

SUBSTANCE ABUSE AND MENTAL HEALTH  
SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT  
NATIONAL ADVISORY COUNCIL

Wednesday,  
January 26, 2005

Sugarloaf, Seneca, and Rock Creek Rooms  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road  
Rockville, Maryland

## IN ATTENDANCE:

Chair

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM  
Director  
Center for Substance Abuse Treatment  
1 Choke Cherry Road, Room 5-1015  
Rockville, Maryland 20857

Executive Secretary

Cynthia A. Graham, M.S.  
Public Health Analyst  
Center for Substance Abuse Treatment  
1 Choke Cherry Road, Room 5-1036  
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Members

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Kenneth A. DeCerchio, M.S.W.  
Director  
Florida Department of Children and Families  
Substance Abuse Program  
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David P. Donaldson, M.A.  
CEO  
We Care America  
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Washington, D.C. 20002

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Professor  
Jackson State University  
1120 Andrew Chapel Road  
Brandon, Mississippi 39047

Melody M. Heaps, M.A.  
President  
Treatment Alternatives for Safe Communities (TASC)  
1500 North Halsted Street  
Chicago, Illinois 60622

## IN ATTENDANCE:

Valera Jackson, M.S.  
CEO  
Village South/West Care Foundation, Inc.  
3180 Biscayne Boulevard  
Miami, Florida 33137

Chilo L. Madrid, Ph.D.  
CEO  
Aliviane NO-AD, Inc.  
7722 North Loop Road  
El Paso, Texas 79915

Francis A. McCorry, Ph.D.  
Director  
Clinical Services Unit  
Division of Health and Planning Services  
New York State Office of Alcoholism  
and Substance Abuse Services  
501 7th Street  
New York, New York 10018

Gregory E. Skipper, M.D., FASAM  
Medical Director  
Alabama Physician Health Program and  
Alabama Veterinary Professionals Wellness Program  
19 South Jackson Street  
Montgomery, Alabama 36104

Eugene White-Fish  
Tribal Judge  
Forest County Potawatomi Tribal Court  
P.O. Box 349  
Crandon, Wisconsin 54520

Ex Officio Members

Richard T. Suchinsky, M.D.  
Associate Director for Addictive Disorders  
and Psychiatric Rehabilitation  
Department of Veterans Affairs  
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1                                   P R O C E E D I N G S                                   (9:15 a.m.)

2                   DR. CLARK: I'd like to call the meeting to  
3 order. This is the 41st meeting of the CSAT National  
4 Advisory Council. We've got several new council members.  
5 Please join me in welcoming Anita Bertrand from Lorraine,  
6 Ohio, Dr. Bettye Ward Fletcher from Brandon, Mississippi,  
7 Dr. Francis McCorry from Yorktown, New York, and Judge  
8 Eugene White-Fish from Crandon, Wisconsin. I'll talk about  
9 them a little more subsequently.

10                               We now have a full council. Before we move  
11 forward, I'd like to entertain a motion for the approval of  
12 the September 1st and 2nd minutes. These minutes were  
13 forwarded to you, council members, electronically. You  
14 have a copy in your notebook. But for those who feel more  
15 comfortable discussing the minutes, is there any  
16 discussion?

17                               (No response.)

18                   DR. CLARK: May I get a vote on accepting the  
19 minutes?

20                   MR. DeCERCHIO: So moved.

21                   MS. JACKSON: Second.

22                   DR. CLARK: All those in favor?

23                               (Chorus of ayes.)

24                   DR. CLARK: Those opposed?

25                               (No response.)

1           DR. CLARK: All right. We're going to accept  
2 the minutes as presented without any corrections. The  
3 minutes are adopted.

4           I want to emphasize again the importance of  
5 your role as council members to the Center for Substance  
6 Abuse Treatment, and also to SAMHSA. It is good that you  
7 are able to take time out to be here. We know that you  
8 have busy schedules. Many of you are running programs or  
9 are involved in community activities, so this is a  
10 sacrifice on your part. We want to make sure that you feel  
11 that the sacrifice is justifiable by giving you an  
12 opportunity to contribute to our thinking, our reasoning,  
13 and our efforts.

14           At this point, I'd like to officially say a few  
15 lines about some of our new members in alphabetical order.

16       We'll start with Anita Bertrand. She is the Executive  
17 Director of Northern Ohio Recovery Association in  
18 Strongsville, Ohio. She has a Master's degree in social  
19 work administration, and a comprehensive knowledge of  
20 public policy and community development in research issues.

21       She has expertise in criminal justice in planning,  
22 implementing, and monitoring new and evolving substance  
23 abuse treatment and housing programs.

24           She is also one of our grantees in one of our  
25 recovery support services grants. I think this is an

1 important thing. She talks about her own recovery. So not  
2 only does she come to the issue of substance abuse recovery  
3 from the perspective of a manager, but also from someone  
4 who has a personal history.

5 Welcome to the CSAT Council, Anita Bertrand.

6 Also joining the council is Dr. Bettye Ward  
7 Fletcher. She is currently a professor of sociology at  
8 Jackson State University, a historically black college and  
9 university. She has expertise in workforce diversity,  
10 organization assessment, capacity building, program  
11 planning and implementation, and research and evaluation.

12 She served as Executive Director of the  
13 Mississippi Department of Human Services, a cabinet-level  
14 gubernatorial appointment. Her research is focused on the  
15 social and behavioral correlates of substance abuse and  
16 HIV/AIDS. Since she's an educator as well as a  
17 policymaker, our whole workforce efforts by which SAMHSA is  
18 concerned will benefit from the contribution of Dr.  
19 Fletcher.

20 Welcome, Dr. Fletcher.

21 I'm delighted to welcome Dr. Frank McCorry. He  
22 is the Director of the Clinical Services Unit, Division of  
23 Health and Planning Services, New York State Office of  
24 Alcoholism and Substance Abuse Services. Dr. McCorry is  
25 responsible for clinical policy and practice improvement

1 issues, particularly in the areas of public health,  
2 co-occurring mental health, addictive disorders, and  
3 managed care.

4 He also oversees development of new initiatives  
5 that respond to emerging issues, such as improving clinical  
6 practice through the adoption of evidence-based  
7 interventions and hepatitis prevention and control. He is  
8 also working with the Washington Circle Group in developing  
9 quality standards for the delivery of services. He has  
10 worked in the field of substance abuse prevention and  
11 treatment for over 30 years.

12 Welcome, Dr. McCorry.

13 And finally joining us on the council is the  
14 Honorable Eugene White-Fish. He is a tribal judge for the  
15 Forest County Potawatomi Tribal Court. Judge White-Fish is  
16 President of the National Tribal Court Association and the  
17 previous Director of the Alcohol and Drug Treatment Council  
18 for the State of Wisconsin. He also provides outpatient  
19 counseling.

20 He was talking about the kinds of materials  
21 that he had to review for this meeting. He said, "Hey, I  
22 limit my lawyers to only ten pages."

23 (Laughter.)

24 DR. CLARK: He said, "I haven't had to read  
25 this much since law school."

1                   With his extensive background and his  
2 involvement with the legal process, we welcome Judge White-  
3 Fish's contribution to the council. He'll be able to  
4 assist us in any number of ways.

5                   So welcome, Judge.

6                   So I have given you a thumbnail sketch of the  
7 new members. The bio document is on the handout in the  
8 back.

9                   Speaking of the back, everyone who attends this  
10 meeting, we would like for you to sign in in the back so  
11 that we will have a record of those in attendance. That  
12 applies to council members as well as staff, and anybody  
13 else in the audience.

14                   With that, I'm going to take a few minutes so  
15 that we can go around the table so that our new council  
16 members are introduced to our old council members, and  
17 those in the audience will be able to hear a few words from  
18 those present.

19                   Why don't we start off with Dr. Fletcher?

20                   DR. FLETCHER: Thank you, Dr. Clark.

21                   I am Bettye Ward Fletcher from Jackson,  
22 Mississippi, where I serve as professor of sociology at  
23 Jackson State University, and probably have come to this  
24 board by way of my involvement in the substance abuse field  
25 over the last 30 years as one of the founding directors of

1 the Interdisciplinary Alcohol Drug Study Center. So I  
2 value the opportunity to be part of this body and look  
3 forward to the discussions.

4 DR. SKIPPER: Hi. I'm Greg Skipper. I'm a  
5 physician in addiction medicine. I run the Physician  
6 Health Program and Veterinary Wellness Program in Alabama.  
7 I'm on the faculty at the University of Alabama in  
8 Birmingham. I'm happy to be here.

9 Thank you.

10 MS. JACKSON: Hello. I'm Valera Jackson from  
11 Miami, Florida. I am with The Village, which is a  
12 treatment center that has been around for about 30 years.  
13 I was a previous Assistant State Director and worked on the  
14 state side as well as the private side. We also have  
15 programs in the U.S. Virgin Islands, and we are affiliated  
16 with West Care, a foundation and corporation which has  
17 programs in seven different states in the U.S.

18 My main interest I think is in a lot of  
19 programming and development areas. I have worked a lot  
20 with SAMHSA and members of the Clinical Trials Network with  
21 NIDA. I just have a great love of this profession that I  
22 can't seem to let go of, so I look forward to the  
23 discussions in our work.

24 MR. DeCERCHIO: Good morning. I'm Ken  
25 DeCerchio. I'm the State Substance Abuse Director in the

1 State of Florida.

2           When we last met, we were on the eve of our  
3 third hurricane in Florida. I thought it was going to be  
4 the last one. But since we met, we've had another one. So  
5 we had a total of four before the discussion tomorrow on  
6 disaster response and preparedness. I certainly have to  
7 compliment SAMHSA's response in partnering with us. We'll  
8 talk more about that tomorrow over those four disasters.

9           Since we last met, I'm in an interim acting  
10 capacity as Acting Deputy Secretary for Substance Abuse and  
11 Mental Health. So I've been real involved in mental health  
12 issues the last 90 days, and look forward to being here.

13           I had a good trip up. Unfortunately, my  
14 luggage didn't have the same kind of trip that I had, and  
15 it is still traversing the countryside somewhere between  
16 Reagan National and Gaithersburg, Maryland. So maybe we'll  
17 reconnect over the course of the day.

18           Thank you.

19           DR. SUCHINSKY: I'm Richard Suchinsky. I'm the  
20 Chief for Addictive Disorders at the Department of Veterans  
21 Affairs here in Washington, D.C. As an ex officio member,  
22 I think I have the privilege and honor of having been the  
23 longest serving member of this council.

24           MR. DONALDSON: Dave Donaldson, President of We  
25 Care America. We are an alliance of primarily

1 faith-based organizations across the country. We focus on  
2 four areas in helping these groups build their capacity.  
3 Government relations, training, we have the National Grant  
4 Center where we research, write proposals, and do grant  
5 management. Then also our Care Corps, which is the  
6 volunteerism. So we have been very active with these  
7 disasters as well, especially with the tsunami.

8 DR. MCCORRY: Good morning. I'm Frank McCorry,  
9 and I'm thrilled to be part of this council. I look  
10 forward to the work we'll do. It is such an exciting time  
11 to be part of such an important body, having an evidence  
12 base that now we can try to move into practice, extending  
13 the continuum of care through such things as Access to  
14 Recovery and bringing faith-based initiatives and  
15 collaboration with other systems, which I think is so key  
16 in terms of substance abuse work, particularly with the  
17 mental health community, but also with criminal justice and  
18 social welfare.

19 It is just a terrific time. It is just an  
20 exciting time to be in this field, and I look forward to  
21 being part of this deliberation.

22 DR. MADRID: Chilo Madrid from El Paso, Texas.  
23 I'm the CEO of a comprehensive drug treatment and  
24 prevention program out there. I'm very happy to be with  
25 you all enjoying the snow. We don't get this type of

1 weather out there where I'm from.

2 DR. CLARK: You can have it.

3 (Laughter.)

4 MS. BERTRAND: Good morning. My name is Anita  
5 Bertrand, and I identify myself from Northern Ohio, which  
6 for me is three major cities, Akron, Cleveland, and  
7 Lorraine. I do work in all three cities. I'm excited to  
8 be here, and just believe that the recovery community has a  
9 lot of valuable input that can be given to other  
10 professionals. I do identify myself as a professional, a  
11 person in recovery. I'm going to be working with the  
12 churches trying to bridge that gap so that individuals can  
13 retain their recovery once we release them from treatment  
14 centers.

15 JUDGE WHITE-FISH: Good morning, everyone.  
16 Thank you for the warm welcome.

17 Most people have not heard of Crandon,  
18 Wisconsin. It is a small community. I represent a tribe,  
19 the Forest County Potawatomi. It has approximately 1,200  
20 members.

21 I am currently the President of the National  
22 American Indian Court Judges Association that represents  
23 tribal courts throughout the United States and Alaska.  
24 This is my second consecutive term. I had hoped to step  
25 down because they limit our terms. However, they decided

1 to change the bylaws on my behalf.

2           When you look at retirement, the main question  
3 is can I take NIDA any further than what I have already  
4 taken it. Apparently some of my members must think so, so  
5 I feel privileged to do that, as well as looking at a very  
6 important issue. In tribal courts, and I imagine in any  
7 other courts, the state courts, the federal courts, the  
8 chemical dependency disease is definitely out there.

9           In training, they asked me where I learned to  
10 write orders. I said, how I learned to write orders is,  
11 all it is is a treatment plan for those people that are  
12 addicted, is what it is. They were impressed that I could  
13 write orders in the way that I did, looking at the full  
14 scope of things, looking at family, and looking all ways.  
15 I think every judge should have some training definitely in  
16 chemical dependency for they may see things through  
17 different eyes if they were.

18           Thank you.

19           MR. KOPANDA: Good morning. I'm Rich Kopanda,  
20 Deputy Director of CSAT.

21           DR. CLARK: Cynthia, do you want to introduce  
22 yourself? Cynthia Graham is the person who is responsible  
23 for coordinating and pulling this meeting together. So I  
24 want to acknowledge her effort, and the efforts of her  
25 coworkers in the back and elsewhere, all working with

1 George Gilbert so that this meeting is a successful  
2 meeting. We appreciate the support of staff as well as  
3 those that have attended.

4           This is an important time period. It is a time  
5 period in transition. We are in the second phase of the  
6 administration. We have got obviously a number of new  
7 political appointees at high levels. Speaking of new  
8 political appointees, as you know, we have a new  
9 Secretary-designate, and that last word "designate" is  
10 supposed to evaporate sometime today. There should be a  
11 swearing in today or tomorrow. I think it is today.  
12 Washington is a strange place. You schedule things,  
13 everybody anticipates it, and then they either happen or  
14 they don't happen. It is supposed to happen today.

15           The reason that is important is because we are  
16 supposed to have Mr. Charles Curie present, and he was  
17 looking forward to presenting. But in anticipation of the  
18 swearing in, he received the call. So when your boss  
19 calls, you can either ignore your boss and say no, I'm  
20 going to go to the CSAT Council, or you can say well, maybe  
21 I'd better go to the swearing in. So he won't be able to  
22 make it here today. He was summoned, and I think it is an  
23 appropriate thing for him to do. So I will be actually  
24 giving his comments.

25           The key issue is this is the second term for

1 this President. Now we get to focus on dealing with a new  
2 Secretary, new policies, and new issues. So this council  
3 comes at a critical time. We can't assume that what we  
4 have done in the past four years will be done in the next  
5 four years. We've got budget issues. This council meets,  
6 basically this is ten days before the budget is supposed to  
7 be delivered to Congress. We will have a new budget, that  
8 is being proposed. So we'll be able to see in ten days,  
9 and you'll get a copy of the new budget when it comes, what  
10 our resources are going to be like for the next fiscal  
11 year.

12 We already know from public accounts that there  
13 are projections of deficits that money is going to be  
14 tight. So we'll see how that affects our programs in short  
15 order. So again, we'll need your input.

16 We have scheduled a number of presentations  
17 from council members in SAMHSA staff on status reports in  
18 specific CSAT and SAMHSA activities. We will also have  
19 presentations from other entities, from Dr. Nora Volkow,  
20 the Director of the National Institute on Drug Abuse, and  
21 Michele Leonhart, the Deputy Administrator of the Drug  
22 Enforcement Administration, each talking about activities  
23 at sister agencies that are important for substance abuse.

24 Since the last council meeting, CSAT has been  
25 very busy. If you have copies of the director's report, I

1 won't read from that directly, but it summarizes a lot of  
2 activities that we have been pursuing as a part of the  
3 largest SAMHSA agenda, working in collaboration with the  
4 other centers and the other offices within SAMHSA, and the  
5 service of Mr. Curie's vision and our mission.

6           We will be releasing a new TIP next week,  
7 "Substance Abuse Treatment for Persons with Co-Occurring  
8 Disorders," on January 31st during a roundtable at the  
9 Press Club. Some of you are familiar with the co-occurring  
10 TIP. It has been long in development. I can tell you it  
11 is a thick document. But of course we are very familiar  
12 with the issue of co-occurring as a very complex issue.

13           Frank, you have done some work in there. So  
14 you can understand the importance of this document.

15           We did have a meeting on e-therapy, telehealth,  
16 and telepsychiatry in December. You'll hear more about  
17 that from my special assistant, Dr. Sheila Harmison.

18           We have been actively involved in the disaster  
19 area. Of course we have had a number of both domestic  
20 disasters, and as was pointed out by Dave in terms of the  
21 tsunami, we have got some international disasters. We have  
22 got SAMHSA staff who have been mobilized to participate in  
23 the relief effort, and literally going off to the Indian  
24 Ocean as a part of the support effort.

25           So SAMHSA in general has been actively involved

1 in a lot of issues. CSAT of course with our central focus  
2 being on substance abuse treatment, but our partnership  
3 with the other centers and the other offices in the service  
4 of Administrator's agenda is to deal with our vision, which  
5 is a life in the community for everyone, and our mission is  
6 building resilience and facilitating recovery.

7           With that, I'm going to give you the comments  
8 from Mr. Curie. Taking the time to read those comments  
9 becomes very important because, indeed, he sends his  
10 regrets. He had up until the last moment planned to be  
11 here. He feels that this is an important council. He  
12 feels that this is an important issue. The block grant is  
13 \$1.6 billion, it is the largest chunk of change that SAMHSA  
14 manages, and so it is understandable that he would be  
15 invested in your opinions and your attitudes.

16           He wanted to welcome you here, and begin by  
17 welcoming you to our new building. That's the other thing.

18       Since our last meeting, as some of you have commented on,  
19 we have a new building. We will have a walk around toward  
20 the end of the day. We are all getting used to it. We  
21 have been here since late August. CSAT moved in, so we've  
22 had time to acclimate. We're still working out the kinks  
23 that happen whenever you move into a new building, a new  
24 place.

25           Mr. Curie wanted to say, "I want to thank the

1 Advisory Council members for the tremendous work you do on  
2 behalf of the people we serve. I want to thank each of you  
3 for grabbing every opportunity presented to you to create  
4 real and lasting change in the President's first term.  
5 With your hard work and the work of SAMHSA employees, the  
6 foundation of lasting improvements was laid.

7 "Now, during the second term, we can move  
8 ahead, cementing our gains and building on our new  
9 initiatives. As we move ahead, I want to review our  
10 progress, examine what still needs to be done, and map out  
11 our future directions.

12 "One of the major changes since our last  
13 meeting is in fact that SAMHSA has moved. I hardly need to  
14 tell you how fundamentally important it is to have SAMHSA  
15 together for the first time in this remarkable new  
16 building. In the past what was working well in one center  
17 was seldom communicated to those in other centers located  
18 in separate buildings. Not so any longer. Where we once  
19 had single stars, we now have one bright constellation.  
20 This building and the sense of community it is creating has  
21 opened a new door to SAMHSA, and will truly help us in our  
22 goal to become one agency with one vision and one mission.

23 "Being together makes our vision of life and  
24 community for everyone a little more attainable. It brings  
25 our mission of building resilience and facilitating

1 recovery a little closer.

2 "Throughout our work to achieve our vision and  
3 our mission, HHS Secretary Tommy Thompson was our biggest  
4 supporter. He supported our move to this new building. He  
5 has supported and believed in our vision and mission, and  
6 he has supported our budget requests. Most importantly, he  
7 made it possible for us to continue to save the lives of  
8 those Americans and families who struggle with mental  
9 illness and battle with addiction. He has been our good  
10 friend and our strongest ally in prevention. I will truly  
11 miss his leadership and guidance.

12 "I also know that Secretary-designate Mike  
13 Leavitt plans to build on Secretary Thompson's legacy. In  
14 his confirmation hearing, he has outlined the issues and  
15 opportunities he sees confronting our nation. I have every  
16 confidence that SAMHSA will continue to receive high levels  
17 of support and will continue to advance the President's  
18 initiatives and directives that benefit the people we  
19 serve.

20 "The people we serve are often thought of as  
21 the unwanted. Those who are homeless, who struggle with  
22 mental illness, and who battle addiction are the very  
23 people our President spoke of in his inaugural address.  
24 During his inaugural address last Thursday, President Bush  
25 said, 'In America's ideal of freedom, the exercise of

1 rights is ennobled by service, and mercy, and a heart for  
2 the weak. Liberty for all does not mean independence from  
3 one another. Our nation relies on men and women who look  
4 after a neighbor and surround the lost with love.  
5 Americans, at our best, value the life we see in one  
6 another, and must always remember that even the unwanted  
7 have worth.'

8 "If ever those were people assembled to pursue  
9 a larger goal and a good with a heart for the weak and who  
10 place value in the lives we see in the unwanted, it is this  
11 advisory council. Among the many tasks that will be asked  
12 of you in the future, I ask you to approach each one with a  
13 sense of surrounding the lost with love.

14 "Some major themes I expect to see emerge over  
15 the next four years include increasing efficiencies and  
16 focusing on outcomes, pushing science to new heights,  
17 containing health care costs, and increasing access to  
18 health care services. I believe you will see major  
19 advances in the use of health information technology. I  
20 expect SAMHSA will play a key role in each of these focal  
21 points, because these themes are already woven throughout  
22 SAMHSA's major initiatives.

23 "The administration's support for and  
24 confidence in SAMHSA, coupled with our sharpened focus on a  
25 few key program areas, could not have come at a more

1 important time. With a recently approved fiscal year 2005  
2 budget of more than \$3.4 billion, SAMHSA will continue to  
3 administer and fund a rich portfolio of grant programs and  
4 contracts.

5 "Clearly we are entering tighter budget times,  
6 and we will not be seeing the same increases we have  
7 enjoyed in the past. However, we have built a solid  
8 foundation through our relationships. We have focused on  
9 common ground, and will undoubtedly be able to swiftly and  
10 judiciously rally our resources.

11 "Our emphasis on fiscal responsibilities are no  
12 stranger to those of us in government, and no stranger to  
13 those who rely on government dollars to operate, nurture,  
14 heal, and support. As you know, SAMHSA's matrix of  
15 priority programs identifies 11 areas to ensure that our  
16 work is focused. I will highlight only two today for the  
17 purpose of my update.

18 "The first is substance abuse treatment  
19 capacity and Access to Recovery. As you know, President  
20 Bush resolved to help people with a drug problem who sought  
21 treatment but could not find it in his 2003 State of the  
22 Union address. Toward that goal, he proposed Access to  
23 Recovery. The President proposed to provide grants for a  
24 state-run voucher program for substance abuse clinical  
25 treatment and recovery support services. It was designed

1 to accomplish three main objectives.

2 "First, expand capacity by increasing the  
3 number and types of providers, including faith-based  
4 providers who deliver clinical treatment and/or recovery  
5 support services. Second, allow recovery to be pursued  
6 through many different and personal pathways. Third,  
7 require grantees to manage performance based on outcomes  
8 that demonstrate patient successes.

9 "Access to Recovery recognizes that the process  
10 of recovery is a personal journey. It can take many  
11 pathways, including physical, mental, emotional, and/or  
12 spiritual pathways. Under the Access to Recovery program,  
13 people in need of addiction treatment and recovery support  
14 choose the programs and providers that will help them most.

15 "President Bush had proposed \$200 million for  
16 this in FY 2004 for SAMHSA's set in place for the first  
17 year of Access to Recovery. Congress ultimately  
18 appropriated \$100 million. The President again requested  
19 \$200 million for Access to Recovery for 2005 to expand the  
20 program. Again, Congress only appropriated \$100 million,  
21 eliminating any opportunity for expansion this year.

22 "I had the honor of joining President Bush in  
23 Dallas in August when he announced the first 15 ATR grants.  
24 Fourteen states and one tribal organization were selected  
25 through a competitive grant review process that included 66

1 applications submitted by 44 states and 22 tribes and  
2 territories. So you can see we've got the investment of a  
3 number of entities in Access to Recovery.

4 "While all applicants had the opportunity to  
5 expand treatment options for different target population  
6 groups and utilize different treatment approaches, they all  
7 had to meet some specific common requirements.

8 "The first was to ensure genuine, free, and  
9 independent client choice of eligible providers. Second,  
10 they had to establish how clients would be assessed, given  
11 a voucher for identified services, and provided with a list  
12 of appropriate service providers from which to choose.  
13 Third, applicants were required to supplement, not  
14 supplant, current funding, thus expanding both capacity and  
15 available services.

16 "Finally, they will all report on common  
17 performance measures to illustrate effectiveness. In both  
18 program design and implementation, applicants delineated a  
19 process to monitor outcomes. These performance measures  
20 that I will discuss later will be used to measure treatment  
21 success and the ultimate success of the voucher program  
22 itself.

23 "The second priority program I want to discuss  
24 is the Strategic Prevention Framework to help all Americans  
25 lead longer, healthier lives, and to get at health care

1 cost containment. We must use the power of prevention.  
2 Fortunately over the years we have shown prevention  
3 programs can and do produce results.

4 "The word about what works in prevention is  
5 getting out, but much work remains to be done in substance  
6 abuse prevention in the relatively new and emerging area of  
7 mental health promotion and mental health prevention. To  
8 provide a structured approach to substance abuse  
9 prevention, mental health promotion and mental health  
10 prevention, we launched SAMHSA's Strategic Prevention  
11 Framework during the National Healthier U.S. Prevention  
12 Summit in Baltimore, Maryland in April of 2004. With the  
13 launch of the framework, both President Bush and Secretary  
14 Thompson recognized that it is time that programming policy  
15 and America as a whole recognize that substance use and  
16 mental disorders should be treated in the same concern and  
17 urgency as diabetes, obesity, heart disease, stroke, and  
18 cancer.

19 "In 2004, we took a major step toward building  
20 this framework. We announced the availability of and  
21 awarded \$45 million to 19 states and two territories  
22 through a competitive grant process. The challenge for  
23 SAMHSA in the coming year is to continue to build a  
24 national commitment to the community-based risk and  
25 protective factor approach to prevention used in the

1 framework.

2 "As you know, the SAMHSA matrix priority  
3 programs are managed by applying the same cross-cutting  
4 principles to all priorities. One cross-cutting principle  
5 that I will provide an update on today is the SAMHSA data  
6 strategy. To help present consistent and reliable  
7 information, we are continuing to implement our data  
8 strategy.

9 "The strategy is simple. The tighter our  
10 measurements become, the more we can prove our  
11 effectiveness. The greater our effectiveness, the greater  
12 the number of people served, and the greater the chances  
13 for a life in the community for everyone.

14 "Developing a data strategy is a task that has  
15 been hanging around for years. Now we have gotten real  
16 about doing it. Just last month we held a major meeting  
17 with substance abuse prevention and treatment leaders on  
18 implementing our strategy. We have committed to holding a  
19 similar meeting with the nation's mental health services  
20 leadership in the very near future. Our work with the  
21 states and our grantees is critical to building  
22 requirements to achieve true accountability in a  
23 performance environment by transforming the way we do  
24 business.

25 "We have learned that a limited number of key

1 outcome measures in structured ways can help us all know  
2 how well SAMHSA and its grant programs are building  
3 resilience and facilitating recovery. Our emphasis on a  
4 limited number of national outcomes and related national  
5 outcome measures is built on a history of extensive  
6 dialogue with our colleagues in state mental health and  
7 substance abuse service agencies, and the people we serve.

8 "Ultimately these outcome measures will extend  
9 across all SAMHSA grant programs. All of our programs are  
10 about achieving our vision of a life in the community  
11 for everyone, and our mission, building resilience and  
12 facilitating recovery. So it only makes sense that SAMHSA  
13 uses the same outcome measures across all of our programs.

14 "The national outcome measures we have  
15 identified are, one, abstinence from alcohol abuse or drug  
16 use, and decreased symptoms of mental illness. Two,  
17 increased or retained employment and school enrollment.  
18 Three, decrease involvement with criminal justice system.  
19 Four, increase stability in family and living conditions.  
20 Five, increase access to services. Six, increase retention  
21 in services for substance abuse or decreased utilization of  
22 psychiatric inpatients beds for mental health. Seven,  
23 increase social connectiveness.

24 "Already SAMHSA is implementing these national  
25 outcome measures through Access to Recovery and the

1 Strategic Prevention Framework. Focusing on these handful  
2 of national outcomes will minimize the reporting burdens on  
3 the states and other grantees, and will promote more  
4 effective monitoring of client outcomes and system  
5 improvements.

6 "Ultimately they show that people are achieving  
7 a life in the community, a home, a job, and meaningful  
8 personal relationships. Achieving SAMHSA's vision of a  
9 life in the community for everyone will require  
10 collaborative efforts from all individuals, organizations,  
11 and levels of government that deliver these services and  
12 supports. Although barriers still exist, they are being  
13 overcome.

14 "Together with our many partners, our new  
15 Secretary Mike Leavitt, and you, our CSAT Advisory Council  
16 members, we will continue to bring the message of hope,  
17 courage, recovery, and the promise of a life in the  
18 community for everyone.

19 "Thank you."

20 Those are Mr. Curie's comments, but I think  
21 they summarize all of what we have been doing here at  
22 SAMHSA, and they capture our commitment to make sure that  
23 we have services available to people, and that we have  
24 outcome measures. It is no longer sufficient to say give  
25 me the money, trust me, I will spend it wisely.

1           As a result of our focus on performance, we  
2 have been able to achieve, shall we say, green status from  
3 the Office of Management and Budget in a number of areas,  
4 because indeed, we recognize that it is critical that grant  
5 programs deliver. If we fail to deliver, then basically  
6 the money can be spent best elsewhere.

7           We all know that we have a major substance  
8 abuse problem in the United States. We have a major  
9 treatment problem in the United States, and that is fueled  
10 in part by denial. There is a profound denial gap in the  
11 United States.

