

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT
NATIONAL ADVISORY COUNCIL

Wednesday,
September 20, 2006

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

IN ATTENDANCE:

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1 P R O C E E D I N G S (9:12 a.m.)

2 DR. CLARK: All right. Although we don't have
3 a quorum, I think we should move forward. We're expecting
4 Admiral Broderick here at approximately 9:15. So I'd like
5 to get some preliminary comments out of the way.

6 Good morning and I'm delighted to welcome each
7 of you to the 48th meeting of the CSAT National Advisory
8 Council. I hope you will find the discussions today
9 fruitful since I think the topics will be of interest.

10 This is a one-day meeting. So we're going to
11 have a full agenda.

12 We also have public guests and we will address
13 that issue later.

14 The first thing I'd like to do is point out to
15 the members of the council that we really value your
16 membership on the council and we appreciate your input.
17 Some of you will be rotating off the council as of this
18 meeting, and we hope you will remain encouraged and
19 continue to be a strong voice for the field because the
20 problem we face with substance use disorders is obviously
21 very much real and ongoing and we need your support. It is
22 not only a domestic problem; it's a worldwide problem for
23 those of you who are embarking on worldwide endeavors.
24 That's you. Dave Donaldson is going off to visit the
25 world.

1 So we will be hearing from Dr. Broderick
2 shortly.

3 As you know, since we last met, SAMHSA has
4 undergone a major transition. Our former director, Mr.
5 Charles Curie, tendered his resignation to the Secretary
6 effective August 5th. Dr. Eric Broderick has been serving
7 as Acting Deputy Administrator and will continue to serve
8 in that capacity until Mr. Curie's successor is named.
9 He's essentially the steward of the agency and he will
10 elaborate on that when he comes down. He has been in the
11 federal service for over 20 years and is an adept
12 administrator, and we welcome his contribution.

13 But as I said before, I really can't
14 overemphasize your role as members on our National Advisory
15 Council. I thank you for adjusting your schedules to
16 attend this meeting and for the advice that you provide.
17 We are here because we're all familiar with the problem of
18 substance use disorders and its major complications. The
19 expertise you bring with you enriches our discussion,
20 facilitates the way CSAT reaches its goals. Some of you
21 have got particular areas of expertise and we have
22 attempted to exploit that for the benefit of the field in
23 general.

24 So why don't we take a couple of minutes to
25 allow members to introduce themselves so that not only all

1 of us will know each other again and familiarize us with
2 any new projects that you've pursued since we last met and
3 also so that those in the audience can know you better. So
4 why don't we start off with Anita.

5 MS. BERTRAND: Good morning. My name is Anita
6 Bertrand from the Cleveland area.

7 No really new projects other than just real
8 busy with Recovery Month activities. We had a banquet on
9 September 7th and Dr. Clark was able to come up. We are
10 getting really good feedback regarding that event.

11 I participated in a race/walk this past
12 Saturday with, I think it was, 40 across the country and
13 walked 3.5 miles. This Saturday we're going to have a
14 motorcycle ride for recovery, and we're expecting over 100
15 riders and our mayor of Cleveland and one of the
16 commissioners.

17 So just keeping busy with Recovery Month and
18 typical treatment and peer recovery support services
19 activities.

20 DR. CLARK: Dr. Skipper.

21 DR. SKIPPER: I'm Greg Skipper and I am a
22 physician. I run the Physician Health Program in Alabama
23 for troubled doctors. Recently I've been involved in a
24 national study of physician health programs to ferret out
25 ultimately, hopefully, are they as successful as reported

1 and what makes them successful. We're hoping to see some
2 activities of those programs that might be translated into
3 the general treatment world. So that's been exciting.
4 It's a study funded by the Robert Wood Johnson Foundation.

5 I've also been heavily involved in more or less
6 serving as a consultant for the ethyl glucuronide issue
7 that's developed nationally, and I'm happy that there's an
8 advisory coming out from SAMHSA. I'm being contacted
9 probably 10 to 15 times a day now by people around the
10 country that have been affected by this.

11 So glad to be here.

12 DR. CLARK: Dave?

13 MR. DONALDSON: Thank you, Dr. Clark. I just
14 want to say that this will be my last day. I want to thank
15 you for your leadership and your effective team, Cynthia
16 and George, Jocelyn, Clif. It's just been a great pleasure
17 and wonderful experience to serve with you.

18 As you mentioned, my world has changed. I've
19 been spending most of my time overseas working in Africa,
20 relief and development, and then also helping the victims
21 of the war in the Middle East.

22 But, again, I just want to say thank you. You
23 and your team have been an incredible catalyst for engaging
24 the faith community that has certainly spilled over into
25 other agencies. I'm looking forward to seeing that built

1 upon in the days ahead. Thank you.

2 DR. CLARK: Thank you for your contributions.

3 Val?

4 MS. JACKSON: Good morning and thank you. I
5 appreciate being here.

6 I think outside of my regular duties, I might
7 mention that I have been very busy being involved with the
8 privatization of services in Florida, that is, the
9 Department of Children and Families putting out money to,
10 for instance, Miami-Dade County, which is the largest
11 district in Florida, and allowing the South Florida
12 Provider Coalition, which is a not-for-profit organization,
13 to be able to distribute the money. The hope with that is
14 that there will be more time for state agencies to look at
15 policy kinds of issues and also more participation in the
16 community in terms of being able to look at the issues,
17 implementation of evidence-based practices and consortium
18 training, those kinds of things that are really beneficial
19 to a community in providing treatment and prevention. So
20 as chair of that organization, I really have been excited
21 about the prospect of that.

22 Thank you very much. I appreciate being here.

23 DR. CLARK: Thank you.

24 Frank?

25 DR. McCORRY: Good morning. My name is Frank

1 McCorry. I want to tell you about a couple of things that
2 are going on both in New York, as well as some other stuff
3 that I've been involved in.

4 One is I was able to attend, I think it was
5 last week, the Medicaid invitational conference, and I
6 thought that was really a terrific thing. This conference
7 was put on by SAMHSA, as well as CMS. We bring together
8 mental health providers with substance abuse providers and
9 leadership in both fields, along with Medicaid directors.
10 It gives us an opportunity really to bring together the
11 financing and the provider arms or the advocacy arms, as
12 well as the state bureaucratic arms and federal arms of the
13 substance abuse service system.

14 What struck me and something that I've raised
15 here -- but, in fact, Cynthia asked me to do something this
16 time, but I hope to do it in the future -- is the need for
17 just this ongoing, sustained dialogue with the Medicaid
18 community and the lack of a real financing model for
19 substance abuse services. It's interesting. We have a
20 treatment model, and if you go to NIDA and you look at what
21 NIDA has put out around the principles of treatment, we
22 understand how to treat much better than we understand how
23 to pay for treatment. This forum, this Medicaid
24 invitational conference, I thought was an opportunity to
25 start to advance that dialogue. So I thought it was a

1 terrific venue for a very important discussion that I think
2 really has to be sustained over the next few years if
3 substance abuse services are really going to move in and
4 become part of mainstream health care.

5 A couple of other things going on in New York.
6 Our commissioner, Shari Noonan, resigned. Fortunately,
7 she's going to stay in the field, running a provider agency
8 in the Albany community, but in New York the single-state
9 agency is in its own transition period, as are the Feds.

10 A couple of other things. Washington Circle,
11 which I've been involved in, is working on two new
12 performance measures and we hope to specify and pilot test
13 them this year. One is around adult screening for alcohol
14 abuse in both primary, as well as other kinds of settings.

15 Interestingly, I just saw something come over the wire
16 yesterday maybe that Medicaid is going to pay for adult
17 screening for alcohol abuse. We hope to develop a
18 performance measure that might fit that bill.

19 We're also looking at a performance measure to
20 drive medication-assisted treatment. To me, when you look
21 at the lack of the use of medication in substance abuse
22 treatment settings, even though they have been shown to be
23 quite efficacious, it's really a tremendous need. So we're
24 hoping to develop a measure that will also conform to some
25 of the standards that are being developed through groups

1 like the National Quality Forum around medication-assisted
2 treatment, and hopefully, the ability to measure it will
3 drive somewhat the interest and capacity to deliver that
4 service.

5 So thank you. It's great to be here. It's
6 always great to see my colleagues on the council. Maybe
7 Dave will get a chance to tell us a little bit about the
8 work that he plans to do in Africa, which is tremendously
9 exciting.

10 DR. CLARK: Well, we will hold up with Bettye
11 and Melody. We have Dr. Broderick here. If you don't
12 mind, Melody. Given his schedule, I'd like for us all to
13 get a SAMHSA update.

14 Dr. Broderick is serving as the Acting Deputy
15 Administrator of SAMHSA. He is committed to advancing
16 SAMHSA's vision of a life in the community for everyone, as
17 well as its mission of building resilience and facilitating
18 recovery. He has over 33 years of experience in the
19 Department of Health and Human Services and extensive
20 experience in health policy development, program
21 assessment, and budget formulation. Between 2002 and 2005,
22 he served as Senior Advisor for Tribal Health Policy in the
23 Immediate Office of the Secretary, Office of Governmental
24 Affairs.

25 Dr. Broderick also has extensive experience

1 managing public health programs, focusing on mental health,
2 substance abuse, and oral health with the Indian Health
3 Service.

4 His bio, along with each presenter's bio and
5 the council members' bios, are in the bio document on the
6 handout table, and I invite you to pick, up a copy of the
7 document.

8 Dr. Broderick.

9 DR. BRODERICK: Thank you, Westley. Hi. How
10 are you all this morning?

11 As Westley said, my name is Ric Broderick. I'm
12 very comfortable if you would call me by my first name. I
13 don't stand on much pretense.

14 I've been at SAMHSA a fairly short time, and I
15 just take this opportunity to come down and greet you and
16 introduce you to me, not that I want to talk all that much
17 about myself, but I've found people most curious as to
18 where I come from and how I came to be here. So I will
19 spend just a few minutes telling you a little bit about
20 myself and add to what Westley said.

21 I'm a dentist by training. As you can tell,
22 I'm a member of the Commissioned Corps of the United States
23 Public Health Service. I get a lot of questions about what
24 does Assistant Surgeon General mean. It's a rank. This is
25 what it means. It's equivalent to a rear admiral in the

1 Navy. As Westley said, I've been with the Department for
2 some time.

3 I practiced in the Indian Health Service in
4 clinical practice for about 12 years and then got advanced
5 training in public health and since that time have managed
6 public health programs principally in the Indian Health
7 Service and, of late, the last four years in the Immediate
8 Office of the Secretary in a health policy role with regard
9 to tribal affairs. Indian communities is where I've worked
10 and what my principal focus has been up to six months ago
11 when I joined SAMHSA. Through an unusual turn of events, I
12 guess, I come to sit before you today as SAMHSA's Acting
13 Deputy Administrator.

14 As you commented, the organization is in
15 transition. The SAMHSA Administrator is a politically
16 appointed, Senate-confirmed position. That process is one
17 that is underway, identification of a successor to Mr.
18 Curie. In that interim time, I see myself as the steward
19 of SAMHSA with the very capable help of Dr. Clark and our
20 colleagues in the other centers and offices.

21 So the process is one that you all are probably
22 familiar with. The White House Personnel Office, along
23 with the Secretary of the Department of Health and Human
24 Services, undergoes a process of search and identification
25 of an individual who will ultimately be nominated by the

1 President, and that will start a process that will lead to
2 Senate confirmation. I can't tell you who that individual
3 will be. If I knew, I would tell you. And I can't tell
4 you when that will be. If I knew that, I would tell you
5 that as well. But I understand that the interviews are
6 underway, and at the point in time that the President
7 identifies an individual, an announcement will be made and
8 Senate confirmation, as I said, will follow. There aren't
9 that many legislative days until the election, and it's
10 unlikely that there will be a lame duck session of
11 Congress. It's difficult to say when the end game will be
12 over and we will have an administrator.

13 But suffice it to say that until that time
14 we're very interested and will continue with some
15 enthusiasm pursuing the goals that you all have helped us
16 set. The SAMHSA matrix is a wonderful tool that allows us
17 to focus our energies and efforts collectively on the
18 things that are important. I've had the good opportunity
19 to talk about and learn much about those goals from Dr.
20 Clark and our colleagues. I've very quickly come to
21 believe that it's the right stuff. So I try to assure
22 people that in this period of transition, the agency will
23 continue along that path. I have a strong belief that
24 there's little to be gained, especially during times of
25 transition, doing things that cause an agency to shift

1 direction. I have no intentions of turning SAMHSA on its
2 ear or making dramatic personnel changes or anything like
3 that. We will stay the course and we will pursue it with
4 energy.

5 The one thing that I've observed over time is
6 occasionally organizations are prone to slow down a bit in
7 times of transition because who knows who the new
8 Administrator is going to be and what his or her priorities
9 are going to be. We are, I think, collectively committed
10 to not allowing that to happen to SAMHSA in this time of
11 transition, to continue to stay the course, to focus on the
12 priorities that we have identified with the field and to
13 continue our efforts to serve the people who need our
14 services so much. So we are, as I said, committed to work
15 with you in that way.

16 Thank you all for what you do. SAMHSA's
17 councils are very important to us. They provide an
18 opportunity in a systematic way to obtain advice and
19 guidance from experts in the field and people who have a
20 perspective that's very valuable that we may not have. So
21 I know it's something that's not within the daily scope of
22 the things you do and it may be an inconvenience to come
23 here from time to time, but it is very, very helpful and I
24 want to thank you personally for taking the time to do
25 that.

1 I've had a number of people say, well, okay,
2 you said the matrix is important and the Redwoods are going
3 to continue, but what is it that really focuses your
4 attention? Where is your passion? What is it that you
5 want to work on? I guess we're all sort of formed by our
6 experiences.

7 I have a lot of interest, because of the places
8 that I've worked and the interactions I've had with
9 communities, in identifying where SAMHSA's resources are
10 applied and compared that with where the burden of disease
11 is. We know that both the application of resources and the
12 burden of disease are not homogeneous across the country.
13 If you were to take a map of the United States and lay out
14 where those two things occur, you see pockets. You see
15 some places receive more resources than others. Some
16 places have a higher disease burden than others. To the
17 extent that there is neatness of fit there, that's a good
18 thing. If it's not, we need to figure out why and see what
19 can be done. It sort of leads us to issues of discussions
20 of access to care. Is where the disease burden occurs
21 where access to care problems also occur? And what can we
22 do to improve access to care in general to substance abuse
23 treatment services, and in those areas where the need is
24 highest, can we figure out ways to improve access in those
25 areas?

1 That sort of leads to a discussion of health
2 disparities with regard to substance abuse treatment. We
3 all know that there are health disparities with regard to
4 substance abuse in general, and it's something that is of
5 great interest to me. As I've said, I've worked in Indian
6 communities for a long, long time. You all know the
7 epidemiology of substance abuse. The disease burden in
8 those communities is great as in other communities where
9 there's a disparate amount of substance abuse. So that is
10 of great interest to me.

11 I worked in several small communities in very
12 rural locations over the past number of decades and saw
13 firsthand the devastation that a community goes through
14 when there's an epidemic of suicide among very young
15 people. I worked in a community in Wyoming in the mid-
16 1980s that had a suicide epidemic, and 15 or so kids from
17 age 8 to 15 or 18 killed themselves over a year-and-a-half
18 period. That community is still devastated by that 20
19 years later. Virtually all of those involved substance
20 abuse. So issues of co-occurring disorders is of interest
21 to me and substance abuse prevention.

22 The intersect between public health and the
23 substance abuse treatment world is also an interest to me,
24 how we involve public health providers and primary care
25 providers as sort of points of actually first contact with

1 folks or actually more contact with people who may need
2 substance abuse treatment than substance abuse providers
3 and how we engage that community in screening and referral.
4 Very important. That stuff works. I mean, I know as a
5 provider myself that if someone came to me for treatment,
6 they weren't coming to me to have their blood pressure
7 screened, but I could very easily screen it and, if there
8 was an issue, refer them. That works with lots of
9 different disorders, substance abuse as well. So that is
10 an interest of mine, all formed by my own experience, quite
11 frankly, as a clinical provider.

12 That's probably enough about me. I'd most like
13 to hear what the areas of interest are for you. I know I
14 interrupted two of you who were making your opening
15 statements and introductions, and I apologize for that. If
16 we could continue with that, that would be great. If you
17 have any questions for me, I'd be more than willing to
18 answer them and just tell you that I'm always interested
19 and very accessible in things that you all might have to
20 say. Please feel free to call on me with any concerns or
21 advice that you might have.

22 DR. CLARK: Thanks, Dr. Broderick.

23 Does anyone have any questions of Dr.
24 Broderick?

25 (No response.)

1 DR. CLARK: Then why don't we have Dr. Fletcher
2 and Melody Heaps introduce themselves and maybe you'll have
3 some questions after those introductions. Bettye.

4 DR. FLETCHER: Thank you very much, Dr. Clark.
5 I'm Betty Ward Fletcher. I'm from Jackson, Mississippi,
6 and I'm with Professional Associates, Inc., which is a
7 research and evaluation firm that does quite a bit of
8 evaluative work in the area of outcomes evaluation.

9 Two areas that are relevant here that I'm
10 involved with currently. One is our firm, along with a
11 local hospital, is sponsoring a training event for pastoral
12 leaders and the clergy on substance abuse treatment and
13 knowledge regarding available treatment resources. That is
14 in collaboration with the National Association of Children
15 of Alcoholics.

16 The second area that I'll share with you that's
17 very dear to me is I was invited to teach a course in
18 substance abuse intervention this semester at the graduate
19 level at the local university, and I am doing that. We are
20 using the treatment improvement protocols, which is a
21 tremendous resource. Students are elated simply because
22 it's a document that they can relate to very easily. Of
23 course, it's cost effective for them because they can get
24 it off the Internet. But it has really proven to be a real
25 resource. So I commend those who have taken leadership in

1 developing those protocols because they are useful, they
2 are being used, and it's a tremendous resource at the local
3 level.

4 MS. HEAPS: Good morning. My name is Melody
5 Heaps and I'm President of TASC, which is an agency in
6 Illinois that connects individuals in need of treatment
7 into treatment from the criminal justice system or the
8 child welfare system or other public systems.

9 Since the last advisory council -- David tells
10 me that's our report for today -- we've been involved in a
11 number of very exciting public forums. The DEA opened its
12 museum in Illinois. We were responsible for helping bring
13 it to Chicago and also to develop the local prevention and
14 treatment story as a part of that, and it's been a very
15 exciting endeavor.

16 In addition, the National Institute on Drug
17 Abuse has hired us to develop their training of judges, and
18 we had a press conference in Chicago to announce their
19 principles for effective treatment in the criminal justice
20 system. I was able to get the mayor and a number of
21 officials there. It was at a police station. It was
22 really kind of fun with some recovering individuals, also
23 related to the upcoming Recovery Month.

24 We are involved in network building both as a
25 result of what we do naturally, which is to develop

1 networks of treatment and partnership, but also in response
2 to ATR and SBIRT and ATR particularly in reaching out to
3 the new service systems, faith-based systems and other
4 systems. That's been exciting.

5 We are anticipating a major initiative. The
6 focus as of late, because of the numbers of individuals
7 returning from prisons to our communities, on reentry, I'm
8 very interested in shifting the focus back to no entry. So
9 we will, in Illinois, be really pushing for a major, major
10 initiative to look at both how one prevents, as well as
11 what I call deter and deflect individuals from either
12 entering the system or further penetrating the justice
13 system so that we can look at no entry as actually one of
14 the reasons TASC was initially set up as a sentencing
15 alternative mechanism.

16 We're also very involved in looking at research
17 projects, developing research projects with regard to
18 buprenorphine and the criminal justice system and community
19 systems and medication support. So we're looking forward
20 to a very energetic year. Thank you.

21 DR. CLARK: Thank you. Are there any council
22 members with any questions of Eric?

23 MS. JACKSON: I just have a comment and perhaps
24 a question of clarification. You mentioned working in
25 Wyoming and also identifying areas that you see where the

1 burden of the disease is.

2 I remember back. It must be in the '80s, and
3 maybe some of this is still going on. I was working mostly
4 with NIAAA, and there was a lot of topographical sort of
5 geographical work identifying hot spots of need. I found
6 that study that was going on at that time very interesting,
7 and I happened to live in South Dakota. I suspect you're
8 familiar with Pine Ridge, South Dakota where the average
9 life span is 53 years old, even today, a very sad
10 situation. I grew up in that area. Now I live in Miami,
11 Florida where there is a whole different set of
12 circumstances, which I find also to be extremely serious.

13 I'm very interested in your ideas of how do we
14 really identify those needs, those hot spots, which I think
15 is extremely important. We need to still serve, of course,
16 the mainstream of America because it doesn't limit itself
17 to one spot or the other. Perhaps a little more
18 clarification on that I would really appreciate.

19 DR. BRODERICK: Sure. There's much information
20 available from many, many different sources about virtually
21 anything one would want to know I guess. But with regard
22 to this field, sort of basic epidemiology tools are
23 available.

24 What I would like to explore -- I've got this
25 map in my head that I've not seen on paper anywhere -- is

1 the ability to use a GIS approach. I don't know how
2 familiar you are with it. I don't claim to be an expert by
3 any means.

4 MS. JACKSON: I'm not an expert.

5 DR. BRODERICK: Yes, me neither. But I know
6 that they take data, and they're not too concerned about
7 data purity. Anything that can be found goes into a GIS
8 system and then you can map based upon multiple variables.
9 So if you want to know cancer deaths and interstate
10 highway systems, the software is such that it can map those
11 two things out relative to one another.

12 So what I would like to do is explore with
13 folks who are expert in GIS the ability for us to be able
14 to map the epidemiology of substance abuse. I suspect work
15 has already been done on it, quite frankly. I can't
16 imagine that it hasn't. But to look at, quite frankly,
17 also mental health and look at then the overlay of
18 resources that we know are available to communities to
19 combat those conditions, whether they're SAMHSA resources
20 or not -- there are many, many parts of the safety net in
21 play -- to try to figure out whether or not there's close
22 approximation or not close approximation with regard to
23 where the conditions occur. So it's not terribly profound,
24 I don't think. It's something that is a pretty fundamental
25 public health approach to looking at resource application

1 as it relates to epidemiology and to find out if the
2 resources are being applied in a way that the most people
3 will get the most good.

4 MS. JACKSON: If I could just add one more
5 thing. When we were dealing with this back in the '80s and
6 working with the project that was an NIAAAA, it sounds very
7 similar, a public health approach to that. I think there
8 were several factors on crashes. This was mostly on
9 alcohol crashes and, of course, cirrhosis, different
10 factors that indicated high density areas where alcoholism
11 was rampant.

12 One of the issues was whether or not, like many
13 things, if you have an area of high density, is that
14 epidemic spreading and do we need to look at it from that
15 factor. Also, of course, that lends itself into
16 prevention. So I would be very interested in your carrying
17 on your work that way. I think it's a great way to go.

18 DR. CLARK: Well, thank you. Dr. Broderick has
19 agreed to linger for a while while we attend to another
20 item of business.

21 As you know, we have five members of the
22 council whose terms end in November. They are Dave
23 Donaldson, Val Jackson, Chilo Madrid, Greg Skipper, and
24 Eric Voth. Dr. Madrid and Dr. Voth were unable to be with
25 us today. However, I think it's noteworthy this is the

1 first meeting that Chilo has missed since he became a
2 member of the council, which is a good thing.

