to me and ask me, "Can  
20 you get us more information?" In fact, I was asked to  
21 participate in a conference along with the federal bar  
22 out in Albuquerque. One of the main topics to tribal

1 courts is exactly the meth problem in Native country.  
2 So, I mean, that is one of the reasons I say thank you  
3 for providing me with all this information now that I  
4 have to share with the Native communities.

5 But the drug courts is exactly what is moving  
6 forward. A lot of tribal nations are looking to drug  
7 courts. They are looking to county courts or the state  
8 courts and working together because a lot of our tribal  
9 courts are located within a county court, within the  
10 county system, surrounded by the county.

11 So the counties and the state and the tribes  
12 come together to work in order to combat these problems  
13 that are in both communities. It isn't a jurisdiction  
14 issue. It becomes a community issue for both communities,  
15 and we need to learn how to better address it to take  
16 care of our own communities. Thank you.

17 DR. CLARK: Gregory.

18 DR. SKIPPER: I'm Greg Skipper and I'm the  
19 medical director of the Alabama Physician Health Program.

20 I have gotten involved in a couple things. One is a  
21 national study. I'm co-principal investigator with Tom  
22 McClellan. We are looking at physician health programs

1 around the country. They boast a very high success rate  
2 for treatment of substance dependence, and long-term  
3 success has been good, and we are trying to verify that.

4 We are also trying to look at what they do that  
5 gives them such a good outcome. Tom pointed out that if  
6 there is any other disease where doctors have a better  
7 treatment and a better outcome than the general public,  
8 there would be an outcry of "Why can't we get that?" So  
9 we are trying to define exactly what is it they do. We  
10 think we know, but we are going to look and see, and see  
11 if we can introduce any of those principles into the  
12 general treatment of addiction in the country in terms of  
13 policy change possibly. Robert DuPont is involved in  
14 that, too.

15 The other thing I have been involved in is this  
16 issue of ethylglucuronide [ph] testing. I brought this  
17 here a couple years ago. I kind of fell into this issue.

18 ETG, as we call it, ethylglucuronide, is a direct  
19 metabolite of ethanol and it hangs around in the body for  
20 a few days. So we now have a marker where we can  
21 actually monitor to see if somebody is abstinent. It is  
22 much more successful than any marker we have had before

1 because all the other markers have been indirect and  
2 require more drinking to tell if somebody is abstinent or  
3 what not. It is a urine-based test, so it can be added  
4 to panels.

5 Well, anyway, I was involved in helping to get  
6 a lab going with that in the United States a couple years  
7 ago, and now that thing has just taken off like crazy.  
8 There are more than 20,000 tests a month now in  
9 monitoring programs where with professionals in safety-  
10 sensitive positions we are using that. It is starting to  
11 be used in criminal justice, i some school settings with  
12 teenagers that are problems because we can monitor  
13 whether they have used alcohol, and even in treatment  
14 centers.

15 Well, this is one case where it didn't take so  
16 long for a product to get to the market, and there are  
17 problems because of that. In other words, the science is  
18 behind. Usually it is the other way around: the science  
19 is ahead and it takes a long time to get it on the  
20 market.

21 Anyhow, this thing is on the market and now I'm  
22 being asked to testify at hearings and so forth because

1 people are getting positives and saying they didn't  
2 drink. The reason is, in part, there are a lot of  
3 products in this country around, here, there, and  
4 everywhere, that have alcohol in them: mouthwash, over-  
5 the-counter meds, foods.

6 So we are working with Dr. Clark trying to  
7 figure out how to get some money to now study this thing  
8 and to contain it so that it doesn't lose its value. If  
9 there is harm done, it could be a tragic thing because we  
10 do think it is valuable. It just needs to be better  
11 defined. So, thank you very much.

12 DR. CLARK: Thank you, Dr. Skipper. Anita.

13 MS. BERTRAND: Good morning. My name is Anita  
14 Bertrand, and I'm the executive director of the Northern  
15 Ohio Recovery Association, and we are located in  
16 Cleveland, Ohio. I want to thank Dr. Clark and the  
17 administration for selecting me for the council. I have  
18 been on the council for a year now. It is really an  
19 honor to be here. Tuesday, I celebrated my 16th sober  
20 birthday.

21 [Applause.]

22 MS. BERTRAND: I won't tell you how old I am.

1 I can still tell for a couple of years, but pretty soon  
2 it's just whatever sober birthday it is.

3 [Laughter.]

4 MS. BERTRAND: But anyhow, I have been quite  
5 busy. I had the opportunity over the past year to  
6 reorganize an organization, and we changed the name and  
7 developed a new board of directors. We are known for the  
8 Peer Recovery Support Services in Cleveland, Akron, and  
9 Lorain.

10 Through that, I have had the opportunity to  
11 start working with adolescents. I have worked with  
12 adolescents for a while but not to the extent that I am  
13 now. I am working in a community where there are a lot  
14 of minority adolescents.

15 Some of the projects I'm working on; we have a  
16 treatment program that is specific for the culture, and  
17 we have infused the Nguzu Saba [ph] model into treatment  
18 elements. We talk about the Seven Principles and we  
19 teach the adolescents about how skills that they have had  
20 all their lives they can use to help them in recovery.

21 In our Peer Recovery Support, the adults are  
22 working with adolescents in a program called Across Ages,

1 which is a SAMHSA model. We take a lot of the  
2 information that is here and we adapt it to our  
3 community. So we take the adults and we train them to  
4 work with youth that are at risk.

5 Another project we have is, there is a  
6 gentleman who is developing a film called "Man Cry." He  
7 is a person in recovery, and he is also a producer. So  
8 they are actually filming a film in Cleveland of this  
9 gentleman's life. We have taken adolescents, some of  
10 them that are at risk, and we have put them on the set,  
11 and we are teaching them skills about wardrobe and how  
12 they can develop wardrobes and makeup and lights and  
13 cameras and what that is all about. So we are using that  
14 model.

15 Then the other thing, in November, and I was  
16 talking to Valera about that this morning, we had a  
17 conference and we brought together a little over 200  
18 people. It was the first conference of this nature in  
19 Cleveland, and it was titled "Building Bridges." The  
20 individuals that were invited were people in recovery,  
21 the treatment providers, and the faith-based community.

22 So we came together and we discussed how we all

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1 can work better to build that bridge because we know that  
2 treatment is a wonderful thing and that it is in the  
3 community where people practice what they learn. So we  
4 want to make sure that in the community that they have  
5 the supports that they need to stay sober.

6 DR. CLARK: Thank you. Ken.

7 MR. DeCERCHIO: Good morning. I'm Ken  
8 DeCerchio. I'm the assistant secretary for substance  
9 abuse and mental health.

10 DR. CLARK: This is a promotion, folks. Give  
11 that man a hand. He got promoted.

12 [Applause.]

13 MR. DeCERCHIO: Like everybody, we are busy.  
14 We have been implementing Access to Recovery, the  
15 Strategic Prevention Framework from CSAT, and our own  
16 version of Mental Health Transformation. Over the past  
17 six months particularly, and really focused on that, we  
18 just released the Florida Youth Substance Abuse Survey,  
19 which we do every year. All but three categories  
20 continue to trend down. Youth substance use continues to  
21 trend down since the year 2000. Tobacco use is now below  
22 marijuana use in Florida.

1           The area that has been the most resistant to  
2 change, while it has decreased about 10 or 12 percent in  
3 that five years, has been alcohol. It still has the  
4 highest use: 29 percent of sixth- to 12th-graders  
5 monthly use. So Governor Bush and Mrs. Bush and Director  
6 Jim McDonough [ph] of the Office of Drug Control, we came  
7 up to CSAP's Under-Age Drinking Initiative, SAMHSA's  
8 initiative with other federal partners, and the governor  
9 has convened a principals workgroup of state agency heads  
10 for Florida's version of reducing underage drinking.

11           Two weeks ago, we had a statewide forum on  
12 strengthening collaboration among child welfare,  
13 community-based care lead agencies -- in Florida  
14 protective services is privatized with community-based  
15 agencies -- with mental health and substance abuse  
16 agencies, in a forum where communities come together and  
17 develop local action plans for providing more integrated  
18 substance abuse and mental health services to families in  
19 the child welfare system.

20           We are very proud of a project that got started  
21 about four years ago called BRITE, Brief Referral  
22 Intervention Treatment to Elders, which we have taken a

1 strategic brief intervention model and modified it, with  
2 some help from folks around the country and the Florida  
3 Mental Health Institute. We have that going in four  
4 sites in Florida. We are seeing reductions in use among  
5 older adults, and it is really progressing and we are  
6 really excited about that work.

7 We have gotten a lot of experience in the past  
8 couple of years in Project Hope, which is our disaster  
9 recovery program. We have an integrated mental health  
10 and substance abuse response crisis counseling with  
11 tremendous support from SAMHSA. We are in 24 counties,  
12 providing crisis counseling, and that has continued. We  
13 are in our second year.

14 Unfortunately, we had a pretty significant  
15 disaster with hurricane season this last fall. In early  
16 November, we participated in mental health and substance  
17 abuse, in doing a disaster food stamp program to almost a  
18 million Floridians in five days in response to those  
19 hurricanes.

20 Since we last met, and in the last 30 days, we  
21 are blessed to bring Stephanie Cullston [ph], Mr. Curie's  
22 special assistant for substance abuse, to Florida as the

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1 state substance abuse director. She is keeping us all  
2 very busy, and we are very glad to have her.

3 Last but not least, Governor Bush yesterday  
4 released his budget, with a \$14.5 million increase in  
5 substance abuse services for closing the public treatment  
6 gap and working with families in the child welfare  
7 system. So that is very exciting for all of us.

8 Thank you. I'm glad to be here.

9 DR. CLARK: Thank you. I think it is important  
10 for all of us to hear that we have a viable and active  
11 council working in states where there is a lot of  
12 activity going on and a lot of interest. So I think the  
13 Administrator chose wisely when he chose you to be on  
14 this council.

15 I will now move to giving my director's report.  
16 Since Mr. Curie is scheduled to arrive at 10:00, I will  
17 truncate my report.

18 **Director's Report**

19 **H. Westley Clark, M.D.**

20 [PowerPoint presentation.]

21 DR. CLARK: I would like to bring you up to  
22 date on the many internal personnel changes that have

1 occurred in CSAT since September. We have had losses and  
2 gains.

3 Rich Kopanda is on temporary detail as the CSAP  
4 acting director. So he has gone from being my deputy  
5 director to the acting director of the Center for  
6 Substance Abuse Prevention, in place of Beverly Watts-  
7 Davis, who was selected by Mr. Curie to be his senior  
8 advisor for substance abuse issues. As Ken DeCerchio  
9 pointed out, Stephanie Cullston, who previously had that  
10 position, has gone on to work with Ken DeCerchio. He  
11 lured her there with promises of good weather and palm  
12 trees, and she couldn't resist the temptation so she  
13 bolted. That happens.

14 While Rich is on detail, George Gilbert is  
15 serving as CSAT's acting deputy director, while retaining  
16 his OPAC portfolio.

17 The Division of State and Community Assistance  
18 has acquired four new employees. Before I get to that,  
19 Karl White is now in Vietnam. He is representing SAMHSA,  
20 working with the Office of Global Health and dealing with  
21 the issue of HIV and substance abuse.

22 We have a number of people who have left CSAT:

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1 Ellie McCoy, Will Saunders, Debra Fulcher, George  
2 Kanuck, Peggy Cockrill, Barbara Kuroda, Cliff Mitchell,  
3 Mady Chalk. Joan is sitting there. The sign says that  
4 she has left, but that is because tomorrow is her last  
5 day.

6 So we want to make it clear that we value the  
7 contributions of these many employees, but as you can  
8 see, while the bulk of these individuals have retired,  
9 the workforce at SAMHSA continues to age. For the  
10 younger staff in the audience, the issue is that we need  
11 to bring you along to replace us. Many of the people in  
12 the federal workforce are of retirement age and are  
13 starting to figure out when they want to retire, when is  
14 the best time to retire. It may be one year, it may be  
15 two years or three years, or in the case of Joan, it may  
16 be one day. So this is a key issue.

17 We have some new employees. I want to mention  
18 Jerri Ellen Brown [ph], Sherry Fowler, Christina Lynn,  
19 and Lisa Creatora [ph.] We have also got Linda Kaplan,  
20 who is working on an IPA on our CSP program.

21 We also have a number of interns. Would the  
22 interns stand up? I would like to have the interns

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1 stand.

2 [Applause.]

3 DR. CLARK: It is not that the other employees  
4 are less important than the interns, but we have to  
5 convince the interns that they should come work for the  
6 federal government. After all, we have to find  
7 replacements. Everybody else has got a job. So they  
8 have options of choosing where they want to go, and I  
9 think those of us in public service need to recognize  
10 that we need to be replaced when the time comes.

11 Joan is going to go tooling around the country  
12 in an RV with her husband. She is going to go to Florida  
13 in the next two weeks, is it, Joan?

14 So Ed Herron [ph] has been asked to be the  
15 acting division director of the Division of Services  
16 Improvement. Since it wouldn't be prudent to have Ann  
17 directing two robust divisions, I have asked John  
18 Campbell to be the acting director of the Division of  
19 State and Community Assistance. John will be doing  
20 double-duty in his capacity, retaining his role as chief  
21 of the block grant branch.

22 So, a lot of activities going on. As any of

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1 you who are working in state government know, you have to  
2 roll with the punches, people retire, processes need to  
3 be put in place.

4 To the budget. President Bush proposed a  
5 budget for CSAT and essentially SAMHSA. Congress,  
6 however, enacted a different budget. The president's  
7 budget was a little more generous than the Congress', but  
8 the Congress decides on what appropriations. The  
9 Congress enacted a total of \$398.9 million, a \$48.2  
10 million reduction from the president's request and a  
11 \$23.5 million reduction from the funding level in 2005,  
12 at \$422.4 million.

13 Congress has included funding to continue the  
14 ATR program at its current level but rejected the request  
15 for additional funds for a new cohort of ATR grants in  
16 2006. So we will not be having a new cohort of ATR  
17 grants in this fiscal year.

18 The SAPT Block Grants were not as heavily  
19 affected. The president proposed to maintain the FY 2005  
20 budget for FY 2006 at \$1,775.6. What was passed was a  
21 budget of \$1,758.6, a reduction in funds of \$17 million.

22 Final funding amounts for the CSAT programs also

1 incorporated a 1 percent across-the-board reduction that  
2 Congress enacted in 2006.

3 A unique feature which I would like to bring to  
4 your attention is the absence of a substantial  
5 congressional earmark for FY 2006. It is an important  
6 thing for us to keep in mind.

7 Moving to 2007, we are working on the 2007  
8 budget. The president announces his 2007 budget next  
9 week, on Monday. So I encourage you to pay close  
10 attention to that because the 2007 budget is the opening  
11 volley. As you know, the 2007 budget won't be in place  
12 until sometime late fall, I believe in mid December,  
13 George? Our 2006 budget? Late December.

14 This is an election year, and so the Congress  
15 may postpone completing the budget. They may do it  
16 earlier, they may do it later. It is an election year  
17 for the midterm elections, so we may not have a budget  
18 again until either late in this calendar year or early  
19 next year. We will have to operate.

20 Congress removed a ban on the 30-patient limit  
21 for groups, resulting from discussions and inquiries from  
22 physicians, patients, and congressional representatives.

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1 The 30-patient limit is for the group practice. There  
2 was a major confusion as to the nature of a group.  
3 Kaiser has thousands of docs, and it was a group. Johns  
4 Hopkins has a thousand docs, and it was a group. So that  
5 was a problem because people couldn't prescribe  
6 buprenorphine. Some practitioners now want the 30-  
7 patient limit removed from individual practitioners, and  
8 so there is ongoing discussion about that.

9 CSAT expects to issue a notice of proposed  
10 rulemaking that will address reports made by many  
11 physicians who claim that they have reached the 30-  
12 patient limit and their ability to treat more patients,  
13 particularly those who are addiction medicine  
14 specialists. They believe that they should be able to  
15 treat as many patients as they can manage.

16 This is an issue that the Congress has  
17 expressed some opinion on in the past, and so we will be  
18 working with the field as well as with the Congress on  
19 this issue. As you know, we continue to have a major  
20 problem with drug abuse from psychotherapeutics.  
21 Prescription drugs we should just call it.

22 Speaking of prescription drugs, another program

1 that remains on the radar is the National All Schedules  
2 Prescription Electronic Reporting Act of 2005. When this  
3 act was passed, there were no funds in the 2006  
4 appropriation to SAMHSA or to HHS to promote this grant  
5 program. There are some requirements in this grant  
6 program in terms of a study, but the fact is a number of  
7 jurisdictions are moving toward electronic monitoring of  
8 prescriptions.

9 We were just talking to Ken Johnson of Maine  
10 yesterday, and Maine is one of those jurisdictions that  
11 has recently adopted a what we call NASPER, National All  
12 Schedules Prescription Electronic Monitoring Process. I  
13 know Ken has been working with Jim McDonough and others  
14 in the State of Florida as they continue to review this  
15 as a strategic approach.

16 It is something that remains in our discussion  
17 at SAMHSA. The act would shift the monitoring activity  
18 to HHS. Justice currently has a grant program under  
19 appropriations. We will see how that unfolds with the  
20 passage of time. Money, of course, is always an issue.

21 Access to Recovery. We have a lot of activity  
22 going on in Access to Recovery. As you know, Texas has

1 an ATR grant, and of course Illinois and then Florida.  
2 So we are represented on council with individuals, and I  
3 encourage council members to be in contact with your ATR  
4 contact points, your SSAs and others, to see what it is  
5 that you can do to help facilitate. Clearly, we don't  
6 want programs encumbered by all the cooks in the world,  
7 but this is an exciting program and continues to be an  
8 exciting program.

9           Earlier last month, we convened a meeting in  
10 Bethesda. Invitations were extended to 69 community and  
11 faith-based provider organizations. Key staff from 14  
12 states and one tribal organization had an opportunity to  
13 meet with me personally to discuss potential barriers to  
14 success, but they met in a plenary as a group. Joan,  
15 Andrea Copstein, the project officers were all there.  
16 Our faith-based people were all there.

17           The key issue is that we were trying to  
18 increase our focus of services onto recovery support  
19 services as well as supporting clinical treatment  
20 services. Mr. Curie is fond of saying there are many  
21 pathways to recovery, and what we want ATR to do is to  
22 help facilitate that activity and it appears that we are

1 achieving some success.

2 As a collateral matter, since Access to  
3 Recovery is also reaching out to faith-based  
4 organizations, some of you may have heard the president's  
5 comment on HIV testing in lieu of care, something about  
6 rapid testing during this session. But the statement  
7 that he made essentially is involving community-based and  
8 faith-based organizations and enhancing rapid testing for  
9 HIV.

10 So we are looking for opportunities to expand  
11 the continuum of care beyond our traditional clinical  
12 treatment structures to make sure that we can facilitate  
13 recovery by embracing the community providers.

14 Our Community and Faith-Based Technical  
15 Assistance Initiative is intended to train and provide  
16 technical assistance to help faith- and community-based  
17 organizations build their capacity to provide effective  
18 services and successfully apply for and receive federal  
19 grants.

20 We have Sherie Nolan, who has been appointed as  
21 the senior policy advisor for faith-based and criminal  
22 justice. Mr. Curie might mention her name. She has been

1 actively involved, as well as Beverly Watts-Davis, who is  
2 a senior policy advisor for substance abuse, including  
3 treatment and prevention.

4 We are pursuing ATR education forums, HIV and  
5 AIDS expert panels, HIV/AIDs in community partners  
6 capacity-building. So we are actively engaged in  
7 expanding that activity.

8 In the area of Recovery Month, we have had  
9 numerous successes to which I would like to credit the  
10 Consumer Affairs Unit within my office. Is Yvette  
11 around? She is back there. Yvette Torres and her group  
12 have been active, and we continue to promote Recovery  
13 Month activities.

14 The 16th Annual National Alcohol and Drug  
15 Addiction Recovery Month began with a major prevention  
16 effort this past September, and then we will be moving  
17 forward to another Recovery Month this September. What  
18 we are doing here is beginning to lay the foundation for  
19 Recovery Month, working with communities in recovery.

20 But I like to always stress that no matter how  
21 successful we are in our annual meetings, we need to make  
22 sure that we involve not just people in recovery but the

1 community must see recovery as a phenomenon that benefits  
2 the whole community. That's always my pitch. Yvette has  
3 heard me make that pitch. Recovery Month should be for  
4 people in recovery, providers, and also the community.  
5 It is the community that is the beneficiary, and  
6 families.

7           So we had a large number of events in our 2004  
8 week. Our last event coincided with our release of our  
9 2004 National Survey on Drug Use and Health, which helped  
10 capture the data that is being used to note that we have  
11 decreased drug use among our youth. As Ken pointed out,  
12 the same event is occurring in Florida. The data in the  
13 national studies have shown that those 12 to 17 have  
14 decreased their drug and alcohol use.

15           What we still have to worry about is the young  
16 adults. While those 12 to 17 have decreased their use,  
17 those 18 to 25 have not.

18           We had a total of 41 community events that  
19 reached approximately 35,000 people in our past Recovery  
20 Month activity. We had 257 press clippings that resulted  
21 in a collective circulation of more than 3 million.

22           So I want to give Yvette Torres and her group a

1 hand. That is a lot of work.

2 [Applause.]

3 DR. CLARK: That is not to minimize the work of  
4 the ATR people or others. I just wanted to make sure so  
5 that people realize that we are trying to make sure we  
6 get the message out.

7 "Treat Me," the 2005 PSA, received two silver  
8 Omni Awards for demonstrating excellence in the  
9 production and services of public service. It also  
10 received -- late-breaking news -- a Mercury Gold Award  
11 for, and I have a slide on this at the end, but I want to  
12 lump these together, public relations industry standard.

13 So, award-winning things. We don't win too many awards;  
14 I don't know why. I guess it is the stigma issue because  
15 we are doing a lot of great work.

16 Now, I also want to commend staff in general  
17 for the work that they have done and that they do and  
18 will do on a daily basis. Would the council join me in  
19 thanking my staff for their tireless effort?

20 [Applause.]

21 DR. CLARK: But with the Mercury Gold Award and  
22 the Omni Award, what we are doing is demonstrating that

1 we are getting the message out.

2 Mr. Curie believes that we also have something  
3 to share with other nations, so at the close of 2005 I  
4 joined the Administrator, working with the government of  
5 Mexico and its Secretary on Health, the National Council  
6 on Addictions at the Sixth Annual United States-Mexico  
7 Bi-National Drug Demand Reduction Conference, in  
8 exchanging information about how to address issues.

9 As I mentioned before, we have Karl White, who  
10 is in Vietnam. We also have, on detail currently, Tom  
11 Cressina [ph], who has also been working with Vietnam and  
12 our international efforts.

13 Now, our jurisdiction is domestic, but the drug  
14 problem is worldwide. For those who don't recognize  
15 that, we can look at Judge White-Fish. We can look at  
16 the methamphetamine problem. Some of you may have seen  
17 the article about the reduction in home labs and the  
18 production of methamphetamine. The home labs have gone  
19 down but the methamphetamine use has not. In fact, one  
20 of the unintended consequences of reduction in home labs  
21 is increased purity of methamphetamine on the streets,  
22 increased cost, and therefore increased crime.

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1           So the problems are very complex, and  
2 methamphetamine is being imported, if you will, from  
3 Mexico. So, a positive relationship with Mexico and with  
4 other foreign countries is very important so that we can  
5 begin to address this.

6           Sharing information is critical. Planning for  
7 a wide range of activities is critical. We have a pilot,  
8 non-denominational individual in family recovery training  
9 which we are supporting with the National Association of  
10 Children of Alcoholics, which was launched recently in  
11 Detroit. Informational materials were distributed at  
12 training events for clergy leaders and congregants in  
13 January.

14           New consumer publications have included  
15 "Alcohol and Drug Addiction Happens in the Best of  
16 Families and It Hurts," "It Feels So Bad, It Doesn't Have  
17 to," and a poster, "Alcohol and Drug Abuse Hurts Everyone  
18 in the Family."

19           So I want to make it clear that we are actively  
20 engaged in sharing some of our information and working  
21 with the NIH and others so that we can have the most  
22 recent information possible. So, not only are we

1 reaching clergy but also community-based organizations.

2 We have noticed that our help line continues to  
3 be sought out. In November 2004, the call volume was  
4 19,807. By November 2005, that had increased from  
5 roughly 20,000 to 25,534. A key issue to keep in mind is  
6 that people are indeed adversely affected.

7 We are going to have community education forums  
8 on medication-assisted therapies. Is Steve LeBlanc [ph]  
9 in the back? I thought I saw him. Yes. Steve is  
10 actively involved in coordinating that.

11 In Atlanta, Georgia, where one of the community  
12 forums is going to occur, we are going to have David  
13 Satcher, who was a former surgeon general, be one of the  
14 keynotes. Our host cities include Houston, Texas;  
15 Atlanta, Georgia; and Memphis, Tennessee. We are trying  
16 to, Dr. Suchinsky, increase the information about  
17 buprenorphine.

18 We also want to make it clear that we are  
19 trying to make sure that we keep track of what is  
20 happening with buprenorphine. There is some diversion  
21 with buprenorphine, primarily among people who cannot  
22 access buprenorphine. One of our previous reports

1 pointed out that a two-tier system is evolving where  
2 people with money get buprenorphine and people without  
3 money don't, and that is a problem. One of the things  
4 that I did notice is that the drug companies have now  
5 created a Compassionate Program where people without  
6 resources can apply.

7           We have two publications being prepared around  
8 medication-assisted treatment and consumer education,  
9 "Introduction to Methadone" and "Methadone Treatment for  
10 Pregnant Women."

11           After my report, Mr. Curie will be here to  
12 provide a SAMHSA update. Over the next two days, you  
13 will be hearing from members of our CSAT staff and  
14 outside presenters who will bring to light specific areas  
15 of activities. You will hear information about our CSAT  
16 Recovery Summit and our Partners for Recovery activity.

17           SAMHSA launched a website dedicated to the  
18 advancement of prevention, treatment, and recovery from  
19 substance abuse and mental health disorders. It features  
20 news and documents on recovery, collaboration, stigma  
21 reduction, workforce development, and leadership  
22 development.

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1 I was really impressed by Sherie Noonan from  
2 the State of New York. We were up there with Mr. Curie,  
3 and Rich Kopanda, representing CSAP, at their state  
4 providers organization. Sherie Noonan stressed the  
5 importance of co-occurring disorders as a construct and  
6 involving a wide range of practitioners in making sure  
7 that we develop pilots that capture the issue.

8 So our Partners for Recovery effort reaches  
9 across all three centers. It involves mental health in  
10 both prevention and treatment. Those of you interested  
11 in the Partners for Recovery website, it is listed here,  
12 at [www.pfr.samhsa.gov](http://www.pfr.samhsa.gov).