12           When we look at our Household Survey data, and  
13 you'll hear from several members from the Office of Applied  
14 Studies, we find that 78 percent of the people who meet  
15 criteria for needing substance abuse treatment services do  
16 not perceive a need. Eighty-nine percent of people who  
17 meet the criteria for needing services secondary to alcohol  
18 abuse and dependence do not perceive a need. So the engine  
19 that drives illicit drug use is not just those who are  
20 presenting for treatment, but actually the overwhelming  
21 body of individuals who do not perceive a need for  
22 treatment.

23           This is why community-based organizations and  
24 faith-based organizations can play a major role. The  
25 vectors of values of a community can help reinforce the

1 notion that recovery is necessary, recovery is possible,  
2 and that people in recovery are welcome in the community.

3           We need to be able to address this issue of not  
4 in my backyard, NIMBY. The community conveys a  
5 contradictory message. We want you to stop using drugs,  
6 but oh, by the way, we don't want you to stop using drugs  
7 in our neighborhood. The interpretation is okay, as long  
8 as we're using drugs in your neighborhood, that's okay.

9           By that, I mean if the community will tolerate  
10 the drunk driver next door or the person using crack or  
11 methamphetamine down the street, but says to the people who  
12 want a drug-free halfway house in the vacant building, we  
13 have this building, we have people who are in recovery in  
14 this building, they say no, we don't want drug users in our  
15 neighborhood.

16           Stigma distorts recovery in the minds of the  
17 neighborhood. For no other condition, if someone says, I'm  
18 trying to recover from diabetes, the neighborhood doesn't  
19 come up with hue and cry and placards and banners saying we  
20 don't want recovering diabetics in our neighborhood. If  
21 you're trying to recover from arthritis, the same thing  
22 does not happen.

23           The community is safer actually for those  
24 people who are saying, I perceive a need for treatment, I'm  
25 actively involved in a treatment process, and I'm actively

1 involved in recovery. But somehow that gets lost in the  
2 dialogue. It discourages people from pursuing recovery  
3 efforts.

4           So what we are trying to do is make sure that  
5 by demonstrating that our programs work, what we are trying  
6 to do is demonstrate that the community needs to have a  
7 commitment and an investment. So all sectors of the  
8 community need to be involved in the recovery process.

9           That is what recovery management services are  
10 about. We started a recovery support services program a  
11 number of years ago to facilitate that kind of construct.  
12 It has been subsumed under Access to Recovery in part  
13 because we see that it is not the acute treatment effort  
14 that resolves the problem, it is that continuum, because  
15 you need acute treatment and you need community support.  
16 If we don't do that, then the attitude is people in  
17 recovery are going to relapse, they are no good, they are  
18 this, they are that, and we don't want them in the  
19 neighborhood. Until of course somebody sends their  
20 daughter or themselves, and then all of a sudden everyone  
21 wants efforts.

22           We need that, because we also recognize that  
23 private payers of insurance have retreated from playing a  
24 major role in paying for services. That is unfortunate.  
25 So one of the things that we will be discussing is this

1 notion. We need council members to bring to us information  
2 about what is going on locally, what is going on in your  
3 jurisdictions, what is going on in the communities that are  
4 struggling with this issue about who you know. Whether it  
5 is at an HBCU, tribal community, recovering community, a  
6 treatment program, or a state agency, we need to all put  
7 our heads together to address this. That makes our efforts  
8 here at SAMHSA more viable. We need to be able to deal  
9 with the needs of those with co-occurring disorders.

10 Our TIP is going to speak to that. We've got  
11 efforts that address that, but they don't constitute the  
12 largest group. The largest group of substance users are  
13 those in denial. We need new strategies. We have got a  
14 screening and brief intervention effort to attempt to reach  
15 people in different settings. If you wait until they show  
16 up at specialty substance abuse treatment programs, clearly  
17 you are dealing with a different group of people.

18 We know from DSM-IV and from your own  
19 experience that people who meet criteria for abuse and  
20 dependence are having problems. So you are not surprised  
21 when the person who is on his fifth DUI comes before you,  
22 Judge, and says, I don't have a problem. He is on his  
23 fifth DUI, and he promises, well gee, maybe the first one  
24 was an accident, and the second one was unfortunate. But  
25 by the time you get down to five, I think pretty much there

1 is a pattern there. Yet this person is able to conclude  
2 that they don't have a problem. How is that?

3           So 78 percent of the illicit drug users are  
4 saying I don't have a problem. We must reach those  
5 individuals in different settings. We can't simply rely on  
6 the professionally driven treatment programs. We need the  
7 treatment programs, but we also need to be able to reach  
8 the people elsewhere like the community health centers, the  
9 schools, whether it is the churches, whether it is the  
10 community centers, or whether it is the employment setting.

11           If you are having problems, they are manifests.

12 We know that these people are having problems, and they  
13 must be manifested to others in their community. We need  
14 the community to help us with the intervention so that we  
15 can address the problem. That hopefully will save money.  
16 That's what we are also relying on. If we address people  
17 early in the addiction, they won't have lost so many  
18 things, they won't have crossed so many barriers and  
19 created so many problems for themselves, their families,  
20 their neighborhood, and their community.

21           So with that, I'm going to ask Melody Heaps,  
22 who has managed to join us, and travel is difficult these  
23 days.

24           Melody, do you want to introduce yourself?

25           MS. HEAPS: It's not travel. It's just reading

1 agendas, which I seem to have lost the ability to do.

2 I'm Melody Heaps. I'm the President of TASC,  
3 Inc., in Illinois. We're an agency that specializes in  
4 sentencing alternatives for substance abuse and the  
5 mentally ill, as well as working with other public systems  
6 to be a referral and case management system for people for  
7 the public sector to get into treatment.

8 DR. CLARK: Melody has been a stalwart  
9 contributor to our reflections and discussions over the  
10 years. So another person who has got a historical  
11 commitment.

12 Welcome again, Melody. Thank you for being  
13 able to make it. That helps us.

14 Before we start, any comments from council  
15 members?

16 DR. MADRID: I had one question, Dr. Clark.

17 On the Partners for Recovery, could you give us  
18 just a very brief rundown as to where we are at with that  
19 one in reference to follow-up on those collaboration  
20 conferences that we had and some of the work that is being  
21 done there?

22 DR. CLARK: We are in the process of doing  
23 follow-up for Partners for Recovery. We are expanding the  
24 steering committee so that all of SAMHSA is able to be  
25 represented. We are going to have mental health

1 representation on the steering committees of PFR.

2           We have got support from Mr. Curie on PFR, so  
3 we are trying to refine that right now. Then we are going  
4 to go off and continue the work about which you speak. It  
5 is clear that the recovery construct is one of paramount  
6 importance to Mr. Curie. It is of also paramount  
7 importance to the President. So recovery is a construct,  
8 and it weaves its way through all of what we do from PFR to  
9 other activities.

10           Some of you may also know that there is the  
11 question of what is recovery. So we have got a  
12 subcommittee working with OAS and others trying to put a  
13 spin on the whole definition of recovery. There has been a  
14 recent report released by NIAAA that was published in the  
15 journal Addiction, trying to capture the essence of the  
16 recovery process.

17           So part of what PFR is doing is not only the  
18 work of which you have been involved in, but also trying to  
19 get a better handle of recovery across the spectrum of  
20 conditions associated with mental illness and addiction.  
21 Mr. Curie points out that the mental health community has  
22 adopted the recovery construct, and now the issue is how to  
23 refine it so that it has meaning to all those who are  
24 pursuing recovery, whether it is recovery from mental  
25 illness, a mental health oriented recovery, or recovery

1 from substance abuse. So we will be working on that  
2 dynamic. So PFR is alive and well, and we will be pursuing  
3 the refinement of our activity over the next couple of  
4 months.

5 Frank?

6 DR. McCORRY: Dr. Clark, I was interested in  
7 Mr. Curie's comments on SAMHSA's data strategy and the  
8 SAMHSA outcome domains. Does the strategy reach out to  
9 other care giving systems, or other systems that might have  
10 some of the data relative to such things as decreases in  
11 criminal justice and an increase in employment, which  
12 really isn't in a mental health substance abuse care giving  
13 system. Does the data strategy talk about an integrated  
14 database that might have to extend beyond SAMHSA, or is it  
15 currently now just trying to get mental health and  
16 substance abuse to come up with the same kinds of measures?

17 DR. CLARK: Clearly, the uniform measure  
18 strategy is the first step, so that you have some common  
19 understanding across platforms. As you know, nationwide  
20 many substance abuse programs are subsumed under either  
21 public health or mental health. So what we need to do is  
22 get everybody on board.

23 What you point out is in terms of additional  
24 data, collateral data, and whether it comes from criminal  
25 justice or child welfare, that's very important, and we are

1 interested in facilitating those kinds of relationships,  
2 because at the end of the day, from the substance abuse  
3 treatment point of view, our biggest referral source is the  
4 criminal justice system. Our data shows that 36 percent of  
5 the referrals for substance abuse treatment come from the  
6 criminal justice system.

7 So it is in their best interest and our best  
8 interest to get data, because at some point, as Judge  
9 White-Fish would say, the questions will be asked of them.

10 Well you've got all these newfangled strategies, what are  
11 they doing? Re-arrest rates, is the community safer?  
12 So all of us are interested in the same outcome, and that  
13 is the beauty of the seven domains.

14 DR. McCORRY: Being new to the council, I don't  
15 know, perhaps there was a presentation recently, but I'd be  
16 interested in kind of knowing more about that at some point  
17 in our deliberations to see both SAMHSA's vision, as well  
18 as its impact on corollary systems or kind of sister  
19 systems in providing care to people who end up with alcohol  
20 and drug problems. Just kind of get a better feel for it,  
21 a deeper feel for it.

22 DR. CLARK: Very good, and we'll put your name  
23 down as someone interested in our data strategy.

24 Val?

25 MS. JACKSON: Yes. I just wanted to make a

1 comment on your comment concerning the 78 percent of those  
2 people who do not perceive themselves to be in need of  
3 treatment.

4 I think we need to really think seriously about  
5 that figure and what that says. One of the things that I  
6 thought about while you were speaking is the fact that it  
7 would be interesting to know if some of that 78 percent  
8 doesn't have a pretty good idea that they need treatment,  
9 but they are scared to death to bring that out into the  
10 open, because that's a dangerous thing to do in many  
11 communities. It is dangerous because people are looked  
12 down upon, it is dangerous because if one person identifies  
13 themselves as an addict, then they seem to not become a  
14 person anymore after they go through treatment. They are  
15 that recovering person, that recovering addict, so their  
16 whole self is defined in that afterward.

17 It would be very nice if we somehow could move  
18 into a state. I see the prevention messages that talk  
19 about I have better things to do than drugs. I think those  
20 are really marvelous. I would love to see at some point,  
21 whether it is us, ONDCP, or our states, get involved in  
22 messages that say you know, recovering is a really positive  
23 thing, recovering is an okay thing. Here is my pal, and  
24 this person is employed. I am speaking to the choir, I  
25 know.

1           It seems like our public perception of  
2 addiction is still really negative. I'd just like to  
3 punctuate that with one thing, and that is some people will  
4 know the name of this once-famous football player who  
5 recently in Miami was arrested. On the news, it was said  
6 he was bipolar and had substance abuse problems, and he was  
7 found recovering in the upper floors of a hotel room. I  
8 don't know if there was a robbery involved or not, but it  
9 was very clear that the man was very ill.

10           The last bite that they did on this was to have  
11 a guy with a nice baseball cap on come up and get  
12 interviewed by the press and talk about the situation.  
13 They said, you know, I wouldn't want to have this guy  
14 around me. That was the bite that got on the 11:00 news.  
15 I thought it was just embarrassing for my field to have  
16 that kind of public image.

17           DR. CLARK: Two things. One, we'll have an  
18 opportunity to discuss the issue of perception and need of  
19 treatment with Joe Gfroerer, who is presenting on the  
20 Household Survey data, where some of this comes from. In  
21 anticipation, though, of his presentation, the questions  
22 are asked to segregate those who perceive a need for  
23 treatment but are reluctant to pursue treatment for reasons  
24 against those who do not perceive a need of treatment.

25           Oddly enough, only about 7 percent of the

1 people who perceive a need for treatment are not in  
2 treatment, and they have a host of reasons, one of which is  
3 stigma. As I interpret the Household Survey data, and  
4 again, we'll have Joe here, he will be able to answer that,  
5 but basically 78 percent do not perceive a need for  
6 treatment, period.

7           The data shows that of the remaining people,  
8 the bulk are in treatment, and then there is about a 7  
9 percent cluster of individuals who perceive a need for  
10 treatment, but who are not in treatment. The chart blows  
11 that 7 percent up. But the 78 percent, that seems  
12 intransigent. But again, you'll have an opportunity to  
13 talk to Joe Gfroerer.

14           With regard to the second matter in terms of  
15 recovery, that's why we have Recovery Month, and that's why  
16 we need communities involved. It is not only celebrating  
17 recovery from the perspective of the person recovering, but  
18 it is getting the community to have an investment in the  
19 recovery construct.

20           Unless we get the community to recognize the  
21 utility of recovery, then we have a problem. Because  
22 indeed, you can have people who disdain those who have  
23 substance abuse problems as if indeed it is not to happen.

24 I think what you are saying is correct, but it is not the  
25 stigma. It is the social reinforcement. You either have a

1 problem or you don't. As long as you've got denial that  
2 says, I've got a job, I've got a family, I've got a car,  
3 I'm doing this, I don't have a problem. So what, me worry?  
4 Why are you telling me I have a problem?

5           So by the time that person crashes and burns,  
6 now the costs go from nominal to astronomical. So then  
7 that remaining 22 percent start to have a problem. But the  
8 problem is actually developing well before you hit the  
9 wall. There is no message to you that they are developing  
10 well before you hit the wall. Recovery Month becomes a  
11 critical construct in this effort.

12           MS. JACKSON: If we could just have Recovery  
13 Year after year, after year, after year. I was seeing PSAs  
14 and so on that were addressing the very things that we do  
15 in Recovery Month. It needs to be a repeated, repeated,  
16 repeated message. I think Recovery Month is great, and I  
17 have participated in it. I would love to see our state,  
18 and every state somehow be able to carry that.

19           I see PSAs on television about diabetes and how  
20 important it is if you have diabetes, you can manage it,  
21 you can take care of it, you can do something about it. I  
22 don't see PSAs about hey, if you've got an addiction  
23 problem, you can manage it, you can do something about it,  
24 you can live with it.

25           DR. CLARK: Okay. Back to Recovery Month, in

1 fact we do produce PSAs. The decision to run the PSAs is a  
2 local decision. Part of the Recovery Month construct is  
3 not just to focus on September, but also to make it clear  
4 to the local media that indeed these are things that we  
5 want to see on TV. If you are going to choose to run PSAs,  
6 we want some of those things on recovery.

7           These things are not September-specific. We  
8 work to design PSAs that are generic, and can be. But  
9 part, again, of the issue is what does the community want,  
10 what does the community say, and where is the message to  
11 pursue recovery coming from? But again, we value your  
12 continued input into this.

13           Ken?

14           MR. DeCERCHIO: I'll pass for now.

15           DR. CLARK: Richard?

16           DR. SUCHINSKY: Apropos of your very  
17 interesting statistic of over one-third of the patients who  
18 come into treatment are from the criminal justice system.  
19 It strikes me that the whole issue of involuntary treatment  
20 really has not been put on the agenda in any sort of  
21 specific way.

22           The criminal justice referrals are involuntary  
23 treatment for the most part. There is a real question of  
24 whether there shouldn't be greater emphasis on involuntary  
25 treatment in the civil system before they enter the

1 criminal justice system. We have all met individuals who  
2 have serious problems who deny that they have any problem.

3 The families are at their wits end as to how to handle  
4 those individuals, yet they have no mechanism that is  
5 implemented, even though most states have involuntary  
6 commitment laws that would allow these individuals to be  
7 induced into treatment even though they perceive themselves  
8 as not having a problem.

9 I understand that it is a very dicey issue, but  
10 on the other hand, I think it is something that should be  
11 on the agenda, because I think it does represent a  
12 mechanism that could be of tremendous use.

13 DR. CLARK: Gregory?

14 DR. SKIPPER: This is interesting to me because  
15 most of what I do with physicians and other professionals  
16 is basically inducing them to face a problem early because  
17 the profession has taken up the mantle, so to speak, and  
18 said we're going to maintain this program to try to  
19 identify physicians earlier, or veterinarians, or other  
20 professionals, the lawyers have it, airline pilots, before  
21 they are actually really ready for treatment, we're going  
22 to go in and say, you've got a problem, here is why, let's  
23 get an assessment.

24 It is a good process. I'm meeting today with  
25 someone to look at studying these professional health

1 programs to see if we can move this into the marketplace  
2 more to get other employers. I have attempted, because I  
3 have seen the utility of having the profession, so to  
4 speak, the workplace more or less coerce treatment. I  
5 wonder if we could get that in the school systems and  
6 through industry and that kind of thing. I have run into  
7 barriers with companies feeling like it is none of our  
8 business. We just want them to perform well, we don't  
9 really want a role in monitoring, we don't want to do  
10 contingency contracting and that kind of thing.

11 But anyway, so we are looking at doing a study  
12 to study these programs and see why they are so effective,  
13 because they do appear to be very effective. Early  
14 detection, accountability, that kind of thing. I think  
15 that would be a good direction to move in.

16 DR. SUCHINSKY: I might just say that I'm  
17 associated with an organization called the Group for the  
18 Advancement of Psychiatry, GAP, and we are about to submit  
19 a paper for publication on the whole issue of involuntary  
20 treatment in the substance abuse field. It is a survey of  
21 what is being done, what is available, and what could be  
22 available in that area. So I think it has relevance to  
23 this. It will probably be in Psych Services sometime in  
24 the next six to eight months.

25 DR. CLARK: Melody?

1           MS. HEAPS:  As someone who runs an involuntary  
2 treatment program or treatment system, I just want to  
3 caution you to think about the impact that would have on  
4 the justice system, that the whole civil justice system now  
5 becomes once more the repository of what we have failed to  
6 do in other health or social service systems.

7           The inability of physicians to early detect,  
8 the inability of school systems, the failure of many of our  
9 institutions to detect, encourage, and make as a  
10 significant alternative the ability to get into treatment.

11          That is one of the problems.  The justice system is barely  
12 functioning now given what has happened in terms of the  
13 explosion of substance abuse, and now we would add this  
14 layer on, and pretty soon all of what we are doing would be  
15 justice oriented.  I'm very concerned about that.

16           DR. CLARK:  Judge?

17           JUDGE WHITE-FISH:  Court systems across the  
18 nation have seen involuntary commitments, but a lot of it  
19 falls back upon them.  When the court system does go ahead  
20 and order it, there are no monies from the county system in  
21 order to pay for that treatment.

22           I was very interested in what Richard was  
23 saying, and I would like to see a copy of that paper  
24 addressing that.  Now, it has been a problem across our  
25 nation for years, especially when insurance then decided to

1 reduce treatment costs, or insure treatment costs down to  
2 14 days from 30 days.

3 I'm one of those old therapists that we kept  
4 our client as long as we possibly could until the disease  
5 was treated. We know there is a lot of, I don't want to  
6 say evidence, that isn't the correct word, but we have a  
7 lot of data saying it takes longer than 15 days to treat an  
8 individual. But if we turn around and look at the justice  
9 systems, their hands are bound as well because a lot of  
10 court systems, a lot of judges cannot order the treatment  
11 because where does that fall upon? That falls upon the  
12 county system or whatever system.

13 Personally speaking from the tribal level, we  
14 have great insurance. All of our tribal members are  
15 insured. The tribe insures every one of the tribal members  
16 once they are enrolled. That is covered at 100 percent, 100  
17 percent. However, the problem is if I order treatment,  
18 even though we have our own health insurance, our health  
19 insurance department will not cover it.

20 So even our tribal members are caught, which I  
21 am pushing even in our own tribal government. If we have  
22 our own health insurance, then why do you limit our  
23 judicial system when we order treatment? It is going to  
24 come off of our health insurance anyway.

25 So what I do, what the judicial system does in

1 my area, I give you an option sir, or ma'am, as you stand  
2 before me. You can either take this as a suggestion of  
3 looking at treatment, or if I have to order it, you are  
4 going to have to pay for it. That is where, again, our  
5 judicial system, and not only ours, but a lot of judicial  
6 systems across the nation, their hands are tied. As Ms.  
7 Heaps says, then it becomes a judicial problem. We already  
8 have one, as has been identified to you.

9 Thank you.

10 DR. CLARK: Ken?

11 MR. DeCERCHIO: We have a civil commitment  
12 process in Florida. But the feedback that I get regarding  
13 it is that as treatment continues, the high expectation for  
14 secure treatment and secure assessment that goes with civil  
15 involuntary commitment, we evidently don't have that. We  
16 have a couple of secure detox or assessment facilities, but  
17 we generally don't have secure residential treatment. So  
18 there is a frustration out there with folks who are very  
19 difficult and very much in denial about not following  
20 through with even initial participation in treatment, then  
21 using the power of contempt and due process in order to  
22 potentially incarcerate someone as part of the sanction  
23 around the civil commitment.

24 You can see where this goes. I mean, you get  
25 into a lot of dangerous areas. You start talking about

1   incarcerating folks over a civil process, you talk about  
2   creating secure treatment. It is a reluctant development,  
3   if you will. It is a reluctant growth, and I'm not sure  
4   that it is one that we want to look at.

5                   I personally have kind of resisted moving in  
6   the direction of secure treatment, frankly, for adults  
7   outside of the criminal justice system. We have some  
8   secure treatment in jails, obviously, and correctional  
9   facilities. But on the civil side, it is a bit dangerous.  
10   It is a bit dangerous. You look at our history, you look  
11   at the Hughes Act and decriminalization, and it is a bit  
12   dangerous I think in the other part of that development in  
13   terms of going very far on that end on the civil side.

14                  DR. CLARK: Frank?

15                  DR. McCORRY: It would seem, though, that this  
16   issue of involuntary treatment may have shifted in the  
17   past, I'd say, because there is a fairly strong database on  
18   the value of involuntary treatment in terms of similar  
19   outcomes, whether it is voluntary or involuntary that was  
20   put out by NIDA years ago. But with the introduction of  
21   drug courts and more of these civil commitment processes  
22   that I see more on the mental health side than on the  
23   substance abuse side, and some kinds of civil coercion or  
24   civil direction, as well as drug courts in which judges are  
25   now acting much more in a clinical or a treatment mode

1 rather than just a judicial mode, that whether this issue  
2 of involuntary and what is considered involuntary versus  
3 some other kinds of shifts in the way clients are engaged  
4 is an interesting topic.

5           There may have been some movement here in kind  
6 of subtle ways, but dramatic ways in terms of how the  
7 cudgel is used as much as the carrot in terms of inducing  
8 someone into treatment. A cudgel might look like it is  
9 judicial, but it really might be kind of more the format of  
10 the court rather than the actual implementation of it. It  
11 is an interesting issue maybe to look at at some point.

12           DR. CLARK: Melody?

13           MS. HEAPS: I obviously have very strong  
14 feelings about this, having worked with the justice system  
15 now for 30 years. It isn't the form. It is the fact that  
16 a defendant comes before a judge and the judge says, you  
17 have two choices. You can either go to treatment, or we're  
18 going to incarcerate you for X number of years. That's the  
19 choice the client has. It is not the form, it is the  
20 sanctioning process.

21           We have absolute research that says there is no  
22 question that that sanctioning process actually is very  
23 effective in breaking down denial and moving persons into  
24 treatment with successful outcomes. In fact, unfortunately  
25 research which is being done on Prop 36 in California where

1 no sanctions are offered, there is simply referral, shows a  
2 very dismal success rate. So we know sanctions work.

3 But to extrapolate from that, we now need to  
4 move to a civil commitment process where once again, it is  
5 like opening Pandora's Box. Ken talked about what happens  
6 from when the person doesn't comply. We have now moved it  
7 into a justice system, into the criminal system. It starts  
8 out in the civil system.

9 The courts right now don't have the capacity to  
10 treat the criminal justice clients that it sees, much less  
11 to add to it. So I just want to caution you that I think  
12 one of the problems becomes, and one of the reasons that I  
13 started TASC, was that I saw that our social and health  
14 welfare system failed and was putting the burden on the  
15 criminal justice system.

16 I hear in some of the dialogue, not just here,  
17 but in other places, oh, well, we can't make it work, so  
18 therefore, let's get the court involved, let's get the  
19 justice system involved. We further criminalize the  
20 population, we further stigmatize the population, and we  
21 take the burden off the physician, off the school, off the  
22 employer, off the family, and off the church.

23 So I obviously feel strongly about that. Not  
24 that we shouldn't look at this, but I think we have to do  
25 that with these factors in mind.

1 DR. CLARK: Gregory, last comment.

2 DR. SKIPPER: I think one thing to look at here  
3 is definition of involuntary. It doesn't have to be moved  
4 into a court. Involuntary, what I'm thinking of is the  
5 family says we've had enough of this. Too often you hear  
6 family members saying well, we're not going to do anything  
7 because they're not ready yet, they don't want it yet. So  
8 the whole idea of enabling and that kind of thing.

9 I consider involuntary treatment as a  
10 definitional thing when the employer says look, you either  
11 get some help or you're fired. It doesn't have to go onto  
12 the court process. So the message we need to get out there  
13 is people don't have to be ready. We can set limits in any  
14 sphere in the community. The community that says that that  
15 crack house isn't my responsibility, we need to have  
16 people know they set the standard for their community, they  
17 set the standard for their family. The employer needs to  
18 say we set the standard for the workplace, and get people  
19 to start demanding a higher level of health with regard to  
20 addiction. That is what I mean by involuntary.

21 DR. CLARK: Well, thanks. That has been an  
22 exciting discussion.

23 (Laughter.)

24 DR. CLARK: Well, it's an important one. I  
25 think you have mapped out the spectrum of concerns, and

1 indeed this is not going to go away. So this dialogue  
2 actually needs to continue, except for not today. We can  
3 bring it back from time to time.

4           We do need to figure out how to get the engine  
5 that drives the illicit drug market to care. I mean, if I  
6 were a drug dealer, as some of you have heard me say,  
7 would I worry about the 22 percent of people who are  
8 either in treatment or want to be in treatment? Or the 78  
9 percent of the people that say, "What, me worry?" That  
10 should be obvious. From the marketplace dynamic, it is  
11 the 78 percent that I'm interested in. They've got jobs,  
12 they are good customers, they don't think they have a  
13 problem, and they are less likely to be narcs.

14           So our job, the community's job, is to say how  
15 do we address that 78 percent? We know that in order for  
16 them to have jobs, they've got to have an employer,  
17 they've got families, they've got this, they've got that.  
18       Somebody knows that there is a problem. So we just need  
19 to figure that out. I'm glad to hear this discussion.

20           Now it is time to move onto our next  
21 discussion, which will be engaging the faith-based  
22 community in recovery. The lead on that is our council  
23 member Dave Donaldson.

24           MR. DONALDSON: Thank you, Dr. Clark, for this  
25 opportunity.

1           Martin Luther King, Jr., once said, "A social  
2 movement that just changes people is revolt, but one that  
3 changes both people and institutions is a revolution."

4           We are experiencing revolution as it relates  
5 to the faith community partnering with government. I  
6 think it needs to be said at the outset that the goal of  
7 this revolution is not to publicly fund proselytizing, but  
8 it is to ensure that both faith-based and community-based  
9 groups can compete on a level playing field, regardless of  
10 whether they are religious or non-religious, so that our  
11 brothers and sisters that we have been talking about here  
12 this morning that are enslaved by drugs and alcohol can  
13 have access to the best help.

14           Nobody is saying that just because a program  
15 is faith-based that it is going to be the best, but it may  
16 be the best. We just need to make sure that the most  
17 effective programs are not marginalized so that people who  
18 have needs, that deserve the best, get it.

19           In this revolution, in many ways CSAT has been  
20 a vanguard. Some of you if you know the history of the  
21 faith-based initiative, it didn't start with President  
22 Bush. President Clinton signed into law charitable  
23 choice, and then part of this bipartisan continuum,  
24 President Bush signed the Executive Order in January of  
25 2001 for the Faith-Based and Community Initiative.

1                   We are grateful for the leadership of Mr.  
2 Curie and also Dr. Clark, and the implementation and  
3 talent of these two individuals right here.

4                   We are going to believe for a miracle this  
5 morning, because we've got three people that are going to  
6 share in 15 minutes. We are going to start with Jocelyn,  
7 and Jocelyn is going to talk about the past successes of  
8 CSAT's outreach to the faith community. I'll talk about  
9 our strategy, and then Clif will talk about the future.

10                   Jocelyn?

11                   MS. WHITFIELD: Well, good morning to you. It  
12 is also a real privilege to have worked with Dave over the  
13 last three years. We have worked with We Care America,  
14 and they were one of our intermediary organizations that  
15 have really pioneered some of the technical assistance  
16 that we have provided to the field in the last four years.

17                   I just wanted briefly to just kind of give you  
18 an overview of what we've done, and some of our  
19 accomplishments. In fiscal year '02, the faith-based  
20 roundtables and discussion groups identified grant writing  
21 as one of the top priorities. As a result of that, we  
22 began to really work endlessly to provide technical  
23 assistance to faith and community groups all throughout  
24 the country.

25                   In fact, I think we covered almost 46 states,

1 did we not, in our first year. We conducted about 42  
2 grant writing workshops. In fiscal year '04, we continued  
3 the emphasis on grant writing and expanded to address  
4 licensure certification, best practices, and 92 events.  
5 As a result of that effort, we had three to five  
6 organizations that have applied for certification and  
7 licensure, and have received it. They are now receiving  
8 state, federal, or local funds as a result of it.

9           In fiscal year '05, our strategic effort  
10 changed a little bit. We recognized that we needed to  
11 begin to look at treatment providers and recovery  
12 providers that could compete for federal funds, that could  
13 work with state systems, and also work with ATR. So we  
14 began to really look at their organizational readiness to  
15 see whether they were capable of providing those services.

16           We wanted to look at the infrastructure and  
17 some of those other things to make sure that they had the  
18 capacity to deliver these services. So we are doing a lot  
19 of work with that this year.

20           Well, as a result of the training, we have had  
21 about 6,500 individuals representing faith and community  
22 organizations that have participated in our training  
23 activities. As a result of those activities, over \$18  
24 million has been awarded to faith and community grassroots  
25 organizations. Most of that has come from private

1 foundations, some from state, and some from the federal  
2 arena.