3 I'd also like to emphasize to retiring members
4 that, although your term officially ends in November, you
5 may be asked to continue to serve as a member of the
6 council until your successor has been named by the
7 Secretary. To give you fair warning, this can take up to
8 six months.

9 I especially thank you for your continued
10 service on the council and the times you've adjusted your
11 schedule to participate in these meetings. It shows that
12 you're committed to the field.

13 To all council members and members of the
14 audience, including staff, we also appreciate your support
15 of CSAT and its efforts.

16 Now I invite Val Jackson, Dr. Skipper, and Dave
17 Donaldson to come forward.

18 As they come, Dave has informed us that he and
19 his family are relocating to Nairobi after the first of the
20 year, part of his company.

21 Val claims to be semi-retired, but we don't
22 know that to be a fact based on her eternal comments.

23 And then Dr. Skipper, I think you're going to
24 Portugal after this meeting. Right? Yes.

25 So all these people who are making these life

1 changes, we really appreciate their contribution.

2 A plaque in each person's name signed by Dr.
3 Broderick and me is dated September 2006 reads as follows:

4 "With appreciation for your outstanding tenure on the
5 Substance Abuse and Mental Health Administration's Center
6 for Substance Abuse Treatment National Advisory Council and
7 gratitude for your tireless effort, support, advice, and
8 insights to the benefit of SAMHSA, Department of Health and
9 Human Services, and the people we serve."

10 (Applause.)

11 DR. CLARK: I want to thank Eric for taking
12 this time out to give a report for SAMHSA and for
13 participating in our recognition ceremony.

14 DR. BRODERICK: Thank you and thank you all
15 again for your willingness to contribute your time and your
16 expertise and wisdom to SAMHSA. We're much the better for
17 it. Thank you.

18 DR. CLARK: Now I will give the CSAT Director's
19 report. This is going to be an overview of some of the
20 changes in CSAT and also a report on our National Survey on
21 Drug Use and Health. Not only have there been changes in
22 the upper echelons of SAMHSA, there have been internal
23 changes within CSAT. I'd like to bring you up to date on
24 what's occurred since our last regular council meeting.

25 The Division of State and Community Assistance

1 has lost three employees to retirement: Terry Schomburg,
2 Nita Fleagle, and Lonn Aussicker. Two have moved on within
3 the SAMHSA organization: Rick Dulin to the Division of
4 Pharmacologic Therapies within CSAT and Rasheda Stevenson
5 to the Center for Mental Health Services.

6 But it's not all losses. They've also gained
7 Alejandro Arias from the Center for Substance Abuse
8 Prevention, Juli Harkins from the Division of Services
9 Improvement, and Bryant Goodine from SAMHSA's MEO. Then we
10 have Ting Mei Chau, our newest emerging leader intern. The
11 Division of Services Improvement's new employees include
12 its new Director, Jack Stein. Dr. Stein is from NIDA and
13 has joined us. He's currently without a secretary, as
14 Paulette Waiters has left SAMHSA, and he's recruiting for
15 someone to assist him in answering his email. Other DSI
16 gains include Natalie Lu and Dawn Levinson.

17 The Office of Program Analysis and Coordination
18 has gained Danielle Johnson, a transfer from the Division
19 of Pharmacologic Therapies, and also Shavonne Reed.

20 Lastly, my office has had its comings and
21 goings. Stephen LeBlanc has been detailed from Consumer
22 Affairs to NIH. He was replaced by Hardy Stone who has
23 been detailed from CMHS. Rich Kopanda's new staff
24 assistant is Millie Nevels, and my new staff assistant is
25 Dolkie, or Dee, Encarnacion, who transferred from CSAP,

1 replacing Elsie Fisher, who left us for NIH.

2 So you can see there's a lot of
3 intragovernmental movement. It's like some kind of current
4 stream. Sometimes it's like el nino, though.

5 (Laughter.)

6 DR. CLARK: So please joins me in welcoming all
7 the new folks to CSAT and to SAMHSA as a whole.

8 (Applause.)

9 DR. CLARK: During the time that CSAT was
10 absent a Director of DSI, I asked Anne Herron to be the
11 Acting Division Director and, at the same time, John
12 Campbell was asked to serve in Anne's place as Acting
13 Director of the Division of State and Community Assistance.
14 I just want to say again how proud I am of these two
15 individuals for their stellar contributions in these
16 "acting" positions. Their support and job performance has
17 been truly outstanding. Thank you, Anne, and thank you,
18 John.

19 Now on to other matters. We have a
20 presentation to give. As you know, SAMHSA recently
21 released the 2005 National Survey on Drug Use and Health.
22 So I'll go up to the podium and present that slide show.

23 As you know, the National Survey on Drug Use
24 and Health is an annual survey conducted by our Office of
25 Applied Studies. It surveys roughly 68,000 people

1 nationwide.

2 You were provided a hard copy of this report,
3 so you don't need to write any of this down, and you can
4 also get the full NSDUH report from our website. So those
5 in the audience also can have access to the full reach of
6 the data.

7 We know that slightly more than half of all
8 Americans aged 12 and older reported being current drinkers
9 of alcohol. This translates to 126 million individuals.
10 This is up from the 2004 estimate of 121 million.

11 More than one-fifth of persons aged 12 and
12 older participated in binge drinking, and this is five or
13 more drinks on a single occasion at least one day in the
14 past 30 days prior to the survey. That translates to 55
15 million people. This is about the same as in 2004.

16 In 2005, heavy drinking was reported by 6.6
17 percent of the population aged 12 and older or 16 million
18 people. This is similar to the 2004 rate. Heavy drinking,
19 of course, is defined as five or more drinks on a single
20 occasion for at least five days in the past 30 days.

21 Among young adults aged 18 to 25, the rate of
22 binge drinking was quite high, up to 42 percent. The rate
23 of heavy drinking was 15.3 percent. These rates are
24 similar to 2002 and 2003.

25 When we look at the rate of current use among

1 youth aged 12 to 17, the current alcohol use declined from
2 17.6 percent in 2004 to 16.5 percent in 2005, and this is a
3 statistically significant drop. So youth drinking has
4 declined, but you'll notice overall current use in the age
5 12 to 20, which is an age range where drinking is illegal,
6 it's basically the same, and then 18 to 20 has remained
7 basically the same. So we're reaching our 12- to 17-year-
8 olds, but the overall current use in that 12 to 20 range is
9 basically the same.

10 Youth binge drinking for 12- to 17-year-olds
11 has declined from 11.1 percent to 9.9 percent, but heavy
12 drinking did not change significantly. It's 2.7 percent in
13 2004 and 2.4 percent in 2005. Although these declines in
14 past month and binge alcohol use among youth 12 to 17
15 between 2004 and 2005, overall underage drinking remained
16 essentially unchanged in the 12 to 20 range.

17 In 2005, about 10.8 million persons aged 12 to
18 20 reported drinking alcohol in the past month.

19 Among persons 12 to 20, past month alcohol use
20 was 12 percent among Native Hawaiians or other Pacific
21 Islanders, 15.5 percent among Asians, 19 percent among
22 African Americans, 21.7 percent among American
23 Indians/Alaska Natives, 24 percent among those reporting
24 two or more races, 25.9 percent among Hispanics, and 32.3
25 percent among whites.

1 In 2005, an estimated 13 percent of persons
2 aged 12 or older drove under the influence of alcohol at
3 least once in the past year. The percentage has dropped
4 since 2002. There's a statistically significant drop
5 between 2002 and 2005. This 2005 estimate corresponds,
6 though, to 31.7 million people.

7 This slide shows the distribution of DUI across
8 age groups, and you still see the peak at the 21 to 25.
9 But you'll notice 18 to 20 is actually quite high. It's
10 one-fifth. 26 to 29 is 22.6. But it persists. It doesn't
11 really decline below 10 percent until you reach 55.

12 Illicit drug use. An estimated 19.7 million
13 Americans aged 12 and older were current illicit drug
14 users, meaning they had used an illicit drug during the
15 month prior to the survey interview. This estimate
16 represents 8.1 percent of the population aged 12 and older.
17 This rate is similar to that in 2004, and you can see the
18 numbers there for 2003.

19 You'll notice, though, for illicit drug use,
20 that there was a statistically significant drop between
21 2002 and 2005 for the 12- to 17-year-olds, and I think
22 that's an important thing. We've made steady progress in
23 the decrement in use in that age group, and it's not clear
24 what specific intervention. We think it's a holistic
25 thing, multiple factors, and of course, parental

1 involvement, media messages, faith community, and perhaps
2 prevention efforts are making headway.

3 When you look at the illicit drugs used, they
4 include the range of substances you see on the slide.
5 You'll note that psychotherapeutics, which are the
6 nonmedical use of prescription medications, is the second
7 most prevalent area. We're quite familiar with marijuana
8 and cocaine, hallucinogens, and inhalants. I'd like to
9 remind people that this is a substantial problem.

10 There are roughly 6.4 million people, or 2.6
11 percent of the population aged 12 and older, who use
12 prescription psychotherapeutic drugs nonmedically. Of
13 these, 4.7 million use pain relievers. 1.8 million used
14 tranquilizers and 1.1 million used stimulants. I think
15 something that we need to keep in mind is that nonmedical
16 use prescription drugs continues to be an issue.

17 There are 2.4 million current users of cocaine
18 aged 12 and older, and that's up from 2 million in 2004.
19 It fluctuates a little but it's not statistically
20 significant.

21 Hallucinogens continue to be an issue at a
22 lower level at 1.1 million people aged 12 and older,
23 including Ecstasy at 0.2 percent. These estimates are
24 similar to 2004.

25 The rate of use of inhalants by persons aged 12

1 and older is 0.3 percent, and that did not change.

2 The past month use of methamphetamine by ages
3 12 and older showed a slight decline from 583,000 people to
4 512,000, but what is most striking about meth continues to
5 be its inexorable march from the West Coast to the East
6 Coast. Using our TEDS data, these are treatment episode
7 data -- so we have a bit of a discontinuous presentation.
8 The maroon indicates 148 admissions per 100,000; the red,
9 55 to 147 admissions per 100,000. As you can see, the TEDS
10 data shows 1994, and 10 years later, the great Midwest has
11 a tremendous number of admissions.

12 Even though the rate of use from the Household
13 Survey data shows a decline, the fact is, as our Household
14 Survey points out, those people who are using tend to have
15 more problems and are presenting for treatment. That shows
16 you the sort of delay that occurs between those people who
17 use and those people who "crash and burn" and present for
18 treatment. So the delivery system needs to be prepared to
19 handle the individuals who present. Here's a sort of
20 another vision of that, and you can see the prevalence
21 rate.

22 Now, the past month nonmedical use prescription
23 type drugs by ages 12 and older reflects an overall
24 increase from 2.5 percent to 2.6 percent. Again, pain
25 reliever is a major issue, but we also discovered something

1 fairly startling about the nonmedical use of prescription
2 drugs. It was assumed that a lot of people were getting
3 their drugs from doctor shopping and the Internet, et
4 cetera. Well, it's turning out that when you ask people
5 where did they get their prescription drugs, most of them
6 got them from a friend or relative for free. So it's
7 fairly startling.

8 This has actually been supported by other
9 studies looking at stimulants. As you know, college
10 students are into stimulants now because it "helps them
11 study." They regard them as smart pills.

12 So our data are showing that a large number of
13 individuals, 60 percent, are getting their pain relievers
14 from friends or relatives: tranquilizers, a little more
15 than 60 percent; and the amphetamine stimulants, about 50
16 percent.

17 And the key issue is, in terms of our education
18 campaign, how do we get physicians to begin to educate
19 their patients and patients to understand that prescription
20 drugs might best be treated like if you have a gun in the
21 house: you lock it up and you don't leave it around for
22 popular consumption and you also don't share. But as you
23 can see from the data, this is an issue.

24 And buying drugs from the Internet is turning
25 out not to be as major of a problem as once thought, but of

1 course it remains an issue and the National Synthetic Drug
2 Strategy is going to be dealing with Internet purchases. I
3 think as people get things from the Internet, not all
4 things that you buy from the Internet are what they claim
5 to be, and maybe that's one of the reasons people rely on
6 friends and relatives for their drugs because they're more
7 likely to be what they claim they will be.

8 For pain relievers, drug dealers are not big on
9 prescription drugs. They are a bigger source for
10 methamphetamine and not for prescription stimulants.

11 This slide indicates the illicit drug category
12 is among the largest number of recent admissions among
13 persons 12 and older for nonmedical use of pain relievers.

14 It's obviously the largest category. These are past-year
15 initiates, and pain relievers exceed marijuana. Although
16 these estimates are not significantly different from the
17 numbers in 2004, it does remind us that there's an upsurge
18 in the nonmedical use of pain relievers, and we need very
19 much to be aware of that.

20 When we look at the ages where people start
21 using, we know that people who begin using drugs and
22 alcohol at a younger age are more likely to develop
23 problems as a result of their use. So we should be, of
24 course, concerned about that. We also note that the mean
25 age of use of pain relievers is 21. The mean age of use of

1 heroin is 22. But inhalants, PCP, and marijuana are at
2 much younger. So we should be very much aware of that.

3 So whatever efforts that we use to discourage
4 people from using drugs should continue. Again, there are
5 questions about single strategies, but I think, as Mr.
6 Curie used to say, there are many pathways to recovery.
7 There are many pathways to communicating to the public
8 about the dangers of substance use.

9 In 2005, an estimated 22.2 million persons, 9.1
10 percent of the population aged 12 and older, were
11 classified with either substance use or substance
12 dependence. Of these, 3.3 million were classified with
13 dependence on or abuse of both alcohol and illicit drugs;
14 3.6 million were dependent on or abused illicit drugs, but
15 not alcohol; and 15.4 million were dependent on or abused
16 alcohol, but not illicit drugs.

17 The specific illicit drugs at its highest
18 levels of past-year dependence in 2005 continued to be
19 marijuana, followed by cocaine at 1.5 million, but then you
20 can see pain relievers continues to be the third most
21 commonly abused or dependent drug at 1,546,000, which is
22 just barely below the cocaine level. So I think in terms
23 of dependence and abuse, we need to be very much aware that
24 prescription drugs have a high prevalence.

25 So what we're seeing in this particular slide

1 suggests that people are doing more than just taking one or
2 two pills. The problem with national surveys is all you
3 have to do is take one pill one time nonmedically in the
4 past 30 days and I'm a current user. But abuse and
5 dependence means I'm having problems. So these data say
6 that even though you may challenge them, because there are
7 people who challenge the Household Survey, you can
8 challenge the magnitude of the problem, but the abuse and
9 dependence is not attached to mere use. It's attached to
10 decrements in function. So this particular slide points
11 out that, indeed, we have decrements in function.

12 Abuse and dependence by males continued to be
13 significantly higher than females in all age groups,
14 something that we need to keep in mind. But you should
15 also note that those 12 to 17, the 7.8 and 8.3, is really
16 quite close.

17 And what about treatment? There are 3.9
18 million persons aged 12 and older, or 1.6 percent of the
19 population, who received some kind of treatment for a
20 problem related to alcohol or illicit drugs in 2005. More
21 than half, or 2.1 million, received treatment in self-help
22 groups. However, 20.9 million people did not receive
23 treatment, and of the 20.9 million people in 2005 who were
24 classified as needing substance use treatment but did not
25 receive treatment in a specialty facility, the vast

1 majority felt that they did not need treatment. This is
2 where our SBIRT strategy comes into play, and we'll hear
3 from Dr. Stein later about SBIRT.

4 The key issue is that we know that because of
5 decrements in function, that people are having physical,
6 psychological, employment, or legal problems as a result of
7 their drug use. Yet, the overwhelming majority of these
8 individuals do not perceive a need for treatment. So we
9 have to identify individuals elsewhere, whether it's the
10 emergency room, the primary care setting, the church or
11 religious setting, temple, synagogue, what have you. The
12 key issue is that somebody somewhere knows that this person
13 is having a problem, and even though this person says I'm
14 having a problem, they don't endorse the need for
15 treatment.

16 So the key issue here is that if everybody
17 showed up to a treatment program who truly needed it, our
18 treatment programs would be terribly overwhelmed. Many
19 people talk about the waiting list, but the waiting list is
20 actually fairly minor compared to the large number of
21 individuals who need treatment.

22 From a public safety point of view, I've always
23 contended the engine that drives the illicit drug market is
24 the big red slice. I can't get heroin and methamphetamine
25 and cocaine from the 7-Eleven or the CVS, so I've got to

1 get it from my dealer. I'm less likely to turn my dealer
2 in if I've got a problem with abuse and dependence and I
3 can't get my drugs from elsewhere. So I'm less likely to
4 do that.

5 I'm fond of pointing out that the people who
6 will remember moonshiners -- some of you my age can
7 remember moonshining. You're less likely to turn your
8 still in to the revenuers if that's where you get your
9 booze. So it creates a public safety problem because then
10 the attendant public safety issues that go from drug
11 dealing go unaddressed because people are unwilling to rat
12 out their dealers because, after all, they won't be able to
13 get their drugs. It's only the people who are ambivalent
14 about it who are more inclined to do something.

15 So of the 1.2 million people who felt they
16 needed treatment for illicit drug and alcohol use, only
17 296,000 made an effort to get treatment, and 865,000
18 reported they made no effort to get treatment even though
19 they felt they needed treatment. A key issue. People
20 aren't always motivated.

21 Of those people who made an effort to get
22 treatment, the reasons for not receiving substance abuse
23 treatment. It's a minority of people, but for that
24 minority cost and insurance barriers play a major role,
25 other access barriers. Some are still not ready to stop

1 using despite the fact that they know they should stop
2 using. And then while it is an issue, stigma is, only at
3 18.5 percent, cited as a barrier.

4 I really think that we've got our work cut out
5 for us in dealing with early intervention, and that is
6 changing people's attitudes about the misuse of
7 psychoactive substances.

8 So we continue to have serious problems with
9 alcohol and illicit drug use in this country, and as we
10 continue our discussions today, we will talk about many
11 things.

12 This slide shows you basically our budget
13 because, despite the fact that we've got a problem, we also
14 have to deal with the issue. As you know, FY 2006 is
15 almost over. We discussed the President's budget when we
16 talked last. The House and the Senate full committees have
17 met, and these are the numbers that you see for our budget.

18 Our FY 2006 budget was \$2.156 billion with \$1.76 billion
19 going into the block grant and the other into the
20 discretionary portfolio. For the 2007 budget, the
21 President's budget, we had \$375 million in the PRNS line or
22 the discretionary line, with \$1.76 million going into the
23 block grant, for a total of \$2.134 billion. The House gave
24 us roughly \$26 million more than the President's budget.
25 The Senate mark is \$3 million less.

1 The full House and the full Senate budgets do
2 not continue the Access to Recovery Program. So you'll see
3 a reduction in funds to the Access to Recovery Program in
4 the Senate side and the House side. But what the House did
5 was to reallocate the money that was targeted for Access to
6 Recovery to the block grant. So you see in the budget a
7 substantial increase in the block grant. There's a \$30
8 million increase in the block grant on the Senate side. So
9 we are still trying to impress upon the legislative process
10 through official channels the importance of the Access to
11 Recovery initiative, so we'll have to wait and see what we
12 are doing.

13 SAMHSA is converting to a new HHS unified
14 financial management system for the new fiscal year. We've
15 already made our grant awards for FY 2006 and we'll be
16 making progress to shift over to the new system.

17 As you know, we have mid-term elections coming
18 up. This probably indicates that we won't have a budget
19 until the start of the new calendar year. So we will
20 probably be on a continuing resolution now. There are
21 reports that there will be a lame duck session, so it is
22 possible that we will have a budget as early as December.
23 But this is all speculation. The Congress moves on the
24 Congress' time table. We do know that when they're in
25 recess, there will be no business. So that much we can

1 count on. There's no business during recess. So there
2 will be a pre-election recess, and then if there's a lame
3 duck session, they may act on our budget. If not, we won't
4 have a budget until the first of the year.

5 You should know that both houses have agreed
6 with the President on a \$25 million methamphetamine
7 program, but they would leave voucher decisions to the
8 states and the grantees. Again, we won't have any final
9 action on any of these budget issues until after the
10 conference when the House and the Senate get together and
11 decide what they're going to do.

12 We've already begun our planning for '08. In
13 fact, we've submitted a budget to the Office of Management
14 and Budget last week, and this is going to be part of the
15 process where we deal with the 2008 budget request, which
16 is going to be announced in February. So that process is
17 now well underway. So this is something I've always found
18 fascinating. We don't have an '07 budget, and yet, we've
19 got an '08 budget in the works. So we'll see what actually
20 happens.

21 Are there any questions? Budget questions,
22 Household Survey questions?

23 (No response.)

24 DR. CLARK: No questions. So very good.

25 MS. JACKSON: I have a question. Perhaps I

1 should know this. It's on the Household Survey. When the
2 Household Survey is conducted, is it conducted in different
3 languages?

4 DR. CLARK: I don't know the answer to that.
5 That's a very good question.

6 MS. JACKSON: Can we find that out?

7 DR. CLARK: Yes, it's conducted in different
8 languages.

9 DR. KOPSTEIN: At least in Spanish.

10 DR. CLARK: At least in Spanish. How about
11 Hmong? No? Okay.

12 Thanks. That was Andrea Kopstein back there
13 and she used to work on the Household Survey, at least for
14 OAS.

15 DR. MCCORRY: Do we have, Dr. Clark, a sense of
16 all dollars spent all sources on substance abuse services
17 in the country? Is there such a figure?

18 DR. CLARK: Yes, we do. Is Rita back there?

19 MS. VANDIVORT: Yes, I am.

20 Yes, we do. SAMHSA does a report that looks at
21 all public and private spending on mental health and
22 substance abuse. In fact, we're going to be coming out,
23 probably in the next two months, with our next report which
24 will be looking at the period from 1993 to 2003.

25 In addition, for the first time, the SAMHSA

1 spending estimates is going to look at projections and will
2 be projecting the public/private spending to major payers
3 out to 2014.

4 DR. McCORRY: Rita, will that include criminal
5 justice dollars, public welfare dollars, HUD dollars? When
6 you say public, it will include if HUD is running a
7 substance abuse program in some of their housing stock.
8 That would be included?

9 MS. VANDIVORT: It is hard to drill down to a
10 lot of detail, and we try to do specialized studies for
11 that. We're right now trying to tease out. We tend to
12 look at the major payers, Medicare, Medicaid, other
13 federal, which includes our block grant, Defense. We look
14 at private insurance. We look at foundation funding and
15 then self-pay.

16 We are trying to drill down more. We have had
17 some studies, for instance, looking at utilization in
18 employer-sponsored, which clearly indicates the decline in
19 inpatient that we've seen in the field, but surprisingly
20 also declines in inpatient. So we do a number of special
21 studies that try to drill down.

22 We're working right now with Rick Harwood to
23 try to see if we can find any good data around criminal
24 justice. It's a very important area, but unfortunately,
25 the data sets don't seem to be out there to do the quality

1 work we like to do.

