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SUBSTANCE ABUSE and MENTAL HEALTH SERVICES ADMINISTRATION

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

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VOLUME II

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1 PROCEEDINGS

2 [9:10 a.m.]

3 DR. CLARK: Welcome to the second and final day
4 of the 45th meeting of the CSAT National Advisory
5 Council. The spread of methamphetamine across the
6 country has alarmed officials at local, state, and
7 federal levels, individuals in tribes within the tribal
8 community, both within reservations and off reservations.

9 The increase of methamphetamine production, trafficking,
10 and use has created pressures on the criminal justice
11 system, child welfare, and the treatment systems.

12 Cheryl Gallagher, public health advisor in
13 CSAT's Division of Services Improvement, Systems
14 Improvement Branch, is our first presenter today. Cheryl
15 will discuss CSAT's response to the methamphetamine
16 problem.

17 Cheryl.

18 **Methamphetamine**

19 **Cheryl Gallagher, M.A.**

20 [PowerPoint presentation.]

21 MS. GALLAGHER: Thank you, Dr. Clark.

22 Good morning. Today, I'm going to talk to you

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1 about methamphetamine and our efforts here at CSAT
2 regarding treatment. First, I would like to introduce my
3 colleague at CRAFFT who is working on methamphetamine
4 activities with me. He will be available for questions,
5 as well as I will, anytime.

6 As you know, and Dr. Clark just said, meth has
7 recently had a lot of media coverage. It is a powerful
8 stimulant, and it is highly addictive. We have had
9 questions from Congress regarding what we are doing here
10 at SAMHSA to address this problem. Mr. Curie and Dr.
11 Clark have testified before Congress and have briefed
12 congressional staff on numerous occasions. Fortunately,
13 we have been doing quite a lot here at CSAT, so we have
14 plenty of information to share.

15 Our first major effort was in 1998. General
16 McAfree [ph] was bringing attention to meth at ONDCP, and
17 here at CSAT we were hearing from the field that meth was
18 a major problem in our western states and was spreading
19 eastward. Our response was to design a cooperative
20 agreement that addressed dependence on methamphetamine.

21 NIDA had identified that the Matrix model was
22 an evidence-based treatment protocol that was effective

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1 in treating cocaine and methamphetamine. Matrix is a
2 manualized protocol, and we wanted to see if it could
3 successfully be transferred to community treatment
4 providers. We also wanted to look at the existing
5 treatment available in the community.

6 We released a request for applicants, and in
7 1999, we funded seven study sites and one coordinating
8 center. The coordinating center was UCLA, and Drs. Doug
9 England and Richard Rossin were the principal
10 investigators. The seven study sites were located in
11 California, Hawaii, and Montana. All of the sites had
12 been treating adults dependent on meth for a minimum of
13 two years. That means they had been treating two years,
14 but the people had to have been dependent for the most
15 part seven and a half years before they came to treatment
16 for meth dependence.

17 The sites offered us a variety of populations.

18 The Billings site had Native Americans from the Crow
19 Reservation. The Hawaii site had Native Hawaiians and
20 Pacific Islanders, and it was an all-women's program.
21 The Hayward site was a drug court population. San Mateo
22 had two locations. One was serving an Asian population

1 and the other, at Pyramid, was serving a rural clientele.

2 The project was successful and produced a lot
3 of lessons learned about knowledge transfer and about
4 meth clients. The collaboration produced several
5 publications. One of the ongoing things that we had was
6 a website, methamphetamine.org. That is still up, and it
7 describes the project, and it had a lot of literature on
8 up-to-date information on methamphetamine.

9 Then the Journal of Psychoactive Drugs
10 published a description of the study and the sites in a
11 special April/June issue in 2000. Lastly, the Journal of
12 Addiction published our outcome paper in June of 2004.

13 The good news was that the treatments that were
14 offered both at the Matrix and the "treatments as usual"
15 at the sites provided clients with recovery at the same
16 rates as recovery from other drug dependence. The
17 "treatment as usual" protocols had many of the same
18 elements as the Matrix model, such as cognitive
19 behavioral therapy, psychosocial approaches, and
20 motivational enhancements. So we weren't surprised that
21 they both looked like they worked, but they did work very
22 well.

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1 We had 978 clients in this study, and the site
2 with the very best results was the drug court site. So
3 we were happy to see that, too.

4 We also, at the same time, published our TIP
5 #33 and the Companion Products Treatment for Stimulant
6 Use Disorders. We participated on the Interagency
7 Taskforce on Methamphetamine that was sponsored by the
8 Department of Justice and ONDCP, and they had their final
9 report published in June of 2000. It is available
10 online, and I have copies if you would like that, too.

11 We collaborated with the State Department to
12 provide technical assistance to the Ministry of Public
13 Health in Thailand on a Matrix model. This was a direct
14 result of the Methamphetamine Treatment Project and the
15 website. It was a psychiatrist working for the State
16 Department in Thailand who was looking for some kinds of
17 information on meth because they were having such a huge
18 problem with methamphetamine in Thailand. So he
19 contacted Dr. Clark, and then the State Department
20 requested that we provide some technical assistance
21 there.

22 So our people from the Matrix Institute on

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1 Addictions, from the UCLA Coordinating Center, Dr. Clark,
2 myself, and John Campbell went to Thailand and provided
3 them with assistance.

4 In the beginning, the program was supposed to
5 be just one pilot study at Tanurak [ph] Hospital in
6 Bangkok, but after we were there for only a week, they
7 decided to expand to seven treatment providers in
8 different sites around Thailand. The next time that
9 there was a meeting with the Matrix people, they had
10 included 12 mental health hospitals. At this time, they
11 have included all their regional hospitals in all of
12 Thailand, so that is 800 sites. So they really have a
13 very extensive rollout of the Matrix model there.

14 We also had a Comprehensive Community Treatment
15 Program on behavioral therapies for gay male stimulant
16 users and alcohol users at the same time. Steve Shoptaw
17 [ph] was the principal investigator on that program, and
18 he took the Matrix manual and adapted it for that
19 specific population. So we have some information about
20 that, too.

21 We also sponsored conferences. The first one
22 was in 1998 in St. Louis. It was a collaboration with

1 our Target Cities project there. Missouri was already
2 seeing problems with methamphetamine in 1998 and was
3 looking for information, so we had a two-day conference
4 there.

5 Then we had a conference in Hawaii that was
6 connected to a town hall meeting that was sponsored by
7 their state legislature. We heard from over 50
8 recovering clients and family members and got a lot of
9 information about what an intergenerational problem
10 methamphetamine use is in Honolulu. Kids would talk
11 about how they couldn't go home at Christmas because
12 their parents were using, so they had to stay in the
13 treatment site. So there are lots of problems there, and
14 we have been addressing that.

15 We had a one-day meeting in Hollywood,
16 California, that did address stimulant use and the gay
17 population. Then, San Mateo and Portland both had
18 conferences with over 500 participants. Portland had 500
19 registered, but other people showed up at the end because
20 people were calling them and saying, "This is a really
21 good conference. You have to come down here." So they
22 opened the doors to the rooms where we had our breakout

1 sessions, and people stood in the halls to hear the
2 presenters because the information was so necessary to
3 their area. I mean, Oregon has had a lot of problems
4 with methamphetamine.

5 Then, Billings had a conference scheduled for
6 right after 9/11, so a lot of people could not get there
7 because there were no flights, et cetera. But they
8 decided to go ahead with the conference, and they had
9 over 200 people drive to the conference and attend the
10 meetings there. So the Billings site was very helpful in
11 keeping that going since we weren't there.

12 Then, in '03, we funded two sole source
13 programs through our Targeted Capacity Expansion: the
14 County of Hawaii, Office of the Mayor in Hilo on the big
15 island of Hawaii, and the Ohio Department of Public
16 Health, which really continued a program that they had
17 begun in a competitive grant with TCE and were having
18 very good results with.

19 Then, in '04, we funded six competitive grants,
20 and they were in urban areas in California, Washington,
21 Oregon, and Texas. Then, this year, in '05, we funded 11
22 new meth grants in rural areas. The rural areas are

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1 really being hit by methamphetamine primarily because the
2 labs could be in rural areas without being detected as
3 easily. So they have had a big influx of meth use and
4 they had not experienced this kind of thing before, so
5 they really needed some help treatment capacity. So they
6 are in Texas, Georgia, Oregon, California, New Mexico,
7 Tennessee, and Montana.

8 We also have family and juvenile treatment drug
9 courts. They, of course, do see a great number of meth
10 clients. We have 41 active drug courts that were funded
11 in 2004 and 14 new ones that were funded in '05. We are
12 encouraging all of those grantees to establish
13 partnerships with their Drug Endangered Children Programs
14 in their local areas to address the needs of children
15 living in environments where meth is manufactured.

16 As I said, we had our best results with the
17 drug court population and the meth treatment study, and
18 we believe that is because it is such an incentive for
19 people to get into treatment and to stay in treatment.
20 The judges really provide a lot of positive feedback to
21 the clients, and it is very helpful for them in
22 maintaining their sobriety.

1 As you heard yesterday, Access to Recovery is a
2 very extensive program here. We have two states that
3 have identified methamphetamine as their specific target
4 area, Tennessee and Wyoming. So we will be hearing from
5 them later how that is going and what they are finding
6 with methamphetamine.

7 Tennessee did have a lot of problems with the
8 labs which probably encouraged them to apply with this
9 specific area. A lot of their hospitals were treating
10 people with burns. It was costing a lot of money because
11 people didn't have insurance, of course, and we did have
12 some people travel there from ONDCP and see the burn
13 units. Of the 14 beds, they were almost all filled with
14 people that were recovering from burns with
15 methamphetamine.

16 We are also engaged in an interagency agreement
17 with the Drug Enforcement Agency, DEA, to provide funding
18 for summits for the governors on methamphetamine. These
19 summits provide a venue for developing strategic plans to
20 address the meth problem in the community. So we have
21 already funded three in 2005 that have taken place,
22 Wisconsin, Georgia, and West Virginia. The next one will

1 be in New York and we think in April. I don't have the
2 specific date yet. After that, we are going to be
3 following up with Virginia.

4 One Sky is our Alaska Native and American
5 Indian national resource center. They held a summit in
6 2005 to develop a strategy to address the high incidence
7 of methamphetamine on tribal lands. The dependence and
8 addiction on the Crow Reservation in Crow Agency,
9 Montana, was the specific target. They have a media
10 campaign to educate the youth on effects of meth. They
11 have an assessment on the severity of meth on tribal
12 lands. They are working on coalition development for the
13 tribal communities, and they are coordinating interaction
14 between the treatment providers to try to maximize their
15 treatment capacity.

16 Our ATTCs are doing a lot of work on
17 methamphetamine. They are expanding training activities,
18 they are bringing empirically supported treatment
19 knowledge and meaningful training opportunities through
20 clinicians in methamphetamine-affected areas, and they
21 are providing products on the knowledge about meth to the
22 public and to treatment providers.

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1 We have 15 ATTCs. They all are doing something
2 regarding methamphetamines, so no matter what area of the
3 country you are located in there is an ATTC with programs
4 available.

5 Two examples, though, are the Pacific Southwest
6 Addiction Technology Transfer Center, which has developed
7 our digital training module, Meth 101, and Meth 102,
8 produced by the Applied Behavioral Health Policy at the
9 University of Arizona. That is a very good product, and
10 I would be happy to share it with any of you. I have
11 some copies in my office if you would like to take a look
12 at it.

13 The Prairielands ATTC sponsored training in
14 Iowa on the history and symptomatology of meth in
15 October. They sponsored a presentation on best practices
16 in assessment and treatment at the Upper Plains Summer
17 Institute in Sioux Falls, South Dakota, in August. They
18 are currently working with Minnesota and North Dakota
19 with the SSA directors on the 2006 training plan
20 regarding methamphetamine.

21 Our Block Grant is working on methamphetamine,
22 also. They are developing flyers and informational

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1 sheets to share with the states as to what is available
2 for technical assistance. They are providing examples of
3 technical assistance that have been provided in the past
4 to help people think about what they need. They are
5 encouraging all the states to request TA.

6 They are planning two regional meetings,
7 Methamphetamine Treatment: Effective Approaches. The
8 first will be in Los Angeles, California, April 5th
9 through 7th, and the second will be in Orlando, Florida,
10 May 23rd through the 25th.

11 We also have a workgroup here at CSAT to
12 address issues on methamphetamine. We are currently
13 working with IHS to help them with their planning of
14 methamphetamine meetings that are coming up this year and
15 to provide resources like speakers and other things like
16 that, perhaps even sponsoring some people going to the
17 conference.

18 SAMHSA also has a Workgroup on Synthetic Drugs
19 that is addressing methamphetamine use, and we are going
20 to be working with them more extensively as time goes on.

21 They are going to be working with ONDCP, also.

22 We are collaborating with CDC on

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1 methamphetamine and infectious disease and also with
2 CSAP. The two centers and the agency are going to be
3 working together.

4 As I said, we have our TIP, which is a
5 wonderful resource on treatment protocols for stimulant
6 use. It is very well received, and people really give us
7 a lot of good feedback on it, the KAP Keys and Quick
8 Guides that accompany it, and our Meth 101 and 102.

9 If you have questions, I would be happy to
10 entertain them now, or you can contact me later. You can
11 also contact Ed Kraft if you would like. His phone is
12 276-1571.

13 **Question-and-Answer Session**

14 So, any questions? Yes.

15 DR. MADRID: Do you have on file the different
16 state legislative directions that legislators have taken
17 concerning methamphetamine, like for example the control
18 of pseudoephedrine and stuff like that?

19 MS. GALLAGHER: We have some of that. We don't
20 have all of it, I don't think, but we can get that for
21 specific states whenever we want to. I mean, that is not
22 a difficult thing to come by. If you want me to get that

1 for you, I can do that.

2 DR. MADRID: I would appreciate it, because we
3 are planning on doing some of those things in Texas. We
4 have already started in the last session, but this
5 session there is going to be a lot of emphasis on
6 methamphetamine legislation.

7 MS. GALLAGHER: Right.

8 DR. MADRID: I would like to see what other
9 states are doing.

10 MS. GALLAGHER: A lot of states have put the
11 pseudoephedrine behind the counter, and it has helped in
12 limiting the labs in their states. However, it has not
13 really affected treatment because we are having just as
14 many people present for treatment and go to the emergency
15 room.

16 The purity of the drug that is coming from
17 Mexico is greater than what they were making in their own
18 labs. So we are having problems with overdose and things
19 like that now, too. So it is not a cure, but it is a
20 help.

21 DR. MADRID: Thank you.

22 MS. GALLAGHER: Yes.

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1 DR. McCORRY: What does the picture look like
2 in terms of methamphetamine use? Is it continuing to
3 increase, or is it still kind of disseminated across the
4 country?

5 MS. GALLAGHER: It is disseminated across the
6 country. It looks like it is increasing. However, here
7 at CSAT, across our whole discretionary portfolio, we
8 have only 5 percent of our population that uses
9 methamphetamine. The other drugs are still ahead of
10 them. In specific states, though, there are more
11 treatments in emergency rooms for meth than for cocaine
12 or for heroin. So it depends on where you are, and it is
13 spreading to the east now.

14 DR. McCORRY: Is there a continued slow-but-
15 steady increase in the number of methamphetamine users?

16 MS. GALLAGHER: I would have to back and look
17 to see if it has increased because I have only gotten the
18 recent studies on it.

19 Do you know, Dr. Clark?

20 DR. CLARK: The Household Survey data does not
21 show an increase in the prevalence. It does show an
22 increase in the number of people dependent. So the

1 people who are using are dependent.

2 But again, the other issue, though, is that we
3 still see a proliferation of labs. We were just talking
4 to Ken Johnson in Maine. They busted two labs in the
5 State of Maine. Last year, we had a meeting with the
6 attorneys general for the New England states, and they
7 were reporting beginning dealing with this issue, but
8 ultimately the New England states and the northeast
9 states have a larger cocaine and heroin problem than,
10 say, the Great Midwest. So you may have reached
11 saturation points due to competing drugs and economic
12 interests and drug dealers and drug wars and that sort of
13 thing.

14 DR. SKIPPER: Do you have any idea why the
15 group that was treated within the drug court did better
16 than the others?

17 MS. GALLAGHER: Well, we think that it had a
18 lot to do with the time in treatment because they were
19 required to stay a longer time and methamphetamine does
20 require time for the brain to heal. They were in
21 treatment longer, so that was one factor.

22 Also, we think that the incentives provided by

1 the judge were very helpful, that kind of motivation.

2 Not only the negative incentives and the sanctions, but

3 also the rewards that they got. Just standing up and

4 saying, "You did a great job" when they did a great job.

5 They had more clean urines than any of the other groups,

6 too, and they were tested twice as often because the

7 court tested them and they were also tested clinically.

8 JUDGE WHITE-FISH: Eugene White-Fish here. Do

9 you have any numbers regarding the Native American

10 population on this?

11 MS. GALLAGHER: No, I don't. I really would

12 have to refer to the people in our agency that deal with

13 the Native populations. Love Foster-Horton is working

14 with One Sky. She is a resource, and George Samoya [ph]

15 could also help with that.

16 DR. CLARK: Our Household Survey data shows, in

17 terms of prevalence rate by population, Native Americans

18 tend to be second only to whites in the prevalence rate

19 of using methamphetamine. Of course, there are more

20 whites than there are Native Americans, so the absolute

21 numbers are greater among the white population. But

22 Hispanics and American Indians tend to be following

1 closely on the heels of white users.

2 The lowest population is African American, and
3 the next-lowest population is Asian, in prevalence rates.

4 MS. GALLAGHER: Yes.

5 MS. JACKSON: I guess, following the
6 conversation, living in Florida, the trend there is not
7 particularly high for meth. Not to minimize it because I
8 think that it is definitely a huge issue in certain parts
9 of the population, but just in following the
10 conversation, is there some work that you are doing or
11 that anybody is doing? You said it is spreading to the
12 east. I don't know if it is spreading.

13 We, meaning my agency, along with a coalition,
14 had a prevention grant to look at the meth use and to do
15 some prevention in that area. We found pockets, but we
16 didn't find a huge prevalence at all. Is there a way to
17 look at this in a sort of pocketed way? Now, I know the
18 judge has indicated that among the Native Americans it is
19 a huge problem. Maybe you are already doing this, but is
20 there a way to kind of focus, and we are not prevention,
21 but ultimately prevention to those areas?

