

SUBSTANCE ABUSE AND MENTAL HEALTH  
SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT  
NATIONAL ADVISORY COUNCIL

Thursday,  
May 19, 2005

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

## IN ATTENDANCE:

Chair

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1                                    P R O C E E D I N G S                                    (9:13 a.m.)

2                    DR. CLARK: I want to say good morning. I want  
3 to welcome you to the 42nd meeting of the CSAT National  
4 Advisory Council. I know that it's difficult sometimes to  
5 make it to these meetings, and so I really appreciate  
6 people, especially Council members, being able to do that,  
7 and I appreciate your being here.

8                    Our first item of business on the agenda is to  
9 vote on the minutes from the January 26th and 27th meeting,  
10 and they were forwarded to you electronically for your  
11 review and input, and hopefully you gave Cynthia your  
12 comments. So I'll entertain a motion.

13                   DR. MADRID: I so move that the minutes be  
14 adopted.

15                   DR. CLARK: A second?

16                   DR. VOTH: Second.

17                   DR. CLARK: Is there any discussion on the  
18 minutes?

19                   (No response.)

20                   DR. CLARK: Then all those in favor of  
21 approving the minutes?

22                   (Chorus of ayes.)

23                   DR. CLARK: All right. Anybody opposed?

24                   (No response.)

25                   DR. CLARK: Okay, the minutes are adopted.

1           Again, I want to thank you for being here, now  
2 that we've got the minutes out of the way. I can't  
3 overemphasize the importance that I place and that Mr.  
4 Curie places on the National Advisory Council input. Your  
5 advice is critical. You're all familiar with the problem  
6 of substance abuse and its complications. We look at our  
7 Household Survey data from 2003, we know almost 20 million  
8 people, 19.5 million age 12 and older are current illicit  
9 drug users. This represents a large number of people in  
10 the population, at 8.2 percent. We know that we have a  
11 large number of people who have problems with misuse of  
12 alcohol. We also know that there's a growing problem with  
13 pathological gambling.

14           We know that there has been an historical and  
15 persistent problem with nicotine addiction, and even though  
16 SAMHSA is not the principle entity that addresses that --  
17 in fact, that is more addressed outside of SAMHSA. Within  
18 SAMHSA, CSAP has the responsibility for Synar-type activity  
19 and not CSAT. Nevertheless, we are concerned about the  
20 impact of these issues on our society. We all have to be  
21 willing to work together to facilitate recovery, make  
22 recovery a reality. As you know from our matrix, building  
23 resilience and facilitating recovery is an important  
24 construct for us here.

25           Your expertise and the expertise of the people

1 who will be presenting is very, very important. I want to  
2 take a couple of minutes now to go around the table, now  
3 that we're all here and settled, to have people introduce  
4 themselves. We'll start off with our recorder on the left.

5 MR. FRIEDMAN: I'm Alan Friedman, your court  
6 reporter.

7 DR. CLARK: Thank you.

8 DR. VOTH: Eric Voth, internal medicine and  
9 addiction medicine specialist in Topeka, Kansas, the center  
10 of the United States, equally far from everywhere.

11 (Laughter.)

12 MS. BERTRAND: Good morning. I'm Anita  
13 Bertrand from the Northern Ohio Recovery Association,  
14 located in Cleveland, Ohio.

15 DR. MADRID: Chilo Madrid, Aliviane, El Paso,  
16 Texas.

17 JUDGE WHITE-FISH: Eugene White-Fish, judge for  
18 the Forest County Potawatomi Tribal Court in Crandon,  
19 Wisconsin.

20 DR. McCORRY: Good morning. Frank McCorry from  
21 the State Office of Alcoholism and Substance Abuse Services  
22 in New York.

23 MS. GRAHAM: I'm Cynthia Graham at CSAT.

24 DR. CLARK: And, of course, I'm Westley Clark,  
25 the Director of the Center for Substance Abuse Treatment.

1 MR. KOPANDA: Rich Kopanda, Deputy Director.

2 MR. GILBERT: I'm George Gilbert, CSAT Office  
3 of Program Analysis and Coordination.

4 MR. DeCERCHIO: Good morning. I'm Ken  
5 DeCerchio, the State Substance Abuse Director, Department  
6 of Children and Families in Florida.

7 DR. FLETCHER: Good morning. I'm Bettye Ward  
8 Fletcher from Jackson, Mississippi, recently retired  
9 professor of sociology after 30 years.

10 MR. DONALDSON: Dave Donaldson, president of We  
11 Care America.

12 MS. JACKSON: I'm Valera Jackson. I'm the  
13 chief development officer and senior vice president for  
14 West Care Programs and the Village, headquartered in Miami,  
15 Florida.

16 DR. SUCHINSKY: Hello. I'm Richard Suchinsky,  
17 chief for addictive disorders, Department of Veterans  
18 Affairs.

19 MS. GOLDSTEIN: I'm Irene Saunders Goldstein,  
20 and I'm writing your minutes.

21 DR. CLARK: Very good.

22 In addition to Council members, we have a few  
23 new faces in CSAT. Is Laura House here? Dr. House has  
24 joined the Division of Services Improvement as a project  
25 officer with the evaluation team. She earned her doctorate

1 from Howard University, focusing on adolescent mental  
2 health, resiliency and cultural issues, and did a post-doc  
3 with NIDA from 2002 to 2004.

4 Is Ken Hoffman around? Dr. Hoffman began his  
5 duty on February 22nd. It's the second medical officer in  
6 the Division of Pharmacologic Therapies. He recently  
7 retired from the Department of Defense Office of Health  
8 Affairs, TRICARE, where he worked in the Surgeon General's  
9 Drug and Alcohol Office.

10 Any other new staff whose name I didn't  
11 mention?

12 We have a fellow from the Office of Global  
13 Health, Wendy Waddy. She literally started this week. She  
14 is from Trinidad and is working in DSCA, among other  
15 things, principally located in DSCA, working with John  
16 Campbell and Anne Herron, but will be obviously working  
17 with others within SAMHSA to get an overview of our  
18 delivery system and the issues that are germane. I think  
19 you are interested, Wendy Waddy, in women's issues and  
20 children's issues. It fits nicely on our matrix and in our  
21 activity.

22 Anybody else whose name I haven't mentioned?

23 (No response.)

24 DR. CLARK: All right. We're also pleased to  
25 welcome the participants in a dialogue for CSAT's Hispanic

1 Task Force, who extended their stay to join us today. Will  
2 those who are participants in the Hispanic Task Force stand  
3 up? Too numerous to name. Thank you very much.

4           We'll be hearing from Ruth Hurtado later,  
5 delivering comments, and members of the task force will be  
6 delivering comments on their observations. Ms. Hurtado is  
7 the public health advisor in the Division of Pharmacologic  
8 Therapies, and she'll be briefing us on the results of that  
9 task force, and she worked with Chilo, who I'm going to  
10 single out. He agreed several months back to work in an  
11 advisory role with the Hispanic work group, so today he's  
12 wearing two hats.

13           I think the issue for Council members -- some  
14 of you have been working with specific issues. I know Val  
15 has been working with e-therapy. These are the kinds of  
16 things that we like to tap Council members for, the  
17 specific kinds of sub-issues that we have to deal with.  
18 Some of you are available and others aren't, but the key  
19 issue is we see this role as an important role, and you can  
20 be of assistance to us as we attempt to address these  
21 issues, and to inform Mr. Curie so that he can make  
22 whatever decisions of importance to SAMHSA.

23           We're grateful to the staff who have worked to  
24 organize this meeting, the members of George Gilbert's  
25 team, starting with Cynthia Graham and others.

1                   Cynthia, do you want to acknowledge the people  
2 who are working with you?

3                   MS. GRAHAM: Just George's office.

4                   DR. CLARK: Just George's office? Julie,  
5 you've become just George's office.

6                   (Laughter.)

7                   DR. CLARK: Doug, where are you? All right.  
8 Well, we should do better than that later. Just George's  
9 office. All right.

10                   Can we put my slide show up?

11                   So I'm going to take this opportunity to  
12 address you today to start off the meeting, of course.  
13 Clearly, it's important for us to recognize that a lot of  
14 things happen between meetings. One of the most important  
15 things that has happened between January and today is that  
16 our '06 budget was released by the President. The '06  
17 budget, of course, is what the President believes we should  
18 be spending. We will find out what the Congress intends to  
19 do as it pursues its deliberations.

20                   You've received copies of the Director's  
21 Report, and it summarizes the activities we've been  
22 pursuing. You'll be hearing from members of my staff, who  
23 will highlight specific areas of importance. So when we  
24 look at the '06 budget that was submitted by the President,  
25 you'll see that there is a modest -- as soon as I can

1 figure out how to make this thing work. Oh, there's the  
2 '06 budget. There is a modest increase in our  
3 appropriations for the Center for Substance Abuse  
4 Treatment.

5           Maybe I should go to the podium. This doesn't  
6 work so well. It puts me way over here. I feel alienated,  
7 estranged.

8           All right. So we're requesting for our block  
9 grant \$1.776 billion. Ninety-five percent of this is  
10 distributed to states and territories by formula. Formula  
11 is based on population, total taxable resources, and cost  
12 of services. This formula is promulgated by the Congress.  
13    The distribution of the money represents about 40 percent  
14 of all funds managed by single-state agencies for substance  
15 abuse prevention and treatment. It supports approximately  
16 10,500 community-based organizations. It includes set-  
17 asides for prevention. Twenty percent of the funds are set  
18 aside for prevention. That goes to the Center for  
19 Substance Abuse Prevention. There's a set-aside for women  
20 and HIV/AIDS. There's a 5 percent set-aside for  
21 jurisdictions with HIV prevalence rates of 10 per 100,000.  
22    So we have about 25 states that have a 5 percent set-aside  
23 for HIV. Then there are also priorities for women  
24 injection drug users and tuberculosis.

25           These are our priority areas that the budget

1 will support. Our modest increase is primarily going to be  
2 directed toward our expanding substance abuse treatment  
3 capacity through the Access to Recovery program. This is,  
4 as you know, a voucher program that is currently underway.

5 Ken DeCerchio is the SSA from Florida and is working with  
6 us in this area, knowing full well that this is an  
7 important thing. In the past, state interest in ATR has  
8 been overwhelming. Some 66 states, territories and tribal  
9 organizations apply for the \$99 million that we had  
10 available in '04. In August of '04, we awarded 14 states  
11 and one tribal organization ATR funds.

12 In '06, the President has proposed \$150 million  
13 for ATR, and that will support the 15 grants that we have  
14 and fund seven new ones. With the addition of \$50 million  
15 in funds, an estimated 62,500 people will be served.

16 The budget also proposes an increase in SBIRT  
17 by \$6 million, for a total of \$31 million. Total Targeted  
18 Capacity Expansion grants are proposed to be funded a  
19 little over \$33 million.

20 So we have \$30 million that is proposed for  
21 homelessness, with those with substance abuse disorders.  
22 The budget will support \$29.6 million, which is a slight  
23 decrease between '05. For children and families, it's \$33  
24 million. It's a slight decrease. For HIV/AIDS and  
25 hepatitis, we are proposing \$61 million for Capacity

1 Expansion for outreach and substance abuse for African  
2 Americans, Latinos, Hispanics, and other racial and ethnic  
3 minority groups disproportionately affected by substance  
4 abuse and HIV/AIDS.

5           We're proposing \$25 million to support programs  
6 that address the treatment needs of adults and adolescents  
7 in the criminal justice system, and this is a \$1 million  
8 reduction. The '06 budget proposes maintaining the  
9 substance abuse and treatment block grant at the same  
10 level, which is, as I mentioned, just under \$1.7 billion.

11           So these are, as most people are very well  
12 aware, delicate times budget-wise. I think we're faring  
13 quite well under the constraints that we have to operate.  
14 Those constraints are dictated by a competing national  
15 agenda. I think the President has treated us very  
16 favorably given the hard choices that he's had to make.  
17 Clearly, not all programs are going to fare well in this  
18 process, so we have to recognize that.

19           The Best Practices Programs which promote  
20 effective treatment through the adoption of evidence-based  
21 practices will be supported by approximately \$28 million.  
22 This is a reduction of approximately 41.6 percent. Our  
23 Best Practices help us to adopt evidence-based practices,  
24 supports training and technical assistance, translates  
25 research to practice, conveying the most up-to-date

1 science-to-services models to the field.

2           We know that with the diminution of \$20  
3 million, affected programs will be program coordination and  
4 evaluation activities, pharmacologic activities, Addiction  
5 Technology Transfer Centers, women and children and family  
6 activities, Knowledge Application Programs, Partners for  
7 Recovery, and others, the SAMHSA Health Information Network  
8 and consumer affairs activities and technical assistance.

9           At the appropriations hearing that Mr. Curie  
10 presented, the issue of our workforce development  
11 surfaced, and it was clear that Congressman Regula has a  
12 personal interest in making sure that we have sufficient  
13 activities in the area of workforce development. So we'll  
14 just have to follow what the Congress does. The President  
15 has had to make hard choices and has done so.  
16 Nevertheless, as some of us are well aware, there are  
17 activities going on in the community that have risen to  
18 almost daily characterizations.

19           So most of us are familiar with Sudafed and  
20 methamphetamines. U.S. News and World Report this week has  
21 a thing on gambling. It showed the addiction disorders are  
22 demanding a lot of attention, and society is having to make  
23 changes. Those of you who are familiar with the Sudafed  
24 issue know that Wal-Mart and Target and K-Mart are pulling  
25 Sudafed behind the counter. Oklahoma has a registry where

1 you have to sign up if you're going to get more than three  
2 grams of Sudafed. So they're making real changes.

3           The paradox is that Sudafed is a medication  
4 used for the treatment of, among other things, allergic  
5 rhinitis, nasal congestion. I reviewed the literature on  
6 Sudafed, and it turns out that it's actually a very useful  
7 medication. So what it represents, then, is sort of the  
8 conflict between how do we deal with the methamphetamine  
9 problem, where Sudafed is being diverted for misuse by  
10 making it a precursor to methamphetamine, and how do we  
11 maintain the health of our nation. It turns out that  
12 allergic rhinitis is responsible for at least \$5 billion a  
13 year in health care costs. It has a disability load and it  
14 does respond to a combination of antihistamines and  
15 decongestants, the major decongestant being medications  
16 like Sudafed.

17           So the pharmaceutical industry is trying to do  
18 other things. Nevertheless, our media is capturing what it  
19 is that I'm talking about in terms of the prevalence of our  
20 issues.

21           We won't be funding our National Alcohol  
22 Screening Day. We will be eliminating funding for our  
23 conference grant program. CSAT has been able to contribute  
24 to the minority fellowship program. We won't be able to do  
25 that under the proposed budget as a result of having to

1 make the concessions that are necessary in order to keep a  
2 viable agenda.

3           We are also trying to get the message out to  
4 the Congress. The question keeps being asked, well, what  
5 are you doing with your money? So especially, as you know,  
6 personally when you're in tight budget times, you ask  
7 yourself what am I doing with the money? What do I need?  
8 What don't I need? What am I getting in return? So  
9 National Outcome Measures, which we'll hear from Stephenie  
10 Colston and others, National Outcome Measures are being  
11 pursued.

12           I want to highlight briefly that CSAT and state  
13 representatives met in Minnesota on May 5th and 6th for the  
14 first of five regional meetings to discuss implementation  
15 of these 10 domains. The discussion included data from  
16 state data systems, admission and discharge data, unique  
17 client identifiers, and timely reporting of data. This is  
18 intended to result in the full National Outcome Measures  
19 reporting within three years.

20           Preliminary data from 2005. Our block grant  
21 applications show that 11 states are reporting admission  
22 and discharge data in the abstinence domain, and all  
23 identify improvement in abstinence. Sixteen states report  
24 data in the employment domain, and all identify  
25 improvements in client employment. Eight states report

1 data in the criminal justice domain, and all identify a  
2 reduction in arrests. For the 13 states reporting data in  
3 the housing domain, 12 of the 13 identify improvements in  
4 stable housing.

5           So we are working with the states. This is a  
6 common agenda. In our discussions with state authorities,  
7 it's quite clear that the state legislatures, the state  
8 governments are asking the same kinds of questions. We  
9 found that some states have been fortunate in generating  
10 additional resources from their governor and from their  
11 legislature, and it appears that being able to answer some  
12 of these questions assists them in that agenda. So this is  
13 an important thing for us to pursue, and Stephenie Colston  
14 will lead the discussion on that.

15           The substance abuse treatment block grant is  
16 very important to the country, of course. More than 50  
17 percent of the funding from the block grant represents  
18 these states, which represent about a third of our block  
19 grant recipients, acknowledge the block grant using 2002  
20 data, constituted greater than half of their public budget.

21       So Alabama at 78 percent, Arkansas at 63 percent, Colorado  
22 at 59 percent, Florida at 52 percent, Georgia at 50  
23 percent, Idaho at 62 percent, and you can see it goes on  
24 and on. In some jurisdictions, like Wisconsin, it's 87  
25 percent.

1           So if we can tell the story about how the money  
2 is spent, we will be telling the story about the substance  
3 abuse delivery system within many of these jurisdictions.  
4 There's a report back there on health expenditures and  
5 substance abuse and mental health, and that report makes it  
6 quite clear that for substance abuse, public dollars  
7 constitute the major source of income for providers. It's  
8 a major source of expenditure. So what we're doing in the  
9 block grant then becomes of critical importance, and I  
10 really appreciate the efforts by single-state authorities,  
11 NASADAD, and of course our staff to work collaboratively so  
12 that we can tell the story to the Congress, and hopefully  
13 continue the funding.

14           As I pointed out with the Sudafed example, we  
15 have these competing interests that need to be mediated  
16 carefully, and we need to show that we're spending the  
17 money wisely, that we're having a positive impact on  
18 criminal justice and child welfare. Methamphetamine is  
19 raising a lot of concerns about child welfare issues.  
20 Those of you who had experience with cocaine in terms of  
21 "crack babies" recognize that we're simply revisiting a  
22 critical issue, but we're revisiting it with alacrity and  
23 dispatch.

24           Since we're dealing with pharmaceuticals, we  
25 recognize that the misuse of pharmaceutical drugs is a

1 major issue, particularly the opioids. On February 9th, we  
2 convened an open dialogue with pharmaceutical companies.  
3 Those of you looking at the slides, these are the companies  
4 who were present, and they represent the major  
5 manufacturers of opioid agents, opioid agents used for the  
6 treatment of pain. We're all very much aware, particularly  
7 with an aging population, that the issue of pain is a major  
8 one, and how to treat pain effectively and carefully is a  
9 conundrum. It's not as simple as all of that. Some people  
10 are undertreated, some people are overtreated, and we all  
11 have to work together collectively to come up with  
12 effective treatment strategies.

13 I know, since we have a fitness center in this  
14 building, 1 Choke Cherry, I've been trying to work out in  
15 the fitness center. I'm walking. I can't run. I've got  
16 bad hips. But I find after about an hour, the pain goes  
17 away, but then later the pain comes back. So I'm becoming  
18 real sensitive. I mean, fortunately, I don't need to take  
19 medications other than Motrin at the moment, but I'm real  
20 sensitive about keeping my options open. So I know when I  
21 poll the audience, nobody wants to suffer. So I guess  
22 we're not all that stoic out there.

23 But this was an important meeting. They are  
24 looking forward to a follow-up meeting which we will be  
25 having to discuss where else we can go with what strategies

1 should be pursued, and we have to work with the DEA and the  
2 FDA. In fact, I just met with the chiefs of police last  
3 week dealing with the issue of drug abuse, prescription  
4 drug abuse. Dr. Hoffman and I met with Karen Tandy and the  
5 chiefs of police. They're very much concerned with  
6 maintaining a proper balance. The continuum of public  
7 safety and public health is an important one, and the  
8 chiefs of police are not interested in creating a  
9 disconnect between the two efforts, which was a refreshing  
10 thing. You tend to see cops as "Let's go get them." But,  
11 in fact, what they basically want is a safe community and a  
12 healthy community, and working collectively and together, I  
13 think we can achieve that without causing a great deal of  
14 consternation by denying people access to legitimate  
15 medications for legitimate medical purposes.

16           So the pharmaceutical company acknowledged our  
17 need to collect data, and we had participants from our  
18 Office of Applied Studies to help us tell the story using  
19 our Household Survey data and our DAWN data to point out  
20 some of the problems. We need to develop specific  
21 strategies addressing the source of each problem, and we  
22 need to plan for adequate evaluation. We have in our  
23 country fairly rigorous rules on how medications can be  
24 approved, so as some people said, well, why don't you just  
25 make a new formulation? It isn't that easy. You just

1 can't run out and make a new formulation. Everything needs  
2 to be tested because there are negative, unintended  
3 consequences which people then get upset with.

4 I was part of a delegation to the United  
5 Nations through the Commission on Narcotic Drugs held in  
6 Vienna. This organization is comprised of 60 nations and  
7 meets annually to address the implementation of  
8 international drug control treaties. At this particular  
9 meeting, we focused on the control of precursors, such as  
10 clandestinely produced amphetamine-type stimulants, which  
11 is a major issue not only in the United States but also in  
12 Asia and other countries.

13 The CND meeting included also special thematic  
14 debates on drug abuse prevention, treatment and  
15 rehabilitation, focusing on community capacity building and  
16 preventing HIV/AIDS and other blood-borne diseases in the  
17 context of drug abuse prevention. We'll hear from Dr. Voth  
18 tomorrow on harm reduction. This was a theme that surfaced  
19 at this meeting, and it was a theme that we addressed. Mr.  
20 Walters, who is the Director of the Office of National Drug  
21 Control Policy, articulated the U.S. stand on needle  
22 exchange programs and other harm reduction strategies and  
23 the drug legalization issue.

24 I was fortunate enough to be able to present  
25 the U.S. position on drug demand reduction and work with

1 delegates with other nations in reviewing proposed  
2 resolutions to assure that the resolutions were consistent  
3 with U.S. drug control goals and policies. There is a  
4 major harm reduction effort afoot, and again we'll hear  
5 from Dr. Voth about that. There's a debate internationally  
6 about what strategies we should employ to address the  
7 HIV/AIDS epidemic.

8           There was no difference of opinion about the  
9 need to address HIV/AIDS. The only question is what's the  
10 best vehicle for that. So I think that's an issue.

11           On April 6th, I participated in a briefing of  
12 the House of Representatives' Addiction, Treatment, and  
13 Recovery Caucus on methamphetamine addiction and recovery.

14    The House is very much concerned about this issue. On  
15 April 11th, I briefed Senate staff on the Subcommittee on  
16 Labor and Human Services, education-related agencies, on  
17 methamphetamine and inhalant prevention programs.

18           We've had a program continuing our activities  
19 on e-therapy. I think we need to bring the substance abuse  
20 treatment community into the 21st century. Val Jackson was  
21 a speaker at that meeting. This was at the Lonny Mitchell  
22 conference.

23           Sheila Harmison. Is Sheila around? Sheila  
24 worked with Patrice Clark, one of our interns. No  
25 relation. But it's a very useful discussion. We'll hear

1 from Sheila on this. She also presented to the Joint Work  
2 Group on Telehealth at the Appalachian Regional Commission.

3 Our SAMHSA News in January/February devoted a top issue on  
4 our December E-Therapy, Telepsychiatry, and Beyond  
5 Conference.

6 We're beginning to recognize that we have to  
7 upgrade not only our MIS systems but our strategies and how  
8 we address the issue of increasing access to care. No one  
9 is suggesting that e-therapy be a substitute for face to  
10 face encounters or replace access to care from face to face  
11 encounters. But what we are saying is that we have far too  
12 few people who have access to face to face encounters, and  
13 we need to recognize it, acknowledge it, and come up with  
14 strategies to deal with it. We met yesterday, Mady Chalk  
15 and I and Fran Cotter, with representatives from the  
16 Netherlands, and they have developed not only a  
17 bibliographic search effort but also an online treatment  
18 for alcoholism, recognizing that not everybody is ready to  
19 address their alcohol abuse problem in a face to face  
20 manner.

21 We're working on Access to Recovery. We have a  
22 very access team. Can my ATR team stand up? We'll hear  
23 about this later, but I want the ATR team to stand up.  
24 That's two, only two. Mady, are you not a part of this?  
25 Thank you very much, Mady. I have a bunch of bashful ATR

1 representatives. You can't do that. You have to be out  
2 there carrying the message. Thank you. I want to tell you  
3 I appreciate your work.

4           ATR allows individualized pursuit of recovery,  
5 providing consumer choice and increasing the array of  
6 treatment and recovery support services. We are trying to  
7 reward performance by offering incentives to providers who  
8 produce results. We're working with state entities. As I  
9 mentioned, we have some 14 states. Florida, under the  
10 leadership of Ken DeCerchio, is one of our grant  
11 recipients.

12           A key issue is client choice in recovery  
13 support services. We believe that we underemphasize  
14 recovery support services in our delivery system, and our  
15 ATR effort will assist us in facilitating that. This will  
16 allow us to increase the array of faith- and community-  
17 based providers to provide clinical treatment and recovery  
18 support services.

19           I will be visiting a number of jurisdictions.  
20 Our staff will be making some site visits to several of our  
21 ATR grants. This is a high priority for this  
22 administration. The problem with having a high-priority  
23 activity is that everybody is watching you, and our hope is  
24 that we can get past the old adage that you can't do  
25 anything right and you can't please everybody. My team has

1 been very actively addressing some of the issues that have  
2 surfaced. A number of issues have surfaced, and we are  
3 working closely with the states. I'm sure some project  
4 officers think we're working too closely with them, but our  
5 objective is to have a smoothly operating Access to  
6 Recovery initiative that produces the best results  
7 possible.

8           Some of you are familiar with our TIP 42. This  
9 is the revised TIP 9, "Assessment and Treatment of Patients  
10 with Co-Existing Mental Illness and Alcohol and Other  
11 Drugs." It's not "Substance Abuse Treatment for Persons  
12 with Co-Occurring Disorders." The key issue is our first  
13 printing has been exhausted at 27,000, and I've had to  
14 request a second printing of TIP 42 to 50,000. Those of  
15 you who are familiar with TIP 42, this is a big document.  
16 For somebody my size, I get to use it for strength  
17 training. It's that big. Yet people are requesting it,  
18 and it's not just the substance abuse delivery system. It  
19 was a TIP that was well done, and I want to again commend  
20 Mady's group.

21           I see Karl White is out there, and Chris Curry  
22 for coordinating this effort. Chris is the lead on the  
23 TIPs. Are you out there, Chris? I can't see you. Then,  
24 of course, we work with our co-occurring and homeless  
25 branch, Charlene LeFauve and others. The co-occurring and

1 homeless branch is Charlene and Jim Herrell and George  
2 Kanuck. So we've been doing a lot in the area of co-  
3 occurring.

4           Just last week I attended a meeting with our  
5 COCE, which is our co-occurring disorders technical  
6 assistance center, and their advisory group met to talk  
7 about how we're going to deal with the issue of co-  
8 occurring disorders.

9           Join the Voices for Recovery. Our theme for  
10 September of this year is Healing Lives, Families, and  
11 Communities, and I think this is important. We want to  
12 have Council members support us in our effort. I'm fond of  
13 saying this is not just for people in recovery. This is  
14 for the community to understand that recovery is possible.

15    If we don't have the community believing that recovery is  
16 possible, if we don't have them acknowledging that recovery  
17 is possible, then we don't get the community support that  
18 we need, and recovery is not possible without community  
19 support. You return people to bars and to crack houses and  
20 to methamphetamine dens and you expect them to stay clean  
21 and sober, I think you do them a disservice.

22           Ivette Torres has worked hard with her team to  
23 deal with this issue. Is Ivette out there? Oh, there you  
24 are. Is Carol back there? So we want to really stress the  
25 importance of this issue. Ivette's group has worked hard,

1 and it's a complex issue.

2           There are a lot of materials out there,  
3 activity kits, flyers, PSAs. Ivette's group has managed to  
4 negotiate with TV and radio, \$3 million in free time. We  
5 have a webcast series, "Road to Recovery." We have the Ask  
6 the Expert chat. Is Michelle out there, Michelle  
7 Westbrook? In any event, some of these things are really  
8 complex, they take a lot of time and a lot of energy, but  
9 we're getting results. We have 10 shows aired in 160 cable  
10 markets, 450 events nationwide. We've got over 940,000  
11 people participating, 111 government proclamations, 8.5  
12 million hits on the site, with 5 million unique visitors.  
13 The website has won six awards over the last year, and the  
14 PSAs have received honorable mentions at the Addies. So we  
15 encourage you to look at [www.recoverymonth.com](http://www.recoverymonth.com).

16           This is all a lot of work, and it raises  
17 awareness and gets the message out. So I'm extremely  
18 pleased by our efforts on Recovery Month. I, for one, wind  
19 up doing mom and pop radio at 11 o'clock at night, 6  
20 o'clock in the morning, and guess what? I love it, because  
21 there are a bunch of people hanging out out there at 11  
22 o'clock at night and 6 o'clock in the morning. It's a  
23 surprising thing.

24           (Laughter.)

25           DR. CLARK: I wake up. Whoa, I should be in

1 bed. I was on one radio talk show that was supposed to be  
2 from 11 to 12 at night, and the guy says, well, can you  
3 stay until 12:30? We were getting calls from all over, so  
4 I stayed until 12:30. But the key issue is that our issues  
5 are important issues. So we've got a lot of activity that  
6 we have to address, and it takes time to address that. Our  
7 website, as all of you are well aware, is [www.samhsa.gov](http://www.samhsa.gov),  
8 and we have a bunch of sub-websites.

9           What I want to do is thank you for your  
10 attention and your participation and your efforts and to  
11 see if Council members have anything to discuss about my  
12 report.

13           MR. DeCERCHIO: Question. In the United  
14 Nations presentation, was there any discussion, either  
15 online or offline, about prescription drugs and Internet?

16           DR. CLARK: Oh, yes, that's the big thing.  
17 That was part of the effort, how do we limit that, how do  
18 we address that. There are a lot of bogus sites out there,  
19 a lot of offshore sites. People are receiving medications  
20 in the United States. We're just trying to quantify some  
21 of these things. Allegedly from Canada, people who are  
22 seeking legitimate prescriptions are getting bogus  
23 prescriptions from offshore sites. It's easy to route an  
24 address through Canada when it's not really in Canada. So  
25 while Canadian pharmaceuticals might be on par with the

1 United States, the fact of the matter is if you do it on an  
2 anonymous website, if you will, you don't know what you're  
3 getting, from where you're getting. So that turns out to  
4 be an issue.

5 Kids are requesting precursors and drugs. Some  
6 drug deals, at least, have been using the Internet to  
7 peddle hard-core known drugs, get your cocaine online.  
8 There are some people who are using the Internet for that  
9 purpose. You can get an anonymous box. You know, the old  
10 brown bag, brown box used to refer to certain kinds of  
11 things. Now it's drugs. So they're working on that.