13 We will be hearing about campus screening and  
14 brief intervention. The issue of underage drinking of  
15 course is important. The National Health Information  
16 Infrastructure Initiative. The recent IOM report, the  
17 need to have an alternative strategy to dealing with the  
18 issue of stigma and dealing with bringing evidence-based  
19 practices and dealing with the Quality Chasm.

20 We are going to hear about the hepatitis  
21 immunization project, CSAT methamphetamine activities,  
22 our STAR program, the Network for Improvement on

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1 Addiction Treatment.

2 SAMHSA's hurricane response. With regard to  
3 the hurricane response, we have had a number of people  
4 who have gone on deployment to the Gulf or who work here  
5 as part of our cert. I would like to give those people a  
6 hand because some of those people inconvenienced  
7 themselves tremendously to make sure that we addressed  
8 the issue of the hurricane.

9 [Applause.]

10 DR. CLARK: I always want to recognize the  
11 people who picked up the extra work while others went to  
12 do necessary work. So that is an important thing for us  
13 to keep in mind. People on deployment were backed up by  
14 people who were holding down the fort, if you will, so I  
15 like to give the people a hand who held down the fort.

16 [Applause.]

17 DR. CLARK: It is an important thing for us to  
18 recognize that we have been addressing the issue of rapid  
19 testing. The president mentioned that in his State of  
20 the Union address. We have been working with a wide  
21 number of jurisdictions on making sure that rapid tests  
22 were available. Sheila Harmison had played a key role in

1 that, and we will miss her contribution. Her efforts  
2 have been picked up by others in the Division of Services  
3 Improvement. Currently, Kirk James is now the lead  
4 person, but Dr. James is working with such individuals as  
5 Dave Thompson, Cheryl Gallagher, Stella Jones, and others  
6 in DSI, and then of course, we have staff people in DSCA,  
7 Rick Dolan and others, who have been working with the  
8 issue of rapid HIV testing.

9           Some of you may have heard some concerns about  
10 rapid testing. There is some question about what is  
11 called "false positive." The CDC has looked into this  
12 and the CDC has concluded that the test is a screening  
13 test. It is accurate at about the 99 percent level,  
14 which means that 1 percent is going to be false positive.

15       When you start doing thousands and thousands of tests,  
16 that 1 percent starts to pop up.

17           What we are reminded is that this is a  
18 screening test. Somebody who screens positive needs to  
19 be confirmed positive, but it doesn't diminish the  
20 utility of the test. It just reminds us that when you  
21 have large-scale testing and you have a 99 percent  
22 specificity or sensitivity rate that that 1 percent

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1 starts to appear. So when hundreds of thousands are  
2 tests are done, you are going to start picking up some  
3 false positives.

4 Rather than running screaming that the test is  
5 faulty, what CDC is saying is, "You are supposed to  
6 confirm. This isn't a one-test process. This is a two-  
7 test process, a screening test with a confirmation test."

8 What people need to do is make sure you have protocols  
9 in place where the testing gets validated.

10 Anybody know where Mr. Curie is? He is being  
11 held up? Gee, I have run out of speeches. Perfect.

12 So that is the end of my comments. I want to  
13 thank you for being here again. We will move to the next  
14 item once we get a sense of Mr. Curie's schedule. He has  
15 been very busy.

16 I will entertain some discussion by the council  
17 while we are waiting for him. Melody?

18 MS. HEAPS: I don't know if this belongs now or  
19 later, but one of the issues not raised was the SBIRT and  
20 where we are on that and how that program is coming  
21 along. That may be something for the next council  
22 meeting in terms of review, but I think it is an

1 important piece. It ties into the medical community, the  
2 IOM report, the pharmacological reports, et cetera. So I  
3 would hope to do that.

4 Also, at some point, a discussion of ATR and  
5 what is going on with that I would like to get into.

6 DR. CLARK: Okay. Val?

7 MS. JACKSON: Yes. Also in terms of things  
8 that have changed, unfortunately, because of the demise  
9 of Dr. Harmison, she was a great lead in the e-therapy  
10 thing, which I was involved in. We had a great  
11 discussion the last council which she led, and I would  
12 hope that we could kind of jump back on that issue  
13 because it is moving on very fast. There is a lot of  
14 stuff going on out there.

15 DR. CLARK: Thanks for bringing both of those  
16 topics up. Tom is going to present on SBIRT Campus, so  
17 we will keep for the next meeting's topics SBIRT and e-  
18 therapy.

19 Oh, we have Charlie here. So we will interrupt  
20 the council discussions and entertain comments from Mr.  
21 Curie, who you all know so I won't go into any elaborate  
22 introduction of Charles Curie. He is the Administrator

1 for the Substance Abuse and Mental Health Services  
2 Administration and has been so for four and a half years  
3 now. He has been on the job for a while.

4 Mr. Curie.

5 **SAMHSA Update**

6 **Charles G. Curie, Administrator**

7 MR. CURIE: Well, thank you, Wes. Great to be  
8 here. It is great to be with your advisory committee. I  
9 just want to thank each of you because I, of course, know  
10 many of you personally. I know what you do day in and  
11 day out for the field, but also, for going the extra mile  
12 to participate in this body. We do take very seriously  
13 your input and what you have to say. You represent a  
14 range of constituents in the substance abuse treatment  
15 field.

16 One goal that we had from day one is to make  
17 sure the national advisory councils of the centers and  
18 SAMHSA's National Advisory Council felt they played a  
19 relevant role. Again, any way we can help continue that,  
20 let us know.

21 I will tell you, CSAT has been blessed with the  
22 opportunity to have a presidential initiative. Some days

1 it doesn't feel like a blessing. We will talk about that  
2 a little bit. But also, I think, clearly, having the  
3 opportunity to help shape and operationalize recovery for  
4 the nation, operationalizing it from a public policy and  
5 public finance standpoint, and to take a personal process  
6 like recovery, which has been a clear concept and a clear  
7 force in the lives of people who had been trapped in  
8 addiction and who were able to regain their lives for  
9 decades.

10 Really, four to five decades we have heard  
11 people talking about being in recovery as that has  
12 evolved, and how that evolved from a personal process out  
13 of the treatment and the 12-Step community and the  
14 traditions that have helped build people up as they have  
15 tried to overcome their addictions. To move it from that  
16 type of process to a public policy and public finance  
17 process has been a challenge, but I think it has been  
18 essential. Recovery helps us keep our eye on the end  
19 game that we are looking for.

20 I think Access to Recovery, that presidential  
21 initiative, is one in which we concretely are  
22 demonstrating elements in public policy and public

1 finance that operationalize recovery. It is giving us a  
2 great opportunity to learn.

3 I just want to thank the CSAT staff. You  
4 really, truly are under the gun when you have several  
5 entities invested in Access to Recovery. Clearly, it is  
6 part of our appropriation. I remember the day I was  
7 called from the Domestic Policy Council about three and a  
8 half years ago when they wanted to explore the  
9 possibility of how we could begin incorporating choice.  
10 They made it very clear: you guys are going to be the  
11 ones on the front line defending this and implementing  
12 it. The White House did very much engage us from the  
13 very beginning in the development of it.

14 As time has gone on, of course, I call ATR a  
15 program with many parents. The big parent is the  
16 president, so we all pay attention to what he wants,  
17 absolutely. But again, we have the White House Community  
18 and Faith-Based Office, we have ONDCP, we do have DPC, we  
19 have OMB involved. We have the Office of Legal Counsels  
20 from not only HHS but from the White House and from  
21 Justice involved.

22 So it is probably one of the most scrutinized

1 programs coming out of the chute. I see my good friend  
2 Ken DeCerchio from Florida. I know Valera has been  
3 involved with this as well. I see my good friend Melody  
4 Heaps. Many of you are in states that are directly  
5 involved in implementing Access to Recovery, and I don't  
6 think you have felt ignored in the process in terms of  
7 people paying attention to what is going on.

8 [Laughter.]

9 MR. CURIE: But I think it is important for us  
10 to talk about those dynamics because we are getting the  
11 first data in. I think the first data is giving us a  
12 clear indication of where things are going well and where  
13 we need to focus our attention further. To me, the key  
14 is transparency as we move ahead in that process with  
15 Access to Recovery.

16 I think we also always need to go into a  
17 massive initiative like this with the clear understanding  
18 that there will be problems, with the clear understanding  
19 that it is an innovative process that is forging new  
20 territory that has its controversies around it.

21 In all frankness, when ATR was first proposed,  
22 there was not an embracement. The field didn't come out

1 and embrace Access to Recovery. Providers didn't say,  
2 "This is great. We love the idea of competition and  
3 opening it up to more people." I speak as a recovery  
4 provider. You begin to take a look at what does the  
5 marketplace come to bear.

6 Then, if you look at this program and its  
7 complexities, and I want to talk about some of these  
8 dynamics because they are all plain and we need to  
9 recognize them, you also have people who have strong  
10 feelings about what they see ATR standing for.

11 I believe ATR stands for the fact that there  
12 are many pathways to recovery. I will never deny someone  
13 in recovery their story. If they come to me and say,  
14 "This was my addiction." It's based on the facts, let's  
15 say. I don't want to talk about this book that is  
16 floating out there. I will deny that fellow, perhaps.

17 [Laughter.]

18 MR. CURIE: We need to have it focused on  
19 facts. But if someone comes forward with their factual  
20 account of their road to recovery and you listen to them,  
21 you hear variation from people in terms of what worked  
22 for them. You hear some common elements. We need to

1 extract those common elements to feed into public policy  
2 and public finance.

3           But we know that there are some people who  
4 point to a particular program that they say saved their  
5 lives, a particular licensed, certified program. A  
6 program such as Val has, a program that Melody has, a  
7 program that many of you represent they can point to.  
8 You know of clients who express their appreciation  
9 because they have reclaimed their lives. That is  
10 wonderful, and that story needs to get out.

11           You also know of individuals, I also know of  
12 individuals, who will point to a faith-based program, who  
13 will say, "It wasn't until the transforming powers of  
14 faith took hold of my life that recovery really took  
15 hold."

16           If our focus is the end game of outcome, of  
17 people realizing recovery in their life, then outcomes  
18 should be what hold us accountable. Outcomes should be  
19 what we are focused on as the common ground. Yes, we  
20 need to think about issues around public safety. We need  
21 to think about issues about making sure providers are  
22 eligible and transparent. There needs to be

1 accountability, absolutely, in the system, but ATR  
2 represents a new way of looking at things.

3           But then it stirs the pot because there are  
4 people who will look at it and say, "If you are inviting  
5 faith-based organizations, we see this as a clear  
6 violation of the Constitution. We think it violates our  
7 rights as Americans," and they feel strongly about it.  
8 I'm not going to deny their position on it because that  
9 is their position and what they look to.

10           I happen to disagree. Because ATR is based on  
11 choice and it is based on opening more pathways to  
12 recovery, if you are going to have a faith-based program  
13 participate and you tell the faith-based program, "But  
14 you can't practice your faith. You can't talk about the  
15 faith part of your faith-based program," like I said,  
16 then you just have a -based program. If that is the part  
17 that made the difference in the lives of people when you  
18 hear them talk about it, I think we have to acknowledge  
19 that.

20           But I respect the different opinions on this,  
21 and I think you can understand, and I do understand, why  
22 there has been a struggle. And, there has been a

1 struggle on the Hill when we try to increase Access to  
2 Recovery from \$100 million to \$200 million so maybe we  
3 could give 15 more states and/or tribes an opportunity to  
4 expand treatment capacity in this country.

5 I have to tell you that is one of the greatest  
6 disappointments I have had as SAMHSA Administrator. If  
7 we would have had the president's proposed budget passed  
8 as proposed over the past three to four years, we would  
9 have close to \$3- to \$400 million more in the CSAT budget  
10 for treatment in this country.

11 Whether you like vouchers or not, having  
12 vouchers and choice and expansion of capacity should be  
13 something we all agree with. Even if you would have  
14 preferred a different type of mechanism to fund, that is  
15 the common ground and that is what we have missed. I  
16 just had to say that because it is an opportunity lost.

17 I think we need to be ever mindful in the  
18 future as we move ahead in the substance abuse treatment  
19 field because we are such a vulnerable field. We are a  
20 fragile field.

21 What makes it not fragile is we have strong  
22 people who make up the field, but when it comes to the

1 infrastructure and the financing -- I'm preaching to the  
2 choir here. I know that. I'm not telling you something  
3 you don't know from your experience.

4 So, hopefully as we move ahead with Access to  
5 Recovery, hopefully as we move ahead with issues around  
6 choice and find new ways, better ways, innovative ways to  
7 give options to people in working with partnership with  
8 states and providers and people in recovery, that we can  
9 take these lessons as we roll out ATR and think about how  
10 we can move ahead.

11 I'm really pleased to see, again, the progress  
12 that we have made with ATR. We met the first year goal  
13 of serving over 25,000 unduplicated clients. I think  
14 that that is something that should not be lost on people  
15 at all. Very significant.

16 We have seen progress overall of the new  
17 category of providers that are called recovery support  
18 services providers, evolve and grow. Again, that is not  
19 just faith-based, that is a range of recovery, 12-Step  
20 types of groups that we traditionally have not  
21 necessarily funded to any great extent and now have the  
22 opportunity to be funded to grow. Again, I think it is

1 very significant.

2 We are seeing a portion of faith-based  
3 providers come in both on the clinical treatment side and  
4 also the recovery support services side. Again, the  
5 growth is greater in some states than other states. But  
6 again, it is working in partnership to see, are we  
7 attaining those overall goals.

8 Also, I think it is very important for us as we  
9 move ahead, and I know that ATR states and our tribal  
10 organization in California, they receive our routine  
11 visits from the project officers doing their jobs. We  
12 had a major conference in January which brought all the  
13 ATR states together. I know Wes has had other  
14 opportunities where he has brought other folks together  
15 just to try to keep the communication open. It is a  
16 challenging job, and sometimes people hear things in  
17 certain ways. That is why we need to keep re-  
18 communicating. We need to gauge our message as we move  
19 ahead to make sure people understand it.

20 Again, with so many eyes on ATR, the more eyes  
21 you have on a project, the more you have different kinds  
22 of expectations with those eyes. So one thing we also

1 are trying to do is to be clear about the accountability  
2 around this: what we are expecting from ATR states in  
3 terms of data and in terms of expectations.

4           Again, I want to stress here that the message  
5 that should be clear and that we have tried to really  
6 clarify, because, again, I think there has been a desire  
7 on the part of many people -- and I include the states in  
8 this, and I appreciate it -- trying to gather all sorts  
9 of information to paint a picture as they are hearing  
10 different questions being raised.

11           That puts strain on everybody. Then we set up  
12 false expectations, I believe, for what type of picture  
13 we can paint. I know my strong position has been,  
14 whatever OMB is requiring in terms of what was certified  
15 in the RFA, we need to be clear with the states what is  
16 required. I think all the states are responding to what  
17 is required. I want to congratulate all the states and  
18 pretty much -- I'm looking at Joan. Not all, okay.

19           MS. DILONARDO: Not all. Almost all.

20           MR. CURIE: Almost all the states. Thank you.

21           I don't want to overstate it. We know the states do  
22 want to meet expectations overall, but again, the

1 required stuff.

2 We also know that some states are able to come  
3 forward with other types of data to paint the picture,  
4 and we invite that anytime that that can happen. We also  
5 know that requests are going to be made, "Can you get us  
6 this data?" but we have to understand, if it is not  
7 required, we have to have the context of that discussion,  
8 and it needs to have transparency around it so that there  
9 is no unclear expectation.

10 Also, going back to being as explicit as  
11 possible. So a lot of the communication now is assuring  
12 that occurs.

13 I view this as obviously still a fledgling  
14 effort. It is the nature of it. Even if we were going  
15 100 percent, all guns, meeting all expectations in all  
16 states, it is still fledgling in terms of it is still  
17 shaping. So I by no means mean that as a criticism. I  
18 think it is what it is, and we have to recognize that  
19 going forward.

20 We are going to be really focusing on success  
21 stories coming out of ATR, because there are many.  
22 Again, hopefully we will have a little time for some

1 discussion here. I would be interested in hearing from  
2 you what you are hearing, what your impressions are, or  
3 answer any questions.

4 One thing we don't want to forget with ATR is  
5 that it is our first major initiative to implement NOMS,  
6 the National Outcome Measures System. I'm sure you all  
7 have it memorized, being part of the National Advisory  
8 Council and know what the NOMS are without me going over  
9 each one. But clearly, the major thrust of NOMS is to  
10 measure recovery.

11 Again, the outcomes we are expecting are  
12 outcomes in people's lives. We are trying to get beyond  
13 just process measures. We are trying to get beyond just  
14 being focused on our symptoms being alleviated. I mean,  
15 that is still a part: are people not using; are people  
16 remaining chemical-free. Obviously, that is an outcome,  
17 but we want to look beyond that because we also recognize  
18 that for recovery to take hold and to prevent relapse  
19 people need to be experiencing outcomes in their lives  
20 and having that life in the community. So it is  
21 important for us to try to be measuring that end game.

22 I want to recognize out front and up front that

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1 that is a challenge. It is hard for providers. It is  
2 hard for states. The follow-up has always been a  
3 challenge, but I think we are learning more how to do  
4 that and that we need to do that up front and give us  
5 that expectation.

6 I think all of you have heard me talk about  
7 when people in recovery or people seeking recovery are  
8 asked what they need and what they want, they define it  
9 by the outcomes in their lives. So we are measuring a  
10 job in these outcome measures, and education. We are  
11 measuring a home and housing in these outcome measures.  
12 We are measuring connectedness to family and friends,  
13 including dates on the weekend, including are people  
14 connected to others in significant ways.

15 We are measuring whether people have access to  
16 the services that they need and supports that they need.  
17 We are measuring whether they are staying, in terms of  
18 retention, in their treatment recovery plan in their life  
19 and staying with that.

20 Then, we are measuring client satisfaction,  
21 perception of care, cost effectiveness, and whether our  
22 field is using evidence-based practices. I think when

1 you hear those outcomes they all make sense.

2           The other major thrust is we want to keep the  
3 domains to a number that is doable and that will really  
4 give us a focus on what is happening, and be clear in  
5 that message, not be putting new measures depending on  
6 the initiative we put out. So we do see NOMS being part  
7 of how we measure the effectiveness of, ultimately, all  
8 of our discretionary grant and block grant initiatives  
9 with states. I'm very pleased to say that states are  
10 stepping up to that partnership.

11           Again, I'm a recovering state director, too, so  
12 I can also say that I know how hard it is to be in a  
13 state and to go ahead and agree that your data will be  
14 out there with every other state, and people can gauge  
15 the data differently. You may rate yourself and you end  
16 up in the top 10, but an advocacy group rates you in a  
17 different way with the same data and you end up being No.  
18 43. You don't want to face your governor at that point  
19 to explain why you are in the bottom 40. That is a  
20 dynamic that is real.

21           So I recognize state directors who come forward  
22 and say, "We are agreeing to this and we will work with

1 you on this," because they also know their governors have  
2 accountability to the public. It is doing their job, but  
3 it is also showing, I think, a large amount of integrity  
4 and courage. You really do put yourself on the line, and  
5 I recognize that.

6 Congress has the early data from our initiative  
7 from NOMS, and the state profiles of the ATR states at  
8 this point are on our SAMHSA website. So I encourage you  
9 to check those out. Again, NOMS will allow us to examine  
10 the impact of our services and also examine our  
11 priorities and where they should be.

12 A couple other things I want to mention, and  
13 then I want to open it up. We are updating the Matrix.  
14 You are going to see some changes. The current Matrix I  
15 have called "The Matrix Reloaded." This will be "The  
16 Matrix Reloaded Again."

17 [Laughter.]

18 MR. CURIE: Just to give you an idea of what we  
19 are doing, and we are going to be rolling this out more  
20 publicly to give you kind of an inside scoop, the  
21 disaster response and readiness is one of our priorities  
22 that we have had. SAMHSA was clearly put to the test

1 during Katrina, Rita, and Wilma, and I just want to say I  
2 congratulate CSAT, which has put forth major efforts;  
3 CMHS, which has had an Emergency Division for years and  
4 really is kind of the integrating body of the SAMHSA  
5 Emergency Response Center; and CSAP. Virtually 100  
6 percent of SAMHSA employees were involved in the  
7 response.

8 I give this off the top of my head, but as I  
9 recall, close to 60 percent of SAMHSA's staff either were  
10 deployed or served extra time in the SAMHSA Emergency  
11 Response Center, and of course the others covered for the  
12 people who did it. So everybody's workload increased.

13 Maybe we should show them the orange shirts  
14 that we have while they are here. SAMHSA response folks  
15 wore the orange shirts, and we got known to be the  
16 "Orange Shirts" down in the Gulf Coast area. We got to  
17 be known as the federal agency which people were pleased  
18 to engage because we weren't asking people for anything.  
19 We weren't telling them to get in line. We were there  
20 saying, "How are you doing?"

21 The partnership of FEMA was very good. FEMA  
22 was so pleased to be able to use us as a resource, and it

1 was a great partnership. All the great planning,  
2 especially after 9/11, that has occurred not only here at  
3 the federal level in getting ready with the SAMHSA  
4 Emergency Response Center but also states getting their  
5 plans in order, you could tell paid off in this process.

6 So another major lesson we learned is while a  
7 lot of what we did worked and planning paid off -- and it  
8 was a classic lesson. You plan and plan well, and  
9 practice -- again, we did some things on the fly. I also  
10 will say this. Katrina is worse than any top-off  
11 exercise we had. We have had a variety of emergency  
12 exercises since 9/11. This would be federal government-  
13 wide, sponsored by Homeland Security, they would entail  
14 maybe a terrorist attack somewhere on the East Coast and  
15 maybe simultaneously on the West Coast and what are you  
16 going to do.

17 Those exercises seemed a lot more manageable  
18 than virtually the whole Gulf Coast getting wiped out.  
19 So it was beyond any exercise, but the exercise prepared  
20 us and prepared us well. So what we found is disaster  
21 readiness and response also impacts everything we do. If  
22 you look at the Matrix, not only did it impact the

1 immediate lives of people -- so we worked in partnership  
2 with FEMA to have the crisis counseling dollars there,  
3 and that was a major part -- but it impacted people that  
4 were in methadone treatment who needed continuity of care  
5 for methadone. So that became a major focus right away.

6 People with serious mental illness who needed  
7 ongoing support and treatment, children with serious  
8 emotional disturbance. Continuity of care issues. It  
9 impacted the homeless population. It impacted the aging  
10 population. It impacted children and families. It  
11 impacted the HIV/AIDS and hepatitis C population. All  
12 those priorities on the Matrix.

13 So, clearly, the lesson learned is disaster  
14 readiness and response is a cross-cutting principle.  
15 While we are going to continue to have our two-year  
16 action plan in place for that and update that, we are  
17 going to be reflecting it as a cross-cutting principle on  
18 our Matrix, still recognizing it as a priority in that  
19 way, but it should, again, be something we are mindful of  
20 in everything that we do, that we need to have a disaster  
21 readiness component.

22 With that said, again, we really worked very,

1 very hard not to put too many priorities on the Matrix  
2 because it diffuses your focus. So we really want to be  
3 careful that we are putting priorities that are going to  
4 make the biggest difference.

5 One priority that we are adding to the Matrix  
6 is suicide prevention. We are going to put a real focus  
7 on suicide prevention and bringing the national strategy  
8 to the forefront. This has implications not only for  
9 mental health as people traditionally think of it, it has  
10 major implications for CSAT because of the clear  
11 connection to alcohol and drug abuse and suicide. So  
12 every center is going to be very much involved in that  
13 priority.

14 Thirty thousand people a year in this country  
15 commit suicide. We know that is a low count because we  
16 know a lot of deaths are ruled as accidental. Single-car  
17 accidents and different things that occur that are viewed  
18 as accidental are likely to be suicide. So that figure  
19 is probably much higher.

20 But if you take the 30,000 and compare it to  
21 the 18,000 homicides a year, I think people stand back  
22 when they hear that figure. Now, our government does a

1 lot at the federal, state, and local level to bring the  
2 homicide rate down, the murder rate down. I want to go  
3 on record that I'm for that.

4 [Laughter.]

5 MR. CURIE: And we need to continue to make  
6 efforts to bring down the homicide rate in this country  
7 and address public safety. But it's time to put the same  
8 emphasis on suicide in this country, and it's a tougher  
9 one because it's something people don't talk about.  
10 There is a stigma around it.

11 But I'm also convinced, if we are serious about  
12 mental health transformation in this country and if we  
13 are serious about moving ahead with the concept of  
14 resilience and recovery in this country at all levels,  
15 suicide is an issue that we should bring to the forefront  
16 and address head-on. If SAMHSA is not going to do it,  
17 nobody is going to do it. Again, I would be interested  
18 in your input and discussion about that.

19 The second priority we are adding -- we are  
20 moving from a cross-cutting principle to really give it a  
21 focus and priority and to have a clear action plan around  
22 it -- is workforce development. Again, it has been a

1 challenge to the substance abuse treatment field for  
2 years and years and years, and it is not getting any  
3 better in terms of trying to recruit and retain people  
4 and have qualified people in the field. It is the same  
5 in the mental health field.

6           So SAMHSA is bringing to bear its work that it  
7 has been doing out of CSAP with the workforce development  
8 efforts. Mady Chalk used to head it up when she was  
9 here. We combined those efforts with the Annapolis  
10 Coalition out of CMS to have an integrated effort  
11 throughout SAMHSA to be focused on it. Issues have been  
12 identified. Deficits have been identified. A lot of  
13 listening has gone on from the field to this process. I  
14 think we have some clear notions of what needs to be  
15 addressed, and some models have emerged that we want to  
16 study and work to bring to scale.

17           I have to tell you, putting workforce  
18 development as a priority out front is not something we  
19 did lightly because we also know that it is going to be a  
20 lot of hard work and it is not going to be easy. We are  
21 talking resource issues. We are talking just some things  
22 that people don't like to talk about, especially when you

1 are looking at budgets that are always tight and  
2 governmental budgets that are always tight.

3           So those are some things to keep in mind. In  
4 the proposed '07 budget which will be coming out, I think  
5 you will see opportunities for innovation and  
6 operationalizing recovery further. I also need to stress  
7 that the federal budget is an extremely, extremely tight  
8 one in which basically the pressure for taking a look at  
9 where things can be reduced was clearly an element in the  
10 guidance in the '07 budget process. I think you hear  
11 that from the Hill. There is a lot of pressure from the  
12 Hill to press that issue.

13           My own opinion is that we are not going to see  
14 that end in '07 but that is going to continue in '08 and  
15 for the foreseeable future. So I think we need to  
16 recognize that. I'm glad to hear revenues are picking up  
17 in states right now. If you turn the clock back three or  
18 four years ago, we were doing better at the federal level  
19 and states were just creamed. So maybe there is  
20 something in the balance that kind of helps us at least  
21 tread water as those revenues come in differently at  
22 different levels, to keep the big picture in mind. But

1 those are the realities we are looking at at the federal  
2 level for the moment.

