

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT
NATIONAL ADVISORY COUNCIL

Wednesday,
March 21, 2007

Salons D & E
Hilton Washington DC North/Gaithersburg
620 Perry Parkway
Gaithersburg, Maryland

IN ATTENDANCE:

Chair

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

Executive Secretary

Cynthia A. Graham, M.S.
Public Health Analyst
Center for Substance Abuse Treatment
1 Choke Cherry Road, Room 5-1036
Rockville, Maryland 20857

Members

Anita B. Bertrand, M.S.W.
Executive Director
Northern Ohio Recovery Association
3746 Prospect Avenue
Cleveland, Ohio 44115

David P. Donaldson, M.A.
CEO
We Care America
44180 Riverside Parkway, Suite 201
Lansdowne, Virginia 20176

Bettye Ward Fletcher, Ph.D.
President and CEO
Professional Associates, Inc.
P.O. Box 5711
Brandon, Mississippi 39047

Valera Jackson, M.S.
CEO
New Century Institute (NCI) Systems, Inc.
4500 Island Road
Miami, Florida 33137

IN ATTENDANCE:

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

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

Judge Eugene White-Fish
Tribal Judge
Forest County Potawatomi Tribal Court
P.O. Box 340
Crandon, Wisconsin 54520

Ex Officio Members

Terry L. Cline, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration
1 Choke Cherry Road, 8th Floor
Rockville, Maryland 20857

C O N T E N T S

PAGE

Call to Order

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
 Director, CSAT
 Chair, CSAT National Advisory Council 7

Member Introductions and Activity Updates 7

SAMHSA Update

Terry L. Cline, Ph.D.
 Administrator, SAMHSA 12

Discussion 23

Director's Report

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM 33

Discussion 51

Legislative Update

Joseph D. Faha, M.Ed., M.P.A.
 Director of Legislation, SAMHSA 63

Discussion 83

Consideration of September 20, 2006
 Council Minutes 84

Substance Abuse Treatment Services for
Individuals with Disabilities Update

Ruby B. Neville, M.S.W., L.G.S.W.
 Public Health Advisor
 Office of the Director, CSAT 85

Discussion 93

C O N T E N T S

	PAGE
Council Roundtable	96
Follow-Up Discussion on the Budget	117
Access to Recovery (ATR) and Recovery Support Services Update	
Anne Herron, M.S., C.R.C., CASAC, NCACII Director Division of State and Community Assistance, CSAT	134
Jack B. Stein, L.C.S.W., Ph.D. Director Division of Services Improvement, CSAT	141
Discussion	151
National Registry of Effective Programs and Practices (NREPP) Update	
Kevin Hennessey, Ph.D. Science to Service Coordinator Office of Policy, Planning, and Budget, SAMHSA	156
Frances Cotter, M.A. Public Health Advisor Division of Services Improvement, CSAT	178
Discussion	182
1993-2003 National Expenditures for Substance Abuse Treatment	
Rita Vandivort, Ph.D. Acting Branch Chief Organization and Financing Branch Division of Services Improvement, CSAT	185
Discussion	195

C O N T E N T S

	PAGE
E-Therapy Update	
Valera Jackson, M.S. NAC Member	210
Stella Jones, M.S.W., L.I.C.S.W., B.C.D. Senior Program Management Officer and Project Lead, E-Therapy Initiative Division of Services Improvement, CSAT	211
Discussion	215
Council Roundtable	216

1 P R O C E E D I N G S (8:50 a.m.)

2 DR. CLARK: I'd like to call the session to
3 order. I'm delighted to welcome each of you to the 49th
4 meeting of the CSAT National Advisory Council. I hope you
5 find the discussions and presentations enlightening. We
6 have much to discuss today. Since we last met, CSAT has
7 laid the groundwork for some substantive changes that are
8 important to assist the Center in accomplishing its
9 immediate and long-term goals, and we want to bring you up
10 to date on that.

11 We have Dr. Terry Cline, SAMHSA's
12 Administrator, and he will be speaking shortly. He has a
13 very tight schedule, so we will start off with comments by
14 him. So we're glad to have him present since he just
15 recently started.

16 Before we further the meeting, I want to invite
17 the members of council to introduce themselves and briefly
18 let us know some of the activities they've been involved
19 in, and then we'll defer to Dr. Cline.

20 Why don't we start with Dave?

21 MR. DONALDSON: Good morning. Dave Donaldson
22 with Convoy of Hope, living part of the time in Africa.
23 We're actually building a compound there and distribution
24 center in Nairobi, Kenya, and doing a lot of relief and
25 development in the Mathare Valley, one of the largest slums

1 in the world. In addition, we're doing a lot of relief and
2 disaster response here in the States. I wasn't expected to
3 be here today, but it was great to get the call that those
4 dates were changes. It's a great pleasure. Thank you.

5 DR. FLETCHER: Good morning. I'm Bettye Ward
6 Fletcher from Jackson, Mississippi. I serve currently as
7 the president and CEO of Professional Associates, Inc.,
8 which is a research and evaluation firm in Jackson which
9 works with primarily indigenous communities around issues
10 of evaluation, particularly outcomes evaluation and
11 participatory community evaluation. In my prior life I
12 served 30 years in higher education as a professor and
13 administrator.

14 DR. McCORRY: Good morning, Dr. Cline. Good
15 morning, everyone. I'm Frank McCorry. I'm with the New
16 York State Office of Alcoholism and Substance Abuse
17 Services. In my capacity there, I work on quality and
18 performance improvement and co-occurring disorders. I'm
19 also a chair of the Washington Circle Group, a national
20 organization supported by SAMHSA to develop performance
21 measures, and co-chair of the National Quality Forum, which
22 will be issuing a report very shortly on evidence-based
23 practices, from screening through continuing care, which we
24 hope will spur some movement towards adoption of these
25 practices, including things like pharmacotherapy and the

1 development of some performance measures that can drive
2 some accountability.

3 MS. JACKSON: Good morning. I'm Valera
4 Jackson. When I started on the council I was the CEO of
5 The Village in Miami, Florida. I live and work in Miami,
6 Florida. I'm currently the executive director of NCI
7 Systems, which is a collaboration of six of the largest
8 agencies in Florida, many that I know that Dr. Clark has
9 been to and recognized. We are dedicated to developing
10 Centers for Excellence. We're kind of at the beginning of
11 looking at opportunities to do innovative work not only in
12 Florida but across the country with the experience and
13 know-how that we have developed in our own agencies and
14 organizations.

15 I also just wanted to mention that I am the
16 chair of an organization, South Florida Provider Coalition,
17 that is a managing entity and manages all of South
18 Florida's substance abuse block grant funds and money, and
19 we are looking now at all of Florida to develop a managing
20 entity privatization of the funds and funding, going
21 through the legislature this year and endorsed now by DCF
22 and hopefully by the legislature soon.

23 DR. CLARK: Greg?

24 DR. SKIPPER: Good morning. I'm Greg Skipper.
25 I'm on the faculty at the University of Alabama School of

1 Medicine, and I run the Physician Health Program in
2 Alabama, and I'm engaged in some national research
3 projects. Thanks.

4 MS. BERTRAND: Good morning. My name is Anita
5 Bertrand and I'm from the Cleveland, Ohio area, and I
6 manage the Recovery Community Services Program and organize
7 individuals in recovery and from the churches to support
8 the largest system, and I am a product of your system, with
9 16 years of recovery, and I'm proud to be on the council.

10 JUDGE WHITE-FISH: Good morning, everyone. I'm
11 Eugene White-Fish. I'm a judge for the Potawatomi Tribe in
12 Crandon, Wisconsin, as well as the president of the
13 National American Indian Court Judges Association. That
14 has judges throughout the United States, including Alaska.

15 One of the things that I'm glad to see as I was
16 talking to Dr. Clark, I said that I see SAMHSA involved in
17 a lot of things in Indian Country since I sat on this
18 board. A young lady that's sitting in the audience, I've
19 seen her a number of times in Indian Country. I can't
20 speak for all Native Americans across the country because
21 they're each sovereign nations, but I'm glad to see that
22 SAMHSA has become more involved. NIDA is pulling all the
23 leaders of all the national organizations together, along
24 with the National Congress of American Indians.

25 One of the things that we're definitely looking

1 at is meth, and I look at SAMHSA also as being one of the
2 leaders in that, addressing the issues across the nation
3 and not forgetting Native and Indian Country across the
4 nation, including Alaska. So that's a good thing. I know
5 the president of NCAI. He and I have both said that's a
6 problem in Indian Country across the United States. So
7 that's definitely on our table, and we're going to be
8 meeting in June in Alaska. Thank goodness we did not
9 choose to meet in Alaska in December or January.

10 (Laughter.)

11 JUDGE WHITE-FISH: I also hear there's no
12 daylight up there at that time.

13 But thank you, and it's a pleasure meeting you,
14 Dr. Cline.

15 DR. CLARK: Before we go any further, I would
16 like the record to show that Dr. Chilo Madrid, a very
17 faithful member of the council, underwent a quadruple
18 bypass about three weeks ago. He spoke with Cynthia last
19 week and informed her that he expects to be back in his
20 office next week. So a comment to Chilo is to hang in
21 there and we wish him a continued speedy recovery.

22 Now I would like Dr. Cline to have his
23 comments. We're delighted that he's able to join us today.

24 Prior to his appointment as the SAMHSA Administrator, Dr.
25 Cline served as Oklahoma's Secretary of Health, a position

1 he was appointed to by Governor Brad Henry in 2004. He
2 served concurrently as Oklahoma's commissioner of the
3 Department of Mental Health and Substance Abuse Services, a
4 position that he had since January of 2001. The important
5 part is that we have a psychologist for mental health and
6 substance abuse becoming the Secretary of Health, and talk
7 about integrated services, a one-man integration team.
8 Throughout his career he has championed the principle of
9 mental health and freedom from substance use disorders as
10 fundamental to overall health and well-being and that
11 mental and substance use disorders should be treated with
12 the same urgency as any other health condition.

13 I won't read his entire bio given his tight
14 schedule, but I encourage you to pick up a copy of his bio
15 on the document table outside the doors, as well as bios of
16 the members.

17 Dr. Cline?

18 DR. CLINE: Thank you, Dr. Clark.

19 It's a great pleasure to be here and to meet
20 all of the members of the advisory council, and I would
21 like to thank you for your service and your volunteer time
22 and your commitment to improving systems across the
23 country, and also advising Dr. Clark and CSAT in the
24 important work they have to do.

25 I would also like to My purpose in being

1 here today, one is to introduce myself and to get to know
2 you a little bit better, although as Dr. Clark mentioned, I
3 will be rushing out the door immediately afterward this
4 morning, and also to provide you with some updates from
5 SAMHSA in terms of some developments, some new information
6 that's come to light that has just recently been released,
7 and also to talk briefly about the budget, all that in
8 about 15 minutes. I don't talk quite as fast as Dr. Clark
9 because I'm from Oklahoma, but I'll do my best to keep the
10 pace moving along there.

11 Part of that experience that Dr. Clark
12 referenced in Oklahoma was very important for me. Being
13 able to oversee the Medicaid agency as well as the
14 Department of Health, as well as the tobacco endowment
15 settlement trust, all of those were in the health cabinet
16 and the Department of Mental Health and Substance Abuse
17 Services. So it was really a unique opportunity to have
18 someone with the behavioral health background at the helm
19 of this health cabinet. It was the first time that had
20 happened in the history of Oklahoma. I don't know if
21 that's happened in other places as well, but I think it
22 speaks to the importance of our issues in the overall
23 health picture, and I would like to commend Governor Henry
24 for the courage to do that. I'm not a physician, and the
25 majority of health cabinet secretaries had been physicians,

1 and I didn't come from the Department of Health or one of
2 the other more traditional organizations. So that was a
3 dramatic departure.

4 Part of what took me down this path -- I'll
5 spend one minute on this -- is my very first professional
6 job was providing home-based family therapy in the housing
7 developments in Cambridge and Somerville, Massachusetts.
8 Most people don't realize that this was an area where there
9 was incredible poverty. Most people think of all the ivy
10 league schools and MIT and Harvard and all those places,
11 but there is a great deal of poverty and many, many
12 struggles. Providing that home-based family therapy took
13 me right into people's living rooms, into their kitchens,
14 and having all of the discussions about the struggles that
15 they were facing every day, and I can tell you that my
16 training as a clinical psychologist had not prepared me for
17 that work at all.

18 One of the things that was most apparent in
19 almost every situation was a struggle with substance abuse
20 and addictions. That may not have been the identified
21 issue, but it actually resulted in a referral. It may have
22 been a child who was acting out in school, it may have been
23 somebody who was falling behind who was getting in fights
24 with their peers. But when you spent time with the family,
25 you learned very quickly that that was usually a leading

1 contributor to some of the struggles within the family.

2 Now, SAMHSA has been engaged in one of the key
3 responsibilities at SAMHSA, and one of the things I've
4 enjoyed a great deal in my two and a half months on the job
5 has been the great wealth of information that comes through
6 SAMHSA and goes across the country. One of our primary
7 missions is helping to spread information, evidence-based
8 practices. You have on your agenda for later today some
9 presentation around NREPP, and hopefully all of you are
10 familiar with the clearinghouse and all the information
11 that's available with that.

12 As the advisory council, I would like to
13 highlight just a couple of issues for you because these are
14 reflective of some of the trends that we're seeing most
15 recently in the United States with the data that we have.
16 One of these trends and one piece of data is coming from
17 our National Survey on Drug Use and Health, which is the
18 kind of extension -- many of you I think are familiar with
19 the old Household Survey. So this is the extension of that
20 survey. One piece of information from that is actually
21 looking at inhalant use among young people, and there's
22 good news and bad news in this picture. The bad news is
23 that there are about 1.1 million adolescents between the
24 ages of 12 and 17 who report using inhalants in the last
25 year, 12- to 17-year-olds who report using inhalants.

1 That's the bad news, over 1 million young people.

2 The good news within that picture is that
3 there's been between 2004 and 2005 the use among those
4 young males is relatively stable. It's about 4.2 percent,
5 and it stayed around that level over that period of time.
6 The bad news in that -- I'm doing the good news/bad news
7 here -- is that we've seen a significant increase for
8 girls. So young females between 12 and 17, the percentage
9 rose from 4.1 percent to almost 5 percent. That's a
10 statistically significant increase in the number of
11 adolescent girls who report using inhalants. So that's
12 very disturbing to see that kind of stability with young
13 males and then to see a significant increase with young
14 females. It's something for you to be aware of.

15 Another piece of interesting information came
16 from the Drug Abuse Warning Network which looks at
17 emergency room visits and those visits that are drug
18 related. In that report, which was just released a couple
19 of weeks ago, there is again good news/bad news results
20 here. The good news is that there's been relatively no
21 change for drug-related emergency room visits from 2004 to
22 2005, but when you look within that data and look at the
23 types of visits that are taking place, there is a
24 significant increase. So here you have overall stability
25 in the overall number of visits, but the types of visits,

1 we see some significant changes, and one of those changes
2 has been a 21 percent increase in the visits that are
3 attributable to non-therapeutic use of pharmaceuticals,
4 non-medical use of pharmaceuticals, including prescription
5 and over-the-counter drugs.

6 So again, as you're looking at trends, if
7 you're looking at systems and the responsiveness that's
8 needed for systems, this is an important change that we're
9 seeing, people who are ending up in emergency rooms who are
10 in need of services and having some sense of what is
11 driving them to those emergency rooms. So we're seeing
12 some changes over time.

13 One of the programs I think you may be familiar
14 with that Dr. Clark has been very active in organizing is
15 the Screening, Brief Intervention and Treatment Program,
16 which is an incredible program which allows us to have that
17 kind of early touch with somebody who is accessing services
18 in what might not be the most desirable course because
19 they're showing up in the emergency room. But if they're
20 there, we have a window of opportunity to reach those
21 individuals to do those screenings and to assess the need
22 for either a brief intervention or treatment, and then to
23 work to make sure that connection takes places. So that's
24 a significant program that has great results, I think is
25 available now through grants in 34 states across the

1 country, five tribal entities and three territories.

2 Is that right? I don't think that's right.

3 No, that's the SBIRT. What's the number for that? Do you
4 remember?

5 DR. CLARK: SBIRT. Reed, help me. What states
6 are we in?

7 PARTICIPANT: We've got 12 states. We've got
8 16 colleges.

9 DR. CLINE: Sixteen what?

10 PARTICIPANT: Sixteen colleges.

11 DR. CLINE: Okay, 16 colleges. So what this
12 program allows us to do is to have that broader continuum
13 of care in addressing these needs for individuals, and
14 that's significant. Again, if people are coming to our
15 attention, we're aware that they're struggling with these
16 issues because they're showing up in the emergency room,
17 what can we do to help make those connections?

18 Also, in looking at those populations where
19 we're trying to get ahead of the curve, what can you do in
20 terms of having those services available in student health
21 clinics, universities and colleges across the country? So
22 that's very exciting work, and again it's an attempt to get
23 ahead of the curve, to make sure that we're intervening as
24 early as possible when we know that people are struggling
25 with these issues.

1 The last issue that I wanted to highlight was
2 the release on March 6 by the U.S. Surgeon General, who
3 released his report on the prevention and reduction of
4 underage drinking in the United States. This is a report
5 that the Surgeon General had worked very, very closely, and
6 Dr. Clark and his staff worked very, very closely, as well
7 as individuals at NIAAA through the institutes, to really
8 help the Surgeon General collect all the latest research
9 and science and findings that are related to underage
10 drinking in the United States. This is another issue
11 that's a good news/bad news picture.

12 While we have seen some stability and actually
13 some declines in tobacco use and some other drugs, underage
14 drinking is one of those areas where we have not seen that
15 decline, so that's a concern for us. If we're thinking
16 about how can we get ahead of the curve, I think everyone
17 is aware that our service systems are working at full
18 capacity, that there are not enough resources at that end
19 of the continuum and we're not able to keep up with the
20 need. So what can we do to intervene as early as possible,
21 and if we can actually prevent young people from beginning
22 to drink, then we may be able to avert some of those
23 struggles that they experience later in life.

24 There are about 11 million underage drinkers.
25 When you start to think about the numbers, they're big

1 numbers. We're not talking about small numbers of people,
2 and nearly 7.2 million of those 11 million are considered
3 binge drinkers. So when you think about the risk
4 associated with the behavior in the immediate in terms of
5 driving and risky behavior, sexual behavior, other
6 behaviors, and this is something that could have a huge
7 ripple effect if we're able to impact this, and the Surgeon
8 General's call to action is really to increase awareness
9 and to make the country, make the nation aware of the
10 significance of this problem and the challenges associated
11 with that.

12 So there's a lot of other data which I'm going
13 to skip over. I would encourage you to take advantage of
14 that information that is available, and certainly as
15 council members I know that you're probably much more aware
16 of the information and data than most people, so hopefully
17 you'll spread that word as you go back to your respective
18 locations as well.

19 I'll talk just a little bit about the budget.
20 I saw that Joe Faha, our legislative director, will be on
21 the agenda later today, so you'll be able to ask him
22 additional questions in addition to any questions that you
23 may have for me. But he can talk some about the process,
24 too. We have the President's budget which gets rolled out,
25 and then we have the response from Congress, who actually

1 appropriate the money and the funds for that. Some of
2 those decisions from Congress will be in alignment with the
3 President's budget, and some of those decisions will not be
4 in alignment. But they are basically the funders, and
5 President Bush has provided the guidelines through his
6 proposed budget. I am going to talk to you briefly about
7 his proposal.

8 He's proposing \$3.2 billion for SAMHSA in
9 fiscal year '08, and there are several areas where we will
10 see continued investment of available dollars for services
11 that include children's mental health, HIV and AIDS,
12 screening and brief interventions -- you heard me talk
13 about that earlier -- suicide, school violence prevention,
14 criminal and juvenile justice, which actually has a
15 significant increase proposed for drug courts, Access to
16 Recovery. Have there been discussions about that program
17 here?

18 DR. CLARK: Yes.

19 DR. CLINE: It's a very innovative program that
20 provides recovery support services for individuals, as well
21 as substance abuse prevention and mental health
22 transformation.

23 The budget more specifically, when you're
24 looking at substance abuse treatment and prevention,
25 provides about \$2.3 billion for substance abuse prevention

1 and treatment activities. Of that, \$1.8 billion is
2 requested for the substance abuse prevention and treatment
3 block grant, which is the same level that we saw in fiscal
4 year 2007. I think all of you are aware that \$1.8 billion
5 is really the cornerstone of funding for prevention and
6 treatment activities across the country. So it's important
7 that that is firmly in place in this President's proposed
8 budget.

9 You should also know that this is a budget that
10 has several reductions that are identified, and some
11 programs that are actually proposed for elimination. The
12 overall message behind this budget was that we are working
13 towards a balanced budget by 2012, and to do that we had to
14 make some very, very difficult decisions. Other areas that
15 had full support in this budget were the Access to Recovery
16 program, which is about \$98 million. That's significant.
17 There will be a new RFA that will be coming out in the near
18 future on that, again a very innovative program.

19 I think I'm going to go ahead and close at this
20 point. I would like to again thank you for your
21 contribution to the National Advisory Council for CSAT. I
22 know that Dr. Clark appreciates your advice and your
23 guidance and the leadership that you've demonstrated by
24 volunteering to participate in this process, and I would
25 also like to join him in thanking you for that

1 contribution.

2 With that, I'll close, and if you have any
3 questions, I'll be happy to do my best to address those
4 questions, or if there are any comments or concerns, I'll
5 turn it back over to Dr. Clark.

6 DR. CLARK: We still have a few minutes of Dr.
7 Cline's time, so this will be an opportunity for council
8 members to raise any questions they might have. The floor
9 is open for that.

10 MS. JACKSON: Well, I'll just raise a concern.
11 You just discussed the budget, and certainly I understand
12 the need to balance the budget in this country. However, I
13 really am concerned about the discretionary funding that
14 has been a cornerstone of SAMHSA, all of the SAMHSA
15 agencies' funding. I think that it has been probably the
16 innovation of so many new treatments. Dr. Clark has heard
17 me talk about this many times because I was in the
18 beginning of the Women with Children and the family
19 treatment initiative back in 1992. We were one of the
20 first 10 agencies there.

21 You know, if it weren't for that having
22 happened and that money being appropriated by Congress, and
23 then CSAT and SAMHSA subsequently being able to spread that
24 across the country to make it into all of the states, we
25 today wouldn't have the attention that's going to families.

1 Of course, it kind of wanes. It goes up, and then it goes
2 down, and now I believe it's being proposed to go down
3 again. I mean, that's just one example, because I think
4 the discretionary funding just is something that cannot be
5 done without if we're going to move forward in the whole
6 services to science. We in the field -- you're there. I
7 guess I'm preaching to the choir, but I'm just saying how
8 do we help to get that message across? We know we can go
9 talk to Congress, and I think that we do. Maybe we need to
10 get more of that going.

11 Are there other suggestions that you have,
12 particularly about the discretionary funds? I know there
13 are many issues, but I'll ask about that.

14 DR. CLINE: Well, thank you for the point, and
15 it's taken to heart. I agree about the importance and the
16 role of these targeted funds to actually make improvements
17 across the country, and certainly the example you gave is
18 an excellent one of services where we can actually get
19 ahead of the curve by making sure that there are babies
20 that are delivered drug-free, and we can break part of that
21 cycle. There are fiscal cases as well as human cases to be
22 made about the importance and the need to do that.

23 Part of the dilemma, I think, that we find
24 ourselves in, just to address this, and it's not specific
25 to any one program, the discretionary programs are more

1 vulnerable in some ways because they have not had as much
2 of the data and the longstanding data to demonstrate the
3 outcomes of these programs. When Congress and the
4 President are in the position of making decisions about,
5 again, where will we reduce programs to help move toward
6 that balanced budget, any program that does not have strong
7 data on outcomes is vulnerable. There has been such great
8 work in just these last few years, and the National Outcome
9 Measures are an example of that, where SAMHSA has worked
10 collaboratively with the states to develop these measures
11 that can be applied and are focused on recovery for
12 individuals, and you can make the case for recovery for
13 entire communities in the impact. But we do not have
14 several years of a track record for many of these programs,
15 and that makes them vulnerable at a time like this.

16 So in terms of what you can do, I think
17 certainly to have those informed discussions, as you
18 referenced, with your congressional members is something
19 you have done and certainly can continue to do, because
20 they may not be as aware of the importance of those
21 programs. I think as advisory council members to have that
22 ear to the ground and to hold these discussions that
23 address issues of accountability, and when you hear
24 discussions about data -- and again, I've been on the other
25 side of those grants and I know how burdensome they can

1 feel at times, and especially if I don't have a good sense
2 of their applicability. It's that void where the data just
3 goes, and it's like what's being done with that?

4 So part of what we need to do is to educate
5 people who are providing the data about the importance of
6 that. The National Outcome Measures are important for
7 multiple audiences. One audience is the audience of
8 Congress. How can we demonstrate that these programs are
9 effective? You've got one dollar to spend. It can be on
10 an ineffective program or one that has a demonstrated track
11 record. If I'm making that decision, whether I'm a program
12 manager in Oklahoma or anywhere else, I'm going to go with
13 the one that's most effective because I can't afford not
14 to.

15 So make sure that those discussions are
16 happening here. If Dr. Clark is not doing that, then you
17 may want to ask him about that. But my guess is that he's
18 been a champion of that. Thank you for the question.

19 DR. CLARK: Frank?

20 DR. McCORRY: Just a quick comment and concern,
21 I guess. My concern is really that whatever the particular
22 projects, that often budgets are driven by projects, even
23 if the data might be very good or it's a strong investment
24 by whoever the executive is in a particular project, and
25 whether it's ATR or SBI, what typically happens in my view

1 is that there's an investment because of the value in it,
2 and some programs in some states benefit.

3 But even within the state, most programs don't
4 benefit. Even what we learn gets exposed or some programs
5 benefit, but the ability to take what we know and apply it
6 systemically rather than a project-driven approach to areas
7 that are important -- so you might, if you're an ATR
8 person, you might feel good that this budget is kind to
9 ATR, or an SBI person at a project level. But at a state
10 and a system level, whether New York or some other state
11 benefits, it's wonderful to benefit from it, but it doesn't
12 really answer the basic, fundamental question of how do we
13 improve quality systemically, not on a project basis but
14 within a systemic structure.

15 Secondly are issues of readiness and
16 performance measures and those kinds of issues that will
17 drive quality, adoption of evidence-based practices. My
18 concern is that budgets that don't have those kinds of
19 capacities built into them in which what we know gets
20 prioritized to be implemented across the particular
21 programs or states that are in the project itself to me
22 fails. It doesn't fail. It's quite successful, but it
23 doesn't necessarily change the actual service delivery
24 system, whether it's within a state or within a country.

25 Even NOMs as an outcome measure, measurement

1 without some strong capacity to help programs to improve
2 and a structural capacity that puts states on the dime and
3 other kinds of entities on the dime to not simply measure
4 but to have a capacity to work with programs to improve
5 based on those measurements, those kinds of elements to me
6 are key, even if the budget was up 20 percent. We might be
7 celebrating, and that's wonderful stuff, but we fail to be
8 able to take that learning and apply it systemically. I
9 was just wondering what your thoughts were on something
10 like that.

11 DR. CLINE: Thank you for the question. You're
12 asking a question and raising some points that address
13 multiple levels, and it really ties back in with the
14 earlier question as well. Part of that gets back to the
15 use of data, the use of outcomes information, and the
16 utility of that. I mean, it doesn't do any good if it
17 doesn't get used in some capacity.

18 There are implications across the entire
19 spectrum of services and management of those services, and
20 there's a great deal of discussion about the use of a
21 public health model in actually moving the needle within
22 the states on a population basis. This is an area that
23 you'll see in the Screening, Brief Intervention and
24 Treatment approach if you've heard about the Strategic
25 Prevention Framework. These are really using public health

1 approaches to improve the quality of life for people
2 across, whether it's a community again or a state or the
3 country.

4 We have had many challenges in the past about
5 gathering data to have a good baseline with that. You
6 heard some of those things with the National Survey which
7 have given us a lot of that information, which has been
8 helpful. How would we know if we were making improvements
9 if we don't have a good sense of the baseline with that?

10 So being able to instill this performance or
11 process improvement culture I think is critical. Again, if
12 you have one dollar, if you're 58 percent effective or
13 efficient with that, then you're wasting half of that
14 resource. That doesn't mean that we don't have individuals
15 who are well intentioned, who are working hard, but they
16 may not have the tools they need to be as successful as
17 they need to be. I think SAMHSA has a demonstrated track
18 record of being concerned about that and concerned about
19 being able to spread that. But I agree with you
20 wholeheartedly that, again, especially with limited
21 resources, but at any time we need to be very cognizant of
22 the process and the performance piece of what we're doing,
23 are we hitting the mark as well as we could be.

24 DR. CLARK: Dave?

25 MR. DONALDSON: Thank you very much, Dr. Cline.

1 I really appreciate what you said about dealing with some
2 of the root causes, and that is alarming for young ladies
3 to see that kind of increase. I'm the parent of two
4 adolescents, so that especially hits home.

5 Our society is just being bombarded with images
6 through television, Internet, and it's saying to these
7 young ladies that if you don't look this way, you're not
8 measuring up. If you're not an "American Idol," you're a
9 failure. Consequently, it's leading these young ladies to
10 have a grudge against themselves, against others, perhaps
11 their parents, and it's leading to these aberrant
12 lifestyles.

13 What do you see as a priority in response to
14 the media and combating these images and putting forth at
15 least a balance to what they're digesting?

16 DR. CLINE: Let me talk about just a couple of
17 examples of the types of things that SAMHSA is involved
18 with. One is working with the industry around what's
19 called the PRISM Awards, which is recognition of those
20 areas of the entertainment industry that are addressing
21 issues of substance use and are starting to address issues
22 of mental illness within their television, whether it's
23 shows or movies, and making sure that there are actual
24 accurate depictions so that substance use does not become
25 glamorized, as you were mentioning it often is in

1 advertising.

2 We know that huge amounts of time are spent by
3 our young people watching television, and there are leaders
4 within the industry that are beginning to take note that
5 they have a responsibility and an ability to influence
6 people across this country by their depictions of substance
7 use and recovery. I don't know if you've seen that in some
8 of the television shows. I mean, some people who are
9 actually struggling with recovery, are firmly in their
10 recovery is being talked about in those shows. So there's
11 a great ability to reach those individuals as well, and we
12 want to make sure those individuals get recognized for
13 that. We don't want them to do all that work and then it's
14 like, so what? It really hasn't made any difference, and
15 not being able to have some recognition from their peers as
16 well.

17 There also have been great collaborations with
18 the Ad Council, and I don't know if you all have seen any
19 of the ads from the Ad Council. Have those been shown
20 here? If they haven't been, I would encourage you at some
21 point to see those. They are very powerful. I mean, I
22 can't watch one of those without being close to tears. I
23 mean, they are incredible. That again is the kind of
24 partnership I think that can help counteract some of what
25 we see. But we're swimming against the tide, so we need to

1 do everything we can in our power to address that.

2 Just before Dr. Clark cuts me off here, one of
3 the things I'd like to clarify, when I was encouraging you
4 to continue in your role as you've done before in terms of
5 talking with Congress, there's a qualifier that as advisory
6 council members, the role really in that capacity is to
7 advise Dr. Clark and CSAT, and you're not able to lobby or
8 to have those conversations with Congress in that capacity.

9 So I just needed to clarify that. I know that many of you
10 have been engaged in those conversations long before you
11 were on the advisory council. So I just wanted to clarify
12 that.

13 DR. CLARK: Thank you, Dr. Cline. I really
14 appreciate your taking time to come here. You are, of
15 course, always welcome. I would speak for the council to
16 say that. We hope you'll be able to join us again in the
17 future. When you have more time to interact with the
18 members, I'm sure they'll be happy to hear from you.

19 I want to thank Rich Kopanda, my deputy -- he
20 has played a critical role in helping to manage CSAT -- and
21 Cynthia Graham for her role in organizing this meeting.

22 We have a number of staff people in the
23 audience who are here to hear from you also. So when
24 council provides input, it's not just to Rich and myself.
25 It's to the number of staff who come to this meeting so

1 that they can hear your opinions, and it influences how
2 they think about what it is that we do.

3 You will see a printed copy of the Director's
4 Report in your materials. Dr. Cline mentioned that the
5 budget process has continued. You heard him talk about the
6 budget. I want to present some slides that review that so
7 you can see it, so I'm going to move up here.

8 As you know, SAMHSA is one of the 11
9 grant-making agencies of HHS. Our vision is a life in the
10 community for everyone, and our mission is building
11 resilience and facilitating recovery. The goals are
12 accountability, capacity and effectiveness. The issue of
13 accountability remains. You heard Dr. Cline talk about the
14 importance of the issue of accountability, and our data
15 focus is a critical part of that.

