SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT

NATIONAL ADVISORY COUNCIL

Thursday,
June 28, 2007

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

IN ATTENDANCE:

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P R O C E E D I N G S (10:00 a.m.)

DR. CLARK: Good morning. I'd like to call this meeting to order. I welcome you to the 50th meeting of the CSAT National Advisory Council.

In opening this public session, I want to acknowledge for the record what I said at the end of our closed session earlier this morning to review grant applications, and that is, I can never say enough about how much I appreciate the service of council members. It's a very important council. We pay close attention to your feedback and your opinions, and I really thank you for your commitment to the field and the service you provide to this council. And I can say this on and on and on again and take up the whole day with accolades and praises, but we have an agenda.

(Laughter.)

DR. CLARK: So our very first item of business on the agenda is to vote on the minutes from the March 21st meeting. The minutes were forwarded to you electronically for your review and input. Hopefully, you had time to review the minutes and give Cynthia your input.

I will now entertain a motion to adopt the minutes. Is there any discussion?

PARTICIPANT: Move to adopt.

PARTICIPANT: Second.

DR. CLARK: Any discussion?

(No response.)

DR. CLARK: All those in favor?

(Chorus of ayes.)

DR. CLARK: Those opposed?

(No response.)

DR. CLARK: The minutes have been adopted as presented. I thank you for that.

It's become customary that we set aside time for our members to briefly introduce themselves and to hear from them about what they've been involved in since we last met.

However, before we turn the floor over to members, we want to formally welcome Dr. Juana Mora, Professor at California State University, Northridge, and the Chicana/Chicano Studies Department at Northridge, California. As I mentioned in the closed session, Dr. Mora is no stranger to SAMHSA. She served on the CSAT National Advisory Council. She's recognized as a national expert and scholar on culturally focused Latina substance abuse treatment and prevention issues and has developed and taught courses on Latino families and women. She's also active in public health policy and advocacy.

Welcome, Dr. Mora. I'm sure you'll be able to expand on my brief bio and introduction. Do you want to

say anything?

DR. MORA: Just that I'm very happy to be here, and I'm very impressed with the level of organization of the council since I was last a council member with CSAT. It's just wonderful to be here and I look forward to the rest of the day. Thank you.

DR. CLARK: By the way, on the handout table is a bio document which contains each member's bio, along with each presenter's bio, and I encourage you to pick up a copy of this document if you've not already done so.

We're also grateful to have Dr. Chilo Madrid back with us. Chilo is a faithful member of the council and has been a strong supporter of SAMHSA. Chilo was unable to be with us in March. He had undergone major surgery. He looks like the picture of health. I was talking to him at the break, and he's running two to three miles a day and he's eating better and he's finding out how to keep his health up. He's lost a little weight, appropriately. So welcome back, Chilo.

DR. MADRID: Thank you all very much for your prayers. I feel real, real good. My doctor said I'll be ready for the next marathon in about 30 days. It's more like 60 days to me, but anyway, thank you all for your prayers and it's real nice to be back.

DR. CLARK: So I want to take a couple minutes

to allow council members to introduce themselves and to let us know of new and existing projects they're working on. We'll begin with Chilo and proceed around the table.

DR. MADRID: Other than my bypass, I was very involved in our legislative session in Texas as the legislative chair of our state association. We pushed a lot of real nice legislative bills, funding bills especially for people that are addicted and are very, very enmeshed with the criminal justice system. We passed some bills concerning counselor licensure. We relaxed some of the requirements from 60 CEUs to 24 in two years. So I was very involved with that during the month of January.

February is when I got my new heart on Valentine's Day. So I laid off for about a month. Then I came back in March-April and a little bit in May, and the session was over in May. So that's all I've been doing the last several months.

DR. CLARK: Anita?

MS. BERTRAND: Good morning. My name is Anita Bertrand, and I'm the Executive Director of the Northern Ohio Recovery Association. And we develop peer recovery support services in three counties in Ohio, Cuyahoga, which is Cleveland; Summit County, Akron; and Lorain and Lorain City. We just recently signed our third lease to open up a resource center in Akron, Ohio, and I've been working very

closely with the local funding bodies and their executive directors to make sure that recovery support services are linked to the professional treatment services in those counties.

DR. CLARK: Judge?

JUDGE WHITE-FISH: Good morning, everyone. I'm Eugene White-Fish. I'm the Chief Judge for Forest County Potawatomi, as well as the President for the National American Indian Court Judges Association.

One of the things in the judicial body that the Native Americans are looking at, as well as the legislature, is the meth problem across Indian Country. A lot of the presidents of national associations of Native Americans are getting together looking at the impact that it's having across Indian Country. They're trying to identify resources on a holistic basis in order to take care of the issues.

And the court systems are starting to get overloaded in some of our court systems in our Native American courts and tribal courts. The funding there is difficult. Some of the tribes aren't as fortunate to have revenue in order to support their court systems. Wisconsin tribal courts -- I want to say some of them don't have the funding. There are other areas that don't have the funding in order to handle the problem that's hitting Indian

Country such as meth.

For some reason, the people are targeting Indian Country with meth because they think they can stay away from the judicial jurisdiction of the outside law. That's exactly what we're trying to do. The courts are also allowing -- because Public Law 280 allows concurrent jurisdiction, but in some, they have their own sole jurisdiction. So the discussion amongst the judges nationwide are trying to handle exactly jurisdictional questions such as that, as well as working with state court judges and federal court judges so that we are able to handle that problem. Judges talking to judges, as we call it, so that these issues do not continue in Indian Country or any other jurisdiction.

Thank you.

DR. CLARK: Val?

MS. JACKSON: Good morning. I want to thank you. I actually was officially through with my term some time ago, but I continue to be on so long as you don't appoint someone else. And I enjoy being here, so I appreciate that. So as long as you don't appoint anybody, I'll just continue on. It's good stuff.

I am the Executive Director for NCI Systems. NCI Systems is an interesting collaborative of six of the largest and perhaps most known human resource agencies in

Florida that are now working to impact not only Florida but the U.S. The centers are the Center for Drug-Free Living in Orlando, Disc Village in Tallahassee, Gateway Community Services in Jacksonville, Stewart Marchman Center in Daytona Beach, Operation PAR in St. Petersburg, and Concept House in Miami, Florida.

It's a new endeavor in that these are not-for-profits, but they have invested in me, a one-person staff, although I get to contract with people every once in a while, to come up with innovative ways for not-for-profits to find lines of business that can then turn around and put money back into the not-for-profits so that we can have better and more quality services.

So as an example, one of the things that we do is a lot of teaching and training and assisting other organizations in best practices, which you're all familiar with, evidence-based practices and/or helping grassroots organizations to build. And we consult to do that. That money then turns around, outside of the money that I need for expenses, and goes back into endeavors within the agencies to try to go back to help put more services and more attention into the communities.

So we're hoping in the future this will be a way, besides all of the struggles of the grants and the communities and the governments, to be able to bring not

only more knowledge and awareness of but more financial security and so on to not-for-profit organizations.

Thank you.

Oh, I want to say one more thing. I have two weddings and a birth this year. One wedding is over. One wedding is coming, and the birth is coming in September.

DR. CLARK: Thank you.

Greg?

DR. SKIPPER: I'm Greg Skipper, Medical Director of the Alabama Physician Health Program.

I guess I'm going to talk this afternoon about some interesting stuff I'm doing. The other thing is I'm working internationally trying to promote physician health, and Switzerland and Austria have invited me to come and help them get a physician health program started, which is kind of neat.

DR. FLETCHER: I'm Bettye Ward Fletcher. I serve as President and CEO of Professional Associates, Inc. That is a research and evaluation firm located in Jackson, Mississippi. Most of our work is with foundations where we help them to evaluate large initiatives, as well as in some instances design initiatives, particularly those that work with nonprofit organizations. We have also been asked to work with the local treatment program in strengthening its outcome evaluation for the services that they provide in

their homeless shelter, as well as their treatment program focused on women. So we continue to do work in that area.

MR. DeCERCHIO: Good morning. I'm Ken DeCerchio from Florida and the Assistant Secretary for Substance Abuse and Mental Health.

Our legislative session ended in the beginning of May. One of the, I think, pieces of legislation that I'm real excited about is called The Substance Abuse and Mental Health Criminal Justice Reinvestment Act that creates a grant program for local communities to come together to plan strategies to divert individuals with mental illness and substance abuse from the criminal justice system. That's something that was really just an idea that we modeled after the Bureau of Justice assistance grants up here and came together in less than a year with funding in a very tight budget year.

In substance abuse, we're excited to be implementing a Brief Intervention, Referral, and Treatment CSAT grant for older adults. It's called BRITE. It's called Brief Referral, Intervention, and Treatment for Elders. We're initiating that in 14 sites to do that initiative for older adults. It's certainly long overdue in Florida.

Then the third thing. Actually this is my last week in my current position. I resigned my position as

Assistant Secretary, and September 1, I'll be working with the National Center for Substance Abuse and Child Welfare, which is run by a company called Children and Family Futures out of California, working on methamphetamine and other substance abuse issues in communities that are working to connect substance abuse services, prevention, and treatment for children and adults in the child welfare system.

Thank you.

DR. MORA: Hi. As a professor, one of my major tasks and activities is to mentor young people. So I work with a lot of new, young scholars in various areas. In fact, I'm having dinner tonight with a Chica, a Latina student, who is doing an internship in D.C. and is very homesick. So I'm going to spend some time with her tonight.

What else? In the last five-eight years, I've also been very interested in doing participatory action research, community-based research. I've changed my focus to doing research with communities and not on communities because it helps me understand what's going on in the grassroots level because I still see a huge divide between what's going on with our communities and what takes place in meetings like this, for example.

So I just finished a three-year project working

with low income immigrant communities in Los Angeles trying to identify what research issues they want to explore, and three issues came up: violence, substance abuse, and environmental health. So I just finished that project. I'm working on publishing some of those results right now. I'm continually fascinated and I learned so much from community groups and try to bring their voices to meetings like this.

I'm also just possibly beginning a new initiative on substance abuse issues along the border.

Thank you.

DR. CLARK: Thank you. Again, I want to thank you for adjusting your schedule to attend this meeting.

I'd also like to recognize that we have had staff that joined CSAT since council's last meeting. If the new staff will stand up. We have some interns. We have Robert and interns. Donna. So another graduate materializing. You're popping up. Okay. They're all bashful and shy. You don't have to be bashful and shy. Thank you very much. Hopefully you will take the opportunity to introduce yourselves to council. Welcome aboard.

I'd like to move to the Director's report. I'm delighted to have this opportunity to address you today.

Before proceeding, I'd like to apologize to

1 those members who may have experienced delays in your
2 reimbursement. The Department made a change to a new
3 accounting system which caused some delays. Not only did
4 the switch affect you, it also affected staff. I can vouch
5 for that. For a moment there, I felt I was subsidizing the
6 federal government. That's a tremendous burden. We hope
7 that the kinks have been worked out, and I invite you to
8 let us know if you continue to experience any kind of
9 problems. I want you to rest assured that we will continue
10 to do whatever we can to expedite your reimbursement. We
11 appreciate your patience and understanding as management
12 resolves these issues.
13 CSAT has had a very productive and active
14 quarter. I'd like to take this moment to bring some,
15 though not all, of our areas of activity to your attention.
16 Fiscal year 2007 started with a series of
17 continuing resolutions. Ultimately, President Bush signed
18 a yearlong continuing resolution on February 15, 2007.
19 CSAT continued to fund grant and contract continuations
20 throughout this period of uncertainty. Now, as we move
21 into the last quarter of the fiscal year, new grant
22 opportunities are being prepared for award. These include
23 a new round of Access to Recovery grants, Targeted Capacity
24 Expansion grants, Targeted Capacity Expansion-HIV, which
25 you've already addressed, and Addiction Technology Transfer

Centers, to name a few.

At the last council meeting, members expressed some significant concern about cuts proposed in the PRNS spending category for CSAT in the administration's FY 2008 budget request to Congress. I'd like to take a few minutes to update you on where things currently stand.

At this point, both the House appropriations subcommittee and the Senate appropriations full committee have completed markups of the President's request that restore the cuts that were made. As you know, this is not yet final. We're beginning to get a feel for the direction in which Congress is headed, and I'm sure the Congress will negotiate with the President on the final budget.

The House report language is not yet available, but we do have a draft Senate report which directs that Science to Services programs such as Recovery Month, Minority Fellowship, and KAP programs, and others be restored to 2007 levels. In fact, all PRNS activities will be restored to 2007 levels except PPW, which is increased. That's Pregnant and Postpartum Women, increased to $20 million in the Senate language, and the requested increase of $13.7 million for criminal justice, the drug courts, is also endorsed by the Senate. The Senate even includes an additional PRNS increase of $26.7 million. The Senate straight-lines the block grant, but the House increases it

to $35 million.

So the process is going on, and it's clear that both the executive and the legislative branches will negotiate at the end. The President has expressed a genuine concern about not disrupting the budget. He's very much interested in a balanced budget. Obviously, because we have a difference of opinion, the executive branch and the legislative branch will resolve these matters in due course.

All this information is included in the budget section of my written report, but I wanted to highlight it to you. So I'll remind you again that this whole discussion between the legislature and the President is not yet final, and we'll keep you posted as things progress.

We'll be moving on to fiscal year 2009. The first is SAMHSA's budget proposal has been submitted to HHS. That is still closed. So I'm not at liberty to discuss this now that we're in this particular phase, but the point is that, again, we're already moving into the out years, which raises questions, in order to invite participation, we should be thinking in terms of 2010. What do you see 2010 entailing in terms of activities?

SAMHSA Administrator Dr. Terry Cline will present the FY 2009 request to the budget council on July 11th. Other center directors and I will accompany the

Administrator to assist in responding to questions, and after the final markup by the Department, the budget will be revised and be submitted to OMB in early September.

Moving on to administrative matters, the center underwent a reorganization of two of its divisions, the Division of Services Improvement and the Division of State and Community Assistance. DSI is now comprised of three branches: Health Systems, Targeted Populations, and Quality Improvement and Workforce Development. DSCA's reorganization was designed to consolidate CSAT data collection, reporting, and analysis of grantee and state block grant data into one organizational unit, the Performance Measurement Branch. There are three open positions in the new branch which are expected to be advertised shortly: Branch Chief, Lead Public Health Analyst, and Public Health Analyst.

I'd like to really stress this issue of having adequate data to justify what it is that we're doing. Questions are always being asked about how are individual grants performing, but they also want to know how programs are performing. Increasingly you have to justify how is this program performing, what is the philosophy of the program, what kind of accountability mechanisms you have structured in the program, and where does this program go in terms of sustainability and in terms of it being adapted

and adopted by states, tribes, cities and counties, and local jurisdictions.

I would like to bring to your attention other program areas. Our ATR grantees are now in the third and final year of the three-year grant period, and CSAT has been conducting a series of sustainability trainings for ATR providers to help them sustain their program efforts after this particular phase ends. To date, eight trainings have been conducted in Washington, D.C., Baton Rouge, Orlando, Los Angeles, Sacramento, Hartford, Connecticut, Houston, and Vancouver, Washington.

Additionally, the 2007 request for applications for ATR programs was posted on March 23rd and closed on June 7th. We anticipate up to $96 million will be available, including our expectation that some $25 million will be spent to address the methamphetamine issue. We anticipate approximately 18 grantees will be awarded.

On April 24th, I represented CSAT in a cross-cutting breakout session on methamphetamine abuse in the Department of Health and Human Services' Ninth Annual Tribal Budget Consultation Session. The Department has been conducting regional tribal budget consultation sessions. The purpose of these sessions is to discuss issues important to tribal members and involve multiple HHS operating divisions. I spoke of SAMHSA's programs and

CSAT's programs specifically and encouraged leaders to apply for grants. I also emphasized SAMHSA's continued commitment to creating healthier tribal environments.

We continue to make progress in our efforts with electronic health records. A SAMHSA-wide strategy for EHR has been developed and improved. In fact, is Sarah Wattenberg out there? Rich Thoreson? We have two CSAT staff actively involved at the SAMHSA level on EHR, Sarah Wattenberg and Rich Thoreson, neither of whom are here, but they're actively involved.

New activities related to development of privacy, security, and other relevant health information technology standards will begin over the summer, the first being a joint SAMHSA/CDC work group on HIV and methamphetamine was held in Atlanta, in conjunction with a TCE/HIV grantee meeting. A steering committee of community leaders, researchers, program administrators, and federal partners were identified to determine the utility of a summit to address the needs of lesbian, gay, bisexual, and transgender populations affected by methamphetamine use.

The new NREPP website for the National Registry of Evidence-Based Programs and Practices was launched on March 1st. Four substance abuse treatment interventions posted on the searchable database included three adult interventions and one women and children's intervention.

The Recovery Community Services Program convened a planning meeting in Washington on May 30th to address organizational infrastructure, peer practice, ethical framework, and guidelines for peer practice and evaluation of peer recovery services. The results of the work group plans will be presented during the annual RCSP grantee meeting in August.

The 2007 RFA for TCE grants was posted on March 29th and closed May 25th. Projects to be funded have been categorized into four major areas: Native American/Alaska Native and Asian American/Pacific Islander populations, E-therapy, grassroots partnerships, and other populations/emerging substance abuse issues. We anticipate the total available funding to be $8 million, with up to 16 grants expected to be funded.

CSAT is particularly pleased with the success that we've experienced in our training initiatives among our faith-based community. Nationwide, over 400 community- and faith-based providers and organizations have received capacity building and sustainability training and technical assistance, including our ATR treatment and recovery support providers. As a result, many of the participants have developed program sustainability plans and been able to market their program services to potential donors effectively. We've successfully held 13 meetings across

the country, with the remaining to be completed before August of this year.

I'd also like to highlight our Partners for Recovery Initiative. As you know, the PFR Initiative is a collaboration of communities and organizations mobilized to help individuals and families achieve recovery. In a concerted effort to promote and support the mission goals and objectives of the agency, PFR continues its efforts through the Partners for Recovery website, the PFR planning and implementing recovery-oriented systems of care regional meetings, performance measurement training, and the NASADAD annual meeting, and then the PFR/ATTC Leadership Institutes.

I'd like to commend our staff in Consumer Affairs for their excellent on "New Morning" and "Labyrinth," two public service announcements which won the Gold Omni Awards for spring in 2007. Omni Awards recipients are chosen by their peers for outstanding media productions that engage, empower, and enlighten.

The 2006 "Road to Recovery" webcast series won two awards, including the 2006 Gold Aurora Award, which recognized the webcast "Addiction & Family: Healing & Recovery," in the social issues/report/documentary category. The Aurora Award is an independent film and video competition for commercial, cable programming,

1 documentaries, and other videos. You'll be hearing more
2 about CSAT's Consumer Affairs and PFR activities this
3 afternoon.
4 I'm very pleased with the successes and
5 achievements of CSAT's staff, our contractors, and
6 associates, as they have performed very well over this past
7 quarter. Later in today's program, the Director of the
8 Division of Pharmacologic Therapies, Robert Lubran will
9 address an issue to which we're giving much attention, that
10 is, the issue of misuse of methadone and mortality
11 associated with methadone.
12 I'm looking forward to hearing from Dennis
13 Moore of the Department of Community Health at Wright State
14 University in Ohio, who will be speaking to us about
15 substance use disorder services for individuals with
16 disabilities.
17 NAC member Dr. Greg Skipper will be presenting
18 with Dr. Robert DuPont, President of the Institute of
19 Behavior and Health, for our afternoon discussions on
20 physician health programs.
21 I'm also pleased to welcome this afternoon
22 Catherine Nolan of the Office of Child Abuse and Neglect of
23 the Children's Bureau, who will speak to us about promotion
24 of Safe and Stable Families Partnership Grants.
25 Finally, as always, we have reserved time for

council input throughout the day, including a council roundtable. We have a long, productive day ahead of us.

I thank you for being here today.

I think we need to move forward to the next order of business. I'd like to give you a few minutes for a general discussion, and then move to the issue of methadone abuse and mortality. The floor is open for questions and comments you may have pertaining to my report.

Judge?

JUDGE WHITE-FISH: I want to say thank you from the Native American communities for participating in the tribal consultation sessions. I noticed also in your report for the American Indian and Alaska Native, that you're also working with them. Comments are out there, and I don't want to expand your head too good. But they asked what SAMHSA is doing in Indian Country a lot more. And I said it's a good thing. It's positive. Don't question them. So thank you.

DR. CLARK: Thank you.

We want to make it clear that our role is not to preempt the activities of IHS or the Bureau of Indian Affairs. We see ourselves as subject matter experts on mental health and substance use at SAMHSA, and the other entities have turned to us. We really welcome the fact

that tribes and tribal organizations are also turning to us in the area of substance abuse and mental health, not just as consultants and providing resources, but so that we can facilitate a resolution to some of these problems.

DR. MADRID: I wanted to comment on something that you mentioned that I think CSAT needs to be commended on, and that is the whole issue of sustainability. One of the things that is so important is when we look at three- and five-year projects, what are we going to do on that last day? Some of your staff I think have done excellent work, especially in the PPW area, Linda White-Young. I don't know if she's here or not.