22 MS. GALLAGHER: Well, I think that is part of

1 the reason that we focused this last GFA on rural areas.

2 We saw that they were having problems and didn't have
3 any treatment capacity to deal with it. Also, I think
4 that the ATRs identified it as a major problem in their
5 states or, in Wyoming's case, in one county. They did
6 focus their activity toward that area.

7 DR. SKIPPER: Is there an inclusion of the
8 prescription methamphetamines in the analysis of this?

9 MS. GALLAGHER: It looks like if people use the
10 prescription things like Ritalin as appropriately
11 prescribed there is no greater incidence of people
12 becoming addicted to methamphetamine when they are older
13 or later in life.

14 DR. SKIPPER: But I'm talking about, are we
15 including in the stats on methamphetamine abuse those
16 that are smart enough to get BlueCross to pay for their
17 supplies?

18 DR. CLARK: The Household Survey does that and
19 the DON data do that, but they appear to be a minority of
20 the users. The Household Survey apparently was never
21 designed to differentiate between prescription
22 methamphetamine and illicit methamphetamine produced by

1 labs. But again, the data do show that that tends to be
2 a minority.

3 We used to have the old ADAM data. They made
4 efforts to differentiate. So they are lumped together.

5 As Cheryl pointed out, the labs are
6 diminishing. The DEA publishes lab seizures, so you get
7 to see, based on the number of labs seized, what the
8 prevalence rate is. You do have to do it from a
9 targeted, community-driven point of view.

10 If you look at the Tennessee prevalence rate,
11 despite the fact that Tennessee has an ATR for
12 methamphetamine, the TEDS data show no substantial
13 increase in admissions in Tennessee because it does
14 statewide data estimates. The Household Survey shows no
15 particular increase in methamphetamine in Tennessee, yet
16 Tennessee has an ATR on methamphetamine.

17 It also has, to my knowledge, the only national
18 registry of methamphetamine offenders. Your name is now
19 online. You can go in and put the county in, and
20 people's names pop up if they have been arrested for
21 methamphetamine. They are up there next to the child
22 molesters and the sexual predators. So Tennessee has

1 taken a very aggressive posture, which clearly means that
2 the jurisdiction feels that it is a problem, despite the
3 fact that the state-based data from national estimates
4 don't show that there is a problem.

5 As Cheryl points out, we have to work in each
6 and every jurisdiction in terms of their perception of
7 the issue and their ability to prioritize the problems.

8 MS. GALLAGHER: Thank you.

9 DR. CLARK: Thank you, Cheryl.

10 [Applause.]

11 DR. CLARK: Our next presentation is going to
12 be on CSAT's Strengthening Treatment Access and Retention
13 Program and The Network for the Improvement of Addiction
14 Treatment. We have invited Dr. David Gustafson, director
15 of The Network for the Improvement of Addiction
16 Treatment, NIATx, to present on CSAT's Strengthening
17 Treatment Access and Retention Program and The Network
18 for the Improvement of Addiction Treatment.

19 NIATx is a technical resource center that
20 advances the use of process improvement methods to
21 improve client access and retention and treatment. NIATx
22 operates a pure learning collaborative for CSAT's STAR

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1 grantees and the Paths to Recovery grantees funded by the
2 Robert Wood Johnson Foundation.

3 Dr. Gustafson chairs the board of the Health
4 Institute. He is a fellow of the Association for Health
5 Services Research and a fellow of the American Medical
6 Informatics Association. He is also a past chair of the
7 Federal Science Panel on Interactive Communications in
8 Health.

9 Dr. Gustafson.

10 **CSAT's Strengthening Treatment Access**
11 **and Retention Program/**
12 **Network for Improvement of Addiction Treatment**
13 **David Gustafson, Ph.D.**

14 [PowerPoint presentation.]

15 DR. GUSTAFSON: Thank you.

16 I appreciate the opportunity to be here. A few
17 of you -- Frank, Richard, Westley -- have heard a fair
18 amount of this before, and so I would appreciate if you
19 don't snore in the process.

20 The Network for the Improvement of Addiction
21 Treatment is a partnership between two tremendous
22 organizations, CSAT and the Robert Wood Johnson

1 Foundation. They started out as separate initiatives.
2 One was called STAR, Strengthening Access and Retention,
3 which was funded by CSAT, and the other was Paths to
4 Recovery, which was funded by the Robert Wood Johnson
5 Foundation, but we soon began to merge those two
6 activities together and have been calling it The Network
7 for Improvement of Addiction Treatment.

8 During this presentation, I really want to make
9 three points. The first one is that there is a lot of
10 opportunity to improve access and retention in the area
11 of addiction treatment.

12 Secondly, I hope that you will leave this
13 conversation with a sense that process improvement is an
14 effective way to do that. Then the third is that in
15 order to really spread the idea of process improvement
16 throughout the field that state governments are key to
17 that. One of CSAT's new initiatives in that area, I
18 think, holds tremendous promise in terms of widespread
19 diffusion.

20 I didn't put any numbers up here, but the
21 picture, I think, tells a key story. Of all the people
22 who need care and addiction treatment, this is the

1 segment that aren't getting anything. Of the people who
2 enter into care, this is the number that complete
3 treatment, while this is the number that needs treatment.

4 Those statistics vary in terms of specificity,
5 but that picture gets the key point across that A) a lot
6 of people are not getting into treatment that need to be
7 there; and B) many people never complete treatment that
8 should.

9 I'm an engineer. When I entered into the
10 privilege of leading this particular program, I didn't
11 know anything about addiction treatment. So I got myself
12 admitted for heroin addiction, and I went through the
13 process of waiting the six weeks to get into my intake
14 and assessment. I went through the three hours of
15 interviews that took place in both New York City and in
16 Madison, Wisconsin. I created a fake persona in order to
17 be somewhat legitimate, although in the agencies that I
18 went through anybody I came in contact with knew I was a
19 fake person and I was just trying to understand what it
20 was like.

21 But it was really an amazing experience, and I
22 learned so much from it about what addiction treatment is

1 like and what it is like to try to get into it.

2 The persona we had created led the people to
3 conclude that I needed in-patient care or residential
4 care. They said, "But we don't have a bed for you. Why
5 don't you call once a week and leave a message to tell us
6 whether you are still interested." That is literally
7 what I did. I would call. I would get an answering
8 message that literally said, "Leave a message" and
9 nothing else. It didn't even say the name of the
10 organization. I called once a week for seven weeks,
11 leaving a message but never receiving any indication of
12 whether I was moving up the priority list, whether things
13 were getting closer to admission.

14 Finally, after seven weeks, they called me and
15 said, "Well, we have a bed for you. Why don't you come
16 in." When I came in, the first message that I got from a
17 person who greeted me at the door was, "You know, you
18 didn't call in Week 5." Those were the first words she
19 said to me. So from that I got this sense that if I
20 really were a heroin addict it would be hard to continue
21 on in treatment in that kind of vein.

22 As I got further into understanding what it is

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1 like in this field, I began to develop an incredible
2 respect for the people who work here. I mean, given the
3 low level of pay, you can understand the high turnover
4 rate, but it is just amazing how committed they are to
5 caring for people.

6 But what happens is that in between those
7 caring people and those people who desperately need help
8 is this enormous gap of business processes, things that
9 can get in the way, ranging from what happens during
10 first contact to what happens during intake and
11 assessment or what happens in the transition between
12 levels of care or the paperwork or the scheduling or the
13 therapeutic engagement. Those nine things that you see
14 up on the right-hand side there are the things that are
15 the targets of NIATx, the kind of processes that we are
16 trying to improve.

17 "Process Improvement" is one of several names
18 that characterize this particular area. Other names
19 include things like "Quality Improvement" or "Total
20 Quality Management" or things like that. But they have
21 been used in many industries around the world. Harley
22 Davidson Motorcycles and Toyota are organizations that

1 have used it, and there has been a lot of use of it more
2 recently in health care through an organization called
3 the Institute of Health Care Improvement. When this
4 initiative started, it started with the idea that these
5 kinds of strategies or approaches could make a
6 difference.

7 One of the key elements in process improvement
8 is to be really specific about what you are trying to
9 accomplish and not have a bunch of different directions
10 that you want to focus on. So we are only interested in
11 four things in this activity. One of them is to reduce
12 the amount of time it takes to get into treatment. The
13 second is to reduce the number of people who don't show
14 for their appointments for assessment. The third is to
15 increase admissions without increasing cost. The fourth
16 is to increase the number of people who stay in
17 treatment.

18 That's it. Nothing else. Those are the four
19 things that we are interested in doing. Nothing more
20 than that.

21 The NIATx activity is built around some
22 research that has been done where a number of researchers

1 have compared successful organizations, organizations
2 that have a reputation for being innovative, against
3 organizations in their industry that don't have that
4 reputation to try to figure out what the factors are that
5 distinguish between those successful and unsuccessful
6 organizations.

7 Only five things stand out. The five things
8 that stand out are, first, to be obsessed with
9 understanding who your customer is, what your customer
10 needs, and how your customer makes their buying
11 decisions. Anytime that one of our organizations moves
12 into a new process improvement activity, we ask them to
13 do a walk-through, like I did, to experience what it is
14 like to be their customers. We ask them to assume that
15 they don't have the foggiest idea what it is like to be a
16 customer of their organization.

17 Now, in addiction treatment that can be tough
18 because a number of people in this field of course are
19 previous patients. So they have the right to assume that
20 they know what it is like, but we really push the idea of
21 every time they move into this area they do a new walk-
22 through to understand what it is like to be a patient.

1 The second thing is that the only kind of
2 problems that people should attack should be problems
3 that, if solved, would help the CEO sleep better at
4 night. So they have to be very careful about selecting
5 problems that are right close to the agenda of the CEO
6 and the organization.

7 The third thing is that the change leader, the
8 person who is running the process improvement activity,
9 should know the telephone number of the CEO by heart,
10 should feel comfortable in calling at five o'clock in the
11 afternoon on a Sunday, and should be highly respected in
12 the organization. We want powerful change leaders in
13 this activity.

14 The fourth is that it is very important that
15 their search for ideas for improvement reach beyond the
16 boundaries of the organization into other organizations
17 and even into another field, like the cement industry.
18 The idea is that the further that you get from the
19 boundaries of your own organization, the more likely you
20 are to come up with innovative solutions to a problem.

21 The fifth is a mantra that we keep on pushing,
22 and that is organizational change is easy, it is not

1 hard. Organizational change can be made overnight, so
2 get over the idea that it is a hard thing to do. Just
3 get out there and say to yourself, "Monday morning, what
4 can we change? Now let's try it with a few patients."

5 When it doesn't work, figure out why it didn't
6 work. Make it a little bit better. Try it again with a
7 few more patients. Try it again with a few more
8 patients. Do this rapid-cycle testing to get results,
9 but get over the idea that change is hard because it
10 isn't. That focus is something that we keep on beating
11 into people.

12 NIATx is a membership organization now funded
13 by RWJ and CSAT that includes 44 organizations around the
14 country. Don't worry about the colors of the dots. It
15 just is an indicator of the time when these agencies
16 entered into the program. It makes no other difference.

17 Those cute circle pictures that are there are
18 the state agencies that have been involved in pilot
19 testing kind of activities. The dots are the 44
20 treatment organizations.

21 When you look at results of change, of course,
22 one of the things that you have to look at is what

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1 changes have been made and what are the results of them,
2 and then secondly, have those changes been sustained.
3 The results I'm about to present to you are what changes
4 have been made in tests, and the issue of whether they
5 will be sustained for another year or two years is a very
6 important question that we will be examining. But for
7 right now, we are talking about changes that have taken
8 place.

9 Thirty-seven change projects attempting to
10 reduce waiting times in 24 treatment agencies, a 51
11 percent reduction. One of the things, for example, that
12 agencies have done is they have just dropped the idea of
13 making appointments. Very often, when we did site visits
14 of treatment organizations and we would look down their
15 appointment books, what we would see is all the slots
16 filled up and then a line crossed through it, "No show."
17 Another line crossed through it, "Canceled." "No show,"
18 "canceled," to the point that when you would look at
19 these appointment books you would find 40 percent were
20 actually completed and about 60 percent ended up being
21 empty slots where there was no opportunity for
22 productivity.

1 So what we are encouraging is a process of open
2 access that says get rid of these appointments. Just let
3 people come in. Make room for them. It has had a
4 dramatic effect.

5 The second area is the area of reducing no-
6 shows. Twenty-eight projects in 21 agencies, 41 percent
7 reduction on average in the number of people who don't
8 show for treatment. A lot of different approaches have
9 been taken, but one of them is to make follow-up calls to
10 ask, "Why didn't you come?" What kind of barriers were
11 there. Figure out with the person how to remove those
12 barriers. Tell them that they are wanted, which seems to
13 be a big deal, and remind them of their appointment.

14 A 56 percent increase in admissions. One of
15 these things is due to just the transition of patients
16 between detox and out-patient, where what you do is try
17 to reduce the fear and increase the recognition of how
18 important that next level of care is. So getting people
19 to attend, maybe, some early meetings of the next level
20 of care down, maybe starting a client in out-patient
21 treatment while they are still in residential detox. One
22 agency's transfer rate has increased by 247 percent, but

1 overall it is a 56 percent increase.

2 Then, increasing continuation. There are a lot
3 of different activities that have been engaged in doing
4 that, but fundamentally one of the more exciting ones is
5 to take this idea of rapid-cycle improvement that has
6 been so successful in organizational change and get the
7 patients themselves to start thinking about that,
8 thinking about what they can do tomorrow. What is the
9 most important thing that they can do tomorrow to change
10 their lives. Try it out, see whether it works, fix it,
11 see whether it works a little better, fix it, see whether
12 it works a little better.

13 Let me give you a specific experience. Bridge
14 House is a treatment agency in New Orleans, or at least
15 it was until the hurricanes. It was pretty much
16 destroyed, and it is trying to get back on its feet right
17 now. It was a long-term residential facility for
18 indigent and homeless males with 130 beds. It was pretty
19 much self-funded. They sold used cars, they had thrift
20 stores, and that kind of stuff to keep going. This field
21 amazes me in terms of their creativity in how to fund
22 some of their work.

1 Their goal was really to try and increase the
2 continuation rate. They had a continuation rate that was
3 running about 53 percent when the project started. They
4 wanted to see if they could get it up to closer to 75
5 percent. They tried both administrative changes and
6 clinical changes.

7 An administrative change was that their
8 counselors had hours that went from noon until 8:00 at
9 night. While that was a heck of a lot better than you
10 see in a lot of places, where it is an 8:00 to 5:00
11 operation, the staff had this pretty clear indication
12 that if they stayed a little bit longer that they might
13 get a higher rate of people coming because it was just
14 difficult in many cases for these people to make it.

15 So one of the changes they made was to change
16 the hours from noon to 8:00, to 2:00 to 10:00. As it
17 turned out, then what they would do is they measured the
18 amount of time that was spent by counselors with clients
19 and found that it increased eight hours a week.
20 Strangely enough, the counselors and the patients were
21 really happy.

22 On the clinical side, an example of the rapid-

1 cycle improvement thing. Their initial intent was to use
2 motivational enhancement therapy to increase their
3 engagement with clients. The way they tried to do it
4 was, after some training, to create this reminder card
5 that said things like, "On a scale from one to ten, how
6 willing would you be to stay at Bridge House?" Or, "If
7 you are a seven, why are you not a six," or "Why are you
8 not a five? What would it take to move you to a nine?",
9 and so on like that. Then they did some reflective
10 summarizing of what the patient had said, and so on.

11 They created these cards after the training in
12 hopes that it would help the counselors in these
13 interactions. It didn't seem to make much of a
14 difference, and so they said, "Well, what is going on
15 here?" One of the counselors said, "Well, these cards
16 that you have given us are way too big. We can't carry
17 them around. They aren't all that useful." So they made
18 the cards smaller and tried it again. Still no impact.

19 Then what they did was they sat back and said,
20 "Well, what is really going on here?" The staff said,
21 "You know, what we really need to do is a lot more
22 thinking about high-risk patients. We know who the high-

1 risk patients are, but we really haven't got a strategy
2 for thinking about how to deal with them."

3 So they initiated a weekly continuation staff
4 meeting where they talked about the high-risk clients and
5 how they could tailor interventions to them, and the
6 continuation rate increased to 84 percent of people who
7 would stay at least 30 days in treatment. So they
8 adopted that. It turned out to be something that they
9 liked.

10 So that is an example of the kind of changes.
11 As you can tell, process improvement is not rocket
12 science. It is not one of these things where we try to
13 do really fancy kinds of stuff. What we are looking for
14 are those opportunities to make really simple changes
15 that can dramatically improve the lives of patients and
16 the efficiency and effectiveness of organizations.

17 In Bridge House, you can see what has happened
18 over a period of time to their continuation rate. If you
19 look at the bed utilization rate, the red line in this
20 picture, you can see a dramatic improvement. Before,
21 they were running a 30- or 40 percent utilization rate.
22 I'm sorry. If you look on the right-hand side they were

1 running a 80- to 85 percent utilization rate. They are
2 up close to 100 [percent] now, or they were before.

3 So I could give you many different examples of
4 changes, but that gives you an example of some of them.
5 Overall, I think the project has been incredibly
6 successful. For that reason, then, CSAT and RWJ began to
7 fund a few quick pilot projects where we would ask
8 ourselves the question, "What would happen if we engaged
9 states as a primary vehicle for facilitating or promoting
10 the use of process improvement?"

11 One of the things that we are saying here is
12 that NIATx can work directly with the treatment
13 providers, but one of the things that they can do is work
14 with the state so that the state can improve their own
15 processes and so the state can create incentives that
16 will make it in the best interest of organizations to
17 improve their own treatment.

18 So the idea behind the state project is to not
19 only work with treatment agencies directly but work
20 through the state to get the states to work on things
21 that can be done. So what we have done is summarized on
22 this chart. I just said it, though.

1 So, in these pilot projects, what we asked
2 states to do was to select a particular aim, like
3 continuation, and then partner with three to six health
4 care addiction treatment providers and pick particular
5 process targets and then quickly test those things.

6 Some examples. In Iowa, the single state
7 agency acted as a convener and used a thing that in
8 industrial engineering we call supply chain management.
9 All supply chain management really is, is trying to
10 understand what happens as a patient flows through
11 different parts of a treatment system and try to figure
12 out where the barriers to efficiency are.