2 DR. CLARK: Melody.

3 MS. HEAPS: Well, certainly you'd be able to
4 get corrections department dollars spent for treatment that
5 they're sponsoring, institutional. You ought to be able to
6 get that relatively --

7 MS. VANDIVORT: The problem with corrections is
8 the multi-layers. You know, you have federal prisons, you
9 have state prisons. We've looked at some of the prisons
10 and what often happens is they have a health plan which
11 covers health services, but the substance abuse they often
12 carve out into a separate contract. You know these things.
13 It is hard to identify that in the data sets.

14 But I'm not the expert. I'm having my experts
15 look at this, and I hope to come back with something.
16 Perhaps we can chat. If you have some suggestions, I'd
17 love to hear them.

18 MS. JACKSON: I assume that also means that you
19 have state general funds. You didn't mention the state
20 general funds, but that's easy to get.

21 MS. VANDIVORT: Yes, other state and local is
22 the other category. I'm sorry if I didn't mention it. In
23 fact, for substance abuse, it is the largest payor. It's
24 like 40 percent of all spending.

25 Now, again, we build, in the specialty area,

1 off of TEDS, and we think some of that state and local is
2 probably criminal justice correctional funding that they're
3 paying for those providers. But the way that TEDS is
4 reported, we can't identify the segment that comes from
5 corrections. We know that referral sources, but not the
6 dollars.

7 Any other questions? I'll stop trying to walk
8 away.

9 DR. CLARK: All right.

10 MR. DONALDSON: Dr. Clark, I had a question.
11 You say the Senate did not want to approve ATR moving
12 forward, or neither?

13 DR. CLARK: Neither the House nor the Senate
14 included a voucher initiative in their appropriation
15 proposal. These are the full committees.

16 MR. DONALDSON: What was their reasoning?
17 Because I know, according to your report, 48 percent more
18 clients than were originally targeted. I know a quarter of
19 those have been the faith-based. I know we had a rough
20 start, but it seems like there's a lot of momentum. Why is
21 that sentiment there?

22 And number two, what are we doing to perhaps
23 recoup it?

24 DR. CLARK: Well, the Congress moves in its own
25 way. So their rationale is not clear. One has to conclude

1 that given the tight budget times, the House decided to put
2 the money in the block grant. The Senate decided to limit
3 the increases. So if individuals want to know the
4 rationale for the full committees, they need to talk to the
5 staffers of those committees.

6 The administration is having ongoing
7 discussions with members of Congress on both sides of the
8 aisle on both sides of the Capitol so that the hope is that
9 they'll change their minds when the bill comes before the
10 full Senate or the full House. And then there's the
11 conference. So when the bill becomes before the full
12 Senate, there's an opportunity; the full House, there's an
13 opportunity. Then there's a conference. So the
14 administration is discussing these matters.

15 Yesterday we met a number of staffers at a
16 meeting that was convened on Capitol Hill to inform the
17 House and Senate staffers about ATR and gave them the facts
18 that you recited. ONDCP was present. We were present, and
19 Teen Challenge was present.

20 MS. HEAPS: I hate to make this more
21 controversial, but it is. One of the reasons, I think,
22 that you are seeing the action of the Congress has to do
23 with the way the funding was attached or opened up the
24 block grant. For natural constituencies of treatment
25 providers who would have supported ATR, that has become a

1 major red herring. Had it gone forward without that, you
2 might have seen it, but most of the provider groups or
3 organizations that support them, NASADAD and other groups,
4 are opposed, therefore, to ATR as it stands and has been
5 proposed by the administration, which is too bad.

6 DR. CLARK: In fact, we've heard that same
7 rationale, and the hope is that there will be some
8 discussion. If the administration is flexible, if the
9 Congress is flexible, they can arrive at a consensus that
10 would be acceptable to all parties. But I think Melody's
11 point is well taken. The use of the block grant is,
12 indeed, controversial. I think I can safely say that.

13 I was in Iowa and I was talking to Janis Vick,
14 who was pointing out that a number of rural providers,
15 they're the only game in town and they need to have
16 maintenance, what they get from the block grant. Even with
17 performance contracts, you've got a maintenance of effort.

18 You need a core financial in stream to keep your doors
19 open. If you go out of business, then that whole community
20 is without a provider. So that's an issue. So we need to
21 think in terms of it. Whereas, as a grant program, it
22 didn't affect that and the provider had its maintenance
23 income, if you will. So it would have enough money to keep
24 its doors open.

25 So those are issues that are being discussed.

1 The administration thinks that its proposal is a good one,
2 but the legislative process is a hazardous one. So there
3 are times when you have to make compromises, if that's
4 possible, or if necessary. So those discussions are going
5 on now.

6 At this point, without any further discussion,
7 why don't we take our break? Then we'll be back at 10:40.

8 Thank you.

9 (Recess.)

10 DR. CLARK: All right. Before our next
11 presentation, our very next item of business on the agenda
12 is to vote for the minutes from our June 23rd, 2006
13 meeting. The minutes were forwarded to you electronically.

14 Hopefully, you had an opportunity to review them. If so,
15 I entertain a motion to adopt the minutes.

16 PARTICIPANT: So moved.

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

19 PARTICIPANT: I second.

20 DR. CLARK: I have a motion and a second. Any
21 discussion?

22 (No response.)

23 DR. CLARK: May I get a vote? All those in
24 favor?

25 (Chorus of ayes.)

1 DR. CLARK: All those opposed?

2 (No response.)

3 DR. CLARK: All right. The minutes were
4 adopted as presented. That's it for the minutes.

5 So we will move to our next presentation, which
6 is our alcohol initiatives.

7 Obviously, alcohol continues to be a major
8 issue in our society, as you noted from the Household
9 Survey data. Psychotherapy treatments for alcohol
10 dependence have been expanded with the recent FDA approval
11 of acamprosate in 2005 and naltrexone for extended-release
12 injectable suspension, otherwise known as Vivitrol for
13 2006. We have Cephalon here for Vivitrol. These are the
14 first new medications for treating alcohol dependence
15 available to physicians for over a decade.

16 We've embarked on a project to update our 1998
17 treatment improvement protocol, naltrexone in alcoholism
18 treatment, to include the newer medications, along with
19 oral naltrexone and disulfiram. Eric Strain, Professor of
20 Psychiatry at Johns Hopkins University, is the TIP chair.
21 He's also associated with the American Psychiatric
22 Association's Council on Addiction.

23 Also, the use of experimental biochemical
24 measurements to objectively assess patients' current or
25 past alcohol use holds forth the prospect for measuring

1 acute alcohol consumption and relapse. These are issues
2 that we title "biomarkers." The idea is to treat people
3 with alcohol dependence adequately using medications where
4 indicated, and clinicians need tools to properly assess
5 recent and past drinking activity and family history of
6 drinking problems. Biomarkers, if appropriately used, can
7 be a good indicator of alcohol use, presupposing that there
8 are no other illnesses or problems.

9 When we talk about biomarkers, we've got a
10 draft of our advisory. Some of you may have got copies of
11 this. It's in your book. The Role of Biomarkers in the
12 Treatment of Alcohol Use Disorders.

13 The advisory summarizes there are indirect
14 measures of alcohol problems like liver function tests,
15 mean cell volume tests, or the carbohydrate-deficient
16 transferrin test. There are direct measures of alcohol
17 exposure or use using breath alcohol, looking at alcohol
18 present or ethyl glucuronide or ethyl sulfate or
19 phosphatidyl ethanol. These latter three are relatively
20 new in the marketplace of strategies to address alcohol
21 issues.

22 Following my presentation, Dr. Skipper will
23 give a perspective on the regulatory side.

24 The issue of the biomarkers has come to our
25 attention from a number of different directions, and those

1 directions have been in the media. There's a Wall Street
2 Journal article in the back which summarizes the
3 discussion.

4 The question is why do we want to use
5 biomarkers. It complements self-report measures, clinical
6 history, self-report questionnaires, and it can give you an
7 objective laboratory test to assist in outcome measures for
8 treatment and studies and to screen to detect problems and
9 some evidence of abstinence.

10 One of the things that we quickly have learned
11 from reviewing the literature and synthesizing this report
12 is, of course, there are limitations to any of these
13 strategies. In a clinical context, these limitations have
14 to be kept in mind, and in a forensic context, they have to
15 be especially kept in mind. A forensic context is when
16 you're doing workmen's comp evaluation. When people's
17 liberties or freedoms or property rights are in jeopardy,
18 then you want to make sure that whatever test you use, the
19 limitations of those tests are well understood. Objective
20 tests can assist us in the clinical context because we have
21 a lot more flexibility. In the forensic context, where
22 there's a lot less flexibility, you want to make sure your
23 biomarkers are more rigorous.

24 In the clinical context, in treatment we can
25 screen for alcohol use problems. We can use the feedback,

1 motivating change in drinking behavior. We can use it to
2 identify relapse to drinking, and we can use it to evaluate
3 interventions.

4 The issue of relapse. I'm fond of citing the
5 situation where in a clinical context it was a drug test.
6 A gentleman came to my office when I was at the VA, and I
7 asked him to go get a drug test in the morning and that I
8 would see him later that day. So he went over and got his
9 drug test and it was not an observed specimen. It was a
10 voluntary specimen. So he shows up in my office. I pull
11 up his file on the computer, since the VA went to
12 electronic health records. For those in the audience,
13 remember that, the electronic health record. We'll talk
14 about that later. So I asked him, have you used any drugs
15 lately? His first answer was no. I said, well, can you
16 explain this positive? He said, okay.

17 So we talked about that. It was a non-punitive
18 context, and I think that's the key issue. Sometimes
19 people are embarrassed and sometimes people don't like to
20 admit it. He could have just as easily not taken the test.
21 He could have gone and come back and said, look, there was
22 a long line. I didn't have it. But instead, he did take
23 the test and it was an awkward moment. I was able to work
24 with him to address that issue.

25 You can use biomarkers to identify relapse to

1 drinking, evaluating interventions, and to document
2 abstinence.

3 Now, the legal reasons. That's the forensic
4 context. That gets to be tricky under the age of 21, child
5 custody for an identified impaired parent, court-mandated
6 abstinence, monitoring, and treatment, and impaired
7 providers/professionals who are trying to continue to work.

8 These legal reasons or these forensic contexts are reasons
9 that we need to pay close attention to in terms of
10 outcomes.

11 In the clinical context, you have flexibility,
12 and you can work with the individual. In the forensic
13 context, some decisions have to be made. Should a mom
14 retain her child? Usually it's a mom. Should a visiting
15 parent be able to visit usually it's his child? Should a
16 professional continue in a monitoring program?

17 I used to be in the State of California and I
18 was on the monitoring board for almost 10 years. So
19 monitoring was something that we used very extensively. We
20 did not use biomarkers as such. We did use drug tests. We
21 didn't use alcohol biomarkers. We used breathalyzers.

22 When you're using biomarker testing, as Ken
23 Hoffman points out, we have to look at the issue of
24 sensitivity, how many true positives we pick up,
25 specificity, how many true negatives we pick up. We need

1 to be able to look at the positive predictive value of a
2 test. Those are the true positives over the true positives
3 plus false positives.

4 You want to be able to estimate the prevalence
5 of a problem based on the test within the population. So
6 different populations have, obviously, different risks of
7 showing positive. For instance, if you do a test for PCP,
8 which is not a drug that's used very often, you want to
9 make sure that that positive is a true positive because
10 it's more likely than not to be an error actually, or the
11 patient may say, well, as I have had patients say, look I
12 do marijuana. I did marijuana. So the patient actually
13 may not know what they're doing. So it really gives you
14 the information in the clinical context to work with.

15 We have to understand the relationship between
16 sensitivity, specificity, positive predictive value in
17 trying to address a test. In the low prevalence rate,
18 positive predictive value can be low with 100 percent
19 sensitivity and high specificity. These are all things
20 that we talk about in our advisory because, indeed, what we
21 don't want people doing is relying on absolute values.

22 Prior to coming to Washington, I used to have a
23 small forensic practice. One of the companies that I was a
24 consultant for -- one of the supervisors would say, well,
25 if the test is positive, I don't need an MRO to tell me

1 anything. The test is positive. The test is marketed as
2 being an absolute statement of a condition when, in fact,
3 it turns out there are other reasons for that. It's an
4 important thing for us to keep in mind that if we don't
5 understand the relationship between sensitivity,
6 specificity, and prevalence, we're liable to essentially
7 challenge someone's credibility when that's not the case.

8 For direct biomarkers, the idea is to be able
9 to detect the presence of the biomarkers after ingestion of
10 alcohol. So the biomarkers listed in the advisory include
11 EtG, EtS, and PEth. The idea is that after the alcohol is
12 ingested, it's metabolized and it produces a moiety and a
13 chemical end product which can be detected. It is argued
14 by some of the labs that it's absolute, when you look at
15 the website. The website says, well, gee, this is proof of
16 consumption. Well, beer and wine and alcohol and liquor
17 will give you the alcohol.

18 But what they don't talk about is what other
19 products will give you alcohol. Remember, the other thing
20 that we're dealing with in terms of positive predictive
21 value is the lower level we get in terms of the particular
22 product, you may get environmental exposure. So there's
23 alcohol-free beer and wine. There's aging juice, over-the-
24 counter medication. It was brought to my attention that
25 the propellant in an asthma inhaler contains alcohol.

1 Lorie Garlick got me involved in this mess. It turns out
2 Dr. Mike Liebman pointed out that Purell -- 62 percent
3 alcohol. Well, Dr. Liebman's point is that it vaporizes
4 and that you inhale it, and it actually registers in your
5 body and produces a low level positive. He's done some
6 studies.

7 Other people point out that if you do a lot of
8 hand washing, your hand gets rough. Indeed, the skin
9 absorbs alcohol. In fact, a number of pharmaceuticals rely
10 on the assistance of alcohol propellants to move other
11 drugs into the body. So alcohol is a fairly ubiquitous
12 thing.

13 The difference between a breathalyzer, which
14 basically registers blood alcohol, and these biomarkers,
15 which essentially registers the exposure to alcohol, is
16 quite substantial. A breathalyzer requires a lot of
17 alcohol to give you a reasonable positive. They've got
18 some fairly good studies correlating the amount of alcohol.

19 If you operate motor vehicles, the DOT says if it's .04 or
20 above, you can't operate the motor vehicles. For DUIs,
21 it's .08 or above.

22 But with some of the biomarkers, we're down to
23 levels of detection which is 50 nanograms. Some labs pride
24 themselves at 50 nanograms. So the question is how do you
25 get 50 nanograms of alcohol in your body. Well, the 50

1 nanograms has no relationship with intoxication. In fact,
2 a couple drinks will give you tens of thousands of
3 nanograms. So when you're down to very, very low levels,
4 if you're using it as a biomarker, you can't distinguish
5 whether a person has been exposed to over-the-counter
6 medicine, whether they've been exposed to foods cooked with
7 alcohol, whether they've been exposed to household
8 products.

9 Does anybody know about Lysol? Did you know
10 Lysol has 70 percent alcohol and 62 percent to 70 percent
11 in Lysol spray? The Lysol people tell you to spray the
12 stuff all over the place. Spray it in the air. Spray it
13 on the hard surface. Get rid of those germs and the
14 viruses. Well, you know, if you spray, you're getting
15 high.

16 (Laughter.)

17 DR. CLARK: No. You don't get high. But
18 you're exposed to aerosoled alcohol.

19 The problem with the biomarkers is how much do
20 you need to detect innocuous use. Most of the people I
21 treated who had an alcohol problem did not drink 50
22 nanograms per milliliter, but they drank for effect.

23 So household products, personal care items,
24 professionally required products may contain very low
25 levels. The other point that we know is that you can't

1 always determine how much alcohol is in a product. There
2 are foodstuffs that have low levels of alcohol that the FDA
3 does not require a declaration of alcohol content.

4 So if a biomarker is picking up low levels,
5 because unlike in drug testing -- in drug testing, we have
6 cutoffs. We have these cutoffs that distinguish between
7 "mere exposure" to opiates.

8 Does anybody know about poppy seeds? The poppy
9 seed opiates. Well, the poppy seed is a very interesting
10 thing. When the labs first started doing opiates, no,
11 poppy seeds could never give you a positive. Somebody
12 decided to test that thesis out. They ate a lot of poppy
13 seed bagels and it gave them a positive for opiates. There
14 is morphine in poppy seeds, incidentally. So the key issue
15 was that we've established a cutoff so that people who ate
16 poppy seeds would not be mistakenly accused of using
17 morphine or heroin or codeine.

18 So there have been no cutoffs established that
19 could distinguish between consumption of alcohol from
20 exposure to alcohol or other products. We talk about that
21 in our advisory.

22 We need to identify possible factors that may
23 influence an individual's biomarker response to alcohol
24 because we also don't know much about the metabolism of
25 some of the alcohol at these low levels. Everybody knows

1 about the high levels, .08, .04, .02. Dr. Liebman was
2 able, in inhaling Purell, to get a .01, which you can pick
3 up from a breathalyzer. Some breathalyzers have a .005,
4 but not below that. They don't really register. You start
5 getting noise.

6 We need to identify the window of assessment
7 associated with various alcohol levels of use. Even low
8 levels won't be positive at three days out because the
9 argument is we can pick up drinking from three days before.
10 But if you've got asthma and you use an inhaler that day
11 of your test, even though it's low levels, it will indicate
12 a low level. The assumption is that at some time earlier
13 you drank, but that's not true.

14 We have to determine the reliability of the
15 laboratory testing procedures. Right now there are just a
16 few labs. When you look at the literature, there are only
17 a few labs that are writing about this. So basically it's
18 like the only game in town, and it's like trust me, I make
19 no mistakes. When is the last time you relied on that? So
20 that's an issue.

21 We have to determine which products can give a
22 positive test result at specific cutoffs. The notion of
23 cutoffs is very, very important. Since methamphetamine is
24 a major issue -- I wish Donna Bush was here -- we have to
25 establish a cutoff at a high enough level so that people

1 who took a lot of ephedrine didn't test positive for
2 methamphetamine. So the labs adjusted to this.

3 So the issue of alcohol biomarkers has become
4 very important. From my point of view, if we don't
5 establish good cutoff values, the risk and benefit of a
6 correct label to the patient needs to be taken into
7 consideration. You have to look at, well, what is the cost
8 of working up a false positive? If someone took an asthma
9 inhaler and registered 50 nanograms per milliliter, the lab
10 says, see, that's evidence of consumption. We interpret
11 consumption generally as being they drank. Some of the
12 labs are very, shall we say, adroit in asserting that.
13 Others say, well, this is alcohol drinking. We have to
14 look at the cost of missing a false negative case.

15 And we have to look at the test-only alcohol
16 detection program. So if we're going to rely on something,
17 we have to look at the possibility of getting 100 percent
18 specificity for no false positive if you're going to
19 sanction somebody as a result of a single test.

20 Again, in the clinical context, we have this
21 flexibility. We don't rely on a single test to make a
22 determination. It is evidence of something, and now the
23 question is what is it evidence of. Let us find out what
24 that is. But if you market something as foolproof and
25 absolute, then you've got people who are willing to rely on

1 that and then people are sanctioned.

2 So our advisory talks about the biomarkers and
3 the limitations of it, and I commend you to the advisory
4 because we want people to not focus on the absolute nature
5 of biomarkers, but their utility as a part of the general
6 clinical construct rather than, well, the test says you're
7 this, therefore you are. As we know, that can be
8 problematic.

9 Injectable naltrexone for the treatment of
10 alcohol dependence. Naltrexone is an opioid antagonist and
11 it's often prescribed as an anti-craving medication for
12 patients dependent on alcohol. It used to be called
13 Trexan. Then it became ReVia. This is the oral
14 medication. Compliance with oral medication for people who
15 generally were in the health professions and trying to
16 recover was pretty good, but for the general population,
17 compliance with oral medication was very poor historically.

18 With the advent of Vivitrol, then the new medication is a
19 long-acting, one-month injectable formulation. It's
20 available.

21 And we'll have an advisory that notifies the
22 field and compares oral with injectable naltrexone. We
23 believe that the injectable has good utility for the field
24 because it's less dependent upon the, shall we say, I
25 decide maybe I want to drink today, so I stop taking the

1 medication. Well, the injectable reduces cravings. There
2 is developing research that this is a good approach to
3 treating alcohol dependence.

4 We're going to have a TIP for medications for
5 use in the treatment of alcohol dependence because these
6 medications are available, and we will review some of the
7 older medications like disulfiram. Acamprosate is
8 available, as I mentioned earlier. The two forms of
9 naltrexone, the oral medication and the injectable.

10 This TIP integrates the use of these
11 medications and testing of evidence-based treatment of
12 alcohol dependence in primary care and addiction medicine
13 settings. As many of us know, a lot of medications are now
14 prescribed in the primary care setting. So we want to make
15 sure that primary care docs have adequate information from
16 an addiction point of view, and we're relying on experts in
17 the field to assist us in putting together this treatment
18 improvement protocol. So when Bettye Fletcher teaches her
19 course, her students will have the latest information by
20 consensus, and this is important.

21 So with the exciting developments with
22 biomarkers and the new developments in medications, we
23 think that we can have a more robust field. We can assist
24 people in their recovery, and we recognize that not all
25 people recover the same way. There are many pathways to

1 recovery.

2 The other point that we need to make with the
3 biomarker point is if, in fact, people are not using and
4 they're accused of using, then it creates a tension in the
5 recovery process. If our biomarkers are so low that we are
6 now picking up environmental exposure, then basically
7 you're telling the person who's in recovery that their
8 recovery efforts are for naught. I'm in recovery. Well,
9 you got a 50 nanogram positive. Well then, but if I'm not
10 drinking and I'm going to be sanctioned for drinking, I
11 might as well drink. That doesn't help the larger society.

12 It doesn't help the person, and it doesn't help the
13 recovery process because, indeed, honesty is one of the
14 basic tenets of the recovery process.

15 So we need to be scientifically honest about
16 what it is that we do and recognize the limitations of what
17 we do so that, indeed, we don't create the conundrum which
18 undermines the whole effort because, above all, we should
19 be doing no harm. The advent of biomarkers will help us in
20 our relationship with our clients and the advent of new
21 medications will help our clients in their efforts to
22 reduce craving and to recover from alcohol abuse and
23 dependence.

24 Greg, do you want to come up here and discuss
25 with the council some of the, shall we say, technical

1 regulatory issues associated with biomarkers?

2 DR. SKIPPER: Thank you, Dr. Clark. I'll just
3 take a couple minutes.

4 In my work, I've worked with health
5 professionals, pilots, other professionals for about 25
6 years, these people that have problems with alcohol and
7 drugs that come to the attention of their profession and
8 get treatment and then are allowed to go back to work
9 contingent upon their abstinence.

10 In 2001, I had been arguing with a malpractice
11 insurance company who stated to me that they were no longer
12 willing to insure doctors who had alcohol problems even
13 after treatment because they were worried that if there was
14 a malpractice case, there was no effective way to really
15 document that that doctor was abstinent and they were
16 worried because the judges in that state were allowing the
17 recovery history into the malpractice case. Without solid
18 proof of abstinence or the ability to prove that, the
19 company didn't want to insure these doctors.

20 So that was the setting in which I heard about
21 new markers, including EtG at an international conference
22 in Italy. So I was very interested in studying this marker
23 to see if it would better serve us to prove abstinence to
24 the benefit of professionals who could then prove better
25 and more absolutely that they were succeeding in recovery

1 and be able to have additional privileges. So that's the
2 context in which I supported this test and thought it would
3 be very valuable, and I think it is valuable in that
4 context.

