

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT
NATIONAL ADVISORY COUNCIL

Thursday,
January 27, 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
Rockville, Maryland 20857

Members

Anita B. Bertrand, M.S.W.
Executive Director
Northern Ohio Recovery Association
P.O. Box 360833
Strongsville, Ohio 44149

Kenneth A. DeCerchio, M.S.W.
Director
Florida Department of Children and Families
Substance Abuse Program
1317 Winewood Boulevard
Tallahassee, Florida 32311

David P. Donaldson, M.A.
CEO
We Care America
10 G Street, N.E., Suite 502
Washington, D.C. 20002

Bettye Ward Fletcher, Ph.D.
Professor
Jackson State University
1120 Andrew Chapel Road
Brandon, Mississippi 39047

IN ATTENDANCE:

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

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

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

C O N T E N T S

	PAGE
Call to Order	
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM Director, CSAT	5
SAMHSA's Disaster Readiness and Response Activities	
Daniel Dodgen, Ph.D. Emergency Coordinator Office of the Administrator, SAMHSA	5
Sheila M. Harmison, D.S.W. Special Assistant to the Director Office of the Director, CSAT	21
Overview of the Drug Enforcement Administration's (DEA) Supply and Demand Reduction Efforts	
Michele Leonhart Deputy Administrator, DEA	34
Discussion	50
Discussion with Disaster Presenters	60
E-Therapy Update	
Sheila M. Harmison, D.S.W.	76
Discussion	90
Council Roundtable	100

1 P R O C E E D I N G S (10:38 a.m.)

2 DR. CLARK: Can we come to order? Our first
3 presentation in the open session will be a discussion of
4 SAMHSA's disaster readiness and response activities. The
5 presenters will include Dan Dodgen, Sheila Harmison, and
6 Carol, are you saying anything?

7 MS. COLEY: I'll say good morning.

8 DR. CLARK: Well, the key issue with that aside
9 is that we've got a focus on disaster readiness and
10 response, both at the SAMHSA and at the center level.

11 Dan is going to give his presentation. He
12 leads up our effort, but his effort is buttressed by the
13 contributions of all of the staff who are working with him.

14 Dan Dodgen?

15 DR. DODGEN: Good morning. I'm Dan Dodgen.
16 Thank you for the nice introduction, Dr. Clark.

17 It is really a pleasure to be here and to meet
18 with the folks here at CSAT. As you probably already know
19 from just having been around folks for awhile, you really
20 have some great people. I certainly want to acknowledge
21 both Sheila Harmison and Carol Coley, who were on the
22 matrix advisory group for the disaster readiness response
23 matrix. They are just invaluable contributors to that
24 group. Of course there are many other staff at CSAT, too
25 many to mention, who have also really done a tremendous job

1 to support us.

2 What I'm going to do today is talk briefly
3 about an overview of SAMHSA-wide activities, and try to
4 give you a thumbnail sketch of how we approach disaster
5 issues at the agency. Then I'm going to hone in a little
6 bit on things happening recently, particularly the tsunami
7 response, and then of course all the hurricanes in the fall
8 to give you a sense of how these different activities play
9 out in a particular incident.

10 I just want to start by making sure that we're
11 all on the same page. There are lots of different
12 definitions for the kinds of things that we're going to
13 talk about this morning, and I just want to make sure that
14 we're at least thinking about the same things when we talk.

15 So disasters, as it says, are natural or manmade events
16 with an identifiable beginning and end in which the impact
17 exceeds the capacity of the local community to respond.

18 Now, obviously there are disasters in local
19 communities that don't exceed their capacity. I don't in
20 any way want to minimize that. Those are very, very
21 important events that merit some kind of response. But I'm
22 talking about from a federal perspective, for something to
23 really invoke a federal response, this is what we're
24 talking about in terms of definitions.

25 A public health emergency occurs when a natural

1 or manmade event creates a need for health services that
2 exceeds the response capacity of the local health care
3 service delivery system. Obviously SARS in Canada was a
4 very, very good example of that. I think many of us are
5 watching very, very closely with the avian flu and waiting
6 to see what is going to happen with that. That probably
7 will be our next big international public health emergency.

8 But again, something that we follow very closely and fall
9 also under this matrix area.

10 Then of course the third, terrorism, is an
11 action undertaken to achieve a political, ideological, or
12 theological goal through a threat or action that creates
13 terror or horror. Of course these are the headlines from
14 the Madrid bombings on March 11th.

15 So what are the SAMHSA activities? These are
16 the basic four areas that we're going to talk about this
17 morning. I'm going to move through relatively quickly.
18 But please, if at any moment you have a question, comment,
19 or something isn't clear, feel free to interrupt me.
20 There's no sense in going so quickly and having it still be
21 confusing when we're done. So feel free to interrupt.

22 I just want to talk about a few key examples of
23 science to services. As you know, that's an important area
24 agency-wide for us. We are really trying. I think many of
25 us that work in this area are aware that the research base

1 is really just starting to develop, both in mental health
2 and in substance abuse. It is not something that we have
3 traditionally focused on, those in the research community,
4 for behavioral health. So we're really in the process of
5 beginning to develop consensus documents and trying to get
6 information out there, trying to get seed money out that
7 will help us to develop even ideas of where we need
8 research, not to mention of course developing the research
9 base that has begun.

10 One of the things that we have done is worked
11 with the National Research Council and the National Academy
12 of Sciences' Institute of Medicine to put together a report
13 on psychological consequences of terrorism that actually
14 proposed a public health model for responding and
15 preparing. That is available on the Internet. If anybody
16 is interested, I can get you the link, or we can make sure
17 that someone sends that to you. I might have a few hard
18 copies in my office if you're really interested, we'll see
19 if we can dig some out.

20 Actually, let me talk about a couple of these
21 others. We also have been doing some expert panels
22 cofunded with NIH really looking at issues around
23 assessment in particular, because as we know, one of the
24 things that is really important in a disaster event is just
25 figuring out what is going on in the population. What do

1 people need? What kinds of presenting problems are they
2 having?

3 If you go back to our definition of exceeding
4 the local capacity to respond, then obviously assessment is
5 really going to be an important part of that because we
6 need to understand what the needs are if we're going to be
7 able to merit how the response needs to be gauged, and
8 whether or not there is a significant federal role in that
9 response.

10 The National Child Traumatic Stress Network,
11 some of you may be familiar with that CMHS initiative that
12 has really grown tremendously in the last couple of years.

13 It started at \$10 million a year, and it is now \$30
14 million. They don't just focus on disasters and terrorism,
15 they focus on other aspects of child trauma, including
16 exposure to violence and maltreatment. But they have
17 developed a significant interest in disaster and terrorism
18 response. In fact, we'll see in a minute that have been
19 very helpful in preparing materials for the tsunami
20 response.

21 Templates for Response, Recovery, and
22 Resiliency, there are a number of different initiatives
23 that you may have been exposed to over the last couple of
24 years as they have evolved. SAMHSA did to an all hazards
25 planning guidance, and I know we are in the process of

1 thinking about developing an appendix for that specific to
2 substance abuse. I think Sheila was probably going to say
3 a little bit more about that, so I won't.

4 We also have developed a cultural competence
5 guideline specific to disaster response for behavioral
6 health, which is really a very unique effort. We are so, I
7 don't want to say primitive, because I think that has a
8 negative connotation, but we are so early really in the
9 whole learning curve. This is work that has basically been
10 going on at SAMHSA for about 30 years since we signed an
11 agreement with FEMA back in '74. Before actually SAMHSA
12 existed, but nevertheless, that agreement dates to '74.

13 So really when you think about the overall
14 picture of disaster response, we are still very much in our
15 childhood of learning about these things. So these
16 guidances in many ways represent a first in the field.

17 Another document that you may be familiar with
18 is our risk communications guidance. For any of you who
19 might ever be put in a position of having to speak to the
20 public about a disaster event, even if it is just a small,
21 local event, I strongly encourage you to take a look at
22 this booklet. If you have not had copies given to you
23 before at this meeting, I can make sure to get some that
24 can be mailed to you, and we can also give you a link.

25 It is an incredible document. It just talks

1 about how to deal with the media, and how to deal with the
2 press in these kinds of situations. How to not get caught
3 into sort of battles about definitions, but really to make
4 sure you keep your focus, and how to explain the nature of
5 these kinds of events to the press in a way that helps them
6 to understand the consequences. It is a very good document
7 that I have distributed everywhere from the Greek officials
8 at the Olympics to local public health officials here, and
9 they love it. It is, I think, a very good example of how
10 SAMHSA is helping to create templates that have an impact
11 not just on the behavioral health community, but really on
12 the larger public health and emergency management
13 community.

14 Some of our infrastructure that we're beginning
15 to put in place, and again have come a long way, there are
16 a number of different things here. The "All Hazards"
17 Emergency Capacity Development Grant Program many of you
18 are probably familiar with. We have given grants to 35
19 different states for them to develop a substance abuse and
20 mental health disaster response plan.

21 Really corollary to that initiative, we have
22 established the SAMHSA Disaster Technical Assistance
23 Center. Are you going to talk a little bit about that
24 more, Sheila? Okay. I think what you need to know about
25 that is it is a new TA center established in 2002, and

1 their job is really to provide guidance and assistance to
2 the state, not just in applying for grants, but also in
3 sort of learning about the knowledge base, pulling
4 information together, what research exists. It is an
5 excellent resource. I will get to our website in a minute,
6 and I'll show you how you can link into some of these
7 resources.

8 The final two things, the regional meetings and
9 the June 18th meeting were national meetings. That was
10 June 18, 2003 by the way, I need to get that added in
11 there. That was really the kickoff for the state planning
12 grants. We have since had six regional training meetings
13 where we have met with officials from states to help them
14 develop their plans.

15 We've met everywhere from Washington, D.C. to
16 Guam. I think Sheila has been at every single one of those
17 meetings, so she may want to comment on them as well. But
18 I think, again, it is an example of SAMHSA's commitment to
19 helping states build infrastructure and learn how to do
20 this, and learn from each other. Because of course in
21 regional meetings, every state is doing something a little
22 bit different, and they get to work together in thinking
23 about these things.

24 Then of course finally what you probably are
25 most likely if you see anything about SAMHSA's activities

1 in the news, what you are most likely to see would be the
2 ones on this page, which is our disaster and terrorism
3 response activities. The FEMA Crisis Counseling Assistance
4 and Training Program, you probably have heard about. That
5 is run through our Center for Mental Health Services. This
6 is a collaborative agreement between FEMA, which is now
7 part of the Department of Homeland Security, and SAMHSA.

8 When there is a federal declaration of disaster
9 from the President that authorizes individual assistance,
10 then SAMHSA immediately can enact this program with funding
11 from FEMA. It is a huge program that although it primarily
12 focuses on mental health, there are substance abuse related
13 activities that are eligible, and we're certainly working
14 to help states figure out better how they can combine both
15 mental health and substance abuse within the parameters of
16 this program.

17 On occasion we get supplemental assistance from
18 Congress. I think Sheila is going to talk a little bit
19 about some of our post-9/11 activities that were
20 administered through the Center for Substance Abuse
21 Treatment. We also recently, I'll be talking about in a
22 minute, we received a similar supplemental from Congress
23 for Florida for the hurricanes.

24 I want to talk a little bit more about the
25 hurricanes, just to give you a sense of how some of these

1 activities work in practice. If you look at this map here,
2 this was in anticipation of Hurricane Ivan. Some of our
3 colleagues from the Center for Substance Abuse Prevention
4 have the capacity to do GIS mapping for us, and have really
5 done I think a wonderful job in helping us plan how we can
6 reach out to our grantees even before a hurricane makes
7 landfall.

8 As you'll see, the three different colors,
9 blue, red, and yellow represent the three SAMHSA centers.
10 You can see as we were anticipating landfall, where we had
11 SAMHSA centers that might have been impacted. Again, this
12 just is a little bit more closely looking at this. Of
13 course as everybody remembers, Ivan followed a very strange
14 path in that it ended up sort of veering back to the east
15 and affecting the Panhandle more than we anticipated when
16 we first had these slides done. This is just looking at
17 the same information in different ways.

18 So what did we really do with all of this?
19 Well, first off, we updated our website. We activated our
20 Disaster Technical Assistance Center to go to extended
21 hours. I'm talking about all the activities as the
22 hurricanes were getting ready to make landfall. Staff from
23 all three of the SAMHSA centers began calling grantees.
24 Some of you who are grantees in the state probably received
25 some of those calls.

1 We updated our service locator on the website
2 so that people from those states if they were having some
3 kind of behavioral health consequence as a result of the
4 stress and everything related to the disaster, could access
5 services if they wanted through our website, as well as
6 providing information for applying for grants.

7 So this is what this famous website looks like.

8 I'm sure all of you have spent many, many hours on the
9 SAMHSA website. I know every time you are on a conference
10 call or something, you just can't help but be compelled to
11 go over and check out that www.samhsa.gov. The next time
12 you do that, if you look in the very middle of that opening
13 screen, it will say disaster readiness and response matrix.

14 I paid a lot of money to have them put our matrix area
15 right in the middle of the screen. I'm kidding, of course.

16 But nevertheless, it is there, so it is really easy to
17 find. If you just click on that, it will immediately bring
18 you go this next page.

19 What you'll find here are links to a number of
20 the different things that we've been talking about today.
21 The 2004 hurricane season, we put a link up there, and I'll
22 show you in minute what that takes you to. The action plan
23 describes our overall activities and current funding
24 opportunities. This is something that we'll need to
25 update. If you go there right now, of course there aren't

1 a lot of current funding activities, but if you follow
2 through some of these others, you'll see some of the
3 ongoing grants. So what I'm saying is we don't necessarily
4 have new grants, we have some ongoing response grants like
5 the crisis counseling that I mentioned a minute ago, and
6 also the SAMHSA emergency response grants that are funded
7 within SAMHSA for situations where there is not a
8 presidential declaration of disaster, but there is still a
9 significant reason for SAMHSA to have a response.