13 What happened was that, in Iowa, they brought
14 together providers in the City of Des Moines and they
15 acted as a convener to think through these processes and
16 figure out what was causing increases in long waiting
17 times. As a result of that, on the average in the City
18 of Des Moines, these waiting times now have been reduced
19 38 percent.

20 North Carolina realized that one of their
21 eligibility requirements eliminated the opportunity for 5
22 percent of the detox patients to even move to another

1 level of care, even if they wanted to. So they changed
2 those eligibility requirements.

3 In Oklahoma, they just said the eligibility
4 determination requirements will be just eliminated for
5 high-performing sites. They went back and they looked at
6 organizations that were great at when they said, "We
7 think our patient is eligible," they were always right.
8 So the state said, for those organizations that have been
9 very effective in eligibility determination in the past,
10 we are not going to do any follow-up screening at all.
11 The wait between first contact at a treatment agency and
12 treatment reduced from 30 days to three days. They also
13 reduced duplicative paperwork and cut down on the
14 admissions time.

15 So, as a result of all of the pilot projects
16 that CSAT was engaged in, the conclusion was reached that
17 this had merit and that there was tremendous opportunity
18 for states to really make a difference in this area. As
19 a result of that, CSAT has now initiated a new activity
20 called STAR-SI. I don't know the exact term for them,
21 but you know when you publish this thing that says, "Hey,
22 there is an opportunity to get money from us"? Whatever

1 that thing is, it is now published. So they are about
2 ready to go.

3 I'm big on labels. It is just my brain doesn't
4 work that way. Forgive me.

5 The final thing that I will mention very
6 quickly is that NIATx provides a number of different
7 kinds of services to organizations. Three of those
8 services are, we try to get people to face-to-face to
9 learn from each other twice a year. We have found that
10 to be very effective because in reality the agencies
11 learn so much by talking to each other. But also, those
12 learning sessions act as an incentive to get
13 organizations to really move ahead on improvement.

14 There are all-member calls once a month. There
15 are also intra-circle calls for people who are
16 interested, for instance, in any of those topics below.
17 There would be a sustainability intra-circle call where
18 they call each other once a month and learn what each
19 other is doing and how they got over problems, et cetera.

20 Then there is coaching, where we send out
21 process improvement coaches to work with individual
22 organizations. We have a website, which I would

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1 encourage you to take a look at. It is called NIATx.net.
2 On that, you will see all sorts of case studies of how
3 this thing works, and you will see reports from the field
4 of new changes that are taking place. You will see
5 various kinds of tools that we have made available to
6 these folks that they can use in their treatment
7 agencies, and you will see articles that have been
8 published on this.

9 I hope that as a result of this talk you will
10 leave with three thoughts. One, I'm sure you know
11 already, and that is access and retention need to be
12 improved. The second is that process improvement works,
13 and the third is that the states are a key player in
14 making this thing happen.

15 Thank you for your time.

16 [Applause.]

17 **Question-and-Answer Session**

18 DR. GUSTAFSON: Yes.

19 DR. MADRID: I have two questions. Have you
20 all done any work concerning standardizing eligibility
21 and payer of last resort requirements for multi-funded
22 programs, as in, for example, a youth program? I am

1 funded by three HMOs that look at Medicaid very
2 differently, one state contract, one foundation contract,
3 and two private insurance agencies, and I'm having to
4 cater to five or six eligibility requirements as I am
5 bringing in the clients for treatment.

6 DR. GUSTAFSON: I can see we have an
7 opportunity to help you sleep at night. It must be
8 incredibly frustrating.

9 The only thing that we have done so far is that
10 in one of those state pilots we have worked with the SSA
11 and Medicaid to try to come up with a uniform set of
12 paperwork to at least make those two particular
13 initiatives more consistent. That has resulted in some
14 real positive feelings on the part of the providers, as
15 you can imagine.

16 We will soon be having a joint meeting
17 sponsored by RWJ and CSAT where we are going to be
18 bringing together managed care providers to take a look
19 at the potential for an initiative in that area. We
20 haven't done it yet and I don't know how well it will
21 work, but certainly that is on the radar screen as
22 something that really needs to happen. I think it would

1 make a big difference if we could.

2 DR. MADRID: My last question is, have you done
3 studies on the time we are taking to do paperwork versus
4 the time we are actually delivering service and how
5 success ties into these two things?

6 DR. GUSTAFSON: Well, one of the things that
7 NIATx tends to avoid in general is a lot of studies. We
8 emphasize getting in there and making change, collecting
9 as little information as you possibly can to determine
10 whether or not the change was successful.

11 So while the other half of my life is running a
12 center of excellence for the National Cancer Institute
13 where it is all research, on this side what we are into
14 is much more just promoting change. So we know that is a
15 problem area, but we have made no attempt to document it
16 in any formal fashion. It is just not what we do in this
17 particular kind of an initiative. It is an important
18 question, but it is not one that we have attempted to
19 answer.

20 Yes?

21 MS. JACKSON: Thank you very much. I really
22 found that to be a stimulating presentation and one that

1 is right on for most of us who are operating and working
2 to help operate centers across the country. Of course,
3 there is a huge national problem of access and retention,
4 so thank you very much for that, first of all.

5 DR. GUSTAFSON: Thank you.

6 MS. JACKSON: You didn't mention whether or not
7 you were just looking at adults or whether you have
8 adolescents in your mix. Are you looking at adolescents?

9 As we all know, adolescent treatment is a challenge for
10 all of us. We certainly have it. I'm from Miami and
11 represent some of Florida. So, how are you working with
12 the adolescents?

13 DR. GUSTAFSON: We actually have treatment
14 programs that cover all sorts of different focuses. One
15 program, the Perinatal Treatment Center, treats young
16 pregnant women who have drug problems, for instance. We
17 have a number of women's-only programs in the activity.
18 So it is certainly not all adult programs.

19 One of the things that you will find is that a
20 number of these intra-circle calls that I have mentioned
21 are for organizations that have an affinity with each
22 other because of the type of patients that they work

1 with.

2 Fran?

3 MS. COTTER: In terms of the STAR-SI, there are
4 none that are specifically targeting adolescents. I have
5 been in touch with Mandy Moxley [ph], who has been
6 working with a number of the adolescent treatment program
7 sites trying to bring some of the progress improvements
8 in.

9 DR. GUSTAFSON: Yes?

10 MS. BERTRAND: Thank you for sharing this
11 morning. It is very informative and very important, I
12 think, to our profession to look at our system and what
13 it is like to access the system. It is just an important
14 issue.

15 DR. GUSTAFSON: Thank you.

16 MS. BERTRAND: Thank you, also, for including
17 the state in that process. I was thinking about
18 sometimes there are regulations that are in place and we
19 want them to encourage individuals to access the system
20 and not deter them. So, I guess I would like to know
21 what information you have along those lines.

22 Also, within organizations that you studied or

1 looked at, did you find that there were similar or the
2 same types of barriers, or were they different among the
3 organizations?

4 DR. GUSTAFSON: As far as the paperwork
5 procedures, a couple of really interesting things have
6 happened. Certainly, paperwork is a big deal. During my
7 admission, just to go back to that as an example of this,
8 I was interviewed, as I said, for several hours where
9 they collected data. I think they probably collected
10 data on the ASI or one of those kinds of fancy things
11 that are collected.

12 Then I went to the staffing where the
13 professionals got together to figure out what to do with
14 me. The person who interviewed me didn't show up at that
15 meeting. What she did was she sent a description of what
16 she had learned in the interview, and it was that much,
17 handwritten on the back of a piece of paper. That's all.

18 Out of all that data that had been collected, the
19 decision about what would happen to me was based on that
20 much information. All that other paperwork was simply
21 done to satisfy a regulation and never had any influence
22 on what would happen to me in treatment. So the issue of

1 paperwork is a big, big deal.

2 One of the states decided to take on paperwork
3 as an issue to take a look at. It was fascinating
4 because the providers got together with the state and
5 said, "Why do you require this?" and the state said, "We
6 don't require that." The agency said, "Well, sure you
7 do," and they said, "No, no, we have never required
8 that." What happened was that as they looked back,
9 somehow or another the treatment agency began to add
10 stuff that they thought was required but never was as
11 part of the treatment process.

12 So not only were there simplifications that
13 took place in the state but also in the treatment
14 agencies in terms of the paperwork. We are just getting
15 started on that, but it is an important thing.

16 Now, at my age, you can't possibly expect me to
17 remember a two-part question.

18 [Laughter.]

19 DR. GUSTAFSON: So we will test you and see
20 whether you do.

21 MS. BERTRAND: We had a conversation similar to
22 this this morning about continuing to have the dialogue

1 from the community base versus the state level and how
2 important that is. So we talked about this council and
3 how we are really happy to be a diverse group that can
4 share these kinds of things.

5 The second part was, do you find that the
6 barriers are very similar from agency to agency or are
7 there things that are different?

8 DR. GUSTAFSON: There is a lot of similarity in
9 what you can learn. Obviously, from state to state there
10 are different reimbursement policies that influence the
11 business case for making changes of one type or another.

12 The motorcycle manufacturers face the same problems. I
13 think that one of the challenges for a field like
14 addiction treatment to get over is the idea that we are
15 different. Yes, we are different; there is no question
16 about it. But the opportunities to learn from other
17 fields are enormous. That is one of the things that we
18 encourage.

19 Ken, you hand your hand up.

20 MR. DeCERCHIO: Hi, Dave. Good morning. Just
21 real quickly, I want to compliment you and CSAT for this
22 whole initiative. In the context of national outcome

1 measures, state outcome measures, provider performance,
2 this is kind of the golden thread of performance
3 improvement all aligned together. In the absence of
4 this, we have measurements without opportunities for
5 improvement.

6 This is exciting. You and SAMHSA and CSAT are
7 really to be commended for providing the opportunities
8 that you have been providing.

9 We have two providers participating in this,
10 and they are just excited because it is not adopting a
11 model program and it is not doing intensive staff
12 training. It is working within their processes to
13 improve their processes. So it is specific to their
14 agencies and it cuts to the heart of it. We are excited
15 as a state, and I think states are excited, because it is
16 that link between what we try to measure and how we link
17 what we do as purchasers with performance. Without that
18 link of process improvement, it is a crap shoot. It is a
19 crap shoot about, "Gee, try this. What works?"

20 I think this is cutting edge, and I think this
21 will go a long way to providing that link between what we
22 are trying to measure at a national level, at a state

1 level, and what providers are trying to do to improve
2 services. It is great work.

3 DR. GUSTAFSON: Thank you, Ken. I appreciate
4 it.

5 Fran, you had your hand up just a second ago.
6 Did you want to elaborate?

7 MS. COTTER: On the basis of the last three
8 years, we have now compiled empirically the data from our
9 network on five promising practices that have been
10 identified for each of our four aims. Just take a look
11 at your packet when you have a chance. We are beginning
12 to try to look cross-cutting across our treatment
13 organizations.

14 DR. GUSTAFSON: Yes, sir.

15 DR. SKIPPER: Great work. I have worked with a
16 number of for-profit treatment programs, all the way down
17 to -- I guess I shouldn't say "up and down," but it seems
18 like for-profit programs are in the business of looking
19 at this because they have the motivation to make a
20 profit. I'm wondering if the programs that want you to
21 help them -- this would just be a question -- are the
22 ones that would change positively anyway. The ones that

1 aren't interested in this are the real problem.

2 For example, I worked with Kaiser Permanente in
3 the Northwest looking at outcomes. They actually were
4 setting up barriers on purpose in a sense because it
5 improved their outcomes. They established a requirement
6 for six hours of attendance at meetings for entering
7 treatment, and they found that that improved their
8 outcomes, really because they screened out the ones that
9 wouldn't endure that.

10 The thing with Chilo where different HMOs have
11 different requirements, I think they really want to put
12 up barriers. So you have apathy and people that really
13 want to have barriers. What would you say about that?

14 DR. GUSTAFSON: First, another key
15 philosophical perspective on NIATx is that we make it
16 hard to get in and easy to get out. We try to be very
17 selective in terms of the organizations. For instance,
18 in some of our work, we, as a requirement for entry,
19 require that they have to make a change in their
20 organization within a short period of time. There is no
21 question that there is a heavy selection barrier.

22 The hypothesis or big question built around

1 STAR-SI is, what happens now when you try to widely
2 disseminate. But also, in terms of this key picture, how
3 are we going to make it in the best interest of
4 organizations to want to improve their efficiency and
5 effectiveness. One of the key elements in this is making
6 sure that people understand how to look at the business
7 case behind making these improvements.

8 Of course, a business case depends on the way
9 in which reimbursement takes place, but we have had
10 organizations improve their contribution to margin by as
11 much as \$1 million a year based simply on getting rid of
12 these appointments and saying, "You all come." So the
13 business case is a really key element in the way in which
14 we approach this.

15 As far as the barriers that are constructed,
16 they are certainly constructed. There is no question
17 about that. I wish I could solve that problem for you,
18 but I can't. At least not today. That might be another
19 project, but it is a really, really tough one.

20 DR. CLARK: Any more questions?

21 [No response.]

22 DR. CLARK: All right. Thanks to you for --

1 [Applause.]

2 DR. CLARK: We have certainly benefitted from
3 the information that you shared.

4 We have a few minutes before we start the next
5 component. We can take a 10-minute break. Please
6 return. We have presenters at 10:30.

7 [Break.]

8 DR. CLARK: If we could reconvene. Thank you
9 very much.

10 To discuss SAMHSA's Response to Hurricanes
11 Katrina, Rita, and Wilma, we have invited three
12 knowledgeable members of SAMHSA's staff. Dr. Daniel
13 Dodgen is SAMHSA's emergency management coordinator.

14 Brenda Bruun is the special assistant to the
15 director, Division of Prevention, Traumatic Stress, and
16 Special Programs in the Center for Mental Health
17 Services. Brenda most recently served as the incident
18 commander for the SAMHSA Emergency Response Center,
19 otherwise known as the SERC. The SERC was responsible
20 for coordinating all of the relief activities of the
21 agency.

22 Anne Herron is the director of CSAT's Division

1 of State and Community Assistance. Anne has been
2 deployed to the Gulf Coast states to aid SAMHSA's
3 hurricane relief efforts. She went at least twice.
4 Three times; that is what I thought. Every time these
5 people disappear, somebody has to pick up the slack.

6 [Laughter.]

7 DR. CLARK: Dan, Brenda, and Anne.

8 **SAMHSA's Response to Hurricanes Katrina and Rita**
9 **Anne Herron, M.S., C.R.C., Daniel Dodgen, Ph.D.,**
10 **and Brenda Bruun**

11 MS. HERRON: Thank you, Dr. Clark.

12 We wanted to start out our presentation for you
13 this morning with something a little bit different. We
14 have received a slide show that was created in the State
15 of Mississippi that we thought might very effectively set
16 the tone and provide a focus for you. So with that, we
17 would like to, very shortly, just show you a short slide
18 show.

19 [Slide Show.]

20 MS. HERRON: We wanted to show you that because
21 we wanted to reinforce what was down there. This project
22 and this initiative from SAMHSA has really deeply

1 affected all of us, and we just wanted to start out by
2 letting you know that.

3 Let me turn it over now to Dr. Dan Dodgen to
4 talk a little bit about what the SAMHSA approach is and
5 what our agency is up to.

6 DR. DODGEN: Thanks.

7 Good morning. It is certainly a very, very
8 powerful set of pictures. I think it does really help
9 frame what it is that we are talking about and why it is
10 so incredibly important that we are doing the work that
11 we are doing, that we continue it, and that we do our
12 very best to continue to improve what we have already
13 been doing.

14 Before I go any further, I did just want to
15 take a moment and pause to recognize and to remember the
16 incredible work that Dr. Sheila Harmison did throughout
17 not just the Katrina response but throughout the time
18 certainly that I have been at SAMHSA and, long before
19 that, in participating in the Disaster Readiness and
20 Response Matrix. I am the Matrix staff lead for that
21 area and have been here close to three years doing that.

22 Sheila, from the very first time that I got

1 here, was always the CSAT person and was always the one
2 not only working hard on these issues but also constantly
3 reminding us of the importance of substance abuse issues
4 in an integrated SAMHSA response to any kind of disaster,
5 as well as integrating it into planning and preparedness.

6 So I do just want to acknowledge the very, very
7 important work that Sheila did and the legacy that she
8 has left by really making substance abuse more fully
9 integrated into the work that SAMHSA does in disaster
10 preparedness and response.

11 What I'm going to do today is talk very briefly
12 with you about the kinds of things that SAMHSA does
13 really from a bird's eye view. I want you to understand
14 from a federal perspective how disaster response works,
15 what the big picture is, and how SAMHSA fits into that
16 picture. If you can see that a little bit, I think it
17 will make it easier, then, for you to appreciate the
18 incredible work that we have done and the information
19 that the two other speakers, Brenda and Anne, will be
20 providing to you.

21 How many folks have heard of the National
22 Response Plan? Does it sound vaguely familiar? A couple

1 of folks have. The National Response Plan is the plan
2 that governs the federal response to any disaster event.

3 Typically, it is when there is a presidential
4 declaration of disaster, but there are certain kinds of
5 events that would invoke the National Response Plan even
6 without a disaster declaration. For example, a pandemic
7 influenza outbreak in the states would invoke parts of
8 this plan even in the absence of a presidential
9 declaration.

10 But this is the big picture. This is what
11 governs what all federal agencies do. It is invoked as
12 soon as two or more federal departments request
13 assistance from the states.

14 Now, there are a couple of things that happen
15 when the National Response Plan is invoked. One of those
16 is that this Intergovernmental Management Group, the
17 IIMG, is established, and the IIMG is comprised of senior
18 representatives of all of the federal departments. The
19 idea is if you put everybody in one room, decisionmaking
20 happens more quickly and more efficiently.

21 One of the comments that I would make about
22 that that will be of interest to all of you is, each

1 department in theory has one seat at the table. For the
2 first time ever, HHS asked if we could have a second
3 person and that that person would be a SAMHSA person to
4 address substance abuse and mental health issues. They
5 were recognizing even very early on in the response how
6 important that was.

7 What SAMHSA did was we arranged to have two
8 senior SAMHSA people available on call at any time to the
9 IIMG because we didn't have somebody that we could send
10 to just be in that seat 24 hours a day, but we so
11 appreciated that the Department and, de facto, the
12 national government recognized the importance of our
13 issues and did that.