But anyway, the concept here is that sustainability starts on day one, not on the third year or the fifth year. I think that we've done something good and I think we need to augment that because I think service providers need more direction, more assistance in this whole issue of sustainability. So I want to commend you for giving it that attention in your report, and certainly Linda White-Young for giving -- I believe there was a conference. Some of my staff attended. They were very impressed with the ideas that CSAT presented and hopefully we can put some of those into practice because I think that that's something that we cannot overlook.

DR. CLARK: Indeed, part of the question that

the Office of Management and Budget would have when we're dealing with some of these issues and dealing with some of our programs is what happens at the end of the program, as you stated. So we want our discretionary portfolio to deal with acute issues but also to help prime the pump so that some of these efforts, hopefully with new technologies, are adopted by local communities, cities, counties, and tribes and states so that, indeed, we can facilitate service delivery.

Anyone else?

(No response.)

DR. CLARK: Then that puts us back on schedule.

According to the National Center for Health Statistics, the number of overdose deaths associated with methadone has risen dramatically in the past five years. SAMHSA is interested in knowing how practices regulated opioid treatment programs are a factor or may be contributing to this public health concern.

In addition, we are concerned about the abuse of or dependence on methadone prescribed or dispensed for pain.

To discuss this important issue is Bob Lubran, the Director of CSAT's Office of Pharmacologic Therapies. He's accompanied by Dr. Kenneth Hoffman, Medical Director of the Office of Pharmacologic Therapies. Is Tod or Nick

Reuter also going to be with you and your group?

MR. LUBRAN: We'll have staff available for comments.

DR. CLARK: All right. Bob and Ken.

MR. LUBRAN: I've asked Ken Hoffman to join me. Ken is our medical officer here working on this issue, and we're going to sort of do this as a team and then we'll be available for comments, as well as other staff.

Let's start back in 2003. SAMHSA recognized that there was a concern about overdose deaths and mortality associated with methadone. We conducted an assessment almost four years ago, May of 2003. A copy is back on the table for your review. And we were concerned because in 2001 we had transferred authority from FDA to SAMHSA for responsibility and oversight and regulation of methadone treatment in the United States, and there was some question whether or not the new regulations that were implemented in 2001 had an effect on this change in mortality with methadone. Alan Trachtenberg at the time was the medical officer and was the medical editor of that report.

Here are the findings that came from the report.

Number one, all narcotics, including methadone, were increasingly associated with diversion, abuse, and

mortality.

Respiratory depressant effects and/or cardiovascular effects at high doses of narcotics can be fatal.

Methadone treatment has a proven safety record, and for this population who are addicted to heroin, particularly injection drug users, methadone actually is very effective at reducing mortality.

There were three scenarios that came out from the report.

Number one, that accumulation of toxic levels of methadone during the early induction period could be dangerous for some people because of their tolerance and the pharmacologic properties of methadone.

Secondly, diverted methadone into the community used by individuals with little or no opiate tolerance was also a factor.

And then there's the synergistic effect of methadone together with alcohol, benzodiazepines, and other prescribed medications that would exacerbate its effect.

We learned that methadone was increasingly being prescribed for pain, therefore, more available in the community.

There was no comprehensive database of deaths associated with narcotics, including methadone.

1 Coroners and medical examiners did not have a
2 uniform case definition so that somebody who was in an
3 automobile accident, upon examination was found to have had
4 methadone, could have been classified as a methadone-
5 related death when there may have not really been strong
6 evidence that methadone contributed to the cause of death.
7 And because of the increased availability of
8 methadone for pain, there was not much of an increase seen
9 in mortality in narcotic treatment programs, or we refer to
10 them as opioid treatment programs, and the increased deaths
11 were not likely to have been affected at all by changes in
12 SAMHSA regulations.
13 Now, scroll four years later. The problem
14 continues to be a serious one because of misuse, diversion,
15 and abuse of methadone. There are significant numbers of
16 deaths being reported, and we're going to go into that in
17 more detail. And deaths associated with methadone are in
18 many communities, or certainly in some areas of the
19 country, outpacing those of other narcotics, and we believe
20 that this requires a concerted effort on the part of the
21 whole public health system at the federal, state, and local
22 level to begin addressing what we can do.
23 Just briefly, methadone is a Schedule II
24 controlled substance. There is a quota on production
25 that's set by DEA. And from '98 to 2006, that quota has

increased over 250 percent. That's based on the demand that the companies project for the use of the drug. The increase is largely attributed to expanded use of methadone for pain. The level of increase for methadone going to opiate treatment programs is fairly steady, and the number of prescriptions has increased 700 percent since 1998, which is very significant.

Ken, I'm going to ask you to come up and walk us through some of the data that we've been gathering from primarily CDC and also our own SAMHSA DAWN system.

DR. HOFFMAN: And to try to keep us on track, I'll go through some of the slides fairly quickly, but what I want to highlight a bit is what we've had in the DAWN, the Drug Abuse Warning Network, system, as well as what the CDC has more recently published, some of which has been referenced already, some of the data that comes from the medical examiner's office in Florida, as well as one of the actually nice and key studies on methadone program causes of death among patients that was published also in the past year.

From the DAWN, clearly we see methadone ranking third among the opioid analgesics, this nice big bar over there. It is a problem. One of the things that is on the back table there is a handout, some initiatives that we sponsored the development by the California Medical

Association for a course, and they're now requiring their prescribers in the state to have additional training in use of opioids in treatment beyond just the methadone program, but just in general. One of the things, having been through medical school myself, is that while the demand has been to please prescribe more opiates for people in pain, the basic training really isn't there, and that's something which has to be developing or reestablished within the basic training. But the California Medical Association at least is starting to tip in with a requirement for those holding state licenses to at least have some hours of training.

This is just showing some of the age distributions of methadone mentions. Now, DAWN will pick up the total emergency room visits that will mention methadone and then the non-medical ones will relate to issues such as overmedication or if there's actually a specific mention of drug abuse. And what one is noticing, I think, is there's an increase. In the older population, there's an issue probably related to the overmedication issue but there's also an abuse possibility going on, and the younger population is also affected. So this is across the board. It compares always to hydrodocone, which has been always the drug that's mentioned with far greater frequency, but as you see, methadone is catching up.

The methadone-related deaths. This is a fairly busy slide, but it summarizes what was in the articles. I think I'll go through some of the slides that graphically illustrate that. But what the CDC has and the National Centers for Health Statistics is access to all the death certificates that are submitted through the states. On the death certificates, you do have causes of death and antecedent causes of death as perceived by the medical examiners or coroner.

Clearly, the problem -- you know, sometimes dissecting this, they'll get coded to basically ICD-10 codes, which is a very nice descriptor of poisoning type deaths and it could be either through suicide or unintentional. Right now the suicide rate is about a quarter of the unintended overdose deaths. You see here basically the take-home for methadone is from 786 that were in the death certificates in 1999 to 3,849 in 2004.

This is just again graphically showing the all poisoning deaths and the poisonings related to methadone going from that 786 or so to 3,800 over the course of time. So the slope is slightly greater for that.

In terms of the age group affected, you see the faster slope going on in this 25- to 34-year-old age group.

In terms of the lethality -- and part of this is when one looks at the FDA labeling changes, as well as

the alert that went out this last December, there's a half-life difference between how long the drug stays in the system and how long it gives pain relief. In general, the pain relief is a lot shorter than the half-life of the drug. So in methadone treatment programs, it is less of a problem because you're giving it because of its long half-life, whereas for pain management, you're giving it because of its pain relief, but the pain relief is going to go about 4 to 6 hours, whereas the half-life of the drug is going to be 9 to 51 hours. So if you're trying to dose the pain relief, you can rapidly overdose on the drug.

In terms of percentage, that's reflected here.

The other thing is in terms of related to the pricing of oxycodone or other such opiates, methadone is actually very inexpensive, and so one of the issues that's been mentioned anecdotally among seniors is that when you hit the donut hole and you have to pay medication out of your own pocket, this is a much cheaper drug that becomes affordable.

This is basically saying the same thing, looking at the percent increase.

Then just to mention, what the CDC does rank -- you see the number of deaths, some of the tables that have been published. This is really the top 10 states. Now, what's not in here actually is the percent of the

population treated, but if you just look at all states total, what you'll see here is mostly in the rural states, there's been a very dramatic increase. New York, for example, isn't here because it's been fairly steady over time, but these are the states where you have the highest increase and the ones that certainly we're on the phone an awful lot with at this point.

Just to complete the information here is the fact that in 1999, there were a few states that actually had no deaths reported in 1999, and over the time to 2004, there have been some with certified methadone programs. You see Maryland, the District of Columbia, and Nebraska. And then without methadone programs, you have these states over here. So there have been deaths reported in those states.

I think one of the things to remember with Maryland and the District of Columbia is that Maryland certainly has had one of the longest-standing opioid treatment programs and with the medical schools, I think they've been very much in tune with how to train the physicians in the appropriate use of methadone and other opiates.

Moving to the Florida data, the medical examiners, which do a fantastic job in going into the different causes of death, I think given that drugs are

1 found in the system, that the highlight here is that you
2 have -- where heroin has been attributed directly as the
3 cause of death, which is the pie here -- you have other
4 drugs like cocaine, propoxyphene, hydrocodone, and
5 oxycodone -- it can be in the system, but not necessarily
6 considered the cause of death. But when you look at heroin
7 and methadone, if it's been attributed to the poisoning or
8 the death of the individual, it's also likely to be
9 considered the cause of death of that individual.
10 Now, getting into this, actually it turns out
11 to be a I think nice standard, but what Jane Maxwell did in
12 Texas -- she's part of the NIDA Community Epidemiologic
13 Work Group, and she's been very interested in methadone
14 deaths in Texas. They accumulated all the records, about
15 766 people between 1994 and 2002 who had died -- this is a
16 reportable event to the Texas Department of Health -- of
17 the 13,264 patients that had been in methadone treatment.
18 What you find here is that most people in
19 methadone programs will not die from the methadone, but
20 people come into methadone programs fairly ill with other
21 medical conditions. That actually does get reflected.
22 They found liver disease, cardiovascular, but overdose is
23 still a significant issue, and most of this is going to be
24 happening kind of in that induction point, those first
25 weeks in treatment when you're trying to stabilize the

patient. But then you have these other causes of death: cancer, motor vehicle accidents, respiratory, suicide, AIDS, homicide, and then just all other causes.

Now, if you look at standardized mortality ratios, for those who have done health risk appraisals and other things, it's a very good way of comparing. Given I'm part of this population, what's my risk of death compared to everybody else in the world. So if you take the distribution of age and gender and match it to the general population for the state and you know how they died, you can generate basically this is what really happened in terms of the population. There were 105 overdose deaths. You can calculate what would be the expected number of overdose deaths in a similar type population.

So this is a standardized mortality ratio, 4.6. So this is a higher than expected value. This is higher than expected, and you go liver disease, respiratory, homicide, AIDS. And then actually the other thing that happens, given that this is a group that died of something, how did the other causes, cardiovascular, motor vehicle -- the risk is actually less in that population, or the mortality ratio becomes less in that population. That becomes reasons for investigation or looking deeper into it.

The other thing that Jane did is comparing the

private and public OTPs. There's a different group that come into OTPs, and I think there's a marked similarity in terms of the age coming into a private or public, days dosed, months, and gender, but when you get into the ethnicity, white, African American, Hispanic, you start to see some marked differences in who's going into the programs. Actually the conditions in which people come into the programs will also differ. So when you look at causes of death between the public and the private, you also see differences in cardiovascular, liver, overdose deaths differentially between the private and the public programs.

This is kind of the quick summary, that patients in opioid treatment, if they die -- most people are being treated effectively, but you have the overdoses, liver disease, respiratory disease, homicides and AIDS among people in opioid treatment that are more likely to suffer deaths from those causes, but less likely to die from cardiovascular disease, motor vehicle accidents, suicides, cancer, and other causes of death.

Then you have the cohort characteristics, the age of the population. If you were in treatment longer, more take-homes, higher doses. These were the people that were older in the programs, and they died more frequently from chronic disease. The younger cohorts died more

frequently from drug overdose and trauma, which would be your motor vehicle accidents. The conclusion of that paper is that the scope of services should include on-site treatment for other medical conditions. Obviously, the physicians in the program become kind of a key focus of attention at this point of the competency and skills and what the programs could be offering. Then the staff is able to counsel concerning risk of death to new patients, and you might get into also a level of care type of issue in terms of what is the best range of services and the intensity needed for patients coming into treatment.

And I'll turn this back over to Bob.

MR. LUBRAN: Well, what does all that mean for CSAT? I think that we've been certainly evaluating what we've been doing up till now and what may be needed in the future, and so I want to talk just briefly about some of the initiatives that are underway.

First of all, we've been working for quite some time to develop revised accreditation guidelines, and those guidelines are very well into the process. We hope to get that out of SAMHSA certainly in the next few months.

Just some highlights on the guidelines.

We want to increase emphasis on ability to provide comprehensive medical, psychological, and preventive services within OTPs. I think if you heard

1 Ken's comment about the summary of the Texas report, I
2 think that's reflective in some of the changes we'd like to
3 see.
4 We'd certainly like to see improved case
5 management capability within the community so that these
6 medical conditions of chronic diseases that we're talking
7 about, cardiovascular, AIDS, hepatitis, and so on, that the
8 programs have a network of providers, if they can't provide
9 the medical care themselves, that patients have a place to
10 go to get the kind of services that are going to reduce
11 mortality in those chronic conditions.
12 We are holding next month two meetings of a
13 consultative nature. July 19th, we are meeting with people
14 specifically around opioid treatment programs and what
15 kinds of opportunities are out there for making some
16 improvements over the next several years that we might be
17 able to propose to the field and that the field themselves
18 may want to engage in adopting some new practices.
19 And then the next day, which is Friday, the
20 20th, we're going to have a reassessment following what we
21 did in 2003. We're inviting back federal agencies, leaders
22 in the field of addiction treatment, pain management,
23 medical oversight through state medical boards, law
24 enforcement, the medical community, cardiology and other
25 aspects of medical care to take another look at the data,

take a look at some of the initiatives that have occurred since 2003 at FDA, at SAMHSA, DEA, and elsewhere and again come up with some findings that we can then go back to Dr. Clark and advise him as to what that means in terms of our programming, our regulatory oversight, our training, need for medical education, and so on.

We also want to take a look at the need for perhaps some better data collection on our part so that we have a better understanding of what is happening with regard to the deaths. As you saw from one of the slides, the top 10 states have a tremendous amount of the numbers of overdose deaths, and there are some other states where the numbers are very low. So we want to better understand what is going on in Florida, Tennessee, Ohio, West Virginia, and that may require some special studies too.

We do think that education of medical staff in OTPs is a priority that we've worked for a number of years now with the medical community around buprenorphine, and we've developed, I think, some excellent programming and support of the medical education of physicians. Now we're starting to take a look at perhaps the similar need for physicians coming to work in this field since there is so little education that the medical colleges provide and very little continuing education for people working in this field.

You heard earlier about the grant program of physician clinical support systems out there for buprenorphine doctors, and we also have a project aimed at helping to educate patients in methadone treatment, buprenorphine treatment through reduction of stigma, through better knowledge, education of what is methadone and what is recovery, and how can people working at recovery do a better job and achieve their goals as well.

We've also been working with the medical community around education of pain. There is a lack of education in the medical world about the use of opiates, and Ken Hoffman has been very actively engaged with not just the American Society of Addiction Medicine, but the American pain management community that we're very concerned about. As Ken mentioned, there's a collaboration with the California Medical Association on a course that's now being held around the country. Online courses are in development. And we're having a lot of interaction. The Federation of State Medical Boards adopted a resolution at their meeting in May to support medical education around substance abuse and use of pain medication. AMA is also considering similar kinds of resolutions.

So we're having a lot of dialogue with the medical groups, with the pharmacy companies, and obviously, we're coordinating our efforts within the federal

government.

So let me just summarize saying that methadone-related deaths continue to escalate. Current data suggests that medication that is intended for treatment of pain is the most likely source of illicit use or misuse of methadone. However, we need to do more surveillance and more review of how that's happening and what effect, if any, OTPs through diversion or misuse are contributing to that.

The prescribers of methadone are practitioners with very little training particularly in the use of methadone. And there's very little training going on through the medical education system, and we're going to continue working to help improve that.

The two meetings we're having next month -- Dr. Clark is going to be chairing both those meetings -- as a way to hear from the field, hear from the community about what are some of the opportunities that the field in general and CSAT for sure can learn about and then try and implement.

(Applause.)

DR. CLARK: I want to thank Bob and Ken for that succinct but comprehensive overview of the issue.

We should take a break, and when we return, we will have discussion.

(Recess.)

DR. CLARK: Council members, please make your way back to the table. I appreciate it. We're running about 15 minutes behind.

You heard Dr. Hoffman and Mr. Lubran present on the issue of methadone misuse, abuse, mortality. Does anybody on council want to discuss this issue? Dr. Skipper?

DR. SKIPPER: Well, first, I want to commend Dr. Hoffman and Bob Lubran for a good presentation and their work in this area and commend CSAT and particularly Dr. Clark for bringing these organizations together last time and the plan to bring them together again to look at this issue. I think it's a very important issue and it's a very complex issue.

But one thing I wanted to point out is if a new drug came out today, say, an antibiotic, and you had a few people die per 100,000 due to some adverse reaction, the drug would probably be pulled off the market. But we have drugs out there that are killing people. It's amazing that 3,000-plus per year die from methadone deaths and not more is done.

I'm not saying it should be pulled off the market. What I'm saying is we should take these actions. It's an important drug. We need it for treatment of

1 addiction and the action to improve training for doctors to
2 know how and possibly encourage requirement of training
3 because I'm a little concerned that if we offer training,
4 it often seems that the doctors who really need the
5 training don't volunteer for it. That's a concern I have.
6 And then the other thing that's critically
7 important is that we do better surveillance of the OTPs to
8 protect the OTPs. We need them to stay, and I do not
9 think, as they mentioned, that the increased deaths have
10 anything to do with opiate treatment programs.
11 There are two other things I'd like to
12 recommend. One is that we support in some way specialty
13 designation for pain management and for addiction medicine,
14 for that matter. It's just still weird to me that
15 addiction is such a prominent problem in our society.
16 There's medicines for treatment of it. Doctors are
17 important in the treatment of it. It is a complex
18 specialty, and yet it's not recognized by the ABMS as a
19 legitimate medical specialty. It's just weird. And
20 chronic pain management needs some kind of specialty
21 oversight as well to encourage them to have standards and
22 do proper treatment. And that's where training could come
23 from if we saw that happen.
24 The other thing is when we do this conference
25 in July, as in 2003, I think it would be good if SAMHSA

popularized the findings more in the popular media. I don't know if that's forbidden or not, but I'd like to see Dr. Clark on "Oprah" or something talking about the hazards because I think a big part of the problem here is the public needs to know that this is going on and kids that are going to steal from medicine cabinets or people that are going to leave their methadone in an improper place where it can be stolen, and even the doctors who are not smart on this, I think if the public knew and we had a little bit more of a push to make this public awareness, I think we could reduce the number of deaths because families that I've known who have lost someone were just not aware that this could happen. I think popularizing this would be good.

Thank you.

DR. CLARK: Chilo?

DR. MADRID: Very fast, I'd like to say that I've worked with opiate addicts for about 30 years and I've run a methadone program for about 20 years. Ten years ago, one-quarter of a gram of heroin, which is about the dose that most heroin addicts use at one time, was $100 a day, and now it's $4 a day and in some places $2 for a quarter of a gram. So what does that tell you? That the supply is really out there on the streets.

We're seeing more heroin addicts at the high

school level now.

The other thing is that 10 years ago it was heroin injecting. Now we have speedballing injecting, which is a combination of heroin and cocaine at the same time. So I think that as we proceed, we need to take into consideration these types of facts.

And I want to thank certainly Bob and Dr. Hoffman for their excellent presentation, and I have just several recommendations in that I concur that we need more training especially with our clinicians.

The recommendations that I would like to present at this time is we need to look at methadone dosing based on the extent of the addiction. In other words, our medical doctors have a real hard time deciding how much methadone our addicts are going to be administered.

Also, we need to train our doctors about simultaneous abuse, and that is, are addicts doing heroin at the same time, methadone, and cocaine? Multiple diagnoses. We have a lot of addicts coming in with many other diagnoses, including mental health, a lot of cardiovascular problems because of the cocaine and the speedballing that I mentioned. We need to train our doctors insofar as the take-home concept. How much should people take home and what should be the protocol there? We need to revisit that. There are a lot of doctors that are

1 doing private methadone versus public.
2 And then the cutting of the heroin -- that's
3 very important in a methadone clinic. The heroin that is
4 being used by the patient coming in -- what is it being cut
5 with? That has a lot of medical ramifications.
6 Then, of course, the old situation of the
7 purity of the heroin. There are times when the purity is
8 really, really high, and we get a lot of overdoses. There
9 are times when it's really, really low and then we tend to
10 overmedicate with methadone. Every addict that I've seen
11 comes into the methadone clinic saying I do 10 grams of
12 heroin a day when in reality they probably do three-fourths
13 of a gram because they want more because of the pain.
14 So I think that all those things need to be
15 discussed as we move forward to teach and to train our
16 clinicians so that we can curb what is being done.
17 But, again, I commend Bob and certainly Dr.
18 Hoffman and the whole CSAT staff that put on such an
19 elaborate presentation.
20 DR. CLARK: Val?
21 MS. JACKSON: Well, I'm just going to appear
22 ignorant and ask the question. I didn't understand
23 Florida. Ken you must understand. But it stuck out like a
24 sore thumb. So can somebody explain to me why in Florida
25 evidently the incidence of death is so much higher than all

of the other states?