10 This was the description that went up shortly
11 after the hurricane season. You can see a little bit more
12 about some of the things that we said there, as well as all
13 of the links on the right-hand side. It is, I think, a
14 very, very nice website.

15 Some of the other things that we did during the
16 hurricane season was we had daily and often twice daily
17 calls. ESF 8, are people sort of vaguely familiar with the
18 National Response Plan and all its activities? Well, ESF
19 stands for Emergency Support Function, and 8 is public
20 health and medical. That is where SAMHSA's primary
21 involvement is.

22 Through that, we are able to collaborate not
23 only with all of our different colleagues at HHS, including
24 CDC, HRSA, and FDA, but also folks like Department of
25 Defense, Veterans Affairs, and Department of Agriculture.

1 I think what is important there is just to know that there
2 is a behavioral health person on all of those calls, which
3 even a year or two ago was not the case. We now are part
4 of all those calls. So as we are sitting there on these
5 calls talking about all of the different activities and
6 planning for them, there is someone there representing the
7 kinds of issues that we're most concerned about.

8 Then as I mentioned a minute ago, part of the
9 response also can involve additional supplemental
10 appropriations from Congress. Following the hurricanes, as
11 our colleague here from Florida can attest, Congress
12 appropriated money of which \$11 million will be for SAMHSA
13 to assist those in need of substance abuse and mental
14 health services.

15 Let me just talk very briefly about the tsunami
16 response, because I know there has been so much in the news
17 lately, and I'm sure you all have been dying to know what,
18 if anything, is SAMHSA doing about that. I actually can
19 report to you that we are, again, for the first time ever,
20 being involved in this kind of international response.

21 CDC, of course the Centers for Disease Control,
22 has been very, very involved in this response, because as
23 you know, there has been wide fears of public health
24 outbreaks because of the poor sanitation and the other
25 conditions there in Southern Asia. CDC has actually

1 reached out and requested that SAMHSA participate with them
2 in their response. They want to have behavioral health be
3 a key part of their response. This again is new. CDC has
4 never reached out to us before and said we want you to be a
5 partner with us in this kind of response. Again, I think
6 it represents a fact that incrementally we are getting our
7 issues more and more at the table. People are thinking
8 about them more clearly at CDC.

9 In addition, the National Child Traumatic
10 Stress Network that I mentioned a minute ago has been very,
11 very active in developing some information sheets for us
12 specifically for dealing with issues of how children might
13 be affected, as well as how people who are working in areas
14 where children have been affected, how they might deal with
15 some of those issues.

16 I think probably most of you know that one of
17 the most traumatizing aspects of disaster response is
18 dealing with the trauma where children are victims, either
19 because they are homeless, or even because they have been
20 killed. That tends to have the highest impact on the first
21 responders, the public health workers, and other people
22 that go in, if there are child victims. So we have got
23 these folks in there working with us, because as you know,
24 part of the recovery effort is disproportionately women and
25 children that were impacted in the tsunami.

1 And then in addition to that, we have developed
2 in the last couple of years some very strong and formal
3 collaborations, as well as formal with the Department of
4 State, and as you know, the U.S. Agency for International
5 Development, USAID, is the lead agency. The person who is
6 in charge of the psychosocial aspects of the response
7 happens to be a close friend and colleague of mine, so we
8 have been able to also informally comment on their plan and
9 provide input as well. I'll check how that looks in a
10 minute before they go out.

11 Some of the current activities []- am I way
12 over, Sheila? I'm wrapping it up. Current activities.
13 The in-service we held for all SAMHSA staff in December.
14 It was very well attended and I think really created an
15 opportunity again to inform the folks here in the building
16 about this work.

17 Sheila is going to talk to you about the
18 post-9/11 grantees report. The concept of operations is
19 something that we're working on right now which will be a
20 protocol that will guide SAMHSA's overall response in
21 disaster and terrorism events that I'm very happy about.
22 We've got so many smart people, we have been doing this a
23 long time in this building, and in previous buildings, but
24 we haven't got it written down. Now it is being written

1 down, and I think it is going to really enable us to
2 respond much more quickly and efficiently in the future.

3 We also held a tabletop regional meeting for
4 the first time ever, an exercise here in the National
5 Capital Region involving three states. Again, all three
6 SAMHSA centers as well as several other federal agencies
7 were involved in this, and it was a public health
8 behavioral health tabletop drill. It has never been done
9 before anywhere in the U.S. on a multijurisdictional scale.

10 And then TOPOFF 3, some of you may have heard
11 of. It is every two years the federal government does a
12 top officials terrorism planning exercise. You will be
13 seeing, and I can't tell you many details, but you will be
14 seeing a lot about it in the news in a couple of months.
15 SAMHSA has been able to be significantly involved in this
16 in helping to develop the scenarios. Again, that's a first
17 and I think something that we should be very proud of.

18 Have you had your building tour yet? That was
19 yesterday afternoon, right? You probably saw that we have
20 an operations center now with all those cool screens and
21 everything and the videoconferencing ability. That will be
22 our operations center in a disaster, up on the 8th floor.
23 We actually are in the process of putting in some very
24 significant electronic equipment that will enable us to
25 keep that place functional even in the event of a partial

1 shutdown of the rest of the building, or pieces of the
2 government. I think it is going to really make it easier
3 for us to contact grantees, have everybody in the same
4 room, and really develop a coordinated SAMHSA response.

5 So a lot of very, very good things happening.
6 When I talk about disasters, I always like to end with a
7 warm fuzzy slide. So being a "Calvin and Hobbes" fan, I
8 just want you to think warm thoughts, both because of the
9 terrible cold outside, as well as just to remind you that
10 we are working to make things safer and develop a better
11 behavioral response.

12 (Applause.)

13 DR. DODGEN: If people, by the way, are
14 interested in hearing more about the tabletop exercise that
15 I mentioned to you, I do have copies of the final report.
16 I'll have them with me on CD-ROM if people would just like
17 to see what the lessons learned were.

18 DR. HARMISON: Good morning. It is a pleasure
19 being with you here today to talk to you about the
20 substance abuse treatment field and disasters.

21 Thank you, Dan, very much for your presentation
22 on the overview of what we are doing here at SAMHSA. I
23 have to say that it has been a pleasure working with you,
24 Dan, this past year and a half I believe it has been that
25 you have come on and taken on this particular role. Thank

1 you so much.

2 To give you a background of course as to what
3 we are doing in SAMHSA at CSAT, let's look at what the
4 definition of trauma is. Trauma is an event that involves
5 an actual or threatened death, serious injury, or threat to
6 one's physical integrity. It is directly experienced,
7 witnessed, or learned about.

8 What does that mean exactly? What would that
9 be? Directly of course are natural or manmade disasters,
10 military combat, sexual assault or physical assault. We
11 have heard of many of our Iraqi soldiers coming back and
12 having problems with PTSD now, so we are dealing with that
13 very heavily within our Veterans Administration hospitals.

14 Sexual assault is a problem that we have to be
15 aware of of course with our clientele, women in particular
16 who suffer from this in the past and often come with this
17 kind of a problem when they are dealing with PTSD.

18 Witnessed events are seeing an accident, a
19 violent assault or disaster, or learned about family or
20 friends having a personal assault, injury, or death.
21 Trauma develops into PTSD, post-traumatic stress disorder,
22 and we can look at it according to event and personal
23 events.

24 The kind of event that we would have here would
25 be the kind of trauma, the kind of disaster, the kind of

1 situation that will be affecting this person. It doesn't
2 have to be a major disaster for someone to get PTSD. But
3 you do have to look at the duration, the proximity, and the
4 severity of the event. You also have to look at where that
5 person is within themselves. What are the supports they
6 have, and what is their internal motivation to get better?

7 All of these pieces can be summed up with
8 looking at their preexisting mental disorders, their family
9 history, their personality, their childhood experiences,
10 and their social supports.

11 Clinical symptoms of trauma of course are a
12 sense of numbing, sense of detachment, being in a daze,
13 derealization, recurrent images, thoughts, and dreams.
14 These sound significant, they sound like a lot of symptoms.

15 But I have to tell you, I have done these types of talks
16 for years now on the disaster after 9/11, and I have had
17 people come up to me after certain events and say thank you
18 very much for discussing PTSD because I suffer from it, and
19 people don't believe me. I have lost my job, I have
20 difficulties, and it is for real. I have had people talk
21 to me for hours about this.

22 Also there is marked avoidance of stimuli that
23 arise with recollections of the trauma. There are marked
24 symptoms of anxiety or increased arousal, having again
25 difficulty sleeping, irritability, poor concentration, and

1 exaggerated emotions.

2 Where does the substance abuse treatment system
3 come in in all of this? Where is it that we can make our
4 interventions? Well, there are many, many places. Of
5 course there is prevention in the beginning to try to help
6 folks. But for treatment itself, you have your trauma that
7 occurs, and I'm just going to quickly go through this.

8 You have your stress symptoms, and right before
9 the stress symptoms, we can do some work. so after a
10 disaster, right after a disaster, we can be there in the
11 field helping out. If we don't get to the client at that
12 time, often what you'll see are acute or delayed PTSD
13 developing. Well, we can work with them right before that
14 happens, too.

15 If we have a client coming in at another point,
16 we can deal with it after those pieces. Chronic PTSD of
17 course is something that we see a lot with our clientele
18 that we deal with. We have to have our therapists and our
19 clinicians trained and ready to deal with this issue
20 whenever those folks come in.

21 Excessive use of alcohol or drugs in response
22 to trauma does occur. There is an increased demand for
23 services often from people with lifetime histories of
24 substance related disorders, and there is an increased
25 demand for services from people with current substance

1 relate disorders. So therefore, you have three different
2 populations you always have to think about whenever there
3 is a major disaster or a trauma that is occurring.

4 First off are those folks who are just trying
5 to cope with the disaster by using substances. The second
6 are those who are in recovery that realize that they are
7 going to have to deal with having those urges again because
8 of the disaster. Then the third population are those folks
9 who have never been in recovery but have suffered from
10 substance use disorders not realized it, but have that
11 sudden revelation with all the extra pressures.

12 So again, we have to look at the nature,
13 duration, and proximity of that traumatic event, and we
14 have to look at where is our staff. Are they prepared to
15 deal with these problems? We have to train them so that
16 they understand PTSD, and we have to have our systems ready
17 so that they can deal with a disaster in a crisis.

18 So what that means is not only having your
19 staff ready, but having your administration of that program
20 ready. We have administrators who are in the process at
21 this time of developing plans for their programs so that
22 their staff can handle the clients that come in once there
23 is a disaster, but also so that their staff can deal with
24 those disasters properly.

25 As you know, in our field we have many

1 recovering folks that are there doing the counseling, so we
2 have to be prepared for their issues also, and the fact
3 that they may be separated from their family should there
4 be a traumatic event.

5 The key is that you have to have the treatment
6 delivery staff able to recognize the symptoms of stress
7 within the staff themselves and among patients.

8 There has been a lot of confusion about
9 substance use being a problem once there is a disaster. I
10 have been out in the field a lot talking about this issue.

11 I have heard many folks say there is no substance abuse
12 problem after a disaster. Well, now we do have much
13 research to support the fact that yes, there are, and I'll
14 talk a little bit about that too a little later on in this
15 presentation, but yes, there can be significant substance
16 abuse issues after a disaster.

17 Some people are unclear, though, of this
18 question. The key difference of course is in the
19 classification schemes defining substance use disorders
20 versus an increase in substance use. Remember, as I have
21 said before, an increase in substance use will occur, but
22 that doesn't mean that those folks necessarily have a
23 substance use disorder. We still though have to deal with
24 the public health and safety problems that come about with
25 that.

1 Let's just take a look at the DSM-IV
2 definitions. For substance dependence, it is "A
3 maladaptive pattern of substance use leading to clinically
4 significant impairment or distress as manifested by three
5 or more of the following occurring at anytime in the same
6 12-month period," and that would be tolerance, withdrawal,
7 the substance taken for longer amounts of time over a
8 longer period than was intended, and there is a persistent
9 desire or unsuccessful effort to cut down on this.

10 There is a great deal of time spent in
11 activities necessary to obtain the substance. Important
12 social, occupational, or recreational activities are given
13 up or reduced because of that substance use, and the
14 substance use is continued despite knowledge of having a
15 persistent or recurrent physical or psychological problem
16 likely caused or exacerbated by the substance.

17 That's different from our substance abuse, in
18 that this is the same definition, except that it is one or
19 more of these following items. It is within the same
20 12-month period. That is recurrent substance use resulting
21 in a failure to fulfill major role obligations at work,
22 school, or home. After 9/11, we found that there were many
23 children that were going to school and saying my mom and
24 dad are drinking a lot and they are not functioning well.
25 I don't know what to do. They were not coping well, and

1 that had to be dealt with at various treatment centers, and
2 at the schools.

3 There is also recurrent substance use in
4 situations in which it is physically hazardous. Of course
5 driving and working in dangerous jobs. There is current
6 substance-related legal problems such as DUIs from that,
7 driving while intoxicated.

8 There is continued substance use despite having
9 persistent or recurrent social or interpersonal problems
10 caused or exacerbated by the effects of the substance.
11 Remember, these symptoms though do not meet the criteria
12 for substance dependence, but they are important to
13 understand.

14 In the American Journal of Epidemiology in
15 2002, Vlahov, et al., looked at the 9/11 disaster and said,
16 I'm going to look at the impact of cigarette use, alcohol
17 use, and marijuana in the Manhattan, New York residents.
18 With that, what we did is he measured what happened the
19 week after 9/11 and compared it with the week before. He
20 did many other studies on this, too, but this is the one I
21 felt was significant for us to look at today.

22 Vlahov reported that 3.3 percent of the
23 respondents started using cigarettes in the week after
24 9/11, but they did not use the week before. Similarly,
25 19.3 started drinking alcohol the week after, but did not

1 use the week before, and 2.5 percent began using marijuana
2 the week after, but not the week before.