16 For CSAT, our mission is to improve the health
17 of the nation by bringing effective alcohol and drug
18 treatment to every community. The matrix is still our
19 guiding principle at SAMHSA. Has anybody here not seen the
20 matrix? I know some of you probably have your walls
21 painted with the matrix and you've got pictures of it, but
22 it continues to be our list of priorities, so I won't go
23 over that because we've discussed it in the past.

24 As Dr. Cline pointed out, our proposed budget
25 for '08 is \$3.1 billion, \$3.168. The 2007 continuing

1 resolution, the budget is \$3.3 billion. So as you can see,
2 there is a reduction proposed between 2007 and 2008.

3 When you look at a comparative analysis in
4 terms of discretionary funding by major activity, Health
5 and Human Services will experience a 0.29 percent increase
6 in budget relative to other departments. If you look at
7 Labor, it's a 9.4 percent reduction in their budget. The
8 EPA budget is a 4 percent reduction. A number of
9 departments like Education have no change, and there are
10 modest increases in others.

11 If you look at SAMHSA relative to other
12 operating divisions within HHS, HRSA has got a 5.61 percent
13 decrease. CDC is a 0.86 percent decrease in the '08
14 proposed budget. SAMHSA would have a 5 percent decrease.
15 ACF would have a 3.9 percent decrease.

16 This balanced budget strategy is requiring
17 people to make some changes. For '08, the proposed
18 decrease for CMHS is 29 percent. For CSAP, the proposed
19 decrease is 19 percent. For CSAT, the proposed decrease is
20 12 percent. Again, relative to other entities, we're
21 suffering decreases. There are some increases in some
22 places and some decreases in others.

23 The guiding principle, as Dr. Cline pointed
24 out, is a balanced budget by 2012, and there's an emphasis
25 on direct services. For the proposed '08 budget, the

1 assertion is that hard choices were required, and therefore
2 hard choices were being proposed. Several factors have
3 been considered in making program reductions and
4 eliminations. One-time expenditures that don't need to be
5 replicated, completed functions and commitments within
6 grants, and the scrutiny of automatic renewals -- indeed,
7 the assertion is that programs should not continue in
8 perpetuity. Programs with purposes that are addressed in
9 other places, the notion is if there's redundancy in the
10 federal government, that redundancy needs to be eliminated.

11 So if we don't eliminate that redundancy, then we're
12 spending too much money.

13 Underperforming programs and programs without
14 solid performance measures, another statement that Dr.
15 Cline made. If you don't have data, you cannot defend your
16 programs. If you have inadequate data, you can't defend
17 your programs. Proposed reductions in the past that were
18 not enacted.

19 So these were guiding principles that were made
20 for the '08 budget, a key issue for us as we shift toward a
21 more performance oriented environment.

22 The SAMHSA decline is about 5 percent or \$159
23 million. The budget funds presidential initiatives like
24 ATR and other priority areas such as our block grant,
25 criminal justice portfolio, SBIRT, and our Minority AIDS

1 Initiative, while making targeted reductions in areas where
2 grant periods were ending, activities can be supported
3 through other funding streams, or efficiencies can be
4 realized.

5 The block grant, as you can see, from 2005, the
6 proposed block grant is actually a reduction from 2005.
7 The 2008 proposal is a reduction from 2005. Our Programs
8 of Regional and National Significance have two components,
9 capacity, with a reduction from 2005 at \$385 million, \$386
10 million, to the proposed 2008 at \$339 million. Of
11 particular note, our science to service line item in 2005
12 that we had was \$36.7 million; for 2008 that is reduced to
13 \$13.1 million. So if you look at CSAT's budget in total
14 from 2005 to 2008, it would go from \$2.198 billion to \$2.11
15 billion.

16 The President's budget includes \$98 million for
17 Access to Recovery, and also has \$25 million targeted for
18 methamphetamine treatment. The \$22 million available to
19 more than triple the number of grants for drug treatment
20 courts, that spectrum of courts that deals with the legal
21 system and substance abuse and juvenile justice, et cetera.

22 An additional \$12 million is to support Screening and
23 Brief Interventions in general medical and community
24 settings. I'm calling this "Back to the Future," the
25 reintegration of substance abuse treatment into the primary

1 health care delivery system. \$25 million is available to
2 fund three new grants to states, 18 new campus grants, 8
3 new grants to medical schools, and 12 new grants to school
4 districts and community health clinics serving Native
5 Americans. Early identification of substance abuse
6 decreases total health care costs by preventing progression
7 toward addiction.

8 As we've discussed before, particularly for
9 SBIRT, some of you have seen what I refer to as the big red
10 slice, 73 percent of the people who meet criteria for abuse
11 and dependence of illicit drugs, and 86 percent of the
12 people who meet criteria for abuse and dependence of
13 alcohol do not perceive a need for treatment, and so
14 they're not knocking on the doors of the substance abuse
15 treatment programs.

16 So we have to find people where they are.
17 They're not knocking on the substance abuse treatment
18 program doors. We believe that you have to go to community
19 health centers, student health services, emergency rooms,
20 and SBIRT is allowing us to screen a large number of
21 individuals and identify and refer people to treatment.

22 When we look at the '08 budget, we should also
23 look at the programs that we'll have to eliminate. The
24 proposed budget would eliminate a number of programs in
25 CMHS, not the children's block grant, which is not being

1 eliminated, but other children's programs will be
2 eliminated. Mental Health Transformation activities would
3 be eliminated. Older adult activities would be eliminated.
4 Adolescents at risk would be eliminated. Consumer and
5 support TA would be eliminated. Disaster response and some
6 of their homeless activity would be eliminated.

7 If we look at CSAP, their evidence-based
8 practices activity would be eliminated. Their Center for
9 the Advancement of Prevention Technologies, their CAP
10 programs, would be eliminated. Dissemination training
11 would be eliminated, and best practice program coordination
12 would be eliminated.

13 When you look at CSAT, our Strengthening
14 Treatment and Access to Retention, the STAR program, would
15 be eliminated. Our special initiatives outreach would be
16 eliminated. Our state service improvement activities would
17 be eliminated. Information dissemination would be
18 eliminated. Program coordination and evaluation, some of
19 our technical assistance, and our contribution to the
20 Minority Fellowship Program will be eliminated.

21 These are the specific STAR activities that
22 would be eliminated in the proposed budget. When you look
23 at our special initiatives outreach, some of our TAPS would
24 be eliminated, our HBCU and the Lonnie Mitchell conference
25 would be eliminated, our planning and special initiatives

1 out of my office would be eliminated, the performance
2 measurement contract in DSI would be eliminated, analysis
3 of the AHRQ's health care costs would be eliminated, and
4 our scientific, technical and logistical support would be
5 eliminated. Our HIV/AIDS cross-training would be
6 eliminated, and our confidentiality training would be
7 eliminated. Our Partners for Recovery activity would be
8 eliminated, and our consumer affairs and education
9 activity, including Recovery Month, would be eliminated.
10 Then our CAP contract would be eliminated. Our printing
11 would be eliminated, and our clinical and technical
12 assistance would be eliminated.

13 We would experience decreases in the following
14 areas. Our COSIG grants would decrease between '07 and
15 '08; opioid treatment programs would suffer a decrease; TCE
16 general would suffer a decrease; PPW would suffer a
17 decrease; RCSP would suffer a decrease; children and
18 adolescent activity would suffer a decrease; treatment
19 systems for the homeless would suffer a decrease; and our
20 program coordination and evaluation activity would suffer a
21 decrease.

22 So the '08 budget is a very tight budget, and
23 we will operate within that budget, making whatever
24 adjustments that we need to make. The President has a goal
25 of balancing the budget, and we also have a war budget. So

1 we need to make critical decisions in order to support that
2 budget.

3 We will begin planning for the FY '09 budget
4 shortly. The Administrator is interested in getting input
5 from a wide variety of stakeholders, and I'd like to
6 solicit your ideas in this process. We don't know the
7 amount of money SAMHSA will be given in '09. I expect we
8 will do what we've done in the past, and that's to plan for
9 several potential funding scenarios using the '08 budget as
10 the base. These possible scenarios include a straight or
11 flatline request -- i.e., no change from the '08 budget --
12 and a reduction from or an increase to the President's 2008
13 budget at different levels, say plus or minus 2 percent, or
14 plus or minus 4 percent.

15 Later this morning, during the time reserved
16 for council roundtable, I'll be asking you for your
17 thoughts on what CSAT's priorities should be as we look
18 ahead to FY '09 based on your expert knowledge of trends,
19 developments, needs in the field, where should we begin
20 allocating our resources, where can we make the most impact
21 and get the biggest bang for our bucks. Should we focus on
22 expanding the availability of treatment services or
23 improving treatment quality through the dissemination of
24 evidence-based treatment practices?

25 Frank, you raised that issue. What good is the

1 information if it stays in Sam Smith's back pocket?
2 Excellent Program X, located in State Y, but never diffuses
3 to anybody else except Excellent Program X located in State
4 Y. It's a great program, but what about everybody else in
5 the game? So we don't really change the dynamic for
6 everybody else, and therefore in the aggregate nothing
7 changes. It's a drop in the bucket. It's a drop of ink in
8 an ocean. Indeed, this becomes an issue. Should we focus
9 on how we disseminate information? If we have an increase,
10 what are the priority areas that we should address first?
11 Are there new programs or activities that we should be
12 focusing on, or should we expand current efforts such as
13 ATR or SBIRT? If we're faced with additional cuts, how
14 would you recommend that we reduce, eliminate or refocus
15 our current programs? Your suggestions will help me in
16 advising the Administrator where SAMHSA should be headed
17 and developing budget proposals for 2009 and planning for
18 the future of the agency.

19 I would also like to stress that this is very
20 important because, indeed, we also don't know what the
21 Congress is going to do in the '08 budget. We know what
22 they did for the continuing resolution. You have that
23 information. But for the '08 budget they may or may not
24 agree with the President, and then we would have a one-year
25 budget, if you will, if they don't agree with the

1 President. So we need to figure out how to operate in that
2 context. We did have an appropriation hearing. Some
3 members of Congress would support the President's budget.
4 Others have raised questions about it, and since we don't
5 lobby, we don't know what position they will take. We
6 support the President's budget and we will operate within
7 that budget. But if we have other resources, of course,
8 because there's a difference of opinion, then we will
9 operate within the appropriated budget.

10 But because you heard the Administrator focus
11 on performance, and because the money is tight and the
12 whole notion of if we're going to save, if you will, the
13 activity that we do, if we're going to demonstrate our
14 utility, we need data, you heard the Administrator make
15 reference to data from the Household Survey with regard to
16 inhalants, you heard him make reference to our DAWN data
17 with regard to prescription drug abuse, he's also
18 interested in our TEDS data, we are interested in taking
19 the large data sets that we have and integrating them into
20 how we function.

21 As a result of that, we have a proposal that
22 we've gotten approved by the Administrator that will affect
23 two of our divisions, the Division of Service Improvement
24 and the Division of State Community Assistance. We propose
25 to restructure our activities so that we can consolidate

1 our data activities currently spread across those two
2 divisions into a new performance measurement branch that
3 will be located in DSCA. This new branch will be
4 responsible for coordinating all of our program performance
5 activity and analysis of national data sets employed by the
6 center so that we can be much more aggressive in using
7 these data. Not only are we dealing with performance in
8 the expectation of the funders, we're dealing with
9 performance in the expectation of the Office of Management
10 and Budget. They want to know how is this program doing
11 and what is your evidence, and where did you get your data.

12 So as you heard reference to the National Outcome
13 Measures, we've got our GPRA data, but we also spend a lot
14 of money collecting other data, and we need to integrate
15 all of that in our RFAs and our TA and our assessment.

16 With the consolidation of the performance
17 measurement activities in the new branch, the plan also
18 affords the opportunity to restructure three DSI branches.

19 But before we go into detail, we believe that
20 restructuring is needed and will improve our ability to
21 accomplish our mission. This culture of performance, a new
22 performance-based environment in which we are expected to
23 manage for performance and demonstrate solid outcomes and
24 results, is a critical environment. We can't ignore it.
25 We can't say, well, the status quo is the most important

1 thing in which we can engage. We didn't do it yesterday;
2 why should we do it tomorrow? We believe that behavioral
3 health needs to be as adaptable as primary care and other
4 systems. If we fail to do that, then we continue to take
5 the hits.

6 I mentioned GPRA in part, and you heard Dr.
7 Cline mention this. With our 2008 budget deliberations,
8 all emphasis will be on documenting our performance. As we
9 talk about 2009, we have some time, and part of what we
10 want to be able to do is to document the utility of the
11 various programs that we have so that there's no debate
12 about how important these programs are or how useful they
13 are. If programs are not performing, we should be the ones
14 to say this isn't working, let us shift gears. If we don't
15 do that, then obviously it's done for us. If we don't
16 establish that we have the administrative and managerial
17 sensitivity to performance, then when that is imposed on us
18 it may not be as, shall we say, delicately done as we would
19 do for ourselves.

20 I appreciate our staff's willingness to rise to
21 the challenge. CSAT's service accountability improvement
22 system embodies almost the ultimate in performance
23 reporting. These are challenges that we face, and I think
24 we will rise to this challenge.

25 SAMHSA is also being asked by OMB to have a

1 SAMHSA-wide data strategy to consider the agency's need in
2 a broader context. Another challenge is the need to
3 examine consolidated versus individual program results so
4 as not to put the latter at risk. We need to anticipate a
5 flood of block grant NOMs data from states when they are
6 reporting next year. They start reporting in October their
7 National Outcome Measures, and we need to be prepared to
8 analyze and understand and report that data, and contrast
9 that data with our TEDS data, which is basically national
10 data. Already with our SAIS data, we can look at the
11 Household Survey data, which shows you national prevalence,
12 we can look at TEDS data, which shows you national service
13 system data, we can look at our GPRA data, which shows our
14 performance data. An example is the inhalant reference
15 that Dr. Cline made.

16 So we looked at our GPRA data and we found, in
17 fact, that adolescent girls do report more inhalant use
18 than adolescent boys in the treatment programs. So it's
19 consistent across the national data, and then you look at
20 who is showing up for treatment and who is using inhalants.

21 So this was an important finding because we can show the
22 relationship between our national data set and our program
23 data set. When there are conflicts or anomalies, we of
24 course should be able to address that. We know that when
25 people submit grants, what they experience at the local

1 level may be inconsistent with what the national data, and
2 even the sub-state data, show, but that doesn't mean
3 they're not having a problem. It does mean that we can
4 account for what is going on, and we can speak to what is
5 going on.

6 PART may expand and drive future budget
7 decisions, so our data will have to be of sufficient
8 quality that we can survive PART reviews. The
9 Administrator's expectation regarding our use of data,
10 including national prevalence and trend data to guide and
11 manage our programs, will be a challenge, and we will work
12 with Dr. Cline. He is actively inviting our input. He is
13 actively inviting your input. But the key issue from his
14 past is that he has used data to drive the performance of
15 his programs, and I think that was one of the reasons he
16 was made Secretary of Health in the State of Oklahoma prior
17 to his arrival. I Googled him and went to Oklahoma, and
18 they checked on the performance of all programs. You got
19 money from the state and your performance was evaluated and
20 it was on the website. How many people you saw, who you
21 saw, how you did, that was all there. So he believes in
22 transparency and he believes in performance. He has been a
23 leader in obtaining and publicizing data on performance,
24 and I would like to have CSAT follow his mark.

25 In our case, we know that things have been

1 scattered among divisions and offices. We were lacking a
2 critical mass of expertise in handling the
3 conceptualization, collection and analysis, and proactive
4 reporting of data and performance results which are
5 critically needed for a performance-driven environment, and
6 these are the things that we would alter with our
7 restructuring plan.

8 This will be, in my mind, tremendously helpful
9 for us, particularly in a cost-conscious environment. So
10 we will pursue the reorganization, and as a result of the
11 reorganization most staff will continue to work in the
12 program areas to which they are presently assigned, but
13 some will be realigned within the new structure. Some
14 staff will be reassigned to new duties, and no employee
15 will lose their job or grade as a result of restructuring.

16 We presented this to the staff yesterday. We've opened
17 the process up between the staff and the union so that we
18 can have ongoing discussions on the specific details, but
19 it is clear that we need to move in this direction. If we
20 fail to move in this direction, then while we are fiddling,
21 Rome will burn, and we don't want that to happen.

22 In conclusion, I'd like to speak to you about
23 our upcoming ninth annual Lonnie Mitchell National
24 Historically Black Colleges and Universities Substance
25 Abuse and Mental Health Conference. As you know, the

1 conference honors the work and legacy of the late Dr.
2 Lonnie Mitchell. Dr. Mitchell was an esteemed educator,
3 administrator, policy adviser and psychotherapist. He had
4 a vision of bringing cutting-edge substance abuse research
5 and policy to the public. The conference is designed to
6 educate students at our nation's HBCUs, Historically Black
7 Colleges and Universities, about substance use and mental
8 health disorders, and to bring to their attention
9 information and strategies used in coping with the problems
10 of substance abuse and mental health in African American
11 communities. Our goal is to expose students to the many
12 ways that we can make a difference in their communities as
13 advocates, providers, policymakers, researchers, educators
14 and in other capacities.

15 We're particularly pleased to announce this
16 year the participation, in addition to our Administrator,
17 Dr. Terry Cline, Mr. John P. Walters, the Director of the
18 White House Office of National Drug Control Policy, will
19 also be there. This will be a wonderful opportunity for
20 students attending the conference to meet top policymakers
21 in the field, and we hope this will not only raise their
22 awareness but heighten their interest in pursuing careers
23 that help individuals, families and communities cope with
24 the problems associated with substance abuse and
25 dependence. The conference will be held next week, March

1 29 and 30, at the Grand Hyatt in Washington, D.C. We're
2 looking forward to an exciting conference this year. If
3 you're going to be in town, I encourage you to attend the
4 conference for this singular opportunity.

5 We appreciate Judge White-Fish's comment about
6 SAMHSA's participation with the American Indian and Alaskan
7 Native communities. SAMHSA, in addition to working with
8 HBCUs, has also been active in making sure that we outreach
9 to the American Indian and Alaskan Native communities.
10 CSAT has also been actively involved in addressing the
11 needs of Hispanics. We have an Hispanic work group, and
12 we're trying to address the needs of each of the
13 populations in the United States, as well as the overall
14 issue, going for an integrated approach without ignoring
15 the specific needs of each unique population.

16 I recently presented at an Asian American and
17 Pacific Islander research meeting in Los Angeles, where we
18 reviewed some of the unique needs of the Asian American and
19 Pacific Islander communities. That said, we realize there
20 are other communities that need assistance. We work
21 actively with rural America, Appalachia and other
22 communities so that we can address unique needs.
23 Obviously, there's not enough money to do everything.
24 We're stretched pretty thin. Sometimes we're one staff
25 deep. I can see some of the staff in the back

1 acknowledging that.

2 We would also like to address the issue of the
3 electronic health record and e-therapy, which we'll hear
4 about later, but the electronic health record we think is
5 an important thing. As we move toward a
6 performance-oriented culture, we need to make sure we get
7 our information uplinked to the largest systems, and the
8 electronic health record is going to play a major role in
9 doing that. If we fail to keep abreast of such changes,
10 then again behavioral health takes a hit because nobody
11 knows what you do, nobody knows how important you are, and
12 despite the ubiquitousness of the problems, we will be
13 unable to demonstrate that. So we want you to know that
14 we've been actively involved in a wide range of activities,
15 and I want to keep you apprised of these things so that you
16 can give us input and you can give us feedback, and
17 whatever it is that you think we need to be doing, we can
18 include those thoughts in our planning, and hopefully
19 working collaboratively we can achieve a reduction in the
20 substance use problems that America faces. Thank you.

21 With that, I want to open the floor for
22 questions or comments pertaining to my report. Questions?

23 Dr. Fletcher?

24 DR. FLETCHER: Dr. Clark, please let me commend
25 you on your report and the activities of CSAT. Given the

1 culture of performance and the results accountability
2 environment that we find ourselves in now, and given the
3 steps that you're taking as a part of the restructuring
4 process, how will that translate in your discretionary
5 programs? Are there new expectations? How will that get
6 communicated in terms of discretionary programs and the
7 need for reinforcing the results accountability notion?

8 DR. CLARK: Thank you for your question. If I
9 interpret it correctly, what we will be doing is building
10 on what we have been doing, and that is making it clear
11 through our TA to our grantees that we expect performance.
12 We will work with them with regard to performance. You
13 take the money, you've got to deliver the services that you
14 promised. If you encounter impediments, we need to track
15 those impediments and figure out subsequently how to
16 surmount those.

17 The key issue is that the project officers are
18 monitoring the performance of grantees. If somebody says
19 I'm going to see 10 patients, they need to see 10 patients
20 or explain why they're not seeing them. Then we're going
21 to find out what happened to those 10 patients. You saw
22 those 10 patients. Did they get better? Did they get
23 worse? Did they remain the same? Again, the whole process
24 is you take the money, you've got to account for what you
25 did with it, and we don't expect perfection, but we don't

1 expect people to say trust me, I spent it well.

2 Frank?

3 DR. McCORRY: Thank you, Dr. Clark, for just a
4 terrific presentation. It's one of the real benefits of
5 being on this council, to be exposed to this information.
6 So I really appreciate you taking the time to kind of lead
7 us through what's happening at SAMHSA and CSAT. I love the
8 phrase "culture of performance" as a kind of organizing
9 rubric for a discussion or for a direction.

10 You mentioned a couple of things. You
11 mentioned a SAMHSA-wide data set, if I got that correctly,
12 and then you also mentioned perhaps restructuring as part
13 of this kind of organizing around -- I wasn't sure if it
14 was organizing around the culture of performance, but
15 trying to put those three elements together, the culture of
16 performance, the SAMHSA-wide data set, and the
17 restructuring at CSAT. Could you just tell me a little bit
18 more about it?

19 DR. CLARK: Well, as you know, SAMHSA spends
20 quite a bit of money collecting data. What is happening
21 under the PART process is that, indeed, those data get
22 regurgitated for us by other entities that use the very
23 same data that we collect. The whole thrust of performance
24 is, gee, what is the relationship between how you spend
25 your money and what you're getting for your money. So if a

1 program says, well, I want to treat people, as I mentioned,
2 for Dr. Fletcher, then we need to know why are we funding
3 this program, we've got to have data, what's the driving
4 problem. So now we have data, as I mentioned. Now we have
5 aggregate data. As you know, the Household Survey has been
6 in existence some four years in the current paradigm. So
7 we can aggregate data.

8 We collect TEDS data, the Treatment Episode
9 Data Set. Well, the Treatment Episode Data Set says this
10 is who we're treating, this is what is happening. So we
11 need to be able to reflect how we spend our money relative
12 to the magnitude of the problem -- i.e., the National
13 Household Survey -- what other problems are saying
14 vis-a-vis the Treatment Episode Data Set, and what we are
15 seeing vis-a-vis our data set, and how we reconcile the
16 differences between them. We also need to have better
17 information about cost bands, how much money is it costing.

18 Are we choosing to spend money in the Cadillac programs
19 versus the Ford Taurus programs? Is there a Ford Taurus
20 anymore? I think they got rid of that.

21 (Laughter.)

22 DR. CLARK: Yes, the Ford Taurus program. So
23 there is that sensitivity there. Then there's the program
24 management. You've got 15 percent of your programs that
25 are underperforming; what did you do about it? We can't

1 say, well, gee, it's out of our control. When you say it's
2 out of our control, then external entities say no problem,
3 it's in our control, and since this isn't working so well,
4 we'll give you 15 percent less money. So that's the issue
5 in my mind in cultural performance.

6 Rich, do you want to add something?

7 MR. KOPANDA: Yes. I was just going to say
8 that from the SAMHSA point of view, what OMB is looking for
9 in terms of the SAMHSA data strategy is kind of a broad
10 picture look across the three centers, in mental health
11 prevention and substance abuse treatment, what data sets
12 exist right now, how do the national surveys, like the
13 Household Survey, provide data that's useful to our
14 programs, how do they integrate with the data we're
15 collecting from our programs, and where are gaps, where are
16 gaps we need to fill. So the agency basically is looking
17 at that overall strategy, but it is integrated with the
18 direct program performance, which is going to be related to
19 our new unit, basically.

20 DR. CLARK: Val?

21 MS. JACKSON: So taking that thought line down
22 to the state level, I don't know about all the other
23 states, but I think that most states are investing
24 substantial funds of money in trying to collect data and
25 get information and become performance based, and a lot of

1 that money may or may not be used wisely depending on where
2 you're at and what your viewpoint is. That means not just
3 that the data doesn't need to be collected, but it's the
4 process of trying to get it there through a kind of
5 cumbersome system. So it's a big challenge, and I'll speak
6 to Florida where the legislature has mandated a set of
7 outcomes that have nothing to do with the NOMs. They
8 expect those to be met, and the ADM folks and the state
9 authority have to reconcile that. She's working very hard
10 to try to move this over to the NOMs and to make that the
11 accountable thing that matches up with you. However, I
12 suspect that's not the only state that's having problems
13 with that sort of thing.

14 How do you connect what you're doing now down
15 to the states, and then ultimately that goes into cities,
16 counties, districts that have to also make decisions on how
17 they collect data and make decisions? Are there thoughts
18 about how all that connects?

19 DR. CLARK: Well, we recognize that there's
20 going to be some conflicts in operability in terms of the
21 expectations. We're trying to work with jurisdictions on
22 that. One of the things that we see in the electronic
23 health record is a potential mechanism by which we can
24 address some of these conflicts so that we can arrogate
25 data without operability conflicts. We have Rich Thorenson

1 and Sarah Wattenberg, Rita Vandivort and others at the CSAT
2 level, and others in CMHS and CSAP and our Office of
3 Policy, Planning, and Budget focusing on that.

4 It's going to take time, but if we don't start,
5 it doesn't happen. We know that this is happening
6 elsewhere in the health care delivery system for the
7 general health care delivery system. So we're going to
8 have to deal with the state by state conflict points in
9 terms of differences in operability and differences in
10 information exchange and differences in outcome measures.
11 If we move toward electronic health records, Internet data,
12 we will be able to address that.

13 At the state level, they're going to have to
14 deal with the NOMs because the Congress is sending the
15 money based on that. In fact, there is a proposal for
16 penalties if you don't do the NOMs at the state level. So
17 rather than focusing on the negative consequences, our
18 objective is to try to focus on incentivizing and working
19 collaboratively with states and community-based
20 organizations so that we can achieve this. For a long time
21 people said, well, gee, we can't do it, it costs too much,
22 et cetera. Well, now computers are throwaway, and the
23 Internet is a giveaway. It's like your cell phones,
24 they're more interested in the service charge than they are
25 in the individual cell phone.

1 So some of the hardware issues have been
2 addressed. We've got to work with the software issues.
3 That's what we've done in the past with WITS and other
4 platforms. This is an evolutionary thing. But you're
5 right, those things exist, but they are surmountable. They
6 do require the concerted efforts of all parties, and
7 naysayers are just now welcome in the room because the
8 people who are writing the check don't really care about
9 the naysayers. They want to know can you deliver.

10 MS. JACKSON: Just a follow-up on that. I
11 support the NOMs, and I think our state supports the
12 development of the NOMs. I don't think that there's any
13 doubt about that. However, as I mentioned before,
14 sometimes the legislature doesn't really know what a NOM is
15 and they don't really understand that that has any
16 importance. Obviously, putting penalties there will get
17 their attention, and I think that in my heart I'm actually
18 for that move. However, I would ask you to please be very
19 cautious about making that move. It's not very easy at the
20 state level sometimes to get those folks to switch around,
21 and we do understand that we need to get on board, but it
22 does take time. As you said, it takes a little time.
23 They're working hard at it.

24 DR. CLARK: And we recognize that. I mean,
25 this is not so Draconian or heavy-handed. But as far as

1 the Congress and OMB are concerned, they've been asking for
2 this for a while. At some point you have to draw a line in
3 the sand. What we're trying to do is to make sure that
4 people are aware that the time is coming for that line to
5 be drawn. We're part of the bureaucracy, and we would be
6 failing our state partners if we did not acknowledge that
7 the patience of the people who write the check is going to
8 be tried if we continue to say tomorrow and tomorrow and
9 tomorrow, we're waiting for Godot, while they're saying,
10 well, you know, we're waiting too, but in the meantime
11 here's the line and here are the penalties if you don't
12 deliver.

13 We're not trying to be heavy-handed. We're not
14 trying to browbeat the states. But even at the state
15 level, as you pointed out, while they may not adopt NOMs,
16 they're drawing NOMs clones, NOMs-like. So they may not
17 use the phrase "NOMs," the acronym "NOMs," but they want
18 outcome measures. They want accountability. So it's
19 uniform.

20 DR. SKIPPER: Is there a provision in this
21 laudable policy that I support for the concept that some
22 programs may be very important and effective for some
23 institutions -- for example, AA and NA, those kinds of
24 programs -- that may be very difficult to prove their
25 effectiveness from a data point of view? I want to be sure

1 we don't lose the idea that some things may be hard to
2 prove.

3 The other caution I wonder about is that we
4 could spend more on trying to prove things than actually
5 providing services if we get too obsessed with assessing
6 performance, because it's quite expensive to assess
7 performance. So I just want to be sure there's a caution
8 in this laudable concept.

9 DR. CLARK: I appreciate that, but the beauty
10 of the outcome measures is it's less interested in your
11 basket of interventions and more interested in what
12 happened as a result of your interventions. So if you say
13 something is working, then you need to be able to
14 demonstrate that it's working. The beauty of the outcome
15 measures is you say I'm treating you for alcohol and drug
16 use disorders; did I treat you for alcohol and drug use
17 disorders? If it doesn't work, then maybe you should try
18 something else, and that's what the beauty of the outcome
19 measures is. It has less to do with specific
20 interventions.

21 Judge White-Fish and I were talking about sweat
22 lodges. A sweat lodge by itself may not do anything, but
23 as a part of a basket of goods it may be terribly helpful.
24 But at the end of the day, the question isn't whether a
25 sweat lodge was used. The question is did that person, as

1 a result of your basket of interventions, stop using or
2 decrease his use of substances? If that's the case, then
3 you can do sweat lodges, you can do motivational
4 interviewing, you can do 12-step programs. That's your
5 basket of interventions and you got good outcome measures,
6 so who am I to say that specific element or a specific
7 thing in your basket is unacceptable, because your outcome
8 measures are the thing that you put out there. As a result
9 of taking the money to reduce substance use, I've achieved
10 that. If I come along and say, well, the evidence base, or
11 this that and the other, that's a different matter
12 altogether, and I think that's what you're saying, that you
13 can't prove a specific component of the basket of goods,
14 but the issue is your treatment program. You treated this
15 program; did this person get better as a result of your
16 treatment? If you say no and the other person down the
17 street says yes and they've got data to prove it, then the
18 emphasis from a performance culture is we're no longer
19 interested in what you're doing because it's not working.
20 The other guy down the street is doing a good job, and the
21 woman across the way is doing an excellent job, so we're
22 going to go that way, that's how the money is going to be
23 spent. That I think becomes the issue. It forces
24 individual programs to diversify or restrategize what it is
25 they do.

1 Anita?

2 MS. BERTRAND: Dr. Clark, I just want to thank
3 the staff of CSAT and SAMHSA for their ongoing support for
4 providing services and administration across the country,
5 and their leadership. I think that sometimes we look at
6 these budgets and we get caught up in what we're not doing,
7 and I think that we're doing a lot of good things. I'm in
8 the trenches, so I know what it's like to be there and to
9 struggle to have to find dollars to provide services to
10 individuals, but there are people who are doing quite well,
11 and I know that there are programs across the country that
12 are doing well.

13 I think that your comment around looking at
14 systems and how we can better become efficient, I know that
15 our clients are in a multitude of systems, and as a
16 director I'm constantly looking in those other systems for
17 ways to enhance what it is that we're doing.

18 But one of the questions I have is what is the
19 data showing from GPRA and the initiatives that you do have
20 in place? What is showing in regards to the consumers that
21 are staying in recovery? Like what are some of the
22 indicators in terms of maybe there are one or two programs
23 that have a 60 percent rate of individuals staying in
24 recovery over a long period of time.

25 DR. CLARK: We have insufficient data for that,

1 and that indeed is one of the issues. One of the questions
2 that does pop up is what does it take for your treatment?
3 Our hope for the recovery community services program is
4 that we'll have better data and we can do a more prolonged
5 analysis. We are very much interested in being able to
6 tell that story. I'm sure staff appreciate your
7 recognition of their efforts. I know I certainly do, so I
8 want to thank you for that. We'll continue to work on the
9 data.