MR. DeCERCHIO: In part, yes. We looked at this issue back in '03 and '04 when it first hit. What happened back in '03 and '04 when it first hit, there were -- if you look at the ARCOS data, which is the data on pharmaceutical prescribing, we had tremendous increases in hydrocodone, OxyContin prescriptions. We had about three or four doctors who were arrested. We had small numbers of doctors in Broward County, Palm Beach, Dade County doing a high volume of prescriptions. Some of those of doctors were busted.

And all of a sudden, after those real high profile busts, Pensacola, Palm Beach, Broward to a lesser extent, the prescribing practices changed. So you saw a major increase in the use of methadone coupled with a lot of press around OxyContin and associated deaths around OxyContin. So you saw a switch. Then the data indicated the switch to the use of methadone, not in addiction treatment programs, but for pain management in other physician settings.

The numbers are worse now. The '06 numbers are over 700.

In my opinion, this is part of a prescription drug problem. We can chase individual drugs. We do that very well both in terms of treatment, as well as

prevention, but this is part of a larger -- in Florida alone, prescription drug deaths -- we take alcohol off the table -- far exceed deaths from heroin and other illicit drugs. All the deaths associated with prescription drugs, excluding alcohol, are much greater than illicit drugs.

I've come to a couple conclusions. I think we've got to have mandated training by the Board of Medicine in states for physicians in prescribing. We had made that recommendation to the Board of Medicine in Florida, and they looked at it as a voluntary piece. But there's mandated training for HIV/AIDS. I think there's mandated training for domestic violence, for CMEs. There's got to be mandated training for the use of opiates and prescribing practices associated with general practice.

We haven't had a major increase in the number of methadone treatment programs in Florida. You can count them on probably two hands in the last five or six years, nowhere near associated with the increases in methadone deaths. And I believe that's what's going on, and it's going to take a lot of work in the public health sector and through the regulatory bodies for physicians I believe, as well as the guilds, coming together to figure this out.

We kind of took a more voluntary, proactive approach with some of the work in the '03 committee. We did that in Florida, passed some laws around prescription

fraud, but we were not able to pass a prescription validation program. This past session there was movement. There's an e-prescribing bill that was passed that mines existing databases, but we're still far short of a statewide prescription drug monitoring/validation program.

So I think it's got to be mandatory education and there's got to be kind of a public health outcry from both chief medical officers and departments of health, i.e., state surgeons general. And we haven't seen the public health outcry at the national level either from either the Surgeon General or related public health officials.

MS. JACKSON: Well, if I could just respond to that as someone in the field in Florida. And certainly I do a lot of reading. I watch the newspapers. I live in Miami-Dade, the most populous county in Florida, and we do know about the drug busts -- I'm sorry -- those physicians and some things that are misprescribing.

However, when I go to conferences -- and I don't know how it is across the country, and I do go to some national ones. But I'm speaking now perhaps of the Florida ones -- it seems like we definitely have a need to get that information out. It's not really being discussed. It's not really being pointed out. The last conference I went to with a very credible person giving statistics, we

were busy talking about methamphetamine, which is, if you look at it, quite a minor problem percentage-wise at least or per capita-wise in Florida and in many states compared to what we were just looking at.

So, Chilo, I think you mentioned the fact that we somehow perhaps need to get to our state SSAs, somehow get to our folks that we get some alerts out here because I will tell you, as a person in the field, I knew that methadone was causing a problem. We have talked about it at these meetings.

And I thought Dr. Skipper had one of the best suggestions, and that was on long-acting pain killers and the prescriptions of such, particularly without having any kind of training and that sort of thing. The attention needs to at least get to some of the agencies and those people who are professionals, and I don't think it's getting out there. I really don't.

DR. CLARK: Any other council members?

I'd like to say before we move to the next topic that we're probably going to have some further discussion in the public comment period. So that will be after our next presentation.

SAMHSA did present on this topic to the pain community this past weekend up in New York. So there are practitioners who are attempting to address this issue.

Obviously, a lot more needs to be done.

So we'll move then to Dennis Moore on substance abuse treatment services for individuals with disabilities.

DR. MOORE: Good morning. My name is Dennis Moore. I'm a professor in the Department of Community Health at the Boonshoft School of Medicine at Wright State University in Dayton, Ohio.

I'm here today to brief you about some emerging issues related to substance use disorder and persons with disabilities. I'm going to go rather quickly through the presentation this morning. It will be more focused on policy and some of the high points rather than actually looking at data because I really don't think we can do both in the time that we have.

I come from a program called SARDI. SARDI is one of the few research and demonstration programs in the country focused on persons with disabilities and the intersection of behavioral health issues. Since 1990 we have looked at a number of things related to substance use disorder, mental illness, and increasingly other often stigmatized conditions such as HIV and hepatitis.

We have several programs in SARDI, and I'm going to tell you about them very briefly because I think it's an important thing to illustrate how some of these connections are made.

We have an RRTC, which stands for rehabilitation, research, and training center, that's focused on substance abuse, disability, and employment. We have a number of projects that are nationwide, working primarily with vocational rehabilitation systems, looking at this issue.

The reason I mention this is that CMHS funds or co-funds four of the RRTCs that are funded through the National Institute on Disability and Rehabilitation Research. This is possibly one model that other branches of SAMHSA might want to look at, especially as NREPP kicks into high gear because some of the funding that goes to these RRTCs ends up in some very high quality research.

Increasingly, we've also been looking at health and disability issues that adversely impact minority populations, and in our area that is primarily African Americans. We have a program called Brothers to Brothers Sisters to Sisters that focuses on people who are living with or at high risk for HIV and/or a substance use disorder. This has been a really exciting, incredibly challenging new area for SARDI. Some of the things we're doing are just fascinating. I'm really enjoying this work a great deal.

I brought a description of our program and a handout. If anyone on the advisory council is interested,

I'll leave them with Cynthia.

One of the things that we've discovered in our work is that a number of people who have pretty severe disabilities don't recognize that, and they don't understand that functional impairments get in the way of everything they do in life, including their recovery. So sometimes it's our mission to help people understand what some of the barriers are for them.

We also run a mobile van and we have a church involved as our primary outreach site in Montgomery County.

By the way, we account for over 25 percent of all of the HIV testing in our county. Our program was responsible for bringing rapid testing to our county, and we are now beginning hepatitis C screening, which is really taking on quite an issue. I don't know if you are aware of it, but in 15 years, the model suggests that hepatitis C will outstrip HIV in terms of morbidity and mortality and the total costs. And when we're talking about hepatitis C, we're quite often talking about IV drug users. So it's a major issue.

The CAM program is one of the few programs in the country that was particularly established to provide substance use disorder and mental health treatment to people with disabilities. CAM has a census of about 350 consumers. The majority of people in that population are

persons who would qualify probably more than once for having a disability. Over half of the consumers have a diagnosis of mental illness or some mental health concern, and about a third of the consumers have a traumatic brain injury. About half of the traumatic brain injuries were never diagnosed, which is actually a fairly common problem.

Our treatment model is different than most SUD treatment providers, and I mention this because I think this is a way we need to think about treatment for people with severe coexisting conditions. We operate on a principle of less intensity, longer duration. That's the only way it works. To begin with, people with multiple disabilities, especially when they involve cognitive impairments, can't tolerate a typical treatment regimen. We just had a discussion with my staff last week about the fact that our consumers can't sit through a two-hour group process. It's just too long for them, and yet, that's what our billing segment requires. So some of those issues come up on a regular basis.

The other thing we do is we integrate medical-somatic services a great deal because, as came out in the previous discussion, people with multiple substance abuse problems quite often have medical issues, quite often are seeing more than one physician, and there are many opportunities for inappropriate prescriptions to be written

or for people to be using their prescriptions in a non-prescribed manner and we really have to pay attention to that.

By the way, CAM was mentioned in a SAMHSA-funded study that the National Association for State Mental Health Program Directors and NASADAD conducted several years ago looking at exemplary models for funding co-occurring treatment disorder programs.

So what about people with disabilities? What do we know? We don't know a great deal about use with disabilities and their substance use patterns. We have managed to conduct one study based on nationally representative data. The National Educational Longitudinal Study was conducted for approximately 12 years. It had a large cohort of kids involved in it, and we were able to differentiate the youth with disabilities in that study.

What we found is that youth with disabilities had slightly higher alcohol and cocaine use rates than their non-disabled peers and they had comparable marijuana use rates by the 12th grade. They also had significantly higher cigarette use and dropout rates than their non-disabled peers in high school, and not surprisingly, their substance use patterns correlated with their dropout rates.

One of the other things that's emerging for youth with disabilities is the percentage of youth with

disabilities who are involved in juvenile justice. A number of kids involved in juvenile justice, if they're given the opportunity for an assessment, are found to have attention deficit disorder, learning problems, or a number of other conditions. In fact, this is a particular challenge for juvenile justice programs.

Defining adults with disabilities is not an easy task. In the Washington area alone, there are 50 functional definitions for disability right now. So I'm going to talk about 10 million people. How's that for a number? That's less than the 60 million people that claim to be Americans with disabilities, but our estimates are a conservative figure, that 10 million Americans who qualify for disability services also have an active substance use disorder. Some day I would love to get the money to really study that and go after it because I think that would be an interesting thing to tie down.

A number of groups of people with disabilities actually do have higher prevalence rates for substance use disorders, in particular, individuals with mental illness and individuals with traumatically generated disabilities, such as traumatic brain injury, spinal cord injury. However, some other subgroups we wouldn't expect also have been measured to have higher rates, such as people with multiple sclerosis. Applicants to state-based vocational

rehabilitation programs appear to have a very high rate for substance abuse. Now, that's about 600,000 people in the United States per year who apply to those programs, and because of their disability, they would like assistance in finding employment.

Our latest findings from a year ago, in doing a validation study on a substance abuse screener, found a prevalence rate of 22 percent active substance use disorders among applicants in Ohio and Illinois. We have that paper under review right now. That figure has been fairly consistent now for about five or six years.

We also know from historical perspectives, as well as recent data, that the Medicaid, Medicare, and Social Security ranks are overrepresented by people with substance use disorders, and if we consider those populations, the public health impact and the total dollar impact of the substance use disorder with people on those benefits is extremely high. It represents a very large expenditure every year.

Even with people who have a disability that might have a lower prevalence of substance use disorder, the consequences of substance abuse are much more severe for them, and that would include people with mental retardation, developmental disability, cerebral palsy, cystic fibrosis, and people who are deaf. I include people

who are deaf in that category simply because we don't have enough data about what the real prevalence is for people who are deaf. There are a number of studies that speculate that the prevalence is much higher. However, there are some studies that suggest that it's about the same as the general population.

Compounding this whole picture, people with disabilities are the group in the United States who are the least employed -- the least employed -- of any minority or subpopulation. They're the people who most often live in poverty. Many of the populations we work with and study, including people attending our treatment program, come from families where the household family income is less than $10,000 a year. That changes the picture in terms of how we go about providing services and think about rehabilitation.

Another problem for people with disabilities is quite often it remains hidden. If that individual walks into a doctor's office or a clinic or a voc rehab program or a counselor in a community college, those individuals are going to look at the disability and look at those issues and not really look deeper at why the individual might be failing or might not be in a situation that they want to be in.

An interesting study on that is looking at the

national prevalence of drunk driving arrests for people who are deaf. We did that locally a while back and we found that the prevalence was about one-tenth what it should be. Essentially what happens, if you have a disability, is people tend to defer to your situation and think that it's too much trouble to really deal with it. So the more severe an individual's disability, the more they have to get into some serious trouble before interventions are done.

If we have to talk about the one probably most common barrier to people with disabilities in accessing substance abuse treatment, I would group it under the label of cognitive barriers. A number of people with disabilities, including individuals with mental illness, traumatic brain injury, even other disabilities, have memory problems and judgment issues that are a direct function of their physical functioning. Either they have a cognitive impairment directly or simply how tiring their day is to them places them in a fatigue situation in many cases, and they're just not up to the normal speed. An individual with a spinal cord injury who has to use public transportation to get to our program probably burns more calories and puts more energy into just getting to our program than most of our consumers who have been there the whole day and have left. So that individual comes into the

program tired already, and that kind of thing also needs to be built into treatment.

And then compounding this issue is there are a number of policy inconsistencies across states in terms of how they make treatment accessible to people with disabilities, and that's both supply and demand issues. For example, I'm doing a nationwide study now of policies in state-based vocational rehabilitation programs, and there's tremendous variation in what they do about or for people with a substance use disorder that might coexist with another disability. The range in those policies goes from, oh, if you have a substance use disorder, you can't apply here, you have to come back and prove to use you've been sober for six months, all the way to some state-based voc rehab programs run their own inpatient substance use disorder treatment programs. So there's a tremendous variation there.

If we grouped the barriers to treatment for people with disabilities, I think the common categories would be attitudinal. A lot of people in substance use disorder settings simply don't have the background or the exposure to disability issues and they tend to jump to conclusions that may not be accurate. We run into that on a regular basis.

We also run into discriminatory policies and

practices, communication barriers. Obviously, people who are deaf are prototypic of that, but there are other communication barriers as well. Some people have a very difficult time understanding a cognitive-behavioral recovery model, which is the most prevalent one used in the United States today.

And even now, 15 or 16 years after the signing of the ADA, a number of treatment programs, especially older facilities or residential facilities, are not architecturally accessible. Or even for programs that are architecturally accessible, treatment personnel in those facilities feel that they can't take people who require attendant care or some of the other conditions that are related to this.

There are most certainly funding barriers. Every alcohol and drug state agency has a list of mandates and a pile of money, and the two don't match already. And when we start talking about people with disabilities, when we start talking about who is going to pay the $40,000 for the interpreting costs for one treatment episode for the sign language interpreter, you can see we run into some conundrums there, and it's not easy.

Some of the disability statutes that have been passed already are not a high priority for alcohol and drug treatment agencies. When we did a recent survey of who in

your agency is responsible for ADA compliance, we asked all of the alcohol and drug directors in the country, including a gentleman here on the panel who has done several very important things in this area. I presented in Florida several years ago at, I thought, a groundbreaking conference and dialogue between a state agency and people with disabilities.

But when we asked the state agencies who was in charge of your ADA policy, the range was everybody from somebody in human resources to most often somebody who wears six hats and this is one of the six hats and, of course, four of the other six hats are mandated funding priorities. So you kind of get the picture there. It's a difficult thing to address.

Then another problem, and Dr. Clark and I have talked about this a number of times in the past, the level of advocacy from the disability community has been minimal because they are, frankly, very ambivalent about addressing this issue. They don't want it coming to the public's attention, and there are articles going all the way back to the 1970s talking about how people who are deaf will not talk about drinking problems because of the stigma associated with it. There are historical roots that literally go back all the way to beginning of the 20th century when institutions were formed and people with

mental retardation were sent to institutions. And that attitude prevails today.

If you're in a wheelchair and you're told that you can't enter a restaurant or can't go into a ball park because it's not accessible, you can imagine the kind of reaction you'd get. If you're in wheelchair and you're told you can't go to this treatment program, the consumer says, whew, dodged that bullet. Okay, well, I'll keep looking, no problem. It's a different issue altogether. So it's sometimes a tricky one to address.

Just a couple of stories. I'm going to give you four very short stories. These are actual cases that have happened to me since we've been running our treatment program.

A person with a seizure disorder and a coexisting mental illness and substance use disorder was forced to change anticonvulsant medication before entering an inpatient residential treatment. He was taking phenobarbital at the time. He had been taking it for many years. He did change the medication. He entered treatment. He had two seizures while in treatment and he was discharged for being medically unstable because of the seizures. He also incurred another head injury when he hit the floor during one of the seizures in the treatment program.

Two residential treatment providers told us that an individual with blindness and a service animal would not be able to enter their treatment program in one case because the individual couldn't find the exits during a fire drill. Real. That's what they said. And the other one was that obviously the person wouldn't benefit from their mandatory vocational training component in their program. Again, this is a complete misunderstanding of what this stuff is about.

We had another individual that we had worked with for several years, a very difficult case in several respects. This is an individual with probably borderline mental functioning and a traumatic brain injury. We worked very closely with a treatment program to get him into residential treatment which he needed, and they agreed. They also agreed to work with our case manager and have the case manager visit the program and assist them.

Unfortunately, they didn't tell us when he was going into treatment, and within three hours of entering treatment, they discharged him for being noncompliant because he became agitated. He thought he had forgotten his toothbrush. And literally all they would have had to do was walk him over to his suitcase and that would have been taken care of. They simply didn't understand his situation and we really tried to get somebody there to help

out, but in that case, it didn't work.

We had another individual with lower extremity paralysis who was denied residential treatment because he would need assistance in transferring from his bed at night, and they said, no, we can't provide that type of assistance. And we said, okay, we will. We'll locate somebody to come in. And the treatment program said, no, that would make us an ICF facility and we're not certified at that level. We're not an intermediate care facility. Then a policy was developed where apparently this line of rationale could be used at any of the residential programs in our county for a while. So it was an interesting challenge.

The other reason they denied this person is he could not do the required, mandatory housework that was in the agency.

The interesting thing to me is we got a hold of New York State data. OASAS has some of the most complete disability data within their treatment system in the country. They also serve a lot of people. And we took a look at some specific disabilities, most recently people who are hearing impaired or deaf, and I expected to see lower completion rates. We didn't. We saw equal or higher completion rates, in part because people who are deaf and hard of hearing tend to be in that better demographic of

they're older and, in some respects, a little more mature. But in any case, if we can get people into treatment from the data that we have available now, they at least make it to the other end and successfully graduate.

The concern that I have for people with disabilities is they need a longer period of recovery and sustained sobriety support in order to really make some of those jumps that they need to make.

SAMHSA has done several things in the past to really address this issue, going all the way back to 1990. There have been issues forums, trainings. A number of conferences have included the disability issue over the years. Myself and a number of other people worked on TIP #29 which looks at substance use disorder treatment for people with physical and cognitive disabilities. They have increased the verbiage in the grant requirements and application procedures so that all applicants for grant funding in SAMHSA have to address disability issues. And they provided state technical assistance to a number of states. I've been involved in several in the MR/DD area, mental retardation/developmental disability. There have also been some in the deafness area, and I believe some for traumatic brain injury. In fact, there may be others as well.

By the way, Ohio has just submitted a TA

1 request to create a statewide system for addressing the
2 needs of people who are deaf, and we've got a convergence
3 in Ohio now of some resources that I think will be pretty
4 exciting. We're going to use telerehabilitation as one of
5 the ways that we're going to address the needs of people
6 who are deaf. So there are some things happening that are
7 pretty cool.
8 The other thing that's happening right now is
9 there is an informal, voluntary advisory committee, chaired
10 by Ms. Neville. Ruby has done a superb job of this, by the
11 way. She's had a lot of experience in working in SAMHSA
12 and so I think she has a very good sense of what can be
13 accomplished in the short term and in the long term and the
14 whole process has been going quite well.
15 In terms of future directions that I would
16 recommend for SAMHSA, we've already got a plan in place now
17 to do a one-day training -- it probably will be several
18 hours -- for SAMHSA staff to address this issue. Many of
19 the people that we trained or provided information to in
20 the past have since moved on, and it's probably time to do
21 that again.
22 The advisory committee has come up with a
23 strategic plan and at this point in time has not been
24 considered by SAMHSA. It's simply offered as a starting
25 point. Again, I have copies in the back of the room for

observers and I have copies for the advisory committee. I am really excited about this strategic plan. I think it's accomplishable. I think it's comprehensive, and it addresses a number of issues that are most important. So I would strongly encourage SAMHSA to consider and CSAT to consider that.

One of the other things that is clear is when I was first funded by NIDRR to look at substance abuse as a disability issue, they had an intense debate internally about whether substance abuse was a legitimate disability issue that NIDRR should be funding. In fact, they decided, no, it shouldn't be. So I was funded for three years and then they planned to send me away and I wasn't going to get any more funding. Well, in three years, we generated data to show that their state-based voc rehab programs are in a world of hurt because of this issue, and we've been funded for 15 years now and we're continuing to do work in this area. So it is important.

But along the way, we've discovered that it very much is a multi-agency, interagency issue, and so I encourage CSAT, I encourage SAMHSA to seek out partners in other federal agencies to address some of these issues. In particular, I think NIDRR, the Administration for Children and Families, and CDC are potentially good partners in that area.