12 Frank?

13 DR. McCORRY: Westley, the NOMs measures are  
14 in-treatment measures? They're not post-discharge  
15 measures?

16 DR. CLARK: Oh, no, they're both.

17 DR. McCORRY: They're both?

18 DR. CLARK: Yes. We want to know what happens  
19 six months afterwards. I mean, the fact that you got  
20 treatment -- remember the 28-day program? You did 28 days,  
21 you were good for 28 days. But on the 30th day -- no, we  
22 want to know what happened.

23 MS. JACKSON: I'm really pleased that you're  
24 continuing with the National Recovery Month in September.  
25 I'm wondering what kind of work are you doing with the

1 states -- we have some state folks here, one of my own --  
2 in terms of getting the states to work across each state  
3 with the communities so that we're building it and building  
4 it? I've been involved in Recovery Month for several  
5 years, and I feel that it's really good. I don't know if I  
6 feel like it's -- I wish it would become a household word,  
7 and maybe that's too much hope, but I'd really like to see  
8 that go. So anything that we could do on the state level  
9 maybe would be more helpful, or is there any money that we  
10 can put into that side of it?

11 DR. CLARK: Well, again, we have a limited  
12 budget. I think Ivette's group is doing yeoman's duty, and  
13 we'll be working with the states. So we'll just keep our  
14 activity up. I mean, that's basically all I can say. I  
15 don't anticipate an influx of new funds. We just have to  
16 figure out how to leverage limited funds, and Ivette and  
17 Michelle and Carol have all worked hard to do that and will  
18 continue to do that.

19 MS. JACKSON: I just wanted to add that I do  
20 really love the materials that you put out. I mean, they  
21 are great. So don't get me wrong on that, because I think  
22 what you're doing is wonderful work. I would just like to  
23 see it grow even greater. I'm a big fan of it. Thank you.

24 DR. CLARK: Bettye?

25 DR. FLETCHER: First of all, I'd like to thank

1 you for an exhaustive report.

2 I wanted to comment on the TIPS document.  
3 Recently, I encouraged the adoption of those TIPS as a  
4 primary reference resource for a graduate training program  
5 in substance abuse treatment. I was wondering if you all  
6 collect any kind of data or information on how the TIPS are  
7 actually used, in what populations and what settings they  
8 are being utilized. It's a tremendous resource.

9 DR. CLARK: Karl, we have a study on the use of  
10 the TIPS, do we not?

11 DR. WHITE: Yes.

12 DR. FLETCHER: That would be great.

13 DR. CLARK: Well, thank you.

14 Dave?

15 MR. DONALDSON: Just to illustrate your comment  
16 about meth and the impact that it's having on child  
17 welfare, I was in Springfield, Missouri last week, and the  
18 front page talked about how 50 to 70 percent of the men  
19 incarcerated are because of meth-related offenses, and how  
20 it's causing them to shift their budgetary priorities to  
21 include dental, but more and more to foster care, so much  
22 so that they're now having to go 90 to 100 miles out from  
23 Springfield to recruit parents for these kids.

24 DR. CLARK: Dr. Voth?

25 DR. VOTH: I think the meth efforts are

1 phenomenal, and one of the things, though, since we're  
2 right in the heart of it in Kansas, I keep trying to keep  
3 at the forefront of the consideration is nobody gets to  
4 meth by waking up one day and saying I'm going to use meth.

5 I mean, they're virtually all starting with alcohol and  
6 marijuana. So we've got to not take our eye off the ball  
7 at alcohol and marijuana because that is the entree to  
8 meth, even though all of the other precursor efforts are  
9 wonderful. I just think we need to keep that heightened  
10 awareness.

11 DR. CLARK: I just got called up to the  
12 Administrator's office, so I will be leaving briefly and  
13 only for a short period of time. But before I leave, I  
14 wanted to introduce the Hispanic Work Group. I alluded to  
15 the newly-formed CSAT work group, and this group has met  
16 several times and would like to share information with you  
17 from the work group. Briefing us today is the chair of the  
18 work group, Ruth Hurtado, a public health advisor in our  
19 Division of Pharmacologic Therapies, or DPT as we fondly  
20 refer to it.

21 Ruth began her federal career with DPT after  
22 completing an internship through the Hispanic Association  
23 of Colleges and Universities, called HACU. In her current  
24 position she's responsible for the certification process of  
25 new opioid treatment programs, OTPs nationwide, providing

1 technical assistance to treatment providers and maintaining  
2 an updated database of over 1,000 OTPs. She also serves as  
3 liaison between the Drug Enforcement Administration and the  
4 state methadone authorities throughout the OTP process.

5           Joining Ruth for the briefing is Council member  
6 Dr. Chilo Madrid. Chilo's experience in the field of  
7 chemical dependency spans back to 1966, when he performed  
8 an internship at the Arizona State Psychiatric Hospital's  
9 Chemical Dependency Unit. While in the military service in  
10 '69, he again worked drug programs at different levels.  
11 Performing graduate work at the University of Arizona, he  
12 worked as a chemical dependency psychiatric technician at  
13 St. Mary's Hospital.

14           Chilo's recent publication titled "The Table  
15 Model: A Replicable, Seamless, Integrated Program  
16 Increasing Student Attendance in the El Paso Independent  
17 School District" is an out-of-the-box model that deals with  
18 drug abuse and violence issues in schools, utilizing  
19 truancy courts and intensive parental engagement. This  
20 model is already producing a 90 percent-plus success rate  
21 with young drug abusers and violent offenders.

22           Rich Kopanda is going to hold my end of the  
23 fort, and Ruth and Chilo will give their presentations.  
24 Thank you.

25           (Applause.)

1 DR. MADRID: Muchas gracias y buenas dias.  
2 Thank you all very much, and good morning to you all. I  
3 wanted, first of all, to thank the Council members for  
4 giving us the opportunity and the time to appear before you  
5 today and talk with you about some issues that are very,  
6 very close to our hearts, issues that involve many, many  
7 people in our country. But before we go into the  
8 presentation, I wanted to again thank the Hispanic  
9 stakeholders that joined us yesterday. We did about one  
10 week's work in one day, and I don't think I've ever met and  
11 exchanged ideas with people that are so bright. It was  
12 very, very stimulating to be.

13 I wanted to, first of all, recognize Dr.  
14 Rafaela Robles. Doctor, thank you. Then we have Dr.  
15 Teresa Chapa. Teresa, thank you. Then we have, to the  
16 right of Dr. Robles, we have Ambrosio from L.A. Ambrosio?  
17 And then right behind or to the left of Dr. Robles we have  
18 our friend from Chicago, Illinois that also we need to  
19 thank, Dr. Marco Jacome. Thank you, Marco. Then we have,  
20 of course, my colleague from Texas, Dr. Rudy Arredondo,  
21 who, by the way, also is a Council member for NIDA. He  
22 joined us yesterday and shared a lot of his experiences.  
23 Then right in front of him is our colleague from New York,  
24 Mr. Moises Perez. Moises, thank you. Then right behind we  
25 have Dr. Mario De La Rosa from Miami, Florida. Thank you.

1 I believe that Dr. Pablo Hernandez -- is he here today?

2 There he is. Thank you, Pablo, very much.

3 I believe that covers everybody. Marcia Gomez  
4 -- is Marcia here? No, she's not here, but she was also  
5 with us, these individuals and myself, as well as some of  
6 the staff. As you all know, we have several staff members  
7 with CSAT that assisted us from the very beginning. We  
8 have at the very, very back, dressed in gray and black we  
9 have George Samayoa. George, thank you very much for your  
10 help. Then to his right we have Ivette Torres, who  
11 facilitated the meeting yesterday, did excellent work.  
12 Ivette, thank you so very, very much.

13 Then we have Ques. Where is Ques? There she  
14 is. She's also been with us from the very beginning. As  
15 you know, the CSAT staff has been meeting regularly as this  
16 task was given to them, and we have a couple of other CSAT  
17 staff members that are no longer with us. Richard Lopez,  
18 who was with us at the beginning, I believe he went to work  
19 at another federal agency. Then we had an intern.  
20 Bernadine Hernandez from New Mexico, who is no longer with  
21 CSAT. These individuals worked real hard, a lot of hours,  
22 on top of their jobs that they're already doing. I want to  
23 personally thank them for all the fine work that they did.

24 So again, Dr. Clark, thank you. Council  
25 members, thank you. I'm going to turn over the

1 presentation, the formal presentation, to the individual  
2 that was selected as chair, who has worked many, many  
3 hours. I don't think she slept last night because we gave  
4 her a lot of homework, as we have for the last several  
5 months, and that is none other than Ruth Hurtado, who was  
6 selected as the chair of this particular work group.

7           So, Ruth, take it away. I will be joining Ruth  
8 at the end to answer any questions. The Hispanic  
9 stakeholders are here also to help us with any questions  
10 that you all might have.

11           So, Ruth, again, thank you so very much for all  
12 the fine work that you did.

13           (Applause.)

14           MS. HURTADO: Well, good morning. I wanted to  
15 thank the Council members and Dr. Clark for giving the work  
16 group the opportunity for us to present this information to  
17 all of you today. Again, thank you to all the work group  
18 members who have contributed to this effort as well.

19           Just to begin, I wanted to start with some  
20 figures to let you know what the Hispanic population looks  
21 like today. We have about 40 million Hispanics who live in  
22 this country today, which makes up about 13 percent of the  
23 population. We're the largest minority group, and we're  
24 growing very rapidly. We have about a 9.5 growth rate  
25 compared to the regular 2.5 growth rate of the rest of the

1 population. About two-thirds of our population is 25 years  
2 or younger. So we're a very young population. We are  
3 expected to be the largest minority group within the next  
4 25 years. So that just gives you an idea of how  
5 significant our population is and really allows us to think  
6 about the unique issues that we need to address also when  
7 we're talking about substance abuse issues.

8           The work group was appointed by Dr. Clark in  
9 October of last year, and when we first met with Dr. Clark  
10 he wanted us to begin by doing an internal assessment of  
11 the activities that were occurring within the Center. So we  
12 began working as a work group and meeting pretty much on a  
13 bi-weekly basis to work on Dr. Clark's recommendation, and  
14 also to develop some goals and tasks for ourselves as a  
15 work group.

16           Some of the goals that we had for the work  
17 group was, number one, to assess the level of services that  
18 were being offered through the CSAT grantees and Spanish-  
19 speaking communities. We also wanted to focus on workforce  
20 development of Hispanics in the field of substance abuse.  
21 We wanted to identify and prioritize recommendations for  
22 services improvement. We also wanted to work on materials  
23 development in Spanish. We wanted this to be a cross-  
24 center collaboration, and so we did invite the other  
25 centers to participate in the dialogue that we had

1 yesterday with the stakeholders, which was a very  
2 productive meeting and a very successful meeting.

3           So some of the tasks that we've worked on so  
4 far, we've identified some of the current data on Hispanics  
5 and substance abuse from the National Survey on Drug Use  
6 and Health, as well as the National Council of La Raza.  
7 We've also identified the current CSAT grantees that are  
8 located in areas with a high Hispanic population. We've  
9 taken these grantees and verified the availability of  
10 Spanish language services within these providers. We've  
11 also done an inventory of the CSAT Spanish language  
12 publications. Finally, we've convened the Hispanic  
13 stakeholders meeting, which took place just yesterday.

14           Just to start, this is some figures from a  
15 statistical brief that was developed by the National  
16 Council of La Raza. They did a report on Latinos in the  
17 federal criminal justice system, so I thought it would be  
18 relevant to include some of these figures since the  
19 criminal justice system is one of the SAMHSA priority  
20 areas. Under the adjudication portion, they found that  
21 Hispanics were more likely to be convicted for drug  
22 offenses and least likely to be convicted for violent  
23 offenses. In 1999, they found that offenders convicted for  
24 drug offenses were -- 42.6 of them were Hispanic.

25           Under their sentencing report, they found that,

1 in 1999, 94.4 of the offenders sentenced to prison were  
2 drug offenders, and only 11 percent of the Hispanic in  
3 prison received any type of substance abuse treatment.

4 Then to go through some of the National Survey  
5 on Drug Use and Health data, this is past month illicit  
6 drug use among youths age 12 to 17, just to show how the  
7 Hispanic population is with respect to the other groups.  
8 This is from 2002 to 2003. There was an increase for the  
9 Hispanic population.

10 This is also illicit drug use, but for ages 12  
11 or older. Again from 2002 to 2003 there's an increase of  
12 about 0.8 percent. Current binge and heavy alcohol use  
13 among those age 12 or older, it seems like the binge use is  
14 one of the bigger concerns here. Also, when we're talking  
15 about the co-occurring issues, serious mental illness among  
16 Hispanics, about 9 percent.

17 Another recommendation that Dr. Clark had given  
18 us was to develop some geomaps to display the areas of  
19 Hispanic population across the nation, and then to see  
20 where our CSAT grantees were in these areas. So with the  
21 help of Charles Reynolds, who actually works in the Center  
22 for Substance Abuse Prevention, he helped us to develop  
23 some maps with this information. This first map shows the  
24 concentration of Hispanic population by county. The yellow  
25 is 12 percent to 29.9, and the pink is 30 percent or

1 higher.

2                   Then this shows the CSAT discretionary  
3 treatment grantees in respect to the areas of the Hispanic  
4 population. So we found that there were about 250 grantees  
5 located in areas that had 13 percent or higher.

6                   So what we did was we took these grantees and  
7 we verified the Spanish language services that were  
8 available in these grantees. From this verification, we  
9 found that about half of the grantees were offering Spanish  
10 language services, and it was listed in the treatment  
11 directory. There were also about 76 grantees who were  
12 offering Spanish language services, but this information  
13 was not listed in the directory. There were about 49  
14 grantees who did not have Spanish language services  
15 available.

16                   So from this we can see that CSAT is sensitive  
17 to the issues, and we are doing a really good job, but it  
18 doesn't prevent us from doing better in this area. This is  
19 just showing the grantees who are not offering Spanish  
20 language services.

21                   Some of the key benefits from this  
22 verification, we now have more updated information for the  
23 Helpline and facility locator. We also have increased  
24 treatment referral options of Spanish language services.  
25 When people call the Helpline, they have more options to

1 turn to. Also, this is the inventory that we did of CSAT  
2 Spanish publications, just a listing of some of the ones we  
3 have here, and then I wanted to show you some of them.

4           This one is "Substance Abuse Treatment for  
5 Persons with Child Abuse and Neglect Issues." This is the  
6 buprenorphine brochure that actually was developed out of  
7 my office, the Division of Pharmacologic Therapies, and it  
8 was printed last year in Spanish. This is a booklet for  
9 families on what substance abuse treatment is. These are  
10 two pamphlets. The one here is "Good Mental Health is  
11 Ageless," which was a collaborative effort between CSAT and  
12 CMHS, and also "Aging, Medicines and Alcohol," which was a  
13 pamphlet developed for the older population and making them  
14 aware of the risks of prescription drug abuse and alcohol.

15       This is the 2005 Recovery Month Spanish flyer out of  
16 Ivette's shop, printed in Spanish.

17           So yesterday, as we mentioned earlier, we had  
18 invited 13 key stakeholders from the field who came  
19 together, and we really had a very intense dialogue on the  
20 issues facing the Hispanic community. It was a one-day  
21 meeting, and we did a lot of work, and out of this meeting  
22 the stakeholders were able to develop some recommendations  
23 for CSAT.

24           Their recommendations pretty much fell into  
25 these categories: workforce development, data and

1 evaluation, systems, and capacity and financing. Under the  
2 workforce development category, the stakeholders felt that  
3 it was important to train new Hispanic service providers  
4 using models such as promotores, which is a model of  
5 training for community health workers to become proficient  
6 in addiction treatment service delivery, and it's a model  
7 that's being used a lot in Hispanic communities. They felt  
8 that this should be one of the recommendations.

9           Also, they wanted to develop some training  
10 opportunities for Hispanic addiction treatment program  
11 administrators, as well as service delivery staff. Also,  
12 the development of science to service finance systems and  
13 license and certification training for Hispanic addiction  
14 treatment service providers.

15           Also, the stakeholders felt that it would be  
16 useful to develop a toolbox for Hispanic service providers  
17 to have this information available to them. Also, they  
18 felt that it would be useful to have a leadership  
19 development and mentoring program that could be done  
20 through local or regional meetings. Also, they felt that  
21 it would be good to work with Hispanic-serving  
22 institutions, as well as health professional schools to  
23 attract more Hispanic students to the field of addiction  
24 treatment.

25           Still under workforce development, they felt

1 that it would also be beneficial to increase the SAMHSA  
2 CSAT Hispanic workforce. They also really felt it was  
3 important to ensure that the CSAT grantees reflect the  
4 communities that they serve in. They recommended a Center  
5 of Excellence which would have a repository of Hispanic  
6 studies, reports, books and other materials and resources  
7 that would be available to students or Hispanic service  
8 providers as well.

9 Under data and evaluation, they felt that CSAT  
10 should work with the Surgeon General to develop a  
11 comprehensive report that would help in identifying some of  
12 the challenges and recommendations on addiction treatment  
13 issues in the Hispanic community, and they also felt that  
14 there was a need for uniform data collection on Hispanics  
15 by state and local providers.

16 Under systems, they felt that they wanted to  
17 make every door a right door for the Hispanic clients and  
18 their families. As we know, many people enter the system  
19 through different mechanisms, and these are just some of  
20 the ones that the stakeholders had mentioned here.

21 Again under systems, they felt that there was a  
22 need to promote system integration at different levels,  
23 starting at the neighborhood, local, state and federal for  
24 services including health services such as HIV, hepatitis,  
25 behavioral health, prevention and intervention, drug courts

1 and schools, and they felt that it was important to have  
2 parental engagement throughout these systems.

3 For capacity and financing, they felt that it  
4 would be useful to develop a targeted Hispanic RFP that  
5 would address the service capacity and workforce issues, as  
6 well as to mandate Hispanic staff integration for all CSAT  
7 grantees operating in areas with high Hispanic service  
8 delivery areas.

9 Also under capacity and financing, they felt  
10 that it would be a good idea to collaborate with the Center  
11 for Medicare and Medicaid Services to assist Hispanic  
12 providers with some of the issues facing the finance  
13 structure, challenges regarding managed care, and possibly  
14 work with CMS to develop a TAP publication. Also, they  
15 felt it was important to include Hispanics in RFA review  
16 panels and to develop a Hispanic talent bank.

17 Finally, for the recovery community, they felt  
18 that it would be a good idea to assist and support the  
19 adaptation of CSAT's current recovery program and adapt it  
20 to the Hispanic community.

21 So some of the next steps. We want to continue  
22 to work with our partners, the stakeholders, and all of you  
23 in the community to identify treatment service gaps for  
24 Hispanics. We want to continue to expand these services by  
25 adopting the implementation that came out of yesterday's

1 stakeholders meeting based on budget and program  
2 priorities. Finally, we want to work with the Center  
3 leadership to really prioritize and then start implementing  
4 some of the stakeholders' recommendations.

5           Just to conclude, I'm very happy to be working  
6 on this work group. It's been a very positive learning  
7 experience for me, and I hope to continue to work along  
8 with all of the work group members and the stakeholders to  
9 continue in this effort. Here's just the contact  
10 information if any of you have questions in the future and  
11 would like to contact me or any of the work group members.  
12 That's it.

13           (Applause.)

14           DR. MADRID: Thank you so very much, Ruth, for  
15 a fine presentation.

16           We'd like to open it up for questions if you  
17 all have any. As you'll notice, one of the first  
18 recommendations was the development of a promotore type of  
19 concept, which works very, very well in the Hispanic  
20 community in other health areas, and that is the training  
21 of grassroots people to do a lot of the outreach, a lot of  
22 the case management. It has proven to be very, very  
23 successful. So we're looking at a lot of very innovative  
24 ideas that hopefully we can develop in the future with the  
25 support of the Council, Dr. Clark and the rest of the CSAT

1 staff.

2 Any questions, or did we just give you too  
3 much?

4 MS. JACKSON: I just wanted to really commend  
5 you on a very relevant subject. Living in Miami, where the  
6 majority of people living in Miami/Dade County are of  
7 Hispanic origin, it obviously is something that's of great  
8 concern to our agency and to our group of agencies. We  
9 have a group known as the South Florida Provider Coalition,  
10 which has 30 different service providers that have come  
11 together as a coalition, and that is one of the issues that  
12 we address. At our agency, we do have a specific Spanish-  
13 speaking program.

14 I just wanted to say that in our history, prior  
15 to the time that we had and developed the monolingual  
16 Spanish-speaking program, and we've been bilingual for a  
17 very long time, had groups, individual counseling was never  
18 a problem to have it in Spanish in Miami. However, much of  
19 the work was done in English, and somebody was trying to  
20 have to translate that.

21 Our percentage of Hispanic population was less  
22 than 12 percent for years and years and years, and when we  
23 implemented the companeros, which is the Spanish-speaking  
24 monolingual program, we immediately jumped. I hate to  
25 give a percentage right now because I haven't measured it

1 lately, but it was doubled the percent of Hispanic folks  
2 who were accessing treatment at our agency. Not only that,  
3 but from the very get-go we had a waiting list, and to this  
4 day we have a waiting list, whereas before we were reaching  
5 out trying to find them. So if you reach out and work at  
6 it, it really works. I'm a testament to that. So I really  
7 appreciate your concern, and I hope CSAT and SAMHSA  
8 continues to really put an emphasis on this because it  
9 works if we put some attention to it.

10 DR. MADRID: Thank you very much for your  
11 comments and for your sensitivity to the Hispanic community  
12 in Florida. That says a lot for you and for your program.  
13 Thank you, Val.

14 Yes, sir?

15 DR. McCORRY: Are there national provider  
16 organizations in substance abuse that have Hispanic roots?  
17 Is there such a thing as a national organization, as well  
18 as national counselor organizations for Hispanic  
19 counselors? Have you given any thought to how that might  
20 be a force for continuing to focus attention on the needs  
21 of the Hispanic community?

22 DR. MADRID: Our preliminary research seems to  
23 indicate that a lot of our Hispanic community is having  
24 trouble with the standardized national licensing exam.  
25 We're trying to develop different recommendations. For

1 example, the toolbox, a lot of workforce type of issues.  
2 There is no Hispanic counselor association nationally.  
3 There is one, an overall association, that a lot of  
4 counselors belong to. There are very few Hispanics that  
5 are members of that association. So again, we're trying to  
6 make headway there, but we need to train people, in the end  
7 get them licensed, and then get them to join these  
8 associations that advocate for the field.

9           So we've got a long ways to go. National  
10 studies seem to indicate that most of the counselors or the  
11 majority of the counselors are not ethnics of color at this  
12 time.

13           I believe Dr. Robles has some comments to make.  
14 Dr. Robles?

15           DR. ROBLES: Yes. I would like to tell the  
16 people from Florida that we in Puerto Rico have about 25  
17 publications in Spanish funded by CSAP. We're called the  
18 Caribbean and Hispanic ATTC. Also, CSAT, with the help of  
19 Dr. Clark and Dr. White, helped to translate into Spanish  
20 the test. So in Puerto Rico, we're giving the Hispanic  
21 test. We have a problem in Puerto Rico because we train  
22 physicians in my school of medicine. I'm at the  
23 (inaudible) School of Medicine, and 61 percent of our  
24 physicians come to the states because they are bilingual,  
25 and they are (inaudible). We have a counselor Master's

1 degree program, and we have already lost 25 of them because  
2 they are bilingual.

3           So in Puerto Rico you have a very good resource  
4 of Spanish-speaking and English-speaking that you need, if  
5 you need. Thank you very much.

6           DR. MADRID: We're very proud of the work that  
7 Puerto Rico has done, and Dr. Robles shared a lot of that  
8 work with us yesterday.

9           Also addressing us will be Mr. Moises Perez  
10 from New York.

11           MR. PEREZ: Perhaps the presentation was so  
12 full that it overwhelmed the members of the advisory group.

13       But I just want to communicate the sense of urgency that  
14 sometimes gets lost in PowerPoint presentations of the  
15 recommendations that we're making. Our community is  
16 growing by leaps and bounds. There are tremendous gaps in  
17 the areas that we presented here. They really do require  
18 some thinking, and they require strategies that are  
19 dramatic.

20           The issues of workforce, the issues of the  
21 reflection of the community in the programs that are funded  
22 -- we looked through the list of grantees that was  
23 presented to us. In New York in particular, there was only  
24 one Latino organization that I can identify there. The  
25 issue of language is important, but it's not enough.

1           So I don't know that the sense of urgency in  
2 terms of the recommendations that we made was properly  
3 communicated, and I hope that you do have a chance to look  
4 at this data, the recommendations, to digest them, and to  
5 maybe walk away with the same sense of urgency that led us,  
6 I think in a very short period of time, to come up with,  
7 quite frankly, recommendations that probably would have  
8 taken, as was pointed out by Chilo, probably a week to pull  
9 together. We really are looking for CSAT to feel this  
10 sense of urgency and to really help us create a stronger  
11 presence organizationally, infrastructure-wise, workforce-  
12 wise, in order to be able to deal with this tremendous  
13 problem in our community. Thank you.

14           DR. MADRID: Thank you very much, Moises. We  
15 all echo your sentiment, and we definitely agree with you.

16           Are there any other questions? Val?

17           MS. JACKSON: You know, I'd like to just make  
18 one more comment. This maybe comes from what I would  
19 perceive as the consumer's view, because I was sitting here  
20 thinking about some of the statistics out of our program,  
21 and I know that in the companeros program, the number of  
22 people who have jobs when they leave treatment is lower in  
23 that program than in our other programs. While I recognize  
24 that it's certainly much more than a language issue,  
25 language is a key thing. You mentioned it, Dr. Robles,

1 about the physicians leaving because they're bilingual.

2 Well, if you're not bilingual, if you come to  
3 our program and we treat you and we work in your culture  
4 and we treat you in the Spanish language, we also try to  
5 teach you English. However, we have a very short period of  
6 time to do that. It's a very difficult thing to do. It is  
7 a huge barrier. Those people who are bilingual get the  
8 jobs. They have an advantage. Those people who only speak  
9 Spanish really have a hard time making a living and making  
10 it out of treatment, and therefore they fail in treatment.  
11 We need to address that.

12 DR. CLARK: Because our next speaker is here,  
13 what I'm going to do is call for the break, and then we're  
14 going to have a public comments period at 11:15 where we'll  
15 hear more, and then we can at the Council roundtable  
16 revisit this issue.

17 So thank you, Chilo, and thank you, Ruth.

18 (Applause.)

19 (Recess.)

20 MR. KOPANDA: I'd like to call us to order.

21 During the Council's January meeting, Dr. Clark  
22 read Mr. Curie's report to the Council. One of the  
23 recommendations in the report was regarding SAMHSA's data  
24 strategy, and the Council roundtable was to get more  
25 information on the stated strategy and the outcome domains

1 that Wes referred to this morning.

2           So we've invited Ms. Stephenie Colston, the  
3 senior advisor to Mr. Curie, to further discuss the data  
4 strategy. Stephenie represents Charlie on administration,  
5 departmental and SAMHSA-specific priorities relating to  
6 substance abuse prevention and treatment. She works  
7 closely with the center directors on a broad range of  
8 policy and program matters. From August 2004 until April  
9 2005, Ms. Colston joined the staff of ONDCP as a director  
10 and senior advisor for demand reduction. She's worked very  
11 closely with the data strategy work group here with the  
12 agency, so we're looking forward to her recommendation  
13 discussion today. You're invited to pick up her bio on the  
14 handout table and get more detailed information on her.

15           So, with no further ado, Stephenie.

16           MS. COLSTON: Thanks, Rich.

17           Good morning. I want to talk a little bit  
18 about the development of the SAMHSA data strategy and kind  
19 of where we are in the process. If anyone is expecting a  
20 single piece of paper to emerge from the SAMHSA data  
21 strategy, you're going to be sorely disappointed.

22           What the SAMHSA data strategy is is a series of  
23 efforts and priorities and a very dynamic and fluid  
24 process. So happy to explain to you where we are at this  
25 point in time.

1                   Can you hear me okay in the back of the room?

2    Okay.

3                   And I'll answer any questions that you might  
4    have.

5                   Just by way of background, I'm not certain if  
6    we've made a presentation to the CSAT Council about the  
7    data strategy. So if I'm repeating things, forgive me.

8                   The Administrator became concerned about a  
9    variety of issues relating to data in the summer of '03 and  
10   asked that we develop a data strategy work group  
11   representing all of our centers and offices in July of '03.

12   The charge of the work group was to prepare a strategy  
13   document to guide the development and refinement of our  
14   data systems. So being good and diligent federal  
15   employees, we hired consultants to engage in that process,  
16   which turned out to be an interesting process. The  
17   consultants basically interviewed dozens of SAMHSA  
18   employees and, of course, worked with the data strategy  
19   work group, reported their findings to the data strategy  
20   work group, established or recommended some data baselines,  
21   and then in February of '04 made a series of  
22   recommendations which I'm going to talk about in a minute,  
23   mostly findings.

24                   The data strategy work group exercised its own  
25   discretion in terms of how they responded to the

1 recommendations of the consultants, which is of course the  
2 federal government's prerogative.

3           One of the most valuable things that the  
4 consultants asked us to do is to kind of think about a  
5 vision statement. As you see, supporting the art of  
6 database management, policy, and programming is our vision  
7 statement. I want to talk a little bit about the  
8 consultant findings and then move pretty quickly into where  
9 we are in the process, because you'll see, I think, the  
10 correspondence between the findings and what we've done as  
11 a result.

12           First, they indicated that SAMHSA lacks an  
13 enterprise model that basically describes how we go about  
14 our business. For example, our bread and butter is getting  
15 grants and contracts out the door. What kind of data do we  
16 have that, for example -- I'm sitting in the Office of the  
17 Administrator. What kind of data do we have in the Office  
18 of the Administrator that would provide early warnings to  
19 us about high-risk grants or contracts, or timelines that  
20 aren't being met so that we're not running around, so to  
21 speak, chasing our tails?

22           Second, that SAMHSA lacks IT infrastructure to  
23 support data collection efforts.

24           Third, no big surprise to any of you who are  
25 community-based organizations or states in the room, SAMHSA

1 does not have standard data definitions in all areas. We  
2 define housing any number of ways depending on the center,  
3 depending on the office, depending on the program.

4 Fourth, SAMHSA lacks the ability to deliver  
5 data to its policymakers and managers in a timely fashion.

6 I'm going to get to some of that in a minute.

7 Fifth, there is significant overlap among  
8 SAMHSA centers -- boy, that was a Freudian slip -- among  
9 SAMHSA systems. Every center has its own data collection  
10 efforts, and there is considerable duplication and lessons,  
11 frankly, and gems in every one of them. So we're right now  
12 in the process of trying to do that analysis and kind of  
13 think through where we want to be.

14 Sixth, SAMHSA in the past has not sufficiently  
15 been involved in national data standard development and  
16 health informatics initiatives.