10 At this point, I'm sure you need to stretch
11 your legs for a couple of minutes. We'll take a 15-minute
12 break, and I encourage you to return promptly so we can
13 reconvene at 10:30. We need to remain on schedule. I
14 noticed Joe Faha is already here. Thank you.

15 (Recess.)

16 DR. CLARK: Joe Faha, SAMHSA's director of
17 legislation, is with us today to give us a legislative
18 update. Prior to joining SAMHSA in 1991, Joe was a
19 legislative analyst with the Office of the Assistant
20 Secretary for Legislation at HHS. Prior to that position,
21 he was on the staff of Senator Bob Dole of Kansas.
22 Needless to say, Joe keeps SAMHSA abreast of any and
23 everything happening on the Hill. So join me in welcoming
24 Joe Faha.

25 (Applause.)

1 MR. FAHA: Thank you. You know, it's really
2 bad when you come to something like this and you're the
3 only one clapping for yourself.

4 (Laughter.)

5 MR. FAHA: It is a telling story. It is true
6 that I came to -- it wasn't SAMHSA at the time, it was
7 ADAMHA, and I can remember the date. It was January 14,
8 1991 that I came to ADAMHA, which makes me a senior citizen
9 in this organization, not just by age but longevity. The
10 first thing I was asked to do as director of legislation
11 was to dismantle the organization, to send the three
12 institutes over to NIH. I wasn't all that popular those
13 first couple of years.

14 Anyway, this is a great pleasure.

15 Am I talking too loud? Can everybody hear me?
16 Okay, good.

17 This is really a tremendous pleasure to come
18 and talk to you. I'm going to give you little highlights
19 of what my perception is of what's going on on the Hill,
20 and then I understand I have two hours of Q&As for anybody
21 that's interested.

22 (Laughter.)

23 MR. FAHA: Let's start with appropriations,
24 since that seems to be the topic du jour. As you know, we
25 have a continuing resolution for the entire year, through

1 '07, and that is at the '06 level. So we basically have as
2 much money to spend for CSAT, CMHS, CSAP, SAMHSA as we had
3 in '06, and there are reasonable guidelines that we need to
4 be able to spend it in much the same way as we did in '06.

5 That's not in every single case, but the general rule is
6 that you spend it in the same way in which you spent funds
7 in '06.

8 That having been taken care of on February 15,
9 when Congress passed and the President signed the full year
10 continuing resolution, we now began the process for '08
11 funding. As is always the case, the President submitted
12 his budget to Congress on February 5 or thereabouts,
13 detailing exactly what he was asking for with regard to all
14 of the federal agencies, and that included the Department
15 of Health and Human Services and SAMHSA.

16 Subsequent to that, SAMHSA found itself as
17 being one of the first agencies to testify before the House
18 of Representatives, which we did on March 12. This is the
19 earliest we have ever testified before the House. As was
20 true for the previous two or three years, three years -- we
21 didn't testify last year. They canceled all the hearings.

22 But in the previous years, the two years before then, we
23 testified along with our sister agencies from NIH, NIAAA,
24 NIDA and NIMH, with an attempt on the committee's part to
25 be able to get a dialogue about the relationship between

1 science and services. So that occurred in a very cozy
2 environment, for those who weren't there. It was
3 (inaudible) for the witnesses. It was one big oval table
4 in which all the witnesses sat at the table along with the
5 members themselves. So at least the setting was collegial.
6 It felt more like you were at a meeting than you were at a
7 hearing. So when Dr. Cline was testifying, Congressman
8 Ryan was sitting right next to him instead of up on the
9 dais. He tailored his comments as best he could to the
10 sense that it was a meeting.

11 The hearing went fine. It is the opening salvo
12 in terms of what will be appropriations season. We fully
13 expect that the House will come up with its marks for the
14 Department of Health and Human Services and at this point
15 probably finish action before the July 4 recess. If not
16 then, then certainly before the August recess. So things
17 are going to happen very quickly. Hearings are happening
18 very fast, much earlier than they had in previous years,
19 and so we're expecting it.

20 Now, there are many who would assume that
21 because the Democrats are now in charge of Congress, both
22 the House and the Senate, that there will be a lot more
23 money for social programs, including substance abuse and
24 mental health. I'm not so sure that the Democrats have as
25 much leeway as we like to be able to think that they would.

1 They, too, are wedded to balanced budgets. They, too,
2 have to deal with the increased costs of the Iraq war and
3 the war in Afghanistan, and so they're under a lot of
4 budget constraints. So I'm giving you an early warning
5 that you should not be looking forward to huge increases
6 for substance abuse and mental health, or actually for any
7 social programs.

8 You certainly will see a redirection. There's
9 going to be a lot of areas where the Democrats will want to
10 move. One in particular related to substance abuse and
11 actually mental health as well is Senator Harkin's endeavor
12 to focus on mental health promotion and the prevention of
13 substance abuse. He is into wellness and believes in that
14 concept, believes that prevention is prevention and that if
15 we're going to focus on substance abuse and mental health,
16 we should also focus on diabetes, obesity, all of those
17 preventable diseases in a unified effort. But you're
18 likely to see a lot of that going on, with additional
19 money, but I just would warn you not to expect huge
20 increases.

21 The Senate will then pick up and work its
22 wonders probably at the same time but will not get their
23 work done. I would expect that there will be normal order,
24 which requires that the House act first before the Senate
25 does on their bills. That doesn't mean that the

1 subcommittees won't hold their meetings and do all the
2 deliberations. It's just that the Senate itself will not
3 consider bills, probably will not consider bills until the
4 House has already acted. So you're looking at after the
5 August recess, which is traditional. This is typically
6 what happens. They go away for the month of August, they
7 come back, and then the Senate picks up where the House
8 left off. If indeed you see Senate bills coming out before
9 the August recess, then they are really moving fast.

10 Any questions about appropriations before I
11 move off of that?

12 (No response.)

13 MR. FAHA: Good. Okay. So this is the year of
14 what I refer to as the perfect storm. If anybody read that
15 book or saw the movie, you know that it talks about a
16 situation in which two fronts come together and they create
17 what is the perfect storm. Well, for a legislative
18 analyst, that's what's happened this year, because we not
19 only have appropriation going on but there is deliberations
20 on the reauthorization of SAMHSA. Let me spend a second
21 just to tell you what that means.

22 It does not mean that SAMHSA as an organization
23 is up for reauthorization. That's not true. The
24 organization continues. It's our programs that are up for
25 reauthorization. Technically what reauthorization means is

1 that if you go to any statutory provision, be it pregnant
2 and postpartum women or services for adolescents, services
3 for child welfare, whatever it may be, there is always a
4 subsection that says there are authorized for purposes of
5 appropriation X number of dollars -- this is not the exact
6 words -- for fiscal year 2001, 2002, 2003. Well,
7 reauthorization means that you just change those dates and
8 you say there are authorized to be appropriated such funds
9 for carrying out this section for fiscal years 2008, 2009,
10 2010. When that happens, that program is considered
11 reauthorized. That's all it means.

12 We do not need to have our programs
13 reauthorized. We continue to receive appropriations for
14 our programs whether it says 2003 or 2010. It doesn't make
15 any difference. Technically, if you receive dollars for a
16 program, let's use the block grant as an example. If you
17 go to that statute, the last year it was authorized was for
18 2003. As long as you are receiving money for a fiscal year
19 -- so we have money, for example, for 2007 -- that program
20 is considered to be reauthorized for the year for which you
21 received funds. So it is reauthorized for '07, but it is
22 reauthorized as it has always been. Then this is why it is
23 important to have a reauthorization process, because it is
24 the only mechanism that you can get changes to statutes to
25 suit or to enable you to do things that you want to do

1 where the current statute limits you. That's the first.

2 The second is that it's about time that we have
3 a significant discussion in Congress about substance abuse
4 and mental health. There has not been a significant
5 discussion about these two subjects since 1999 when they
6 last held hearings and considered our reauthorization. The
7 exception is certainly parity, but there really has not
8 been a significant discussion, and this is our way of
9 engaging Congress in this discussion.

10 Now, whenever you engage Congress, you have to
11 be careful because you don't always get what you want. You
12 get a lot of what they want, and sometimes that's not
13 exactly what you want, and so the debate goes on. But the
14 benefit is usually worth it. You get the dialogue, you get
15 the exposure, you get the conversation, and so change
16 occurs just because you've done that, and along the way you
17 typically get the changes that you are looking for in the
18 statutes so that you can do programs.

19 For example, keeping with the frame of the
20 block grant, we have authority currently to require states
21 to provide performance measurement data. However, we are
22 relying on a very nebulous provision that says that the
23 Secretary can require anything else he wants, or she wants.

24 What we want to do in this reauthorization is to make it
25 much more clear what it is that we're after and to

1 stipulate that we do expect states to be able to put in or
2 to submit performance-related data, and in our case
3 National Outcome Measurement data. So that's the purpose
4 of reauthorization.

5 Now again, it opens up Pandora's box, and you
6 get a lot of conversation that you don't want. So for
7 example, even though we're not interested in having --
8 first let me say that with regard to your discretionary
9 grant authority for CSAT, it's very generic, and CSAT has
10 the authority basically right now to do anything it wants
11 to. However, Congress has pet projects and pet issues that
12 they want us to attend to. So I'm going to go through a
13 small list of the kinds of issues that they want to be able
14 to bring up in this discussion.

15 Custody relinquishment. It's a mental health
16 issue, but I'm just letting you know that there are
17 situations in some states where parents, in order to get
18 mental health services for their kids, literally have to
19 give their kids over to the state so that they can go into
20 child welfare in order to receive the mental health
21 services that they need. So there's going to be a
22 discussion about that.

23 There's going to be a discussion about services
24 for older adults. I mean, our own statistics suggest that
25 this is something we should be concerned about. Well,

1 Congress is equally concerned about it, and they're going
2 to tell us exactly how they want us to do it.

3 Child welfare, particularly related to
4 methamphetamine; methamphetamine itself as a service.
5 Despite the fact that the general numbers showed a slight
6 decline, meth remains a major issue for many, especially
7 representatives from rural districts. So there will be a
8 lot of discussions, though I would note that at our
9 preappropriation hearing there was not one question from
10 anybody about methamphetamine.

11 Supportive housing and services, mental health
12 and substance abuse services for people living in
13 supportive housing programs.

14 Workforce development, a major issue that will
15 come up.

16 Accountability, which I've just mentioned.

17 Mental health promotion and the prevention of
18 substance abuse from Senator Harkin.

19 Mental health services in schools.

20 Suicide prevention, and then the proverbial
21 formula will be up for discussion, and we will not be a
22 part of that discussion, but I can assure you that the
23 winds of the formula are already blowing across the
24 corridors of the Senate and the House and there will be
25 bloodletting over the fight for some of the funds that will

1 be appropriated for that program.

2 So we will be brought into the debate on many
3 of these issues, and several others, as we go through
4 reauthorization. It will start off with a hearing which
5 was first going to be on March 29, then it was moved to
6 March 23, then it was early April. As of yesterday, it
7 looks like early May now. So it will start in the Senate,
8 and it will likely be a hearing. Terry Cline will testify,
9 and it will begin opening season. I can assure you that
10 right now the Senate HELP Committee are already working on
11 provisions to be included in that reauthorization package.

12 So if people are interested in contacting -- you can't
13 contact on our behalf, but if in fact you are talking to
14 members, now is a good time to have those conversations,
15 largely because this is when they're putting their stuff
16 together.

17 Then it should not be a contentious debate.
18 Except for the formula, I don't know of any issue that's
19 come up that's going to cause us to have a contentious
20 debate in the committee, in HELP Committee. For those who
21 recall, when we were reauthorized in 1999-2000, the Senate
22 did all the work. Then when the Children's Health Act came
23 up for consideration, the House said, okay, we'll basically
24 accept the Senate bill without them ever having held a
25 hearing or having had any deliberations. The House just

1 acceded to the Senate and the Senate bill, almost word for
2 word, was put in the Children's Health Act. I wouldn't be
3 surprised that the same thing would happen this year. I'm
4 not suggesting or forecasting that it will, but the winds
5 are correct, the winds being that there's not a lot of
6 controversy, and when there's not a lot of controversy it
7 makes it easier for bicameral cooperation to go on. So I'm
8 looking into my crystal ball, but I wouldn't be surprised
9 if that happens.

10 So that's going to be the reauthorization
11 process. Are there any questions about that?

12 DR. SKIPPER: Who's on the committee?

13 MR. FAHA: The reauthorization committee?

14 DR. SKIPPER: Yes, as far as Congress goes.

15 MR. FAHA: You're testing my memory here, so
16 let's see how good I am. Senator Kennedy is the chairman,
17 and the Democrats would include Christopher Dodd from
18 Connecticut, Barbara Mikulski from Maryland, Harkin from
19 Iowa, Jack Reed from Rhode Island, Sherrod Brown from Ohio,
20 Obama from Illinois, Clinton from New York, Bingaman from
21 New Mexico. I think that's all of them. On the Republican
22 side, the ranking member is Mr. Enzi from Wyoming, and it
23 includes Senator Hatch from Utah, Senator -- they've done a
24 lot of changes over there, so it's Senator Coburn from
25 Oklahoma is a brand new one, Isakson, I think Sessions is

1 still on there. I think you'll find that anybody who
2 follows the HELP Committee that a lot of the health issues
3 are typically Democratic issues, so many of the Republicans
4 just listen to their ranking member.

5 Pardon me if I'm a little bit foggy on their
6 membership. Does that give you enough information about
7 it?

8 DR. SKIPPER: I was just trying to feel out if
9 because we're in a presidential campaign, are there going
10 to be pet issues that come up from people who are -- you're
11 saying there are no controversial issues, so that won't
12 change.

13 MR. FAHA: No, I don't know of any
14 controversial issues, but that never stops members from
15 coming up with new ideas. Actually, there are two ways of
16 looking at that. If, in fact, they're generating new
17 ideas, because you've got two presidential candidates on
18 the subcommittee -- three, actually, Mr. Dodd, Ms. Clinton
19 and Mr. Obama -- that if indeed they are generating, that
20 means our issues are in the press and are important. So
21 you get that, and we'd love to see that. The other side is
22 we really don't want to see that, because that means we've
23 got to deal with all these provisions.

24 However, you do bring up a point. We're
25 looking forward to our first hearing because it's

1 undoubtedly that Ms. Clinton and Mr. Obama will be at the
2 hearing, along with Mr. Coburn, who is probably one of the
3 more conservative members of the Senate, and they have
4 significantly divergent opinions about what ought to
5 happen. So I think it will be an overcharged hearing.

6 DR. McCORRY: Could you give me an example of
7 how these issues, any one of them, gets translated into the
8 reauthorization language, how you take the wellness, the
9 accountability, and somehow that gets traction and it's
10 going to be put into the reauthorization language that in
11 some way is going to shape the direction of SAMHSA in the
12 future?

13 MR. FAHA: Sure. Any time we're being
14 reauthorized, it's the process of amending existing
15 statutes. Now, our statutes are Title 5 and Title 19 of
16 the Public Health Service Act and Protection and Advocacy
17 for Individuals with Mental Illness. Those three statutes
18 govern everything that we do. It's the language for our
19 block grants, for discretionary grants, et cetera, et
20 cetera. So reauthorization is merely a process of amending
21 current statute.

22 What you're talking about is let's say that Ms.
23 Clinton and Ms. Collins have a provision on custody
24 relinquishment, okay? So how it will appear is that Title
25 5 of the Public Health Service Act is amended to add the

1 following subsection, and then it will be Section 599,
2 Custody Relinquishment, and that's in essence how it
3 happens. It's no different than you amending a speech or
4 anything else with an add-on. It just gets added.

5 DR. McCORRY: But would it say, in custody
6 relinquishment, that they wanted to make that unnecessary
7 in the future that parents have to surrender children in
8 order to get mental health services? So there would be a
9 position advocated in the language that says any child with
10 -- I'm just making it up, but any child with mental illness
11 where parents cannot afford it and must subsequently turn
12 to public welfare to receive services, SAMHSA should do
13 this, that, and this about it?

14 MR. FAHA: No. I have a better understanding
15 of what your question is about. What they will amend are
16 our statutes. What you're talking about is amending
17 welfare statutes, child welfare statutes, which in many
18 cases are not under their jurisdiction. So what the
19 typical approach would be is creating an authority for us,
20 again an authority that we don't need but they will create
21 it, that will assist with that process, okay?

22 DR. CLARK: And it may not get funded.

23 MR. FAHA: We have 14 authorities right now
24 that have never been funded, and in our reauthorization one
25 of our proposals is to get rid of them. It's not that the

1 subject areas are not important, it's that they're just
2 taking up space because Congress is not putting money to
3 them. In addition, remember I told you that we have all
4 the authority we need to do anything we want to. So
5 whether we get rid of a provision that provides for the
6 creation of emergency mental health centers, as an example
7 of one that comes to mind, Congress wanted to set up these
8 systems to deal with mentally ill individuals who were
9 being picked up by law enforcement and are being sent into
10 law enforcement as opposed to going into treatment, and
11 they wanted to set up these systems so that police could go
12 there, get an evaluation and make a determination whether
13 or not treatment is appropriate, and to facilitate that
14 treatment. It's a good thing. However, no money has ever
15 been appropriated to it, and if we wanted to do that, we
16 could do it under current statute.

17 But you're bringing up a good point, and I may
18 have mentioned this here before. You've got to keep in
19 mind that General Motors can do anything it wants unless
20 statute says it can't, unless the statute places limits on
21 their flexibility, and it does so for very good reasons,
22 monopolization and other kinds of things. In the case of
23 the federal government, we can only do what the statute
24 tells us we can do. So if it says that you can produce red
25 M&Ms, you can produce red M&Ms, but you can't produce blue

1 ones. But we have the authority pretty much as wide as we
2 can.

3 MR. DONALDSON: What I'm hearing in Congress as
4 far as a kind of growing chorus is on the one hand the
5 stewardship of existing resources, as Dr. Clark put in his
6 report, but the other is the leveraging of existing
7 resources. We're hearing this even in the speeches by the
8 candidates, the outreach to corporate, for example. A good
9 example of that is the GDA program in USAID. They
10 appropriated \$1.1 billion through corporate relationships,
11 multiplied that three times -- Starbucks, Chevron, et
12 cetera. So I'm wondering, with our strategy here, do we
13 have any kind of skunk works committee that's focusing on
14 innovative ways to engage corporate, leverage these
15 resources? And two, with your approach to Congress --
16 because I think that would be very endearing for them to
17 hear how we're multiplying these funds with these kinds of
18 partnerships.

19 MR. FAHA: You're presenting a wonderful
20 situation that is a lose/lose in many ways. You want me to
21 go up and lobby Congress to tell them how wonderful we're
22 doing about getting money from the private sector, at which
23 point they immediately think in terms of, well, okay, then
24 we can reduce your funds. So it places us in a precarious
25 position. I know what you're saying, but there's a

1 win/lose out of this thing, and believe me, Congress is
2 looking for ways they can not reduce services, yet at the
3 same time create a balanced budget. The Democrats are
4 equally as worried about that as the Republicans are.

5 Having said that, I don't know that we have
6 ever -- are you going to create an office in a university
7 and call it a development office? I'm asking that
8 facetiously.

9 DR. CLARK: I know.

10 (Laughter.)

11 MR. FAHA: I don't know. That's an interesting
12 thought, though. I'll bring it up for Terry's
13 consideration.

14 Any other questions? I've got a couple more
15 things, and then I'll run out of here as fast as I can.

16 The reentry. There was a hearing yesterday in
17 the House Judiciary Committee on reentry. As you know,
18 what's being considered up there is various ways of dealing
19 with persons who have been in the judicial system, both
20 juveniles and adults, to provide services for them to
21 successfully get back into society. This bill that's going
22 around primarily gives funding and amends laws that pertain
23 to the Department of Justice, not to us, but we have been
24 equally interested in this subject largely because we have
25 a lot of reentry programs and have been supporting a lot of

1 this through CSAT.

2 Heretofore, it's unfortunately not been
3 something that we've been able to get active in largely
4 because there's only so many ways I can be divided. But I
5 have hired somebody to help me with legislation now, and
6 she was at the hearing and will be thoroughly involved with
7 the reentry efforts, both in conjunction with our
8 constituent groups, all of whom seem to be supportive of
9 the legislation that's going through, will keep track of it
10 for us. It is limited for the Department of Health and
11 Human Services to be really active considering that it
12 isn't our statutes being affected, but we can enter in and
13 give technical assistance and suggest that there be a lot
14 more cooperation between DOJ and DHHS. So that's that.

15 DR. MCCORRY: Is there a dollar amount on this
16 at all?

17 MR. FAHA: You know, I forget. There is always
18 a dollar amount of some sort, but I forget exactly what.
19 My recollection is that most of it is "such sums." So that
20 means it leaves it wide open.

21 The other thing that you may be participating
22 in is parity with regard to there being parity legislation
23 coming out of the 110th Congress. You're probably aware
24 that the Senate committees, the HELP Committee, passed
25 legislation on parity some weeks ago that really was

1 clearly just a parity legislation. It was never intended
2 to fix the problems that we have with insurance companies
3 related to substance abuse and mental health services. It
4 was only an attempt to create parity in the considerations.

5 Many substance abuse groups are very concerned about the
6 fact that while it does include substance abuse, in the
7 Senate they would like substance abuse to be much more
8 pronounced in the legislation. Let me be clear. The
9 Senate bill includes substance abuse. Whether it's out
10 there in the title, whether it's out there in anything, it
11 does include substance abuse, and that's important to
12 remember.

13 The second issue is that it doesn't do anything
14 about medical necessity and utilization reviews that have
15 typically caused problems for those seeking insurance
16 coverage for substance abuse treatment.

17 The third issue has to do with out-of-network
18 coverage. The Senate bill says that even if the plan
19 covers mental health, and even if there is out-of-network
20 coverage for general and surgical benefits, that no plan is
21 required to have mental health/substance abuse
22 out-of-network coverage. So in essence what it would
23 force, or at least it sets up this situation where, yes,
24 you get substance abuse and mental health coverage, but it
25 needs to be in some kind of in-network, and if your

1 in-network is not adequate and doesn't provide the options,
2 then there's no requirement that insurance plans create or
3 cover those services in an out-of-network facility.

4 The House bill is, first of all, much more
5 pronounced than the inclusion of substance abuse and
6 addresses medical necessity and utilization reviews to
7 ensure that they aren't being used to reduce or to deny
8 coverage for mental health services, and also insists that
9 if indeed you've got out-of-network coverage for surgical
10 and general medical procedures, that you must also have
11 equivalent coverage for substance abuse and mental health.

12 So, as you know, Congressman Patrick Kennedy
13 and Congressman Jim Ramstad and many other members of the
14 House have been holding hearings throughout the United
15 States. We had one here in Montgomery County. Dr. Cline
16 went up and testified at one, and I would like to say that
17 this is the first time that an administration witness
18 testified with regard to parity, and he was selected to do
19 that. So he is very honored in the fact that he wants to
20 be a spokesperson on behalf of parity. But anyway, that
21 happened on March 12, and there have been many efforts to
22 promote parity. You've probably seen a lot of this stuff.
23 If not and you haven't had enough of it, then I recommend
24 you go to Patrick Kennedy's website. You'll get more than
25 you need.

1 So that is going on. Right now, the House bill
2 is much closer to the Senate bill than it had been two
3 months ago, but these issues are major issues. Therefore,
4 I'm not sure as to what's going to happen.

5 Wes is giving me all kinds of signals that
6 maybe I've talked too long. So are there any other
7 questions that people may have?

8 DR. McCORRY: Not a question, but I just wanted
9 again to say thank you. It's the kind of presentation that
10 gives me, as a member of the council, a real kind of review
11 or a view of the scope of work around legislation and
12 appropriations that's really helpful. So I appreciate the
13 presentation, and I encourage keeping you on the agenda
14 because it keeps us informed.

15 MR. FAHA: Wait a minute. Can I say something
16 about that?

17 (Laughter.)

18 DR. CLARK: Thank you, Joe Faha. It sounds
19 like your comments were really appreciated, and we
20 certainly appreciate you taking the time to be here.

21 MR. FAHA: Thank you for inviting me.

22 DR. CLARK: With that, are there members from
23 the public who would like to address council? If so, could
24 you please come to the standing mike and give us your name
25 and the name of your organization, if you do have one?

1 (No response.)

2 DR. CLARK: Going once, going twice, no public
3 members. Then we can attend to a bit of housekeeping.

4 Our next business on the agenda is to vote on
5 the minutes from the September 20, 2006 meeting. Hopefully
6 you've had an opportunity to review the minutes. I will
7 now entertain a motion to adopt the minutes.

8 DR. SKIPPER: Move that they be accepted.

9 MS. JACKSON: Second.

10 DR. CLARK: It's been moved and seconded to
11 adopt the minutes.

12 Is there any discussion on the minutes?

13 (No response.)

14 DR. CLARK: May I get a vote? All those in
15 favor?

16 (Chorus of ayes.)

17 DR. CLARK: Any opposed?

18 (No response.)

19 DR. CLARK: The minutes are adopted.

20 Obviously, as we talk about the reintegration
21 of substance abuse into the health care delivery system,
22 the primary health care delivery system, there are a number
23 of issues that need to be addressed. One of the topics is
24 substance abuse treatment services for individuals with
25 disabilities.

1 Ruby Neville, CSAT's lead with respect to
2 services for individuals with disabilities, will provide us
3 with an update on what she and her colleagues have been
4 doing with regard to this important initiative since she
5 addressed the council at its September meeting.

6 Ruby?

7 MS. NEVILLE: Thank you, Dr. Clark.

8 Good morning. At the last NAC meeting, of
9 course, I presented to you some of the needs of individuals
10 with co-existing disabilities. But today, as Dr. Clark
11 mentioned, I'm just going to give you a real quick, brief
12 update, so there's no PowerPoint presentation to go along
13 with this.

14 One of the things that we have done since our
15 last meeting with you is that we have a regular monthly
16 conference call with experts in the field, the field of
17 individuals with co-existing disabilities, and some of the
18 things that have come out of those conversations, I'm going
19 to discuss those with you now. One of the biggest issues
20 is that of the traumatic brain injured individuals who have
21 substance abuse needs. This has become a significant
22 problem for the treatment providers as far as learning how
23 to provide evidence-based treatment for these individuals.

24 I want to also, before I go on to that, I
25 wanted to give you the names of the individuals who are

1 supporting this conference call discussion from the field.

2 We have Ken Perez from New York, the Office of Addiction
3 and Substance Abuse Services. Of course, Cynthia Graham is
4 participating with us in that. Jacqueline Hendrickson from
5 OPT and CSAT; Dennis Moore from the SARDI program with Rice
6 State University in Ohio; Debra Guthmann from the
7 California School of the Deaf; Deborah Larson-Venable,
8 executive director of the Granada House in Massachusetts,
9 and she is a consumer; Harry Kressler, the director of the
10 Pima County Partnership in Tucson, Arizona; and we have
11 also a potential participant, Dr. Francis Sparadeo, and
12 he's been working in Rhode Island and has specialized in
13 traumatic brain injury. That has not been confirmed as
14 yet, but that's a potential participant.

15 So regarding this topic on TBI, if you look at
16 some of the quick stats you'll see that as far as U.S.
17 hospitalization rates, it's on the rise. Actually, the
18 Centers for Disease Control has also stated this, that TBI
19 is on the rise. If you use the most recent available data,
20 there was a report published in the March 2 issue of the
21 Morbidity and Mortality Weekly Report, and it showed that
22 overall TBI-related hospitalization rates increased from 79
23 per 100,000 in 2002 to 87.9 per 100,000 in 2003. So again,
24 the CDC is also estimating that at least 5.3 million
25 Americans currently have a long-term or lifelong need for

1 help to perform activities of daily living as a result of
2 TBI, so it is a significant problem.

3 Some of the other discussions in regards to the
4 group, those out in the field are saying there are still
5 attitudinal issues, of course, there are some
6 discriminatory policies and practices, there are some
7 communication barriers, architectural barriers, and of
8 course, as there always is in the behavioral health care
9 field in general, there are funding barriers. As far as
10 with the disability community itself, they often do not
11 refer these individuals to substance abuse treatment, and
12 they are in need of such.

13 Additionally, our group has mentioned that
14 there's a need to modify TEDS data to be more inclusive of
15 individuals with disabilities, develop fact sheets on
16 individuals with these disabilities, brochures for the deaf
17 and hard of hearing, TBI, MR, and the developmentally
18 disabled and the blind. They've also recommended that we
19 develop a TIP on the deaf and hard of hearing and to
20 increase capacity for individuals through training and TA,
21 for individuals to actually serve these populations.

22 There was a recommendation to develop a
23 listening session in this area, and one of the final
24 recommendations was to include extra scoring points on RFAs
25 for potential grant solicitation, targeting treatment

1 services to individuals with co-existing disabilities.

2 So in the midst of some of the financial
3 constraints as far as what we have done here in CSAT, there
4 has been technical assistance provided to state systems,
5 and actually in DSCA they will be reviewing TA needed for
6 states who are seeking to develop infrastructure to provide
7 substance abuse treatment for persons who are deaf.

8 The other thing is that four members of the
9 disability conference call work group, they will be
10 participating in the DSCA state systems technical
11 assistance program to actually be experts to provide TA to
12 the states that need to enhance their capacity to serve
13 individuals in this population. They would be Dennis
14 Moore, as I mentioned earlier, Debra Guthmann, and then
15 also we have a potential person here again, Dr. Sparadeo,
16 who is a TBI expert, and then Ken Perez.

17 If you look at some of the SAMHSA data for
18 2004, the N-SSATS showed that 3,886, or 29 percent, of the
19 U.S. facilities provide services for hearing impaired with
20 sign language capabilities. Another 2,468, or 39 percent,
21 have on-call interpreters.

22 Something else we have done, as you know, CSAT
23 supports the ATTCs, and the Gulf Coast ATTC has recently
24 developed its first American Sign Language video, and this
25 is to actually screen the deaf for drugs and alcohol abuse.

1 This was created with input from the deaf community
2 itself, actual deaf experts in their field, and it has
3 shown to have good reliability, and also validity. Some of
4 the contents would include start-up information, frequently
5 asked questions about drug and alcohol, assessment for the
6 deaf, and there is an answer sheet, and also psychometrics
7 of the data itself.

8 If you look again at some of the TEDS data and
9 you look as far as those in the labor force, there are 40
10 percent age 16 and above who were not in the labor force.
11 Out of that group, 26 percent were actually disabled. Of
12 course, they have substance abuse issues just like those
13 who do not have a disability. 40.3 percent are using
14 tranquilizers, 40 percent heroin, 34.5 percent alcohol, and
15 30.5 percent smoke cocaine.

16 So we continue also to assist the youth who
17 have co-existing disabilities. We need to help them to
18 access substance abuse treatment services. Again, these
19 discussions have come from our conference call group, but
20 in addition, regarding some work that SAMHSA is doing with
21 the Administration for Children and Families, there is this
22 collaboration with ACF's Family Support 360 Program and the
23 SAPT block grant. Basically what it is is I was able to
24 get the 360 Program. It's a family support program. They
25 provide services to individuals who have developmental

1 disabilities, but they also support the family members. So
2 if they have human service issues, whatever they are, they
3 will refer them to the appropriate human service agency.
4 So we were able to swap those lists. The SSA list we gave
5 to ACF, and the 360 Program, we gave it to DSCA to increase
6 some type of collaboration between those two entities.
7 There's not a lot of money, but there are some things we
8 can do, even during this time of budget constraints.

9 Also in SAMHSA, we have the Cuyahoga County.
10 They have a Strengthening Communities' Youth grant, and
11 also a Systems of Care grant from CMHS. The whole purpose
12 of this is to provide treatment for youth with co-occurring
13 mental health and substance use disorders. They are
14 working with the University of Akron in the ongoing
15 development of integrated co-occurring treatment models.

16 So the reason why I included this one in here
17 is because I know when you think of co-occurring, you think
18 of mental health and substance abuse. However, this model,
19 they had the idea that these individuals had multiple
20 co-occurring conditions. So it conveys a preference for
21 using a multiple co-occurring conditions perspective when
22 you're serving these individuals. So it's not just mental
23 health and substance abuse. It could be substance abuse
24 and many other types of disabilities that will be
25 associated with that.

1 Also, SAMHSA is working in partnership with the
2 Department of Labor's Employment and Training
3 Administration and other agencies to support DOL's ETA --
4 that's the Education and Training Assistance Program --
5 through the Shared Youth Vision Program, and that basically
6 is to help youth at risk who may have substance abuse and
7 mental health issues to get the services they need. Larke
8 Huang actually is working with that, and I'm supposed to
9 support her with that as far as looking at the substance
10 abuse, keeping that component in there too, to address
11 those needs for those individuals.