5 I presented on this here at this council a
6 couple years ago, and Dr. Clark prophetically cautioned
7 that there could be problems with false positives.

8 Indeed, as labs took this very rapidly after
9 its introduction, much more rapidly than most things go
10 from lab to field, this thing has caught on like crazy. I
11 talked one lab into running the test, I think it was, in
12 2003. NMS up in Philadelphia started running the test, and
13 now there are more than 10 or 12 labs and more than 20,000
14 to 30,000 tests a month being done mainly in the context,
15 rightfully, of monitoring people who have agreed to be
16 abstinent.

17 Again, it's very successful when the test is
18 negative. The question comes along, when it's positive,
19 what do we do? And particularly the low positives.

20 So what I wanted to say is that the problems
21 that have emerged regarding EtG testing really have in many
22 ways highlighted intrinsic problems with drug testing in
23 general, not just for alcohol, and the substance abuse
24 field at large. The most prominent problem that it's
25 highlighted is the inherent discordance between the

1 legal/moralistic and the medical/clinical approaches to
2 substance abuse problems. Lawyers, judges, regulatory
3 boards and others using drug testing as evidence want
4 certainty. They want it to be black and white. A positive
5 test means you're guilty; a negative test means you're
6 innocent. If a drug test is positive showing the presence
7 of a drug or alcohol, they want to know it means relapse to
8 substance use, much like they rely on fingerprints and DNA
9 testing.

10 Alternatively, doctors and other clinicians
11 know that you must treat the patient, not the lab test.
12 All laboratory tests have limits. We call these limits
13 sensitivity and specificity. Dr. Clark has gone through
14 that. This applies to drug and alcohol marker testing as
15 it does to all other lab tests. Therefore, when a health
16 professional receives a lab report that doesn't fit the
17 clinical situation, they wisely question the lab report,
18 repeat it, and/or attempt to understand why the test may or
19 may not be accurate.

20 Therefore, in a sense we can see drug testing
21 in the same dilemma as the entire field of substance abuse
22 where we're trying to decide whether we're dealing with a
23 crime or an illness. Is punishment or treatment warranted?
24 It's really what it kind of boils down to. We're at the
25 interface between the legal and the clinical.

1 Being involved in introducing EtG and EtS
2 testing in the United States, studying this marker and
3 reporting on its potential benefits, using the test in the
4 field to monitor physicians -- we use it in our program
5 currently -- consulting with laboratories, moderating an
6 e-group where I met some of the people here today regarding
7 EtG testing, and finally coming to realize how quickly the
8 test has been marketed and used, sometimes inappropriately
9 which has harmed some individuals, actually many
10 individuals, has been an education to me. I've learned
11 many things from this experience, but the most disturbing
12 has to been to witness the rigid and sometimes punitive
13 manner in which the tests are being used by some agencies.

14 Another thing that I've learned that's
15 disturbed me is the very limited role that MROs take in
16 trying to resolve these problems. I commend Dr. Clark and
17 his staff for their interest in this problem.

18 I personally issued an advisory in 2004 and in
19 2005 warning agencies that positive EtG tests could be from
20 incidental exposure to alcohol, and a positive test does
21 not always mean beverage alcohol consumption. Some of
22 these agencies wrote me and said that I was a traitor, that
23 I brought this test here and now I'm changing sides. I
24 didn't ever mean to be on one side or the other. I was
25 really trying to bring something valuable to the field.

1 I was impressed how little my personal advisory
2 was actually heeded. I felt like I had started a
3 locomotive moving and was now unable to slow it down. I
4 met with Dr. Clark last fall and discussed SAMHSA issuing a
5 more authoritative advisory, and I'm delighted that a
6 proper advisory is going to now be available.

7 Because of my role with EtG, I'm being
8 contacted daily by no less than 10 or 15 unique people
9 every day who claim they are being falsely accused of
10 drinking. Many of these individuals are being returned to
11 prison, losing custody, or losing their licenses. I'm
12 hopeful that this advisory will positively influence those
13 in positions of authority to be thoughtful and careful
14 about using these really potentially very valuable tests.

15 More research is needed to perform. Proper
16 research funding is desperately needed.

17 Finally, I strongly recommend that SAMHSA
18 organize a meeting inviting regulatory licensing boards,
19 representatives from criminal justice, and others using
20 these tests to participate in a workshop or presentation.
21 Donna Bush and I were talking about this but we need this
22 workshop to fully help them understand this advisory and to
23 know how to properly use these tests. The advisory here is
24 an excellent first step, but I believe we must pursue this
25 additional effort to help slow this locomotive, to educate

1 people who use these tests so that individuals will no
2 longer be harmed by this valuable test that should be meant
3 to help and not to harm.

4 I might also point out that even low positives,
5 when used by a clinician that understands this, can be
6 useful. For example, last week I had an EtG test reported
7 on one of our doctors of 115 nanograms, a low positive.
8 When I called him to do my MRO function, I fully expected
9 him to say, because the media now has promoted this idea,
10 it was Purell or something like that. In fact, when I
11 said, Doc, you have a positive test for drinking, he said,
12 I've been drinking beer. I need help. So it can be a very
13 valuable test to detect early relapse, but we've got to
14 address this issue of clinical use to support people and
15 inappropriate legal use to slam people and take things away
16 from them.

17 Thanks.

18 DR. CLARK: It also could be a useful test to
19 advise people about incidental use. Many people aren't
20 aware of the alcohol in their environment. If you've got a
21 problem with alcohol, the question is how much alcohol do
22 you need to prime the pump, if you will. So if I'm
23 unwittingly consuming alcohol, I may be predisposing myself
24 to relapse. But that's the clinical context. If you use
25 it in the forensic context, then it's a different matter

1 altogether.

2 DR. SKIPPER: Can I mention one other thing
3 about that? I'm currently doing a study with Purell, which
4 you mentioned, and I'm having people use it every 2 minutes
5 for an hour. That's heavy use. I'm having them use it
6 close to their face, as some people often do with hand
7 gels, and we're doing it in a small room. The breathalyzer
8 we've had go up to .2, very high. .2, yes. We think a lot
9 of that is because the ethanol is actually in the airway,
10 in the vapor and it's not really a blood level, as a matter
11 of fact, because drawing a blood alcohol at that time shows
12 like .01 or .02. So the breathalyzer is not effectively
13 measuring blood alcohol when you are exposed to vapor.

14 The other issue I'll bring up is that there is
15 a product being marketed now called AWOL, Alcohol Without
16 Liquid, where you basically nebulize vodka. It's in bars
17 in Europe. I think it's being marketed in the United
18 States as well. If you look on the Web, look at Google,
19 AWOL alcohol and you'll see this product. But we should
20 worry about alcohol vapor I think and what it's doing to
21 people's brains.

22 Right now it's being promoted to be used
23 frequently in hospitals. Some nurses say they use it 40
24 times a day, even pregnant nurses. We don't know what that
25 could mean. So that needs to be looked at too.

1 DR. CLARK: Council?

2 DR. SKIPPER: Dr. Clark, would it be possible
3 to have public comment now?

4 DR. CLARK: We'll move to the public comment
5 right now. The following members of the public would like
6 to address the council at this time: Lorie Garlick and
7 Nancy Clark. Dr. Garlick and Ms. Clark, you may come to
8 the standing microphone and address the council. If there
9 are other members of the audience who wish to address the
10 council, please form a line behind Ms. Clark.

11 DR. GARLICK: I'd like to first thank the
12 council for allowing me to speak today. My name is Lorie
13 Garlick. I'm a pharmacist from California, and I'd like to
14 read a prepared statement about some of the problems with
15 EtG and how it's affected me personally.

16 My journey in recovery began in 2003 with a
17 jump start from my licensing board. I was monitored
18 through random testing, and in May of 2005, I tested
19 positive for EtG. As a result, my license was immediately
20 suspended and has remained that way for the past 16 months.

21 The second-chance opportunity that had been so graciously
22 given to me was taken away through no fault of my own.

23 I can't begin to describe to you how this has
24 devastated my life. I am said to represent a risk to the
25 public in my role as a professional pharmacist should I

1 return to work. I have a license revocation hearing
2 scheduled for next month which threatens to end my 20-year
3 career.

4 Not only had I not consumed any alcoholic
5 beverage to precipitate this test, but I couldn't come up
6 with a single credible thing that should have caused me a
7 problem. I was aware that EtG was sensitive, and I was,
8 therefore, extremely careful with what I ate.

9 My search for answers led me to the Internet
10 where I discovered Dr. Skipper's website and discussion
11 group, and I found that there were others across the
12 country who were experiencing exactly what I was. While it
13 was comforting to know that I was not alone, it was also
14 very disturbing to hear that in light of what was happening
15 to people's jobs and licenses as a result of erroneous
16 diagnoses of relapse, nothing was being done to help them.

17 At Dr. Skipper's suggestion, I did self-testing
18 for EtG at home on some things that were being tossed
19 around that were thought to be problematic. I elicited
20 positive tests from foods that contained vanilla extract,
21 as well as from applying Purell. I volunteered then to
22 undergo testing in an inpatient facility where I again
23 tested positive using Purell at levels of 440 and 770, the
24 latter being over three times what my licensing board had
25 used to suspend my license.

1 When Dr. Skipper introduced EtG to this council
2 in 2004, he hoped the cutoff of 100 that the labs had
3 chosen to use would only be able to be positive if an
4 alcoholic beverage had been consumed. I believe he
5 expressed that the intent was to be positive only if more
6 than 1 ounce of alcohol had been consumed. While I believe
7 that these hopes were genuine, the post-marketing
8 experience over the past two and a half years has rendered
9 this cutoff inadequate. The labs' own toxicologists have
10 testified in hearings that levels below 1,000 are in the
11 gray area and that you cannot just look at a number in and
12 of itself and decide whether it was incidental alcohol or
13 beverage alcohol.

14 I learned through my own research and inquiries
15 that EtG testing is regulated solely by peer-reviewed
16 scientific literature. So I would refer you to that
17 literature to read the studies that support a cutoff being
18 placed at 100. However, you would find that no such
19 literature exists. In fact, there are no published studies
20 on the effect of medications, gender, endogenous alcohol
21 production, and individual variations in metabolism on EtG
22 levels. I've reviewed all of the published articles on EtG
23 and they provide a good correlation that if you drink, you
24 will test positive. What the literature is sorely lacking
25 in is research that would give you one reassurance that if

1 you don't drink, you will test below the cutoff of 100.

2 Some say that the problem does not lie with the
3 cutoff but in how the results are interpreted. Plain and
4 simple, EtG is being utilized as a diagnostic test and not
5 as a screening test, eliminating any opportunity to assess
6 any clinical correlation of relapse.

7 My own licensing board has adopted a
8 disciplinary guideline that "any confirmed positive test
9 for alcohol or for any drug shall result in the automatic
10 suspension of practice," mandating action based solely upon
11 a number.

12 It should also be noted that EtG use, as these
13 gentlemen have recognized, is growing by leaps and bounds
14 in criminal justice programs where severe consequences of a
15 positive screen are the mainstay.

16 In light of what we have learned about EtG over
17 the past two and a half years, the labs continue to
18 staunchly defend their test, stonewalling inquiries for
19 information, and quietly pretending that there is not a
20 problem. The test continues to be used. The cutoffs
21 remain the same. There's been no research over the past
22 two years. People continue to be told that "false
23 positives just don't happen with EtG," and people's lives
24 continue to be torn apart. I would ask you if a new drug
25 were causing this kind of chaos and damage in people's

1 lives, would we sit idly by and watch it happen without any
2 intervention.

3 While I applaud your issuance of this new
4 advisory, I ask you to continue to facilitate the flow of
5 information with regards to the limitation of this test to
6 all licensing boards, third party administrators, MROs, and
7 criminal justice programs. Clinical correlation must be
8 required and not suggested. It must be specifically
9 defined and concretely identified. Denial, prior relapses,
10 and a past history of substance abuse do not qualify as
11 valid clinical correlators, but these are the only things
12 that I'm hearing used as such.

13 I urge you to issue letters to all laboratories
14 currently doing the testing, warning them against the
15 unethical marketing practices which they currently employ,
16 and reminding them of their duty to educate and inform
17 their clients of what they know, both good and bad.

18 Since the science behind EtG is so lacking, I
19 would urge you to encourage NIAAA to include this in their
20 research portfolio. It is peculiar to me that a test,
21 whose use is practically exclusive to the United States,
22 was developed and researched almost wholly in Europe.

23 I've heard the problem with incidental alcohol
24 compared to that of poppy seeds and opiate testing before.
25 There's one big difference. I believe that the avoidance

1 of poppy seeds is fairly simple, while that of ethyl
2 alcohol is not. The National Institutes of Health has a
3 comprehensive listing of household products containing
4 ethanol that is 13 pages long and contains literally
5 thousands of items, and that doesn't include any of the
6 food sources. I hope that the 1998 change in the opiate
7 cutoff in response to the poppy seed issue taught us that
8 post-marketing recognition of a problem with drug testing
9 necessitates swift action in the area of research and
10 remedy and that government intervention is both possible
11 and necessary.

12 Thank you.

13 MS. CLARK: Hi, everybody. My name is Nancy
14 Clark. I would like to acknowledge Dr. Clark and all the
15 distinguished members of this committee. I would like to
16 say since September is Recovery Month, I would like to
17 applaud all the good things that SAMHSA has done to promote
18 recovery.

19 I know when I started a 12-step program, a lot
20 of people that would come into the program would say they
21 don't understand the difference between religion and
22 spirituality. It was said one time -- and I really like
23 this definition -- religion is for those people who don't
24 want to go to hell, and spirituality of recovery is for
25 those people who lived in hell and don't want to go back.

1 You know, for me that's very true.

2 Recovery has been the best thing that has
3 happened to me in my life. It was a little over five years
4 ago, and my life has changed incredibly. That's a hell
5 that I don't want to go back to, is addiction.

6 The reason I'm here today is also to make a
7 statement on EtG. I feel that I'm here not only to speak
8 for myself, but to be a voice for a lot of the people that
9 have been falsely accused by a positive EtG and did not
10 drink. One of the most devastating things to the human
11 spirit I have found is not being listened to, not having
12 your truth heard, and not being acknowledged. That is
13 something that we have lived with the EtG thing for almost
14 two years.

15 When I signed a contract, I admitted my
16 addiction, and I signed a contract that I would abstain
17 from alcohol and drug use. In that contract was that any
18 positive urine would be an irrefutable violation of
19 contract. When I signed that contract, I believed that I
20 would be treated ethically and I would be tested ethically.

21 I believe that if I didn't use or if I didn't drink, I
22 would do fine in the program. And that didn't happen. I
23 ended up with a positive EtG. To this day, I still do not
24 know what caused my positive. I actually had two
25 positives. I had my license suspended twice with positive

1 EtGs. And I wasn't listened to. There was no clinical
2 correlation done. By contract, a positive is an
3 irrefutable violation of contract.

4 Honesty and accountability is the foundation of
5 recovery. I would like to ask if the labs who promote this
6 test shouldn't be held to the same level of honesty and
7 accountability that the recovering addict is. Laboratories
8 say that boards and monitoring agencies are responsible for
9 interpretation of the test. Yet, I have in my hand the lab
10 report that I lost my license on the first time, and it was
11 a positive of 370. On the bottom of the lab slip, it says,
12 any value greater than 250 indicates ethanol consumption.
13 I ask with that statement, where does that leave room for a
14 board to interpret these results if their main focus is to
15 protect the public?

16 I think compelling evidence of the way labs
17 have been marketing this test and the lack of knowledge by
18 the boards are showing that the boards and the monitoring
19 agencies are almost as much victims of EtG as we are
20 because they just don't know and they're being told the
21 wrong things.

22 A lab expert at a recent hearing had stated
23 that "there are no published studies to show a level as
24 high as 780 can come from incidental use." A truthful
25 statement should have been there are no studies on

1 incidental use, individual variations, age, gender, or
2 variations of pathway metabolism. A lack of studies
3 doesn't mean that it's proof that there aren't any.

4 We know that there are studies on Purell, as
5 Dr. Skipper has said, but they're not yet published. That
6 study was brought up at the ASAM convention in May and this
7 lab expert testified after that conference. So the
8 knowledge was there. You know, it just wasn't published.

9 Dr. Skipper, as you said, had put out the
10 advisory in 2005, and I really applaud him for that. He's
11 been really great in trying to help get this out and word
12 on EtG what's happening. As he said, there wasn't very
13 many changes from that. The ASAM conference that brought
14 up the issues with Purell and a lot of the questions that
15 are happening around EtG -- things aren't changing. The
16 lab websites, as Dr. Clark had pointed out, still say that
17 it's proof of alcohol consumption.

18 I did look up the word "consumption" and I
19 should have brought it along because Webster's says it's
20 not like consumption is equal to exposure. Consumption
21 means that you partook in something and it says actually in
22 an excessive amount.

23 Without the changes in marketing, there have
24 things that haven't changed besides the marketing, and
25 that's the amount of people that are being prosecuted and

1 hit over false EtGs. Since the recent Wall Street Journal
2 article, things I don't think are changing other than
3 people are finding the website and finding help. Since the
4 Wall Street Journal article, two people from Pennsylvania
5 have tracked me down and asked for help in fighting this
6 and support because they had nowhere to go. They thought
7 they were alone in this. Thank goodness that that came out
8 and increased public awareness.

9 ISBRA had the 206th World Congress on Alcohol
10 Research. The conclusions of that read: "The findings
11 suggest that direct ethanol metabolites have potential in
12 detection of previous ethanol intake in a variety of
13 situations and settings. Their combined use and conjoint
14 use with traditional markers and self-reports might be
15 promising." Yet, U.S. labs continue to market this test as
16 the stand-alone gold standard.

17 I question how many more victims have to be
18 crushed by this test. My first positive test, I had three
19 years in recovery. When I started recovery, I embraced
20 recovery because I knew that was the only way I was going
21 to live. To get through this, I used every tool I had in
22 recovery, a really strong spiritual connection, and the
23 support of my home group in a 12-step recovery program, and
24 recovering friends. Unfortunately, a lot of people that
25 are caught in this early in recovery don't have that. It

1 could jeopardize their recovery.

2 The foundation of our legal system is innocent
3 until proven guilty. We are innocent and we have been
4 labeled guilty and we have suffered devastating
5 consequences. I personally have lost my license, lost my
6 job, lost my reputation because it was publicly printed in
7 a newsletter from the state board that I also am unable to
8 practice because of unreasonable safety and skill due to
9 the positive EtG test.

10 I'm here today to also express my concerns over
11 a lot of the things that Dr. Clark brought up. When I
12 heard Dr. Clark talk, I thought that you looked at my
13 statement and did everything from here because you did put
14 in a lot of things in my statement that I wanted to have
15 looked at.

16 When you had said about being non-punitive, I
17 was told that if I would admit to alcohol use, I wouldn't
18 lose my license, but I could continue in the monitoring
19 program. I didn't drink and I wasn't going to admit to
20 drinking. Therefore, my license was suspended.

21 Clinical correlation, as Lorie brought up.
22 There has to be a definition of clinical correlation. The
23 clinical correlation that was used against me in my second
24 hearing was I knew about incidental alcohol, so therefore,
25 I should have known the thousands and thousands of things

1 that contained alcohol and should have been able to avoid
2 them.

3 I really liked Dr. Skipper's suggestion as far
4 as promoting education on this test. I think that's where
5 we're having a lot of the problems. The boards and
6 monitoring agencies look towards the labs for information
7 on this test, and the labs are marketing it as the gold
8 standard, proof of alcohol consumption. There has to be
9 education on these biomarkers.

10 Also, Dr. Clark has up there as far as it needs
11 to have a defined cutoff. I ask in the interim, until we
12 do research and have the defined cutoff, what happens. The
13 labs are running the cutoffs at 100, 250. Some have put it
14 up to 500. Yet, Purell makes a 770 and higher. So what
15 happens in that interim until we have adequate cutoffs set?

16 Like I said in the beginning, I believe that
17 recovery should be the focus of any addiction program.
18 Recovery has changed my life. Unfortunately, a lot of the
19 monitoring programs are not looking at recovery. They're
20 looking at the negative test. Just like somebody brought
21 up, if you have a positive test, that's it. You're guilty.

22 A positive test equals guilty. We have to go back to
23 recovery is the issue here. We need to look at somebody's
24 recovery basis.

25 Actually I believe that's all I have. Thank

1 you.

2 MS. SCHROEDER: My name is Tina Schroeder, and
3 I'm an R.N. from Wichita, Kansas.

4 Actually I was just about ready to give up my
5 license due to the fact my first test was a 963 nanogram.
6 That one was the state. Our Kansas Nurse Assistance
7 Program gives out a letter saying avoid Benadryl and over-
8 the-counter cold products. I avoided everything they did.

9 I didn't change any other routines, continued to rinse out
10 with Listerine, got a 963. After evaluating, when I go in
11 to take my urine test, I'm not worried at all. I haven't
12 drank anything. I get this value back. You drank two to
13 three drinks. You tested at a 963. I did not.

14 I was dumbfounded. I couldn't figure out why I
15 tested so high. So immediately I'm searching on the
16 website. Everybody says what did I do. We start reading
17 every label in the house, going crazy. What did I do? I
18 found it was -- I go to bed at night. Oh, my God, it's my
19 Listerine. I quit that immediately. I've had several
20 negatives for a while.

21 My next positive was 147. They gave me a
22 warning on that one and said one more positive, I go get
23 diversion, state board.

24 My next positive was a 310. This is over two
25 years. That's 20 tests, three positives. I'm now in a

1 diversion. One more strike and I'm out. I'm not a nurse
2 anymore.

3 I was ready to say, heck with it, go back to
4 school, become an accountant, something else. I've got a
5 good head on my shoulders. Not very good at public
6 speaking, obviously. But a quadriplegic patient of mine
7 begged me, don't do it, said I'm an awesome nurse and I
8 should not give it up. So I'm fighting. What do I got to
9 lose? One more bad test and I'm out anyway. I'm going out
10 with a bang.

11 DR. CLARK: Council?

12 DR. SKIPPER: Can I make a recommendation on
13 the advisory, just one suggested addition, if it is still a
14 draft.

15 DR. CLARK: Sure.

16 DR. SKIPPER: On page 3, bottom right corner,
17 where it says, "until considerable more research has
18 occurred, use of these markers should be considered
19 experimental," I'd like to add after that a comma "and
20 legal or disciplinary action based solely on a positive
21 test should not occur. These tests should currently be
22 considered valuable clinical tools, or potential clinical
23 tools, but their use in legal settings is premature."

24 DR. CLARK: Dr. Fletcher?

25 DR. FLETCHER: I'm not knowledgeable in this

1 area, but I'd like to ask are there data available on the
2 test. If so, are there gender variations?

3 DR. SKIPPER: We do not know if there are
4 gender variations at this point. What's been looked at on
5 this test is we've looked at alcohol use shows up positive,
6 and in the small groups that have been looked at that
7 haven't drank, they're negative. What's not been looked at
8 adequately is larger groups, different genders,
9 medications, diseases, and what all these kinds of
10 incidental exposure actually do. We're looking at Purell,
11 but we need a much bigger study before we can know where
12 cutoffs should be for different kinds of systems. I should
13 emphasize that because low cutoffs are fine if you take a
14 clinical approach and you're not punitive, but in a
15 punitive system, as with poppy seeds, we're going to need a
16 much higher cutoff I believe so we don't harm people as
17 we've done.