17 Seventh, SAMHSA conducts surveys and studies  
18 that don't justify the high precision and cost.

19 Now, the consultants made a series of  
20 recommendations, but what the work group decided would be  
21 the most efficient way to proceed is to take those seven  
22 findings and develop some subgroups to work on implementing  
23 them. For example, on development of enterprise model, we  
24 discovered that Dr. Javaid Kaiser, who works for Anne  
25 Herron and Rich Kopanda and Westley Clark in the Center for

1 Substance Abuse Treatment, has a considerable amount of  
2 experience in implementing enterprise models. The  
3 enterprise model is important to SAMHSA not only because  
4 the consultants recommended it but because the United  
5 States Department of Health and Human Services is mandating  
6 that we implement an enterprise architecture, and there's a  
7 whole federal enterprise architecture statute and  
8 implementation model. So Dr. Kaiser is in charge of that  
9 effort.

10 In addition, he's in charge of developing a  
11 technology architecture plan, which is a little further  
12 down the road, and enforcing technical oversight on IT  
13 projects.

14 The task of developing standard data  
15 definitions we asked the director of our Office of Policy,  
16 Planning and Budget, Daryl Kade, to assume responsibility  
17 for, and I'm going to talk about that in a minute in terms  
18 of our National Outcome Measures.

19 The task of adopting standard IT tools and  
20 platforms we asked the acting director of our Office of  
21 Applied Studies, Dr. Charlene Lewis, to assume  
22 responsibility for.

23 The task of consolidating our multiple client  
24 data systems we asked Dr. Ron Manderscheid to develop a  
25 work group to work on.

1           Then Mady Chalk is in charge of engaging in  
2 behavioral health data standards setting.

3           We did a gap analysis and asked some  
4 consultants that were working with our IT folks on  
5 developing the SAMHSA enterprise architecture to do a gap  
6 analysis for us. We asked every center to basically map  
7 their data collection efforts to our National Outcome  
8 Measures, to our GPRA -- Government Performance and  
9 Reporting Act I believe is what GPRA stands for -- and to  
10 our vision and mission statements. We discovered that we  
11 have 33 data sets and information sources, that we're not  
12 quite ready for an enterprise model, which is why we've  
13 slowed things down a little bit. There's an issue of the  
14 Office of Applied Studies and the efforts that they've been  
15 engaged with over a number of years. There's an issue of  
16 three centers and the efforts that they've been engaged  
17 with over the past several years. So it's going to take us  
18 a while to work through these internal kinds of processes.

19           In addition, our gap analysis revealed that our  
20 data informational priorities kind of lack a context.  
21 We're not a data-driven organization. That has become  
22 clear. We don't make enough management decisions based on  
23 some good, strong, accurate, timely data. Next, our  
24 corporate culture -- this kind of is the same issue --  
25 doesn't require data for decisionmaking.

1           So we kind of took a step back and said, okay,  
2 if an enterprise architecture helps us define our business  
3 processes, then what does that mean? Basically, this tells  
4 you -- and I'm not going to go through every single one of  
5 these things -- what is comprised of developing an  
6 enterprise architecture in compliance with our federal  
7 requirements.

8           The outcomes of engaging in this process should  
9 be and will be more efficient business processes, cost  
10 savings, reduced burden on states and grantees. The  
11 Administrator has made it very clear that he wants  
12 streamlined reporting at the community level that can be  
13 aggregated to the state level, that can be aggregated to  
14 the national level. This will also result in improved data  
15 quality and efficient and integrated IT support.

16           Let me just kind of tell you what we've done so  
17 far, and Mady and Anne and Javaid, feel free to correct me  
18 if I miss something here. We've developed a baseline data  
19 reference model in a pretty brief period of time, I  
20 thought. In doing so, that put us ahead of all other  
21 OPDIVs in HHS. We actually went to the centers and  
22 instructed them, as I mentioned earlier, we want you to map  
23 everything you're doing to National Outcome Measures, to  
24 the goals of accountability, capacity and effectiveness,  
25 and our vision and mission.

1           So we did that and, as you know, we have matrix  
2 data elements. We have matrix action plans. So we asked  
3 that the centers map them to that. We found that 44  
4 percent, not surprisingly, of the data elements didn't  
5 match to any of our National Outcome Measures.

6           Are you all familiar with the National Outcome  
7 Measures and kind of the history there? Do you want me to  
8 go through that, anybody? That's good news.

9           We also did not just work on programmatic. We  
10 didn't just go to the centers and ask. We are now in the  
11 process of looking at our performance measures of our  
12 administrative systems, getting back to the issue I talked  
13 about earlier of getting grants and contracts out the door.

14           Now, we've worked pretty hard on the National  
15 Outcome Measures. They're a critical part of how SAMHSA is  
16 proceeding. They're a critical part of the SAMHSA data  
17 strategy. As many of you in the room may know, we've just  
18 recently published a procurement that will be the crux of  
19 how we intend to implement our National Outcome Measures,  
20 and that's the State Outcomes Measurement and Management  
21 Systems Procurement. I think it came out on May the 12th.

22           We've worked very hard with NASADAD, over 10 years as I  
23 understand it, and NASMHPD, the National Association of  
24 State Mental Health Program Directors, and we've reached  
25 agreement to phase in the National Outcome Measures in all

1 states in three years. This information is actually on the  
2 SAMHSA website. I'm not sure if we have the mental health  
3 information on the website. I know we have the substance  
4 abuse information on the website, and we have state  
5 profiles that are also on the website. We've been working  
6 very closely with single-state authorities for a good bit  
7 of time.

8           Our plan is to collect National Outcome  
9 Measures across all funding streams, all grant portfolios,  
10 all centers, everything we do, and that's going to be  
11 another relatively significant challenge for us. There are  
12 specific discretionary programs that need specific  
13 measures. Again, remember that theme and that goal is to  
14 reduce the reporting burden. We want everyone to report on  
15 the National Outcome Measures, and we have to work out  
16 those additional kinds of measures. We don't want 50  
17 measures per program. We're just not going to do it, okay?

18           We're also trying to look at every single data  
19 collection and analysis contract that we have in this  
20 agency, no small feat, to look at how we can better  
21 coordinate and where, if we can, consolidate to increase  
22 efficiency and decrease waste.

23           Now, our next steps are to develop SAMHSA-wide  
24 performance outcome measures, not just for programmatic  
25 efforts but, as I mentioned earlier, for administrative

1 functions. So now we've managed to not only make the  
2 centers extremely nervous, but all of our offices are  
3 extremely nervous.

4 Our second goal is to try to think about some  
5 entity, and I went ahead and put this up here because we  
6 don't really know what that's going to look like at this  
7 point in time, but we need to have some data control board  
8 that's comprised of SAMHSA staff whose mission is primarily  
9 greater participation of all SAMHSA centers and offices in  
10 our more centralized Office of Applied Studies data  
11 collection sharing and analysis.

12 We're working really hard. Charlene Lewis is  
13 doing a terrific job as acting director of our Office of  
14 Applied Studies, under some fairly tough financial  
15 situations, and we've been working really hard with  
16 Charlene to think about how to make OAS, and particularly  
17 the DAWN and the Household Survey, which are massively  
18 large surveys, responsible and accountable, and making sure  
19 that they meet the needs of our centers and other offices.

20 We want to produce management reports for  
21 compliance and for oversight. It gets back to that issue  
22 of using data to make management decisions. We're just  
23 beginning the effort of identifying what kind of management  
24 reports and technology we need. The acting deputy  
25 administrator, Andrew Knapp, has asked that we identify

1 high-risk grants and contracts. So I now get an email, it  
2 seems like every day, but I'm sure it's only once a week,  
3 that identifies high-risk grants. It helps. It helps.  
4 It's just a very basic thing, but we need to collect the  
5 data so that that becomes fairly easy and isn't a paper  
6 reporting kind of mechanism.

7           We have directed the Office of Applied Studies  
8 to map the National Household Survey -- I'm sorry, I can't  
9 call it NSDUH. There's something in my brain that just  
10 can't get there -- DAWN and DASIS, which is the treatment  
11 episode data system within the larger DASIS umbrella, it's  
12 the state substance abuse data collection system, to SAMHSA  
13 program and management outcomes, and we're going to work on  
14 realigning our SAMHSA resources, which means we have to  
15 focus on does the data collection mechanism make sense for  
16 us, does it have functional value, what does it cost, and  
17 what's the technology that drives it.

18           We're going to coordinate and consolidate as  
19 best we can our state data infrastructure efforts across  
20 the Center for Substance Abuse Treatment, the Center for  
21 the Substance Abuse Prevention, and the Center for Mental  
22 Health Services. We're asking that given that we're moving  
23 into the performance environment with the state, we're  
24 asking that they look very, very carefully at prioritizing  
25 technical assistance so that states can report on the

1 National Outcome Measures. We have a three-year window.  
2 We've told Congress we will have all states reporting  
3 National Outcome Measures in three years. We have to get  
4 going.

5 We have to identify IT solutions. Frankly,  
6 SAMHSA, as an operating division of HHS, doesn't have a lot  
7 of independent authority here. HHS has centralized its IT  
8 efforts. So where we're focusing on is what I said  
9 earlier, the bread and butter issues of SAMHSA. So do we  
10 need to think about changing the state data infrastructure  
11 grants? For example, the contracts for cooperative  
12 agreements for greater SAMHSA involvement? Don't know. We  
13 have to think that through as a group.

14 As I mentioned, we've made state IT capability  
15 the highest priority in providing data infrastructure  
16 assistance.

17 I'm happy to answer any questions. Any  
18 questions?

19 Hi, Ken. How are you doing?

20 MR. DeCERCHIO: I just wanted to kind of  
21 compliment CSAT, and I'm sure you were involved in terms of  
22 the regional workshops and integrating those. I know we're  
23 in Louisville next week and the southeast region, and  
24 integrating CSAT and CSAP. They're important. We're  
25 constantly doing a lot of work on measurement, a lot of

1 work on data. It's a slow process. We have issues in the  
2 state, but any time we look at either changing measures or  
3 collecting data, at a minimum it's a two-year process in  
4 terms of consultation and collaboration and engagement of  
5 all the stakeholders and providers, and then beginning to  
6 test the collection capability in year two. If all goes  
7 well, in year three you're ready to kind of throw the  
8 switch.

9 I know that SAMHSA has been sensitive to that,  
10 and we kind of share that responsibility in terms of that  
11 three-year target, and it's a collective responsibility.  
12 So we're just going to have to keep plugging at it and keep  
13 the communication going.

14 MS. COLSTON: I agree. It's not going to be  
15 resolved in a day. I think just reaching agreement on the  
16 National Outcome Measures and rolling them out in Access to  
17 Recovery, to getting some field experience with some of  
18 these measures -- we know, for example, that the measure in  
19 the Access to Recovery initiative on social connectedness,  
20 what Mr. Curie calls that social glue, isn't quite what we  
21 would like it to be, and I've had several discussions with  
22 state directors about, well, it isn't just about whether I  
23 attend an AA meeting. There's a factor about am I isolated  
24 because of my substance abuse. So we're trying to grapple  
25 with how you measure those, what is the measure, because

1 again, we do not want 10 measures for this.

2           So it's a goal, and we'll know more in a couple  
3 of years once we have some experience.

4           Dr. Voth?

5           DR. VOTH: Hi, Stephenie. Good to see you.

6           MS. COLSTON: Good to see you, sir.

7           DR. VOTH: I work very closely in the  
8 electronic medical records process nationally and locally,  
9 and one of the great challenges we have there, which I  
10 think you're also going to face, is the phenomenal turnover  
11 of hardware and software systems in terms of data  
12 collection. So I hope you will all be very sensitive to  
13 that because state agencies don't have any great excess of  
14 funds to be buying expensive systems and turning that over  
15 and turning it over. I know in the medical arena, we're  
16 all just pulling our hair out to try to find a central,  
17 workable thing, and about the time you do, everything is  
18 turned over again.

19           MS. COLSTON: Well, not only that, but every  
20 state has a different structure. I don't know if Missouri  
21 still has this, but Missouri used to have a state chief  
22 information officer. So just like HHS, SAMHSA as an  
23 operating division doesn't make IT decisions in a vacuum.  
24 In Missouri, Michael Kootai doesn't make IT decisions.  
25 He's a division in a state agency, one of many state

1 agencies in Missouri. So it's a complex issue.

2 Dr. McCorry?

3 DR. MCCORRY: Thanks, Stephenie, and thanks for  
4 the presentation. It was good to hear SAMHSA's overall  
5 plan, and I see in SAMHSA's draft, Mr. Curie's draft  
6 strategy plan, that data strategy has become an important  
7 element in it.

8 I have several issues that I just want to raise  
9 and get your comments on.

10 MS. COLSTON: Sure.

11 DR. MCCORRY: In my work for the Washington  
12 Circle, we've struggled with some of the same issues that  
13 SAMHSA is struggling with, and I just wanted to raise some  
14 issues and just see what you might say about them.

15 One is this emphasis on outcomes versus  
16 processes of care. Of course, everyone knows that outcomes  
17 are the crucial, final result of whatever service is  
18 delivered, but we also know that it can be expensive to  
19 collect. Things like case mix or gaming can make outcomes,  
20 or self-selection or particular selection in terms of  
21 clients can lead to outcomes that are really distorted from  
22 what the actual service is.

23 Washington Circle has taken something of a  
24 different approach in a couple of different ways. One is  
25 this whole idea of a process of care, kind of like a model

1 of recovery. I was wondering how to look at that in terms  
2 of these National Outcome Measures, that runs from  
3 prevention through recovery support, prevention,  
4 recognition, treatment, and recovery support or maintenance  
5 of effects, so that there's this underlying kind of  
6 paradigm of what substance use as a chronic relapsing  
7 condition is, and the model of care that kind of supports  
8 addressing that.

9           In developing our measures, we looked in this  
10 process at prevention, recognition, treatment. We went  
11 with three measures simply around recognition or early  
12 treatment, identification, initiation, and engagement,  
13 engagement being three or four services in the first 30  
14 days of treatment, and they could be considered early  
15 retention measures, but you have to identify someone before  
16 you can worry about whether they stay in care or not. We  
17 know that outside of the behavioral health sector in  
18 primary care settings, the level of identification of  
19 people with alcohol and drug problems is woefully low, in  
20 managed care organizations woefully low.

21           So putting measures in that are predictive of  
22 outcome rather than the outcome itself as the focus,  
23 knowing that if you identify someone, you're more likely to  
24 be able to help that person get the help they need to lead  
25 to recovery, and it's predictive. If you're able to hold

1 someone for 30 days, it's predictive of whether they're  
2 going to recover. That's one issue.

3 I just want to raise a second issue and then  
4 get your comments on it. The second is something of what  
5 might be kind of a disconnect between the science-to-  
6 service approach, which I am very enthusiastic about -- I'm  
7 really supportive of it. I do that work back home in New  
8 York -- and the emphasis on outcomes that SAMHSA is taking.

9 For example, use of medication as a measure.  
10 We have NIDA and NIAAA and NIMH, but particularly I'm  
11 talking about the substance abuse side, spending a  
12 tremendous amount of research support to develop  
13 medications to enhance the therapy delivered to folks in  
14 need. Yet, when you look at our substance abuse service  
15 delivery system, the use of medication is tremendously  
16 inadequate, and it's very difficult to move the field  
17 towards accepting medication as an adjunct to counseling  
18 therapies.

19 So we have a disconnect somewhat in terms of  
20 not having measures that would be considered process of  
21 care measures. When do you introduce the notion of when  
22 someone should be offered the option of medication? Not  
23 forced to take, but offered the option. Where does that  
24 fit in an assessment or an early treatment plan which would  
25 fit as a performance measure and would kind of correspond

1 to NIDA and NIAAA's initiatives and thrust but doesn't  
2 quite fit into what's been developed in terms of outcome  
3 measures?

4           So wrapping up this kind of long monologue that  
5 I've done here --

6           MS. COLSTON: I know there's a question there.

7           DR. McCORRY: There's a question. How can we  
8 move from outcomes to process of care measures that are  
9 really more directly tied to evidence-based practice, so  
10 that the measurement is around the evidence base rather  
11 than some kind of global outcome of abstinence or however  
12 they are listed here? How can we move from a kind of  
13 global outcome to a set of measures that are very specific  
14 to processes of care that have a strong evidence base in  
15 our field as being predictive of recovery? Should we? Of  
16 course, I'm advocating we would, but I'd like your comments  
17 on it.

18           (Laughter.)

19           MS. COLSTON: I think we should. I think it's  
20 a matter of priority and moving forward with our outcomes  
21 first. We've talked about this internally and, frankly,  
22 struggled some. There's been a lot of groundwork with the  
23 Washington Circle group. I can remember, I don't know how  
24 many years ago, listening to Duane Simpson talk about the  
25 black box and beginning to struggle with the process of

1 treatment and how you measure the process of care.

2           Where we are today has more to do with wanting  
3 to be able to demonstrate results and be accountable for  
4 the expenditure of our federal dollars, and also I think  
5 the state of the research to try to lead us in new  
6 directions. So I would say that that's -- I know it's a  
7 very brief answer to a fairly lengthy question, but that's  
8 Stephenie Colston's personal opinion.

9           What frankly has driven the National Outcome  
10 Measures were a series of lengthy, challenging discussions  
11 we had with researchers, practitioners from the field in  
12 trying to think about the Access to Recovery measures. We  
13 had a mandate from the White House to have outcome measures  
14 and to ensure measurable outcomes, and to be accountable in  
15 addition to other mandates, but that was right up there at  
16 the top of the list.

17           So what Mr. Curie has done is look at those  
18 outcomes, and having talked to a lot of folks, he said  
19 these work across prevention, treatment, and mental health  
20 services. So I think that's what's driving the National  
21 Outcome Measures. No one disagrees with you about the  
22 process measures, and I hope we get there soon, but we just  
23 ain't there yet.

24           DR. McCORRY: If I could just follow up,  
25 perhaps, as you said, I was interested in noting that only

1 44 percent of the data elements can be tied to outcomes.

2 MS. COLSTON: Kind of scary, isn't it?

3 DR. McCORRY: But in some ways it could have  
4 been worse, I guess.

5 MS. COLSTON: It could be.

6 DR. McCORRY: As you create these data  
7 elements, perhaps we can look at them, we you kind of  
8 revamp your collection, to allow for data elements that  
9 could be more directly tied to the evidence base or the  
10 process of care so that we might be able to have the best  
11 of both worlds, be able to know what --

12 MS. COLSTON: Once we know what that is,  
13 absolutely. Once we define evidence base, absolutely.

14 DR. McCORRY: Very good.

15 MS. COLSTON: Dr. Suchinsky?

16 DR. SUCHINSKY: I was really impressed with  
17 what you're doing and what you're attempting to do.

18 MS. COLSTON: I don't sleep much, sir.

19 DR. SUCHINSKY: Having been through something  
20 very similar in our organization. A couple of questions  
21 occurred to me as you were talking. First of all, has any  
22 thought been given to developing any sort of interagency  
23 coordination group? Because I think what we're seeing is a  
24 number of rather large governmental bodies all struggling  
25 to do something very similar somewhat in isolation. I know

1 the things that you've been discussing about process versus  
2 outcome and so forth is something we've been struggling  
3 with for years. In fact, we started with doing outcome  
4 studies, and that was a disaster.

5 MS. COLSTON: Oh, that's good news.

6 DR. SUCHINSKY: We eventually decided that it  
7 would be better to do some process measures, which we've  
8 been much more successful in implementing. But we're going  
9 to have to go back to outcome measures because we're under  
10 the same pressures that you are to demonstrate the worth of  
11 what we are doing. I was wondering whether it might not be  
12 worthwhile to begin to set up some sort of mechanism for  
13 interagency cooperation on this, because we don't have to  
14 all invent the same wheel.

15 MS. COLSTON: Absolutely. When I was on detail  
16 at the White House Office of National Drug Control Policy,  
17 that's actually why one of their priorities is a drug data  
18 initiative. I'm no longer there on detail, but I represent  
19 SAMHSA on that group, and one of the things that both Mr.  
20 Curie and myself have been emphasizing -- he's obviously at  
21 the agency head group and I'm obviously at the staff  
22 working group -- is that we need common measures across  
23 federal agencies that deal with substance use and abuse  
24 particularly, obviously. That's what ONDCP would be  
25 dealing with.

1           So I think Mr. Walters hears that and, as you  
2 know, there used to be -- what was it called? Demand  
3 Reduction Working Group. I can't remember the name of it.

4       I'm sure that with the drug data initiative, that kind of  
5 effort will have to begin again. So hopefully we can start  
6 talking to each other.

7           I actually participated in several conference  
8 calls while I was at ONDCP with many VA centers talking  
9 about National Outcome Measures. So I've been talking with  
10 lots of VA folks for a long time.

11           Chilo?

12           DR. MADRID: Stephenie, I also want to  
13 congratulate you for the fine work that you all are doing.

14       I do have two very short questions.

15           Number one, in Texas, for the last four years  
16 we've developed what we call the BHIDPS system, behavioral  
17 health integrated data program system, and it works real  
18 well. We perfected it. Everybody is happy with it,  
19 providers, the state, other advocacy groups. So my two  
20 questions are, your national outcome system, how compatible  
21 is that to the state systems that are in effect at this  
22 time, and how friendly is it to the providers that wrestle  
23 with these data systems on a daily basis?

24           MS. COLSTON: Well, let me answer the second  
25 question first if I could, Chilo. The Administrator's goal

1 is to streamline and reduce reporting burden on community-  
2 based organizations, so it's very provider friendly.  
3 That's a very important part of the vision. Secondly, in  
4 terms of BHIDPS, lots of states have made great strides in  
5 having an infrastructure in place for reporting process  
6 measures and outcomes. So I would say that states like  
7 Texas, states like Florida, who have slogged it through --  
8 I remember one time going down for a review in Florida and  
9 witnessing a legislative hearing and watching Ken have a  
10 lively discussion with some senators about we want  
11 performance, we want results.

12           So some states have, at the direction of their  
13 legislature, started on this process fairly early. Now,  
14 he's got measures that are a little different. I mean, the  
15 wording is a little different, and that kind of stuff we  
16 have to work on. But I think BHIDPS would be one of the  
17 strongest foundations. I'm assuming that's why they got an  
18 Access to Recovery grant. So you will know probably and  
19 should report back to this group in a few months.

20           Has Texas started implementing its Access to  
21 Recovery yet, Mady? Not yet. If and when they do, and  
22 they will by May 31st, then you'll know. You'll be able to  
23 tell us.

24           Thank you all.

25           (Applause.)

1 DR. CLARK: Thank you, Stephenie.

2 We'll move to the next item on our agenda,  
3 which is public comment.

4 DR. DE LA ROSA: Good morning. My name is  
5 Mario De La Rosa. I'm from Florida International  
6 University in Miami, Florida, and I'm a member of the  
7 stakeholder groups. First of all, I'd like to thank Dr.  
8 Clark for his leadership in such an important issue as the  
9 one we discussed yesterday.

10 There were many recommendations that were made,  
11 as you probably noticed, and they probably will require  
12 some far-reaching discussions, and probably strategies and  
13 changes in investments, and probably policy changes and  
14 priority changes in CSAT and SAMHSA.

15 My question is -- and I think this is a  
16 question that the group discussed after the meeting -- what  
17 comes next? I think this is a question for Dr. Clark in  
18 relation to what are his thoughts and ideas about where do  
19 we go from here, the process that we undertake, and an idea  
20 in terms of a timetable and how those individuals who are  
21 here can help in such an important endeavor? He knows and  
22 he's been truly part of it.

23 DR. CLARK: In response to the comment from the  
24 work group, we will be digesting the recommendations and  
25 trying to put them into a time framework. The commitment

1 is there, so the objective is only to make sure that we can  
2 do things within the purview of the Center. Some of the  
3 recommendations tend to be more global than others. Those  
4 that are more global, of course, we will want to refer up  
5 the line. Those things that we can do within the Center,  
6 we will want to focus on with dispatch.

7 Anybody else with public comment? Melissa.

8 MS. STAATS: I'm Melissa Staats at the National  
9 Association of County Behavioral Health and Developmental  
10 Disability Directors. We're an affiliate of the National  
11 Association of Counties, and we have provided written  
12 testimony before. I don't have any today. There are just  
13 two things that I would like to raise that are on our  
14 association's agenda.

15 The first one, which we just had a presentation  
16 on, the data piece. I just would encourage CSAT and  
17 SAMHSA, in their discussions with state governments, to  
18 also consider county government. County government has  
19 responsibilities in 22 of the states across the country,  
20 representing over 70 percent of the population, and there  
21 is not a lot of communication going out to county  
22 governments or to local authorities, whether they're  
23 counties or their authority is in a board, about how to go  
24 about collecting information to align their systems with  
25 the National Outcome Measures. If you believe that it's

1 expensive at the state level for information systems,  
2 counties and lower local levels of government are even  
3 further behind in the state. So I would just encourage  
4 CSAT to reach out to our association and others to start  
5 getting information out.

6           The other piece I just wanted to talk briefly  
7 about is methamphetamine. The National Association of  
8 Counties has convened a work group, and NACBHDDD  
9 participates in it, as well as others. We would, again,  
10 encourage CSAT to do what it can to focus some of the  
11 activities in methamphetamine on treatment and prevention.

12       Right now it's really a focus on criminal justice issues,  
13 and to help us with the message that methamphetamine  
14 addiction is treatable and folks can recover.

15           Thank you for your time.

16           DR. CLARK: Thank you, Melissa.

17           Any other public comment?

18           (No response.)

19           DR. CLARK: No other public comment. All  
20 right.

21           We've got another presentation.

22           MS. HERRON: Good morning, everybody. This is  
23 the first time I've found that being short is kind of  
24 helpful for these microphones. Maybe not.

25           DR. CLARK: Anne Herron is the director of

1 CSAT's Division of State and Community Assistance, and  
2 she'll discuss the state performance management efforts  
3 under the block grant program. Anne has worked in  
4 addiction treatment for over 23 years, joining SAMHSA as  
5 the director of the Division of State and Community  
6 Assistance in March of 2003. In this capacity, she is  
7 responsible for the management of the substance abuse  
8 prevention and treatment block grants in the states and  
9 territories, and she also has a branch that focuses on co-  
10 occurring disorders and homelessness, and a branch that  
11 focuses on the data needs of CSAT in the states.

12           Prior to that, Anne worked for the New York  
13 State Office of Alcoholism and Substance Abuse Services as  
14 the director of treatment, responsible for the development  
15 and improvement of over 1,300 treatment programs throughout  
16 that state.

17           Anne?

18           MS. HERRON: Thank you very much, Dr. Clark.

19           It's my pleasure to be here and speak with you  
20 a little bit around what's going on in the block grant  
21 program, how we're looking to integrate some of the  
22 information that Ms. Colston just talked with you about  
23 around the data strategy, and how we're implementing  
24 National Outcome Measures. The last thing that I want to  
25 mention is some of the work that we're doing in relation to

1 performance management with the states, which is one of the  
2 topics that's near and dear to my heart.

3           But to start, just to kind of give you a sense  
4 of the context for us, CSAT-SAMHSA clearly has been  
5 involved in looking at data and reviewing data for quite a  
6 while. You've heard mentioned already and you've heard  
7 presentations in the past about a Government Performance  
8 and Results Act. That really is looking at the  
9 relationship between CSAT, SAMHSA, and our grantees. How  
10 are you spending the money? Are you spending it  
11 effectively? Should we continue to give it to you? Those  
12 kinds of questions.

13           Now, the performance and assessment rating tool  
14 asks those same kinds of questions but asks them in a  
15 different context, really looking at Congress to us, so  
16 looking at programs like our discretionary grant programs,  
17 our block grant programs. How are we spending the money?  
18 Are we spending it effectively, and should they continue to  
19 give it to us?

20           Well, one of the areas in our recent PART  
21 review, the Performance and Assessment Rating Tool review  
22 of the block grant, was critical of the fact that we didn't  
23 have performance data and we didn't look at data in  
24 relation to the states' use of the block grant money.  
25 Well, welcome to national outcome demands. At the same

1 time that we are being asked these questions, again just to  
2 give a context, the states are being faced with very, very  
3 similar kinds of questions and asked to provide data on  
4 things around accountability, capacity and effectiveness.

5 State legislators, funders, other state  
6 systems, payers, all are asking those same kinds of issues  
7 and questions of state systems. So they were beginning to  
8 develop, look at and use data that they're collecting from  
9 providers, counties, regions, et cetera.

10 Well, we all know treatment is effective.  
11 We've gone down this road. The research exists. We know  
12 that it reduces substance use. We know that it reduces  
13 crime. We know that people who complete treatment become  
14 more productive, responsible and stable members of society.  
15 That's not always enough information. People want to know  
16 what's going on in my state, in my county, in my district,  
17 in my programs. So again, the importance of looking at and  
18 collecting data.

19 In the substance abuse prevention and treatment  
20 block grant, we've been asking for data for quite a long  
21 time. States submit admission data through the Treatment  
22 Episode Data Set. You've heard that mentioned before. But  
23 most states collect more information and more data for  
24 their own use than what they submit to us through TEDS. A  
25 subset of states really are involved and becoming really

1 quite elegant in their use of that data in performance  
2 management kinds of efforts and initiatives.

3 Well, how do we bring this all together? This  
4 is where the National Outcome Measures really play a major  
5 role for us. You had heard already in December of 2004  
6 there was a meeting between the states and SAMHSA where we  
7 reached agreement on some guiding principles and the  
8 outcome measures themselves. Ms. Colston mentioned the  
9 state outcomes measurement management system, the concept  
10 that was proposed in the 2006 budget document, which really  
11 is the mechanism -- I'll mention a little bit more about  
12 this later, but really is the mechanism that SAMHSA is  
13 looking to use to collect and analyze and use the data from  
14 the states.

15 You've heard that we are realigning our  
16 technical assistance resources to support the states in  
17 their ability to report and use the national outcome  
18 measure data, and we're making what data does exist more  
19 public. There is the NOMs, the national outcome measure  
20 data available on the SAMHSA website. What is available is  
21 what is currently accessible to us.

22 You've all heard about and seen the National  
23 Outcome Measures. They're fairly intuitive when you look  
24 at what is expected to happen as the result of a successful  
25 substance abuse treatment episode. I won't go through them

1 all. You've seen them several times before.

2           But one of the things that I did want to  
3 mention are some of the guiding principles of the  
4 agreements that we've reached with the states around the  
5 National Outcome Measures. One of the agreements is that  
6 for treatment, the National Outcome Measures will be based  
7 on that data that's already submitted to TEDS. For those  
8 measures where we don't have TEDS variables, we're going to  
9 use the Access to Recovery program to test out some other  
10 measures.

11           We're looking at data being collected at  
12 admission and discharge, so two points in time. We're  
13 looking at a unique client identifier, with a goal of being  
14 able to watch a client as they move through the system from  
15 episode to episode; and again, the redirection of technical  
16 assistance.

17           Even though those things are all in place --  
18 we've reached agreements, we've got the three-year time  
19 frame -- we don't have to wait until the end of those three  
20 years to look at some of the data. In the substance abuse  
21 prevention and treatment block grant application every  
22 year, there is a section where we have asked states, if  
23 they are able, to report to us voluntarily the data they  
24 have on some of these outcome domains. We do have  
25 preliminary data available from a subset of states, and

1 what we're using it for right now is simply to look at  
2 those states who are doing a really good job in collecting  
3 and using data so that we can direct some technical  
4 assistance.