3 Smith, et al., stated and found with his
4 research that alcohol consumption often increases following
5 a disaster. After Hurricane Hugo, beer consumption went up
6 25 percent. After the Oklahoma City bombing, alcohol
7 consumption in the year after that increased two times
8 greater than in a controlled community whenever there was a
9 comparison done. This is after the Oklahoma City bombing.

10 Cottler, et al., in 2002 looks at substance
11 abuse and disasters within the current drug users
12 themselves. Of an N of 166, 36 percent of these people
13 experienced a traumatic event. People that were exposed to
14 these traumatic events were more likely to meet the
15 criteria for antisocial personality disorder, affective
16 disorder, schizophrenia, and generalized anxiety disorder.
17 Eighteen percent of the sample had PTSD.

18 Zatzick, et al., found in their study in 2004
19 that 58 percent of 269 randomly selected injury survivors
20 hospitalized at a level one trauma center had high levels
21 of immediate post-traumatic distress or alcohol abuse and
22 dependence. So the take away message from this particular
23 study is early mental health screening and intervention
24 procedures that target both PTSD and alcohol use should be
25 developed for acute care settings. This is critical in

1 that we're always looking at screening devices and ways
2 that we can go into these situations and evaluate what is
3 happening.

4 In 2004, Adams, et al., reported on a sample of
5 1,762 Connecticut adults. They reported an increase in
6 substance abuse, alcohol or tobacco, after 9/11 also. So
7 perhaps we should screen people for increases in tobacco
8 use, alcohol consumption, and sleep problems as a better
9 way of identifying folks who need the formula help that we
10 have in the wake of a disaster, rather than asking
11 questions of whether they are experiencing mental or
12 behavioral problems.

13 If we don't ask them, obviously they're not
14 going to tell us. It is important for substance abuse
15 treatment providers to recognize that these events leave
16 their imprints on patients. Disasters, terrorist attacks,
17 and other generalized traumatic events may activate
18 preexisting PTSD or compound the effects of previous
19 trauma.

20 If you don't ask about it, they're not going to
21 tell you. Again, the program should be set up so that
22 there is a disaster plan. The administrators should have
23 an idea of how to maintain the setting and operations, as
24 well as how to reach out to the localities and the state to
25 get the resources they need.

1 The treatment programs should offer therapeutic
2 experiences designed specifically to folks on the histories
3 of trauma and of PTSD, and those programs should be
4 prepared to address disasters and terrorist attacks within
5 and outside of their agencies.

6 The public health system response to trauma
7 thus is that we have to look at the administrative as well
8 as the clinical piece of these systems going from the
9 programs up to the state level, and federal, of course. In
10 the short term and in the long term, what type of research
11 and training are we going to need?

12 CSAT at this point has done quite a few things
13 after 9/11, and with Dan's help also, I just wanted to
14 share with you some of the products that we have developed.

15 At your place setting where you are at, I've had Carol
16 hand out these CDs. These were developed by the Division
17 of State and Community Assistance and are compiled of many
18 of the materials that we discussed today already, in that
19 you have the substance abuse treatment state "All Hazards"
20 plan document that has been developed by Jean Summers-
21 Miller, and the other expert panel members that we have at
22 CSAT. That includes Ivan Watt, who is a medical doctor and
23 was involved in the 9/11 D.C. anthrax response, as well as
24 Henry Bartlett, who is the President of COMPA, which is an
25 organization of methadone directors in New York City.

1 So look through this document, if you will, and
2 let me know if you have any feedback, because we're anxious
3 to see if it is going to be helpful.

4 We also do oversight of opioid treatment
5 program accreditation standards for emergency and disaster
6 planning. That is on here where you have one document that
7 is a programmatic document. It has got a big X on it, it
8 is for methadone programs. It is a template for methadone
9 programs to use whenever they need to start developing
10 their own programs in addressing disasters.

11 We also have the 9/11 CSAT supplemental grant
12 report that is on here. I think all of you received this
13 earlier, this one document. It is on the nine states that
14 we funded. We have also at this point put in some funding
15 support to DTAC, and we're happy to say that we have
16 further research sources in the future now to use and to
17 help us develop more products.

18 Before I end, I just want to thank Carol Coley,
19 who has been my partner in crime, if you will, at the
20 Disaster Response and Readiness Workgroup. She is our
21 program lead. I have been the policy lead. We have Steve
22 Shapiro, Terry Schomburg, and our new members on that
23 workgroup are Arlene Stanton and Jocelyn Whitfield.

24 Thank you very much.

25 (Applause.)

1 DR. CLARK: You got a lot of information in a
2 short period of time. I think because our presenter from
3 the DEA is here, Michele Leonhart, we will have her
4 present, and then we can have discussion subsequently if
5 that is okay with council members.

6 Ms. Leonhart was unanimously confirmed as the
7 Deputy Administrator of the Drug Enforcement Administration
8 by the U.S. Senate in March, 2004, following her nomination
9 by President Bush. She is a Special Agent. She graduated
10 from college in Minnesota with a B.S. in criminal justice.
11 She has pursued her career goal to be a police officer,
12 joining the Baltimore Police Department.

13 Special Agent Leonhart graduated from the
14 Baltimore Police Academy and performed patrol functions in
15 the northwest district of Baltimore. Her career interest
16 in law enforcement led her to the DEA. She was hired as a
17 DEA Special Agent in late 1980. She selected Minneapolis
18 as her first duty station. So the weather here should be a
19 piece of cake for you. She has arrested a number of drug
20 traffickers, varying from millionaires to street-level
21 dealers.

22 She has moved around the country a little. She
23 went to St. Louis, Minnesota, and she is now in Arlington,
24 Virginia. In 1993, she transferred to the DEA Headquarters
25 as an Internal Affairs Inspector and was again promoted and

1 served on DEA's career board until her assignment of
2 Assistant Special Agent in Charge of the Los Angeles Field
3 Division.

4 In 1996, she was promoted through the ranks to
5 Senior Executive Service, and was assigned to oversee a DEA
6 special agent recruitment program at DEA Headquarters. In
7 '97, she was made Special Agent in Charge of the DEA San
8 Francisco Field Division, where she served until her
9 appointment in September of 1998 as the SAC of DEA's L.A.
10 Division.

11 So she has been around the country, she has
12 seen a lot, and she is here to talk to us.

13 MS. LEONHART: Thank you. Thank you very much,
14 Dr. Clark, and George, thank you for the invitation.

15 When we received the letter, it was addressed
16 to DEA Administrator Karen Tandy. She is in Phoenix today
17 addressing the U.S. attorneys who put our drug traffickers
18 in jail, so she couldn't be here, but she asked if I had an
19 interest in it. I said I definitely do.

20 Over the last two years, the Deputy
21 Administrator has had the great privilege to meet some of
22 you around the country and at DEA Headquarters, and I
23 believe in what you do. I think it is real important for
24 you to hear from me, a career drug agent, a narc, truly a
25 narc, what you and your profession and the treatment

1 professionals really mean to us.

2 If you watch the movies, if you read the
3 papers, it always looks like enforcement, prevention, and
4 treatment, we've got the boxing gloves on, and they're
5 always boxing. It always cracks me up. Even at Christmas,
6 I have six other brothers and sisters, and we get into all
7 these debates. We talk about all this, and I said, you
8 don't understand. We have probably never been this
9 organized with the three prongs, which are really
10 enforcement, prevention, and treatment. So it is a great
11 honor, and I thank you for the invitation to be here today.

12 In the letter, it said will you please come and
13 discuss supply efforts on DEA's behalf and some demand
14 reduction efforts. I looked at it when I saw that it also
15 wanted trends. I have got to tell you, after being an
16 agent now for 24 years, about 12 of it which was truly on
17 the street, my first buy I ever made was from a podiatrist
18 who gave me Dilaudid for a stubbed toe.

19 I really have to tell you, there are two
20 professions that have taught me about drug abuse, and have
21 made it easier, especially in those first 12 years on the
22 job, and now working in policy, I am so thankful that I
23 have that background and that I have had those great
24 relationships with many in your profession. Two sets of
25 people really tell DEA agents what is going on, setting

1 aside the informants and set aside those that we lock up
2 and put in jail.

3 It is the treatment professionals. I learned
4 that very early on in Minneapolis. I went to South
5 Minneapolis as a new agent, and really wanted to know. We
6 had a group of people that moved into Minneapolis into one
7 neighborhood, and they dealt cocaine. We had never seen
8 cocaine at the high purity level that was starting to be
9 distributed in the early '80s.

10 We asked around, we asked the street cops, what
11 is going on? Has somebody new moved into the neighborhood?

12 Why all of a sudden have I been alerted by my treatment
13 friends that they have seen a spike? Why has this
14 happened? So I was a grade seven, what they call a
15 narcling, a baby agent.

16 (Laughter.)

17 MS. LEONHART: I realized if I really want to
18 know what is going on, I go to the treatment people. They
19 were able to show me the correlation between availability
20 of cocaine on the street.

21 In one particular neighborhood, in fact, all my
22 buys were out of a bar called Joe's Bar in the men's
23 bathroom. They were the ones that were able to say, okay,
24 this is why. This group from Cuba and South Florida has
25 moved into the area and has brought with them the most high

1 potent cocaine that the area has ever seen. People
2 couldn't handle it. So you started seeing them.

3 The other profession that has helped me out my
4 whole career is my sister, who I love dearly. Here I am a
5 cop, I'm a narc, and she is a teacher, and I respect that
6 profession so much. I have got to tell you, she is in L.A.
7 Unified in a school that has every kind of drug problem
8 mentionable, and when we get together and go out to dinner,
9 she'll ask me, what about this and what about that?

10 I often find myself taking out a pen and
11 writing it down, because I have no clue as to what it is,
12 and here I am 24 years in the Drug Enforcement
13 Administration. With my sister, the treatment
14 professionals that helped me in the early days really
15 taught me about cocaine use and abuse, and really helped me
16 in San Diego understand methamphetamine.

17 It was a treatment professional in San
18 Francisco that met with DEA and told us, "Look, what I'm
19 hearing is methamphetamine is now abuse. It is spreading
20 across the nation. It's no longer a problem in the West."

21 As a treatment professional, that flipped the switch for
22 us, and we have been fighting the nationwide meth problem
23 ever since.

24 So teachers and treatment professionals. So
25 that is why I'm very, very happy to be here today.

1 Let me add two other people that I understand
2 are on your board that have helped. It is very
3 interesting. We recently heard about all these successes
4 in Chicago, and I want to tell you about some of the
5 successes, because not every major city can say this.
6 I believe the answer is combined enforcement, prevention,
7 treatment, and community attack.

8 In Chicago, the overall crime rate is down 4
9 percent, homicides are down 25 percent, and non-fatal
10 shootings are down 39 percent. The police commissioner and
11 superintendent went out and announced this. We know it is
12 because in Chicago, and I appeared at a heroin symposium
13 last summer, we know that Chicago has gotten their act
14 together. We see that we're not going to arrest our way
15 out of the problem, it is not all about prevention, because
16 what do you do after someone starts taking drugs, and
17 treatment is on the back end. So it is a combined effort.

18 I wanted to mention Melody, because I know it
19 is her efforts in that area that have helped Chicago.

20 Another person, I understand he's not here, but
21 I have to actually add a third profession that has really
22 helped DEA.

23 Now, I was a SAC in San Francisco, Special
24 Agent in Charge, and I was a Special Agent in Charge in Los
25 Angeles. The best person dealing with medical marijuana

1 issues and legalization and all that for the last seven or
2 eight years, it was a doctor who has got a nice science
3 background that was probably the best person I ever heard
4 talk about the effects of marijuana. He belongs to this
5 board, and it is Dr. Voth. I was really, really hoping to
6 see him here. I have met him. He spoke at a class I
7 attended in Monterey about five years ago. Absolutely
8 outstanding.

9 You asked for what are some of the successes
10 that DEA has seen, so let me talk about some of that, but
11 with a caveat. When I talk about these successes, it is
12 not just DEA. Every time I talk about it, it is really
13 about the three of us, the three-prong approach.

14 Much of our DEA resources are devoted to
15 pursuing major illegal drug trafficking organizations,
16 cartels, and like in Chicago, the violent traffickers.
17 More often than not, these organizations are complex and
18 frequently have multinational and/or international links.
19 We seek to destroy these groups by not simply seizing the
20 drugs and getting the criminals locked up, but to seize
21 their assets and destroy their financial base.

22 We have put a lot of effort into intelligence
23 gathering, coordination, and cooperation with other federal
24 agencies, both state, local, and our foreign counterparts,
25 which are key, in order to build the best and hard hitting

1 cases.

2 One persistent tenacious problem that you very
3 early have been helping us with is methamphetamine. When I
4 talked about it a little bit earlier, I saw people shaking
5 their heads. Methamphetamine. We saw this drug initially
6 in the western region of the U.S., but today it exists
7 nationwide, largely in rural areas. I'm certain most of
8 you, if not all of you, have seen the devastating effects
9 in your communities with methamphetamine addiction, and the
10 effects they have on their families and their communities.

11 Most recently our greatest impediment to doing
12 something about the meth problem has been the fact that the
13 primary ingredient, if you think about it as a recipe, the
14 primary ingredient you need is a nasal decongestant, which
15 I need right now, called pseudoephedrine. It has
16 widespread legitimate use and availability.

17 Unlike other illicit drugs that require some
18 knowledge of chemistry to produce it clandestinely, meth is
19 easily made with household equipment and materials
20 purchased at major chain store retailers, or even truck
21 stops. Instructions are easily found on the Internet, and
22 we have children attempting to make methamphetamine.

23 DEA and our law enforcement partners have been
24 aggressively targeting the meth superlabs that were
25 responsible for producing and distributing all over the

1 country about 80 percent of the meth found in the country.