14 So that is part of the National Response Plan.

15 Another very, very key factor in the National Response
16 Plan is that it codifies an incident command structure.
17 An incident command is something that Brenda will talk,
18 probably, a little bit about in a minute. It is the
19 structure that governs how we work in a disaster
20 response. It is very prescribed. Somebody is in charge
21 and has to make the decisions on how the lines of command
22 work.

1 That is very, very important because as you can
2 imagine, in a disaster, you can't have people second-
3 guessing. You can't have people saying, "Well, yes, I
4 know you are in charge of this disaster, but you are not
5 my regular boss and I don't really have to answer to
6 you," whatever things might happen. It would be another
7 disaster if we had those kinds of things happening.

8 So part of this incident command structure is
9 really to establish what the lines of command are so that
10 things can work better. If there are any knowing smiles
11 around the room, clearly this is something that we need
12 to continue to work on because, although people
13 understand it in theory, it is not something that
14 everyone in the federal government necessarily has a lot
15 of practice with. We still need to learn better how to
16 do it, but it is certainly in there.

17 Also in the National Response Plan, of course,
18 are the roles and responsibilities of different federal
19 agencies and departments. Now, the ones that are going
20 to be most important to us are the ones that I put on
21 this slide.

22 The ESFs, Emergency Support Functions. There

1 are 15 all together. The ones that SAMHSA is most apt to
2 be involved in are No. 6, which is the mass care. The
3 Red Cross is actually the lead for that one, but as we
4 know, in Red Cross shelters, which are ESF6 functions,
5 very often there are people who were already clients of
6 the systems that we are responsible for now in shelters.

7 One of the things, of course, that is part of working
8 with ESF6 is how do we support the shelter activities and
9 still maintain the services that are needed for people
10 with mental health and substance abuse concerns.

11 No. 8 is really the one that Department of
12 Health and Human Services is most directly responsible
13 for. They are the lead agency. It is public health and
14 medical. We worked very, very hard, and I was at many,
15 many, many meetings, to make sure that public health and
16 medical was defined to include substance abuse and mental
17 health issues, which it previously had not.

18 No. 14 is the long-term community recovery and
19 mitigation. In theory, ESF14 should be in the lead right
20 now. Many of those pictures you saw, sadly, could have
21 been taken on August 30th or January 30th. As a result,
22 the distinction between the response phase and the

1 recovery phase has been much more difficult to determine
2 in this disaster than in many others simply because of
3 the long response phase.

4 I think one of the things that we clearly are
5 seeing at a national level is this ESF14 is really not
6 discrete from the other 14 ESFs. I think one of the
7 things that we are really seeing now is that we need to
8 put a lot more public health, transportation, small
9 business, and all the other things into ESF14. I think
10 the fact that they have been discrete has not served us
11 well in this disaster, but it certainly is a lesson
12 learned.

13 Then, of course, ESF15, external affairs, is
14 also one that SAMHSA has a role in, because this is
15 really about how you communicate with the public.
16 Clearly, there are important psychological, mental
17 health, and substance abuse issues that need to be part
18 of public communication strategies.

19 Now, where does SAMHSA fit in all this. Well,
20 of course, one of our key roles is in the work that we do
21 with FEMA and the ARFs, which are the Action Request
22 Forms. MAs, Mission Assignments. ESFs; of course, you

1 now know what that is. We will have a quiz in five
2 minutes.

3 The mission assignment process is sometimes a
4 long and convoluted one. Of course, Ken knows all about
5 this. The state says, "We need 100 mental health and
6 substance abuse workers to come down to help Louisiana,
7 and here is what we think they should do." So they fill
8 out an ARF. Then FEMA looks at it and says, "Okay, that
9 makes sense. We ought to do that. Who can fill it?"
10 Then they call SAMHSA and they say, "Can you do that? Is
11 this reasonable? What do you think?" Then we say, "Yes.
12 Here is what it would cost," and whatever.

13 There is a give and take, but it is a long
14 process, often very iterative with a lot of back and
15 forth. It really depends on the nature of the request
16 and the ability to help whoever it is that ultimately is
17 making the decision at FEMA understand the importance of
18 mental health and substance abuse issues. Some people
19 get it instantly and some don't. There probably isn't a
20 person in this entire room that doesn't know what I'm
21 talking about when I talk about the fact that some get it
22 immediately and some don't.

1 So there is a lot of deconflicting. That is a
2 term that you see a lot of. I know Brenda is sick of me
3 using the term, but it is such a big part of what we do.

4 Often you get conflicting sources of information and
5 conflicting pieces of information about almost everything
6 in a disaster. That is just the nature of it. Everybody
7 sees their little piece of the elephant, but very few
8 people see the whole elephant. As a consequence, things
9 can get very confusing.

10 So a lot of this process is also just figuring
11 out what is really the need, who is requesting it, and
12 how can we best help.

13 SAMHSA's accomplishments in this area are
14 amazing. We have never before used the mission
15 assignment process. As you will hear from Brenda, we did
16 and are continuing to do an amazing job not only because
17 of the leadership of folks like Brenda and Anne, and Ann
18 Matthews and Eunice from CMHS, but also because we have
19 been steadily making the case and are continuing to make
20 the case with the Department and with FEMA that these
21 issues are important.

22 I do think people are beginning to hear. I

1 know that all of you at the levels that you work at are
2 also making that case. I think people are beginning to
3 hear it, slowly but surely.

4 Of course, it is important also to remember the
5 Crisis Counseling Program. If we had been doing this
6 talk a year ago or two years ago or three years ago, that
7 would have been 90 percent of the talk, the Crisis
8 Counseling Program, which we have been doing with FEMA
9 for 30 years.

10 Of course, in addition to working with FEMA, we
11 do a lot of work with other parts of the federal
12 government, particularly with our own department. There
13 are twice-daily actual ESF calls with all of the ESF8
14 partners, so that includes not just all the other HHS
15 folks, HRSA, CDC, SAMHSA, et cetera, but also the VA.
16 The VA has, as you can imagine, a fairly large deployable
17 workforce of direct clinicians in the substance abuse and
18 mental health area. They sent a lot of people into the
19 field. Of course, the Public Health Service Corps, which
20 is largely part of HHS, did that as well. The military
21 is also an ESF8 partner that we work every day, and the
22 Red Cross.

1 We are on these calls daily trying to make sure
2 that within the public health and medical sector, if
3 problems are emerging, we are addressing them right away.

4 If there is a conflict, if there is confused
5 information, or if there is just a need to make plans
6 about what to do, then we are all talking.

7 The Secretary's Operations Center is really the
8 hub of ESF8 activities. There is a picture of that in
9 the current "SAMHSA News." It is the one that has
10 Secretary Leavitt in it.

11 The Secretary also has emergency response teams
12 in all of the impacted states. In Mississippi, Alabama,
13 and Louisiana, as well as for a time in Texas, there was
14 a team on the ground. Of course, there were SAMHSA
15 people. In addition to having a SAMHSA person every day
16 at the Secretary's Operations Center, we also had SAMHSA
17 representatives at the CERT, and we did definitely deploy
18 CSAT people down.

19 Then the Secretary also established a Policy
20 Group for the Katrina response which also had a SAMHSA
21 member.

22 So, what did we do. We were on these ESF8

1 calls. We, of course, spent a lot of time maintaining
2 contact with all of our federal partners and non-
3 governmental organizations like the Red Cross. We also
4 continued to work with other key stakeholders, including
5 OSHA, the Occupational Safety and Health Administration,
6 which is responsible for support to workers that go out
7 in the field and respond to disasters.

8 The Secretary actually appointed SAMHSA to be
9 the lead in working with OSHA on providing support to
10 workers because there was such a recognition that the
11 mental health and substance abuse issues were going to
12 end up being among the most critical ways that we had to
13 support folks.

14 I think I have already talked to you a little
15 bit about these calls.

16 The bottom line is, what really is our role
17 here. Anybody have any idea what this is a picture of?
18 Brownie points if you do.

19 [No response.]

20 DR. DODGEN: No huge silent film buffs in here?

21 This is Harold Lloyd in "Safety Last," which is sort of
22 his classic. He plays this guy who ends up having to

1 climb up the side of a 12-story building to win enough
2 money to marry his sweetheart, who is waiting at the top.

3 DR. McCORRY: [Off mic.]

4 DR. DODGEN: That's the same movie. That's at
5 about the fifth floor or so that that happens. I
6 actually was looking at graphics for the clock, but this,
7 I thought, better represented SAMHSA's efforts, which are
8 really to assist the local communities in their response.

9 Of course, I think our role is quite a bit more active
10 than this young lady, and the states, of course, are a
11 lot more empowered, probably, before Harold is in this
12 picture.

13 Nevertheless, I just wanted to emphasize that
14 our role is not to take over from the states but really
15 to provide assistance to them and to help, in a sense,
16 pull them up in areas where extra help is needed.

17 Of course, to coordinate resources, assets, and
18 activities. Assets, in our case, are primarily people
19 who can provide services, but sometimes they can be other
20 things as well. Certainly, informational materials,
21 things like that.

22 And of course, to provide subject matter

1 experts. As you know, we deployed a lot of folks down to
2 the field who are DTAC -- that is our SAMHSA Disaster
3 Technical Assistance Center cadre of experts -- as well
4 as project officers who could assist in writing grants
5 for states that were applying for crisis counseling or
6 other grants.

7 Then, of course, we do provide grants that I
8 think you all are familiar with from past talks, and
9 coordination and response.

10 Does anyone know who this is?

11 PARTICIPANT: Charlie Chaplin.

12 DR. DODGEN: That is Charlie Chaplin, right, in
13 "Modern Times." The question now is, how do we translate
14 all this into action and what really happens on a day-to-
15 day at the ground level?

16 Anne and Brenda are, I think, the people who
17 can really best answer those questions for you all. So I
18 will step aside and let them answer those questions.

19 MS. HERRON: Hurricanes Katrina and Rita hit.
20 We had a plan. We had procedures. We knew what we were
21 supposed to do, so how did it all work.

22 Very, very shortly after the hurricane hit, Mr.

1 Curie activated the SAMHSA Emergency Response Center, the
2 SERC as we lovingly call it. Now, the SERC really
3 brought together people from all parts of the agency --
4 the centers, the offices, the Office of the Administrator
5 -- to do what Dan had described, to coordinate.

6 But it was more than a function. It was also a
7 place. We physically took over the conference room on
8 the eighth floor just outside of Mr. Curie's suite of
9 offices, so we had a location that we would go to and we
10 would work out of. So when people said they were going
11 to the SERC, they really went to the SERC.

12 MS. BRUUN: The SERC is modeled on the incident
13 command system, which Dan briefly described earlier. We
14 put up this organizational chart to give you an idea of
15 not only how it works within the agency but how our
16 operation connected with the Secretary's operations
17 center. Some people might feel it is redundant to have
18 an incident command system and an operations center at
19 the departmental level and then have one in each agency,
20 but the reality is that the job is huge.

21 To manage it at the departmental level when
22 there are 26 operating divisions within the Department of

1 Health and Human Services and each one has a different
2 function and role and specialty, meant that Dan was our
3 man at the Department. The Secretary's operations center
4 and the SAMHSA Emergency Response Center were in contact
5 daily. I can't even count the number of times we had to
6 be on the phone with each other, coordinating between
7 what information he was receiving from our other agency
8 partners, us getting information from the field. Passing
9 it back and forth had to be a two-way street, and
10 sometimes that was information overload to the extreme.

11 There are five main functions. There is an
12 incident commander and the incident commander's staff.
13 The incident commander during a disaster reports directly
14 to the Administrator. I think what is significant for
15 SAMHSA is it is the first time we have actually operated
16 under an incident command structure. What was unique
17 about it is that you lose any rank you have when you walk
18 into the SAMHSA Emergency Response Center and you report
19 to the incident commander regardless of what your job was
20 during the day.

21 We look at it as kind of like you were
22 deployed. Even internally you were deployed and that was

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1 your job. Having a separate space to work was very
2 helpful because then people could focus on one task and
3 not be worrying about answering their Emails back at
4 their desk, or their voice mails.

5 MR. DeCERCHIO: [Off mic.]

6 MS. BRUUN: Well, the incident command
7 structure has been around for about 40 years. It started
8 off in the emergency medical services field, and police,
9 fire, and rescue, but it has been adopted by the federal
10 government as a very efficient management structure for
11 crises. It is flexible and can expand to the size of the
12 disaster. In some disasters, you may need all of these
13 functions. In others, you may only need one or two,
14 depending on what resources you need to mobilize.

15 DR. DODGEN: Also, Ken, if you are asking about
16 ours, this was the first time. We had partially
17 activated it during the three exercises last spring, but
18 this was the first time it was fully activated and
19 operational.

20 MS. BRUUN: Yes. You also have personnel
21 functions. We are going to go into more detail about
22 what those are. Logistics includes not only setting up

1 the command center but also travel, supplies, equipment,
2 anything that is needed.

3 The planning section helps craft the scope and
4 magnitude of the disaster and begins to help the agency
5 and the incident commander figure out how we are going to
6 mobilize the agency's resources, partner with other
7 agencies for additional resources, and get those
8 efficiently deployed.

9 Finance is responsible for tracking every
10 expenditure we make, including how much overtime staff
11 are putting in, the travel costs for deployments, any
12 grants awarded, contracts that are maintained. They have
13 to maintain all of the audit trails for it, and that
14 process has already started.

15 Public information has a critical role. I
16 think our Office of Communications did an outstanding job
17 putting out some very easy-to-read fact sheets and
18 getting public service announcements out to promote our
19 efforts.

20 So this is really the role of the SERC, and the
21 incident command system helps us convey that, but it is
22 to mobilize our agency's resources very quickly to ensure

1 that we provide a very coordinated response and it is
2 consistent. We utilize our resources as effectively as
3 we possibly can, and this eliminates the ability for
4 people to work across purposes even if it is
5 unintentional.

6 MS. HERRON: Since August 29th, SAMHSA has
7 deployed both to the field and to the SERC 257 staff.
8 That is roughly half of our agency. Now, CSAT
9 specifically has deployed 55 staff. We have only about
10 103 FTEs, so that gives you a sense of, really, the
11 amount of staff time and effort that went into these
12 activities.

13 Now, when staff were deployed, they really had
14 one of three functions or three tasks that they might
15 have been assigned to. Some of the staff went to provide
16 direct service, and that could have been direct clinical
17 services, for those of us who have some clinical
18 background. Physicians, psychiatrists, nurses, social
19 workers, counselors, et cetera, would participate as part
20 of the crisis counseling teams on the ground in
21 Louisiana, Mississippi, and Alabama.

22 Now, I will tell you, that was not a cushy

1 assignment, particularly in the beginning. We are not
2 talking availability of restaurants and hotels. Many of
3 our staff ended up sleeping in places that were not
4 terribly comfortable. You can see the staff nodding in
5 the background. People went on two-week rotations and
6 then came back to their regular job. So it was an
7 interesting process, and I'm sure we have lots of very
8 interesting stories if any of you want to talk to some of
9 the staff.

10 The other kind of direct care and direct
11 services that could have been provided had to do with
12 direct administrative assistance, usually to the state
13 staff, state employees, but also to some providers as
14 well, providing such things as consultation around
15 planning, around grant development, as Dan had mentioned;
16 some very specific kinds of debriefing activities for
17 state employees; special projects around planning for the
18 rebuilding of the system or the redevelopment of the
19 system.

20 Then, staff also were providing monitoring of
21 some of the volunteers that we had deployed throughout
22 the state. We got volunteers from all over the country,

1 so they were really monitoring and managing some of those
2 teams as well.

3 The second kind of a thing that staff might
4 have done really was more support to the SERC operations.

5 There were lots of activities, as Brenda described,
6 around personnel and planning and public relations. Just
7 a very few highlights of activities that CSAT staff had
8 engaged in include working to replace over 15,000 rapid
9 HIV tests that were lost in the storm.

10 Our Division of Pharmacologic Therapies
11 provided an incredible amount of attention, time, and
12 effort in assisting the states in continuing the
13 availability of methadone treatment for people both
14 within the state and those who had left the state, making
15 sure that there were some guest services, guest dosing,
16 and continuation of care. Fourteen clinics in New
17 Orleans were lost, as you may know.

18 Also, in relation to the methadone, again our
19 Division of Pharmacologic Therapies worked closely with
20 the DEA to properly dispose of doses of methadone that
21 had been contaminated. Things you don't normally think
22 about when you are addressing these kinds of things.

1 Another big area had to do with assisting in
2 the SERC with the development of data to support
3 substance abuse-specific mission assignments. We will
4 talk about that in a minute, but this is the first time
5 that there has been a FEMA-approved, substance abuse-
6 specific mission assignment.

7 One last thing before I go to this slide. I
8 talked about three things that CSAT staff or SAMHSA staff
9 did in clinical services and administrative support. The
10 big one I want to make a point of referencing. Dr. Clark
11 mentioned it earlier. The half of us who were doing
12 direct clinical care or administrative support were
13 really held up by the other half of us who carried on the
14 business of the agency. It is an amazing amount of work
15 when you think about it. So I want to just recognize
16 that.

17 MS. BRUUN: This disaster required SAMHSA to
18 implement structures it had never tested with its staff,
19 which meant that at the time that we were implementing
20 and carrying out our response activities, we were also
21 training. I can't even describe how it was to watch
22 people who had never experienced this, wanted to help,

1 stepped up, were willing to learn new jobs, play new
2 roles, work well into the night, weekends, be called in
3 on their few hours off to carry out jobs to do this.

4 One of the things that we did is, within 14
5 days of the hurricane, we were able to locate some
6 additional resources within SAMHSA's budget to provide
7 Emergency Response Grants to the four most directly
8 impacted states: Texas, Louisiana, Mississippi, and
9 Alabama. Those Emergency Response Grants allowed them to
10 do whatever emergency need they had prioritized at the
11 moment.

12 For instance, in Texas and Louisiana, there was
13 significant attention paid to methadone treatment and
14 their applications. Mississippi chose to set up an
15 emergency response plan for their staff so that they
16 could mobilize their resources quickly. Alabama also did
17 some methadone treatment, as well as some emergency
18 services type of mental health services to the impacted
19 population until other resources could come available.

20 The Crisis Counseling Program has been around
21 for 34 years. In an average year, we might have about 20
22 applications. With this disaster, all 50 states plus the

1 District of Columbia were eligible to apply for crisis
2 counseling programs. We actually received 34
3 applications, and they all had to be reviewed in about a
4 week.