Going back to not enough advocacy within the disability community, I think this needs to be a two-way street, and perhaps SAMHSA could do some social marketing to the disability community and disability advocates to generate a little more momentum on this.

Perhaps most important of all of these, as we go to GPRA, as we go to accountability standards, as we go to effectiveness measures, we have to have data, and right now the data systems within CSAT don't represent people with disabilities to the degree that they could. In particular, the TEDS data system, the Treatment Episodes Data Set, and also the National Survey of Drug Use and Health could ask really just literally two or three more questions and get a great deal of information about people with disabilities and their substance use patterns.

Then, of course, as things are transitioning to state plans, anything CSAT can do and SAMHSA can do to encourage state-level compliance with this would, obviously, be a great benefit.

With that, I am done, and thank you very much.

(Applause.)

DR. CLARK: Thank you, Dr. Moore.

Council questions, discussion on this matter? Val?

MS. JACKSON: I just wanted to really thank you

for that presentation. Having been in this field for many, many years, I think it's something that, for reasons that you pointed out, is very hard to get it into the main stream. Having run a treatment organization for a number of years, we did take in some people with impairments, and we attempted that. But what you said about many of our people who are professionals who have all the empathy and care in the world also just simply do not understand or they feel like, no, I can't take care of that. It's impossible for me to do that.

So I really appreciated your comments and wanted to thank you and hope that we can find better ways because I agree with you that the incidence is probably something like 1 in 6, if maybe not more, and something needs to be done. So thank you.

DR. CLARK: Anita?

MS. BERTRAND: I have a question. Can you talk a little bit about why you think over the next couple of years there will be an increase in the number of individuals with hepatitis? I just know personally a lot of people are beginning to say that they have it.

DR. MOORE: Sure. To begin with, I am not an expert on hepatitis, and I am just learning this area myself. It's my understanding that the increase in morbidity and mortality is actually related to people who

acquired the condition many decades ago, starting in the '70s. And what's happening is as they're aging, more and more people are progressing to a chronic and acute condition which kills them.

We had a meeting in Dayton with a SAMHSA-funded project last week, and the leading physician in Dayton who is an HIV specialist said my patients don't die from HIV anymore. They die from hep C. And that's what the projection is. The cost in human lives and in dollars in about 15 years will be greater from hepatitis C from people who already have the condition now.

MR. DeCERCHIO: Dr. Moore, in terms of treatment approaches, your recommendation for lesser intensity over longer duration really links to what I think is one of the major barriers, and that's funding. And if we start talking about residential programming and the examples that you gave around the associated costs, I mean, it's a major barrier. But the idea of doing more less intensive either in home settings or in non-24-hour settings, more natural types of treatment, which is we've been trying to do with substance abuse treatment -- I mean, the opportunity I think is there as opposed to building -- the physical modifications I think are relatively minor and probably have been overcome compared to the other types of modifications that you referenced.

DR. MOORE: I agree.

MR. DeCERCHIO: It's a bad word to use, but accommodation, you know.

So could you speak to either models or what your observation is about outpatients and/or in-home types of substance abuse services and less reliance on cognitive approaches?

DR. MOORE: Okay. Agree, and I'll do it very quickly. I'll cover a lot of ground very quickly.

Yes, we need to go to less intensity for treatment, outpatient as a preferred modality.

Home-based treatment might be an alternative, but for many people with disabilities, the nexus of the problem is the home. Other family members are creating the problem or feeding the fire. So it would have to be family-based treatment if it were done that way.

One of the issues that we need to address certainly in Ohio and probably in other states is some kind of Medicaid waiver that will allow us to bill slightly more than the standard Medicaid rate because our amount of individual counseling and case management and other costly things is greater than the treatment episode for someone without a disability. And that's one of the things we need to look down the road toward. It's somewhat difficult now because every state has their own standard for that.

1 DR. CLARK: All right. Thank you, Dr. Moore.
2 We need to move to our next segment. That's the public
3 comment. We have four individuals from the public who have
4 expressed a wish to comment. We'd like to keep that to no
5 more than five minutes per person.
6 Pat Taylor from FAVOR?
7 MS. TAYLOR: Hi. I'm Pat Taylor, the Executive
8 Director of Faces and Voices of Recovery.
9 Dr. Clark and council members, I really
10 appreciate this opportunity to talk with you for just a
11 couple of minutes about the focus on a recovery-oriented
12 system of care. There's tremendous interest around the
13 country from local recovery community organizations,
14 treatment providers, and others, and we were very excited
15 to receive from you, Dr. Clark, the report from the 2005
16 Recovery Summit last month. What I'd like to talk with you
17 about is how can we raise the profile and pull together at
18 CSAT and develop a stronger leadership role in terms of
19 thinking about developing a recovery-oriented system of
20 care.
21 As I said, there's a lot of interest around the
22 country and there a lot of different things happening here
23 at CSAT and also outside of the agency. So in addition to
24 the report from the Recovery Summit, there are these
25 regional meetings that were described in the report. These

are follow-up meetings to the Recovery Summit. We've received phone calls from recovery advocates around the country who are wondering about what are these regional meetings about, how does that fit into developing a recovery-oriented system of care, and how can I participate in these kinds of regional meetings. So those are kind of two things that are going on.

There's a great interest in having more of a recovery-oriented research agenda. We had meetings about two years ago talking about the fact that we don't know how many people are in long-term recovery in this country. We don't know how they got there. We don't know what made it possible for them to achieve long-term recovery and to sustain their recovery and the barriers that they faced. We don't have the kind of information that we really could use to make it possible for more people to achieve long-term recovery.

And there's tremendous interest in the recovery community, among recovery community organizations and faith-based organizations as well, in providing peer recovery support services. Hundreds of organizations have applied for seven or eight grants as part of the RCSP program. That tremendous interest in peer recovery support services I think really comes from the fact that there's a greater understanding that a recovery-oriented system of

care is more than treatment. It's making treatment beyond treatment work and many people do get into recovery without formal treatment and they need ongoing recovery support services and other kinds of opportunities to sustain their recovery.

We have a situation right now where states are defining what peer recovery support services are. Insurance companies now are defining what peer recovery support services are. And there are real opportunities for CSAT and SAMHSA to play a leadership role in terms of bringing together this interest in this activity and this desire to develop a recovery-oriented system of care and raising its profile at the national level and also, likewise, engaging the public policy makers and others in moving forward to develop a recovery-oriented system of care.

So we were recently contacted about a recovery definition that a consensus panel has put together at the Betty Ford Institute about what is recovery, defining recovery for research purposes. Those kinds of activities are going on outside of SAMHSA and CSAT, and I think it indicates that people are trying to get involved and get engaged in making this recovery-oriented system of care work.

What I'm here for and want to talk with you

about is I think it's really important for SAMHSA and CSAT to pull together all of the various strands that are going on within the agency, but also bring in outside folks and organizations to put together an action agenda of what SAMHSA and CSAT want to see happen to make a recovery-oriented system of care happen, who the people should be there to lay out what that agenda would look like and then move forward and aggressively and proactively say we are behind developing a recovery-oriented system of care. These are the things that we know need to happen, and this is a time line that we as an agency are going to follow to make sure that those activities are carried out.

So I thank you very much for this opportunity. I know there's a lot going on within the agency and within the general public, and we need to pull that together, be very much more proactive in terms of getting that message out.

DR. CLARK: Thank you, Pat.

The next person is Walter Ginter.

MR. GINTER: Hi. My name is Walter Ginter. I'm Project Director of the MARS Project in New York.

Like Pat, I'd like to talk about recovery services for a long time, but unfortunately I can't because that's not what I'm here for. But I do want to say I do agree with Pat, and as a FAVOR Board member -- FAVOR, I

1 want to repeat, is kind of an umbrella group for all of us
2 in recovery in the United States, a whole lot of
3 organizations, and Pat speaks for pretty much most of the
4 recovery community. So we're all very much concerned.
5 I know that she mentioned the Betty Ford
6 definition of recovery. Well, to those of us in medicated
7 assisted recovery, that was actually an offensive
8 definition of recovery. So I think as Pat said, it's
9 perhaps time for CSAT and SAMHSA to step in and coordinate
10 some of these things.
11 As I said, I'd like to talk about recovery,
12 especially medicated assisted recovery, but unfortunately,
13 I can't. That's not what I'm here for.
14 I'm here to talk about the methadone-related
15 mortalities. I'm with the National Alliance of Methadone
16 Advocates. I'm a methadone patient for more than 25 years.
17 What I wanted to say is that 4,000 deaths from methadone
18 is just a horrendous thing. As an OTP patient, my initial
19 inclination is always to say, yes, yes, it was the other
20 guy. See, it didn't come from us. But that's pointless.
21 What difference does it make where it comes. There are
22 4,000 people who are dead from the use of a medication,
23 when used correctly, shouldn't be hurting anybody.
24 We all know that opiate medications are
25 dangerous. The issue is not a control issue. It's an

education issue. We put X numbers on buprenorphine for treatment and we made the doctors get an X number before they could prescribe buprenorphine. Perhaps methadone needs an X number. Perhaps we need training of physicians before they can prescribe methadone and giving them a number the way we did for buprenorphine.

This is a very powerful question. I think that we really need to handle it as an education issue.

One other thing. Dr. Madrid made a statement before which kind of caught my attention. He was mentioning dosage guidelines for people in addiction treatment. As a methadone advocate, that always raised the hair on the back of our necks because the next step from dosage guidelines is dosing caps. And we know that a lot of doctors, when they see guidelines, they read "caps."

New York State a while back wanted to put into their regulations saying that any dose over a certain level, that the doctor would notify the agency. They didn't have to ask permission. They just had to notify the agency. Well, within about five minutes, every doctor in the state said, well, if New York State wants me to go over that amount, they wouldn't have me notify them, so nobody went over that amount. And that's where I'm afraid dosing guidelines may go. So I think although dosing guidelines might be important from a physician's standpoint, I'd like

to make sure that it's presented very, very carefully.

I think that's all I really have to say, but I hope that the council and CSAT will consider some kind of a training program for physicians prescribing methadone for addiction and for pain. Thank you.

DR. CLARK: Thank you, Mr. Ginter.

The next public commenter is Martha Hottenstein.

MS. HOTTENSTEIN: Hello. My name is Marti Hottenstein. I'm the founder of the National Diversion Department for HARMD.

My son went in to try to receive help. He came to me in September. And I don't want to stay on the issue of my son because this is more than my son. He came to me in September and told me that he had a Percocet addiction. The hospital wouldn't help him. He was assessed. They told him -- he didn't get the help he needed.

On October 22nd, I went into my son's apartment. This is my child. And I found him dead. I'd like you to look at this picture. I found him dead laying there, blood coming out of his mouth, purple. I couldn't believe my eyes.

I got his toxicology report and he didn't receive the help, and this is how I became a National Diversion person for HARMD specialist.

I mourned for about four months, and with not good intentions for myself to get better, I laid around, and then I decided I would inform the public about methadone. Then I started to do some research, and I got involved with HARMD. I believe it was March that I found the National Diversion Department. Without any marketing, only on our website, I've had 20 cases of diversion from clinics and from clinic deaths, 20 cases. And I don't have any articles in newspapers.

I have a kid here who died. His name is Matt Conger. He died. I have a picture of the liquid methadone bottle they found at the scene. They closed the case. They sent this in. I'd like to pass that around too.

I have another young boy from North Carolina, Aron Streppa. The father knows who sold him the dose. He came from a clinic. I called North Carolina and let them know just for protection because I know with the federal regulations, when it comes to diversion and public safety we are allowed to be involved. So nothing was done. He reported it to the police. There's an eyewitness who saw this boy take some kid's liquid take-home dose and the police have done nothing. His name is Aron Streppa. He's dead.

I want to make it very, very clear. I am not anti-methadone. However, I am anti-methadone deaths and I

am anti-methadone abuse. I'm not here just to blame clinics. I know that I will be at other places, other than clinic diversion. I will also be going to places for MMT and also giving speeches to doctors. I just want to let you know that I don't want to do the blame game. I want us to be aware this is happening. One death is too many and thousands is outrageous. As a mother and as a citizen that lost her child, I am not going to sit back. I'm not going to go away.

I am for methadone. However, there are people who wait in line to get in a clinic and if someone is abusing that and someone really wants recovery and they can't get in that spot because someone else is abusing it, that is not fair to the person who really wants to recover and who doesn't want to abuse it.

I have one more issue I would like to bring up. We had an arrest. Matt Schalck who sold six take-home doses in my town. He sold it to the undercover police in Warminster three times. He was arrested. I have the article right here. And I have a letter from a father who he sold his methadone to. And also, they found him slumped over in a car, and if they wouldn't have found him, he probably would have died.

We cannot turn our back on diversion from clinics. That's nonsense. But we can't just say it's

clinics. What I want is more education to the doctors. I want public safety, and I want public safety and I want safety for the patients.

I had a case that came into me last night. A boy went into the clinic. He tested positive for cocaine. There was no opiates on the system. They gave him the methadone. They didn't even wait for the results to come back. He died in four days.

We have a serious problem. And I'm sorry to address it this way. Hardcore. But guess what. I can't go away. My son died and I stand here today to be the voice of many children who died from this. I'm finding out a lot of young boys are dying, and I'm really wondering if the doctors from the methadone clinics really educated. Are the doctors out there educated? Are the MMT doctors educated?

And Melissa has a case that came in. I just got the toxicology report, which she'll share with you. But let me show you these documents of the rest.

But what really gets me is as this boy is arrested for selling six take-home doses, he is still welcomed into a Pennsylvania methadone clinic, which I find outrageous. And that's the kind of regulation I would like to see changed. I would like to see anyone abusing methadone -- obviously, if you're selling it, it's not

working.

Thank you.

DR. CLARK: Thank you. I want to make it clear that the whole purpose of public comment is to, indeed, get your input. So you don't have to apologize for your thoughts on this matter. These are obviously very important, particularly since SAMHSA does regulate opioid treatment programs.

So the next speaker, I guess, is Melissa Zuppardi. Is that how I pronounce your last name?

MS. ZUPPARDI: Yes. My name is Melissa Zuppardi.

I am the President of HARMD. We've only been an organization -- it's very new. We started in February. It's kind of accidental how it happened. Just a bunch of parents, a bunch of family members, a bunch of loved ones just started communicating with each other and saying, what can we do? What can we do? We have pain patients dying. We have people going to clinics, doing the right thing, trying to get help, and they're dying.

I'm actually going to read you two quick stories from two mothers.

My story is a little bit different. I know some of you already know my story. My fiance went into treatment for a Percocet addiction. He went into a detox

center that was apparently not licensed to dispense methadone for opiate addiction, and he died on his fourth day inpatient in this facility. He had no opiates in his system when he checked in. He was already starting to experience withdrawal from the Percocet, and he started out on 60 milligrams of methadone, along with valium, Clonopin, and Restoril. And he died in his sleep, was left for dead for about 10 hours while inpatient. He obviously wasn't monitored correctly.

That's what I want to address, more of the monitoring and the assessment of these patients. Because they're seeing such an influx of pain pill addicts coming into the facilities or into the clinics, I don't know how much of a tolerance that they have to be able to withstand the methadone doses or at least starting out on the 30 milligrams and being raised, many of them, within the fourth day, double-dosed. A lot of them are coming in with other medications already in their system, such as antidepressants and benzodiazepines.

This is one person's story. This is from Carla Moore. Her son, Justin Harriage, developed a pain pill addiction in 2004 after his appendix ruptured. He spent 10 days in the hospital and became addicted to the Vicodin that he was given for the pain upon leaving.

He heard of a methadone clinic that would treat

opiate addictions, and being the trusting person he was, he entered the program. He advised them that he had been on Zoloft. He went five days, during which time they doubled his dosage. During the five days, he was nodding off during the day, falling asleep at the wheel, and indicated he was not receiving the proper amount.

On January 12th, 2005, he went and received his morning dose of methadone. On the way home, he became very sleepy and briefly fell asleep but woke back up, a danger of a lot of people on methadone. She's mentioning the driving. He made it to our house and passed out. Oh, he made it to their alley and passed out, ran into the neighbor's fence, and woke up. With his car he ran into the fence. Woke up. Backed up. Came into the house. He made a phone call and then laid down and went to sleep. She returned home that night from a business trip around 9:00 p.m. and found him. That's one story.

I have another one here. This has to do with somebody requesting a hardship clause to go to another clinic because he wanted to continue using benzodiazepines, and the clinics in his state didn't allow that. His mother is a registered nurse, and she says, I regret to say that I was unaware of the danger and the lethal abilities of this drug. My son died June 20th, 2006. My son was on vacation in South Carolina at the time of his death. I spoke with

the coroner, Tamara Wallard, and she told me the amount of methadone that was in his possession should be investigated. The cause of death was a drug-induced cardiac arrhythmia.

I requested his files and found that he and his friends had been traveling to Rossville, Georgia so they could file exception or hardship clause that would allow them six days of take-home medications. This was my son's first time to register with a treatment center. His friends had been going to Knoxville prior to this and discovered if they had a prescription for Xanax in Georgia that they could legally take both drugs. According to the lab work sent to me, my son was only clean one month before he was allowed six days of take-home medications.

I had a lawyer review the medical files and she thought the clinic had misrepresented Colt's case to the state in order to obtain a grant of hardship clause. She stated in November of 2005, he continued to test positive for benzoids. However, the clinic continued to file for an exception clause to permit more take-home doses.

I spoke with Todd Rosendale from CSAT and he told me that he granted the hardship clause due to travel and employment. The paperwork they accepted for proof of residence was a light bill with a balance of over $1,000. They also accepted for proof of job status a copy of a

personal check for $150. When I questioned Todd Rosendale about why they didn't check the job status, he said this would deter employment. This explanation was not acceptable to me. If you're going to allow people to travel and grant hardships, you should be concerned about why you granted this clause.

I was also told the counselor that was seeing my son was in training, that he was seldom seen by a doctor. I called the clinic here in our town and they informed me that many people travel to these clinics in Georgia due to lenient practices.

Then she goes on to just discuss more about the clinic and different things that go on at the clinics and how they've been selling and trading their methadone.

But I think what we need to look at is the people that are continuing to abuse drugs while on the clinic are posing not only a danger to themselves but they're posing a danger to the society as a whole when they get into cars and drive away. I mean, we know that relapse is part of addiction. We know that. But to give them a lethal drug mixed with other drugs that they may be taking I think is irresponsible. These are the things that we think that need to be changed within the clinic system.

As Marti said, there's a lot of changes that need to be made with the doctors, and I agree with the

training. I think that they should have a special license, just like they do with buprenorphine, in order to prescribe methadone. But the clinics need to do better assessment, regulations. They need to monitor their take-home doses. This is just outrageous how many deaths I have directly attributed to clinics and clinic diversion.

This is Eric Kramer. He died. He was a heroin addict. He's actually only one of very few of my heroin addicts that have died from methadone. He went to the clinic four days. He was started on methadone and his dose was doubled within the four days. He had nothing -- nothing at all -- in his system, when we was found dead, besides methadone. So he was taking it exactly as prescribed. He didn't abuse any other drugs. He just was not monitored and assessed correctly.

I don't want to take up any more of your time, but I hope that everybody can see some of these faces. If you want to see my website, you'll see a whole lot more people. It's www.harmd.org. It's very sad. About 50 percent of the people listed on the website and in our -- we have over 400 families right now, and we have some methadone survivors as well, which I'm really happy to say that we have survivors. Some people have survived with brain damage, but they are survivors. About 50 percent of the people were legally taking it and taking it as

prescribed that died. So I think that that needs to be taken into consideration.

Thank you very much.

DR. CLARK: Thank you.

Comments by council members?

MR. DeCERCHIO: I just appreciate you all coming forward and sharing your personal tragedies, if you will, as well as your advocacy in helping us look at this issue.

DR. CLARK: Any other comments?

(No response.)

DR. CLARK: With that, again, I want to thank the public for being here. Room is provided on the agenda to make sure that we have a wide range of input.

It's time for us, at this point, to adjourn for lunch, and we will break for lunch and resume the meeting at 1:30-ish. Thank you.

(Whereupon, at 12:34 p.m., the meeting was recessed for lunch, to reconvene at 1:30 p.m.)

AFTERNOON SESSION (2:08 p.m.)

DR. CLARK: I'm going to have to excuse myself, and Rich Kopanda, my deputy, is going to chair the meeting in my absence. We have a few council members who are out.

I've also been informed that Dr. DuPont is not going to be here.

So, Rich, it's all yours.

MR. KOPANDA: Good afternoon. For the SAMHSA employees, and particularly the CSAT employees, I think we've decided that in the future we're going to submit waivers for having food in the building at council meetings after today's experience. We do have this as a new option for us.

I guess we'd just like to go right into your presentation.

DR. SKIPPER: So I am Greg Skipper, and I do regret that, because we ran over, Dr. DuPont had a 2:30 appointment, so he informed me he could not stay. But I am delighted to have the chance, and I thank very much Cynthia, Dr. Clark, Rich Kopanda, and others for giving me this chance.