3           As a result of that, as a result of our  
4 effort, what has happened is that we have been able to  
5 increase access to private funding. We have been able to  
6 increase treatment recovery options and services, and we  
7 have been able to engage state FBOs and single state  
8 agencies in partnering with our faith-based organizations.

9           These are some of the training activities that  
10 have taken place. We have dealt with grant writing  
11 programs, development programs, and evaluation. We have  
12 also provided training on evidence-based practices,  
13 because we wanted to make sure that they are providing  
14 quality treatment and recovery services.

15           We have also done a lot with addiction  
16 certification for counselors, and licensure for  
17 faith-based organizations to make sure they are meeting  
18 the standards and licensure requirements of the state.  
19 One of the publications that I'm going to talk about in a  
20 few minutes, most of you have in front of you, and that's  
21 our national overview. That's a technical assistance  
22 document that will provide these community organizations  
23 and faith-based organizations with the standards and the  
24 licensure requirements state by state, and also the  
25 counselor and prevention professional requirements for

1 certification and credentialing.

2           These are some of the services that  
3 faith-based organizations have offered in the past. It  
4 isn't that they just started offering these things. They  
5 have been doing it historically for a long time. They  
6 have offered mentoring programs, job training programs,  
7 housing programs, and transportation programs. They have  
8 also provided support groups. You are talking about  
9 recovery support today, but they have been doing this for  
10 the last 15, 20 years.

11           So these are some of the things that they are  
12 offering, and still are offering the community at large.  
13 They have also partnered with SAMHSA to do some of these  
14 things as well.

15           These are the two resources that will be  
16 available to you and all of the consumers as of February  
17 of 2005. They will be on the SAMHSA website, and you can  
18 get them from NCADI. That is the national review that I  
19 talked about previously, "Successful Strategies for  
20 Recruiting, Training, and Utilizing Volunteers."

21           So I want to thank you and Dave.

22           MR. DONALDSON: Thank you, Jocelyn.

23           Give her a hand. I thought that was  
24 tremendous. Thank you. That was good and fast.

25           (Applause.)

1                   MR. DONALDSON: Engaging the faith community.

2       First of all, hopefully you've had a chance to read the  
3 report that was done by SAMHSA in the "Core Competencies  
4 for Clergy and Other Pastoral Ministries." I'm not going  
5 to read it, but there is some interesting information that  
6 the panelists delineated. The multiple intersecting roles  
7 of clergy and other pastoral ministries in our country.

8                   It is just a terrific report on how the faith  
9 community is part of the answer to addressing the crisis  
10 that we're in. The strategy that we've employed with  
11 engaging the faith community is what we call the five R's.

12       The first is relationships, and as Dr. Clark mentioned,  
13 finding common ground. These workshops that have been  
14 conducted across the country have been just a fabulous  
15 catalyst for bridging this relational gap between SAMHSA  
16 and the faith community.

17                   It is interesting, some of the ones that I  
18 have spoken at, I have asked for a show of hands on how  
19 many even knew there was a government office there. Most  
20 of them were not even aware. So that was a good place to  
21 start. Also we have helped literally thousands of groups  
22 understand the process of how to apply for the grants, how  
23 to work with SAMHSA, and specifically CSAT.

24                   For many of these groups, working with  
25 government, it is like dancing with a porcupine. They

1 don't know exactly where to grab onto. So we have been  
2 able to I think help there as well. But we feel like on  
3 the SAMHSA site, some ways to build the education there is  
4 through your in-service day, which can focus on CSAT's  
5 work with the faith community, and to inform SAMHSA, but  
6 also to solicit feedback. Regular communications, such as  
7 email updates, that's another that needs to happen.

8           The second is representation. Another  
9 byproduct of these events that again, have happened across  
10 the country, are coalitions that have evolved.  
11 Multisector coalitions. It has also been a unifying way  
12 for the faith community to come together, which is not  
13 easy. But we have seen faith-based organizations that are  
14 now working together, sharing best practices. So these  
15 coalitions are beginning to emerge across our nation.

16           We need to increase faith-based involvement in  
17 the review process, and we're going to be working more on  
18 that. Application, making sure that more are applying for  
19 the funds. We want to continue to work with Ivette for  
20 mobilizing for the National Recovery Month. That's a  
21 wonderful entry point for the faith community.

22           Three is results. Results. We want to  
23 mentor. We really feel as we have literally got an idea  
24 of what is out there, that there are many groups that have  
25 the potential to qualify. Those are the ones that we need

1 to coach, we need to mentor and get them over the goal  
2 line.

3 We also want to continue with developing our  
4 trainer of trainers, the TOTs, so that we can move from  
5 addition to multiplication. There are people out there  
6 that have the ability, they have the expertise, they just  
7 need to be equipped to equip their sphere of influence.

8 Resources. Leveraging private with public  
9 resources. We heard this morning about the cuts and how  
10 we are needing to tighten our belt. We need to  
11 communicate to these groups that are applying that they  
12 need to leverage their private with public resources. I  
13 think there needs to be incentives there. Increased  
14 scoring points for groups that are leveraging those  
15 resources.

16 Another thing that I didn't mention is that  
17 with our committee, our Subcommittee on Faith-Based, this  
18 has not been organized here. A lot of it is because there  
19 has been a lot of turnaround for this council. But now I  
20 think we've got a group here that is going to be here for  
21 awhile. So if you are interested on serving on the  
22 Subcommittee for Faith-Based, if you'll talk with me,  
23 Jocelyn, or Clif, we want to get that organized.

24 Unofficially, we'd like to see an alliance  
25 with many of these network leaders that we are working

1 with across the country. So if that is of interest to  
2 you, please see us afterwards.

3           The last is replication. We want to see the  
4 multiplying of these effective models. I know through the  
5 TFE, it was Targeted Fast Expansion Grants, that has been  
6 helpful, but we need to establish standards for recovery.

7           Dr. Clark, you mentioned earlier that we need  
8 to define what is recovery. What is recovery? For the  
9 faith community, we need to help them understand what  
10 recovery management services are they currently engaged in  
11 that are congruent with ATR.

12           So that is really one of our next areas. I  
13 know, Clif, you are going to mention that. We need to  
14 establish standards for recovery. What is a successful  
15 recovery model? What does it look like? And then  
16 finally, using our web system to exchange these best  
17 practices.

18           If I can just conclude with this. I think  
19 I've got ten seconds left. Just a personal note on why  
20 I'm involved. I have experienced firsthand the havoc that  
21 substance abuse can have, not only on the user, but also  
22 on a family. It was in 1969 my mother and father were hit  
23 head on by a drunk driver. My father was killed. My  
24 mother survived, but they pretty much had to pin her body  
25 back together again.

1           It was this community, not just the faith  
2 community, but this community, the different sectors  
3 coming together that helped our family get on our feet and  
4 serve as wounded healers. So I conclude with that to say  
5 that's why I'm involved. That's why I'm so grateful for  
6 all the great work that each of you do.

7           Thank you.

8           (Applause.)

9           MR. MITCHELL: I think the conversation that  
10 you were engaged in this morning is really apropos to what  
11 we are trying to do. I was just sitting there glad to  
12 hear this, because we need your help. We really need you  
13 to be more active in your communities. We appreciate you  
14 coming here and advising us, but we need you to go back to  
15 your communities and help us change the attitude of what  
16 is going on in the country.

17           We have approximately 15 to 20 coalitions in  
18 cities around the country. Jackson, Mississippi, Newark,  
19 New Jersey, Omaha, Nebraska, El Paso, San Antonio,  
20 Pittsburgh, all around the country we have these  
21 coalitions that are being developed. We plan to bring  
22 these coalitions together so that we can expand capacity.  
23 That is what ATR is all about.

24           The President wanted to bring about vouchers,  
25 but the ultimate goal was expanding capacity. We can't

1 expand capacity if you are just going to concentrate on  
2 treatment programs. There is a huge resource out there  
3 that has been doing recovery work since the beginning of  
4 time. That has been our faith organizations. They have  
5 been providing this kind of support.

6           We have to make it easier for them to come to  
7 the table, easier for them to get the training that they  
8 need to provide the kind of quality services, and we need  
9 your help in that. Recovery. ATR. The President and  
10 many people are missing the goal on that.

11           I'm going to say this, and politically some of  
12 you may get upset with me. But this President of the  
13 United States talked about faith-based organizations. But  
14 because of political ramifications, it couldn't go down  
15 that way. So we now talk about faith-based and  
16 community-based. But the underlining thing is bringing  
17 faith-based programs to the table to help us. They have  
18 got the resources. They are there, and they have been  
19 doing it.

20           We talked about Recovery Month, and I think  
21 Dr. Clark made it very clear. It should not just be  
22 Recovery Month in September. Recovery Month is year  
23 round. I think one of you mentioned that. It is year  
24 round. That's the only way we can change attitudes. We  
25 really need to change attitudes and change stigma. That

1 is what it is all about, folks.

2 I bet you there are quite a few people sitting  
3 in here who have had problems, but because of stigma, they  
4 don't want to come out and talk about it. This is what we  
5 are trying to do with our programs and bringing  
6 communities together, bringing the coalitions together.  
7 We bring the state, local, churches, the stakeholders, we  
8 bring them all together to talk about this. We've got to  
9 develop a constituency out there.

10 For example, one of the coalitions that we  
11 have in Omaha, Nebraska. I was surprised to go to Omaha,  
12 Nebraska and find out that they had people with programs  
13 up there that could be replicated across the country.  
14 Case management, job training, parenting classes,  
15 transitional housing, GED classes. They are doing what we  
16 also want them to do and provide the jobs for the patients  
17 who come through there. They just negotiated a contract  
18 with a franchise, a national franchise, to provide \$90,000  
19 a year in work for the people who come through the  
20 program.

21 Recently we negotiated with five ministers in  
22 Richmond, Virginia, to start a job training program where  
23 these men will learn how to clean tile. They will be  
24 learning how to clean tile and start their own businesses.  
25 Sustainability, this is what we're talking about, where

1 we can get these programs not only to receive federal  
2 funds and state funds, but become self-sustaining, that  
3 they don't have to depend on the government.

4           The worst thing that can happen to any  
5 community is to have a program to start and be there for  
6 three years, and then cease. So what we're trying to do  
7 with them is teach them how to be self-sustaining so they  
8 continue.

9           Also we don't want people to be trained in  
10 jobs where they go back to being waiters and waitresses.  
11 We want them to have meaningful jobs. We want them to  
12 have jobs where they learn with their hands and their  
13 minds, where they can be successful.

14           I used to run a methadone clinic. When a  
15 person would walk into my clinic with a hard hat on and  
16 mud on their shoes, and I'd see his wife in a clean dress,  
17 and I'd see the child going to school, that was a success.

18           Many people have attitudes about methadone. That is just  
19 one means of treatment.

20           But that is what this faith initiative is all  
21 about, getting people spiritually motivated to be welcomed  
22 back into the community. That is what we are attempting  
23 to do. These are just some of the things that our  
24 programs are doing.

25           And as I said before, we really need your

1 help, the council. We need you, the staff here at SAMHSA,  
2 to help change these attitudes, because recovery is about  
3 building up our communities. Recovery is about people  
4 having dignity. We've got to do away with stigma.

5           A lot of people get upset because the people  
6 who are in treatment think that we are trying to take  
7 money away from them. We are not trying to take money  
8 away from treatment. We are trying to help treatment to  
9 do a better job. Traditionally, federal and state has  
10 never funded treatment programs adequately. You do six  
11 months, you do 90 days, you do 30 days, then you are  
12 released. Where is the aftercare? That is where the  
13 faith community comes in.

14           We are telling them that the faith community  
15 can be your partners and take care of the continuing care,  
16 because recovery could be six months, nine months, it may  
17 be a lifetime. That is what this is all about. But we  
18 really need your help. We really need your help to help  
19 us with this. This is what the President wants, this is  
20 what Dave Donaldson wants, this is what the Muslim wants,  
21 this is what the Baptists want, this is what the Jewish  
22 community wants. This is something we all are yearning  
23 for, and we really need your help.

24           We have changed our strategy because of budget  
25 constraints. Instead of having large conferences where we

1 being people in and get them hyped up and get them some  
2 training, we can no longer do that because of the budget  
3 cuts. What we are doing now with the 15 coalitions we've  
4 got around the country is identifying those programs who  
5 already have the 501(c), having some infrastructure where  
6 we can bump them up to move where they can compete with  
7 everybody else. That is what our strategy is for this  
8 year, to bump up folks.

9           It was shown where we had one coalition last  
10 year that got \$10 million from the Department of Labor.  
11 Coalition California, \$10 million. We are shooting for \$8  
12 million this year. We are shooting high in case we can't  
13 make it here, we will fall there. We are not going down  
14 there. We are shooting up here. But that is what this is  
15 all about.

16           I thank you.

17           MR. DONALDSON: Thanks a lot.

18           (Applause.)

19           DR. CLARK: I want to thank Dave Donaldson,  
20 Clif Mitchell, and Jocelyn Whitfield for their comments  
21 and for their presentation.

22           I'll entertain discussion from council,  
23 starting with Dr. Fletcher.

24           DR. FLETCHER: First of all, I'd like to  
25 commend CSAT and this group for the work that you are

1 doing with faith-based communities, because there is such  
2 a tremendous need in this area.

3 My experience in Mississippi is that the need  
4 is particularly demanding in terms of working with small  
5 faith-based organizations that do not have the  
6 infrastructure development that would allow them to be  
7 successful in this area.

8 One of the areas that I would hope that, and  
9 maybe it has happened already at some point in time, there  
10 could be some further discussion regarding how do we link  
11 those local faith-based organizations with the resources  
12 in their communities so that there can be a mentoring  
13 process?

14 For instance, how can we begin to forge  
15 relationships between colleges and universities and  
16 faith-based organizations? I appreciate Mr. Mitchell's  
17 comment in terms of not wanting to go in and do a project.

18 I call it "projectizing." You go in and provide a  
19 project for a number of years, the funding ends, and the  
20 project is gone and there is nothing left.

21 How can we build the indigenous capacity in  
22 those communities by linking them with the opportunities  
23 in their local community so that they become proficient in  
24 interacting at the local level I think is so critically  
25 important. This work I think is very important, and I'd

1 like to be a part of this task force.

2 DR. CLARK: Ken?

3 MR. DeCERCHIO: I agree with you 100 percent,  
4 Bettye.

5 I know, Clif, you exude passion, and you have  
6 for awhile on this. That's helpful when you come into our  
7 state as well.

8 I think that's the promise of Access to  
9 Recovery. In addition to increasing access and involving  
10 faith-based organizations in that process, it is the  
11 linkages between faith-based organizations and more  
12 traditional, not more traditional, but let's say publicly  
13 sector funded, traditionally funded. We have a number,  
14 and that is really one of our goals, so that when the  
15 Access to Recovery dollars go away, the partnership, the  
16 networking that is occurring, and we've got agencies that  
17 are doing staffings together, all the training that is  
18 available in community-based agencies in Orlando is now  
19 open to probably 10 or 15 faith-based organizations.

20 They actually have a network with treatment  
21 organizations and faith-based organizations that do any  
22 level of recovery work. Some are licensed treatment  
23 agencies, others provide housing, and others are just  
24 ministers that are ministering to their congregation.

25 We are requiring those types of partnerships

1 and linkages so that you are infusing the obvious. You  
2 are infusing both the passion, the compassion, and the  
3 power of faith healing into the publicly funded system,  
4 and some of the clinical expertise, some of the training,  
5 some of the practices and infusing that into the  
6 faith-based organizations. I think that that is the  
7 longevity that you're talking about, and one of the real  
8 promises of Access to Recovery.

9 DR. CLARK: Melody, and then Chilo.

10 MS. HEAPS: Yes, I absolutely concur with  
11 previous speakers. I want to get specific about Access to  
12 Recovery. Forgive my own ignorance since we are one of  
13 the agencies participating in it, I know what we do. But  
14 can you tell me in terms of Access to Recovery the  
15 requirements, or what specific activities CSAT has engaged  
16 in or could engage in in terms of working specifically  
17 with those sites on Access to Recovery to help develop  
18 these coalitions. Is that part of the requirement? Part  
19 of the monitoring? And I don't know this, and I'm sorry,  
20 I probably should.

21 MR. MITCHELL: At all of our workshops, ATR  
22 was a primary part of the workshop.

23 MS. HEAPS: Right.

24 MR. MITCHELL: Where we explain what ATR was  
25 all about, and we bring the stakeholders together and we

1 try to show them how to collaborate and work.

2 As I mentioned before, under ATR, each state  
3 has a goal of how many people they are supposed to bring  
4 into treatment or recovery.

5 MS. HEAPS: Right, right.

6 MR. MITCHELL: We recognize the fact that they  
7 can't do that with just treatment alone. So what we are  
8 trying to do is work with the faith community to help them  
9 expand their capacity.

10 MS. HEAPS: Right.

11 MR. MITCHELL: We provide technical  
12 assistance, we call the state faith-based office. Some  
13 states have faith-based offices. We contact them and  
14 offer our services to provide technical assistance to work  
15 with them.

16 When we go in to do conferences or workshops,  
17 we let the state know so that the state official can be  
18 there. In this ATR process, we know three states.  
19 Because of the workshops that we did, they developed ATR  
20 plans from those workshops. They have focus groups at our  
21 workshops, and so their plans came out of those workshops.

22 MS. HEAPS: I would like to volunteer, and I  
23 guess we would do it through our committee, to  
24 specifically focus on the ATR component and how we might  
25 accomplish the kinds of things that Ken has been doing in

1 Florida. Maybe a more directed set of guidelines that  
2 might go along to helping some of the states do this.

3 Oftentimes a single state agency is not, or  
4 the applicant agency is not the best one to organize the  
5 faith-based. It may be a lead community agency, or a lead  
6 coalition agency. I think there are ways that we can set  
7 up some guidelines and directions in ATR that would  
8 continue to facilitate this kind of coalition development.

9 I'd very much like to be a part of that discussion if  
10 that's possible.

11 MS. WHITFIELD: (Inaudible.)

12 MR. DONALDSON: Yes, there are, and for  
13 example, Anita, in your state, Ohio, with Christian, the  
14 state Faith-Based Director is doing a great job at  
15 building those coalitions, and also helping to integrate  
16 the various funding streams, including compassion, capital  
17 fund, the healthy marriage initiative, TANF, as well as  
18 incorporating the business community, too.

19 DR. CLARK: While ATR is not a faith-based  
20 program, the objective is to diversify those providers  
21 that are contributing to the recovery of people in a  
22 community. We believe the community-based organizations,  
23 including faith-based organizations, can play critical  
24 roles in that.

25 One of the reasons we articulated a model that

1 involved recovery management services, because the  
2 recovery process extends from the traditionally licensed  
3 professional treatment providers into the community. If  
4 you look at entities like AA, they have known that all  
5 along. I mean, I don't know how many AA programs are  
6 licensed providers in any jurisdiction. Does anybody  
7 know? To my knowledge, it is probably zero. But I may be  
8 wrong.

9           But the key issues is that those entities have  
10 played a key role in the recovery of individuals by  
11 offering say 24/7 community support. As someone who  
12 provided treatment through people through the VA, we made  
13 liberal use of community support. I see you three hours a  
14 day, what do you do the rest of the time? What happens  
15 when cravings ensue, or you encounter a buddy, friend, or  
16 spouse who wants you to do drugs? How do you cope with  
17 that?

18           What happens when you are feeling overwhelmed,  
19 anxious, or tempted? How do you cope with that? So the  
20 community support becomes a key issue. Faith-based  
21 organizations play a role in that larger construct of the  
22 vectors of values in the community-based organizations,  
23 faith-based organizations, so that we without having to  
24 infuse large amount of funds to recreate the community,  
25 you could invest in the traditional system, recreate that

1 system, but it becomes cost-prohibitive.

2           So we need to augment the traditional delivery  
3 system by creating this conduit of care, if you will, that  
4 reaches into the communities and that mobilizes community  
5 constructs in the service of the recovery effort. That  
6 way, we don't increase our cost to the point that it  
7 discourages the Governor.

8           The Governor isn't going to say, well, how  
9 much more is this going to cost me? If we tell her, this  
10 is going to cost you three times what you've been  
11 spending, they'll say "Not!" And we know that. At least  
12 those government officials know that, and people who are  
13 writing programs know that.

14           So Access to Recovery was created to link  
15 traditional providers. It is not to substitute  
16 traditional providers, but to enhance and to leverage the  
17 reach of traditional providers by bringing in  
18 community-based organizations to facilitate the recovery  
19 process. The focus of introducing recovery management  
20 services into the construct offers the state an  
21 opportunity not to have to say okay, everybody has got to  
22 be licensed, everybody has got to be certified, so we are  
23 going to create this stultifying, bureaucratic process  
24 that essentially leaves us where we are.

25           By extending the conduit of care, we preserve

1 the contribution of the professional and traditional  
2 providers. We leverage that by reaching out to new  
3 providers in the construct, and we target the services  
4 that an individual needs.

5 I recall, Judge, you mentioned the 28-day  
6 program. One of the reasons the 28-day program crashed  
7 and burned is because it was used indiscriminately. A  
8 person had one DUI, never had an alcohol problem in their  
9 life, they got 28 days. A person was drunk every day of  
10 his life, in and out of treatment, in and out of jail,  
11 they got 28 days. It didn't make any sense.

12 When the studies demonstrated that it didn't  
13 make any sense, the insurance company said exactly what we  
14 wanted, no more \$10,000 a pop, we're not investing.  
15 Shortly after that, other studies came about after the  
16 great change that demonstrated the fact of the utility of  
17 the 28-day program.

18 The message was that one size does not fit  
19 all. If you can differentiate, there were a group of  
20 people who benefitted from the 28-day programs, but the  
21 damage had been done. So our construct of there are many  
22 pathways to recovery is the construct that we're trying to  
23 enhance here by offering the person who is adversely  
24 affected by alcohol and drugs a choice, by mobilizing the  
25 community to participate in that so that traditional

1 providers in effect are able to demonstrate their utility,  
2 and that utility is leveraged by a positive relationship  
3 with community organizations, including faith-based  
4 organizations. So that six months after the treatment  
5 episode, if you will, you are able to demonstrate that  
6 this is working.

7           The Prop 36 data, Prop 36 actually works. But  
8 if you don't look at the data correctly, it doesn't work.

9     It turns out that because of the absence of mandating  
10 treatment, a lot of people are not actually engaging in  
11 treatment. But of those people who actually engage in  
12 treatment, they are doing better than the control groups.

13           It is these kinds of things that we have to  
14 address. I appreciate your willingness to work with Dave,  
15 Bettye, and others here so that we can clarify. There is  
16 a lot of confusion about ATR. Some people are saying it  
17 is a faith-based program, and other people are saying  
18 you've got to have all these licenses.

19           We are erecting barriers to treatment, and  
20 part of what ATR is trying to do is to eliminate the  
21 barriers. At the end of the day, this is only a  
22 three-year program. As was pointed out, we need to think  
23 about how do we enhance care beyond ATR? It doesn't  
24 appear to be any movement to infuse a large amount of  
25 money to any question.

1           The issue is okay, we need to reassure the  
2 community that treatment works. We have the data, but  
3 nobody seems to believe it. We need to reassure the  
4 community that the person living in the halfway house in  
5 their neighborhood is contributing to the vitality of the  
6 neighborhood and is creating an option not only for those  
7 individuals, but for the families of the people in the  
8 neighborhood.

9           We can only do that not just with  
10 professionals, but with community-based organizations and  
11 faith-based organizations working collectively together,  
12 tied in with criminal justice and child welfare, which is  
13 the community. When the community acknowledges that the  
14 community has to be invested in recovery, then recovery is  
15 possible.

16           Chilo?

17           DR. MADRID: I'd like to go ahead and pull  
18 back a little bit if I may, Dr. Clark, and allow Anita to  
19 say a couple of words since she is developing an excellent  
20 faith-based program in Ohio.

21           Anita?

22           MS. BERTRAND: Thank you. This is a wonderful  
23 initiative. I think that it is this type of thinking that  
24 is going to help us reach the 78 percent that is meeting  
25 the criteria that you're talking about, Dr. Clark.

1           In Ohio, we are looking at efficiencies and  
2 ways that we can help the faith-based communities work  
3 with other community-based organizations. An example  
4 might be, does each organization need a fiscal officer?  
5 Is there a way that we can share staff and collaborate? I  
6 think that we can help achieve this goal through  
7 cross-trainings.

8           I think that you are doing a wonderful job.  
9 But also if we can identify some leaders in the community  
10 to help bring the churches and the pastors to the table,  
11 because many people are misinformed about the work that  
12 we're doing. I think the major city projects, because  
13 they are leaders in the community, and as most of you  
14 know, a lot of the 12-step programs are in the churches,  
15 which means that the pastors are supporting the work that  
16 we're doing, but they don't know everything about some of  
17 the regulations and barriers, and they're being  
18 misinformed. So I want to also say that I'd like to talk  
19 to you at some point about the subcommittee and the work  
20 that you're doing.

21           DR. CLARK: Chilo?

22           DR. MADRID: I'd like to go ahead and commend  
23 Dave and certainly Jocelyn and Clif for their walk, as  
24 well as their talk. I certainly thank Dr. Clark, Clif,  
25 and Jocelyn.

1           We had a real nice conference in El Paso, a  
2 faith-based conference, the first annual Cesar Chavez  
3 Conference. We had 300 people join us, and about 150 were  
4 kids, teenagers, and high schoolers.

5           I was very, very moved when Clif got up there  
6 and talked about faith-based programming and kids. Then  
7 at the end of this talk, he was flocked and ganged by  
8 about 150 of those kids asking him all kinds of questions.  
9 This longing, this hunger, for the spiritual way.

10           Clif, thank you so very much for the  
11 assistance that you all gave us.

12           We're planning on doing it again. We have  
13 about 20 programs on the Mexican side that used Christ  
14 therapy. So this coming year, it will be a faith-based  
15 conference, but it will have a lot of the international  
16 flavor. Hopefully it will be as successful, if not more  
17 successful, than the first one.

18           So Clif, thank you, and Jocelyn, and certainly  
19 Dr. Clark for giving us that opportunity along the border.

20           DR. CLARK: Frank?

21           DR. McCORRY: Thank you. I'd really like to  
22 publicly articulate our continuum of care, because it has  
23 always been going on in faith-based communities, but it  
24 wasn't really articulated.

25           It is just a terrific opportunity. Also this

1 term of "Recovery Management Services." You have these  
2 kinds of different parts of the continuum of care working  
3 together. It is terrific.

4 I know the treatment community, as ATR  
5 unfolded and faith-based organizations came to the floor,  
6 was worried about how their work might change. I was  
7 interested in looking at it from the other side. I'd be  
8 interested in hearing from David, Jocelyn, or Clif, what  
9 were some of the fears that the faith-based organizations  
10 might be confronting in working with public sector  
11 community organizations, or in taking public sector  
12 dollars and the requirements that come with that. What  
13 were some of the FBOs struggling with as they kind of  
14 entered this kind of relationship?

15 MR. DONALDSON: I actually wrote a book with  
16 Stanley Carlson-Theis, who set up the faith-based offices  
17 on that issue. I'll get you a copy so you can double the  
18 circulation for us.

19 (Laughter.)

20 MR. DONALDSON: I think it would be good for  
21 Anita to chime in here, and Clif and Jocelyn. It is a  
22 very important issue. The faith community is concerned  
23 that in taking public funds, it is going to lead them down  
24 a slippery slope. Instead of being faith-based, they are  
25 going to be based.

1           So through these workshops, and even Dr. Clark  
2 has come and shared, we have been able to communicate to  
3 them that they can create a fire wall where they don't  
4 have to compromise their mission, their values, and their  
5 methodology, and at the same time, receive public funds.  
6 So that has been part of our education, and has probably  
7 been, wouldn't you say, Jocelyn and Clif, one of the  
8 strongest questions that are asked.

9           DR. CLARK: Ken?

10          MR. DeCERCHIO: What our faith partners have  
11 taught us, or have communicated on that issue, is don't  
12 chase the money in communicating to other faith-based  
13 organizations. If it can support your mission and it is  
14 part of your ministry of what you do and there is an  
15 enhancement, look at it. But don't change, and don't  
16 chase the money, because you'll go down that slippery path  
17 and not stay centered, I guess. Early on that was a very  
18 strong message in the work that we've done that we've  
19 heard communicated.

20          MR. DONALDSON: That's well said. We have  
21 communicated don't let the next RFB be your next mission  
22 statement. Secondly, don't become dependent on public  
23 funds. I know for the President, the last thing he wants  
24 to see is a new welfare system called nonprofits.

25          So a lot of our education has been tied around

1 that. You couple the relationship building with that  
2 education, and we've done a lot of spade work. One of the  
3 concerns that I do have about ATR is that right now, we  
4 are looking at 14 states and a territory, which is  
5 wonderful, but we've done a lot of great spade work in  
6 some of the major cities that are not in those 14 states.

7 I'd hate for us to lose the momentum that has been  
8 developed there.

9 DR. CLARK: Again, we're working together with  
10 state and local jurisdictions, as well as  
11 community-based and faith-based organizations to flesh out  
12 the construct of Recovery Management Services. We are  
13 trying to do that in the service of the recovery process.

14 We have three states actually represented here. One  
15 officially in terms of Ken, who is a state official, but  
16 Illinois, Melody has pointed out that she's at an agency.

17 Wisconsin also has an ATR.

18 Part of what we are, as we start to unfold,  
19 and this is essentially phase one of ATR, is addressing  
20 some of these barriers and clarifying some of these issues  
21 so that we dispel the fears. There is a lot of mythology  
22 that has crept up around ATR.

23 I like what Florida is doing, to reassure  
24 traditional providers that this is not a repudiation of  
25 their works, or an abrogation of their contribution, while

1 at the same time recognizing we need to extend our reach  
2 of the recovery process into the community. In doing so,  
3 it doesn't endanger, it doesn't threaten, but only  
4 enhances and facilitates, because it gives us a better  
5 message that we can go to funding agencies, Medicaid, the  
6 Governor's Office, and the federal level.

7 Not only do we work, but we can give you good  
8 numbers in the long run. At the end of the day, the Judge  
9 is going to be confronted with the question, are your  
10 orders working? Is my community safer? Child welfare is  
11 going to say, is this parent a safer parent? If we can't  
12 answer those questions, then it doesn't matter whether you  
13 are a licensed professional or a certified recognized  
14 faith-based provider or community-based provider. The  
15 monies won't be there. Not only the monies, but the  
16 community attitudes won't be there.

17 I think as we deal with stigma, we have to  
18 deal with this issue of community attitudes. The  
19 community will not mobilize if they perceive us as not  
20 meeting their needs for a healthier and safer community.