5 The staff of that program is three, so a lot of
6 very good project officers from across the agency came
7 together to help them review these so that we could get
8 award recommendations made to FEMA very quickly. They
9 are currently reviewing 24 regular services programs.
10 This is the longer-term needs program. It lasts roughly
11 nine months to a year. Not all of the states that
12 originally applied for the immediate program chose to
13 apply this time around. Having some evacuees return to
14 their homes, they felt like who was remaining they could
15 take care of within their existing structure.

16 We also received mission assignments for the
17 first time in SAMHSA's history. Dan explained a little
18 about how the mission assignment process is, but the
19 reason it is different from other kinds of grant programs
20 or grant assistance is that when a disaster like this
21 occurs and a state and a local area is completely
22 overwhelmed and unable to obtain resources on its own,

1 FEMA can go to another federal agency and say, "Well,
2 this is a mental health and substance abuse area that is
3 in your job description. Can you carry it out? We will
4 pay you to do it."

5 In this case, we started off with, actually,
6 Louisiana being the first out of the gate on getting the
7 mission assignment process to work for mental health and
8 substance abuse, with \$1 million specifically to support
9 the cruise ships parked in the New Orleans Harbor.

10 There are about 4,000 people remaining on those
11 cruise ships. One ship, the Ecstasy, is specifically for
12 housing the police department and their families. The
13 other ship is fire and rescue and other city workers and
14 their families who lost their homes. A very large
15 population remains on that ship.

16 We received a request from the State of
17 Louisiana for \$5 million for 100 mental health workers
18 around the state. I think we have far exceeded that at
19 this point. Not too long after that, we also received \$5
20 million for substance abuse workers around the state, and
21 we are continuing those deployments.

22 We have also received \$300,000 for the cruise

1 ship in Mississippi. That population is just evacuees,
2 and that population is declining as they approach their
3 March 1st deadline for relocating into land-based
4 housing. And, \$1 million in Alabama for mental health
5 and substance abuse services that came through fairly
6 recently. We are working with them to structure a
7 program for those services.

8 As you can imagine, at this point in the
9 disaster needs are changing somewhat, so we have to
10 rethink some of our deployment models. Deploying on two-
11 week rotations at the very beginning of the disaster was
12 the most effective way and very needed. At this point in
13 the disaster that is not always the most effective model,
14 so we are working with each of the states to tailor and
15 adapt our response for their current needs.

16 Mississippi applied for a substance abuse and
17 mental health mission assignment in the amount of \$1
18 million as well. It was denied by FEMA. They are
19 appealing that process, and we are awaiting an outcome on
20 that.

21 As I mentioned, we have 24 current crisis
22 counseling applications under review, requesting \$140

1 million. This is more than we have awarded in one year,
2 ever. They are in the process of review. FEMA thinks
3 that the awards may start being made sometime in March.

4 They are very complicated applications. I
5 included the dollar amount requested. That is not
6 necessarily what will be approved because each of those
7 grants are decided on a case-by-case basis. But I
8 thought it was significant to let you see what the states
9 perceive is the magnitude of the need for mental health
10 and substance abuse services in their state as a result
11 of Hurricanes Katrina and Rita.

12 We are also expecting some new emergency
13 response grant applications from Louisiana and
14 Mississippi. Their original grants have run out of
15 funds, but the need exists. These grants are
16 specifically to pay for items that cannot be covered
17 under the Crisis Counseling Program.

18 As we mentioned, Louisiana has, for the first
19 time, received a substance abuse-specific mission
20 assignment. We are still awaiting the decision on
21 Mississippi's application.

22 Yes, sir?

1 MR. DeCERCHIO: Can you clarify what exactly
2 that is, the difference between the substance abuse FEMA
3 mission assignment and regular requests for services
4 grants under Crisis Counseling?

5 MS. BRUUN: Well, under the grant programs, the
6 state basically says, "We have the capacity but we don't
7 have the money." So we give them a grant in order to
8 carry out a scope of work that they feel will be helpful.

9 When you use a mission assignment, it is
10 because they are saying, "Just giving us the money won't
11 help. We don't even have the capacity." So what we do
12 is we either use our own resources, staff, supplies, and
13 materials, or we contract for resources to be brought in
14 for the state to utilize for however long they need.

15 The planning section I think is a critical
16 section of the incident command system. Their first job
17 was to do an estimate of the magnitude of the disaster.
18 Without a full picture of what the scope of need is, you
19 can't develop a comprehensive plan for response. You
20 don't know what resources you need.

21 So one of their first tasks was to do
22 projections based on what we know about trauma, what we

1 know about substance abuse, what we knew about the damage
2 areas, and then map that to our grantees, where our
3 community mental health centers were, where we knew that
4 we had treatment facilities, detox facilities,
5 residential services, and which ones of those were
6 damaged. It took a significant amount of staff effort to
7 try and gather this data when there was nobody there to
8 answer their phones anymore.

9 So the usual methods that we use for gathering
10 information weren't always effective in some cases, and
11 this is typical after a disaster. You have to work on
12 the best information available and then be ready to
13 change on a minute's notice.

14 We contributed to HHS documents on
15 infrastructure recovery needs, especially around the
16 mental health and substance abuse treatment system. We
17 developed a lot of geomapping analysis, thanks to Charles
18 Reynolds, who I believe works in CSAP, to map damage
19 areas onto where we have grantees so that we could target
20 our assistance and our requests for information directly
21 to those needed facilities and to determine how fast we
22 could help them restore services, even if it meant in

1 temporary locations.

2 MS. HERRON: In terms of public information,
3 you all know in any kind of disaster or situation where
4 things are very, very fluid you need information. You
5 need access to resources and you need documents that you
6 can put your hands on, particularly as a provider or a
7 state who is trying to apply for some assistance. The
8 easier it is for you to put your hands on some
9 information, the better.

10 So SAMHSA expanded our website to include a new
11 component, "SAMHSA's Hurricane Response: Empowering
12 Recovery." There are all kinds of information, technical
13 assistance documents, publications, fact sheets, and all
14 kinds of things that are available on that site.

15 We worked with the Ad Council and the
16 Department to develop public service announcements.
17 Again, just an incredible amount of information. If you
18 haven't had an opportunity to take a look on the website
19 and see some of the resources that are available, I
20 strongly encourage you to do that.

21 We updated many of the substance abuse-specific
22 kinds of related information for this disaster, all of

1 which is located, again, up on the website.

2 MS. BRUUN: To help understand how we can
3 mobilize with such a small agency so many resources, one
4 thing is, kind of using a population exposure model, to
5 recognize that some people can be well supported by
6 providing them TIP sheets or fact sheets that allow them
7 to recognize signs, normalize the reactions that they are
8 having to a disaster, promote effective coping
9 strategies, and then point them to additional resources.

10 One of those resources is the National Suicide
11 Prevention Lifeline, which is sponsored by this agency.

12 We recognized instantly with the large number
13 of displaced individuals that a typical outreach model
14 probably wasn't going to be as effective because these
15 people were scattered all over the country. One of the
16 quickest ways to give them a central point of access to
17 disaster information and crisis support was through our
18 National Suicide Prevention Lifeline.

19 We quickly mobilized that network. There are
20 about 140 crisis centers across the country that
21 participate in that. When you call the number, it picks
22 up your area code and routes your call to the crisis

1 center closest to you. That crisis center then is
2 available to help connect you with local resources that
3 can be accessed immediately if in need.

4 Call volume, as you can see, has spiked. It is
5 well over 62 percent of what it was prior to Katrina on a
6 daily basis, and we are still seeing some pretty
7 significant call volume rates in Louisiana, Mississippi,
8 and Texas, where the largest number of evacuees are
9 housed.

10 That system was overwhelmed at one point. We
11 had crisis centers in Baton Rouge and New Orleans. The
12 New Orleans crisis center was destroyed. We helped them
13 relocate their services to a temporary facility, gave
14 them volunteer staff from other crisis centers around the
15 country that we supported their travel to. Then we
16 worked with the other states to offload call volume to
17 their states as call volume increased to the point that
18 some centers couldn't handle the load. So I think that
19 we were able to mobilize an existing resource very
20 quickly.

21 After that, we used public information as self-
22 help kinds of assistance that also point to referral

1 resources, and then you start getting into more intensive
2 needs through crisis counseling outreach services and to
3 direct clinical treatment services as people get closer
4 and closer to the exposure of the disaster.

5 MS. HERRON: Personnel. This was the fun part.

6 I can say that now because we are looking back on it a
7 little bit.

8 Some really interesting things came about when
9 we took on this particular task. We contracted with a
10 consulting firm called Westover to identify and deploy
11 professionals from all over the country and outside of
12 the country into the affected areas. We deployed, as you
13 heard, SAMHSA staff and other federal staff. It was
14 really an amazing process.

15 It brought with it some other things that
16 SAMHSA doesn't typically think about, things like how are
17 we going to identify our deployees. I will do my Vanna
18 White. I will do it while you describe it. So, how do
19 we identify our deployees, and then what do we give them
20 when they are going into these areas where, as I
21 mentioned before, there are no restaurants and there are
22 no comforts of home.

1 We came up with these Go Packs. I will be
2 Vanna. You do the description.

3 MS. BRUUN: All right. Early on, we recognized
4 that there was a large number of disaster relief
5 organizations, both governmental and non-governmental,
6 deploying to the impacted areas, and they all had a shirt
7 so that they would be recognizable. So we recognized
8 that there was actually a need for our folks to be
9 identified as a mental health resource that was available
10 to them. We wanted to be very visible in the field so
11 that you could easily identify and recognize the helpers.

12 So we came up with international orange. On
13 the back it says "SAMHSA Emergency Response Team." These
14 shirts are very popular. Anne and I just returned,
15 actually, about three weeks ago from a trip through the
16 south and visiting some of our clinicians and visiting
17 community leaders, state officials, and interacting with
18 some disaster victims themselves. One of the things that
19 we consistently heard is, "Oh, you are an Orange Shirt.
20 You are one of the good guys."

21 There are TV ads on the cruise ships that say,
22 "Need to talk? Find an Orange Shirt." We have newspaper

1 ads in the Gulfport, Mississippi, area that say that as
2 well. They are visible in the community. If you need to
3 talk to somebody, if you are stressed out, burned out,
4 whatever, "Find an Orange Shirt."

5 And it worked. People really very much
6 responded to that. They said, "You need someone to
7 listen to? There is an Orange Shirt for you."

8 The Go Packs was a different idea. When we
9 first started our deployments, the physical condition of
10 the area was horrible. We were sending our folks into
11 places that they were probably not used to, to work long
12 hours, without access to resources that you would
13 typically need during the day to stay safe and healthy.

14 For instance, access to fresh water. You had
15 to carry your own in. Snacks or food to sustain you
16 through the day. There was no place to go buy them: no
17 gas stations open, no 7-Elevens, nothing, no fast food
18 chains.

19 So we provided Go Packs, which is just a
20 backpack with materials they would need on how to work
21 with individuals after a disaster, fact sheets they could
22 give out, suicide warning cards, KAP Keys on how to

1 recognize the difference between different substance
2 abuse disorders or reactions. But then it had a few
3 other things that I think our Logistics Team isn't used
4 to buying in supplies: bug spray, sunscreen, first aid
5 kits.

6 A lot of times, the best access to an
7 individual to assess mental status or emotional status is
8 to fix a cut and put a band-aid on. It makes them
9 resourceful, plus a few of them needed it themselves when
10 they got injured by some debris that was lying around,
11 things like Vicks. People may ask, "Why Vicks?" Because
12 the smell is horrible. If you put a little Vicks under
13 your nose, it helps a touch. It doesn't get rid of it,
14 but it helps a touch.

15 Sanitary hand-wash that you don't need water
16 for. These are the kinds of things that the staff needed
17 in order to remain safe.

18 The other thing that we did was, we established
19 a process for our folks before they left, and our
20 clinical volunteers around the country also get this
21 process. It is just managed by the contractor. But they
22 are briefed before they go out on what to expect, what

1 their role is, what their mission is. If there is any
2 lack of clarity, then we do the best we can. Then we
3 tell them, "Your biggest job is to do what you need to
4 do; be flexible. If you have any questions, call us."

5 We also established a buddy system where you
6 got called every single day for a check-in: how are you
7 doing; do you need resources; can we problem-solve with
8 you.

9 We've heard about a lot of staff who have come
10 back and said, "You know, there were other people I was
11 deployed with from other departments who didn't get that,
12 and they were jealous. Nobody called them to see how
13 they were doing."

14 It is an intense assignment. You do see an
15 overwhelming amount of need. The hours are long and you
16 are sleeping in some horrible conditions. Dr. Bazell,
17 who might be here today, was sleeping on a bench in a
18 hallway at the State School for the Blind. Our staff
19 stepped up and filled the need despite the temporary
20 discomforts.

21 MS. HERRON: The teams now, as a part of the
22 mission assignments, what they are doing and where they

1 are going. They are being placed in schools and in
2 mental health and substance abuse clinics to provide
3 enhanced services, sometimes to expand the hours of
4 operation to provide services on Saturdays or weekends.
5 Other times, to provide, quite honestly, administrative
6 respite and clinical respite for the staff there who have
7 been working for five months now.

8 They have been providing services in the
9 trailer and the tent cities. We could spend an entire
10 day talking to you about what is going on in some of the
11 trailer and tent cities and what those situations are
12 like. We have teams on the cruise ships, as Brenda had
13 mentioned, and some of the other shelters in place.

14 Again, teams were deployed on a 14-day
15 rotational basis. We are really changing that model now.

16 What we are doing, particularly in Louisiana, is we are
17 beginning to focus on identifying resources and people
18 who are returning to the state who may not be fully
19 employed or are underemployed who can provide some
20 additional time in these clinics, schools, and settings.

21 So, really trying to focus on kind of a longer-term type
22 of local deployment.

1 The data. Basically, we have provided
2 somewhere in excess of 50,000 clinical sessions. The
3 element that I would like to point out is the referral to
4 local substance abuse services. In the beginning, that
5 percentage was fairly low. It was around 2- to 3
6 percent. It is, most recently, up to around 7 percent.

7 The issues that the teams are seeing, just to
8 give you a sense of what these folks are dealing with.
9 Those who are identified in the mental health and
10 substance abuse clinics and in schools really are
11 addressing waiting lists. There are people who are
12 waiting a long time to see someone, so that is one of the
13 things that they are addressing.

14 They are seeing significant alcohol, opiate,
15 and prescription drug misuse, and there is a great
16 connection with people who were previously medicated for
17 pain who no longer have that medication available to
18 them. They are seeing domestic violence, child abuse,
19 assault, things that are not surprising to you when you
20 think about the environment and the conditions in which
21 folks are living and the stress with which they are
22 dealing.

1 Also, a great deal of co-occurring disorders.
2 Again, not surprisingly, depression and anxiety. Just
3 remember some of the pictures from before.

4 The issues that folks are seeing on the ships
5 are a little bit different than what they are seeing in
6 the communities. The ships have some very interesting
7 and very specific issues related to them. For a number
8 of reasons, there has been a reduction in the access to
9 transportation for people to get off the ships to find
10 employment, housing, and to get into the community. So
11 feelings of isolation are clearly occurring.

12 Child care issues. Families are on the ships.
13 There is very little child care, if any. Most of the
14 child care is being provided by our teams, with
15 recreational services, activities, parenting groups,
16 those kinds of things.

17 MS. BRUUN: The ships in New Orleans are still
18 different than the ship in Mississippi. The difference
19 primarily is the location. In New Orleans, they can get
20 off at the River Walk and walk to services. Some public
21 transportation has been restored.

22 In Pascagoula, it is in the middle of a naval

1 shipyard, probably four miles to the closest part of the
2 town that has clinical services available, restaurants,
3 things like that, and there is no public transportation.

4 So if you don't have a ride, you can't leave.

5 So that makes it particularly challenging --
6 and in some respects I think it is probably much more
7 frustrating for those folks -- how to empower them to
8 take control of their own situation and begin to move and
9 make longer-term plans. Some of the resources they need
10 to do that just aren't there. A significant clinical
11 issue that we are working with is frustration and anger.

12 MS. HERRON: That is the substance of what we
13 wanted to tell you. The last thing that we wanted to
14 really leave you with is that while we are really slowing
15 down our involvement, the states most certainly are not.

16 The pictures that you saw in the beginning were
17 taken in September and October.

18 [Slide show.]

19 MS. HERRON: These pictures were taken two and
20 a half weeks ago. There are hundreds of miles of
21 coastline that have not been touched. Debris has not
22 been removed and people still can't get back to their

1 homes.

2 Thank you very much. We will be happy to take
3 any questions.

4 [Applause.]

5 MS. HERRON: Oh, I forgot. The card is an
6 example. We put out all the things that were in one of
7 the Go Packs. If you are interested in seeing what
8 people were traveling with, that's it.

9 **Question-and-Answer Session**

10 MR. DeCERCHIO: If I may, a quick comment. We
11 just certainly have to say thanks for all that work.

12 Another thing that has gotten lost amongst all
13 of the, I guess, criticisms and play around federal-state
14 partnerships and response is that I have heard positive
15 things and I have never heard a single thing negative
16 about SAMHSA's response in all of that. I think that is
17 a reflection of Mr. Curie's leadership and the Center
18 Director's leadership and the commitment of all the
19 staff.

20 There was a big piece on NPR a couple weeks ago
21 about mental health services. Even with a focus on that,
22 Orange Shirts were recognized, and the work that everyone

1 has done. It wasn't a negative piece about any of those
2 issues that we hear a lot about nowadays in this
3 response. So you all are to be complimented for that.

4 MS. HEAPS: I was wondering if you wanted to
5 take over the whole FEMA process.

6 [Laughter.]

7 MS. BRUUN: One of the mental health
8 commissioners that we have been working with actually
9 suggested that, too. I think that sometimes it is
10 important to do one thing and do it really well. I
11 think, given our druthers, we will stick to this.

12 MS. HEAPS: I just want to say it was very
13 moving and absolutely inspiring. Congratulations to you
14 and to the staff that dedicated themselves to this. It
15 is remarkable. And to the SAMHSA leadership.

16 DR. MCCORRY: Just a wonderful presentation.
17 Thank you. It makes me feel proud to be part of this
18 field to see what you guys have done.

19 A couple of quick questions. One is, we heard
20 up in New York about the issues with methadone and how
21 difficult it was for patients to get their medication and
22 the kind of crisis that developed around that. So I

1 would be interested in hearing more about how SAMHSA
2 responded and lessons learned from that.