12 That particular program is called the Shared
13 Youth Vision Federal Collaborative Partnership. Some of
14 the agencies that are participating in that are the U.S.
15 Department of Agriculture, Education, of course HHS, ACF
16 and SAMHSA, HUD is also participating, Justice, Labor,
17 Transportation, Social Security Administration, the Office
18 of Program Development and Research, and the Corporation
19 for National and Community Services.

20 I also wanted to speak to you briefly, and this
21 will be it for me for the day, about the disability as
22 secondary condition. There was a progress review relating
23 to Healthy People 2010 that took place November 16, and I
24 attended that particular meeting. There was a take-home
25 message, and it was to include people with disabilities in

1 population-based surveys, include people with disabilities
2 in mainstream health promotion efforts, and gather evidence
3 for interventions targeting people with disabilities.

4 I'm currently having discussions with the
5 SAMHSA Healthy People 2010, and now 2020, representative,
6 and we are trying to help out as far as ensuring that we
7 have measurements for substance abuse as well as mental
8 health for Healthy People 2020. The goal in Healthy People
9 2010 was to promote the health of people with disabilities
10 between secondary conditions in this particular focus area,
11 and eliminate disparities between people with and without
12 disabilities in the U.S. population. Some other activities
13 I'm looking at right now is to pursue discussions with CSAT
14 and SAMHSA staff to include measurements for the disabled
15 community.

16 Also, I wanted to mention to you that Dr.
17 Moore, Dennis Moore, who again is from Rice State
18 University, and again he's with the SARDI program, he will
19 present in June at the NAC meeting. So he'll give you more
20 information regarding what he's finding. He's done a
21 tremendous amount of research in the field around
22 individuals with co-existing disabilities, and he will be
23 available again in June to present that information to you
24 all.

25 That's it.

1 DR. CLARK: Thank you, Ruby.

2 For council, do you have any comments or
3 questions you'd like Ruby to address?

4 Frank?

5 DR. McCORRY: Thank you, Ruby. Two quick
6 comments, I guess, and a question or a suggestion. They're
7 kind of related. We had done a TBI small study as part of
8 our practice improvement collaborative in New York. It was
9 through Mt. Sinai in the city, but it was an upstate set of
10 providers who were interested. Sure enough, tremendous
11 positives on the TBI screen that they were developing and
12 validating, which led providers and CEOs to get really
13 concerned because there were no psychologists available to
14 do the follow-up assessment on the positive screens. So
15 they started to feel this vulnerability around having
16 something in the record that they weren't able to address
17 in the treatment plan. So one issue is capacity.

18 The related comment on it is when you think of
19 the fact sheets, I'm thinking is there a way to do
20 something -- I believe there's a TIP on this, but is there
21 a way to do something basic? Every provider has people
22 with traumatic brain injury on their caseload. Clearly,
23 that's sure. So are there things that can be implemented
24 that are more sensitive and responsive to people with those
25 kinds of impairments, cognitive impairments, that's just a

1 matter of kind of restructuring the way you help someone to
2 schedule their appointments that might be practical that
3 could receive wide dissemination? And not so much around
4 informing, not the fact of its prevalence, but more like
5 TIPS where we could say, okay, let's do things this way,
6 because for those we might not want to diagnose, or we
7 can't diagnose because we don't have the capacity, but
8 let's start to structure our program to allow this
9 responsiveness to the population.

10 MS. NEVILLE: Well, first of all, that first
11 question, I remember that came up at the earlier NAC
12 meeting. Again, that can be a problem. As I mentioned at
13 the earlier NAC meeting, that's why it's so important for
14 us to engage in regular discussions around this topic,
15 participate in existing listservs, if there are any, to
16 respond to those types of questions, because there are
17 folks out there who are successful in having the right
18 expertise available to address these individuals' needs.
19 There needs to be some form of communication so we can make
20 others aware of what's available.

21 As far as developing the right type of
22 evidence-based treatment and screening instruments and all
23 of that, that's one of the reasons I'm having the
24 discussions with -- actually, Dennis Moore has been working
25 with TBI, as well as Ken Perez. But most recently I found

1 out that Dr. Sparadeo, that's all he's done for 10, 15, 20
2 years, working with the TBI. In having discussions with
3 him, he is very familiar with what works, because actually
4 he's working with folks who have the TBI, as well as some
5 returning veterans who have those issues.

6 So it's folks like that, we want to get their
7 information and we want to share it with everyone else so
8 that they can become familiar with it. Obviously, I'm not
9 doing direct service, but I'm familiar on the macro level
10 with what's going on, and that's the whole purpose of
11 having these conference calls, because we want to ensure
12 that we get the message out there. So a question like you
13 have, that can be resolved, and there are folks who are
14 doing it. Somehow, maybe through the SAMHSA newsletter or
15 whatever, posted on websites -- Anne Herron has taken the
16 lead on the technical assistance that's going out there in
17 the field when we do have funds available, and we have
18 these people who are experts, and hopefully Dr. Sparadeo
19 also can be involved in this, and he said he would be
20 willing to participate. We just haven't gotten it approved
21 yet through Dr. Clark and everyone else. But those folks
22 have that information for you. So I would think that
23 providers can, when the funds are available, if they are
24 right now. I don't know because I'm not involved in that
25 area, but they're there to provide that type of expertise

1 for providers, as well as on the state level.

2 DR. CLARK: Anybody else?

3 (No response.)

4 DR. CLARK: Thanks again, Ruby. We look
5 forward to a more detailed report at the June NAC meeting.

6 I also want to echo Ruby's reference to
7 returning vets. As you know, TBI is an evolving issue in
8 our veteran population. Since some of our treatment
9 programs may be dealing with individuals from the National
10 Guard or Reserves who return, we need to have a better
11 understanding so that we can work with the VA and DOD on
12 this issue, since they have the primary mission.
13 Nevertheless, individuals with military or combat
14 experience will show up in our treatment programs.

15 We've set aside the next half hour to have an
16 open forum for you to talk to us. So far this morning
17 you've listened to us, and I think it's only fair that we
18 listen to you. So I'm particularly interested in your
19 thoughts about the priorities for CSAT as we look forward
20 to the FY '09 budget. The formulation process will be
21 underway shortly, and now is the time for us to receive
22 your input because there is an embargo on the process once
23 the process becomes formalized and the process becomes more
24 tightly controlled. So we want you to feel that you have a
25 voice, and the council roundtable provides us with the

1 opportunity to put topics on the table.

2 Any thoughts? Comments? Val?

3 MS. JACKSON: Thank you, Dr. Clark. I
4 appreciate the opportunity to discuss this, and I thank
5 you.

6 I had a question about the discussion that is
7 to be had on the formula. When that discussion comes up,
8 is there anything that SAMHSA is proposing to change at
9 this point? What kind of rumors are out there? That can
10 always get to be a little Pandora's box in and of itself,
11 so I wasn't sure if I should ask the question, but I
12 thought I'd just throw it out there.

13 DR. CLARK: The formula is basically something
14 that the Congress is going to deal with. They're the ones
15 who came up with the formula, and they're the ones who are
16 going to have to negotiate the components of the formula.
17 So when you're not officially a member of the council,
18 which is the rest of the time of the year, that's an issue
19 that you should address at your local level, because indeed
20 the struggle about the formula is basically going to be
21 between states. So I want to encourage you to address it
22 there.

23 MS. JACKSON: I understand. I think what I was
24 asking more was that there are certain set-asides on
25 particular populations and so on, and I guess I felt that

1 SAMHSA did have a hand at some point in suggesting certain
2 set-asides in the past. Am I wrong about that?

3 DR. CLARK: You're distinguishing the formula
4 versus the set-asides.

5 MS. JACKSON: Which is a part of the formula.
6 I am distinguishing that, yes.

7 DR. CLARK: Rich, do you want to say something?

8 MR. KOPANDA: Well, with respect to the
9 formula, SAMHSA historically and this year is not taking a
10 position. We have in the past made some recommended
11 changes to the set-asides, particularly with the 35/35/30,
12 if you know that, but as far as I know, this year SAMHSA is
13 not recommending any changes to that aspect of the formula,
14 or of the set-asides.

15 DR. CLARK: I'm not aware of any.

16 Any other thoughts? Greg?

17 DR. SKIPPER: I just want to bring up my thanks
18 and appreciation for the advisory that went out regarding
19 alcohol markers. I believe it's had a tremendously
20 positive impact. I've had far fewer complaints and calls
21 and concerns. I think it was very effective, and I
22 appreciate your efforts in that regard.

23 DR. CLARK: Thank you. Obviously, the issue
24 continues. We know that people are very much concerned
25 about trying to measure alcohol. Our only thing is making

1 sure that whatever they do, they do the right thing. I
2 appreciate your contribution and council's contribution. I
3 think it's an important thing to recognize that that was a
4 substantial contribution that was picked up by a wide range
5 of media and has had a positive impact.

6 DR. SKIPPER: In that regard, especially with
7 the news recently about the high rate of binge drinking on
8 college campuses and so forth, I do think that this kind of
9 test that discovers recent alcohol use for people for whom
10 it's illegal or inadvisable to be drinking could be a very
11 effective thing, and we need more research to more clearly
12 define that. Today there's really been no funding, and I
13 know we don't fund research here, but if there's anything
14 that we can do to encourage that, I think there may be some
15 opportunities coming. But it really needs to happen,
16 because I believe that drug testing is a very effective
17 deterrent. Addiction thrives in secret, and when we can
18 test people -- I know there's this question of civil
19 liberties and all that, but as you might have seen on the
20 news, New Jersey schools have started using EtG testing for
21 kids, and I think it's a good thing. But we just have to
22 have common sense, and we need more research on this.
23 Thanks.

24 DR. CLARK: Frank?

25 DR. McCORRY: I wish when I was speaking with

1 Administrator Cline this morning, I wish you had said,
2 because you said it so much better than me around this
3 issue of systemic improvement. I know it's probably
4 hitting that horse one too many times, but one more time on
5 this culture of performance, and I'm relating this to the
6 executive budget and the three elements of it, the outcomes
7 that you see in NOMs, and the two other elements of
8 performance improvement, which has both a quality
9 improvement and a process improvement, a business practice,
10 and finally measurement, that if you want to have a culture
11 of performance, we have all the elements there in terms of
12 NOMs, a performance improvement delineation of quality and
13 process improvement, and we have measurement. The quality
14 and performance improvement aspects, though, in measurement
15 are really out of this budget. NOMs is in this budget and
16 projects are in this budget, but the performance
17 improvement as defined by quality and process improvement,
18 that element of this triad of culture of performance and
19 measurement are really out of this budget, and it's a very
20 minimal amount of money involved here.

21 But to me, that adds up to setting an
22 expectation on providers and states without addressing the
23 capacity to meet the expectation. You can always say
24 payers, well, we just want the outcomes, you guys figure
25 out the rest, but I don't think, particularly in a block

1 grant environment, particularly when states and providers
2 are so dependent on the federal government for delivering
3 substance abuse services, I don't think the federal
4 government can step back and say we're just payers, give us
5 the outcomes we want and that's all we're interested in.

6 The other two pieces of that triad have got to
7 be as integral to the outcomes initiative, and that is
8 performance improvement as defined by quality and process
9 improvement techniques, and the development of measurement
10 that helps inform the quality and performance improvement
11 activities.

12 In a hospital environment it's less important
13 because of Medicaid and other kinds of services. There's
14 an ongoing funding relationship, or there's an
15 institutionalized funding that doesn't rise and fall based
16 on congressional whims as much. In a block grant
17 environment in which whole state systems are limited to or
18 defined by the money that CSAT gives them in terms of
19 treatment, to assert one without developing a capacity for
20 the other is just, to me, really short-sighted and really
21 not in keeping with the kind of relationship that has to
22 exist between provider states and the federal government to
23 actually improve care.

24 So again, a long-winded way of saying it, but
25 to me it's just wrong-headed to assert an outcomes

1 measurement initiative that does not include a dynamic and
2 involved quality and performance improvement capacity and a
3 strong measurement capacity.

4 DR. CLARK: I appreciate your comments. I
5 actually agree with the importance of quality improvement
6 and process improvement as a part of performance
7 improvement. One of the things that we're trying to do is
8 to operate with the limited resources that we have at our
9 disposal, but you are very much correct. We did support
10 NIATx and STAR as a result of that, and indeed we believe
11 that those kinds of efforts actually enhance the ability of
12 programs to operate in a cost-conscious environment. I'm
13 fond of citing the Tarrows project that I visited in
14 Phoenix. Fewer dropouts means less resources diverted to
15 assessments and more resources are targeted toward
16 increasing outcomes as a result of the intervention. The
17 point I'm making is it costs a lot of money to assess a
18 person every time that person drops out and you assess
19 another person. That person drops out and you assess
20 another person. Much of your resources are spent at the
21 front end. In order to be careful, you wind up using far
22 more sophisticated staff during the assessment process, but
23 there's no take if the individual is not engaged. So in
24 essence, you're losing a lot of that money. If you only
25 retain 50 percent of the people you assess, then you've

1 lost a lot of money because that person is generally lost
2 to follow-up.

3 Part of the NIATx effort was, well, gee, how do
4 we keep these people engaged, how do we avoid no-shows, how
5 do we keep them long enough for the program to begin to
6 have an effect. So these are things that are critical in
7 terms of the service delivery system. Otherwise, the cost
8 bands are going to be distorted and the average outcomes
9 won't be nearly as impressive as they could be if we don't
10 invest in trying to discover more about the dynamic of
11 service delivery, and most treatment programs just don't
12 have the resources to focus on that. They will do a good
13 job with whatever strategies that they have, but the state
14 of the art never changes, and in a cost-conscious
15 environment we want that state of the art changing, and we
16 want business practices changing. If we don't change those
17 things, then we may be losing funds that we could squeeze
18 out of the process by enhancing effectiveness and
19 efficiency in the delivery service. So I agree with that.

20 Dr. Fletcher?

21 DR. FLETCHER: CSAT has heretofore assumed a
22 leadership role in terms of addressing substance abuse and
23 higher education, particularly among the HBCUs, and with
24 the demise of the Mitchell program, will there be a
25 continuing involvement particularly around the national

1 survey of HBCUs that you've done heretofore that provided
2 an invaluable source of data on this population group that
3 has been used by many of those institutions, as well as
4 those who have been doing research in that area? Will
5 there be a continuing involvement at some level?

6 DR. CLARK: As we look at the budget, the HBCU
7 initiative would not be continued in the '08 period. So,
8 of course, that is a concern, and we would have to look
9 around to see where else in the federal government or the
10 state and local communities that focus is being maintained.

11 It's also the Minority Fellowship Program, which goes
12 beyond HBCUs. It involves the Hispanic community, the
13 Asian communities, and the American Indian and Alaska
14 Native communities in terms of individuals who are
15 interested in careers in mental health and substance abuse
16 disorders. That initiative will be discontinued. So
17 social workers and psychologists, psychiatrists and
18 marriage and family therapists and others would not have
19 those additional resources should this process be endorsed
20 by the Congress. So we'll just have to adapt to changing
21 circumstances should the Congress agree with the proposal.

22 MS. BERTRAND: Dr. Clark, during your
23 presentation, I noticed that the Partners for Recovery and
24 the consumer affairs education line items are eliminated as
25 well. What do those line items actually pay for?

1 DR. CLARK: Well, the Partners for Recovery
2 helps facilitate a number of activities, including some of
3 our leadership institutes and some of our outreach. So we
4 would not have resources for the leadership institute.

5 One of the things that is implicit in some of
6 the efficiency of our system is having managers who have
7 some sophistication. When you're on a shoestring operation
8 and your manager's got two weeks more seniority than your
9 service provider, than your counselor, then you've got a
10 problem. Your hope is that you've cultivated enough
11 managers and you not only know how to make the thing work
12 in paying salaries and doing billings and hopefully writing
13 grants, but also providing management supervision to the
14 staff and leadership so that they're operating not only for
15 their program but for the community in the community,
16 working with cities, states, tribes, trying to address the
17 issue of substance abuse disorders or mental health
18 disorders, forging relationships with other entities in the
19 community.

20 Those of you who work in communities know that
21 it's a lot easier to get business done if you have an
22 operating relationship with other providers in the
23 community, and they're often reluctant to get out of their
24 lane if they don't know who you are and they don't know
25 what you're about and they don't know how reliable you are,

1 and they ask what's the quid pro quo. With some leadership
2 and adequate sophistication, they know what the quid pro
3 quo is, and they know that you'll be there for them, and
4 therefore they'll be there for you, and that sort of thing.

5 That gets lost when you lose that leadership.

6 George?

7 MR. GILBERT: If I could, Anita, I just wanted
8 to expand a little bit on what Wesley said about the PFR
9 program. We have supported the leadership institutes, and
10 we're continuing to do that. PFR has also supported the
11 Recovery Summit a couple of years ago, and we're now at the
12 stage where we're going to start rolling that out through
13 some regional meetings. Those kinds of things would have
14 to be discontinued. We supported the development of the
15 "Know Your Rights" brochure, which was used for some very
16 successful meetings at the state level to make people aware
17 of rights under federal law and corresponding rights
18 available under state law to people that are in treatment
19 or with histories of substance use disorders in terms of
20 employment discrimination and housing and things like that.

21 We've also sponsored briefings for state legislators on
22 performance measurement with regard to treatment, and those
23 have been very well received.

24 So there have been a number of things that
25 we've been able to do with those limited resources to try

1 to promote notions of recovery and recovery-oriented
2 systems of care, working on anti-stigma efforts, working on
3 leadership training and workforce development efforts. We
4 supported the production and the development of the CSAT
5 Workforce Development Report. Those are the kinds of
6 things that PFR has been able to move forward.

7 In the consumer affairs area, the big thing
8 that is going to be lost would be the annual Recovery
9 Month, which some of you may actually be serving on the
10 planning committee that Yvette Torres has. That's an
11 annual campaign, and of course she's presented on that many
12 times. But that would also be an activity that would be
13 eliminated under the 2008 budget.

14 MS. BERTRAND: As I look at those line items,
15 it seems like we're going to have to continue to look at
16 workforce development issues, because I think that when we
17 talk about looking at recovery-oriented systems of care,
18 Recovery Month gives us an opportunity to actually
19 celebrate the work that we do, and I think there are so
20 many individuals in our community who do not know the work
21 that we do or see the success. So I think that communities
22 will still be able to hopefully organize some of the
23 events, but when I think about workforce and recruiting new
24 people into the profession, we're going to have to think
25 about creative ways to make that happen.

1 DR. CLARK: Thank you.

2 Val?

3 MS. JACKSON: The question that I was going to
4 ask previously really related, in a sense, back to -- I
5 think you made mention of the returning veterans and the
6 TBI. I think certainly in our news, and I think it was
7 national news, there seems to be quite a bit of attention
8 coming to that now, and also just recently I believe there
9 was a news item about methadone being prescribed and sent
10 home as a painkiller to a number of individuals, some of
11 whom are now no longer with us either because of accidental
12 overdose or whatever happened.

13 It's a tragedy, and I wondered if this is
14 handled totally separate from SAMHSA, and is that over in
15 the veterans department. I mean, how does that work?

16 DR. CLARK: The care of veterans ostensibly is
17 the jurisdiction of the VA. Not all veterans go to the VA,
18 so SAMHSA has a safety net supportive role. We had a
19 meeting on this issue. Arnie Owens is the SAMHSA lead on
20 this, and he's working with DOD and the VA so that we can
21 establish the appropriate role for SAMHSA in this process.

22 We're very much concerned about veterans. Again, not all
23 veterans receive services from the VA or DOD, and they go
24 to community providers, and those providers need to have
25 adequate resources to address the unique needs of veterans.

1 That's one of our concerns. We will be working on that,
2 and Arnie's got some thoughts about how to increase this
3 partnership because, as you know, there have been a number
4 of problem areas identified in the media that the
5 administration is trying to address so that we make it
6 quite clear that we support our returning veterans.
7 They're heroes who deserve the best that this nation can
8 give them.

9 With regard to the methadone overdose deaths,
10 we are also very concerned about the use of methadone in
11 terms of pain. We don't regulate the practice of medicine,
12 but Bob Lubran and his group -- Bob is in the back -- plan
13 to have a meeting. So we work with pain docs to address
14 the use, the adequate education of practitioners about the
15 use of methadone. I mean, some of you are aware that we've
16 used methadone for years and years and years and years when
17 it was unattractive to the general health care delivery
18 system. It was basically reserved for opioid
19 medication-assisted treatment, no problems. The occasional
20 overdose death, no problems. Suddenly, when the OxyContin
21 scare came, practitioners started diversifying, and I think
22 also some of the cost-conscious issues, people started
23 diversifying.

24 They were saying, oh, yes, methadone is a pain
25 medication, I'll just use it the way I use any other pain

1 medication, and we think that that thing has turned out to
2 be a nightmare for a number of individuals, particularly
3 when you're dealing with complex cases, individuals with
4 substance use histories, individuals with other
5 psychological problems, and then practitioners don't seem
6 to be as sophisticated with that population. The veteran
7 issue that you're describing, there have been recent
8 reports describing individuals who have complex
9 presentations, not just pain, not just PTSD, but a wide
10 range of pain, PTSD and substance use disorders. That
11 creates the need for those practitioners who are providing
12 the prescriptions to have a lot more sophistication than
13 they would for a person with "simple pain" or a person with
14 "simple PTSD," should we actually have that. So you're
15 right.

16 We are working with that. Bob and his team
17 will be having that meeting sometime this spring or summer.

18 Greg?

19 DR. SKIPPER: I just want to comment on that
20 because we did a methadone mortality conference that you
21 put together a couple of years ago. It was great. But my
22 thinking is that the issue really is long-acting opioids,
23 no matter what they are, whether they're methadone or
24 OxyContin or whatever. There's really no data that I know
25 of -- tell me if I'm wrong -- that shows that long-acting

1 opioids are more effective for treatment of pain than
2 shorter-acting opioids. They just have to be given a
3 little more often, and there's a lot more risk of death,
4 particularly in opiate addicts or substance-abusing
5 children who get a hold of these drugs. There's a lot more
6 risk of death from the long-acting opioids.

7 For example, when the FDA was looking at
8 releasing paladone, the long-acting -- what's it called? --
9 hydromorphone, Dilaudid, it was a very potent long-acting
10 opioid, Dilaudid. I was involved in testimony on that, and
11 there was real concern that anytime you have a drug where
12 one tablet can cause death in a novice user, you've got a
13 dangerous situation. So kids getting a hold of these
14 things can be pretty dangerous because they take the drug,
15 they don't get an effect right away, they take another one
16 and another one, and then they're dead eight hours later.

17 So I think from the point of view of substance
18 abuse, we should really oppose long-acting opioids. It's
19 really just a convenience as far as I can tell for chronic
20 pain patients. They get just as much good from the
21 shorter-acting ones, and they possibly are a lot less prone
22 to causing death.

23 Anyway, I'd like your opinion on that.

24 DR. CLARK: We're going to have the meeting,
25 and we are also having a panel at the American Pain Society

1 meeting. So rather than speculate, I think your
2 considerations are the considerations that we'll also
3 incorporate in the deliberations we have with the
4 clinicians in the field. Clearly, something is awry.
5 You're correct in terms of our fear that young people get a
6 hold of these medications. The data show that with regard
7 to non-therapeutic use of prescription meds, people get
8 those meds not from drug dealers, not from the Internet,
9 but from friends and family. Sixty percent of those drugs
10 are got from friends and family. So if you've got a bunch
11 of paladone sitting on the shelf, or if you've got one of
12 these new devices sitting unwrapped and someone dies and
13 leaves medication unattended, then those things get
14 diverted and we need to address that.

15 But because this is the practice of medicine,
16 we need to do that in concert with the medical community
17 and organized medicine. Our principal focus is the misuse
18 of these medications requiring treatment and prevention
19 strategies to deal with that. So it is in our best
20 interest to work with the prescribers, to work with the
21 medical community so that we can come up with appropriate
22 standards and appropriate advice so that we can hopefully
23 reduce that. But it is a major issue.

24 DR. SKIPPER: Just one final point of
25 clarification. I think the meeting should be about

1 long-acting opioids and not just restricted to methadone,
2 because they all have potential problems, whether it's
3 fentanyl patches, which are eaten or whatever, and that
4 causes death, or OxyContin or anything otherwise that could
5 be a concern. It's not just methadone.

6 DR. CLARK: Well, that agenda hasn't been fixed
7 in stone. Bob Lubran is back there listening and nodding
8 his head. We appreciate your input and we'll incorporate
9 your themes into that meeting. We'll point that out.

10 Dave Donaldson.

11 MR. DONALDSON: George, you're talking about
12 the removal of the Recovery Month, the consumer affairs
13 education, which encompasses Recovery Month? What else is
14 out? What else does that include, consumer affairs
15 education that's being cut?

16 MR. GILBERT: It's basically the entire
17 consumer affairs activity. Recovery Month is the largest
18 portion, I think, of what Yvette's activities are, but she
19 also does other campaigns. She sponsors and supports the
20 annual Inhalant Week that SAMHSA is involved in. She has
21 campaigns on prescription drug misuse aimed at older adults
22 and youth. I'm trying to think of what some of the other
23 -- she has a group that -- Bob, you would know about this.
24 She has a group that you worked with. It's the opioid
25 consumers group.

1 MR. LUBRAN: She calls it the Patient Consumer
2 Support Education Project.

3 MR. GILBERT: The Patient Consumer Support
4 Education Project. Can you say a little bit about that,
5 because I'm not totally familiar with that.

6 MR. LUBRAN: Just briefly, this is a group of
7 primarily patients and families who are involved with
8 methadone treatment and come together periodically to talk
9 about educational initiatives focusing on patients and
10 consumers, and we're meeting March 30, actually, to talk
11 about the issue of methadone-related deaths.

12 MR. DONALDSON: Does it include, though, the ad
13 campaign that Dr. Cline referred to earlier?

14 MR. GILBERT: No, I think he was referring to
15 the ONDCP partnership campaign.

16 MR. DONALDSON: Is that still in the budget?

17 MR. GILBERT: Well, that's not our campaign.
18 That's funded through the Office of National Drug Control
19 Policy.

20 MR. DONALDSON: So out of this agency here, is
21 there any consumer affairs, or is that all being cut?

22 DR. CLARK: Again, those activities are slated
23 for cuts, and some of our faith-based activities are slated
24 for cuts.

25 MR. DONALDSON: Because I agree with what Anita

1 said. I've been involved in that Recovery Month. Besides
2 the obvious education that it provides to the general
3 public, it does highlight the good work that CSAT does.
4 Three, I think it's been a great entry point for
5 faith-based, community-based groups that are not going to
6 get involved right away but they will participate in some
7 kind of public affairs campaign. So just based on reports
8 that I've heard in here and my own participation, I think
9 it's been highly successful and I'm personally disappointed
10 that this is being cut.

11 MR. GILBERT: Well, I'll speak for myself. I
12 share your disappointment.

13 MR. DONALDSON: I understand balancing the
14 budget, too, believe me, but I think this is back to what I
15 talked about, multiplying and leveraging resources, and you
16 can do it especially through the media.

17 DR. CLARK: Dr. Fletcher?

18 DR. FLETCHER: Just a very quick question.
19 Would you clarify if this includes your TIPS, those
20 publications that come out? Are they included in the cut?

21 MR. GILBERT: Those are in the CAPT program.
22 The CAPT line includes our TIPS and those publications.

23 DR. FLETCHER: How sad.

24 DR. CLARK: We're going to have more time for
25 roundtable discussion this afternoon, but I won't be here.

1 I've been called away. So Rich Kopanda will be chairing
2 the meeting for this afternoon, but I will have lunch with
3 you.

4 Before we depart, let me thank the staff and
5 the contractors. I want to thank the staff for coming,
6 taking time out from their busy day to be here. I want to
7 thank, again, Cynthia Graham and your contractors.
8 Everyone's got busy schedules. I think people needed to
9 hear your concerns about the budget, and we will move
10 forward on this. Thank you very much.

11 So let us adjourn for lunch.

12 (Whereupon, at 12:02 p.m., the meeting was
13 recessed for lunch, to reconvene at 1:30 p.m.)

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21 AFTERNOON SESSION (1:35 p.m.)

22 MR. KOPANDA: Good afternoon. I would like to
23 get started this afternoon. I trust everyone had a nice
24 lunch.

25 We're going to deviate a little bit from the

1 agenda because there have been a number of questions come
2 up on the 2008 budget and on the presentation this morning,
3 and I think it might be possible to have a little bit more
4 discussion with the council. We have a little bit of time
5 in our first presentation, which is on ATR, Anne Herron.
6 Jack Stein said that their presentations are fairly short,
7 although we'll still leave time for questions at the end of
8 that. But we wanted to just put up a couple of the slides,
9 clarify some things, and George is going to mention a
10 couple of things on the budget. If there are any follow-up
11 questions from this morning's discussion, we can address
12 them.

13 The one thing we wanted to point out is that it
14 was not clear in some of the slides that the dollars were
15 in thousands, which meant we were looking at millions when
16 we were looking at the slides.

17 MR. GILBERT: There were apparently a few
18 things that might have been confusing this morning, maybe
19 more than a few things, so let me go back to some of these
20 slides. I want to make clear in this slide that this slide
21 is showing the discretionary program funding, not the
22 entire funding for the centers. So the \$352.1 million for
23 '08 is just the discretionary programs.

24 Then this slide is showing the entire CSAT
25 budget, if you will, and you see the Programs of Regional

1 and National Significance. That's the discretionary line,
2 and you see all the way in the right-hand column \$352.1
3 million consisting of \$339 million in the capacity
4 programs, which is our major services programs, like Access
5 to Recovery, drug courts, SBIRT, et cetera; and then the
6 science-to-service programs, \$13.1 million, and those are
7 things like the ATTCs and the CAPT program.

8 Then I think these slides showing programs that
9 were eliminated, I want to point out in the small printout
10 in the upper right-hand corner dollars in thousands. All
11 of these slides are showing you dollars in thousands. So
12 it's actually millions of dollars. For CMHS children's
13 programs, there's \$8.2 million in program activity that's
14 being eliminated, and going down to the CSAT slides, this
15 display, the various lines equate to lines that are in our
16 budget document that goes to Congress, the CJ if you will,
17 the budget bible. There's a page in here called the SLOA
18 tables, Summary List of Activities, and these lines relate
19 to lines in that table. Then what Dr. Clark was trying to
20 show you was the summary, and then how that breaks out.
21 So, for example, for the STAR line, that's both grants and
22 technical assistance. In 2008, the budget proposes to
23 eliminate funding for the STAR program, and in this case
24 for us this means we would have to terminate grants that
25 would otherwise be getting their third year of funding in

1 2008. Those grants were first funded in 2006. They're
2 three-year grants. So if this proposed cut is accepted by
3 Congress, we would have to terminate grants.

4 MR. KOPANDA: I might just add that that's the
5 only grant program that would be terminated in terms of
6 active grants terminated.

7 MR. GILBERT: In other grant programs where
8 there are cuts, the cuts are as a result of the natural
9 expiration of current grant programs. So we wouldn't
10 actually be faced with terminating active grants.

11 This shows you the special initiatives outreach
12 line in the summary slide, what are the individual
13 activities under that that would be affected. Most of
14 these are contract activities. The HBCU and Lonnie
15 Mitchell actually is supported by both grant and contract
16 dollars. This activity comes to a natural end at the end
17 of 2007. We would not be able to continue that activity in
18 2008, but we wouldn't be terminating it early. This is, as
19 Westley said, money that was in the Office of the Director
20 for special things that he would want to support that would
21 not be available. These are contract activities here. All
22 of these are contract activities.

23 Rich, did you have a comment on that?

24 If any of you have a question as we go along,
25 just raise your hand.

1 In this state service improvement line, what
2 we'd be losing is HIV/AIDS cross-training and
3 confidentiality training, things that we've supported for
4 years to assist states. It's hard to say what was going on
5 when some of these decisions were made. We were talking
6 about it at lunch. We think that the kinds of things where
7 you saw program increases are things that people
8 understood, like criminal justice, drug courts, SBIRT, ATR.
9 The kinds of things that got cut by and large were
10 programs that probably people didn't understand what this
11 was. What's state service improvement? We don't know.
12 Okay, let's cut it. What's special initiative outreach?
13 We don't know what's there. Okay, let's cut it. We're
14 speculating that because maybe they didn't know what was
15 behind those lines, they didn't really understand what they
16 were cutting when they decided to cut that out of the
17 budget, and these were all things that were decided once
18 the budget went to the Office of Management and Budget.
19 Program coordination and evaluation. Well,
20 that looks like something that's nothing, right? But
21 what's behind it? It's Partners for Recovery, it's all of
22 our consumer affairs efforts, the things that we talked
23 about this morning. It's Recovery Month. I think we're in
24 our 17th or 18th year. I don't think the people at OMB
25 understood that they were making that cut, at least I'd

1 like to think that they didn't understand it.