3 Let me open it up for you to respond and ask  
4 questions. I have a few minutes. Anything you want to  
5 say or anything you want to ask, it's your time.

6 Yes.

7 DR. McCORRY: Thank you, Charlie. Frank  
8 McCorry from New York. Thank you for coming up to visit  
9 us this week. It was great to have Charlie, Westley, and  
10 Rich Kopanda all presenting. It was really terrific to  
11 see you all up on the stage.

12 I really liked the way you kind of  
13 conceptualized recovery from a personal process to a  
14 public policy process. I wanted to just comment on how I  
15 have thought about ATR and perhaps another way of  
16 presenting it publicly.

17 If you look at substance abuse as a chronic  
18 disorder that needs kind of specialty care, then it is in  
19 the specialty system. But if you look at, say, primary  
20 care, there is a lot of talk in managed care about a  
21 medical home as a kind of necessity in terms of both  
22 preventing development of disease as well as managing

1 chronic disease.

2 I have always thought of ATR in a similar way.

3 People need a home once they move out of the episodic  
4 specialty care in a very similar way to primary care, but  
5 it is not within the medical setting, it is within the  
6 community setting. A faith-based provider providing  
7 recovery support services really kind of makes sense from  
8 this notion of having a home post-treatment to continue  
9 their recovery. Very similar to the way you would define  
10 primary care, you might go in the hospital for a  
11 condition but that the ongoing relationship is somehow  
12 grounded with a primary physician, it is grounded in a  
13 community base.

14 I just wanted to get your reaction to kind of  
15 constructing ATR in that way, as more an element in  
16 continuing care, moving out of the specialty care sector,  
17 and where some people in a community get their resources  
18 or get their continuing, ongoing support through a faith-  
19 based support. It might be a way of looking at this in a  
20 less confrontational way.

21 MR. CURIE: I think, clearly, ATR can be framed  
22 and can definitely be operationalized that way. I think

1 we clearly have the opportunity to do that. I think  
2 framing it as the way ATR can be operationalized is very  
3 appropriate, and I think tying it to what is emerging in  
4 medical care in general as you described in the concept  
5 of primary care.

6 I think the one element of ATR, and this is  
7 where the confrontational aspect occurs, is there are  
8 those individuals who would say, though, they would want  
9 to go directly to recovery support services, whether it  
10 is faith-based or not, depending on where they are at a  
11 particular choice. If they need medical detox, that is a  
12 whole different ball game than if they don't. Or, if  
13 they are in more of a mode of they know their history and  
14 know where they are, again that would fit with your model  
15 and what you have just described, and that is more of a  
16 recovery with ongoing support.

17 So I think we could frame it that way in many  
18 situations. I think the thing with ATR that is tricky  
19 when you are talking about many pathways to recovery is,  
20 I know initially when ATR was conceptualized there were  
21 some who were trying to say, "Here is how ATR works. You  
22 need medical detox as the first step. You get medical

1 detox, then you get into some sort of treatment, whether  
2 it is in-patient residential, then intensive out-patient.

3 As you go along, you begin to explore. You may become  
4 familiar with the 12 Steps. Then, if you happen to be a  
5 spiritual individual, you might find out that  
6 spirituality helps you. So this gives you an opportunity  
7 to gain that support later on."

8 My response to that is "Absolutely." That can  
9 be a valid pathway to recovery, and there are thousands  
10 of people who would describe that that is their pathway.

11 But there are also thousands of people that look at that  
12 and say, "Well, that is not how it worked for me" or "I  
13 have been through these other programs several times and  
14 it wasn't until I went to X faith-based program."

15 Now, the one element that I think is very  
16 interesting is, a lot of folks will say every program  
17 they went through benefitted them, even though they may  
18 not have attained a sustained recovery and there may have  
19 been a relapse.

20 I think that could be, also, another part of  
21 the paradigm, just kind of thinking out loud here, as we  
22 work with ATR, and that is recognizing the fact that

1 there are many people in recovery who, while they may say  
2 they went through a program or different programs two or  
3 three times, many times in those conversations I hear  
4 them say, "But you know what, each built on the other."

5 DR. McCORRY: So it is an incremental quality.

6 MR. CURIE: Exactly. That is research-based.  
7 I think we need to bring that forward, too. So that is  
8 very helpful. Let's examine that. Thank you.

9 MR. DeCERCHIO: Good morning, Charlie. Nice to  
10 see you. To change gears into the Block Grant, what is  
11 your take on, I don't know if I have the language  
12 exactly, but whether it is OMB or GAO in terms of the  
13 overall assessment based on how the federal government  
14 assesses performance indicators that the Block Grant is  
15 particularly ineffective in its ability to demonstrate  
16 effectiveness. Could you kind of tell us where we are  
17 with that?

18 From a state perspective -- well, from our  
19 collective perspective. This isn't a polar issue by any  
20 means. But, I mean, the president mentioned the other  
21 night reductions in new substance abuse. It is hard to  
22 say that substance abuse prevention is not effective, and

1 it is hard not to recognize the critical role of CSAP and  
2 the block grant in that effort, for one.

3 Many of us have been working very closely for a  
4 number of years with the criminal justice system. We can  
5 show in correctional settings and in community settings  
6 and in folks coming into the criminal justice system that  
7 treatment reduces criminal justice outcomes, whether it  
8 is further penetration, et cetera.

9 So at the same time, when we look at however  
10 the rating tends to occur about the Block Grant, to have  
11 that kind of overall stigma associated with the Block  
12 Grant that somehow it is not effective and not meeting  
13 those types of expectations, how do we advance the ball.

14 Where is that? NOMS will be a major piece to advancing  
15 that piece and to advancing that discussion.

16 MR. CURIE: You gave the answer, or one of  
17 them.

18 MR. DeCERCHIO: But at the same time, the  
19 intersection of that with the pressure on the federal  
20 budget and some of what has happened in the last couple  
21 years with programs that are rated low effectiveness or  
22 are particularly at risk, can we talk a little bit about

1 that intersection and whether we are going to be able to  
2 put that forward?

3 MR. CURIE: I think the challenge to the Block  
4 Grant always is the fact that if you look back to the  
5 original conception of a Block Grant, it was to give the  
6 state flexibility. Now there are set-asides and all  
7 sorts of things in the statute and all that came along  
8 with the Block Grant over time, as people hung different  
9 things on it. Again, I think we would all agree many of  
10 those things are worthwhile to vulnerable populations,  
11 but again, whenever you put them on as a requirement,  
12 sometimes they don't quite play out the way you would  
13 want them to in a state.

14 But I think that is the inherent challenge of  
15 someone coming in and doing an outcome assessment, be it  
16 GAO. Is it an effective in the PART review that OMB is  
17 committed to.

18 NOMS is a major part of the answer. If we can  
19 begin to show outcome data how the Block Grant is spent  
20 in states: we are seeing reductions in substance abuse,  
21 we are seeing more people who were addicted sustaining  
22 employment, staying out of trouble with the criminal

1 justice system. I think over time that that is going to  
2 be extremely helpful.

3 I also think, again, as you take a look at the  
4 Block Grant, you are going to see continued pressures  
5 because of the questions raised in PART review. Do we  
6 need to work with states to consider how the block grant  
7 dollars are spent, and can we encourage and work with  
8 states to spend the Block Grant dollars in ways that can  
9 demonstrate outcomes and have accountability more  
10 quickly.

11 So I think that is the type of pressure you are  
12 going to see. The good news with that kind of pressure  
13 is it doesn't mean an automatic cut to the Block Grant.  
14 I mean, again, I think what we need to be examining is,  
15 while there is pressure and you have articulated it well  
16 -- it sounded like you listened well to the State of the  
17 Union the other night -- that pressure is on that  
18 programs aren't deemed as effective. Part of that would  
19 be a low PART score. That will be a gauge that is being  
20 used. Then pressure will be on to cut.

21 The alternative would be, if there isn't going  
22 to be like major cuts, how can we work with the folks

1 receiving these dollars in a way to get to the place of  
2 being able to demonstrate the outcomes and  
3 accountability. So that also is part of shaping that  
4 dialogue.

5 Does that kind of help? Okay.

6 Melody.

7 MS. HEAPS: Thank you for coming. It was very  
8 interesting. On the ATR issue, in the beginning when you  
9 talked about all the cooks that are trying to make this  
10 broth, I think, unfortunately, some of us who have been  
11 intimately involved in this have felt various pressures  
12 or information, et cetera, that only makes the ATR  
13 process more nervous. I think SAMHSA and CSAT have been  
14 trying very hard to work on what is fundamentally a  
15 systems change. Systems change doesn't take overnight.

16 MR. CURIE: And it can be messy.

17 MS. HEAPS: And it can be messy. By now, using  
18 language like "faith-based organizations," we are  
19 assuming they look like one thing. They are all over the  
20 map. There may be some very strong national faith-based  
21 organizations that may have one desire and may be set up  
22 to be able to immediately attach to the ATR. There are

1 so many more, smaller, other kinds of community faith-  
2 based organizations that would like to be involved but do  
3 not have the mechanisms. We need to help them to  
4 develop.

5 This is a systems change. This is a capacity-  
6 building change. It does not happen overnight. If the  
7 point of ATR, which you want to focus on recovery and  
8 focus on choice, is to be successful, then our message to  
9 those other parties beyond SAMHSA would be, understand  
10 the magnitude of the systems change and the need for some  
11 time for this demonstration to work.

12 There is a reason that, long ago, the federal  
13 government and HHS used to have three-year demonstration  
14 programs. We figured out it takes at least three years  
15 to be able to demonstrate and do what you need to do. So  
16 I think, unfortunately, all of the other cooks outside of  
17 SAMHSA have somehow made some of us in the states and our  
18 state directors and participants more nervous than they  
19 need to be, and almost allowed us to not be focused on  
20 that which we are really trying to do, which is change a  
21 system and change a way of doing business.

22 MR. CURIE: Thank you, Melody. Well said. I

1 think, from my perspective, clearly we need to go right  
2 back to the expectations. We need to always remember the  
3 RFA was developed for a reason the way it was developed.

4 I can assure you the RFA was put under a lot of scrutiny  
5 by a wide range of federal agencies.

6 Every federal agency that has an interest now  
7 knew what was in the RFA and why as it went through the  
8 scrub. So, to me, that is what we go back to.

9 Again, someone could say, "Is the glass half-  
10 empty or is the glass half-full?" I think when you take  
11 and examine, for example, the first data we got in, we  
12 also know the first data we got in perhaps is scrubbed a  
13 few times and then we get more refined data as we go  
14 along, and that is the nature of it, too. So I don't  
15 necessarily expect an automatically accurate picture.  
16 There are those who do, but I don't expect it because we  
17 have been through this. It is preliminary data that you  
18 are getting in that gives you an idea how the needle is  
19 moving overall.

20 I think what we have found is, when I view that  
21 our baseline was basically zero in terms of faith-based  
22 participation and you have a couple measures that states

1 can demonstrate how they have increased the pool of  
2 faith-based providers, that is a first step, even if  
3 those faith-based providers didn't get a voucher yet, or  
4 very many vouchers, because they are just starting.

5           The other thing to keep in mind is it was the  
6 first year and there were those of us making it very  
7 clear not to expect hardly any vouchers issued the first  
8 six months because it is a whole new way of doing  
9 business. States have to develop the infrastructure and  
10 get the provider base developed, and it may be six  
11 months. And it was in many states. It varied. Some  
12 states were issuing vouchers who had some infrastructure  
13 two or three months into the process. Others took longer  
14 than six months. It was probably closer to nine or  
15 whatever. But the average probably ended up being right  
16 around six, which we anticipated.

17           That is why we also had the 25,000 goal, which,  
18 again, I want to stress is a three-year goal. We are  
19 expecting 125,000, because we knew it would have  
20 variation. But that was based on 50,000 a year in a  
21 fully running program. So we shaved off 25,000 for the  
22 first year ramp-up, and that has really worked out to be

1 about right. Again, I think states should be  
2 congratulated, but thank you.

3 DR. MADRID: Just a brief comment. I'm Chilo  
4 Madrid from Texas. It was rough for us at the beginning,  
5 but I think that this point Dr. Wansher [ph] and our  
6 state people are really putting it together. We feel  
7 very comfortable. As a provider, I'm beginning to feel  
8 very, very comfortable with ATR.

9 MR. CURIE: I'm pleased to hear that. That's  
10 great.

11 DR. MADRID: We got Probation involved. We  
12 have a lot of people flowing into our agency.

13 MR. CURIE: Texas has a drug-court focus.

14 DR. MADRID: A drug-court focus, yes. In El  
15 Paso, we have seven drug courts. Five of them are very  
16 strong with us insofar as ATR. The other two are rolling  
17 in. So we are beginning to see a lot of activity, and as  
18 a provider, I like that.

19 I wanted to say also, insofar as the systems  
20 that Melody was talking about, I had the pleasure of  
21 speaking before 70 faith-based providers in San Antonio  
22 last week. I think it was a SAMHSA-sponsored activity.

1 We were training them on very simple things: how to  
2 develop your board, how to participate with ATR. They  
3 were really gung-ho about it. I wanted to compliment  
4 SAMHSA on that training because it was a grass roots  
5 thing, teaching grass roots people how to play with us,  
6 how to become one more pathway to this whole recovery  
7 process.

8 I saw a lot of growth in two or three days  
9 there, and I think we need to do a lot more of that.

10 MR. CURIE: Thank you. That is music to my  
11 ears. Thank you so much. I'm pleased to hear that.

12 Melody.

13 MS. HEAPS: I don't know if you can answer this  
14 question. If it would be helpful, if it would not  
15 complicate things, would it be helpful for perhaps, if  
16 the council wanted to, to develop some letter or  
17 resolution that supported SAMHSA/CSAT's efforts in ATR  
18 and how it recognizes the difficulties of transition and  
19 systems development. Some of us would be very happy to  
20 encourage that.

21 MR. CURIE: I think the way you framed it, if  
22 this is a genuine feeling you all have and you want to go

1 on record in light of how you see systems change  
2 occurring and that you as an advisory council are viewing  
3 the progress of ATR in such a way that you want to  
4 recognize the efforts, I think that is within the purview  
5 of the council.

6 MS. BERTRAND: I just want to add that I had  
7 the opportunity to participate in the Recovery Summit.  
8 You won't be here later when we discuss that, but the  
9 consensus from that group was the same thing that you are  
10 talking about. The element of recovery we talked about  
11 is using the principles of recovery throughout the fabric  
12 of this organization. There were 100 of us that came  
13 together twice this past year in '05, and that that is  
14 something that is really supported at the grass-roots  
15 level.

16 You are right, Melody, about faith-based  
17 organizations. I think people often think that they are  
18 churches. We have a faith-based organization, and we are  
19 not a church, but we offer the alternative to individuals  
20 that want to go to churches and may have experienced that  
21 early in their lives before they acquired their addiction  
22 or whatever. And we were able to receive a certification

1 from our state to provide treatment.

2 MR. CURIE: Wonderful.

3 MS. BERTRAND: So I think it is very valuable,  
4 all these things that we are talking about. I think that  
5 this administration has done a wonderful job of keeping  
6 the community-based level in the ball game in terms of  
7 providing and being a viable service provider and that  
8 individuals that go to the treatment programs that have  
9 been around traditionally for a long time, we keep them  
10 in treatment, but it is in the community when we are  
11 bridging that gap back into the community that we see the  
12 slug.

13 I think that the outcomes can be helped by  
14 utilizing volunteers. Dave is not here, but I know he is  
15 a big advocate for that. But volunteers can provide  
16 services economically, and they enjoy doing it.

17 MR. CURIE: Anita, thank you so much. I  
18 appreciate that. I know, Val, you have been trying to  
19 say something.

20 MS. JACKSON: Although I think that what Anita  
21 says is very good, the collaboration of community and  
22 community-based services can work with ATR. It is a

1 systemic development that takes time.

2 In looking at that, I want to go back to Ken's  
3 comments on the Block Grant. As a provider and as a  
4 provider who has -- I avoid giving my age -- been around  
5 since we had the Block Grant and had it implemented, I  
6 remember all of the shaking and fear that went along with  
7 the implementation of block grants for substance abuse  
8 and mental health.

9 Over those years, like you said, they wanted it  
10 flexible, so they didn't put too many "Here's what you  
11 have to do"s on it. At the same time, I think that  
12 accountability is very important.

13 I will say, as a community-based provider, as a  
14 person who is the chair of a managing entity that  
15 oversees 25 contracts, all of which have Block Grant  
16 funds in them, that it is the base and the blood of what  
17 we do. If I can be of any assistance in helping to work  
18 out the measures. I know you are working very hard on  
19 them.

20 I certainly would hate to see the Block Grant  
21 somehow be chopped up or changed to a point where we  
22 cannot provide the professional services that we have

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1 worked so hard to do, the work that SAMHSA has done to  
2 professionalize this system. I believe most of that has  
3 been done through the Block Grant. It is enormous,  
4 enormous.

5           Actually, I have two other points. One last  
6 one on that is to please keep the discretionary funds as  
7 a portion of the Block Grant. I have not done any  
8 studies on this since it is not my job to do studies,  
9 though I have asked a few questions here and there.  
10 People have told me if I ask the right people I will get  
11 the right answers. It appears sometimes that there is a  
12 leaning toward providing -- what should we say --  
13 infrastructure money to states. I will just say as a  
14 provider I don't feel like I'm getting a piece of that or  
15 impact from that, not like getting dollars but like  
16 getting impact.

17           So maybe it is just that I'm not feeling it and  
18 others are. I will only say this as a provider and  
19 something to look at. Discretionary funds, as Melody  
20 just said, we had this certain period of time to develop  
21 concepts that then became, in many cases, really sound  
22 approaches that have impacted this entire system.

1 One last comment?

2 MR. CURIE: Sure, Val. Go ahead.

3 MS. JACKSON: I'm sorry. I don't want to be so  
4 long.

5 I won't even talk about what happened with  
6 Katrina because I was in Wilma, which has no comparison  
7 to Katrina. My heart goes out to all of those folks who  
8 are impacted by Katrina.

9 But the morning after Wilma decided to die down  
10 in Miami, I couldn't walk outside of my house, and I had  
11 70-foot trees that fell down, and I'm in a fortunate  
12 position where I could call up and pay for services to be  
13 done. Prior to that, when Katrina happened, we had, at  
14 Westcare, something like 25 people who wanted to go and  
15 work in the Gulf Coast. We called SAMHSA because we felt  
16 that that was the approach we should take. We had had  
17 Emails from you.

18 MR. CURIE: Sure.

19 MS. JACKSON: So this is for your information.

20 People were working around the clock, I know, and I  
21 applaud you for that. So please take this in the spirit  
22 that it is given. I'm sure everybody was just working so

1 hard.

2 One of the things that turned out was that  
3 obviously you wanted licensed people, and I understand  
4 the need for licensed people, and that appeared to be the  
5 emphasis of what you were asking for. We had a number of  
6 people who were counselors. However, for instance, in  
7 the State of California, they are certified, they are not  
8 licensed.

9 Therefore, they were out before they were ever  
10 in, and yet they were very happy to give time, and we  
11 wanted to work with you because we felt that that was the  
12 best way for us to do it and not just go show up  
13 someplace and say, "Hi, I'm here." That would cause more  
14 confusion than it is worth.

15 Perhaps a look at, if you have a disaster, how  
16 can those people who may not be the Ph.D.s licensed in  
17 these marriage and family therapies but the people who  
18 have a number of skills, be included in the relief  
19 effort. I think there were a lot of them out there. I  
20 mean, I mentioned 20 in our agency alone, and that was  
21 without really going out and asking.

22 MR. CURIE: Surveying.

1 MS. JACKSON: Yes.

2 MR. CURIE: Well, I think you bring up a very  
3 valid point, which we are actually examining. That was a  
4 major challenge with the SAMHSA Emergency Response  
5 Center. We were wanting to, of course, include anyone  
6 who was coming forward who had qualifications and  
7 experience in the effort.

8 Several things we found complicated that, and  
9 that is why you were probably hearing that message. One,  
10 we were working with each state, and there were states  
11 that weren't allowing folks in unless they were licensed,  
12 so we wanted to be respectful of that. So part of, I  
13 think, the task in terms of the debriefing around Katrina  
14 is working with states to talk about, "Here are some  
15 unintentional barriers. We understand why these  
16 standards are in place, but let's talk about the fact  
17 that we did have a number of people coming forward to  
18 volunteer that we weren't able to deploy or it didn't  
19 look like there was a place for them, and yet it was  
20 capacity that was needed at the time."

21 Also, we were running a lot of interference, I  
22 know, in Texas with the shelters there, as well as the

1 shelters in other states. The Red Cross was running many  
2 of those shelters. They had their licensing rules, and I  
3 know we were running a lot of, if you will, interference.

4 I was talking even to the headquarters here in D.C. at  
5 the National Red Cross.

6 We were able to get some flexibility and  
7 latitude. I think one major lesson learned from this  
8 unprecedented, horrendous, catastrophic event is a lot of  
9 the disaster response approaches and regulations and  
10 rules that are in place around shelters work well if it  
11 is going to be a temporary shelter for a week or two or  
12 for a few days, but this was not the case. We needed to  
13 begin making a community right away for folks in the  
14 longer term.

15 So I think there are going to be many lessons  
16 learned in that process, but one was clearly that there  
17 were qualified people coming to the door of the shelters  
18 that weren't allowed in because they didn't meet certain  
19 criteria.

20 So I think you make a very valid point. It is  
21 clearly something that we are going to examine as we move  
22 ahead. I thank you for that concrete example because it

1 drives it home.

2 One more. Melody?

3 MS. HEAPS: Actually, I want to make a motion,  
4 if that may be in order, Dr. Clark?

5 MR. CURIE: I will let you guys handle that.

6 DR. CLARK: Thank you, Mr. Curie.

7 [Applause.]

8 DR. CLARK: Mr. Curie's bio, as well as the bio  
9 of each of the presenters, is in the bio document on the  
10 handout table. I invite you to pick up a copy of that  
11 document.

12 You wanted to entertain a motion?

13 MS. HEAPS: Yes, sir. I would like to make a  
14 motion to express our appreciation and support for the  
15 goals of ATR, including the manner and method by which  
16 SAMHSA/CSAT has been assisting states in transforming  
17 their systems so that recovery support, including faith-  
18 based organizations, can be integrated into our substance  
19 abuse system of care.

20 [Secoded.]

21 DR. CLARK: Any discussion?

22 MR. DeCERCHIO: Are we translating that into a

1 letter of support? Was that part of the motion?

2 MS. HEAPS: We certainly can. I would  
3 recommend that it be a letter of support including that  
4 language, I suppose. I don't know the technicalities  
5 here, but yes.

6 DR. CLARK: To whom would you send this letter?

7 MS. HEAPS: I'm sorry?

8 DR. CLARK: This motion, to whom would you send  
9 it?

10 MS. HEAPS: To the director of SAMHSA, copying  
11 the director of CSAT.

12 DR. CLARK: All right. I'm sure the  
13 Administrator would appreciate that. Any further  
14 discussion?

15 MS. HEAPS: Unless there is someone else we  
16 should be sending it to.

17 MR. DeCERCHIO: I don't know the protocol, but  
18 we could consider sending it to the Secretary.

19 MS. HEAPS: I think that is an excellent idea,  
20 actually. Yes, I would recommend that it be sent to the  
21 Secretary.

22 DR. CLARK: Any other discussion?

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1 MS. JACKSON: With a copy to the SAMHSA  
2 director and the director of CSAT.

3 MS. HEAPS: Yes.

4 DR. McCORRY: Are we voting on developing a  
5 letter? Are we voting on language to be incorporated  
6 into a letter that we will see? What is this process, so  
7 that I can understand a little better.

8 MS. HEAPS: As we are evolving this motion, I  
9 believe we are voting on language which would be included  
10 in a letter to the director of HHS and presumably we will  
11 be able to get that letter done by tomorrow so that we  
12 can all look at it and be secure by it. Unless some of  
13 you would give, for instance, Ken and I leave to develop  
14 the letter along these lines.

15 DR. McCORRY: Because, Melody, I was wondering  
16 what manner and method. I wasn't sure what you were  
17 trying to say there. I just didn't understand it. I  
18 think the letter is a great idea, but I just wanted to  
19 know what we were --

20 MS. HEAPS: That SAMHSA is doing it right. So  
21 if you have different language, I would be happy to --

22 DR. McCORRY: The draft, I thought, was a good

1 idea, and then circulate it. So the resolution is to  
2 draft a letter for the council to approve to send to the  
3 Secretary and appropriate copies using language such as  
4 suggested.

5 MS. HEAPS: I accept that friendly amendment or  
6 friendly revision of the motion, yes.

7 DR. CLARK: Okay. We need a restatement of the  
8 motion.

9 MS. HEAPS: I move that we draft a letter of  
10 support for SAMHSA with regard to ATR and the way it has  
11 been administering the program to be sent to the  
12 administrator of HHS, and that we include language such  
13 as I iterated before in that letter, to be circulated  
14 before it is finally sent to the board.

15 [Secoded.]

16 DR. CLARK: Any further discussion?

17 [No response.]

18 DR. CLARK: It has been moved and seconded that  
19 we do as Melody spelled out. All those in favor?

20 [Chorus of ayes.]

21 DR. CLARK: All those opposed?

22 [No response.]

1 DR. CLARK: The motion is carried.

2 [Motion carried.]

3 DR. CLARK: I assume, then, that you two would  
4 draft this for tomorrow. Thank you very much.

5 We can take a five-minute break, and then we  
6 need to move on.

7 [Break.]

8 DR. CLARK: Sorry that we are a little delayed,  
9 but I think the opportunity to talk to the Administrator  
10 for as much as we got is such an opportunity it was just  
11 too good to pass up. I really appreciate the questions  
12 asked and the issues.

13 Although we have not had a face-to-face meeting  
14 since our last meeting in May, we have been quite busy at  
15 CSAT. Our presenters today will discuss some of the  
16 initiatives we have been working on.

17 Cathy Nugent, the project officer for CSAT's  
18 Addiction Technology Transfer Program, will give us an  
19 update on the Recovery Summit. Cathy also worked on the  
20 RCSP Program and has shifted, but her heart remains in  
21 recovery activity, in addition to our ATTCs.

22 After we hear from Cathy, Donna Cotter,

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1 coordinator for CSAT's Partners for Recovery, will bring  
2 you up to date on some of the activities that PFR have  
3 been involved in.

4 Cathy.

5 **Recovery Summit**

6 **Cathy Nugent, M.S.**

7 [PowerPoint presentation.]

8 MS. NUGENT: I'm delighted to have the  
9 opportunity this morning to talk with you about CSAT's  
10 National Recovery Summit. Clearly, our conversation this  
11 morning has demonstrated the centrality of recovery to  
12 everything that we do at SAMHSA and at CSAT, and it was  
13 just in keeping with that emphasis that CSAT convened a  
14 National Summit on Recovery September 28th and 29th.