2 Through enforcement operations, we have been
3 able to see a shift in the pseudo availability. The
4 traffickers in the west set up these big labs, mass
5 production labs, and were shipping to L.A., they were going
6 to Iowa, they were going to Illinois, they were going to
7 Minnesota, they were going to Nebraska. I have been gone a
8 year, I was back at Christmas and got briefed on a couple
9 of cases, now they are going to Atlanta, South Carolina,
10 and the east coast.

11 We know that the key is cutting off the access
12 to the main chemicals needed to produce methamphetamine.
13 Those are pseudoephedrine and ephedrine. We have made
14 great success. When we got together with our state and
15 local partners, we realized the major superlabs were not
16 going into the Walgreens and getting their pseudoephedrine.
17 They were getting it in bulk coming across the border in
18 Canada.

19 At the time when we started the operation, a
20 lot of the brokers were middle eastern traffickers, and
21 this is right after September 11th. So we set our sights
22 on trying to find out what the connection was, and we were
23 very concerned about terrorist financing and the proceeds
24 from selling this product that you and I can go and get in
25 a drug store, but in bulk, that is our problem.

1 Today we may finally be on the cusp of
2 realizing the serious impact of this drug problem. A
3 number of states have enacted legislation to restrict
4 availability of pseudo, which goes beyond the limits
5 imposed federally. I was reading yesterday that Senator
6 Feinstein, and I believe 12 other Senators, have just
7 rolled out proposed legislation similar to other
8 legislation in states, very aggressive legislation that
9 will help the control of pseudoephedrine.

10 Why? Because the superlabs that used to
11 produce for the whole entire country, we have basically
12 shut down. They are dropping at dramatic rates. So it is
13 these small toxic labs we call "Beavis and Butt-Head" labs
14 out in your communities, the ones that blow up, the ones
15 that cause all the environmental damage, and are right in
16 the middle of your nice neighborhoods. That is our threat
17 right now.

18 Legislation, state legislation, is really
19 moving quickly, and it is the right thing to do. Now we
20 see a rollout of federal legislation.

21 I'm happy to tell you that we realize a
22 significant number of successes each year by actually
23 targeting the right criminals and putting them out of
24 business.

25 The example is LSD. You remember LSD back in

1 the '70s. What is it? Tune in, tune out, whatever. Dr.
2 Leary. You remember that. It was a major problem in the
3 '70s. Then it went away. But it has popped up, the same
4 with Ecstasy, and has been a very popular drug for young
5 adults, and especially in connection with rave parties.

6 Well, we targeted the right person. Although
7 it took us 30 years to get there, it was as simple as
8 identifying and realizing when we came upon him that there
9 were two individuals in Northern California that probably
10 produced the world's supply of LSD.

11 There were only three LSD labs seized in DEA
12 history. The fourth one was seized in 2001 as a result of
13 this great focused enforcement approach with our state and
14 local partners.

15 They were operating this major lab out of a
16 missile silo in, if I get this right, Winteka, Kansas. The
17 middle of nowhere. They were producing the world's LSD
18 there.

19 Well, guess what? Great investigators go out
20 there, arrest them, arrest their product. For the first
21 time, you can see since that happened, every year there is
22 this decline, decline, decline of LSD. You probably see
23 it.

24 You cannot find LSD right now. Over a 60
25 percent reduction, 60 percent reduction. So here is a DEA

1 operation just focusing on the right person that wipes out
2 LSD. But that is not always going to work with some of
3 these other drugs, and that's why it is so important for us
4 to work together.

5 We had Ecstasy kind of drop on top of us, and
6 all of a sudden kids were going to rave parties, young
7 adults, we had deaths, and it became a national problem.
8 You saw it. It was the whole community. Law enforcement,
9 enforcement, and treatment that did something about it.
10 You have all been out there talking about it, spreading the
11 word, and doing community education on it.

12 It is a good time for me to introduce, I
13 brought Catherine Harnett with me. She is our Chief of the
14 Demand Reduction Section in headquarters. She thinks the
15 world of this group. I had a chat with her this morning.
16 We would like to be invited. If you want us to give you
17 the latest trends and you can give us five minutes, we'll
18 come and do it. If you want to see us here for an hour,
19 we'll do it. Catherine is the one to coordinate with.

20 There are outstanding things being done by our
21 demand reduction coordinators in the field. If you haven't
22 met one, there is one in all 21 field divisions, and some
23 of them have two. I would suggest that is the greatest
24 resource for you is they are DEA special agents, but they
25 have an interest and they have the desire and the drive to

1 do something about abuse.

2 I talked about this Ecstasy case. It was
3 called "Candybox." Again, it is focused enforcement, we
4 picked an operation and little did we know when we started
5 it a few years back, that it would wipe out 15 percent of
6 the country's MDMA, or Ecstasy, supply. So if you are
7 seeing fewer people coming in, fewer people with abuse of
8 Ecstasy, they are having a harder time finding it.

9 We implemented an impact study basically to try
10 to find out, that's our biggest challenge, how do we, and
11 it is probably one of yours, too, how do we really show
12 that we are making a difference? By looking at that one
13 operation, we were able to show a 15 percent reduction in
14 availability.

15 We were able to show in the cities where we had
16 enforcement operations, in the cities where we did combined
17 treatment, prevention, education of the public, the price
18 went up, and the availability is down. It has been
19 sustained over a six-month period. So we are proud of
20 that.

21 There is more major successes, and I'll just
22 mention a few, because I know you guys probably want to go
23 to lunch. But I mention them, I just told you about two
24 enforcement operations. But these successes are huge.
25 They are because of your efforts and our combined

1 partnership.

2 Since 2001, 600,000 fewer teenagers are using
3 drugs. Could you ever imagine that? I know I couldn't.
4 Current marijuana use by teens has dropped, and marijuana
5 was our biggest. We have been worried about marijuana
6 because we saw that use go up. Well, since 2001 it
7 continues to drop. It dropped 11 percent last year, and
8 now I think Catherine we're up around 17 percent. It is
9 unbelievable.

10 Cocaine. So many of you handle cocaine
11 problems. Well, the entire South American cocoa harvest is
12 at its lowest level in nearly 20 years. The cultivation of
13 coca has been slashed 21 percent in Colombia. You haven't
14 felt that yet, but we have people that are charting this
15 out, and they think for the first time by summer we may see
16 indications of availability problems with cocaine.

17 We indicted 89 percent of the leaders of the
18 most wanted international drug organizations responsible
19 for supplying drugs to the United States streets. I told
20 you about meth superlabs. Cocaine use has plummeted over
21 70 percent during the past 15 years, with almost 3.5
22 million fewer Americans using cocaine today than two
23 decades ago. Phenomenal.

24 DEA has almost doubled the seizure of drug
25 proceeds from these traffickers in the past year. We see

1 this as a success. Over \$5 billion in drug controlled
2 funding was allocated for treatment, prevention, and
3 research in 2004. Communities in 42 states are the
4 recipients of over \$18 million in '04 to establish or
5 continue drug courts.

6 So those are great successes that we all share
7 in, but we also share in the challenges. The biggest
8 challenge for us is to get out the message, what is the
9 effect of drug use on the non-user? Our administrator
10 likes to call it the secondhand smoke message. How do you
11 convince someone that says look, I don't use drugs, my kids
12 don't use drugs, so it doesn't bother me. I don't care if
13 this saves the country money, I don't care, fewer people
14 going to jail, I don't care because it is not going to
15 affect my family.

16 What we do is we try to send the message that
17 in 2002, 11 million Americans age 12 and above, and I
18 always wondered how you could be a 12-year-old driver, but
19 12 and above admitted that they drove under the influence
20 of illegal drugs in the past year. An innocent driver may
21 not have abused drugs, but the innocent driver is the
22 victim on the road when someone has taken drugs and decides
23 to drive.

24 Just like the dangers of secondhand smoke, the
25 drug use kills 21,000 Americans each year. Nearly half of

1 the people stopped for reckless driving who weren't drunk
2 tested positive for marijuana. Three-quarters of illegal
3 drug users are employed in the workplace, which means
4 employers have the problem, and then we pass on the health
5 care problems.

6 Illegal drug use leads to crime. Two-thirds of
7 men arrested for crime in 36 cities nationwide tested
8 positive for illegal drugs. One-third of all AIDS cases
9 are drug related. Who is the biggest victim here? It is
10 children.

11 Last year alone, 9,000 children were abused by
12 parents involved in methamphetamine in Iowa. That abuse
13 and neglect strains our social services, and we all pay the
14 price. I could go on and on and on. I hope what you got
15 from what I said today was how this is really a
16 partnership, and we all, if we can find a way all staying
17 in our lanes, doing our individual what we are supposed to
18 be doing, but doing it together, we can make a difference.

19 DEA is committed to it, and I don't want to
20 leave you without telling you, you asked for trends, I get
21 trends from you, but hopefully I can give you a new trend.

22 You saw what happened with OxyContin. Huge abuse all over
23 the country, hit a lot of people by surprise, but I'll bet
24 you saw it first.

25 Well, there is a new type of OxyContin that was

1 released in January. It is called Paladone. Four times
2 more potent than OxyContin, eight times more potent than
3 morphine. Released in January. How long until it starts
4 being diverted and hits our streets?

5 So if there is any one trend, I felt I can't
6 leave, you can give me the hook and take me off. I needed
7 to tell you about that, because that is going to cause all
8 of us a major problem. The pharmaceutical problem is
9 growing and growing, and for the first time, you heard the
10 President talk about it, it is in his National Drug Control
11 Strategy, you heard the drug czar John Walters talk about
12 it, you've heard former -- I guess almost today, tomorrow
13 -- former Attorney General John Ashcroft talk about it, and
14 you are going to hear DEA talk about it.

15 We've got to do something about the
16 prescription drug problem. Why can't we just use our
17 regular techniques on our side, because now it is available
18 over the Internet. We see these spikes in pharmaceutical
19 drugs caused by the Internet. So we're working on it.
20 We're putting strategies together, we're working with you

21 Our demand reduction agents out in the field
22 would love to be invited to your meetings and give your
23 folks updates on drug trends. We have been wanting to do
24 that for years. So again, I just want to thank you so much
25 for the invite to come today and to share that.

1 I know they wanted a little question and answer
2 period, so I've got Catherine here to help on demand
3 reduction questions. I've got my assistant, Joel Fries, in
4 the back who has got 30-plus years as a diversion
5 investigator working the prescription side. What can we
6 help you with?

7 DR. CLARK: Melody?

8 MS. HEAPS: The Afghan heroin specter, where
9 are we? Have we seen it? It is hard in Illinois, in
10 Chicago, because we tend to be a heroin capital. We are
11 seeing some increase, but we're not sure yet.

12 MS. LEONHART: Right. Let me say this. A lot
13 of people are asking DEA, why are you even interested in
14 Afghanistan heroin? Because you don't find it very often
15 in the United States. It has flooded Europe, they should
16 be worried about it. But they say, why should DEA be
17 worried about it in the states? Well, we are very worried
18 about it.

19 It was just years back when Afghan heroin
20 supplied three-quarters of all the heroin in our country.
21 So we have to learn from history. We can't let up. As we
22 are attacking and doing all these things in Colombia and
23 Mexico, you had better believe that with the right
24 traffickers having the right access to domestic
25 traffickers, you are going to see Afghan heroin cheaper

1 than the other heroin, more potent than the other heroin,
2 we suspect, if nobody is doing anything about it.

3 So I didn't put it up as a trend, because it
4 really isn't showing up yet, but it is another thing, like
5 Paladone. Let me throw it out to you. Thanks, Melody, for
6 bringing it up.

7 Let me throw it out to you to watch. If that
8 gets out of control, we're in trouble. There are no jails
9 in Afghanistan. We have 12 agents over there trying to do
10 drug work. There is no counterparts. We are just training
11 a police force. There is no prisons, there is no judges.
12 There is no prevention, there is no treatment.

13 So the United States takes on that
14 responsibility to do something about it. We have got
15 something in place, and we are hoping, it is called
16 Operation Containment, to contain it, contain it there in
17 the region, not let it out of the region, and not let it
18 affect the U.S. drug market.

19 Thanks for that question.

20 DR. CLARK: Dave?

21 MR. DONALDSON: Two questions for you. First,
22 I was talking with Richard yesterday about the national
23 survey that we received on drug use. Speaking of
24 geographic trends, we were curious about the drop in the
25 rural area, which according to this, was very significant.

1 More than half. He said he didn't believe it, especially
2 with the spread of meth.

3 MS. LEONHART: Right.

4 MR. DONALDSON: Is this correct? And if so,
5 why?

6 MS. LEONHART: Well, I'll ask Catherine if she
7 knows about that study. I haven't read that, but there are
8 a couple of people that have said has there been a change?
9 Can we actually say there has been a change in drug use in
10 rural areas?

11 I find it very hard to believe, but I haven't
12 seen the study, and I don't know, was it specific drugs? I
13 don't know who they looked at. But I will say this. If it
14 was regarding methamphetamine, I believe that is the
15 residual of all those efforts on your behalf and the
16 efforts on the enforcement to shut down that pseudo supply
17 out of Canada. It is just a matter of time.

18 We have already seen a slight rise in these
19 "Beavis and Butt-Head" labs in rural areas, and moving
20 east. So that does surprise me.

21 Catherine, are you aware of this?

22 MS. HARNETT: Which survey is it? The report
23 that was out last December?

24 MR. DONALDSON: Correct.

25 DR. CLARK: It is the Household Survey.

1 MR. DONALDSON: Yes.

2 MS. HARNETT: I know that the meth numbers, at
3 least some of the prevention people that we talked to,
4 there is some concern that they are not capturing
5 everything we need to capture. I think also with the
6 arrest data not available anymore in the form that it was,
7 we may be missing some rural users.

8 But really I'd like to look at it more
9 carefully and talk to some more people, but it does show
10 either meth declining or steady I think in a number of
11 areas. But I'd like to check more into it. As you know,
12 it is easier to measure in some of the urban areas than it
13 is in the rural areas.