18 DR. CLARK: Melody?

19 MS. HEAPS: This is draft even though it looks
20 final?

21 DR. SKIPPER: It's a pretty draft.

22 MS. HEAPS: Yes, it's a pretty draft.

23 Actually without looking at page 3, if you look
24 at page 1, the second column, last sentence, currently in
25 determining abstinence, "There is no biomarker test that

1 sufficiently proves specificity for use as a primary."

2 So it would seem to me that the purpose of this
3 as an advisory ought to have, starting out, what the
4 advisory is highlighted. That paragraph that I just
5 referred to -- or that sentence, as well adding then what
6 Dr. Skipper was talking about I think ought to be up front.
7 It ought to be emboldened. This is the advisory.

8 Part of the problem I had in reading this is if
9 I were a judge, if I'm a person who wants to reach for an
10 easy, quick fix, I don't know that I'd get through this
11 paper. I need something up front that says the biomarkers
12 are this. There are tests. You may be using it in
13 professional, regulatory, and/or justice-related things.
14 This advisory is for the purpose to let you know that, and
15 then go on to all of the detail. I really think we need to
16 get that up front.

17 DR. CLARK: Val?

18 MS. JACKSON: Yes, I really agree with what
19 Melody is saying. I also would like to recommend Dr.
20 Skipper's recommendation to SAMHSA that perhaps -- I don't
21 know if it's a workshop. I don't know exactly what method
22 it is, but some way of actually taking a stance on this as
23 you have described the lack of answers and to try to get
24 this out. Hearing these stories and understanding the
25 issue a little bit seems like a serious issue that may be

1 impacting a lot of people's lives.

2 DR. CLARK: Well, we will take into
3 consideration Dr. Skipper's suggestions and those of Melody
4 and yourself before we do the final publication copy. This
5 is a prepublication copy which we wanted to get before this
6 council. We would not want to make substantial changes in
7 the document since it's been approved.

8 Frank?

9 DR. McCORRY: I'd also like to suggest that I'm
10 not quite sure who the audience is on this because it seems
11 like this audience is very, very large because people are
12 being affected, whether it's through criminal justice,
13 through licensing boards, through courts, through public
14 welfare, that there has to be a very, very strong education
15 campaign here because it's undercutting the people in
16 recovery based on a test that doesn't have merit for that
17 kind of action.

18 Another suggestion, I think the suggestion
19 about NIAAA moving on this. We are the services branch of
20 the federal government -- to recommend strongly to NIAAA
21 that they find a way to fund some studies that can start to
22 get at this issue of cutoff and trying to draw some
23 distinctions as well around the use of these kinds of
24 markers for legal sanctions as opposed to clinical
25 sanctions.

1 DR. CLARK: We have discussed the content of
2 this advisory with NIAAA and part of the consensus process
3 involved their opinions on the matter.

4 I think the key issue from our point of view is
5 to focus on the science, and if the science is absent, we
6 need to stress that. That's what Dr. Garlick has brought
7 to our attention. As a result of that, Greg and others
8 have done a fairly exhaustive review of the literature and
9 we keep coming up with the same conclusions that you've
10 heard, that if, indeed we're going to use these tests, that
11 they need to have a stronger basis in the science because
12 it does undercut recovery, both in terms of criminal
13 justice and in a non-criminal justice context.

14 DR. McCORRY: Statements like a score above 250
15 is proof positive of alcohol consumption, which by the
16 science is -- I'm not sure if we'd say it's false. It's
17 false. As we understand the science today, it's false.
18 Whether there's some legal opinions that can be rendered to
19 that from SAMHSA or CSAT around just the scientific basis
20 that, in fact, that is not the case, that consumption of
21 alcohol is not proved at those kinds of levels, whether
22 it's in the advisory or some other -- I agree with Melody.
23 We'll read this, but that drug court judge or that
24 licensing board wants -- like it's got to be there, and
25 also perhaps advising the labs that in fact those

1 statements are libelous. I mean, those are actionable in
2 terms of legal if they are defining something which in fact
3 isn't in evidence.

4 DR. CLARK: Ms. Bertrand?

5 MS. BERTRAND: I just want to say to the ladies
6 that spoke here today that I commend you for being the
7 voice for those people out in the community who have
8 probably experienced the same thing that you have. I'm in
9 recovery for 16 years and I can only imagine what it's like
10 to have overcome the most difficult challenge of my life to
11 go back and have my profession sort of taken from me
12 because of some measure that's not accurate.

13 Dr. Clark, you said this at a conference I was
14 at a while back about how alcohol and other drugs actually
15 hijack your brain, and to overcome that and then deal with
16 the stigma that's attached to being in recovery and then
17 the oppression from not being able to practice in something
18 that you've spent many years and you're like in that lower
19 -- you know, one of the few. So I just encourage you to
20 continue to be the voice for those that are also
21 experiencing what you are.

22 And I encourage the council for us to put
23 something together to advise the licensing boards that
24 there are no absolutes in the way that we measure the
25 things that we do. The work that we do is odd. I tell

1 people all the time it's not right or wrong. It's really
2 just our discretion.

3 DR. CLARK: Melody?

4 MS. HEAPS: I'd like to move that the council
5 initiate leadership in this working with, of course, CSAT
6 on creating an educational campaign to professional and
7 criminal justice bodies with regard to the limitations and
8 the properties of this test and its effects.

9 MS. JACKSON: Second.

10 DR. CLARK: It's been moved and seconded that
11 CSAT -- do you want to repeat?

12 MS. HEAPS: That the advisory council with the
13 Center for Substance Abuse Treatment staff help develop an
14 educational campaign for professional regulatory bodies and
15 criminal justice agents around the country regarding the
16 limitations of this test and its potential for negative and
17 adverse effects.

18 DR. CLARK: It's been moved and seconded that
19 CSAT and its council develop materials to inform and
20 educate professional bodies around the country.

21 DR. McCORRY: Melody, what are your ideas on
22 it?

23 MS. HEAPS: I want to be clear that we're
24 talking more than materials. The idea would be that we
25 would help in the development of some materials, user-

1 friendly materials, and then plot out whether we can ask
2 Dr. Clark to write letters, for instance, to the American
3 Probation and Parole, the American Correctional
4 Association, or the single state agency directors, saying
5 you have been informed. Many of you may be using. This is
6 an advisory. So there are those kinds of ideas. So it's
7 more than just the materials. It's the dissemination and
8 the method of communication.

9 MS. BERTRAND: I just wanted to say like a news
10 alert.

11 MS. JACKSON: And I was going to add the
12 physicians' assistants, the lawyers' assistants, the
13 clinical boards. I mean, those are all identifiable groups
14 that can be warned, so to speak, or advised -- let's not
15 use the word "warned." These ladies might want to use
16 "warned," and I'm not too sure if I would blame them.
17 However, I think that it definitely needs to be widespread
18 among those licensing, anyone who could be considered
19 punitive, black/white kinds of decisions.

20 DR. SKIPPER: I would like, if it's possible
21 and not too costly, to have an educational program where we
22 would invite representatives from each state to come and at
23 least educate one person from each state about this, maybe
24 spend a day with them and go over it in more detail.

25 DR. CLARK: It sounds like we've got a complex

1 motion. What I'd like to do is table the motion and bring
2 it back up later this afternoon so you'll all have an
3 opportunity to reflect on it. I'm assuming everyone is
4 going to be here. And then we can bring it to a vote.

5 MS. HEAPS: Dr. Clark, I'm not sure I agree
6 that it's complex. The actual activity may be complex, but
7 this concept of working with CSAT to develop an educational
8 campaign is -- I don't know how complex that is.

9 DR. SKIPPER: We could work out the details of
10 what the educational campaign included later.

11 DR. CLARK: All right. Well, then we'll take
12 it to a vote. All those in favor of the motion?

13 (Chorus of ayes.)

14 DR. CLARK: All those opposed?

15 (No response.)

16 DR. CLARK: The vote is unanimous. Thank you
17 very much.

18 With that, we will adjourn for lunch and we
19 will see you this afternoon. I have a competing meeting at
20 1 o'clock, but I'll be back later. George Gilbert is going
21 to chair the meeting. Thank you.

22 (Whereupon, at 11:57 a.m., the meeting was
23 recessed for lunch, to reconvene at 1:30 p.m.)

24

25

1 and policy analyst at the UCLA Integrated Substance Abuse
2 Programs and also an Assistant Professor of Economics and
3 Policy Analysis in the School of Public Policy at
4 Pepperdine University. We're delighted to have them with
5 us today to present the results of this analysis.

6 Larry and Angela, are you on the phone with us?

7 DR. CARR: Yes, we are.

8 DR. HAWKEN: Yes, we are.

9 MR. GILBERT: Great. Welcome. Thank you for
10 taking time out of your schedules to make this presentation
11 today. We're sorry our video hookup didn't quite work, but
12 we do have your PowerPoint presentation. So we're going to
13 follow along as you present the study. Anne Herron from
14 our Division of State and Community Assistance is going to
15 play the Vanna White role today and flip the slides for us.

16 So, Larry and Angela, it's all up to you.
17 Thank you.

18 DR. CARR: Good afternoon. I'm Larry Carr with
19 the California Department of Alcohol and Drug Programs. I
20 would like to thank the meeting organizers for inviting Dr.
21 Hawken and me to present today.

22 You're about to hear a brief overview of the
23 cost/benefit analysis conducted by the University of
24 California at Los Angeles about California's Proposition 36
25 initiative. We should still be on our title slide here.

1 This analysis is part of a much larger five-year statewide
2 evaluation of this initiative. The final report will be
3 published in January of 2007. Previous annual reports are
4 available on our website at www.adp.ca.gov, and we can come
5 back to the website at a later time if people didn't get a
6 chance to write it down.

7 Let me direct your attention to slide 2. I'd
8 like to acknowledge the Proposition 36 Evaluation Advisory
9 Group. This is a group of scholars and academicians who
10 have helped us over the past five years. They asked
11 critical questions of UCLA as the evaluation is being
12 conducted and the analyses were being conducted.

13 Also, I'd like to acknowledge the authors of
14 the evaluation: Dr. Angela Hawken, who we'll hear from in
15 just a moment; Darren Urada of UCLA; and Douglas Anglin of
16 UCLA; and finally, Douglas Longshore of UCLA, the principal
17 investigator. We lost Doug Longshore to cancer in December
18 of last year, and we miss him very much. He has provided
19 for us one of the most stellar works that has been seen in
20 the drug abuse area regarding Proposition 36 and alcohol
21 and drug abuse in association with the criminal justice
22 system.

23 I'd like to direct your attention to slide 3 at
24 this point. I don't know if I want to read this to you,
25 but this just provides you the background of Proposition 36

1 for those individuals that aren't familiar with it.
2 Proposition 36 was passed by the voters of California in
3 November of 2000 and enacted into law as the Substance
4 Abuse and Crime Prevention Act, lovingly called SACPA.
5 Adults convicted of nonviolent drug-related offenses and
6 otherwise eligible for SACPA may be sentenced to probation
7 within the community drug treatment system instead of
8 either probation without treatment or incarceration.
9 Offenders on probation or parole who commit nonviolent
10 drug-related offenses or who violate drug-related
11 conditions of their release may also receive treatment
12 under this initiative. An independent evaluation of
13 SACPA's implementation, fiscal impact, and effectiveness
14 was also mandated by the initiative.

15 I'd like to direct your attention at this point
16 to slide 4. This is considered such a landmark study that
17 the 2005-2006 California budget trailer bill language was
18 enacted to highlight the critical importance of this
19 analysis.

20 At this point, with those introductory remarks,
21 I'd like to turn the discussion over to Dr. Hawken who will
22 take us through the substantive areas of the analysis.

23 Dr. Hawken?

24 DR. HAWKEN: Thank you, Larry. Good afternoon,
25 everybody. Thank you for beaming us in this way. It's a

1 pleasure to be speaking with you all.

2 Before I begin, I'd just like to make one
3 comment and that is I do apparently have a slight accent.
4 So what I'm going to do is try and slow this down as much
5 as possible, but if anybody in the room is having a hard
6 time understanding, if someone can wave something to me
7 over the phone, that will help.

8 Just to give you an overview, the newsworthy
9 aspects of this, here are our key findings. I'll now start
10 speaking to you from slide number 5.

11 SACPA substantially saved costs in California.

12 DR. HERRON: Angela?

13 DR. HAWKEN: Yes?

14 DR. HERRON: Excuse me, Angela. Would it be
15 possible for you to slow down just a little bit? People
16 are having a little bit of difficulty.

17 DR. HAWKEN: Sure.

18 Our first key finding is that Proposition 36
19 saved a lot of money. We estimate that during the first
20 five years of the law, we saved the state about \$800
21 million.

22 Our second key finding is that outcomes were
23 much better for certain kinds of offenders than for others.

24 SACPA doesn't work equally well for everybody.

25 Our final key finding is that this policy can

1 be improved, and one of the purposes of the evaluation is
2 to identify ways to keep on refining this law to make it a
3 more and more efficient law.

4 Bringing your attention now to slide number 6,
5 just to give you an overview of this talk today. I want to
6 start by describing the cost/benefit analysis to you
7 describing three studies that we performed, including
8 details of our comparison group and why this research is
9 really quite different from any other treatment evaluation
10 research you've seen before. I'll walk you through our
11 study design, share with you our findings, and then finally
12 move on to our conclusions and our recommendations.

13 The first study we conducted we called SACPA,
14 an evaluation of the policy. What we did was compared
15 outcomes for anybody who was convicted of a Proposition 36-
16 eligible crime and compared their outcomes to a group of
17 comparison offenders. Where our comparison group comes
18 from is a group of individuals who were convicted of the
19 same charges but just prior to the time that Proposition 36
20 was implemented. So this really looks at the effect of
21 SACPA on the entire policy environment. We don't only
22 study people who had opted into SACPA. Everybody here is
23 included.

24 In the second study, we looked at how costs and
25 outcomes changed based on the offender's degree of

1 participation in SACPA. Here we compare outcomes for those
2 who never entered treatment, for those who entered
3 treatment but did not complete, and for those who went all
4 the way through the treatment program and successfully
5 completed treatment.

6 Our final study, study 3, we refer to as our
7 cohort comparison study. The goal of this study was to try
8 determine whether cost outcomes changed as the Proposition
9 36 policy matured. We were concerned that we might have
10 seen changes as law enforcement or the treatment community
11 reacted to the implementation of Proposition 36. We were
12 concerned that we might find that the first year following
13 implementation was quite different from follow-up periods.

14 So we did an outcome analysis of the people who were
15 convicted during Proposition 36's first year and compared
16 those outcomes to what we observed during the second year
17 after the law had been implemented.

18 Just to give you a highlight of our study
19 findings, when we evaluate SACPA as a policy, here we look
20 at outcomes for anybody who was convicted of a Proposition
21 36-eligible crime irrespective of whether or not they
22 accepted Proposition 36. The idea here is to provide an
23 evaluation of what we in the research community call an
24 intention-to-treat model. The benefit-to-cost ratio here
25 was 2.5 to 1; that is, we found that \$2.50 were saved for

1 every dollar invested in the program.

2 Our second study, which considered outcomes
3 based on the degree of participation in Proposition 36,
4 found -- and this is probably no surprise to any of you in
5 the room -- that outcomes were much better for individuals
6 who managed to go all the way through the treatment
7 program. For treatment completers, we find a benefit-to-
8 cost ratio of \$4 for every dollar invested.

9 And finally, our cohort comparison study. We
10 did find some small changes in the second year. In
11 particular, we found improvements in arrest and conviction
12 costs in the second year, but by and large, the
13 cost/benefit ratio was quite similar from year 1 to year 2.

14 I'm now going to slide number 9. One of the
15 strengths of this evaluation was our ability to identify a
16 very closely matched comparison group. The SACPA group got
17 Proposition 36 offenders that we'll be describing to you
18 today for those who, in the primary analysis in our first
19 two studies, were individuals who were sentenced during the
20 first year of Proposition 36, that is, between the 1st of
21 July 2001 and the 30th of June 2002. Our comparison group
22 were individuals who were convicted between the 1st of July
23 1997 and the 30th of June 1998. The reason we had to roll
24 back so far to pick up our comparison group is we wanted to
25 allow sufficient time to follow offenders up in our post-

1 period for 30 months. We had to roll back in time to give
2 ourselves enough room to follow up those offenders before
3 Proposition 36 kicked in.

4 Moving on to slide number 10, to give you
5 details of our design, a further strength of this analysis
6 was our ability to secure administrative data on all of our
7 offenders across many, many outcome domains. The
8 limitation of some of the other research you've seen is
9 that many treatment evaluation studies rely on self-
10 reporting from offenders. This isn't necessarily very
11 reliable and would certainly be a problem when you're
12 looking at a study that looks forward and backwards as long
13 as our does, which is a 30-month follow-up and follow-back
14 period. Our ability to rely solely on administrative data
15 really gives added credibility to the findings that we
16 present today.

17 The study perspective was an interesting one.
18 In California, we have been in an era of tight budgets.
19 The Governor and certainly our policy makers in Sacramento
20 have been very concerned about the fiscal implications to
21 the state of the implementation of Proposition 36. Our
22 study perspective that we chose was called a taxpayer
23 perspective. What this means is that only costs and
24 benefits that directly affect state or county budgets are
25 included in the analysis. So, for example, we did not put

1 a value on the benefits of changes in quality of life
2 because people have received treatment. We only make a
3 tally of any cost of benefits that has a direct budget
4 effect.

5 The unit of analysis in this study is a per-
6 offender analysis, and at the end, we aggregate up based on
7 the number of individuals who are sentenced each year under
8 SACPA. In California, we sentence each year just under
9 70,000 individuals who are convicted of a SACPA-eligible
10 crime.

11 Our follow-up period for year 1 and year 2 is a
12 30-month forward and back window. Study 3. This is our
13 cohort comparison between year 1 and year 2 uses a 12-month
14 follow-up and follow-back period. The reason we switched
15 to a 12-month window in the final study is that for year-2
16 offenders, there was not 30 months of data available for
17 that group.

18 I'm moving you now to slide number 12. This is
19 a cost analysis. Costs and benefits are made up of two
20 components. The one is a quantity. Here we used our
21 administrative data to provide us with counts of numbers of
22 days in jail, numbers of days in prisons, number of days in
23 treatment by modality, et cetera. We count how many days
24 or how many crimes, depending on the outcome variable for
25 the 30 months following and the 30 months before the

1 offender was convicted of their SACPA-eligible crime.

2 To this we attached a price. In some of the
3 outcome domains, we collected prices directly ourselves as
4 part of the evaluation, and for some of the domains, we
5 relied on some authoritative source and went to the
6 literature for those.

7 Because of the strength of the data and the
8 very large databases that we were able to secure and
9 because of our comparison group, we were able to implement
10 a study design that allows us to make very strong calls or
11 statements about the effect of Proposition 36. To do this,
12 we implemented what is referred to as a difference-in
13 differences design. What this means is that we look at the
14 outcomes for Proposition 36 offenders in a follow-up
15 period. We compare that to their follow-back period, and
16 we compare that difference for the Proposition 36 offenders
17 to the difference that we observe in the comparison group.

18 The difference between those differences is what we
19 attribute to being the causal aspect of Proposition 36 and
20 each of those outcomes (inaudible).

21 I'll move you to slide number 14. Everything
22 you're going to see here today is going to be represented
23 as a very simple bar chart. Just trust us -- go on faith
24 -- that underlying each of these bar charts is a lot of
25 highly sophisticated statistics that we will not make you

1 march through today, but for those of you who are
2 interested, the report is available online and our
3 technical appendix is forthcoming in our five-year
4 evaluation report that's due out at the end of this year.

5 Moving to slide number 15, what I would like to
6 do is briefly walk you through how you would interpret the
7 values that you're going to see here today, how you
8 interpret the difference-in-differences estimates. For
9 example, if you see on a hypothetical module an estimate of
10 minus 1,000, how you would interpret that value is at the
11 per-offender costs on that outcome are \$1,000 lower than
12 what we would have expected to see had Proposition 36 not
13 been implemented. In other words, any negative sign is a
14 cost savings to the state; any positive sign is an
15 additional cost that the state has borne as a result of
16 Proposition 36. Again, this is compared to what we would
17 have expected had the law not been implemented.

18 I bring you to slide number 16. These are the
19 domains over which we were able to cost our offenders.
20 Anything in green we were able to collect data on and were
21 able to use the data as part of the evaluation. The
22 numbers you will see reported today include prison costs,
23 jail costs, probation, parole, arrest and convictions, drug
24 treatment costs, health costs, and taxable earnings.

25 UCLA was able to obtain information on welfare.

1 Unfortunately, we were not able to include this even
2 though it's clearly a very important domain. We were not
3 able to include this in our final numbers because it was
4 impossible for us to disentangle the effect of Proposition
5 36 from the effect of California's welfare reform. What we
6 observed when we looked at that data are individuals
7 tumbling off of the caseload. Now, we were not able to
8 attribute the tumbling effect cleanly to Proposition 36.
9 We have a descriptive report where we show what happened to
10 welfare for our Proposition 36 offenders. Fewer of them
11 received welfare following their entry into Proposition 36,
12 but the benefit of that welfare reduction is not in the 2.5
13 to 1 that I mentioned earlier.

14 Finally, a domain that we had very much wanted
15 to include is mental health. Many of our offenders
16 entering Proposition 36 have mental health issues, mental
17 health problems. We were not able to include mental health
18 costs into our analysis because of the way the data had
19 been collected. Our Proposition 36 offenders had good data
20 in terms of mental health, but in our comparison group,
21 unfortunately, in 1996, 1997, they were not collecting that
22 data electronically. Given that we were studying hundreds
23 of thousands of offenders, it was simply not feasible for
24 us to capture that data to include it into the study.

25 Moving you now to the findings, would you

1 please move to slide number 18. This is what we have
2 found.

3 Study 1, just to remind you, is our evaluation
4 of SACPA as a policy. This is an intention-to-treat model
5 here. We studied anybody who was convicted of a
6 Proposition 36 crime irrespective of whether they accepted
7 participation in SACPA. This is a study of the entire
8 policy environment.

9 What we find, moving quickly to slide number
10 19, is an explanation of how the difference-in-differences
11 model works. I'm going to do this for just prison costs
12 and jail costs and then take you to an executive summary
13 slide where you can see a snapshot of our findings across
14 all of the domains.

15 If you look at the prison cost module here, the
16 first thing to notice is the values that you're seeing here
17 are averaged over all offenders. That means it's averaged
18 over individuals who did have a prison stay, as well as
19 those who did not. If someone was not sentenced to prison,
20 they would have had a zero cost assigned to them for prison
21 costs.

22 What I'd like to do to start is direct you
23 toward the left of the graphic that you're seeing where it
24 says "comp." That means comparison group. If you have the
25 benefit of color on your end -- I'm not sure what you're

1 seeing -- if you look at the most left-hand bar there -- on
2 my screen it's colored in blue -- what you'll see there is
3 a value of \$3,250. This is the pre-period average cost
4 over all offenders for prison stays. For the 30-month
5 period prior to their conviction, the average comparison
6 group offender had a \$3,250 prison cost associated.