15 The effort was led and staffed within CSAT as a  
16 collaborative initiative with the Partners for Recovery  
17 and the Recovery Community Services Program and the  
18 Office of Policy. There was a CSAT workgroup where every  
19 division and office in CSAT was represented in helping to  
20 plan the summit, as well as representatives from the  
21 Office of the Administrator of CMHS.

22 I particularly want to acknowledge Dr. Clark

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1 and Mr. Gilbert for their leadership and guidance on this  
2 effort, and to thank my colleague, Donna Cotter, with the  
3 Partners for Recovery, who really was a co-creator and  
4 collaborator with this effort.

5           The purpose of the summit was to help shape a  
6 vision of what a recovery-oriented system of care could  
7 look like from the point of view of different important  
8 stakeholders in the field. Obviously, this purpose fits  
9 with our mission to promote resiliency and facilitate  
10 recovery. We wanted to capitalize on the energy and  
11 momentum in the field around the notion of recovery and  
12 let the summit serve as a focal point for galvanizing  
13 that energy so that CSAT could move forward with the  
14 recovery-oriented system of care and also that our  
15 partners out in the field could do the same.

16           So, specific goals of the summit were to  
17 develop new ideas that would help transform policies,  
18 services, and systems toward a recovery-oriented  
19 paradigm, and the idea here is, as we all know, recovery  
20 is a larger construct and treatment is a very important  
21 part of recovery. But when we talk about recovery, we  
22 really mean the larger set of activities that help people

1 sustain their recovery for the long haul and have a  
2 meaningful life in the community.

3           We wanted, at the summit, to articulate  
4 principles and measures of recovery that could be used  
5 across programs and services to promote and capture  
6 improvements in services and systems and to promote data-  
7 sharing and enhanced program collaboration and  
8 coordination. We wanted to generate ideas for advancing  
9 a recovery-oriented system of care in a variety of  
10 systems and for specific populations such as criminal  
11 justice, faith-based, peer-based, women's services,  
12 different racial and ethnic groups, medication-assisted  
13 treatment. So we were really looking at how would these  
14 principles play out across a broad range.

15           We accomplished this through a process of three  
16 separate meetings. The first was a Planning Group  
17 meeting which was held in June of 2005. We had  
18 approximately 20 stakeholders, and they met to give us  
19 input on the summit agenda to help us really look at what  
20 were the key issues that needed to be addressed and how  
21 could we best shape a process that would help us  
22 accomplish our goals.

1 I want to acknowledge Ms. Anita Bertrand and  
2 Dr. Chilo Madrid, who were members of that Planning Group  
3 and who were active participants at the summit. We  
4 really do appreciate their help as council members in the  
5 process.

6 The Planning Group members included recovery  
7 community leaders, family members, states, treatment and  
8 recovery support services providers, researchers, and  
9 others.

10 The second step in our process was the actual  
11 summit that was held as part of this year's Recovery  
12 Month observation on 28 and 29 September. We convened  
13 approximately 100 representatives of the treatment and  
14 recovery field in its full diversity for a series of  
15 conversations in small breakout groups to look at what  
16 does recovery mean and how do we operationalize it.

17 Then, finally, after the summit, we brought  
18 back the members of the original Planning Group that had  
19 met with us in June for a follow-up synthesis meeting,  
20 and at that time we worked with them on reviewing the  
21 findings of the discussions at the summit, validating  
22 them and synthesizing them, and helping us articulate

1 next steps.

2           The accomplishments through this process have  
3 been the following. Through the process of the planning  
4 meeting, the summit, and the follow-up meeting, we have  
5 identified 13 broad, overarching principles of recovery  
6 that relate to individuals in or seeking or needing  
7 recovery, and we have identified 17 elements that help us  
8 answer what are the key dimensions of a recovery-oriented  
9 system of care. So we have principles at the individual  
10 level and elements at the systems level that we have  
11 identified through the summit process.

12           We also, through the summit, were able to  
13 articulate recommendations for how we would advance a  
14 recovery-oriented system of care and the recommendations  
15 were for CSAT to move forward, as well as recommendations  
16 for six sectors in the field: systems professionals,  
17 researchers, treatment providers, recovery service  
18 providers, advocates, and mutual aid groups.

19           Basically, at the summit, we looked at what  
20 each sector is currently doing to help this movement  
21 toward a recovery-oriented system of care and what else  
22 they could be doing and some specific strategies they

1 could undertake.

2           The primary recommendations for CSAT included  
3 the following. The first was to look at what we already  
4 have within CSAT in terms of products, programs,  
5 activities, and services that are recovery-oriented, so  
6 that we can build on that foundation. It was also  
7 recommended that CSAT take the lead with our partners at  
8 NIDA, NIAAA, NIMH, and CMHS to convene a research summit  
9 to really look at how researchers deal with the issue of  
10 recovery, how they operationalize it, and to look at  
11 performance measures on recovery.

12           Another recommendation was for CSAT to outreach  
13 vigorously to our partners, national organizations, and  
14 through our ATTC network to share materials and training  
15 and to become a vigorous force in helping to develop  
16 networks that could promote the idea of recovery.

17           Another recommendation was that CSAT convene  
18 regional meetings. We had 100 very diverse  
19 representatives at the summit, but we want to reach out  
20 more broadly and more deeply into grass-roots communities  
21 and into states. So there was a recommendation that we  
22 have a series of meetings to further our agenda and the

1 agenda that the field gave us at the summit.

2 CSAT was encouraged to provide education and  
3 technical assistance on recovery-oriented approaches. We  
4 were asked to facilitate a discussion of the ethical  
5 framework for peer recovery support services. The idea  
6 here was that when you are working with peers who are not  
7 professionals, you can't just import codes of ethics or  
8 ethical standards that work in professional settings  
9 because there are some unique challenges in peer-to-peer  
10 settings.

11 CSAT has experience and history through our  
12 Recovery Community Services Program, so we want to take  
13 the lessons learned there and help elevate them and  
14 disseminate them, perhaps in the form of a technical  
15 assistance guide and in other ways.

16 CSAT was asked to take the leadership in  
17 promoting and encouraging the development of financing  
18 models that move systems from a sole focus on acute care  
19 to the longer-term recovery kinds of services and systems  
20 that are needed. We were encouraged to continue to  
21 ensure that voices of recovery, and a full range of  
22 voices of recovery, are reflected in our initiatives and

1 in the process of moving the summit agenda forward.

2           So the summit deliberations are informing an  
3 action plan that CSAT will use to infuse recovery  
4 principles and measures into our policies, programs, and  
5 services. This part of the initiative, which really  
6 carries us forward into the future, is going to be  
7 carried out under the auspices of the Partners for  
8 Recovery Initiative.

9           The immediate next step that we envision is to  
10 have a series of five regional meetings, which will  
11 probably be held over the next 12 to 18 months, where we  
12 will vet the principles of recovery and the elements of a  
13 recovery-oriented system of care more widely, elicit  
14 refinements to those principles and elements, and work  
15 with the recommendations that were provided for different  
16 sectors that I mentioned earlier so that we can work with  
17 the field to develop strategies for implementation of  
18 those sector recommendations at the community and state  
19 levels.

20           An additional progress piece came from our  
21 Synthesis Group that met in December. This was the group  
22 that was charged with helping us synthesize the findings

1 from the Recovery Summit. That group helped us develop a  
2 working definition of recovery that we now need to vet  
3 widely with the field. This early definition says that  
4 recovery from alcohol and drug problems is "a process of  
5 change through which an individual achieves abstinence  
6 and improved health, wellness, and quality of life."

7 Finally, I want to mention that we are in the  
8 process of developing a report from the summit which we  
9 want to share with the field. That, I think, will be a  
10 very significant contribution to help keep the dialogue  
11 going and move us forward to shaping systems that really  
12 meet the full needs of people beyond acute treatment into  
13 the long haul of recovery and how people can meaningfully  
14 reengage with the community.

15 So as a final piece, I would like to ask if Ms.  
16 Bertrand or Dr. Madrid would care to share any  
17 impressions that you had as members on the Planning  
18 Group, or at the summit itself.

19 MS. BERTRAND: Thank you, Cathy. That was a  
20 good presentation of the consensus of what the  
21 individuals at the planning meeting and the follow-up  
22 meetings really felt.

1 I guess, for me, it just was a group of diverse  
2 individuals from different backgrounds. There were  
3 people that were in recovery. There were researchers,  
4 professors from universities. I think there was a little  
5 struggle in the beginning to just try to make sense of  
6 this large charge, because recovery is such a large thing  
7 that we talk about.

8 But anyway, when it was all over, I think that  
9 individuals were at peace with the recommendations that  
10 we came up with, and there was much consensus about, I  
11 want to say, the manner in which we wanted to see this  
12 particular summit move forward.

13 One of the things I think that I heard  
14 throughout the weekends or the weekdays that we were  
15 there was that they wanted this to be something that was  
16 ongoing and not just an event that we hosted. You know  
17 how sometimes people talk about strategic plans where  
18 they end up on the shelves? Just that this become an  
19 action step to something larger.

20 MS. NUGENT: Thank you, Anita.

21 DR. MADRID: I would also like to echo what  
22 Anita just said. At the beginning, there was a lot of

1 diverse thought. A little bit of debate, but it was very  
2 healthy. I think that at the end we converged, utilizing  
3 the approach that Mr. Curie used that there are multiple  
4 pathways to recovery. I think that that was what we came  
5 up with at the end.

6 I would echo again what Anita was saying, that  
7 we wanted the conversation to continue, for us to  
8 reinforce it and go regionally, as you said. I found it  
9 a very productive meeting. I think it was long in  
10 coming. It was very needed, and I think all of us felt  
11 that way. Again, the CSAT staff did an excellent job in  
12 keeping us together at the beginning when we were  
13 struggling and then supporting us when we came together  
14 at the end. So, thanks.

15 MS. NUGENT: Good. Thank you very much.

16 I'm going to turn it over to Donna Cotter now,  
17 who is going to talk about Partners for Recovery and some  
18 of the ongoing activities there. Thanks for the  
19 opportunity to present on this.

20 [Applause.]

21 **Partners for Recovery**

22 **Donna M. Cotter, M.B.A.**

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1 MS. COTTER: I have the best job at CSAT, hands  
2 down. The reason that I do is that I get help with my  
3 job from virtually all of you.

4 I have chosen to not use the slides that I have  
5 prepared because they have a lot of good information but  
6 you got it. So you can look at those at any time.

7 When I talk about getting help from you and I  
8 look around this room, do you know that Partners and its  
9 predecessor will be going into its ninth year of  
10 operation and funding within CSAT/SAMHSA? I am told that  
11 is unprecedented, and I am very, very pleased to be  
12 allowed to assist the field in improving the delivery of  
13 substance abuse treatment and substance use disorder  
14 treatment. I look around here and I know that you all  
15 have my back. I know that Melody and Chilo are on our  
16 Steering Committee directly and have been virtually  
17 walking with us the entire way.

18 Some of you in CSAT may not realize, but people  
19 like Val Jackson have been directly related to Partners  
20 for Recovery because Val was a mentor at our leadership  
21 institutes that are jointly supported through Partners  
22 and the ATTCs.

1 Ken DeCerchio was a witness to testimony given  
2 back in '99 in Tampa, Florida. Anita Bertrand and Chilo,  
3 as you know, worked on the Recovery Summit event, and we  
4 are so grateful to them.

5 I look out there and I see Pat Taylor, and I  
6 know we have had workings through the stigma effort that  
7 is being pursued. We have given support to your  
8 conference and to conferences in New York and conferences  
9 in Florida.

10 These are the kinds of things that people don't  
11 hear about that we are doing but that it has been that  
12 critical little program that has been allowed to support  
13 many of the functions that our Steering Committee and  
14 SAMHSA have deemed to be important.

15 [PowerPoint presentation.]

16 MS. COTTER: This is our new website, and we  
17 are very, very proud of it. Dr. Clark mentioned it. You  
18 see across here the five focus areas that we currently  
19 pursue, and you may wonder how we got those focus areas.

20 Well, it was a combination of looking at SAMHSA's  
21 Matrix, designated by our administrator, and determining  
22 which of those we viewed as significant and critical for

1 continued pursuit. That was the decision of the Steering  
2 Committee.

3 So I hope you have all been to it, but if you  
4 haven't, let me just show you a few things so that you  
5 feel a little more comfortable.

6 You will hear a story about what the PFR is,  
7 its history. If you click here, you will go to its  
8 partners and you will see its Steering Committee. One  
9 thing that you need to notice is that the Steering  
10 Committee no longer has only substance use disorder  
11 treatment people on it. In fact, it is populated by  
12 mental health, prevention, and substance use disorder  
13 treatment individuals who are interested in pursuing  
14 efforts to improve the lives of people with both  
15 substance use disorder and mental illness.

16 The last time that we met was August of '04.  
17 While we don't meet very frequently -- budgets prevent  
18 that -- we do have a lot of projects going on. If you go  
19 into the focus areas, you will get information about  
20 resources that are not just PFR resources, although we  
21 are very proud to be able to showcase our resources in  
22 one location because over the years many people have

1 contributed to them.

2 I know that Melody Heaps' staff has worked very  
3 hard in assisting us in developing this website,  
4 particularly Daphne Bell, and Daphne has contributed a  
5 document here under "Leadership." Well, I can't find it  
6 right away and I don't want to cause you delay in looking  
7 for it. But I want you to know that there are areas in  
8 particular, such as state activities, where we are going  
9 to turn the tables around and ask you to help us populate  
10 this.

11 This is a locus for the five areas that  
12 Partners currently focuses on, and we would very much  
13 encourage you, if you have good ideas at the state level,  
14 to contact me so that we can get them on the website so  
15 that we can share them with all of you.

16 There are significant numbers of links both  
17 from a national perspective and a federal perspective.  
18 This could get unwieldy, so we have some parameters. We  
19 try to keep it to national organizations to which we  
20 link, but we are offering any of you to take ours and  
21 connect our site with yours. We would be very, very  
22 happy if you would do so.

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1           There is an area where you can go into the  
2 latest news. As you can see, we have information here  
3 not just about substance use disorder treatment but about  
4 prevention, about the CADCA conference and the leadership  
5 academy. We welcome from our partners within SAMHSA  
6 information that we can add to the Partners for Recovery  
7 website.

8           I hope you use it a lot. See how happy the  
9 people are there who did use it?

10           [Laughter.]

11           MS. COTTER: You see your friends there? That  
12 actually occurred. That was a picture we took at the  
13 Collaboration Forum that Melody Heaps and her staff  
14 managed for us. We are all in it together.

15           I would like to mention a few things to you to  
16 bring you up to date on what is happening. Yesterday we  
17 were asked to do an administrative exercise of figuring  
18 out how many meetings and conferences that we were going  
19 to support in 2006. When Partners started to add them  
20 up, we will conceivably be doing 22 events around the  
21 country.

22           Some of those will be the combination of SAAS,

1 the National Conference on State Legislators, and TRI.

2 It is our great pleasure that a joint effort among those  
3 three groups is resulting in Tom McClellan and his staff  
4 going around the country with PFR funding to speak  
5 directly to state legislators and to engage them in  
6 understanding the performance measures in addiction  
7 treatment so that people start to understand and don't  
8 blame people who suffer from substance use disorders when  
9 they relapse, so that they can understand how we measure  
10 what we do and the fact that we do have our successes.

11 In 2006, he and his staff will be meeting in  
12 Boston with the legislature; Denver in March; Concord,  
13 New Hampshire, in April; Nashville in August; Cheyenne,  
14 Wyoming, Tallahassee, Florida, and Oklahoma City in  
15 spring to late fall. That is the very latest that I  
16 have, so it is a little bit more current than what you  
17 will see on the slides if you rely on the slides. Very,  
18 very pleased about that.

19 Then, of course, you know we have the "Know  
20 Your Rights" brochure, which was developed initially  
21 through Yvette Torres' shop and then Partners joined to  
22 be able to give training around the country.

1           Training has occurred in four states. Well, it  
2 is two states but twice in those two states because it  
3 was so popular. We tried to figure out a way that we  
4 could take it to all 50 states.

5           So what we are doing is we are going to go out  
6 with regional training. Can you believe it; this booklet  
7 we printed 75,000 copies of. Now, that would be in  
8 comparison to 30,000 copies of the National Treatment  
9 plan when we came out with it a few years back. In one  
10 year, all 75,000 copies are gone. They are in the hands  
11 of hungry, hungry people.

12           So we are rushing to get it reprinted so that  
13 we can do the "Know Your Rights" regional training around  
14 the country. What you are going to see are nodes of  
15 training. For instance, there will be eight sessions,  
16 and in those locations we will allow as many people as  
17 want to come to those trainings, but we will be  
18 supporting the travel of people from surrounding states.

19           For example, in Atlanta, Georgia, there will be  
20 a training, and the states that will be invited -- and  
21 PFR will pay to bring as many as three people -- will be  
22 Florida, South Carolina, North Carolina, Atlanta, and

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1 Tennessee. We are going to repeat this so that at least  
2 we can touch every state in the country.

3 Now, I know three people isn't many, but what  
4 we are looking for is interested people who can be  
5 trained to carry the message. So this is a train-the-  
6 trainers type thing.

7 Let me read them to you. There will be a  
8 session in Boston in March, with the surrounding states  
9 invited. There will be one in April in Baltimore. May,  
10 Atlanta. Chicago will be also in May. In June, San  
11 Francisco; July, Minneapolis; August, Denver; and  
12 September, Dallas/Fort Worth.

13 If you are in a state that is not the host  
14 state, or in either case, we would really ask for you to  
15 identify attorneys because the Legal Action Center simply  
16 can't do this much training on "Know Your Rights." But  
17 it is so valuable and the people are starving for it. So  
18 we would ask you to identify attorneys that you may want  
19 to attend this training and let us know so that we can  
20 make sure they get invited.

21 PARTICIPANT: [Off mic.]

22 MS. COTTER: Yes. In the host states I would

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1 strongly encourage people in recovery to attend. We will  
2 open the doors.

3 Yes, Melody?

4 MS. HEAPS: Will you be asking, for instance,  
5 the provider associations as a member of a team? Is that  
6 the kind of training you are talking about?

7 MS. COTTER: Yes, yes.

8 MS. HEAPS: It would seem to me that would be a  
9 critical component of the states if they had one.

10 MS. COTTER: Right, and the Recovery Support  
11 Services Program. An attorney, the provider association,  
12 the state. We would like them to come from the  
13 surrounding states.

14 If the states are close enough and people  
15 really want to make it, the doors will be open for them.

16 There is no prohibiting this. We wish we had the money  
17 to do this in every state. As a matter of fact, in New  
18 York we literally had to do a second training within two  
19 weeks because we had to turn people away at the door.  
20 There was no room in the building to hold all these  
21 people. They are hungry for this information, and we are  
22 glad to be able to give it to them.

1           There will be some technical assistance offered  
2 beyond that actual day of training to the states by the  
3 Legal Action Center that have not had the direct training  
4 occur in their organizations. So we are trying to give  
5 some backup there.

6           I want to very briefly, before I take  
7 questions, thank all of my partners at CSAT, particularly  
8 my contractors, who worked literally day and night. The  
9 logistics contractor who supports you in your advisory  
10 meetings is also the PFR logistics contractor, Apt  
11 Associates. Melody Witt and Peter Gomand [ph] are right  
12 here. If you have any questions, they have done some  
13 tremendous work over the past year on a workforce  
14 document and they have been supporting the leadership  
15 institutes around the country. There is just so much  
16 that Partners is able to do, and as I said, I have the  
17 best job in CSAT.

18           So, thank you. I will take any questions you  
19 have.

20           [No response.]

21           MS. COTTER: Good. Take care.

22           [Applause.]

1 DR. CLARK: I want to thank Cathy Nugent and  
2 Donna Cotter for their presentations. I want to thank  
3 Donna Cotter for feeling she has the best job in CSAT.  
4 It is nice to know that we have such jobs.

5 [Laughter.]

6 DR. CLARK: I will entertain some questions  
7 regarding the Recovery Summit and PFR.

8 [No response.]

9 DR. CLARK: No questions. Both of these are  
10 very important activities, and so I want to commend the  
11 staff for their investment and the support council has  
12 given both of these activities. They would not be as  
13 dynamic without your contribution, your input, and your  
14 opinions.

15 Since we are running a little late, I want to  
16 raise the issue of public comments, as that is a critical  
17 part of these meetings under FACA.

18 So, do we have any members of the public who  
19 wish to make comments? If so, go to the standing mic.  
20 Going once? Going twice?

21 [No response.]

22 DR. CLARK: No members of the public want to

1 make comments, and so I think that satisfies the  
2 requirements of our FACA. That is, making sure these are  
3 open meetings and the public is aware of that.

4           What you have received is a little "save the  
5 day" card regarding "The Road Home: The National  
6 Conference on Returning Veterans' and Their Families'  
7 Behavioral Health." On March 16th and 18th, SAMHSA is  
8 going to have this meeting, and it is in partnership with  
9 the Therapeutic Communities of America. It will address  
10 a range of issues dealing with the issue of returning  
11 veterans.

12           As we know, Department of Defense and the VA,  
13 Dr. Suchinsky's parent organization, have the principal  
14 obligation for addressing the needs of returning soldiers  
15 and returning vets. Nevertheless, community-based  
16 organizations, states, and others can play a role in  
17 addressing those needs.

18           There are people who initially do not present  
19 to the VA or people who choose not to use the services of  
20 Department of Defense even though they are eligible for  
21 those services and therefore may present at community-  
22 based organizations or state-financed institutions.

1 There are, of course, family members who are affected by  
2 the military experience, and they may choose to use  
3 community resources.

4           So for those two days, there will be a fairly  
5 extensive discussion. Speakers from the National Guard,  
6 Department of Defense in general, the VA, and others will  
7 be present to share information, in concert with speakers  
8 from private provider organizations, from peer groups,  
9 from veterans. As we educate individuals and get  
10 educated about the role that community-based  
11 organizations can play and state-financed, or civilian-  
12 financed if you will, entities can play in addressing the  
13 needs of returning veterans.

14           Again, I want to stress that DOD and the VA  
15 have the principal responsibility. When you go to their  
16 websites, they are making it clear that they are  
17 addressing those issues. But as in any kind of system,  
18 there are cracks. People fall through the cracks. I  
19 think the non-military, non-VA system can be poised to  
20 assist as junior partners in this larger effort to deal  
21 with the needs of returning veterans.

22           So, more will be pending on this, but I wanted

1 to give you a heads-up on that meeting. We have Cathy  
2 Nugent, Charlene LeFauve [ph], and Stella Jones, who have  
3 been working on that effort. As we get more information  
4 regarding the specific agenda, that will be posted on the  
5 website. Within the next week or so?

6 PARTICIPANT: Next few days.

7 DR. CLARK: The next few days. So, if in your  
8 community you provide services to a veteran population or  
9 the families of a veteran population, you might be  
10 interested in participating in this conference.

11 Well, we have had a full morning, and I'm sure  
12 you are anxious to get out and stretch your legs. Since  
13 we have no further comments, we are going to break for  
14 lunch.

15 Val?

16 MS. JACKSON: Is it appropriate to go back and  
17 make a comment about something that was said earlier this  
18 morning? Okay. Thank you.

19 DR. CLARK: Yes, it's your council.

20 MS. JACKSON: Well, when Mr. Curie was  
21 presenting, of course he mentioned "The Matrix  
22 Restructured," or whatever it was, and he mentioned

1 workforce development. This council has had a lot to say  
2 on workforce development, and we certainly have a high  
3 interest in it. We were talking about other things and  
4 didn't really get to that.

5 I'm sure that it has been conveyed to him  
6 through you and through other folks who have talked to  
7 him, but I just wanted to emphasize the importance of the  
8 workforce development movement. Many of us have a  
9 critical interest in that. So I certainly would be one  
10 to want to endorse including it as a part of the Matrix.

11 Also, perhaps we can get some more information  
12 on exactly what that entails and how you are going to go  
13 about that.

14 DR. CLARK: Of course. The key issue is that  
15 it is a critical element. You are correct; not all of  
16 these are applicable to the larger SAMHSA, but CSAT has  
17 been actively involved in workforce development issues  
18 for a number of years. We would want council members to  
19 continue to play a role in addressing it. We have  
20 several state officials here. We have representatives  
21 from the recovery community. We have providers  
22 represented on the council.

1           So any effort on workforce development has to  
2 take into consideration those realities: state officials  
3 in terms of certification, licensing, reimbursement, et  
4 cetera; what is it that we need in terms of providers;  
5 what kind of services we can use.

6           We are working with the Annapolis Coalition as  
7 the largest SAMHSA construct, but we don't want to  
8 diminish the activity that you have been pursuing to date  
9 or that we have been pursuing as a group to date. So  
10 certainly, we want to make sure that that continues.

11           We are also preparing a response to a report to  
12 Congress based on some of the activity that we have  
13 pursued within SAMHSA. So we will be continuing to work  
14 on that.

15           Frank?

16           DR. MCCORRY: I'm glad you brought that up,  
17 Valera, because I thought we kind of gave short shrift to  
18 workforce development when Charlie was here.

19           Another point related to that that I just  
20 wanted to bring up is that workforce development, I  
21 think, might be a part of it. There is another side to  
22 that coin that I think is important, and that is this

1 treatment model that we have, which I think actually has  
2 evolved over the past 20 or 30 years. It is a very  
3 different treatment model.

4 If you look at what NIDA has put out as the  
5 principles of treatment and what I call the "NIDA oval,"  
6 which looks like kind of like a Ford logo, in effect  
7 providers are trying to provide these kinds of services  
8 that include wraparound services, case management,  
9 clinical supervision, medication management.

10 This is the reality of the treatment model.  
11 Yet I think somehow the issues in workforce development  
12 are reflective of the complexity of delivering care to  
13 this population. I would like to see us focus, not just  
14 this group but the field, more on that model. That model  
15 might need an update in a basic, fundamental way to say,  
16 "This is what we do today." It is not a 1970s group and  
17 into 12-Step and thank you very much. It is a much more  
18 complex service pattern, which calls for a much more  
19 complex set of skills, which probably requires a much  
20 more complex set of resources.

21 DR. CLARK: Since we have a bus to catch, we  
22 need to adjourn. We can resume this discussion when we

1 return from lunch. So, why don't we do that. Thank you.

2 I'm not trying to cut you off, Melody, but we  
3 need to catch the bus.

4 [Lunch recess taken at 12:10 p.m.]

## 1 AFTERNOON SESSION

2 [Reconvened 1:50 p.m.]

3 DR. CLARK: We are going to reconvene our  
4 council meeting. Because we are a little behind what we  
5 are going to do is reverse our next two speakers. We are  
6 going to go to the National Health Information  
7 Infrastructure first and then we are going to do Campus  
8 Screening and Brief Intervention.