5 All of this fits into the GPRA and the PART  
6 process that I had very briefly mentioned before. The  
7 National Outcome domains really is in that area of looking  
8 at effectiveness. We've mentioned the accountability and  
9 capacity, very important measures, and efficiency. Those  
10 of you who have heard the presentation, I believe it was a  
11 couple of meetings ago, by the Division of Services  
12 Improvement, heard about the development of cost bands for  
13 particular levels of care for individuals. The states in  
14 their block grant applications used those same cost bands,  
15 and I'm pleased to say that all states report services  
16 within those cost bands.

17 Of the states who are reporting data to us,  
18 it's really good news. Twelve of the states who report  
19 data in the abstinence domain, all of them report  
20 improvements from admission to discharge. There are 17  
21 states who report data in the employment domain. All of  
22 them report improvements between admission and discharge.  
23 It's employment including training and in-school, by the  
24 way. Thirteen states report data in the housing domain.  
25 Twelve of the 13 report improvements. The one who didn't

1 report improvement has maintained the same level. So there  
2 was no decrease. Then nine states report data in the  
3 criminal justice domain, all of them reporting a reduction  
4 between admission and discharge. So again, very good news.

5           Just to give you a sense -- this is my Easter  
6 map, I think, with all the colors. To give you a sense of  
7 the range of reporting capabilities across the country,  
8 what we did is we looked at states' ability to report in  
9 the five domains that are defined currently and identify  
10 those states who can report in five, four, three, et  
11 cetera. So this just gives you a sense that right now,  
12 there is a great deal of difference among the states across  
13 the country with what they can report.

14           We mentioned already that the National Outcome  
15 Measures are on the Web. There's other information that's  
16 on that website, including the Household Survey and TEDS  
17 data, as well as the block grant application data.

18           I did briefly want to mention some of the  
19 things that different states are doing with this data,  
20 because they're all implementing performance management in  
21 slightly different ways. In some ways, Frank, this goes to  
22 your question earlier around performance management really  
23 being a developmental process and kind of starting small  
24 and becoming more elegant, if you will, as you spend more  
25 time in the system.

1           North Carolina, for example, has developed a  
2 fascinating consumer data warehouse which looks not only at  
3 client outcome data but at reimbursement data and marries  
4 those things around client outcomes and program process.  
5 It's very, very interesting. They provide regular reports  
6 to their providers, which in turn directs technical  
7 assistance and support.

8           The State of Washington has gone in a little  
9 bit different direction. Their data system is really very  
10 rich. They've got administrative data that they use in  
11 addition to data from their own providers, which means  
12 going into the other state agencies to find data about the  
13 clients that they're serving, and they've spent a great  
14 deal of time and effort developing marketing, public  
15 relations, educational material that really have been used  
16 by a number of the other states, planning documents,  
17 research papers, press releases. Very, very nice, very  
18 polished documents and material based on their data.

19           The State of Connecticut, requiring all of  
20 their licensed providers, regardless of funding source, to  
21 report data to the state. They, in turn, provide monthly  
22 reports on performance to the providers. What's a little  
23 interesting about Connecticut are the comparison groups  
24 that they've developed when they report that data back to  
25 their providers. They look at like and similar programs

1 either in terms of client demographics, obviously level of  
2 care, location in the state, those kinds of issues. So it  
3 provides a very interesting comparison process for the  
4 providers to use in their own performance management.

5           The State of Oklahoma has developed really a  
6 very interesting integrated provider performance management  
7 report which ties in performance data from their providers  
8 with data from external databases, the administrative data  
9 sets, and then provides that all in a comprehensive report  
10 that they give to their providers, again directing  
11 technical assistance and working with them to continually  
12 improve the service mix.

13           The State of Virginia has developed an  
14 automated data quality assurance process, again looking at  
15 improving and trying to maintain the highest quality data  
16 and information coming into the state so that the  
17 information that it's used for is as solid as is possible.

18           In Virginia, instead of monthly reports, they  
19 provide quarterly reports to their providers, but again  
20 using some comparison groups around similar providers,  
21 regional, and then state averages. So each state is doing  
22 this just a little bit differently, but you can see the  
23 themes are quite similar.

24           Now, we mentioned earlier a little bit about  
25 the state outcomes measurement and management as the

1 mechanism that SAMHSA is proposing to use to collect the  
2 data that we've been talking about from the states. We've  
3 been working very closely with the Office of Applied  
4 Studies to modify what is currently the TEDS system to be  
5 able to collect this data at admission and discharge, and  
6 to collect it in a frequent way. Right now there are  
7 differences in the time frames with which states report the  
8 data. So looking to improve the timeliness of some of  
9 that.

10 One of the elements that is built into that  
11 particular program is an expansion of the TEDS payment or  
12 the DASIS payment to states who are able to report the  
13 National Outcome Measures data.

14 One of the other things that we've been working  
15 with the Office of Applied Studies fairly closely on has to  
16 do with that one submission of data multiple uses. We've  
17 been working to identify mechanisms whereby we can use  
18 submissions to the TEDS process to prepopulate the block  
19 grant application so that a state would not have to report  
20 data several times during the course of a year. We think  
21 that would be very helpful to the states.

22 We've mentioned this, so I'm going to skip  
23 right over this slide.

24 We have established a series of meetings with  
25 the states over the course of this summer talking about all

1 of these issues. We've got a series of five regional  
2 meetings -- one has been held already. The next one is  
3 scheduled for next week -- where we talk about, jointly  
4 with our sister center, the Center for Substance Abuse  
5 Prevention, the issues of the National Outcome Measures,  
6 data outcomes measurement and management system, and  
7 discuss more specifically some of the performance  
8 management strategies and issues that the states are using,  
9 and their success with those.

10           NASADAD, in turn, has been working with its  
11 member organizations to encourage and support state-to-  
12 state technical assistance and, again, the realigning of  
13 our technical assistance resources.

14           We've got things to do over the next five  
15 years. There is no question about it. Probably much  
16 longer than that, but your eyes start spinning counter-  
17 clockwise if you talk much further. We're looking again at  
18 the data on a state basis, looking at it nationally,  
19 establishing some operational definitions, common data  
20 definitions, clarifying the role of the state outcomes  
21 measurement and management system, and then applying the  
22 National Outcome Measures both to the block grant, as well  
23 as our discretionary grant programs.

24           So that's what we're doing. That's what we did  
25 on our summer vacation, and that's what we're working on

1 with the states and with the block grant program.

2 I thank you very much for your attention, and  
3 any questions or comments I'd be happy to take.

4 MR. DeCERCHIO: Can you state the time frame  
5 again for --

6 MS. HERRON: The three years?

7 MR. DeCERCHIO: Yes. When did that start and  
8 when does it end?

9 MS. HERRON: It ends at the end of federal  
10 fiscal year 2007 or the October 1 application for 2008.

11 MR. DeCERCHIO: Thank you.

12 MS. HERRON: Sure.

13 DR. CLARK: Any other questions? Richard.

14 DR. SUCHINSKY: What time frame do you use to  
15 assess outcome? In other words, is this six months, 12  
16 months, 18 months?

17 MS. HERRON: The way it's currently designed is  
18 really fairly simplistic. It's between admission and  
19 discharge. So it's really outcome at discharge.

20 DR. SUCHINSKY: At discharge. So if a patient  
21 does not improve over that period of time, the program  
22 really has problems.

23 MS. HERRON: They'll certainly get a lot of  
24 questions from us, yes.

25 Thank you very much.

1 DR. CLARK: Thank you.

2 I want to acknowledge Anne's work and the data  
3 team with whom she's working, her branch chief, Javaid  
4 Kaiser, and the others who are working to provide  
5 assistance, Hal Krause. Is there anybody else from the  
6 data team back there? I can't see. Javaid, Hal, Rich  
7 Thoreson. We're working across centers to make sure we get  
8 this job done, working with OAS, CMHS and CSAP. Thank you.

9 Any other issues? Any other questions?

10 (No response.)

11 DR. CLARK: Very good. Then why don't we  
12 adjourn for lunch, and we will reconvene at 1 o'clock.  
13 Thank you.

14 (Whereupon, at 11:56 a.m., the meeting was  
15 recessed for lunch, to reconvene at 1:00 p.m.)

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1 the Boston contingent when the Yankees lost. The day after  
2 the World Series I took serious abuse for it. So you catch  
3 it, I guess, either way.

4 MR. STEGBAUER: Yes, I think so. As a Mets  
5 fan, you probably have a little abuse coming. You're from  
6 Queens, right? You're a Queenie.

7 DR. MCCORRY: National League.

8 MR. STEGBAUER: National League.

9 I appreciate the opportunity to talk with  
10 everyone about Screening and Brief Intervention. This  
11 project is managed in the Division of Services Improvement  
12 and in the Organization and Financing Branch. Joan  
13 Dilonardo, Dr. Dilonardo, is our branch chief. Joan is not  
14 with us. She's been injured, and she's out for a while, so  
15 I appreciate the chance to talk with you.

16 We do a couple of other things in our branch,  
17 and I'll just have a commercial here for a minute. We do  
18 the GPRA work for CSAT, and we also are involved with a  
19 publication called "The National Spending Estimate." I see  
20 Rita Vandirvort is here, so make sure that you get a copy  
21 of this. This is a real wealth of information. With that,  
22 we'll continue.

23 People who need treatment for problems, it's  
24 well known, do not recognize that they need treatment. If  
25 we go to a standardized measuring tool like the AUDIT or

1 the DAST, people tell us in huge percentages that they do  
2 not need treatment, and these are people who score in  
3 ranges that tell us they need to have treatment. In recent  
4 estimates, you see that males, almost 80 percent of males  
5 who have illicit drug problems scored by a repeatable  
6 instrument do not think that they need to have any kind of  
7 treatment, and 87 percent of people with alcohol problems  
8 that indeed pass the AUDIT to a point where they should be  
9 treated don't think they have a problem. So we use that as  
10 a base to think about what we're doing and what we're doing  
11 with SBIRT.

12           We know that substance abuse has significant  
13 social and financial consequences. We're all aware of  
14 that. We know that effective treatments exist, but few  
15 people get to those treatments. You saw on the prior  
16 slides how very few people actually get there. We know  
17 from other chronic problems and our work with chronic  
18 substance abuse issues that the earliest we can get  
19 involved and the earliest an intervention takes place, the  
20 less the chronicity has in terms of long-term impact on  
21 society and, of course, on the individual, and we know that  
22 many times illicit drug use and alcohol abuse problems are  
23 not even addressed by medical professionals in primary  
24 care.

25           We do know that when we bring research -- and

1 there's a tremendous body of research about screening and  
2 brief interventions -- when we bring it to medical  
3 settings, we know that the best places to do this are in  
4 primary care. So we are involved with this project in  
5 emergency services, in trauma care, primary care, dental  
6 offices, breast exam clinics, adolescent clinics, schools,  
7 and we are using a chronic treatment model, but we are  
8 involving the primary care, not waiting for specialty  
9 treatment to pick up issues, but we are involving primary  
10 care as early as possible, and including primary care all  
11 the way through the treatment process.

12           There are some goals that we have. But let me  
13 say that our primary goal is to bring screening and brief  
14 intervention into primary care. The primary goal is to  
15 change how primary care is looking at substance abuse  
16 issues. We want to increase access for non-dependent users  
17 as early as we can. Again, we want to bring the generalist  
18 in, not wait for specialty treatment only but bring the  
19 generalist in as soon as we can, get rid of as many  
20 barriers as we can, increase the numbers of brief  
21 interventions, reduce the prevalence of alcohol and drug  
22 and medication-related disorders, and we want to build  
23 coalitions across providers in all areas.

24           We have some core components, and just take a  
25 minute to define what they are. We see screening as a very

1 brief identification, a very brief screen that occurs in a  
2 primary care practice or a primary care entry point to a  
3 system. What we have in our grants currently is the use of  
4 an AUDIT or a DAST. We have a numerical system, and when  
5 scoring gets to a certain level, then we proceed with an  
6 intervention or a brief treatment.

7           An intervention for us is an encounter that  
8 raises the awareness of the patient that they have a  
9 problem. We use motivational skills to do that, and brief  
10 treatment is the first step in the treatment process.  
11 Those are typically two to six treatment sessions. When we  
12 go beyond six sessions, we typically talk about that as a  
13 longer-term treatment.

14           So the focus, very much up front, is let's talk  
15 to patients when they come into primary care, let's score,  
16 let's intervene as early as we can, let's begin the  
17 treatment process, and for everyone that process is going  
18 to be a little bit different. The grants that you all have  
19 been involved with awarding are listed here, as well as the  
20 values. We have grants in six states and one tribal  
21 organization, and we're going to talk a little about those  
22 as we move ahead.

23           But the first thing I want to tell you about is  
24 really exciting to me. This stuff works, guys. Look at  
25 this. Here are 2,900 patients. This is very early data.

1 We've just been doing this for a year. These are patients  
2 that entered our system, had an intervention or a brief  
3 treatment, and then six months later we followed up with  
4 those patients and asked them how they're doing. We have a  
5 39 percent change rate on people who are drinking to  
6 intoxication. That definition is people who have five or  
7 more drinks in one session. And for illicit drug use, we  
8 have nearly a 20 percent improvement. These are people who  
9 have abstained for more than 30 days.

10           These are big numbers. We don't see this kind  
11 of effectiveness in many places at all. So we're really  
12 excited about this.

13           Let me tell you a little about how we get those  
14 numbers and what's going on in each one of our grants.  
15 Again, these are the areas that we have grants, and I'm  
16 just going to walk through them very quickly. We'll start  
17 in Pennsylvania. In Pennsylvania we have activity going on  
18 in Philadelphia, in Lewistown, and in Pittsburgh. In  
19 Philadelphia we're in a public hospital. Excuse me, we're  
20 in a public health clinic operated by the Philadelphia  
21 County Health Department, and it's in District 3, which is  
22 the most economically challenged part of Philadelphia. So  
23 they're doing a heck of a job with a really tough  
24 population.

25           Lewistown is in the Lewistown Hospital. It's a

1 community 501(c)(3) not-for-profit hospital. They are  
2 doing brief intervention screening with their emergency  
3 room population.

4 In Pittsburgh we're working with the residency  
5 programs at the university to help teach the residents how  
6 to use screening and brief intervention early so it becomes  
7 integrated with their training and they carry it forward  
8 into practice.

9 In Illinois, we're in Steger County Hospital.  
10 We all know Steger County Hospital is Cook County Hospital.  
11 We're in the main hospital in the trauma center, we're in  
12 the emergency room, and we're in the community health  
13 clinic center there. We are also seeing patients on the  
14 floors after admissions. In Cook County we are seeing more  
15 illicit drug use than we are in any other of our  
16 facilities, and we're picking up more heroin dependence  
17 than we ever thought we would see. But the public  
18 population that's using that facility is a highly at-risk  
19 group, and that's why we're seeing those.

20 In Texas we're in the Harris County Hospital  
21 District. The Harris County Hospital District operates Ben  
22 Taub Hospital. It's the Level 1 trauma center for that  
23 area. They have an emergency room, a medical clinic, three  
24 community clinics, Strawberry Park, and they're in the  
25 schools in the Houston area. They're in the Galina Park

1 school system, where 4,000 students have a health clinic,  
2 and in that clinic we're using screening and brief  
3 intervention with all of the providers. Texas is giving us  
4 a real win example.

5           But as a contrast, we're seeing many more  
6 Hispanics, as you would imagine, in the Houston area than  
7 we are anywhere else. So that's a particular kind of  
8 intervention or a particular experience that we're getting,  
9 and we're also interacting with the Texas Medical College  
10 and with Baylor Medical School. So wonderful residency  
11 interaction, and we're making a lot of progress.

12           New Mexico. We're in 25 rural health clinics.  
13 We could almost describe those as frontier clinics. Most  
14 of those clinics are in very underserved areas. We have  
15 Indian population with the Hopi Indians, we have the Navajo  
16 Indians, and we have a little interaction beginning in  
17 Farmington with the tribes over in Arizona. We also  
18 experienced some interesting things in those frontier  
19 areas. We have places, for example, in Espanola, New  
20 Mexico, where we're seeing more black tar heroin use than  
21 we are anywhere else. Espanola is the black tar heroin  
22 capital of the world, I think.

23           It's interesting when talking with people  
24 there, they don't have a hepatitis problem, and they don't  
25 have a hepatitis problem because the things that people

1 have to do to their needles to get them to take the black  
2 tar heroin will kill the hepatitis. So it's interesting  
3 but really challenging to have third-generation black tar  
4 heroin users coming into primary care settings and getting  
5 challenged about what they're doing simply by some simple  
6 questions by the provider they're used to seeing for their  
7 flu, for their school physicals, who are starting to ask  
8 them about what are you doing with illegal substances and  
9 how often are you using them.

10 California has a tremendous experience. In  
11 California, they were doing screening and brief  
12 intervention much before our grant through a company called  
13 Altim in San Diego County, soon to expand, and we think  
14 that may be into Los Angeles. Because of their vast  
15 experience, we're getting about 40 percent of all of our  
16 use coming through San Diego, but they use a different type  
17 of intervention than anywhere else. In San Diego, they  
18 hire interventionists right off the street, and we call  
19 them health educators. Health educators have to have a  
20 high school diploma, and that's it. They prefer them not  
21 to have any more education because they want to teach them  
22 a rote way to interact with the patients, and specifically  
23 they want it done their way, not somebody else's way. It's  
24 very effective. It's working quite well.

25 They are getting 14 percent of the patients

1 that come into the emergency room at Scripps Mercy and in  
2 the community health centers to tell them about illegal  
3 drug use and heavy drinking. So that's a wonderfully high  
4 percentage and very close to what we expect to have from  
5 the literature that we're bringing into practice.

6 In Washington State, we're in hospital trauma  
7 centers only. We're in the Level 1 trauma center at Harbor  
8 View, and we're in trauma centers in Yakima, in Takoma, in  
9 Vancouver, and in Everett, Washington. That's an  
10 interesting experience because in Yakima we deal with a  
11 very agricultural community, high Hispanic, high migrant  
12 population. In Everett, Washington, we're dealing with the  
13 Boeing workers. They're putting together airplanes, and at  
14 Harbor View it's a Level 1 trauma center and they're  
15 getting any comer. They're the safety net facility for the  
16 entire region.

17 So in one facility we have quite a microcosm of  
18 what's going on, and we're getting to understand a little  
19 about how payment sources affect drinking patterns and  
20 affect how we are able to interact with ESPRES and how we  
21 can make that much more effective.

22 In Alaska, we're working with tribal  
23 organizations. We're working with the Cook Inlet Tribal  
24 Council, and we're working with the South Central  
25 Foundation, and they are working entirely in the Native

1 Alaskan community. Here's a little bit of what our numbers  
2 look like through the 5th of this month. We had screened  
3 more patients than we had targeted. In fact, we're up at  
4 this point almost 15 percent. Our screenings are up much  
5 higher than we had anticipated, but you see where we're  
6 struggling.

7           We're struggling with this brief treatment  
8 concept, because it's a new concept to bring in. Providers  
9 are more used to let's see a person, let's screen him, and  
10 let's refer him to long treatment, and we're trying to  
11 introduce the concept of two, three, four, five treatment  
12 sessions may be effective. So that's tough in every  
13 grantee spot that we have, and we're focusing a lot there.

14           But you'll also see that we're getting about  
15 the number of referrals to long-term treatment that we  
16 expected. What that means simply is that the dollars that  
17 we put into this grant are not being moved into the  
18 specialty treatment area. They're being invested in  
19 screening, brief intervention, and brief treatment. So  
20 that's a good measure for us.

21           So our goals again. Expand the states'  
22 continuum of care; include screening, brief intervention,  
23 brief treatment into primary care settings; support  
24 clinically appropriate treatment for non-dependent --  
25 underline non-dependent -- substance users; develop

1 collaborative linkages between specialty care and primary  
2 care; and identify opportunities to change policy. We are  
3 identifying lots of opportunities.

4           Let me tell you, sustainability is a huge issue  
5 that everyone's been working on. Everyone in every state  
6 has a plan to help address their local Medicare systems,  
7 address their local insurance companies, et cetera, to try  
8 to get some movement. An example. Rochester, New York.  
9 Blue Cross has listed a code for screening, brief  
10 intervention and referral to treatment. Yay!

11           Okay, here's some other stuff going on. UPPL,  
12 we've done a lot of work with UPPL. We're working with CMS  
13 to develop code. CMS introduced a code this year to screen  
14 all new enrollees in the Medicare system, and we're using  
15 it for screening, brief intervention, referral for  
16 treatment. All of our grantees are involved with doing  
17 that.

18           NHTSA is doing lots of work with hospital  
19 emergency rooms, as you can imagine. ONDCP loves this  
20 program. This program is the number 2 initiative for ONDCP  
21 to promote nationwide and help us get some extra dollars.  
22 You see the American Society of Addiction Medicine is also  
23 involved.

24           A couple of things around the corner. You're  
25 going to look at grants to universities and colleges

1 through a Targeted Capacity Expansion opportunity. You're  
2 going to see that tomorrow. We're going to talk about  
3 that. We have some possible opportunities in the '06  
4 budget that's gone to the President to have two more grants  
5 to two more states. So we're doing some work there. And  
6 we have activity going on worldwide. There is screening  
7 and brief intervention work going on in Amsterdam, in  
8 Brazil, in Athens, in Spain, and we're working with the  
9 World Health Organization.

10 So I'm going to stop at that point because I  
11 probably talked enough, and Dr. Clark wants to get on  
12 schedule. But do you all have any questions that I could  
13 respond to?

14 DR. VOTH: Yes. This is Dr. Voth over here.  
15 Is drug screening being used in any part of that? I mean,  
16 I know the administration is very supportive of the idea  
17 particularly of student drug screening, and it seems that  
18 would be a hand-in-glove kind of a fit for at least some of  
19 these projects.

20 MR. STEGBAUER: Our grantees are doing a couple  
21 of things, but the screening tool that's most commonly used  
22 is the DAST. The DAST is being used to do screening in  
23 almost all of the grantee locations. Related to a clinical  
24 screen, some places are using clinical screens. By the  
25 time we have a clinical screen ordered for a person, we're

1 already into our treatment and our intervention process.  
2 So we don't advocate a chemical screen, but we certainly do  
3 advocate the DAST and good interviewing techniques, you  
4 bet.

5 DR. FLETCHER: Are you seeing any variability  
6 in the utilization of the screening in terms of gender,  
7 ethnicity, those kinds of demographic characteristics?

8 MR. STEGBAUER: Ann Mahoney is here, and Ann  
9 did a report in one of her states about the distribution  
10 across gender, and we are seeing a slightly higher, not  
11 significant, but we see a higher percentage of females in  
12 the screen than we do males. In some of our grant  
13 locations, it's simply because we have a higher percentage  
14 of females going to primary care, and that accounts for a  
15 lot of it. Related to gender, because of the way we  
16 screen, the screening is done in many locations for 100  
17 percent of the people that walk in the door. So we can't  
18 follow that through. We will have some information about  
19 screening positives or negatives or the referral patterns  
20 that might be interesting, however.

21 DR. SUCHINSKY: Do you have any data which  
22 shows an impact, if any, on individuals who have true  
23 dependence rather than just abuse? Because one of the  
24 things we hear is shouldn't primary care take care of the  
25 dependent population, too?

1           MR. STEGBAUER: In our follow-up work, we  
2 contact patients six months after our intervention with  
3 them and we ask what's going on with you, and we make some  
4 record of that. So we are going to have some information  
5 that will be very interesting to you. What we have seen,  
6 we have seen people move downward in our scoring categories  
7 from a high user to a moderate user to a light user. We've  
8 seen that type of movement on our scoring screens. So I'm  
9 not sure that's directly what you're asking for, but that's  
10 how I can respond.

11           DR. SUCHINSKY: It would be interesting to see  
12 whether there's a difference between various drugs. I  
13 mean, with alcohol, I can see this is happening. I'm not  
14 sure I can see it with opiate addiction.

15           MR. STEGBAUER: Yes, but with a 20 percent  
16 change in pattern, we're pretty excited about that.

17           DR. MCCORRY: I love this initiative. I think  
18 it's great. I think the substance abuse field is so much  
19 further ahead than the mental health field in terms of  
20 screening brief intervention, and it's great to hear the  
21 kinds of results you're having.

22           A quick question. Any thought to introducing a  
23 mental health screen as part of the SBIRT setting?  
24 Secondly, any thought around introducing medications?

25           (Laughter.)

1 DR. McCORRY: Is this the wrong advisory  
2 council?

3 MR. STEGBAUER: I think we're going to have Dr.  
4 Clark respond to that.

5 DR. McCORRY: Also, you mentioned black tar  
6 heroin and buprenorphine in primary care settings. Any  
7 thoughts on that topic?

8 MR. STEGBAUER: You know, we were in Lewistown  
9 on Monday of this week, and we talked with the physicians  
10 who are on the buprenorphine panel in Lewistown, and  
11 they've really seen a response that's been heartening for  
12 them. So I can just talk from the vignette of one example.  
13 They had an experience with screening people in their  
14 clinic and then a higher entry into the buprenorphine  
15 clinic. So that's a bit of a response.

16 But I'm not going to tackle the first part of  
17 that question. That's a Dr. Clark question.

18 MR. DeCERCHIO: A question and comment. The  
19 comment is that we're using this in Florida with older  
20 adults. We have three sites. We've partnered with the  
21 Florida Mental Health Institute, and we're using the SBIRT  
22 model to do older adults in senior settings, not in  
23 traditional treatment settings, and that's being evaluated.  
24 I think it has a lot of promise for that population in  
25 alcohol, and even prescription misuse, not abuse but misuse

1 as an educational model. So if you do another round, I  
2 would encourage not just limiting it to either the  
3 emergency or primary care settings but looking at other  
4 populations.

5           The 63 percent you were concerned about in  
6 terms of engaging in SBIRT in the treatment part, but  
7 considering you're screening people kind of cold in other  
8 settings, what do we know about why it is they're not  
9 participating? You kind of alluded to the deliverer of the  
10 services not being comfortable with the model, but you've  
11 got folks who may be dependent who are not ready to engage  
12 in four to six sessions, and knowing more about that number  
13 and what's driving it, it may be a delivery issue, but it  
14 may very well be an issue of folks' willingness to  
15 participate, denial, et cetera.

16           MR. STEGBAUER: So let's just look at our  
17 numbers for a minute and we'll kind of answer this  
18 question. The research says that we should have somewhere  
19 around 20 percent of everyone that we simply screen that  
20 will screen positive. By screening positive, we simply  
21 mean that there should be about 20 percent of everyone that  
22 would fall into screens that we should talk to about their  
23 substance use problems because it's problematic, and that  
24 we should have most of those people just go through an  
25 intervention when they say, you know, I appreciate you

1 talking to me about it, I didn't realize I had that much of  
2 a problem, et cetera.

3 About 5 percent should go on to some type of  
4 further treatment, and that's the distribution we're  
5 getting. We're getting about 80 percent of people we talk  
6 to who are screening through just fine and don't have a  
7 problem. But the other 20 percent are people that are in  
8 that initial category that are saying I don't have a  
9 problem, and gosh, their screens are picking them up, and  
10 somebody is starting to talk to them about their problems.

11 DR. CLARK: Ann, did you want to say something?

12 DR. MAHONEY: Yes. I just wanted to speak. I  
13 was the project officer for New Mexico and Illinois SBIRT  
14 projects. Illinois has started to do some work with  
15 buprenorphine referrals connected to SBIRT, and I'm  
16 actually leaving this minute to go talk to New Mexico about  
17 their potential and their interest in doing that. The big  
18 issue with buprenorphine, of course -- well, it's two-fold.  
19 One is the infrastructure, and secondly is the cost. It  
20 is more costly, and we do have cost bands for treatment.

21 DR. McCORRY: We were talking, though, at lunch  
22 around this whole idea of primary care as the continuity of  
23 care, and that specialty care might be episodes within this  
24 continuous health relationship between a primary care doc  
25 and his or her patient. So even after treatment, even

1 after extended treatment, when we talk about recovery  
2 support, where do we locate recovery support? Maybe back  
3 with the primary care doc who will have a continuous health  
4 relationship, and there might be another piece on the back  
5 end of this model post-discharge in terms of recovery that  
6 has the relationship between the physician or the health  
7 practitioner and the person in recovery on a continuous  
8 basis.

9 DR. MAHONEY: Stay tuned for Illinois.  
10 (Inaudible.)

11 DR. CLARK: Stay tuned for Illinois. We'll  
12 wrap this discussion down and move to the next item on the  
13 agenda, which is an Access to Recovery update.

14 Dr. Andrea Kopstein will give us an update on  
15 Access to Recovery. She's currently branch chief of the  
16 Practice Improvement Branch within CSAT's Division of  
17 Services Improvement. Andrea is also CSAT's lead on the  
18 Access to Recovery initiative. She has spent 12 years  
19 working on substance abuse-related issues with the federal  
20 government prior to joining CSAT in 2001. She was a survey  
21 statistician working on the National Household Survey on  
22 Drug Use and Health, first at the National Institute of  
23 Drug Abuse and subsequently at SAMHSA.

24 DR. KOPSTEIN: Thank you.

25 I know that you all heard some about Access to

1 Recovery already today, and hopefully some of what I'll  
2 present will be new or informative.

3           One thing I will say is, in terms of data and  
4 things like that, Access to Recovery, many of the sites  
5 have just implemented recently, and some have yet to  
6 implement. So right now we're just starting to get our  
7 first tricklings of GPRA data, and just this last week the  
8 Office of Management and Budget has approved the Access to  
9 Recovery data collection instrument. So that's in the  
10 future at this point in time.

11           I just thought I'd go through some of the  
12 requirements. These grants were awarded -- oh, I guess it  
13 was in August of 2004, and I just want to go through some  
14 of the requirements that are being asked. I know some of  
15 you come from states where there are Access to Recovery  
16 grants. First of all, they have to assure that there's  
17 client choice of service providers. They have to implement  
18 a voucher system that supports both clinical treatment and,  
19 importantly, recovery support services. They have to do  
20 significant outreach to a range of service providers  
21 previously not receiving federal funds, and that includes  
22 faith-based organizations.

23           All these grantees had to develop eligibility  
24 systems for both the clinical treatment they would be  
25 providing and for the recovery support services. They have

1 to, in the course of these three-year grants, maintain  
2 updated lists of these eligible providers.

3           They have to make sure that all the clients  
4 that enter their systems are assessed and given appropriate  
5 levels of service for what was determined during the  
6 assessment. Again, they have to collect the data that  
7 we're requiring, GPRA and the seven domains outcome data,  
8 which will be forthcoming. Of course, they have to prevent  
9 fraud and abuse.

10           At this point in time, 12 of the 15 Access to  
11 Recovery grants are implemented, and that would be  
12 Connecticut -- I should have had a map like Tom had, that  
13 looked good -- Connecticut, Florida, Illinois, Louisiana,  
14 Missouri, New Jersey, New Mexico, Tennessee, Washington,  
15 Wisconsin and Wyoming. The three -- Texas, California, and  
16 the California Rural Indian Health Board, our only tribal  
17 organization -- will all be implementing in the next couple  
18 of weeks. So by the end of May, everybody.