7 The purple bar or the lavender bar -- I'm not
8 sure what you're seeing -- is the second month follow-up
9 cost for a prison stay that's averaged over all of the
10 offenders. You'll see that there's a big increase
11 following the date of conviction of this nonviolent drug
12 arrest. The average prison cost over all offenders is
13 about \$9,000. In the comparison group, what we saw is the
14 difference between the follow-up period and the follow-back
15 period was about a \$6,000 increase in prison costs over the
16 group.

17 If you now go on to the right-hand side of the
18 bracket, you'll see the SACPA. That's the Proposition 36
19 offenders. From that group we found there's a \$2,300
20 increase in prison costs per offender.

21 In the difference-in-differences model we're
22 now concerned with the differences between those two
23 values. What we find is a \$3,500 reduction in the average
24 prison costs for Proposition 36 offenders. That is, we
25 spent \$3,500 less on average than what we would have

1 expected to spend on them for prison costs had the law not
2 been implemented.

3 To walk you through some of the details here,
4 for example, for this prison costs module, we were able to
5 obtain the number of days served in prisons for each of our
6 Proposition 36 offenders, as well as for the comparison
7 group, and for those days -- the counts now, the quantity
8 of days they spent in prison, we attached a price. And the
9 price we obtained from the California Department of
10 Corrections, and in 2005 dollars, it was \$84.74 a day.

11 A very similar pattern we see for jail costs, a
12 much more significant cost in the comparison group -- this
13 is now slide number 20 -- a much larger increase for the
14 comparison group than for the SACPA group, and what we find
15 here was about \$1,500 reduction in the average jail costs
16 for our offenders.

17 Moving now to slide 21, you'll get a snapshot
18 of our findings across all the domains. The easiest way,
19 just to remind you, to interpret this graphic is the X
20 axis, the X bar, you can think of as being cost neutral.
21 Anything above the line is an additional cost to the state
22 as a result of implementing Proposition 36. Anything below
23 the line is to be interpreted as a cost saving.

24 What you see very quickly, very clearly is
25 that, by and large, the savings because of Proposition 36

1 are due to incarceration. Very significant reductions in
2 costs due to prison and jail.

3 Looking at probation, we see a slight increase
4 in the average offender cost for probation. It's
5 absolutely to be expected. SACPA is an alternative
6 sentencing policy. More individuals are on probation
7 because fewer of them were incarcerated.

8 We see a reduction in cost, the savings, for
9 parole. This too is not a surprise. There were fewer
10 individuals under Proposition 36 who made it into prisons
11 and therefore, as we follow them out, fewer of them turned
12 into parolees. There was a slight parole savings as a
13 result of Proposition 36.

14 Looking next to arrest and conviction, what we
15 find is the uncomfortable bump in the middle of the
16 graphic. This is arrest and conviction costs, and what we
17 find is compared with what we would have expected if
18 Proposition 36 had not been implemented, we've got a \$1,300
19 increase per person in arrest and conviction costs.

20 Now, clearly this was an issue of concern for
21 us, so we spent much time at UCLA trying to understand what
22 it is we were seeing here. Compared with the comparison
23 group, there were many, many more Proposition 36 offenders
24 who stayed on the streets rather than being diverted to a
25 jail or prison. Simply by virtue of being on the street

1 rather than in jail or prison, individuals have more
2 opportunity to be arrested for a new crime. They're on the
3 street. They're available to commit new crimes.

4 What we did do was make an adjustment for
5 ourselves just to make sure we really understood what was
6 going on there and converted this to a dollar per day spent
7 on the street. If you adjust for incarceration time, what
8 we do find is that there's really no difference. Indeed,
9 the Proposition 36 offenders were significantly less costly
10 in terms of their crime costs overall.

11 Still, we wanted to understand the arrests and
12 convictions better. Clearly, there's a public safety issue
13 in this regard. So we did a very careful analysis of who
14 was driving these arrest and conviction costs. I would
15 love to be before you right now with a white board and
16 scribble this down for you. But what we found is that most
17 of the offenders commit very little crime and contribute
18 very little to crime costs overall, but there's a tiny
19 group of offenders who really bump up the arrest and
20 conviction costs, a small group of them who are responsible
21 for a significant contribution to that end.

22 UCLA was quite concerned about that and did an
23 in-depth study to try to figure out whether we would be
24 able to determine the characteristics of the individuals
25 who were most likely to be in that high crime cost category

1 and compare those individuals to individuals who
2 contributed nothing or very low amounts to overall costs.

3 We initially did a study. We looked at
4 demographics, and what we found was that there was very
5 little difference based on gender. There were high crime
6 costs individuals who were slightly less likely to be
7 female. In other words, there were slightly more males.
8 They were very slightly younger. There was no difference
9 based on race/ethnicity to help us predict if someone would
10 be a high-cost offender or a low-cost offender. We did
11 find one characteristic of that group, that very high-cost
12 group, that had a striking policy implication, and it's
13 highlighted in our recommendations in our report. The best
14 predictor of whether or not someone was going to be a high-
15 cost offender was the number of prior convictions they had
16 had in the 30 months preceding their current conviction
17 after their Proposition 36 offense.

18 We then looked to see how crime costs changed
19 as the number of prior convictions increased, and we found
20 a very clear threshold effect, a huge jump in the person's
21 follow-up crime costs. We went from four prior convictions
22 -- now, this is convictions, not arrests -- to five prior
23 convictions in the 30 months preceding. We find that the
24 group of individuals -- they're a very small group -- about
25 1.6 percent of Proposition 36 offenders have five or more

1 prior convictions. And that group itself contributes
2 hugely to the overall arrests and convictions that we find
3 in the follow-up period. This proportionally contributes
4 to that cost.

5 But clearly we have a recommendation there and
6 have suggested that that group of individuals either be
7 made ineligible for Proposition 36 or that they be
8 monitored much more strictly in the community if they
9 remain under Proposition 36 (inaudible).

10 Moving now to the next bar where we see
11 treatment, this is treatment programs, the treatment
12 alternatives. We are not surprised to see an increase in
13 treatment costs per offenders, although we did indeed find
14 that.

15 The next module, health, is an interesting one.
16 As we started this analysis, we wondered what would be our
17 a priori expectations. What we mean by that is before we
18 look at our data, what would we expect to see in terms of
19 health outcome. The recent literature on this domain was
20 quite mixed. A number of studies you'll hear referred to
21 as the cost offset study mention the benefits of treatment,
22 and one of the benefits that you'll see lists expenditure
23 on health care, suggesting that we would find here an
24 additional savings to the state. Other literature had
25 movement in the opposite direction, that if someone enters

1 treatment, they're more likely to seek out health care, and
2 that literature suggested to us that we would find an
3 additional cost here.

4 We did the analysis and what we found is that
5 there was an increase in health care costs associated with
6 Proposition 36. We disaggregated this data into monthly
7 costs where people were contributing and found something
8 quite interesting. We found that at the time the
9 individual entered treatment, there was a real spike in
10 their health care costs. Clearly, individuals are showing
11 up for substance abuse treatment and their providers are
12 encouraging them to seek out the other kinds of medical
13 care that they need.

14 What we find very quickly, though, is that
15 health care costs start to settle down, and this really
16 speaks to the importance of longer-term evaluation so we
17 can get past those spike points to see how individuals'
18 health care costs then start to fall as they're receiving
19 the care that they need. They've had their health care
20 needs taken care of, and now they become much less costly
21 over time in that health domain.

22 The final module we looked at was employment
23 earnings. We only studied the taxable portion of that. To
24 be consistent with our taxpayer perspective, we looked at
25 how much money they had paid to the state. You'll notice

1 it's below the line, which suggests that the cost savings
2 to the state for the tax one. What this means is that
3 Proposition 36 offenders paid more in taxes than the
4 comparison group offenders and more people were employed
5 under Proposition 36 than were employed in the comparison
6 group. Individuals were more likely to keep a job.

7 This was not a very high-earning population.
8 The tax implications of Proposition 36 are not significant,
9 but clearly there are benefits here. The greater benefits
10 come in just having people employed. They're less likely
11 to be on welfare. It's good for a child to see their mom
12 and dad getting up in the morning and putting on a suit or
13 putting on lipstick and heading out the door. So there are
14 certainly greater social implications of the tax module
15 even though the tax savings or the tax gain were not very
16 large.

17 Just the last point on that slide 21. Across
18 all of the domains, when we tally up, we found about a
19 \$2,800 per-offender savings across all the domains. What
20 that leads us to conclude, once we do all the math, is
21 about a 2.5 to 1 benefit/cost ratio. That is, about \$2.50
22 saved for every dollar invested.

23 Briefly, to walk you through our second study,
24 the second study we looked at how outcomes changed based on
25 the individual's participation in treatment. If someone

1 was referred but never entered treatment, comparing those
2 to individuals who went in but didn't go all the way
3 through, and the individuals who make it all the way
4 through the program and successfully complete treatment.

5 In this slide number 24, you'll see a summary
6 slide of our findings based on treatment participation.
7 For the first 2 months, for prison and for jail on the
8 left-hand side of your screen, you find exactly what you
9 would expect to see. The yellow bars are the individuals
10 who completed treatment all the way through, a much larger
11 savings for those who go all the way through the treatment
12 program. For those who have some treatment but don't
13 complete, we see more significant savings on prison and
14 jail than for those who don't receive any treatment at all.

15 But it's interesting to note that across all three of
16 those groups, there were sizeable savings in terms of
17 incarceration costs. Again, this is not a surprise. This
18 is an alternative sentencing program. Individuals were
19 being offered treatment in lieu of incarceration.

20 There's not much to write home about in terms
21 of probation and parole. You'll see the savings there
22 reported.

23 The module I'd like to direct your attention
24 to, which is an interesting one, is the arrest and
25 conviction module. What you'll notice for arrest and

1 conviction is that the yellow bar here is our treatment
2 completers. They add much less to arrest and conviction
3 costs than do those individuals who don't complete
4 treatment.

5 But what's striking about this module is the
6 purple bar in the middle there. Those individuals who
7 entered treatment but did not complete are more costly in
8 terms of criminal recidivism than those who never entered
9 treatment at all. This looks like a surprising finding,
10 but clearly we went back to our offices to try to figure
11 out what was going on. There are a few underlying
12 explanations for this module.

13 The first is individuals who never entered
14 treatment at all were much more likely to land back behind
15 bars. Once they were taken off the street, they had less
16 opportunity to commit new crimes.

17 The second issue was the nature of the
18 individuals who chose never to enter treatment following
19 their referral into Proposition 36. We studied the
20 characteristics of those folks who never appeared, and they
21 broke out into two very clear, distinct groups.

22 The one was a group of individuals who had
23 squeaky clean histories, very little going on, no priors,
24 very little in the way of prior treatment history. These
25 were individuals who figured out for themselves that if

1 they never arrived at treatment, that nothing was going to
2 happen to them.

3 The other group of individuals were exactly
4 opposite. They were the really bad apples. They had long
5 criminal histories, all sorts of nonsense going on. The
6 bad apples who just decided that they weren't going to go
7 to treatment anyway. It just wasn't for them.

8 The good apples in that group really messed
9 around with our averages there because they decided not to
10 go to treatment, but they were moving forward and being
11 picked up again, and between the two effects of having a
12 group of individuals who didn't get to treatment who had
13 quite clean histories both in their priors and their
14 follow-up period and the effect of those who were the bad
15 apples very quickly being reincarcerated, we found that
16 unusual result in arrest and conviction.

17 Finally, for our treatment module, we see
18 exactly what you would expect to see. Those who go all the
19 way through treatment cost more, in terms of treatment,
20 than those who never enter or those who don't go all the
21 way through.

22 Small differences by health. Those who
23 complete treatment had slightly more expenditure on health.
24 Again, that's very likely to be the effect of actually
25 going through substance abuse treatment and having service

1 providers encouraging them to get their other health needs
2 taken care of.

3 And then finally, we see more significant tax
4 returns from those who go all the way through treatment.

5 So, by and large, no real surprises in this,
6 the treatment completers doing much better than everybody
7 else, and on slide number 25, we find the benefit-to-cost
8 ratio for those who finished the program of about \$4 to \$1.

9 That is, \$4 were saved for every dollar that was invested
10 in the individual who made it all the way through
11 treatment.

12 Study 3. This is our cohort comparison study
13 comparing how outcomes changed during Proposition 36's
14 first year with outcomes during the second year. This
15 study used a 12-month follow-up and follow-back period I
16 mentioned earlier. We didn't have data for a 30-month
17 follow-up study for our year-2 offenders.

18 What we see is that looking at slide number 27,
19 outcomes are really quite stable, some improvement in terms
20 of arrest and conviction costs, but our benefit-to-cost
21 ratio is really quite stable from year 1 to year 2. That
22 was about \$2.20 saved for every dollar invested looking
23 over a 12-month window.

24 Moving into slide number 30, I'm going to talk
25 about conclusions and recommendations that followed from

1 our cost analysis and recommendations included in the final
2 UCLA evaluation. I'm breaking these up into three
3 sections. One is those that followed specifically from the
4 cost analysis, and I'd like to separate those out from the
5 other UCLA evaluation recommendations that we've been
6 making.

7 Our first recommendation is that with
8 Proposition 36, funding has yielded a favorable cost ratio
9 and that, at least on fiscal grounds, continued funding of
10 SACPA is justified.

11 Our other recommendations are to improve
12 treatment entry and treatment retention in the program.
13 One of our concerns at the moment with Proposition 36 is
14 how many individuals are gone and never set a foot into a
15 treatment provider facility. We lose about 50 percent of
16 our offenders between the date of conviction and time of
17 treatment entry, and 30 percent of them never receive care.

18 So we have recommendations to improve treatment entry as
19 well as completion.

20 Following from the findings on arrest and
21 conviction, we found that a very small percentage of
22 offenders are responsible for a large percentage of the new
23 crimes committed. There was 1.6 percent of the offenders
24 with five or more prior convictions who were really driving
25 up our follow-up arrest and conviction costs. We have

1 recommendations that speak to managing this difficult
2 population differently. For those individuals with many
3 prior convictions, we suggested either changing eligibility
4 of SACPA to exclude them from sentencing under SACPA or to
5 have greater offender and agency accountability, possibly
6 putting them into residential care rather than outpatient
7 care to start.

8 Moving now to UCLA evaluation findings not
9 based on the cost study, one of the recommendations that
10 UCLA is making is to improve treatment matching. Following
11 the implementation of Proposition 36 -- and I'm sure you
12 can appreciate the shock that Proposition 36 resulted in in
13 the treatment community. We had 2,000 individuals
14 convicted of Proposition 36 each year, a huge, huge shock
15 to the system. The number of individuals referred to
16 treatment through criminal justice doubled the year
17 following implementation of Proposition 36.

18 As a result, we simply ran out of capacity very
19 quickly in terms of, particularly, residential care. One
20 of the recommendations we've made is increase the use of
21 residential placement for our high-addiction severity
22 offenders.

23 Proposition 36 not only led to many, many more
24 people entering treatment through the criminal justice
25 system, but also resulted in big differences in the kind of

1 individuals entering care. This is, by and large, a much
2 more seriously addicted population than what we've seen
3 before.

4 We've also made a recommendation of an expanded
5 use of a narcotics replacement therapy. In California, if
6 an individual refers to treatment with an opiate addiction
7 and enters care, 87 percent -- that's 8-7, 87 percent -- of
8 those individuals are put into a narcotics replacement
9 therapy program. Among Proposition 36 offenders, that same
10 rate is 14 percent. That's 1-4. So 14 percent of those
11 offenders are receiving maintenance care. So we've made
12 recommendations to try to understand better the barriers to
13 expanding that kind of care.

14 Finally, looking to address cultural issues to
15 make sure that our offenders are being placed in a facility
16 that is sensitive to their cultural needs and where they
17 feel comfortable and more likely to complete treatment.

18 Looking at slide number 37 now, we would like
19 to make sure that there is an improvement in assessment and
20 treatment show rates. Our recommendations here really seek
21 to reducing the hassle factor of getting people into
22 treatment, to make it as easy as possible for folks to
23 succeed.

24 Our first recommendation is to locate
25 assessment either at the court or near the court. We've

1 found that for a number of individuals, if the treatment
2 assessment center was located far from the court, they were
3 much less likely to ever put their foot through the door to
4 be assessed. So we found that in those counties that made
5 the practice of pushing assessment centers right close to
6 the court, outcomes were much better.

7 To the extent that it's possible and fiscally
8 feasible, we'd like to see the incorporation of drug court
9 approaches, wherever possible.

10 Certainly allowing walk-ins, as well as
11 scheduled assessments, making it possible for someone to be
12 assessed whenever it's convenient for them.

13 And also to require only one visit. We did
14 find that in a number of locations, individuals were
15 required to come back multiple times to complete their
16 assessments, and when that happened, we were much, much
17 more likely to lose our offenders and never see them in
18 treatment.

19 We have a number of other recommendations in
20 our report that are not based on UCLA's group that rely on
21 outside research.

22 The first, and this is something which is quite
23 controversial, is our recommendation of expanded use of
24 sanctions. Our treatment providers themselves have been
25 calling for increased use of sanctions under Proposition

1 36, looking for an incentive package that includes both
2 rewards, as well as sanctions to help them encourage
3 offenders to comply with the terms of their treatment. So
4 we've recommended a graduated sanctions package of rewards
5 and sanctions, as well as frequent drug testing to make
6 sure that the offenders view that it's being a fair
7 process.

8 To be credible, we want to make sure that this
9 is consistently applied, that it's sure and it's swift.
10 It's at a point now beginning. The call for increased
11 sanctions is not coming from the criminal justice
12 community. This call for increased use of sanctions is
13 coming from our treatment providers themselves.

14 MR. GILBERT: Dr. Hawken?

15 DR. HAWKEN: Yes.

16 MR. GILBERT: This is George Gilbert. We'd
17 really like to have a little bit of time for council member
18 questions, and we're running a little short of time. I'm
19 wondering if you might be able to wrap up in a minute or
20 two so we could have a little bit of time for dialogue.

21 DR. HAWKEN: That's perfect. I'll wrap up in a
22 second.

23 MR. GILBERT: Thank you.

24 DR. HAWKEN: Our final recommendation is what
25 the study was able to do was show us how we could improve

1 this law. So our final recommendation was to have this
2 ongoing evaluation cycle of really understanding our
3 offenders to keep making refinements to Proposition 36. So
4 we've recommended this quality improvement cycle, which is
5 currently underway.

6 Finally, just to sum up, the bullet take-away
7 here is that Proposition 36 has saved California taxpayers
8 a significant amount of money. Most of those savings were
9 due to prison and jail. It resulted in much greater cost
10 savings for those who finished the program. To the extent
11 that we were able, we want to make sure individuals have
12 every opportunity to get all the way through their
13 treatment program.

14 Finally, this law can certainly be improved,
15 and UCLA will be working away at this to figure out how to
16 make Proposition 36 work as well as it can for California.

17 Thank you for your attention. I appreciate the
18 opportunity to speak with you today.

19 MR. GILBERT: Well, Dr. Carr and Dr. Hawken,
20 thank you very much for that very comprehensive
21 presentation on Proposition 36.

22 I think we're having a little bit of difficulty
23 with the connection. Dr. Hawken, your voice was breaking
24 up a little bit there at the end, but we have a few minutes
25 questions, if there are council members that would have

1 some questions for our presenters.

2 Val Jackson?

3 MS. JACKSON: Yes. I was wondering. You speak
4 of treatment in very general terms when you talk about it.
5 Did you define treatment in this study?

6 DR. HAWKEN: Right. One of the issues with
7 Proposition 36 is we really think of it as being perfectly
8 eight different models. Each county in California has
9 autonomy to make these decisions on their own. So there
10 was no consistent definition of treatment. If the
11 individual had complied with the terms of their county's
12 program, they would have been deemed to have successfully
13 completed treatment. But each county has its own
14 determination for what this would be. We have 58
15 Proposition 36 models in the State of California.

16 MS. JACKSON: Well, you still had success.
17 That sounds good. But it would be very interesting to know
18 a breakout of criteria, for instance, using ASAM criteria
19 and/or what kind of assessment instruments were used, that
20 kind of information on the other side. That could be very
21 helpful in terms of looking at the population and its
22 outcomes also.

23 DR. HAWKEN: The next round of the evaluation,
24 which is about to begin, is going to have a significant
25 portion of that evaluation dedicated to looking at best

1 practices. In that section, we will definitely be digging
2 down into a much more detailed analysis of what was going
3 on there and what kind of approach seems to be working for
4 most offenders. So if you stay tuned, that will be
5 forthcoming a year from now.

6 MR. GILBERT: Any other questions?

7 (No response.)

8 MR. GILBERT: Well, I guess that's it then.

9 Oh, we have one question here very quickly. Ali?

10 PARTICIPANT: I was just curious to find out
11 whether the patients received any mental health treatment
12 at all or not.

13 MR. GILBERT: Did you hear the question?

14 DR. HAWKEN: Could you repeat the question?
15 I'm sorry.

16 PARTICIPANT: Did the clients receive any
17 mental health treatment?

18 DR. HAWKEN: Yes. I mentioned early on they
19 didn't receive mental health care under Proposition 36, but
20 a number of the Proposition 36 offenders had co-occurring
21 disorders. We do have mental health data, and we are
22 currently working with alcohol and drug programs to define
23 a study to really understand that better. A number of our
24 offenders did receive mental health treatment. We were not
25 able to include that in our study for the reasons I

1 explained earlier. The comparison group did not have
2 electronic data available on their mental health services.

3 We do have data for the Proposition 36 offenders, though,
4 and we have a report that will be coming out on mental
5 health for the Proposition 36 offenders.

6 MR. GILBERT: Melody Heaps, please.

7 MS. HEAPS: I just have some comments and I'd
8 be happy to call Mr. Carr or Dr. Hawken with it.

9 I also just want to comment on Doug Longshore.
10 I think this is absolutely one of the seminal studies in
11 our field, and we owe so much for him and his vision and
12 obviously to UCLA, but he was a remarkable man and I just
13 want to say thank you.

14 Two very brief comments and then I'll call
15 further. When you look at your increased conviction and
16 arrest costs, I take it one of the things that you've
17 considered is that when you engage the system in mandating
18 treatment, for those people who have failed or are not
19 completing all the way through, you have extra costs in
20 bringing them back to the system and in further
21 prosecution. Of course, that's going to raise those costs.

22 The question is are those costs now being borne
23 by the county alone and we have to take a look at that in
24 terms of how the state funds these kinds of things.

25 The second is when you talk about the

1 recommendation on residential care, having gone through
2 this extensively and intimately in Illinois, one of the
3 things we looked at is we were always screaming about
4 residential care and we continue to do so. But what we
5 also discovered is that by intensive case management and by
6 putting in place a managed care kind of system where we
7 could move people from least intensive to more intensive,
8 back down, and include recovery homes and so were living
9 environments, always within case management, we were able
10 to cut the costs of pure intensive residential treatment.
11 We were able to increase it but not absolutely rely on it
12 alone. So there's a whole continuum in the management of
13 treatment which is very important in this.