14 MR. DONALDSON: Yes.

15 MS. HARNETT: In terms of both prevention and
16 statistics, that's an area that we really need to do a lot
17 of work in.

18 MR. DONALDSON: Yes. According to our
19 networks, in the rural areas it is just spreading out of
20 control. I was shocked to see that. I hope that's
21 correct.

22 MS. HARNETT: And I think the Monitoring the
23 Future also shows similar reductions in meth, or no
24 increases from last year.

25 MS. LEONHART: We'll remember that. We can now

1 go back and look. I was surprised, the huffing or the
2 inhalants, I grew up in rural Minnesota, and that was big
3 back in the '70s. Rural drug use seems to be a lot
4 different than big city drug use. But I am very interested
5 in your question, and we'll definitely take a look at it.

6 MS. HARNETT: And our demand reduction people
7 across the country that serve in rural areas continue to
8 say that meth is an enormous problem.

9 MR. DONALDSON: The other question is you
10 mentioned different institutions that you are partnering
11 with to help you. What about the faith community? How are
12 you partnering with the faith community, and how can we
13 better help you?

14 MS. LEONHART: Well, I can tell you Catherine
15 is our go-to person on that. She has briefed me and the
16 administrator, and I know that there are some good projects
17 coming up down the pipeline.

18 Catherine?

19 MS. HARNETT: Particularly in Missouri, we have
20 a very strong relationship with the Addiction Academy, I
21 think it is called, in Missouri. Our DRCs, some of them
22 across the country are working very closely with the faith
23 community both in prevention and in addiction treatment.

24 It varies from place to place depending on what
25 kind of programs are in place. But we do as best as we can

1 where the communities are set up in the vein to work with
2 them. That is one of our priorities, working with the
3 faith community.

4 We do, I think, in Baltimore have some
5 programs, and Missouri, the St. Louis area, I think is our
6 strongest faith-based programs. But it is something that
7 we consider a top priority where it does have an impact on
8 the community.

9 MS. LEONHART: Anyone else? Sure.

10 DR. MCCORRY: Could you say a little bit more
11 about DEA's plans with prescription misuse?

12 MS. LEONHART: Sure.

13 DR. MCCORRY: Or their version of prescription
14 drugs, and what is the kind of game plan for addressing
15 that?

16 MS. LEONHART: Well, to stand up and talk about
17 pharmaceuticals and what we are doing, we have our hands on
18 so many different things that we have never done before, so
19 I'll throw out a few and you'll see.

20 One is through Catherine and our very talented
21 diversion folks. They have come up with what we call the
22 Medical Examiners Database. The administrator when she
23 came on board a year ago said, we wait for DAWN data,
24 that's too late for policymakers and for all of us to
25 really be able to react quickly to changing trends.

1 So it is just in the pilot right now, but I
2 believe we have got people working on it and we were able
3 to bring it to medical examiners, and is it seven or nine?

4 MS. HARNETT: Nine.

5 MS. LEONHART: We have nine medical examiners,
6 some rural, some big city, state, some are city or county
7 coroners, and others are for the state. Now for the first
8 time we have given them the tool to talk to each other.
9 This is going to become very important when we see what
10 happens here with Paladone being released. All of a sudden
11 we see this spike. And are the medical examiners able to
12 pick it up?

13 And I think the dream would be if all of us
14 working in the area could have some method to talk to each
15 other on a regular basis and to post, here we are seeing a
16 spike and you need to know it might not be anything, but
17 here law enforcement, you need to do what you can on it,
18 here treatment and prevention, you guys need to know about
19 this, it could be headed your way. That is one of them.

20 Our Internet strategy, I've got to tell you, we
21 are back at Internet 101. There is one thing the agents
22 aren't real good at, and that's the Internet. They're out
23 making drug cases. The bulk of our agent workforce is not
24 from the techie age. So we are at 101, and we're learning
25 about the Internet.

1 We have this new technology we call the
2 Webcrawler, which is going to these Internet pharmacies.
3 There could be one organization or one person behind it,
4 and they could have 100 pharmacies. There was no way to
5 connect the dots to be able to show, okay, that one person,
6 here we are focused on this one Internet pharmacy, but that
7 person is controlling all of these.

8 Our Webcrawler technology is in there. Think
9 of it as a huge Google. It crawls in there, finds the
10 connections, and then it makes a snapshot for us. We're
11 going to be able to use that in prosecution and in focusing
12 on resources.

13 Another very interesting thing, and I never can
14 say it right, I want to say phenylephrine. We are hoping,
15 there is a manufacturer that just released a new nasal
16 decongestant that they claim cannot be used in meth labs.
17 If that proves to be correct, you are definitely going to
18 see an impact on methamphetamine use. People are not going
19 to be able to get it. That goes back to the controlling
20 the pseudoephedrine.

21 There is legislation in '05, and we are just
22 waiting to sit down with the FDA, which actually puts DEA
23 on a panel to review new drugs coming out with the
24 potential for abuse, and lets DEA look at it and give
25 comment. With Paladone, we suggested, but it wasn't taken.

1 We were almost powerless there that it really be marketed
2 for severe pain. I mean, four times OxyContin, eight times
3 morphine. But we run this balance and we also realize that
4 these are very, very sick patients. They need this kind of
5 medication. So we walk this tightrope. We are very, very
6 happy to see more interaction now in DEA. We are hoping
7 to, so we don't have an Oxy problem jump up on us, put
8 things in place that can give us the red flag and say look
9 at this.

10 If there was some way we could develop that
11 with this group, that would be the best of all worlds. I'm
12 going to go back and talk to Catherine about it. If it
13 works with the ME database, could we do something else?
14 They are talking to each other. They are posting warnings.
15 Fentanyl lollipops. They are the first people that told us
16 this stuff was happening. So that's just a few things.

17 DR. CLARK: One last question, Melody.

18 MS. HEAPS: The ADAM program. There was word
19 that it was going to be resurrected and put in a different
20 place outside of Justice, and we haven't heard anything
21 about it. It was a fabulous tool for many reasons.

22 MS. LEONHART: Right. First of all, all of us
23 use ADAM, we use DAWN, and we needed QUICK. When we heard
24 about ADAM going away, we were very concerned, because we
25 depend on it. It tells us what they are using, and the

1 last I heard, and I'm going to let Catherine speak if it is
2 wrong, but the last I heard, they were looking at possibly
3 ONDCP picking up the funding and carrying the ball so that
4 we don't lose.

5 I'm worried about losing one year's worth of
6 data. So we stand with you. We definitely stand with you
7 concerned about ADAM. We are hoping for some of these
8 other things like the ME database and just prescription
9 monitoring programs in the individual states.

10 It was great. We did testimony on the Hill and
11 we could show in the 22 states I think it is that have
12 prescription monitoring programs and that have gotten
13 grants to set these up, they have the lowest abuse of
14 OxyContin numbers. I mean, they are the lowest. So there
15 is definitely a correlation there. Then you look at the
16 states that have done nothing on prescription monitoring,
17 and they are high. Good question.

18 Well, thank you very much. Really, we offer to
19 come and give you drug trend information. I had a
20 PowerPoint I was going to give you, but I really think I
21 needed other things to tell you rather than how cocoa in
22 Colombia is produced and all that.

23 Thank you.

24 (Applause.)

25 DR. CLARK: We still have our disaster people

1 here for questions.

2 Frank?

3 DR. McCORRY: Just a quick question around
4 critical incident debriefing, which we kind of use a lot in
5 New York and has been used a lot. But then I understood
6 that it was not viewed as favorably as a post-disaster kind
7 of intervention. Is there anything on that?

8 DR. DODGEN: This is actually a somewhat
9 complicated issue. What makes it complicated is that, as I
10 said earlier, the research base is just not very
11 sophisticated in this area, particularly when we are
12 talking about intervention.

13 For those of you who don't know, critical
14 incident stress debriefing is a popular model used by many
15 law enforcement, DEA actually uses it, as do many branches
16 of the military in many of their units as a way of
17 addressing potential stress problems with people who are
18 first responders to some of these different kinds of
19 events.

20 The reason it has become controversial is that
21 there is some research that suggests that if the
22 intervention is done in certain ways, there is actually a
23 potential for harm. Not just for having no benefit at all.

24 It appears to be that in particular when people use a
25 model that is really designed for group processing, but

1 they do it with individuals, for people who use sort of
2 their multiple steps that are part of the intervention and
3 don't necessarily follow all those steps, for example,
4 verifying that you have a heterogeneous or a homogeneous
5 group, which is what it is designed for, people who already
6 know each other, already work together, already have sort
7 of shared experiences and you do this process with them, it
8 has benign effects, and in some cases, very positive.
9 Versus if you just sort of pull a bunch of people who were
10 called into an emergency situation and don't know each
11 other and in many cases compel them to go through a group
12 processing of experience, that is where you get some of the
13 harmful effects.

14 So the research, again, is very, very early on
15 this. I'm not going to say that we've got definitive
16 research on this, but what I'm seeing so far suggests to me
17 that if the model is adhered to pretty strictly, there is
18 little potential for harm, and significant potential for
19 positive benefit. If the model is not adhered to strictly,
20 there is in fact potential for harm for people.

21 As we know, for some people you can
22 retraumatize them by having them sort of go through the
23 experience again verbally. If you have either unskilled
24 clinicians doing that or people just not following the
25 model, I think there is potential for harm, and it is

1 something we need to be very cognizant of.

2 MR. DONALDSON: Well, I want to thank you for
3 your presentation. It was very good. This is an area of
4 service of great interest and great concern. I was
5 involved in the national summit that you mentioned in New
6 York helping to facilitate the faith-based side.

7 I just wanted to follow up on some of the items
8 that were discussed then to see where we are at. First was
9 the collection of the needs assessment data. You might
10 want to write down a few of these. Two, the delineation of
11 roles and duties. I know for a fact that there is still
12 confusion on the grounds. It is like adding disaster to
13 the disaster.

14 I think there were some good things that
15 happened in Florida, the team that has been comprised
16 there. But where are we at with the plan for the
17 continuation of services? So do we have guidelines for
18 handling the stockpile of medications, for example? What
19 about food?

20 DR. DODGEN: Let me talk about this in a couple
21 of different levels. At a level particularly of SAMHSA in
22 terms of what we're doing, the expert panels that I
23 mentioned to you a minute ago, some of the issues that are
24 brought up in that consensus document from the meaning that
25 you're referring to, we've actually had multiple expert

1 panels. I mentioned assessment as one, but also outreach,
2 intervention, a number of different issues.

3 All of those if you go to the report from that
4 9/11 meeting []-

5 MR. DONALDSON: But I'm not referring to
6 information gathering. I'm referring to implementation.
7 We have been talking about this going on four years.

8 DR. DODGEN: Right. If you'll allow me to
9 continue. What I was going to say, because I think your
10 point is exactly right on the money. What we need to do
11 first is really find out what we already know and get the
12 experts together. That has actually been done. That is
13 what I was talking about.

14 Now what we're going to as the next phase,
15 which is exactly what you pointed out, the implementation
16 phase, and part of that of course is our Disaster Technical
17 Assistance Center, it is some of the other activities that
18 you're referring to where we need to get the people who are
19 now providing the technical assistance up to speed on what
20 is happening. In fact, that is what we're doing right now,
21 that is part of why we created the Technical Assistance
22 Center.

23 It is so that when people who are developing
24 plans call into us and say, hey, what are we supposed to

1 do, then we actually have some answers for them. The
2 reason that I caution is because I'm not going to tell you
3 that we have all the answers and all this, we don't. But
4 we are developing, and we are getting the information that
5 we have out there.

6 I think your other question is really a big
7 picture HHS question in terms of the Strategic National
8 Stockpile and in terms of some of the other things. The
9 Strategic National Stockpile, as you probably know, has
10 been a very, very tricky issue because in the legislation
11 that created the Department of Homeland Security, that was
12 actually moved from the Department of Health and Human
13 Services over to the Department of Homeland Security.

14 That was probably not an appropriate thing to
15 have happen, because they really didn't have the expertise
16 over there. It has now moved back, although sort of the
17 authority to deploy it and the authority to administer it
18 are now housed in two different places. That is a long way
19 of saying that as a consequence, it is both a political and
20 a policy issue in terms of what happens with the Strategic
21 National Stockpile.

22 Having said that, though, I will say that there
23 are people now looking at the contents of the stockpile in
24 ways that they weren't a couple of years ago in terms of
25 what are some of the other kinds of medications that need

1 to be in there beyond sort of just the initial kind of
2 vaccination and sort of emergency medical response
3 medications that were initially part of it, some of the
4 Mark IIs, the anti-agent things that were in there. So I
5 think that we're actually seeing progress in where that's
6 at.

7 But again, in terms of the list of what's in
8 there, I can't really talk about that in a public forum,
9 but I know that people are talking about some of the
10 issues. Does that help? Does that address that question?

11 MR. DONALDSON: Not really.

12 DR. DODGEN: Okay.

13 MR. DONALDSON: To be honest with you, you are
14 working on it, and I know that we're working on it as well.
15 But this is very important.

16 If I can just follow up on a question I brought
17 up the last time we met. You weren't here at that time.
18 It pertains to the use of volunteers. Relating to
19 substance abuse, we know what happened on 9/11. Many
20 clergy and chaplains were turned away. In fact, one study
21 said over 700, because there was no certification process
22 in place.

23 Bobby Polito, he was there in the counseling
24 center. He reported back to the Secretary that people were
25 looking for their pastor, priest, or rabbi to talk to, but

1 all that we had there were psychiatrists. Many of the
2 psychiatrists were in a back room playing cards because
3 nobody wanted to meet with them.

4 In part of your discussions, is there any kind
5 of certification process that would allow those that have
6 been laboring around those disaster sites for decades,
7 again, clergy, chaplains, that would have that kind of
8 organized and approved access?