2 DR. FLETCHER: May I ask a question before you
3 leave that? Would you back up that slide?

4 MR. GILBERT: Sure.

5 DR. FLETCHER: Are these evaluation dollars for
6 programs that you currently sponsor? And if so, if those
7 dollars are being eliminated, how do you honor the results
8 accountability, the culture of performance? How do you
9 honor that if you don't have the dollars to do it with?

10 MR. GILBERT: Actually, the line is a bit
11 misleading, and I think this may be part of what's going
12 on. These are not evaluation activities. These are small
13 program activities that were lumped together into an
14 overall category. At one time there may well have been
15 evaluation activities in here, but as budgets change from
16 year to year, some activities will come out, new activities
17 will come in, but it's a category, a general category
18 that's in the SLOA table that gets displayed without a lot
19 of discussion, without a lot of explanation and opportunity
20 to really say what is the activity behind that line. So we
21 are somewhat speculating here that people didn't understand
22 program coordination and evaluation. They didn't know what
23 that was supporting. Obviously, it was a very tight budget
24 year. They had to make cuts. They understood criminal
25 justice. They understood SBIRT. They understood that if

1 you were looking at adolescents, they could see we had a
2 cohort of grants that's expiring. Okay, we don't need to
3 continue money for that. But they didn't understand this.
4 So our speculation is they just said let's get rid of it.
5 We've got to cut. We can save money here.

6 Yes, Val?

7 MS. JACKSON: So are you telling me, then, that
8 you must submit a budget up to them?

9 MR. GILBERT: We do. SAMHSA prepares a budget
10 that goes first to the Department, it's reviewed in the
11 summer, they come back with a mark, then we prepare a new
12 submission which goes to the Office of Management and
13 Budget. It also gets reviewed by the Office of National
14 Drug Control Policy because it's part of the President's
15 drug control budget. So in the executive office of the
16 White House, it's both OMB and ONDCP who are reviewing our
17 budget.

18 MS. JACKSON: So do you have a chance to either
19 respond or prioritize any of these things that are on
20 there? I mean, there must be some conversations at some
21 level.

22 MR. GILBERT: Rich?

23 MR. KOPANDA: In addressing that, I'd also like
24 to respond to Dr. Fletcher in terms of the evaluation.
25 What George is saying is correct. Some of these lines are

1 just -- there are so many \$2 million things, small things,
2 which we have to aggregate in a line item like that, and
3 when we do, we come up with a title which may not indicate
4 the importance of that activity. So in terms of the
5 evaluations, our understanding is that services were
6 accorded a priority, such things as TA and evaluation,
7 across the board and not just in SAMHSA, and across the
8 agencies was not prioritized, which is a little bit of a
9 disconnect with OMB's -- for example, the PART process.
10 Dr. Clark referred to the OMB PART process where they
11 analyze your programs, and there's a heavy emphasis on
12 evaluation and the results of evaluation in that process.

13 Now, as George is explaining here, these lines
14 don't include a lot of our evaluation dollars. In fact, a
15 lot of our evaluation dollars are built right into the
16 program. Take the Access to Recovery program. We have
17 approximately \$3 million per year built into that program
18 for evaluation of that program.

19 So this does not cut out all of our evaluation.
20 But nonetheless, in those areas where it stood out and
21 where it might have been collapsed with other things, it
22 was not given the priority of direct services.

23 MS. BERTRAND: Under the special initiatives
24 category, what were some of the things that you all
25 conducted, and is that line item -- I saw \$300 million or

1 whatever. Is that the total amount that was there, or is
2 that a percentage of what was there? I think it's the
3 slide before this. There it is, planning and special
4 initiatives. Is that the total amount? So is it zero
5 there?

6 MR. GILBERT: Yes, that's correct, the entire
7 line was cut out.

8 MS. BERTRAND: And what kind of activities did
9 you have under that initiative?

10 MR. KOPANDA: As you can see, it's kind of a
11 mixture of our activities. It includes the HBCU grant, the
12 Lonnie Mitchell conference. Planning and special
13 initiatives is, if you will, Dr. Clark's reserve for
14 special conferences, events, if he wants to pull together a
15 special team of experts to deal with an issue, those kinds
16 of funds, a performance measurement contract, work we do
17 with other federal agencies, in this case the Agency for
18 Health Care Research and Quality, which is a small dollar
19 amount, and logistical support for some of our programs.
20 So it's a variety of things that we have to collapse in
21 terms of that line item. When you call it special
22 initiatives, it just doesn't resonate as something that --
23 but yet we have \$4.2 million when you add them all up, and
24 we have to put them somewhere.

25 MS. BERTRAND: In seeing this now, is there a

1 department that analyzes how the funding that you do have
2 is distributed into the community? Like who is responsible
3 for that in terms of the RFAs and how they're worded? Who
4 is eligible for those grants and things of that nature?

5 MR. KOPANDA: Well, if I understand your
6 question right, each of our divisions, and you're talking
7 about grant programs primarily, when we're establishing the
8 funds and analyzing how we're going to spend the funds for
9 a particular grant program, the work begins in the program
10 division. Our program divisions are set up such that the
11 DSI division deals with criminal justice, pregnant and
12 postpartum women's programs, drug courts, Targeted Capacity
13 Expansion, anything in those areas. They would initiate
14 what we call an RFA, a Request for Application, and that's
15 kind of a long document that will eventually be published.

16 In that, they will have a discussion internally
17 in terms of what the best target population is, what have
18 we done before, what kind of grants have we gotten before,
19 what kind of pressures are we getting either internally or
20 from the Hill to direct the funds in a particular way, are
21 they saying to do it through states or looking at the
22 statutory authority, what statute are we going to use to
23 fund the program, and they will make a recommendation.
24 We'll review it in George's office, the OPAC office, the
25 Planning and Policy Office, and send it to the Office of

1 the Administrator. From there it possibly goes up the
2 line. Some, like Access to Recovery, ATR, get reviewed all
3 the way up to OMB and the White House, basically, but most
4 of them stay within the agency. So it would be an
5 agency-level decision, but many parties participate in the
6 discussion and analysis as to how a grant program is
7 designed and executed.

8 DR. FLETCHER: First of all, can I comment?

9 MR. GILBERT: Sure.

10 DR. FLETCHER: I want to thank you all for
11 revisiting this issue because it helps me to understand the
12 process that you went through in arriving at this, which I
13 truly did not understand this morning. I'm probably the
14 only one here who didn't, but I thank you for enlightening
15 me on that.

16 MR. GILBERT: We had the sense that there was
17 some general lack of understanding. We wanted to make sure
18 that we came back to it because it is important and it's
19 confusing.

20 DR. FLETCHER: In the midst of my lack of
21 knowledge in this area, I want to make an observation. I
22 make an assumption that budgetary decisions and cuts are
23 based on impact on budget. For instance, if you want to do
24 a budgetary savings, a significant savings, you have to
25 make sure that you get the volume that you want. Many of

1 the cuts here would merely a drop in the bucket, if you
2 will. However, it has the potential programmatically to
3 impact a significant population.

4 Example, the HBCU initiative. There are 107
5 HBCUs in this country. There is no program that I'm aware
6 of that speaks to substance abuse in higher education at
7 HBCUs. So it has a tremendous impact in terms of the
8 number of institutions that it reaches, but there are not a
9 lot of dollars tied to it. So how do we rationalize it?
10 Help me understand that.

11 MR. KOPANDA: Well, I think those of us within
12 the center anyway would agree with you in that regard. We
13 understand the importance. We believe in the program, and
14 we think not only is it doing an excellent job, but it's
15 doing something that we need to be doing. Part of it is
16 difficult budget decisions, and we do as well as we can in
17 terms of justifying them, providing the data when it's
18 requested. But at some point the rubber just meets the
19 road and the cuts are made, and we do the best we can to
20 accommodate.

21 Oftentimes what will happen, too, is we'll get
22 an appropriation, say in this case for 2008, and we'll have
23 some flexibility, and within that degree of flexibility
24 we'll be able to restore some things and actually make
25 judgment calls as to which of the key priorities to

1 continue. Possibly that will happen in 2008, but we are
2 waiting until the spring here to see what the House and
3 Senate action is on our bill.

4 MR. GILBERT: And I think, to kind of build on
5 what Rich said, I think you all got a copy of this. This
6 is the CJ, the Congressional Justification, that was
7 submitted to Congress for the 2008 budget. It's also
8 available online. If you take a few minutes and you look
9 at it, if you look in the CSAT section, the treatment
10 section, you're not going to find the level of detail that
11 Bettye is talking about. I mean, it's going to focus on
12 the big-ticket items. It's going to focus on ATR, it's
13 going to focus on the increases in the budget, but it
14 doesn't get down to this level. Part of that may be
15 something that SAMHSA may want to reconsider in terms of
16 the way we display and explain our budget.

17 I think there is a lack of understanding about
18 exactly what we are supporting. I don't think, when people
19 made decisions, they understood this, but I also think what
20 was driving this was they had to meet some targets for
21 cuts, and they sort of looked at things and if they didn't
22 understand it, it was probably gone, not necessarily a
23 rational process in the sense of what makes sense
24 programmatically maybe, but in the sense of having to meet
25 certain targets for reducing overall spending. That's what

1 they had to do.

2 The process, as Rich said, we support it as
3 best we can, try to provide explanations, but a lot of
4 times I think decisions get made where the questions don't
5 get asked. You don't ever get a chance to explain
6 something. You don't know that something is on the block,
7 so you can't say wait a minute before you do that, you
8 might want to consider what it really is all about. So
9 it's not a perfect process.

10 We talked about this a little bit. We talked
11 about this. This one, Frank, what you were talking about
12 this morning, how do we take successes at the individual
13 project level and how do we go from there to systemwide
14 change. Well, our CAPT project supports our knowledge
15 dissemination program. It supports the TIPS. It supports
16 materials development. It supports the CAPT keys, all the
17 tools that we've used traditionally to try to take the
18 lessons that have been learned and the best knowledge that
19 we have about what works and disseminate it out to the
20 field. It doesn't seem to make a lot of sense to eliminate
21 that. But again, if you looked at information
22 dissemination and you were a budget examiner at OMB, you
23 may not know that what you're cutting out is TIPS, which
24 has been sort of one of our flagship products, but that's
25 what it was. They didn't ask us what is this; we just

1 found out about it after the fact, so we never really had a
2 chance to defend it or to argue for it.

3 Technical assistance. This includes both
4 printing and clinical TA. Clinical TA is a problem for us,
5 and this doesn't show the whole story. If you were to look
6 in the document, and you don't have it, this doesn't really
7 show the whole story either. Traditionally when we've
8 budgeted, we have budgeted for TA within our program lines.

9 So for example, we have one large clinical TA contract,
10 but that provides TA for a variety of our discretionary
11 programs, our PRNS programs. We take money from each
12 program and we pool it to fund this contract. Then we have
13 some other little pieces of TA that aren't included in that
14 contract, and that's what we use to show on this clinical
15 TA line. However, this past year a decision was made to
16 put all the clinical TA on one line.

17 So if you were at OMB and you got a budget
18 that's showing roughly \$1.2 million a year for clinical TA,
19 and all of a sudden it jumps to \$10 million, you're going
20 to ask questions about that. They didn't accept it, and
21 not only that but they eliminated the \$1.2 million. So we
22 lost not only this little \$1.2 million, we lost \$10 million
23 in TA. We're going to have to go back as we move forward
24 and build all over that capacity for TA, starting with
25 taking little bits and pieces out of programs as we get it

1 and building that back up. We didn't lose it all. We have
2 a very good budget person, and she's managed to protect
3 some of it, but we lost a lot of what we had had in TA, and
4 probably part of that is our fault because of the way the
5 decision was made to display that. But anyway, that's how
6 things sometimes work out.

7 Yes, Frank?

8 DR. McCORRY: George, the clinical TA, does
9 that include TA on COSIG or out of COSI? I assume the
10 clinical TA includes the TA provided after a block grant
11 audit. Does it include either or those, or no?

12 MR. GILBERT: No. Anne could speak to the
13 block grant TA. That's actually funded out of a separate
14 account, the block grant set-aside. That's another story.
15 We do have money that is available, but even that is
16 shrinking because of pressures on the set-aside.

17 DR. McCORRY: And the COSI money for TA?

18 MR. GILBERT: Bob, do you know?

19 Bob is sitting in the back. He's in my office
20 and works on budget issues.

21 I think we're okay there.

22 PARTICIPANT: (Inaudible.)

23 DR. McCORRY: So what is in the clinical TA
24 that's being cut?

25 MR. GILBERT: Well, it's money that goes into

1 our large clinical TA contract that supports clinical TA --

2 MS. HERRON: That's the TA that goes to the
3 adolescent grantees, pregnant/postpartum women, HIV, I
4 believe drug courts too, criminal justice.

5 PARTICIPANT: (Inaudible.)

6 MR. KOPANDA: Most, but not all, is
7 discretionary grants. Primarily it's discretionary grants
8 in our DSI division.

9 DR. McCORRY: So when they X'ed out the
10 discretionary grants, they X'ed out the TA that comes along
11 with it, in essence.

12 MR. KOPANDA: Well, as George mentioned, for
13 the budget display purposes for this year, it had all been
14 consolidated in one line.

15 MR. GILBERT: Most of it did.

16 MR. KOPANDA: Yes, most of it did. In looking
17 at that line, it looked like that line all of a sudden grew
18 because it wasn't built into all the pieces. So that's why
19 it got eliminated.

20 We are going to have to end the budget
21 discussion fairly soon here. I just wanted to mention one
22 thing. If you think back to the table that showed our
23 percentage of discretionary reduction, we were the least of
24 the three SAMHSA centers. So these kinds of discussions
25 and these kinds of issues are being faced by all of the

1 SAMHSA centers, and really it goes beyond SAMHSA. Many of
2 the department agencies are facing these kinds of cuts in a
3 whole variety of programs, and they're probably doing the
4 same thing, saying a lot of our support activities are not
5 being given priority in this way.

6 MR. GILBERT: Rich, if I could, let me just
7 make two more short points, because this chart apparently
8 was confusing to some people.

9 These are showing decreases. These programs
10 are not eliminations. So it's showing you what we expect
11 to have in '07 and what the request is for '08, and the
12 difference is the amount of the decrease. For grant
13 programs in this column, we're not going to have to
14 terminate grants, but this will reflect the natural
15 termination of existing cohorts of grants.

16 The other thing I want to say, as Rich was just
17 pointing out, the cuts in our budget all came out of the
18 discretionary side of the budget, the PRNS column. So
19 while the SAMHSA cut overall was 5 percent of our total
20 budget, for CSAT, if you look at our discretionary, since
21 it all came out of the discretionary side, it's more like
22 12 percent, 13 percent of the discretionary dollars. So
23 the block grant was essentially protected. The
24 discretionary side is where the cuts came from.

25 DR. FLETCHER: Just one procedural question,

1 Richard. If my colleagues concur, can we come back to this
2 issue during roundtable?

3 MR. KOPANDA: Absolutely.

4 We're pleased to have with us Anne and Jack to
5 present on the Access to Recovery program and the results
6 today. Arnie Owens, who is one of the senior advisors to
7 Dr. Cline, was going to present on our recovery support
8 service conference in Florida. He will not be here to do
9 that, unfortunately can't be with us, so I think Anne is
10 going to do that part of the presentation.

11 MS. HERRON: I'm going to be Arnie, I think. I
12 asked Jack to please hum while I did this for you, and he
13 said no. So I just want you to know that. It could have
14 been very entertaining, and he refused to do it.

15 (Laughter.)

16 MS. HERRON: If they coax you? Okay.

17 (Laughter.)

18 MS. HERRON: There's just no integrity anymore.

19 (Laughter.)

20 MS. HERRON: What I did want to do, though, I
21 wanted to take a few minutes to let you know about a
22 meeting that we had really following up on some of the
23 points that you had made earlier this morning about taking
24 some lessons learned from some of our grant programs and
25 finding a way to share them more broadly and share them

1 with states and with other providers. In this particular
2 case, the meeting that we had was on recovery support
3 services. What we did is we added on two days to a meeting
4 that was already being scheduled for the Access to Recovery
5 program grantees, and we brought together the Access to
6 Recovery grantees, some of our RCSP grantees, Recovery
7 Community Services Support grantees, who are doing a great
8 deal of work around utilizing and supporting recovery
9 support services, we brought together the regional
10 directors from NASADAD, and we brought together members of
11 the CSAT faith-based expert panel that we had developed in
12 support of ATR.

13 All together there were about 65 people that
14 came together for a day and a half to talk about lessons
15 learned and how to share that information with states and
16 providers. The background of the slide showing that we had
17 this in Ft. Lauderdale is actually the view out the window
18 of the room that we had the meeting in.

19 What we wanted to do is we wanted to provide a
20 forum really to discuss the experiences of the grantees,
21 both looking at the evidence that supports the ongoing
22 development and support of recovery support services, what
23 it is we mean about recovery support services, the
24 definitions, how they were implemented and some of the
25 procedural issues both from the community provider side as

1 well as from the state side, and then the experiences
2 really from the provider perspective with providing these
3 kinds of services as part of an existing continuum of care.

4 Again, we talked and brought in and utilized
5 the experiences from ATR, RCSP, some of the work that had
6 been done last year that George mentioned in the
7 recovery-oriented systems of care, the recovery summit, and
8 then looked at some of the research and some of the
9 outcomes that had been looked at and developed around the
10 evidence base for the services.

11 So I'm going to tease you a little bit about
12 some of the things that came out of the meeting just to
13 kind of foreshadow what you will be seeing in a couple of
14 months, we hope. One is we wanted to talk about what the
15 role of recovery support services is and continues to be.
16 Overwhelmingly, what the group was saying and reasserting
17 is that recovery support services really function as a way
18 to expand the continuum of care, that they allow the system
19 and the field to focus on strength-based services, and the
20 relationship between recovery support services and
21 treatment services is very much complementary and
22 compatible, and they in fact enhance the outcomes of each
23 other.

24 The other thing that was talked about was how
25 recovery support services really provide the ability to

1 respond to very specific clinical issues, whether it's
2 related to culture, experience, gender, age, any particular
3 specific issue that the treatment programs, because of the
4 limited funding and limited number, simply can't always
5 respond to, again looking at how we can expand this
6 continuum of care using very limited resources to provide
7 ongoing, sustained support for recovery.

8 We looked at the evidence base. We looked at
9 some of the information coming out of the research around
10 treatment completion. We looked at the importance and the
11 significance of ongoing connection with recovery support
12 services, mentoring connection with other kinds of
13 supports, and the impact that has on long-term recovery and
14 continuing sobriety.

15 The other thing that came out through the
16 discussions from a number of different venues was the
17 importance that the addiction field has developed in
18 relation to the ongoing treatment of chronic illness,
19 simply that provision of wraparound services, of treating
20 an individual and family holistically and providing the
21 kinds of things that people need in their ongoing
22 development and life.

23 Some of the challenges and the barriers we
24 discussed had to do with really how some of the recovery
25 support service providers that were new to the system

1 lacked the necessary business infrastructure. Clearly,
2 many of the states were finding this issue and many of the
3 providers were finding the issue around financing, around
4 clinical documentation, around the ability simply to fill
5 out all of the paperwork that we have found is necessary in
6 the field.

7 Another issue had to do with a lack of
8 consistent ability and direction and agreement on how to
9 establish rates for recovery support services. Some of the
10 discussion from the states really talked about how they
11 would go into the phone book and find out what the going
12 rate was for transportation. That's how they set their
13 rates. There was no other information to use. There was
14 no historical base of information.

15 Then we talked about really the sustainability
16 of the recovery support service providers and the networks
17 as the specific grant funds go away.

18 From the state perspective, I mentioned the fee
19 structure, how they're reimbursing these programs, looking
20 at issues of workforce quality and credentialing, and some
21 interesting things came out of the discussion. Some of the
22 states were looking at credentialing or acknowledging
23 individual providers. Others were looking at credentialing
24 a program, which is kind of an interesting change for our
25 field. We typically talk about credentialed individuals,

1 not credentialed programs for a service. So that was
2 interesting.

3 Some of the other issues around state activity
4 had to do with how they conducted their outreach and how
5 they brought new providers into the system, and then the
6 kinds of training that they developed and are continuing to
7 provide around business practices, and that, by the way,
8 was not only for the recovery support service providers but
9 for treatment providers as well. Good business practice is
10 really something that we need to pay attention to.

11 From the provider perspective, the difficulty
12 of continuing and sustaining their marketing of the
13 strength-based approach, that there really was kind of a
14 tension about focusing on not talking about the deficits of
15 individuals but talking about their strengths, and again
16 just trying to support a paradigm shift within the
17 continuum. Instead of talking about treatment planning,
18 and this goes to the strength-based approach as well,
19 talking about recovery planning and really developing
20 formal relationships and partnerships between the treatment
21 programs and the recovery support service programs; and
22 then again expanding the continuum of care.

23 The next steps, and this is what we hope you
24 will see soon. We are working on the development of a
25 draft white paper which will go through all of these issues

1 and really provide a guidance document for providers and
2 for states for those who are interested in implementing
3 recovery support services. These are the issues. These
4 are things you need to think about, and here are some
5 strategies that worked for some states and providers. Then
6 because of the individuals who were at the meeting, the
7 NASADAD regional representatives, membership from the
8 faith-based expert panel, and our providers, talking about
9 different ways in dissemination strategies for getting this
10 information out.

11 So that was the day and a half meeting in Ft.
12 Lauderdale, and hopefully you'll be able to see some of the
13 products and the benefits.

14 Frank?

15 DR. McCORRY: Just quickly, the National
16 Quality Forum is coming out with a consensus. They're
17 going to be voting on these evidence-based practices, 10 or
18 11 of them. One of the four domains that they have as an
19 evidence-based practice -- they don't list a practice
20 underneath it, but it's a domain -- is continuing care
21 management, because they discussed addiction within a
22 chronic care model. So it will be interesting if this gets
23 passed by NQF's policy group in terms of a vote because
24 it's really a domain. We didn't put a practice underneath
25 it. But this ties very nicely into it because continuing

1 care is seen both within but really after the completion of
2 treatment, the extension of the treatment model into a
3 continuing care/recovery management kind of domain. So it
4 will be interesting -- this is well timed -- if that report
5 actually gets endorsed by NQF. NQF's endorsement is what's
6 used by CMS in the development of Medicaid funding and
7 Medicaid performance measures. So there is some
8 possibility of some movement down the road on this.

9 MS. HERRON: Great. Thank you.

10 MR. KOPANDA: Any further questions for Anne?

11 (No response.)

12 MS. HERRON: Thank you very much.

13 MR. KOPANDA: Jack?

14 DR. STEIN: Thank you, Anne, and good
15 afternoon, everybody. It's nice to be here and nice to see
16 the council again. Last I actually spoke before you, I
17 think I was literally several weeks old at CSAT. I've hit
18 my six-month mark, and I have survived, and it's been quite
19 a wild ride and an exciting one, actually. I've really
20 learned an amazing amount these last six months in terms of
21 the operations of SAMHSA and CSAT and how we work and the
22 whole budget process. I really appreciate your comment
23 earlier around understanding this process. It really is a
24 very, very challenging one, and the more we're all aware of
25 it and how it works, the better it is for us.

1 Let me follow up with really what I wanted to
2 provide, which is an update on where we are with the Access
3 to Recovery program. I'm sure most people here on council
4 are familiar with Access to Recovery, and so I'm just going
5 to really kind of give you a very quick overview of that,
6 but I think it builds nicely on the comments that Anne has
7 just mentioned.

8 I think we're really on to something very
9 exciting, and Access to Recovery has really been one
10 vehicle to assist in that process, and that is how we
11 really shift the paradigm from an acute model of care to a
12 recovery-oriented system of care. I think Access to
13 Recovery is really one of the grandest experiments in how
14 to do so.

15 A quick historical perspective. I'm sure most
16 people are well aware of many of these bullets, and I'll
17 just highlight them very quickly. Access to Recovery
18 really was established in 2004. It was a presidential
19 initiative, so it takes very high priority here, with the
20 goal really being to provide clinical treatment and
21 recovery support services to those people who have been
22 identified as having an alcohol or other drug misuse or
23 dependence problem. The goal that was set forth, our
24 target, was to serve 125,000 clients over a three-year
25 period with approximately \$3 million funding. So that

1 really is the target goal of individuals, as well as the
2 cost.

3 It was implemented officially in August 2004.
4 Grants were awarded of approximately \$100 million to 14
5 states and one tribal organization. Overall, these 15
6 awards started up in August and were slated to end on
7 August 2, 2007. More than half of the grantees will ask
8 for a no-cost extension until August 2008. So we really
9 will be seeing in our first cohort that many of them
10 actually are continuing through '08 with a no-cost
11 extension.

12 The goals, as I mentioned, and just so you can
13 see very specifically how it was based, is a discretionary
14 voucher-based grant program designed to expand capacity,
15 support client choice, and to require the grantees to
16 manage performance based on outcomes that demonstrate
17 patient successes. The voucher-based component of ATR is
18 really one of the most unique aspects of what ATR is all
19 about. The idea is that we're really looking at, in
20 essence, an alternative approach to how treatment and
21 recovery support services can be both administered, managed
22 and delivered, a very unique experiment in how best to
23 improve and expand treatment services.

24 Our objectives we actually teased out into five
25 major objectives: to expand treatment capacity; facilitate

1 the pursuit of recovery through many different personal
2 pathways; increase the number and types of providers,
3 including faith-based providers who deliver clinical
4 treatment and/or recovery support services; as I mentioned,
5 the utilization of vouchers as a means to obtain services;
6 and manage performance based on outcomes that demonstrate
7 patient success. So it really tries to incorporate many of
8 those issues that Dr. Clark raised this morning.

9 Just as a quick snapshot of our grantees, what
10 I just posted here on the left are what we call state-based
11 grantees. We gave each of the states, the governors'
12 offices that were the recipients of these dollars, an
13 opportunity to determine, based on need, how they'd like to
14 spend the dollars. Many of them actually chose to
15 implement ATR on a statewide basis. You can see them
16 listed here. The rest of them actually decided to do it on
17 a more focused regionalized type of basis, again very
18 interesting to take a look, and we will do so this upcoming
19 year, as to where some of the successes lie.

20 I'll jump right to the bottom line here.
21 Already ATR, in terms of reaching its goals, has been a
22 resounding success. As you see on the bottom bar there,
23 the three-year target was 125,000 clients to be reached.
24 Already we've reached that number. We've served to date
25 over 137,000 clients through this system. So already we've

1 been very, very excited that, in fact, our grantees have
2 been coming through and reaching their target goals.

3 Quickly, some of the highlights that we've
4 seen. As just mentioned, over 137,000 people have actually
5 been served, exceeding the target, and just some breakdown.

6 I don't want to overwhelm you with a lot of different
7 statistics here, but recovery support services have truly
8 played a large role in the program. About 64 percent of
9 the clients for whom status and discharge data are
10 available have received recovery support services. Nearly
11 50 percent of the dollars redeemed were redeemed for
12 recovery support services, and over 50 percent were for
13 clinical treatment services. So it really was very, very
14 balanced. About 30 percent of the dollars redeemed for
15 clinical and recovery support services have been redeemed
16 directly by faith-based organizations, again one of the
17 objectives of this initiative.

18 Very quickly, you can see the breakdown of the
19 clients served, at least in terms of data that we have to
20 date. Over half were males, about 32 percent females. A
21 breakdown of race and ethnicity; again, I think it's pretty
22 self-explanatory. Again, some of these numbers will
23 probably be shifting as we collect the remainder of data
24 over the next couple of months.

25 I think this is actually pretty interesting as

1 well in terms of the service distribution of the type of
2 services that are being delivered by ATR. You can see that
3 clinical treatment services accounted for about 35 percent
4 of the services delivered, but case management and all
5 these other services that really fall under the recovery
6 support services really complete the complement of services
7 that are provided through ATR. This is kind of a nice
8 breakdown. We're really beginning to get a better sense
9 that when we talk about recovery support services, what
10 exactly does that mean and how are they actually being
11 delivered.

12 The services and voucher data, again, I think
13 are interesting. About 64 percent of the clients received
14 recovery support services. Almost \$150 million worth of
15 services have been redeemed to date. Forty-nine percent of
16 the dollars paid were for recovery support services, and 34
17 percent of the dollars paid were to faith-based
18 organizations. Lastly, faith-based organizations accounted
19 for 22 percent of recovery support services and 34 percent
20 of clinical treatment providers. So again, we've been
21 really tracking the data on a number of different levels to
22 really get a much better grasp of how are these different
23 states cumulatively identifying where the need and the
24 dollars should be allocated.

25 I think one of the most exciting things, when

1 we take a look at our GPRA data to determine is this making
2 a difference, is that we're seeing some really significant
3 changes, and it really is remarkable. From intake to
4 discharge, and this is what we're looking at here, we're
5 seeing nearly 70 percent of individuals who came in with a
6 problem with substance use report abstinence at discharge.
7 That's pretty remarkable. About 22 percent increased in
8 stabilized housing. Nearly 30 percent increased in
9 employment. Over 50 percent increased in social
10 connectedness. Again, these are some of the NOMs measures
11 that we've been talking about this morning. A very large
12 percentage of individuals reported a reduction in criminal
13 justice system involvement.

14 It's important, of course, to tease out a lot
15 of this data. This last one, for example, the majority of
16 people coming into the system actually did not have a
17 criminal justice background. So it's actually a very small
18 N that we're dealing with here, but again, we're seeing
19 some remarkable changes, and I think it really speaks to
20 the fact that we're talking about a continuum of care.

21 Just to wrap up, technical assistance has been
22 a critical component of the Access to Recovery. Many of
23 the organizations that are part of Access to Recovery are
24 very small grassroots organizations and need a lot of
25 assistance. This past January right after the meeting that

1 Anne had talked about, we held a technical assistance
2 conference for our grantees. It was called "Optimizing
3 Outcomes Through Sharing Knowledge." We focused on a
4 couple of major issues. We're in the last phase for this
5 cohort of grantees, and so we were talking a lot about
6 grant closeout issues, how to keep on collecting follow-up
7 data, and sustainability of course is one of the really key
8 components.

9 Lessons learned I think is really one of the
10 biggest areas of interest for us at CSAT, and so I'd like
11 to just wrap up with two things. One is that, in fact, we
12 do have plans for an evaluation to really take a very close
13 look at the impact, both the process and the outcome, of
14 ATR, and we also recognize that at their own discretion
15 many of the ATR grantees have been conducting their own
16 evaluations, which is actually quite exciting to take a
17 closer look at what have they been coming up with.

18 But let me wrap up with a couple of the
19 successes that have been reported over the last couple of
20 years. I think one of the most interesting ones has to do
21 with the voucher management systems that all of these
22 grantees basically were required to set up in order to
23 establish a system to track and monitor the clients served.

24 These voucher management systems look very different
25 depending on the state. Some of the states have actually

1 contracted out to similar companies. Others have taken it
2 upon themselves to do so. But we're seeing some very
3 unique, different approaches to how these vouchers can be
4 managed. These are all electronic systems.

5 They all seem to have streamlined the
6 processing of information, of offering services, increasing
7 the capacity to monitor fraud, waste and abuse. This to me
8 is an area definitely worth investigating for future
9 funding of ATR grantees as well as other types of systems
10 of care.

11 The implementation of evidence-based practices
12 I think is also another really important lesson that we've
13 seen learned. Many of the grantees are reporting how they
14 have been implementing a number of the NIDA, NIAAA
15 evidence-based practices that, of course, CSAT and SAMHSA
16 have been advocating over these last number of years.
17 Tracking this even more closely I think would be useful.

18 Sustainability strategies. For example, some
19 states have implemented what they call transition
20 coordinators over this last year and a half, how to really
21 ensure that the legacy of ATR continues. Some states have
22 literally transformed their treatment systems so that ATR
23 has actually become more of a model for them, which is my
24 next point here, the restructuring of actual state
25 treatment systems to include recovery support services and

1 faith-based organizations. If you look at states like
2 Connecticut, for example, many of you know Tom Kirk. He
3 actually speaks very highly about how, in fact, ATR dollars
4 really helped to transform his state system, and as Anne
5 had mentioned, the credentialing of recovery support
6 service providers. What does that mean? The providers as
7 well as the programs.

8 We have much work to be done in this area. I
9 think ATR has really given us much to build on. Many of
10 them have actually also reported linkages with other health
11 care systems and other types of systems, such as the
12 criminal justice system.