14 DR. HAWKEN: Well, thank you for those
15 comments. To respond to that, in terms of the county
16 costs, the costs of processing, UCLA has -- and it's coming
17 out in our report that we just finished and submitted to
18 the state now. We do have an analysis of divvying up the
19 costs and benefits between those that fall on the state and
20 those that fall on the counties. So much of the new arrest
21 and conviction costs have been allocated to the county and
22 the state certainly is keeping an eye on where is the
23 county saving money, where is the county bearing more cost
24 as a result of Proposition 36. The study will be kept in
25 mind as we move forward thinking about funding rates and

1 also the allocation formula.

2 One of the important issues in that, though,
3 when it comes to county savings, when you look at our data,
4 you'll see that the counties benefit from a significant
5 reduction in jail costs. The counties don't end up really
6 experiencing that as a significant reduction. Our jails in
7 California are so overcrowded, that if you take away
8 Proposition 36 offenders, someone else is still there
9 because we're so overcrowded. The counties may not
10 experience that kind of cost savings as a real bottom-line
11 change to their budgets. So we have brought these kinds of
12 issues to the attention of the state, particularly in our
13 cost-sharing report that you'll see in a couple of months.

14 On the issue of residential care, our concern
15 there was that in California we're running huge
16 (inaudible), individuals who really do need that kind of
17 care. We simply just don't have the capacity to do it. We
18 are gearing up to make that become available, but we're
19 certainly adding more on the demand side than we are on the
20 supply side. But certainly the continuum of care is
21 something we'd want to do and can do with the resources
22 that we have.

23 Thank you for your question.

24 MR. GILBERT: Well, Dr. Carr and Dr. Hawken,
25 again we thank you very much for being with us today, and

1 we enjoyed your presentation. Thank you.

2 DR. HAWKEN: Thank you so much for having us.

3 DR. CARR: You're very welcome. Thank you.

4 MR. GILBERT: Bye-bye.

5 A little bit of problem with the sound there
6 towards the end, but let's move along then.

7 The next item on our agenda is for an update on
8 e-therapy, and Val Jackson chairs the council's E-therapy
9 Subcommittee, and she will be reporting on results of
10 meetings held with CSAT staff over the summer regarding
11 e-therapy. Captain Stella Jones in the DSI in CSAT is the
12 government project officer for this initiative.

13 Val and Stella, we turn the program over to
14 you.

15 MS. JACKSON: Come on up, Stella.

16 First of all, just for purposes of memory, I
17 wanted to remind the council that when we developed the
18 subcommittee, which I believe was -- I can't remember -- it
19 was at the last council meeting. I agreed to chair. Ken
20 DeCerchio is on it. Melody is on the subcommittee. Chilo
21 Madrid, who is not here today, and also Judge Eugene White-
22 Fish from Wisconsin are the advisory members who all wanted
23 to be on the subcommittee. I think our sense was that this
24 was an important mission.

25 I know all you need is another PowerPoint here,

1 so I'll try to flip through it quickly.

2 What we did through the summer was to basically
3 try to get a handle on what it was we really wanted to
4 accomplish with the e-therapy. Everybody says, gee, it's a
5 great idea. We need to go someplace, but where do we need
6 to go? So Stella and I know Tom Edwards was part of the
7 staff and MayaTech worked very hard on this. We had a
8 conversation with a few experts. What we did was we came
9 up with some goals and objectives. I'm going to report to
10 you briefly on the activities to date and the outcomes. So
11 just to let you know this is really what we did this summer
12 in terms of progress.

13 I think it's important, though, to mention that
14 we had to go looking for experts who were in the e-therapy
15 profession and also had knowledge about either related or
16 specific areas of substance abuse because, in a sense --
17 you know, we can all go on the Internet and find all of
18 these things. I remember when Sheila Harmison showed us a
19 lot of Internet advertisements for e-therapy, but some of
20 them were probably scams, and we really had no idea. So we
21 went to look for some experts. This is the list of folks
22 who were found and participated in this summer's work.

23 Add something if you want to. If I say
24 anything wrong, add to it. Okay?

25 Some of the things that the e-therapy expert

1 panel put together were some definitions. To preface that,
2 I'll say that it was very important that we get some of the
3 basics down because we felt what we needed to do was to
4 come out with a guidance perhaps -- that came up in the
5 first meeting -- that would either go to providers or to
6 states -- I don't know that it was totally defined exactly
7 the recipient and who it would be distributed to, maybe
8 both -- that would come up with the issues, as well as a
9 definition, and some of the things that needed to be
10 addressed. So that's primarily what we're going to talk
11 about today.

12 E-therapy is the use of electronic media and
13 information technologies, for instance, the Internet, PDAs,
14 text messaging, telephone, videoconference, to provide
15 services for participants in different locations. It is
16 used by skilled and knowledgeable professionals, and we
17 need to, of course, address who are the counselors and the
18 therapists, who are the people that use it, to address a
19 variety of individual, familial, and social issues.

20 I'll try not to read all of these to you, but a
21 couple of them I think are important.

22 There's a range of services that e-therapy can
23 do. I think we've talked about them before. In my sense,
24 it can be used to engage. It can be used to treat and
25 stand alone. It can be used as a following and continuing

1 care. It can be used in relapse. So there are many, many
2 uses for this. The challenge is to pin those down and to
3 find practices and ways to make it work at a cost that we
4 all feel comfortable with.

5 The expert panel came together with this really
6 as the areas of resources that had to be looked at. We
7 have to look at the community resources. I think
8 regulations and legislation. One of the issues that has to
9 be looked at is that each state has separate regulations
10 about whether or not, for instance, they can even use
11 e-therapy as a paid service in that state. And there may
12 be many other regulations that I'm not even aware of and we
13 haven't investigated yet that each state would have to look
14 at individually as well as federal laws that may apply in
15 this area. Obviously, cultural, linguistic kinds of
16 competence. The administration. Is it state run,
17 privately run, however it is. One of the very difficult
18 things about e-therapy is that it needs rigorous
19 evaluation. That is a challenge in and of itself and it's
20 something that needs to be addressed in the guidance I
21 believe.

22 The community resources. Of course, going
23 through the state agencies, the expert panel identified
24 different resources that might be used in e-therapy.

25 I want to hit this regulation and legislation

1 just a little bit because if we get into it and if it's
2 state-regulated, it means that quite likely there would be
3 mandated reporting requirements. Obviously, we have the
4 client confidentiality requirements, requirements for
5 practitioners. I mentioned that before. Informed consent.

6 How do you handle that in an e-therapy mode when you may
7 never have seen the person? In some cases, the people that
8 were the experts had a face-to-face session before they
9 agreed to any other kind of session, but of course, that
10 would limit your location. In a rural location, that would
11 make it more challenging to try to run e-therapy. The
12 insurance liability and legal protections, in terms of
13 malpractice, are also very important issues that the panel
14 came up with.

15 Elements of cultural and linguistic competence.

16 I think that these apply to most of the interventions that
17 we do, including the ethnic and cultural, being able to
18 face and find answers to real and artificial barriers to
19 cultural competence.

20 Administration. Again, insurance, electronic
21 billing, how you do that, client record keeping. These are
22 all issues that just as a panel the folks came up with that
23 are challenges that we're going to have to somehow come up
24 with either some answers or some suggestions for if we're
25 going to go forward with e-therapy. I'm believing that we

1 do need to go forward with e-therapy, but I'm also seeing
2 that there's a lot of issues here. It's a very complex
3 proposition. However, SAMHSA can do anything.

4 (Laughter.)

5 MS. JACKSON: Evaluation was discussed, and I
6 think, again, that's one of the most difficult things in
7 terms of e-therapy. At lunch we were talking with Jack
8 Stein, talking about how do we come up with demonstrations
9 or evaluations for this kind of service, and if we do,
10 particularly in e-therapy, it may be very, very difficult
11 for us to look at exactly all of the indicators that we
12 want to look at for evaluation, elapsed time, the
13 retention, such things as that, substance use. You know,
14 you don't have someone on hand to do urine testing or other
15 kinds of testing. You may not even see the person in terms
16 of their functioning.

17 The targeted outreach. We started out this
18 particular topic very early in June when we talked about
19 it. Dr. Clark, of course, has always talked about the need
20 for rural populations. If you recall, at the last meeting,
21 there was some controversy about that. Well, controversy.

22 I'll say that because Judge White-Fish isn't here, but
23 he'd probably agree with me because I remember very
24 specifically him saying, gee, I don't know that I would
25 want e-therapy in my neck of the woods. He doesn't

1 necessarily believe that on the tribal reservations that e-
2 therapy would even be appropriate. And yet, rural is
3 probably the first thing that comes to mind.

4 If you talk to me and ask me about it, I think
5 of adolescents who are in urban Miami, because I come from
6 Miami, who do not have transportation or the ability to
7 continue their care, let alone even get primary care, and
8 probably could use e-therapy as a modality if we were to
9 develop that kind of thing.

10 The group looked at other kinds of underserved
11 and hard-to-reach populations. So, again, that's a
12 question that we have. We don't have all the answers yet.

13 To sum it up and try to keep it moving, I
14 really was pleased with the provoking thoughts and
15 challenges that the group came up with this summer. I
16 think that it tells us that we have a really complex issue
17 here. However, we are all on the Internet. At least, I
18 would suspect all of us are on the Internet. We know that
19 our adolescents are so Internet-friendly, so text message-
20 friendly, that if we do not do something about Internet
21 therapy or e-therapy, because it's a lot bigger than the
22 Internet, we're way behind the times. So I would hope that
23 maybe we can put our heads together this afternoon and move
24 forward.

25 I think that a couple of the suggestions have

1 been, number one, to ask SAMHSA to continue and to work
2 towards a guidance that spells these issues out more and
3 perhaps down the line -- I'm not too sure if we're ready
4 for it yet. I'd be happy to hear your comments on it,
5 whether or not we are ready for an evaluation or a
6 demonstration or a pilot. So what are your thoughts? I
7 think I'll open it with that.

8 Sorry. I missed a slide I guess. This is the
9 e-therapy staff: Anne Herron, Stella Jones, Reed Forman,
10 Ruby Neville. And then the MayaTech staff also worked on
11 it too. I thank you very much. They did a great job.

12 So with that, any questions?

13 DR. FLETCHER: Thank you, Val, for a very
14 instructive presentation.

15 You noted the significance of moving towards
16 some rigorous evaluation of this program, but at this
17 juncture, do we have any sense of or any preliminary data
18 on the extent to which e-therapy is being utilized and what
19 some of those experiences are preliminarily? Are we
20 finding it works better with one population group than
21 another subpopulation group? Do we have any of that kind
22 of data at this point?

23 MS. JACKSON: I'm going to defer to Stella for
24 any information that came out of the group that I was not
25 at. However, my sense of it is that, no, we don't.

1 Stella?

2 MS. JONES: There is really no research that we
3 have to say that e-therapy is effective, also in terms of
4 the different kinds. But what we hope to do in our
5 guidance is to identify some providers or practitioners who
6 have had some success with various modes of technology with
7 specific populations, but not considering it research per
8 se.

9 MR. GILBERT: Melody?

10 MS. HEAPS: My concern -- and it's not all that
11 different from our discussion on the alcohol biomarkers --
12 is that people come up with what they say are solutions or
13 new treatment techniques and they begin to sell them.
14 There is a gullible group out there -- and that's almost 90
15 percent of the population -- who buys them. Oh, this is a
16 new thing. This will work. And there is no group or
17 anybody who is saying, wait a minute, there's no research.
18 Wait a minute. We need to look at this.

19 It would seem to me that CSAT has a
20 responsibility at least to issue advisories on these kinds
21 of things. Is NIDA presently engaging in any research on
22 this question? What are the states and state directors
23 doing about this question? I'd like to know that baseline.
24 And then think about what CSAT can do when this and other
25 silver bullets or promising potions come down the line.

1 What is CSAT's responsibility in alerting people that just
2 because somebody says it works doesn't mean it works when
3 there are proven methods and best practices out there?

4 I feel like sometimes our population, the men
5 and women that I serve in terms of my clients, can be
6 experimented on. It doesn't matter. You name it. If it
7 works and you say it works, what the heck. Let's use them.
8 It makes me very uncomfortable.

9 MS. JACKSON: I appreciate what you're saying.
10 I do think that we have to consider that, yes, e-therapy
11 is here. It is being practiced. I guess I would suggest
12 that CSAT needs to be aware, at least as you had mentioned,
13 of what is going on and perhaps we can put some parameters
14 on what might be a practice that could work. Perhaps they
15 can go from service to science in this one.

16 The concern I have at this point is that while
17 there is a little research that shows e-therapy is
18 promising and it has worked, it's just not enough to really
19 make any grand statements about it. You're absolutely
20 right. It compares somewhat with the previous conversation
21 we had.

22 MR. GILBERT: Dave?

23 MR. DONALDSON: Thanks, Val. I tell you I'm a
24 big proponent of this. I think that for many people this
25 will be the front end of the continuum of care. In the

1 faith community, you look at even the context of a church
2 where people value their anonymity, and many pastors have a
3 difficult time getting to those people that need help
4 because of the stigma in the church. I think you would
5 find a highly receptive audience to this in the faith
6 community as well.

7 But good work. Please keep going with this.
8 You're on the right track.

9 MR. GILBERT: Melody?

10 MS. HEAPS: Yes. I don't want to appear that I
11 don't agree necessarily that this may be a very promising
12 method. I just think we need to exercise some discipline
13 as to what, how, when, and where its promise can be
14 fulfilled as opposed to just generically so then we have
15 everybody coming out saying, I do e-therapy, and it may not
16 be the best kind.

17 MS. JACKSON: So perhaps all I need, as
18 chairing a subcommittee here -- George, I'll take your
19 guidance -- is that we had started out and the group seemed
20 to talk about a guidance which would address some of these
21 issues and give us some more details about that. It would
22 go further into some of the research and we could further
23 refine that. I think that there is a commitment to go
24 forward that way. So if that works, I'm happy to continue
25 working with that, but I didn't want to do that without the

1 council feeling that that's an appropriate way to go.

2 MR. GILBERT: Greg, did you have a comment to
3 that?

4 DR. SKIPPER: I've recently seen a
5 demonstration of a technology that I think I should mention
6 because it's a little more comprehensive than just
7 e-treatment, and that's technology where drug testing is
8 reported through an online mechanism, notification for when
9 to test. People log in and get notification. Interested
10 players, employers, people that are monitoring an
11 individual can have their own log-in and see how the person
12 is doing. Therapists can log in attendance. It's not so
13 much just the treatment in an online setting, but it's a
14 management system that I was very impressed with. So I
15 think we've got to expand our idea too beyond just
16 treatment online or aftercare online to a comprehensive
17 sort of package where drug tests reporting, in and out
18 reporting, and management, attendance. All that could be
19 very effective, and I'm very much in favor of using the
20 Internet to coordinate all that. So good work.

21 MS. JACKSON: Thank you. I like that.

22 MR. GILBERT: Anita?

23 MS. BERTRAND: Yes. Just a suggestion. I was
24 thinking about like some of the groups that are having
25 online support, such as Weight Watchers has online

1 meetings, 12-step programs have. They're calling it
2 support. So I guess my suggestion is that when the
3 committee meets again, maybe study what have they done to
4 overcome some of the barriers that I guess the council was
5 thinking about.

6 I think that when we look at technology and
7 where it is today, it's something that we really need to
8 continue to think about because if we don't plan ahead, we
9 will have people moving forward doing things that they're
10 labeling as therapy because I've heard of inappropriate
11 therapies online. So if we're going to have that, we need
12 to have something to counter it too.

13 So just when the group meets again, maybe look
14 at what Weight Watchers is doing. I mean, they have online
15 programs, online 12-step support groups going for people
16 that travel and who can't get out and all that other stuff.

17 MS. JONES: In the expert panel work group,
18 there were many discussions with regard to e-therapy using
19 other means or other clinical interventions other than just
20 saying treatment. Also, there was a discussion around
21 patients or clients with addictions having other addictions
22 as a result of using the Internet system because there are
23 other ways they could go in and get information. Sex might
24 be one of those, just as an example. So there was a lot of
25 discussion more broadly around some of the areas you've

1 mentioned, and we will continue to do that work and
2 continue to do literature reviews to finalize our
3 discussion and report on our guidance.

4 MS. JACKSON: Greg, is it possible for us to
5 get the name of the person that gave you the demonstration?

6 That's very interesting.

7 DR. SKIPPER: I'll get that to you.

8 MS. JACKSON: Yes, we'll discuss that.

9 MR. GILBERT: Bettye?

10 DR. FLETCHER: Thinking about the students that
11 I interact with, it surely would be instructive for me to
12 have also a better understanding of the knowledge transfer
13 mechanisms that are out there as it pertains to this issue,
14 as well as how is professional development taking place, in
15 what form, what does it look like, and how does one access
16 that? If this is a modality that surely has potential and
17 value, then those two questions become very important to
18 me.

19 MS. JACKSON: Well, thank you very much. I
20 think that this is good discussion information, Stella, we
21 can carry forward.

22 MS. JONES: Yes.

23 MS. JACKSON: All right. Thank you so much.

24 MR. GILBERT: Thank you, Val. Thank you,
25 Stella, and thanks to the staff on CSAT who have been

1 working on this as well, and also to all the committee
2 members who have been working on it.

3 I think we've reached the point in our schedule
4 where we're supposed to take a short break. We are
5 scheduled to start public comment at 3 o'clock. Do we have
6 public comment? Okay, yes. We do have at least one member
7 of the public who wants to offer a comment. I'd like to
8 suggest that we come back in 10 minutes please. Thank you.

9 (Recess.)

10 DR. CLARK: If we can return, we have a lot of
11 things to do before the session ends today.

12 We are at the public comment section of our
13 agenda, and it's my understanding that Ms. Thelma King
14 Thiel from the Hepatitis Foundation would like to make
15 comments. Now, if there are other members of the public
16 who wish to address the council, if so, please come to the
17 standing mike and form a line behind Ms. King Thiel.

18 MS. THIEL: Thank you, Dr. Clark. I really
19 appreciate that.

20 As you know, I'm probably better known as the
21 "liver lady." I'm going to go to my grave saying they
22 didn't know enough about their liver. But again, we have
23 found that you can't change what you don't know, and
24 there's such a lack of information that's not being taught
25 in the schools, in colleges. Parents don't know how to

1 communicate with their children about it, and we really
2 have found that our unique approach of using humor and
3 analogies and information that people can relate to is
4 helping them to assess their own risk behaviors and
5 actually to change some of their behaviors.

6 Of course, we are looking forward to
7 collaborating more with CSAT. We have trained over 2,500
8 of CSAP's grantees and have more on our docket. I just did
9 a program recently for an AIDS group down in Dallas, Texas
10 for case managers, and they asked us to come back again.
11 We're on their docket for next year and for the next few
12 months. But they ordered 125 of our videos.

13 We have 14 videos that are all on liver
14 wellness, hepatitis B and C, and substance abuse
15 prevention. We've won awards with them, and we're really
16 very excited about the success that we're having with them.
17 They're being used in STD clinics. They're very
18 inexpensive. For a \$35 video in an STD clinic, you can
19 reach hundreds of people that are participating in high-
20 risk behaviors to at least inform them so that they can
21 assess their own risk behaviors and possibly change some of
22 those.

23 We had an opportunity to collaborate with Dr.
24 Jody Rich up at the University of Rhode Island, and one of
25 his colleagues, Dr. Nick Zaller, who is running a methadone

1 clinic with a CSAT grant. He invited us up to do a
2 training session for 40 of their methadone counselors. I
3 would just like to read for you his comments following that
4 training. Of course, we've done on our own evaluations,
5 and I would be happy to send you a copy of that, if you
6 would like. But I just thought I would like to share his
7 comments with you.

8 "The methadone clinic staff has taken the
9 knowledge and strategies presented in the Foundation for
10 Decision-Making Program run by the Hepatitis Foundation,
11 and is using them in their client counseling and group
12 sessions. Given that this clinic has nearly 700 methadone
13 patients, the potential to reach many people who are at
14 high risk for viral hepatitis and liver disease is great.
15 I highly recommend Mrs. Thiel's presentation to all CSAT,
16 HIV, TCE, and CSAP grantees and that Mrs. Thiel be included
17 in all future meetings among CSAT and CSAP grantees as a
18 presenter, as a wonderful resource."

19 Of course, I'm wearing my crown now, and I
20 think that's wonderful. It's so nice to get that kind of
21 feedback.

22 But, again, we are excited about the fact that
23 we are filling a gap. There's a definite gap in what we're
24 trying to do to attack substance abuse prevention and
25 treatment. We find, too, we're getting feedback from some

1 folks that when people are on the treatment for hepatitis,
2 which is difficult to take, they are complying more with
3 the medication once they find out how important it is to
4 themselves and to their liver.

5 So we really are looking for ways that we can
6 collaborate. We met recently with Dr. Clark and showed him
7 some of our videos. We have a new one for adolescents that
8 really rocks. It's exciting. It's upbeat and positive,
9 and we've already received several hundred orders for
10 copies of it. But we are looking for more collaboration
11 with you folks and we just are excited about the success
12 that we're having.

13 Thank you.

14 DR. CLARK: Thank you, Ms. King Thiel.

15 Any other public representative, member who
16 would like to comment? All right. Going once, going
17 twice.

18 (No response.)

19 DR. CLARK: We're moving on to the next item on
20 the agenda. Next we will have a presentation about
21 substance abuse treatment services for individuals with
22 disabilities. Ruby Neville, our public health advisor at
23 SAMHSA and CSAT in the Division of State and Community
24 Assistance, will discuss CSAT's position on this important
25 issue.

1 Ruby?

2 MS. NEVILLE: Good afternoon, everyone.

3 First of all, I guess the first thing that may
4 come to your mind, as it has for others, is why the focus
5 on the disabled. Why do we need to do that? Well, first
6 of all, it comes from the administration.

7 In 2001, the President had the President's New
8 Freedom Initiative. The purpose of that initiative was to
9 promote access to community life, and they were to use the
10 efforts to implement the Supreme Court's Olmstead decision
11 to actually do that. Are all you familiar with Olmstead?
12 Anyone who isn't? Okay.

13 So basically that initiative was not only
14 implemented to help states implement the Supreme Court's
15 Olmstead decision as far as helping individuals with
16 disabilities gain full access, but it also had a component
17 as far as integrating Americans with disabilities into the
18 workplace.

19 In June 2001, there was another executive order
20 that expanded the New Freedom Initiative. This one
21 directed federal agencies to work together to tear down
22 barriers to community living. This actually called for a
23 government-wide framework to help the elderly people with
24 disabilities and again to help the elderly people, as well
25 as those with disabilities, to fully participate in

1 community life.

2 In 2005 -- and you're all familiar with the
3 Deficit Reduction Act. There's a component in that for
4 Welfare to Work. Basically the states now are being
5 encouraged to get individuals who have disabilities fully
6 engaged in the workplace. This DRA is informing that what
7 they need to do is to ensure that they provide support
8 services for these individuals. For those individuals who
9 have substance abuse needs, they're asking them to increase
10 screenings and assessments and to actually tailor substance
11 abuse treatment for the Welfare to Work population.

12 So right now, I'm just going to give you a
13 little idea of what it's like for individuals who are
14 seeking substance abuse treatment services who happen to be
15 disabled.