3 Anne, you have seen it now from both sides.
4 You ran our state's disaster response for 9/11. I would
5 be interested in, since now you have had both the state
6 and the federal experience, what was that? What are some
7 of the lessons that you see in having seen it from both
8 sides?

9 MS. HERRON: Can we postpone your flight? We
10 could sit here for a long time.

11 [Laughter.]

12 DR. MCCORRY: And tomorrow, we will finish up.

13 MS. HERRON: Tomorrow maybe.

14 That is very, very difficult to answer quickly,
15 but I will say, just very, very briefly, there was a very
16 different scope with this disaster. While there was some
17 loss of infrastructure in Manhattan and around Ground
18 Zero, the loss of infrastructure here was almost beyond
19 description. We got back communication in a couple of
20 weeks. We got back the ability to have electricity and
21 move about the streets in a month or so. There are parts
22 of the Gulf Coast where that is still not the case, and

1 it is five months after.

2 But it is an interesting point. One of the
3 things that we are putting together as a result of all
4 our work is a lessons learned document, so that will be
5 coming.

6 Again, with methadone, people were appearing
7 states and states away from where they lived. Ray,
8 Antoine, Arlene, perhaps you would like to comment on it.

9 They are all from the Division of Pharmacologic
10 Therapies.

11 But again, just the numbers and the geographic
12 distance and the lack of ability to access doses.

13 MS. STANTON: Hi. My name is Arlene Stanton.
14 I'm with the Division of Pharmacologic Therapies. What
15 happened after 9/11, actually, I think was tremendous
16 argument for how important recovery is to our patients.
17 In the midst of all the chaos, over 1,000 patients were
18 displaced in the New York Metro area. They were finding
19 themselves in very different places than they might have
20 expected to.

21 What we found later was that it was a
22 tremendous problem, of course, because programs were

1 already coping with their own staff, their own patients,
2 and then having an unexpected number of people showing
3 up. Of course, with methadone, you have to verify that
4 person really is a patient as well as verify their dose.

5 They were trying to do that with tremendous
6 communications difficulties.

7 I think the worst case was if patients were
8 self-reporting, it looked later like most of them in fact
9 knew their dose and reported correctly. A few high-dose
10 patients actually, if anything, underreported because of
11 the fear that they would not get treatment if they told
12 the real dose.

13 In a few cases, when clinics couldn't verify
14 the dose, they were sometimes forced to titrate it over
15 the course of a day. Imagine if you need medication and
16 there are buildings falling down around you and you are
17 worried about your family and your life, and you have to
18 sit there for several hours while they give you the dose
19 of the medication that you need.

20 The good thing that came out of this was that a
21 number of stakeholders have been tremendously supportive.

22 They worked with SAMHSA and CSAT. We came up with the

1 idea of a centralized Web-based database that would
2 basically allow a program over here to access and verify
3 that your patients get recent dosing information.

4 We have done a planning feasibility study, a
5 shorter project after that to do some initial work
6 related to developing infrastructure, and in the fall of
7 this year, we were funded for what will be a regional
8 pilot. At this point, we are at the point of creating
9 the infrastructure and then moving toward development of
10 a pilot that would be centered in New York, with the
11 possibility of other locations.

12 DR. MADRID: I also want to commend the staff
13 for the big sacrifice that you all went through. In
14 reference to methadone, I remember we received about
15 1,000 people into the El Paso Civic Center. A day later,
16 our drug program was called because there were some
17 people that needed methadone.

18 So we sent our doctor out there to do an
19 assessment, and half of the people were methadone clients
20 from the methadone program in New Orleans, but we found
21 out the other half were inmates. We did the assessment.

22 They were opiate addicts, very, very sick, and we

1 medicated them one day, and then they disappeared the
2 second day. So, talking about lessons learned, I think
3 that is certainly a lesson that we learned.

4 MS. HEAPS: Actually, when this happened, Dr.
5 Clark and I got into a discussion about the issue of
6 clients who had been on probation or parole or in jail
7 who also were either mandated to treatment or in
8 treatment and what would happen to them as they
9 scattered. I wondered if you, in your experience or in
10 the calls, have had any discussion or if that issue has
11 emerged in your work at all.

12 MS. BRUUN: Actually, it came up multiple times
13 in the disaster in multiple areas because the reality is
14 that prison systems and jails, they all have to be
15 evacuated as well. What we found is some concern on the
16 part of certain shelters in accepting these folks into
17 the traditional sheltering population.

18 What I think probably is an area that really
19 needs to be worked on is the forensic sheltering and
20 identifying appropriate space that they can be safely
21 cared for and treated as well.

22 DR. CLARK: Then there is the issue of people

1 under the supervision of parole and probation who are not
2 incarcerated but who are unable to maintain contacts with
3 parole and probation officers. Then there are, shall we
4 say, the more severe offender who is being monitored, or
5 the sexual offenders and the people who are registered
6 sexual predators. All of these things have been at
7 issue.

8 We also were dealing with another population of
9 opiate users, and that is those people who are not in
10 treatment and not in the criminal justice system. They
11 were very happy using opiates as long as they were in the
12 community, and the supply dried up. So they were going
13 through withdrawal, and they had never had any intentions
14 of being on methadone because heroin or other drugs were
15 readily available. In clinical situations they had to
16 deal with that. Anne, Antoine, and Kenneth Hoffman
17 helped with protocols for dealing with people who had
18 precipitous withdrawal who were not previous methadone
19 clients.

20 So you get a whole spectrum of consequences. I
21 think Brenda and all others did a yeoman's duty trying to
22 sort these things out, coming up with models and

1 algorithms that dealt with the reality of a circumstance
2 that was far greater than most people had prior
3 experience with.

4 MS. BRUUN: Thank you.

5 MS. HERRON: Thank you.

6 DR. CLARK: Thank you, Dan, Brenda, and Anne.
7 Appreciate the presentation.

8 [Applause.]

9 DR. CLARK: Melody?

10 MS. HEAPS: Dr. Clark, in the interest of time
11 and to make sure we have a quorum, the issue that was
12 raised yesterday about a letter to the Director of HHS
13 vis-a-vis the ATR program, I very rough draft. Ken
14 DeCerchio cleaned it up beautifully, and we have a copy
15 we would like to pass out to the council for their review
16 and hopefully vote.

17 Do we all have it? We have it. Okay.

18 DR. CLARK: I'm assuming, Melody, that you are
19 proposing that we wait a couple minutes for people to
20 read this?

21 MS. HEAPS: Yes. I'm sorry; yes. I trust when
22 it is in final form the English majors will make sure --

1 I was one, which you would never know -- it is perfectly
2 editorially okay.

3 DR. CLARK: We will need a final language
4 check.

5 MS. HEAPS: Well, it is only minor changes,
6 right? Minor editorial language changes. "Curious name"
7 is spelled wrong, for instance. What else? "Request for
8 applications," second line, first page. The fifth line
9 down from the top there is an "RR" in the word "recovery,
10 comma." It should just be one R, not two Rs.

11 If anyone else sees anything else, feel free.

12 MS. JACKSON: Melody, on the second page in the
13 second paragraph, it says, "Premature conclusions about
14 the status of the current implementation of this
15 initiative weaken those partnerships." I like all that.

16 "As with any transformation effort, ATR states
17 must demonstrate 'early wins.'" Is that clear? I guess
18 I don't understand for sure what it means, but it may be
19 that I'm not in that loop, so I'm just asking.

20 MR. DeCERCHIO: I guess I would ask if it is
21 clear to anybody else. I was in a presentation around
22 transformation by Mike Hogan from Ohio, the mental

1 director. One of the principles of transformation is
2 achieving "early wins," so that is why I quoted it. I
3 used quotation marks because of Mike Hogan. The
4 quotation marks kind of refer to something outside of
5 what we were saying.

6 If it doesn't work for folks at first reading
7 or something like that, then certainly we can reconsider.

8 But that is where it came from, and that is what I was
9 thinking.

10 Linking that to Mr. Curie's comment yesterday
11 about meeting first year's goals, I would ask George if
12 we accurately reflected Mr. Curie's comments by including
13 that.

14 MS. JACKSON: I have no problem with it. I
15 just wondered, when it is being read, does the Secretary
16 understand the "early win."

17 MS. HEAPS: Let me just suggest, instead of
18 "early wins," "must demonstrate some immediate
19 successes."

20 MR. DeCERCHIO: Sure.

21 DR. McCORRY: "State substance abuse offices,"
22 is that a single state agency?

1 MR. DeCERCHIO: That is what I was thinking.

2 DR. McCORRY: Is that the proper term, though?

3 "Single state agency" or "single state authority"?

4 MR. DeCERCHIO: Yes.

5 MS. HEAPS: What line is that?

6 DR. McCORRY: It is the fourth line, second
7 page.

8 MS. HEAPS: So, "as well as the single state
9 authority."

10 DR. McCORRY: Is that the proper term for it?

11 DR. CLARK: [Off mic.]

12 DR. McCORRY: Is that a better way to say it?

13 MS. HEAPS: Okay. We will leave it.

14 DR. McCORRY: I'm fine either way. I just
15 wasn't sure.

16 MR. DeCERCHIO: I thought it might be clear to
17 someone outside of our business. "Single state
18 authority" has meaning to those of us that are single
19 state authorities and do this work. Outside of that, I
20 don't know that it has any resonance at all.

21 MS. HEAPS: So the sentence stands?

22 MR. DeCERCHIO: Yes.

1 MS. JACKSON: I think it looks like a very well
2 written letter that says what we discussed yesterday.

3 DR. CLARK: Does everyone feel they have
4 adequate time to read the document? The chair will
5 entertain a motion to adopt it.

6 [Moved.]

7 [Seconded.]

8 DR. CLARK: All those in favor?

9 [Ayes.]

10 DR. CLARK: All those opposed?

11 [No response.]

12 DR. CLARK: The motion is adopted, and the
13 letter as edited will be sent.

14 [Motion carried.]

15 DR. CLARK: I will arrange to have people's
16 signatures attached to the document.

17 PARTICIPANT: I guess I'm unclear. I thought
18 yesterday the discussion was around Melody and Ken
19 sending the letter on behalf of the council. Now you are
20 saying you all want to sign it?

21 MS. HEAPS: I was hoping the whole council
22 would sign it. Can't we authorize you to sign it for us?

1 No, we can't?

2 PARTICIPANT: No.

3 MS. HEAPS: How does that work?

4 DR. CLARK: Either you can have representatives
5 sign it or we pass it around the whole council to sign
6 it. Either way.

7 DR. MCCORRY: Do you need the actual signature
8 or can it be "From the CSAT Advisory Council members
9 listed below"?

10 DR. CLARK: We have used a previous mechanism
11 where Melody sent the letter out, so we can use that
12 mechanism.

13 We have to have public comment at this point.
14 Is there anyone from the public who wants to have a
15 comment? Is there anyone from the public out there? No
16 public?

17 [No response.]

18 DR. CLARK: All right. Then we should move to
19 our last presentation. The final topic of the agenda is
20 HIV Rapid Testing. This is actually made even more
21 important given that the White House has announced a
22 special Rapid Testing Initiative. If you go to the White

1 House webpage, for '07 they have already announced it.
2 Part of the HIV strategy is to increase rapid testing and
3 involving faith-based organizations as part of the rapid
4 testing effort.

5 Dr. Kirk James, the medical officer in CSAT's
6 Division of Service Improvement, is going to discuss
7 SAMHSA's HIV Rapid Testing Initiative. In addition, he
8 will talk about recent reports of false positive results
9 with the oral rapid HIV tests and how SAMHSA and CSAT
10 have responded to the issue.

11 Dr. James.

12 HIV Rapid Testing

13 Kirk E. James

14 [PowerPoint presentation.]

15 DR. JAMES: It is my distinct pleasure to
16 present to you today on the SAMHSA Rapid HIV Testing
17 Initiative. I know yesterday you heard Dr. Kenneth
18 Hoffman talk about hepatitis and the vaccination program,
19 but today what I really want to do is kind of give you an
20 overview of the SAMHSA Rapid HIV Testing Initiative and
21 what we have done here at SAMHSA as a whole. This is a
22 cross-center project.

1 Some of the learning objectives that you see
2 here are just really for me to report out to you our
3 mission here at SAMHSA in the context of prevention and
4 treatment as well as mental health when it comes to
5 reducing HIV/AIDS and the targeted populations.

6 Also, I want to give you some information
7 specifically about training and technical assistance
8 associated with Rapid HIV Testing, as well as the
9 eligibility and readiness requirements that you see here
10 for sending, and I have highlighted this, free kits to
11 our eligible providers. Free test kits, as well as free
12 controls for the Rapid HIV Testing.

13 Then I will just talk a little bit at the very
14 end about some of my evaluation methods and some of our
15 pilot data as far as results.

16 This slide is really a very rough structural
17 organization chart of SAMHSA, but just to emphasize that
18 this is a cross-center initiative. I'm speaking,
19 obviously, today as a CSAT staff member, but I have
20 worked with members in the other two centers as well.

21 Of course, you have all seen this as the
22 Matrix. You see here one of the redwoods on, if you

1 will, the Y-axis is HIV/AIDS and hepatitis. I know Dr.
2 Kenneth Hoffman spoke about hepatitis, and I obviously
3 will be speaking about HIV/AIDS and what we are doing
4 with this initiative.

5 What I would like to do, however, is start off
6 with some epidemiological background when it comes to
7 HIV/AIDS. This is information that comes out of the
8 Centers for Disease Control and Prevention, CDC. There
9 are just a couple of slides I want to share with you.
10 Some of you may be familiar with these slides, but I
11 would like to emphasize a couple of points here.

12 As you will notice, this slide is focusing in
13 on the different racial and ethnic populations. What you
14 see here is that for each population there is an incline
15 in the estimated number of persons living with AIDS,
16 looking at the 10-year span from 1993 to 2003.

17 What you will notice, if you can concentrate
18 your eyes on the yellow line, looking at white, non-
19 Hispanics, back in 1993 we were talking about 80,000
20 individuals who were estimated to be living with AIDS.
21 That has climbed up in 2003 to about 130,000.

22 What you see and what I want to point out here

1 is that cross, where you see African Americans, black
2 non-Hispanic, starting off at about 60,000, a little less
3 than the white non-Hispanics when it comes to the
4 estimated number of persons living with AIDS, and that
5 rising to about 170,000 by the year 2003.

6 So what you see and what I think this graph
7 illustrates is that there is a changing face of this
8 epidemic. Of course, we knew this some time ago as being
9 a white male, gay disease, HIV/AIDS. I say that not to
10 minimize the detrimental effects it has caused for that
11 segment of our population, but just really to point out
12 that it is indeed a changing and a target population that
13 we need to focus on.

14 The next slide from CDC, I think, points out we
15 are looking at males with an estimated number of HIV
16 cases. I think the important thing is to really look at
17 not so much the cases but the rate, the cases per
18 100,000. What you will see as you look at the black non-
19 Hispanics, at 127, versus your white non-Hispanic, we are
20 talking about at least a sevenfold increase. Looking at
21 blacks compared to Hispanics, they make up a double
22 amount when you talk about the rate cases per 100,000.

1 That is looking at males. The next slide
2 focuses in on females and some of the same information
3 when we are talking about African American females, with
4 a rate of 66 cases per 100,000. So we are looking at 22
5 times the rate when compared to white non-Hispanic
6 individuals as far as adults and adolescents. So it
7 really points out a couple of things.

8 This last slide from CDC I wanted to illustrate
9 here is just a comparison as far as the mode of
10 transmission. When it comes to being infected with HIV,
11 you see here, looking at your left, looking at the pie
12 chart for males, 63 percent has to do with male-to-male
13 sexual contact. The next-largest area is the 17 percent
14 in the red for heterosexual contact. Obviously, from our
15 perspective as a substance abuse agency, looking at
16 injection drug use, 14 percent for males compared to
17 about 19 percent, surprisingly, for females. Actually,
18 the females have a higher percentage when it comes to
19 that mode of transmission for being infected with HIV.

20 So that is just some background as we go into
21 an overview of the Rapid HIV Test Initiative from SAMHSA.

22 Here I will talk about the history of this initiative,

1 which started in June of 2004. It is scheduled,
2 actually, to come to an end officially in the end of
3 March of this year. But I will give you a little bit of
4 history from the goals of this initiative, the target
5 populations we are hoping to reach and the partners that
6 have been assisting us with this effort.

7 When we talk about money, we are talking about
8 \$4.8 million given to SAMHSA, SAMHSA-wide, for this HIV
9 testing initiative. I will get into more of the
10 specifics of that, but just to point out that \$4 million
11 was really to be directed towards purchase of Rapid HIV
12 Testing kits and another \$8 million for technical
13 assistance and other factors which go into really making
14 this project happen.

15 Basically, our aim was to reduce the HIV
16 incidence rates, as well as, really, prevalence among
17 minorities, as you see here, as well as other high-risk
18 populations, i.e. substance users, individuals who may
19 have co-occurring disorders, substance use disorders in
20 combination with mental health disorders.

21 Then, to support Rapid HIV Testing training.
22 Obviously, we are handing out kits, but we are in the

1 planning stages of providing necessary training to
2 increase capacity to allow the testing to go on,
3 especially within our targeted populations, which have
4 typically been missed in the past.

5 As far as the goals, to really provide HIV
6 testing capability to our grantees in particular. We do
7 provide Rapid HIV Test kits to other organizations, but
8 we definitely wanted to hit our grantees. They are
9 really our priority. Then, to do some outreach to
10 underserved minority and other high-risk populations
11 which are found in what we call non-traditional settings.

12 Then, to retest those individuals who may have
13 been tested before and were negative.

14 Another thing about the testing is it not only
15 allows you to do some testing with the Rapid HIV Testing,
16 but you also have an opportunity to do some counseling.
17 It is mandated that you do some pre-test counseling. You
18 have the test. The test takes about 20 minutes. Then,
19 following the test, you have some post-counseling which
20 needs to be done. That is regardless of whether the
21 screening test comes out as positive or negative.

22 Here is just a list of the different target

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1 populations that we are aiming to reach. Substance use
2 disorders I mentioned, co-occurring disorders, and mental
3 health. Obviously, injection drug users, commercial sex
4 workers, and so forth. And definitely re-entry
5 populations, hopefully to stop that vicious cycle of
6 individuals coming out of the prison systems that may be
7 infected and coming back into the community and then
8 going back into the criminal justice system.

9 Here is just a list of our partners involved in
10 this initiative. We are probably most involved with
11 working with the CDC in this effort.