13 So let me end and I'll field some questions,
14 but I just wanted to recognize the amazing work that the
15 staff and the contractor agency, AIR, have done for our
16 work on ATR. I walked into ATR literally in its very last
17 year of operation, so I literally cannot take any credit
18 for the success of ATR, as opposed to having the luxury of
19 being able to report many of the successes. It was clear
20 that ATR has been managed incredibly well by the CSAT
21 staff. Andrea Kopstein is the branch chief; Natalie Lu is
22 the team leader; Linda Fulton; Dawn Levinson; Carol
23 Abernathy, whose name is not here. She had left CSAT a
24 couple of months ago, but she also contributed; and our
25 staff at AIR, particularly Roula Sweis, whose name is here,

1 who was onsite with us and just an amazing contributor to
2 the process.

3 So with that I'll stop and field any comments
4 or questions on the ATR update.

5 MR. KOPANDA: I want to first thank both Anne
6 and Jack for their presentation on an excellent program.
7 Also, I'll just mention that, of course, we are right now
8 working on the new ATR announcement. We're going to be
9 able to announce approximately another \$100 million worth
10 of grants this year. In fact, George was just on the phone
11 I think with OMB discussing some technical aspects of the
12 RFA.

13 DR. McCORRY: Jack, could you tell me the
14 treatment outcome data, intake to discharge? A couple of
15 questions. One is what's the kind of average length of
16 stay in an ATR service? This would be like at report, the
17 intake into ATR to the discharge. There's a report by the
18 individual, and there was like 68 percent more reports of
19 abstinence? That's what that means?

20 DR. STEIN: Yes. What you're looking at is
21 anyone who came in at intake, for this data that you're
22 looking at, we're only going to be looking at an individual
23 who reports within the last 30 days that they were involved
24 with the criminal justice system, for example, or that they
25 did not have stable housing. So we're just looking at that

1 past 30-day period of time.

2 DR. McCORRY: The past 30 days in terms of
3 their use, their housing status?

4 DR. STEIN: Exactly, and this is being
5 collected via our traditional GPRA. It's not a unique one
6 to ATR. We will then be tracking people over the course of
7 a six-month period of time, as well as discharge.
8 Discharge could occur before or after that six-month period
9 of time as well.

10 DR. McCORRY: And what's the average length of
11 stay in an ATR program?

12 DR. STEIN: That's a good question. I don't
13 have that at my fingertips, but that's a good question. As
14 you can tell, the nature of recovery support service is so
15 ongoing that it really can vary.

16 DR. McCORRY: Yes, and that's what I was
17 wondering, because the end of that service is discharge.
18 So then I was interested in what would be the average
19 length of it.

20 DR. STEIN: We can easily find that because we
21 seem to have data on everything for ATR.

22 Other questions?

23 MR. DONALDSON: Well, just to congratulate you,
24 Anne, and your staff. I mentioned to Rich that CSAT has
25 been a vanguard in engaging the faith community, and this

1 is further examples of that mission and success. So thank
2 you and your team. Outstanding.

3 DR. STEIN: Well, thank you. You know, last
4 week I had the opportunity to attend a grantee meeting for
5 our HIV grants and was given the opportunity to spend a
6 good chunk of one morning being toured throughout Atlanta
7 by one of our grantees. It wasn't an ATR grantee, but it
8 was one of our RCSP, which is the recovery support program,
9 and I got to visit three small African American churches,
10 all of whom had been willing to open up their doors to be
11 sites for rapid HIV testing and counseling. These churches
12 were getting nothing from this experience. When I talked
13 to all of the pastors there, what I heard from them is this
14 is what we do; we serve. It really was both obvious and
15 not so obvious from those of us who are on the side where
16 funding is everything. They were willing to basically
17 contribute to the type of work that we're doing so that, in
18 fact, we can do HIV testing and counseling in venues that
19 are hard to reach populations.

20 Following that, I went to a homeless shelter
21 for 700 men in Atlanta, and again there were just
22 individuals there who were clearly in need, and the person
23 who was taking me around literally was recruiting people
24 right then and there and bringing them into detox by
25 encouraging them to come on into the van that we were

1 driving in. It was recovery support services happening
2 right before my eyes. So it really was quite astounding to
3 see. It really plays a critical role.

4 If I could just end quickly with one more note.
5 Yesterday I was invited to speak to the National Institute
6 on Drug Abuse, NIDA's Clinical Trials Network Steering
7 Committee, particularly around the blending initiative that
8 we've engaged with them for the last number of years. But
9 I used that opportunity to actually talk about the whole
10 recovery oriented system of care, because when I was at
11 NIDA, which many of you know I was, the concept of recovery
12 is actually pretty narrowly viewed, more from the concept
13 of after-care, somebody immediately comes out of treatment
14 and goes into some type of work release program or some
15 type of immediate step-down type of care, versus this
16 ongoing concept of recovery support, and I really
17 challenged them.

18 I asked these researchers there please help us
19 with giving us the science base behind recovery support
20 services. It's what the field needs, it's what everyone is
21 asking for, it's the paradigm in which we're working. I
22 wasn't met with blank stares at all. I think people are
23 beginning to get it, but I think it's part of our
24 responsibility to keep on asking those types of questions,
25 because the evidence base is there. I think it needs to

1 grow so that we can really identify what do we mean by
2 recovery support services and how do we start quantifying
3 them and figuring out costs for them, et cetera.

4 I know you're tight on time, so I'm going to
5 take my seat.

6 MR. KOPANDA: Well, thank you, Jack.

7 I just want to reiterate the thanks to the
8 staff, and the grantees as well. I think when we started
9 this program we had no idea that this would be one of our
10 most, if not the most, intensely managed programs that
11 we've ever had. We collect more data from these grantees
12 on more different subjects and do more frequent reports
13 than I've ever seen before. It was eye-opening to us, but
14 the staff have borne a lot of the pressure in terms of
15 being in contact with their grantees and delivering this,
16 and they've just done a fantastic job on that.

17 I'd like to next introduce Kevin Hennessey. He
18 works for our Office of Policy, Planning, and Budget in the
19 OA. He's going to present on the National Registry of
20 Effective Programs and Practices, or NREPP. Also with him
21 is Fran Cotter from CSAT, and she's going to provide some
22 background and be able to answer questions on CSAT's
23 contribution to NREPP.

24 Kevin?

25 DR. HENNESSEY: Unfortunately, I forgot to

1 check with my eight-year-old about the latest jokes so I
2 could keep you guys entertained while we're finding the
3 slides.

4 (Laughter.)

5 DR. HENNESSEY: Well, it's a real pleasure to
6 be here today. I checked my notes, and the last time I
7 addressed CSAT's council was September 14 of 2005. At that
8 point we were right in the middle of the Federal Register
9 notice where SAMHSA, the agency, had outlined what we
10 thought should be happening vis-a-vis the National Registry
11 of Evidence-Based Programs and Practices, and we were right
12 in the middle of that public comment period to hear what
13 the field thought we should be doing. Lo and behold, the
14 field really gave us some good thinking in that regard, and
15 as a result we ended up making some major modifications to
16 the National Registry. So I'm here and pleased to tell you
17 that I guess a year and a half later we actually have
18 launched the system, we're up and running, and I'm here to
19 tell you about it, as well as a few other things, trying to
20 give some plugs to a few other science-to-service
21 activities that we have going on. Then you'll hear a
22 little bit from Fran Cotter about a few specific CSAT
23 science-to-service activities as well.

24 We all know that there's a substantial research
25 to practice gap. It's a well-defined problem. We know

1 that few research innovations are successfully implemented
2 in typical settings, that most in treatment don't receive
3 some sort of evidence-based intervention. There's been a
4 lot of study about that in the last, say, decade or so, as
5 well as many fairly formal reports that have documented
6 this problem and recommended various courses of action,
7 including all the way back in 1998, the last millennium
8 even documented this, an IOM report about bridging the gap
9 between research and practice, as well as several other
10 seminal reports, the Surgeon General's report on mental
11 health in 2000, another recent IOM report, "Crossing the
12 Quality Chasm," the President's New Freedom Commission.

13 We have documented this problem, so now we need
14 to move to solutions. The knowledge to practice gap still
15 stands at 15 to 20 years, meaning the time it takes from an
16 intervention being developed, in usually some sort of more
17 tightly controlled setting, to the time when it's diffused
18 or disseminated and adopted more broadly in clinical and
19 community-based settings. So we need to do a better job of
20 closing that gap because if we don't, we're always playing
21 catch-up. The vast majority of people would never be
22 getting the best that we have to offer, and that's simply
23 not acceptable. So we need to do better in that regard.

24 What are we doing to try to improve that, try
25 to reduce that research to practice gap? We are providing

1 decision support information on evidence-based services,
2 and that really is our reformulation of the National
3 Registry of Evidence-Based Programs and Practices. I'm
4 going to spend most of my time talking about that.
5 However, I do want to give you kind of coming attractions a
6 la the movie, and one is developing clinically relevant
7 effectiveness summaries. Our working title is SAMHSA's
8 Library of Systematic Reviews. It's really about taking
9 the aggregate research and trying to present it in very
10 accessible ways so that people can use it to make some
11 decisions. Then finally, recognizing successful
12 implementation of evidence-based programs. Many of our
13 activities and our systems are around identifying and
14 making appropriate selections of those programs, but the
15 rubber meets the road where you try to implement these
16 interventions. So we really need to try to provide some
17 greater visibility and some greater attention and
18 recognition to the hard work that's being done by
19 community-based agencies to try to implement these programs
20 in typical practice settings. So you'll hear a minute or
21 two about that as well.

22 There you have our new website. We were going
23 to try to have a live Internet connection, but I really
24 have some screenshots that will give you the flavor of the
25 Internet, plus it will hopefully encourage you to log on to

1 the new system yourself. You can get there very easily
2 through SAMHSA's homepage. There's an NREPP icon if you
3 just scroll down a little bit, right in the middle of the
4 page. It's also listed under the Browse By Topics in that
5 alphabetical listing along the left-hand side of SAMHSA's
6 homepage. So lots of roads lead to NREPP.

7 This is the homepage, and again it's a
8 searchable database for interventions for the prevention
9 and treatment of mental and substance use disorders, and
10 we've tried to really redevelop this resource to help
11 people, agencies and organizations implement programs and
12 practices in their communities.

13 A few contextual words. How do we put NREPP in
14 context for people out in the field who really might want
15 to use this system? What is NREPP? Again, this is the
16 second paragraph, and I apologize if it's a little hard to
17 read. You do have slides of these screenshots as well.
18 The purpose, though, is to assist the public in identifying
19 approaches to preventing and treating mental or substance
20 use disorders that have been scientifically tested and that
21 can be readily disseminated to the field. So again, it's
22 that balance of they have a pretty good scientific base,
23 but equally important, perhaps more importantly, they're
24 ready for broader dissemination to the field. Many things
25 that have a scientific basis aren't necessarily ready for

1 that broader implementation. We're trying to zero in in
2 NREPP on interventions that do have that broader base.
3 It's one way that we're trying to improve the access to
4 this information and tested interventions and thereby
5 reduce that research to practice gap.

6 The third paragraph there talks about NREPP
7 being a new registry and that it's going to have continual
8 updates. At this point we have launched the system. We
9 launched on March 1 with about 25 interventions
10 representing the full array of SAMHSA domains. We had some
11 mental health treatment and some mental health promotion
12 interventions. We also had a few substance abuse treatment
13 and some substance abuse prevention interventions, as well
14 as a few co-occurring disorder interventions.

15 We have over 200 interventions in the review
16 queue at this point, and every year we will be adding to
17 that queue. So we're going to be playing catch-up for a
18 little while, but what that translates into is that we
19 anticipate adding about five to ten interventions per month
20 for the foreseeable future. So you will want to revisit
21 and come back to NREPP on a fairly frequent basis.

22 We're in the process and should within the next
23 week or so have an opportunity where people can log on to
24 the system, provide their email address, and then get the
25 monthly updates. It will say "this month 10 interventions

1 were added to NREPP, totaling 35 interventions," or
2 something like that, and it will have hyperlinks in the
3 email directly to the new interventions that were added.
4 So we're trying to make it fairly user-friendly.

5 Contextually it's important what do we mean by
6 evidence-based practices in the context of NREPP, and
7 that's really the last paragraph here. NREPP does not
8 attempt to offer a single authoritative definition of
9 evidence-based practices. SAMHSA expects that people who
10 use this system will come with their own perspectives and
11 contexts for understanding the information that NREPP has
12 to offer. By providing a range of objective information
13 about the research that has been conducted on each
14 particular intervention, SAMHSA hopes that users will make
15 their own judgments about which interventions are best
16 suited to particular needs.

17 This language is up here, and the language I'm
18 about to show you on the next slide is up here very
19 deliberately, and that's because we had a lot of the public
20 comments that weighed in on various issues, but one of the
21 consensus comments was that NREPP very much needs to
22 provide better guidance about how to use the system, and
23 some cautions about how not to use the system. One of the
24 legacies of the previous NREPP was that there were some
25 unintended consequences where particular some purchasing

1 agents, states in some cases, and others, developed
2 policies that said you really only should select an
3 intervention, we will only reimburse for interventions that
4 are on the NREPP system, or even more narrowly defined that
5 were model programs on the NREPP system. That's not
6 guidance that we would suggest purchasers follow, because
7 clearly NREPP is a limited registry. No matter how many
8 interventions we add to this registry, it will always have
9 gaps. There's just no way that any single entity could
10 provide an exhaustive list of evidence-based practices or
11 cover all of the population needs and service setting needs
12 that would be out there. So we're trying to be very, very
13 proactive about the guidance that we provide, which is
14 directly tied to the public comments that we perceived in
15 response to how to redesign this registry.

16 With that in mind, we provide here an important
17 note for NREPP users, and I just want to jump back to show
18 you that on the homepage you can see it's the first thing
19 we put on the left-hand side because we really do want to
20 encourage people to go there. If you click on that box
21 that says "Important Note," it will take you right to this
22 page. Again, at the risk of sounding like a broken record,
23 we do provide this guidance.

24 The first paragraph there is "NREPP users are
25 encouraged to carefully weigh all information provided."

1 Just let me read you the first paragraph, because I think
2 that's important. "It's intended as a decision support
3 tool, not as an authoritative list of effective
4 interventions. SAMHSA does not 'approve, recommend or
5 endorse' specific interventions." Again, this is there for
6 users to figure out if this meets their needs. "Being
7 included in the registry, therefore, does not mean an
8 intervention is recommended or has been demonstrated to
9 achieve good outcomes in all circumstances." You clearly
10 will find interventions on the registry that have positive
11 outcomes for particular populations or in particular
12 service settings. What you have to be careful about is
13 then extrapolating that information to say it would work in
14 all settings. That was, quite frankly, one of the problems
15 with the old NREPP, that the interventions would be posted
16 there and the data might have suggested that it reduced
17 binge drinking over a 30-day period, 30-day outcomes in
18 reduction of binge drinking for 10th graders, and suddenly
19 the intervention was being marketed, in many cases by the
20 program developers, as reducing alcohol use, marijuana use,
21 you name it, for all teenagers or for all high school and
22 middle school students. So there was this overmarketing,
23 really, of many of these interventions beyond the specific
24 data.

25 You won't find that happening, or at least it

1 will be much harder to do, with the new NREPP because the
2 interventions are listed specific for the outcomes that the
3 intervention achieves. So it will be much more difficult,
4 if not impossible, to overmarket the interventions because
5 the new system is very transparent in that regard.

6 The last sentence in that first paragraph is
7 also very important. "Policymakers in particular should
8 avoid relying solely on NREPP ratings as a basis for
9 funding or approving interventions." We need to be very
10 clear about that, and that's why it's language on the
11 website. We want to really protect and caution against
12 using this as an exclusive or exhaustive list. There
13 clearly are too many populations out there, too many
14 service gaps, to think that NREPP or any other single
15 entity could provide the exhaustive information.

16 Again, it's not a comprehensive list of
17 interventions, although we are adding to it each time, but
18 we do think it's a good place to start to begin researching
19 interventions that might work for you, and the emphasis is
20 on might.

21 Okay, enough of my disclaimers, if you will.
22 How do you go about finding an intervention? As you can
23 see, this is defined on the intervention page, and it
24 currently includes 25 interventions. You can search a
25 couple of different ways. If you know a program developers

1 name or if you know the intervention name, or any other
2 word if you just want to find interventions that have maybe
3 been targeted to Latino populations, you could use the free
4 text up at the top left there in terms of just putting that
5 word in and hitting search, and it will come out with the
6 interventions; or you could use some of our check boxes,
7 and you can check more than one box at a time. So you can
8 check the topics, substance abuse treatment, and you can
9 check the race/ethnicity, American Indians, you could check
10 age, you could check gender, setting. You can also check
11 the bottom right, proprietary or public. Many of the
12 interventions are a mix of both. There's some proprietary
13 information that you have to purchase, and some public
14 information maybe through their own website or whatever.
15 But again, very important information if you're on a
16 limited budget and trying to decide what interventions are
17 going to work in my particular setting.

18 So if you do that search -- because I don't
19 have a live Internet connection I'm not going to do the
20 search for you, but it's very simple to do -- these are the
21 interventions that are posted currently on NREPP. Of those
22 25 that are listed on NREPP, these are the ones that have
23 to do with substance abuse treatment, either specifically
24 or through programs for co-occurring disorders. So
25 Behavioral Couples Therapy for Alcoholism and Drug Abuse,

1 Dialectic Behavior Therapy, the Matrix Model, Network
2 Therapy, Seeking Safety, and Trauma Recovery and
3 Empowerment models. So those six are up there already.

4 Currently under review, and I would anticipate
5 that they would work their way in in the next, say, one to
6 three months, that the intervention summaries would be
7 posted, are family behavior therapy, brief treatments for
8 cannabis dependence, Forever Free, multisystemic therapy,
9 and motivational interviewing. We have in the queue some
10 various stage of prereview but it's been identified for
11 review -- generally it's because the NREPP contractor has
12 to get additional materials from the program developer --
13 we have probably a dozen or more interventions. So we're
14 working to populate the registry with substance abuse
15 treatment interventions.

16 I'm going to quickly take you through what an
17 actual intervention summary looks like. When you print it
18 out, and they are easily printable from the website, it's
19 anywhere from 10 to 12 pages. This one is on TREM, the
20 Trauma Recovery and Empowerment Model. You can see that
21 you can use these boxes, the blue boxes. If you click on
22 that it will take you further down the summary to that
23 particular information. So you can go to the descriptive
24 information, outcomes ratings, demographics, replications,
25 contact information. You can see along the side that it

1 starts with topics, populations, then it tells you the
2 outcome, it gives you an abstract, tells you what settings
3 the intervention has been tested in, some areas of interest
4 which kind of track to our "Find An Intervention" page,
5 whether or not it's been replicated, and that's in many
6 cases a formal replication, a study which is then listed
7 below on the website, whether it's proprietary or public
8 domain, and in general the costs of the program. We're
9 trying to provide as detailed information as possible. In
10 some cases we're limited by what the program developer can
11 tell us, but we again try to provide you with some general
12 information about costs.

13 As is the case with much of this information,
14 if you want more detail, we encourage you to contact the
15 program developer directly and/or their agents. Sometimes
16 they have a marketing arm of their intervention. So that
17 information is provided incomplete at the bottom of this
18 summary.

19 Whether or not there are any adaptations, again
20 that can be important if you're thinking about a program
21 that's only been adapted once versus one that has over
22 1,000 adaptations or implementations. Then you get a
23 little bit of the implementation history, also adverse
24 effects, which can be very important as well to know when
25 you're making these decisions.

1 Each outcome has its own separate box which is
2 a description of what the outcome is and how they measured
3 it, and some of the key findings, and this is where we
4 really are encouraging end users of the system to zero in
5 on, because you could have interventions that achieve
6 certain outcomes, but you really need to go into the
7 details to see if it's an outcome that fits for you in
8 terms of how they began to assess it.

9 The research designs are there in case people
10 want to make judgments based on how rigorous was the
11 design, was it a randomized control trial or was it
12 something that was less rigorous, and then down at the
13 bottom you can see quality of research rating, 2.7 on a 0
14 to 4.0 scale. What I've done, and this is a separate page
15 on the website, is tell you a little bit about what these
16 two ratings that the NREPP system produces, the reviewers
17 under the NREPP system produced. The first is the quality
18 of research rating. Essentially, that summarizes the
19 amount and general quality of the evidence supporting the
20 conclusion that the intervention rather than another factor
21 or other factors produced the reported results or outcomes.

22 So with this measure, higher scores indicate stronger,
23 more compelling evidence, and each outcome is rated
24 separately. Essentially, what you're getting is the
25 quality of the research, how confident are the scientists

1 that are reviewing this program, how confident are they
2 that the intervention was produced specifically by the
3 outcome as opposed to some other factors, the difference
4 between the experimental group, the one that received the
5 intervention, and the control group that got treatment as
6 usual, that that difference is attributable to the
7 intervention and not to some other factors like passage of
8 time or a lot of other factors that scientifically can
9 affect outcomes. That's one rating.

10 The second rating, and this is new to the
11 system, is a readiness for dissemination rating, and that's
12 largely because, again, it's important to have a strong
13 scientific base, but you really need to know how ready is
14 this intervention for broader dissemination. So this score
15 summarizes the amount and general quality of the resources
16 available to support the use of the intervention, and again
17 higher scores indicate more and higher quality resources
18 that are available.

19 Again, back to the TREM intervention, Trauma
20 Recovery and Empowerment model, it shows you what a typical
21 summary looks like in terms of the outcomes and the six
22 factors or the six criteria that are used to assess that
23 outcome, as well as in the yellow box on the far right the
24 overall rating for each outcome on a 0 to 4 scale.

25 We provide a little bit of the strengths and

1 weaknesses because while the scores are important, and I
2 know a lot of people are going to zoom right to the scores,
3 you want to know about the strengths and weaknesses because
4 that actually may be the most helpful thing, even more
5 helpful than the numeric ratings, in determining whether or
6 not this intervention is for your particular setting or
7 your particular situation. So you want to read the
8 strengths and the weaknesses.

9 The same thing with readiness for
10 dissemination, the single overall score based on three
11 criteria, and then the strengths and weaknesses.

12 The next section down in the review summary as
13 you scroll down is study demographics. This may be very
14 helpful to determine if you want to look for interventions
15 in your particular setting to address Native American
16 populations, you might want to see whether or not the
17 intervention has ever included any subpopulations of Native
18 Americans when they actually tested the intervention. So
19 this gives you kind of a quick box score of whether or not
20 age, gender and race/ethnicity factors. For some
21 interventions they may not have been tested in the
22 population that you're interested in implementing the
23 program with, but maybe there's enough data to suggest that
24 it's something that is replicable with that population. So
25 that will give you some information.

1 This jumps to a little bit about the minimum
2 requirements for interventions that are considered for
3 NREPP review, and again we want to be very transparent with
4 this whole system, so all of this information is on the
5 website. There are three basic requirements to be
6 considered for interventions to meet for consideration for
7 NREPP review. The first is that the intervention
8 demonstrates one or more positive outcomes at the
9 conventional statistically significant level of P less than
10 0.05, and those outcomes have to either be in mental health
11 and/or substance use behavior among individuals,
12 communities or populations.

13 The emphasis is on actual behavior change in
14 those individuals, communities or populations. In some
15 cases we will consider programs that change knowledge or
16 change attitudes, particularly if that was the overall goal
17 of the program. But in general, what most of the public
18 are interested in, and therefore we're interested in, is
19 programs that actually change behavior.

20 The second requirement is that the intervention
21 has been published in a peer-reviewed publication or is
22 documented in a comprehensive evaluation report. Then the
23 third requirement -- and this really is getting to that
24 broader dissemination issue -- is that there is
25 documentation of the intervention and its proper

1 implementation which is available to the public so that it
2 can facilitate dissemination. If I'm sitting in Cedar
3 Rapids and I'm interested in putting an intervention in
4 place to deal with substance use and I see one that exists
5 in Florida, if I call that person up in Florida, I need to
6 be able to get some materials to help me implement that
7 intervention and/or to get some training. If that training
8 or those materials aren't available, it's really not going
9 to help me all that much. So, therefore, this third
10 requirement that you have materials and you have the
11 ability to train is pretty critical if you're going to take
12 that intervention to scale or implement it more broadly.

13 In addition, because we anticipate over time as
14 NREPP expands that the demand for inclusion in NREPP may
15 greatly exceed the resources available that SAMHSA has to
16 review these interventions, in addition to the minimum
17 requirements, we've established a couple of priority points
18 so that all else being equal, we'll probably end up
19 accepting for review the interventions that meet these
20 priority points before the ones that meet just the minimum
21 requirements. Everybody has to meet the minimum
22 requirements, but then you get a couple of extra priority
23 points depending on, again, if the primary targeted outcome
24 is in one or more of the priority areas established by
25 SAMHSA's three centers.

1 I think we've established a fairly interesting
2 approach to this, interesting in a positive way, that every
3 year SAMHSA's three centers will each decide what the
4 priority areas are from a content standpoint, the types of
5 programs that they would like to see come in for NREPP
6 review. So if you submit during the open submission period
7 and you're in that content area, you'll get a priority
8 point.

9 The second priority point is the type of study
10 design. We're again looking for more rigorous designs.
11 They tend to be more replicable, more generalizable. So
12 you get a priority point for that.

13 Let me check on my time. Just let me do a
14 minute or so on this. That was NREPP in a nutshell, and
15 I'm happy to answer more questions about it. Many of the
16 questions probably can be answered by accessing the website
17 as well.

18 SAMHSA's Library of Systematic Reviews. There
19 are some very simple goals here, and this is something
20 that's in development currently, and Jack is part of the
21 technical advisory group that's assisting us in helping to
22 develop this. It's to identify the best evidence from
23 systematic reviews. People who are familiar with the
24 Cochrane Collaborative and some of the other efforts that
25 really look at systematic reviews, meta-analyses or other

1 more rigorous reviews of randomized controlled trials, step
2 2 is to present this evidence in plain language synopses or
3 journalistic style synopses. Sometimes those reviews
4 aren't particularly accessible. We're trying to make them
5 much more accessible by the way we describe them.
6 Basically, the journalistic style is to report the author's
7 conclusions, that it's not a critique of the science, it's
8 basically just trying to present the science in a very
9 accessible way, and then to categorize based upon what the
10 review says. Is this an effective intervention? Is it an
11 intervention where the results are mixed and there are some
12 tradeoffs? Is there not enough research to really make any
13 sort of definitive conclusions, or equally important maybe,
14 is it an intervention where the research has shown it to be
15 harmful?

16 So we'll try to provide some quick access on
17 that, and then to provide pathways or links to additional
18 information. So if you want to dig deeper, if you want to
19 look at the abstract for that systematic review, or the
20 actual study for that systematic review, or additional
21 resources through SAMHSA's website or through other
22 Internet websites, or PubMed or other places where you can
23 get even more information if you're interested in that
24 particular are.

25 These are the effectiveness classifications

1 that we're talking about. Two check marks is a beneficial
2 form of care that the systematic review said this is a
3 beneficial intervention, all the way through forms of care
4 with a tradeoff, the check and the X, forms of care likely
5 to be ineffective, a question mark and an X, or harmful, a
6 double X.

7 This is our working model. This is up on a
8 beta test site at this point. This is what one of these
9 summaries would look like. So in this case skill-based
10 programs in schools deter early stage drug use,
11 particularly hard drugs. It gives the two paragraphs. It
12 tells you whether or not there are any adverse effects, the
13 original article. Along the right-hand side you'll see
14 this is going to be hyperlinks. You can click on the
15 abstract. You can click on the original article. You can
16 click on SAMHSA-related articles. You can click on other
17 articles by the author.

18 These next slides give you a look at what it
19 would be like if you actually clicked on that. So this is
20 a case where you clicked on the actual article, and it
21 pulls it right up out of PubMed. Then this is a case where
22 you click on SAMHSA's related sites, and it does a quick
23 search of SAMHSA's website to pull out anything that's
24 related.

25 I'm pretty excited about this tool. I think it

1 has a lot of potential. It's still in the development
2 stages, so hopefully, maybe in another year and a half I'll
3 be back to talk about this with council.

4 Finally, SAMHSA's Science to Service Awards.
5 I'm very pleased about them. You can tell I'm very pleased
6 about a lot of things, but I'm pleased about this one as
7 well. This is to recognize community-based organizations
8 that are doing the hard work of implementing these
9 evidence-based programs. The purpose is to publicly
10 recognize them in their work, and we've done up to three
11 awards each year in each of four areas: substance abuse
12 prevention; substance abuse treatment and recovery; the
13 third area is mental health promotion; and the fourth is
14 mental health treatment and recovery. The nominees were
15 assessed according to established criteria for successful
16 implementation, and the goal again is that these very
17 visible awards will enhance awareness of the role of
18 implementation in promoting broader consideration and
19 uptake of evidence-based services.

20 I'm really pleased to say that we did the
21 applications for this award, the first ones being issued in
22 2007. No money is associated with these awards. It's just
23 the recognition, and if you're selected as a finalist and
24 get the award, the organization will get to send one or
25 maybe two people to an awards ceremony that will occur

1 probably through the National Press Club sometime later
2 this year. We're working with Mark Weber and the
3 communications folks to make this happen.

4 We had over 100 applicants to this, again
5 non-monetary awards. So it's putting effort into actually
6 applying for this award. You're getting the recognition.
7 But that to me just underscores that there are a lot of
8 people and a lot of organizations out there doing some very
9 significant work. So my hope is that we can recognize them
10 appropriately, and we'll hopefully have the awards ceremony
11 sometime this fall.

12 One of my favorite quotes about science to
13 service activities: "We've got a lot of this stuff, but
14 it's just not widely distributed, so we're working on
15 trying to distribute that." For those of you with a good
16 memory, I actually used this quote the last time I
17 presented to your council, but I liked it so much that I
18 thought it was worth a second go around.

19 Let me turn it over quickly, and I'm sorry I've
20 taken up some of Fran's time, but there are a couple of
21 things that she wants to go through that are specific to
22 CSAT science to services.

23 It's a delight. I just want to say how much I
24 enjoy working with Fran, too, on these efforts.

25 MS. COTTER: And then we definitely want to

1 have time for questions.

2 First of all, talking about being pleased, I
3 want to say that the science to service lead within CSAT,
4 working with Kevin Hennessey and his leadership on NREPP
5 has been just a delightful experience. We have a system.
6 It's managed, and each of the three centers provides funds
7 to the effort. It's about a half million dollars apiece.
8 Kevin immediately set up what he calls an investors group
9 so that we are part of the decisionmaking of each and every
10 piece of the rollout, and I think it is a wonderful model
11 for all of us when we look at some of the collaborative
12 activities such as NREPP.

13 It was a long birth. I look around and see in
14 the council I think, Frank, you were there at a meeting we
15 had almost four years ago as we began thinking about the
16 redesign of NREPP. What I would like to do is, based on
17 this and follow-up discussions, encourage council input.
18 We're just starting a rollout phase. Every year CSAT is
19 going to be looking for your input and advice. You are in
20 touch with elements of the field, and I just encourage you
21 to email me and/or others concerning your thoughts about
22 NREPP itself and the rollout of it.

23 I also want to acknowledge Linda Fulton, who is
24 working at CSAT as my collaborator on NREPP, and also will
25 be one who can answer questions.

1 When we talk about what we're doing on NREPP, I
2 wanted to reinforce Kevin's statement that although we have
3 a new system that's being rolled out and it sounds a lot
4 like the old NREPP, it is a very different tool than was
5 the old NREPP. Because of that, I think it's going to be
6 important for all of us to help educate the field around
7 the fact that this is a decision support system and tool
8 and not simply a comprehensive list of programs and
9 practices that people go to and pick and choose without
10 closely looking not only at the registry but at the other
11 resources that are out there. That's why I wanted to give
12 just two slides identifying what I think all of you are
13 aware of, of what the full pool of evidence-based practices
14 is currently within CSAT, and recognize that as people are
15 looking at what practices to implement, they should be
16 looking not only at NREPP but at our other resources.

17 Of course, first and foremost, there's been a
18 lot of discussion about the TIPS, but they are a
19 consensus-based rather than a peer-review-based set of
20 protocols that are really at the core of the treatment
21 field's evidence base and always referred to and should
22 continue to be used as source material.

23 In addition, as you know under our Knowledge
24 Application Program, we have elected to put into training
25 manuals and materials a number of evidence-based practices

1 that evolved through CSAT initiatives, and I think there
2 you see the list, and I think the most recent one that's
3 been disseminated is the Matrix Program for Stimulant
4 Abuse.

5 In addition, the ATTC program, if you go on to
6 the national office, the ATTC network also has a full
7 series of online and other kinds of training materials and
8 products.

9 In addition to that, we have the blending
10 products, and the Clinical Trials Network. There was
11 reference to this earlier today, but our ATTC program and
12 NIDA, through the Clinical Trials Network, are developing
13 both awareness and training materials for the findings that
14 are coming out of the NIDA Clinical Trials Program.