9 DR. DODGEN: Yes. I think actually there are a
10 couple of different answers to your question. I think it
11 is a very good one. I know I actually am myself a Red
12 Cross disaster mental health worker, and have been doing
13 that for about 12 years, 13 years now.

14 I agree with you. I think many people are more
15 comfortable talking with clergy than they are talking with
16 people that are identified as mental health professionals
17 or substance abuse professionals. I think that there are a
18 couple of different ways that that question has to be
19 answered.

20 First off, of course in the volunteer
21 organizations, I'm sure you're familiar with the Red Cross,
22 it actually has a chaplain core that is integral to them,
23 and it has its own certification process. Anytime the Red
24 Cross deploys, they are deploying clergy as well. The
25 little green-vested people if you think in your disaster

1 site, and of course there is the whole aviation incident
2 response which also has a spiritual care unit.

3 So I think on the volunteer side, they actually
4 have been looking at these issues for a long time and
5 already have mechanisms in place for addressing it. I
6 think on the federal side, of course you know the
7 Department of Defense which was very involved in the
8 Pentagon, less so in the response in New York City, also
9 has significant chaplains. Those folks, all of the
10 Department of Defense's response teams include clergy as
11 well as perhaps social workers, mental health, as well as
12 nurse or physical health care.

13 So I think there are a number of places where
14 that is already incorporated. At the end of the day, is
15 the Department of Health and Human Services going to
16 develop an initiative that includes clergy? Probably not.

17 The department is actually trying to avoid sort of
18 bleeding over beyond our public health response, so it is
19 unlikely that they would develop actually a certification
20 process.

21 As you know, certification and credentialing is
22 an incredibly complicated and very controversial issue,
23 period. I don't care if we're talking about mental health
24 or substance abuse, or if we're talking about nurses,
25 physicians, or whatever. We actually have to be really,

1 really careful to not get into issues that historically
2 have been the guilds' responsibilities in terms of sort of
3 who is credentialed and who is qualified.

4 So I don't anticipate the department trying to
5 come up with some sort of procedure for doing credentialing
6 or certification for clergy, or really for anybody else in
7 a disaster setting. That is actually something that I
8 don't think at the federal level we want to get into.

9 MR. DONALDSON: That's unfortunate, because I
10 feel like this is one of the greatest entry points for us
11 to help professionalize many of the clergy and chaplains
12 that we have out there.

13 DR. DODGEN: Well, I appreciate that comment.
14 And I can actually convey that up. I won't tell you it is
15 not going to happen, because as you know in the last couple
16 of years, many different things have happened that we
17 didn't think were going to happen.

18 I'll be happy to actually pass that forward.
19 It would be interesting to see if that generated discussion
20 department wide. It would just be hard to know where that
21 would go, but I can pass that forward.

22 MR. DONALDSON: Thank you very much.

23 DR. CLARK: Ken, and then Anita.

24 MR. DeCERCHIO: Let me speak to some of your
25 comments. What we found is we learned from Andrew in

1 Florida, just to give you the scope, we had four hurricanes
2 in five weeks. The first hurricane, Charlie, 24 counties
3 out of 67 were a disaster. Frances, 42 counties were
4 declared disaster out of 67. Ivan, an additional 16, and
5 16 more with Jean. At any one point in Florida, all but
6 about 13 counties were declared a disaster area.

7 Dave, on your point, a couple of things. We
8 ended up networking this time that we didn't do with Andrew
9 with the Florida Interfaith Network. Jody came to me a
10 couple of years ago and said look, we didn't connect in
11 Andrew, and there is an opportunity here. We don't have to
12 certify them. I mean, they have a process by which they
13 engage, they engage ministers and ministries.

14 Our role was to just make them a part of our
15 team in a coordinative way and let them not get in their
16 way, and then tap into the tremendous resource, support,
17 coordination, that they do, so that it was, well, for
18 obvious reasons. So I guess I'm suggesting in that respect
19 there is a lot of activity, and maybe a role to identify
20 those types of organizations.

21 We trained people to go out in these disasters
22 on basic crisis counseling that were accountants. So the
23 idea that a clergy would have to be certified as opposed to
24 get the basics in terms of the crisis response, I think
25 we're overdoing it in terms of a certification process as

1 opposed to people with compassion and clergy skills in
2 terms of here are some core things, depending on where in
3 the disaster you are connecting, that I think could turn
4 lose a tremendous cadre of what your intent is.

5 That is just from our experience. We did a
6 better job of coordinating with Lutheran Disaster Response,
7 and let them work it. The scope was kind of phenomenal. I
8 have to say that I really appreciate Sheila's work and
9 SAMHSA's work on this from a recipient, from someone that
10 was in the middle. I wasn't in the middle. I was kind of
11 in a coordinative role for people in the field. But early
12 on I asked for a coordinator response from SAMHSA with FEMA
13 so that we weren't having a quarrel with Centers for
14 Substance Abuse Treatment and the Center for Mental Health
15 Services.

16 Our responses were coordinating with mental
17 health through part of the mental health team, so we
18 weren't just communicating with the field in substance
19 abuse in one path in mental health and one path in
20 communicating up. I found that to be very extremely
21 critical. It required access to crisis services and crisis
22 response grants that was inclusive of substance abuse. One
23 of the largest responses in the state for crisis counseling
24 was managed by primarily a substance abuse provider network
25 that had mental health agencies. They handled the response

1 in all of Southwest Florida in terms of the immediate
2 crisis services grant.

3 I won't go on and on. I have to say I really
4 appreciate SAMHSA's response to that and coordination with
5 other federal partners. The tendency for us in the state
6 is to reach out to the community and say what do you need,
7 and start deploying. The tendency for the feds is to call
8 us and say, what do you need? There are times when the
9 responses all have to be measured.

10 We found that waiting when an area is hit and
11 letting the area assess and determine their needs and then
12 having people prepare to move in was pretty critical.
13 Communication. You can't over-communicate in these
14 situations all over the place. I just can't say enough
15 about the level of communication that is required, both
16 with our federal partners and across the state with the
17 state emergency disaster response and with communities.

18 We were having two calls a day with each of the
19 areas that were affected. A lot of our role was
20 coordinating with FEMA and the big state disaster response.

21 You really have to respect what communities are going
22 through and not want to have a bunch of folks reaching down
23 doing things across purposes that at the local level seems
24 like chaos.

25 You can think about the chaos created by the

1 disaster, and then folks reaching down trying to do things
2 all over. They want a coordinated response. A lot of what
3 we do as managers was facilitating that.

4 I won't go on beyond that. The idea of opioid
5 preparedness was a big one. Thankfully we only really had
6 one situation where a patient had to call us and said I
7 can't get access. The providers were tremendous and we
8 gave a lot of flexibility in providing and letting them
9 access and create all kinds of opportunities for doing
10 guess dosing and access to centers, because we had a fair
11 amount of impact, large areas that you can imagine were
12 impacted.

13 So if you are not prepared, get prepared.
14 There is nothing like going through it for the lessons
15 learned. I just really have to say that I appreciate all
16 the support in helping us put together the crisis
17 counseling grants, the crisis response grants, and the
18 supplemental, which is in process. Pretty critical, pretty
19 critical.

20 The takeaway, there is a lot of focus in the
21 first 30 days and the first 60 days, but the trauma is for
22 a couple of years. So we are really trying to put together
23 a plan that extends out over a period of time, and that
24 creates some enhanced treatment capacity that typically is
25 not available through traditional crisis services grants.

1 So I really appreciate everything that everybody did,
2 frankly.

3 DR. CLARK: Anita?

4 MS. BERTRAND: Good morning. I thought the
5 presentation was very informative. I have a question. You
6 all may know this, but I'm the new kid on the block, so I
7 want to ask.

8 I was thinking that perhaps as we talk about
9 workforce development, that there is ways that we can
10 intertwine curriculum to support, I want to say the
11 vulnerable population. There is a large percentage of the
12 people that are abusing substances that when disaster
13 strikes, and you talked about this in your presentation,
14 that will cross that line.

15 I was wondering also if the other departments
16 are working in conjunction with CSAT. I know we are on the
17 back end to put supports in place for the vulnerable
18 populations who are, I want to say abusing. I think that
19 that's critical.

20 DR. DODGEN: Yes. I think, again, that's a
21 very, very good question. You have a really good council
22 here. You guys have some great questions.

23 I think that increasingly we are beginning to
24 look at issues of all kinds of special populations that
25 even a few years ago we probably weren't looking at,

1 including the homeless, including people who are
2 HIV-positive, including people who are just not ambulatory
3 for whatever reason. They may be seniors, they may be in
4 nursing homes, they may be in some other kind of inpatient
5 facility.

6 I think the situation in Florida that Ken was
7 just talking about actually really illustrated that very
8 well, because they actually had to set up some special
9 needs shelters in Florida just for some of these groups
10 that really couldn't just get in their cars and leave, and
11 weren't going to be able to respond to some of the typical
12 evacuation procedures for a number of different reasons.

13 So I think that there is an increasing
14 awareness of this. There are in the plans that are being
15 developed, some of which have been released, like the
16 National Response Plan, where there are now sections about
17 special populations, now your question is about two things,
18 though.

19 One is are we thinking about it, and I think it
20 sort of gets back to your question, are we thinking about
21 it, and are we doing anything about it. As you know, that
22 is a multistage process. So I think the answer is I don't
23 think a few years ago people were even really talking very
24 much about special populations, particularly people with
25 chronic mental illness and substance abuse, but a number of

1 other special populations as well.

2 I think people are now talking about those.
3 Those are now being written into plans. I think that you
4 probably know that, for example, CDC and HRSA both have
5 their big billion dollar state plans for bioterrorism
6 preparedness. They are now being asked to look at special
7 populations.

8 The reality is the quality of what is in many
9 of these plans as it addresses these special populations is
10 still not very good. So we have, again, to go back to the
11 implementation question, we have to do a better job I think
12 of pulling the information that we already have together to
13 give assistance to states, and then we have to hold
14 people's feet to the fire a little bit to make sure that
15 they do it.

16 They are getting federal dollars in some cases
17 for development of these plans, and I think we need to do a
18 better job of making sure that the plans really reflect
19 what the guidance says they have to. So we are starting to
20 talk about it, we are starting to ask people to do it, but
21 when you actually look at what is written into the plans,
22 we still have a ways to go before we really can say that we
23 are successfully addressing these issues.

24 DR. CLARK: Thank you, Dan. I appreciate your
25 presentation, and your presentation, Sheila, and the

1 support that you both have, Carol and others, Ruby, and
2 Jocelyn. Thank you very much.

3 Why don't we just move to the last presentation
4 of the day instead of taking a break, and then you can
5 decide whether you want to linger on or not. The last
6 presentation is on e-therapy. We are going to dial in Val
7 Jackson.

8 Sheila, do you want to come forward?

9 DR. HARMISON: Hi, Val. This is Sheila.

10 MS. JACKSON: Hi, Sheila.

11 DR. HARMISON: I'd like to begin with telling
12 you a bit about where we are at with e-therapy. But before
13 we do that, let's take a look at what the President had
14 said in his State of the Union address on January 28, 2003,
15 supporting the work that we're doing here.

16 "Addiction crowds out friendship, ambition,
17 moral conviction, and reduces all the richness of life to a
18 single destructive desire. Let us bring to all Americans
19 who struggle with drug addiction this message of hope: the
20 miracle of recovery is possible, and it could happen to
21 you."

22 This support has been invaluable to us, as we
23 have been working towards increasing our understanding of
24 how our populations have specific needs for substance abuse
25 treatment and the kinds of interventions that we can use

1 for that.

2 SAMHSA's seven performance outcome domain
3 should always be thought of when we are considering a
4 different type of intervention, or a different vehicle for
5 an intervention. That includes social support of recovery,
6 abstinence from drug and alcohol use, family and living
7 conditions, employment and education, crime and criminal
8 justice, access or capacity, and retention in treatment.
9 We call that the SAFECAR, that's why that little car is
10 there. This is Dr. Clark's invention.

11 As such, you can look at these particular
12 outcome domains and always have them in the back of your
13 mind when it comes to how we are going to put out this
14 particular kind of initiative and think about it in terms
15 of the substance abuse field.

16 We have been working very hard in SAMHSA and
17 CSAT of course to look at the changes and make some kinds
18 of different interventions within these various new things
19 that are occurring in SAMHSA. One of course is the
20 involvement of new providers such as the faith community,
21 the emphasis on recovery and associated services, the use
22 of treatment vouchers, changing the service milieu, which
23 is primary care settings, drug courts, reentry, and
24 co-occurring disorders. The requirement to employ
25 best/proven practices, science-to-services, new drug

1 treatments, an emphasis on program performance and outcomes
2 reporting, and telemedicine.

3 What is information technology? It includes
4 all of these and more. It is telemedicine, it is
5 telehealth, e-health, e-therapy, e-counseling, online
6 counseling, and e-records. I can't tell you the debate
7 that I've had with other federal agencies on is this
8 e-therapy, e-health, is this e-counseling? What is it?
9 Well, actually there is no real definition of what
10 e-therapy or e-health is at this point. So we are in the
11 process of development.

12 Information technology is a vehicle for
13 delivering counseling and treatment services. This can
14 include text messaging, chat groups, e-mail, instant
15 messaging, and audio and video-teleconferencing through the
16 Internet. Those of you who have children understand
17 instant messaging. I have to tell you, when I'm on the
18 computer, I'm always turning off that instant messaging.
19 They're getting constant discussions with their friends,
20 even when they're not there.

21 Many underserved patients are vulnerable to the
22 stigma within our field, and can really benefit from this.

23 There is not only stigma that they have to deal with, but
24 sometimes disabilities, as well as the location that
25 they're at. Rural clients of course are our main focus at

1 CSAT when it comes to these kinds of initiatives. Within
2 that, you have the Native American community, you have
3 communities also that are impoverished, you have
4 prescription drug abusers, juveniles, gay, lesbian,
5 bisexual and transgender, and the elderly population.