19           This number is almost a half month old now, but  
20 the numbers of actual services and vouchers and clients are  
21 escalating rapidly as they all come on board. But at the  
22 end of April, we had about 3,700 vouchers that had been  
23 issued by the implemented grantees. These grantees have  
24 agreed over the three-year period to serve a total of  
25 125,000 clients, which is actually in their notice of grant

1 award. That was the intent.

2           Again, all of the 15 Access to Recovery grants  
3 are doing a range of targeted populations, a range of  
4 different service combinations, a lot of variety but some  
5 commonalities also. Again, this number is from the end of  
6 April, so it's certainly larger than that, but they had  
7 seen 1,700 clients that had been screened and assessed, and  
8 a high percentage of these clients do get vouchered  
9 services. Many of them seem to be getting clinical  
10 treatment and recovery support services. Some get only one  
11 or the other.

12           As I said, grantees have to do outreach, and  
13 there are a variety of mechanisms being used. They're  
14 using waiting lists, self-referral, family, friends, self-  
15 help organizations, social support systems, faith-based  
16 organizations, et cetera. There are lots of places where  
17 they're doing outreach. A lot of these grantees have some  
18 sort of 800 number or hotline for potential clients to call  
19 in.

20           We have multiple grantees in Access to Recovery  
21 that are doing criminal justice populations, and therefore  
22 their outreach is to jails, drug courts and prisons, where  
23 they're getting their clients.

24           Again, large eligibility lists. Most of these  
25 grantees have websites for doing outreach, both to clients

1 and to new providers. This is just the same, that they're  
2 preventing fraud and abuse.

3           With this particular initiative, we told the  
4 grantees that we expect them to manage these programs based  
5 on the performance of these providers. With the reporting  
6 systems, the eligibility lists need to be updated. They  
7 need to be looking to see are they doing what they were  
8 expected to do, and many of them have client satisfaction  
9 surveys in place. So they'll be looking to see are the  
10 clients who get referred to these particular providers  
11 happy with what they got.

12           Grantees, of course, because this is such a  
13 high profile initiative, we have a lot of reporting  
14 requirements, endless reporting requirements. We have  
15 their weekly reports, monthly reports, quarterly reports,  
16 we're doing quarterly Congressional reports. It's really  
17 interesting.

18           The next slides are just going to go through  
19 the grantees and give you some basic information. Like I  
20 said, there's not much data on any of these right now, so  
21 what I thought I'd provide on all of them for you is just  
22 when they implemented, if they did, which target  
23 populations they're doing, and where in the geographic area  
24 are they actually implementing the Access to Recovery  
25 program, because that does vary site by site.

1 California is planning to implement by May 31st  
2 in just two counties. It's such a huge state that they  
3 decided to just focus on Los Angeles and Sacramento  
4 Counties, and they're focusing on youth 12 to 20 years of  
5 age in those two areas.

6 The California Rural Indian Health Board is  
7 also obviously in California, and they're actually doing  
8 statewide, and their implementation date is next week, May  
9 24th, and they're going to be serving rural and urban  
10 dwelling American Indians and Alaskan Natives in the State  
11 of California. This includes 51 tribal councils and Indian  
12 health provider organizations that they're trying to have  
13 on their eligibility lists.

14 Connecticut implemented on January 31st, and  
15 they're targeted non-dependent adults who abuse drugs and  
16 people in need of recovery support services. So the  
17 general population, basically, which most of them have  
18 targeted more specifically than that. They are going  
19 statewide.

20 Florida implemented February 9th of 2005, and  
21 their target populations include adults 18 and older who  
22 are involved with the criminal justice system and drug  
23 courts, 18 and older adults involved with the child welfare  
24 system and putting children at risk, and adults who have  
25 co-occurring disorders or abuse prescription drugs.

1 They're implementing in five districts in the State of  
2 Florida, and they do have a hotline, as do many others.

3 Idaho just implemented on April 18th of 2005,  
4 and they're serving both youth and adults, and they're  
5 emphasizing delivery of services to Native American and  
6 Hispanic-Latino populations. They're focusing on rural and  
7 frontier sections of Idaho.

8 Illinois implemented on April 20th. Like I  
9 said, a lot of them just implemented, so that affects those  
10 numbers you saw. They're focusing on a population of  
11 probationers with substance use disorders referred to  
12 clinical treatment by the Circuit Court of Cook County and  
13 the Illinois 5th and 6th District Courts. The counties  
14 they're targeting in Illinois include Cook, Champaign,  
15 Christian, Clark, Coles, Crawford, Cumberland, DeWitt,  
16 Douglas, Edgar, Effingham, Ford, Iroquois, Jasper, Logan,  
17 Macon, McLean, Moultrie, Piatt, Sangamon, Shelby, and  
18 Vermillion. So a lot of counties.

19 Louisiana implemented on March 1st, and this  
20 particular program is targeted residents with special  
21 emphasis on women and adolescents with addictions to  
22 alcohol, cocaine, heroin, and OxyContin. They will be  
23 going statewide, but they're implementing over time by  
24 region.

25 Missouri implemented on April 1st, and they're

1 expanding clinical treatment and recovery support services  
2 for adults ages 17 and older, so again the general  
3 population, and another one that is going statewide.

4           New Jersey also implemented March 1st, and  
5 their initiative is providing both clinical treatment and  
6 recovery support services, with priority to clients ages 16  
7 to 34 who abuse heroin. This is another statewide Access  
8 to Recovery grant.

9           New Mexico implemented March 14th, and they  
10 will be serving adults over 18 in four counties, and also  
11 adults 18 and over who are members of the five Sandoval  
12 Indian pueblos, with particular outreach to women, Native  
13 American and Hispanic women, and people exiting from jails  
14 or prisons after in-prison clinical treatment.

15           Tennessee implemented on April 5th, and they  
16 are providing services to adults 18 and older with a  
17 current or past history of substance use or addiction, and  
18 they are particularly focusing on methamphetamine in  
19 Tennessee.

20           Texas will be implementing next week, and  
21 they're focusing, like others, on individuals from the  
22 criminal and juvenile justice systems. They're proposing  
23 in the first year to do Bexar County, Dallas and Tarrant  
24 County, El Paso County, and Travis County. Some of the  
25 courts that are going to be participating include felony,

1 family, adult, juvenile, reentry, diversion, and pre-trial  
2 drug courts.

3 Washington State implemented their Access to  
4 Recovery initiative on February 1st, and they're focusing  
5 on low-income individuals, although many of these Access to  
6 Recovery client eligibility standards did include some kind  
7 of measure of socioeconomic status. But they particularly  
8 emphasized that they will be dealing with Child Protective  
9 Services, shelters and supported housing, free and low-  
10 income medical clinics, and community detoxification  
11 programs.

12 Wisconsin was actually our first Access to  
13 Recovery site to start up. They started in December of  
14 2004. They started mainly with clinical treatment services  
15 but recently have expanded and starting issuing recovery  
16 support services. They implemented just in Milwaukee  
17 County, where they say it's the area of highest need in the  
18 state.

19 Then Wyoming, the last one, just implemented on  
20 May 2nd, and they are targeting adolescents who have been  
21 adjudicated through the Wyoming Circuit Court system and  
22 their families. Wyoming is focusing on Natrona County.  
23 They said that's the highest need for clinical treatment in  
24 their state.

25 Then just in summary, basically all these

1 grantees have made a lot of progress recently, and so we do  
2 expect the numbers to start swelling in terms of clients  
3 served, vouchers issues. We're providing technical  
4 assistance as we go along.

5           In summary, these are the main goals of Access  
6 to Recovery, which is where we're all going to with these  
7 grants. It's supposed to expand capacity by increasing the  
8 number and types of providers, including faith-based, who  
9 deliver both clinical treatment and/or recovery support  
10 services, and some of these grantees, many of them, have  
11 training programs in place to help some of these non-  
12 traditional type of providers get to the eligibility  
13 standards that they've established for these services.

14           They are also supposed to be allowing recovery  
15 to be pursued through many different and personal pathways,  
16 and another main goal is requiring grantees to manage  
17 performance based on the outcomes that demonstrate client  
18 successes.

19           That was the end of my slide show. Do you have  
20 any questions?

21           DR. McCORRY: It seems the implementation of  
22 this grant has been particularly difficult. Looking  
23 overall at the implementation process, what were the real  
24 difficulties, the things that have just been real tough to  
25 work through to get this up and running?

1           DR. KOPSTEIN: I'd say one of the most common  
2 issues that grantees had to surmount to actually implement  
3 had to do with the recovery support services component of  
4 this, because I think many of the traditional grant  
5 programs have emphasized clinical treatment, and there's  
6 not a lot of national information available to these  
7 grantees on recovery support services such as rate-setting  
8 and definitions. The other thing is they're dealing with  
9 different levels of sophistication of what some of these  
10 recovery support services providers actually have. We have  
11 a lot of reporting requirements. Not all of these  
12 providers -- many of these providers I think do not have  
13 the sophistication, do not have computers on board or the  
14 staff to do the data reporting that we require. That's a  
15 big one.

16           Some of the other really significant barriers  
17 that these grantees have been dealing with is just the  
18 infrastructure it takes to track. We're requiring a lot of  
19 tracking. So they have to have the infrastructure in place  
20 to track these vouchers that they're issuing, and be  
21 monitoring for fraud and abuse what they're tracking, and  
22 figuring out what outcomes are coming. So it's a  
23 fascinating opportunity, but it has a lot of components of  
24 it that had to be addressed and were different from what  
25 they dealt with before.

1 MS. BERTRAND: I had a question about recovery  
2 support services that weren't historically allowed to be  
3 billable under many states. How are they working with  
4 those that are not professional services to allow them in  
5 terms of the data?

6 DR. KOPSTEIN: In terms of the data?

7 MS. BERTRAND: In terms of being able to bill  
8 community-based organizations that are not a professional  
9 service. How are they working that out?

10 DR. KOPSTEIN: Well, I'd say that's one of the  
11 barriers that I was talking about, that they had to figure  
12 out how to -- well, first of all, what standards do they  
13 have to establish. For instance, if they're going to cover  
14 transportation, do you need the transportation people to be  
15 a licensed driver, to have a good safety record, to be  
16 insured? Whatever. They had to establish those standards  
17 for every service they said they're going to cover, and  
18 then they had to figure a way how to bill them, and it's  
19 also on the grantee to figure out how they're going to get  
20 the outcomes data reporting that we need.

21 What we had said in the pre-application period  
22 was sometimes clients are in multiple services  
23 simultaneously, in which case you could have some of that  
24 outcomes data being collected in a more traditional  
25 setting. If they're not, you need to figure out how to get

1 some version of it. They're obviously figuring out ways to  
2 do that because, as I said, we're seeing each week bigger  
3 and bigger numbers of recovery support services being  
4 provided, even in the last couple of weeks. So obviously  
5 they're figuring it out.

6 MR. DeCERCHIO: I just wanted to reinforce what  
7 Andrea is saying. I mean, it's a whole different delivery  
8 method. So we're outreaching to organizations that we've  
9 never had contracts with. If you introduce state financing  
10 and accountability and just the purchasing mechanism, the  
11 method of payment, we're using a managing entity, a non-  
12 profit that's going to have much more flexibility in those  
13 types of fiduciary relationships with those organizations  
14 rather than running a reimbursement voucher all the way up  
15 to the comptroller's office and getting approval in the  
16 required documentation. That's been very real, as opposed  
17 to just going through the traditional contractors and  
18 providers.

19 So this is slow to start, but this is a whole  
20 new delivery. Vouchers, issuing the vouchers, tracking the  
21 actual expenditure against the voucher. At the same time,  
22 you're issuing it against the front end and you're putting  
23 a dollar amount on the front end and then tracking what's  
24 coming in and what's being expended so you don't get in  
25 trouble and overobligate. That's a whole new delivery

1 mechanism for most of us in the states. We don't usually  
2 have that issue. You pay as you go. You're not  
3 authorizing. So you need online data. You need to know  
4 every day how much is being redeemed, at the same time how  
5 much you're authorizing and issuing at the front end.

6           We've gone out to a third-party managed care  
7 organization to do that rather than say we don't have with  
8 our data system the ability to do that. So there are real  
9 challenges. The clinical challenges in my mind were less  
10 than these operational issues. It's a fair amount of  
11 infrastructure. In one certain place, I think you'll see  
12 geometrically implementation. I know you're under a lot of  
13 pressure. We all are. But developing and having that  
14 infrastructure and putting that in place to hit the core  
15 tenets has been a major, major challenge, and a very real  
16 one.

17           DR. KOPSTEIN: And I will add to that. Two of  
18 our grantees had existing voucher programs. Milwaukee and  
19 Wisconsin did, and Albuquerque, but both of those systems  
20 were just doing clinical treatment. So adding that  
21 recovery support service component of it has even  
22 challenged them.

23           DR. CLARK: Nevertheless, the recovery support  
24 services are a cornerstone of the endeavor, and I really  
25 appreciate Andrea and Mady and the team working on this,

1 because indeed it is clear that the President expects that  
2 we will use the voucher mechanism and that we will expand  
3 our list of providers to include community-based and faith-  
4 based providers, and the best mechanism for those providers  
5 to participate in this initiative is in the arena of  
6 recovery support services.

7           We'll be working with Dave Donaldson and our  
8 faith team, Jocelyn Whitfield. As I mentioned in my  
9 presentation, I'll be visiting a number of these  
10 jurisdictions, essentially carrying the message that we are  
11 welcoming non-traditional providers into the fold of  
12 delivery and recovery management services. So I think with  
13 the ingenuity of my team and the cooperation of the state  
14 authorities like Ken, we'll be able to make this work to  
15 the satisfaction of all parties involved.

16           Anita, you had another question?

17           MS. BERTRAND: I wanted to just thank you and  
18 encourage the staff here to continue to work with those  
19 states because I believe that the non-traditional services  
20 are where people really recover, and they're so important.

21           Although they're not sophisticated enough to be able to  
22 deal with the professional services, they're very valuable.

23           DR. KOPSTEIN: Oh, yes. Thank you. As we  
24 talk, we're planning a new round of site visits to try to  
25 get out there and see what barriers and issues these

1 grantees are experiencing so that we can help them. We  
2 provide ongoing technical assistance, and as they go along  
3 they're figuring out also what kind of technical assistance  
4 they need. I don't think it was obvious to everyone in the  
5 beginning what it would take. So we are working with them,  
6 and thank you very much. Yes.

7 DR. CLARK: I want to also acknowledge the  
8 contribution of DSCA under Anne Herron. Given this  
9 activity and given its complexity and given the closeness  
10 with which we have to work with state authorities, our  
11 Division of State and Community Assistance is playing a  
12 major role working in partnership with our DSI under Mady  
13 Chalk. So the issue here is this is an all CSAT kind of  
14 activity, and the partnership requires not only what we do  
15 internal to SAMHSA but what we do external.

16 MR. DeCERCHIO: One of the beauties of ATR is  
17 when the grant ends, the partnerships that are formed  
18 between faith-based organizations and licensed providers  
19 and community organizations providing recovery support  
20 services will sustain, and oftentimes the sustainability is  
21 not always accomplished with these types of grants. But  
22 those partnerships are very real and are forming in order  
23 to deliver this, and those are going to remain. That's a  
24 core part of what we're doing, and I think that is a  
25 significant promise. That is sustainable and it's

1 expandable within how we currently do business.

2 DR. CLARK: Any other discussion on Access to  
3 Recovery?

4 (No response.)

5 DR. CLARK: Well, we'll keep you apprised. We  
6 probably won't be discussing it at our next Council meeting  
7 unless there's something that develops. We'll allow this  
8 to mature a little bit and we'll keep you apprised of  
9 what's developing. The key issue is that, again, this is a  
10 Presidential initiative. The White House talks about it.  
11 The Secretary of HHS talks about it. Obviously, Mr. Curie  
12 talks about it. So from our point of view, we get  
13 inquiries from the White House, the Department, and the  
14 Administrator's Office -- not that we're operating under  
15 any pressure.

16 (Laughter.)

17 DR. CLARK: We can't talk about it. We've got  
18 to do it. This is a key issue.

19 At our last meeting, we asked you for topics  
20 you would like to include for future agenda topics. One of  
21 those was the issue of treatment as it relates to women,  
22 families and children. Sharon Amatetti has worked with  
23 Stella Jones and Linda White-Young to pull together a  
24 report. Sharon is a public health analyst in CSAT's Office  
25 of Program Analysis and Coordination. She's also the

1 coordinator of the Center for Women and Families'  
2 coordinating committee. In this capacity, she is  
3 responsible for ensuring that women, youth and family  
4 issues are coordinated with the Office of the Administrator  
5 and other SAMHSA centers and federal agencies, and that  
6 adequate attention to women, youth and families is  
7 incorporated through all CSAT programs.

8 Sharon also manages the Center's activities  
9 pertaining to child welfare, the impact of parental alcohol  
10 and drug abuse on children.

11 Linda White-Young is a project officer for  
12 CSAT's PPW grants in the Division of Services Improvement,  
13 and Stella Jones is a project officer for CSAT's HIV/AIDS,  
14 also in DSI.

15 Sharon?

16 MS. AMATETTI: Good afternoon, and I thank you,  
17 Dr. Clark.

18 I thought it was funny that Anne Herron thought  
19 that she was short and had trouble being seen.

20 (Laughter.)

21 MS. AMATETTI: If you can't see me, I'll try to  
22 at least speak loudly so that you can hear me.

23 As Dr. Clark mentioned, Council member Betty  
24 Ward Fletcher did ask at the last meeting that we look at  
25 the issue of women's treatment, and particularly not so

1 much about our specific programs but sort of overall what  
2 is CSAT doing regarding women's treatment and what are some  
3 of the particular treatment barriers for women, and that's  
4 what I wanted to spend time talking about today.

5 I wanted to begin by talking first about what  
6 our national survey on drug use and health tells us about  
7 the treatment need. You'll see here on this slide that  
8 approximately 14 million men and almost 8 million women  
9 reported in the year 2003 that they had behaviors related  
10 to alcohol and other drug use that reflected a need for  
11 treatment. They didn't say that they needed treatment, but  
12 the questions that we asked them in that survey indicated  
13 that they needed treatment.

14 Of those people, you'll see that a very small  
15 percentage, the middle two bars, indicate those people who  
16 actually received treatment at a specialty facility. When  
17 we do the math, we see that only about 9 percent of men and  
18 8 percent of women who this survey indicated needed  
19 treatment actually got treatment.

20 Now, I want to talk a little bit about those  
21 people who did not receive treatment. That's the group on  
22 the right there, the men and women on the right there,  
23 those bars there. If you look at that, you'll see that the  
24 vast majority of people who this survey indicated needed  
25 treatment did not receive treatment. So we have to ask

1 ourselves why not. So here are the same two bars from the  
2 last slide that showed that these people who are data  
3 indicated needed treatment did not receive treatment. What  
4 we learned, and Tom talked about this very briefly in a  
5 slide, is that the vast majority of people who we thought  
6 needed treatment didn't feel that they needed treatment.  
7 This is sort of the denial bars is what I would call them.

8           In the middle bars there, you'll see that those  
9 people who didn't receive treatment but some of them did  
10 feel that they needed treatment but they still didn't get  
11 it, that that is a very small percentage of the whole.  
12 Here's another way of looking at it. You'll see that,  
13 really, 95 percent of both men and women who needed  
14 treatment didn't feel that they needed treatment, and only  
15 5 percent of those who did identify that they needed  
16 treatment didn't get treatment.

17           That's a pretty big issue for us. I think that  
18 we have to look at the whole picture, but one of the things  
19 we want to ask ourselves is why not? Why aren't people  
20 getting treatment, even those people who felt that they  
21 needed treatment and didn't get treatment? Why? Why did  
22 that 5 percent who said that they felt that they needed  
23 treatment didn't receive treatment?

24           These are the things that they tell us. Forty-  
25 one percent were not ready to stop using. Thirty-three

1 percent said something about cost or that there were  
2 insurance barriers. Twenty percent talked about something  
3 having to do with stigma as being a barrier to getting  
4 treatment. Seventeen percent felt that they could handle  
5 the problem without treatment, and 12 percent talked about  
6 other access barriers such as there were no programs that  
7 would suit them in their area, they couldn't get to  
8 treatment, they didn't have any type of transportation.

9           So in terms of treatment barriers, we have some  
10 challenges in terms of helping individuals in need of  
11 treatment to recognize the need for treatment, and once  
12 recognized, to do something about it. I think our programs  
13 like our Screening and Brief Interventions really talk to  
14 those types of issues. But what would we do if denial and  
15 lack of readiness did not exist? I mean, that's something  
16 that we need to think about. Imagine if what we wish for  
17 came true. Would our treatment system be anywhere near  
18 ready to address the desire for treatment if there was no  
19 such thing as denial?

20           But let's go back to the 5 percent of folks who  
21 knew they needed treatment but did not end up getting  
22 treatment. We might think of these people sort of as the  
23 people in our showroom. If we use the analogy of buying a  
24 car, these are not the folks out there driving a clunker  
25 that keeps breaking down but who think their car is fine

1 even though they can't reliably get to work or get to where  
2 they're going. They're also not the ones who know that  
3 they need a new car but they hate the car-buying process,  
4 so they're just going to put that off.

5           These are the people in our showroom ready to  
6 take action. But then they find out that the cost of the  
7 car is way beyond their means, so they're not going to be  
8 buying a car today. Or perhaps they think that other  
9 people in their neighborhood will think that they're sort  
10 of snobby if they come home in a brand new car, so they're  
11 not going to deal with getting a new car, and they turn  
12 away and go home. Or perhaps they like the car and they  
13 have the money and they don't care about the neighbors, but  
14 then they find out when they go to test the car that they  
15 can't actually reach the gas pedal, and I can assure you  
16 that does happen.

17           (Laughter.)

18           MS. AMATETTI: So these are the types of  
19 barriers that come up for treatment clients, too, those  
20 having to do with costs, those having to do with stigma and  
21 other program characteristics. Now, all the people in this  
22 showroom are women, because we know that men and women have  
23 different buying practices. So we're just going to talk  
24 about all these barriers as they pertain to women.

25           These are the types of barriers that most

1 commonly come to mind when we talk about treatment  
2 barriers. We think about things having to do with cost and  
3 with stigma and the program characteristics. There are  
4 some things that are different about these issues -- cost,  
5 stigma, program issues -- for men and for women, and I just  
6 want to talk a little bit about some of the gender issues  
7 having to do with cost, because there are some. There's  
8 sort of a good news and a bad news about this when it comes  
9 to women.

10                   We know that more women receive Medicaid due to  
11 their parenting status, which is helpful, you would think,  
12 for women. But we also know that there are coverage  
13 limitations that limit the usefulness of that, and that the  
14 residential family model and the very comprehensive  
15 programs tend to cost more than other programs. So the  
16 benefits of being a woman can be both positive and negative  
17 in terms of expenses of program costs.

18                   We also know that more women receive welfare or  
19 temporary assistance for needy families. But then again,  
20 there are some downsides to that, which is that clients  
21 with felony convictions often cannot get hold of those TANF  
22 benefits, and that work requirements and child care can be  
23 problematic as well.

24                   I know that many of you are very familiar with  
25 these issues, but I just want to sort of go over some of

1 the gender issues briefly. In terms of stigma, I think  
2 women certainly share the shame applied to all alcoholics  
3 and addicts, male and female, but women tend to be held at  
4 a higher standard due to their status as being women who  
5 have children. This is particularly true for pregnant  
6 women who are using. Women with HIV are doubly stigmatized  
7 and may be reluctant to talk to treatment programs about  
8 their HIV status, or even to talk to family members.

9           There are program-specific barriers that impact  
10 women differently than men. Certainly accounting for  
11 children, we know how difficult it is for women to enter  
12 residential programs if there's no opportunity for them to  
13 have their children participate, and even to participate in  
14 outpatient programs when they don't have childcare for  
15 their children. We know that it's also much more limited  
16 in terms of getting treatment opportunities for pregnant  
17 women.

18           In terms of family and partner resistance, that  
19 becomes much more of an issue for women than it does for  
20 men. Many of their partners are resistant to them  
21 participating in treatment because then they need to deal  
22 with the children in the household or other  
23 responsibilities that the woman generally takes on. We  
24 know that women have a higher prevalence of co-occurring  
25 mental health needs and medication, and many of the

1 programs are reluctant -- and I think a Council member  
2 talked about this this morning -- are reluctant to work  
3 with clients who are taking psychotropic medications, and  
4 also some of the mental health providers are reluctant to  
5 work with clients with those medications who are also  
6 taking methadone.

7           In terms of the greater prevalence of  
8 victimization trauma, we know that anywhere from 50 to 90  
9 percent of women participating in substance abuse treatment  
10 programs have reported this history, depending on how it's  
11 measured and determined, but programs often are not  
12 prepared to deal with those histories, and that can be very  
13 off-putting to a woman who comes into treatment with trauma  
14 histories.

15           There's a great need for drug-free housing for  
16 women, particularly women with children or who are trying  
17 to be reunited with their children, and then also limited  
18 AA and NA meetings that are women-only meetings often in  
19 rural areas can be a problem.

20           So I've described a lot of the barriers, and  
21 we'll come back to those in a little bit to describe what  
22 some of the grantees have told us they're doing to address  
23 those barriers. But I did want to just familiarize you a  
24 bit with what CSAT is doing and what services and programs  
25 we have supported for women. This is a table that shows

1 the discretionary portfolio that CSAT supports and the many  
2 different grant programs that we have that have women only  
3 or women predominantly in their programs.

4           Only one of these seven programs is designed  
5 just for women, and that's the last program, the pregnant  
6 and postpartum women in residential treatment for women and  
7 children programs, and we have 20 of those programs, and  
8 Linda White-Young is the project officer for all of those.

9       But we also have many other grant programs that have  
10 grantees who are just serving women in those grants, or  
11 predominantly serving them. Of the 423 programs that we  
12 support in these categories, a quarter of them are serving  
13 predominantly women.

14           We also serve women through the block grant, of  
15 course. We have the block grant set-aside, which gives  
16 priority access to pregnant and parenting women, and then,  
17 as you heard, Andrea talked about some of the ATR programs  
18 are focusing their services for women. Louisiana,  
19 Wisconsin, and Florida, with their emphasis on child  
20 welfare, are providing services for women, and I'm sure  
21 there are many others, but they've not been identified as  
22 such.

23           These are just some slides about the  
24 discretionary portfolio and the services that they describe  
25 themselves as offering. I just wanted you to see that 33

1 percent of those programs are offering HIV/AIDS services  
2 because we have a very large portfolio of TCE HIV grantees,  
3 and 25 percent of them do have programs that care for women  
4 with their children with them.

5           This is just some more of the different types  
6 of specialty services that the providers have reported that  
7 they're serving.

8           This slide really is just to show you that in  
9 that group of grantees, it's about a 50-50 mix in that half  
10 of them are outpatient programs and half of them are  
11 residential programs, approximately.

12           I wanted to talk about, getting back to the  
13 barriers, some of the strategies that our grantees have  
14 employed to address the barriers having to do with cost,  
15 having to do with stigma, and having to do with the  
16 program-specific concerns. Some of them are helping their  
17 clients to apply for Medicaid and TANF. We hear that often  
18 clients need help just getting the proper documentation  
19 that they need in order to be able to make an application.

20           They're providing such things as family support  
21 activities, couples counseling, family days, education,  
22 communications, all the types of program services that you  
23 would find in good comprehensive programs such as you would  
24 find at The Village. Val is here from The Village on our  
25 Council, and her program is an example of a very

1 comprehensive program that's done a lot of these types of  
2 things to address those barrier needs; providing women-only  
3 groups, of course; allowing children to attend with mothers  
4 and providing child care, and identifying additional  
5 caretakers for children.

6           In terms of some other things that they're  
7 doing, there is, as we said, a reluctance to work with  
8 clients using medications for mental health disorders among  
9 substance abuse treatment providers, and some have sought a  
10 better relationship with psychiatrists in their communities  
11 to be able to provide more thorough and comprehensive  
12 services for clients with co-occurring disorders. Also,  
13 the issue of getting appropriate medication through  
14 Medicaid-supported clients has been a problem that some of  
15 the grantees have had to address.

16           Also, being able to provide more state of the  
17 art trauma services for clients. We have just really  
18 wrapped up our five-year study of women, co-occurring  
19 disorders and violence, which looked at different  
20 interventions for women with histories of trauma and co-  
21 occurring mental health disorders, and a lot of the work  
22 that came out of that study is now being translated so that  
23 the programs can use what we've learned.

24           In terms of housing, there are efforts to  
25 collaborate with supportive housing agencies, assist

1 clients to budget for housing, to seek out women-only AA  
2 and NA meetings, and when that's not possible, to develop  
3 alternative meetings through the help of the program, to  
4 develop meetings that they call Double Trouble for people  
5 who have more than one issue they're confronting, such as  
6 an HIV-positive woman who is in recovery, to provide  
7 facilities at the agencies for clients to hold those  
8 meetings, and of course provide transportation to meetings  
9 when they are available.

10           So I went through that very quickly. There are  
11 many people at CSAT besides myself who work very closely  
12 with our grantees. As I mentioned, Linda White-Young  
13 manages all of the pregnant, postpartum, residential women  
14 and children's programs, as well as many of the other  
15 Targeted Capacity programs that serve women. Stella Jones  
16 has been working with the TCE HIV programs, and Rita  
17 Vandirvort has been working with us around treatment  
18 financing because of the issues around cost and portability  
19 insurance. So there are other people at the Center who are  
20 working in these issues along with me, and we're here to  
21 talk about any issues that you want to discuss.

22           Thank you.

23           DR. FLETCHER: Sharon, please let me thank you  
24 for a very informative report on issues related to women.

25           Does the research tell us anything about the

1 entry into treatment in terms of women given that there's  
2 this perception that the mono phenomenon exists? When they  
3 enter treatment, the level of addiction, is there  
4 variability in terms of that?

5 MS. AMATETTI: Well, what we know is that women  
6 generally need to use for a shorter period of time and at  
7 lower amounts to develop serious and multiple problems when  
8 they present for treatment, as compared to men. So we're  
9 getting women presenting at treatment with quite an array  
10 of issues, already in a very short period of time compared  
11 to men often having serious problems, and that's why it's  
12 so important, I think, to have very comprehensive  
13 approaches to working with these clients, and that's really  
14 what we're trying to model through our grant programs.

15 MS. JACKSON: Thank you very much, Sharon.  
16 That was a wonderful presentation to something that's very  
17 near and dear to my heart. We've been working with women  
18 and children since CSAT/CSAP started in 1992, and I'm happy  
19 to say that we had a five-year grant which you were the  
20 project officer for, which started are women and children's  
21 program, and since then have been able, through the State  
22 of Florida, to continue that program, and it's flourishing.  
23 We have actually 50 beds for women with children in our  
24 program at The Village.

25 The point, I guess, is that through all these

1 years, we continue to have waiting lists for women and  
2 their children. I think that the barriers that you  
3 mentioned are really appropriate. I mean, you really hit  
4 the nail on the head with a hammer, and I think that's  
5 something that we need to look at.