9 We have invited Dr. John Carnevale, an  
10 internationally recognized expert in the field of drug  
11 policy, to discuss the National Health Information  
12 Infrastructure. He is the chair of the Behavioral Health  
13 Treatment Standards Workgroup. The BHTS Workgroup is a  
14 broad behavioral health stakeholder workgroup  
15 representing the public and private sectors in substance  
16 abuse treatment and prevention and mental health. It  
17 seeks to influence national standards-setting  
18 organizations and policy bodies as they craft the  
19 foundation and electronic architecture of the Nationwide  
20 Health Information Infrastructure Initiative that is now  
21 underway.

22 He was selected for this workgroup because of

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1 his broad understanding of health industry and the  
2 federal government. He has consulted with SAMHSA  
3 leadership on data strategy. He is a key player in the  
4 national policy issues, and he of course has some  
5 political savvy. Sometimes.

6 [Laughter.]

7 DR. CLARK: He has worked to gain consensus on  
8 a wide number of issues involving stakeholders, both  
9 public and private, and the number of contexts of service  
10 delivery to forge a common agenda to sustain the  
11 behavioral health treatment field, a new world order of  
12 electronic health records, and nationwide standards for  
13 the transmission of clinical health care information.

14 He has served three administrations and four  
15 drug czars within the executive branch of the U.S.  
16 government at the White House Office of National Drug  
17 Control Policy. He directed the formulation of the  
18 President's National Drug Control Policy, as well as the  
19 federal drug control budget. He is recognized as a key  
20 architect of the performance measures of the  
21 effectiveness system that ONDCP used to determine  
22 progress toward national goals and objectives.

1 He is also credited with directing policy  
2 research that shifted the primary focus of the nation's  
3 drug control strategy from supply to demand reduction.  
4 In the Bush-Cheney transition, Dr. Carnevale was  
5 responsible for leading ONDCP activities.

6 John.

7 [Applause.]

8 **Nationwide Health Information Infrastructure**

9 **John Carnevale, Ph.D.**

10 DR. CARNEVALE: Thank you, Dr. Clark, for that  
11 excessive introduction. This is when I'm not being very  
12 good at being political, by saying that.

13 [PowerPoint presentation.]

14 DR. CARNEVALE: I have been asked today to talk  
15 about the Behavioral Health Treatment Standard Group, but  
16 to do that, we have to actually talk about other things.

17 We are going to be talking about the National Health  
18 Information Infrastructure.

19 This has been a very interesting project that I  
20 started almost a year ago here at SAMHSA, and it has been  
21 a very complicated one to work in terms of what we have  
22 had to do, but it has been very satisfying. I think we

1 are making a lot of progress in an area that, as somebody  
2 who has been involved in public policy for an awfully  
3 long time, especially substance abuse policy and mental  
4 health policy lately, it is an important area that we  
5 must pay attention to. I see this shaping a lot of  
6 direction in terms of public policy, and you will learn  
7 more about that as we go through this discussion.

8           So the agenda today is to talk about sort of  
9 what I call this historical policy context. When I  
10 started this project, that was one area I needed to  
11 really put into perspective so we would have a better  
12 understanding of what and why we are doing certain  
13 things.

14           There is a need to talk about some basic things  
15 in behavioral health, background information. Then,  
16 finally, I can talk about a group I chair called the  
17 Behavioral Health Treatment Standards Workgroup and our  
18 recent activities.

19           So, to start, the policy context is really a  
20 very simple one. Most policy issues are very simple.  
21 Our solutions sometimes that emerge from are complicated,  
22 but the issues that start things off usually are very

1 basic. In this case, I think that is the case.

2           There was concern in the '90s about basically a  
3 health care crisis in America. There was a real  
4 understanding that there were serious problems with the  
5 health care industry. This is the broad health care  
6 industry, including behavioral health. I think this is a  
7 good report that came out that represents the thinking of  
8 the whole decade. The IOM released a study in 1999  
9 called "To Err Is Human," and in that study they  
10 revealed, among other things, that up to, we will say,  
11 98,000 or 100,000 people die each year due to preventable  
12 mistakes.

13           So there was a real concern about that,  
14 obviously, and there were, of course, other issues that  
15 the report raised about the health care industry or the  
16 state of the health care industry that then caught the  
17 public policy eye.

18           So the solution really was a simple one.  
19 Someone sat around -- and we will talk about how this  
20 worked -- and thought about this a while and said, "Well,  
21 you know what we need to do? We are in a new electronic  
22 age. We need to build a modern health information

1 support system, or an information electronic  
2 infrastructure that we can use to provide information in  
3 the health care industry so that we can make better  
4 decisions, informed decisions, not make mistakes, and  
5 improve the overall effectiveness of the delivery of  
6 health care services."

7           This system became known as the National Health  
8 Information Infrastructure. Our first acronym was NHII.

9 My joke when I deal with people at SAMHSA about this is,  
10 in my old days, because of drug policy I used to deal  
11 with the CIA, the Department of Defense, and the DIAs,  
12 all the things that end in As. They had so many acronyms  
13 I was really good at. I didn't realize that was just  
14 basic training to deal with acronyms that are in the  
15 health care industry. This industry is much more  
16 complicated. As my staff say, it is an acronym-rich  
17 environment, or ARE.

18           [Laughter.]

19           DR. CARNEVALE: So it's really interesting. A  
20 lot of my learning has just been dealing with acronyms  
21 because people in this industry we are working with are  
22 very good at speaking in those terms and we spend time

1 trying to get caught up.

2           So we have the problem: we have a health  
3 industry that is not working very well. We have a  
4 solution: thinking about an information architecture  
5 basically being brought to bear on it. So in terms of  
6 historical highlights, I think this is a good way to  
7 understand in terms of background what is going on.

8           In 2001, we had the National Committee for  
9 Vital Health Statistics. Again, this is a committee that  
10 reports to the Secretary of HHS. It has been around for  
11 about 50 years. They put together a strategy for  
12 building the National Health Information Infrastructure.

13           In 2003, they then got very specific  
14 recommendations in terms of how to implement that  
15 strategy, which they presented to the Secretary of HHS.  
16 One of the things, of course, was the real issue of  
17 implementing NHII, or the National Health Information  
18 Infrastructure.

19           In 2004, President Bush issued an executive  
20 order -- we will talk about that in more detail in a  
21 moment -- to establish this thing called ONCHIT. It is  
22 the Office of the National Coordinator for Health

1 Information Technology, sometimes called ONC, the first  
2 three letters. That confused me for about three months,  
3 by the way. I thought they were two different places and  
4 I didn't dare ask.

5 [Laughter.]

6 DR. CARNEVALE: I worked for Sarah Wattenberg,  
7 who is here in the audience, and I didn't dare ask her,  
8 "Are these two the same thing?" I finally, through a Web  
9 search, figured this out.

10 In 2004, ONCHIT -- now you are into the acronym  
11 world here -- basically put out a strategy. It was  
12 formed. It thought, "Okay, we have this national  
13 information infrastructure we want to build. How are we  
14 going to do it? Let's develop a strategy." They  
15 developed a strategy, and then, later that year,  
16 obviously as part of the strategy, they decided that one  
17 thing we need to do -- and this is a big theme that I  
18 want to make sure keeps coming up -- is to make sure that  
19 this is a public-private sector partnership in terms of  
20 how we go forward in building this infrastructure in the  
21 health care industry.

22 So the ONCHIT issued a request for information,

1 an RFI. We did have those in the defense world when I  
2 was over there. The RFI was to solicit ideas, basically,  
3 from the public about how best to proceed in terms of  
4 building this thing.

5 In September 2005, ONCHIT formed the American  
6 Health Information Committee to basically help strengthen  
7 the private sector involvement in this implementation of  
8 this architecture. In September 2005, HHS issued four  
9 RFPs and funds them in September to really begin the  
10 implementation process.

11 So historically, you can see that there is a  
12 public policy issue being raised in the '90s, a lot of  
13 discussion in the '90s, culminating in a report by IOM.  
14 Their reports tend to get attention at least inside the  
15 Beltway, in Washington, D.C. It caused a public policy  
16 response, which is that we need to go out and build this  
17 National Health Information Infrastructure. Then we have  
18 a whole series of things that occurred to make that  
19 happen, and important things.

20 Now let's talk about the executive order issued  
21 by President Bush in 2004. In terms of the text, you can  
22 see what it says: to "provide leadership." He created

1 ONCHIT in the Executive Order to provide leadership,  
2 basically, in building this information technology.

3           But the real point of that executive order is,  
4 he set a goal. The goal said, we want to have the  
5 widespread adoption of interoperable electronic health  
6 records within 10 years, or by 2014. This is a health  
7 care system-wide goal that we hope to achieve. So the  
8 head of ONCHIT is responsible now for trying to help us  
9 to achieve that goal.

10           So a little bit now about ONCHIT. These are  
11 things, again, we need to understand, I think, before we  
12 can talk about behavioral health and what my group is up  
13 to.

14           Again, this was formed by the administration.  
15 Its director is David Brailer, who is charged with  
16 implementing a National Health Information  
17 Infrastructure, the NHII. Again, one of the things he  
18 did to do that is he issued that RFI that we talked  
19 about, the request for information. Dr. Brailer clearly  
20 wants to make sure that the public and private sector  
21 work together to build this infrastructure to achieve the  
22 goal of the executive order that we discussed a moment

1 ago.

2 In addition, there were a couple other things  
3 that occurred under Dr. Brailer's leadership, which we  
4 will talk about next. The American Health Information  
5 Community, AHIC, and then the National Health Information  
6 Network. I don't even know how to pronounce that, but we  
7 will talk about those two things. They are byproducts of  
8 the ONCHIT effort.

9 The National Health Information Network, what  
10 it is and what it isn't. It is basically a knowledge  
11 base that we are trying to build. It is comprehensive,  
12 and it is meant to be interoperable, which means that we  
13 can have systems talking to each other, exchanging  
14 information.

15 What it is not: it is not a national or central  
16 database; it is not a big medical record sitting  
17 someplace inside the Beltway or someplace in a mountain,  
18 we'll say, in Virginia or someplace.

19 The difference between NHII, the National  
20 Health Information Infrastructure and the National Health  
21 Information Network? In concept, they are really the  
22 same thing, but I like to think of NHII as really the

1 goal that we are trying to achieve, the system that we  
2 are trying to build, and the network itself is really the  
3 means by which we are going to do it.

4 Now, we can talk a lot more about that, but I  
5 think in a nutshell that is what we are thinking about or  
6 talking about.

7 The American Health Information Community was  
8 formed in 2005. Here again, it is under ONCHIT. The  
9 Secretary of HHS formed this group to make sure that the  
10 private sector was involved in this whole process of  
11 implementing this National Health Information  
12 Infrastructure and achieving the goal of the executive  
13 order within the 10 years that we have been talking  
14 about.

15 It has about 16 members who come from  
16 hospitals. We have certain docs who are on that  
17 committee, insurance companies, IT folks, and federal and  
18 state agencies. Again, the theme is to advise the  
19 Secretary of HHS -- obviously this means ONCHIT since  
20 that issue has been delegated to Dr. Brailer -- about how  
21 best to achieve the goal of implementing the National  
22 Health Information Infrastructure.

1           Now, AHIC has formed four groups. One that I'm  
2 very interested in in terms of what we are working on is  
3 the one at the bottom here having to do with electronic  
4 health records. There are a lot of different groups out  
5 there focusing on this in the public and private sector,  
6 and when we get to my group, you will find out part of  
7 what we are trying to do is to bring all this together,  
8 at least to make sure that we have some connections to  
9 each of these groups that are worried about the nature  
10 and shape of these electronic health records.

11           So we have been talking about electronic health  
12 records; what are we talking about. This is an  
13 interesting issue. As you can see, we took the  
14 definition from the Institute of Medicine. Notice how  
15 they do this. They generally define an EHR as a system -  
16 - the word "system" is important -- that has information  
17 that is longitudinal, going back in time, like a  
18 collection of electronic health information for and about  
19 people.

20           It enables electronic access to people- and  
21 population-level information by authorized users.  
22 "Authorized" is very important when you get into the

1 issue of discussing behavioral health, and 42 CFR, Part 2  
2 and privacy, and so on.

3           It provides the provision of knowledge and  
4 decision support. In other words, we are going to have  
5 information available to docs so that when they are  
6 working with a patient they can make sure they have a  
7 full understanding of that patient's history so they can  
8 make the best decisions about giving the best health care  
9 they possibly can to that patient.

10           And of course, to improve efficiency. I mean,  
11 the goal of all this as well is to ensure that we have  
12 increased efficiency in the industry.

13           Now, you will hear a lot of things about EHRs,  
14 which is the electronic health record. That is, in my  
15 mind, the master file. Then there is something called a  
16 PHR, the patient health record. The EHR is something  
17 that is maintained by the providers or the health care  
18 setting. The PHR is something that a patient will  
19 generate from the EHR, but it is a subset of the  
20 information that the patient then would take around and  
21 present to docs in terms of their own history.

22           When you talk to physicians, though, and

1 clinicians, they are going to want to have more access to  
2 EHRs because there is some information in the electronic  
3 record that doctors may not want their patients to have  
4 access to. We can discuss that later on as well.

5 So there are a lot of things about EHRs, PHRs,  
6 and it goes on and on from there. But we are focused, at  
7 least initially, when we get to discussing my group, on  
8 the electronic record.

9 Now, behavioral health; what do we mean by  
10 that. Well, the way we are defining it, and I think it  
11 is the way everybody defines it, we are dealing with a  
12 system for treating mental health and substance abuse.  
13 Hence SAMHSA's interest in this, given its statutory  
14 authority to do work in both of these areas.

15 In behavioral health, we have a couple  
16 challenges that I think are quite important, and these  
17 are challenges that have emerged from the group that I am  
18 managing. The first one is how to manage information to  
19 improve patient care and safety while at the same time,  
20 and this is very important, protecting patients' rights  
21 and privacy.

22 We know in our business a lot of patients have

1 information about addiction, about criminal behavior, and  
2 things that they don't necessarily think need to be  
3 shared widely. We have one person on our group that  
4 talks about the fact that she has tried to get, for her  
5 business, insurance so she can provide insurance for her  
6 business and keep things going. The fact that she might  
7 have been a drug addict in the past means that she can't  
8 get access to that. These kinds of things are issues in  
9 our field, and we have to be very worried about that.

10 The next challenge is how best to integrate  
11 into national efforts to modernize and become more  
12 mainstream. In terms of my own public policy interests  
13 and I think in having conversations with folks in this  
14 field and all the interest groups, one of the things that  
15 substance abuse and mental health would love to be is  
16 more mainstream in health care. Sometimes we come to the  
17 subject of public policy debates about the nature of  
18 addiction and is it a disease that we should treat and  
19 think in terms of health care or is it a crime and should  
20 it be, really, something that falls under the auspices of  
21 the criminal justice system.

22 I think we, at least in this group, are hoping

1 that this becomes more mainstream health care so that  
2 substance abuse and mental health can be part of that  
3 health care system in a better way and maybe  
4 depoliticized in terms of some of the issues that we have  
5 been dealing with for the past 30 years, quite frankly.

6           So the next one, we have a problem. The state  
7 of the behavioral health care industry. We, I think, all  
8 understand that the state of the health care industry --  
9 I wanted to write "is not good," but I figured that would  
10 be too depressing and too negative. So I said, well, it  
11 could be better. Without giving you any benchmarks here,  
12 it could be better.

13           [Laughter.]

14           DR. CARNEVALE: We have an opportunity to  
15 improve.

16           There have been some studies out there, at  
17 least in the case of substance abuse, by Tom McClellan,  
18 for example, who went out and did some surveys of a lot  
19 of substance abuse providers in the country because he  
20 was trying to do a certain research project. He took the  
21 SAMHSA list of all the treatment providers in the nation  
22 and took a sample and started calling them up. In a way,

1 I think he wished he hadn't done that because the  
2 findings were a little troubling.

3 He said he found things like that most  
4 substance abuse treatment providers lack a full-time  
5 physician on staff, or a nurse. Many report significant  
6 problems in terms of using computers. In fact, he said  
7 most report they don't have computers, or at least a lot  
8 report that they don't have computers.

9 If they do have computers, they probably use  
10 them for financial management and also for reporting to a  
11 host of folks up the food chain that have information  
12 requirements that they must satisfy.

13 He said that about one-sixth of all substance  
14 abuse programs that were supposedly in operation, in fact  
15 he couldn't find them. They didn't exist. They closed.

16 The turnover rate in our industry is not very good.  
17 Actually, it is very good, excuse me. Not very good,  
18 depending on how you want to view this.

19 [Laughter.]

20 DR. CARNEVALE: From a public policy area it is  
21 bad, but in terms of just the turnover rate, it is quite  
22 high. We shouldn't be proud of that. That of course

1 creates problems for our industry, when you have that  
2 kind of thing.

3           We have workplace issues where people, we all  
4 know, have low salaries. It is hard to retain staff. So  
5 when you start thinking about the goal of having  
6 electronic health records to inform clinical and  
7 administrative decision-making in a behavioral health  
8 setting in 10 years and you have staff coming and going  
9 quite frequently, you have training issues that are very  
10 complicated just inside this industry.

11           The other thing he found; he said almost none  
12 of the programs had information systems that could  
13 support clinical decision-making. Again, when we go back  
14 to the whole goal of the executive order issued by  
15 President Bush, it is to improve health care, ultimately.

16           Most of the systems we have in behavioral health really  
17 are not dealing with clinical decisions, they are dealing  
18 with administrative issues. So, again, the state of the  
19 industry could be a little bit better.

20           Now, finally, the Behavioral Health Treatment  
21 Standards Workgroup. About a year ago, Sarah Wattenberg  
22 called me up. Sometimes I say to her, "Why did you call

1 me?" But, anyways. I actually am thrilled she did.  
2 This has turned out to be quite interesting in terms of  
3 public policy.

4 But she called me to say that she wants to get  
5 a group together to start worrying about what is going on  
6 with this whole transition to electronic health records  
7 and how we can bring in the behavioral health industry  
8 groups that we deal with, especially in this agency of  
9 SAMHSA, to raise awareness of behavioral health issues as  
10 we transition to an electronic world, to make sure that  
11 our needs and issues are represented in that transition,  
12 and very well represented. So we formed this group to do  
13 that.

14 Our mission. This mission is probably going to  
15 continue to evolve. As of about seven months ago we  
16 said, well, it is increased knowledge, understanding, and  
17 use of behavioral health standards in substance abuse and  
18 mental health.

19 Basically, what are we doing in terms of this  
20 group. We are identifying opportunities to influence  
21 standards-setting activities.

22 Now, of course, the question is, what do we

1 mean by "standards." Well, in the background, as we are  
2 putting together electronic health records, there are  
3 groups like software vendors who are writing software for  
4 the health care industry. When they get into issues of  
5 behavioral health, they may want to know, "How do we  
6 write a standard in terms of sharing information from one  
7 provider to another when we have to deal with 42 CFR,  
8 Part 2? What do we do about that?"

9           They are looking for standards so they can pull  
10 that information down to give them guidance. Standards  
11 are not laws. They are not rules or regs. They are just  
12 basically good advice if we do it well. So part of our  
13 mission is to get involved with these standard-setting  
14 organizations, all of which are not government  
15 organizations. They are usually nonprofit organizations  
16 set up over the years to coordinate within the industry,  
17 in this case the health care industry and others,  
18 information exchange standards and so on.

19           Our membership. At this point, we have about  
20 34 groups representing state and local substance abuse  
21 and mental health organizations. Local would be  
22 community-based organizations. You can look at this

1 list. I am not going to read that. I can't even see it  
2 myself. But there are a lot of organizations dealing  
3 with states and community, mental health and substance  
4 abuse. We have some federal agencies involved that we  
5 bring in because the feds need to be involved in this  
6 whole transition to EHR. Obviously, when we looked at  
7 those early slides with the history, the Department of  
8 Health and Human Services is really leading the charge  
9 with respect to this whole effort to achieve the  
10 executive order.

11 We have national behavioral health, I call it,  
12 representative bodies. One thing I really like in terms  
13 of this workgroup is, ultimately it is about people, but  
14 we want people representing large organizations. So when  
15 you look at the National Council for Community Behavioral  
16 Health Care, they have a few thousand organizations out  
17 there they are representing who are providers. We want  
18 large organizations, so as we start to develop  
19 information and positions and views and start promoting  
20 awareness, we then give it to them and they disseminate  
21 to this very large audience.

22 We have software vendors. One thing that has

1 been going on in behavioral health over the past decade  
2 is that there has been a bunch of software vendors who  
3 have been hired by folks in behavioral health to come in  
4 and build software systems to help them with clinical and  
5 administrative decisionmaking. They have come in and  
6 there have not been standards to help them do that, but  
7 they have developed their own standards in a sense  
8 because they have had to write software. So they have a  
9 lot of knowledge of what needs to be done from the  
10 software side, and we have some individual groups and an  
11 organization of software vendors as well.

12 I think just as importantly, we have consumer  
13 groups. We now have representatives on the committee who  
14 work both mental health and substance abuse consumer  
15 issues to make sure that, as we do our work, as we work  
16 with these standard-setting organizations nationally, the  
17 consumer interests are always there on the table. Again,  
18 privacy concerns, confidentiality, the stigma that we  
19 have talked about in our business that is associated with  
20 substance abuse and mental health. All of these things  
21 present problems in terms of how information gets passed  
22 on and around, and we are worried very much about that.

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1           So that is the current membership. There has  
2 been a lot of discussion, and when we have had our first  
3 meetings, it has been kind of fun because when we first  
4 met we weren't really sure what we were going to do.  
5 This is a wide-open area, and we are coming in not  
6 necessarily late, but we are coming in a little behind,  
7 certainly.

8           At the first meeting I had to confess, "I don't  
9 know what we don't know yet." We all have to start this  
10 discovery process in terms of what the lay of the land is  
11 in terms of who is doing this work out there nationally,  
12 how we become involved, what our positions are going to  
13 be on certain issues, how we are going to weigh in in  
14 terms of these issues.

15           These groups are voluntary groups. They are  
16 not paid to be part of this organization that I'm running  
17 on behalf of SAMHSA. So we are trying to figure out who  
18 should be on the committee.

19           The public policy types who come in feel a  
20 little inadequate in the sense that "I'm really here in  
21 Washington working policy issues. Boy, this sounds an  
22 awful lot like IT, and we are dealing with electronic

1 health records and software and computers. I'm going to  
2 call my computer person." "Well, no," is what we say  
3 back to them. "We would like both of you in the room  
4 because there is a lot of public policy going on here."

5           How we set standards around confidentiality.  
6 If we do things poorly, we may end up causing problems in  
7 that area. Or it could be the case that some of the  
8 groups that are dealing with those kinds of issues. I  
9 don't mean to just narrow in on that, but that is one I  
10 think everybody understands quite well.

11           It may be that folks will decide that these  
12 confidentiality/privacy issues are just too difficult to  
13 manage in this health care industry and let's go change  
14 the laws on the Hill.

15           So there are policy things in the background  
16 that I want to make sure that we are very aware of.  
17 Hence the membership. We are trying to push very hard to  
18 expand it, make sure we don't exclude anybody, and  
19 obviously, have the right people at the table.

20           Our priorities. We set a bunch of priorities  
21 eventually, after we started to gain, I think, a lot of  
22 understanding of what we had to do. I think this will

1 continue to evolve. We have a meeting at the end of this  
2 month, at the end of February, where we are going to sit  
3 and review things that have happened in the past couple  
4 months that I will tell you about in a second.

5 But in terms of the big priority, we know that  
6 the opportunity to really weigh in is really the  
7 electronic health record effort. The executive order is  
8 very significant. In 10 years, the executive order is  
9 hoping for the widespread adoption of EHRs to improve  
10 clinical practice and administrative practice. We want  
11 to be part of that.

12 We have talked about issues around the  
13 electronic health record. What kind of information  
14 should go into a record. We have asked questions about  
15 how long should some information stay in a record. When  
16 you talk to docs, they will say, "Forever, because I want  
17 to know that patient's history." But when you talk to  
18 recovering addicts, they will tell you, "I was an addict  
19 at 18. I recovered and went through a program at 21.  
20 I'm 65 years old. How long do they need to know that I  
21 was an alcoholic," and so on and so forth.

22 Some docs will say "Forever, because I don't

1 want to prescribe a drug to you like OxyContin in 30  
2 years when you were addicted to it back here." So you  
3 can understand the debate and the tension that is going  
4 on between the clinical side versus the patient side.

5 We are very worried about HIPAA and privacy  
6 standards in the age of electronic health records, so one  
7 of our priorities is to keep an eye on that. We have  
8 substantial expertise on the committee in this area that  
9 we are bringing to bear in a number of forums to make  
10 sure that we are raising awareness on that.

11 Finally, basically, there is this thing called  
12 standard-setting organizations. There are about five of  
13 them out there. We are working with one called Health  
14 Level 7. There is another one called X12. I thought I  
15 was reading comic books when I got to these acronyms, my  
16 old comic books from the Fantastic Four or something.

17 But anyway, we want to make sure that we have  
18 really good relationships with these organizations  
19 because these are the ones that are developing standards  
20 that everybody will look to when they go ahead and  
21 develop their electronic health records.

22 We also have issues in terms of prescription

1 drugs. Basically, e-prescribing, prescription drug  
2 monitoring programs. There are a lot of things out there  
3 where information is being shared with folks almost  
4 freely and for various reasons. We are getting involved  
5 in that. We are not really too involved yet in that.

6 Performance measurement and management, the  
7 administrative side of the business. Electronic health  
8 records are going to generate information for a care  
9 setting, a provider, where they roll up information for  
10 patients. We will say, in the case of substance abuse,  
11 they probably can talk about treatment admissions in the  
12 past month, number of people discharged and length of  
13 stay, things that get at some very basic information.  
14 Also, they are going to talk about information related to  
15 billing and so on.

16 They have a lot of performance management  
17 measurement requirements, and also, I think providers  
18 across the industry are realizing that these electronic  
19 records, this database, can help them internally manage  
20 their business. Ultimately, it is about managing  
21 business, at least on the administrative side.

22 Our current activity is raising awareness. I'm

1 here today as part of that mission. At our next meeting,  
2 I'm going to be -- and I have actually been working on  
3 this -- trying to find a number of forums where I can go  
4 and then eventually my workgroup can go. I hope that is  
5 soon because this is a pretty laborious process. But we  
6 want to get out there with some basic discussion slides  
7 and explain who we are, what we are doing, and most  
8 importantly, why it is important to that audience that we  
9 are talking to that they worry about this whole  
10 transition to electronic health records.

11 We are participating in standard-setting at  
12 HL7. We were just in Phoenix for a week, sitting in a  
13 room looking at pages and pages and pages of standards  
14 that are being put together having to do with electronic  
15 health records. There have been a number of issues in  
16 there where, if some of the standards were written as  
17 they were proposed, it would present problems for  
18 behavioral health, mostly having to do with the  
19 information architecture being designed where information  
20 would go from one person to another, or one clinic to  
21 another.

22 We wanted to make sure there was understanding

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1 that in the case of behavioral health there may have to  
2 be certain constraints on that information as it moves  
3 around, basically.