6 Again, as I said, e-therapy is well suited as
7 stigma often discourages individuals to take access of
8 service.

9 Let's look at some of the challenges to
10 e-therapy. There are restricted reimbursement codes, you
11 have licensing for in-state treatment only, there is no
12 generally accepted minimum standards of care, there is
13 limited measurements of effectiveness, and you have privacy
14 issues. Currently there are numerous sites on the Internet
15 though that offer e-therapy as such. In fact, there are
16 thousands of them.

17 Some sites offer prescreened therapists who
18 interact with the clients online, one on one. The cost, we
19 have been involved in this project for years, and two years
20 ago the costs were just about the same, they haven't gone
21 up too much, but they are high. That is \$1.60 a minute to
22 \$90 per hour for a chat session, or \$30 per
23 e-mail exchange.

24 Our history has been, as I say, over a long
25 period of time, beginning in April of 2002 when CSAT held

1 an interagency federal government conference on e-therapy
2 held at the direction of HHS Secretary Thompson.
3 Representatives from NIMH, NIDA, NIAAA, HRSA, and the
4 Veterans Affairs attended, and the topics were those of
5 course that we're all invested in at this time still on
6 outcome research, the e-therapist's roles, quality of care,
7 ethical and legal guidelines,
8 licensure/standards/regulation, and confidentiality.

9 In the spring of 2003, SAMHSA with all of its
10 various centers, NIDA, NIMH, and NIAAA, met with the
11 Secretary's Interagency Workgroup on E-Therapy to discuss
12 the feasibility of e-therapy. A conference was beginning
13 to be planned, but somehow it didn't occur at that time.
14 So in March of 2004, CSAT invited other federal agencies in
15 to talk about where they wanted to go with e-therapy. What
16 is it they think that they can do with it?

17 We did discuss then a conference, and sure
18 enough in December, we did our conference entitled "E-
19 Therapy, Telehealth, Telepsychiatry, and Beyond." I'm not
20 certain how many of you have received that notebook. We
21 sent it out to everyone. Speaking to Val, I know that she
22 had just got it yesterday, so it may not have been
23 delivered to your door yet, but please do glance through
24 it.

25 We had 32 speakers there, so I'm not going to

1 list them all. That takes up six slides. But the topics
2 there were the same as before, but expanded. We looked at
3 the definitions and the clinical applications of e-therapy,
4 and we looked at the technology of it. We had Comcast,
5 Verizon, and a company that does Internet through antennas,
6 and that company is called Comspeed. They are through
7 Arizona. Some of you may have heard of them.

8 We talked about financing issues and had
9 representatives from CMS there. We talked about
10 practitioner organizations and what it was they could do,
11 and they demonstrated. We had probably five different
12 demonstrations of the kind of work that is going on there
13 now with substance abuse treatment, prevention, and mental
14 health.

15 Remember, this was a conference for all three
16 areas, not just substance abuse. But we wanted to get an
17 idea of what the scope was in the field and where we might
18 go. It was an exploratory conference, if you will. They
19 dealt with rural populations, ethical and legal issues,
20 medical applications, and the dark side of the Internet.

21 The dark side of the Internet was cyber
22 suicidology, and it is one thing that most people don't
23 think about, but it does occur.

24 We in our explorations of the Internet have
25 come across some very interesting e-therapist

1 advertisements, and wanted to share those with you as to
2 what has been occurring out there and that you might want
3 to just look at.

4 This is Melodie. Melodie is rated at five
5 stars. They don't say who rated her at five stars, but she
6 is rated at five stars. Her degrees are in dual diagnosis,
7 certified relationship counselor, and she is a social
8 worker. Her fees are comparable to the others, in that you
9 are talking about a tarot reading, or a mini, one question,
10 five or six paragraphs for \$45. It is about the same that
11 we had before. Comprehensive, three questions, 12 to 15
12 paragraphs, \$75. She is an expert in addiction and
13 substance abuse. That is how she touts herself.

14 Let's look at another one. This is AbbieGrrl.
15 These are on the Internet. You have to be aware that they
16 are there, and these folks are doing business.

17 AbbieGrrl is an "expert in addiction and
18 substance abuse." She is a "Bona-Fide practicer [sic] of
19 12 steps, recovering for over a decade." She wants to
20 share her experiences with you. Her degrees are "I came,
21 Came to, and Came to Believe. The 1st step is the only one
22 you have to work perfectly each day."

23 She has experiences and qualifications of I
24 think basically being a recovering person herself and
25 wanting to share that with others. She wants to remember,

1 "The fear, the shame, the big black hole of loneliness in
2 her gut."

3 I'll leave it up to you to evaluate these kinds
4 of business ventures on the Internet.

5 There are numerous types of online
6 communication. Synchronous and asynchronous. Synchronous
7 I like to think of as a circuit. As such, when you make a
8 request, you get a reply back. That would be your instant
9 messaging. It is an immediate reply back. There are chat
10 rooms where you can talk to someone, and these are real
11 time, that you can hear back from them. Or webcast.

12 Asynchronous are those that you make a request
13 or you put out a response to somebody. It is going to sit
14 there for awhile. It is not an immediate real time piece.
15 That would be email, listservers, or message boards.

16 Health care and pharmaceutical wireless
17 applications are numerous at this point. We did discuss
18 some of these within our conference. We have patient care,
19 which is remote patient monitoring and visiting nurse
20 services. They do use e-therapy, they use this kind of
21 technology.

22 Hospital environments. You have patient
23 trackers, patient bar coding, wireless medical glossary,
24 notification and alert. With practitioners, you do have e-
25 prescriptions, billing, chargebacks, electronic patient

1 medical records, clinical results, and CPOE. We'll go over
2 that one a little later also in this presentation. This is
3 Computerized Physician Order Entry.

4 Pharmaceutical. We have customer relationship
5 management, call reporting, sample tracking, library,
6 physicians desk reference, diagnostics, specimen tracking,
7 and you can think of that also when it comes to doing drug
8 testing, computer aided dispatch, and messaging. These
9 applications are numerous, and they can be used within the
10 substance abuse treatment field also. It is just a matter
11 of what the limitation innovations are at this point.

12 The available network technologies for
13 telepsychiatry are traditional integrated services, digital
14 networks, plain old telephone system, broadband fiber,
15 satellite, wireless, ADSL, and asymmetric digital
16 subscriber lines. These were some of the presentations
17 that we had, and they talked about these various
18 applications within those 32 speakers that we had at our
19 conference.

20 Let me talk to you about the ones that relate
21 directly to our field, Join Together. They have what is
22 called AlcoholScreening.org. This is one of a couple that
23 they have. This is a screening and brief intervention
24 model that targets all drinkers who are dependent. It
25 refers likely dependent drinkers, and it advises risky,

1 non-dependent drinkers to cut back on their use.

2 It does not label, and it educates all visitors
3 about moderate drinking. What they use is an instrument
4 called AUDIT. That AUDIT instrument has numerous questions
5 that they answer, and from that, they get a score.
6 Twenty-one percent of the users with possible alcohol use
7 or dependence click through to the "Learn More" or "Get
8 Help" area at the end of that AUDIT piece. There is no
9 interaction with a therapist, it is just your test. But
10 they can go and get more help from Join Together if they
11 want to learn more or get help.

12 Then 15.8 percent of the users drinking
13 hazardous amounts or binge drinkers click through to the
14 "Learn More" or "Get Help" and 9.4 percent of the non-
15 hazardous drinkers click through to "Learn More" or "Get
16 Help." So that is significant when you take a look at the
17 entire population that came in and took those tests.

18 Another presentation talked about HealthSim,
19 Inc. It is research with computer-based interventions.
20 These are educational components for prevention. They are
21 science-based substance abuse prevention multimedia
22 programs that have been developed for middle school-aged
23 children, as well as elementary school-aged children. You
24 have HIV prevention for adult injection drug users,
25 customizable HIV, STD, and hepatitis prevention programs

1 for young drug users, and computer-based therapeutic
2 education systems for substance-abusing adults.

3 eGetgoing. I know we have all heard of
4 eGetgoing. eGetgoing is a provider of live, real time
5 online substance abuse treatment delivered in a group
6 setting via the Internet. It is the first and only online
7 provider to receive CARF and JCAHO accreditations for its
8 adult and adolescent services.

9 How does it work? It uses a distance-learning
10 platform for groups of up to 10 clients to come in and log
11 into group sessions. That is all they do are group
12 sessions. They are facilitated by a professional counselor
13 who is video-streamed into the session. Clients can see
14 the counselor on their computer, but the counselor cannot
15 see the clients.

16 The clients cannot see each other, so you do
17 still have that anonymity that's present, though there is a
18 person that the client can talk to, and that person is on
19 the screen.

20 Through voiceover IP, clients can speak
21 spontaneously to each other and the counselor. The
22 counselor has a wide range of interactive tools and a large
23 library of multimedia to engage the client. This includes
24 slides, videos, and surveys.

25 There is also a personalized home page that

1 provides each client with their own space to journal and to
2 do homework assignments, and to also relate directly to
3 their counselor if they want to.

4 What is the impact of the Information Age when
5 it comes to the federal government? Well, there is a
6 federal response in general, and there is a Department of
7 Health and Human Services response specifically. The
8 report to the President, "Revolutionizing Health Care
9 Through Information Technology," talks about specific
10 frameworks for health care information infrastructure, in
11 that they would want to see electronic health records for
12 all Americans that provide every patient and his or her
13 caregivers all necessary information required for optimal
14 care while reducing costs and administrative overhead.

15 This is a focus that CMHS is taking also, and
16 they are looking very closely at electronic health records
17 and doing computer assisted clinical decision support in
18 some fashion possibly with that. But e-health is what
19 Kathryn Power spoke about whenever she spoke at the
20 conference. I invite you to take a look at her slides.

21 Again, computer assisted clinical decision
22 support has been written up as a part of this framework
23 also to increase the availability of health care providers
24 to take advantage of state of the art medical knowledge as
25 they make treatment decisions, enabling the practice of

1 evidence-based medicine.

2 The PITAC, or proposed framework, that is just
3 a little pseudonym for them, for a health care information
4 infrastructure by stating also that they would have a
5 computerized provider order entry. CPOE, remember we spoke
6 about that earlier, just a few minutes ago, such as for
7 tests, medicines, and procedures both for outpatient care,
8 and within the hospital environment. They also advocate
9 for a secure, private, interoperable electronic health
10 information exchange, including both highly specific
11 standards for capturing new data and tools, and for capture
12 of non-standards-compliant electronic information from
13 legacy systems.

14 DHHS itself also has a plan they have just put
15 out in July of 2004. Their strategic framework stated as
16 delivering consumer-centric and information-rich health
17 care. This framework talks about informing clinical
18 practice, interconnecting clinicians, personalizing care,
19 and improving population health.

20 The vision for consumer-centric and
21 information-rich health care is you have fewer medical
22 errors, less variation in care, consumer-centric care,
23 medical information moving consumers, and care that's
24 delivered electronically as well as in person. This is
25 where we could fit in medical records being protected from

1 unauthorized access, your privacy issue again, and
2 clinicians spending more time on patient care.

3 What are the critical issues at this time to
4 consider? Well, we have to define terms in relation to
5 e-therapy. We do have to look at the conceptual framework
6 for this. We have to define what is required for
7 licensing, credentialing, and regulations, and the
8 limitations of them. We have to look at the controls on
9 the technologies, such as the secure sites. Some are not
10 so secure. And we have to protect clients from
11 non-credentialed counselors.

12 We also have to train counselors in the use of
13 this technology, we have to consider the confidentiality,
14 we have to do information security, look at cultural
15 issues, and the cost.

16 What is next and when? Are we really ready to
17 consider e-therapy now as a viable therapeutic
18 intervention? I think we are. I have to say that the
19 evaluations that came back from the conference were really
20 very supportive of this, in that it is now time to begin to
21 look at this. This is a cheap way of doing therapy, and it
22 is not appropriate in all aspects, but is it something that
23 we want to consider?

24 At this time, we at CSAT are developing and
25 pulling together an expert panel which Val Jackson is going

1 to be the chair of -- that's why she is here with us today
2 -- to start looking at these various issues and to start
3 really considering do we have the wherewithal to ask our
4 field to do this, and is it something we would want to
5 support.

6 Thank you.

7 (Applause.)

8 DR. HARMISON: Any questions? Yes?

9 DR. FLETCHER: Thank you very much for a very
10 interesting discussion. I promise you I'm on information
11 overload at this time, as well as congestion overload, but
12 this caught my attention.

13 I'd like to ask you a couple of questions. In
14 terms of your explorations and developments in this area,
15 do you have preliminary data that speaks to the efficacy of
16 e-therapy as a modality of treatment, and also have you
17 taken into consideration and deliberation the implications
18 of e-therapy, particularly for indigenous communities and
19 groups that are not literate in technology? Would that be
20 a factor that might further limit their access to
21 treatment?

22 DR. HARMISON: Well, in taking your first
23 question, yes, we do have research data that was presented,
24 and I encourage you to glance through the materials that we
25 sent that show that this type of therapy done online is as

1 effective as seeing someone face to face.

2 You do have to watch for the factors that you
3 have to have some kind of support available close to that
4 client should there be an emergency, and that you have to
5 be really comfortable with the technology to be able to, if
6 you are viewing that client, to be able to understand body
7 language. You're only going to be seeing a part of that
8 body language.

9 Dr. Clark?

10 DR. CLARK: Yes, I think, again, we are still
11 in the preliminary stages, but it is quite clear. I
12 presented from George Mason, whose in fact target
13 population were communities of color and low income
14 individuals. There are issues in terms of access to the
15 technology, but broadband is remarkably cheaper. The
16 hardware, you don't need elaborate computers, you can get
17 Internet-accessible devices that are fairly inexpensive.