I might say that this is an influential thing to do and that's why I wanted to do it, is to get some information on the public record which happens when you

speak at these things. This is pre-publication data. It will be published probably later this summer or early fall. It's regarding a study that we've done that I think contains some information, and Dr. DuPont and Dr. McLellan, who were co-authors in the study, believe could really be influential in improving outcomes for addiction treatment.

Let me just tell you about this and we'll get through it pretty fast I hope. What happened was I was approached by Dr. DuPont and Dr. McLellan. DuPont is a former chief of NIDA and the first Drug Czar in the United States. Tom McLellan is kind of the dean of addiction treatment outcome research in Philadelphia at the Treatment Research Institute. And they approached me because they were interested in studying physician health programs.

Physicians have about the same rate of addiction and substance abuse as the general population. At some point, they thought it was even higher than the general public, but it's no lower.

Looking at physician treatment is a chance to see how good treatment can be because you have an excellent population with a lot of resources, a lot of caring about what happens, and so they felt like let's look at this treatment for physicians and see what's in it, see if it's as good as people say because there's really been no national study, and then see if we can get out of it

1 something useful for everybody, and instead of just saying
2 doctors do well because they're doctors, to see if there's
3 something in this process that can help all patients. And
4 I think we've found an important thing that was right there
5 probably. Like many things that are important, they're
6 kind of right there in front of us, and we didn't think
7 about it.
8 So I'll tell you the punch line at the
9 beginning and then go through this. The punch line is that
10 what we've discovered in looking at this model and at this
11 concept of contingency management that's already in the
12 addiction literature, we really think that that's what
13 makes this work. Contingency management has been done in
14 little ways here and there, and what it means is drug
15 testing somebody following treatment and reinforcing
16 negative drug tests with a positive reinforcement and
17 having a negative consequence or a therapeutic consequence,
18 if you will, some kind of consequence for relapse, but
19 doing this in a longitudinal way. And there have been lots
20 of studies under this concept of contingency management --
21 I'm going to call it CM for short -- which have been very
22 effective in children and with amphetamines, with
23 marijuana. There's lots of data.
24 But it's not caught on because it's really not
25 been long-term, and the types of reinforcements they've

used have been deposits to an account that would build that they'll eventually get access to some money, or I'll take that away if they have a positive. And that's really been kind of hard for people to swallow, paying addicts for doing well.

Well, in this model, we've got a long-term CM and we're using employment, the right to continue to work in your profession as a positive reinforcer and as a negative consequence -- and it really isn't negative, but it's an appropriate consequence -- is further evaluation, treatment, and possibly losing your profession.

So I'm going to run through the data real quick.

Well, first of all, let me just run through this real quick. This is Tom McLellan's little thing about the current state of addiction treatment not for physicians but for everybody. And I don't know if you all have seen some of his stuff, but it's pretty eye-opening.

There are over 13,000 addiction treatment programs in the U.S.A. Thirty-one percent treat less than 200 patients per year. So there are a lot of small ones, mostly government-funded.

Criminal justice has become the most common referral source to treatment. It used to be other sources, families and other sources. It's never been that hospitals

and physicians have referred to addiction treatment, a very low source for referrals.

It's shifted from mostly residential in the '70s to mostly outpatient. Methadone treatment has stayed pretty level, 9 percent up to 12 percent over 30 years.

Mostly what people get in addiction treatment is group counseling, and look at the bottom one. Nine percent of people get more than one drug test throughout their treatment. Most people get a drug test when they enter treatment and that's it.

There's a huge turnover in counselors in addiction treatment and directors of programs. This couldn't be good.

There's very little actual physician input. Fifty-four percent of programs had no physician involved. Thirty-four percent had a part-time. Nurses were involved somewhat, social workers. Mainly it's counselors, which is okay, but it would be nice to have more higher level involvement.

And outcomes are bad. Fifty percent of patients drop out within a month, and then 50 to 60 percent use drugs within six months.

What about private addiction treatment? Is it any better? The answer is no. And they looked at people of "means and prominence," people with lots of money in

some of these programs like Betty Ford and Hazelden. They get more residential and they get more individual counseling. No more urine tests, though. They get the same very few post-treatment testing. And they have a 40 to 60 percent relapse rate in six months.

What about drug courts? They do better, and they all get drug testing. They all get more than one drug test. And they still get the main other types of treatment, group counseling. They have a higher retention and a higher completion, but once they're out of the drug court system, they do a have a higher rate of relapse.

So the reason to study doctor programs is to see how good it can get, see what they do. Is it really that good?

And we did two phases. One was to see what physician health programs are. What are these things? And we found that 48 states and the District of Columbia have a physician health program. Two states, Nebraska and North Dakota, do not have physician health programs. We surveyed all of them and 41 participated. So we had a high rate of participation. We wanted to see how they were organized and about their services in the phase one.

This was a huge debate. It's like what are these things. They don't provide treatment. What do they do? Well, what they do they have a hard time describing

and I run one of them, by the way, in Alabama, and I have a hard time describing it. But really, it's sort of glorified EAP work or case management, long-term case management, treatment supervision. And I'm going to make a strong plug for us to think about whether that can be inputted into the public model. Could we have somebody that oversees treatment long-term and does case management?

What they basically do is they try to get early detection, and then they do interventions, and they refer to evaluation and treatment and they oversee that process. And then they monitor people long-term. That's really what they do.

They all have agreements with the licensing boards. They all have some kind of agreement where the regulatory board that oversees the licensing of doctors says, okay, you can do this and we support you.

Some have legal authority. Of those that have legal authority, most have specific state laws that created the right of these programs to intervene in these doctors' lives. So the program says we want these people to do well. We give you the right and we give you some immunity from liability. And that's going to be important probably in the long-term if we ever want to get this model going for the public, is to have some kind of immunity for the people that do this work because if you take away

somebody's right to work, they could sue you. So as a director of a program that oversees doctors, I have immunity as long as I'm operating in good faith trying to help the public basically.

Most of the programs are nonprofit foundations.

It costs about $23 per licensee nationally per year to fund these programs. So, again, thinking in a sense of trying to move this out of just elite professionals, could we rebolster an EAP movement that gets funding to do case management for work places? About half the people addicted in this country are employed. Could we key off of that, and are there other things we could do to form long-term case management agencies that are funded to follow people long-term?

About 50 percent of the overall funding comes from the regulatory boards, and then they charge the participants some fee, hospitals, malpractice companies, other people that care about this person's health.

I'm going to skip over a couple of things here just because we don't have time.

There's quite a bit of coercion that is involved in getting doctors that have trouble into these things. About 31 percent are required. They're mandated by some authority. Only 16 percent actually like come forward and say I need help. It's amazing that it's that

high. Then there are sort of intermediate forms of coercion. You know, you either go in or we're reporting you and stuff like that. So we tried to measure that.

Alcohol is the main drug, as it is with the public, as far as causing addiction. But unlike the public, opioids are second in a prominent way. I think there's more stimulant abuse, marijuana abuse in the public sector. But with doctors it's alcohol and opioids.

There's a pretty high rate of co-occurring psychiatric disorders. Over a third have a diagnosis of psychiatric disorder.

I'm just going to kind of zip through this a little bit. These are the things that these programs want doctors to do. They use 12-step support groups. Very few use agonist therapy. Very few use methadone. Fourteen of 36 programs said they had at least one doctor, but when we contacted them, it was usually a doctor that was unemployed and it was usually one or two. And you'll see from the phase II, there are very few that actually get methadone. So mostly it's abstinence therapy. All of them get drug testing.

Again, I'm going to kind of speed through here a little bit.

They're careful about selecting the evaluation and treatment programs. They monitor how well what they do

what they do, and they stop referring to the ones that don't do well. So they really keep an eye on trying to get good outcomes.

They do report to the licensing board if somebody really messes up and is not safe or refuses to cooperate. Then they report them. Ninety-two percent of programs had reported one doctor in the past year.

They mostly use urine for testing, though hair is gaining a little bit. They're starting to use some hair testing for monitoring. And breath and saliva are used to a more limited degree.

They use sophisticated panels. Instead of just doing a NIDA 5, they use these more complex panels of looking at the benzos. You don't pick this up on a NIDA 5. You get more expanded panels with the opioids and other drugs that they use.

And they get a lot of drug tests. It's about every two weeks, and it's shifting to month to month after a year or so.

They use EtG which monitors for alcohol use and every program requires doctors to not drink. So unlike drug courts which say it's okay to drink, just don't use cocaine, they really believe in abstinence as a more complete form of ideology for that.

Phase II. We asked all these programs to do a

chart review, and we had a chart review instrument to complete. And we gave them $20 per chart review to try to get as many doctor charts sequentially as we could. So we asked them to start five years ago, which was in 2001. We did this last year. So we had them start looking at charts in 2001 and do no skipping of charts, do consecutive charts going back in time because we wanted at least five years of outcome data on these doctors.

We were able to get 16 programs scattered around the whole country to participate, and we were able to get 908 charts. We had to exclude four because they were out of sequence. They weren't consecutive, and we wanted them to be consecutive so there wouldn't be any bias. We wanted every chart in a row. So we had 904 charts reviewed.

There was underinvolvement with women. Twenty-five percent of women were physicians in 2001, and only 14 percent of women were represented here. So like the general public, women have less trouble from addiction overall.

The average age was 44 years.

Here's an interesting one. Fourteen percent used IV and only 9 percent of the general population, according to SAMHSA's data from 2001, used IV.

And also the arrest history -- 17 percent had

been arrested for a drug-related incident, and the general population is 13 percent. And 9 percent had been convicted of a DUI or some kind of more significant crime. So we're not talking about necessarily a milder form of addiction in doctors. They have a serious form of addiction.

Certain specialties are overrepresented. Anesthesiology, emergency medicine, psychiatry, family practice were overrepresented. Peds, surgery, and pathology were underrepresented.

The most common source of referral was actually the regulatory board. So if somebody would report a doctor for something -- you know, alcohol on the breath was the most common thing, 22 percent, but other sources were here seen.

A high percentage got residential treatment, 63 percent of this 904 doctors.

Only 1 doctor out of the 904 was on methadone. Naltrexone was used in 46 of the 904, and quite a few got antidepressants, 32 percent.

Now, there was a huge number of drug tests done. The average doctor got 83 drug tests. That's one every two weeks for five years. It actually was a 7.2 year average follow-up because we started at 5 and went back. And the rate of positives was only .26 percent of the 73,942 drug tests on these 904 physicians. That is a very

low positive rate. It's definitely lower than the general public. The lowest group we could find was the nuclear regulatory area, and they have a .31 percent positive rate. And that's everybody. But his group of doctors, all of whom had problems, had a very low positive rate. They get a lot of tests. Twenty-two percent of them did relapse over the 7.2 years average. Twenty-two percent was the rate of relapse.

These are things that they did, and AA was prominent. They required AA in 92 percent of the cases. They required group attendance long-term and other things, but nothing really stands out as real prominent except for drug testing. A hundred percent got drug testing.

The relapse rate, like I said, was 22 percent. Six percent was in the setting actually around patients, and the other 16 percent was like off duty. And then that 15 percent at the top is when they stopped doing things but didn't have a positive drug test. They stopped going to their groups or they lied about going to AA or things like that. They called that a certain level of relapse before there was even a positive drug test, which I think is an interesting concept.

There were two suicides, five malpractice suits, and only one episode of patient harm was reported. I don't have that on the slide right here, but it will show

1 up in a minute. Four percent lost their medical license.
2 So not a large number. But there were other actions taken,
3 suspension and so forth and so on.
4 So important points. Seventy-eight percent
5 remained abstinent for an average of 7.2 years. So a great
6 outcome.
7 There was a single report of patient harm,
8 which is pretty incredible to me and suggests to me that
9 the boards are very harsh with doctors, you know, maybe
10 rightfully so, but they act like this is a source of great
11 patient harm and it may not be in this day and age. I
12 think people get reported pretty early and they don't
13 actually cause a lot of harm. There may be harm from
14 accidents. There's evidence that patients are harmed by
15 medical mistakes, but I'm not sure they come from
16 recovering doctors or addicted doctors.
17 So the most significant services they provide
18 are drug testing, 100 percent; supervised group therapy; AA
19 attendance; and residential treatment. So out of all that,
20 it looks to me like the drug testing is the unusual thing.
21 Rate of revocation of license was low. They
22 didn't have a milder form of addiction, and certain
23 specialties had a higher rate. Alcohol was the most common
24 drug. Virtually all treatment was abstinence-based.
25 So the point of this and what we're thinking

about is the good outcome may be transferable if we can figure out a way to do it, and that is, to do more long-term testing, do more long-term case management, treat this like a chronic illness like diabetes where you want somebody to follow that person long-term, and have some built-in contingency management. So monitoring with the drug testing, support, and consequences may be the key.

That's it. Any questions or comments?

MR. KOPANDA: Thank you, Dr. Skipper. Be sure to thank Dr. DuPont as well.

Does the council have any questions?

DR. MORA: I have a quick question. You mentioned that there was a high rate of co-occurring psychiatric disorders?

DR. SKIPPER: Yes.

DR. MORA: What were some of those?

DR. SKIPPER: The most common was major depression, and then it went all the way through. There were two that were schizophrenic but that was due to stimulant abuse at the time. Bipolar disorder was prominent, and ADD, the things you would guess. And personality disorders. We counted those too when they diagnosed them. Most common was narcissistic personality disorder.

(Laughter.)

MR. DeCERCHIO: Do we know what the cost to treat was outside of the PHP?

DR. SKIPPER: Good question because the main cost of treatment was borne by the doctors.

MR. DeCERCHIO: Right.

DR. SKIPPER: And it varied a lot because some went to outpatient, the length of time was varied a lot, but when they went to residential, it was high.

The cost for drug testing is not trivial either. They got an average of 7.2 years. Or this was 7.2 years of follow-up. Most people that were diagnosed with chemical dependence got, I think it was, 4.1 years of monitoring. It was average. And they got an average of one drug test every two weeks. But the cost of that is not huge when you do it in bulk. It was $30 that was the average cost for a drug test. That's every two weeks. That's $60 a month, $700 a year.

MR. DeCERCHIO: The other thing that's interesting is the scatter of type of drug and referral. High alcohol is not inconsistent with the public system but low stimulant is. So you got alcohol and opioids, both central nervous depressives, and 32 percent being treated with antidepressants. So there's some stuff going on there with physicians who are not happy about their outlook on life.

DR. SKIPPER: That's right. And if they're self-medicating, they're using the wrong drugs.

Judge?

JUDGE WHITE-FISH: How long was the average stay of treatment?

DR. SKIPPER: I don't have that right in my head actually, but I'm going to guess. We do have the data. For residential, it was like 63 days or something like that and for outpatient, it turned out to be more like four months, and it reduced from like the intensive outpatient to once a week, and we counted all that. We have data on both. So that was the formal treatment.

But there was a question whether you call the rest of what they got as treatment, which is required attendance at groups and almost five years of drug testing and groups. So really that could be called treatment. They didn't like to call it that. These programs don't like to see what they do as treatment, but it probably is.

Yes.

MS. JACKSON: Well, I think there is a similar treatment for impaired lawyers.

DR. SKIPPER: There is.

MS. JACKSON: And it would be very interesting to see the same kind of outcome data on that because that is one transference certainly.

The other question that I would have then, though, is of course, each of these professions, the medical profession -- and I don't know whether you go below, say, nurses for somebody who has had at least four years of college invested in their careers, that sort of thing. But generally speaking, you're talking about somebody who has a high investment in their life career. I'd just like to hear your comments on the transference because the key to me it really does seem to work, and I personally have someone in my family who this has worked for and I'm very grateful for that. My question is in the general public --

DR. SKIPPER: How to transfer it.

MS. JACKSON: Yes. How does it transfer?

DR. SKIPPER: Well, I'm optimistic that it could be transferred because of the CM data that Nancy Petri and others have published where just $5 deposited in an account for a negative drug test with the provision in the contract with the person that they would test weekly -- and these were mainly teenagers. So maybe it means more to them to have $5, but still, that's not a huge positive. And in the contract, if they had a positive drug test, it would wipe out the whole account to zero, and they'd have to start over. It led to twice the success rate. Over 60 days is all they went during treatment.

But how much does it take and what can you use? Can you use employment? Can you use issues around relationships and stuff? You know, you can stay at home and live here if you do well, but otherwise you have to move out. We know of things like that that matter. So could that be formalized and followed and more people get drug tests? The question remains can it work and what can you use as leverage. But I think it would be good to look into what we can use and try to do this more.

Thanks very much.

MR. KOPANDA: Thank you. That was fascinating.

Our next presenter is Catherine Nolan from the Administration for Children and Families. She's going to assess their new program, Promoting Safe and Stable Families, the Partnership Grant Program.

Before you begin your presentation to the council, I want to thank you and ACF on behalf of SAMHSA and CSAT for reaching out to us to collaborate with you in the development and announcement of these grants. We appreciate the opportunity to share our expertise on the treatment of substance abuse disorders, particularly with regard to enhancing treatment for families involved in the child welfare system due to parental substance abuse. This cooperation and coordination at the federal level models the kind of partnerships these grants seek to promote at

the state, local, and regional levels to improve services and outcomes for children and families.

I also want to thank you for agreeing to increase to $1.5 million your contribution to the National Center on Substance Abuse and Child Welfare, jointly funded by SAMHSA and ACF. This increased funding will support critical technical assistance to these new grants and we are extremely pleased to be able to partner with you in these efforts.

MS. NOLAN: Great. Thanks very much. I appreciate that.

Well, good afternoon, everyone, and thanks to Westley and to Sharon Amatetti for inviting me to address you this afternoon. I was very pleased to be able to take the invitation, and I appreciate what you just said. Everything is right on target there. We have a long history with SAMHSA and I'll go into that in a few minutes, but we're very pleased with the collaboration and with the evolution of the relationship over the years.

I'm sure none of you know me, so I'll just take a couple minutes to tell you who I am and why I'm able to talk with you today. I'm Catherine Nolan, the Director of the Office on Child Abuse and Neglect, which is a small office within the Children's Bureau in the Administration on Children and Families within HHS.

The Children's Bureau has a wonderful history. We were first formed in 1913 and we were housed within the Department of Labor because the main reason that the bureau was formed -- and my understanding from looking at the Children's Bureau history is that it was a very, very contentious and highly debated move as to whether or not we should have a Children's Bureau within the federal government. But the advocates won, and the initial areas of concern that the Children's Bureau addressed, as you might guess, were child labor issues and adoption.

So over the years, the bureau has moved to the Department of Health and Human Services, and today, when you look at the work that we do, we really reflect the spectrum of child welfare services. We really have the lead in this country on up-front prevention of child abuse and neglect, the child protective services aspect, which is the immediate sort of response to allegations of child abuse and neglect, and then when children cannot be maintained safely in their home, sort of the next step is placement in foster care, and the bulk of the budget that we manage goes into foster care payments to the states. When children cannot be safely reunited with their families and the parental rights are terminated, the children are then placed in adoption. And so we have a whole adoption assistance program. And then for the children who age out

of care, as a result of the work of Senator Chafee from Rhode Island a few years back, we now have a very successful independent living program, which is money that goes to the states to help support the kids when they age out of foster care.

So basically my role is a very small role within the Children's Bureau, which is managing the Office on Child Abuse and Neglect. And the main areas that my office covers are the managing of the prevention programs. We have the Children's Justice Act, which is $17 million a year that we get from Justice for systems improvement in child protective services around reducing trauma to child victims of sexual abuse, improving the rate of prosecution in child sexual abuse cases and improving the handling of abuse-related fatalities.

We also are the focal point for the Department on issues of child abuse and neglect. We have special initiatives. Under the our legislation, under the CAPTA legislation, we're required to be the point of collaboration and coordination across federal agencies relate to abuse and neglect. So that's why this is a great opportunity today. I take that responsibility very seriously, as does everyone in my office. So this is a nice example of being able to carry that out today.

Then we have some technical assistance work

that we do. We have a National Center on Child Protective Services. We co-fund the National Center on Substance Abuse and Child Welfare with SAMHSA. We have a national conference on child abuse and neglect every two years, which usually brings together about 2,000 people in the field, multidisciplinary. We were just in Portland, Oregon the week of April 16th. We had a great week.

So those are some of the kinds of things that my office does.

But let me just get to what I really want to focus on today. And you'll see the overview of my talk right here. I want to talk with you a little bit about the Promoting Safe and Stable -- oh, I just noticed a typo here. "Sage" is good, though.

(Laughter.)

MS. NOLAN: Safe and Stable Families Legislation. Are you familiar with the Social Security Title IV, Subpart 2? That's what this is. But anyway, I'll talk a little bit about the reauthorization and the creation of this new program, the purpose of the grants, the development and the content of the program announcement itself, and then the review process.

So basically Title IV-B, Subpart 2, used to be called the Promoting Safe and Stable Families Program. It was reauthorized at the end of September 2006, and named

the Child and Family Services Improvement Act of 2006.

As you know, in the legislative process, whenever laws are reauthorized, there are usually some changes that take place in the reauthorization. In this instance, I would say there were several major changes. If you look through the entire piece of legislation, there were some very major changes.