12 So let's get to the purchase. We talked about
13 the \$4.8 million and how that was broken down. Again,
14 the \$4 million was to be delegated to the purchase of the
15 OraQuick Advance Rapid HIV-1 and 2 Antibody test kits.
16 This test was fairly recently approved by the Food and
17 Drug Administration. It was also to purchase the control
18 kits. The critical feature of this test obviously was
19 the time: 20 minutes to get your results. That is not
20 to say that the whole process will take 20 minutes, but
21 an individual would come in, be given the pre-counseling,
22 and then take the test. Within a 30- or 40-minute

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1 period, that test would be read and the individual would
2 then proceed from post-counseling.

3 Here I think is a good time to really talk
4 about some of the false positives. As I think you are
5 probably aware from some of the media that has come out,
6 there have been some false positive results out of New
7 York, San Francisco, and Atlanta. We are very conscious
8 of that here at SAMHSA, and we work with the FDA and CDC.

9 I have contacts at both agencies to report out any
10 formal complaints that we get from any of our providers
11 that we will be providing kits to. They in turn do what
12 they need to do with that information.

13 I do want to point out there is a difference
14 between oral fluid and finger stick. Previously, it was
15 a finger stick. You get a blood stick, you do the test
16 within 20 minutes, you get your results. If you look at
17 the finger stick, you see there is a sensitivity. That
18 is, the proportion of individuals who are tested and
19 found to be positive that are truly positive is high. It
20 is 99.6 percent.

21 Now, if you compare that to the oral fluid,
22 where we have been getting the false positives, the

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1 sensitivity is a little bit lower. It is not that much
2 lower, but it is 99.3 percent. The problems that we have
3 been hearing about have to do predominantly with the oral
4 fluid testing. That was most recently approved by the
5 FDA. I think in fact OraSure Technologies may have plans
6 to have this as kind of a take-home test kit. Of course,
7 that is raising some concerns as we hear more about these
8 false positives.

9 But I do want to caution you that, as it stands
10 right now in my conversations with FDA, what they are
11 finding is that even though you are getting these false
12 positives, it falls within the label as far as the number
13 of false positives that you expect to receive.

14 The problem, of course, is nobody wants a false
15 positive. If you are the individual who has a false
16 positive and you get that information, it is going to be
17 very dramatic to you and it could result in a lot of very
18 negative behavior. That individual could possibly take
19 their life or could take the life of another individual
20 they think may have transmitted that HIV to them. We are
21 very conscientious of that.

22 But as it stands right now, the FDA is working,

1 along with CDC and ourselves and with OraSure, the
2 manufacturer of this product, to try to ensure to the
3 best of their ability that we don't get outside of that
4 boundary, if you will, of what you expect. Of course, no
5 test is 100 percent sensitive with 100 percent
6 specificity. I did want to touch on that because that is
7 something that has been coming out in the media quite
8 often lately.

9 This is just a general picture of the apparatus
10 that is used to provide the testing. Fairly simple. I
11 have attended the training myself in Atlanta. There is a
12 lot to it. The test itself is pretty straightforward,
13 but there are a lot of things that go around the
14 counseling. The people who are doing this testing and
15 counseling need to be adequately prepared.

16 One thing I do want to touch on, too, is that
17 there are a number of things that FDA is concerned about
18 as far as the false positives. One is, is there a
19 problem with the apparatus. Another possibility is, is
20 there a problem with the quality assurance. Are the
21 individuals who are doing the testing being appropriately
22 trained.

1 When you are looking at this control, as you
2 see the result window here, you have an internal
3 procedural control, and then there is a red line that
4 will come up. Sometimes that line is very faint, and
5 that shows whether or not that person is positive. So
6 you really need to have good lighting when you are
7 looking at this. Obviously, the person's vision has to
8 be pretty good. They at least have to have glasses to
9 correct for any bad vision. So you need to be very
10 careful there.

11 Here is a picture showing how you collect the
12 sample with the swab around the outer gums and upper
13 gums. If people touch the roof of the mouth or the
14 cheeks, that could present a problem because that could
15 result in a false positive.

16 I'm going to move now to our planning model
17 framework here at SAMHSA. I will talk a little bit about
18 our program orientation process, site selection,
19 readiness requirements, of which there are quite a few,
20 training and technical assistance, data collection, and
21 evaluation to this point.

22 This is a fairly busy slide, but as you can

1 see, what we found early on in the stages of this project
2 is that we need to make sure we have a good relationship
3 with the different states. I know out of DSCA, Division
4 of State and Community Assistance, Vic Doolan was very
5 instrumental in having these conference calls and pulling
6 individuals from single state agencies and departments of
7 health together and working through this process to set
8 up these calls to get these individuals on board in Phase
9 1 and Phase 2.

10 Ultimately, that information will be compiled.

11 There will be a state coordinator for each individual
12 state that we can work with directly. Once that
13 individual would find out whether or not certain sites
14 were ready, willing, and able to conduct the test, that
15 information would be passed on. Eventually, it would get
16 to me to make a final approval and send that information
17 out to OraSure Technologies for them to in turn ship
18 those kits. So it is a multi-step process.

19 Under the SAMHSA Minority AIDS Initiative, we
20 received funding. We wanted to look at the opioid
21 treatment programs to get not just information but get
22 the kits out to them and to our set-aside states and

1 territory sub-recipients, as well as other SAMHSA Block
2 Grant states and territory sub-recipients, and then our
3 data wave physicians. That has to do with our opioid
4 treatment programs that prescribe buprenorphine. That
5 would hold up the process. So we really wanted to focus
6 on those physicians. Also, other opioid treatment
7 programs regulated by SAMHSA.

8 This slide really just kind of graphically
9 represents the set-aside states. You see here the
10 targeted states where there is a high infection rate when
11 it comes to HIV/AIDS.

12 Now I'm going to move into the readiness
13 requirements. There were a number of things that needed
14 to really be taken care of before individuals would be
15 given these kits at no cost, along with the controls.

16 Here you see the readiness requirements.
17 Again, it is very important to point out the state
18 requirements. We had to be sure that we were in
19 alignment with what the states were doing. Sometimes we
20 found that there were small nuances between states when
21 it came to conducting this Rapid HIV test.

22 I do want to point out the CLIA Certificate of

1 Waiver from the Clinical Laboratory Information Amendment
2 of 1988. This allows this type of test began of its,
3 quote, "simplicity" to be done in a non-traditional
4 setting outside of a lab. So this type of test is CLIA
5 waived.

6 It was also important to us that there were
7 appropriate linkages of care so when we test these
8 individuals that they would have an established way of
9 referring these individuals out to other organizations if
10 they weren't capable of treating those individuals who
11 may have been HIV-positive.

12 Then, quality assurance. I sort of touched on
13 that earlier. We wanted to make sure that there was some
14 protocol in place to ensure to the best of their ability
15 that they were conducting these tests and hopefully not
16 getting the false positive, or false negative for that
17 matter.

18 And of course, informed consent. HIPAA
19 compliance was necessary, and just general safety and
20 data security. We are talking about very sensitive
21 information.

22 Finally, data collection. They would present

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1 this information to CDC. CDC has a protocol, using their
2 PEM System, the Program Evaluation and Monitoring System,
3 to collect a lot of demographic information about
4 individuals who are coming in to be tested for HIV.

5 Then, to give you kind of a summary of the
6 training that has gone on since the initiation of this
7 project, the training as well as the technical
8 assistance, or TA. There is a manual that was initially
9 developed by CDC. We have since, because of our
10 particular area, adapted that manual to a certain extent
11 to include some scenarios when it comes to the counseling
12 that would involve substance use or mental health issues.

13 Prior to that, it was more general in its approach.

14 Also, it was important to initiate enhanced
15 Rapid Testing training for our target-specific areas.

16 This graph kind of gives you an illustration of
17 the type of testing that was done. Initially, we started
18 off doing the training of trainers, to get our trainers
19 out there, who would then, in turn, be able to train
20 other individuals.

21 With the assistance of our contractor,
22 MayaTech, we were able to get this underway. You can see

1 the number as far as the number of participants in your
2 far right column. We are talking about upwards of
3 between 4- to 500 individuals. We are talking about the
4 OraQuick HIV testing Part 1. When Part 2 came out, we
5 had to go back and make sure people were being tested
6 appropriately for both Parts 1 and 2. Not that there was
7 a major difference between the two, but you had to have
8 appropriate certification.

9 Just to give you a sense of where we have gone
10 with our trainings to date, you see the different states
11 that we have gone to, the dates on which those trainings
12 were held, and the number of participants for each one of
13 those training sessions. There are still some additional
14 training sessions that are being scheduled, as indicated
15 by this slide here.

16 This takes us, really, to the end of the
17 initiative at the end of March. It is important to note,
18 too, that there is a maximum of 24 participants per
19 training.

20 So let's get down to the data collection and
21 evaluation. I know we are probably running a little over
22 here, but this obviously is an area where we want to find

1 some information that will be helpful for us in possibly
2 increasing effectiveness of this particular initiative.

3 We do have some pilot data, which I will report
4 out in just a moment, but we obviously want to look at
5 some of the process measures, both intermediate and long-
6 term outcome measures, and the data collection component.

7 You can see here a listing of some of the process
8 measures. I know Dr. Laura House was very helpful in
9 gathering this information and working with Westat to
10 assist us in this matter.

11 Then, the intermediate outcome of measures, the
12 percentage of people tested, were they positive or
13 negative, did you have intermediate results. Of those
14 people who were tested, were there referrals made for
15 treatment and case management. Those are some of the
16 questions we were trying to get answers to. Of course,
17 this is very early on in the process, with the project
18 coming to an end just in March.

19 Here are longer-term measurements. As you can
20 see here, the question being posed here, did the
21 introduction of our initiative increase the percentage of
22 substance abuse prevention and treatment as well as

1 mental health clients being tested. That is obviously
2 the population we are trying to reach. Did the project
3 increase the zero positivity rate, which is what we
4 really expect, given what we consider to be a high-risk
5 population.

6 Some of the different data collection levels
7 you can see here as far as site level. Our contractor,
8 MayaTech, was instrumental in helping us with this area.

9 With product level, we turned to OraSure Technologies
10 when it comes to distribution and tracking of the kits
11 and controls. Then, at the very individual level, to try
12 to get some demographic information regarding the
13 individuals who were coming in for the testing.

14 What we are trying to develop really is a
15 repository of the information that is going to come from
16 these three different levels of data collection and
17 eventually we will put that into our services
18 accountability improvement system, which is something we
19 have been using at SAMHSA for some time now to collect
20 our GPRA data.

21 This slide just mentions a number of different
22 data elements. I'm not going to go through each and

1 every one of them, but some of the demographic variables
2 that we were looking at when it came to Rapid HIV
3 testing.

4 Just in graphical form, this illustrates that
5 this particular pilot involved five different projects.
6 You see Houston, Minnesota, New York, Oklahoma, and
7 Washington. What we found was that, out of these almost
8 13,000 clients, most of the clients were tested in New
9 York and Houston, as you see here. Again, we are talking
10 about 13,000 clients.

11 I would point out that by the end of December
12 2005 we had distributed some 352,000 Rapid HIV Test kits
13 across the country.

14 I placed this slide into the presentation
15 really to point out the different types of sites that we
16 are getting to. Again, this is limited to those 13,000
17 individuals. You see here 39 percent field visits, so
18 more of a non-traditional way of reaching individuals who
19 may be at high risk for being infected with HIV. Of
20 course, you have your public health centers, at 28
21 percent. Interestingly enough, we have the prison and
22 jail system at 11.2 percent. As far as drug treatment, a

1 little low at 6.6 percent, but again, this is only
2 looking at 13,000 individuals.

3 This graphic just shows you gender-wise the
4 individuals that we have been testing at least within
5 this pilot population of almost 13,000 clients.
6 Predominantly, males have been the ones we have been
7 testing.

8 This slide is important to show because we are
9 talking about race and ethnicity. Obviously, our
10 targeted areas are minorities and other high-risk
11 populations. You see here that the majority of
12 individuals there were tested within these 13,000 clients
13 in this pilot data were mainly blacks, Hispanics, and
14 others, as compared to the 31.5 percent for white non-
15 Hispanics.

16 This slide illustrates, really, just the age
17 range. We were finding most people come in to be tested
18 range between the 20- and 39-year age range.

19 I have highlighted some areas here because I
20 think they are of particular interest to us, coming from
21 SAMHSA, not that all of them aren't important. This is
22 being self-reported by individuals who are coming in for

1 the test. So they can put down one or more of these
2 items as a reason that they would come in to be tested.

3 To highlight the one in blue, "No acknowledged
4 risk," I can only speculate here but it is just because
5 of a sense of denial about why they are coming in to be
6 tested. For some people, as part of their workup maybe
7 they are being tested. But interestingly enough, you
8 find there are other areas. Sexual relationship with
9 men, or MSM, the population is 17.3 percent.

10 I think this really brings us to a close here.

11 Again, I would caution you that this is preliminary
12 data. This is pilot data coming out of those five
13 project areas. I think an important thing to remember is
14 that, with the typical test it would take about two weeks
15 to get a result from your testing. What CDC has
16 estimated is that a large percentage of individuals were
17 not coming back. I think the estimate has been as high
18 as 20 percent of individuals who were not coming back.
19 Now that they have taken the test, they are not coming
20 back to receive those results.

21 CDC has estimated that of 900,000 people
22 supposedly infected with HIV, approximately 200,000 do

1 not know what their zero status us. So to have, as
2 illustrated in this graph, stayed for the test, we are
3 talking about 20 minutes or so. Most people are going to
4 stay. So, not 100 percent, but we are talking about 99
5 percent, and that is what showed up here.

6 As far as the test results, what we are finding
7 from this preliminary data is 1.5 percent. Again, this
8 is a screening mechanism, a screening tool. This test
9 has to be confirmed by another method, i.e. Western blot,
10 to make a confirmation of that test. But again, if
11 someone gets a false positive at the screening level, it
12 raises a lot of anxiety, I need to say. So we need to
13 make sure that we are on top of that.

14 I think that the next slide is not in your
15 handouts, but I did want to point this out because this
16 is sort of hot off the press. Dr. Clark had mentioned in
17 his opening statements the president's State of the Union
18 address as far as the money that sounds like it is going
19 to be coming for reaching individuals in these targeted
20 populations.

21 You can see here some information specifically
22 mentioning Rapid HIV testing. Not your traditional

1 testing, but Rapid HIV testing.

2 In the second bullet, you see the president's
3 call for a nationwide effort working closely and
4 specifically with African Americans, churches, and faith-
5 based groups, as Dr. Clark mentioned, to deliver Rapid
6 HIV tests to millions, to end the stigma of AIDS, and to
7 come closer to a day when there are no new infections in
8 America.

9 Other important highlights I did want to point
10 out for particular populations are those people who don't
11 know their status. I talked about that just briefly a
12 moment ago. The president has a proposal to direct a
13 total of more than \$90 million to the purchase and
14 distribution of Rapid HIV tests. Then, the testing of
15 prisoners, obviously one of our target populations as far
16 as the criminal justice system, reaching those
17 individuals. The president's proposal is to direct
18 approximately \$20 million to directly facilitate the
19 testing of more than 600,000 prisoners.

20 Finally, as far as substance use, intravenous
21 drug users. Estimated undiscovered cases are
22 particularly high among IDUs. The president again

1 proposes to direct approximately \$20 million to
2 distribute Rapid HIV Test kits to drug treatment centers
3 and health care professionals. Obviously, this is
4 talking about this agency and the individuals that we
5 fund.

6 I think that brings me to a close. I would
7 like to say, before I take your comments or questions, I
8 am indebted to the individuals who have worked with me.
9 As I say, this is a cross-center initiative involving the
10 help of a lot of individuals, even in preparing this
11 presentation. I'm indebted to those individuals, and
12 hopefully making this initiative worthwhile and impacting
13 the lives of many throughout this country. Thank you.

14 [Applause.]

15 DR. CLARK: Thank you, Dr. James.

16 Any questions from the council?

17 MR. DeCERCHIO: On the issue of false positives
18 and the confirmation, that is part of the protocol now?
19 In other words, is that happening through public health
20 in terms of having the Western blot done as the
21 confirmation for the immediate positives?

22 DR. JAMES: We don't fund the confirmation

1 test.

2 MR. DeCERCHIO: Right.

3 DR. JAMES: We are funding the actual HIV Rapid
4 Testing kits. That is a screening tool. Once that
5 individual comes up as being positive, that needs to be
6 confirmed by Western blot, and there is another
7 mechanism, immunofluorescent.

8 MR. DeCERCHIO: As a quick follow-up, the sites
9 that are doing this, do they have to have a protocol by
10 which they can access that Western blot?

11 DR. JAMES: Right, right. An established
12 referral.

13 MR. DeCERCHIO: A linkage so that we are sure
14 that those follow-up confirmations are happening.

15 DR. JAMES: Like anything, we can't force
16 individuals to go, but there has to be an established
17 mechanism in place for each of the states that we deal
18 with as far as the grantees who are receiving these kits.

19 MR. DeCERCHIO: Thanks.

20 DR. JAMES: Yes?

21 DR. McCORRY: I'm aware of a program that I
22 think is called Project Wave. I was wondering about

1 state plans. Project Wave works with local deejays that
2 African American youth listen to, and the deejays get
3 tested using the Rapid HIV test. They also have a show
4 go on, so they have some rappers that get up. They said
5 this has been incredibly successful and a number of kids
6 show up to get tested.

7 What I see listed are all kind of traditional
8 outreach sites for HIV testing, whether it is drug
9 treatment or a community health center. Is there any
10 sense of innovation in their plans in terms of using this
11 technology in non-traditional settings to reach
12 populations that typically don't get tested?

13 DR. JAMES: I think that is pointed out,
14 actually, in one of the slides. I think I will go back
15 to it. It was sort of vague, I think. "Field visits,"
16 at the very top, at 39 percent.

17 DR. McCORRY: That's what that is?

18 DR. JAMES: Yes, yes.

19 DR. McCORRY: Oh, okay. Very good.

20 DR. JAMES: That is what we are saying. We
21 want to be innovative in our approach. I think our
22 sister agency, CDC, was dealing more with the general

1 population. We want to reach individuals who were
2 typically not reached in the past.

3 DR. MCCORRY: Very good. Thank you.

4 DR. JAMES: You're welcome.

5 Any other questions or comments?

6 [No response.]

7 DR. JAMES: Thank you.

8 DR. CLARK: Thank you, Kirk.

9 [Applause.]