18 As we were pointing out, especially in low
19 population or low-resource dense areas, one of the things
20 is it is easy for people to say well, this isn't as good as
21 a face to face. But then you say well, there is no face
22 for somebody to face. So essentially you are saying but
23 for something that may not be as good, if we don't do it,
24 then the person is left with nothing.

25 So the question is is nothing better than

1 something? If we don't stimulate the dialogue, then we
2 don't have the discussion. This is also useful for online
3 assessments. Join Together is doing it, oddly enough, our
4 Household Survey is a face to face online computer
5 assessment, computer assisted assessment. So we spend \$50
6 million collecting information upon which we rely that is
7 driven by technology.

8 So not a panacea, not for every person in every
9 situation, but it allows many individuals to deal with
10 issues. Dave raised the issues of a faith community. It
11 allows people of specific faiths to congregate together
12 online to pursue matters from their perspective. There are
13 any number of facets, if you will, that this offers. The
14 key issues is, as was pointed out, we need to tease out
15 some of these variables. But I don't see the issue of
16 limited access based on economics or culture imperative to
17 be an overwhelming barrier.

18 These are things that we need to address, but
19 they are also the same things that are applicable to our
20 traditional delivery system. We saw the presentation on
21 the workforce that has been raised, and it is turning out
22 as Chilo pointed out, look at our workforce. So from a
23 cultural competence point of view, we have some of these
24 same barriers. We need people like you raising these
25 questions. But we should also forge ahead, I believe.

1 Kids use it, predators are using the
2 technology, and they are able to do it very effectively.
3 Yet, we have some problems saying well, it doesn't work, it
4 doesn't do this, it doesn't do that. We just heard Ms.
5 Leonhart from the DEA saying drug dealers are using it.
6 Everybody is using the technology, but the traditional
7 providers who are really interested in preserving the
8 integrity of the system and the welfare of individual, we
9 shouldn't shy away from the technology which we can use to
10 provide ethical care, carefully crafted care, and we can
11 tie in with the NIH, which is one of the things we had Dr.
12 Pickle from Arkansas present some of this data associated
13 with buprenorphine. They are using it fairly effectively.

14 Again, not a panacea. One size does not fit
15 all. It won't work for every person, but this is something
16 that we should seriously consider. If not just
17 assessments, if not for specialty issues, not for
18 augmentation, then some other form of intervention that we
19 are comfortable with.

20 MS. JACKSON: Dr. Clark?

21 DR. CLARK: Yes, Val?

22 MS. JACKSON: Yes, thank you. I really
23 appreciated being included on this conversation. I am also
24 very excited about being able to help led the workgroup to
25 explore and tease out some of those things that you were

1 just talking about.

2 I did want to say that at The Village, we
3 actually did not end up running an e-therapy group, but we
4 had one all set up as a demonstration, and we were working
5 with eGetgoing when they were starting out.

6 One of the things that we did is to decide at
7 that time that what we would do is to start the group, the
8 Internet therapy group. We were going to do it with
9 adolescents, and we were going to do it while our
10 adolescents were still in residential treatment with us.
11 That way they would get comfortable with it. Then we were
12 working either with a school or a library if they didn't
13 have the technology at home, so that when they moved into
14 aftercare and their continuing care, they would have access
15 set up at school, and the time frame set up at school so
16 that they could continue the therapy there.

17 While we didn't actually carry out that study
18 that we had set up, I thought that it was a really
19 interesting approach in terms of being able to actually
20 access kids once they get out of their primary treatment.
21 I think it probably has places for primary treatment, but I
22 see a lot in terms of an adjunct for treatment also, and a
23 continuation of the recovery.

24 I think that that is definitely a possibility
25 for this. In that case, the kids that we had, some of them

1 came from foster care or from homes where they really
2 didn't have technology in their household.

3 DR. CLARK: And that's an important point,
4 recovery management services as a component. So after you
5 finish formal care, what about recovery management services
6 as an element using technology to facilitate that, the
7 notion of using boys and girls clubs, libraries, schools,
8 and other sites for places to access the hardware.

9 The George Mason study, they just gave the
10 hardware to the clients and they reported the hardware
11 didn't disappear, and the hardware wasn't hard to find
12 subsequently. It turns out that people actually used it
13 and made good use of it, and they didn't have any problems
14 with it.

15 So at some point from a larger systems
16 perspective, depending upon the complexity of the person's
17 problems, it may be cheaper just to provide the stripped
18 down hardware that functions as an Internet access tool
19 than to worry about the price. So there are all these
20 issues that we need to sort out. I think with Val's
21 leadership, we'll be able to pursue some of these
22 questions.

23 Frank?

24 DR. McCORRY: This is more on a related issue
25 that I heard, and Sheila, you mentioned in your

1 presentation.

2 I understand CMHS is doing a fair amount of
3 work on decision support, I guess computer decision support
4 for treatment planning and level of care assessment. I
5 wasn't sure what CSAT is doing around those kinds of
6 issues. I understand it to be computerized decision
7 support is the term that is used for this kind of
8 technology that supports clinical decisionmaking in some
9 way.

10 I might be overinterpreting what CMHS is doing,
11 but I understand they are looking at different software
12 packages. Perhaps it is another area for us to explore
13 somewhere in the future.

14 DR. CLARK: That's a good point.

15 Judge?

16 JUDGE WHITE-FISH: Having a background prior to
17 being a judge, I guess I just want to go on record, some
18 flags come up for me.

19 Looking at ethnic minorities, I know my
20 community, even though the money is available with my
21 tribal members, I can go into a household and I know I
22 cannot find a computer. They have no use to run computers.
23 It is not in our society. It is just the way it is.

24 Being a small community, everything is done by
25 word. A lot of verbal, but that is our tradition. There

1 are a lot of traditions in the native culture.

2 Being a therapist before I was a judge, being a
3 counselor, I mean, I have to say right away it is like
4 what? Wait a minute here. But as time goes on and if the
5 numbers are there, I mean, it is up to me to have an open
6 mind being a recovering person myself to have that open
7 mind.

8 However, as I heard in the training that I
9 received, my greatest concern would be the licensing. I
10 know I have had extensive training in AODA, and I have
11 spoken nationally on it. On licensing, I have always said,
12 and I will always say it, counselors are a dime a dozen. A
13 darn good therapist is hard to find.

14 Now, what are we going to attract by using the
15 machines? That's the question. Again, when they wanted to
16 make counselors be certified in a degree with all the
17 others, I said match me, because I'm a recovering person,
18 against somebody with a degree, a counselor with a degree,
19 and I bet you I will beat them.

20 First of all, looking at an individual, the
21 body language, looking at their eyes, as I do as a judge to
22 the people that stand before me. A lot of attorneys want
23 to appear telephonically in front of me. I decline. I say
24 no, if it is important, your client's case is important
25 enough, you will appear in person in front of me. Well,

1 Your Honor, I have to go 600 miles. Well, sorry. That is
2 not my problem. If you want to really defend your client,
3 then you appear before me. I leave it there. Needless to
4 say, they do.

5 Again, here. The appearance is a great deal.
6 I can easily tell you no over the telephone. Appear before
7 me, and I might listen to you. I mean, that's personal,
8 and that is exactly what client-oriented therapy is about.

9 Maybe we're inventing a new one called telephonic-oriented
10 therapy. Maybe I'm an old counselor from way back.

11 But I know in my teachings, they told me, even
12 a blind dog can find a bone.

13 DR. CLARK: That's a good metaphor, even a
14 blind dog can find a bone. The question is what is the
15 bone. So again, we're not suggesting that technology is a
16 substitute for the one on one therapy. What we are
17 pointing out is that we need to leverage our resources,
18 technology has a way of reducing the cost of services, and
19 the question on the table has to be what are the
20 appropriate uses of technology.

21 If we don't examine, if we don't think about
22 it, if we don't contribute to the dialogue, then we are
23 overshadowed by events where the technology is elevated
24 anyway. The kids are using the technology. There are a
25 lot of people who are now much more comfortable with

1 technology.

2 Banking is now technology driven. So the
3 question is what is the appropriate place, and that is what
4 we are pursuing here.

5 Bettye?

6 DR. FLETCHER: I certainly support that idea,
7 because technology permeates all areas of our lives at this
8 juncture. However, my concern would be as we continue on
9 this council, to have a continuing dialogue regarding how
10 this technology is impacting subpopulation groups, and
11 whether or not we are seeing variations in terms of the
12 efficacy of this approach with different populations.

13 DR. CLARK: Indeed, and again, that's one of
14 the reasons why we now have a subcommittee. We have a
15 council member who is concerned about this matter, and of
16 course we will have your input, and if you're interested in
17 working with the subcommittee, I'm sure Val would welcome
18 your contribution.

19 Anita?

20 MS. JACKSON: Yes, I absolutely would love it.

21 MS. BERTRAND: Just a quick comment. The
22 recovery community uses the technology tool for support in
23 a lot of ways. When we are away places like this, we can
24 go online and log in and talk to other people in recovery.
25 Just sometimes that two lines of information.

1 Weight Watchers uses the technology. But I
2 understand the point about being careful and the difference
3 between therapists, counselors, professionals, or
4 non-professionals. I support various levels of care, and
5 think that even the community-based level, faith-based
6 level that we need to look at some out of the box types of
7 ways of reaching people. I want to say since I have been
8 in the profession for 13 years, things are changing. So we
9 have to continue to look at new ways of reaching very
10 difficult to reach populations.

11 DR. CLARK: Thank you. Thank you, Sheila.

12 DR. HARMISON: Thank you.

13 DR. CLARK: With that, the question on the
14 table is do we have any further items to discuss? This is
15 the roundtable for council. Or are you worn down
16 sufficiently?

17 (Laughter.)

18 DR. CLARK: As Dr. Fletcher said, I got so much
19 information.

20 Chilo?

21 DR. MADRID: I want to personally thank
22 certainly Dr. Clark for such a very stimulating meeting.
23 There was a lot of information given to us, a lot of views
24 were articulated both ways.

25 And certainly George Gilbert for planning this

1 and for giving us a lot of support as a council, and
2 certainly a big round of applause to Cynthia for being
3 there for us.

4 (Applause.)

5 DR. MADRID: My last statement is for the next
6 meeting, I'd like to perhaps get the workforce people from
7 the Partners for Recovery to come in and talk to us about
8 some of their studies, some of their deliberations, some of
9 the direction that they're thinking about taking, and then
10 affording us the opportunity to give them some feedback in
11 that area.

12 DR. CLARK: All right. That is a topic for the
13 next council meeting.

14 Dr. Fletcher?

15 DR. FLETCHER: Yes, if it is appropriate, I
16 know that gender transcends all areas of the work of CSAT.
17 Might it be appropriate at some point in time to be able
18 to be briefed or have some information on treatment as it
19 relates to women as much as they bring some unique issues
20 to the table?

21 DR. CLARK: Not a problem. It is part of our
22 matrix, and we'll work out with Cynthia whether it is this
23 meeting or the next meeting. We have a lot of activity in
24 the area of women's issues, women and children's issues,
25 and family issues, which would include women and children,

1 as well as men. So we can look at the issue from a number
2 of perspectives. We have documents completed and documents
3 in the works also.

4 Judge?

5 JUDGE WHITE-FISH: To follow up on the ethnic,
6 I would be more than willing to be involved in that,
7 because I have a great concern. That concern being, again,
8 if you were to look at the 12 core functions that I had
9 learned, those 12 core function are ethnic-oriented. They
10 are from white class, or middle range income white class,
11 are where those 12 core functions came from. They are not
12 kind of related to the ethnic population. You wonder how
13 come the counselors, the number that you see in our
14 communities and in the Native communities, and I would
15 guess even in the African American communities and in the
16 Asian American communities, I would guess your counselors
17 are not Asian American or African American. I know they
18 definitely are not Native American in my community. They
19 are other than Native American.

20 So you have the 12 core functions that don't
21 really work. It works, and I'll use my analogy again, even
22 a blind dog can find a bone. But it doesn't work to the
23 proportions that I see culturally relevant and culturally
24 specific treatment work. I would like to, if I can assist
25 with some of that information, I'll gladly do that.

1 It scares me to see those numbers. I have
2 always know that, though, that the numbers on counselors, I
3 have always known that. Like I said, I have been a judge
4 for over 10 years. It was the same problem I think 12
5 years ago when I was in the chemical dependency field, and
6 I just moved here to a different level and I say wait a
7 minute, we're still facing that same problem. So hopefully
8 I can be somewhat of a solution to that problem.

9 DR. CLARK: All right. We will put you with
10 Chilo and anybody else who is interested in this issue.

11 Any other topics? Dave?

12 MR. DONALDSON: Just we may want to consider
13 allocating some of the time for the subcommittees to meet.
14 After chastising Dan about implementation, I want to make
15 sure that we're putting adequate time into not just
16 talking, but what do we do with all this information.

17 DR. CLARK: Good point.

18 DR. McCORRY: I'd like to see the issue of like
19 a data presentation or the performance measures and that
20 whole thing, just put it in the queue where it belongs.

21 DR. CLARK: Again, another issue of great
22 concern. You heard that from Mr. Curie's comments. So it
23 sounds like the things that this council are concerned
24 about are the things that SAMHSA and CSAT specifically want
25 for this council. So we are all in alignment with the same

1 discussions. The topics aren't easy, but discussing the
2 topics is going to be easy, because we are very anxious to
3 get your input on those topics.

4 Anything else?

5 (No response.)

6 DR. CLARK: If there is nothing else, I'll
7 entertain a motion to adjourn this meeting of the council.

8 DR. MADRID: So moved.

9 DR. FLETCHER: Second.

10 DR. CLARK: All those in favor?

11 (Chorus of ayes.)

12 DR. CLARK: Then our next council meeting is
13 tentatively what, Cynthia?

14 MS. GRAHAM: May 18-19.

15 DR. CLARK: May 18th and 19th. I look forward
16 to seeing you then. Thank you.

17 (Whereupon, at 1:05 p.m., the meeting was
18 adjourned.)

19

20

21

22

23

24

25

1

2