15 What have we done? CSAT, as I think many of
16 you know, and I just circulated this, has developed a
17 listing that we call Effective Substance Abuse Treatment
18 Practices, and in doing this what we are offering is a
19 guidance to grant applicants and others that identifies the
20 full range of programs and practices that we offer the
21 field, and particularly grant applicants, when they're
22 applying so that they have the resource information they
23 need on evidence-based practices. We will, of course, be
24 adding NREPP to this list, but please keep in mind that
25 this represents a full group of materials and publications

1 we have available.

2 Finally, related to this whole area of
3 evidence-based practices, I wanted to make known to you
4 that I circulated another information on a summation
5 conference that we're doing in the area of business
6 practices and evidence-based practices. As we talk about
7 this whole area of evidence-based practices, I want to keep
8 in your mind that we're not only looking at clinical
9 practices but also those kinds of business processes that
10 can improve treatment efficiency, access and retention.
11 You have that information and I've circulated it.

12 Terms of issues related to rollout. We will be
13 each year working within CSAT to set priorities, as Kevin
14 had said, for applicant submissions under NREPP, and we
15 will be looking at the balance within the portfolio. We
16 want to over time make sure that all matrix areas are
17 addressed, and we also want to continue to encourage as
18 many applications as we can. Currently we are limited to
19 approximately 25 reviews per year.

20 So let me open it up for questions.

21 MS. JACKSON: Well, I just want to congratulate
22 you on putting together this arduous task that I know had
23 lots of field comments and feelings, because I was involved
24 in a few of them and the feedback, and I think that's a
25 very healthy thing to have the national feedback that you

1 did have on the NREPP, and what you came up with is
2 something that really is usable. It was so affrontive a
3 few years back to think that we were going to end up with
4 this list of some 15 programs that were kind of it. While
5 that's a very simplistic statement, that's what it felt
6 like. So as a provider, I'm one person that really
7 supports the idea that you're promoting now that these are
8 guides, these are support mechanisms to help people find
9 the treatment that is most appropriate for their
10 population. So I just want to congratulate you. This had
11 to take a lot of work. I know it did, and I really liked
12 your presentation. Thank you.

13 DR. HENNESSEY: Thanks very much, appreciate
14 that.

15 MR. KOPANDA: I'd like to just point out that
16 the NREPP, our contribution and the NREPP system in general
17 is funded in the 2008 budget. It's fully funded.

18 The other thing I'd like to point out is that
19 the list Fran had is the list of effective practices and
20 programs that we really require our service grant
21 applicants to use, not the NREPP right now but the more
22 extensive list. If an applicant is going to come in for a
23 service program, they need to make sure it's on that list.

24 MR. GILBERT: Let me just clarify that a
25 little. We tell our applicants for services programs that

1 they have to use an intervention that's evidence based, and
2 we provide this list in the RFA as a list of practices that
3 if they're going to implement, they can say we're going to
4 implement this practice and they do not have to justify it
5 any further. However, if they want to propose some other
6 intervention, they have to provide the evidence for it, and
7 it's evaluated by the reviewers. So they're not restricted
8 to the list, but this is sort of the preapproved list, if
9 you will, and it includes everything that would be on
10 NREPP, as well as what's in the TIPS, as well as many of
11 the other products that Fran cited in her presentation.
12 But the effort here is to try to be sure that our services
13 grantees are using evidence-based practices and that the
14 evidence is evaluated by the reviewers when they review the
15 applications.

16 MS. COTTER: Yes, thank you for that
17 clarification. The intent here is to inform applicants of
18 the broad range of evidence-based practice resources
19 available.

20 DR. FLETCHER: Could I also echo Valera's
21 comment, and also point out another invaluable use of this
22 resource, and particularly the TIPS. In addition to you
23 sharing that with your applicants, it's being used as a
24 training tool for those who are planning careers in the
25 substance abuse field. Some credentialing agencies

1 reference TIPS as a primary resource for those who are
2 preparing themselves for credentialing. So it truly is a
3 valuable resource. I'm on the user end, and it has been a
4 valuable resource.

5 MR. KOPANDA: Thank you for that comment.

6 Any other questions?

7 MS. JACKSON: You said NREPP continues in the
8 funding, but I thought I heard earlier, George, that TIPS
9 wasn't going to be funded anymore.

10 MR. GILBERT: Yes, in the 2008 budget, the
11 funding for TIPS would be eliminated.

12 MS. JACKSON: I just want to go on record that
13 I really object. You said if there's ever flexible money,
14 TIPS is probably one of the best publications, as somebody
15 said flagship publications, across these United States that
16 is so used, it's just really sad to hear that, and I hope
17 that there is some way that we can work around that in the
18 future.

19 MR. KOPANDA: If there are no more questions,
20 I'd like to thank both Kevin and Fran for their excellent
21 presentation, and I think it's time for a break. If we
22 could have about a 15-minute break and return just maybe a
23 little bit after 3:30. Thank you.

24 (Recess.)

25 MR. KOPANDA: We're pleased to have with us

1 this afternoon Dr. Rita Vandivort. She's acting branch
2 chief in our Organization and Financing Branch. She's
3 going to talk to us about the National Expenditure Survey
4 for Substance Abuse Treatment.

5 DR. VANDIVORT: Thank you very much, Rich.

6 Well, it's been a long day for you all, and
7 you're still here listening to more reports, so I'm going
8 to try to intrigue you with the only joke I know to try to
9 lighten up and engage you, or the only joke I can tell.

10 You all may remember a few years ago there was
11 a lot of concern as managed care came into some of our
12 public systems. Well, this is a story about a CEO of a
13 managed care company. He was at his desk and he was kind
14 of squeezing the utilization and trying to be sure not one
15 extra dime went for services, and all of a sudden he had a
16 massive heart attack and died right there at his desk, and
17 he wakes up at the Pearly Gates. He's kind of looking
18 around, and St. Peter comes over and says, "I'm sorry,
19 you're looking a little confused. Is something wrong?"
20 And he says, "Well, I did kind of squeeze those services
21 and lower the authorizations, and I'm kind of surprised to
22 find myself here." And St. Peter said, "Well, wait a
23 minute, let me look it up. Yes, here you are. You're
24 authorized for three days."

25 (Laughter.)

1 DR. VANDIVORT: So, you know, maybe what goes
2 around comes around. I don't know, ultimately.

3 So I'm going to talk about a report that I do,
4 the National Expenditure. I think it was actually sent to
5 you, a blue book. This comes out of the SAMHSA spending
6 estimates. This is a cross-center project between the
7 Center for Mental Health Services and the Center for
8 Substance Abuse Treatment to try to look at what this
9 country is spending on mental health and substance abuse
10 care, both in the private sector and the public sector. We
11 now have data. This is our fourth round of studies. We
12 now have data back to 1986, and I'm very pleased to share
13 that we did a specific article looking at substance abuse
14 trends in spending from 1986 to 2003 that has been accepted
15 by Health Affairs. We're pleased about that because it
16 gets a broader audience thinking about what's happening in
17 substance abuse treatment.

18 Our prime contractors are Thomson Medstat.
19 They also work with the Actuarial Research Corporation, the
20 Lewin Group, NASMHPD and NASADAD, and as I said, it's from
21 both centers.

22 As I said, the scope is to look at all public
23 and private payers nationally, and to also look at major
24 provider types. We also compared this to CMS's Centers for
25 Medicaid and Medicare's National Health Accounts, which is

1 kind of the gold standard of health spending.

2 We also have some special reports. There's a
3 copy of a journal article from the Journal of Substance
4 Abuse Treatment that came out of this project which looked
5 at detox, and it showed that those receiving only detox
6 compared to those that received detox and treatment were
7 far more likely to have to come in again for detox, and
8 they came in at a shorter interval than those who had
9 received treatment.

10 We include all mental health and substance
11 abuse diagnoses that are usually covered by health plans.
12 We don't include dementias, tobacco dependence,
13 developmental delays or mental retardation. We don't
14 include prevention services or the burdens and costs of
15 illnesses.

16 As I said, we do this so that we can compare
17 this to CMS' National Health expenditures, and we look at
18 both the specialty providers as well as what mental health
19 and substance abuse may be occurring in primary care and
20 other general health care sectors. We also look at
21 pharmaceuticals.

22 So let me get into some of the results. If you
23 look at 2003, mental health and substance abuse spending
24 was \$121 billion, which was as a percentage of all health
25 spending 6.2 percent for mental health and 1.3 for

1 substance abuse treatment. That said, I do want to say
2 that there is probably some hidden substance abuse
3 treatment in mental health because the financial incentives
4 are such that mental health has better reimbursement. So
5 providers, if you had a co-occurring patient, you'd be
6 smart to code them as mental health. So I think that
7 substance abuse is actually understated here, but it's very
8 difficult to determine what portion.

9 If you look at the years from 1993 to 2003, the
10 dark line is substance abuse and the pink line is all
11 health spending. As you can see, substance abuse treatment
12 spending has not kept up with all health spending. This
13 was particularly true during the 1990s.

14 This looks at all public and private spending,
15 and as you can see, we are largely public spending for
16 substance abuse treatment, more than three-quarters. The
17 private spending includes private insurance, charitable
18 foundations, as well as out-of-pocket spending. But if you
19 look on the public side, you will see that state and local
20 dollars, which includes not only general revenue but also
21 probably criminal justice, some of those local dollars, is
22 really the largest payer for substance abuse treatment.
23 Interestingly enough, I think a lot of people aren't aware
24 that the second-largest payer is really Medicaid.

25 One thing about Medicaid is that if you look at

1 one state, you've looked at one state. Every Medicaid
2 program is different in every state. So in your particular
3 state there may not be a lot of Medicaid spending, but in
4 some states there is quite a bit. So it varies. This
5 looks at it nationally.

6 Then next to that, other federal, which
7 includes the block grant, is a large payer. Medicare is a
8 relatively small payer.

9 If you look at the 10-year period, part of this
10 report looks at a 10-year period. So if you look at the
11 growth of spending between public and private between 1993
12 and 2003, you'll see almost all of it is public spending.
13 This is 4.6 percent annually has been the growth rate in
14 the public sector. But if you look at private insurance,
15 it's 0.1 percent. Essentially, over this 10-year period,
16 private insurance spending has not grown. As a result, in
17 1991, one in every four dollars was from private insurance.

18 In 2003, only one in ten dollars is from private
19 insurance.

20 We also look at major provider groups, and what
21 I have here is a look at 1993, the providers, and at 2003.

22 So you can see the community specialty substance abuse
23 center was the largest single provider, and it is even a
24 larger provider today. What has declined? Well, you see
25 specialty hospital has declined from 9 percent to 3

1 percent. General hospitals with specialty units have
2 declined from 20 percent to 14 percent. A little bit
3 troubling, general hospitals without any kind of specialty
4 psychiatric or substance abuse beds have actually grown a
5 little. I'm not sure if that's detox, we're seeing more
6 detox or what. Another fourth of the providers are M.D.s
7 and other professionals. This strange acronym, MSMHO, is
8 multi-service mental health organization. That's really
9 the community mental health centers. They have a small but
10 a somewhat growing portion in substance abuse treatment.

11 By the way, retail drugs aren't included
12 because they are such a small percent. They are a growing
13 percent, and I gave the numbers down here. In 1993, they
14 were 0.2 percent of all substance abuse treatment spending,
15 and in 2003 they're 0.5 percent. Now, that is only retail
16 drug spending. That doesn't look at methadone. Those
17 costs are built into facilities.

18 If you look at that one-quarter that are in
19 kind of private practice, we look at the M.D.s and the
20 other professionals, the portion between mental health and
21 substance abuse is similar, around a fifth of all spending,
22 but where it's spent or what professionals are very
23 different. So on the mental health side, physicians
24 account for 62 percent of all the spending in this
25 category, whereas in substance abuse other professionals,

1 other counselors, CACs, social workers, account for 61
2 percent. So our portion that's M.D. is significantly less,
3 and what's interesting is that the other M.D., not the
4 psychiatrist, is actually a larger portion.

5 We're doing some studies right now looking at
6 who is writing the prescriptions for the substance abuse
7 drugs, and it's very interesting that it looks like primary
8 care docs are pretty comfortable writing prescriptions for
9 alcohol treatment drugs, but the psychiatrists are the ones
10 who are involved for drug treatment more often. We'll be
11 coming out with that.

12 One of my favorite payers, because I've been
13 studying it for 20 years, is Medicaid. Believe me,
14 Medicaid is always changing, so I can keep studying it
15 forever I figure. What's interesting is that it has really
16 become a growing portion of substance abuse treatment. In
17 1986, Medicaid accounted for only 10 percent of all
18 spending, but in 2003 it accounted for almost 20 percent,
19 at 18 percent. If you look at that Medicaid substance
20 abuse spending, you'll see that our largest provider,
21 substance abuse clinics and specialty centers, are really
22 taking an increasing share of those Medicaid dollars.

23 Because of that, I want to digress just a
24 little bit to mention some changes that have been happening
25 in Medicaid, because they are affecting states, and some

1 states rather dramatically. So I want to just mention a
2 few of those changes. There are some audits going on by
3 the Office of Inspector General, OIG, looking into Medicaid
4 spending, and they are finding and asking for reimbursement
5 for services that in the past were covered. So, for
6 instance, they have identified wraparound services often
7 used for children and adolescents. They no longer want to
8 have that in bundled rates. They want you to break out
9 each individual service. We saw in Georgia that they
10 looked at a residential treatment facility and they said
11 that they wanted all of the charges unbundled for
12 residential treatment. They didn't want a day charge.
13 They questioned psychosocial rehab as a Medicaid
14 reimbursable service, and they also questioned residential
15 supports.

16 Another area that OIG and CMS have been looking
17 at is something called the rehab option, and it's a more
18 flexible financing option under Medicaid and has been used
19 a lot in the substance abuse treatment field for intensive
20 outpatient, and other kind of community-based, consumer
21 support recovery services. Well, it is clear that some of
22 the interpretations are now changing. For instance, they
23 are now making a distinction between rehabilitation, which
24 is restoring functioning for a client, versus habilitation,
25 which could be new services. So, for instance, a March

1 2005 audit in Iowa, they were providing socialization
2 skills to some clients, and CMS said it should not be
3 reimbursed by Medicaid because this wasn't restoring
4 functioning, it was creating new functioning, and therefore
5 it was habilitation.

6 They also have interpreted that treatment must
7 be very specifically directed at children, not the family,
8 the child who is eligible. So, for instance, they have an
9 audit to disallow any reimbursement for services if the
10 child is not in the room. If the therapist is talking to
11 the family, as we all know in terms of family therapy,
12 without the child in the room, Medicaid no longer considers
13 that directly service to the Medicaid beneficiary and is
14 denying those services.

15 I think for you providers who may use these
16 options, it's very important to know that their
17 requirements to have specific treatment goals, to document
18 every service date, to be sure that your providers have
19 Medicaid status is another area of audit. So in Illinois
20 in September 2006, the lack of service documentation in
21 treatment plans not signed off on by all specified parties
22 resulted in CMS asking Illinois to pay them back \$5.971
23 million.

24 Other states have also been impacted.
25 Massachusetts was asked to return \$1.7 million because CMS

1 said they should not use targeted case management to pay
2 for social work salaries of child protective services
3 workers. In Georgia, they were asked to return \$40 million
4 because they didn't deem all of these rehab services to be
5 treatment. Some of these were social services, like
6 recovery or psychosocial education, and those aren't
7 medical services. They came to that conclusion. Texas is
8 paying back or is supposed to pay back \$9 million because
9 the school did not well document that their providers had
10 Medicaid provider status or the individualized educational
11 plan wasn't sufficient for treatment.

12 So I just mention those to give you all the
13 heads-up about that.

14 Getting back to the National Expenditure report
15 and kind of summarizing some of the trends, when we look at
16 payers I think it's important to see that private
17 insurance's share of all substance abuse treatment has
18 declined. So over three-quarters of the substance abuse
19 treatment spending costs are being borne in the public
20 sector. It's important to recognize that states have a
21 tremendously important role in directing and designing some
22 of those dollars, although clearly federal leadership is
23 called for in terms of promoting the best practices.

24 Looking at providers, I think the slide that I
25 had about two-thirds of substance abuse providers being

1 other professionals indicates that our workforce
2 interventions may be something a little bit different than
3 mental health workforce interventions, where physicians
4 predominate. So I think workforce is an important issue
5 both sides of the fence, but I think it's important to
6 recognize differences in the make-up of the workforce.

7 Also, the specialty facilities are very
8 important providers who are increasing using Medicaid, but
9 as they enter into those Medicaid arrangements, they have
10 to develop infrastructures for claims-based billing, for
11 encounters, for checking eligibility. It is an
12 infrastructure that many of them who have been used to
13 program grants are really struggling to adapt to, and I
14 think it may be an area that greater attention could be
15 paid.

16 So that's my short and sweet little report. I
17 don't know if you all have any questions or comments.

18 MR. KOPANDA: Bettye?

19 DR. FLETCHER: Thank you very much for your
20 presentation. I'm sitting here trying to digest this, so I
21 need to verify if I heard right. You said that the private
22 share of expenditures for treatment is declining, the
23 public share is not level but dipping a little bit, and
24 Medicaid is narrowing its definition of treatment. Am I
25 correct thus far?

1 DR. VANDIVORT: Yes.

2 DR. FLETCHER: What does all that mean?

3 DR. VANDIVORT: Well, I personally, as somebody
4 who is always trying to figure out how to finance substance
5 abuse treatment, I think we focused a lot on the specialty
6 substance abuse provider in the substance abuse treatment
7 field. I think we need to, as Dr. Cline mentioned, look
8 perhaps more broadly at some of the general sector. I
9 think we also need to wrestle with employer-sponsored
10 health insurance, which has really been a huge decline in
11 terms of payment. So I think we need to think of
12 strategies that can make the case better, I suppose, to
13 employers that there is value and there is value that they
14 will gain if their employees have access to private health
15 insurance that covers. In fact, we recently did a study
16 tagging onto the Kaiser employer study looking at substance
17 abuse treatment benefits and limits, and what they
18 indicated was that clearly substance abuse treatment has
19 day limits, has visit limits, has higher deductibles.

20 That said, almost 90 percent of those employed
21 have some substance abuse coverage, and yet we see
22 declines. I think some of it is utilization management
23 controls that are part of the managed care arena. But I
24 will tell you that private health insurance knows they
25 serve the employer, and if the employer says we need to be

1 sure we have access to substance abuse treatment,
2 utilization management guidelines can be loosened so that
3 the needle you have to thread to get into substance abuse
4 treatment is not quite so difficult.

5 Does that answer? Does that help? That's part
6 of it.

7 DR. FLETCHER: That does help some. I'm just
8 sitting here reflecting on where we were 10, 15, 20 years
9 ago in this field, and it looks like little has changed.
10 We're still struggling with some of the same issues.

11 DR. VANDIVORT: I think we are. Clearly, some
12 other numbers I didn't share today show the huge shift from
13 inpatient. The 28-day residential, which was the gold
14 standard in the '80s, is just not available to most people,
15 whether you're covered publicly or privately. So I think
16 we have to be sure, though, that we support alternative
17 models, like intensive outpatient. Commercial insurance
18 tends to have inpatient and outpatient. It has nothing in
19 between, and I think we need to look at the reimbursement
20 for those kinds of community based so we have a real
21 continuum in benefit structures.

22 MR. KOPANDA: Val?

23 MS. JACKSON: What you're saying makes a lot of
24 sense to me.

25 DR. VANDIVORT: Great.

1 MS. JACKSON: I think that from your numbers,
2 the percentage of insurance has not gone up, it's gone
3 down. However, Medicaid, which is a national insurance, is
4 expanding and going up for a certain group of people. If
5 in this country we recognize that addiction is a disease,
6 and there's quite a bit of evidence to show that it is,
7 then it seems like it would be the job of SAMHSA to really
8 help to educate -- I mean, it's the job of all of us, but
9 I'm talking as a council person here.

10 What can we do to help get the message that you
11 just said across? And that is that someplace along the
12 line, there's the parity in Congress. Folks need to get
13 out and support that. That's an outside thing. I realize
14 that. But at the same time, can you as SAMHSA -- you can't
15 lobby, but you can certainly provide information, and that
16 information that you gave is pretty key, and I'm sure
17 there's some other information that you probably have that
18 you didn't even present that shows an even more stark
19 thing.

20 I mean, when you see it in the papers -- I'll
21 speak for Florida -- that 50,000 kids, 60,000 kids,
22 whatever it is, don't have any insurance, and another
23 20,000 are running out of insurance before the year's end
24 that are supposed to be covered by the state that we pay
25 taxes for, you kind of wonder, gee, what happens, and

1 what's happened to our country that we don't have some
2 insurance benefits not only for kids, but then I take it to
3 this and I say for substance abuse and mental health? It's
4 an issue that used to be on the table a lot more often. I
5 don't know how to get it back on there, but it's
6 frustrating to see this report. I mean, it's a very
7 interesting report. Don't get me wrong. But it's
8 frustrating to see --

9 DR. VANDIVORT: The trends.

10 MS. JACKSON: The trends, yes.

11 MR. KOPANDA: Frank?

12 DR. McCORRY: Thanks, Rich.

13 I love seeing this information, and of course
14 it's kind of overwhelming. You don't know quite what to do
15 with it.

16 I wanted to ask you, Rita, so this gives us the
17 Medicaid picture relative to private insurance. I count
18 about seven or so actual funding sources going into any
19 program in any state in varying degrees from Medicaid,
20 commercial insurance, block grant, state appro, local
21 appro, self-pay, grants, foundations, six or seven, right?

22 Some states don't have Medicaid at all, no substance abuse
23 services, and I hear also now Medicaid is starting to get
24 more finicky about what they're going to consider to be a
25 medically necessary condition for reimbursement.

1 DR. VANDIVORT: Absolutely.

2 DR. McCORRY: I try to figure out state by
3 state how Valera and Anita do it. How do you construct a
4 sustainable program of services when you've got these kinds
5 of constantly shifting dynamics around funding within a
6 particular locality? That's one question. Have you
7 figured out a way to get a handle on that?

8 Secondly, is there a way to -- for example, for
9 the State of New York versus the State of New Jersey, how
10 these funding streams, the percentage of services covered
11 and the arrangements by which the funding is used? I'm not
12 sure I'm saying it correctly, but it's such a patchwork,
13 it's such a quilt, that it's really difficult to
14 understand. It's hard almost to call it a system. It's
15 hard almost to call it a financed system of care. It's so
16 variable by locality, by provider, by policy. What do we
17 do about that? Give me some hope.

18 (Laughter.)

19 DR. VANDIVORT: Well, I don't have a magic
20 wand, but I will say I think we were talking earlier about
21 sustainability being something that people should worry
22 about from day one when they get a discretionary grant. I
23 have a very large document that I'm trying to finalize
24 that's a financial catalog looking at all funding streams
25 for children and adolescents for mental health and

1 substance abuse. The problem with it is we can point to
2 programs, but as you say, every state is different.

3 So we can say here's the general outlines of
4 the program, now go talk to your SSA, or go talk to your
5 Medicaid director. So I think part of it is trying to
6 empower people with some tools to say -- because I think
7 what people have to do is have a very diverse strategy.
8 I'm sorry Chilo isn't here because he's one of the best
9 providers to speak about that. I've had him at my finance
10 meetings. He says I'm looking for the payer of least
11 resistance, because everybody wants to be the payer of last
12 resort. Unfortunately for providers, it is a struggle, I
13 think, for the states. But I think you have to diversify
14 as much as you can, try to see what other states have done,
15 see if it works for you.

16 DR. McCORRY: I'm sure you've spoken to NIDA
17 and NIAAA, because they talk about health services research
18 all the time and they always have a financing piece in
19 their RFA. I haven't seen any financing studies myself.
20 They might be out there, but I haven't really looked. Is
21 there a way for CSAT and NIDA and NIAAA to figure out a
22 study in which the state profile of expenditures that
23 support -- and I'd use the NIDA principles as the standard
24 of care, and that we would be able to do a descriptive
25 study of what elements in what percentages and with what

1 conditions exist.

2 Can we develop a protocol that would allow for
3 us to have a view within a particular political district or
4 division, a state or some subdivision, of how these monies
5 flow in and out to create what we call the substance abuse
6 treatment system?

7 DR. VANDIVORT: Actually, I think my boss has
8 much better connections to NIDA than I do. I mean, I think
9 it's a very interesting idea, Frank. I think we need that
10 kind of data. I was earlier this afternoon in a
11 conversation about Medicaid and some regs that are trying
12 to be cleared around the Deficit Reduction Act, and we're
13 going to have a conversation with them to try to portray
14 what happens to our populations when some of these
15 regulatory changes are made.

16 But Kathryn Power came to me and said, now
17 where's the data for this, and can you show that if this
18 changes, that it will have a negative impact? We're going
19 to scramble and try to get some data, Jeff Buck and I, but
20 it's a struggle.

21 MR. KOPANDA: I'd like to mention just very
22 briefly that I represented Dr. Clark on the recent SAMHSA
23 National Advisory Council meeting, and the council had a
24 very interesting, not very long but an interesting meeting
25 in terms of all the changes, kind of putting on the table

1 with extensive discussion all the changes that are
2 happening in the system, from in our case buprenorphine
3 being prescribed by physicians and therefore we have a
4 whole other set of treatment providers even that's
5 represented in these data, the fact that we're moving more
6 toward recovery-oriented systems of care, the fact that we
7 have more paraprofessionals in our system and what does
8 that mean for the future, the fact that we're really
9 providing more services, moving more toward, as Dr. Clark
10 mentioned this morning, the primary care system being more
11 engaged through not only screening but through the
12 provision of referral to treatment through community health
13 centers, the fact of the realities of the funding change
14 that we're seeing here, and as Rita mentioned, the more
15 intensive use of outpatient treatment.

16 So everything that's happening, we describe it
17 more like a sea change is happening in the entire system,
18 and we didn't come to any conclusions, but there was some
19 initial thinking that maybe we need to develop some kind of
20 an overall construct for where we want the system as a
21 whole to go. But within that mix was the reality of cuts
22 in Medicaid funding, the changes in the whole funding
23 structure and the fact that we may or may not get parity
24 legislation.

25 DR. McCORRY: I don't know if anyone could

1 actually define it, but what is the financing model of
2 addiction treatment in this country? What does it look
3 like? Because I think the variability is so great that not
4 only is it each state but it's so variable and it's so
5 unique in its expression that to call it a financing model
6 is perhaps an overstatement. It's a collection of
7 accommodations and opportunities, the payer of least
8 resistance, as well as tremendous reliance on the feds, as
9 Rita describes here.

10 It's just interesting to think that such a huge
11 public health issue can be funded in such an ad hoc kind of
12 sixes and sevens, let's grab what's available kind of
13 approach. It just doesn't make sense to me.

14 MR. KOPANDA: One thing you see from these data
15 is that really it's the state and local funding which is
16 the core of the support for the whole system. It's really
17 not federal funding, even counting Medicaid.

18 DR. McCORRY: Even counting Medicaid?

19 DR. VANDIVORT: Yes, that's true. Those data
20 were built up from the facility level up.

21 I think it is a patchwork, but I think it would
22 be helpful to have more data. I think we need to make our
23 case better. For instance, one of the things we're looking
24 at for private insurance is that you'll see in private
25 insurance disease management techniques right now, and

1 they're very willing to go into depression because they're
2 spending a lot of money on depression drugs. They don't
3 think they're spending money on substance abuse treatment,
4 but they are spending money. It's in their medical
5 services, and we're trying to tease that out. We're using
6 some AHRQ data sets to try to tease that out so that we
7 have better data to make our case.

8 MS. JACKSON: And maybe as you look at that,
9 you're looking at it from a kind of an aggregate and from a
10 large picture, although I appreciate the fact that you
11 pointed out some Medicaid things in certain states that are
12 going on. It might be interesting to take a sampling of
13 some of the agencies. Like if you take The Village in
14 Miami, there are anywhere from 25 to 30 funding streams on
15 any given day. It is amazing, and managing it is amazing.

16 DR. VANDIVORT: Yes, it is.

17 MS. JACKSON: And being audited for all those
18 25 funding streams is amazing.

19 DR. VANDIVORT: You've got to keep it straight
20 and report it separately.

21 MS. JACKSON: Exactly. But also
22 diversification became a goal of ours in the '90s with this
23 trend, saying we can't just get our funding from the state
24 block grant or DCF because, frankly, we're putting
25 ourselves and our agency and our clients in jeopardy and at

1 the mercy of whatever happens there. So our goal became to
2 diversify, and we were very successful at it, which I'm
3 pleased to say. The other side of that, though, is that we
4 have this ball juggling thing, and it's a never-ending ball
5 juggling thing. Then you go to the agency down the street
6 and they're barely hanging on with some homeless funds,
7 along with getting paid \$40 a day for residential and
8 barely hanging on with a little bit of outpatient here.

9 We have these wonderful health maintenance
10 organizations who knock on the door and say please sign up
11 with us, we want you as our provider. We're Joint
12 Commission accredited, all kinds of things, we've got lots
13 to offer, and we say great, that will be really nice. I'm
14 sure that we have 50 of those things signed, and how many
15 referrals do you think we get? We don't. I mean, it's
16 very small. There are maybe one or two of those HMOs who
17 actually recognize that there are some people with
18 substance abuse problems, and they will refer them usually
19 for some outpatient, and they do recognize intensive
20 outpatient. So there are a couple I give credit to, and
21 maybe you'd find those, and there might be some answers
22 there.

23 So not to carry on, but to say it's maybe a
24 look from the grass up and from the top down to see if we
25 can figure out some answers.

1 DR. VANDIVORT: Great suggestion.

2 MR. KOPANDA: Anita, do you have a question?

3 MS. BERTRAND: Yes, just a comment on what Val
4 and Frank were saying. I think that, Val, you're exactly
5 right, because I had the opportunity to go to Florida and
6 to look at a model program, and what I found as I visited
7 the program and looked at the diagrams that they showed me,
8 it's almost like when we walked out of there I had a couple
9 of board members with me, and we looked at how they
10 actually had maxed out other systems, and not just this
11 system but our clientele are struggling with housing, and
12 our clientele are struggling with trying to retain their
13 children back. So you have all these other departments who
14 you could partner with, and it's really an art to be able
15 to do that.

16 So I commend providers that are able to do it,
17 and I'm still trying to learn that. But it's something
18 that could be taught to executives. A lot of times
19 executives are grandfathered up into those roles, but do
20 they really have the skills in order to pull those kinds of
21 things off?

22 Dr. Stein and I talked about this over lunch,
23 how do you set up a structure like that, and one of the
24 main things you have to have is an infrastructure. You
25 have to have your directors and a good finance person to be

1 able to manage it so that you can juggle that ball, and I
2 agree with you, Val, that we could look at a couple of
3 model programs around the country to see what they're doing
4 and how they're doing it, because I think it does help our
5 system to look at it more globally.

6 A question I had was about the IMD rule, if you
7 know anything about how that's going, because I look
8 economics in terms of leasing a building, and we could
9 lease the third floor of a nursing home, but we can only
10 put 16 beds in there. It's like if we wanted to expand
11 those services for individuals and to pay, we would expand
12 on the light bill a little bit more. But it's just more
13 economical to be able to have our clients held in one
14 building. So where are they in terms of looking at that
15 room?

16 DR. VANDIVORT: IMD, just real quickly for
17 people who aren't familiar, stands for Institutes of Mental
18 Disease, and when Medicaid was passed, you all may remember
19 in the mid-1960s, there were huge state hospitals, and
20 Congress was very clear they didn't want to pick those up.
21 They wanted the states to keep paying for those. So they
22 put in this rule that said Medicaid funds can't go to an
23 institution that's primarily directed at mental illness, to
24 which they include substance abuse because we're both in
25 the DSM-IV.

1 I will tell you that in the late '90s there
2 were some states that were able to waive the IMD through an
3 1115 waiver, but CMS has telegraphed that when those 1115s
4 come up for renewal they will no longer continue those IMD
5 waivers. I wish I could give you a lot of hope on that,
6 but I think it's pretty much going to be continually
7 enforced. There isn't a way around it right now. I'm
8 sorry.

9 DR. FLETCHER: Rita, could you speak to what
10 you think will be the programmatic impact of this
11 redefinition or reinterpretation of support services? For
12 instance, the notion that service can't be paid if the
13 child is not in the room. Are we redefining what
14 constitutes treatment?

15 DR. VANDIVORT: Again, some of these are being
16 done by audits. There are a number of regs from the
17 Deficit Reduction Act that should be coming out soon to
18 clarify this. I think we as SAMHSA are trying to make a
19 case that as CMS says that it supports community-based
20 living, what our folks need for that community-based living
21 are these types of supports and flexibilities. But we're
22 still trying to discuss that. Medicaid is the 100-pound
23 gorilla, and when you look at it, in their whole funding,
24 substance abuse accounts for a little over 1 percent. So
25 it's like trying to wave down the gorilla when you're a

1 little mouse. So you're trying.