6           A couple of things that I don't know for sure  
7 if this is nationwide, but just through talking with my  
8 colleagues and so on, the denial or perhaps lack of  
9 emphasis on treating this particular population. One of  
10 the things that I know is happening, and I think it's still  
11 happening in Miami/Dade -- it was still happening a few  
12 months ago, so I'm sure it hasn't changed -- several years  
13 ago, there was a lot of testing when babies were being born  
14 of the mothers. Almost all mothers, in fact, were being  
15 tested at Jackson, for instance, in Miami/Dade County. One  
16 hundred percent of the moms who were giving birth were  
17 being tested for drugs because there happened to be a grant  
18 there, a research grant, and they were able and willing to  
19 do it at the time.

20           Once most hospitals decided that they didn't  
21 want to pay for that drug testing, the rule now is that you  
22 only test if a mother is obviously high or shows those  
23 kinds of signs. So the detection system for, for instance,  
24 mothers who are giving birth, is really very poor.

25           Another area that I would like to see us

1 explore a little bit more is the work of another agency,  
2 Healthy Start, where they do a lot of screening for  
3 substance abuse, but we happen to have a Healthy Start  
4 program, and we find that in our area at least, very few  
5 women show up with the screening device showing that they  
6 have any need at all for substance abuse. I really have to  
7 question what kind of screening -- I know what kind of  
8 screening they're doing. I have to question the  
9 effectiveness of the screening or the training of the  
10 screeners. I don't know exactly what's going on. These  
11 are things we've looked at in our community.

12           Finally, I really am appreciative of CSAT and  
13 SAMHSA. I mean, to see that a quarter of our discretionary  
14 programs are going for programs for women is heartening,  
15 because I have been very worried that this was kind of  
16 going to go by the wayside eventually, unless we do  
17 something to really figure out how we can treat women with  
18 their families. The comprehensive treatment that we do is  
19 an extremely expensive way to treat women, yet it's a very  
20 effective way to treat a whole family, and cost effective  
21 when you look at the whole family.

22           I don't know how many research projects -- I  
23 know that this is not SAMHSA's area to do research on this.

24           I don't know how many research projects are going on at  
25 NIDA, for instance, or if you're even informed of that, and

1 how much national emphasis there is on that.

2           So those were just a couple of thoughts that I  
3 had, the research, the issues about not testing, drug  
4 testing pregnant moms, and the costs, of course, are just  
5 tremendous. Do you see that as being a national problem?  
6 Those are certainly problems that are in our area.

7           MS. AMATETTI: Well, in regards to the  
8 substance-exposed infants at birth, we have a national  
9 center on substance abuse and child welfare that is  
10 supported with Administration of Children and Families, and  
11 really looks at the involvement of families in the child  
12 welfare system as the result of parental substance use.  
13 We're in the middle, actually, of an analysis right now  
14 looking at state policies around screening for children in  
15 the hospitals. This really came at the impetus of a new  
16 amendment to the Child Abuse Prevention Treatment Act,  
17 which now says in the Act that all states do screen. It's  
18 not so much that they screen, but if they screen, if they  
19 are screening and they get a positive result, they need to  
20 make a mandatory referral to child welfare for  
21 coordination.

22           So it doesn't require screening per se, but it  
23 says if you are screening, you have to make a referral,  
24 with the language in the rule saying that it's to provide  
25 early intervention services, not to be a punitive response.

1 But we were looking at this rule and said, well, what's  
2 going to happen and how are states going to respond? What  
3 we're finding is a very chaotic picture out there in terms  
4 of very diverse responses of the states to this issue,  
5 really not a lot of resources to address it on a very broad  
6 scale. When things are being done that seem like they're  
7 effective and cutting edge, they tend to be local  
8 interventions and not statewide interventions.

9 So I think in the future, and I'd be happy to  
10 come back after we're done with this work to talk about  
11 what we found from that analysis. But the early analysis  
12 is that it's all over the place.

13 In terms of working with NIDA, I'm excited  
14 because we're now working with both NIDA and NIAAA planning  
15 a big national women's conference for next summer. In  
16 fact, we're having a meeting tomorrow. They're coming  
17 down. We're looking at what the evidence base is, and we  
18 want to term this conference "News You Can Use." That's  
19 what our slogan is. So it's really about what's coming out  
20 of the women's treatment research that we can share with  
21 audiences in that venue.

22 Ken?

23 MR. DeCERCHIO: Sharon, a quick recommendation.  
24 I think I would put the cumulative block grant set-asides  
25 or targets for a woman as part of -- I know it's a

1 discretionary slide, but I think it's fairly substantial.  
2 I mean, at a minimum, we're spending \$13 million, and I  
3 think it's a low figure, in Florida. I think it's a  
4 strength of the substance abuse system that SAMHSA can take  
5 a lot of credit for.

6           Prior to the set-aside, we didn't have many  
7 women's programs. Mental health doesn't have gender-  
8 specific programs, and I think it's a tremendous strength.

9       We see a growth. We see women's and kids' programs  
10 sprouting up that we're not even funding, that they're  
11 seeking funding in other areas. I've seen this expand  
12 beyond what we're funding, and I think it's a tremendous  
13 strength to the system. Yes, the glass is always half  
14 empty, but I think it's a significant strength. It's  
15 major.

16           When we've spoken with child welfare, the  
17 ability to do this, we've got 13 women's and children's  
18 programs that have residential capacity, probably 50  
19 specialized gender-specific programs. So I think we can --  
20 I hate to use the word "marketing," but I think we can take  
21 more credit as a system, and this administration can take  
22 more credit as a system. It's a tremendous asset.

23           The other thing is I think we need to look at  
24 other models, too. We need to try to figure out how to do  
25 better in-home services. We're not going to build enough

1 residential capacity to bring enough moms and kids in  
2 concurrently who need treatment, and we need to figure out  
3 ways to get smarter about it and look at some in-home  
4 models and some intensive case management and wrap-around,  
5 some harm reduction, maybe even applying SBIRT to a group  
6 of women who aren't going to part with their children in  
7 order to get treatment. We're going to have to figure that  
8 one out.

9 MS. AMATETTI: That's a good recommendation,  
10 and thank you for that. We will do that.

11 I do want to tell you one of the things I think  
12 we're doing well right now is when that set-aside, the  
13 block grant set-aside was put in place, many of the states  
14 reassigned assignments to something they called the women's  
15 treatment coordinator. For the past several years CSAT has  
16 been organizing that group of coordinators, and we meet  
17 with them regularly every year. This year we're going to  
18 be down in Florida with the NASADAD meeting. We're going  
19 to visit Val Jackson's program, and we're also going to be  
20 sharing with them our collection of women's treatment  
21 standards.

22 We asked all of the women's treatment  
23 coordinators to send us the standards that their states are  
24 using for women's treatment. They don't all have them, of  
25 course, but we've now compiled them, looked at what are the

1 best parts of different ones, and we're going to be sharing  
2 that back with them. So I'm encouraged that we have that  
3 opportunity to meet with them.

4 DR. CLARK: Chilo?

5 DR. MADRID: One of the biggest barriers that  
6 we face where I come from regarding women and children's  
7 treatment is Child Protective Services. A lot of our women  
8 are very scared to lose their kids. So my question is, is  
9 there any work being done at the federal level to make  
10 these agencies a bit more sensitive?

11 The other question that goes along with that is  
12 this whole issue of Medicaid concerning funding. Women  
13 with children, women that are single, women that have  
14 children but their children have been taken away from them,  
15 what are some of the funding issues concerning those three  
16 types of populations, and what are some of the things that  
17 are being done to sensitize Medicaid to help us as well as  
18 Child Protective Services, as well as adult protective  
19 services, so that the responsibility doesn't fall just on,  
20 let's say, the drug treatment office?

21 MS. AMATETTI: First your question about Child  
22 Protective Services, families involved with that. Well, as  
23 I mentioned, we have now a National Center for Substance  
24 Abuse and Child Welfare, and the Center predominantly works  
25 with state organizations and agencies around doing better

1 work together. We have a program of in-depth technical  
2 assistance where we go out to states. It's an application  
3 program where states have to come together with a team from  
4 child welfare, from substance abuse, from the criminal  
5 justice sector, to commit to working together and to  
6 develop a program and do systems change. In fact, Florida  
7 participated in that program last year, and we now have a  
8 new cohort of states that we're working with.

9           We've conducted a great amount of technical  
10 assistance across states and really are trying to deal with  
11 some of the issues around stigma, very many of them having  
12 to do with other agency responses to our clients, but also  
13 the practical implications of working together across  
14 systems and making that work more effectively, looking at  
15 things like the family drug treatment courts, which we also  
16 support, but there are many of them that are supported with  
17 other funds that have been a very effective model as well.

18           So we are looking to be better coordinated with  
19 child welfare certainly, and we've gotten a great response  
20 at the federal level as well.

21           Around the Medicaid issues, I don't know, Rita,  
22 if you want to respond to that question at all.

23           Rita really works with our financing issues.

24           MS. VANDIRVORT: Well, I wish I had some good  
25 news to share about Medicaid. Clearly, Medicaid is really

1 a state-driven program, especially when you're talking  
2 about substance abuse, because substance abuse is  
3 essentially an optional program under Medicaid. Things  
4 like Resources for Recovery that Robert Wood Johnson has  
5 initiated to try to expand the understanding about how to  
6 use Medicaid options, I know I've spoken to most of our  
7 grantees at CSAT around ways to utilize Medicaid to expand  
8 its coverage.

9 I guess the bottom line is if states want to  
10 utilize Medicaid and expand their substance abuse coverage,  
11 it's certainly possible. The mechanisms are there. But as  
12 you all know probably better than I do, the pressures that  
13 states have been under, Medicaid budgets have been cut, as  
14 have a great deal of other budgets.

15 The women and children are probably the most  
16 core group, and even some of the proposals changing  
17 Medicaid talk about the mandatory group retaining much of  
18 the service array they have. The mandatory group is the  
19 women and children on TANF. So some of the other groups  
20 are probably most in jeopardy.

21 We've had some discussions with Mady, with  
22 Joan, with Dr. Clark, and with Anne's help, and I think we  
23 think it's probably really working with the states at this  
24 level rather than looking to CMS to move in a different  
25 direction, which is where we'll probably get some action

1 working with states, because the big policies probably  
2 aren't going to go in that direction.

3 DR. CLARK: Eric?

4 DR. VOTH: Great compliments about these  
5 programs. I think they're spectacular, and I always find  
6 myself trying to look at some of these things from a 10,000  
7 foot view. To a little bit of an extent, we're trying to  
8 put the genie back in the bottle, which is great. But just  
9 imagine for a moment if we had a way to intervene at  
10 earlier stages, and I'm talking here about student drug  
11 testing. I mean, if you had SBIRT programs geared toward  
12 student drug testing, or drug testing on demand that had  
13 support systems, you'd take all these gals who are in their  
14 20s with kids and there you started with an average of 12  
15 to 13 years old, some were being dominated by boyfriends,  
16 early sexual activities, et cetera, and I'll tell you that  
17 the reasons the schools don't do it is because they're  
18 afraid of sticking their toe in the water and finding out  
19 that it's a huge iceberg phenomenon out there.

20 If they had the support of things like SBIRT,  
21 which is great, and if it can be broadened -- and I'm kind  
22 of on a soap box here -- I think we'd be looking at a  
23 reduction in the need for these kind of phenomena. But  
24 again, it's getting people to accept that, and I think  
25 that's going to be very difficult. But that may be

1 something that could be done in a kind of sticking our toe  
2 in the water, starting funding processes down some of those  
3 roads, et cetera.

4 DR. CLARK: Frank, and then Val.

5 DR. McCORRY: Thank you, Sharon, for a great  
6 presentation, and the discussion I think has really been  
7 very interesting. I really enjoyed the Council members  
8 comments.

9 I want to make a comment, ask a question, and I  
10 was picking up on what Rita was talking about, because I  
11 was thinking maybe it would be great to get CMS to present  
12 to the Council. My idea was, and it was from Sharon's  
13 presentation around barriers, helping clients who apply for  
14 Medicaid. But, in fact, this whole idea of financing the  
15 system of care, I know we have block grants. New York is a  
16 very big Medicaid state, and we have local appropriations,  
17 as well as county appropriations, and we have self-pay, all  
18 supporting a very large treatment system in New York, and  
19 yet it's very difficult for me to understand it from my  
20 perspective, even within the system.

21 I don't know whether issues related to  
22 financing the system of care and the role of Medicaid in  
23 both supporting it or inhibiting it is something that might  
24 be -- I'd certainly be interested in it. I don't know if  
25 the Council would be interested in it, certainly to

1 understand it and to see if, in dialogue with CMS or in  
2 dialogue with other federal agencies, as well as state  
3 structures like NASADAD, that there might be some ability  
4 to -- for example, SBIRT is so well established as an  
5 evidence-based practice that CMS would not be endorsing  
6 that within the state Medicaid plan.

7           Is it substance abuse treatment? No. But it's  
8 really kind of primary care, medical care, and whether it  
9 would cost more or less is always a discussion.

10           So my first issue is whether financing the  
11 system of care, and particularly the role of Medicaid in  
12 supporting or not supporting it, might be of interest to  
13 kind of take on here for a little discussion. Then I have  
14 a second one.

15           MS. VANDIRVORT: I just want to comment. I do  
16 think that the whole notion of SBIRT and moving a lot of  
17 this screening into primary care is very much in line with  
18 some of the initiatives that this administration has pushed  
19 to be sure that there is a primary care benefit. So there  
20 may be some ties there that we can build on.

21           We also have in the past worked with them  
22 around the work of the New Freedom Initiative, the New  
23 Freedom Commission and some of their work. I certainly  
24 think there might be some bridges we could make around some  
25 of our initiatives and their initiatives that might give

1 more boost to them.

2 DR. McCORRY: It's amazing what other systems  
3 don't know about the care that we deliver. Even knowing  
4 this might be of benefit.

5 The second, Sharon, is you mentioned meeting  
6 with NIDA tomorrow, and I thought out of the NIDA treatment  
7 principles, I think there is in that oval but I'm trying to  
8 remember whether child care services is one of the ovals in  
9 terms of principles of treatment effectiveness that NIDA  
10 espouses. When Ken was talking about new models, I was  
11 wondering whether we could pursue that a little bit more.  
12 How do we help women who still have their kids, as well as  
13 they don't lose them? But also, how do we support women to  
14 be able to access treatment who have family  
15 responsibilities?

16 I thought of ATR. I don't know whether, as a  
17 recovery support service, child care services for women in  
18 treatment who have children would be an interesting thing  
19 to add to the ATR portfolio. But also I thought with NIDA,  
20 as you speak to them about these kinds of issues, as they  
21 define principles of treatment effectiveness, the real role  
22 of women who are responsible for children and how that can  
23 play out both in terms of the research, and then how we can  
24 infuse that into these kinds of grant structures.

25 MS. AMATETTI: I just want to say quickly, I

1 don't remember either, but I think they speak to ancillary  
2 services more broadly, with child care being one of them.  
3 But CSAT has revised its comprehensive model of services  
4 for women that will be in the new women's TIP when it is  
5 published that talks very much about the services for  
6 children, child care and beyond, not just child care but  
7 all of the services that children would benefit from when  
8 they're living in a household and participating in  
9 treatment with their mother. So look for that.

10 DR. CLARK: Val, and then Ken.

11 MS. JACKSON: Thank you. I think in-home  
12 onsite, as Ken mentioned, is a very viable thing for women  
13 with children. But what I wanted to address was to carry  
14 on what Sharon is saying. You mentioned student testing  
15 and the SBIRT model. I think that the way that we have to  
16 view this is beyond child care. If you have a mother who  
17 has her children or who is possibly going to get her  
18 children back, or a father who may have custody -- by the  
19 way, we treat fathers, and we also treat couples.

20 The issue is that you cannot stop with child  
21 care. So what's happened -- and I can only speak for my  
22 agency. I don't want to keep referring back to my agency,  
23 but I think it applies to a lot of other organizations  
24 across the U.S. -- is that as we've grown and gone through  
25 the evolution of first having just child care, we found

1 that what we have to do is we have to assess every child.  
2 We are now to a point where we've gone to a foundation.  
3 The Chris Everett Foundation supports us in actually  
4 providing psychiatric or psychological services for the  
5 kids, developmental services for the kids. The therapists  
6 go to school with the kids to meet with the teachers, along  
7 with the parents.

8 I mean, there's just a whole host of things  
9 that I could go on and on and on about that must begin, and  
10 when you talk to the parents and to the kids once the whole  
11 family is receiving services, you see this amazing  
12 transformation. I think it's definitely something we have  
13 to look at. That's preventing, perhaps preventing -- I  
14 don't know that there's research on it -- but preventing,  
15 or at least bringing to light the next generation of  
16 addiction much earlier, or preventing it totally, and many  
17 other problems.

18 Secondly, I wanted to mention that one of the  
19 things that we do -- and I do think that Florida is  
20 somewhat of a model with the family and with women with  
21 children's services, because there is great support  
22 statewide for it. One of the things that we've negotiated  
23 is to have joint custody. We literally have joint custody  
24 with the state for the children who are with us. So an  
25 incentive for the mom not to leave treatment is that she

1 can't take her kids with her. She can't walk out the door  
2 with those kids. She'll have to leave them behind. That's  
3 a big carrot that you have, and I think that that also  
4 satisfies the child's safety considerations that is in  
5 child welfare.

6           Of course, they're also doing a lot in Florida,  
7 in northern Florida, working with the child welfare folks  
8 to actually use the substance abuse money and child welfare  
9 services to make sure that the kids and the families are  
10 getting services. But that joint custody we found has been  
11 a really good benefit to getting and keeping moms and  
12 families.

13           DR. CLARK: Ken?

14           MR. DeCERCHIO: I think part of the  
15 exploration, too, was the financing. That would be a good  
16 discussion. Part of that discussion would be good to have  
17 RWJ here to talk about what they've observed as not a  
18 point-counterpoint but as another perspective on the  
19 Medicaid issue.

20           On financing, a couple of our providers,  
21 Gateway in Jacksonville, have created supportive housing.  
22 They're now accepting more children, more families into  
23 supportive housing, and they've deemphasized residential  
24 supportive housing and wraparound. So they're getting  
25 higher numbers of children who are involved in child

1 welfare.

2                   Well, guess what? Those children are with  
3 their moms. They're not eligible for 4(e) home care  
4 dollars. So they've come to us and said we're having a  
5 hard time for the financial support for larger numbers of  
6 kids, whereas before they would only take an infant in or  
7 an under five-year-old to residential treatment. Now  
8 they've got three and four children, and they've got 15,  
9 20, 25 families in supportive housing that are not really  
10 eligible for any of the child welfare funding, not  
11 substance abuse treatment or even wraparound, but the kinds  
12 of support. Because the children haven't been removed,  
13 they're not eligible for 4(e), and in some cases they're  
14 being diverted from child welfare, in other cases under  
15 protective supervision.

16                   I think part of the financing exploration is  
17 this nexus with 4(e) funding, the categorical funding in  
18 child welfare. It would be nice, through the national  
19 center, to come back and talk about that and have a similar  
20 discussion with the Administration for Children and  
21 Families about how we can jointly finance some of those  
22 support services that create incentives to keep families  
23 together, rather than create incentives for higher levels  
24 of reimbursement for kids that have been removed from their  
25 homes.

1 DR. CLARK: Rita?

2 MS. VANDIRVORT: I absolutely agree with  
3 everything you said. That's right.

4 I just wanted to mention that I am working with  
5 Sybil Goldman, who is a special assistant for children and  
6 families here, on a project where we're developing  
7 information for providers, kind of a catalog for funding,  
8 because underneath what you were saying is Medicaid is  
9 important, and I think there are opportunities there, but I  
10 think we have to look across all of the funding streams to  
11 really put together a system today. Nobody has a lot, so  
12 it's kind of understanding where your opportunities are  
13 across child welfare, across juvenile justice.

14 So it's a multi-year project. In fact, I think  
15 we tried to get Chilo to come to that meeting. I hope he  
16 does.

17 DR. CLARK: Hint, hint.

18 MS. VANDIRVORT: We're looking at the different  
19 funding streams. The first year is going to be kind of a  
20 comprehensive catalog. The next year we'll talk about  
21 blending and braiding funds and how you really put it  
22 together.

23 DR. CLARK: Dave?

24 MR. DONALDSON: I think we have to insert into  
25 that the preventive side, such as the President's other big

1 initiative, the healthy marriage initiative, which is going  
2 to the states as part of TANF. I was wondering, are you  
3 having any collaboration with ACF on that?

4 MS. AMATETTI: Yes. The Office of Family  
5 Assistance, which manages the TANF program, we've been  
6 working very closely with them over the years, actually  
7 from when TANF was first implemented. We're looking  
8 closely at the reauthorization and we keep waiting for  
9 that, when that's going to happen, because it has the  
10 stipulation in there that you can now more broadly count  
11 participation in substance abuse treatment as an allowable  
12 work activity, which would be very helpful. Some states  
13 have done that already on their own, but it's not across  
14 the nation. So we're looking to see when that will be put  
15 into law.

16 MR. DONALDSON: Yes, like Ohio, which they have  
17 now a whole division called Strengthening Marriage and  
18 Family. That would be good if you haven't tapped into  
19 that.

20 MS. AMATETTI: Right, and the marriage  
21 initiatives there.

22 DR. CLARK: Okay. Thank you, Sharon. I really  
23 appreciate your presentation.

24 (Applause.)

25 DR. CLARK: I think we sat through a number of

1 presentations, all wonderful. You probably need to stretch  
2 your legs. So why don't we take a 15-minute break and  
3 reconvene at 3?

4 (Recess.)

5 DR. CLARK: Two more presentations. We would  
6 like to get moving. It's been a long day. It will be  
7 longer the longer we delay.

8 One of the topics that was requested by CSAT  
9 Council is an update on Partners for Recovery, or PRF, and  
10 their treatment and workforce development efforts at CSAT.

11 Presenting on this topic is Dr. Karl White, workforce  
12 development team leader at CSAT's Division of Services  
13 Improvement, and project officer for the Addiction  
14 Technology Transfer Centers.

15 He will be joined by Ms. Donna Cotter, CSAT's  
16 Partners for Recovery coordinator. Donna is currently  
17 responsible for coordinating the development of SAMHSA's  
18 Partners for Recovery initiative, a collaboration of  
19 communities and organizations mobilized to help individuals  
20 and families achieve and maintain recovery and lead  
21 fulfilling lives.

22 Karl? Donna?

23 DR. WHITE: The first thing you're to notice  
24 today is how Donna and I coordinated our outfits for this  
25 presentation.

1 (Laughter.)

2 DR. WHITE: We wanted to make sure you noticed.

3 The next thing we want to recognize right up  
4 front is that we have squeezed at least two hours worth of  
5 material into 20 minutes. So we're going to run through it  
6 fairly quickly, and we'll be happy to take as many  
7 questions as you have when we finish.

8 Partners for Recovery has launched two  
9 workforce initiatives in conjunction with the Division of  
10 Services Improvement. The first was to produce a report on  
11 workforce development, and that was commissioned by Dr.  
12 Mady Chalk, our division director. The second was to work  
13 in the area of leadership development, which Donna is going  
14 to talk about after I talk about the new report.

15 This will be the cover of the report. We would  
16 give you a copy today except it's in content clearance and  
17 we don't have clearance to pass it out. But the material  
18 we'll be discussing with you is directly from the report.

19 Tom McClellan has always been one of the wise  
20 sages in our field, and this quote by Tom talks to the fact  
21 that if we don't take care of our workforce issues, and we  
22 do have a workforce crisis, we're not going to end up  
23 meeting the needs of the clients that we serve.

24 CSAT started really looking at workforce  
25 development issues back in 1999, and the program that it

1 was a part of has morphed now into Partners for Recovery.  
2 To start the work on our current report, we commissioned an  
3 environmental scan. This was a new word to me, and as  
4 we've used it it's taken on a whole lot of new meaning.  
5 Our environmental scan meant taking everything we had at  
6 CSAT, all of our workforce surveys produced by our ATTCs,  
7 all of the research that we could find in the area --  
8 McClellan's research, Rick Harwood's research, and anyone  
9 else's name that you can mention who has done research in  
10 this area -- and boiling it down into what were the  
11 commonalities, what were the differences, and what were the  
12 trends that emerged.

13           After we did that, we saw that we needed to try  
14 it out on the stakeholders, is this still relevant in your  
15 situation. So we convened stakeholder groups. The groups  
16 are listed. I don't need to read them to you. But the  
17 last one on the list stands a little explanation. We had  
18 two sections of the country that had not completed any  
19 workforce data, the upper midwest and the middle southern  
20 states, Texas, Oklahoma, Arkansas, Missouri. We convened  
21 providers, state directors and ATTC directors from those  
22 areas after we did the workforce report and said does this  
23 fit? Are these the issues being faced by your states and  
24 in your regions?

25           In both -- we couldn't call them focus groups.

1 In both of our stakeholders information gathering groups,  
2 they concurred that what we had discovered through our  
3 environmental scans still fit in their region.

4 What the report revealed and what our scan  
5 revealed was the composition of our workforce looks like  
6 this, and as you read the bullets under gender, age,  
7 ethnicity and race, you'll see that we have problems and  
8 inconsistencies in each area. Seventy percent of the  
9 counselors in training today in academic institutions are  
10 Caucasian women. That in no way matches the client base  
11 that we serve across the country. I was thinking about the  
12 statistics this morning from our Hispanic work group. It's  
13 a problem. We need to change the way this looks.

14 Education level. We have a lot of people with  
15 degrees. Very few people receive their addiction training  
16 as part of their formal education. I didn't. All the  
17 training I have in addiction came -- besides what I learned  
18 in the fraternity house --

19 (Laughter.)

20 DR. WHITE: -- came after graduation and  
21 through formal training. We need to work on that. We  
22 should be graduating people with what we know about  
23 evidence-based practices and addiction treatment, not  
24 waiting until they graduate to train them.

25 Medical staff. I think these statistics are

1 telling. Dr. Clark and I met recently with the Addiction  
2 Nurses Association. They want to work with us in  
3 attracting more nurses into the addiction specialty so we  
4 can have more nurses in our treatment programs.

5 Kind of an historical context for the key  
6 issues that are facing the field. We don't have a  
7 workforce to meet the demand currently. We have a changing  
8 profile of those needing services across the country. Not  
9 only do we have some people coming in from Central America  
10 and South America that can't read or speak English, their  
11 literacy level is such that they can't read Spanish. So  
12 many of the educational techniques that we use in our  
13 treatment programs are no longer effective, and this is a  
14 big problem.

15 We have increased public financing challenges,  
16 and I would add another word to this slide, challenges and  
17 barriers to adopting evidence-based treatment in many  
18 settings, and increased utilization of medications and  
19 treatment. I mean, there are programs now that are willing  
20 to adopt medication-assisted treatment that for years  
21 prided themselves on being "drug-free" treatment centers.  
22 Betty Ford has recently entered into, as part of the  
23 Clinical Trials Network with NIDA, has been using  
24 buprenorphine as part of their detoxification. I was in a  
25 meeting with their clinical director in Los Angeles

1 recently, and the rapid results they get in readying  
2 patients to fully participate in treatment with  
3 buprenorphine detox is just amazing, and those results will  
4 be released in some training materials through our ATTC  
5 network in the next six months.

6           Movement to a recovery management model of  
7 care, where we're no longer looking at just treatment but  
8 we're looking at a full continuum of recovery services,  
9 we're looking at providing treatment in non-traditional  
10 settings, our outreach to faith-based organizations and  
11 other types of community-based organizations to provide  
12 services in the recovery process. Stephenie talked this  
13 morning and Dr. Clark has talked about the performance and  
14 patient outcome measures and how that's currently impacting  
15 the work that we do, and we still have discrimination  
16 associated with addiction both for our clients and, to some  
17 extent, for those of us who choose to work in this field.

18           The report examines in detail this list of  
19 areas, and the next few slides will just barely illuminate  
20 it.

21           Before I go any further, I neglected to do the  
22 people that have really done the work on illuminating these  
23 issues for us. We have with us in the audience today  
24 Melanie Witter and Peter Gomand from Abt Associates, who  
25 have been primary authors on helping put together this

1 report. They could tell you page and number from where  
2 these slides came. But I wanted to recognize that they're  
3 here, and they're also a resource for you to talk to.

4 Peter and Melanie, raise your hands. Good.  
5 Thanks.

6 Infrastructure issues facing the addiction  
7 workforce. We have a workforce shortage. Staff turnover,  
8 the second bullet, from Jeff Knudsen's study. Workforce  
9 turnover doesn't necessarily mean people are leaving.  
10 We're beginning to see workforce churning, where people are  
11 leaving one job and going to another for as little as \$500  
12 more a year. So it's not people departing the field so  
13 much as the turnover can be attributed to the low salary  
14 level, and another slide speaks to that.

15 We talked this morning about the money we're  
16 putting into our TCE programs. It's a double-edged sword.  
17 We increase treatment capacity. We don't have the number  
18 of treatment providers to treat the clients. So we need to  
19 continue to work on increasing our workforce.

20 Again, accountability, performance measures,  
21 complex leadership and management issues. Leadership is  
22 reaching retirement age. We've talked about the graying of  
23 the field, the aging of the field. Last Saturday night I  
24 was at a concert and heard one of my favorite female  
25 vocalists, and she said, "You know, 30 years ago when I

1 started, I had blue eyes and black hair. I still have blue  
2 eyes." I look around at my colleagues and, yes, a lot of  
3 us are in that same situation now. We still have the same  
4 color eyes, and some of us have managed to hide the gray.  
5 But we do have an aging workforce, and we really do need to  
6 look at sustainability and replacement of those leaders,  
7 and Donna will talk to that in a few minutes.

8           Recruitment. We know we're going to have a  
9 workforce shortage. Rich Landis' research talks about the  
10 unfilled positions.

11           Low salaries. When Melanie and Donna and I met  
12 with our stakeholders group of counselors, and again with  
13 our group of clinical supervisors, and we flashed up  
14 \$28,000 as an average salary, half of the people in the  
15 room were making less than half that amount in the  
16 counselor group, and the clinical supervisors said they  
17 would love to be making \$28,000. So when you average  
18 salaries across the nation, it's not really reflective of  
19 the low salary level in many areas of our country.

20           When you look at the health care disciplines,  
21 and then you look at the low number of people that are  
22 addiction certified or certified as addiction specialists  
23 across the different health care specialties, it gives us  
24 cause for concern. We need to recruit people as addiction  
25 specialists in all of the different disciplines.

1           Academic education. It's one of the  
2 recommendations that, through our ATTC network, we've  
3 already started to work on. We have 442 colleges and  
4 universities offering some kind of degree or certificate in  
5 addiction science, addiction counseling, addiction  
6 education. What we don't know is what those programs  
7 consist of. There are no accrediting standards or  
8 standardization of addiction science programs. We're  
9 working with INCASE. Some of you may be familiar with  
10 INCASE. It's the International Consortium of Addiction  
11 Science Educators. About 125 of these colleges and  
12 universities are members of that organization.