21 So with that, we can continue later, but we're  
22 going to take a break, as has been promised, and we can  
23 come back in 10 minutes.

24 (Recess.)

25 DR. CLARK: We're running behind, so we need

1 to move forward. Our next presenter is going to be Chilo  
2 Madrid. Chilo is going to talk about treatment in ethnic  
3 communities.

4 DR. MADRID: Thank you so very, very much, Dr.  
5 Clark.

6 I'd like to go ahead and preface my  
7 presentation by taking the gum out of my mouth.

8 (Laughter.)

9 DR. MADRID: And again commend the last  
10 presenters.

11 All of us I guess in life have certain biases,  
12 and certainly I do also. My thoughts are as follows, and  
13 that is whether it be in personal or professional life,  
14 the Lord comes first, family second, and then my job comes  
15 third.

16 I have been in the drug treatment business for  
17 over 30 years. I come from an area where heroin is a lot  
18 cheaper than methadone, and a lot cheaper and more  
19 convenient than treatment, believe it or not. So I have  
20 developed some biases concerning that.

21 I also come from an area where the NIMBY  
22 concept, not in my backyard, is alive. I remember I spent  
23 three years fighting a community over the opening of a  
24 residential treatment center of which now it is running  
25 after five lawsuits. It is running, it is doing real

1 well. Most of the people in that facility getting  
2 treatment are people from that small town. Most of the  
3 people that run that facility are from that small town  
4 also. So a lot of things have changed.

5 I also have my thoughts concerning criminal  
6 justice, and I'm giving you this preface because I think  
7 the fact that I'm very, very involved with criminal  
8 justice has definitely developed some thoughts and biases  
9 on my part.

10 Where I come from, I have to work with the  
11 DUI/DWI court, the family drug court, the felony drug  
12 court, the truancy drug court, the juvenile drug court,  
13 and the adult drug court. So as you can tell, I spend a  
14 lot of time in court. I'm glad that I'm on the other side  
15 of the bench. That works well.

16 Being that heroin is a lot cheaper than  
17 treatment, 90 percent of our patients, of our clients,  
18 come through the courts, whether I want them to or not.  
19 We force them to court mandated type of treatment, and  
20 that's the way it is where I come from.

21 I believe also, and I have formed some biases,  
22 that stigma is worse than the sickness. Certainly where I  
23 come from, that is very, very real.

24 I also grew up with a father that was an  
25 Apache Indian, a mother that was a German Jew, and I grew

1 up in a Mexican American community. So that developed  
2 some ideas and some thoughts.

3 I come from an area, believe it or not, where  
4 heroin is not called horse. To a lot of people in the  
5 country, horse is the nickname for heroin. Where I come  
6 from, it is called "goat," like an animal, G-O-A-T. I  
7 come from an area where addicts, when they use drugs, they  
8 say they are going to "go jump off," not get high.

9 Why is it that Mexican American addicts are  
10 talking about jumping off and not getting high? Why is it  
11 that they want to feel down rather than move up or go  
12 high? That type of mentality has a lot of ramifications  
13 in the treatment that I do.

14 Then lastly, as I'm prefacing my presentation,  
15 I am very, very convinced that when it comes to youth in  
16 the high schools that are beginning to use cocaine or  
17 marijuana, and in some instances heroin, that it is very  
18 simple. I think I have come up with a treatment approach  
19 that can be 97 percent successful. All we have to do with  
20 those kids is send them to school with their mother  
21 holding their hand for two months. The mother gets to sit  
22 between the boy and the girlfriend for two months.  
23 Believe me, 97 to 98 percent of those kids will get it  
24 together very, very fast. So that is a big bias on my  
25 part.

1           Now, why did I tell you all these things?  
2   Because as I do my presentation, a lot of these thoughts  
3   that I have given to you have affected me through the  
4   years, and they have formed certain biases on my part. So  
5   now that I have told you how I think, let me go ahead and  
6   talk with you about my real presentation. If I can go  
7   ahead and move my technology piece here.

8           I'm going to go ahead and review with you some  
9   data. Before I go into the national percentage of  
10   substance abuse or dependency by ethnicity, I'd like to go  
11   ahead and tell you that the Services Accountability  
12   Improvement System under CSAT as of January '04 talks  
13   about ethnics of color occupying approximately 66.8  
14   percent of all treatment slots. In more specific terms,  
15   let me just say that Hispanics, 46,000 Hispanics or 28  
16   percent were in treatment and captured by the SAIS data  
17   system. Then 43,000, or 27.8 percent were African  
18   American, and then 10,000 or 6.7 percent were American  
19   Indian, and then 6,000 or 4 percent were Asian or Pacific  
20   Islanders.

21           Now, that's a total of 66.8 percent of  
22   minorities of color that were captured by the SAIS data  
23   system. When we look at the clinicians nationally, we  
24   see that most of them are white, most of them are 45 or  
25   older, and most of them are women. So when we look at the

1 majority of clinicians, and when we look at the majority  
2 of people in treatment as captured by the SAIS, you can  
3 see that there are some major differences there that we  
4 need to look at, study, analyze, and then proceed  
5 accordingly.

6           The reason why I say proceed accordingly is  
7 because according to the Institute of Medicine in 2004,  
8 they talk about the desire and the need to advocate for  
9 what they call racially concordant health care. That is  
10 very, very important. We talk about how the National  
11 Institute of Medicine in their latest report, "In the  
12 Nation's Compelling Interest: Ensuring Diversity in  
13 Health Care," they call for increasing racial and ethnic  
14 diversity among health care professionals.

15           I'm going to talk an awful lot about health  
16 care professionals, because one of my biases is that in  
17 the substance abuse arena, we talk about the 5 and 10 cent  
18 store in our workforce. We pay them the least amount,  
19 they have the least amount of fringe benefits, and I can  
20 just go on and on.

21           I run an agency with about 200 employees, of  
22 which probably two-thirds are counseling employees. I  
23 have a lot of turnover. They are always going from my 5  
24 and 10 cent store to the store where they get paid  
25 sometimes twice as much. I'm talking about private health

1 care. I'm talking about other more recognized public  
2 health care agencies.

3 So there is a big, big workforce problem. Let  
4 me just touch on some of the charts, and then I'll try to  
5 come back on that particular issue.

6 When we look at some of the TEDS data,  
7 Treatment Episode Data Set, for the year 2000, when we  
8 look at just three particular drugs, it is very, very  
9 clear to me that opiates are hitting the Hispanics in  
10 great numbers.

11 I think Cynthia passed to you a copy of an  
12 article on hepatitis C that came out in the El Paso Times.  
13 Apparently a health care worker infected six patients at  
14 Sierra Medical, and the health care profession in El Paso  
15 are up in arms because there are all these hepatitis C  
16 issues. Yet when we look at I.V. drug users in our area,  
17 we are looking at 87 percent of those individuals being  
18 hepatitis C-positive.

19 I want to thank CSAT for developing training  
20 programs in hepatitis C, especially those programs that  
21 deal a lot with I.V. drug users. I think that's a very,  
22 very good start. But that article begins to point out  
23 that it is pouring into the private sector now, and that  
24 something that we always knew was a big problem to them is  
25 a new problem.

1                   So again, when we look at cocaine in  
2 non-Hispanic blacks, we look at about a 29 percent reading  
3 there. So that is also significant. So what I'm  
4 presenting to you is not new data. It is data that the  
5 federal government, CSAT, and SAMHSA has developed, but it  
6 is data that I think we need to look at when we look at  
7 developing perhaps some type of direction concerning the  
8 different ethnic groups that we deal with.

9                   I'm talking about all ethnic groups, not just  
10 Hispanics, blacks, American Indian, but all groups. We  
11 need to be very sensitive as to their preferences and how  
12 they perceive, whether it is a horse, whether it is a  
13 goat, whether some of them want to get down, or whether  
14 some of them want to go up and get high, we need to be  
15 very sensitive to those type of issues.

16                   The next one, again, this one is for females.  
17 You can see that it is almost the same as for males when  
18 we look at preferences concerning these three drugs.  
19 Again, Hispanics are into a lot of heroin. Non-Hispanic  
20 black are into a lot of cocaine, and there are certainly  
21 very, very clear trends there.

22                   When we look at, for example, such issues of  
23 ethnicity as associations, when we look at NAADAC, which  
24 is probably the largest association that I know of, and  
25 I'm very proud to be a member, they are very sensitive to

1 my issues. Yet when I look at their membership, you can  
2 see that among the ethnicities, there are some very clear  
3 patterns that I think we need to seriously look at,  
4 consider, and develop some type of effort to attract a  
5 more diverse representation there.

6 In America, when we look at different studies,  
7 we notice that there is about 9.1 percent of Americans  
8 that are either abusing or dependent to a certain degree.

9 But when we look at the American Indian or the Alaskan  
10 Native, we are looking at 17.2 percent. Again, this is  
11 not my data, this is data that the federal government has  
12 developed through years of study.

13 My question is what are we doing there, what  
14 are we going to do, and what type of future agenda should  
15 this particular group, who in my opinion is the leading  
16 treatment group in the nation, what are we going to do  
17 with that type of issue? The issue of Native Hawaiians,  
18 Pacific Islanders, looking at 12.9, that is a big, big  
19 problem. When we look at Hispanics and white at about 9.2  
20 versus 9.1. Again, it is not just one group, we need to  
21 look at all the groups, and we need to look at their  
22 individual issues.

23 The last section that I want to just spend a  
24 little bit of time talking about is the possible and  
25 probable considerations. When I talk to some of my

1 counselors, I say, what do you all need when you work with  
2 Hispanic heroin addicts and when you work with American  
3 Indian individual patients that have a real severe and  
4 acute alcohol problems?

5           They say, we need tool boxes. We need a  
6 universal tool box for everybody, and then we need a tool  
7 box for people that have heroin problems, for Hispanics,  
8 for American Indian. That is what we need, we need the  
9 tools. If the research is there, let's go ahead and get  
10 it together, get it in here, and then present it to us in  
11 a way that will be useful for us.

12           So again, we need something that definitely  
13 bridges that research to practice in this case. When we  
14 look at our ethnic minorities equally represented in  
15 associations, those that are licensed, we know that  
16 they're not when we look at ethnic minorities. So we need  
17 to develop a workforce strategy. For example, Partners  
18 for Recovery has been looking at workforce audits.

19           They are advocating for, for example, loan  
20 forgiveness programs and loan repayment programs. They  
21 are looking at more practical internships for young  
22 people. I mean, there are a lot of us in the field that  
23 are getting old. I was telling Mr. Gilbert that I have  
24 been in the field since '65, so that's about 40 years. I  
25 do tint my hair, that's why I don't look too old.

1 (Laughter.)

2 DR. MADRID: But eventually I will be retiring  
3 and we need to attract young people. They are coming and  
4 going faster than they are coming in. So we need to look  
5 at a lot of the strategy that Partners for Recovery is  
6 developing, has been studying, and I think that we really  
7 need to engage that strategy, advocate for that strategy,  
8 and try to move it forward very, very fast.

9 In federal government, there are many groups  
10 that look at ethnic minorities, that look at ethnic ideas  
11 and patterns. There is the SAMHSA Minority Fellowship  
12 Program, the National Institutes of Health National  
13 Incentive for Minority Health, and so forth. I think that  
14 we might want to consider collaborating with those groups,  
15 and inviting them to the table. What are they doing?  
16 What are Partners for Recovery doing concerning the  
17 different ethnic situations and ethnic problems in this  
18 country? Rather than maybe reinvent the wheel, proceed  
19 from there.

20 So that is something I think we need to look  
21 at very, very seriously. Again, why reinvent the wheel?  
22 Let's go ahead and proceed accordingly.

23 One thing that I work with a lot in the ethnic  
24 minority community where I live is I work a lot with HMOs.  
25 I think that when we look at managed care, when we look

1 at Medicaid, when we look at children's insurance  
2 programming, we need to be very, very aware and cognizant  
3 as to how these particular payers of last resort, fast  
4 resort, or first resort are looking at the different  
5 ethnic groups, and how they are being affected.

6 I think that that is very, very important. I  
7 think that as we proceed to study this issue a little bit  
8 further, we need to be very realistic and look at the  
9 money and how it is flowing, not just from CSAT, but from  
10 the states and other payers.

11 So again, I think that Dr. Baxter is not here,  
12 but I talked with him to great length about this, and I  
13 think that SAMHSA has published a cultural competence work  
14 some years ago, so perhaps looking at that again, and then  
15 proceeding accordingly.

16 Lastly, I think that what we need to do is to  
17 look at the different ethnicities in this country and some  
18 of their unique needs, and be sensitive. Even though  
19 there are universal things that happen, there are very  
20 unique things that we need to be on the lookout for, that  
21 we need to analyze, and that we need to look at as a gauge  
22 as we approach these groups with best practice, with  
23 evidence-based approaches, and so forth.

24 So again, I presented to you an overview of  
25 the existing data, some of the ideas that perhaps you all

1 might be considering, or you might want to consider, or  
2 discuss more in depth concerning ethnicities in this  
3 country in substance abuse.

4 Are there any questions at this time? Yes,  
5 ma'am? Melody?

6 MS. HEAPS: Chilo, you talked about tool boxes  
7 which could be used in helping to treat various  
8 populations. Do you know if anything like that exists?  
9 Are there particular guidelines or publications which  
10 would be helpful to send to treatment programs so that  
11 they are more aware?

12 I say this because I remember a discussion  
13 with someone in California who was treating the Asian  
14 population and how very, very difficult it was because of  
15 the issues of shame, the issues of not wanting family  
16 involvement because of shame, and their needing to bring  
17 in someone who was a healer. It was a very interesting  
18 discussion. I wondered if anything existed anywhere that  
19 represents a tool box, or some publications.

20 DR. MADRID: I really haven't seen a tool box  
21 let's say for Asians, but I have seen, well, I have seen  
22 some tool boxes that are universal, but I've never really  
23 seen a tool box that is for a specific ethnic minority.

24 However, if somebody else knows of one, I  
25 stand corrected. But if there isn't one, I think there is

1 a need, and I think our counselors are really craving for  
2 this type of support.

3 Yes, ma'am?

4 MS. JACKSON: Thanks, Chilo. I really liked  
5 your presentation. I think that it is an extremely  
6 important issue. Certainly one that we face in Southern  
7 Florida, and I know the rest of the country faces in  
8 different populations.

9 As to the tool box thing, I think that's a  
10 very good comment. There should be tool boxes that are  
11 maybe in a sense tweaked. I mean, we have evidence-based  
12 practices. I certainly recall, as I'm sure you do,  
13 Melody, and you also, Chilo, reading the research on  
14 evidence-based practices that say this has been tried in  
15 certain populations, and so we know that there are  
16 practices out there that have evidently worked for  
17 different populations and have been proven to work for  
18 that.

19 Perhaps, and maybe somebody else can shed some  
20 light on this, what we haven't done is to come at it from  
21 that angle of saying how would we tweak this particular  
22 evidence-based practice so that it would be much more  
23 effective for this population based on the discussions and  
24 work of those people who worked with those populations.

25 DR. MADRID: Again, when we look at the

1 American Indian, the Alaskan Native, we are looking at  
2 some very serious alcoholism problems. I think that  
3 definitely a tool box, something would be very, very  
4 indicated there. Not just for the American Indian, but I  
5 think for all ethnicities, because we all have unique  
6 problems.

7 Bettye?

8 DR. FLETCHER: Chilo, I too thank you for your  
9 presentation.

10 I would ask a little bit more fundamental than  
11 the tool box. How is training related to ethnic groups  
12 incorporated into curricula as a means of  
13 institutionalizing content in those areas so that  
14 counselors and other professionals in the field get that  
15 as a part of their training?

16 DR. MADRID: Bettye, I think that's a very,  
17 very good point that the Partners for Recovery has dwelled  
18 in. What they are talking about is curriculum that is  
19 practical and that is relevant for the different groups in  
20 this country. So I think that's a very good point in that  
21 we all learn a little bit differently.

22 I think that there are a lot of studies,  
23 learning studies that have been done, and we need to look  
24 at those as we approach the different ethnic groups. So  
25 curriculum that is practical and that is relevant.

1 Frank?

2 DR. McCORRY: Chilo, I took two points from  
3 your presentation that I'd ask you to kind of expand on.

4 To me, substance abuse treatment has become a  
5 much more complicated enterprise over the years that I've  
6 been doing this. Yet your point about workforce and the  
7 turnover in workforce that no matter how we address these  
8 issues, if we can't hold onto the folks that we're trying  
9 to train to be sophisticated in this care for lack of  
10 incentives in being able to retain them, I don't see how  
11 we make progress in improving care unless we can stabilize  
12 our workforce. That's one point.

13 Second point, your NAADAC slide in which  
14 clearly the treating people are different ethnically and  
15 racially from the people they are treating in large part.

16 Our ability to attract minority candidates and hold onto  
17 them, that will reflect ethnically and racially the people  
18 that we are trying to serve.

19 Those two thoughts, our basic problem with  
20 workforce, and then our basic problems in attracting  
21 people who are from the same ethnic and racial communities  
22 that we are treating. Your thoughts on how we might, and  
23 I know there is probably a lot going on on this, but we  
24 just haven't been able to really crack that. We can't  
25 hold onto our folks, and we haven't been able to diversify

1 our workforce efficiently to meet the needs of the people  
2 we're treating.

3 DR. MADRID: Well, both points are \$64 million  
4 issues that I don't think I can answer completely. But  
5 again, your first point, how to retain our counselors, our  
6 workforce. We need to be competitive as far as salaries,  
7 and we need to develop some type of an incentive system  
8 very similar to what Partners for Recovery is looking at.

9 I think that is very, very important, and we need to  
10 totally engage PFR for the work that they're doing.

11 On your second point, God, I don't know. I  
12 would need some help on that one.

13 DR. MCCORRY: I was talking about Bettye in  
14 terms of we talked a little bit yesterday about that,  
15 trying to set up something within the historically black  
16 colleges and other kinds of institutions in minority  
17 communities that might able to promote the value of  
18 working in this field.

19 DR. FLETCHER: I think that's a very critical  
20 area. For instance, at Jackson State University, one of  
21 the older graduate programs in substance abuse treatment  
22 and prevention is offered, and special efforts are made to  
23 recruit students into that program.

24 It requires a lot of outreach, it requires  
25 working with the field as well as the credentialing bodies

1 that relate to those areas. My earlier point, however, in  
2 terms of working with special populations, one of the ways  
3 that we have developed our competencies and our skills in  
4 that area I would say is through institutionalizing that  
5 content into the curriculum.

6 DR. MADRID: Thank you all so very much. I  
7 think my time is up. Again, hopefully this will be the  
8 beginning of this conversation.

9 Thank you.

10 (Applause.)

11 DR. CLARK: Thank you, Chilo.

12 I wanted to reiterate that workforce issues is  
13 on the matrix. We are at SAMHSA engaged in a cross-SAMHSA  
14 effort to address this. These issues are not particular  
15 to substance abuse treatment. They are also evident in  
16 substance abuse prevention and mental health. In fact, in  
17 nonprofits in general. So we will be putting our heads  
18 together and value the input of this process.

19 We are now moving to the public comment  
20 period. But before we do that, we had planned to have Joe  
21 Faha give a legislative update. It looks like we have run  
22 out of time for the first half of the day.

23 The question is would council like to hear  
24 from Mr. Faha later today around 3:15? If that's  
25 something that you would like, he has graciously agreed to

1 appear then. He has a meeting from 2:00 to 3:00, but  
2 would be available later.

3 MR. DeCERCHIO: I would like to have him come  
4 back, if he is willing and available.

5 DR. CLARK: All right. Then we will do that.

6 In the meantime, public comment. We have  
7 Arthur Dean from CADCA, who would like to approach the  
8 council. He also has a brief slide show.

9 Have at it, Arthur.

10 GENERAL DEAN: Well, good morning to all of  
11 you. It is a pleasure.

12 Thank you, Dr. Clark, for the opportunity to  
13 give some public comment during the CSAT Advisory Council  
14 meeting.

15 Before I start, though, I would like to just  
16 thank you for your service, because your service is  
17 important not only to CSAT, but to the country as a whole.

18 We all are trying to improve substance abuse, which is a  
19 major public health problem as you know.

20 With that said, I want to just take a couple  
21 of minutes to acquaint some of you and reintroduce others  
22 of you to Community Anti-Drug Coalitions of America. I  
23 know most of you just looking at your faces are familiar  
24 with us, and I did meet one council member this morning  
25 who had not yet heard of us. I want to give you a little

1 information.

2           That's our mission, to strengthen the capacity  
3 of community anti-drug coalitions across America so they  
4 can help build in their communities safe, healthy, and  
5 drug-free communities. That is what we have been doing  
6 for some time now.

7           This is what we call an anti-drug coalition.  
8 It is a lot of words, but I wanted you to kind of get a  
9 feel for what is it I'm talking about when I refer to the  
10 Community Anti-Drug Coalition. It is really normally a  
11 nonprofit in the community where sectors in the community,  
12 all of them, to include the faith, to include education,  
13 to include judicial and law enforcement, all come together  
14 to work the problem holistically and strategically to rid  
15 their community of the problems associated with, and we  
16 are talking about underage drinking, we are very concerned  
17 about that obviously.

18           We are concerned about illicit drug use, we  
19 are concerned that people who are beginning to get  
20 involved with drugs are intervened with, and then we want  
21 to see them get into treatment. Then we're concerned  
22 about them staying on the road to recovery. So it is all  
23 encompassing that we're talking about.

24           That is who we are. We came out of a  
25 presidential commission in 1992. That council met from

1 '89 to '92 and recommended that to help these  
2 community-based groups that were being developed, and  
3 Miami was one of them, that a nonprofit be created to  
4 provide those kinds of core areas, and we have been doing  
5 that for some time.

6           We take great pride in being the voice of the  
7 substance abuse field on Capitol Hill. I have a  
8 registered lobbyist that works for me in a public policy  
9 department, and they work across the federal budget  
10 totally from Justice, Education, HHS, to SAMHSA, to DEA.  
11 We are the voice there doing the very best to make sure  
12 that the appropriate laws are passed, and that  
13 appropriations are obtained. So we work that very  
14 diligently, as well as train in other items.

15           That is what we represent now. That sign says  
16 5,000 community anti-drug coalitions. The last count I  
17 looked at, it was a little over 5,400 of them existed  
18 across America. Obviously we are in all 50 states, but we  
19 have an actual association where there is kind of a  
20 membership in 40 of the states. We have a webpage that  
21 has more than 400 pages of information. Every Thursday  
22 afternoon at 5:00 we send it out online to talk about what  
23 is happening in the field so people can have it. It is  
24 free. Anyone can subscribe. It goes to 12,000 people.

25           We started one recently that talked

1 specifically about evidence- and scientific-based  
2 practices. That is the one that you see there where we  
3 have over 1,000 subscribers.

4           You were talking about cultural competency.  
5 We are doing on the 24th of February a satellite downlink  
6 that goes into the cable network system. The title of the  
7 one on 24 February is "CADCA Across Cultures: Uniting the  
8 Community to Work Together." We are going to be talking  
9 specifically about the importance of how we make the  
10 training and other items culture-specific at the community  
11 level. So the topics that you were talking about are very  
12 important topics.

13           Those are the electronic means that we  
14 communicate with people. I just wanted to share those  
15 with you. You can go onto my webpage at [www.cadca](http://www.cadca) and be  
16 a part of any of these that you wish to be a part of.

17           We do training in the mid-year. Last year it  
18 was in Chicago, and this year it is going to be in Desert  
19 Ridge in Phoenix, Arizona. We do four days of training,  
20 in-depth training there where people are trained in  
21 subjects like grant writing and others that go from two to  
22 four days in length. This one is going to be 25 to 28  
23 July in Phoenix, Arizona.

24           We just finished with the support of our  
25 federal partners, and I wanted to highlight CSAT there and

1 thank them and Dr. Clark for being a platinum sponsor, we  
2 just finished our first convention that we had in the D.C.  
3 Convention Center. We have outgrown all the hotels here  
4 in Washington. That was the 15th one that we've had. We  
5 had 2,500 attendees. They were there from Monday through  
6 Thursday, 80 workshops, five plenary sessions. We had a  
7 press conference that got national coverage on alcohol and  
8 recovery, and we had a press conference with NIDA on  
9 inhalants that got national coverage. A half page was in  
10 the Washington Post just this Monday. Our next one,  
11 number 16, will be February of 2006.

12           We were fortunate enough to have a law passed  
13 called the Drug-Free Communities Act. It now funds 714  
14 local groups. They get \$100,000 annually for up to five  
15 years. They can reapply for six through ten. They must  
16 have an equal match, so therefore they end up with about  
17 \$200,000.

18           In that Act recently when it was re-approved  
19 or reauthorized, they created the National Community  
20 Anti-Drug Coalition Institute, and CADCA bid and was  
21 awarded that grant to manage the institute. It does these  
22 three things. Provides training and technical assistance,  
23 dissemination in tools, and research to practice. I'm not  
24 going to take a lot of your time to explain all the  
25 details and the importance, but this is a way for the

1 federal government through a grant to help  
2 institutionalize the training that these coalitions  
3 desperately need across America.

4           Just a summary of some of the kind of things  
5 that we have done. At our big conference we had just this  
6 month, many of our workshops were around the areas that  
7 are important to you. It is prevention, it is  
8 intervention, it is treatment, and it is recovery. Dr.  
9 Clark has appeared on one of our downlinks. We are always  
10 there for you and with you on Recovery Month. We have  
11 workshops that relate to that.

12           We actually published a scientific base with  
13 NIDA that lays out the effective principles of treatment  
14 that went out to all of our groups. We are encouraging  
15 our coalitions to be holistic in their approach, and we  
16 even have a few coalitions now like the one in St.  
17 Petersburg, Florida that the actual coalition manages 125  
18 in-resident based treatment facilities and then those that  
19 do not have close relationships like Miami does with The  
20 Village, and we encourage that across the country.

21           We think that we can help with the denial  
22 issue. I heard you talk about that. We certainly have a  
23 problem with stigma. When I was going down to Miami to do  
24 TV and radio, we had a doctor that was going to appear.  
25 At the last minute he backed out because he didn't want to

1 go public. He had already agreed, and at the last minute  
2 he did not go public.

3           We certainly believe that you talked about  
4 this morning that building capacity at the local level is  
5 what really is key. Getting the civic and business  
6 leaders involved which leads to greater treatment, also  
7 improved treatment, and institutionalize it. We just  
8 think that in order to resolve this problem, you have got  
9 to work it holistically. Otherwise, you're not going to  
10 have any real benefit.

11           So I wanted to come by and thank you for your  
12 work and share with you some of the things that we are  
13 doing to introduce CADCA to others of you.

14           I know Westley does not like for people to  
15 recognize him for his work and leadership, but he has been  
16 a staunch supporter of ours, and I want to publicly thank  
17 you for that.

18           (Applause.)

19           DR. CLARK: Thank you, General Dean.

20           We have another public comment from Katherine  
21 Fornili from the International Nurses Society on  
22 Addictions.

23           Katherine?

24           MS. FORNILI: Good morning. Many of the  
25 people in this room know me through other capacities that

1 I have in the substance abuse treatment field. But I'm  
2 here today to represent the International Nurses Society  
3 on Addictions.

4 On behalf of our president, Dr. Christine  
5 Savage, and our Executive Director, Mr. Jim Scarborough,  
6 and myself, the chair of IntNSA's public policy committee,  
7 I'd like to thank the members of the advisory committee  
8 for inviting us to participate in the dialogue here at  
9 CSAT.

10 A couple of the messages that I'd like to  
11 portray to you from IntNSA is that we are committed to  
12 improving the quality of substance abuse treatment  
13 research and prevention. By doing that, we believe that  
14 we can help accomplish several of SAMHSA's missions, which  
15 would include increasing capacity for treatment by having  
16 more addictions nurses become credentialed and certified,  
17 and by recruiting nurses to the field of addictions.

18 Nurses are highly qualified to work in this  
19 field, but they have not traditionally worked in the field  
20 as much as social workers, counselors, LPCs, and  
21 psychologists. So one of our goals is to recruit new  
22 nurses to the field, and train and credential them.

23 Another way that we think that we can help  
24 improve capacity is by trying to get support from SAMHSA  
25 and the federal government to consider advance practice

1 nurses being allowed to prescribe buprenorphine or other  
2 pharmacological therapies. Right now the data 2000  
3 restricts the prescription of these buprenorphine products  
4 to physicians, but there are a lot of Masters and  
5 Ph.D.-prepared nurses who have advanced prescriptive  
6 authority in their states. I think we're underutilizing  
7 the nurses in that capacity.

8           We are well aware of the workforce issues. We  
9 know that our membership is aging out and we're not  
10 recruiting enough members to our organization. We are  
11 aware that at the same time, there is the aging of our  
12 patient population. So we are trying to prepare for the  
13 workforce crisis in the coming years.

14           The three major activities of our organization  
15 are credentialing, we have the only addictions registered  
16 nursing credentials, so a national certification. There  
17 is the CARN, or Certified Addictions Registered Nurse, and  
18 a CARN-AP for Masters Prepared Specialists in Addiction.  
19 We have a certification test process.

20           Another activity that we're highly involved in  
21 is peer assistance, working with nurses who have addiction  
22 histories in their own backgrounds and current addiction  
23 problems to make sure that they're not excluded from  
24 future work and nursing if they're able to achieve their  
25 recovery objectives.

1                   Lastly, we have the only peer-reviewed  
2 professional journal for addictions nursing. It is called  
3 the Journal of Addictions Nursing. I serve on the  
4 editorial board of that, and on the Board of Directors for  
5 IntNSA, like I said, as the newly appointed chair of the  
6 Policy Committee.

7                   So to summarize, I'd like to say thank you  
8 again for inviting us to participate in this process. I  
9 hope that we can continue to engage in dialogue with you  
10 about how nurses can increase their role in visibility and  
11 usefulness in the field of addictions.

12                   DR. CLARK: Thank you.

13                   Any other public comment?

14                   (No response.)

15                   DR. CLARK: With that, then we shall adjourn  
16 for lunch and reconvene at 1:15. Thank you.

17                   (Whereupon, at 12:15 p.m., the meeting was  
18 recessed for lunch, to reconvene at 1:15 p.m.)

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1 research training and science education programs.

2           Prior to joining NIDA, Dr. Condon coordinated  
3 research service programs at the former Alcohol, Drug  
4 Abuse, and Mental Health Services Administration -- that  
5 is ADAMHA, and that was awhile ago -- for four years,  
6 serving as the Deputy Associate Administrator for Policy  
7 Coordination and Deputy Associate Administrator for  
8 Science.