The one, obviously, that we're focusing on today is section 437f. That was the section that authorized the Secretary to make competitive grants to regional partnerships to provide integration of programs and services or to create new programs and services, all with the sort of end goal of increasing the well-being of and to improve the permanency outcomes, and enhance the safety of children who are either in out-of-home placement or at risk of out-of-home placement because of their parent's or caretaker's methamphetamine or other substance abuse.

Just for those of you who are not in the child welfare field, "permanency" can be a strange word. Basically what it means is that whenever children come into the child welfare system our goal is always to get them back home as soon as we can, as long as it's safe. So the notion of permanency refers to the philosophy that the Children's Bureau has which is that every child deserves a

permanent and safe home, be that their natural family, a foster family, adoptive family, relatives, whatever. But the notion around permanency is that every child really deserves and has a right to a permanent home.

I don't know if any of you here have had a chance to actually look at the legislation itself, but if you do, you'll see that it's very prescriptive in some ways and broad in others. But it really lays out what they mean by regional partnerships. It notes that the child welfare agency must be a partner unless it's a tribal partnership, and then if it's a tribal partnership, the child welfare agency does not have to be involved, but there needs to be at least one non-tribal entity in a tribal partnership.

And then the language outlines the authority of the grant awards. So, for example, it specifies that for fiscal years 2007 to '11, the grants cannot be less than $500,000 and not more than $1 million per grant per fiscal year. And it specifies the time period. The grants cannot be less than two years or more than five fiscal years.

It lists the application requirements, use of funds. There's a matching requirement that's very complicated. I don't know if any of you apply for grants, but for those of you who do, generally speaking there's just either no match requirement at all or a standard, stable match requirement each year. Congress' intent was

to have communities that get this money increase the amount of investment that they have in the project over time, leading ultimately, hopefully, to community sustainability. So there's an odd fiscal arrangement in terms of decreasing funding over the five years and increasing match on the part of the grantee.

The law also has very specific language around requiring that we create performance indicators in consultation with the grantees and with our partners around benchmarks that the projects can follow or use over time to measure their progress toward their goals. There are specific reporting requirements and then there are an initial report to Congress on the prevention indicators themselves and then annual progress reports to Congress.

So let's go back a little bit. What is the purpose of this grant program? Basically the idea behind the grant program is that we give funds to assist regions in building their capacity to address the issues related to the outcomes, permanency, safety, and well-being of kids because of their parental substance abuse, methamphetamine use.

So what happened was this law was passed at the end of September. October 10th, we convened a working group. I basically just sent out an email to our colleagues in the Children's Bureau and partners in ASPE,

our Office of Policy, Research, and Evaluation, SAMHSA, a few other folks, and just said we have this new grant program that we have to develop. Any of you who are interested, come and join us. And it was fabulous. We got a great response, and we had about 30 people from all of those agencies working together on actually walking through the legislation and really trying to analyze it well and respond well to all the requirements that were laid out in the legislation. As I say, we literally immediately, within 10 days, had engaged our partners in the beginning of this process.

I mentioned in my opening remarks that we have a long history with SAMHSA. On this slide, you'll see what are some of the activities that we've been involved in over the years.

This first began with the passage of ASFA in 1997. There was a requirement that the Department submit a report to Congress on barriers to collaboration across the child welfare system and the substance abuse treatment system. So I was relatively new to the Department at that time. So I was assigned to work on this project with some of our other colleagues. And the end result was that working with folks from CSAT and from the SAMHSA Office of the Administrator at that time and from ASPE, we developed this report to Congress. It went through a lot of

iterations, and we had a lot of consultation and focus groups, but we were very pleased with the ultimate result.

What we laid out was five basic areas, five areas of recommendations, and under each recommendation what would the federal responsibility be, what would the state responsibility be, and what would the local responsibility be. At the federal level, we gave ourselves a number of tasks, and I'm happy to say 10 years later that we've actually done pretty well on carrying out the tasks that we assigned to ourselves.

So one of them was convening regional teams, multidisciplinary teams, to talk more fully about this report and to really get the communication going in the different states across the agencies. So we spent about two years doing that with SAMHSA.

Then one of the issues that really became very clear was that we really needed to have a standing sort of technical assistance provider around child welfare and substance abuse issues. So really, I'd say thanks to Sharon really pushing for this and some of the folks on my staff and myself, but really Sharon was our leader, I think, in this. We were able to create the National Center on Substance Abuse and Child Welfare. We have co-funded that for five years now, and we're in the process of recompeting for another five years. We've been very

fortunate with the organization that won the competition. They've been doing a fabulous job and hard, hard work with the states on trying to improve this collaboration across the systems.

In the Children's Bureau, we have the child welfare waiver demonstrations, and some of those do include looking at this whole issue of substance abuse and child welfare since there is such a connection there.

Last May we had a conference jointly sponsored on the impact of meth on children in the child welfare system that was very well received. So you see that we've really kind of been working together on a number of exciting activities over the years.

Sharon and I were just talking and kind of reminiscing about some of this, but we think part of why we've been able to maintain the continuity is that several of us who worked on the initial report are still in our same positions. So we have those relationships. We've brought different people on at different times, and certainly my staff has been very involved in this work. But it's nice to see the continuity.

Just to give you the details on the development of the program announcement itself, we formed the work group in October. As I say, we really looked at it very carefully. We realized that because of the requirements to

have performance indicators and because of the unusual funding structure in the law, that we really needed to develop some subgroups to really look at that a lot more intensely. So we did that. We had two subgroups, and they were fabulous.

We had one woman, the Assistant Secretary for Planning and Evaluation. She was great on really helping us with the performance indicators and the conceptual framework. I don't know if you see on the last page of your handout with the slides, the very last page is the conceptual framework that the group developed to help lead our thinking on the actual development of the indicators, but also to really help the applicants. We included this in the program announcement so that the applicants could have a start, you know, maybe have this jump start their thinking about how they might want to go about developing some kind of a program with this money.

And also the funding structure. We had another woman who volunteered from ASRT, and she was fabulous in terms of helping us to really look at different funding scenarios. Again, because the money is so odd, the amount of money in the first year that we have available to give out is $40 million, and then the next year it goes down to $35 million, and then $30 million, $25 million, $20 million. So we start out with $40 million and by the end

we only have $20 million. So for any of you who give out money, it's very tricky to figure out how to do that equitably over time. This woman Sara was wonderful with helping us with that.

So at any rate, the subgroups did their work. I had an emerging leader on my staff at that time, Miguel Vieyra, who was a great writer, and he was wonderful with taking all the different pieces that people had written and really putting that together in one document for us. Then we had lots of discussion and debate and review and had several iterations.

Then finally, when we felt we had a really good product, we briefed our Children's Bureau leadership and then we did submit a final draft for clearance December 8th, 2007. So we were pretty pleased with ourselves that in eight weeks' time, with the help of 30 people, we could create this document and submit it into clearance.

Now, again, for those of you who are familiar with federal clearance, that's a whole other animal, and that took four months unfortunately. But we did finally have the announcement published on Grants.gov May 4th of 2007.

So I don't know if any of you have had a chance to actually look at the program announcement, but if you do, you'll see that the key components include, number one,

that the applications must represent a regional partnership formed by a collaborative agreement, and the application must have demonstrated documentation of either the existence of a partnership or the new creation or development of a partnership. The legislation calls the regional partnership a collaborative agreement entered into by at least two of the regional partnership organizations.

If you look both in the law and on the program announcement, there's a laundry list of who the potential partners can be. And then, as I said earlier, they must have the child welfare agency involved if they're non-tribal, and if they are a tribal application, they must have at least one non-tribal entity.

One of the entities listed in that laundry list is the state substance abuse prevention and treatment block grant agency, but the law says that the partnership cannot be just the state child welfare agency and the state substance abuse agency. There's got to be at least one other partner.

So the regional partnership must designate a lead agency, and the law and the program announcement both talk about what the capacity of the lead agency must be. And that's got to be demonstrated in the application.

Then, as I say, we had the unique funding structure, and basically after all that debate that we had

in our subgroup, we came up with four program options with two possible federal award amounts and two possible grant periods. So what we say in the announcement is that the partnership must select one program option. One partnership can only apply for one program option, and then they must select the option and then justify their selection in terms of accomplishing their project goals.

So what it looks like is this. We have, as I say, the money declining over time. The million dollar awards decline in the outyears, and the $500,000 awards remain fixed. As I said earlier, all the awards have an increase in match over time.

So if you look here -- and this is all in the program announcement -- for Program Option 1, that's a $1 million annual award for three years declining over time. So it's $1 million in the first year, $825,000 in the second, $750,000 in the third. You see on the chart there the increase of the grantee match: 15 percent in year 1, 15 percent in year 2, 20 percent in year 3. Again, that comes right out of the legislation. Then we anticipate funding up to eight awards under Program Option 1.

Under 2, again, it's the million declining over time, the increasing match right from the legislation, and then we anticipate funding up to five $1 million awards for the five-year time period.

Just to tell you, again, there was a lot of discussion about this, and the group finally came to consensus that even though the law said the grant awards could be from two to five years, the group really felt that two years was too short of a time period. By the time you actually get the money, you get up and running, and then you only have one year. How much could you really accomplish? So we made the group decision that we would have it be either a three-year time period for the grant or five years.

So then you go to Program Option 3, and this is the $500,000 annual award, and it's $500,000 each year, but again with that increasing match.

And then Program Option 4, is the $500,000 for a year for five years.

There's another section in the law which we then really kind of explicated in the program announcement which talks about use of funds. So what are the various activities that a grant could propose? So basically what we tried to explain in the program announcement is that it's really up to the regional partnership, number one, to define what is their need in their region and then what approach would they propose to address that need. So we say they can choose to test a broad-based approach to substance abuse treatment and child welfare collaboration

or focus their efforts on a point along the continuum of care from prevention to treatment to aftercare services. And you'll see that on pages 6 to 10.

We talked a lot in the working group about really wanting to support evidence-based practices. You know, we always talk about what works, what's effective, and at the federal level, we always get nervous about saying what's effective because you really want to have something to stand on if you're going to make that statement.

So we had a lot of discussion and Sharon was particularly helpful here in terms of looking at what is the evidence that we do have about approaches that at this point in time, to the best of our knowledge, are effective in terms of both practice and intervention. So you'll see here some of the things that we proposed. Again, this is not exclusive. Grantees who are applying don't have to select from this list, but we were trying to give them as much information as possible to say we would really like you to suggest an approach that has some grounding in an evidence base.

So we talk about systems collaboration and improvements. Again, if you look at your conceptual framework, you'll see these headings in your conceptual framework. Systems collaboration and improvements, for

example, support for comprehensive training across disciplines; support for family drug courts. Treatment linkages: support for co-location of staff. Services for children and youth, such as the DEC or substance-exposed newborns to enhance identification and intervention with infants identified as substance-exposed at birth. Substance abuse treatment services: support for long-term residential treatment programs where children may reside with their mothers and services are provided for all family members. Other services for parents: continuing care and recovery support; parenting skills training and other ancillary services. So you see that there's a real broad range here of potential uses of the funds.

Again, I think the idea was that we hope we conveyed in the program announcement that the regional partnership really take a look at their targeted region, whatever that may be. It's up to them to define it. It could be a county. It could be a series of neighborhoods in an area. The language calls for inter- or intrastate. So the thinking was in some of the rural states, the contiguous four states, there may be a rural sort of four-county area, something like that. But the point was to really tell us what your region is and tell us what is the demonstrated need in that area and then what is the approach that you are going to propose to address that

need.

So in the working group, for example, there was discussion about an area may have services but they're having a hard time getting people engaged in those services, and they don't have a family drug court. So they might propose to create a family drug court to help with that engagement and retention in the treatment services that do exist. Another area may not have any services at all and they really need to create some services, and so on. So you get the drift here. The idea was for the applicants to really tell us this is what we need in our area and this is what we want to use the money for, and again, with the goal of improving the rate of parents recovering from substance and meth use and reducing the rate of children having to go into child welfare as a result of their parents' drug abuse.

I mentioned earlier this whole requirement about the performance indicators. Congress told us very clearly that they wanted data to support the expenditure of these funds. They wanted to hear from us in a quantitative way what is the progress that these grants are making because of the investment that we've made on our end. So there's the statutory requirement to develop the performance indicators.

As I say, we did have a subcommittee on that

and we looked at the current data collection efforts of SAMHSA and the Children's Bureau because all of the federal agencies are now involved in the PART process in some way or another, which is the federal government's looking at our data and support for the outcomes of our programs.

Sharon, what's the name of the data collection system that you have for the Family and Children's --

MS. AMATETTI: The SAIS system that we're using for our discretionary portfolio.

MS. NOLAN: Right. So we looked at the SAIS system very closely. We have a very, very limited data collection system for our discretionary grants within the Children's Bureau. It's just been created recently and it's pretty straightforward. It's nowhere near as sophisticated as the SAMHSA system.

And then we looked at other data collection systems that we have. We have an NCAN -- you know, the National Child Abuse and Neglect -- data system. We have the AFCAR system. So we basically looked at all the existing data collection systems and kind of came up with some of the things that you see in the conceptual framework, and also if you look at the announcement, you'll see the various performance indicators that we suggested that they might use as a starting point.

There was another requirement in the law that

talked about consultation with grantees. Again, it was one of these odd things. We're not awarding the grants until -- the final award will be made no later than September 30th. So we couldn't have a consultation within nine months of the legislation, which was what the language was, without having any grantees.

So the way we decided to respond to that nine-month requirement was that in the announcement, we have this whole section on the performance indicators and we explain the statutory requirement for consultation. And we asked them in their application back to us to look at those performance indicators that we've suggested, select the ones that they think are most relevant to what they're proposing and comment on those. And then if there are any indicators that aren't there that they would like to suggest, to include that. If there are any that they feel are not relevant -- so whatever commentary they may have on what we've proposed we're asking them to include in their application back to us. So that's the proxy for consultation in this case. So you see there what we asked them to do.

I want to say again it was very helpful to have the input from the SAMHSA staff and particularly to walk us through your data collection system to help us think about the indicators that we wouldn't be as familiar with.

So you see here the categories include child and youth outcomes, adult outcomes, family relationship outcomes, regional partnership/service capacity outcomes because, again, if you look at this, there are sort of two key components in the law. There's a piece that talks about treatment and substance abuse treatment services, but then there's this whole other piece that really has much more to do with sort of infrastructure building and really improving that relationship across the various disciplines in that regional partnership.

In the Children's Bureau for the last several years, we've required our discretionary grantees to have an evaluation component. So in this instance what we have said is that we encourage the partnerships to have a local evaluator not only to assist in their own evaluation of their own program, but also to really help with this work on the selection of the performance indicators.

Congress also had an idea that -- or not an idea -- a requirement in the law that greater weight should be given to those applications that have the most sort of demonstrated need and problem in this whole area of parental meth use. So, again, looking at the program announcement on page 42, what we say is, under objectives and need for assistance, identify and describe the impact of meth use and addiction on child welfare within your

targeted region and then propose grant-funded services and activities that appropriately address meth use and addiction in the geographic area and the population targeted.

Again, we got a lot of questions on this, but the idea was that the bonus points really were directed at the meth. In other words, you couldn't just come in saying, well, we don't have a meth problem, but we have an other substance abuse problem. You won't get the bonus points if you don't have the meth. It can be meth and other substance abuse, but the meth piece has to be there for that 5-point bonus.

So where are we right now? We had a technical assistance webinar. This was a first for us in the Children's Bureau. We had a very successful webinar on May 22nd. I was told by the webmaster that we had 400 lines. So we're assuming we had over 1,000 people because most people were telling us that their teams would be in on the webinar. So we were very pleased about that. We got about 165 questions during the webinar, and we've had many, many calls and emails every day since. So we've been providing lots of technical assistance to all of the potential applicants.

The due date is July 3rd. They must be received by 4:30 that day. Any that come in after that

time will be classified as late, and they'll be screened out, which means they will not be reviewed.

Our system of reviewing within the Children's Bureau is that we recruit experts and we ask them to come in for a week. We sequester them in a hotel for a week, and each panel three panelists and one chair are assigned 10 applications to review and score. So that will be happening here the week of July 30th. Again, we're grateful to SAMHSA for supplying us with a list of your approved reviewers. Our goal is to have one SAMHSA reviewer and one CB reviewer on each panel and then a third person who could be from wherever. The selection of the panelists is very intense. We look at their resumes, and we only select those folks to be invited who have the appropriate expertise.

So all the applications will be reviewed and scored that week, and then we have a decision meeting with our ACYF Commissioner, Joan Ohl, in August, hopefully the second week in August. And then she makes the final decisions based on the scores, and then the final grant award letters go out to the successful applicants no later than September 30th, the last day of the fiscal year.

Also, I think this is true across all of HHS, but we have a procedure whereby the final decisions are made. All of that paperwork then goes to our grants

management office, and they actually do the award letter and all of the technical stuff around the funding and how you draw down your funds and so on.

While that's all happening, the Congressional Liaison Office of HHS is also notified of all the successful applicants. So that office notifies the various members of Congress whose constituents have won. I think we give them three days to do whatever they want to do with that information, and then we can, as the Children's Bureau, publicly announce who the successful applicants are.

So it's always a very stressful summer, and this is going to be no exception. The applicants work very, very hard, especially this one. This is a complicated announcement. They're very anxious to know what the results are. Again, as I say, it's a little frustrating for them because we really can't give them any information until the congressional offices have done their thing. So usually by the middle but, again, as I say, no later than September 30th, they'll have their letters.

So this last slide is just for you. The announcement itself is available at this website. If you haven't had a chance to look at it, you may want to.

Then, again, this was very exciting for us this year. It's the first time we were able to do this. After

the webinar, we were able to post the transcript of the presentation, all the slides, the transcript of the Q&As. We didn't have time to answer about 60 questions, and so we just developed written answers and posted those. So all of that is on the website you see there. And it's been great, when we've gotten calls, just to be able to say to folks I'm going to send you the link. Go on the link. There it is. So this is probably the most massive technical assistance certainly my office has ever done for a grant announcement.

So that's where we are. Any questions or comments?

MR. KOPANDA: Thank you very much, Catherine.

I'd just like to note that I failed to mention earlier Sharon Amatetti. Many of you might not know Sharon. She works in our policy office, and she works very closely on a variety of issues with ACF. She's been instrumental in helping us get involved in this new program.

MS. JACKSON: Thank you very much, Catherine.

I wanted to say, as a person who has been involved with treating families and women with children over a number of years, that of course, SAMHSA has been very active in getting that going, and if it weren't for SAMHSA -- in fact, CSAT -- we wouldn't have women with

children's treatment in this country. So I give lots of credit to SAMHSA.

But I think just listening to you -- and also, I have read the program and the announcement, and I found that it really does stretch across a bridge that is very badly needed in this country of trying to work out the differences. I wanted to note particularly -- and I don't know if you want to make a comment on it or not, but the difference in perceptions between those people who work in child welfare and obviously look at the safety side of things and then those of us who are over on the substance abuse side -- and while we certainly care about the safety of the family and the children, we do believe addiction is a disease, and once it gets treated, we can rehabilitate families very well. So I want to thank you for that bridge.

I'm hoping that, while I saw the complicated -- and you've explained the money thing. That was good. I hope that we can go forward with that.

And I just wanted to see if you had any comments on how you see your agency continuing to try and work on that bridge with SAMHSA. Does your joint committee, for instance, cease with the funding or will you continue on? How will you continue to address this issue?

MS. NOLAN: That's a great question.

The work group that I described was really convened very specifically to help us write the program announcement and then to help us with some of the launching of the program in terms of getting the reviewers.

We haven't gotten this far yet, but I'm sure that in terms of -- once we launch a grant program and we actually have a group of grantees -- and in this instance, we're looking at probably about 55 grantees. We sort of try to create a community around them. So we call them a grant cluster. We bring them together. The first year we're actually going to bring them together three times because we'll have a kickoff meeting to do the final selection of the performance indicators with them and with our contractors, and some of the work group members will be involved in that. Then we'll have a second meeting which will be their first annual grantees meeting, and then we'll have a third meeting, which will be more of a subject matter-oriented meeting.

We have a plan anyway. I hope it works, but we have a plan that over the next five years, there will be two meetings every year. The traditional sort of grantee meeting, which usually focuses on a wide range of things, both subject matter and more technical grant-related, but then our plan for this group is to also have a second meeting per year that is just strictly subject matter-

oriented. So it might be two days really focusing on the collaboration. That's huge.

What you just described -- I mean, we really dove into that in the report to Congress in 1999, and we had some stakeholder meetings. And I'll tell you there were fireworks in those early meetings. People just did not get along.

I have to say -- I don't know if Sharon would agree with this. Westley, you've been to all those meetings. I want to say having Dr. Clark also here following us for the 10 years, there's something to be said about having that stability in personnel.

But I think we started that in a real formal way 10 years ago to really say you can just bring people together. I remember we had four regional meetings for that one time period, and at the end of each one, we had this little routine -- it was kind of fun -- where we'd go around. We had the states all sitting together in teams at their tables. The last question of every meeting was where do you think you are now and what are your plans for when you go home because the whole point was this team-building thing. We're bringing you together because we want you to meet each other and we want you to do something with all this material and talking we're doing for the two days.