13           We would like to work with them to know what's  
14 actually being taught, that a B.A. in addiction counseling  
15 from South Carolina and a B.A. in addiction counseling from  
16 UCLA prepares the person to provide the same services when  
17 they enter the treatment field. So it's a challenge. It's  
18 an uphill climb, but we are beginning to look at that area.

19           Retention issues. Rick Harwood's slide I think  
20 speaks again to what Jeff Knudsen said about the churning  
21 of the field. We didn't find that much evidence of people  
22 leaving but changing jobs, and sometimes going into a  
23 mental health position that paid more than their addiction  
24 treatment position, which is not leaving if they're working  
25 on co-occurring, but still they're changing jobs. Then we

1 don't have any safety net. When we met with human resource  
2 directors in our constituency group and this small woman  
3 from TASC finally spoke up and she said, you know, the  
4 elephant is in the room. We don't take care of our own.  
5 We are so short-staffed that we ignore the signs and  
6 symptoms in our own staff members until sometimes it's too  
7 late. So we need a safety net for the workforce in our own  
8 profession.

9           Study issues. At SAMHSA, we don't do research,  
10 but we have lots of recommendations for the institutes on  
11 what they could be doing to look at the preparation of the  
12 workforce for our field.

13           Recommendations. We need career paths. We  
14 need loan forgiveness. Through the federal government you  
15 can get loan forgiveness for lots of professions.  
16 Addiction counselors are not currently listed.

17           We need to train better clinical supervisors.  
18 We have no hope of adequately implementing evidence-based  
19 practices with any fidelity if we don't have clinical  
20 supervisors who are trained in that implementation.

21           We need to sustain leadership and management  
22 training. Donna is going to talk about leadership  
23 training. The other side of the coin is teaching CEOs how  
24 to balance a checkbook, teach them how not to go out of  
25 business.

1           We need to expand the recruitment of health  
2 care professionals. I've talked about that. We need to  
3 improve student recruitment. The lack of diversity in the  
4 pre-service academic courses that are being taught is  
5 scary. We really need to increase our efforts to recruit  
6 diversity into the workforce, and I think part of that  
7 needs to start in recruiting students from diverse  
8 backgrounds into our academic programs.

9           Support the adoption of accreditation  
10 standards. I've mentioned that. We need to encourage  
11 boards for all health professions to start including test  
12 questions on addiction. We need to address substance abuse  
13 misuse and relapse in the workforce and encourage our  
14 institutes to do studies.

15           Those are the recommendations that you'll see  
16 when you get the full report. There is a lot more in the  
17 report than could be covered in these few slides, but we  
18 feel like we're beginning to get a handle on some of the  
19 initiatives that need to be funded, some of the action  
20 steps that we need to be doing at CSAT.

21           So in terms of next steps, we want to complete  
22 this document. We want to get it through content clearance  
23 so that we can start working with our various stakeholder  
24 groups to develop an action plan. We want to roll it out.

25           This report will probably end up being incorporated into a

1 bigger strategic plan for SAMHSA that's being prepared by  
2 the Annapolis Coalition. The SAMHSA leadership contracted  
3 with the Annapolis Coalition to provide a strategic plan  
4 for workforce development. Two of our ATTC directors,  
5 Steve Gallin from the Northwest Frontier and Mike Flaherty  
6 from our Northeast ATTC, are chairing the Substance Use  
7 Subcommittee to develop this strategic plan. They are  
8 joined by several other people who have worked with us for  
9 a long time, and we will have one-third of that plan, the  
10 mental health, prevention and substance abuse treatment.  
11 We see a lot of their work already prepared in this  
12 document that can be rolled into the strategic plan.

13           We want to encourage stakeholders at all levels  
14 to take a close look at their workforce issues and come to  
15 us and let us know what is needed to improve the quality of  
16 the workforce at all levels.

17           I'll turn it over to Donna, who will talk about  
18 one -- I'm going to go ahead and call it a successful  
19 initiative that was started in the area of leadership  
20 development, and then we'll both be available for  
21 questions.

22           MS. COTTER: Thank you, Karl.

23           First of all, I've had these cubes delivered  
24 for each of you. We also are offering to ship them for you  
25 if you don't want to put them in your suitcases. I hope

1 you'll use them and I hope you'll remember the Partners for  
2 Recovery, because as programs go in the federal government,  
3 Partners for Recovery has outlasted most. It started, as  
4 you know, as the National Treatment Plan, and with your  
5 support, and with the guidance of Chilo and Melody Heaps,  
6 who is not here today I see, has continued into Partners  
7 for Recovery. As you saw, the workforce report is a  
8 Partners-supported effort, and the Leadership Institute is  
9 also Partners supported.

10           There's a lot to say about these leadership  
11 institutes. I agree with Karl; they are a success. They  
12 are not a one-week course that you attend or a two-day  
13 course that you attend and then you walk away a leader.  
14 These are intensive. That's a key word here. They're six  
15 months in time, length. They have a variety of methods for  
16 training, including a one-week intensive seminar. We have  
17 asked the U.S. Department of Agriculture graduate school to  
18 assist us in providing the leadership training in that one  
19 week, and they have just had the most marvelous trainer.  
20 Everyone wants to clone this woman across the country.  
21 They do have other trainers who we will use.

22           Why do we need this training? Karl says I dye  
23 my hair, and he's right.

24           DR. WHITE: I didn't say that.

25           (Laughter.)

1                   MS. COTTER: There's a lot of workforce  
2 turnover. He's told you that. Frankly, there aren't very  
3 many educational opportunities for addiction training  
4 professionals. You know that.

5                   This began, actually, with an Addiction  
6 Technology Transfer Center in Florida, and they took it on  
7 and designed it. It became so successful that, frankly, we  
8 stole it. We put some more money behind it. We polished  
9 it up on the edges, and they too are improving it, as  
10 they've done now two sessions in Florida, and we asked the  
11 ATTCs to take it on and conduct it. There are 15  
12 leadership institutes scheduled from October of 2003 to  
13 2005. Eleven institutes were conducted through May, and  
14 145 emerging leaders have been trained.

15                   This is a quick look at the ATTC network just  
16 so that you can familiarize yourself with the fact that  
17 most of the country at least has some coverage with regard  
18 to offering this institute.

19                   This is a list of where the institutes have  
20 taken place in the past. Ne is northeast, and I've learned  
21 that NE is New England. So we have them going through the  
22 end of this year, and then we're going to support another  
23 complete round. Some of these institutes, I think it's  
24 important to mention that two of them have been focused on  
25 Hispanic clinicians. I have heard raves about the one that

1 was performed in Puerto Rico. It was bilingual, and I  
2 heard you put on a show, Rafaela. It was quite popular and  
3 very highly acclaimed. The one in New England, while not  
4 done in Spanish, was done for an Hispanic group of  
5 clinicians. So we're attempting to be culturally sensitive  
6 in everything that we, the Partners, do.

7           Of course, the intended outcomes are to develop  
8 and retain the potential leaders of the future for this  
9 field and build capacity to meet both organizational and  
10 system demands. This is a little bit of an in-depth about  
11 what the six-month institute is about. First of all, the  
12 protege gets a 365-degree assessment. So by the time they  
13 arrive at the training, their bosses, their peers and their  
14 directors have already talked to them -- not actually  
15 talked to them but filled out questionnaires about them.  
16 So whether or not they want to know it, this is an in-depth  
17 look at each individual -- what am I about, what are my  
18 strengths, what are my weaknesses.

19           Then they go through a five-day immersion  
20 training, and I cannot tell you the rave reviews that have  
21 come back from people who have taken this course. Then  
22 they develop their own individual leadership development  
23 plan, and they also have mentors matched to them. As we've  
24 said before, Val has been a mentor, and we're grateful for  
25 that. Many, many of you who do color your hair, or who

1 don't, could be excellent mentors in this program. We're  
2 hoping that it becomes institutionalized. We're hoping  
3 that we can keep it sustained because it's very positive,  
4 and it's working.

5           There is a three-month booster session. The  
6 people use e-learning through Blackboard, and of course  
7 they get their continuing education credits, and then they  
8 present a project at the end, and they go through an  
9 official graduation. We're hoping to have finances to be  
10 able to, on an annual basis, bring together across the  
11 nation the emerging leaders who have taken this training.

12           Approximately 200 will participate in this  
13 first cycle. The participants evaluate it after they've  
14 taken it, and we're also setting up evaluation criteria for  
15 the full institute. The second cycle will begin in October  
16 2005, and as you see, we're creating a new generation of  
17 leaders. So we'd all better watch ourselves.

18           Here's what one participant stated. We didn't  
19 put these words in their mouths. "This training is  
20 comprehensive, fast-paced, personal, experiential, and all  
21 together important. A year after participating, I'm still  
22 using what I learned. This hasn't benefitted only me but  
23 my agency and colleagues as well." Another individual said  
24 to me this was a life-changing experience. So we're  
25 really, really, really pleased to have the PFR engaged with

1 the ATTCs in this effort.

2           My boss has told me that if I make it brief, I  
3 could just tell you a little bit more about what the  
4 Partners for Recovery have been doing. We've been so busy,  
5 we haven't had the opportunity to brief you. I want to  
6 just run down a list.

7           I believe the "Know Your Rights" brochure was  
8 in your packet. This brochure is available in Spanish. We  
9 will be releasing it in Spanish. This has been very  
10 popular. We've given pilot trainings in Pennsylvania and  
11 New York, and they want more. We're going to try to do  
12 some regional-based trainings across the country. This is  
13 very helpful for people in recovery, people in treatment,  
14 family, friends, loved ones.

15           There's a national public education campaign to  
16 reduce stigma spearheaded by NCADD, and Partners for  
17 Recovery has provided some seed money, along with Ivette  
18 Torres' shop, to get the basics of this campaign defined.

19           In the area of recovery, I was glad to see  
20 Kathy Nugent here. Partners is providing the logistics  
21 support for a recovery summit that she is doing in  
22 September, and we're going to hopefully be able, for the  
23 substance use disorder field, to define principles of  
24 recovery and talk about systems of care that would support  
25 recovery.

1           In the area of collaboration, some of you know  
2 we did a 2004 forum. We sponsored it, Partners did, to  
3 begin dialogue among substance use disorder treatment,  
4 prevention, and mental health services disciplines. As a  
5 matter of fact, the Partners for Recovery steering  
6 committee is now reconfigured, and it has representation  
7 from the mental health side, the prevention side, and the  
8 substance use disorder treatment side. We will be  
9 reconvening that committee in late July. So the direction  
10 for the future will be coming and defined by that group.

11           Some other areas, very quickly. SAS, NCSL and  
12 Tom McClellan have put together a training package for  
13 state legislatures on performance measures, PFR money.  
14 NASADAD establishing their national treatment network, PFR  
15 money. Data strategy experts that Stephenie talked about,  
16 several of them were funded by the Partners for Recovery.  
17 The Hispanic stakeholders meeting was paid for, the  
18 logistics were paid for by the Partners for Recovery.

19           We are also supporting state conferences, and I  
20 want you to know that a website is developed for Partners  
21 for Recovery. We are in the midst of getting it cleared,  
22 and hopefully we will release it in July. It will be  
23 [www.pfr.samhsa.gov](http://www.pfr.samhsa.gov), pretty simple. You can also get it  
24 directly through the SAMHSA site because it is a  
25 government-supported website. You're going to see a lot of

1 good information on that. We're also going to get some  
2 states to contribute to it for us.

3 I just want you to know, and probably Dr. Clark  
4 is going to give me the hook, but Partners, under the 2006  
5 budget, is targeted for a 50 percent cut. We're going to  
6 do the very best that we can to keep this initiative alive  
7 because even though you don't hear about it, you hear about  
8 all these programs. A lot of times, our fingers are in the  
9 pot providing the basic structure and support for this.

10 So I guess I'm done.

11 DR. CLARK: Any questions?

12 MR. DeCERCHIO: I just want to recognize -- we  
13 get lots of good feedback from other state directors, from  
14 the ATTC, our ATTC, and I compliment you all on this  
15 initiative. With a small cadre of folks, you've got your  
16 fingers in a lot of things. For many of us, this is a hard  
17 initiative to get our arms around, the state directors, and  
18 we really appreciate the fact that you've taken it and run  
19 with it and really impacted many different areas. So  
20 thanks for all your work on this.

21 DR. MADRID: I also would like to compliment  
22 the Partners for Recovery. The leadership institutes, I  
23 think, is a fabulous idea, the fact that you included two  
24 Hispanic groups. You just fulfilled one of the tasks that  
25 we kind of gave ourselves, and I think that even though

1 finances are restricted at this time, I will probably  
2 encourage you and talk with you all about maybe partnering  
3 on some other things that the Hispanic work group has  
4 talked about.

5 So again, thank you for all the fine work that  
6 you all are doing.

7 DR. CLARK: All right. Thank you, Karl and  
8 Donna.

9 (Applause.)

10 DR. CLARK: We should move into our next topic.

11 Another topic of interest expressed at the last Council  
12 meeting was to examine CSAT's efforts with regard to co-  
13 occurring disorders. As you know, this is one of the  
14 redwoods, one of the four major issues of concern for Mr.  
15 Curie and SAMHSA. Joining us today to discuss this issue  
16 is Dr. Charlene LeFauve, branch chief for the Co-Occurring  
17 and Homeless Activities Branch in CSAT's Division of State  
18 and Community Assistance. Charlene is a clinical  
19 psychologist who specializes in treating addictions and co-  
20 occurring disorders for 12 years before joining the federal  
21 workforce in 1998.

22 Her federal career includes policy, legislative  
23 and research experiences at the National Institute on Drug  
24 Abuse, the White House Office of National Drug Control  
25 Policy, and the National Institute on Alcohol Abuse and

1 Alcoholism. She came to SAMHSA last summer from the  
2 National Institute on Alcohol Abuse and Alcoholism Division  
3 of Treatment and Recovery Research, where she served as a  
4 program official for pharmacotherapy and behavioral  
5 clinical trials research for treatment of alcohol use  
6 disorders with co-occurring psychiatric disorders.

7 Charlene?

8 DR. LeFAUVE: Thank you, Dr. Clark.

9 I've been sitting in the middle of the back  
10 area and I've had a little bit of trouble hearing today.  
11 So I told my colleagues I was going to speak very loudly  
12 when I got up here. Not only that, I'm the last speaker,  
13 so I hope everyone is still excited and alert.

14 The phenomenon of co-occurring psychiatric  
15 alcohol and/or substance use disorders is one that  
16 continues to challenge our nations, individuals, spouses,  
17 children, families, communities, providers, payers, the  
18 military, policymakers, legislators, the workforce, the  
19 research community, and every aspect of our society is  
20 significantly impacted.

21 In my former role at NIH and in academia, I  
22 spent 100 percent of my focus on the clinical management  
23 and etiological aspects of co-occurring disorders. I have  
24 treated every variation and permutation of co-occurring  
25 disorders across the spectrum of severity that one can

1 imagine: VA populations, inpatient locked units, detox  
2 units, outpatient walk-in clinics, residential care,  
3 chronic pain management narcotic-addicted populations,  
4 HIV/HCV, alcohol-dependent liver transplant candidates, gay  
5 and lesbian populations with co-occurring cocaine  
6 dependency and alcohol abuse and borderline personality  
7 disorder, and I can go on and on. The list is not finished  
8 here.

9           But the point is I list this intentionally to  
10 illustrate a very significant piece, and that is despite my  
11 experiences to date, I have never been as challenged as I  
12 have been in my current position where the pieces of the  
13 puzzle, all of varying sizes and shapes, are not fitting  
14 together very well in terms of our understanding of how to  
15 address service delivery issues and treatment challenges in  
16 real-world settings across our nation.

17           I am excited to have this opportunity to  
18 address you all today, and I want to thank Dr. Clark and  
19 Ms. Herron for their support and leadership.

20           During this presentation, you will hear a bit  
21 about the epidemiology of co-occurring disorders and  
22 treatment, some data on homelessness among substance abuse  
23 treatment populations, areas in which the field is seeking  
24 guidance, and a description of some key initiatives in our  
25 branch. I will also discuss SAMHSA's vision and CHAB's

1 mission, and close with some SAMHSA-relevant co-occurring  
2 programs that relate to our collective vision and mission.

3 The last section of my talk will not include all SAMHSA  
4 activities that relate to co-occurring disorders, only a  
5 few that are pertinent to our discussion.

6 This slide is an illustration to us all that  
7 the faces of co-occurring psychiatric and alcohol use or  
8 substance use disorders are literally everywhere. Unlike  
9 the homeless population, where more often than not the  
10 presence of a person on a step or under an overpass or in a  
11 doorway, on a park bench, or at an entryway to the transit  
12 system is evident, a person who has had a lifetime struggle  
13 with, say, generalized anxiety disorder and panic attacks  
14 and severe alcohol abuse or dependence could be an  
15 associate sitting next to you in this room.

16 An undiagnosed dysthymic person with bulimia,  
17 chronic pain, and opioid dependence could be anyone you see  
18 in an elevator during the day or at a professional meeting,  
19 or working in a toll booth, or standing next to you in a  
20 tailored suit at the airport. On the other hand, you can  
21 also imagine that co-occurring disorders have the same  
22 faces as you and I. They are the face of our nation, more  
23 than we may be able to truly quantify if we look across the  
24 lifespan and across special populations.

25 Let's take a look at some of the data that has

1 been recently published to provide a snapshot of one piece  
2 of this puzzle. Twenty percent of those persons surveyed  
3 in a National Epidemiological Survey on Alcohol and Related  
4 Conditions, also known as NESARC, funded by the National  
5 Institute on Alcohol Abuse and Alcoholism, 20 percent of  
6 those in this general population study with any substance  
7 use disorder, also have at least one mood disorder, and 18  
8 percent have at least one anxiety disorder. Twenty-nine  
9 percent of individuals with a current alcohol use disorder,  
10 and 48 percent of those with a drug use disorder, have at  
11 least one personality disorder.

12 Another data source tells us, in terms of our  
13 youth, those who are incarcerated, one-half to three-  
14 quarters of those suffer from a mental health disorder.  
15 More than half have substance use problems as well. Four  
16 million adults sampled from our National Survey on Drug Use  
17 and Health have a serious mental illness and a substance  
18 use disorder as well. These are people 18 years and older.

19 Illicit drug use is more than twice as high among persons  
20 with SMI than it is for those who do not have SMI.

21 Now, I have this one slide here on suicide just  
22 as a point of information. This is a significant and  
23 serious public health problem that devastates individuals,  
24 families and communities. In our nation in 2001, the  
25 latest Center for Disease Control study data show that

1 30,000 people committed suicide, and it is the eighth  
2 leading cause of death in the United States in particular  
3 for men. Women report attempting suicide during their  
4 lifetime about three times more than men. The point here  
5 is to say that those people who use alcohol, who have a  
6 history of mental illness, substance abuse disorders, or  
7 alcohol use disorders are most consistently impacted by 90  
8 percent of all the people who die by suicide.

9           So those are the people who we see. Those  
10 folks with co-occurring disorders are at greatest risk of  
11 committing suicide, and the protective factors are to  
12 clinically treat mental illnesses and substance abuse ahead  
13 of time to prevent suicide and to have successful  
14 encounters with care.

15           In terms of treatment, 49 percent of persons  
16 with co-occurring severe mental illness and substance use  
17 disorder received no past-year treatment for either  
18 disorder. This is from our National Household Survey data.

19       Only 7.5 percent received treatment for both disorders.  
20 That's a very small percentage. 40.7 percent of  
21 individuals who sought treatment for alcohol had at least  
22 one mood disorder, and 33 percent had at least one anxiety  
23 disorder.

24           Now, one dilemma we face as an agency -- I've  
25 discussed this with Dr. Clark and others -- is that 80

1 percent or more of people with co-occurring disorders do  
2 not perceive a need for treatment. So we have a lot of  
3 people walking around who don't perceive a need for  
4 treatment even though they have a disorder, and there are  
5 others who don't know they have a disorder. All their  
6 lives they've been very, very nervous in situations or  
7 having hyperarousal when they're just sitting in situations  
8 in an unpredictable fashion, and they don't know that they  
9 have an undiagnosed panic disorder. They've been drinking  
10 or binge drinking since high school, and they're now 50  
11 years old and finally may realize they're undiagnosed.

12           Forty-three percent of youth in mental health  
13 treatment have co-occurring substance use disorders. I  
14 know Sharon Amatetti gave a nice overview of women's  
15 issues, but women in substance abuse treatment report  
16 sexual abuse as children or adults, so that complicates  
17 treatment of women as well.

18           Our branch also focuses on homelessness. Up to  
19 50 percent of homeless adults have co-occurring mental  
20 illnesses and substance use disorders, depending on the  
21 study and the methodology associated with it. Nearly a  
22 quarter of homeless substance abuse treatment admissions  
23 from our Treatment Episode Data Set had co-occurring  
24 disorders in the year 2000. That was of about 120,000  
25 treatment episodes. Among homeless veterans, one-third to

1 a half have co-occurring mental illnesses and substance use  
2 disorders, and among detainees with mental illnesses, 72  
3 percent also have co-occurring substance use disorders. So  
4 our criminal justice system is overly represented with  
5 folks who have co-occurring disorders.

6           So we tried to think about what the field wants  
7 to know and the kinds of questions we're getting from our  
8 grantees and when we attend various and sundry grantee  
9 meetings and other meetings. One is what are the best  
10 screening and assessment approaches. Again, if you don't  
11 know that someone has a co-occurring disorder, you can't  
12 even begin to tackle the problem.

13           What are the evidence-based practices for co-  
14 occurring disorders? How do we pay for services given the  
15 complexities of the funding mechanisms in our states and  
16 the problems with substance abuse and mental health parity  
17 in the private insurance sector? How do we develop the  
18 workforce? I was nodding vigorously listening to Karl  
19 White's commentary and his presentation. Frankly, when I  
20 was in graduate school and was making a selection for my  
21 postdoctoral training, I had mentors who really thought I  
22 had a lot of promise, and they said don't go specialize in  
23 substance abuse, whatever you do. You don't want to treat  
24 those people. Trust me. Do neuropsychology. Do something  
25 else like forensics, but don't do substance abuse.

1           This is real for a lot of people. That goes  
2 from counselors coming out of high school all the way up  
3 through the professions into the medical arena. It is not  
4 a popular area of expertise, and people who treat co-  
5 occurring disorders or even attempt to do so suffer from  
6 burnout, frustration, high recidivism of the clients, and a  
7 lack of pay that's consistent with their skills, among  
8 other things. So I'm excited to comment that we are  
9 collaborating with Karl and Mady Chalk's shop on an  
10 initiative to look at how we can improve the workforce in  
11 relationship to co-occurring disorders with a small budget.

12           SAMHSA's vision for co-occurring disorders is  
13 to provide leadership and direction in defining and  
14 transferring the latest evidence-based practices, services  
15 and infrastructure to all levels of co-occurring disorders  
16 in the service system. Our mission is to support that  
17 vision by improving the quantity and quality of treatment  
18 services for persons with co-occurring disorders and those  
19 at risk for homelessness and who are homeless, serving as a  
20 resource within SAMHSA for state of the art treatment  
21 interventions, approaches, science-based evidence for co-  
22 occurring and homeless issues, and collaborating with our  
23 sister centers -- Anne used that term earlier; I like that  
24 -- collaborating with our sister centers, CMHS and CSAP, to  
25 forge a SAMHSA-wide effort to address co-occurring

1 disorders.

2                   This happens through our co-occurring work  
3 group, through the matrix model, and just through our  
4 linkages and out of necessity. We have to work together.

5                   We also provide policy and planning. We fund  
6 contracts. We conduct information dissemination and work  
7 to develop tools, like through the Treatment Improvement  
8 Exchange, some TIE communiques or something that we've been  
9 discussing as a possibility, and other relevant review  
10 articles that would be helpful to the states and to the  
11 field.

12                   Our initiatives that I'm going to briefly  
13 describe include the COSIG grants, which are Co-Occurring  
14 State Incentive Grants, Co-Occurring Targeted Capacity  
15 Expansion Grants, quadrant validation and screening  
16 instrument, quadrant operationalization, and homeless  
17 initiatives. I'll start with how we are trying to  
18 operationalize SAMHSA's vision.

19                   This is through our Co-Occurring Center of  
20 Excellence. In the Co-Occurring Center of Excellence,  
21 there are a number of functions and activities, one of  
22 which is to provide technical assistance to the COSIG  
23 states, and the funding for the COSIGs is in collaboration  
24 with CMHS. We support grantees and systems change and  
25 infrastructure development. We support grantees in

1 overcoming service delivery barriers, such as standardizing  
2 screening and assessment tools and developing issues in  
3 terms of workforce development and credentialing. This is  
4 a function of the COSIG itself, and the COCE assists in  
5 that process.

6           We enhance service coordination, improve  
7 financial incentives, and share information among  
8 stakeholders. Right now there are 11 grantees, and four  
9 new grantees are being managed by CMHS, and they are being  
10 awarded this year, in '05.

11           The quadrant model. I have it here because  
12 it's a key aspect of our mission in terms of identifying  
13 ways to improve systems of care for folks with co-occurring  
14 disorders who fall into different parts of this quadrant,  
15 and it was developed as a framework conceptually by some  
16 researchers in collaboration with NASADAD and NASMHPD to  
17 provide a mechanism to address symptom severity and level  
18 of service coordination on a continuum from less severe to  
19 more severe disorders, and from a consultation and  
20 collaboration to integration model, respectively. It's not  
21 intended as a way to classify individual clients or  
22 diagnose them. Rather it displays sort of the universe of  
23 individuals with co-occurring disorders and just is  
24 supposed to be a tool for the field and service providers  
25 to figure out what would be the best approach to care.

1           Although the quadrant model is a valuable  
2 conceptual tool, the population systems and services are  
3 presented only in general terms. So we do have a project  
4 that we're working on now to develop more precise and  
5 clinically useful descriptions of each quadrant, and look  
6 at the clinical and diagnostic characteristics of each  
7 quadrant, and identify appropriate clinical interventions,  
8 and consider how services are funded in each quadrant, and  
9 identify funding opportunities and barriers associated with  
10 those quadrants.

11           Also, we have a contract managed by Rick Ries  
12 at the University of Washington to use large existing data  
13 sets of persons receiving a systematic assessment of  
14 substance use and mental disorders. The goal primarily is  
15 to assess or test the assumptions of the quadrant model and  
16 to develop a clinical screening instrument.

17           A second mechanism that we are using through  
18 the COCE and as a branch to improve care of co-occurring  
19 disorders is the Co-Occurring Policy Academy Model. The  
20 objective for these academies are to develop state action  
21 plans to enhance the provision of services to persons with  
22 co-occurring disorders. To date, we have conducted two,  
23 one in Baltimore last year, one in D.C. this January, and  
24 we have another one coming up in Philadelphia. We're also  
25 exploring the possibility of a national summit on co-

1 occurring disorders for American Indian and Alaska Native  
2 populations.

3           Dr. Clark has already praised and talked about  
4 the TIP. I will say nothing more other than the fact that  
5 we are working very closely with the co-occurring matrix  
6 work group and Kathryn Power and Elizabeth Lopez and Mark  
7 Weber's shop to identify user-friendly digestible bites of  
8 TIP 42 that would not be functional as weight-lifting  
9 equipment that might be targeted to primary care. I've  
10 heard primary care mentioned quite a bit today. We hear  
11 you. We are exploring that, and we intend to target them  
12 and other medical ER frontline personnel.

13           The COCE mission is to receive and transmit  
14 advances in science and advances in evidence-based  
15 treatment for co-occurring disorders, and to guide  
16 enhancements in infrastructure and clinical capacities, and  
17 to foster the adoption of evidence-based practices. There  
18 are core products and services associated with the COCE  
19 that you will see on our website, which I'm going to show  
20 in the next slide. There are overview papers and technical  
21 reports we've produced that are on the web. There's TA and  
22 training that some of you may have experienced through your  
23 linkages through the states. There's the COCE website I  
24 just mentioned. We do meetings and conferences. I  
25 mentioned the policy academies, and we're involved in a

1 pilot evaluation of measures for the COSIGs to look at  
2 performance management issues.

3           Here's a snapshot of the website. It is a  
4 reservoir of information on co-occurring disorders and  
5 provides linkages to other very valuable sources and to our  
6 other federal partners.

7           This is a list of our COCE overview papers.  
8 They're covering pretty much the gamut, as you can see, and  
9 providing sort of an overview of all the experts in the  
10 field of co-occurring disorders and services as it relates  
11 to these areas: definitions, workforce, systems,  
12 prevention, evaluation and monitoring, screening and  
13 assessment.

14           We have a COCE steering council that has  
15 membership from all of these organizations, and we work  
16 very closely with the Division of State and Community  
17 Assistance in collaboration to achieve the missions I've  
18 described here. How do we do that? Well, through the  
19 substance abuse prevention and treatment block grant. We  
20 collaborate in terms of the policy academies, providing  
21 targeted technical assistance. We work with the state  
22 systems development program, and I mentioned the Treatment  
23 Improvement Exchange earlier, and we also have some  
24 alliances being built in terms of rural and frontier,  
25 special populations such as trauma, women and families,

1 HIV, Native American and Alaska Native.

2 I'm going to just comment very quickly on  
3 NREPP. This is not housed in our branch, but it is a  
4 National Registry of Effective Programs and Practices that  
5 is very relevant to what we're doing as we try to identify  
6 the best approaches for co-occurring disorders. This is a  
7 resource that has been around since 1998, and CSAT has  
8 initiated its involvement in 2003.

9 It's an integrated part of our science to  
10 service piece, and potential promising programs or programs  
11 that people feel would be a model program for service  
12 delivery and treatment effectiveness are reviewed through a  
13 rigorous scientific review process. In the end, there's a  
14 determination of whether the program is promising, whether  
15 the program is in a particular stage of development and  
16 that others can benefit from it.

17 Another piece of what we want to make sure is  
18 important for co-occurring is to look at systems-level  
19 approaches. Systems of care for people with co-occurring  
20 disorders have to be comprehensive and involve multiple  
21 systems. You all know that. Also, key precepts of systems  
22 integration include successful systems, and it can occur  
23 only when a comparable emphasis is placed on integrated  
24 services. It doesn't need or require necessarily the  
25 creation of new services but rather existing agencies

1 coming together to form a seamless program, and it can be  
2 measured both at the systems level and in terms of client-  
3 level outcomes. This is about improving people's lives.

4           How do we sustain the momentum of our programs  
5 in CHAB and SAMHSA? Continued collaboration within SAMHSA  
6 and across our centers, working with those of you in the  
7 room who represent state authorities, county authorities,  
8 tribal authorities, NASADAD, NASMHPD, NACBHD, which we  
9 heard from earlier, and our other federal partners.  
10 Working with provider organizations, client-consumer  
11 advocacy groups, and so on are key to our success.

12           I'd like to acknowledge everyone in my branch  
13 and thank Bryant Goodine, George Kanuck, Jim Herrell,  
14 Joanne Gampel, Edie Jungblut, Ali Manwar and Kirk James for  
15 their input into this presentation, and I'd like to open  
16 the floor for discussion. Thank you.