2 DR. FLETCHER: You eat gorillas one bite at a
3 time.

4 (Laughter.)

5 DR. VANDIVORT: I like that. Thank you.

6 MR. KOPANDA: I'd like to thank Rita for that
7 enlightening presentation.

8 I know it's been a long afternoon. We have one
9 more presentation. Val Jackson, who is a CSAT E-Therapy
10 Subcommittee member, will present on e-therapy initiatives,
11 along with Captain Stella Jones from our Division of
12 Services Improvement.

13 MS. JACKSON: I'm going to say that I'm sort of
14 the nodding head up here, because fortunately Stella and
15 her colleagues have been working very hard on this
16 initiative. So I'm going to ask Stella to give us a
17 presentation today, and then I'd just love to hear a little
18 bit of comment about how we might go forward with this,
19 because we were talking at the break about the fact that
20 the contract time for this is really pretty much up. We're
21 coming up with a publication, and where are we going to go
22 from here? So as you're looking at the presentation, I
23 hope you kind of think about e-therapy in a general way and
24 what's going to happen to it. It's going to go, it's going
25 to happen. Are we going to have input, and where do we

1 want to go with that?

2 Thank you, Stella.

3 CAPTAIN JONES: Thank you, Val.

4 The title of today's presentation is
5 "Implementing E-Therapy in Special Populations." An
6 overview of today's discussion will include lessons learned
7 from the literature review with regard to e-therapy. I
8 will highlight and brief what providers of care may
9 consider when implementing e-therapy in special
10 populations. I will identify some of those hard to reach
11 populations, some of the key factors to consider when
12 implementing e-therapy, and talk about challenges when
13 implementing e-therapy and proposed solutions. I will
14 provide a response to a discussion from the National
15 Advisory Council meeting held in September, and lastly I
16 will discuss next steps, which is a follow-up from
17 September National Advisory Council meeting.

18 What literature informs is that e-therapy can
19 potentially provide treatment to underserved and hard to
20 reach populations. Providers must be knowledgeable of
21 issues related to cultural and linguistic competence.
22 Successful implementation of e-therapy, however, requires
23 more providers to be trained in online counseling, possibly
24 additional languages and cultural nuances within special
25 service populations.

1 We've learned that more research is needed on
2 the efficacy of e-therapy within diverse populations.
3 Also, what's critical is that licensure and regulations for
4 e-therapy must be clarified, particularly for treatment
5 provided across jurisdictions, and that implementing
6 e-therapy requires a certain level of technological savvy
7 for both the providers of services and for clients.

8 Some of the special populations that we've
9 identified are the elderly, American Indian, Alaska Native,
10 rural populations, as well as adolescents.

11 Some of the key factors in implementing
12 e-therapy are accessibility, cultural competence, and
13 usability, and I will expound on those.

14 Accessibility requires more availability of
15 computers, telephones, video equipment, Internet access and
16 other uses of technology. Equipment costs for service
17 providers can be very costly; and, of course, the digital
18 divide.

19 With regard to cultural competence, language is
20 a big factor, educational level, the level of psychological
21 and physical functioning, and recognition and respect for
22 the ethnic, language, cultural, and age-related
23 characteristics.

24 Usability. These, of course, are the
25 challenges: skill and experience with technology, fine

1 motor skills, as well as visual and hearing impairment.

2 Some of the proposed solutions. With regard to
3 accessibility, there should be increased availability of
4 computers and Internet access. This may occur through
5 community centers, schools, faith-based organizations, and
6 also senior organizations for the elderly. There should be
7 training programs to train staff on use of various kinds of
8 technology. Software for novice users is also a solution.

9 With regard to cultural competence, service
10 providers trained to understand social and economic factors
11 that may initially impede treatment efforts, that's a
12 proposed solution. Cultural appropriate assessment and
13 treatment tools, this is very useful in particular for use
14 with the Internet and has been very successful with
15 adolescents. Translation and interpretive services, there
16 may be a great need for those. Bilingual and bicultural
17 providers should be part of the staff that one considers.

18 Usability. The provider of care may need
19 enlarged graphics, interfaces and targets, universal access
20 to new technology, support for older hardware and software
21 to accommodate fixed incomes, and implement programs to
22 facilitate comfort with technology.

23 I would like to respond to some of the
24 discussion from the National Advisory Council meeting held
25 in September with regard to a question having to do with

1 research findings on the efficacy of e-therapy. We found
2 that for substance use disorders, treatment is promising
3 for rural populations as well as for adolescents. Research
4 investigating the efficacy of Weight Watchers and other
5 12-step programs, use of e-therapy is limited, and that was
6 another question that was raised.

7 Next steps. We were to synthesize and finalize
8 the review of e-therapy literature, and the review and
9 synthesis has been completed. Develop an e-therapy
10 guidance document; development of guidance document is in
11 progress. Assess readiness to provide e-therapy.
12 Literature review can be used to inform the development of
13 readiness assessments for e-therapy service delivery. The
14 last is determine the feasibility of e-therapy
15 demonstration projects, and literature can also be used to
16 inform the feasibility of e-therapy demonstration projects,
17 we found.

18 I'd like to recognize the CSAT advisory council
19 e-therapy subcommittee, Val Jackson, and other members that
20 are here. Also, I'd like to thank the SAMHSA CSAT
21 e-therapy staff who are present here for their support in
22 this effort. I'd also like to recognize the contractor,
23 MayaTech Corporation, who has been very, very helpful in
24 helping us with this particular document and this
25 initiative. Thank you.

1 Are there questions?

2 MR. KOPANDA: Any questions?

3 I just might mention that for this year for our
4 Targeted Capacity Expansion Program, we have a program
5 called Targeted Capacity Expansion General. We generally
6 have it available for different kinds of activities, and
7 this year for the first year we intend to have a focus area
8 on e-therapy. So for the first time ever we expect to make
9 some e-therapy-related grants this year.

10 Question?

11 MS. JACKSON: Did the whole council or the
12 members of the committee get the document that you sent
13 out?

14 CAPTAIN JONES: The entire council. No, the
15 subcommittee.

16 MS. JACKSON: Right. The subcommittee was sent
17 only a couple of weeks ago, so I'll have to get in touch
18 with the other members who aren't here today. You sent us
19 a draft of the guidance document that is being developed.
20 I have had a chance to partially review it, so I'm as
21 guilty as anyone for not getting information back. Judge,
22 perhaps we'll have to get together and have a conference
23 call or a talk or something, but if you want to go through
24 that and make comments, that really would be helpful
25 because what they need to do is to get the guidance

1 document completed. I think they have a limited time frame
2 for that. So I'm going to get my comments back in very
3 quickly and we'll work on this, and maybe we can get in
4 touch with the others who aren't here today.

5 CAPTAIN JONES: Thank you. Thank you so much.

6 MR. KOPANDA: Other questions?

7 (No response.)

8 MR. KOPANDA: No questions?

9 (No response.)

10 MR. KOPANDA: Thank you very much, Stella. We
11 appreciate it.

12 I think we're just a tiny bit ahead of
13 schedule. We have now time for council roundtable. We do
14 have at least 25 minutes. We could get back to the 2008
15 budget or any other issues that the council would like to
16 discuss.

17 DR. SKIPPER: Thank you. I'm eager to talk
18 about two things that I think are really important, and to
19 make it concise I'm going to look at my notes here. One is
20 about drug testing. There's a growing body of evidence
21 regarding the benefits of drug testing both in improving
22 outcomes of treatment and in prevention of substance abuse,
23 like in schools and so forth. Preemployment, random and
24 for-cause testing in the workplace is known to decrease
25 substance use in the workplace, and I think SAMHSA oversees

1 drug-free workplace rules and so forth. Testing in schools
2 I mentioned. The concern I have is while the ONDCP and
3 NIDA both are supporting more drug testing, and I suggested
4 SAMHSA develop an interest in promoting appropriate use of
5 drug testing both for prevention and treatment of substance
6 abuse, currently there's no agency that oversees drug
7 testing in schools by licensing boards, from homes --
8 there's a growing group of people who buy the test kits and
9 test their children and so forth in homes -- and I suggest
10 SAMHSA do three things about this.

11 One is, like I said, promote an increased use
12 of drug testing, which I think has been shown to prevent
13 initial use and decrease relapse in aftercare situations to
14 improve outcomes.

15 Two, promote training of licensing boards,
16 schools, courts, parents, et cetera, in the proper use and
17 interpretation of the drug testing. A lot of people are
18 doing drug testing, and nobody regulates how they interpret
19 the result and how they use it, and it would really be good
20 if we set up some educational programs for boards, did
21 something for parents and schools and so forth to let them
22 know, yes, it's a valuable resource, but it needs to be
23 used in a certain way. We kind of launched into that a
24 little bit when we issued the advisory about EtG testing.
25 I just think we need to do it more.

1 Three, I think we need to promote increased
2 training of MROs. These are the medical review officers
3 under federal testing guidelines that we oversee for the
4 drug-free workplace. MROs get one day of training and
5 certification, and I've been very disappointed in these
6 physicians that are supposed to oversee these testing
7 procedures, that they don't have the training or knowledge
8 to really interpret tests properly. They generally just
9 see their role as being sure the form is signed, and
10 there's no prescription, and they're not looking into
11 issues around incidental exposure and so forth, and they
12 don't want to because it takes them more time. So I think
13 SAMHSA might want to look at what can we do to improve the
14 education of the doctors who are supposed to oversee drug
15 testing.

16 So I'm going to throw that one out there and
17 see if there are any comments, but I have another issue.

18 MR. KOPANDA: Thanks for your comments and your
19 recommendations. As you mentioned, drug testing in SAMHSA
20 is primarily done within the Division of Workplace Programs
21 for federal drug testing in the Center for Substance Abuse
22 Prevention. We'll provide them with your comments.

23 DR. SKIPPER: Well, I think it needs to be
24 looked at from the point of view of CSAT, and I'm going to
25 try to get on the agenda next time. There's a growing body

1 of data that if we take people after treatment, and very
2 few receive ongoing drug testing, but there's research now
3 under contingency management protocols where if you do drug
4 testing periodically and set up some kind of reward, either
5 positive or negative reward system with money, work,
6 different ways to do rewards, families, privileges for
7 teens to drive the car, this and that, outcomes just really
8 improve, almost double in the studies I've seen. So we're
9 not just talking about prevention. We're talking about
10 introducing this to improve outcomes. Like the program I
11 run for physicians, I think it's one reason we have such
12 high success, because we do long-term, periodic, random
13 drug testing. So I don't want to just relegate this to
14 CSAP. I hope CSAT looks at it, too.

15 MR. GILBERT: I think that we're getting a
16 little bit maybe on thin ice here, but I think that we
17 already do address drug testing in the context of
18 treatment. I think a number of TIPS talk about the
19 appropriate use of drug testing for exactly the kind of
20 thing you're talking about. So I think it's an issue that
21 we have looked at, but there may be some way to pull
22 together a more cohesive response or something. But it's
23 not an issue that has been ignored by the treatment side of
24 SAMHSA. We recognize that testing can be an important
25 incentive.

1 DR. SKIPPER: Let's boil it down to I would
2 propose that we set up some educational programs for
3 medical boards, maybe even drug courts and others that are
4 already doing testing to be sure they do it properly. I
5 don't think that's really been proposed, and maybe some
6 literature for home testing and school testing.

7 DR. McCORRY: I thought you were going, Greg,
8 with a kind of aftercare testing as well, which I don't
9 think has been studied. I don't think there's much
10 literature on that, as you want the continuing care
11 management issue and the role of testing in that capacity,
12 as well as contingency management, which could be a little
13 bit controversial but it's an interesting idea. I hadn't
14 thought of it.

15 MR. KOPANDA: Any other comments? Anita?

16 MS. BERTRAND: In light of our budget and where
17 we are, I would like to see us continue to support
18 community-based and faith-based organizations in some
19 manner, and even as we look at the initiatives that are
20 coming out and the language that we put into those RFPs,
21 that we make sure that those that are in need of the
22 services can get the services and that the dollars are not
23 eaten up in administrative costs, not that I have problems
24 with state bodies and local bodies, but just those
25 administrative pass-throughs sometimes, or if there's

1 things that we can do. As we talk about having a
2 recovery-oriented system of care, that we continue to keep
3 the consumer in mind. If I had to sort of look at a couple
4 of things up there that it sounds like the council really
5 thought about, it would be like the TIPS we'd like to see
6 things around, and the Recovery Month event, because that's
7 an opportunity for us to continue to showcase the success
8 of the work that we do. So I just want to kind of put that
9 on the radar, that I think that's something important and
10 just ask the council to consider it as we draft up those
11 things that we remember, that the end result is getting the
12 services that the people need.

13 MR. KOPANDA: And, by the way, the previous
14 discussion that we had on the 2009 will be all considered
15 in the 2009 budget as we begin to develop our proposals for
16 2009. The issues you've raised about Recovery Month, about
17 all the activities that we're not able to do, we will take
18 that into account, as well as any other suggestions you
19 have for things that have come up during today or for new
20 activities.

21 I'll just mention a couple of things with
22 respect to what you just mentioned. It's a small amount of
23 money, but the TCE money that we're going out with this
24 year, we're also going to have a focus area on
25 recovery-oriented systems of care whereby the grantee

1 applicant would come in and have, for lack of a better
2 term, grassroots organizations, small organizations with
3 operating budgets of, say, \$500,000 or less, and that they
4 would operate a system or propose to operate a system of
5 care involving those small organizations, which could
6 include faith-based organizations. We may take that
7 approach in other programs as well.

8 MS. BERTRAND: Just also in looking at the
9 review process and what I know about it historically, and
10 just to empower the staff, because I know that you all have
11 a lot of expertise around knowing what a best practice
12 might be, just to consider having some input from the
13 project officers around what they may think would be a good
14 initiative to invest in, as opposed to having an outsider
15 that knows absolutely nothing about this particular system,
16 or maybe not even about the application that they're
17 looking at, because we've got some wonderful places that
18 can write very well, and then you have some that can't
19 write very well but can do very good work and reach the
20 people who are really out there in the trenches. So I just
21 wanted to say that as well.

22 DR. SKIPPER: My other issue is around the
23 issue of prescription drug abuse. As it's growing and has
24 become the greatest source of drugs of abuse now,
25 prescription drugs, I'm thinking that SAMHSA needs to take

1 a little more active role in talking with the FDA about
2 drugs that may be the most risky and whether, as we talked
3 earlier, their availability should be reduced, and if they
4 are available, to encourage training of the doctors who
5 prescribe these drugs. Right now we require training for
6 doctors to prescribe buprenorphine, and yet no training to
7 prescribe Dilaudid, Demerol, OxyContin and so forth, not
8 that doctors don't have training, but no specific training
9 around addiction. I think the availability of all these
10 drugs obviously is coming from physicians who prescribe
11 mostly for chronic pain, and some states have taken some
12 action toward requiring training, specific training for the
13 doctors that treat chronic pain.

14 I think on behalf of addicted or potentially
15 addicted patients and those that will relapse because of
16 all these drugs out there, we should take a little more
17 active role. I know we can't regulate what drugs are
18 released. That's the FDA or the DEA's job. But we can
19 certainly make recommendations. I don't know how that
20 works, but I would like to see SAMHSA move toward getting
21 concerned and expressing that concern, even to the point of
22 saying we think this drug should be pulled off the market.
23 That's pretty bold, but we can say that to the FDA. I've
24 done that myself.

25 MR. KOPANDA: I see we have Ken Hoffman here

1 with us, Dr. Hoffman, and our Division of Pharmacologic
2 Therapies will be holding a meeting, as we discussed
3 earlier, on methadone, and we'll take that up at the
4 meeting.

5 DR. McCORRY: During this time, we say things
6 we'd like to do? Is that what we're on? I just want to
7 make sure.

8 MR. KOPANDA: It's a roundtable. It's
9 basically open.

10 DR. McCORRY: Great. I'd like to add one to
11 the list. I'd like to see a presentation here from ONDCP,
12 because I understand it's still about a
13 one-third/two-thirds split between demand reduction and
14 supply reduction. I'd like to understand how the
15 two-thirds supply reduction related to outcome data, the
16 impact that they've had relative to the work of -- I
17 understand statistics about the number of metric tons of
18 cocaine taken off the street. I want the policy issue of
19 impact on actual availability of drugs. I'd like to hear
20 ONDCP talk about that and square that up with the
21 two-thirds/one-third split in federal money for supply
22 versus demand reduction. My understanding is that we've
23 never been more efficient in taking drugs off the street
24 and that it's had minimal impact on availability or on
25 price. So the policy question becomes why are we spending

1 all that money on supply reduction when there seems to be a
2 greater need on demand reduction.

3 MR. KOPANDA: Thank you. We will talk about
4 that at one of the upcoming council meetings, inviting
5 ONDCP to present.

6 Judge White-Fish?

7 JUDGE WHITE-FISH: I tried to understand this
8 budget, but I was still lost in the budget process. I'm
9 not a financial individual, but it kind of scares me
10 overall. If we look at Native American Country, I don't
11 believe the addictions have decreased. I can't speak for
12 all nations, but I would hope in some part of the Native
13 American nations the addictions have decreased. Yet, our
14 budget in looking at addictions, it's decreasing and
15 they're cutting. It's really sad to see it. I do realize
16 that I'm happy that none of SAMHSA employees are going to
17 be losing their positions, and I don't say that
18 facetiously, because of the work and what's trying to be
19 done in addictions, and it's sad that we have to allow our
20 monies in order to control that. By the cuts in the
21 budget, one would naturally assume that addictions are in a
22 decline. Does the board agree with that? That's exactly
23 what they're trying to tell us is the way I feel inside.

24 My people have told me that we start at home
25 with taking care of our people, taking care of our elders

1 and taking care of our youngsters, and I've heard different
2 presenters talking about prescriptions on the rise in our
3 elders, and I see that at home. A lot of our elders are
4 beginning -- we have a pharmacy. Our tribe is very
5 fortunate. We have our own pharmacy. I don't believe how
6 many elders I see up there at the counters getting
7 prescriptions, and I'm questioning myself because of my
8 background.

9 But to see the cuts in the overall budget of
10 SAMHSA and CSAT, it saddens me, and I say that
11 wholeheartedly because I know the addiction is still out
12 there and I haven't seen any reports or anybody telling me
13 that it's on a decline here, but yet they will cut the
14 budgets drastically. Anita and I were sitting here, we
15 were trying to figure it out, and then we found out it was
16 in the millions of dollars. That wasn't just \$4,000. That
17 was \$400 million or something. It's, like, uh-oh. I mean,
18 we're talking about lives out there, and yet we know where
19 the money is going, and lives are being taken there. But
20 we still have to take care of our people at home. I guess
21 I would question it. Maybe we need to look at starting new
22 programs. If SAMHSA and CSAT are going to do new programs
23 coming up, we've already got programs that work. Weren't
24 we talking about evaluating and what's working? If we're
25 going to let this work, if this works, then let's keep

1 doing it. If we have a program that's working right now
2 and the budgets are being cut, then let's continue those
3 programs that are working rather than exploring new
4 programs that we don't know are going to work if they're
5 going to continue to cut.

6 I'm going to use a quote that I heard. I was
7 back here two weeks ago. As we all know, I come from the
8 north woods. I come from Wisconsin, and this is my most
9 favorite place to come because I get lost all the time.
10 Something always happens to me in Washington, D.C. No
11 clothes until this morning. I didn't know I had a ticket
12 until the day I took off, and then I ran from one plane to
13 another in Milwaukee, Wisconsin. My clothes couldn't run
14 as fast as me, I guess.

15 (Laughter.)

16 JUDGE WHITE-FISH: But thank goodness they got
17 here and everything worked out. I had the attitude that if
18 everything is meant to be, then that's the way it is, and I
19 told the airline that, and they were quite surprised, and I
20 told Mr. Basher that. It was not meant, then a ticket will
21 not arrive, and that's okay, I have to accept that.

22 But there are things I can accept, and there
23 are things I cannot accept. It's real hard for me to
24 accept that budgets are being cut so drastically. When I
25 was out here for the National Congress of American Indians,

1 I heard it stated, and I'm only quoting it because I
2 remembered it very well: "If there's \$700 billion that's
3 being spent, take 1 percent of that and leave it at home
4 for our people." We have people that are suffering from
5 this disease, and the monies need to take care of our
6 people at home. I don't know how much more I can say on
7 that, but I hope that the people further up, instead of
8 cutting these just because they didn't have an explanation,
9 as I was talking -- they explained it that they didn't have
10 an explanation. Okay, what is this? They didn't
11 understand it, so we're cutting it. Some of the monies
12 were meant for a good reason and a good cause, and they've
13 been effective. It's sad that they were cut looking at
14 that, but we're affecting our people, our own people, and I
15 hope their eyes open and at least release some of that
16 money so that we can continue to do and progress in the job
17 that we're meant to do, I guess, that we were put here to
18 do. Thank you.

19 MR. KOPANDA: Thank you for your comments and
20 your sentiments on that. I think they're widely shared
21 here.

22 DR. FLETCHER: May I please, Richard? I'd like
23 to echo the distinguished Judge's comments. I think
24 they're quite apropos.

25 As I listened to the presentations this

1 afternoon, the morning discussion really framed and created
2 the window through which I received those presentations.
3 For instance, I heard in the recovery support system
4 presentation, the need for infrastructure support. When we
5 had the ATR presentation, I heard talk about the need for
6 technical assistance for faith-based organizations. When
7 the NREPP presentation was made, the extent to which our
8 knowledge in this field is driven by some of the work that
9 has been done with the TIPS. So saying that, my question
10 was, my God, is this budgeting process one that is lacking
11 evidence-based budgeting, if you will, to use my own
12 terminology?

13 (Laughter.)

14 DR. FLETCHER: It does not appear to be
15 evidence based.

16 Two points I want to make to that extent. One
17 is the extent to which the reductions do not reflect
18 efficiency. I use that as an example of the HBCU program,
19 which has an expansive scope but few dollars. Is that
20 informed decisionmaking when we decide to cut such a
21 program that's reaching 107 institutions of higher
22 education in this country for a very modest amount of
23 money? So it raises an efficiency question for me in terms
24 of that process.

25 My second point is the extent to which the

1 budgeting decisions have the potential of retarding our
2 progress in the field of substance abuse. Again, I use as
3 the example the TIPS documents that have become a major
4 reference source and a knowledge dissemination tool that we
5 are using to advance the field. My question becomes -- and
6 it's a rhetorical question -- whether or not there's a
7 potential there for retarding our movement in that regard.

8 So I would close my comments with the question
9 not to the staff here but to my colleagues whether or not
10 we as a collective body, the council, share a need to
11 somehow express our concerns regarding the budgeting
12 process? While we might all do things individually, is
13 there an opportunity here for us to speak in unison on this
14 issue? And that was not a rhetorical question.

15 (Laughter.)

16 JUDGE WHITE-FISH: I just want to say as a
17 judge they tell me I can't lobby, and I heard Dr. Clark
18 mention that we can't lobby. I guess for me right away Dr.
19 Fletcher comes to mind. Okay, if I can't lobby, what can I
20 do? Can I call it education, as I do on the Hill when I
21 go?

22 MR. GILBERT: I think in the lobbying question,
23 I think the point that was trying to be made this morning
24 that as a council member -- Cynthia, keep me correct here
25 -- when we travel you in here for the council meetings, it

1 would not be appropriate for you to be up on the Hill
2 lobbying. As a private citizen who also serves as a
3 council member, if you are in contact with your
4 legislators, it's appropriate for you to express your
5 opinions if you want to do so, but it would be
6 inappropriate for our funds to be supporting your lobbying
7 efforts. So there is a distinction there that I think was
8 trying to be made. Maybe it wasn't clear.

9 MR. KOPANDA: But it would be possible if you
10 had a statement of your sentiments in that regard, for you
11 as council members to put together some kind of statement
12 that you would provide to Dr. Clark or to Dr. Cline or
13 someone within the agency and express yourself in that way.

14 MS. GRAHAM: We don't have a quorum right now.

15 MR. DONALDSON: It appears to me also that
16 we've got to do a better job when this budget is presented
17 on defining what these line items are and their value,
18 because, George, what I have heard from you is that it just
19 seems so arbitrary. It looks like it's not worth the
20 budget investment; cut it. I mean, is it that? Is it
21 about scissors and paste? Because that's tragic. You look
22 at the major corporations that are succeeding globally,
23 like General Electric, they're putting a lot of money into
24 evaluating their programs, their marketing. They take that
25 bottom 10 percent and they move that money to the top 10

1 percent of the high performance. It just seems
2 unsophisticated for such a sophisticated, evaluative
3 process, like Bettye said.

4 MR. GILBERT: I don't know all the
5 conversations that went on and the negotiations between the
6 Department and OMB and SAMHSA and OMB this year. Looking
7 at it, I think a lot of the comments that you said about
8 how it just doesn't seem to make a lot of sense -- I mean,
9 certainly some of the decisions that were made strike us
10 that way as well.

11 One of the things we recently had an
12 opportunity to brief Dr. Cline, Westley briefed him on the
13 substance abuse treatment capacity matrix area and the
14 programs, and the issue of the budget came up, and he
15 indicated that he wanted to review the way we present our
16 budget. He thought that maybe we could do a better job of
17 doing that. So I think that's on his radar.

18 I think part of it is we do need to try to do a
19 better job of educating OMB as to exactly what it is we're
20 doing and the successes that we're having. I do think a
21 lot of what was going on this year also was the drive to be
22 able to present the big picture that the administration was
23 making the commitment to head towards a balanced budget by
24 2012 and showing that there were cuts being made to head in
25 that direction in spending. So it's probably a lot of

1 factors. I think we need to try to figure out what are the
2 ones where we can try to make sure that the information is
3 available so that people know what the programs are, what
4 the outcomes are, and what's behind some of these lines so
5 that they aren't making arbitrary decisions.

6 MR. DONALDSON: So even the faith-based
7 initiative part of CSAT, even though you wouldn't know it,
8 that's being significantly cut.

9 MR. GILBERT: Yes.

10 MR. DONALDSON: You would never know that, even
11 though that is one of the President's initiatives, a
12 presidential initiative.

13 MR. GILBERT: And on its face, it doesn't make
14 sense. It doesn't make sense to you. It doesn't really
15 make sense to us. I'm thinking that if I had to try to
16 look at what were the criteria they used to make that
17 judgment or what the criteria that had been offered as to
18 why the decisions were made, people examining the budget
19 may have said, well, you know, you're doing a lot through
20 the ATR program to involve faith-based and community-based
21 organizations, so there's another way to address that issue
22 rather than this little program over here. That's if they
23 understood that that money was even there. But we weren't
24 in a position to really know how the decisions were made,
25 so we're kind of a little bit in the dark too.

1 Even in the discussions we've had with the
2 SAMHSA budget folks, I think the process this year was
3 characterized overall by kind of a lack of information
4 sharing. A lot of times information wasn't available.

5 DR. McCORRY: I was just trying to do some
6 quick math. When you look at the Programs of Regional and
7 National Significance in which almost all of the X'ed out
8 programs exist, it's about \$46 million. Then I tried to go
9 through all the X'ed out areas in which there's no money,
10 and I came up with \$40 million, but I'm probably just not
11 adding it up right.

12 I think one point can be made around simply the
13 closing of programs versus a reduction in programs as a way
14 to do budget reduction, budget curtailment in light of
15 other priorities, to X out, to no longer fund programs that
16 aren't slated for defunding, or even in the areas I think
17 is a legitimate point to make. It's only \$46 million. I'm
18 not sure how that squares with your 12 percent reduction in
19 CSAT money. What's the overall reduction to CSAT? It's 12
20 percent. Is that \$46 million, or no?

21 MR. GILBERT: Yes. That's percent of the
22 discretionary funds.

23 DR. McCORRY: And most of the \$46 million is in
24 the Programs of National Significance and have been X'ed
25 out, including Bettye's comment on HBCUs, David's comment

1 on faith based, my comments on performance measurement, and
2 it just makes no sense. You could even argue it might make
3 sense to reduce things in light of a curtailed budget. I
4 wouldn't argue that in this instance, but you could at
5 least argue that. But certainly to discontinue funding, to
6 abruptly end makes no sense, and perhaps that point should
7 at least be made from this council to Administrator Cline
8 and to Dr. Clark, just a letter saying it exactly as Bettye
9 said it, that some of these programs have huge impact, and
10 they're very modestly funded. We're not talking \$100
11 million, very modest, but they have a long reach, and that
12 the council opposes the elimination of programs, much as it
13 understands the need to balance the budget, and that we
14 encourage Dr. Clark and Administrator Cline to look to
15 restore these funds within the context of their budget, and
16 that we endorse the introduction or the reintroduction of
17 funds to keep these programs whole, something like that.

18 If we get consensus on that, maybe we could
19 draft something up. I could draft something up and send it
20 around.

21 MR. KOPANDA: I think Cynthia would be the
22 contact person. She would probably work with you if the
23 council would like to pursue something like that.

24 DR. FLETCHER: I would support the council
25 drafting a letter or whatever is appropriate to articulate

1 what Francis has just described. So what is the mechanism?

2 Can I offer a motion?

3 MS. GRAHAM: We can't do a motion because we've
4 lost our quorum, but what we can do, as we've done in the
5 past if you remember, if there's a position that the
6 council wants to take, you can certainly draft something
7 and send it to us. You can draft it to Dr. Clark. We will
8 go through that and send it to all of your colleagues to
9 get them to sign off on it. From there it would go to Dr.
10 Cline for his consideration.

11 So please feel free if you want to work with
12 Frank to draft this document and send it to us. We'll get
13 it back to you guys and all of the council members will
14 sign that.

15 DR. SKIPPER: I'd like to have a chance to look
16 at it and make a little edit or whatever. So not just sign
17 it.

18 MS. GRAHAM: It will go to everyone before it's
19 sent out, before we send it to Dr. Cline.

20 DR. McCORRY: It sounds like the members here
21 want to be part of the initial writing committee. So I'll
22 do a first cut, send it just to our folks, to these folks,
23 to all of us, and then after everyone gets their comments,
24 then we'll send it to the larger council to say we've
25 drafted this. But we'll all get a chance at the early

1 level of writing.

2 Also, if someone else wants to take a crack at
3 it, that's absolutely fine with me. If someone prefers to
4 be the initial drafter, that's fine with me, too.

5 Okay, I'll do the initial cut, and the six of
6 us will get the first cut at shaping it the way we want.
7 Then to send it on to our colleagues for approval.

8 MR. DONALDSON: Could you use a better word
9 than "cut"?

10 (Laughter.)

11 DR. McCORRY: Oh, that's a terrible word.

12 MR. KOPANDA: Are there any other comments on
13 this or other subjects?

14 MR. GILBERT: I just want to kind of emphasize,
15 of course, and I hope it's clear to everybody, that the
16 budget that has been submitted to Congress is the first
17 step in the process of the congressional consideration of
18 the budget. So they still have to go through their
19 process. The Administrator testified before the House
20 Appropriations subcommittee earlier this month. The
21 subcommittee will mark up, the full committee will mark up,
22 and the same process will occur in the Senate. They'll
23 take their bills to the floor, and then once they've passed
24 their bills, they will then meet in conference and resolve
25 differences. So this represents the administration's

1 proposal and it's now up to Congress to decide what they
2 want to do.

3 DR. McCORRY: Can I ask, George, because I
4 didn't get down when you were breaking apart those
5 categories a little bit more on what's inside it, could you
6 give me something like that? Or give it to us all? I'll
7 send it around as well. So the categories that are being
8 eliminated here or defunded had some further --

9 MR. GILBERT: Yes. They're in the slides, but
10 we can talk about it afterwards. You can give me a call on
11 the phone and I can help walk you through and explain it to
12 you.

13 DR. McCORRY: Great.

14 MR. GILBERT: So whatever questions you have,
15 we'll explain the information that we were trying to convey
16 in the slides.

17 DR. McCORRY: Very good.

18 MR. KOPANDA: Any other issues?

19 (No response.)

20 MR. KOPANDA: Well, if not, I'd like to thank
21 you all for your participation today. I hope you enjoyed
22 the presentations and you found them enlightening, as I did
23 I, for sure.

24 I certainly appreciate all the comments and
25 suggestions you've made, and I think your recommendations

1 will certainly be well received within the agency. That's,
2 after all, the role of the advisory council, to give us
3 some advice, and that is what you've done on both the 2008
4 budget and hopefully moving into 2009.

5 So with that, unless there are any other
6 suggestions, I will entertain a motion to adjourn.

7 PARTICIPANT: So moved.

8 PARTICIPANT: Second.

9 MR. KOPANDA: Moved and seconded. Council
10 agrees. Council adjourned. Thank you very much.

11 (Whereupon, at 5:11 p.m., the meeting was
12 adjourned.)

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