And it was amazing the number of tables that

would say, well, when I got here, I didn't know anybody at my table, and now I find out that she works just one floor up from me and he works down the hall from me and we already have a lunch date planned for next Wednesday. And that happened over and over again. There were some who said, oh, yes, we've been working together. Some of the states had already taken this on and were already advanced with it, but that was a neat example of really one thing the federal government can do is convene. And we do that pretty well I think.

So we'll continue that. We'll continue the convening. The requirement in the program announcement is that the meetings must be attended by the program director, the evaluator, and then whoever they perceive as the key partners in the partnership. So that will be going on for the next five years.

We have our National Center on Substance Abuse and Child Welfare, and that's all they do. So at least for the next five years, these will be the things that we'll be doing. Beyond that, I have no idea. I have ideas, but there's not anything carved in stone after the next five years.

DR. MADRID: One question. First of all, I wanted to congratulate you for a very needed type of RFP.

Your funding options were most interesting.

Three years is very, very fast. They type of graduation, insofar as matching, is also very interesting.

You mentioned in your funding options Title IV-B and Title IV-E. Here at CSAT, with the direction of some of the staff, including Linda White-Young, we've been talking about sustainability on day one. So what I wanted to hear about this particular RFP, since you're working with Title IV-B and Title IV-E, how are you planning on tying in with the Medicaid situation since children are going to be involved, as it relates to sustainability?

MS. NOLAN: I'm not sure what you mean when you say we're tied in with IV-B and IV-E. This whole program is a new section. It's section 437(f) of the latest reauthorization of Title IV-B, Part 2. The only relationship with IV-E is that IV-E is what pays for foster care. The idea behind this program is that if we make investments in communities and they improve all their connections and relationships in substance abuse treatment, that it will help reduce the number of kids going into care. So that's the only connection with IV-E per se, and then for IV-B, this is a new program under IV-B.

DR. MADRID: How can we, for example, as providers take advantage of Medicaid dollars to do sustainability on day one with some of these children? I guess that's my question.

MS. NOLAN: It's a good one and it came up a lot in our discussions in terms of the development of the program. And a lot of the people calling, the potential applicants, have asked if they can use the Medicaid as a match, which they can't because the match has to be non-federal dollars.

This whole issue also came up in our regional meetings when we had the regional stakeholder meetings. In fact, we had Medicaid representatives at all of the meetings.

I don't know that I have a specific answer to your question other than to say it's a real good one. Medicaid is so complicated because it's state by state. So I think that it's a great question and it would be a good one for us to consider in our discussions of when we bring our grantees together. I don't know if that's helpful or not. It's kind of a wishy-washy answer.

DR. CLARK: Well, thank you. It was great to hear from Catherine.

We're down to the final stretch of this meeting. Our last two presenters are Ivette Torres, Associate Director of the Office of Consumer Affairs, and Shannon Taitt, Coordinator, Partners for Recovery. They will each provide an update on their programs and activities.

So that we may remain on schedule, we did not set aside time for council discussion following their presentations. However, if you have questions or comments for Ivette or Shannon, you may raise them during the roundtable which follows their presentations.

Ivette?

MS. TORRES: Good afternoon. First, before I start, I really want to think the council because I was not here during the last council meeting, and I heard some of you were really terrific in defending Recovery Month. So I applaud you for that, and I am very appreciative.

Many of you know the Recovery Month goals, but for those of you who don't, it's to support the demand reduction goals; build momentum for holding state events, regional events, national events that basically assist individuals in recovery; take the message home that addiction treatment works, that recovery is possible; and that we need money to do that.

This is a presentation that I use for the ELT. So I'm going to go very quickly through it. You may get to see some of the stuff and some of the stuff I'm just going to go really quickly through because we are, indeed, short of time.

I want to just show you this. Very important. Recovery Month. From the year 2002, we spent roughly $1.7

million, and we're now spending about $2 million. The $2 million covers the kit, the commemorative posters, and all of the materials, as well as the public service announcements, which is our PSAs and our webcast, the multi-media materials, as well as the meeting logistics. So I would say it's a relatively inexpensive package given the exposure that we get for not only SAMHSA but for the issue that we're helping to publicize.

Speaking of the series, we did nine shows, and I want to say -- Melody Heaps is not here, but she just finished doing our justice show and it will be aired in August. Or is it July? I think it maybe is July because I have it in my computer to view the final version. She did a fantastic job. So I am saying that to encourage all of you to want to be on the show, and if we invite you as a panel, we will cover your travel.

What I'm going to do is -- we're having a meeting next week and we're meeting with the contractors -- I'm going to get the topics. One of the topics I think that necessarily has to be in there is that whole issue of the recovery continuity systems of care. We will do one on that because I know, Chilo, you were mentioning that you had a keen interest in that and pushing that through anyway we could through our materials and efforts. So we're going to be doing one like that.

So I want you to think about it. If you have ideas for a show, also give them to Cynthia or George, and Cynthia or George will make sure to get it to us. It's a very fluid process. So think about being on the show.

The number of stations airing. We're up to about 349. The impressive point is that we're in 27 percent of U.S. households. When you think about what it costs other people to even get a fraction of that in terms of exposure, I think we're doing darned good. What does that translate into? It's roughly 14.4 million or 14.7 million households, generating free air time of more than $8 million, roughly, a year. Those were the topics for this year, which we've already seen the promo.

Recovery Month events. We're hosting around 54 events this year. We're trying to go on a state basis so that we're no longer encouraging people or funding a city and saying, okay, so do it in your greater metro area. What we're doing is trying very hard to work with the SSAs. That came up as an issue not only that we have been trying for a long time to get them engaged, but as the funding continues, hopefully not to decrease -- but we're not looking at a very expandable budget. So we really do have to get those states to begin to spend some of their dollars related to Recovery Month and for local communities and coalitions to begin to tap private sources and to get other

resources to assist in the observance of Recovery Month.

So for this year, we're going to have a Fun Walk here at SAMHSA. We had a very successful one. And Carol DeForce is in the back. She was instrumental in putting together last year's.

What else can I tell you? Adolescents and teens. We're doing five events focusing on them.

African Americans, American Indians. I called, after our last meeting, our council member who wanted to get engaged, and he got a hold of White Bison, and now he's connected to helping us to put together an event. So that was great. Asian and Pacific Islanders and Latino targeted events.

Addiction Professional Day. I don't know if a lot of you are familiar with that. It's NAADAC. NAADAC was one of the very first organizations actually to put together Treatment Works Month, which was the predecessor to Recovery Month. We're in our 10th year of calling it Recovery Month in 2007.

Recovery Rides. I'm famous to wanting to go on those rides. Here's Anita who did a very successful ride last year in Ohio, and she got me someone to cart me around and drag me off. But they're very enjoyable and actually it gets a very nontraditional sector of the recovery community to get engaged and to get involved in telling

their story to others in that sector.

Let's see what else you need to know about community events. Tons of people. Last year 59 events generating 64,500, roughly, people that attended those events. Nationwide we had 665 events posted in 2006, reaching nearly 4 million people. That's overall. That's SAMHSA plus everyone else. So it's very impressive.

Let me go back to that so you can see the growth from 2002 to 2006. This year we want to reach 1,000. So go back to your communities. Tell them to please post those events online because that's the only way we can figure out that someone had an event.

Attendees nationwide, 3,800,000, which is not bad. Again, what we have to continue to look at is the investment that we're making and what we're getting for it.

Proclamations, 140 last year from 126 in 2005. So we're increasing.

Let's see what else. Our web page for this year, www.recoverymonth.gov.

It looks better every year. I don't know how our contractors do it, but it really continues to improve and every year somebody thinks of something else and we just enjoy that.

Website. Incredible. From January to April, we've received 4,500,000 hits. So it's always increasing.

This is funny because I went into the SAMHSA website, and I usually end up checking different websites all the time, and we didn't even have the Recovery Month icon on our home page. Later I asked the communications office upstairs for them to, please, put it on. But those are being generated without the SAMHSA traffic to that website, which is substantial. So hopefully, now that we've got the SAMHSA icon back on, we'll be able to generate even more.

As you can see, the growth, the average number of hits per year, and we're up to 15 million for last year, 15,800,000. So we're just very happy.

PSAs. I want to show you the new television PSAs. Here we go. Let's see the first, and I hope this work.

(PSA shown.)

MS. TORRES: That was called "Celebrate." No applause?

(Laughter.)

MS. TORRES: And the second one is called "Cost," if I can find it.

(PSA shown.)

(Applause.)

MS. TORRES: Thank you.

So as you can see, the treatments every year

really carry the message of recovery extremely well, focusing on the individual that's in recovery. Our 2006 campaign was in the top 10 percent of the Nielsen-rated campaigns around the country. What does that mean? Nielsen takes about 481 campaigns around the country and they take a look at the ones for quality and for the number of plays of the public service announcement. So we're in the top 10 percent.

As for a breakdown, because I want to know what other campaigns are out there that are within that top 10 percent so we can see -- what I really want to do is see how much somebody else is spending to come back and say, ha-ha, they need $15 million, and here we're doing it with $2 million. But it's going to be interesting to see if there are even any other government agencies that are, indeed, in that top 10 percent or it it's all corporate, you know, pharmaceutical, or if they're considering the pharmaceutical industry with their public education, what they consider public education PSAs. So we're very proud and we're doing extremely well.

National Association of Broadcasters has done that booklet for their stations, and they're helping tremendously in terms of getting out those PSAs as well.

You already know that we were in the New York Times huge screen there in Times Square last year.

I'm just going to tell you, $14 million August 2002 to December 2006, and free air time for television, and for radio, $7 million. So it's getting out there.

But the real measure of the success of this campaign is not in the awards. And I'm going to go very quickly by. It's not in the amount of money. It's really in the number of calls that we're getting every single month from individuals and families who need help and are actually calling our help line. In 2002, we got 22,000 calls on average per month versus 2007. We're up to 29,165 for the month of -- I think that was for January through April. An average number of calls was 29,165. So that's an awful lot of calls. I'm sure that all those individuals are getting help -- either information or they're getting help.

We cannot track how many people are referred to treatment. So we don't know how many of those calls are for information or referral because the government is not allowed to do that. Otherwise, we would be doing it.

We just got a MerComm for the entire campaign. We always get PSAs or the kit or the web. We got our first award for the entire campaign. It just came in yesterday or the day before -- the GALAXY Award. And now we're competing for the super-duper GALAXY. They told us that we're going to wait for another couple of weeks and

then they're going to tell us who won what they call the grand prize.

But you can see. I mean, for the web, for the series, even the webcast series is winning awards. That's why I want you to be in it so you can be an award-winning panelist. So we're very happy.

With that, I'm finito.

(Applause.)

MS. TORRES: Thank you.

MS. TAITT: That was wonderful, Ivette. I don't have quite as many bells and whistles as Ivette, but it was a wonderful demonstration on what Recovery Month does.

For those of you that don't know me, my name is Shannon Taitt, and I'm the new Partners for Recovery Coordinator. I have some pretty big shoes to fill. I took over for Donna Cotter who retired in December, but have been really pleased to be in this position and learned what Partners for Recovery is about.

So here today I don't have a PowerPoint presentation because those of you around the table should have received our new fact sheet, and that should be in the binder that you have. For those of you who are out in the audience, that is on the back table. So that is one of the new developments for this year since I've come on board.

Let's see. Partners for Recovery, created in 1998, was based upon input from the field, and it's a collaborative effort for communities and organizations that mobilize to help individuals and families achieve and maintain recovery. PFR Initiative supports and provides technical resources to those who deliver services in the prevention and treatment of substance use and mental health disorders.

As you see on the fact sheet, we have five broad focus areas: recovery, workforce development, cross-systems collaboration, stigma, and leadership development. And I'm not going to go over everything that is on the sheet because you do have a copy of it, but some of the major highlights that I did want to go over are that some of the core activities are including supporting and facilitating the development of recovery-oriented systems of care in states and communities, that we've been fostering collaboration among various systems, equipping recovering individuals, providers, and state and local governments, and other stakeholders with the tools to respond to stigma, and that we've been preparing the next generation in the substance use and mental health fields.

In some of our cutting-edge initiatives in collaboration, The Outcomes of Addictions Treatment and Approaches to Monitoring Performance was a series of

1 briefings that were done. In addition to the briefings
2 that were held at the NCSL Spring Forum, there was an
3 annual conference and Critical Health Areas Project
4 meeting. Some of the outcomes in the collaboration area
5 are that 29 states and the District of Columbia were
6 represented among 31 legislators, 18 legislative staff
7 members, and 14 other state officials attending a briefing
8 at the NCSL annual conference. Eight state-specific
9 briefings have also been held.
10 On the back of the fact sheet, you will see
11 some information on stigma reduction. PFR developed the
12 "Know Your Rights" brochure which provides individuals in
13 treatment and recovery and their friends and allies
14 information regarding federal anti-discrimination laws
15 regarding employment, housing, public benefits, and other
16 domains. The training manual is available on
17 www.pfr.samhsa.gov, and the brochure was done in English
18 and in Spanish.
19 Some of the outcomes in the stigma reduction
20 area were that there was a very high demand for the
21 brochure and the initial stock of 75,000 copies was
22 exhausted in less than 10 months. Approximately 600
23 stakeholders from all 50 states have attended "Know Your
24 Rights" training sessions.
25 In the workforce development area, PFR

activities focused on recruitment, retention, and professional development. The document, "Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce," was developed by PFR as a catalog for major addictions treatment and recovery workforce challenges.

Also in the workforce area, some of the outcomes are that PFR is currently funding activities related to improving recruitment efforts. Some focus groups are going on around the country. One was done earlier in April this year in collaboration with the Dr. Lonnie E. Mitchell Substance Abuse Conference that focuses bringing African American students from historically black colleges and universities to the Washington, D.C. area so that they can learn more about the public health field. So focus groups were held with students that are thinking about entering the field and also some returning students that are older and have decided that the public health field is an important area that they wanted to go in. So we looked at second career people and wanted to see why they decided as a second career to go into public health.

In the leadership development area, Partners for Recovery, in collaboration with the ATTCs, has worked with the Leadership Institute in 13 ATTC regions across the country. Part of the overall strategy of PFR is to

identify emerging leaders and build capacity to meet both the organizational and systems demands in this field. It's a six-month program that involves self-assessment, formalized appraisal by supervisors, colleagues, and direct reports, and it has been going on for the last three years. There's been approximately 342 graduates of the Leadership Institute, and 4 CSAT staff have graduated from the Leadership Institute, including myself. I'm graduating this year.

The Second Annual National Conference for Leaders of Addiction Services is going to convene its conference in August this year, August 5th through the 7th, at the Grand Hyatt in Washington, D.C. These institutes have also brought together some national experts such as Dr. Carlo DiClemente, William White, and other state directors.

One of the major areas that I wanted to talk about just for a moment that we've been focusing on is the recovery area. This is a very important area for Partners for Recovery right now, and we are in the process of conducting regional meetings across the country that will help states and communities implement recovery-oriented systems of care. We did our first regional meeting in April, April 10th through the 12th, in Portland, Oregon, and 10 states were represented there. Our next meeting

will be held in Dallas, Texas on July 15th through the 17th, and we will have about 10 states for that region. And in September and October, we will go to the Chicago area, and then we'll finish out the year in probably the Rhode Island or Massachusetts area. We're waiting to see what we can do about getting those meetings set.

So we wanted to make sure that as we go to these meetings, that we're talking to not only the state directors, but we're bringing in the recovery support community, we're bringing in researchers, we're bringing in treatment providers and bringing them in as a team from each state to be able to look at the challenges and look at the strengths that they have in their states already to start implementing recovery-oriented systems of care.

We also have an opportunity for them to share across states and see what information they can gather from other states as they go home and figure out how they can go forward with recovery-oriented systems of care.

As far as next steps with Partners for Recovery, on May 30th, the Partners for Recovery Executive Committee had a meeting to discuss the future direction of Partners for Recovery. The Executive Committee decided to take a proactive approach to the proposed elimination of Partners for Recovery. So we appreciate the fact that the National Advisory Council has been so supportive of

Partners for Recovery. So the Executive Committee wanted to meet and discuss some of the issues that would move us forward in all of the work that we've been doing. We discussed next steps to engage the prevention and treatment field and additional Partners for Recovery activities that will support the initiative's continuation.

As it was stated during this morning's public comment section, CSAT needs to step in and coordinate some of the efforts around recovery and recovery-oriented systems of care, and we believe that CSAT and Partners for Recovery are doing just that. We are committed to working with the field and bringing people to the table to look at the paradigm shift towards recovery-oriented systems of care, and we want to make sure that Partners for Recovery stays on the cutting edge of the issues that are important to the field and also important to SAMHSA and CSAT on the whole.

As some of you may know, Partners for Recovery developed out of the National Treatment Plan and its guiding principles: invest for results, no wrong door to treatment, commit to quality, change attitudes, and building partnerships. This shows us that these guiding principles are still relevant today.

PFR will have another meeting of stakeholders on July 26th here in the Washington, D.C. area to continue

discussing where we've been, where we are now, and where we plan to go. We are committed to the recovery support community and we will also have representatives from those areas there as well.

As I said earlier, the National Advisory Council has been very supportive of Partners for Recovery. Melody Heaps, who couldn't be here today, is the chairperson to the Partners for Recovery Steering Committee. I know Frank McCorry has also been a big supporter of the initiative, as is Dr. Chilo Madrid. He's been a part of Partners for Recovery since its inception and even before that with the National Treatment Plan. So as I close, I'd like to introduce Dr. Madrid to talk about Partners for Recovery as it relates to him in the field and also being a part of the National Advisory Council.

So I thank you for your time.

DR. MADRID: Thank you, Shannon, and I'd like to commend Shannon and Ivette for all the fine work that both of them have been doing concerning recovery.

I think that Anita Bertrand said it best during the last council meeting when she said that so many things have happened that are good concerning recovery and we are confronted with a lot of funding restrictions, that it's time to get real creative and move this agenda forward, whether it be the summit, whether it be PFR.

What I have done is I have talked to my congressional delegation and they have informed me that that very conservative look that we looked at concerning the budgets during the month of March is turning a little bit better. The markup on those bills June 21st shows an increase both on the Senate side, as well as on the House side, not just with the block grant but regular CSAT money. And during the March meeting, there were a lot of decreases and a lot of cuts that were being proposed. It was a very conservative look at our CSAT budget, and I think it was a very smart perspective to take.

But I think that has a member of the Partners for Recovery, what I'd like to do is ask this council to communicate to Dr. Cline the fact that Partners for Recovery and all the work that Ivette has been doing is essential. It has moved CSAT forward in many areas. It has represented everything that we are and we do. It has looked at cutting-edge type of situations. Again, as Anita said during March, we need to get creative. We can't look the other way. Times are very tough and we know that, but we need to carry the movement forward and not take steps backwards or sideways but take them up and take them forward.

So I hope that this council takes this request seriously. As we communicate to Dr. Cline, I believe that

Melody Heaps wrote a letter, and I believe that during the last council meeting, this council talked about addressing a letter to Dr. Cline concerning some of the things that we thought were important. Again, these are the things that are represented so well by what Ivette has been doing and certainly what Shannon is doing.

I believe that Cynthia has just passed around a letter that was addressed to Dr. Cline by Bettye Ward Fletcher on behalf of the council. Where is Bettye? Oh, she left. I wasn't privy to this particular letter, but is the recovery movement elaborated here? Oh, okay.

The other thing that I was going to say is that I was informed by my congressional office that there's a very promising bill, Senate bill 1367, that looks very promising by Senator Harkin that might bring in another $100 million into (inaudible). I don't know if you all are familiar, and it talks about recovery. It talks about a lot of things that we've been talking about today.

So keep your fingers crossed because these are the things that I think will turn this thing around. In other words, during the month of March, we were facing a lot of decreases in budget. As of June 21st, most of those decreases have been restored. And then, of course, right after July, there's going to be the full Senate, the full House that will look at that, and then it will go to

conference. Up to now, even though the House is the most gracious to us, the people on the Senate side are saying that they are going to support the House version. So hopefully with the help of these people and the Lord, SAMHSA/CSAT will experience an increase rather than a decrease. It looks very favorable.

As we do that, I think that we need to take another look at the recovery situation with what Ivette has been doing. And I think there were some people here testifying this morning concerning recovery, the Recovery Summit, a lot of things that really put us on the map that we need to bring them back and restore them and move it forward.

Anita, do you want to say something?

MS. BERTRAND: Thank you, Shannon and Ivette, for the presentation.

In our community, each of the counties over the years -- I think this is the fifth year that we'll be having this annual Recovery Month banquet, and it's just amazing, right in the area that I'm in, just to see the different counties that are starting to develop other Recovery Month events.