9           From 1986 to '89, he served as Science Policy  
10 Analyst Project Director at the U.S. Congress Office of  
11 Technology Assessment, where he directed an assessment of  
12 emerging technologies in the neurosciences. He received  
13 his Ph.D. in neuroscience from the Ohio State University  
14 College of Medicine. He pursued post-doctoral research in  
15 neuroendocrinology and neuropharmacology at the University  
16 of California-Los Angeles Brain Research Institute and at  
17 the Oregon Health Sciences University.

18           He joined the faculty at OHSU in 1985. He has  
19 been working with NIDA for awhile during the six years  
20 that I have been here and have had the pleasure of  
21 interacting and working together in an effort to forge a  
22 functional relationship between the science-based people  
23 and the services-based people so that we've got this  
24 bidirectional bridge. They do science, we do services,  
25 and yet the two have to inform each other. Tim has played

1 a major role, and of course he works in the effort of his  
2 boss, Dr. Volkow. But independently, he has been -- how  
3 many directors have you worked for?

4 DR. CONDON: My fourth director.

5 DR. CLARK: Fourth director. So he has been  
6 in it for the long haul, and I really appreciate his  
7 presence here.

8 I'll turn it over to Tim Condon. Thank you,  
9 Dr. Condon.

10 DR. CONDON: Well thank you, Westley.

11 I'm delighted to be here today, and actually  
12 when I got the call this morning, so this is a true story.

13 I got the call this morning, and I was supposed to be on  
14 the NIH campus because the President was visiting.

15 I got the call that Dr. Volkow was ill and she  
16 wouldn't be able to come and do this. So there was this,  
17 what should I do? Of course I was delighted to come here  
18 to talk to all of you, because I know a lot of you  
19 already, and this is one of the things that quite frankly  
20 has been something that I can point in my own career to  
21 something that is working really well.

22 I thank you, Westley, for mentioning that.  
23 But it has taken a lot of effort by a lot of people.  
24 People in this room, Dr. Clark, his staff. I want to  
25 particularly mention Mady Chalk, Carl White, and some of

1 the other staff that I, quite frankly, and my staff find a  
2 delight to work with on these science to service issues.  
3 We call it blending research and practice, but call it  
4 what you want.

5 I'm going to tell you a little bit about what  
6 we're doing in terms of our research portfolio in  
7 translational kind of research, where we are just up front  
8 of translational research, and then I'm going to tell you  
9 about some of our dissemination efforts and some of the  
10 science to service efforts.

11 Fran Cotter. I forgot Fran Cotter. We have  
12 been working with Fran for awhile as well.

13 Then we can have some discussion. As I said,  
14 I know a number of you because of our efforts in trying to  
15 make our research, and this was an Alan Leshnerism. He  
16 was the Director for eight years. Alan always said, "We  
17 need to make our research useful and used." That really  
18 has been our mantra for the last 10 years now.

19 So I actually have learned how to use  
20 technology a little. It is a surprise, I know it was a  
21 surprise to somebody here today. Was it Dr. Suchinsky,  
22 you said you were shocked that I could do this myself.  
23 But let me tell you a little bit about it from our  
24 perspective.

25 Advances in science are and have been bringing

1 us to really a new understanding of drug abuse and  
2 addiction. We spent a lot of investment and basic  
3 research having to do with drugs in the brain, showing  
4 that there are changes in the brain, and that that is  
5 really some of the essence of addiction. But that is not  
6 just about changes in the brain, it is not just about  
7 chemistry. It is actually about the environment and  
8 behavior as well.

9           One of the issues here is that this knowledge  
10 is allowing us to develop more targeted strategies, both  
11 behavioral and pharmacological, for prevention and  
12 treatment. The problem is that we've got this bottleneck,  
13 if you will, from the bench to the bedside, to the  
14 community. These are very real barriers. Moving from the  
15 bench to even the clinic or the bedside, and then quite  
16 frankly I tell all my audiences, years ago I used to be a  
17 lab neuroscientist where I'd get electrophysiology. I did  
18 intracellular recordings in these incredibly tiny cells in  
19 the brain. That was easy compared to moving things from  
20 the bedside to the community. So it really is a science  
21 and an art, and it is something that we're learning a lot  
22 about.

23           Here is an article that was published by Steve  
24 Hyman, the former Director of the National Institute of  
25 Mental Health. We call this the translational bottleneck.

1 Steve did a great job of demonstrating it in this  
2 pictorial. The top here is the number of research papers  
3 published on cognition and schizophrenia. You can see  
4 this dramatic increase over the years down here around 50  
5 to 300 papers in 2001/2002. Of course it is not a  
6 surprise that NIH's budget was increasing during this  
7 time.

8 But if you look at the number of clinical  
9 trials associated with that increase in those publications  
10 of kind of basic research, you see that there really  
11 hasn't been much of an increase. So not just in our field  
12 of substance abuse, but in every area of medicine there is  
13 a bottleneck of moving these things from the bench to the  
14 clinic, and the clinic to the community.

15 So I guess we could take some satisfaction in  
16 knowing we're not alone, but in fact the situation in some  
17 people's mind is particularly acute for substance abuse.

18 This is another paper published in the New  
19 England Journal of Medicine by these investigators. What  
20 they really did was they just looked at standard practice  
21 of care. This is the percentage of recommended care  
22 received. They looked at all these specialties.

23 Senile cataract. Well, this is what the  
24 recommended standard of care is, you know, as identified  
25 by the specialties. You can see 80 percent. That's the

1 best, about 80 percent. Breast cancer, hypertension. You  
2 can see in here depression. We're not doing really badly,  
3 a little over 55 percent, but the only one for substance  
4 abuse that they indicated was alcohol dependence. As you  
5 can see here, they were suggesting that about 10 percent  
6 of those who in fact were doing treatment were in fact  
7 using the recommended care, I believe in this case  
8 established by ASAM.

9           So anyway, it says that we have a problem in  
10 all areas of medicine that in fact the information and the  
11 evidence-based practice is not getting out, so you have to  
12 think about why that is not happening, or is it the right  
13 material to get out. Are we doing the right research? So  
14 this goes to what Dr. Clark said. It is the  
15 bidirectionality of the science to service.

16           Is science really servicing the service  
17 community and vice versa? Is there some barrier that we  
18 can figure out how to get more evidence-based practice?  
19 That is what we spend a lot of our time doing.

20           The science to service cycle, this is of  
21 course a concept that we've all very much been  
22 participating in. I believe Charlie Curie coined this  
23 early on. We early on had our own terminology called  
24 blending research and practice. But this really has kind  
25 of come to be known as this interaction between NIH and

1 SAMHSA, the science to service workgroup. In fact, we  
2 have a workgroup, and it has AHRQ on it also. It has  
3 three of the NIH institutes, NIAAA, NIMH, and NIDA on it,  
4 as well as our colleagues from SAMHSA and AHRQ.

5           We also have research to practice liaisons  
6 that I'm going to tell you a little bit about. This is  
7 essentially our cofunding of the ATTCs, NIDA's cofunding  
8 of the CSAT ATTCs. I have got to tell you, originally  
9 when we proposed this idea, and Jack Stein -- are you  
10 here, Jack Stein? This was really Jack Stein's idea about  
11 six years ago. It was a time when Alan Leshner was the  
12 Director. Telling Alan, we're proposing to give \$1.5  
13 million to CSAT at that time, you can imagine it took a  
14 little convincing. But he eventually agreed that this was  
15 a good idea, to use the infrastructure that was out there  
16 and to work with our colleagues in the field to get  
17 evidence-based practice out there.

18           Maybe we are a little slow to get going, but I  
19 tell you, I think it is going gangbusters now, and I'm  
20 happy to tell you a little bit about that. Blending  
21 teams. Well, that has to do with our dissemination  
22 efforts, and I'll explain a little bit about what those  
23 are. But those are the dissemination of materials both  
24 from NIDA's research portfolio, but also from the Clinical  
25 Trials Network.

1                    Consultation on evidence-based practices.  
2    NIDA staff is working with CSAT staff on the NREPP  
3    program, giving out advice, making recommendations about  
4    who should be on these panels because they are peer  
5    review, and giving them ideas about what treatments are  
6    ready for prime time, as we call it. What treatments have  
7    a good base of evidence, if you will, or research  
8    publications that are ready for really movement into the  
9    field.

10                   We have also done some grant writing technical  
11    assistance with SAMHSA grantees with the interagency  
12    support of NIDA research. We have a criminal justice drug  
13    abuse treatment system project, the CJ-DATS we call it.  
14    We have a primary care initiative, and we have a state  
15    research capacity building, all of which we are  
16    cosponsoring, or all of which SAMHSA is cosponsoring with  
17    us. So we call this the braiding of funding streams. In  
18    fact, I believe this is really the wave of the future,  
19    too. As resources get tight, we're going to in fact be in  
20    a good position to get the biggest bang for our research  
21    and our services buck.

22                   So science and service treatment research.  
23    Well, we are continuing the clinical research on  
24    medication development, on behavioral research, the  
25    behavioral treatment research development. We of course

1 established awhile ago the Clinical Trials Network in  
2 community-based settings, and we have a health services  
3 research portfolio second to none looking at how to in  
4 fact apply these evidence-based practices in real life  
5 applications.

6           You all know we've got four medications  
7 essentially for the treatment of substance abuse. Well,  
8 treatment for opiate abuse. We of course have a couple  
9 more now for alcoholism. But we haven't been successful  
10 for cocaine or methamphetamine yet.

11           I am just putting this up to let you know that  
12 we've got a lot of targets in various phases. Phase I,  
13 Phase II, and Phase III clinical trials trying to identify  
14 medications for cocaine addiction. It also is true with  
15 methamphetamine, and it is also is true with opiates. We  
16 have a number of things, but I left the slide out for the  
17 opiates. But in fact we also have a number in Phase I and  
18 Phase II clinical trials trying to identify a medication  
19 for methamphetamine addiction.

20           That is a program we started a little bit  
21 later than the cocaine, but building on what we learned  
22 from the cocaine program since they're both stimulants, we  
23 actually were able to get a little bit of a jump start on  
24 it. So this is very important. The point here is that  
25 there are a number of things in the queue.

1           NIDA is not just about medication development,  
2 it is also about behavioral therapies. So part of what we  
3 have identified, and these are the behavioral treatments  
4 with a strong science background, again, a number of  
5 these, actually I think all of these are treatments that  
6 we've suggested to CSAT that are ready for prime time,  
7 because they do have a strong evidence base.

8           You can see a number of them in behavioral  
9 treatments for marijuana abuse, behavioral treatments for  
10 smoking, and cognitive-behavioral therapy. It shouldn't  
11 be a surprise to anyone. Motivational incentives,  
12 motivational enhancement therapy, family treatments, drug  
13 counseling, there is a contingency management approach.  
14 There is a number of these here that in fact are ready for  
15 prime time.

16           But just so that you know, we also have a  
17 couple in the queue. So about 10 years ago, we said if  
18 we're going to develop medications using the FDA model --  
19 Phase I, Phase II, Phase III clinical trials -- we should  
20 be doing the same thing for behavioral therapies. In  
21 fact, Phase I behavioral therapies are supposed to be in  
22 our program that are theory-based from the basic  
23 behavioral science.

24           What is a good idea? That's where contingency  
25 management would have come from, the reinforcing effect of

1 things like vouchers or incentives. Cognitive-behavioral  
2 therapy came from early on from research on cognitive  
3 neuroscience.

4           There is no test here, Melody. You don't have  
5 to study. I see you're studying.

6           These are a number that we have in these  
7 various phases. Hopefully they'll in fact be fruitful in  
8 the future and that there will be a lot more in the  
9 pipeline to move onto our colleagues at SAMHSA.

10           Well, the research/practice gap has a couple  
11 of different elements to it. The accessibility gap. Do I  
12 have the same resources as a researcher? I heard it all  
13 the time. You come in, you do the research, the feds drop  
14 their payload, they move on, and what is left? Well, can  
15 we support at the community level what the practice was,  
16 what was shown to be successful? It is something that  
17 we're paying a lot of attention to in our health services  
18 research portfolio.

19           A couple of ways we're doing that, and I'll  
20 mention one, is in our behavioral research portfolio, in  
21 some of those ones that I saw, we had a meeting this past  
22 year, which hopefully will initiate, well, it has  
23 initiated a number of grants, where we are trying to  
24 identify in-therapies that have been shown to be effective  
25 to tease out what the active ingredients are, if you will.

1           We know that if you do a big comprehensive  
2 Cadillac program, you're probably going to have a good  
3 success. But if you can tease out what really the  
4 critical active elements are, you may in fact be able to  
5 reduce the cost, make them more user friendly, and  
6 actually be able to maintain fidelity.

7           Credibility gap. How different is the  
8 implementation setting? Things need to be transportable.  
9 We recognize that. We have a number of grants in the  
10 health services portfolio that are addressing that.

11           The expectation gap. Is it necessary or  
12 realistic for me to use science-based interventions, or  
13 can I just approximate? Well, that's the one that is  
14 always critical.

15           We call it the wobble or the drift. If you  
16 understand the technology transfer theory -- and I have to  
17 admit, I didn't understand it two or three years ago, but  
18 I've tried to learn a lot more about it -- there is a  
19 natural drift that comes with the transfer of technology  
20 from one organization to another.

21           This was pioneered by a gentleman who recently  
22 passed on. Everett Rogers is the pioneer on this.

23           It is estimated that for some of the research  
24 that NIH does, it takes about 17 years to get from the  
25 bench to the community practice for a finding. Well, Dr.

1 Zerhouni has told us that's way too long.

2 I have to tell you, I've taken some solace  
3 when we talked with Everett Rogers, who actually pioneered  
4 this work I believe in the '60s. Actually his first  
5 studies were studying hybrid seed corn in Iowa. He kind  
6 of looked at me and said, yes, that was my first study.  
7 He became a world expert on this, because what he found  
8 was it took 14 years for the farmers of Iowa to adopt  
9 hybrid seed corn. So I looked at him and I said, we're  
10 not doing so bad. He said, well, you've got to do better.  
11 That is what our goal is in terms of technology transfer.

12 Developing an evidence-based practice is only  
13 one piece of the translational puzzle. We know that, that  
14 the intervention itself as we try to strip out particular  
15 things, we try to make it user friendly, transferrable,  
16 keep the fidelity, and keep the active ingredients. There  
17 are lots of other things that are important. Again, we  
18 have a portfolio in organizational structure and climate,  
19 environmental stigma and financing, provider knowledge and  
20 behavior, and access and engagement. These are all  
21 critical factors, and we probably have a good portfolio in  
22 all of these, but we need to do a little bit more in each  
23 and every one of them.

24 A couple of examples of what we've been trying  
25 to do in terms of outreach over the last few years to try

1 to make research more relevant, is we have established  
2 these two things. One is the National Drug Abuse  
3 Treatment Clinical Trial Network, and one is the NIDA  
4 Criminal Justice Drug Abuse Treatment Study Center. I'm  
5 going to talk a little bit about each one of these.

6           The vision for the CJ-DATS is to improve  
7 outcome of offenders with substance abuse disorders by  
8 improving the integration of drug abuse treatment with  
9 other public health and public safety systems. Grandiose  
10 vision, so where does the rubber meet the road?

11           Well, a couple of the research questions  
12 currently being addressed are alternative treatment  
13 models, particularly for understudied approaches, research  
14 on systems integration, and that is critical if we're  
15 going to make some progress in this area. Types and  
16 levels of criminal justice system, drug abuse treatment  
17 integration, linkages between the correctional health and  
18 drug abuse treatment professional. Melody, are you  
19 listening? Are you smiling? Is this making you happy?

20           Continuity of care and after care during  
21 reentry, treatment models matching chronic nature and drug  
22 use. A couple of other ones, treatment and recovery  
23 process, external and internal motivation, and the  
24 relation to coercion. For a long, long time, people  
25 thought you needed to change, you needed to want change

1 really for any treatment in substance abuse to be  
2 effective.

3           We now know that in people, people who become  
4 incarcerated and have some levels of sanctions leveled  
5 against them can in fact eventually be helped by various  
6 kinds of treatment.

7           Role of monitoring surveillance and sanctions,  
8 relationship between public safety level and treatment  
9 progress and outcome. That is always a critical issue.  
10 One of the things that I've learned over the last two  
11 years actually working with Melody and her organization is  
12 that there is always this balance when you talk to a judge  
13 between public safety and public health.

14           That is something they are always cognizant  
15 about, something we need to help them more with. Access  
16 to medical, mental health and social services after  
17 reentry. So we have a number of centers around the  
18 country. One is the Research Coordinating Center, and  
19 that is here, and then a number of CJ-DATS, a total of  
20 about ten, ten altogether. I believe two of them are  
21 adolescent centers, studying adolescents in the criminal  
22 justice system as well.

23           So we are very excited about this. This is  
24 kind of under the leadership of Jack Stein and Wilson  
25 Compton, the Division Director there. It is very

1 exciting.

2                   Our federal partners on this are many. Of  
3 course SAMHSA is a partner on this, the Center for Disease  
4 Control, NIAAA, Bureau of Prisons, the Department of  
5 Justice, and again, a number of organizations within  
6 there. So this really is truly a great collaborative  
7 effort. I actually think it is going pretty well,  
8 although it is very early in the establishment of this,  
9 but I have great hope for that.

10                   I have great hope for that because of the  
11 success of this one. This is one that we launched about  
12 five or six years ago. This came about as a result of an  
13 Institute of Medicine report that said we really needed to  
14 do a better job of bridging the research into the  
15 community.

16                   Alan Leshner was the Director then, and so we  
17 established what we called the NIDA Clinical Trials  
18 Network. Its mission was to conduct clinical trials to  
19 determine the effectiveness of drug abuse treatment  
20 interventions in diverse community-based treatment  
21 settings, and with diverse patient populations, and to  
22 transfer research results to treatment programs, and for  
23 clinicians and their patients to improve the quality of  
24 drug abuse treatment throughout the nation.

25                   I'm also going to tell you a little bit about

1 some of the protocols over the last five years, and the  
2 ones that are current. These are selected CTN trials that  
3 really I think are in current progress. Opiate  
4 dependence, we have a couple on buprenorphine, one for  
5 tapers, one for adolescents, and smoking cessation. We  
6 have motivational enhancement therapy for Spanish  
7 speakers, as well as for pregnant women, and a protocol  
8 called "Seeking Safety Intervention for Trauma and  
9 Substance Use."

10 We have a pretty large study for families,  
11 brief strategic family therapy for adolescents, as well as  
12 a number related to HIV, HIV and hepatitis intervention,  
13 and HIV risk reduction in both men and women. These are a  
14 number of the ongoing protocols currently. I think they  
15 are all shown there pretty much.

16 A number of protocols have already been  
17 completed, and these are the list here. Buprenorphine for  
18 detox, detox outpatient/inpatient, and motivational  
19 enhancement therapy. We are not ready to disseminate that  
20 one yet, but that one I believe has finished.  
21 Motivational interviewing, motivational incentives, and  
22 drug-free clinics, as well as methadone clinics. Those  
23 are topics that we're already working with SAMHSA on  
24 disseminating. What we call the tele study was a follow-  
25 up post-discharge headed up by a number of investigators.

1           We have positive findings so far in all the  
2 studies that have finished. Coordinated dissemination  
3 efforts, I'm going to tell you a little bit about what  
4 we're working with the ATTCs on. I'm going to tell you a  
5 little bit about what some of the proposed studies for the  
6 current year and the next couple of years are for CTN. Of  
7 course I'm from NIDA, so I have to show you a brain scan.

8           This actually isn't Nora Volkow's work, but I  
9 believe this is work from our colleagues at Wayne State.  
10 I just use this as an example of normal control methadone  
11 maintained patients. What this is telling you, this is  
12 looking at the occupancy of the receptor, the opiate  
13 receptors in the brain.

14           What this is telling you here is that in the  
15 methadone patients, you can see that this is in the normal  
16 control. This is the total number of opiate receptors,  
17 occupancy, and then methadone displaces this radio label  
18 opiate receptor agonist in these particular areas. You  
19 don't need to know about what the areas are, but it says  
20 that methadone really does in fact occupy those receptors,  
21 but it doesn't occupy a grand percentage of those, a  
22 really great percentage of those receptors, as you can  
23 see.

24           If it occupied a great percentage, you might  
25 envision as a neuroscientist that I'd tell you, well gee,

1 if it occupied all the receptors, then it would probably  
2 be a pretty good thing if somebody took heroin, they  
3 probably couldn't get high from it because our receptors  
4 would be occupied. There is a whole host of things that  
5 you might conclude from this.

6 Well, buprenorphine as it turns out, and we  
7 didn't know this early on when we developed it, but we  
8 know it now, with the 16mg dose of buprenorphine, this is  
9 MRI, this is bup zero, this is 2mg, 16mg, this is how much  
10 opiate receptor is available when these patients are  
11 medicated. You can see that there is a reason that the  
12 pharmacology or the pharmacokinetics of buprenorphine are  
13 very different, and that the patient population may be  
14 different, and that the safety in fact of this particular  
15 medication is very different. You can see 85 to 92  
16 percent.

17 So this says a lot in terms of heroin  
18 addiction, but it also might say a lot about how do you  
19 use buprenorphine in some of these pharmacotherapies for  
20 this epidemic that we're seeing. That is the increase of  
21 prescription drug opiate analgesics in this country. This  
22 is a big problem of national importance, and this is one  
23 of the priorities that Dr. Volkow has decided we need to  
24 do a lot more work in.

25 Another area that Dr. Volkow has been very

1 interested in is attention deficit hyperactivity disorder.

2 I'm not an expert on ADHD, but in fact there is data out  
3 there to show that 15 to 30 percent of those individuals,  
4 especially in adolescence, who are being treated for  
5 substance abuse also suffer from ADHD. So there is a  
6 comorbidity going here.

7           If you stretch that a little, as we always do  
8 if we're clinicians, neuroscientists, or treatment  
9 providers, if they are having problems paying attention,  
10 they may in fact seek out drugs to do self-medication. We  
11 know that's true for many kinds of mental disorders that  
12 people are likely to do self-medication with substances of  
13 abuse. In fact, we think that is what is going on here as  
14 well.

15           This just shows you some of the odds ratios.  
16 What this is telling you is that adjusted affect of ADHD  
17 and pharmacotherapy on substance use dependence, this is  
18 unmedicated individuals versus controlled, and this is  
19 medicated ADHD versus unmedicated ADHD.

20           What this is just telling you is that an  
21 individual who is unmedicated is six times as likely to in  
22 fact abuse substances than in fact somebody who is  
23 medicated. Six times for alcohol and marijuana. A little  
24 bit different in terms of prevalence or incidence in  
25 tobacco, but the major drugs of abuse, you can see that

1 there is definitely a beneficial effect to treating people  
2 on their substance abuse outcomes.

3           So again, that is another reason of a very  
4 important research opportunity and one of the things that  
5 we're going to be exploring in the CTN. We have a couple  
6 of new studies in the Wave 5 that we're looking at. One  
7 is a randomized controlled trial of buprenorphine naloxone  
8 in assessing liver function in opiate dependence  
9 treatment.

10           Well, this is a study that the FDA required to  
11 study liver toxicity or liver function in the opiate  
12 addicts that are undergoing buprenorphine treatment. So  
13 we are investing a large amount of money, and I'm sure  
14 Westley would share this opinion. We have a lot invested  
15 in buprenorphine. We think it is a very good medication,  
16 and we want to make sure that it succeeds and that we do  
17 everything that we can to make sure it gets in the hands  
18 of practitioners.

19           We are also starting this randomized control  
20 trial of -- now, how many of you know what OROS is?

21           (No response.)

22           DR. CONDON: Well, I didn't know it until this  
23 morning either. I am looking at this going, what is this?  
24 Oh, this is long-acting methylphenidate. So it is a  
25 long- acting preparation. It is an osmotic preparation.

1 It is an oral preparation. That is what OROS is, oral  
2 osmotic release something or other.

3           Anyway, the bottom line is that these are  
4 long-acting methylphenidate looking at ADHD in adolescence  
5 and substance abuse, and we are also doing one in adult  
6 smokers who have ADHD as well. We are also starting one  
7 to address the prescription drug issue of the opiate  
8 analgesic looking at the use of buprenorphine as a  
9 treatment for opiate analgesic dependence.

10           So services research at NIDA, and this is part  
11 of our portfolio, one of the things that we're doing in  
12 the bup liver study as we call it, it is actually not  
13 being done by the CTN, but is being done in the CTN by one  
14 of our other divisions. So in other words, one of our  
15 goals in the future is to have this infrastructure around  
16 the country of the CTN, and to use it as a platform for  
17 doing other kinds of research. All kinds of research.  
18 Health services research, genetics research. In this  
19 case, we are going to be doing some toxicology research  
20 related to the pharmacotherapies.

21           The criminal justice, the CJ-DATS, which  
22 SAMHSA cofunds, we actually think that is also another  
23 infrastructure, and we are so delighted with our  
24 collaborators that we are establishing this infrastructure  
25 out there around the country, and we'll build an

1 infrastructure that everybody can use to do these kinds of  
2 studies.

3           Primary care initiative, which is something  
4 that Jack Stein is leading, and we had an RFA out on the  
5 street, and I think it is closed and the applications are  
6 in, if I'm not mistaken. That is something that also our  
7 colleagues here at SAMHSA, and that is in fact essentially  
8 getting health care, primary care physicians at all  
9 levels, to do brief interventions to assess and to do  
10 referrals.

11           A new thing for us is enhancing state capacity  
12 to foster adoption of science practices. We put out an  
13 RFA where we encouraged states to send in applications to  
14 give small grants so that they too can start to build a  
15 research infrastructure to start to apply for some of the  
16 other projects.

17           Science to service research dissemination. I  
18 want to run through this quickly. NIDA publications. We  
19 have, as I say, the CTN/ATTC blending teams, the blending  
20 products and the conferences.

21           Again, this is the CTN. I love to show this  
22 slide, because this is where we've established the  
23 Clinical Trial Network sites around the country. There  
24 are 17 of them, and we see them as the snowflakes. The  
25 CTN is the snowflakes.

1           If we add to that the ATTCs, which are also  
2 geographically distributed around the country, you can see  
3 that we've got a good partnership here now that we've  
4 linked the ATTCs and the CTNs, as well as with  
5 headquarters for both NIDA and SAMHSA.

6           Research findings. Well, one of the things  
7 that I always tell the groups because I stay personally  
8 involved in these research dissemination efforts, one of  
9 the things that I've been talking to the groups about, and  
10 it is kind of just the way things are, is that we have  
11 never really done this kind of research dissemination in a  
12 systematic way. We don't really have a guidebook.

13           There is technology transfer theory, and let  
14 me tell you, there are lots of people's ideas about what  
15 needs to be done. But we really have never done it in a  
16 systematic way before that I can tell. As you heard, I  
17 have been around for awhile.

18           So I tell them we're making this up. To some  
19 of them people laugh and giggle, but the truth is we are.  
20 We are making this up as we go along. I don't think  
21 we've made any missteps yet, and I'm very pleased with  
22 these efforts.

23           We start with a research finding from a CTN,  
24 let's say, from one of the clinical trials. Let's say the  
25 first one I think we did was the motivational interviewing

1 protocol. It had a positive finding. So we had what we  
2 call a handoff meeting where we bring most of the  
3 researchers from the CTN together with some of the  
4 colleagues from SAMHSA and the ATTCs, and we sit there and  
5 talk about the protocol, what went on, what were the  
6 barriers, what did we think was right, what was wrong, and  
7 what the results were. Then we kind of make a  
8 determination, is there something here to disseminate? Is  
9 there something here that is useful?

10           Each one of the three handoff meetings we've  
11 had have said for these first two protocols, yes, there  
12 is. Then we create the charge for the blending team based  
13 on the results of the protocol and how it can address  
14 critical needs in the treatment field.

15           The blending team is then headed by our  
16 colleagues at ATTC and SAMHSA. It involves three of the  
17 key members from the CTN who were involved in the  
18 research. But really it is the ATTC who are going to  
19 develop the products for dissemination. In fact, so far  
20 we have done a couple of products. I think I have the  
21 next slide here.

22           We have done one for bup awareness. We call  
23 it the buprenorphine treatment, which is really for the  
24 non-physicians. So we call that bup awareness. We are  
25 doing one also on Addiction Severity Index. Again, these

1 were two that didn't come out of the CTN, but these were  
2 things that we had on the shelf and were ready for  
3 dissemination. We got one of them out on the street  
4 already, and the ASI is coming out soon.

5           The CTN protocols, as I said, the short-term,  
6 the motivational interviewing, is one that it improves  
7 retention in stimulant abusers entering treatment. The  
8 buprenorphine detoxification here. In fact what this is  
9 telling you, and this is a Walter Lynnism, who was the  
10 principle investigator here, you have to treat 5.44  
11 patients with clonidine to get the same effect of treating  
12 one patient with buprenorphine and naloxone. So it shows  
13 the efficacy and the effectiveness of buprenorphine versus  
14 something like clonidine.

15           High acceptability. Many drug-free clinics  
16 have already adopted it in terms of detox, and they  
17 participated in some of the early studies. We got very  
18 excited when some organizations that before would never in  
19 fact use methadone or some of the other medications  
20 stepped up to the plate and said we want to participate in  
21 these studies. Now, for a number of them it is actually  
22 standard operating procedure. So we think that that is a  
23 great success in moving forward evidence-based practices.

24           Motivational interviewing. Again, this is  
25 very interesting. This is a very simple protocol that was

1 studied. Again, it is this particular protocol. It is 20  
2 minutes on the assessment intake battery, 20 minutes of  
3 motivational interviewing in the beginning, and 20 minutes  
4 at the end. Forty minutes at the beginning had an effect  
5 30 days later. Go figure. There was a 25 percent  
6 increase in retention in these treatment programs. That  
7 says a lot about what we can learn from this.

8           The last one is motivational incentives, low  
9 cost incentives are effective. This is the fishbowl  
10 approach to motivational incentives in promoting  
11 treatment, retention, and abstinence successfully  
12 introduced to the community. Positive reinforcement  
13 versus punishment.

14           We have also collaborated with CSAT on a  
15 number of blending conferences. We had a meeting in  
16 Portland, Maine at last year's NASADAD meeting with our  
17 colleagues at CSAT. That was, I think, very well  
18 received.