4           Of course, in the clinical settings there were  
5 issues about how information gets used and shared when it  
6 deals with our population. We, I think, had a tremendous  
7 impact on HL7 in terms of their group because they are  
8 dealing again with sort of the clinical side. X12, by  
9 the way, tends to worry more about the administrative  
10 side, the business side of exchange of information, with  
11 insurance companies.

12           On the clinical side, I think we have had a  
13 tremendous impact that we are proud of. I'm not going to  
14 get into the language issues that we had to deal with.  
15 It was like being in English class at some point because  
16 of the wording we had to fight over. But we set it up so  
17 that under certain conditions -- in other words,  
18 behavioral health conditions, at least -- where you have  
19 issues that are really unique to behavioral health in  
20 this case that there are certain rules put in place  
21 automatically to protect the patient and to make sure  
22 that the information moves appropriately.

1           Again, our current activities; expanding  
2 membership. We are looking for others to come in and  
3 help us. As I said early on, we have some individuals  
4 who simply are uniquely qualified in certain areas and we  
5 are bringing them in to help us understand what it is we  
6 need to do, but I'm really looking for organizations in  
7 the behavioral health world that are representative  
8 bodies who need to worry about this whole transition to  
9 electronic health records, for example, from both the  
10 clinical and administrative setting.

11           So, with that, I will do what everybody likes  
12 me to do best. I will stop talking and answer any  
13 questions that you may have.

14           Frank.

15                           **Question-and-Answer Session**

16           DR. MCCORRY: John, I just want to applaud the  
17 job that you have done with this Behavioral Health  
18 Treatment Standards Workgroup. I have been part of it as  
19 part of the policy side of things, and it is amazing that  
20 you were able to, in a short set of slides, get through  
21 this, since my eyes glaze over usually. I mean, it is  
22 just such a complicated and difficult area to really

1 attend to, and yet this is, to me, one of the most  
2 central initiatives that SAMHSA can be involved in.

3           With defining the data standard elements is  
4 defining how things are going to be reported and recorded  
5 and collected for the future. I think it is really  
6 important to recognize the maturation of this field. We  
7 have never been part of these kinds of processes. If you  
8 look back at Medicaid data or other data sets and you  
9 say, "What does that mean? Why has it been defined that  
10 way?", it was typically done by someone who is a code  
11 professional or a Medicaid professional with no clinical  
12 experience or no understanding of what substance abuse  
13 services might be about. Then we live with that data as  
14 we try to make sense of the world that we are trying to  
15 manage.

16           It is an incredible leap forward that we have  
17 you and SAMHSA has a group that is right into the kind of  
18 guts of data standards. We are right at the table as we  
19 are constructing this electronic health record. An  
20 incredible achievement, and shows the kind of growth that  
21 this field has undergone, even if it is really, really  
22 difficult to understand.

1 DR. CARNEVALE: It is a tough topic, I agree.

2 DR. McCORRY: Better you than me, but thank  
3 you.

4 DR. CARNEVALE: Thanks. Sarah has been very  
5 patient. When she pulled this together and brought me  
6 in, I would like now to go back and revisit that  
7 conversation and see how I reacted to what you were  
8 saying, Sarah. It sounded on the surface like, "Okay,  
9 this sounds pretty straightforward and not too  
10 complicated." Then, about a week later, I thought, "Oh  
11 my god. There is just so much going on."

12 One of the big issues we have as a group now is  
13 that there is so much going on that we really need to pay  
14 attention to, but it is the old economic problem of  
15 limited resources and unlimited needs here. We have to  
16 set some probably more significant priorities, I think,  
17 in terms of what we are going to do, and that is part of  
18 our agenda. But how best to sort of make sure we are  
19 representing the issues at the right moment, at the right  
20 time, all that, is now on the table.

21 But again, I think you are absolutely right.  
22 Once I got into this, I realized from a policy

1 perspective it is fascinating what is going on here, and  
2 it is almost a back-door policy, which I think we always  
3 have to worry about.

4 DR. McCORRY: Could you describe the experience  
5 of working with mental health? Because they really see  
6 it as a behavioral health.

7 DR. CARNEVALE: Well, actually, in SAMHSA, I  
8 think it is important to emphasize, and I should have  
9 said this up front, we actually have been working with  
10 CMHS. They are participating aggressively in this. We  
11 also have Prevention working on this because there are a  
12 lot of requirements standards being set in this business  
13 where if there is a certain medical condition there may  
14 be requirements for consumers to get access to  
15 information. The Prevention folks have made it very  
16 clear that there is a lot of prevention information that  
17 we have on best practices and other things that we might  
18 like providers to put out there.

19 So we have actually been dealing with all three  
20 centers here, and they are all participating in this,  
21 which has been really good. As we have always talked  
22 about in terms of mental health and substance abuse,

1 there is a continuum here in terms of problems. We want  
2 to make sure that is reflected in the effort.

3 So again, we are working with all three, and  
4 their involvement has been, I think, also very helpful  
5 because the issues of stigma and everything else in that  
6 field are just as serious, obviously. Their  
7 understanding of that has helped us work these standard-  
8 setting organizations.

9 MR. DeCERCHIO: Two questions, John. One is,  
10 what is the time frame for some of the standard  
11 development? The goal is 2014 for an integrated network.

12 We just started an electronic records workgroup,  
13 particularly in mental health. So, what is out there in  
14 terms of availability of even budding standards or the  
15 time frame for that? Here is an initial set of core kind  
16 of criteria and standards. First question.

17 Second question is, talk a little bit more  
18 about the intersection between this and more consumer-  
19 directed care. You referenced the tension around health  
20 care practitioners not wanting certain information turned  
21 back so the consumer can access it. At the same time,  
22 though, I think electronic records are viewed,

1 particularly in the mental health field, as being an  
2 important element of consumer-directed care, more choice  
3 and more integrated care that they drive. With their  
4 mental health record, they are driving access and choice  
5 decisions, et cetera.

6 So, how are those discussions going?

7 DR. CARNEVALE: Well, with respect to the first  
8 question in terms of timeline, this meeting in Phoenix  
9 was dealing with the basic infrastructure around support  
10 services, clinical care, direct care, and information  
11 infrastructure. There have been groups meeting to put  
12 together what they call functions, and it gets very  
13 complicated.

14 But I think, probably for about two years, they  
15 have been working on what we looked at as a thing called  
16 a "ballot," where we get to offer our views on this  
17 thing. That process, at least the one we are involved in  
18 right now, is coming to a conclusion, but it is not over  
19 because then it goes to another level. People keep  
20 adding these things to these ballots.

21 So it is ongoing, but I think when you looked  
22 at the timeline in the beginning, clearly from 2001 on

1 the administration got very aggressive in terms of  
2 pushing this. There is a goal of 2014. So I think that  
3 is going to drive everything to go and to occur very  
4 quickly. If you have widespread adoption of EHRs by  
5 2014, I hope we have standards done pretty soon. I don't  
6 know how to answer more specifically than saying "pretty  
7 soon" to help that occur.

8 In terms of the consumer interest in this  
9 stuff, while electronic health records are really things  
10 that the provider community is responsible for  
11 developing, the focus is on patient safety, patient care,  
12 and patient health. So they are, I think, consumer-  
13 centric by design.

14 The issue, I think, in the background is how  
15 that information is shared and maintained, and that is  
16 what is really being debated, and that is what we are  
17 worried about the most, if that helps.

18 DR. CLARK: Thanks, John. I'm going to have to  
19 cut off the discussion as we move along on our agenda.

20 DR. CARNEVALE: Sure.

21 DR. CLARK: I really appreciate your input, the  
22 work of Sarah Wattenberg and others in this arena. This

1 is an important part of the behavioral health paradigm.

2 Our next presenter will be Tom Stegbauer, the  
3 team leader and acting branch chief of the Organization  
4 and Financing Branch in DSI. He will give an update on  
5 Campus Screening and Brief Intervention.

6 I would like to remind you that a bio for Tom,  
7 as well as John Carnevale, is included in the bio  
8 document on the handout table. So if you were not with  
9 us this morning, I invite you to pick up a copy of that  
10 document.

11 Tom.

12 **Campus Screening and Brief Intervention**

13 **Tom Stegbauer, M.B.A.**

14 [PowerPoint presentation.]

15 MR. STEGBAUER: Great. Thank you. I really  
16 appreciate the opportunity to come and talk with you and  
17 share some of what has been going on with SBIRT and  
18 specifically to give you a quick update on what is  
19 happening with the college program. I really have  
20 enjoyed working on this.

21 This is Joan Dilonardo's branch work, so I just  
22 have to mention Joan again. She is leaving us tomorrow,

1 and I'm going to miss her like you can't believe. She is  
2 not here so I can say that to her.

3 A little background I thought would be helpful.

4 First, as we know, the impact of hazardous alcohol and  
5 substance use is very far-reaching and has huge medical,  
6 social, and financial consequences to the entire society.

7 In the traditional treatment for substance abuse, we  
8 wait until the person falls off the edge of treatment.  
9 We wait until they have a huge catastrophe, and then we  
10 pick them up and we start to work with them. But there  
11 has been very little attention paid to that prediagnostic  
12 group that are not yet dependent and who could  
13 substantially benefit from some type of intervention.

14 Just going back and taking a look at the  
15 alcohol pyramid, we work with more than alcohol, of  
16 course, but the pyramid is very illustrative in looking  
17 at various groups. We are interested with the SBIRT  
18 Program in looking at low-risk drinkers for education and  
19 at-risk drinkers for some type of intervention that may  
20 help.

21 We also work, of course, with people that are  
22 dependent, and we try to get them into appropriate care.

1 We find that excessive drinking and illicit use are  
2 often undiagnosed, untreated, and go on and on for a very  
3 long time. So we have worked and looked back into the  
4 literature and looked at the core components of a program  
5 that would identify problems up front and begin to treat.

6 Recall, I shared this with you before as we  
7 talked about the Hope Program, so I just wanted to show  
8 it just as a refresher.

9 And this as well. This is SBIRT in the context  
10 of traditional treatment. You can think of SBIRT as kin  
11 of a front end for what typically goes on.

12 In 2003, we awarded grants to six states and  
13 one tribal organization. Here are our states. The  
14 tribal organization is an Alaska group. That is our core  
15 group, and I will share some of our stories as we go  
16 along here a little further.

17 This effort that is underway is to look at  
18 college and university drinking patterns. We find that  
19 about 43 percent of students consume alcohol at at-risk  
20 levels, we find that college students are more likely to  
21 binge drink than any other groups, and we find that more  
22 people enrolled in college in the age groups of 18 to 22

1 drink excessively than other cohorts of that same age.

2 Here is what drug and alcohol use looks like in  
3 college students. You see at the bottom of the page 83  
4 percent of all kids in college are consuming at a rate  
5 that would consume us. We find that one-third of all the  
6 kids in college are using some type of illicit drug or  
7 using prescription drugs in an inappropriate way.

8 We find there are huge consequences. Now, this  
9 is from a study from '98 to 2001 and reported out in  
10 2005. You see during that period we had 1,700 deaths  
11 related to alcohol alone. We had almost 100,000 sexual  
12 assaults. We had a half a million injuries, and assaults  
13 generally at almost 700,000. This is a huge epidemic  
14 going on at all of our colleges. So let me say that we  
15 didn't have a whole lot of problem interesting colleges  
16 in taking a look at this program.

17 Here are the awards that we made. We made  
18 awards to 12 schools, and they are all across the United  
19 States. We have one at UTEP that is proving to be a very  
20 interesting program. Each one of these programs has  
21 their own way of integrating screening and brief  
22 intervention into their campus health programs, and I

1 will give you a little update on what each one of them  
2 are doing so you can get a feel for it.

3 But this is not a rubber-stamp program. We are  
4 not cookie-cutting a program from place to place. We are  
5 asking each institution to help us learn from the  
6 experiences they have.

7 This is our geographic distribution. The green  
8 blocks are the big SBIRT programs that were awarded in  
9 2003. I guess the rust-colored or supposedly red circles  
10 are where the colleges and universities are located. So  
11 you see we are across the country.

12 Some other variant that you will see is that we  
13 have 11 universities and one junior college. From those,  
14 we have 10 public institutions and one private. Some are  
15 using computer-based technologies. Some are accepting  
16 judicial referrals. A lot of them, by the way, are  
17 working with their athletic programs.

18 We will screen 70,000 students annually in this  
19 program, so it is a very heavy screening program. We  
20 have the most commonly used model that comes out of  
21 Washington State, and it is the BASICS Program that many  
22 of us are experienced with.

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1 I'm going to walk through a little on each  
2 program. I'm not going to read the slides, but I'm going  
3 to give you a little indication of some of the variance  
4 that goes on.

5 Bristol Community College is the junior  
6 college. It is in a Boston suburb. At Bristol Community  
7 College, the program has been in effect since last fall.

8 They got all of their IRB work done very quickly, et  
9 cetera. Their rate, by the way, of picking up students  
10 and referring them for intervention and treatment is at  
11 50 percent. Fifty percent of the students that they are  
12 screening go on to some type of treatment. Just an  
13 absolutely huge number.

14 New Mexico Highlands University. This program,  
15 by the way, is being implemented by the same staff that  
16 does our state program in New Mexico, so they have a  
17 little advantage of knowing very well how the program  
18 will work. They are in health clinics. They are in the  
19 athletics program. They do the freshman orientation.  
20 They just completed last week orienting all the residency  
21 halls in how the program works. This program has been up  
22 since September.

1           They are treating, by the way, with referrals  
2 out. A lot of the programs refer all of their treatments  
3 outside of the university.

4           This is at Northeastern in Boston.  
5 Northeastern is a private university. It is almost all  
6 commuter kids. They don't have a residency hall to speak  
7 of. They just received their IRB approval in January, so  
8 their program is just starting to get up and be  
9 implemented, and they will be seeing students in the  
10 program in the next couple of weeks. We are rather  
11 pleased to have them involved.

12           We have SUNY in Albany, the State University of  
13 New York. They are going to screen 28,000 students  
14 annually. They are going to screen everybody that is  
15 enrolled in the institution. They have started taking  
16 referrals. Of the first 63 screenings they did, 40 were  
17 referred to treatment. Huge numbers. So, a program that  
18 is really doing a dynamite job for them.

19           This is at Arizona. By the way, Arizona, I  
20 just mentioned, is very involved with the athletics  
21 program. They started doing their intakes last semester,  
22 so this program came up very quickly in the fall, and

1 they have been referring students to treatment for some  
2 time.

3           UCLA. Now, there is a conflict between what I  
4 will tell you. The slide here says their IRB was  
5 completed in November. That is not accurate. Their IRB  
6 was completed on Monday of this week, so they have just  
7 been able to start seeing students.

8           They were very interested in doing an athletic  
9 program as well. I have mentioned athletics four times  
10 now because we had such a discussion just yesterday in a  
11 small group trying to figure out how we get the athletics  
12 programs very involved. So we are pleased to have UCLA.

13           In Delaware, they term their program "MOSAIC."  
14 They just completed their IRB, and it was scheduled in  
15 their application to start with the spring semester. By  
16 the way, spring semester is February. It is now. Spring  
17 semester is February 6th for them, so that program is up  
18 and going as well.

19           At Hartford in Hartford, Connecticut, it is  
20 interesting. A lot of work has been done in Connecticut  
21 on SBI and SBIRT. There is a little bit of competition,  
22 as you can imagine, between the people working at Yale

1 and Hartford and in the community, et cetera. So we have  
2 some of those things to get over, but it is fun to be  
3 working with them.

4 This year alone, that is in January, they  
5 referred 60 students to treatment. So, a very effective  
6 program for what they have been able to do.

7 In Hawaii, we are at the University at Manoa.  
8 That is just up on Diamond Head, as you come into  
9 Honolulu. They have been to their IRB twice so far and  
10 not been able to get through the IRB. They will be going  
11 back on the 21st of this month. They are going to have  
12 to receive a certificate of confidentiality.

13 Let me say, Hawaii has more diversity at that  
14 institution than anyone else that we work with. All the  
15 islanders that are in the program really raise some  
16 significant confidentiality concerns, and so we want to  
17 be very sensitive to those and work closely with them.

18 UMass at Amherst. They are working with our  
19 BASICS Program. They are just starting the program as  
20 well. They had some computer vendor problems as they  
21 tried to bring their program up. We got through those at  
22 our winter conference, and so they have now been able to

1 get their program implemented.

2 University of Tennessee. You see they are  
3 going to annually screen everybody in their student body.

4 They are going to do almost 30,000 students. Their  
5 website to do this work became active on the 9th of  
6 January, and their first blush to go out was to touch  
7 18,000 students. So that is their enrollment for this  
8 time of the year. They were rather pleased with that.

9 At UTEP, again, this says that their IRB was  
10 completed in September. That is not accurate. Their IRB  
11 was completed last week, so they have just been to a  
12 point of being able to start working with the students.  
13 Of the students that they have screened thus far, and  
14 they have only done 38 students, they have had 48 percent  
15 of those students referred on to treatment.

16 There are some things that are very exciting  
17 about working with the colleges alone, and one of them is  
18 the e-therapy that is going on. Northeastern University  
19 is doing online screening using a tool called CRAFFT. We  
20 have SUNY in Albany doing an online audit. We have the  
21 University of Hawaii doing an electronic program called  
22 CHUG. Mass at Amherst is doing the family history and

1 their audit online. University of Tennessee is doing an  
2 entirely online screening, and they are doing some brief  
3 interventions that are online as well. So that is a  
4 quick walk-through for what is going on.

5 Let me tell you that I get really pumped up  
6 about this program. I'm going to share this data. This  
7 is from our GPRA information. While you are looking at  
8 the numbers, let me say very carefully, this is not  
9 research. This is performance information. This is  
10 reported to us by our grantees, and it may or may not  
11 represent a full cross-section. So this is not  
12 publishable information, but it is a wink at what is  
13 going on within the grantees.

14 What gets us excited is, six months after an  
15 intervention, 50 percent of the people have an abstinence  
16 of more than 30 days. That is in alcohol alone. With  
17 illicit drugs, we are able to change the use rate by 42  
18 percent. Those numbers are incredible, especially as you  
19 compare those to traditional treatments. So that helps  
20 to get me really pumped up. But again, let me say that  
21 that is not research.

22 MR. DeCERCHIO: That is 30-day use?

1 MR. STEGBAUER: Thirty days, 30-day abstinence.

2 I also wanted to give you just a little wink of  
3 where we are. This is the big SBIRT Program. We are  
4 just beginning to get the college information, so I don't  
5 have information to share with you. It is too early and  
6 would only be looking at, really, five or six of the 12  
7 programs. I thought that was not fair.

8 We have now done intakes on 315. Currently, we  
9 are over 320,000 distinctly different patients. From  
10 those, you see the distribution that we are getting.  
11 Just over 15 percent of those intakes are receiving  
12 either an intervention or treatment, and just over 5  
13 percent are getting either brief treatment or a long-term  
14 treatment.

15 So with that as a quick run-through on what we  
16 have done thus far, let me tell you that we have a  
17 future. Our future is we are expecting to have some  
18 funds in the federal budget for 2006 to go out for  
19 another round of RFAs at the state level.

20 We have a study that is underway on UPPL law.  
21 Let me give you a little more definition. There is a law  
22 on the books of many of our states that says that if you

1 present for treatment and the cause of your presentation  
2 is use of alcohol or an illicit drug, the insurance  
3 company can deny payment for your medical treatment.  
4 Those are called UPPL laws. We have a study underway to  
5 help groups and states overturn those laws and to get  
6 those laws thrown out. Washington has been the most  
7 recently successful group at doing that.

8 We are doing a research-level cross-site  
9 evaluation. We are comparing one big SBIRT site to  
10 another. We are looking at the variability between the  
11 sites and trying to understand what causes that  
12 variability. We also have a Sustainability Workgroup  
13 underway. The Sustainability Workgroup is looking at  
14 issues to help carry forward with the work that is being  
15 done so far. They are looking at reimbursement concerns,  
16 they are looking at accreditation on licensing issues,  
17 they are looking at quality concerns. So a lot of that  
18 assistance is going to be available.

19 We have a toolkit under development, and we  
20 have a website that we will be announcing that you all  
21 can stop in and take a look at very soon.

22 So that is a quick run-through on what is going

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1 on with colleges and universities. I will answer any  
2 questions that you all may have.

3 Yes, sir.

4 **Question-and-Answer Session**

5 DR. McCORRY: Tom, I know they were small Ns,  
6 but large numbers of college students referred to  
7 treatment, that was after a positive screening. Those  
8 were referred for formal treatment, not for a brief  
9 intervention, the ones you quoted?

10 MR. STEGBAUER: That is correct.

11 DR. McCORRY: They bypassed the brief  
12 intervention. Upon assessment, they were sent right to  
13 treatment?

14 MR. STEGBAUER: That is correct. Yes, huge  
15 numbers. Absolutely.

16 Yes.

17 DR. MADRID: How many of these students are  
18 being sent through the ATR system?

19 MR. STEGBAUER: I can't tell you that. We  
20 don't collect information, and the concept behind the  
21 SBIRT Grant did not incorporate ATR.

22 We do have a Targeted Capacity Expansion Grant

1 in Connecticut that is tied very closely to ATR, but that  
2 is a \$500,000 separate grant that was done through TCE.  
3 So I don't have information and I don't have a way to  
4 collect it.

5 So, thanks for the opportunity to talk with you  
6 and give you a quick update on what is going on with  
7 SBIRT at the college level.

8 DR. CLARK: We have a brief break. I want to  
9 thank Tom for his work and, again, John Carnevale. We  
10 will take a brief break of six minutes.

11 [Laughter.]

12 DR. CLARK: Because we are going to have Connie  
13 Weisner via video. So you are going to miss the video if  
14 you don't come back in six minutes. Connie on the big  
15 screen.

16 [Break.]

17 DR. CLARK: We will see if modern technology  
18 works. Joining us via video from Oakland, California, is  
19 Dr. Connie Weisner to discuss the Institute of Medicine  
20 report, "Improving the Quality of Health Care for Mental  
21 Health and Substance-Use Conditions, Quality Chasm  
22 Series," released this past November.

1 Billions of Americans today receive health care  
2 for mental or substance use problems and illnesses.  
3 These conditions are the leading cause of combined  
4 disability and death in women, and the second-highest for  
5 men.

6 In addition to being a former CSAT National  
7 Advisory Council member, Connie served on the  
8 distinguished IOM committee that developed this important  
9 report. She brought a wealth of knowledge and expertise  
10 to the SAMHSA council and to this report. She directs  
11 the research program addressing access, outcome, and cost  
12 effectiveness of alcohol and drug treatment. She is a  
13 member of the International Expert Advisory Group on  
14 Alcohol and Drug Dependence of the World Health  
15 Organization and the National Advisory Council of the  
16 National Institute of Drug Abuse.

17 She is the principal investigator in a number  
18 of research grants: NIAAA, NIDA, Robert Wood Johnson  
19 Foundation, research grants that study costs and  
20 effectiveness of alcohol and drug treatment  
21 interventions.

22 An emphasis of her work has been on women and

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1 adolescents. She has received merit awards from NIAAA  
2 and NIDA. Her ongoing work focuses on the changing  
3 system of receiving substance abuse and mental health  
4 services.

5 Connie.

6 **Institute of Medicine (IOM)**

7 **Constance Weisner, Dr.P.H. [via videoconference]**

8 DR. WEISNER: Thank you. Can we start by  
9 having the members of the council introduce themselves?  
10 I'm not sure who is on the council. When you do that,  
11 would you lean forward, because I only can see part of  
12 you.

13 MS. HEAPS: Hi, Connie. You're looking good.  
14 Melody Heaps with TASC in Illinois.

15 DR. MCCORRY: Hi, Connie. Frank McCorry.

16 MS. JACKSON: Hi, Connie. Val Jackson from  
17 Miami, The Village, and WestCare Foundation.

18 JUDGE WHITE-FISH: Good afternoon, Connie.  
19 Eugene White-Fish.

20 MS. BERTRAND: Hi, Connie. Anita Bertrand from  
21 Ohio.

22 MR. DeCERCHIO: Hi. Ken DeCerchio, Substance

1 Abuse and Mental Health in Florida.

2 DR. WEISNER: Thank you. I'm going to try and  
3 hit the highlights of the IOM committee report, and I  
4 definitely want to leave time for discussion.

5 I think we should see this the way I'm seeing  
6 it, and it is mostly with a positive light. It is a  
7 general document that we can shape and that, hopefully,  
8 has recommendations that are general enough that we can  
9 shape and move the field forward in ways that we all  
10 consider important.

11 This is a new technology for me, so I think you  
12 have two to a slide. Just looking at the first two  
13 slides, I want to point out that this was the tenth in a  
14 series of IOM studies that addressed quality in health  
15 care. The most famous one was the one called "To Err Is  
16 Human." That showed that 100,000 people a year die  
17 unnecessary deaths getting medical care in the country.

18 Then the other one, which is on Slide No. 2,  
19 the one that this one is adapted from, was called  
20 "Crossing the Quality Chasm." It made the point that  
21 systems of care needed to be changed in order to improve  
22 health.

1           We had the sort of famous, as they try to think  
2 of it, six aims for changing the quality of health care.

3       Looking at the next two slides, one, it should be safe,  
4 avoid injuries from care. It should be effective. It  
5 should be based on scientific knowledge and avoid  
6 services that didn't help. It should be patient-  
7 centered, respecting and responding to patient  
8 preferences, needs, and values. It needs to be timely,  
9 reducing waiting and delays. It should be efficient,  
10 avoiding waste. It should be equitable. Care should not  
11 vary in quality due to personal characteristics, gender,  
12 ethnicity, geographics, or socioeconomic status.  
13 Clearly, the health care system, as well as our substance  
14 abuse system, has a ways to go here.

15           This original "Quality Chasm Report for Health  
16 Care" settled on 10 rules that they thought should be  
17 important paradigms in redesigning health care. So the  
18 next two slides show those. Rather than care based on  
19 visits, it should be based on continuous healing  
20 relationships. It should be customized to patient needs  
21 and values. Rather than professionals controlling the  
22 care, the patient should be the source of control.

1 Instead of information being on a record, it should be  
2 shared and information should flow freely. Rather than  
3 decisions being based on training and experience of the  
4 clinician, it should also be evidence-based.

5 On the next slide, the "Do no harm" used to be  
6 an individual clinical responsibility, and the new  
7 Quality Chasm saw it as a system responsibility. Rather  
8 than secrecy, all health care should be transparent.  
9 Rather than the system reacting to needs, needs should be  
10 anticipated. Rather than seeking to reduce cost, the  
11 focus should be on decreasing waste. Rather than a  
12 preference for professional roles over the system, there  
13 should be cooperation among clinicians as a priority.

14 So these paradigms are very hard to argue with,  
15 and it is also very clear that the health care system in  
16 general has a long ways to go.