But I guess I just want to make another request that the administration of CSAT really hears what we're asking here in regards to -- I know I participated in the

Recovery Summit. I participated in a planning meeting actually earlier this month with the group, Health Systems Research, that has the technical assistance grant for the Recovery Community Services Program. But just that we put on the forefront of CSAT's agenda that we look at the policies and just taking on some leadership because what I would like to see is that from this level some sort of stage is set and that we don't wait for the states to do these things and that we just respond in a proactive manner.

MR. KOPANDA: Thank you very much for those comments. I think we're kind of into the council roundtable here. I do want to thank both Ivette and Shannon for their presentations. Dr. Clark once again was called away. This is usually the way it goes here. But we could begin with any comments we have for them following up on the recovery comments or any other issues that the council would like to raise.

MS. JACKSON: Thank you very much, and Ivette, thank you very much for all of your hard work regarding Recovery Month. I think that it is very important. And I have a couple of ideas for air time things, so I'll give them to you.

I want to follow up on what Anita just said because one of the things that I think we have mentioned

here before but I feel like we need to -- I don't know exactly what action needs to be taken or how we can stage it. I think you said "stage" it, and that's probably a very good word. Somehow it would be very nice if the National Advisory Council for the Center for Substance Abuse Treatment -- if we were discussing in our roundtables what we would like to see in 2008 and 2009 and 2010. You guys start planning very early. We begin to hear about it a little bit later, and we appreciate that. Don't get me wrong because I feel like I get lots of information and I'm very well informed.

But at the same time, for instance, what Greg Skipper talked about earlier today, the idea of possibly coming up perhaps with a discretionary grant or a pilot or something that looks or somehow, again, sets the stage to be looking at the way that recovery comes to the professions, the medical professions and also in the legal professions. You can't argue with those statistics. They're very, very important and they're very impressive. I think we need to look at that.

There are other areas. One of the things that struck me this year, while I am, as most people here know, an avid, avid supporter, and have been ever since we got started, of women with children's programming, and it's truly a part of my life's passion, it was interesting when

I looked at target populations for some of the grants that people I worked with took on this year. Frankly, it's really, really difficult for men to get treatment. It's not easy. I don't think that there is much progress in increasing money at the state level.

So that's just a couple of ideas and thoughts that go through my mind kind rambling here just a little bit. I'll stop. But I would love to have a discussion of what's important from the home front of those of us, and we can also go out and ask a lot of other people, if we're encouraged to do so, and then help perhaps to formulate some of the policies and ideas that come forward for the future and have more discussions about that. We would really appreciate that.

MR. KOPANDA: Thank you, Val. Yes, that is very important.

To kind of follow on something Chilo said -- and it was mentioned earlier -- from the time that the council submitted the June 22nd letter to Terry Cline -- and we've received both the House and Senate marks -- it's become a bit different story for us, if you will. Last time we were discussing the possibility of eliminating these programs. Now we're talking not only the restoration but also hopefully some growth, but hopefully not too limited a growth either. So we would be in a different

mode within CSAT in looking at how to program those dollars.

We would value the input of the council either now or in some future meeting. But as we begin to go between now and -- you know, we like to get the announcements out early. So I would suggest that any comments or suggestions you have now would be well received or in some future council meeting because we're not at the final part of our process yet.

We also have a number of things going on that we do support in recovery. Of course, we have our Recovery Support Services Program, and we're just at the point of reviewing, as you know, the awards for that. We also have the Targeted Capacity Expansion Program where a portion of it is targeted toward recovery-oriented systems of care. That's the first time we've kind of focused on that particular aspect of services and we'll see how that comes out as well.

But any suggestions you have on recovery or other areas I think would be well received.

DR. MORA: I have a comment related to that, our input specifically.

But before I address that, I wanted to say that I support the recovery efforts and I will follow up with my congressional representatives after this meeting regarding

funding in that area.

But based on hearing everybody today, it seems that our role is more to advise on policy and priority areas, that kind of a thing, but there's no real place for us to do that. So one of the places that might be feasible, as Dr. Clark mentioned, is at the writing of the RFAs where priorities are set and identified. Where are we on that process? I mean, what input can we have in that process? Maybe we can talk about that at our next meeting in addition to talking about grant reviews. How can we get at the front end of that so that we can have some input about geography, about whatever issues we think are important based on our involvement in the community?

MR. KOPANDA: Well, some of our initial discussions regarding funding for the upcoming year have to do with how we distribute the money more or less among the RFAs, how much in Targeted Capacity Expansion, how much in Pregnant and Postpartum Women, how much for methamphetamine, how much directed to the American Indians/Alaska Natives. Those kinds of discussions we have.

In addition, we're accommodating the Hill priorities as stated. For example, the Senate language here says maintain all your programs at last year's level. Well, okay. There we go. There's a lot of the

discretionary funds already set because we're continuing the programs at no less than what we spent last year. They also have earmarks. So the amount of money left for which we are looking at different areas is much smaller than you might otherwise think.

But, nonetheless, we do have some discretion in there, and the first thing we look at is where that money goes. And I think that's what we would first look to the council to say where would you suggest we put what we would assume would be a moderate or modest amount of money. Once we determine that, then we get into the issue you're talking about, which is how are we going to do those funds.

I can bring up another issue I have here which, depending on council time, is the kind of questions we're faced with in terms of what are our longer-term priorities. How do we decide where we put the money? How do we establish that within some kind of a strategic framework of where the agency is going, those kinds of questions.

DR. MORA: Well, I had those similar questions. Is there some kind of strategic plan available that we could look at to learn more about what the long-term strategic goals are not only for CSAT but for SAMHSA, things like that that would help us help you and provide appropriate input in whatever areas have been already identified.

MR. KOPANDA: SAMHSA does have a strategic plan which we could provide you. I'm not sure -- George may here -- it gets to the level of determining where you come down to this kind of money, you know, that level, the degree of --

DR. MORA: That's okay. I think for me it would help me understand what the general kind of future direction is. Also, even I understand that some monies are already earmarked for TCE or whatever, but we may be able to have some input within the parameters of a certain body of funding. Maybe we can target within that target some special need or whatever. So I think we'd like to find out where we might have that kind of a role because otherwise we see the proposals and the grants after the fact and we have to just have faith that they've been reviewed appropriately.

MR. KOPANDA: Other comments?

MR. DeCERCHIO: I think, just to follow up, Rich, I was thinking more in terms of the front end. When Dr. Clark this morning mentioned something, I think the '09 -- SAMHSA is having some internal discussions and internal executive branch discussions about recommendations for the '09 budget. So from my perspective, it was looking at that level, you know, '09, '010, like Val mentioned and Dr. Moore mentioned because you are going to have those

restrictions on what you have. Believe me, the sensitivity around how you allocate dollars and those processes have to be very transparent. But what is important in '010? Is there another area that should be looked at or in '09? Are there other areas that have run their course?

And I don't know the answers to that, but maybe in an upcoming session, we can just dedicate some time to what the agency's thinking is and what our thinking might be around that and have kind of a constructive dialogue session around that, you know, being way out in front of it and my perspective is less, in terms of, well, you got your money, what are you going to do with it. By that time, you asked for it in a certain way to do certain things, and it's really even hard to change that. Two years ago you proposed this is what we're going to do with it. Now they give it to you. Because we want to see it go somewhere different, you can't come in and really change that game plan very much. But now, having that discussion about two years from now I think would be an expansion and a good use of the advisory council.

MR. KOPANDA: I agree. I think that's an excellent suggestion and we should put that on our next advisory council agenda.

MS. JACKSON: And if it's possible, I think that is a way that you're hearing we would really like it

to go. I think that we certainly understand that Congress dictates a lot of what you do and that that is going to happen or it depends on somebody who is very strong and lobbies a particular issue. As we saw today, the results of the ACF money was certainly a result of a strong effort last year, which is very good. I applaud that. At the same time, had I had something to do with the front end of it, I might have worded it a little differently. I'll say that on the record. It's okay.

I think that if we were to discuss this, like Ken is saying, which would be very helpful for '09 and '010, some guidance perhaps -- George, you're great at that. Rich. Whoever would do it would kind of give us some of your thoughts and what you're hearing because, of course, you've got a national ear, and then we have an ear and a perspective from different areas at a different level. But a little guidance that way, and then perhaps a little bit of structure to help us to then give you the input would be very, very helpful, not just an open dialogue, even though I think it has to be open, but maybe guided and open.

MR. KOPANDA: Yes, that's very important as well. We are, of course, in the middle of the 2009 budget discussions.

And I should just reiterate to the council that

if you are going to talk to your Hill contacts, it should not be in the context of your official SAMHSA council membership.

But along the lines you're talking about, the broader framework, what we see right now is kind of a confluence of a number of things which are impacting our programs and priorities and budgets. Several things.

The GAO, for example, which is now, as you know, the Government Accountability, rather than Accounting, Office, has decided to take a look at the PART process, the OMB program review process which scores us based on a number of aspects of our programs, and is questioning how managers use the information from evaluations and other aspects of their program to determine program priorities for the future. We could go through that a little bit. I actually did bring some of the questions from PART. There are many, many questions.

The second issue is actually the PART process, which we just completed for the Access to Recovery Program. Once you go through this process -- we've done it before, but it's a very labor-intensive process. We found, for example, that what we might think, in terms of meeting the goals, not everyone necessarily might agree that those are the goals of the program. So you do need to take a very, very careful and close look.

And we're looking at the application of PART principles to many of our current programs to say if you were PARTed for this program, how would you answer the question, are your goals aggressive? How do they go up from year to year? We think we hold grantees accountable, but how do you really hold them accountable in a more intensive way, akin to the PART process?

Other types of questions we face through the budget process, we've just noted a few. Why is your proposal the right thing to do? How does it clearly fit within the scope of your mission and avoid mission creep? For example, one example might be are programs focusing on American Indians and Alaska Natives. Why are you doing it rather than the Indian Health Service? Why are you doing this type of program rather than HRSA? That kind of thing.

How would your proposal fit within the complete package that the Department is putting forth? In other words, are you out on your own doing something? Are you proposing to do something over here, or is it consistent with the rest of the Department's priorities?

How does your proposal benefit the field in the longer term beyond just simple, immediate client services? Rather than just increasing the number, how are you influencing? I like to think of how you are influencing the field. My thought is that our programs are not all

intended to provide a grant to every single provider or to every single state, and we do have kind of an influence that goes beyond the specific dollars for that specific program, especially when our programs kind of end after a while. We don't continue them forever. So how do we capture the nature of that influence and kind of build it into our program planning process for the future?

That influence might even extend, for example, to unsuccessful grantees who, by developing an application which would propose to use, say, recovery support systems of care in their area, have thought about that. They might not get the federal grant, but they have conceptualized where the federal government wants them to go. So these are the kind of thoughts that we want to be bringing forth in terms of our future. We're going to be asked and forced actually to bring into the future discussions about the budget that it would be good to have the council input on.

DR. MORA: Well, just one comment related to that. One of my major concerns for a long time and still is is that I noticed that your grants, your RFAs are getting more and more complex, and there's a lot of very good community-based organizations that do not have the technology, the support, the resources to compete even though they have the trust of the community. So I want to have that dialogue with you guys. What can we do about

things like that?

MR. KOPANDA: Ken?

MR. DeCERCHIO: Are there any proposed changes to the block grant formula that are being contemplated? Anything new on that or new or revised for either '08 or '09?

MR. KOPANDA: I mean, we are going through the reauthorization process right now. The word we're hearing informally is that nothing formal is being proposed right now in terms of changes to the block grant formula.

MR. DeCERCHIO: Informally is there any feedback about there's a problem with this or this needs to change?

MR. KOPANDA: Well, there are some members who are concerned about the relationship between the formula and the need and its relationship to need for funding, need for services. That's a very difficult issue because it gets into the issue of every time you change it and you think you're doing this, some states -- you have winners and losers. And it's never always intuitive -- I'll put it that way -- as to who is going to win and who is going to lose when you make a change like that.

Of course, how do you define need in terms of a formula? The initial formula actually was constructed in a way which is supposed to mirror or mimic need in a way that

not everyone agrees right now is accurate. So I think those are the kind of discussions that are going on, but they have not resulted in anything concrete.

MR. GILBERT: I wanted to just add that apparently there is some thought being given in the reauthorization of SAMHSA this year to include a provision that would mandate a study of the formula and what some options might be to change it to better reflect need. The last time the formula was changed, I think the GAO wound up doing something like 86 or 90 formula runs for the Congress. What it ultimately boiled down to was which one of those formulas was going to get the votes they needed to pass the bill. I mean, how do you jigger it so that you can get enough members to sign on?

MR. DeCERCHIO: I was on the NASADAD work group when there were $275 million on the table under President Clinton and Barry McCaffrey. It was a very tenuous kind of consensus on modifications to the formula that got put in appropriations bills every year until the last reauthorization between like '99 and, I guess -- so it is real tricky and real touchy. There were concessions made as that was being done in order to get exactly what you said, the votes needed.

So anytime that's back on the table, it's one that requires a lot of attention and really an opportunity

for -- and I'm not advocating for a change. I'm just saying it's always a tough issue, and sometimes the field can lose. In other words, sometimes even though there are winners and losers within, it can end up where the whole field kind of loses if it's not -- in a political process. Let me just put it that way. So if there's any strong movement around that, we certainly would like to be apprised of it as it unfolds.

MR. KOPANDA: Also in answer to your question, I have heard a little bit about the possibility of changing the minimum state allocation. I'm not sure where that's going. We haven't seen any actual proposal along those lines.

DR. MADRID: I did want to add that on the House side at this time, as of June 21st, there are $35 million more being proposed for the block grant. And there is some talk about how that is going to be allocated based on the present formula.

But I wanted to perhaps make a recommendation based on what Dr. Mora talked about this morning that she's doing a lot of research concerning border issues. Maybe this coming year we should look at that. For example, in my case I'm right on the border. There are 23 other programs on the other side of the border, treatment programs. There are several methadone programs. I know

some of my people are getting double-medicated, but I don't have that type of relationship with the methadone programs on the other side.

There are millions of dollars being poured by the federal government on both sides concerning the supply side, but there are zero dollars being invested concerning the demand side. We have a lot of young boys that we saw pictures of that are getting very addicted to methadone, as well as heroin. The prices are really, really down.

So there's just so much that we could study along the border. So perhaps we can spend some time this coming year looking at how we can collaborate better and take a serious look at the demand side, perhaps as serious as we're taking a look at the supply side.

I was telling Shannon, going into Partners for Recovery, why not also this coming talk about a Partners for Recovery national plan? The National Treatment Plan was a big success with a lot of the treatment providers and others, and perhaps we can learn from that and move that forward if we have the opportunity concerning the budget restrictions that are confronting us at this time.

But, again, on the border issues, there's just so much that we can do together. Criminal justice is doing it. Why can't we do it also from the demand side?

MR. KOPANDA: We will consider that for future

discussion as well.

Val?

MS. JACKSON: Another issue that came up this afternoon in our ACF presentation on that initiative is the fact that Congress saw fit to fund it the way that they did last year, which is a very complicated funding system that then the agency was stuck working with. I don't know if that was unique. I would hope that it is.

However, one of the problems with match money is that it is very difficult as an agency to -- you know, we can put in some soft match, but we are expected, for instance, in Florida before we ever begin, we have to match 25 percent of everything that's primary alcohol-related. So we have a match that somehow the state expects that we will magically come up with a quarter of what we need in order to minimally do services within the state. Then if that happens to come up in other issues nationally such as it has in the ACF, I think it makes it even harder on agencies.

For instance, earlier today you talked about sustainability and how we need to think about sustainability from day one. Well, you're absolutely right. We all do need to think about sustainability from day one. However, if you are a not-for-profit organization trying to live on grants on what you can get out of the

state through your block, on hopefully a few foundations, on a very little bit of -- at least in our state -- third party pay.

It used to be there was actually some insurance that would come in to an agency and help support it, and there used to be some cash that would actually come in to an agency and help support it. Those two things have just basically disappeared. In our agency, The Village, for instance, 10 years ago probably 15 percent of our funds came from third party pay. I would say now it's probably less than 2 or 3 percent.

And yet, the match kinds of things that come up are really, really difficult for not-for-profits, which is what you deal with, to manage. So I think that that's another issue that we would like to perhaps at some point have a discussion about, look at maybe perhaps from the SAMHSA side the sustainability, but with an eye to the fact that if Congress is going to begin to throw match into anything, we would really like for you to try to represent us in the difficulty of any of that kind of thing and to be understanding about even the sustainability. We understand you have five years to run a grant, but let me tell you, the sixth year is a very, very difficult year and being able to do anything rational about that.

MR. KOPANDA: Yes, thank you. There are a

1 couple of issues there. One is I guess the core question,
2 does match help? I mean, the purpose of match, as they
3 define it, is to permit grantees to begin to develop and
4 think about those outside sources before the money just
5 runs out. Certainly the Pregnant and Postpartum Women
6 Program has been one. As you mentioned, Linda has been
7 working on the sustainability issue, but we've never really
8 looked systematically as to whether match programs are
9 sustained -- I don't think we have -- at any greater rate
10 than any of our other programs.
11 But I think the second and more key issue is
12 the dollars in the system as a whole from Medicaid on down.
13 If you're not seeing much growth in the dollars in the
14 system as a whole, then it's difficult to increase your
15 capacity. And we're giving to these grants. You know,
16 well, where are they going to get their match from because
17 the system as a whole, no matter where you're getting your
18 funds, private payments and such, are declining.
19 MS. BERTRAND: One more thing. And with match
20 for smaller organizations and community-based organizations
21 is that it alienates them because they cannot match,
22 whereas your larger hospital institutions and foundations
23 and universities may be able to make those matches.
24 MR. KOPANDA: Any other issues?
25 MR. GILBERT: Rich, if I could. I just wanted

to go back to the issue that Ken raised about the formula. There was something that I thought about just as we kind of finished that conversation. There is not anything that I know that's going on in terms of changing the formula, but there is a proposal in the administration's budget this year that would require states -- we've said for a long time that states would be required to report against the NOMs, the National Outcome Measures, beginning in 2008. And that's been negotiated and worked out with NASADAD. But the President's budget this year included a provision that would withhold from a state 5 percent of their award if they failed to report.

That provision -- we don't know what the House is going to do with it. The Senate Appropriations Committee has said they won't support it. So that's still kind of hanging out there as an issue that could come up in the appropriations process that could affect the amounts that states would get under the block grant program.

MR. DeCERCHIO: That's a large withhold, 5 percent.

MR. GILBERT: Yes, it is.

DR. CLARK: Well, I guess the key issue remains the expectation of performance and data. I mean, for the longest, people would say, well, we can't produce that. And increasingly the Congress, both parties, said we want

accountability. I think while we haven't promoted that, we see this notion of accountability.

Fortunately, for the substance abuse community, most jurisdictions have been responsible. There's always the outlier. And we continue to do that. So we raised the alarm about these negative consequences, but you're fighting uniform opinion that they want people to deliver on the goods. They don't want promises.

You're right. It's a large amount and we're very sensitive to that. We haven't supported that, but that's outside of our decision-making. What we can do is make sure we work with jurisdictions so that we don't have to visit that. We don't have to go there if we can produce the data that we need to demonstrate that the money is being well spent.

I'd like to let you know that we have tentatively scheduled a teleconference meeting for grant review on August 23rd at 1:00 p.m., Eastern Standard Time, and the next face-to-face meeting is tentatively scheduled for mid-October. We'll have a better idea of what the '08 budget is going to look like by then. We'll know whether they're going to move forward or not by mid-October.

I really appreciate your thinking about '010 in terms of what we're doing, and in terms of this notion of performance, I encourage you to look at the OMB website for

the PART, Performance Assessment Rating Tool, so that you'll get a sense of what it is that is being expected of all of our portfolio, not just the block grant, not just the discretionary grant. It's very rigorous. The issues remain that people want to know what we're doing with the money.

And as we think about where are we going philosophically, why do we need the block grant? I think we in our hearts know that, but we need to be able to articulate that. Why do we need a discretionary portfolio? You've heard us articulate principles about that in the past, but as we think about '010, we should do that.

I'm fond of pointing out, at least in the arena of illegal drugs, there's a unique federal role because, indeed, the Controlled Substances Act is a federal act, and if indeed we don't play a role, we create an unfunded mandate for the states because, unlike physical health which you can say, well, is it a local jurisdiction issue, the area of illegal drugs and prescription drugs has been carved out by the federal government as federal government territory.

Now, I don't know that that's compelling to the decision-makers, but indeed, these questions do surface. We need to recognize that. You're in a good position as council members to have a sense of if this money dried up

over here, what it would mean; if money is invested over there, what it would mean. So we can think about 2010.

So is there any other business we need to discuss?

(No response.)

DR. CLARK: If no further business, I will entertain a motion to adjourn.

PARTICIPANT: So moved.

PARTICIPANT: Second.

DR. CLARK: It's been moved and seconded that we adjourn. All in favor?

(Chorus of ayes.)

DR. CLARK: The motion carries. This meeting is adjourned and I look forward to talking to you in August and seeing you again in October.

Sorry that I've been in and out. We had multiple meetings I'm juggling. That's the problem with having a meeting in your own house.

(Whereupon, at 4:30 p.m., the meeting was adjourned.)