19           Ken, I'll reserve judgment on that.

20           We have been trying to work much more closely  
21 with NASADAD in all of these dissemination efforts. You  
22 guys blew me away when you did this, Ken. When we were up  
23 in Portland, Maine, they told us that they were going to  
24 collocate the NASADAD annual meeting this coming June just  
25 before our blending conference in Miami. So we are very

1 excited about that potential for collaboration. So we're  
2 going to be doing some stuff there.

3           Again, we cosponsored a similar meeting in  
4 Denver and Detroit, and as I said, we'll be doing it in  
5 Miami in 2004, and we'll be having this NASADAD  
6 preconference.

7           Future directions. Well, we need to continue  
8 with what are the characteristics of interventions that  
9 can reach the large number of people, be broadly adopted  
10 in different settings, be consistently implemented by  
11 staff with moderate training expertise, and produce  
12 reliable and long lasting effects. Also things in fact  
13 that can be reimbursed at reasonable cost. Our  
14 partnerships are essential to making this all happen.

15           With that, I'll say thank you for your  
16 attention and hope that was useful.

17           (Applause.)

18           DR. CLARK: Any questions for Tim?

19           MR. DeCERCHIO: Just a quick comment. I had  
20 15 years in the community substance abuse before going  
21 into a state job. In the community, I don't ever remember  
22 a single NIDA study or NIAAA study kind of filtering down  
23 and saying okay, we're going to change our practice as an  
24 agency as a result of it. I got to the state and they  
25 said, we have a \$90 million block grant, and we're

1 evaluating its progress.

2 I said gee, what is the connectivity to all  
3 this research over here? How come that is not helping us  
4 decide what we should be buying in terms of all of our  
5 special initiatives under the block grant? So that  
6 doesn't seem to make sense. You guys have made sense of  
7 it. Alan started it, and you and Nora continue it.

8 The last five, six years, seven years between  
9 the Clinical Trials Network, the connectivity to providers  
10 and the connectivity to states, the support has been  
11 really remarkable in terms of the overall change. It is  
12 affecting our providers in a positive way, the direct  
13 relationships. It is affecting helping how we do business  
14 in the state. It is very exciting.

15 I remember the IOM report. It was like this  
16 is a big gap, how do we get our arms around it. Through a  
17 lot of what NIDA has done in relationship with SAMHSA and  
18 CSAT, it has been very rich. I think it is having an  
19 impact in creating a culture change around the adoption.

20 DR. CONDON: Dead on arrival?

21 (Laughter.)

22 MR. DeCERCHIO: The embracing of good science  
23 and good practice where it is available. I think it has  
24 been a very important and a very positive initiative, and  
25 certainly you all should be commended for that work,

1 frankly.

2 DR. CONDON: Thanks for that feedback, Ken. I  
3 appreciate it.

4 DR. CLARK: Frank?

5 DR. McCORRY: I would also like to commend  
6 NIDA for realizing that they have partners in states and  
7 among providers. There is just a tremendous, tremendous  
8 culture change, Ken said, taking place. I think we  
9 realized it on the SAMHSA side that we needed you, but to  
10 see NIDA recognize how much you needed us for your work to  
11 be effective is just terrific. It holds a tremendous  
12 opportunity for positive results in terms of the care  
13 delivered to people.

14 Two issues. One, in terms of science to  
15 service, as you said making it up, I work for a state  
16 agency. We are making it up, too. We are part of a  
17 couple of the NIDA initiatives to continue to look at  
18 delivery mechanisms to promote the adoption and sustaining  
19 evidence-based practices.

20 We are learning that everything from training,  
21 for example, focusing on an individual practitioner versus  
22 a program since public sector funding is often program  
23 related, even though there are separate credentials for  
24 it, doesn't make the kind of change that you perhaps want.

25 That seems to be supported by the literature as well that

1 you want to introduce motivational interviews, and you've  
2 got to get your staff together, not get a couple of  
3 clinicians go to a central site for three days to learn  
4 about it.

5           So to continue to look for states and  
6 providers to understand the dynamics, the facilitators and  
7 inhibitors to change in terms of evidence-based practice.

8           The second issue is more one of concern than  
9 the first one, which I think is more a research question.

10          That is I like the way you said CTNs as a platform for  
11 effectiveness studies. That is the way I view them.

12           We do a lot of work in New York with the  
13 Clinical Trial Networks trying to partner with them in  
14 terms of trying to have evidence-based practices adopted.

15          We view that as a tridirectional process of setting the  
16 priorities for Clinical Trial Networks and Wave 5 studies.

17           That involves policy folks like state folks,  
18 practitioners, researchers, and of course other folks  
19 would say consumers is as well as a fourth partner in  
20 that. That kind of caldron of competing priorities that  
21 kind of yields a research agenda that somehow can be  
22 bought into by all of those parties we see as a process.  
23 We think NIDA probably should be the one driving that  
24 process.

25           NIDA should be kind of requiring, insisting,

1 and looking for input from those other stakeholders when  
2 they are creating studies. So while it is great that  
3 we're studying prescription opiate misuse, I'm not sure  
4 that that would be something that from my viewpoint I  
5 would say is a priority. But that doesn't mean that it  
6 isn't, that just means from my viewpoint.

7 I think if we're going to transform the  
8 culture, the state culture, the research institute  
9 culture, the provider culture, it is necessary for all of  
10 us to kind of work through these issues on how we set  
11 priorities around the work we do. So I just encourage  
12 NIDA to not be bashful in that, even though it might be a  
13 difficult process, to continue to see a research agenda  
14 develop that might have to in some ways react to outside  
15 forces and outside influences saying have you thought of  
16 this direction to go in.

17 DR. CONDON: Thank you for your comments. On  
18 the last point, I couldn't agree with you more. One of  
19 the things, and we haven't done it in the last couple of  
20 years, but we have done it on almost a yearly basis, or  
21 every other year, is we started this, actually Alan  
22 Leshner started this about 10 years ago. That was we  
23 would have a constituent conference where we brought  
24 together all the stakeholders.

25 I would tell you we're going to have another

1 one this year budget permitting, but I'm pretty sure we're  
2 going to have one. I would tell you if I looked out over  
3 the audience, if you will, who would be invited to that, a  
4 lot of the stakeholders would have changed. Certainly  
5 everybody that you talked about at the state level, at the  
6 community level, would be a part of that.

7 I'll tell you how successful that was. In the  
8 first couple of years we did that, we were genuine about  
9 this. Tell us what we're not doing. We got all these  
10 requests and we looked at them and thought gee, what are  
11 we going to do now? We actually systematically looked and  
12 went through it and by the second year, we gave them a  
13 report card about how we had done.

14 I won't speak for all of them, but I'll tell  
15 you, it was so well received that NIDA would pay attention  
16 to this, would actually implement things, a lot of it to  
17 be honest, were things we were already doing, they just  
18 didn't know about. But we did this, this is a good idea.  
19 All the good ideas just don't come from the NIDA staff,  
20 although lots of them do, and we recognize that.

21 We got As on those first couple of report  
22 cards, so I have talked to Dr. Volkow about reenergizing  
23 that. With that said, these are all the priorities.  
24 Priorities in the flat budget years are going to be real  
25 tough, and there is going to be a lot of competing

1 interest.

2 So that is really not asking the questions and  
3 getting the input, but trying to really be responsive is  
4 going to be a great challenge in the coming years.

5 DR. CLARK: All right. We need to get back on  
6 schedule.

7 I want to thank you, Tim, and I hope Nora's  
8 illness is brief. We appreciate your comments.

9 Thanks, Jack, for accompanying him.

10 DR. CONDON: Thank you so much.

11 DR. CLARK: Thank you.

12 (Applause.)

13 DR. CLARK: All right. So we're now going to  
14 move to the next discussion involving Joe Gfroerer, who is  
15 going to present information from the National Survey on  
16 Drug Use and Health. Joe is the point person for NSDUH  
17 and is relied upon by many and all.

18 Thank you, Joe.

19 MR. GFROERER: I'm happy to be here and to  
20 present some data from the National Survey on Drug Use and  
21 Health. What I'm going to do is present primarily the  
22 most recent results that we released in September from the  
23 2003 survey, and talk a little bit about some of the  
24 future plans we have for this year for other analyses and  
25 reports.

1           First of all, a little bit about the design of  
2 the survey. It is represented nationally and within each  
3 state. It covers the civilian non-institutionalized  
4 population age 12 and older. Data are collected with a  
5 face-to-face interview using a computer, a laptop  
6 computer, that all the interviewers have with them. Most  
7 of the questions, particularly the sensitive questions on  
8 substance use, are answered by the respondent by keying in  
9 the response, they are self-administered questions.  
10 Questions come up on the screen and they key in the  
11 answers, so the interviewer doesn't know what the answers  
12 are.

13           We had about 67,000 respondents in 2003. One  
14 of the things that affects some of the analysis we can do  
15 is the changes we made in the survey in 2002 that disrupt  
16 the trends. So basically what we have is a two-year  
17 trend. Here, we can compare 2002 data to 2003, and that's  
18 the main focus of the report in September.

19           First some of the findings on tobacco use and  
20 alcohol use. These are the overall rates of tobacco use.  
21 About 30 percent of the population has used some tobacco  
22 product within the past 30 days. Most of these estimates  
23 are a reference period of the past 30 days. That's driven  
24 by the cigarettes, which is 25 percent of the population.  
25 You can see there is virtually no change between 2002 and

1 2003.

2           Now looking at youth cigarette use, here again  
3 there is really no significant change overall among 12- to  
4 17-year-olds. The rate is about 13 percent on average,  
5 plus you can see there is quite a wide range across the  
6 age group from less than 2 percent among 12-year-olds, up  
7 to 26 percent among the 17-year-olds.

8           You can see a little bit of a decline there at  
9 each age. Only the 13-year-old trend was significant.  
10 There was also a statistically significant decline in  
11 youth cigarette use among females, female 12- to 17-year-  
12 olds.

13           For alcohol, we have three measures that we  
14 look at, within the past month again, all of these. Any  
15 use within the past month is what we call current alcohol  
16 use. Then we have binge use, which is having five or more  
17 drinks on at least one occasion within the past month, and  
18 then heavy use is having at least five binge occasions  
19 within the past month. About half the population, or 119  
20 people 12 and older are current drinkers, 23 percent with  
21 binge use, and 7 percent with heavy use. These numbers  
22 are virtually identical to what we saw in 2002, so there  
23 is no changes going on in alcohol use.

24           Looking at underage drinking, again breaking  
25 it up by age group, and also by the different levels of

1 use, you can see the wide range from 4.5 percent up to 51  
2 percent in the 18- to 20-year-olds. That's for current  
3 use. You can see that the majority of the underage  
4 drinkers are binge or heavy drinkers. That isn't the case  
5 for older adults. But for the underage drinkers, it is  
6 primarily binge and heavy use.

7           Let me move onto the illicit drug use data.  
8 Now here, looking at any illicit drug use within the past  
9 30 days, the overall prevalence is about 8.2 percent.  
10 Again, no change between 2002 and 2003. Most of this is  
11 marijuana use at 6.2 percent. You can see the other  
12 drugs. Psychotherapeutics is basically prescription-type  
13 drugs, but only used non-medically within the past 30  
14 days.

15           We did look at the data a number of different  
16 ways and did find some interesting changes between 2002  
17 and 2003. For example, hallucinogens. When we look at  
18 the number of people using hallucinogens within the past  
19 12 months, past year of prevalence, we do see significant  
20 declines, particularly with ecstasy and LSD. Ecstasy went  
21 down from 3.2 million to 2.1 million. So these are pretty  
22 significant drops.

23           On the other hand, the one area where we see  
24 possibly an increasing trend is among the non-medical use  
25 of pain relievers. These numbers represent the number of

1 lifetime users in millions. You see 31 million people  
2 have used at sometime in their life a pain reliever  
3 non-medically.

4 We can break this down by the specific drug  
5 categories. You can see Vicodin, Lortab, and Lorcet,  
6 significant increases for all of these specific  
7 categories. OxyContin is from 1.9 up to 28.8 million.

8 Another decline that we found was when we  
9 broke it out by geographic areas. We find that in rural  
10 areas, overall illicit drug use did go down between 2002  
11 and 2003. Also among youth, even though the overall  
12 illicit drug use rate, and even the marijuana use in the  
13 past month rate didn't change between 2002 and 2003, there  
14 are indications of decline.

15 The lifetime use that is ever having used  
16 marijuana in a lifetime went down from 20.6 to 19.6 among  
17 youth. That was statistically significant. The other  
18 estimates were past year and past month. It declined a  
19 little bit, but they're not statistically significant.

20 Also when we look at youth marijuana use by  
21 how frequently they use, and we focus on the almost daily  
22 users, whether over the past 12 months, 300 or more days  
23 within the past 12 months, or within the past month, 20 or  
24 more days, there are significant declines in heavy  
25 marijuana use among youth.

1           At the same time, looking at the attitude  
2 data, this is perceived great risk. Proportion of youth  
3 who think that there is great risk in using these  
4 different drugs. Here we see an increase in the percent  
5 of youth saying that smoking marijuana is risky, from 32.4  
6 to 34.9. No significant change for any of the other  
7 drugs. Same things for cigarettes and alcohol, no  
8 changes. Just the marijuana.

9           Let me move onto dependence and treatment  
10 data. What we do in this survey is we have a series of  
11 questions related to symptoms of dependence and abuse,  
12 basically the DSM-IV criteria. Based on those responses,  
13 we classify people as having dependence or abuse on each  
14 of the substances. This is what the estimates look like.

15       In 2002 and 2003, these are the estimated numbers in  
16 millions. Basically 22 million people with dependence or  
17 abuse. It is primarily alcohol. There is no change  
18 between 2002 and 2003.

19           Now, looking at the specifics within the  
20 illicit drugs, these are the rates for that same measure  
21 within the illicit drug category. This is any illicit  
22 drug dependence or abuse. Marijuana is the primary drug  
23 here with 4.2 million, and then you have cocaine and pain  
24 relievers, and then all the other drugs with less than  
25 half a million.

1           Now, this is some new data that we'll be  
2 putting out in a couple of weeks in our state report based  
3 on the 2002 and 2003 surveys using our model-based  
4 estimation methodology. What you look for here is the red  
5 states have the highest states of use, the white states  
6 have the lowest rates of use, so you can see the pattern.

7       It is those northern states. Now, this is alcohol  
8 dependence or abuse. Northern states generally have the  
9 highest rates, also Arizona and New Mexico. Southern  
10 states typically have the lowest rates. This is a pattern  
11 that we have been seeing in the data since 1999 when we  
12 started the state estimation.

13           Now, it is a little different pattern when you  
14 look at illicit drug dependence or abuse. Those northern  
15 states fall in the lowest category pretty much. North  
16 Dakota, Minnesota, Wisconsin are all in the lowest  
17 category for illicit drug, and some other states kind of  
18 show up in New England, Louisiana, State of Washington,  
19 and Arizona and New Mexico are still in there in the top  
20 for illicit drug dependence or abuse.

21           I wanted to present this data here. This is  
22 from a study we did last year relating to older adult  
23 substance use. This is a study where we did projections  
24 based on the aging population, age 50 and older, trying to  
25 guess what the rates would look like and the numbers would

1 look like in 2020. Here we show that because of the  
2 population increase, a 50 percent increase in the  
3 population, a 70 percent increase in the rate of  
4 dependence or abuse, we would expect about 150 percent  
5 increase in the number of 50 and older persons with  
6 dependence or abuse on alcohol or drugs.

7           Now moving into the treatment. This looks at  
8 the people who need treatment, which is primarily the  
9 dependence and abuse population, but it also includes an  
10 additional set of people who receive treatment. Here you  
11 can look at the people who have received treatment among  
12 those who needed treatment. So the yellow part of that  
13 bar is the treated population. That is any treatment  
14 within the past year at a specialty facility. This is  
15 drug or alcohol.

16           What we have here is basically no change in  
17 the treatment need, but we did have a decrease,  
18 statistically significant decrease, in our estimate of the  
19 number of people who have received specialty treatment,  
20 from 2.3 million to 1.9 million. We don't have a good  
21 explanation for that, but that is the estimate that we  
22 see. It seems to be concentrated more on the older adult  
23 population. There was not a decrease among the 25 and  
24 under population.

25           Now, if you take that 22 million people who we

1 estimate needed treatment based on the criteria collected  
2 in the survey, the 8 percent who were treated, that's the  
3 same 1.9 million from the last slide. Now here we break  
4 it out by their responses to some other questions.  
5 Basically do they feel they need treatment? Perceive need  
6 for treatment? The respondents, even though they have  
7 reported that they have all these symptoms that allow us  
8 to classify them with dependence or abuse, 87 percent of  
9 them say they didn't feel a need for treatment within the  
10 past 12 months.

11           Five percent, or about an estimated 1 million  
12 people do report that they felt a need for treatment, but  
13 they didn't get it. Out of that 1 million, about 26  
14 percent in a follow-up question reported that they tried  
15 to get treatment, made an effort to get treatment, and  
16 didn't get it.

17           So for those people who say they needed  
18 treatment but didn't get it, we asked them, why didn't you  
19 get it. These are the responses to that question. The  
20 number one response is that they're not ready to stop  
21 using the drugs. The cost and insurance barriers account  
22 for about one-third of these people, and stigma is about  
23 20 percent.

24           Now, here we have among those people who did  
25 get treatment, we are looking at the substances that they

1 reported that they received the treatment for. The  
2 interesting thing here that is not obvious from looking at  
3 this is that it is very consistent with the treatment  
4 data, the TEDS data that Deb will be talking about.

5           If you look at any drug involved in the  
6 treatment episode, treatment admission, the distributions  
7 are very similar to this. About 65 percent for alcohol in  
8 TEDS data and 35 percent for marijuana, so it is very  
9 consistent.

10           Now, we also asked respondents who have  
11 received treatment how they paid for their treatment.  
12 These are the responses that we get. About half, almost  
13 half report that they used some of their own savings or  
14 earnings. Only about one-third said that they used  
15 private health insurance, that private health insurance  
16 paid for their treatment, any part of their treatment.  
17 Then we have public assistance other than Medicaid, and  
18 Medicaid and all the other categories there.

19           Now, a little bit of data on the mental health  
20 characteristics. We created this estimate of serious  
21 mental illness based on a scale of six questions that we  
22 have in the survey. You classify all the respondents as  
23 having serious mental illness, which is defined as having  
24 any mental disorder, plus having some impairment in the  
25 past year. The prevalence in 2003 was about 9 percent.

1 This is only asked among adults.

2           Now, here is what it looks like when you cross  
3 the SMI, serious mental illness, with substance dependence  
4 or abuse, showing the comorbidity. Among those with SMI,  
5 21 percent have an alcohol or drug disorder. Among those  
6 without SMI, only 8 percent have a drug or alcohol  
7 disorder. Now, that 21 percent represents about 4.2  
8 million people, and that's a population that we call the  
9 co-occurring population in some of our reports.

10           I should point out it is not really the full  
11 co-occurring population, because we are only talking about  
12 serious mental illness here, not any mental disorder. But  
13 still it is a population that definitely has a mental  
14 health problem and a substance abuse problem. So we look  
15 at those people, whether they got treatment, and here, you  
16 can see it is about half, 49 percent got no treatment at  
17 all in the past 12 months.

18           Only about 7.5 percent received treatment for  
19 mental health problems and for substance abuse problems.  
20 Forty percent received the mental health treatment, but no  
21 substance abuse treatment, and another 4 percent just got  
22 substance abuse treatment. This is among that 4.2 million  
23 co-occurring population.

24           I want to talk a little bit about some of the  
25 reports we have coming up this year. In a few weeks we

1 should have the state report coming out from 2002 and  
2 2003. I showed you a couple of maps from that. The  
3 report will have maps just like that for about 20  
4 different measures and for different age groups.

5           Another project that we have that we expect to  
6 be releasing a report on this year is our substate  
7 estimation project. I'll say a little bit more about that  
8 in a minute. We also have a report on immigrants and  
9 substance use where we have taken our sample of the  
10 foreign-born population and looked at their substance use  
11 by specific country of birth, compared that to the  
12 U.S.-born. Then around September we expect to release the  
13 national findings from the 2004 survey, and we'll have an  
14 additional year to compare with the last two years all  
15 these charts and data points to see what has happened over  
16 the past three years, and the trends.

17           We have some methodological reports coming  
18 out. One is on assessing and improving methods of various  
19 studies that we've done to look at survey methods and  
20 experiments that we've done to test new methods. Then of  
21 course there will be these very short reports, probably 20  
22 or 30 of those over the next year on various topics.

23           I just wanted to say a little bit about the  
24 substate estimation project. This has been something that  
25 has been a collaboration between our office, the Office of

1 Applied Studies, and CSAT. The way this is coming out is  
2 that our first step was to basically determine the  
3 substate regions. How do we break up the states into  
4 different areas? We certainly can't with our sample make  
5 an estimate for every county in the country, so we have to  
6 come up with some boundaries. We have been working on  
7 that. It is a very difficult process.

8           Through CSAT and working with state  
9 representatives, we have finally come up with a set of  
10 boundaries. So that is basically completed and we are now  
11 into the next phase where we are starting to do the  
12 modeling and the estimation to produce these results. We  
13 are using the 1999 to 2001 data for this project. Once  
14 that is done, we're hoping we get some feedback, see how  
15 it works, and then we'll be revising it as needed, working  
16 with the states to give them something useful, and then  
17 run the same estimation procedure through the 2002 to 2004  
18 data and hopefully we'll have that sometime next year.

19           Just to give you some examples of what some of  
20 the states look like and how we've broken them up, this is  
21 what Delaware looks like, just the three counties in  
22 Delaware. Florida has quite a few areas. We have a big  
23 sample in Florida, so we're breaking it up. You can see  
24 those numbers are the sample size. Every single one of  
25 these areas that we're making estimates for, we do have

1 sample in those areas. So it works pretty well.

2 This is Ohio, which I think has over 20  
3 different regions where we'll have estimates. South  
4 Carolina, South Dakota, and finally Texas.

5 That's it. Thank you. Any questions? I'd be  
6 glad to answer.

7 (Applause.)

8 MR. DeCERCHIO: Real quick. The state level  
9 samples are representative based on actual surveys,  
10 they're not extrapolations or synthetic estimates at the  
11 state level?

12 MR. GFROERER: That's right. The substate  
13 estimates are not synthetic. That's why I said every one  
14 of the substate areas that we make estimates for will have  
15 a sample of at least 275 basically was our cutoff. So it  
16 is a combination of the direct estimate and the model  
17 based on the national data.

18 DR. CLARK: Melody?

19 MS. HEAPS: On the decreasing number of people  
20 who had access to treatment, is there any program to  
21 really look at what that was, or why that was?

22 MR. GFROERER: Yes, we actually did a lot of  
23 follow-up analysis on that to try to come to an  
24 explanation, which we really didn't come up with a good  
25 answer, other than that it was concentrated more on the

1 older adults and not in the younger population. But  
2 certainly when we get to 2004 data, we'll look more  
3 closely. We'll have three years. It may have just been a  
4 sampling issue or a blimp in the data.

5 MS. HEAPS: Thanks.

6 DR. CLARK: Francis?

7 DR. MCCORRY: The slides, by the way, I have  
8 used the slides that you sent out, that package. It is  
9 just terrific to have this PowerPoint on my computer. I  
10 use the slides all the time on presentations, when you  
11 start off a presentation in epidemiology.

12 A quick question on the K6. I remember  
13 looking at those questions, but I haven't looked in  
14 awhile. They didn't seem like seriously mentally ill  
15 questions. But if that thing was piloted, I don't know if  
16 it was validated, but what is the degree of confidence  
17 that SMI estimate off of those K6 questions?

18 MR. GFROERER: Well, what it is based on is a  
19 study that we did in Boston on about 150 respondents taken  
20 from the general population, it wasn't a treatment sample.  
21 It was a general population sample where we administered  
22 a whole series of questions related to serious mental  
23 illness.

24 There were three or four different scales. K6  
25 was one of them, and there were some others.

1 DR. McCORRY: Another one is I think the CIDI.

2 MR. GFROERER: Yes. And this was done in a  
3 household-type interview. Actually, it was done in an  
4 office setting. No, it was in a household setting. But  
5 it was done with our exact same questionnaire using our  
6 methodology. Then a clinical interview was done on these  
7 people afterwards to match it up. So it is kind of a  
8 validation. It is more I guess I'd call it a calibration.

9 So we calibrated the K6 to the results of the clinical  
10 interview to match it as closely as possible to what that  
11 clinical interview showed.

12 DR. McCORRY: And what was considered SMI? Is  
13 there a standard?

14 DR. CLARK: It's not diagnosis-specific.

15 MR. GFROERER: Well, it is basically any  
16 diagnosis, any disorder plus having an impairment within  
17 the past 12 months. The questions don't actually measure  
18 all diagnoses, but statistically in terms of the way we  
19 did that study, it matches pretty well.

20 DR. McCORRY: And the impairment was like a  
21 functional impairment?

22 MR. GFROERER: Right.

23 DR. CLARK: One last question, Gregory.

24 DR. SKIPPER: How do you define the  
25 non-medical use? How do you define that?

1           MR. GFROERER: Well, its use is not prescribed  
2 by a doctor or --

3           DR. SKIPPER: So it doesn't count people like  
4 a neighbor that took it for a headache.

5           MR. GFROERER: No.

6           DR. SKIPPER: Like if somebody got drugs from  
7 somebody else for a medical problem, would that be  
8 non-medical use?

9           MR. GFROERER: Yes. It has got to be  
10 prescription drugs. It is only prescription drugs.

11          DR. SKIPPER: To them.

12          MR. GFROERER: Used without your own  
13 prescription.

14          DR. SKIPPER: Without your own prescription.

15          MR. GFROERER: Yes.

16          DR. SKIPPER: Okay. So it wouldn't  
17 necessarily represent, all of those wouldn't be abuse  
18 necessarily?

19          MR. GFROERER: No.

20          DR. CLARK: Although theoretically it is  
21 illegal. Or actually technically it's illegal to use  
22 somebody else's controlled substance.

23                 Thank you, Joe. Once again, that was a great  
24 presentation.

25                 We move to our next speaker. We will have a

1 presentation overview of residential treatment by Deborah  
2 Trunzo, also from the Office of Applied Studies.

3 MS. TRUNZO: Good afternoon. Today I'm going  
4 to be talking about some results from the Drug and Alcohol  
5 Services Information System, otherwise known as DASIS,  
6 with some findings on residential treatment.

7 There are basically two kinds of data as part  
8 of the DASIS data sets. The first is facility data that  
9 comes from our National Survey of Substance Abuse  
10 Treatment Services, or the N-SSATS. The second is  
11 client-level data from the Treatment Episode Data Set.

12 First I'm going to describe some findings from  
13 the N-SSATS survey for you. It is conducted annually, and  
14 it is actually a census of all known substance abuse  
15 treatment facilities. That is all the treatment  
16 facilities in the nation that we're able to identify from  
17 a variety of sources.

18 It includes public and private facilities,  
19 freestanding facilities, and specialty units within other  
20 organizations, such as hospitals or mental health centers.

21 The survey collects data on facility characteristics,  
22 services offered, and the number of clients in treatment  
23 on the survey reference state. So in effect what it  
24 provides is a snapshot of treatment resources in  
25 utilization on a particular typical day in the treatment

1 year.

2                   Now for some of the data. I'm going to be  
3 presenting data from our most recent survey, which was  
4 conducted March 31st of last year. 13,454 facilities  
5 responded, saying that on that date they were actively  
6 providing substance abuse treatment services.

7                   As you can see, the vast majority, 81 percent,  
8 provide outpatient care, 27 percent said they provided  
9 non-hospital residential treatment, and only 8 percent  
10 provided hospital inpatient care. You might notice that  
11 this adds up to more than 100 percent. That is because  
12 some facilities provide more than one level of care.

13                   This slide demonstrates that this distribution  
14 of treatment services has remained pretty much unchanged  
15 since 1997. That is the year starting in which the survey  
16 was conducted in a more or less consistent manner, so I've  
17 only gone back that far. But it is an amazingly stable  
18 trend.

19                   On March 31st a year ago, there were about  
20 1,080,000 clients in treatment at all of the 13,000 plus  
21 facilities. The distribution of these clients by type of  
22 care received more or less mirrors the distribution of  
23 types of care offered by the facilities that I just showed  
24 you. Facilities reported that almost 90 percent of  
25 clients were in outpatient treatment, while about one-

1 tenth that many were in residential care. Again, this  
2 picture has remained pretty much unchanged for the past  
3 six years.

4           Now I'm going to take a look at the  
5 residential services in particular. There were 3,680  
6 facilities that reported that they offered residential  
7 services. Most of these, over 80 percent, offered  
8 long-term residential treatment, that is a treatment  
9 program lasting for 30 days or more. About half as many  
10 offered short-term treatment programs lasting less than 30  
11 days, and about one-fourth offered detoxification  
12 services.

13           This slide shows the distribution of the  
14 102,000 clients receiving residential treatment on March  
15 31st, 2004. Again, this parallels the results shown in  
16 the previous slide with most clients in long-term  
17 treatment, and about one-third as many in short-term  
18 programs.

19           In the survey, we asked facilities to indicate  
20 whether they are owned or operated by a private or  
21 government organization. About three-quarters of all the  
22 residential facilities reported that they were private,  
23 not-for-profit entities, and just 12 percent claimed to be  
24 private, for profit. A much smaller percentage of  
25 residential facilities said that they were government

1 owned, either local, state, or federal, and just 1 percent  
2 claimed tribal ownership.

3           This result surprised me, because it is quite  
4 different than the pattern for outpatient facilities.  
5 Outpatient facilities report being 55 percent private  
6 nonprofit, and 30 percent private for profit. I know that  
7 there is some interest here in faith-based treatment. We  
8 can't say for certain how many of these residential  
9 facilities are what you might call faith-based. One  
10 reason that we can't is that there really isn't a  
11 definition that we can use in our survey when it is sort  
12 of precise enough. But we do ask facilities if they are  
13 affiliated with a religious organization. I don't have  
14 that result for 2004, but in 2003, about 8 percent of the  
15 residential facilities said that yes, they were affiliated  
16 with a religious organization.

17           We also asked facilities to tell us what they  
18 considered to be their primary focus. Most residential  
19 facilities of course report that substance abuse treatment  
20 is their primary focus, but not all. Fourteen percent say  
21 that their focus is equally divided between substance  
22 abuse treatment and mental health services, and 3 percent  
23 say that mental health services is their primary focus.

24           We are asked a lot of questions about  
25 treatment capacity. In an attempt to answer these

1 questions, we asked a question that is shown here on our  
2 survey on March 31, 2004, how many of the residential beds  
3 at this facility were specifically designated for  
4 substance abuse treatment.