17 The next slide talks about the components that  
18 the original Quality Chasm said were the pathways for  
19 achieving aims and rules and the components. In other  
20 words, it needed to be reengineered, new ways of  
21 delivering care, effective use of information technology,  
22 managing the clinical knowledge, skills, and deployment

1 of the workforce, effective teams and coordination of  
2 care across patient conditions, services, and settings,  
3 improvements in how quality is measured, and payment  
4 methods should be conducive to good quality.

5 Now, the report did not address mental health  
6 and substance abuse treatment, and so on the next slide  
7 the study sponsors, of which SAMHSA and certainly CSAT  
8 played a major role, went to the Institute of Medicine  
9 and asked them to have a committee to adapt these  
10 recommendations from the Quality Chasm to the mental  
11 health and substance abuse field. That is why I  
12 introduced what was there in the original report. It  
13 definitely did have a strong guidance for how we did our  
14 work.

15 The charge that the Institute of Medicine was  
16 given is there on Slide No. 8. To explore the  
17 implication of the Quality Chasm report for the field of  
18 mental health and addictive disorders. That is how it  
19 was stated. To identify barriers and facilitators to  
20 achieving significant improvements along all six  
21 dimensions, examining both environmental factors such as  
22 payment, benefits coverage, and regulatory issues, as

1 well as health care organization and delivery issues.  
2 And, based on a review of the evidence, to develop an  
3 agenda for change.

4           The next two slides show the committee members  
5 who were on the committee. As you can see, Mary Jane  
6 England was the chair. She comes from the mental health  
7 field. With many of the individuals on the committee we  
8 felt mental health was slightly more represented. We did  
9 get an additional member on the committee after the first  
10 meeting. That was Tom McClellan. I can talk about who  
11 some of these individuals are if anyone wants to during  
12 the discussion, but you probably know most of them.

13           The conclusion of the report, Slide No. 12.  
14 Juts go to the bottom line at first. Improving care  
15 delivery and outcomes for any of these problems, mental  
16 health, substance abuse, and general health, depends upon  
17 improving care outcomes for the other two.

18           I want to say right here at the outset that, as  
19 you can imagine, a huge issue was how to address the  
20 issue of comorbidity versus primary disorders along these  
21 conditions. The committee was very concerned that we  
22 realize that there are high levels of comorbidity but it

1 is a continuum. There are also primary substance use  
2 disorders, primary mental health disorders. Health care  
3 is also a big comorbidity with both substance use and  
4 mental health problems. We did have representation from  
5 the primary care field.

6 Another overarching recommendation is that  
7 health care for general, mental, and substance-use  
8 problems and illnesses must be delivered with an  
9 understanding of the inherent interactions between the  
10 mind/brain and rest of the body.

11 Slide No. 13, the next two slides. This  
12 summarizes the basic issues that the committee first  
13 identified, we thought were important, and looking at the  
14 Quality Chasm, which was to really think about what are  
15 some of the differences between substance use and mental  
16 health care as compared to general health care. Why did  
17 we need a new IOM report. Why couldn't we just say the  
18 Quality Chasm report fits perfectly well with us.

19 That was because both fields have increased  
20 stigma, discrimination, and coercion compared to health.

21 Patient decisionmaking ability is not as anticipated and  
22 supported by the system. Diagnoses are sometimes more

1 subjective, no lab tests or sugar levels and so forth.  
2 We have a less developed quality measurement and  
3 improvement structure in our infrastructure in our field.

4           There are more separate care delivery  
5 arrangements. There is less involvement in our field  
6 than in the National Health Infrastructure Improvement  
7 and use of IT. There is a much more diverse workforce  
8 and more small, solo practices. Finally, there is a very  
9 differently structured marketplace, as we are all aware  
10 of.

11           So we focused on these differences between  
12 health care and mental health and substance use treatment  
13 in our report. We summarized now a series of problems  
14 that map onto this, and recommendations. I'm going to  
15 talk about the six problems in the quality of health care  
16 and mental and substance use problems and their  
17 solutions. I'm going to go over that briefly, and then  
18 I'm going to talk about the recommendations coming from  
19 your report that are addressed to the various  
20 stakeholders: patients, clinicians, programs, health  
21 plans, government, and so forth.

22           So the first problem, then, on Slide No. 15,

1 has to do with stigma and the threats to patient-centered  
2 care that have to do with stereotypes, stigma, and  
3 discrimination. The view was that how individuals are  
4 perceived by others affects how they perceive themselves.

5 Then, those have an effect many times on policy and  
6 their care. The problem with stigma in our field is that  
7 it lessens patients' opportunities to manage their  
8 illness and initiate recovery. It encourages non-  
9 therapeutic clinician attitudes and behaviors, and  
10 fosters discriminatory public policies that create  
11 barriers to recovery. These are all more severe than we  
12 see in general health.

13 In terms of discriminatory public policies, on  
14 the next slide, that includes insurance discrimination,  
15 less benefit coverage, especially for children and  
16 particularly for the substance abuse field. Often with  
17 private insurance, higher co-pays. In order for people  
18 to receive services for their children, they often have  
19 to lose child custody.

20 There is also punishment added to criminal  
21 sanctions for non-alcohol substance convictions. This  
22 was articulated loudly in the report. There are such

1 things as decreased access to student loans, potential  
2 lifetime ban on food stamps and welfare. Many of these  
3 policies are diminished resources that people need to  
4 change their life in ways that are necessary for  
5 recovery.

6 Slide No. 17, the six remedies that were put  
7 forward to achieve patient-centered care, have to do with  
8 the culture, really, of patient-centered care that would  
9 combat stigma and support decisionmaking at the site of  
10 care. That requires organizational leadership and  
11 policies, education orientation, and lack of tolerance  
12 for "bad" decisions.

13 It would involve consumers much more in design,  
14 administration, and delivery of care, and provide  
15 decisionmaking support to consumers, including peer  
16 support and the use of advance directives.

17 The next three of the remedies would be to  
18 support illness self-management, and it should say  
19 "recovery programs and practices," make transparent  
20 policies for determining decisionmaking capacity and  
21 dangerousness, and preserve patient decisionmaking in  
22 instances of coercion. I guess an example I can give

1 close to home is that with Proposition 36 in California  
2 it looks like someone sometimes is having to choose  
3 between jail and treatment.

4           These individuals should be told what the odds  
5 are of doing well in treatment, what kind of outcome  
6 rates do those treatment programs have, what are the  
7 possible treatment alternatives, what are the real  
8 implications of going to treatment and not making it,  
9 which has, actually, a worse impact on your legal  
10 trajectory.

11           Those kinds of issues -- I'm just using that as  
12 an example -- are the kinds of transparency that should  
13 be involved in patient decisionmaking, even in issues of  
14 coercion.

15           The second problem, having to do with weak  
16 measurement and improvement infrastructure, is really  
17 kind of based on the philosophy that you can't improve  
18 what you can't measure. There really has been, in both  
19 the substance use and mental health field, inefficient  
20 production of the evidence base. Assessment and  
21 treatment practices haven't been codified and captured in  
22 administrative practices. Outcome measurements aren't

1 widely applied. We haven't used enough evidence that is  
2 really there from non-randomized studies, observational,  
3 and other non-RCT study designs.

4 In case I don't get a chance to mention it  
5 later, MWEB [ph] was definitely cited as the kind of  
6 evidence that should be used, as well as clinical trials,  
7 in looking at best practices.

8 Dissemination of advances right now often fail  
9 to use effective strategies and available resources. For  
10 example, CDC does a very good job of disseminating  
11 treatment to health care. They haven't been involved in  
12 our field.

13 Performance measurement for mental and  
14 substance use. Health care has not received the same  
15 attention in the private sector, and public sector  
16 efforts have not achieved consensus, although the report  
17 really does laud the efforts that have been made in  
18 recent years there.

19 But on the whole, there is a feeling that  
20 quality improvement methods have not permeated the day-  
21 to-day operations of providers and mental health and  
22 substance use services.

1           So the report talks about filling gaps in the  
2 evidence by using alternative study designs. Huge issue  
3 about studying existing programs that are doing well,  
4 rather than just having investigator-initiated studies  
5 that are the next step in some individual's career, the  
6 next mechanism to study.

7           Should include standardizing and coding  
8 interventions, outcome measurements, and coordination of  
9 initiatives to analyze the evidence.

10           The infrastructure for measuring and reporting  
11 quality and supporting quality improvement practices.  
12 The third problem, having to do with poor linkages across  
13 separations in care, this was a large focus of the  
14 report. It touches on issues of whether mental health  
15 and substance abuse services should be more part of  
16 mainstream medicine. The whole issue of carve-outs  
17 versus integrated care was clearly on the table.

18           The argument came down to really thinking about  
19 new ways of coordinating care. It talked about the fact  
20 that there was much more separation of mental health and  
21 substance use services from general health care and from  
22 each other. Very little linkages, compared to what is

1 necessary, between substance use and mental health care  
2 with education, child welfare, criminal justice, and  
3 other non-health sectors where many individuals needing  
4 services are located.

5           There has not been accountability for  
6 coordination, and the report discusses at great length  
7 the reasons for this and different systems of care and so  
8 forth. Within this is mechanisms for coordinating care  
9 involving sharing of patient information, the very top  
10 issue, as we all know, in terms of confidentiality,  
11 especially in the substance use field. So patient  
12 knowledge and consent is important.

13           There has to be targeted screening for health,  
14 mental health, and substance use in each of these systems  
15 of care. There needs to be better coordination and  
16 evidence-based coordination and linking mechanisms, and  
17 maybe some more developed coordination mechanisms that  
18 can be shown as model collaborations at the federal and  
19 state level.

20           Problem 4, Slide No. 23, talks about lack of  
21 involvement in the National Health Information  
22 Infrastructure and the need for better records, maybe

1 electronic health records, data standards, and a platform  
2 exchanging information across clinical settings that  
3 provides the full patient confidentiality and so forth.

4           There was a great deal of discussion about the  
5 fact that the community-based organizations are really  
6 lacking in the kind of infrastructure that can make them  
7 players in this new technology.

8           The actions. We asked DHHS, Department of  
9 Veterans Affairs, and so forth to charge the Office of  
10 the National Coordinator of Health Information Technology  
11 and SAMHSA to jointly develop and implement a plan for  
12 ensuring that the National Health Information  
13 Infrastructure addressed mental health and substance  
14 abuse health care as fully as general health care. It  
15 has been left out. And, there should be related  
16 activities by the private sector insurers.

17           The fifth problem has to do with the  
18 workforce's insufficient capacity. This is not, on the  
19 whole, a whole lot different than health care. We have a  
20 graying of the workforce. There is grayer variation in  
21 our field than in others.

22           Across-the-board deficiencies in education. We

1 reviewed some literature that showed that the average  
2 psychiatrist residency program gives eight hours of  
3 information on substance use in the residency, for  
4 example. So the training is across-the-board, whether it  
5 is need for training psychiatrists, psychologists,  
6 medical doctors, social workers.

7           Very much concerned about the variation in  
8 licensure and credentialing across states. There is  
9 difficulty in moving knowledge forward when you have so  
10 many solo practitioners that are not integrated in any  
11 way with a program and the national directives. There  
12 has been limited preparation for Internet and  
13 communication technology.

14           So we recommended sustained national attention.

15           That has been, actually, given for the physician and the  
16 nursing workforce for health care in general. We need  
17 that in our field as well. We suggested the creation of  
18 a federally funded public-private Council on Mental and  
19 Substance-Use Health Care Workforce, similar to the  
20 Council on Guidance in Medical Education, COGME I think  
21 it is called, and the National Advisory Council on Nurse  
22 Education and Practice, NACNEP.

1           This would collaborate with SAMHSA and so forth  
2 and with institutions of higher education to develop  
3 standards for training and licensure and so forth.

4           Finally, the last problem we addressed, because  
5 of feasibility, does depend on how accommodating the  
6 marketplace is, and we really have a differently  
7 structured marketplace, with a dominance of government  
8 purchasers.

9           We have the carve-out system for most of our  
10 services. We have limited coverage compared to other  
11 health conditions, and substance use definitely gets the  
12 shorter end of the stick with many states that have  
13 mental health parity, such as California not having  
14 substance abuse treatment.

15           Across the board, substance use is not as well  
16 covered as mental health. Also, we have discussed the  
17 issue that this includes Medicaid as well.

18           The strategies that we discussed address both  
19 public and private payees. On the insurance side,  
20 suggesting tools for reducing adverse selection. A big  
21 push on parity, realizing, though, that parity alone  
22 isn't going to do it. Asking state governments to really

1 give the greatest weight to quality rather than only cost  
2 savings. Using quality measures in making funding  
3 decisions. That is said in two ways there.

4           So our recommendations then, addressed on Slide  
5 No. 29, are addressing these issues, and they are focused  
6 on the various stakeholders: clinicians, health care  
7 organizations, health plans, purchasers, state policy  
8 officials, federal policy officials, accrediting bodies,  
9 institutions of higher education, and funders of  
10 research.

11           The remaining slides are recommendations for  
12 each of those groups. I want to leave enough time for  
13 discussion, so I'm going to have them in front of you.  
14 I'm going to just briefly highlight some of those.

15           For individual clinicians, really a focus on  
16 patient-centered decisionmaking, screening for comorbid  
17 conditions, routinely assessing outcomes, finding ways to  
18 clinically share information with other providers, and  
19 provide coordination. These recommendations we hope are  
20 backed up now with we are asking of the other  
21 stakeholders.

22           For organizations providing care, they need to

1 develop policies to enable and support all of these  
2 actions. They need to involve patients and families in  
3 design, administration, and delivery of services. They  
4 need to have linkages with other institutions: criminal  
5 justice, child welfare, and so forth, and get involved in  
6 infrastructure, the National Health Information  
7 Infrastructure.

8           Health plans need to pay for recovery-oriented  
9 services, peer support, illness self-management. They  
10 need to provide patients with comparative information of  
11 quality, of services, and providers. Payment and service  
12 exclusions need to be removed, and they have to support  
13 development of quality measurement and improvement. They  
14 need to work on appropriately sharing patient information  
15 between primary care, mental health, substance use.  
16 Provide incentives for IT. Use tools to reduce adverse  
17 risk selection. Use measures of quality and  
18 coordination.

19           State policymakers. Those are listed here as  
20 well. It is really important to help make coercion  
21 policies transparent and revise laws that make  
22 communication between providers difficult. We are a

1 group focused on high-level mechanisms to improve  
2 collaboration and coordination across agencies. Work on  
3 parity. Reorient state procurement processes towards  
4 quality.

5 DHHS, which I guess your group is most  
6 interested in, should coordinate identification of  
7 evidence-based practices, develop procedure codes for  
8 administrative data sets, use evidence-based approaches  
9 to disseminate and promote uptake of evidence-based  
10 practices, assure use of general health care opinion  
11 leaders in dissemination, like CDC and AHRQ, full  
12 essential quality measurement and reporting functions,  
13 provide leadership in quality improvement, and provide a  
14 continuum among federal agencies.

15 The federal government also should revise laws,  
16 rules, and other policies that obstruct sharing of  
17 information across providers, again taking patient  
18 confidentiality into consideration. Continue to fund  
19 demonstrations to transition to evidence-based care.  
20 Make sure that the new Highway Infrastructure addresses  
21 information infrastructure and addresses mental and  
22 substance use care.

1           This Council on the Workforce should be  
2 authorized and funded. Faculty leaders in health  
3 profession schools should be supported. They should  
4 provide leadership, development support, and funding for  
5 research and development on quality improvement in care.

6           Accreditors should adopt standards that would  
7 measure patient-centered decisionmaking throughout care,  
8 involve consumers in design, administration, and delivery  
9 of services. Require formal linkages with community  
10 resources, and use evidence-based approaches to  
11 coordinating care.

12           Finally, institutions of higher education  
13 should increase interdisciplinary teaching in core  
14 competencies and facilitate the work of the council that  
15 was recommended.

16           For funders of research, we really focused on  
17 development and refinement of tools that would be easy to  
18 use in setting and could easily assess response to  
19 treatment. We wanted a set of vital signs. Some of this  
20 is in development already, but the whole issue of how to  
21 better understand the relationship between clinical work,  
22 new questions that need to be answered, and primarily to

1 take advantage of what is actually known already on the  
2 ground. Study that and get some of that there on the  
3 list of evidence-based practices.

4 But the overall recommendation in the end is  
5 that the recommendations on improving health care that  
6 were in the original Quality Chasm should be  
7 intrinsically applied throughout mental health and  
8 substance use care and that they should be tailored,  
9 however, to reflect the characteristics that are unique  
10 to mental health and substance use care.

11 I'm happy to discuss any parts of this that  
12 people would like to.

13 DR. CLARK: Before we proceed with questions,  
14 Sarah Wattenberg will discuss CSAT's IOM activities as  
15 they relate to the IOM report. Sarah is a public health  
16 advisor in CSAT's Division of Health Service Improvement  
17 and SAMHSA's HIPAA coordinator, and will provide an  
18 update on this.

19 **CSAT's Activities Related to the IOM Report**

20 **Sarah Wattenberg, LCSW-C**

21 MS. WATTENBERG: Hi, Connie.

22 I'm going to tell you a little bit about what

1 CSAT is doing around the IOM, but first, I really want to  
2 say to Connie, you did yeoman's effort on representing  
3 the field during this process.

4 I don't know how many of you know; she was one  
5 of three substance abuse representatives out of 24 people  
6 I think it was on the committee. I think that under that  
7 kind of circumstance you brought a tremendous amount of  
8 grace in trying to really represent our issues. So I  
9 think the field owes a debt to you for that.

10 When we heard that this report was coming out,  
11 CSAT quickly convened a co-sponsored meeting with the  
12 Robert Wood Johnson Foundation to convene the substance  
13 abuse treatment leadership to hear what their thoughts  
14 and reactions were to the report and to get a sense of  
15 their priorities. If we were to move forward, we wanted  
16 to do that in concert with the field.

17 The general reactions were that the report was  
18 not perhaps as balanced between mental health and  
19 substance abuse as they might have wanted. There were  
20 some big chunks missing in terms of providing a context  
21 for substance abuse treatment. But I think people were  
22 very excited and I think they felt that there was enough

1 of a foundation, there was enough information, there were  
2 enough broad, overarching recommendations that this was  
3 something we could really move forward with and that we  
4 should be pleased and that we should come together with  
5 the government and with the field and come up with how we  
6 want to use this.

7 We already are doing a number of things that  
8 the report had recommended. So in that way, the report  
9 really reflected, from the wisdom of the IOM, that we  
10 were on track, that what we were doing was pretty much  
11 what needed to be happening in the current context of the  
12 health care environment, and that we could use the report  
13 to identify new initiatives and to support those that  
14 were sort of in the pipeline.

15 So the first recommendation that they had was  
16 for us to come back and essentially create a crosswalk  
17 between the IOM recommendations and the current  
18 activities that we are engaged in, and to go back a few  
19 years on activities that we have already done to identify  
20 the gaps between what we have done, what we are doing,  
21 and what the report is saying that we should do.

22 Then we would have a sense for, "We are the

1 government. We have limited resources. They are the  
2 field. They have limited resources. But what can we do  
3 to come together and make some decisions about what the  
4 critical elements are?" So that is what we are in the  
5 process of doing.

6 We are going to try and have the IOM come by  
7 and talk to CSAT. They already came and did one  
8 presentation, but we didn't get a lot of notice for it.  
9 We really want to see that people at CSAT are clear about  
10 what the messages are for this so that we can work with  
11 the field and move it forward in the way that we think is  
12 appropriate.

13 So that is really all I had to say. I think  
14 that once we meet with the field and we compare this  
15 inventory we will have more of a sense of what we want to  
16 do. We are just in the beginning phases of that right  
17 now.

18 DR. CLARK: Thank you, Sarah. Thank you,  
19 Connie.  
20 Council.

21 **Question-and-Answer Session**

22 DR. McCORRY: A couple of questions, Connie and

1 Sarah. I was interested what the general buzz around the  
2 report was. It seemed to get off to a slow start. I  
3 think it was released on a busy news day and so it didn't  
4 get much coverage.

5           Secondly, as Sarah mentioned, the absence of  
6 the role of criminal justice in the substance abuse  
7 setting and services is a large chunk. Is there any plan  
8 or thinking for IOM to revisit some of those large chunks  
9 to do a kind of appendix to the report or a follow-up to  
10 the report in which they captured some of the more  
11 substance abuse-specific kinds of dynamics?

12           MS. WATTENBERG: Connie, do you want to  
13 respond, or do you want me to take a stab at it?

14           DR. WEISNER: Yes, if you can. Certainly.

15           MS. WATTENBERG: As to the buzz, it was  
16 unfortunate. I think it was the flu epidemic that took  
17 the big press event away. It just sucked the life out of  
18 our IOM press event. Actually, one of the  
19 recommendations that came out of the meeting was to  
20 actually try and find a way to relaunch this when the  
21 final report came out. Maybe we will try to do that if  
22 there is a way to do that.

1 I had a lot of phone calls afterward, and my  
2 sense was that the field was already moving and grooving  
3 on this. I mean, we had some people just developing  
4 recommendations for their own organization. We have  
5 several other organizations that are meeting together to  
6 craft an agenda moving forward on various chapters.

7 So I think there is a lot of buzz, and the  
8 question is, how can we use that to leverage more  
9 resources and get it out into not just the substance  
10 abuse field but the general medical sector as well.

11 DR. CLARK: One of the omissions in the report  
12 is that despite the fact that it focuses on integrating  
13 behavioral health into primary is that there is no real  
14 reference to HRSA in the document. As you know, HRSA has  
15 the primary care activity for the federal government.  
16 They have the community health centers, et cetera.

17 So we did have a briefing, and Tom McClellan  
18 participated in that. Mr. Curie had a briefing for the  
19 IOM report, and they had Betty Jean Duke, the  
20 administrator of HRSA, present and one of her deputies so  
21 that this information could be presented to them.

22 DR. WEISNER: That is something that is going

1 to be talked about at the ASAM meeting. I think that it  
2 was really unfortunate that we didn't have that  
3 information. It is very important to get that out. It  
4 is a model program and needs to be talked about.

5           Some of the other things that weren't focused  
6 on in the report were because there have been recent IOM  
7 studies on them. For example, there was a report  
8 recently on health care in minorities and culture that  
9 did address this to some extent. So we did not have a  
10 special emphasis on that in this report.

11           The other issue was that I think that we really  
12 took the IOM by surprise. They really saw this as a  
13 health report. Health reports do not look at criminal  
14 justice or child welfare. They were dealing with the  
15 health care system, and the feeling was that we have so  
16 much work to do in the health care system itself that  
17 that is where the focus should be.

18           However, we didn't feel comfortable leaving it  
19 with that. So we did attempt to address the issues of  
20 linkages, especially in the chapter on coordination and  
21 how to develop linkages with systems outside of the  
22 health care field.

1           We also talked about the fact that, for  
2 instance, in school systems there is really a lack of  
3 balance. There is a lot more mental health care. That  
4 funding does not provide services for substance use.  
5 There are big problems across this in terms of  
6 coordinating services.

7           So we did address it somewhat, but not nearly  
8 as thoroughly as it should be. The focus has been on the  
9 health care system. I think it would be wonderful if  
10 people put pressure on the Institute of Medicine to do  
11 that kind of a study.

12           MS. WATTENBERG: Frank, I think there was a  
13 point at which we thought the IOM could produce some  
14 additional supplementary document or material. I don't  
15 think that is the case for a number of reasons both in  
16 terms of process and how the IOM works and also because  
17 of the funding.

18           There are a lot of ideas flying around, and one  
19 of them is to get one of the journals to devote an issue  
20 to the substance abuse field's response to the IOM  
21 report. I think that could be a good opportunity and a  
22 good venue.

1 DR. CLARK: Go ahead, Ken.

2 MR. DeCERCHIO: Connie, I was just wondering if  
3 you could comment a little more on the idea of carve-out  
4 versus integration. The service systems for mental  
5 health and substance abuse came about because of the lack  
6 of attention or lack of response to those issues in  
7 traditional health care. Now, as we look at challenges  
8 for putting them back together to improve linkages,  
9 without losing those specializations of disciplines, can  
10 you give us a sense of that type of discussion?

11 DR. WEISNER: That is a very heated issue with  
12 the IOM committee as it is, I'm sure, for all of us in  
13 our various locations. There is a need to have  
14 coordination. We spent a lot of time, for example,  
15 talking to the mental health people on the committee  
16 about why a full integration between mental health and  
17 substance use wouldn't work and the history, et cetera.

18 There were some people on the committee who  
19 were really feeling that services shouldn't be  
20 integrated, they shouldn't be part of health care, they  
21 shouldn't be carved out. There were other people on the  
22 committee that wondered how would we handle the

1 community-based programs, how would they become part of  
2 the health care system unless there was a total revamping  
3 at some higher level.

4           It was just considered something that couldn't  
5 be addressed. The field wasn't ready. There wasn't  
6 consensus on it. There wasn't ability to make any strong  
7 recommendations. There was a tremendous amount of  
8 discussion on this. I think in Chapter 5 there is a lot  
9 of discussion on moving ahead with different models of  
10 collaboration. The whole issue of patient  
11 confidentiality also comes in here greatly.

12           It is, I think, one of the really tough issues  
13 that our field is facing. It doesn't make any sense to  
14 the health care field when they look at it.

15           DR. CLARK: Melody.

16           MS. HEAPS: I saw the original report that  
17 would preordain your involvement, Connie, and I think you  
18 did a wonderful job of representing the field. Where  
19 this report has come to from where it started is  
20 remarkable, and I want to thank you very, very much. I  
21 know it was not an easy task. I was in the original  
22 meeting.

1           As someone who is, pardon me, embedded in the  
2 justice system in terms of delivering substance abuse  
3 services, I am very concerned that CSAT, if IOM will not,  
4 find a mechanism for translating the IOM report into how  
5 that can be translated for treatment in the criminal  
6 justice system. The issue of transparency is a good  
7 issue. It is a nice issue. It does not always work in  
8 all jurisdictions where plea-bargaining might occur. We  
9 need a much more sophisticated understanding.

10           If we are to work with drug courts and other  
11 criminal justice offender management programs, TASC,  
12 Breaking the Cycle, judges, corrections, we really do  
13 need to have some standards that I think raise the bar of  
14 service and treatment. The IOM provides a good outline  
15 for that. I think we need now to make a translation for  
16 people in the justice system. So I would hope that CSAT  
17 might consider taking a lead in that.

18           DR. CLARK: Anybody else, any other questions?

19           [No response.]

20           DR. CLARK: Well, I think, before we say  
21 goodbye to Connie, the important thing for us is to  
22 continue to look at the framework of the IOM report and

1 address in that framework the specifics.

2 Mr. Curie has acknowledged the importance of  
3 the IOM report to behavioral health in general. What we  
4 need to do is to make sure that we are able to advise the  
5 Administrator by addressing specific areas of concern  
6 that are peculiar to substance abuse treatment and  
7 prevention. Criminal justice has a unique role in the  
8 substance abuse arena, much more so than in the mental  
9 health arena. We have to recognize that child welfare  
10 also has some unique needs and expectations.