10 DR. CLARK: I would like to point out that Dr.
11 Sheila Harmison, in order to the disaster work, was the
12 lead person on this. Dr. Kirk James stepped in after
13 Sheila became ill. Dr. Harmison was responsible for
14 getting the bulk of the tests into the hands of the
15 health departments while we were developing the other
16 aspects and working in concert with the HIV Taskforce
17 within CSAT and within SAMHSA.

18 As Dr. James pointed out, there are a number of
19 individuals who worked on this issue. I see Vic Doolan,
20 Dave Thompson, Stella Jones, and Laura House, and I think
21 there may be other people back there. I know Cheryl
22 Gallagher was also involved in it. But I think people

1 have stepped up and we are making this initiative. We
2 will see what happens with the president's proposal. It
3 is only a budget proposal. It is '07 funds. It all
4 turns on what the Congress does, but it is clear that,
5 for the administration, addressing the issue of HIV is of
6 paramount importance.

7 **Council Roundtable**

8 DR. CLARK: We have almost made it through
9 another meeting. The final item on the agenda is the
10 Council Roundtable, and you now have the floor.

11 Val?

12 MS. JACKSON: Thank you.

13 We started to talk about this yesterday, and
14 then I think Mr. Curie came in or another issue came up.

15 I had been the lead person for the look at e-therapy,
16 where we might be and where we might be going on that.

17 Dr. Harmison had been the person who had done the
18 presentations and was the lead for SAMHSA. I know Ken
19 had volunteered to be a part of that. I think Melody
20 also did, and Chilo did, too.

21 There was a lot of interest on the council
22 about that. I would like to bring it up and ask the

1 council whether or not we want to continue that. I don't
2 know whether you call it a subcommittee or whatever. A
3 subcommittee? Thank you. A subcommittee which was
4 formed before. So I just need your leadership on that.

5 DR. CLARK: I think we have continued interest
6 in it, particularly when we are dealing with special
7 populations in geographic areas. So while we have had
8 some staffing changes due to Sheila's death and some
9 retirements, we intend to revisit the issue of e-therapy.

10 DR. McCORRY: I was struck, this morning, by
11 Chilo's comment to David Gustafson when he started
12 describing the funding streams that come into running his
13 program. He mentioned about four or five that are just
14 around a youth program.

15 Last time, I think in May, I had brought up
16 getting CMS in to talk about funding, but I'm thinking
17 there is a broader issue. It is more to ask whether the
18 council is interested in this.

19 I listed about 12 funding streams, permanent or
20 temporary, just sitting here that probably a program
21 director is managing. Some are temporary, some are
22 permanent. A Block Grant is permanent. A research grant

1 might be temporary, or a foundation grant.

2 I know the financing of the system has been
3 looked at at some level nationally because I know I have
4 read some studies from folks like Dennis McCarty where
5 they talk about the Block Grant is this percentage of
6 funds spent in a particular state.

7 To me, my sense is, even though there are these
8 permanent funding streams, the stability of the financing
9 of the system is relatively unstable. There is some
10 permanency, but then there are these kinds of irregular
11 funding opportunities. Sometimes, some systems might
12 step up and fund. Like, criminal justice might get
13 involved, or criminal justice might not get involved, but
14 everyone is doing criminal justice work.

15 So I don't know whether this is a good topic
16 for the council, whether it is just a presentation or
17 whether we actually tried to look at the impact of these
18 multiple funding streams on stability, the
19 comprehensiveness of care, and the model that is actually
20 supported in dollars rather than the model that gets
21 delivered. Just, a sense of how the treatment model is
22 supported or inhibited or impeded by the kind of

1 disparate set of funding streams that seem to be in these
2 programs.

3 I'm interested, even though I'm not a financing
4 guy. It just seems to me like an important issue. But I
5 don't know whether the council members would be
6 interested in pursuing it a little bit more, or whether
7 it is worth a group like us actually trying to do
8 something in that area.

9 DR. MADRID: I would like to echo what Frank is
10 talking about because I think that these are grass-roots
11 issues that providers are confronted with on a daily
12 basis. These are grass-roots issues that faith-based
13 programs will confront as they are unfolding and coming
14 in as providers.

15 So I think that perhaps sometime in the near
16 future we should have somebody present some type of
17 presentation that deals with the different payers out
18 there, the payers of last resort, the providers of last
19 resort, and the whole financing system. Perhaps an
20 overview of what is out there, how managed care is
21 affecting us, and so forth.

22 Certainly, I would like to echo, also, what

1 Valera said because I was working with Sheila Harmison,
2 also. She was very encouraging to me. I'm pilot-testing
3 an e-therapy program in Texas. It is bilingual. Sheila
4 helped me a lot with a lot of ideas.

5 I have a team of staffers at my agency that are
6 working with that real hard, and we are going to continue
7 the struggle, continue trying to delve into this e-
8 therapy situation. I'm finding it very, very
9 interesting, to say the least.

10 DR. CLARK: With regard to the financing issue,
11 this council had actually suggested the topic before. We
12 weren't able to do it. Frank, you were going to come and
13 deal with it, and you weren't able to do that. So I
14 suggest that we, in conjunction with the staff person,
15 address this issue.

16 It is particularly important given your other
17 comments with regard to our expectation of training of
18 individuals in the work force and the modern demands of
19 the substance abuse delivery system. If that delivery
20 system changes its portfolio of products, then it is
21 going to, of course, expect reimbursement for providing
22 the services and the products within that portfolio, and

1 want to make sure that jurisdiction is acknowledged, as
2 well as the legitimacy of the efforts. Otherwise they
3 won't be able to do that.

4 So if a state says, "Well, you can't provide
5 the following kinds of services," then that won't happen.

6 Or, if the criminal justice system says, "We will
7 reimburse for five of the 10 necessary services" and that
8 leaves you in the hole for the other five, then that
9 obviously affects what it is that you do. The same thing
10 with child welfare or TANF or any other of the public
11 funding entities.

12 Then there is always the other sometimes small,
13 sometimes large streams, but oftentimes limited,
14 regardless of the size.

15 MS. JACKSON: I would really endorse that and
16 be willing to work with that as an agency. We have
17 something like 30 different funding streams, and I don't
18 think that is uncommon. There are a lot of funding
19 streams that go into putting together a comprehensive
20 agency. Even those that may only be one piece of it
21 still have to constantly search.

22 I am aware right now of an agency in North

1 Carolina that we are doing some technical assistance
2 with. Last night my husband said, "They have 83 clients.
3 They are going to have to close their doors." So there
4 are some real economic issues there that I think are
5 important, and we need to investigate and look at them
6 for future purposes. So I would endorse that.

7 DR. MADRID: I mentioned at the beginning of
8 the meeting that I was in San Antonio last week, where we
9 were training 60 or 70 new, prospective service
10 providers, faith-based mostly.

11 They were very concerned with should they go
12 501(c)(3), 501(a), limited liability corporations. They
13 were very concerned about the type of Medicaid funding
14 available. They were very concerned about should they do
15 indirect costing, administrative costing. They were very
16 concerned about, are we going to survive when we jump
17 into this thing or are we not. They were very concerned
18 about the whole economy thing, the whole financial
19 situation.

20 A lot of them looked like they were very well-
21 off groups from churches that are very, very well
22 intentioned, very smart people, but they don't have the

1 slightest clue as to what fiscal survival is in the
2 delivery of drug services.

3 MR. DeCERCHIO: I guess I would ask us to
4 consider what is our focus on financing? Just to
5 understand the complexity? You know the complexity. I
6 guess I would say maybe we can be a little more focused
7 in our feedback or request.

8 If it is informational so that we understand
9 the different funding streams and how complex they are,
10 that is one thing. I'm a little less interested in that.

11 I know, Frank, you are very operational.

12 One area to maybe consider is kind of related
13 to financing. What I hear from our folks all the time in
14 our community-based agencies is, "We now have national
15 outcome measures." Well, to what extent are other
16 funders willing to consider utilization of those national
17 outcome measures in the substance abuse services that
18 they fund.

19 So we may not be able to get more integration
20 on funding streams. You know how that goes. But it
21 would make life easier at your level if all of a sudden
22 the Bureau of Justice Assistance or Juvenile Justice

1 says, "That is a measure we could adopt.

2 We could accept that measure, or the array of
3 measures, or part of the array of measures," which then,
4 while not eliminating the funding streams, creates some
5 efficiencies and economies for people at the bottom of
6 the funnel, if you will. That would be something we
7 might want to consider: other opportunities by which we
8 look to deal with this issue.

9 DR. CLARK: Anita?

10 MS. BERTRAND: Really quickly, I see it as an
11 opportunity to teach organizations how to better run
12 their businesses in terms of being creative.

13 When I think about residential treatment, I
14 look at the children that are in the program with their
15 mothers and how we look for "Help Me Grow" dollars and
16 the TANF dollars to support the work that substance abuse
17 does. It crosses over so many areas of our life: do our
18 leaders, through workforce development, know how to tap
19 into those sources to better their programs.

20 We are thinking about things like consignment
21 shops and thrift stores. I was happy to hear that
22 someone in Louisiana was doing those types of things

1 because this system is taxed in terms of what it is, and
2 we need to be creative. So I was thinking about it from
3 a workforce leadership development point of view.

4 DR. CLARK: Val, and then Frank.

5 MS. JACKSON: I think that those are very
6 interesting points that need to be investigated, but I
7 also believe, in answer to Ken's question, that it is
8 quite possible that if we went about this right we could
9 impact some of the major funders of substance abuse.
10 Take Ryan White, for instance.

11 Ryan White in some states is providing nothing,
12 basically, or very little for substance abuse treatment.

13 I happen to be in an area where they are providing a
14 lot, which is very good.

15 Now, the price of those services and what they
16 are actually providing for is another big question. Just
17 as an example, in Florida, the Department of Corrections
18 has a very different view of what substance abuse
19 treatment is from what the Department of Children and
20 Families has. I suspect that that is true in many, many
21 states.

22 So you have \$40 a day versus, whatever, \$150 a

1 day. Well, that is a lot of difference in services, and
2 that means differences in outcomes and, ultimately,
3 differences in national outcomes. So I think we need to
4 look at some of those issues.

5 DR. McCORRY: I think these are great
6 suggestions for what we might start to focus on once we
7 delve into financing. Valera was just hitting on exactly
8 one of the points I was thinking.

9 I love the idea of the workforce and tying it
10 to outcomes, but my contention is that there are systems
11 that should be invested in our system of care and that it
12 is almost optional whether they are. Criminal justice is
13 a great example. Public welfare and certainly public
14 health. Ryan White is a good example, but there are
15 other examples.

16 If you look at NOMS, the outcomes talk to the
17 impact they have in other systems. Yet, those other
18 systems don't necessarily have an investment in our care,
19 or if they do, the determination of both the level of
20 investment as well as the focus for the investment, what
21 they are willing to pay for, is somehow independent of
22 the expertise that resides in the program. Even a single

1 state agency might not be involved in the determination
2 of what another system might be willing to pay for, or
3 whether they are willing to pay for something at all.

4 So these kinds of things and looking at
5 expectations on payers in terms of NOMS, expectations on
6 payers in terms of outcome, and then investments in the
7 substance abuse service system because of the benefit to
8 their mission, and trying to understand the piecemeal
9 quality of the financing and the way that might lead to
10 these kinds of questions, that might ultimately lead to
11 some kind of position or paper or further initiative, in
12 which the funding gets more normalized because these
13 other care-giving systems or other stakeholders start to
14 see their responsibility in it.

15 DR. CLARK: All right. We will put that on the
16 agenda for a future meeting and raise this as a concern
17 of the council as we refine the arguments, recognizing
18 that SAMHSA's jurisdiction is SAMHSA. But there are
19 partnerships that need to be forged with a wide range of
20 entities, and we are already doing that with criminal
21 justice and child welfare, et cetera. So we can elevate
22 the scores.

1 So there are two topics?

2 DR. MADRID: Another topic that we heard at
3 this meeting is the whole issue of hepatitis A and B and
4 the vaccine. So the question now is, what are we going
5 to do when that vaccine runs out? It is a one-time deal.
6 There is vaccination happening all over the country for
7 A and B. There is nothing for hepatitis C. The
8 Secretary apparently allocated this money one time and
9 that's it. So, what comes next after the money runs out,
10 after we use up all that vaccine?

11 DR. CLARK: Yes, that's a good question.
12 Again, we can put infectious diseases back on the agenda.
13 We have actually applied for resources over time, so we
14 may choose to submit that again when funds appear on the
15 horizon. I also think it's incumbent upon the
16 constituency and council members to also keep their
17 fingers on the pulse of what is going on in the
18 communities.

19 We have often found drug treatment programs
20 unwilling to step up to the plate to do HIV testing or
21 even to administer the vaccine. That is one of the
22 things that you heard. So perhaps our next effort is

1 educating clinical programs about the importance of it.
2 The first thing we hear is, "We need staff people," or,
3 "Are you going to pay for this? Are you going to pay for
4 that?"

5 So if indeed we are going to integrate care,
6 our system needs to be able to figure out how it can
7 address some of these issues in a comprehensive or
8 holistic manner. They are adversely affected by the
9 negative consequences of not providing the vaccine or not
10 doing the HIV testing, but unfortunately the marketplace
11 drives business behavior and people who are living on a
12 shoestring often learn to adapt to not having the best of
13 all services. So there is that tension we have to sort
14 through.

15 Any other issues?

16 DR. MADRID: The last thing that I want to
17 bring up, and I think I brought it up during the meeting,
18 is the whole issue of workforce and maybe inviting the
19 Annapolis Coalition to come in and talk to us.

20 DR. CLARK: We intend to do that. I don't mean
21 to cut you off, but we have already raised that issue and
22 we will invite the Annapolis Coalition. If you have some

1 specific questions on that, please feel free to submit
2 that because that is an integral part of Mr. Curie's
3 Matrix. We are spending money on this, and I think it is
4 important for this council, based on all your experiences
5 and your positions, to be reassured that these issues are
6 being adequately addressed.

7 Any other questions?

8 [No response.]

9 **Future Meeting Dates**

10 DR. CLARK: I would like to bring to your
11 attention a couple of changes in the meeting schedule for
12 the advisory council to facilitate the council's review of
13 grant applications.

14 The next face-to-face meeting was originally
15 scheduled for May 17th and 18th. We are now looking at a
16 one-day, face-to-face meeting on June 23rd, which is a
17 Friday.

18 We were also considering a teleconference
19 meeting the week of August 7th. That date has now
20 changed to Thursday, August 24th.

21 Thursday, September 21st, and Friday, September
22 22nd remain on the schedule. Let me explain, briefly,

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1 the reasons for these schedule changes.

2 Beginning in October of this year, SAMHSA will
3 be switching to a new Department-wide unified financial
4 management system. To accomplish this transition in time
5 for the start of the new fiscal year on October 1st,
6 SAMHSA must make all grant awards by September 1st. This
7 is two weeks earlier than last year.

8 This, coupled with the late action by the
9 Congress last year in approving an appropriation bill for
10 the Department, has significantly compressed the time
11 available to process awards and, in particular, has
12 required adjustments in the schedule for reviewing grants
13 and preparing summary statements by the SAMHSA Grants
14 Review Office.

15 By adjusting the council's schedule, we
16 anticipate that we will be able to spread your review of
17 grants over two meetings and provide summary statements
18 well in advance so as not to create an undue burden on
19 you.

20 We appreciate your understanding and
21 cooperation in fulfilling this important council
22 function.

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1 Any questions about that?

2 MR. DeCERCHIO: Could you give us those dates
3 again, the revised dates? The revised dates are the same
4 ones we have already been given?

5 DR. CLARK: Yes.

6 PARTICIPANT: Friday, June 23rd. Thursday,
7 August 24, for a teleconference call, and Thursday,
8 September 21 and Friday, September 22.

9 MR. DeCERCHIO: Thank you.

10 DR. CLARK: In addition, on the 22nd of June,
11 we will have an African American in-service training, and
12 the possibility of you attending that is also on the
13 table. So we will inform you of that and let you know to
14 give you an opportunity to attend that.

15 As we leave, let me repeat how grateful I am to
16 you for taking the time out of your schedules. You sat
17 through a day and a half and you have been attentive, and
18 I really appreciate that. I know the staff appreciate
19 that, those that are left.

20 The issues are of great concern. I think, as
21 Brenda Bruun pointed out, and Anne Herron and Dan Dodgen,
22 particularly with the disaster work, we have been able to

1 establish the legitimate role of substance abuse
2 prevention and treatment to the disaster. It has taken a
3 little while to do that, but it is important that you
4 understand.

5 I think Ken, of course, knows up close and
6 personal this issue, as well as Dave Wandser [ph] and, of
7 course, Mike Duffey, in experiencing some of these
8 issues. Frank, both the blackout and 9/11/01 brought
9 that to our attention.

10 So with Mr. Curie's leadership, we have been
11 able to make it clear that we are part of the larger
12 public health delivery system and should not be
13 sequestered off to the side and our issues and our needs
14 left as an afterthought. I think Dan, Brenda, and Anne
15 pointed that out. The larger media tends to focus on,
16 shall we say, the more global issues, and that leaves the
17 intricacies to us.

18 So if there is no further business, I will
19 entertain a motion to adjourn.

20 [Moved.]

21 DR. MADRID: I would like to go ahead and
22 second it, but I would also like to commend you, Dr.

1 Clark, and Cynthia and certainly George and the rest of
2 the CSAT staff for another well organized meeting.

3 Cynthia, thank you for cracking the whip on me.

4 Thank you for your compliments. I, too, wanted
5 to thank Cynthia and the other staff that worked on this
6 meeting. Unfortunately, we also had a staff person who
7 had an accident and hurt herself as a result of her
8 enthusiasm to get the job done, so I think that
9 demonstrates the commitment of my staff to make sure that
10 you have what it is that you need to make this work. We
11 have Doug Basher and we have contractors who have been
12 actively involved in this.

13 Nevertheless, we are trying to make sure that
14 you are able to make your contribution to our ability to
15 inform the Administrator as to the various issues that
16 are confronting the American public with regard to
17 substance abuse treatment.

18 Back to the motion. It has been moved and
19 seconded that we adjourn.

20 All those in favor?

21 [Chorus of ayes.]

22 DR. CLARK: All those opposed?

1 [No response.]

2 [Motion carried.]

3 DR. CLARK: The meeting is adjourned. See you
4 then.

5 [Whereupon, at 12:48 p.m., the meeting was
6 adjourned.]

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