5           Amongst the facilities that provided an answer  
6 to that question, they reported about 125,000 residential  
7 beds, which works out to an average of 39 beds per  
8 facility. So when we divided the number of residential  
9 clients in treatment on March 31st by the number of beds,  
10 we get a utilization rate of 77 percent on that particular  
11 day.

12           Now I'm going to move onto the Treatment  
13 Episode Data Set, which is not a survey. It is a  
14 client-level database on treatment admissions. It is  
15 collected by the state substance abuse agencies from the  
16 facilities that they monitor or fund. So these are  
17 largely facilities that are receiving public funds,  
18 including federal block grant funds.

19           The states then convert their own unique data  
20 into a standard format, which they then submit to us, and  
21 we aggregate it and then are able to analyze it on a  
22 national level. It is a huge data set. We get about 1.9  
23 million records annually at this point.

24           One thing to keep in mind when I show you some  
25 of the data is that TEDS counts admissions, it doesn't

1 count individuals. So some individuals can be admitted to  
2 treatment more than once in any given year. So it may be  
3 that these numbers reflect multiple admissions for a  
4 certain proportion of the clients.

5 The TEDS data elements include date of  
6 admission, client demographics, their drug use history,  
7 and treatment variables that describe the treatment  
8 services that the client is being admitted to.

9 In 2002, the most recent year for which we  
10 have complete TEDS data, 34 percent of all admissions were  
11 to residential treatment. Like the survey results, TEDS  
12 paints a remarkably steady picture. This 34 percent has  
13 been the case since 1992, which is the first year for  
14 which we have TEDS data. There has been very little  
15 change.

16 This slide shows clients primary substance of  
17 abuse at the time of admission by the three major service  
18 categories. Here we can see how primary drug differs for  
19 outpatient versus residential versus hospital inpatient  
20 admissions. The residential admissions are more likely to  
21 report alcohol and opiates as primary substances than  
22 outpatient admissions, but less likely than the hospital  
23 inpatient admissions.

24 Also marijuana, that's the pink bar in the  
25 middle, is less likely to be the primary drug of abuse for

1 residential admissions than it is for outpatient  
2 admissions.

3 MR. DeCERCHIO: This is adults and  
4 adolescents?

5 MS. TRUNZO: Yes, it is. I'm trying to  
6 remember. Of that 1.9 million admissions in 2002, I'm  
7 trying to remember the portion that are for adolescents.  
8 I think it is somewhat less than 9 percent.

9 DR. SKIPPER: (Inaudible.)

10 MS. TRUNZO: This is primary drug. TEDS gets  
11 primary, secondary, and tertiary. This is just primary.

12 In terms of gender, there are only slight  
13 differences between the three types of service. A  
14 slightly higher proportion of residential admissions than  
15 outpatient admissions.

16 Here we can see that residential admissions  
17 tend to be somewhat older than outpatient admissions, but  
18 younger than hospital inpatient admissions. The little  
19 blue bar represents clients under 18, and the purplish one  
20 on the right represents clients 45 and over.

21 I'm looking at race and ethnicity.  
22 Residential admissions are slightly less likely to be  
23 white, and more likely to be African American and Hispanic  
24 than outpatient admissions. American Indian and Alaska  
25 Natives represent about 4 percent of all residential

1 admissions. That's the little yellow bar. Asian and  
2 Pacific Islanders, about 1 percent.

3           Looking only at residential admissions, in  
4 2002, just over half were for detoxification services, and  
5 the rest were equally divided among long and short-term  
6 residential rehabilitation. Again, long term was defined  
7 as over 30 days, and short term as 30 days or less. Once  
8 again, there has been very little change since 1992 in  
9 this distribution.

10           Looking at primary substance for just  
11 residential admissions, you can see that the pattern  
12 differs according to service with detox having a much  
13 higher proportion of alcohol and opiate admissions, which  
14 wouldn't be surprising. The short term and long-term  
15 rehabilitation having higher proportions of marijuana,  
16 cocaine, and stimulant admissions.

17           Here is gender for residential treatment  
18 services. The detox admissions tend to have a higher  
19 proportion of males. The long-term treatment admissions  
20 have a slightly higher proportion of females. Age, the  
21 detox admissions are a little bit older. There are very  
22 few detox admissions under the age of 18, and about one-  
23 fourth of the detox admissions are 45 and over.

24           Looking again at race and ethnicity, long-term  
25 treatment admissions are somewhat less likely to be white,

1 and more likely to be African American or Hispanic than  
2 other residential admissions.

3 I think a lot of these demographic differences  
4 are in fact driven by the affect of primary drug, and that  
5 the age, gender, race, and ethnicity differences are more  
6 determined by patterns and primary drug, which I'll show  
7 you in a minute.

8 Here we do have residential admissions by race  
9 and ethnicity by primary substance. You can see that each  
10 of the race and ethnicity groups shows quite a different  
11 pattern. Over 70 percent of American Indian and Alaskan  
12 Native residential admissions are for primary alcohol  
13 abuse, whereas only 35 percent of Asian and Pacific  
14 Islander admissions reported alcohol as the primary  
15 substance. This is limited to just residential  
16 admissions.

17 On the other hand, Asian and Pacific Islander  
18 admissions are the most likely to report stimulants as  
19 their primary drug, if you look at the yellow bar there.  
20 In looking at the sort of tealish, aqua-colored bars, you  
21 can see that Hispanic residential admissions are the most  
22 likely to report opiates as the primary drug.

23 To finish, I'm going to give you a preview of  
24 some of our data from the 2002 TEDS discharge data set.  
25 The bar on the left represents total discharges from all

1 treatment services. In looking at the yellow area, you  
2 can see that 42 percent of all discharges completed  
3 treatment, and another 8 percent were transferred to  
4 another level of treatment. Combined, this is 50 percent,  
5 and represents what you might call a positive end to the  
6 treatment episode.

7           The remaining 50 percent were divided between  
8 those who dropped out of treatment, that is represented by  
9 the pinkish segment, those whose treatment episode was  
10 terminated by the facility, that's the purple color, and  
11 then the little blue segment at the top is represented by  
12 death, incarceration, and other reasons.

13           If you compare this total bar to the bars on  
14 the right for the three types of residential service, you  
15 can see that discharges from residential short-term  
16 treatment have by far the highest treatment completion  
17 rate, at 65 percent. But discharges from long-term  
18 residential treatment do only half as well, with only 33  
19 percent reporting that the treatment episode was  
20 completed. Also among discharges from long-term  
21 treatment, the dropout rate equals the treatment  
22 completion rate.

23           That's all the numbers that I have for you  
24 this afternoon, but our report on all 2002 discharges that  
25 has an incredible amount of detail is going to be released

1 in about another month. So when it is, I encourage you  
2 all to have a look.

3 Yes?

4 MS. JACKSON: On this last slide, you said the  
5 other was by death or incarceration on that blue?

6 MS. TRUNZO: Yes.

7 MS. JACKSON: Wouldn't it be more appropriate  
8 to somehow detail that closer to the completed transfer,  
9 since there is no control there, and keep the dropped out  
10 terminated as the top two? Since everybody interprets  
11 completion so seriously and wants to have a higher  
12 completion rate, the ones that there is no control over,  
13 it seems a little unfair to classify that with the  
14 terminated and the dropped out.

15 MS. TRUNZO: Yes, I can do that the next time  
16 I present the slide. That other also includes sort of  
17 unknown, records that we get without reason for discharge  
18 where we don't know what to do with them. So it is kind  
19 of a mixed bag.

20 MS. JACKSON: Yes.

21 MS. TRUNZO: But certainly I can stack them in  
22 order.

23 MS. JACKSON: But if it is indeed, because we  
24 do have a certain number of people who end up being  
25 incarcerated or something like that, then that is a

1 non-control issue.

2 MS. TRUNZO: Another thing I might do next  
3 time is actually split those out.

4 MS. JACKSON: Split that out, yes. Thank you.

5 DR. SUCHINSKY: Do you have any data on the  
6 percentage of all patients who are in treatment who  
7 receive a residential period of treatment during the year?  
8 Obviously it would be more than 10 percent, but do you  
9 have any data which imputes that number?

10 MS. TRUNZO: No. Not all the data that we get  
11 has the unique client ID. We'd have to be able to link  
12 treatment episodes and figure that out. We haven't even  
13 attempted that yet. We are just starting to look at  
14 whether or not the ID that we get with the data would  
15 permit that. But that would be something we'd like to do  
16 eventually.

17 DR. SUCHINSKY: The other question I have is  
18 on the occupancy rates of the residential programs, do you  
19 have any data on the number of programs that had  
20 occupancies of 90 percent or above?

21 MS. TRUNZO: Yes. Yes, I had a slide on that  
22 and I took it out because I thought I was going to be  
23 going on for too long. I can't remember what the result  
24 was.

25 But if you look for the 2003 survey, that data

1 is out on the web. If you look at the SAMHSA website  
2 under statistics and data, and then under N-SSATS, the  
3 2003 report will have the utilization rate in categories  
4 of 90 to 100 percent, I think, and then it is 51 to 90  
5 percent and so forth. Anyway, it will provide some  
6 insight on that.

7 Yes?

8 DR. MADRID: One question. Do you all have  
9 any data on success at follow-up on treatment completions  
10 versus dropouts?

11 MS. TRUNZO: No, we don't.

12 DR. McCORRY: I think this follows up on  
13 Richard's question. That 77 percent utilization rate,  
14 have you run that data dropping out the detox beds? It  
15 looks like the system is overbedded.

16 MS. TRUNZO: Unfortunately, the way we collect  
17 the data, we can't just distinguish the detox beds from  
18 other residential treatment beds.

19 DR. McCORRY: How are you able to compute the  
20 other statistics then?

21 MS. TRUNZO: We asked for the number of  
22 clients in detox in long term and in short term on March  
23 31st. But then when we asked for the number of beds, it  
24 is for all the residential clients in the facility. I  
25 mean, for the entire facility. So we don't ask them to

1 tell us their number of detox beds.

2 DR. McCORRY: Because I'd hate to be  
3 delivering a message that we have 28 percent, 23 percent  
4 underutilized in residential if essentially it might be a  
5 problem of not closing inpatient detox beds, which tends  
6 at least in New York, tends to still be overbedded,  
7 because they are pretty good cash producers.

8 MS. TRUNZO: Right. No, our instrument is not  
9 that precise. However, we are doing a redesign in 2006,  
10 so I'll take into consideration your comment, because we  
11 want the data to be useful.

12 DR. CLARK: Last question, Melody.

13 MS. HEAPS: I would more than strongly urge  
14 you to do that. I think Frank's comments are important.  
15 I think there is a bit of a devastating impact that that  
16 number will have. We are dealing with treatment waiting  
17 lists in Illinois.

18 If someone got hold of that, if Congress got  
19 hold of that, I think it is a very, very serious question  
20 that people would say, what is the problem here? You are  
21 underutilizing it, and it will have economic impacts.

22 The other thing, I mean, I have to tell you I  
23 have some concerns about what I'm seeing. I think that we  
24 ought to be concerned about it. I'm not suggesting the  
25 data is not good, I think it is, but the successful

1 completion of long-term residential when so much of our  
2 money is going into long-term residential, clearly these  
3 are harder clients, I understand that. But I'd like to  
4 look at that, if you could look at that, because that is  
5 another piece of data that when it gets out there, gets  
6 interpreted in ways which say long-term residential care  
7 does not work. That is what the data shows.

8           So I hope you are thinking in those terms  
9 about now it may be that we need to look at that issue.  
10 I'm not saying we shouldn't look at it. But a 33 percent  
11 success rate compared to the others is not a good success  
12 rate. Even though I know it, even though I could have  
13 told you that, it is still not good. We need to look at  
14 that.

15           DR. CLARK: All right.

16           Val, you're the absolute last one.

17           MS. JACKSON: I'll be quick. Following up,  
18 though, I think Melody made a very important point. The  
19 question would be in your redesign to look at what is the  
20 completion rate. How are you measuring the completion  
21 rate? Go ahead.

22           MS. TRUNZO: Yes, the data on completion  
23 doesn't come from the survey, it comes from this Treatment  
24 Episode Data Set. That is the administrative data that we  
25 get from the states. So it isn't really subject to

1 redesign, in that that is what the state sent us.

2 MS. JACKSON: Okay. We do our completion  
3 rates in Florida, and they are certainly not even close to  
4 what you're reporting. I mean, they are much higher, the  
5 completion rates.

6 MS. TRUNZO: Yes. This is an aggregate of all  
7 the states that are reporting. It varies from state to  
8 state.

9 MS. JACKSON: But if the states are only  
10 reporting by, for instance, X number of days or when there  
11 was graduation day, I mean, it is so complex, it is so  
12 much more than that. We are giving a very misleading  
13 picture.

14 MS. TRUNZO: This was just one piece of the  
15 data. We have other information on average length of  
16 stay, median length of stay in terms of days in treatment.  
17 So there is a lot more to balance out and round out the  
18 picture. That will be in this upcoming report.

19 DR. CLARK: Thank you, Deborah.

20 (Applause.)

21 DR. CLARK: We were supposed to have a break.  
22 We've got two more presentations. What is the will of  
23 the council? All right. Let us proceed.

24 Our next speaker will be Joan Dilonardo, Dr.  
25 Joan Dilonardo from Division of Systems Improvement

1 Organization and Financing Branch. She will give us an  
2 overview of residential treatment in CSAT's discretionary  
3 portfolio.

4 DR. DILONARDO: So I heard in using science,  
5 bridging science, I heard that the things that you  
6 practice when you're younger stay with you when you're  
7 older. So I'm recovering from some foot surgery, and I'm  
8 practicing the use of a cane. I expect when I'm 85 and I  
9 need a cane, I will be really, really good at this.

10 What I'm going to talk to you about today is  
11 what we know about residential services in the  
12 discretionary portfolio that CSAT funds. My folks who run  
13 the data system for us, for the discretionary grantees,  
14 put this presentation together for me. That's Deepa  
15 Avula, Kevin Mulvey, and Pat Roth. Pat is going to work  
16 the slides, and Deepa is going to answer the technical  
17 questions.

18 MS. HEAPS: Joan, do we have copies of these  
19 yet?

20 DR. DILONARDO: Do you have copies? They're  
21 in the book. I think we added one, so that one is just  
22 coming out.

23 I'm going to try to go through this quickly.  
24 I don't think there are any big surprises. I know that  
25 this is in response to the interest that the council

1 expressed before in terms of what are we doing about  
2 residential treatment within the discretionary portfolio.

3 Let me first remind you of a couple of things.

4 The discretionary portfolio are sort of a variety of  
5 announcements, mostly under the rubric of Targeted  
6 Capacity Expansion, which for the most part, and that is  
7 what is represented in these data, are for people to apply  
8 for grants to serve underserved populations.

9 Now, sometimes it may be a population that is  
10 rural, sometimes we may change it and shift it to like we  
11 have an announcement out now as part of TCE, one of the  
12 populations is college students. So to a certain extent,  
13 the people that are in our portfolio are a result of what  
14 we put out in the announcements, and also a result of who  
15 applies and wins.

16 We don't have enough data to really start  
17 looking at trends and differences over time. We expect to  
18 do that later on, but I'm just telling you, so it is not  
19 representative of anyone, but who applies to and when CSAT  
20 grants.

21 The other thing I want to point out to you is  
22 although we are certainly beginning to work on bringing  
23 our data together across SAMHSA, the kind of data that I'm  
24 presenting to you are different than what Deborah  
25 presented to you from TEDS where she talked about what

1 TEDS has is mostly admissions. We don't have admissions,  
2 we have people. We are actually moving to getting both  
3 people and admissions, so it is somewhat different.

4           For those of you who aren't aware of this,  
5 this particular system is a web based reporting system,  
6 grantees who get our money to provide services or best  
7 practices activities have certain kinds of GPRA data that  
8 they have to report. The data is supposed to be in the  
9 system within seven days of the person being seen. So it  
10 is a live, active system. The numbers change each day.  
11 It is what it is.

12           Currently we have in the whole portfolio, 508  
13 discretionary services grants. So those are the grants  
14 providing services to people. The grants are funded to  
15 target varying populations, generally populations which  
16 are underserved and vulnerable, including adolescents,  
17 minority groups, women, pregnant, postpartum and parenting  
18 women, homeless individuals, those affected with HIV or  
19 AIDS, those with co-occurring mental health substance  
20 abuse disorders, persons in recovery, or other underserved  
21 groups.

22           Our grants go to a wide variety of people.  
23 Sometimes they go to a state, county, or city, and then  
24 onto providers. Some of them go directly to providers.  
25 In the end, the services that are provided are a wide

1 variety of things, including outpatient treatment  
2 services, intensive outpatient services, outreach,  
3 methadone maintenance, recovery support, as well as  
4 residential treatment services. So residential treatment  
5 is just one of the kinds of services we fund through our  
6 discretionary portfolio.

7           Currently there are two programs at CSAT which  
8 require grantees to provide residential treatment  
9 services. The first of those was a grant announcement  
10 that focused on adolescent residential treatment and  
11 supports residential treatment services for  
12 substance-using adolescents. There are currently 17  
13 grants in that part of the portfolio.

14           Another portfolio which requires residential  
15 treatment be provided is the pregnant, postpartum, and  
16 parenting women portfolio, which support residential  
17 services for pregnant women. That program currently funds  
18 20 grants.

19           Then we have all of the other kinds of grants  
20 where people write in and say, to serve this part of the  
21 population, I want to provide this kind of a service. I'm  
22 getting ahead of myself. We have people that provide just  
23 residential services, and then we have people that provide  
24 residential services as well as other kind of services.

25           We have some grantees that come in and propose

1 sort of a service with residential stepping down to  
2 something else. We have people who provide services, say  
3 intensive outpatient and residential. They take patients  
4 in and they assign them to what is needed.

5           So for the residential services only, we have  
6 besides the two portfolios, the 37 grants that are  
7 adolescent and the pregnant and postpartum women grantees,  
8 we have a couple of other grantees who are providing  
9 residential services only. That totals only about 9  
10 percent of all the grantees in the discretionary program.

11 The other ones are sort of all over the map. A couple of  
12 HIV programs, a couple of TCE general programs, and some  
13 homeless programs.

14           Then as we go onto the grantees who provide a  
15 combination of modalities that include some residential  
16 treatment, we have another 115 grantees who provide  
17 residential treatment in addition to one or more other  
18 modalities. So those grantees compromise about 23 percent  
19 of all of our grantees in the discretionary portfolio.  
20 So about one-third of our grantees are providing some  
21 residential services.

22           For the people that are combining residential  
23 with something else, the most requested thing that it is  
24 combined with is outpatient treatment. But we also have  
25 people providing residential with intensive outpatient,

1 and then also outreach and then residential.

2           The residential programs are located all over  
3 the country. This is the piece of paper you just got  
4 today. The highest number is in California, and you'll  
5 see substantial numbers of residential programs also in  
6 Florida, Massachusetts, Texas, the larger states, as well  
7 as nine residential programs.

8           Now I'm going to switch gears a little bit and  
9 talk about the patients. Our data show that only 12.2  
10 percent of all the patients served under our discretionary  
11 grants have received residential treatment services.  
12 Targets, that is the number of people to be served, which  
13 are proposed by grantees in their applications providing  
14 residential services, are generally lower.

15           So if we have grants for \$500,000 and you come  
16 in and you apply for outpatient services, the likelihood  
17 is that with that money, you'd be proposing to serve a  
18 larger portion of patients, whereas typically people who  
19 are proposing residential services propose to serve a  
20 smaller number of people relating to the larger costs for  
21 residential services.

22           In general, we looked at how many weeks of  
23 residential services the patients in our portfolio are  
24 getting. Unfortunately, we didn't look at treatment  
25 completion, although after listening to Deborah's

1 presentation, that's something we'd certainly want to go  
2 back and do.

3           We don't use distinctions in our portfolio  
4 like short and long term. These data represent actual  
5 lengths of stay, not planned lengths of stay. You can see  
6 that if you want to use the rubric that long term is more  
7 than 30 days, that we have a large portion of patients who  
8 are staying in residential treatment for long term. Only  
9 about 30 percent are exiting residential treatment within  
10 one to five weeks.

11           The other lack of comparability in the data  
12 that Deborah was presenting to you from TEDS and these  
13 data is that we have very few detox of any things going on  
14 in the discretionary portfolio. Generally we don't get a  
15 ton of applications proposing to provide detox, and so we  
16 don't fund it. We might have maybe one in the entire  
17 portfolio of 508.

18           So we see patients that are staying quite a  
19 length of time. I was pleased when I saw this. If you  
20 look at the research, people that are staying in treatment  
21 longer than 90 days have a better outcome, so I'll be  
22 interested in looking at that. I didn't bring the outcome  
23 data today, but we can certainly look at that if you all  
24 are interested in it next time.

25           In addition to receiving these weeks of

1 residential service, about 70 percent, just slightly more  
2 than 70 percent of all these folks who get some  
3 residential services also get case management services,  
4 and then about 20 percent of them also get outpatient  
5 services, and then it goes about 10 percent get outreach  
6 in addition to their residential services.

7           We did look a little bit at the demographics  
8 and drug use characteristics of the people getting  
9 residential services within the discretionary portfolio.  
10 A surprise to me, more men than women. I thought it might  
11 be largely populated by pregnant and postpartum women, but  
12 that is not the case. We looked at why that was. Was it  
13 mostly criminal justice, GFAs, or other kinds of  
14 announcements contributing to that? The answer is no, it  
15 is just no across the board.

16           In terms of folks getting residential  
17 treatment in terms of their race or ethnicity, you see  
18 that these are really not that different than the overall  
19 sort of race and ethnic profile of our discretionary  
20 portfolio period. There is one difference in that there  
21 is a larger percentage of American Natives and American  
22 Indians getting residential treatment. But largely really  
23 not that different, which I thought was a good thing to  
24 see.

25           MR. DeCERCHIO: But it is different than the

1 other slides on other presentations in terms of the  
2 overall TEDS data. So the fact that this is targeted  
3 capacity targeting certain populations, it is 42 percent  
4 or 48 percent, which is like 32 and 26 percent before.

5 DR. DILONARDO: Right.

6 MR. DeCERCHIO: So in that respect, it is very  
7 different.

8 DR. DILONARDO: It's very different than the  
9 national benchmarks. It's very different from TEDS. It  
10 is also very different from what was the sample developed  
11 in the alcohol and drug services survey, a nationally  
12 representative sample. I have that slide in a couple of  
13 slides.

14 This slide represents the age distribution of  
15 folks getting residential. Again, 15 percent of  
16 adolescents, but it is not 50 percent adolescents, it is  
17 15 percent. It somewhat mirrors what you normally see or  
18 often see as a distribution.

19 Speaking to the point that Ken just brought  
20 up, what this slide shows is the comparison of the  
21 demographic characteristics of folks in the discretionary  
22 portfolio who get some residential and the folks in the  
23 discretionary portfolio who don't get residential. So all  
24 the other people in our discretionary portfolio get  
25 outpatient or something other than residential, as well as

1 TEDS. And then also the distribution in ADSS for  
2 residential. So it is a little bit different. But still,  
3 you see significantly our residential doesn't look that  
4 different from our non-residential. We are basically  
5 serving the same kinds of people within the discretionary  
6 portfolio and residential, except that we're serving a  
7 larger proportion of American Indians and American  
8 Natives, and a slightly smaller proportion of blacks. But  
9 it is hardly remarkable.

10           The differences between the discretionary  
11 portfolio and who is served by the discretionary portfolio  
12 in terms of their demographic characteristics are  
13 significantly different than what we see in the TEDS data,  
14 and also significantly different than what we see in the  
15 ADSS data.

16           Lastly, I'm going to go onto this slide. This  
17 is not the primary drug abuse kind of variable that  
18 Deborah showed you in the TEDS data. This is we asked  
19 people, we take them through a long, lengthy lists of  
20 drugs. You can just see for discretionary residential,  
21 alcohol is the first drug most frequently mentioned,  
22 cocaine is the second, onto marijuana. Whereas there is a  
23 little bit of difference in the discretionary  
24 non-residential clients who mention alcohol most often,  
25 marijuana most second, and cocaine shortly after

1 marijuana. There is a slight change in the ordering in  
2 that.

3           So if you can take home anything from this, in  
4 the non-residential portion of the CSAT discretionary  
5 portfolio, we are seeing more people, slightly more  
6 people, with marijuana than you see in the other sort of  
7 distributions. People with problems with cocaine are more  
8 likely to be in residential treatment in a discretionary  
9 portfolio than in the non-residential part of the  
10 discretionary portfolio.

11           So basically going the same place we went  
12 before, which is that in the discretionary portfolio,  
13 CSAT's residential portfolio, we are basically treating  
14 very similar kind of populations that we treat in the rest  
15 of our discretionary portfolio. But the population is  
16 more diverse and more minority than seen in TEDS or ADSS.  
17 We are also serving more women in the discretionary  
18 portfolio than you see in TEDS or ADSS. We are serving  
19 more Hispanics, and in general, more minorities.

20           As we go down the road with these data, and as  
21 our data become better and better, we actually want to  
22 look at sort of a predictive model to look at what is the  
23 contribution, what are the things that get you into  
24 residential treatment, what are the things most likely to  
25 get you into residential treatment in our portfolio, and

1 then also look at and try to follow up on what Deb was  
2 talking about before in terms of how treatment completion  
3 does or doesn't predict outcome, and how that relates,  
4 what the treatment completion outcome looks like in the  
5 discretionary portfolio in comparison to the TEDS  
6 portfolio would be a really interesting comparison I think  
7 to make.

8                   Comments? Questions?

9                   MS. HEAPS: It seems to me that you are doing  
10 what you are supposed to be doing. The data shows that  
11 you're doing what you are authorized to do. So  
12 congratulations.

13                  DR. DILONARDO: And we all said look at this,  
14 isn't this great.

15                  MS. HEAPS: Congratulations. It doesn't  
16 always happen.

17                  DR. DILONARDO: Thanks. Well, and also  
18 recognize that we have these data because our grantees,  
19 although we require them to do this, they actually collect  
20 and send the data to us. So I would also like to  
21 recognize all of the work that all of our grantees do in  
22 sending the data in and in dealing with us about data  
23 issues, questions, and problems.

24                  The grantees have really come around and have  
25 made a tremendous number of changes in a short period of

1 time. So without that, we wouldn't be here.

2 DR. CLARK: Thank you.

3 I'd also like to acknowledge the staff of DSI  
4 who work with the grantees to we make sure we get the data  
5 in. I periodically look at the SES data and harass people  
6 about why is this program performing so poorly, yada,  
7 yada, yada.

8 DR. DILONARDO: And he occasionally does  
9 sprinkle in a positive. I'm glad to see these grantees  
10 really doing well.

11 DR. CLARK: But the key issue is we have a  
12 mechanism by which we can do near real-time monitoring of  
13 performance, and so we don't have to wait six months  
14 before we discover whoops. That's the key issue.

15 We've got one more presentation. That is Joe  
16 Faha, who has graciously consented to return. We were  
17 supposed to hear from him earlier, but because of the  
18 scheduling, he was unable to present. He is going to give  
19 us a legislative update.

20 MR. FAHA: Good afternoon. Cynthia asked me  
21 on the way down here, she asked me if I would give her a  
22 small bio. So I provided one, but they didn't use it.  
23 They said basically he's tall, dark, handsome, able to  
24 jump tall buildings with a single bound, faster than a  
25 speeding bullet. They chose not to use that.

1 (Laughter.)

2 MR. FAHA: I also am pleased -- although I was  
3 supposed to present this morning, unfortunately the  
4 calendar got a little stretched, so I wasn't able to do  
5 it. But George Gilbert was kind enough to give me a call  
6 and say, "Can you show up at 3:15. They were unanimous in  
7 wanting you to come and talk." I said, "Thank God,  
8 because if somebody objected, I would not have come."

9 (Laughter.)

10 MR. FAHA: My role here today is to just give  
11 you a flavor as we start the 109th Congress about what is  
12 currently going on on the Hill. First I'm going to do a  
13 little bit of discussing about how the personnel members  
14 are shifting and what is happening with regard to various  
15 committees. We'll talk a little bit about that and what  
16 the repercussions are and share with you the current state  
17 of lack of resolution of what the assignment is going to  
18 be. Then maybe a couple of issues, and if you have any  
19 questions, by all means, feel free.

20 Melody, you and I have met over a hearing in  
21 which you testified, along with Charlie. I don't believe  
22 I've had the opportunity to meet everybody else, but  
23 hopefully before the end of the day, and certainly before  
24 you leave this council.

25 Let's start with appropriations, because that

1 is always the most important it seems to me. We have a  
2 lot of discussion about authorization and policies and  
3 what we can and cannot do. The push is in the  
4 appropriations. So I want to give you first a breakdown  
5 as to what is happening on the various committees.

6 First of all, Mr. Stevens from Alaska has  
7 resigned as chairman of the Appropriations Committee in  
8 the Senate, largely because he has been in that seat for  
9 six years, and the Republicans adopted a six year and then  
10 out along with their Contract with America back in 1994.  
11 He gave up his seat in favor of Mr. Thad Cochran from  
12 Mississippi. So you will start seeing in our budget  
13 discussions in the future less money going to Alaska, and  
14 more money going to Mississippi.

15 (Laughter.)

16 MR. FAHA: Be assured of it.

17 Over on the House side there was a  
18 considerable debate over three people potentially taking  
19 over the chairmanship from Mr. Young from Florida, who  
20 also served his six years out. Ken I'm sure knows him  
21 very well, in that he served his six years, and instead is  
22 now going to become chairman of one of the subcommittees.

23 It was between three people. Ralph Regula,  
24 who has been our chairman of our Labor-HHS-Ed Subcommittee  
25 and Appropriations, Jerry Lewis, who had been the chairman

1 of the Defense Appropriations, and Harold Rogers, who was  
2 Homeland Security chairman. The end result was that the  
3 leadership chose to give it to Jerry Lewis from  
4 California.

5 Is there anybody here from California?  
6 Anybody particularly from San Bernardino area? No?

7 MR. DONALDSON: Los Angeles, Orange County.

8 MR. FAHA: All right. If you know anybody in  
9 San Bernardino, they're important to us. That is his  
10 district. That is who he represents.

11 I'll talk about organization right now, and  
12 I'll explain to you why it is that they have not made a  
13 lot of decisions. Mr. DeLay put in a proposal as part of  
14 the Republican leadership in the House to reduce the  
15 number of subcommittees from 13 to 10. Now, you have to  
16 understand this. There is a lot of logic to this.