11 Then we have to recognize that we need to view  
12 the IOM report in the context of the needs of community-  
13 based and faith-based organizations as providers of  
14 recovery-oriented services within the continuum of care  
15 offered by the delivery system. That is another area  
16 that was inadequately addressed by the IOM report,  
17 despite the fact that we have had our Access to Recovery  
18 initiative in place for a while. So we have some unique  
19 issues, but the basic rules and guidelines that they have  
20 promulgated can be addressed.

21 You heard from John Carnevale about HL7 and  
22 X12, X1 and X2. We have Sarah Wattenberg and Rich

1 Thorenson [ph], who have been working on that. We need  
2 the field to help come up with treatment standards that  
3 can be transmuted into the new information technology.  
4 It is not just a data framework and it is not just  
5 operating systems like Windows or UNIX or the software  
6 that people promulgate. We often find that software  
7 doesn't meet the needs of the people in the field.

8           What it requires is some subject matter  
9 expertise, and that is what Connie brought to the  
10 calculus and what Tom McClellan brought to the calculus.

11       What we all need to bring to the calculus is the rules  
12 as they apply to our field, the issues that are of  
13 concern to us, such things as mandated care. It is  
14 somewhat controversial in the mental health field, but in  
15 the substance abuse field, given criminal justice issues  
16 and child welfare issues, it is something that we accept.

17           There is the issue of impaired health  
18 professionals and other professionals, like lawyers and  
19 other people in positions of responsibility where the use  
20 of alcohol and drugs may endanger the public but, on the  
21 other hand, society has put a lot of money into equipping  
22 these people to provide the kinds of services they

1 provide. So there are these balances that are achieved  
2 through some of the approaches that we have taken.

3 As Sarah pointed out, we need to move forward  
4 with the IOM report. We need to tailor it to meet the  
5 specific needs of the substance abuse prevention and  
6 treatment community. If we fail to do that, then what we  
7 will have is a report that inadequately addresses our  
8 unique needs and in fact may have unintended consequences  
9 of creating other delivery systems that step in to  
10 provide the very services that we are already providing  
11 without, if you will, the safeguards and concerns the IOM  
12 report articulates as basic infrastructure.

13 So thank you, Connie, for your work and for  
14 taking time to inform CSAT's council. We will continue  
15 this ongoing relationship. Of course, we have staff  
16 people and, obviously, council members who are very much  
17 interested in this. So as we move forward, we will be in  
18 touch with you. Thank you, Connie.

19 DR. WEISNER: Thank you.

20 [Applause.]

21 DR. WEISNER: Anyone who wants to call or Email  
22 me -- [inaudible.]

1 DR. CLARK: That puts us back on schedule. Is  
2 Ken Hoffman around? Can we have the A/V people terminate  
3 the video link? We will go to the next presentation.

4 While we are working on the next presentation  
5 technically, Dr. Kenneth Hoffman is a medical officer  
6 within CSAT's Division of Pharmacologic Therapies. He  
7 will discuss the Hepatitis Immunization Project. Dr.  
8 Hoffman's bio is on the table in the back of the room, as  
9 I have mentioned before. So I will simply turn the  
10 discussion over to Dr. Hoffman.

11 Ken.

12 **Hepatitis Immunization Project**

13 **Kenneth Hoffman, M.D.**

14 DR. HOFFMAN: Thank you. I would like to thank  
15 you for the opportunity to be able to address this  
16 project, the SAMHSA Hepatitis A/B Vaccine Initiative.  
17 The hepatitis A/B vaccine is otherwise going to be called  
18 Twinrix for the rest of this talk, which is the trade  
19 name for the combined vaccine.

20 I will try to keep this presentation brief,  
21 relevant, and interesting, given that I think I'm the  
22 last speaker of the day before you get to leave.

1           What I will give you is an overview of where we  
2 are right now. I mean, basically, it is a program to  
3 deliver Twinrix vaccine to substance abuse treatment  
4 settings and evaluate the efficacy of vaccinations in  
5 individuals at risk for liver disease progression. It  
6 has been a very hot topic, I think, in terms of the  
7 number of people infected with hepatitis C and with HIV.

8       All of this actually creates quite a bit of stress on  
9 the liver, and whatever you can do to decrease the burden  
10 on this organ is going to be very good.

11           We want to establish collaborative  
12 relationships to enhance vaccination against hepatitis A  
13 and B infections for patients at risk for either HIV  
14 and/or hepatitis C.

15           Why do we focus so much on A and B when this  
16 whole focus is on C. Well, if one really looks at the  
17 whole problem, this is a high-risk population that  
18 because of the risk behaviors that they have been  
19 involved with actually carry a high risk of getting  
20 hepatitis A, which is a fecal/oral way of transmitting.  
21 That is how you get the virus. If you get that virus,  
22 you are going to be sick as a dog for about a month or

1 so. It will linger on for about two months. You are  
2 probably not going to go to work for that month. There  
3 are a few people, especially if their liver is vulnerable  
4 anyway, who will die. There are a few deaths per year.  
5 It is not a lot; you usually recover. But this is  
6 hepatitis A.

7           Hepatitis B is sexually transmitted and serum-  
8 spread. It is much the same as HIV or HCV. It is the  
9 same mode of transmission. About 10 percent of those,  
10 however, will be going on to develop chronic hepatitis.  
11 Some of those will also get infected by a special type of  
12 hepatitis, which is delta particle. You can only get  
13 that if you have B already in you. This is a group,  
14 actually, that has a high risk for liver cancer. In  
15 terms of preventable cancers, it is right after tobacco  
16 as a preventable cause of cancer.

17           So again, it is a good thing to be concerned  
18 about and to vaccinate against. It is the only thing we  
19 can do, given the hepatitis C problem, which the only  
20 interventions we have are kind of behavioral. Actually,  
21 75 percent of that progresses to a chronic problem. In  
22 the drug-using population actually, very quickly after

1 intravenous use you are going to probably become positive  
2 with hepatitis C.

3           So it is impressive in terms of the spread, and  
4 impressive in a bad sort of way. If one looks at what we  
5 can do to bring services to the patient, we can actually  
6 improve the quality of life, the survival, and the  
7 capability of the individual to function given that they  
8 have some very serious chronic disease problems.

9           The idea here is to really focus on the  
10 individual as a whole and not on the specific disease of  
11 substance abuse. What has happened, I think, in our  
12 normal health care structure and what I have found as I  
13 have been talking to programs is that they will try to do  
14 the right thing with the individual standing before them,  
15 but the system itself is a little bit chaotic in terms of  
16 trying to provide those services. So as a centerpiece,  
17 we have the ability then to focus on helping to take care  
18 of these individuals.

19           This has been a unique project for SAMHSA. We  
20 put in for one year of Secretary's money last year, and  
21 it was awarded to us. So we are given an opportunity to  
22 demonstrate what we can do given a supply of vaccine.

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1           Actually, over the past years before I got  
2 here, there had been a lot of discussion going on with  
3 the hepatitis C coordinators, with CDC, with the states,  
4 with the different programs. Essentially, there was a  
5 cherry-picking, if you will, that went on with the  
6 programs that looked as though they had a pretty good  
7 immunization process somehow involved in patient care,  
8 that we wouldn't be creating a new program with resources  
9 we wouldn't be able to sustain, and we could demonstrate  
10 why this might be useful, what some of the missed  
11 opportunities would be.

12           As you look at the areas where you are going to  
13 do substance abuse treatment, you basically have the  
14 opioid treatment programs and the methadone treatment  
15 programs. There are office-based buprenorphine treatment  
16 programs. The ones we looked at were the ones that tend  
17 to be hooked up also with HRSA as a special program of  
18 national significance. There is a lot of research going  
19 on with those programs under IRB protocols, and the New  
20 York Academy of Sciences is doing the evaluation, I  
21 think, of those programs.

22           Then, of course, we have our CSAT and CSAP

1 grantees on the Minority AIDS Initiative, and we wanted  
2 to get a constellation of programs there. We looked for  
3 programs that had an active assessment and management of  
4 HIV and HCV and that had protocols in place either at  
5 their facility or maybe in collaboration with the health  
6 department, because the funding streams tend to be to the  
7 health department for public health and immunization,  
8 which is prevention. Then you have a whole separate  
9 funding stream, single status authorities that are kind  
10 of dealing with the substance abuse issues, and sometimes  
11 they really don't meet when they really could.

12           So with this example of something which is very  
13 important and preventable, and a care that patients  
14 actually appreciate that you go out of your way to  
15 provide the service, we have a winning combination here  
16 in terms of improving the care to our community.

17           We established participation by invitation.  
18 Letters went out at the end of November, just before  
19 Thanksgiving. As of this point, actually, we looked at  
20 about 60 programs. That comes up in a later slide. We  
21 had 11 opioid treatment programs, three of the  
22 buprenorphine type programs, five CSAT and five CSAP

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1 grantees. So it is 24 or 25 participants that I have  
2 signed agreements with at this point or one that is on  
3 the way.

4 Now, moving into how do we do this, it is  
5 really done as we do a lot of things. It is all through  
6 contract. Relative to the firm fixed price contract we  
7 have, there is a minority, women-owned, small business  
8 who does an occupational health program and has worked  
9 with vaccine and immunization tracking programs. So you  
10 can't buy heart and soul, but it is nice when you see it  
11 in a contractor. This is their first federal contract,  
12 and they are absolutely delighted to be working on this  
13 project. So it has been a pleasure to have them come  
14 aboard.

15 Then, for the evaluation, you want the firm and  
16 proven, solid standard, and Westat is the one that is  
17 going to be working on the evaluation side of the house.

18 We want to describe use, basically, within the  
19 opioid treatment programs, and the Minority AIDS  
20 Initiative grantees on the CSAP and the CSAT side. In  
21 the buprenorphine programs we really don't expect a lot  
22 of people, and that has actually been proven. These are

1 such good programs, they have all the vaccine they need.

2 So if we can leverage any of the things that they know,  
3 that is actually good information for us as well.

4 The evaluation strategy basically has been  
5 descriptive. I mean, this is just the beginning, so this  
6 is a work in progress as I'm speaking right now. I'm  
7 collecting their operating procedures, a description of  
8 the vaccine program, having a sense of how these programs  
9 are trying to work together, and looking at the  
10 acquisition process. The letter of agreement was very  
11 simple, at least in my mind. It was like, who is going  
12 to talk to the evaluator, who is going to order the  
13 vaccine. So we have points of contact for the  
14 contractors. Then we can look at how this actually gets  
15 implemented in a real setting.

16 Pretty simple, actually. You have the at-risk  
17 patients, some of whom will get the first shot. I don't  
18 know quite how much we will find out about that global  
19 environment, but for those that receive this first shot,  
20 there are varying levels of information quality and  
21 collection things in place.

22 But some health departments, for instance, have

1 a fairly solid immunization tracking system. I do a  
2 part-time practice. They show up, they don't show up,  
3 they are late, they are not late, and I'm pretty lucky if  
4 I know who is late and who is not showing up. So at some  
5 level you are going to be looking at who has gotten the  
6 first shot, and from that cluster of people, that group,  
7 who is not returning and why might they not be returning.

8 They might not be patients anymore. They might not want  
9 the shot. But we will just have a sense, not going into  
10 research but staying very much within program evaluation,  
11 as to how successful this program penetrates and what the  
12 missed opportunities have been.

13 The analysis as we have it at this point.  
14 Basically, it has been coming in at about 50 to 2,000  
15 patients per program. I basically used all the money I  
16 had to buy as much vaccine as I could. So it is  
17 basically 43,950 doses. Because of the packaging, once  
18 you commit one you have to commit two more. So that  
19 totals out to 14,650 people.

20 As agreements come in and I try to estimate,  
21 basically you end up with, how much could you do in the  
22 next year if you had vaccine that you normally couldn't

1 use. It is like free gas for a car, actually, when you  
2 think about it. I'm not trying to create the  
3 infrastructure to do training. People can call up Glaxo-  
4 Kline Smith and they will be glad to come out and do  
5 training or something like that. They can do that. In  
6 the meantime, I can get the vaccine out and allocated to  
7 what the programs think they can do at this point in  
8 time.

9           So the sums really have come in. I think there  
10 is an honest attempt to figure out, seriously, what will  
11 we use in the next year and how many patients might we  
12 see. So it has been between 50 to 2,000 patients, which  
13 has actually been almost two to three times more than we  
14 thought programs would be requesting. So there is really  
15 an unmet demand.

16           In your booklet, you will see that I said at  
17 the beginning of the month it was 6,137 or so people  
18 spoken for over about 18 programs. As of today, I think  
19 we have actually hit our target. But I can account for  
20 13,900-and-something, so I can negotiate with some of  
21 these larger numbers to kind of feed in the smaller  
22 programs that still might want to be part of it, but we

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1 are rapidly reaching our cap. Then we will try to  
2 reallocate with the shipments that will go out to the  
3 programs in terms of how many are you really reaching out  
4 to. As soon as there is a remainder of three, there is  
5 somebody else that might be able to get the vaccination.

6 So this is where we kind of look at the percent  
7 finishing one, two, and three shots. There is a backup  
8 if anything really nasty happens in the series. The  
9 VAERS reporting system should be picking that up, but we  
10 will be picking up more of the process and penetration  
11 and the ability of us to provide the service within these  
12 different treatment settings.

13 The initiative outcomes really are, I think,  
14 initially to identify the missed opportunities. It has  
15 been pretty clear that we have had some fairly large  
16 areas that we are just not set up for. They say, "We  
17 know we need the service and we would love to be able to  
18 do it, but with funding cuts and everything we can't even  
19 get the staff."

20 There have been other places which have been  
21 kind of surprising. You find out that they are getting  
22 money from here and they are getting money from there and

1 they kind of pull things together underneath, but this  
2 report goes there and this report goes there. If I start  
3 talking, I can say, "You actually understand this? You  
4 know what is going on?" "Yes."

5 They will say, "Do we have to vaccinate just  
6 the people that are under this grant?" "No, you get to  
7 the people that need the vaccine given the criteria we  
8 set up." The only bias I'm putting in play is, can you  
9 predict the people that you might see over the next six  
10 months so we can target.

11 Then, we want to describe the connectivity that  
12 is going on between the immunization or the substance  
13 abuse treatment program to see whether there is some kind  
14 of a best practice that is evolving. What has come out  
15 at least in two sites is that there is an underlying  
16 primary care practice that actually serves several  
17 different grantees.

18 A lot of these prevention grantees do have  
19 treatment capability. Treatment programs and treatment  
20 grantees do have prevention capability. They have  
21 actually tied this stuff together. But you are really  
22 looking at the connectivity to kind of figure out how you

1 can get a comprehensive service.

2           There have been at least two where the primary  
3 care people that actually do immunizations connect both  
4 ways. They have been, actually, very helpful. Then what  
5 you might be seeing is that you have a very complete  
6 program here and you have a very complete program there.

7           What you really need is a little hinge to bring it  
8 together, and that might be very low-cost. But the thing  
9 is, it just has to be acknowledged and recognized to  
10 bring it together.

11           So part of the process that has happened just  
12 in the conversations I have had and the interest that  
13 people have had since the beginning of this has been that  
14 they have actually been talking together to see how can  
15 they improve the flow of information and, for that  
16 matter, a little bit of the funding. It is not actually  
17 the money but it is the nurse that might be needed to go  
18 here to do the immunization. They just haven't really  
19 met the treatment program all that well, but they know  
20 each other. So this brings them together.

21           So with that, I will leave this open to  
22 questions. As I say, this is a work in process. Over

1 the next couple of months, there is going to be an awful  
2 lot of vaccine going out.

3 Yes.

4 **Question-and-Answer Session**

5 DR. McCORRY: Ken, it is amazing to me the gap  
6 that exists between county health departments and  
7 substance abuse treatment programs. It is just amazing  
8 how little these two institutions relate to each other  
9 within a particular locality. These kinds of programs  
10 are exactly what we need to bring them together.

11 I don't think New York is part of your study,  
12 but we went to the Department of Health and we developed  
13 a "Vaccinate, Don't Procrastinate" pilot program in which  
14 we are looking at two small counties, modest-size  
15 counties, and trying to get everyone who is in treatment  
16 vaccinated with A and B using the county health  
17 departments. We got the vaccine from the state health  
18 department, who gets it from the CDC, I think, for free.  
19 There is some kind of deal there.

20 So we are looking at it just trying to develop  
21 relationships. We are also incentivizing. So someone  
22 that is lost to treatment, if they show up at the county

1 health department, they will get a \$10 gift certificate  
2 or something. We are doing a little contingency  
3 management on it.

4 But this is absolutely amazing. How can public  
5 health exist, at least in New York, so separately from  
6 substance abuse treatment, except on like HIV. But even  
7 there, we have developed a capacity within the substance  
8 abuse treatment system around HIV in high-incidence  
9 states and high-problem states. So there is a real  
10 separation and kind of like an ignorance between both  
11 systems around the capability of either system to help  
12 both of them around issues like vaccination.

13 I don't know why we don't get pneumonia  
14 vaccinations. There is a whole vaccination public health  
15 initiative. When we know that our folks are the vectors  
16 for so many of these kinds of diseases, why aren't we on  
17 the list of places for county health department nurses to  
18 show up to vaccinate folks, whether it is A or B or some  
19 of these other conditions.

20 DR. HOFFMAN: Relieving a bit of history --  
21 well, maybe not totally reliving it, but the 1950s where  
22 we almost got rid of tuberculosis, but because we ignored

1 the population that we could have eliminated it within,  
2 look what we have now. So you are absolutely right.

3 DR. CLARK: Chilo.

4 DR. MADRID: With heroin going at \$2.50 a  
5 quarter of a gram where I come from, there are a lot of  
6 IV drug users on the street that need hepatitis A and B  
7 vaccinations. When I talked with you, Dr. Hoffman, I  
8 said, "Well, we have the health department and we have  
9 two primary health clinics that will vaccinate for us.  
10 We went to them and they said, 'Wait a minute. We don't  
11 know whether we want to do that or not.'" At this time,  
12 what we are going to do is we are going to get our  
13 methadone doctor and nurse to do it. So what we are  
14 faced with is developing a vaccination department within  
15 our agency.

16 But again, that is what we were talking about  
17 here, and that is the type of collaboration that is  
18 needed, but yet they said, "We will do it, but do you  
19 have monies for our doctors and for the nurses' time and  
20 so forth?"

21 Again, I think this is a very, very good  
22 program. It is much needed, and we are going to be right

1 there developing it.

2 DR. HOFFMAN: I was looking forward to hearing  
3 from you. That is exactly right. Actually, I did have a  
4 phone call today from El Paso.

5 DR. CLARK: This effort is funded by the  
6 Department but I think was imagined by the Division of  
7 Pharmacologic Therapies. We have Bob Lubin [ph] in the  
8 audience and several of his staff, including Dr. Hoffman.  
9 They should be commended.

10 Oddly enough, today I received one of these fax  
11 things on my Blackberry. There is a jurisdiction, which  
12 I won't name, where they are discussing this issue of  
13 vaccination. It said, "Please Email or fax me a letter  
14 of support for the important health care bill. It can  
15 save lives and our health care dollars. Hepatitis A and  
16 B are preventable diseases that can affect the homeless.

17 "The department of health does not currently  
18 provide hepatitis A vaccine to uninsured adults. The  
19 insurance company may not pay for hepatitis A or B  
20 vaccine for the homeless if they do not fit into very  
21 specific criteria, even though the homeless can be at  
22 high risk for exposure to infectious diseases. I have

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1 often seen some mentally ill and/or homeless even eating  
2 out of garbage cans or picking up cigarette butts to  
3 smoke, where exposure to hepatitis A and other infectious  
4 diseases can be easily transmitted. Please send me a  
5 letter of support," et cetera.

6 So this whole issue is something that SAMHSA  
7 has anticipated and the Department has seen fit to give  
8 us funds so that we can begin to address it. So I want  
9 to commend Dr. Hoffman and the Division of Pharmacologic  
10 Therapies for envisioning the need for this. This is a  
11 parallel effort with our Rapid Testing Initiative.

12 We do encounter resistance. It is an odd kind  
13 of thing. People say, "Well, if you don't pay for this  
14 and you don't pay for this, we can't do it." So they  
15 basically say, "If we don't look for it, it is not  
16 there." As we know from the prevalence rates, it is  
17 there whether you look for it or not.

18 So I want to commend my staff for their  
19 imagination and persistence for getting this done, and  
20 Ken, for your working on this specifically. Clearly, as  
21 you point out, it makes no sense not to do it.

22 At some point, some wise and sophisticated

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1 lawyer -- how long before I retire? -- will decide to sue  
2 one of these programs for failing to do this because the  
3 client next to him has hepatitis A or B and that could  
4 have been avoidable. It was predictable that they would  
5 share cigarettes, they would share this, they would share  
6 that, and they got their hepatitis from the negligence,  
7 if you will, of the delivery of the system.

8           But I think in fact we need to keep these  
9 things in mind. We have reservoirs of infection and we  
10 can begin to address these reservoirs of infection  
11 through our immunization and testing strategies. I think  
12 that this is a very important thing, and that is one of  
13 the reasons we have taken advantage of the Department's  
14 willingness to invest in these areas. We can't deal with  
15 these issues if we don't start. I mean, it is not going  
16 to happen.

17           We can't always pay for sophisticated  
18 infrastructure, particularly when in our delivery system  
19 we are supposed to be doing some passing physicals or  
20 passing health care assessments anyway. The immunization  
21 and the testing are fairly de minimis in terms of  
22 intrusion in people's lives, but they can help save

1 people's lives.

2 Any other questions for Dr. Hoffman?

3 DR. HOFFMAN: I would also like to give a lot  
4 of credit to Tom Cressina, who is on loan from NIDA, who  
5 actually is from an infectious disease background and  
6 really amplified, I think, the need to get engaged in  
7 this area for us. So everyone works well together.

8 DR. CLARK: We are all working with the CDC on  
9 this, and we don't want to diminish that collaboration.  
10 Our effort is to work within the agencies of HHS to  
11 achieve this. We have a buprenorphine effort with HRSA  
12 in their HIV arena.

13 Again, if we are going to talk about primary  
14 care, if we are going to talk about being integrated, we  
15 have got to make some concrete efforts rather than  
16 rhetorical efforts, and that is what we are trying to do.  
17 So I think council needs to hear about that.

18 I think that is our last formal presentation  
19 for today. The remaining time is set aside as an open  
20 discussion period for council members to bring up and  
21 discuss any issues that they may wish to pursue, whether  
22 they are related to today's presentations or other

1 matters of interest. I turn it over to the council.

2 Melody.

3 MS. HEAPS: Finishing from Frank McCorry's  
4 comments about workforce development this morning, two  
5 things. One, I can't remember who made a presentation at  
6 one of our last meetings about workforce development that  
7 you were doing and a report that was coming out. I know  
8 that Partners for Recovery has been working on a report.

9 So I would recommend two things: that the  
10 advisory council see the report and that next time we get  
11 a full briefing on what the workforce development project  
12 is because I think, as Frank said, it is critical.

13 Everybody, actually, that talked today, the IOM report,  
14 the issue of information, it is all there. It is like  
15 the gorilla or elephant in the room.

16 DR. CLARK: Well, in fact, SAMHSA is working on  
17 a report to Congress, as you know, on the appropriation  
18 bill. It was a requirement that there be a report to  
19 Congress on substance abuse treatment. So we will be  
20 working on that, and once the report is complete, we will  
21 be able to share that report with council members. Once  
22 it is submitted, it becomes a document that will be

1 readily available.

2 I think Frank's point, even though he had to  
3 step out, is critical. We need to conceptualize the  
4 continuing care based on that report, and we can also, as  
5 we work with the Annapolis Coalition, remind them of some  
6 of the issues.

7 One of the issues that we have talked about is,  
8 the people who present for substance abuse treatment  
9 often have co-occurring disorders, but we have a  
10 financing structure in terms of public sector financing  
11 that sequesters the mentally ill into the category of the  
12 severe and persistently mentally ill.

13 Those people who don't meet those criteria are  
14 generally not eligible for publicly available care, which  
15 means that if they don't have a co-occurring disorder in  
16 terms of a substance abuse problem, they don't get their  
17 issues addressed. It is critical that substance abuse  
18 treatment programs recognize that there is a high  
19 prevalence of co-occurring mild to moderate depression  
20 and mild to moderate anxiety disorders.

21 We have fewer people in the whole system who  
22 suffer from psychotic disorders, but with

1 methamphetamine, we are also finding that there are  
2 people who are presenting for treatment who suffer from  
3 psychotic disorders secondary to methamphetamine  
4 triggers. Again, our substance abuse treatment programs  
5 are having to address some of these issues.

6           So we need to make sure we have staff, as Frank  
7 pointed out, who have the skill set necessary for the  
8 assessment and the monitoring and the referrals or the  
9 medications, depending on the context of the program, so  
10 that we can address this broad spectrum of issues. It is  
11 a different presentation.

12           Chilo?

13           DR. MADRID: Would it be proper to request that  
14 the Annapolis group come in sometime in the future and  
15 give us a report as to their activities concerning  
16 workforce issues?

17           DR. CLARK: I think that would be proper. We  
18 will see what the procedure is to do that. All three  
19 centers are contributing a substantial amount of money to  
20 this activity.

21           Council has, I think, an appropriate role in  
22 seeing how that progresses from a substance abuse

1 treatment point of view. So we will find an appropriate  
2 time for them to present a summary of their activities  
3 with regard to substance abuse treatment.

4 Any other questions?

5 DR. MADRID: The hotel is willing to provide  
6 special transportation to Reagan tomorrow. They will  
7 pick us up here at 1:00 in the afternoon at a reduced  
8 rate. How many of you are going to Reagan tomorrow?  
9 Three of us? I will them in the morning. Four? Maybe  
10 five. They are willing to take the van at a reduced  
11 rate.

12 DR. CLARK: All right. Now that we have  
13 another major public policy issue addressed, any other  
14 items for discussion?

15 [No response.]

16 DR. CLARK: No other items, no other questions  
17 for today? Well then, I will entertain a motion to  
18 adjourn for today. We will reconvene tomorrow at 9:00.

19 [Moved.]

20 [Seconded.]

21 DR. CLARK: It has been moved and seconded that  
22 we adjourn for today and reconvene tomorrow at 9:00. We

1 will adjourn tomorrow by 1:00.

2 All those in favor?

3 [Motion carried.]

4 DR. CLARK: So moved. We are adjourned.

5 [Whereupon, at 4:27 p.m., the meeting was  
6 recessed, to reconvene the following day at 9:00 a.m.]

7 + + +

**CERTIFICATION**

This is to certify that the attached proceedings

BEFORE THE: CSAT National Advisory Council

HELD: February 2-3, 2006

were convened as herein appears, and that this is the official transcript thereof for the file of the Department or Commission.

DEBORAH TALLMAN, Court Reporter