17           (Applause.)

18           MR. KOPANDA: Thanks, Charlene.

19           Are there any questions?

20           DR. MADRID: I want to thank you for the  
21 excellent presentation. I do have a question.

22           The chemotherapy involved in dealing with the  
23 multiple diagnoses of individuals coming into treatment,  
24 what type of work are we doing concerning medication, the  
25 administration of the different types of medication, the

1 funding of the different types of medication? It's real  
2 tough for me as a service provider -- for example, a  
3 criminal justice contract, \$58 a day residential treatment,  
4 an individual coming in that has three or four diagnoses  
5 requiring a lot of medication to just stabilize so that we  
6 can begin the work. What direction are we taking to  
7 address that particular grassroots issue?

8 DR. LeFAUVE: Thank you for that very  
9 penetrating question. Actually, I'm aware of some  
10 activities in Bob Lubran's shop, collaborating with NIAAA  
11 in terms of medications for the treatment of alcohol  
12 dependence and the buprenorphine. But specific  
13 pharmacotherapies targeting co-occurring disorders is a  
14 conversation that we will continue to have. We don't have,  
15 to my knowledge, an active program in CSAT that targets  
16 pharmacotherapies to treat co-occurring disorders  
17 specifically. We are presenting at the American  
18 Psychiatric Association, and Kenneth Hoffman is in the  
19 room. He is our new medical officer under Bob Lubran's  
20 shop, and I am happy to have him offer any insights into  
21 your question given that this is his primary area of  
22 expertise.

23 Dr. Hoffman?

24 DR. HOFFMAN: Thank you. I'm new into this.  
25 Certainly I've jumped right in to look at, first, the ones

1 that are geared specifically toward the treatment of  
2 addiction, medically assisted treatments. And you're  
3 right, we're moving into looking at the alcohol issues.  
4 CMHS has also come up with an evidence-based co-occurring  
5 disorder. So I suspect with Mady, we'll be looking to work  
6 more with them. Certainly in the field at this point  
7 there's a lot of use of the various antidepressants,  
8 antipsychotics, anticonvulsants, mood stabilizers with  
9 people that have these disorders, and I think this is  
10 probably a good time to start to judiciously sort out where  
11 these different things might fit given that you inherit a  
12 lot of people coming in for addiction treatment who might  
13 not have been diagnosed, been overwhelmed with this other  
14 substance and, by the way, they've gotten all these other  
15 psychotropics.

16           So I think there's two avenues to approach at  
17 this point, and this has to be, I think, integrated into  
18 the work that you're doing.

19           DR. LeFAUVE: Thank you.

20           Dr. McCorry?

21           DR. McCORRY: Thanks, Charlene. Thanks for the  
22 presentation. You've given me some homework here in terms  
23 of looking at the COCE overview papers, which I haven't  
24 done. So I have a lot of reading to do once I leave the  
25 meeting.

1           Also, I was really happy to hear and pleased to  
2 hear about Rick Ries' work in populating the quadrant,  
3 because my questions are somewhat related to that. I do  
4 this work back in New York, and my issue as I see it, and  
5 I'm just hoping you can comment on it for me, that the term  
6 "integrated," which is on the dual diagnosis lists that  
7 SAMHSA puts out, and those are wonderful lists -- you can  
8 from clinical through systems stuff. But whenever you talk  
9 co-occurring disorders, when they talk about integrated  
10 care, it very quickly becomes a discussion about the  
11 seriously mentally ill. But there's integrated care needs  
12 within the substance abuse treatment system.

13           So sometimes it's difficult or it's not quite  
14 clear what the model is for integrated care within the  
15 substance abuse service system, which is actually treating  
16 the majority of people with mental health issues, not the  
17 seriously mentally ill but the wider population of people  
18 who have mental health issues, depression, anxiety,  
19 personality disorders, but don't rise to the threshold of  
20 seriously mentally ill.

21           Second to the integrated is the issue of  
22 coordinated care, which is talked about in the SAMHSA  
23 report but you almost never hear about it in terms of  
24 models, in terms of actual functional models of what  
25 coordinated care looks like between two systems. So I want

1 to add one thing and then ask you to comment on it.

2           My thought around an integrated service  
3 delivery model for AOD involves clinical supervision,  
4 probably a little bit more psychiatric nursing care, some  
5 case management off-site capacity, and probably some more  
6 individual counseling capacity. Those are the four or five  
7 that I've been able to pull out of my work back in New  
8 York. I've never checked the evidence, if there is  
9 evidence, to say, gee, that makes sense or not. But my  
10 concern is really more at a systems level.

11           One is the model. I'd like to know if people  
12 have figured out what a really effective substance abuse  
13 integrated program looks like. I'd like to know that,  
14 because then I could take it and try to implement it in New  
15 York.

16           Secondly, I'd like to know if there's models  
17 that have shown coordinated care to work.

18           Third is this kind of more political systemic  
19 issue in which integrated care almost invariably ends up  
20 being a discussion of the seriously mentally ill, which  
21 leads our field to a one-down position, not that their  
22 needs aren't great, but integration is typically defined as  
23 for the seriously mentally ill despite the fact that most  
24 of the folks in need of integrated care are on our side of  
25 the ledger.

1                   So again, a long speech again, but I was  
2 wondering, either through COSIG or COCE, are we kind of  
3 pushing through to that issue of what does it have to look  
4 like in a New York program dealing with co-occurring  
5 disorders, or Florida, or whatever program, that we could  
6 say this is what you should be aiming for, this is what  
7 you're going to need, even though you might be a long way  
8 from it but we know you're going to need these kinds of  
9 things to treat the typical population of individuals with  
10 both disorders who really belong on our side of the service  
11 system because they're not seriously mentally ill but they  
12 are seriously addicted?

13                   DR. LeFAUVE: Thank you. Thank you very much  
14 for that question. I know it probably sounded a little  
15 silly when I said thank you for that penetrating question  
16 earlier, but I thought that was kind of funny.

17                   But anyway, I'm going to defer to TIP 42, and  
18 without identifying particular scientists and particular  
19 models, I'm going to say that TIP 42 does offer general  
20 guidelines and has chapters targeting particular disorders  
21 that are very useful models for someone such as yourself,  
22 or anyone in the nation, to at least attempt to  
23 approximate. Our NREPP, as far as I know, has not right  
24 now identified a specific co-occurring disorders program.

25                   I do have Dr. Jim Herrell here, who sits on the

1 NREPP committee, who might be able to comment a little bit  
2 more about that piece. But to my understanding, that's  
3 where we are.

4 Jim?

5 DR. HERRELL: Thanks. The NREPP program  
6 solicits persons to submit treatment and related  
7 interventions that they have reason to believe are good,  
8 and then they have to demonstrate that they have an  
9 evidence base to back it up. As of now, the really small  
10 number of co-occurring focused programs are all specific  
11 interventions. They're not systems, they're not  
12 integrating a variety of levels of services. They're  
13 pretty focused interventions. The actual research on  
14 integrating services is much harder to do than kind of  
15 individual focused things. As you probably know, even to  
16 the extent there's an evidence base, it's a little bit  
17 fuzzy on whether integration really improves the quality of  
18 service, depending on how integration is funded. You've  
19 got a long, long way to go on that.

20 DR. McCORRY: One follow-up. Have the COSIG  
21 grants yielded anything around what it should look like on  
22 the AOD side?

23 DR. LeFAUVE: The COSIG grants -- actually, my  
24 whole branch is here. So if they want to jump in, please  
25 do. But the COSIG grants at this stage are not at that

1 point where we have an answer to that kind of question. I  
2 think we're in year -- let me defer to Jim. Yes, year 2.

3 Jim, please, step up to the microphone.

4 In short, the answer is not yet.

5 DR. HERRELL: The COSIG grants are also -- the  
6 acronym is co-occurring state infrastructure grants. They  
7 are not even required with our money to provide treatment,  
8 although many of them choose to do so. They're  
9 specifically to reorganize the way they provide services.  
10 Some of them are doing pretty good studies of what they're  
11 doing. So we hope to get some evidence from it. We're  
12 doing at two or three different levels a multisite  
13 evaluation of the COSIG program to try to learn  
14 generalizable lessons, but nothing yet. Just anecdotes so  
15 far.

16 DR. CLARK: Val, and then Ken.

17 MS. JACKSON: Thank you. Thank you for the  
18 presentation.

19 Maybe I'm just not very knowledgeable. I mean,  
20 I'm knowledgeable about co-occurring, but maybe I'm not  
21 knowledgeable enough about the field. All day today I have  
22 heard references to the resistance and just coming on of  
23 treatment centers being okay with utilizing pharmaceuticals  
24 and so on to treat co-occurring disorders, as well as such  
25 things as buprenorphine, and other uses too. But co-

1 occurring certainly has been here all day.

2           Do we know the percent of agencies across this  
3 country that utilize pharmaceuticals that have an  
4 assessment system for co-occurring? I mean, have we done a  
5 baseline here from where to go someplace? Because it seems  
6 like I really like the work that I'm hearing, but my mind  
7 always goes how does it get to the field and how do we grow  
8 it? That's where I'm coming from. So what do we know, and  
9 how do we get that information, and is it important to get  
10 that information?

11           DR. LeFAUVE: CSAT does not, or SAMHSA, as far  
12 as I know, does not have a systematic data strategy or  
13 collection on aspects of pharmacotherapy in co-occurring  
14 disorders. Bob Lubran is in the room and, Bob, I'm going  
15 to ask if you have any other knowledge to the contrary. It  
16 is an important issue. I don't have a plan for you in  
17 terms of what next steps would be in that area. I do know  
18 we are in dialogue with Ken Hoffman and Bob Lubran. We are  
19 collaborating across divisions and branches, and it is a  
20 very important issue. This is what I did before I came  
21 here, was pharmacotherapies and behavioral therapies  
22 combined to treat co-occurring disorders.

23           DR. CLARK: We actually do have something from  
24 our TEDS data about the use of pharmacotherapy specifically  
25 for addiction, but not necessarily for co-occurring

1 disorders. It gets to be a complex thing. You saw Karl  
2 White's data about the number of physicians that our system  
3 has. So implicitly for the substance abuse program itself,  
4 that becomes a problem because they don't have access. So  
5 they're either working in coordination with the mental  
6 health center, where the prescriber is, or they're trying  
7 to, like Gateway, attempting to prescribe its own  
8 medication, and they encounter problems because, again, the  
9 cost of medications is an issue.

10           That's something that we also have to  
11 acknowledge in dealing with these co-occurring. But the  
12 substance abuse treatment program, to truly be in the arena  
13 of co-occurring, as part of a no-wrong-door paradigm, you  
14 have to have Medicaid eligibility in order to prescribe the  
15 medication. Otherwise, what you're doing is getting  
16 compassionate dispensation from the hardship prescription  
17 practices from the drug companies, which is not a good way  
18 to build a strategic approach to dealing with the  
19 medication needs of your patients.

20           So that is one of the limiting steps. Those  
21 programs that have access to both state funds and to  
22 Medicaid for psychiatric care, then it's less of an issue.

23       Under many jurisdictions, as Frank pointed out, in order  
24 to be eligible for mental health funds, you have to  
25 prioritize the severe and persistently mentally ill. That

1 goes beyond SMI. Oddly enough, under the mental health  
2 block grant, all you need is SMI. But states, through  
3 their statutes, have often refined down the population  
4 served to severe and persistently mentally ill, which means  
5 if you have a depression of some six-month duration, you  
6 might not make criteria. Nevertheless, the substance abuse  
7 treatment program is coping with somebody who is suicidal  
8 or depressed enough so that they're disabled. Some  
9 jurisdictions go so far as to say you need to be  
10 psychiatrically disabled for a year in order to meet  
11 criteria.

12           So there's wide variation. What we'll be doing  
13 with the COCE and the COSIG and the other centers within  
14 SAMHSA is getting a handle on these matters. The NESARC  
15 data also show that some 40 percent of the individuals who  
16 present to substance abuse treatment have a co-occurring  
17 anxiety disorder. The conundrum is how do you treat that  
18 anxiety disorder, or does it merit treatment? We know from  
19 a recent RAND study that both depression and anxiety  
20 disorders subside with the provision, oddly enough, of  
21 substance abuse treatment.

22           The beauty of being abstinent, guess what? A  
23 lot of the symptoms, they may not completely go away, but  
24 they're manageable, especially with cognitive-behavioral  
25 strategies. So medication should be part of the

1 armamentarium but should not be the objective of the  
2 intervention. What should be the objective is a return to  
3 functional care, and we use whatever strategies will assist  
4 us in achieving that, and sometimes medications are not  
5 warranted.

6 MR. DeCERCHIO: The feedback that I hear from  
7 our providers is that the financing of psychiatric  
8 medications is a very significant issue. Many of our  
9 providers have psychiatrists and have doctors, but it's  
10 increasingly becoming an issue of how to finance, and it's  
11 increasingly coming to us. We did a small budget issue,  
12 \$150,000 for a drug program to give small grants to  
13 programs for medications. One of our large co-occurring  
14 centers I think came and needed another \$30,000 alone  
15 because of the increased medication costs. Folks coming  
16 out of county jails have three days of medication in their  
17 transition from a drug court into our treatment centers,  
18 and if they're on medication, we've got to pick up that tab  
19 right away.

20 I hear more about that than I do, gee, Ken, how  
21 come you're not funding buprenorphine, or we need more  
22 access to naltrexone. I hear this is the issue more and  
23 more in terms of financing medications. You mentioned the  
24 drug companies, and I know it's not ideal, but perhaps  
25 we've got to do a better job of connecting our providers to

1 even some of that to help with their situations.

2 DR. CLARK: I think what this Council can do  
3 for our co-occurring and homeless branch is to reiterate  
4 these themes and examine what it is that we do in light of  
5 your experience in the community so that our message to the  
6 larger SAMHSA discussion is to address some of these  
7 components, particularly when you're dealing with the  
8 severe and persistently mentally ill. The key issue is  
9 adherence to medication, and as some of my patients in the  
10 past have said, well, you know, why did you stop taking  
11 your medications? Well, I'm not stupid, you can't take  
12 this and drink at the same time. So they drink and don't  
13 take the psychiatric medication, and then, of course,  
14 decompensate.

15 So what we need are cognitive-behavioral  
16 strategies to facilitate adherence. Nevertheless, those  
17 issues need to be addressed, and they need to be addressed  
18 in concert with the mental health delivery system because  
19 we need to know what the limits of the mental health  
20 delivery systems are in the context of how do we pay for  
21 care and what are we going to use.

22 We know from the disability point of view that  
23 a lot of our clients are not recognizably disabled.  
24 Because of active substance use, they don't meet criteria  
25 for SSI determination of disability, which means again no

1 Medicaid eligibility, which means no medication. So you've  
2 got a person who, because of active substance use, does not  
3 meet criteria for SSI disability determination and yet who  
4 has a psychiatric condition that lends itself to medication  
5 intervention. So these are ongoing issues.

6 Eric?

7 DR. VOTH: Well, and I think it's reasonable  
8 even further upstream, to HHS, to say that we are pointing  
9 out again and emphasizing a need for affordable psychiatric  
10 medications at all levels, whether that means governmental  
11 support, whether it means negotiating with drug companies,  
12 whether it means new R&D. If you track the cost of new  
13 psychiatric medicines, it's staggering. SSRIs came on the  
14 market and they were considered expensive then. Look at  
15 the new mood stabilizing agents. It's just phenomenal.

16 So we can highlight our concern in that regard.  
17 If the cost of some of the new antipsychotics was a third,  
18 we'd have three times as much availability for people that  
19 need it.

20 DR. CLARK: It's an issue when you think you  
21 can pay \$10 a day for the pill alone. So in practical  
22 terms, as we do systems development, when you've got a  
23 shortage of funds, the system is confronted with, gee, do I  
24 pay \$10 a day for the medication or do I pay \$10 a day for  
25 the behavioral intervention, including the ACT team? The

1 ACT team is useless without medication compliance, without  
2 the medication. So the ACT team winds up getting chopped  
3 because I'm forced to make a Hobson's choice, and I choose  
4 to interpret -- my Hobson's choice is I prefer medication  
5 over behavioral intervention because the medication acts as  
6 at least some form of control.

7           So, yes, we need to develop strategies that  
8 address that issue, and we need to make sure that we're  
9 working. There are 340(b) issues in community health  
10 centers. There are formularies. There are a whole host of  
11 strategies that can be mobilized. But the first thing we  
12 have to do is use our existing resources to adequately  
13 highlight these issues.

14           Anxiety disorders and mild depressions may fall  
15 into sort of a gray zone. How much medication do you need  
16 for mild depression and mild anxiety disorders may not be  
17 that clear, but we do need a system that will allow people  
18 who are managing the person, working with the person to  
19 manage their condition to address this without risk of  
20 suicide and risk of decompensation.

21           MS. BERTRAND: I want to thank you for your  
22 presentation. I'm just thinking, trying to wrap up all  
23 that we've heard today. A lot of what I'm hearing ties  
24 back into integrating components into substance abuse  
25 programs, whether it be this co-occurring disorder, and

1 earlier you talked about women's issues and the sexual  
2 abuse that people experience and all of those things. I'm  
3 on a committee with Kathy Nugent -- she's not here now --  
4 and we're putting together a technical assistance group for  
5 July, and what I'm really trying to encourage us to look at  
6 is a lot of it ties back to workforce development in terms  
7 of designing programs and finding ways to leverage other  
8 systems outside of the substance abuse system, because many  
9 of them, we all know, tie back to what we're all doing,  
10 whether it be children's issues and parenting and all these  
11 things.

12                   But a lot of directors and CEOs and  
13 professionals don't realize that they have so much at their  
14 disposal if they would look outside of this system.  
15 Healthy Start, Families and Children First in Ohio, \$50,000  
16 here to support this treatment program in this area, and  
17 all of those things tie right back into some of the things  
18 that we struggle with in our programs. My other colleagues  
19 and those that work with me, I try to encourage them to  
20 look outside of this system. What is impacting the work  
21 that we do? If it's criminal justice, let's look at our  
22 criminal justice department and try to leverage funding to  
23 support the work that we're doing here and tie it all  
24 together, make a comprehensive program.

25                   It takes a lot of work, but there's ways to do

1 it. So I encourage us just to keep looking at training  
2 professionals into thinking outside of just this particular  
3 profession, because we have so many other systems that are  
4 impacted by the work that we do.

5 MS. JACKSON: Can I say one last thing?

6 DR. CLARK: Yes, Val?

7 MS. JACKSON: You know, I think that that's  
8 exactly right. I like that you've mentioned the workforce  
9 development and the slide that was up there that looked at  
10 the percentage of physicians, PAs and so on that are in our  
11 centers. I still have to say that our agency has  
12 physicians and we have a full-time PA, and we do prescribe  
13 and go chase down medications however we can -- that's  
14 definitely a problem -- when they're needed.

15 But we have a lot of people. If you look at  
16 the agencies that are like ours, we have a lot of people  
17 that have much more serious mental illnesses than mild  
18 depression or anxiety. We have bipolar, we have  
19 borderline, we have schizophrenic, we have any number of  
20 those, and they are coming to our door because evidently  
21 they're not getting what they need at a mental health door  
22 or some other door. Probably some of that has to do with  
23 the entire behavioral health medical system that we have  
24 now.

25 So we are faced with treating that, and I think

1 that we have to find ways to get not only the medications  
2 but the proper people there that can do that. Some of it  
3 comes from outside. I don't have any problem with that.  
4 But when they're sitting in our front lobby, we need to do  
5 something with them outside of expelling them and saying go  
6 down the street and see if you can find something there. I  
7 really think it's important.

8 DR. CLARK: Indeed, that's what the Co-  
9 Occurring Policy Academy and the COSIG strategy and the  
10 COCE are trying to do, to make sure that we have a no-  
11 wrong-door paradigm and to identify barriers to care. So  
12 if indeed you're the first door that the person suffering  
13 with schizophrenia presents and you treat that person,  
14 that's fine. But if that person is being bounced to you  
15 because their substance abuse problem is deemed "out of  
16 control" and they're not being treated at the mental health  
17 center where otherwise they might be treated, that's not  
18 fine.

19 So our approach is to stress the need for  
20 integrated care, which includes no wrong door. Wherever  
21 you present, the care model starts. That might militate  
22 against the kinds of experiences that you're having. Now,  
23 of course, we've got to deal with consumer choice. Some  
24 people may prefer to have a substance abuse problem, as  
25 opposed to being deemed out of control from a psychiatric

1 problem, and vice versa. So again, we've got these devices  
2 in place. It is a priority for the Administrator. We'll  
3 continue to press for strategies that we can use so that we  
4 can address these matters, and we need your input, whether  
5 it's a matter of psychopharmacology, whether it's a matter  
6 of systems, whether it's a matter that our policy academies  
7 are good or bad or ugly.

8                   These are the kinds of things that we have to  
9 sort through because, in a sense, we are blazing new  
10 trails, and sometimes you don't get what you want, but at  
11 least you're trying to get something for the people who  
12 need care.

13                   PARTICIPANT: Sometimes you get what you need.

14                   DR. CLARK: Sometimes you don't get what you  
15 need either.

16                   DR. LeFAUVE: Thank you.

17                   DR. CLARK: Thank you, Charlene, and thank your  
18 branch for being here to give you support and answer  
19 questions.

20                   (Applause.)

21                   DR. CLARK: Well, we are actually well into the  
22 Council roundtable, so are there issues that you'd like to  
23 address now or would you prefer to address them tomorrow  
24 during Council roundtable? Are you roundtabled out? Do  
25 you have another half-hour or not?

1           MR. DeCERCHIO: A quick comment. In your  
2 presentation this morning, I noticed in the proposed budget  
3 some of the scaling back of the best practices initiatives  
4 and potentially for '06. A lot of good work has been done  
5 with NIDA in bridging the gap and blending work, and NIAAA,  
6 and just the counter to that potential budget issue is to  
7 continue that work. I think it's having an impact and it's  
8 reaching down into the providers of the Clinical Trials  
9 Network. The only way we're going to counter that is to  
10 continue that type of work. I don't know if we'll counter  
11 it per se, but there's research money, there are  
12 initiatives, and then being able to link back to us through  
13 you and through states and directly to providers is going  
14 to become increasingly important as we all have increased  
15 expectations for the use of evidence-based practices.

16           It's just an observation on my part. A lot of  
17 good work has been done by SAMHSA and you in connecting  
18 with the branches, but it's obvious it's going to have to  
19 continue as the distinction between research on the one  
20 hand and services on the other seems to be kind of being  
21 made again.

22           DR. CLARK: Val?

23           MS. JACKSON: To kind of follow up on that, and  
24 I think very relevant to it is that two or three weeks ago,  
25 I think at the recommendation of CSAT SAMHSA, I was asked

1 to attend a NIDA meeting -- Melody Heaps was also there --  
2 that discussed really that very thing, Ken, in terms of  
3 how, looking from NIDA's perspective, do they get  
4 sustainability of their evidence-based practices and be  
5 able to actually get them into the centers and get them  
6 into standard practices.

7           The Clinical Trials Network is obviously one  
8 approach, but they were looking at other ways and from  
9 other divisions of NIDA. One of the things is there was a  
10 SAMHSA representative there sent by Dr. Clark who I talked  
11 to. Science to service came up, and I requested Dr. Stein  
12 to -- that I think probably SAMHSA has a lot to contribute  
13 in terms of -- they were saying what do you want  
14 researched, and the answer in my mind was, hey, you ought  
15 to go over and talk to CSAT and CSAP and CMHS because all  
16 of us who are out here doing services could tell you a lot  
17 of questions we'd really like to get answered. We  
18 mentioned lots of them today, and we just got done talking  
19 about the co-occurring issue.

20           I don't know how that connection works really  
21 so much, but they were very responsive and said, yes,  
22 that's a good idea, we should be talking more, but I don't  
23 know what that really means.

24           DR. CLARK: Well, in all fairness to the NIH,  
25 we are talking. We have a designated person at SAMHSA,

1 Kevin Hennessey. We are actively involved in partnership  
2 with NIDA and NIAAA and NIMH. Mr. Curie is in dialogue  
3 with Dr. Zerhouni. But I think the institutes correctly  
4 want to talk to service providers directly, not mediated  
5 through another entity. Nevertheless, we talk to service  
6 providers because we're funding them, and it's good that  
7 you have some exposure to the research enterprise, because  
8 then when we have these kinds of meetings, you can confront  
9 us with the activity of the research enterprise and the  
10 potential.

11           So I think that works well. It's a good mix.  
12 We try to sponsor to our CPDB meeting, to NIDA's CPDB  
13 meeting, providers from the field so that they can go see  
14 what's happening in the research arena, not for the purpose  
15 of doing research but for the purpose of understanding  
16 what's happening in the arena of science that might affect  
17 what it is they do and how it is that they do business. In  
18 order to translate science to services, people on both  
19 sides of the equation have to have some sense of what's  
20 going on. It's an incremental and long-term proposition.

21           Mr. Curie is really chagrined that it takes so  
22 long to bring new developments in the field to practice.  
23 NIDA just released a study on the use of motivational  
24 incentives for methamphetamine and cocaine, and it's taken  
25 them a long time to get around to finding paradigms that

1 are morally acceptable to the field. The real question  
2 will be will they be adopted? So the research says this  
3 works, people stay in treatment longer, they produce fewer  
4 urines that are positive for proscribed substances. But  
5 the real question is, okay, now that we've done that, will  
6 it work? Because if it won't work, if it's not adopted --  
7 it worked in the laboratory, it worked in the controlled  
8 clinical setting, but if it's never adopted by treatment  
9 providers, it doesn't work.

10 MS. JACKSON: Yes, and that's kind of exactly  
11 the point. A very good example, actually, that we were  
12 talking about in that meeting is that a lot of times what  
13 NIDA is researching -- and I'm on one of the nodes of the  
14 Clinical Trials Network, which I love and I value in great  
15 terms, so I'm not trying to be disparaging or critical.  
16 I'm only saying that in many cases, some of the studies  
17 that are being done, some of the studies that get approved  
18 at the national level are practices that definitely are  
19 evidence-based practices, but they are either too costly,  
20 they're one-on-one individual versus group approaches, some  
21 things like that, that really will probably preclude them  
22 from being used on a daily basis down the line after the  
23 research is over.

24 Somehow, what I think we need to do is to take  
25 some of the practices that we know work, we know either

1 from our own experiences or from some other evidence, and  
2 begin to get those into the best practices manuals, and we  
3 need to look at some group approaches. I know it's very  
4 hard to research groups, but NIDA needs to research group  
5 processes.

6 DR. CLARK: Well, they just figured out how to  
7 research acupuncture. So if you can come up with a double-  
8 blind dummy study with acupuncture, you can figure out how  
9 to research groups. They've got some positive results on  
10 acupuncture. That was one of the problems. How do you  
11 come up with a blind for an acupuncture needle? If they  
12 figured that out, they can figure out how to do groups.

13 But it is the dialogue that's important in my  
14 mind. I know Nora Volkow is very much interested in making  
15 sure that health services research at NIDA is done. The  
16 only question, of course, is how do you refine that? We'll  
17 all continue to work together. She's sent her staff here;  
18 we've met with them. We've had an ongoing relationship.  
19 It is not going to be perfect, but the objective is to  
20 produce more in the way of things that can be used. She,  
21 too, is concerned about the long lag time between the  
22 evolution of an idea and the institutionalization of that  
23 idea.

24 From our point of view, for instance, let's  
25 take motivational incentives again as an example. If it

1 works, then how do we get the field to adopt it? The issue  
2 is also getting the field to adopt it. We can't say we  
3 have some practices that work but we don't want to use your  
4 practices that work. We can't have it both ways. We want  
5 you to research our practices and come back in 10 years and  
6 tell us that they work. So you say, well, we've been doing  
7 this for 10 years, it works, would you mind adopting it?  
8 No, we're not interested. That gets to be a conundrum.

9 I know you're not saying that, but these are  
10 some of the dynamics that we have to compromise with at the  
11 interface.

12 MS. JACKSON: Doesn't SAMHSA limit the  
13 incentives to be something like \$20 or something like that?

14 DR. CLARK: Well, that's the beauty of the most  
15 recent study. The incentives actually turned out to be  
16 very minor, and the people apparently did well just with  
17 the prospect of a chance of getting an incentive. They  
18 didn't even need the actual incentive. There was something  
19 about being valued apart from regular motivational  
20 enhancement. These are people who are not guaranteed an  
21 outcome, and then what they got as a reward was nominal.  
22 Maybe it has to do with dopamine. Maybe it has to do with  
23 gambling. We don't want to ask those kinds of questions.  
24 You've got to be in it to win it.

25 But they were able to produce better results,

1 they had fewer positive urines, and they had greater  
2 adherence to the treatment strategy and better retention.  
3 They got better results. So what do we say to that?  
4 Exactly. We, in an applied sense, could probably do  
5 something similar to that without being that disruptive.  
6 Is it that ethically or morally repugnant that somebody  
7 uses a nominal incentive to get up that morning, to go to  
8 group or to go to treatment and produce the kinds of  
9 results that we want? We need a field that's going to be  
10 flexible enough that's going to say, okay, we can do that,  
11 that's not such a bad thing.

12 Frank?

13 DR. McCORRY: Just to go back because I had  
14 mentioned it earlier, and in Rita's presentation earlier,  
15 whether the Council might in the future want to look at the  
16 financing of the system. Ken and I were speaking briefly  
17 about it. I had kind of raised it in terms of Medicaid.  
18 But really, so many systems have stakes in our system of  
19 care in terms of our outcomes. Public welfare, public  
20 safety, health care, social welfare, they all have stakes  
21 in what happens to our clients, and Anita said it. Well, I  
22 get \$50,000 from here, and then something over there, and  
23 providers kind of cobble together these systems that are  
24 bigger than what you get from the single funding source of  
25 CSAT or SAMHSA.

1           I just think understanding that better and  
2 appreciating that better, and then perhaps being able to  
3 advocate a little differently with these other systems of  
4 care, having them recognize their stake in our system of  
5 care, I thought it might be interesting over a few meetings  
6 to kind of explore that a little bit, knowing that it's got  
7 to be very individualistic by state, even below state  
8 level, but I thought it might be an interesting thing to  
9 do.

10           DR. CLARK: We'll put that down and see what we  
11 can come up with and consult with you.

12           Any other issues, dialogue?

13           (No response.)

14           DR. CLARK: If there are no other issues for  
15 today, we can bring this meeting to a close. We will  
16 adjourn. We will return tomorrow. The public meeting  
17 opens, although there doesn't seem to be any public left --  
18 the public meeting opens at 10:00 in the morning. The  
19 closed session is from 9:00 to 10:00, so we'll expect  
20 Council members here at 9 o'clock. We'll do some grant  
21 reviews, and then the public meeting is at 10 o'clock.

22           So I'll see you in the morning.

23           (Whereupon, at 4:50 p.m., the meeting was  
24 recessed, to reconvene at 10:00 a.m. on Friday, May 20,  
25 2005.)