17 Programs that are of like mind are finding  
18 themselves being brushed aside because they're not the  
19 most important program. His interest was in NASA, as an  
20 example, and NASA was not being considered appropriately,  
21 he felt, in the subcommittee in which they were assigned  
22 to. So he set out to suggest and recommend.

23 What that meant was that they referred to them  
24 as appropriation cardinals, very powerful positions in the  
25 House and in the Senate, were going to lose their jobs.

1 So this became a real political concern. There was enough  
2 push back that he has basically abandoned that. However,  
3 there is a commitment on Jerry Lewis's part, and I can  
4 only assume that it was part of the deal to get him to  
5 become chairman, that there would be a reorganization. He  
6 is currently going through a discussion with all of the 13  
7 cardinals about what moves can happen from one  
8 subcommittee to another subcommittee in a hope that he  
9 will either reduce, that is one possibility, reduce the  
10 number of subcommittees, but certainly rearrange  
11 responsibilities.

12 Now, this is going to cause a lot of havoc  
13 because the Senate, Mr. Cochran, has already said he's not  
14 interested in changing. So in the political process, you  
15 run into a problem where you have a subcommittee on the  
16 House side that is going to deal with example, Commerce,  
17 Justice, Labor-HHS, but a subcommittee over on the Senate  
18 side that only deals with Commerce and Justice, and they  
19 are supposed to sit down with each other. One has a bill  
20 that covers Commerce and Justice, the other one has a bill  
21 that covers commerce, Justice, Labor-HHS, and they have to  
22 conference those.

23 So it causes some future problems politically  
24 for them, and they're going to have to work this out. In  
25 the meantime, that means that the chairmanships of all the

1 subcommittees have not been decided yet. So while Mr.  
2 Regula is the probable chairman of Labor-HHS-Ed, it has  
3 not been decided yet. Nor have we found out whether or  
4 not his subcommittee will lose jurisdiction over certain  
5 programs, be added, or have additional responsibilities.

6 So all of that is up in the air. Until that's  
7 resolved, they can't move ahead, they won't move ahead.  
8 I'm talking in terms of hearings.

9 Continuing with the House. Given that, Mr.  
10 Lewis has promised to have all the bills done on the floor  
11 by June, which would be huge. Just to tell you that the  
12 Labor-HHS bill didn't pass last year in the House until  
13 September. So that means that they'd have to do a hell of  
14 a lot of work about a bill that has an enormous amount of  
15 implication, very costly, very controversial, being done  
16 roughly in three and a half months. That is quite a  
17 challenge.

18 In the Senate side, they are less prone. Mr.  
19 Cochran has said, you know, I kind of like things the way  
20 they are, and we're going to leave this alone. Which  
21 would mean Mr. Specter and Mr. Harkin will continue as  
22 chairman and ranking member of our subcommittee on  
23 Appropriations, and both of whom have been very generous  
24 to SAMHSA in the past, and we would hope would continue to  
25 be generous to us in the future. But we have to wait for

1 all of this to settle down.

2           Hearings in the appropriations process only  
3 occur on the House side. The Senate gave up jurisdiction  
4 of holding hearings a long time ago when Mr. Harkin was  
5 chairman and he was running for President, and all of a  
6 sudden we didn't need all these hearings because he needed  
7 the time to be running. When they gave it up then, they  
8 never pulled it back. So there are no Senate hearings  
9 typically. They occur in the House. Staff in the Senate  
10 come over and listen to the debate.

11           This year it is very likely that our hearing  
12 will be late March or early April. It will also probably  
13 be similar to the one we had last year where Charlie  
14 appeared with the Directors of NIMH, NIAAA, and NIDA.  
15 That hearing was probably one of the best appropriation  
16 hearings I have ever gone to. If any of you were here for  
17 it, you would have heard considerable and intelligent  
18 conversation about substance abuse and mental health  
19 issues, both prevention and treatment, and the interplay  
20 between science and services. It really was probably the  
21 best hearing I have been to. Therefore, it is likely it  
22 will be repeated.

23           What is our outlook this year? If anybody  
24 listened to the news or read the paper this morning,  
25 you'll see that the federal government has declared there

1 was a deficit in '04 of \$412 billion, and that the  
2 projected deficit in '05 is \$427 billion, \$412 billion  
3 having been the highest deficit that we have ever run in  
4 one year, and now we're closing in on this year being \$427  
5 billion. That's just the deficit, it is not the debt.  
6 The debt is well over several trillions of dollars that we  
7 owe.

8           The President is getting an enormous amount of  
9 pressure from conservatives to pull back. Let's conserve,  
10 we need to cut. In addition, he is coming forth with a  
11 bill for another \$80 billion for Iraq and Afghanistan. So  
12 I'm just laying the work here that every year, and again  
13 this year, we are going to face some monumental mountains  
14 that we're going to have to get over from a funding  
15 standpoint.

16           So you can probably expect that the '06 budget  
17 is going to reflect this concern for all agencies. This  
18 is just a general comment. You're going to see Congress  
19 and Mr. Lewis, especially, be very conservative about  
20 funding opportunities for '06.

21           Any questions about that before I move onto  
22 the other side of our Hill responsibilities?

23           (No response.)

24           MR. FAHA: Such uplifting information, wasn't  
25 it? I figured as much.

1           With regard to authorization, now the other  
2 side of the picture with regard to the Hill is that they  
3 also give us the authority to do what it is that we do. I  
4 need to put this in context.

5           General Motors is free to do what it wants to  
6 do unless the law says they can't. The federal government  
7 is only free to do what the law says it can do. So the  
8 law is very important to us, because it defines who we  
9 are. We try to make sure through our authorization  
10 process that we have the statutory language that permits  
11 us to do what we want and need to do.

12           If it gave us authority to make ice cream, we  
13 could make ice cream. But we can't make ice cream right  
14 now. We're not authorized to make ice cream. If they  
15 gave us authority to make ice cream with chocolate  
16 sprinkles, we can make ice cream with chocolate sprinkles,  
17 but we can't put strawberry sprinkles on it.

18           So that is the kind of thing that we have to  
19 be very careful about in dealing with the authorizers. In  
20 that case it is the Senate Health, Education, Labor, and  
21 Pensions Committee that has jurisdiction over our  
22 programs. In the House, it is the Committee on Energy and  
23 Commerce.

24           The Health Committee is now being taken over  
25 by Senator Mike Enzi from Wyoming, as opposed to Judd

1 Gregg from New Hampshire. This is quite a shift. Mr.  
2 Gregg was against any kind of legislative action. There  
3 were very few mark ups in his tenure as committee chair,  
4 and he refused basically to have any discussions about  
5 health policy and health legislation unless it was  
6 desperately needed, and he needed to be convinced that it  
7 was desperate. So there wasn't any casual conversations  
8 about bills to pass to do this, that, or the other thing.

9           Mr. Enzi is being joined on the Republican  
10 side by several new members. Mr. Frist will continue to  
11 serve, Mr. Alexander from Tennessee will continue, Mr.  
12 Gregg will still be on that committee, and Mr. DeWine from  
13 Ohio will continue to serve on that committee. Mr.  
14 Roberts from Kansas, Mr. Sessions from Alabama, and then  
15 Mr. Ensign from Nevada. Then we have three new members  
16 who are taking the places of Senators Warner, Bond, and  
17 Graham. Mr. Hatch returns to the Health Committee, Mr.  
18 Hatch being from Utah, and Mr. Burr, Richard Burr, a new  
19 Senator just elected from North Carolina will be on that  
20 committee, along with Mr. Isakson from Georgia will serve  
21 on that committee.

22           The Democrats will remain the same. They lose  
23 one seat on that committee, but that seat was held by John  
24 Edwards who has resigned, as we all know. That seat will  
25 not be filled because they in essence lost a percentage.

1 They have been reduced from what is it, 49 to 45 percent,  
2 and as a result, they lose a seat on that committee.  
3 That, just to remind everybody, includes Senators Kennedy,  
4 Dodd, Harkin, Mikulski, Bingaman, Murray, Reed of Rhode  
5 Island, Clinton from New York, and Jeffords as an  
6 independent sides with the Democrats.

7           They have reorganized the committee. Mr. Enzi  
8 has reorganized it completely. There were four  
9 subcommittees. There still remains four subcommittees,  
10 but the Subcommittee on Substance Abuse and Mental Health  
11 is gone. It has been taken away. Instead we have four  
12 subcommittees, basically one on bioterrorism and public  
13 health, another one on aging and pensions, one on  
14 education and early childhood development, and a fourth on  
15 labor.

16           Historically the chairmanships of  
17 subcommittees have gone to senior members, yet two  
18 freshman Senators will be chairing two of these four  
19 subcommittees. Mr. Burr from North Carolina will chair  
20 the Subcommittee on Public Health. Mr. Isakson is taking  
21 over the one on labor. They are both freshmen. Highly  
22 unusual.

23           However, one would assume that our issues, and  
24 all public health issues, would fall under Mr. Burr's  
25 jurisdiction. No, not quite. Mr. Enzi has decided that

1 all public health issues will reside in the authority of  
2 the full committee, not the subcommittee. So that all  
3 hearings about public health issues will happen before the  
4 full committee, not the subcommittee. That includes  
5 substance abuse and mental health.

6           You should be aware that when he sent out his  
7 summary of responsibilities for the full committee and  
8 all of the subcommittees, mental health and substance  
9 abuse were not mentioned at all. So it tells you where  
10 substance abuse and mental health are in priority  
11 listings.

12           Do we know what their agenda is going to be?  
13 No. We'll get to some of our hopes in a second. In the  
14 House, Mr. Barton, Joe Barton from Texas, is now the  
15 chairman of the Energy and Commerce Committee, having  
16 taken over from Mr. Tauzin when he left to become a  
17 lobbyist. Mr. Barton is thinking seriously about redoing  
18 a lot of the organization of that committee. So that  
19 where we had a Subcommittee on Health, which is where we  
20 were for jurisdictional purposes, he is seriously thinking  
21 about changing the subcommittees and changing the scope of  
22 responsibilities. Those decisions have not been made yet,  
23 so we're still up in the air. Nevertheless, who will  
24 continue as chairman and ranking members?

25           So structurally you can see what kind of

1 disarray we currently have right now in terms of trying to  
2 understand what is going to happen in Congress. If you  
3 don't know who the players are and what their interests  
4 are, then you can't figure out where to go.

5 So let me set that aside, unless somebody has  
6 a discussion about that, and talk about some things that I  
7 know will happen.

8 MR. DeCERCHIO: What's the time frame? Is  
9 SAMHSA's reauthorization overdue and you want an  
10 extension? Or is that coming up?

11 MR. FAHA: Yes, that's exactly where I was  
12 going to go. So unless there is an organizational  
13 question from anybody else, let's go there, let's start  
14 there.

15 SAMHSA seems historically to get a three year  
16 reauthorization every 10 years. We were authorized from  
17 1992 through 1995, and then we were unauthorized until  
18 2000. Currently our programs are unauthorized as of the  
19 end of fiscal year 2003. So we are entering 2005, which  
20 is our second year without authorization.

21 What does that mean? This is not critical,  
22 folks. Despite the fact that we were not authorized, we  
23 still got a lot of money in '04, and we got a lot of money  
24 in '05. What it basically means technically is that every  
25 authority, regardless of which one you look at, let's say

1 the one for pregnant and postpartum women, Section 508 of  
2 the Public Health Service Act, the last section of it says  
3 authorization of appropriation.

4           It says they are authorized to be appropriated  
5 for fiscal year 2001, \$10 million, and such sums for  
6 fiscal year 2002/2003. Reauthorization means you say they  
7 are authorized to be appropriated for fiscal years 2005,  
8 \$10 million, and such sums as are needed for 2006, 2007.  
9 When you have done that, you have reauthorized the  
10 program.

11           So from a technical standpoint, it doesn't  
12 mean much. However, you need to appreciate it is the only  
13 time that you get to have a policy discussion with  
14 Congress around those policies that you need to talk about  
15 so that you can do what you want to do.

16           So reauthorization should not be looked at  
17 from a budget/appropriation perspective. It is not  
18 needed. We don't need it. What we do need is if we want  
19 to move ahead in a direction that the current statute  
20 limits us from, we want to have that discussion with  
21 Congress so that we can get the authority to do it.  
22 That's what reauthorization presents us with.

23           From a political perspective, if you do not  
24 have an agenda, if you do not have policy concerns, then  
25 politically you are better off staying out of the fray,

1 because you may get something you don't want. Guaranteed  
2 you'll get something you don't want.

3           So if you don't have an agenda, if you don't  
4 have a need, then politically you just kind of pull back  
5 and let them set the agenda. You don't push it, you let  
6 them have it, and just hope that you remain safe.

7           MS. BERTRAND: The Substance Abuse  
8 Subcommittee that you talked about a minute ago that you  
9 said was taken away, can you talk about that a little bit?  
10 Is that the same committee that Congressman Jim Ramstad  
11 developed, or is that different?

12           MR. FAHA: You're talking about two different  
13 things. Let me just finish this thing on reauthorization.  
14 Let me finish this story, and then get right back to your  
15 question, if that would be okay. Notice I call it a  
16 story.

17           So the question is does SAMHSA have a  
18 tremendous need. As of right now, no. We have a lot of  
19 things that we would be able to change, but I don't know  
20 that there is something flagrant out there of what I refer  
21 to as critical mass that would generate a need to have  
22 reauthorization.

23           Having completed that, is it going to happen  
24 in the Senate? Not clear. Until Mr. Enzi sets his  
25 priorities, I have no clue. We do know that in the House,

1 Mr. Barton feels it very important that he reauthorize the  
2 agencies under his jurisdiction. So we are on the queue  
3 on the House side. However, we are behind several others.  
4 Notably, NIH, which is expected to be first on the queue,  
5 and then Ryan White. So as I said, we are in the queue,  
6 we just don't know if and when it is going to come up.

7 To get to your question. The Subcommittee on  
8 Substance Abuse and Mental Health, which was a  
9 subcommittee of the Senate HELP Committee, full committee,  
10 was chaired by Mr. DeWine and several other Republicans,  
11 Mr. Reed, and several Democrats were on that subcommittee.  
12 They focused purely on substance abuse and mental health  
13 issues. That is a subcommittee of the full committee.

14 What Mr. Ramstad has set up, along with Mr.  
15 Patrick Kennedy, is a caucus, which is basically a group  
16 of members of the House who are interested in substance  
17 abuse issues. That is what that is. They have no power.

18 It is just those of like mind who get together to talk  
19 about, discuss, plan, see if they can coordinate efforts  
20 on substance abuse issues.

21 I don't mean to belittle it. It is important.

22 Mr. Ramstad, the last time we gave a presentation on a  
23 National Household Survey, he stayed for the whole hour  
24 and a half personally asking us questions, showing his  
25 commitment to this issue. Unheard of that a member of

1 Congress spends that much time and energy on this issue.

2 I hope that explains the difference.

3 Other issues that are going to come up.

4 Buprenorphine and getting rid of the 30-patient limit for  
5 group practices. Unfortunately, they started an effort to  
6 do this and eliminated it six months ago, and it still  
7 hasn't been done. One would wonder why it is that it is  
8 not done since it is not so controversial.

9 Part of the problem was a personality issue  
10 between, to be quite frank, two staff people on the House  
11 side. There was a pissing contest going on and it got  
12 held up. Then at the last minute, Mr. Sensenbrenner, who  
13 is the chairman of the Judiciary Committee, decided that  
14 he wanted to hold hearings on an issue that nobody  
15 objected to. I have no clue as to what the problem is,  
16 because there is no force out there that we know of that  
17 is objecting to the issue of releasing the limit on group  
18 practices.

19 But that should come back up. In fact, I know  
20 Jackie Parker from Mr. Levin's office was putting together  
21 the language. She sent me a copy of it yesterday to make  
22 sure that is what was needed, and they were going to  
23 introduce it.

24 You can expect monitoring, an electronic  
25 monitoring bill to come back. Here we have Mr. Harold

1 Rogers of Kentucky initially set up a program through the  
2 Department of Justice. Kentucky started an electronic  
3 monitoring system, along with I believe 19 or 21 other  
4 states that have such systems in some capacity.

5 Mr. Harold Rogers is still firmly supportive  
6 of the fact that this should stay at Justice. Mr. Rogers  
7 is a member, as I just mentioned, who was running for  
8 chairman of the Appropriations Committee.

9 Mr. Whitfield, another member of Congress from  
10 Kentucky, wants it to come to the Department of Health and  
11 Human Services.

12 MS. HEAPS: Electronic monitoring?

13 MR. DeCERCHIO: Prescription monitoring.

14 MS. HEAPS: Not a bracelet.

15 MR. FAHA: Oh, no, no. I'm sorry. I made an  
16 assumption. So Mr. Rogers has said no money will be  
17 appropriated to such a program if it in essence goes to  
18 the Department of Health and Human Services. You figure.

19 There is a lot of support in both chambers for  
20 such a system. There is a lot of support in SAMHSA, there  
21 is also a lot of discussion in SAMHSA about whether or not  
22 that is something that we think is appropriate.

23 Finally, there is an enormous amount of  
24 interest in methamphetamine. At 2:00 today, Mr. Talent  
25 from Missouri, along with Ms. Feinstein and others,

1 indicated that they were introducing a bill on  
2 methamphetamine that had changes to criminal statutes, to  
3 treatment and prevention, and that should be available for  
4 everybody to see. It is not a startling bill, but it  
5 shows you a great deal of support for methamphetamine,  
6 both from a law enforcement, treatment, and prevention  
7 perspective.

8 That having been said, are there any other  
9 questions?

10 MR. DeCERCHIO: Any discussion around child  
11 welfare and substance abuse? The legislation about two or  
12 three years ago, is that dead?

13 MR. FAHA: It has not been reintroduced so  
14 far, and I have heard no discussion. I know what you're  
15 talking about. It set up a block grant for folks, kids  
16 who were involved in the child welfare system.

17 To be very honest with you, it is going to  
18 have an appropriation issue to it. The bottom line is it  
19 is nice to have an authority. We have over 20 authorities  
20 that have never been appropriated right now. If indeed  
21 this one were authorized, it would have to compete with  
22 the SAPT block grant for funds.

23 So you in essence get into this battle. Yes,  
24 that looks nice. If it is a block grant program, then  
25 you've got to have some size to it, or else what states in

1 essence get would buy a postage stamp to submit your  
2 application and then all the paperwork SAMHSA would  
3 require. You understand where I'm coming from.

4 Any other questions? I think I've run over my  
5 time. Yes?

6 MR. DONALDSON: Frank, go ahead.

7 DR. McCORRY: Thanks, David.

8 What was the group that recommended NIDA and  
9 NIAAA being merged? Is that part of the NIH  
10 reauthorization?

11 MR. FAHA: No. The NIH reauthorization is  
12 primarily going to focus on too much independence of the  
13 individual institutes to pull together their own  
14 professional budgets. Its major achievement, if Congress  
15 has its way, would be to give more authority to the  
16 Director of NIH to stipulate what those budgets are going  
17 to be, and to keep these professional budgets to a  
18 minimum.

19 DR. McCORRY: So it is not an organizational  
20 reorganization?

21 MR. FAHA: No, and the NIH is not proposing a  
22 reorganization to incorporate NIDA and NIAAA.

23 David?

24 MR. DONALDSON: So glad you came back this  
25 afternoon. Fascinating. We have a government relations

1 office, and I just want to present this. We may be able  
2 to help you.

3 Pam Pryor, I don't know if you worked with  
4 her, she was the chief of staff for J.C. Watts and is good  
5 friends with Jerry Lewis.

6 MR. FAHA: Good.

7 MR. DONALDSON: So if we can be of support  
8 there.

9 MR. FAHA: I didn't bring a card. I'll give  
10 you my phone number.

11 MR. DONALDSON: Also, you may have heard that  
12 there is a faith-based caucus called the Community  
13 Solutions that we've helped develop with Harold Ford and  
14 Tom Green. They are looking for different pieces of  
15 legislation that tie back to community-based efforts. So  
16 that might be one horse to saddle.

17 MR. FAHA: I need to cleanse my spirit here  
18 and let you know that we cannot encourage anyone to lobby  
19 on our behalf. But I want to let you know that I am  
20 always available to provide technical assistance.

21 MR. DONALDSON: That's exactly what I was  
22 thinking.

23 DR. CLARK: For the staff and the audience,  
24 pay attention to those words.

25 MR. FAHA: Any other questions?

1 DR. CLARK: All right.

2 MS. HEAPS: You said methamphetamine was  
3 Feinstein and who else?

4 MR. FAHA: Talent. Mr. Talent. In fact, I  
5 thought maybe I brought a copy of that bill with me. No,  
6 I guess I didn't. Yes, I did. So if you want a copy, or  
7 do you want to make copies of this, we can get copies  
8 made.

9 Thank you very much for your attention. I'm  
10 sorry if I kept you from going asleep. I hope that you  
11 got something out of it.

12 Thank you very much.

13 (Applause.)

14 DR. CLARK: Now we're in the penultimate part  
15 of the day, the council roundtable. It is during the  
16 council roundtable that council members get to articulate  
17 areas of interest should they desire, or to further pursue  
18 concerns.

19 Dr. Skipper?

20 DR. SKIPPER: I wanted to bring up an issue  
21 about buprenorphine.

22 DR. CLARK: Buprenorphine.

23 DR. SKIPPER: Probably everybody knows, and  
24 maybe I'm right on this, but buprenorphine, the law that  
25 allowed physicians to prescribe buprenorphine in their

1 practice occurred in about 2001, was it? I think it was  
2 about 2001.

3 DR. CLARK: Two-thousand.

4 DR. SKIPPER: Two-thousand. The year 2000.  
5 And so SAMHSA has maintained a website that lists all  
6 those physicians that have gone through the process of  
7 training and obtaining a waiver. That is good. However,  
8 I have received numerous calls, and it seems like  
9 increasingly, of patients unable to find a doctor that  
10 will prescribe buprenorphine for them.

11 So I have directed them, early on I was  
12 directing them to the website, and now I'm getting a lot  
13 of comments that nobody on the website will prescribe for  
14 them. You know, I've gone through every doctor on the  
15 list, and nobody will prescribe.

16 DR. CLARK: Is there anyone from DPT here?  
17 Oh, Bob.

18 Bob, do you want to comment on that?

19 MR. LUBRAN: Bob Lubran with DPT, and I had a  
20 chance to talk to Greg during one of the breaks.

21 The issue has several parts to it. One is  
22 that we only have about 70 percent of the physicians  
23 listed on that locator to begin with because we have to  
24 ask each physician for permission to list their name. So  
25 there are some physicians who don't even appear on that

1 list.

2           Secondly, we know that there are more people  
3 in need of treatment and seeking treatment than there are  
4 physicians in many communities who are authorized to  
5 provide it. Our primary goal really from day one has been  
6 to expand the capacity and expand the number of physicians  
7 who are authorized to provide that treatment.

8           So in 2005, there are over 60 trainings being  
9 planned by the five major medical organizations in the  
10 United States throughout the country to expand that  
11 number. So we hope that the number of physicians which  
12 currently is around 4,000 who have a SAMHSA waiver is  
13 going to almost go up by 70 or 80 percent by the end of  
14 the year.

15           Thirdly, there are some patients who are  
16 interested in detox, and only detox, and there are some  
17 physicians who would rather not provide that service.  
18 Likewise, there are some patients who would like long-term  
19 maintenance on buprenorphine, and physicians who may not  
20 be prepared to do that. So getting that right mix in any  
21 community requires some work.

22           Last year we funded a project called the  
23 Clinical Support Network with ASAM, American Society of  
24 Addiction Medicine, in collaboration with the other  
25 medical groups to provide support to primary care doctors

1 in communities who may be reluctant to take on patients,  
2 or who may not want to provide maintenance treatment in  
3 order to educate them, provide them assistance, and if  
4 necessary, additional training in order to get them to be  
5 more comfortable with that whole effort.

6           So that said, we would love to work with you,  
7 with ideas you might have to address the problem, which we  
8 recognize is there. So please feel free, or any other  
9 council member who has experienced that problem in your  
10 own state, to be in touch with us, and let's try to work  
11 out some other solutions.

12           MS. BERTRAND: So Bob, you and I discussed the  
13 trainings are great. I'm wondering if, as you and I  
14 discussed, if we could somehow get information from docs  
15 that are prescribing buprenorphine to get a sense of their  
16 satisfaction, and use that as advertising to get others to  
17 do it.

18           MR. LUBRAN: Actually, that's something we  
19 discussed. I did want to explain that we have a series of  
20 surveys that we're conducting, starting with a survey of  
21 physicians, roughly 1,000 physicians from October of 2002  
22 to October of 2003. We did get those results. They are  
23 available through our website, and we've made  
24 presentations on that.

25           The second survey was a survey of 400 patients

1 who have been on buprenorphine to try to get a sense of  
2 their experience and some of the things that they liked  
3 and didn't like.

4           Finally, we just started last week with  
5 another survey of 1,833 physicians randomly selected. I  
6 asked Greg if he got a survey, which it turns out he  
7 didn't, probably because you weren't in the pool, but we  
8 randomly selected over 1,800 physicians, and we're going  
9 to ask them a whole set of questions along the lines of  
10 what you talked about. I hope based on that survey that  
11 it is going to give us some insight into some other areas  
12 we can follow.

13           Lastly, I did want to pick up on the comment  
14 that Joe Faha made about the legislation to remove the cap  
15 on group practices. We know already that that is a  
16 serious problem that has restricted both physicians and  
17 patients from getting care. So we have been working with  
18 Joe in terms of consulting with Congress, and also with  
19 Dr. Clark and the administrative office in terms of  
20 looking at perhaps a regulatory fix to address the  
21 problem.

22           So yes, there are some things from the surveys  
23 from physicians that are going to help us a good deal.  
24 We're going to be presenting that at some of the national  
25 meetings coming up this year.

1 DR. SKIPPER: I'm wondering about identifying  
2 certain areas that may be quite deficient. Like, for  
3 example, in Alabama, I have yet to find a physician that  
4 will prescribe buprenorphine for maintenance therapy in  
5 the entire state. None of the methadone programs will.

6 I wonder if we could identify areas like that  
7 that are real needy and do some kind of further promotion,  
8 other than trainings.

9 MR. LUBRAN: Yes. I think through the  
10 physician surveys we are going to discover a good deal  
11 about the practices and where there are gaps, and through  
12 the ASAM project. So one of the things that I would again  
13 encourage you to do is to share with us some of those  
14 ideas. We'll get back to ASAM and some others, and to  
15 you, and work together on trying to improve that system.

16 DR. SKIPPER: I'm kind of wondering if we're  
17 going to see in areas that are underserved by  
18 physician/patient ratios as in Alabama, Mississippi, and  
19 other places where they are already too busy that they may  
20 not be very interested in taking on a further patient  
21 load. So I don't know how to get around that.

22 MR. LUBRAN: Well, one of the activities that  
23 we have is a plan to invest in four rural areas in the  
24 United States, starting in March. We are going to be  
25 going to Huntington, West Virginia, Lexington, Kentucky,

1 Jackson, Mississippi, and St. Louis, Missouri. Four areas  
2 that serve somewhat of a regional population.

3 We found that in those states, particularly in  
4 the three states of West Virginia, Kentucky, and  
5 Mississippi, there is a shortage of physicians who have  
6 signed up for buprenorphine. We think that in working  
7 through the public health system and working through some  
8 of the migrant services in the rural communities, that  
9 we'll be able to educate a lot more physicians. We know  
10 there is going to be some trainings in those communities  
11 as well.

12 DR. SKIPPER: And then finally you and I  
13 talked about trying to get a website or something that  
14 does detail what service is provided by those physicians  
15 so that patients are so frustrated that they call  
16 everybody on the list and find that nobody is prescribing  
17 it.

18 MR. LUBRAN: Right. We are going to look into  
19 that. Right now we collect data from the physicians who  
20 are applying to us. It is very limited in terms of what  
21 we collect. Some of the things that you mentioned to me,  
22 we just don't collect that data. So we're going to go  
23 back and look at what would it take in order to expand our  
24 notification form where we collect data.

25 If not, we'll look at some other options,

1 including the medical groups who may be willing to add  
2 that information. Greg was asking, for instance, if  
3 physicians offer detox services or maintenance services.  
4 That information is currently not available on our  
5 website. But we'll look into it and see what is involved  
6 and consult with you down the road.

7 DR. SKIPPER: Thank you very much.

8 DR. CLARK: Frank?

9 DR. McCORRY: Just a quick point. Would it be  
10 possible to get the slide presentation today  
11 electronically? Is that possible? I'd appreciate having  
12 sets that I'd be able to look at and pull. Thank you.

13 DR. CLARK: Anybody else?

14 MR. DeCERCHIO: Before we leave, I wanted to  
15 talk quickly on today's discussion, or this morning. I  
16 think you alluded to maybe coming back to it. Maybe at a  
17 future meeting we could have an update or presentation.  
18 It is such a big issue, the status of those performance  
19 domains and where we are with indicator development. It  
20 is such a big issue that resonates down to the state  
21 level, and down to providers at that level.

22 And then of course in terms of our whole  
23 collective stake in terms of being able to depict success  
24 of what we collectively do. Maybe we could agenda that  
25 for a future meeting and have a discussion around that.

1 DR. CLARK: That's the purpose of this  
2 roundtable, so we'll put that there.

3 Val?

4 MS. JACKSON: Yes, I also had a request. That  
5 was at a future meeting if we could talk a little bit  
6 about the development of the topics for the RFAs for  
7 discretionary funds.

8 I know that that is kind of within the realm  
9 of us being able to give suggestions as an advisory  
10 council. I appreciate all of the information that we were  
11 given today. I think it was really a very good day in  
12 terms of learning. So I wanted to thank you for that  
13 also.

14 Then I just wanted to say I'm only going to be  
15 on the phone a little bit tomorrow because I'm going home  
16 to help my daughter have a baby.

17 DR. CLARK: Thank you.

18 Any other questions?

19 (No response.)

20 DR. CLARK: After this, we will tour the  
21 building. So given that there are no questions for today,  
22 I'll entertain a motion to adjourn. We'll reconvene in  
23 the morning. Is there such a motion?

24 DR. FLETCHER: So moved.

25 MS. HEAPS: Second.

1 DR. CLARK: It's been moved and seconded that  
2 we adjourn for today and reconvene tomorrow.

3 (Whereupon, at 4:03 p.m., the meeting was  
4 recessed, to reconvene at 10:30 a.m. on Thursday, January  
5 27, 2005.)

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