16 Look at this one here. We have an individual
17 with a seizure disorder and a history of traumatic brain
18 injury. This particular individual is denied inpatient
19 treatment while taking a prescribed anticonvulsant,
20 phenobarbital. These are real-life cases.

21 We have another here of a young man with work
22 and alcohol-related blindness. Now, this person was denied
23 treatment because of his visual impairment. He was told to
24 actually wait one year, then come back when your vision
25 improves. A little hilarious, but real-life cases.

1 I just want to say also there are folks out
2 there who are doing a great job, but we still need to
3 improve or enhance services to this population.

4 Here's another one. A man with a mild mental
5 retardation and late-stage alcoholism was denied treatment
6 because of medical problems requiring regular visits by a
7 nurse or visits to a clinic.

8 This last one. An individual with lower
9 extremity paralysis was denied inpatient treatment because
10 he would need assistance transferring to bed at night and
11 would require minimal assistance from a personal assistant.

12 And he was denied also because he wasn't able to do the
13 required housework, which was also a component of the
14 program. For individuals receiving treatment, they had to
15 do housework, and he couldn't do that. So those were the
16 reasons why he was denied services.

17 So now, this brings us to the ADA. What is the
18 Americans with Disability Act, and why is that so important
19 to individuals with coexisting disabilities?

20 Well, I think, first of all, we need to look at
21 exactly what it is. Back in 1990, the Americans with
22 Disabilities Act provided comprehensive civil rights
23 protections to individuals with disabilities in the areas
24 of employment, state and local government services, public
25 accommodations, transportation and telecommunications.

1 So now who is protected under ADA? A person
2 who has a physical or mental impairment that would
3 substantially limit their major life activities. The
4 person would have to have a record of such impairment or is
5 regarded as having such an impairment.

6 So, again, the relationship of ADA and
7 substance abuse addictions, drug and alcohol addictions
8 alone would not count for a disability. I think you all
9 may be aware of that. Back in 1996, the law was changed
10 stating that -- at one time prior to 1996, individuals who
11 had a substance abuse addiction, that was considered a
12 disability. But after that, it was no longer back in 1996
13 with new legislation. So are disability benefits denied to
14 an individual with a disability and an addiction? Those
15 are questions people ask. No. It would only be if the
16 drug or alcohol addiction is a contributing factor material
17 to a finding of disability.

18 So the fundamental question one would have to
19 ask when they're trying to determine who's considered
20 disabled or not, as far as the populations we should want
21 to serve, is would the disability have remained in the
22 absence of drugs or alcohol. And that's the fundamental
23 question.

24 So this brings us to barriers. This is one of
25 the reasons why we're here today because there are barriers

1 out there as far as individuals with coexisting
2 disabilities or those with a substance abuse and another
3 form of disability as far as them accessing services.
4 Providers like information in really determining what the
5 level of service is for their particular disorder.
6 Cognitive and physical disabilities are at high risk for
7 substance abuse disorders. However, they are less likely
8 to receive effective treatment for substance abuse problems
9 than those without the coexisting disability disorder.

10 Now, for the TBI, or the traumatic brain
11 injured, they're challenged to didactic training and group
12 interventions, and we know that that takes place in
13 substance abuse treatment systems. Also, in the TBI
14 population, there's a lack of abstract reasoning abilities
15 and reduced ability to solve problems that may be
16 undetected by providers. Providers have to know how to
17 serve their population. So these are the types of
18 situations and the characteristics of these different
19 populations and for this one in TBI. So you can understand
20 why they will need to understand that population in
21 developing a treatment plan.

22 Another barrier for the blind and the visually
23 impaired. There's actually a potential to receive a
24 misdiagnosis. In other words, what we have found or the
25 literature is saying that oftentimes they are prescribed

1 mood-altering drugs as opposed to recognizing that they
2 have a substance abuse treatment issue. There is, again, a
3 lack of treatment professionals with the expertise, of
4 course. Again, referrals are not made oftentimes for the
5 blind and visually impaired.

6 What happens normally is rehabilitation
7 professionals tend to focus on the disability and they miss
8 the signs of substance abuse, which is sort of natural, if
9 you think about it. If you're not used to dealing with a
10 certain population and they come in with a serious
11 disability, it's a natural thing to focus on that
12 disability as opposed to what they really need. That's the
13 reason why, again, we need to talk about it and need to
14 develop some plans and training and all of that to assist
15 these ones in conducting accurate assessments, as well as
16 treatment plans.

17 Now, the deaf and hard of hearing. Here the
18 providers lack formalized assessment tools that are
19 designed for that population. They are unfamiliar with the
20 deaf community and the specific treatment needs. They're
21 not fluent in American sign language. There are problems
22 with interpreter availability, and then the interpreters
23 who are available sometimes lack appropriate
24 qualifications.

25 And then there are just general difficulties

1 with a third party as part of the assessment process. You
2 can imagine that. The person would have to know a little
3 bit about substance abuse treatment in order to have this
4 effective communication going to and from between the
5 person who needs the assistance and the provider. So
6 that's needed as far as accurate interpretation.

7 Now, Debra Guthmann was an expert in the field
8 of substance abuse treatment for the deaf and hard of
9 hearing, and she still is. She was the former Director of
10 the Minnesota Chemical Dependency Program for the Deaf and
11 Hard of Hearing. This is what she found. Debra said the
12 deaf individuals lack a familiarity with assessor
13 terminologies that exist. She said but the deaf hesitate
14 to seek clarification. So, again, another barrier is
15 imposed when they come for treatment. So there's something
16 that's needed on the client's end as well.

17 And then self-report and computerized tools.
18 Some people feel, well, why don't we just stick to that,
19 that that probably works. But the problem there is that
20 oftentimes these tools are based only in the English
21 language. What about for other populations who do not use
22 English as a first language? There's another barrier.

23 I'm going to talk now a little bit about what
24 we have done in CSAT, as far as working with the
25 individuals with coexisting disabilities or substance abuse

1 and a disability. We had the Minnesota Chemical Dependency
2 Program for the Deaf and the Hard of Hearing. They were a
3 grantee of CSAT. This program provided inpatient and
4 outpatient substance use disorder treatment. We look at
5 our N-SSATS, and we know this is for all public and private
6 substance abuse treatment facilities, behavior health
7 treatments throughout the country. This is what we found,
8 that 29 percent of them provide hearing impaired services
9 with sign language capabilities, and 39 percent had on-call
10 interpreters. So there are some programs who are targeting
11 these populations, but again, there's always room for
12 improvement.

13 Then CSAT awarded a three-year grant to the
14 Ohio State University. Of course, the purpose was to study
15 methods for improving the ability to actually engage the
16 TBI, or the traumatic brain injured, in treatment for
17 coexisting substance use problems.

18 Then CSAT also supported the Wright State
19 University School of Medicine's SARDI program. That's the
20 Substance Abuse Resources and Disability Issues program.
21 SARDI is committed to improving the lives of people with
22 disabilities and those affected by substance abuse.

23 They have a few programs under SARDI. One is
24 the CAM. As you see, here is a community-based outpatient
25 alcohol, drug, and mental health treatment program. And

1 then we have PALS. PALS is an award-winning model for
2 substance abuse prevention training activities for youth.

3 Then SARDI also provides technical assistance
4 on the state and local level regarding program evaluation
5 as it relates to substance use disorders.

6 CSAT also supported the Brothers to
7 Brothers/Sisters to Sisters program, and this particular
8 program addressed the risk of minority populations in the
9 U.S. as they relate to contracting HIV/AIDS.

10 CSAT also funded an exemplary treatment model
11 program called the Chestnut Health Systems. This is
12 Bloomington, Illinois. This program provides substance
13 abuse treatment services that would extend, because it's
14 not only these populations, to the attention deficit,
15 hyperactivity disorder and the ADHD combined adolescents.

16 Then we have the Anixter Center, which is a
17 component of Chestnut Health Systems. The Anixter Center
18 actually receives funding indirectly through the SAPT block
19 grant program, through the SSA in Illinois. Again, they
20 provide in- and outpatient substance abuse services for the
21 deaf.

22 We look at our SSTAP, or our technical
23 assistance. CSAT has provided technical assistance to the
24 states who are in need of that as far as targeting the
25 coexisting disability population. In North Dakota, there

1 was TA that actually improved vocational rehab services,
2 and then in Massachusetts in 2005, there was TA to help
3 Massachusetts develop a three-year strategic plan and
4 mentoring program that focused on providing services for
5 the deaf population.

6 Now, this brings us back again to why we need
7 to focus on this population of individuals with coexisting
8 or individuals with substance abuse and a disability. In
9 addition to what we mentioned earlier, as far as the
10 executive orders, the Surgeon General actually put out last
11 year this call to action to improve the health and wellness
12 of persons with disabilities.

13 There were four goals that came out of that
14 Surgeon General's call to action. Number one was to
15 increase understanding nationwide that people with
16 disabilities can, of course, lead lives like most of us,
17 long, healthy, and productive lives; and two, to increase
18 knowledge among health care professionals and provide them
19 with the tools to screen, diagnose, and treat the whole
20 person with a disability and do that with dignity. And
21 then the third goal was to increase awareness among people
22 with disabilities of the steps that they have to take to
23 develop and maintain a healthy lifestyle. The fourth goal
24 in this report was to increase accessible health care and
25 support services, and this was to promote independence for

1 people with disabilities.

2 So the question now is what's next to increase
3 access to substance abuse treatment for these individuals
4 with disabilities. There's a group of us who work here in
5 CSAT on what we call our disability group. We felt that
6 it's important to encourage inclusion of all of these
7 populations, the TBI, the traumatic brain injured, the
8 blind, the physically impaired, and include them in
9 treatment programs. That's number one. And then provide
10 support to programs like the Brothers to Brothers/Sisters
11 to Sisters to participate in cross-agency activities for
12 the disabled. That's very important. That way we're
13 looking at their needs holistically as opposed to just the
14 behavioral health care needs. And encourage grantees to
15 target services to coexisting populations. Also, to
16 encourage linkages among substance abuse treatment
17 providers and other providers who are serving this
18 population. We feel it's important for us here to initiate
19 inclusion of the coexisting populations within some of the
20 CSAT activities we're focusing on, some of the most
21 significant ones, like the criminal and juvenile justice,
22 workforce development, cultural competence, children and
23 families, suicide prevention.

24 Of course, we want to continue to support the
25 Olmstead Supreme Court decision, which is very significant.

1 It's something we're encouraged to do on the
2 administration level. Encourage and expect CSAT funded
3 providers to include in their strategic plans efforts to
4 extend treatment to these individuals, and then to provide
5 training by way of ATTC and TA and to also explore
6 development of additional publications. We have had TIPS
7 and TAPs, particularly TIP 29 that dealt with substance
8 abuse with this particular population and we need to
9 explore that a little further and other resources that
10 would assist providers.

11 That's pretty much my presentation. I hope you
12 were able to get a sense of the needs for this population.

13 DR. CLARK: Thank you, Ruby. Lovely
14 presentation. Very comprehensive.

15 DR. McCORRY: I was going to ask a question of
16 Ruby. In New York, as part of our adoption of evidence-
17 based practices, we put in place a traumatic brain injury
18 screen for a while, and a few providers, who volunteered to
19 do it from Mount Sinai Medical Center, developed it as part
20 of their TBI center and a number of individuals screened
21 positively. There was a high incidence of traumatic brain
22 injury in our population.

23 The problem came up was that they screened
24 positive, and in many places there were no psychologists
25 who were available to do the neuropsych assessment. Then

1 the CEOs of these provider agencies started saying, well,
2 here I got my treatment plan. I have a positive screen for
3 TBI. I can't find, particularly outside of New York City,
4 someone to do the assessment. So now I've created this
5 kind of vulnerability because now it's in the treatment
6 plan and they have no way to address it.

7 That's one issue. I wanted to see what CSAT
8 might thinking about how we get assessments done.

9 Secondly, it seems that a lot of providers just
10 don't have any knowledge really of how to modify their
11 treatment services to incorporate people with these kinds
12 of cognitive deficits, to really speak to that abstract
13 reasoning and not really seeing how they engage folks just
14 is not going to be as really helpful. They're not going to
15 be able to participate in treatment as fully as they should
16 because they just haven't been able to modify the treatment
17 plan to reach those with some cognitive impairments.

18 I was wondering if you would just comment on
19 both issues. One is around getting the assessment done.
20 The other is just really a lack of skill, I think, in our
21 system around working with people with cognitive deficits.

22 MS. NEVILLE: Well, one of the things I could
23 say, when I was conducting my little literature review, I
24 found that there are some states who have some promising
25 practices in their area. I think basically it calls for

1 collaboration, as well as getting ideas from other states
2 as far as how are they doing this, because there are folks
3 who are doing it. We have provided, as I mentioned
4 earlier, TA to other states just around some of the
5 questions you're talking about now. So I think it's
6 important for us to look at what others are doing and I
7 know that was mentioned earlier, e-therapy, but we need to
8 look at what other states and other programs are doing and
9 then try to work together as far as getting other folks to
10 replicate what's working out there. I think that's very
11 important.

12 Then, of course, TA. Again, that was included
13 in my presentation. Technical assistance is valuable to
14 helping providers.

15 As far as modifying treatment plans, again, I
16 go back to looking at what other folks are doing. That's
17 how we work in the behavioral health care system. We find
18 out what's working and then it gets to be replicated. So I
19 think it's important that we replicate what's already
20 working.

21 Again, the TA, the ATTCs, as I mentioned to Dr.
22 Carr, those are very good avenues as far as teaching
23 providers and states on what is needed to develop
24 appropriate assessments and appropriate treatment plans
25 because that's what this whole presentation was about, how

1 do we do it. So with the TA, the ATTCs. There was the
2 SARDI program I mentioned earlier. They also provide
3 technical assistance to states around that particular
4 population. So we have to call on the folks who are doing
5 it and replicate what they're doing.

6 DR. CLARK: All right. Thank you, Ruby. Any
7 other questions?

8 (No response.)

9 DR. CLARK: All right. We will move to our
10 next presenter. The council requested an ATR and SBIRT
11 update to be included on the agenda for this meeting. We
12 do have significant developments to report today. Jack
13 Stein, the Director of the DSI, will discuss these
14 developments.

15 Jack?

16 DR. STEIN: Well, good afternoon, everyone.
17 Thank you for inviting me, and Dr. Clark, thank you for
18 entrusting me to speak before the council after being here
19 for less than four weeks. I think that's a vote of
20 confidence, I hope. I promise not to say anything that I
21 shouldn't say. Thank you very much.

22 I think I've actually had a chance to meet most
23 of the present council members, and I had the fortunate
24 opportunity to fill in for Dr. Clark just yesterday at the
25 Latino Behavioral Health Institute Conference that was

1 being held in Los Angeles and got a chance to spend a
2 little time with Chilo Madrid, who is one of the council
3 members. So we got a chance to speak a bit more about the
4 direction of the council. So that was a nice opportunity.

5 Well, again, thank you for having me. It
6 really is a delight to be here finally at CSAT. I think
7 one of the things I've learned very quickly is to be a good
8 manager, the key is to surround yourself by really good
9 people. In the audience are some of the key staff that are
10 involved in both SBIRT and ATR. So, in fact, when some of
11 those hard questions come up, we'll be able to turn to them
12 as well. So I thank you for that.

13 That's also one of the things that I quickly
14 noticed once I came to CSAT just a couple of weeks ago, the
15 strength of the staff here, and it's been a delight to work
16 with them and to have them orient me.

17 I understand the council was interested in
18 hearing a bit about what's gone on with SBIRT and ATR, and
19 we've put together a very brief presentation to just kind
20 of highlight some of the activities in that respect and
21 then, hopefully, we can respond to some questions.

22 So let's tackle the SBIRT program first, which
23 is Screening, Brief Intervention, Referral, and Treatment
24 Initiative, which is a very exciting one. It was launched
25 several years ago in FY '03 and I'll explain and show you

1 who, in fact, we initiated some grants to.

2 But just as a quick overview, for those of you
3 who are less familiar with the breakdown of SBIRT, what's
4 unique about it is it really demonstrates, we view, a
5 paradigm shift in the provision of treatment for substance
6 use and abuse, particularly because as initially presented,
7 the new target audience was targeting those individuals
8 with nondependent substance use as an opportunity to really
9 triage them, identify them early in the stages of drug
10 abuse problems, and triage them to the appropriate
11 services. So it really was the implementation of a system
12 within communities and/or specialty settings, such as the
13 primary care arena, emergency departments, et cetera, to
14 screen for and identify individuals with or at risk for
15 substance use-related problems.

16 At the core of SBIRT is really some very, very
17 specific components: a screening process that can occur in
18 a variety of different types of settings, and based on what
19 we learn from that screening, using some very, very
20 specific type of screening instruments -- and there are
21 quite a number of them out there -- to engage the
22 individual in either a brief intervention, a brief
23 treatment, or in fact, if we do see dependency operating, a
24 referral to a more comprehensive type of treatment. So
25 this really is the concept that's been operating here, and

1 through our assessment to date, we're seeing some very,
2 very promising results.

3 In terms of who received the initial several
4 awards, it went to several state agencies and one tribal
5 organization. You see them listed before you. I had a
6 chance to chat a bit with Melody over lunch in terms of
7 what's happening in Illinois. I believe it's with the Cook
8 County Hospital. Is that right? Each of these grant
9 recipients have very, very unique models, and that's what's
10 exciting about the SBIRT program. Even though we had a
11 very specific intent in mind, each of these states and the
12 tribal organizations were empowered to actually create a
13 model that in fact, hopefully, can be useful and effective.

14 In FY '05, we launched a very exciting
15 component to SBIRT, which was targeting colleges and
16 universities. You see before you all of the ones that in
17 fact were recipients of that award process. What's
18 exciting about this is recognizing that we're seeing
19 certainly a growing problem, if not an existing problem,
20 amongst young people who are in the college/university
21 sector and often one that's not targeted. So really
22 targeting screening and brief intervention in that arena is
23 a newer area for us to all target, and again, I think it's
24 a very, very promising opportunity.

25 This is just a map that gives you a sense of

1 geographically where we have placed those. Those with the
2 red dots are the original SBIRT grantees, the states and
3 the tribal organizations. The green boxes are the
4 screening and brief intervention grantees, which are the
5 colleges and the universities. Or did I get that
6 backwards, Tom?

7 MS. HEAPS: You've got it backwards.

8 DR. STEIN: I got it backwards, okay. Sorry.

9 MS. HEAPS: You're missing Cook County.

10 DR. STEIN: They're backwards, but yes, you're
11 a green box, Melody. Sorry.

12 But you can see that geographically spread out.

13 We are very pleased to announce at the Latino Behavioral
14 Health Institute that many of them are serving
15 Latino/Hispanic communities.

16 Data is being collected on an ongoing basis. I
17 was quite impressed when I came to CSAT a couple of weeks
18 ago to understand our data collection system, what we call
19 SAIS, S-A-I-S, which perhaps some of you have heard about.

20 It's a very efficient system that really collects GPRA
21 data in a very nice manner. Just, to date, what we're
22 seeing is that the total number of SBIRT screenings that
23 have been conducted cumulatively is over 165,000 and
24 already we've exceeded the target for this year. So the
25 management of these grants and the operation of these

1 grants is really right on target. I think Tom Stegbauer
2 could really help us if we have some questions in terms of
3 some more of the outcome data that's coming out of these
4 grants.

5 Just in terms of some newer activities that are
6 happening, one, we've recently launched a new cohort of
7 states. We're developing a tool kit with the American
8 College of Surgeons and also a website. Let me just share
9 briefly with you some of those findings.

10 One is that new grants to the states, which
11 were just recently awarded, one to Colorado, Wisconsin,
12 Florida, and Massachusetts. So we're anxious to see those
13 get up and running.

14 With the American College of Surgeons, we have
15 been working on a tool kit, and this has been done in
16 collaboration with the National Highway and Traffic Safety
17 Administration, as well as the Centers for Disease Control
18 and Prevention, CDC, a nice collaboration targeting again
19 the medical arena.

20 One of the neat things that I've seen that Tom
21 Stegbauer has shared with me is a quick guide for trauma
22 surgeons and coordinators. This is a draft version of it.

23 It's not been distributed yet, but it's in the process of
24 being developed. The goal here is really to be targeting
25 physicians who are working in trauma centers to really

1 allow them the tools to actually conduct screening and
2 brief interventions.

3 Training modules are under development, as well
4 as a web-based screening and brief intervention tool kit
5 for primary care practitioners.

6 So this is, I think, a really great initiative
7 that's really reaching out way beyond the specialty sector
8 of the substance abuse treatment arena and allowing us to
9 again see new pathways to enter treatment.

10 Let me move on to Access to Recovery, and then
11 I think if we have some time, we can open it up to any
12 questions that may arise or issues.

13 ATR, of course, is probably well-known to
14 everyone here on the council, a presidential initiative
15 that was established in 2004. To my understanding, it's a
16 \$300 million initiative for a three-year period of time,
17 which will be ending in August of '07.

18 As you know, it's a discretionary, voucher-
19 based grant program and with three major goals.

20 One is to expand capacity of treatment.

21 The second is to support the client's choice in
22 where, in fact, treatment is actually delivered.

23 And the third is to increase the array of
24 faith-based and community-based providers for clinical
25 treatment and recovery support services. Those are very

1 two distinct type of service delivery mechanisms: actual
2 clinical treatment that's being provided by licensed
3 clinicians or recovery support services. Sometimes it
4 could be done by the same entity. But recovery support
5 services would be other type of services, vocational
6 assistance, et cetera, that in fact really expands what I
7 think all of us in this room strongly believe is the
8 appropriate approach to recovery model, a very
9 comprehensive approach.

10 The goal of ATR is a relatively simple one.
11 Achieving it is no easy task, of course. But 125,000
12 clients over a three-year period of time was the overall
13 goal for ATR.

14 The grantees consist of the following. I
15 believe there are 14 states and one tribal organization,
16 the California Rural Indian Health Board, and these are the
17 14 states that have been up and operating over the last
18 several years.

19 This table quickly summarizes how well I
20 believe the staff here at CSAT, the technical assistance
21 that's being provided, and the hard work of these grantees
22 has been to actually achieve some really remarkable results
23 in terms of at least the process that's gone on over the
24 last number of years. Clients served as of June 30th are
25 over 92,000 individuals. The target that we agreed to set

1 was only 62,500 individuals. So already we've really met
2 the expectations. And if you look at the three-year target
3 of 125,000 that has been set, I think we're well on our way
4 to really achieving the ultimate process goal of reaching
5 individuals who perhaps would not have been reached through
6 other types of mechanisms. So I think that's kind of some
7 very exciting findings in that respect, and again, a lot of
8 acknowledgement needs to go to the CSAT staff for managing
9 what I think has been a very, very challenging process to
10 get up and operating in such a very quick period of time.

11 The data that are being collected from our SAIS
12 system are rather impressive as well. Let me just share a
13 little to date and keep in mind that data are very
14 preliminary. We can't do any comparisons with other type
15 of treatment programs that are out there. So we really
16 want to be very careful in how we interpret all of our
17 data. But look at what we're seeing to date.

18 Over 63 percent of the clients have received
19 recovery support services, so a very large percentage of
20 individuals are actually receiving services beyond the
21 actual clinical arena.

22 In terms of where the dollars are being spent,
23 48 percent of them, nearly 50 percent of the dollars paid,
24 were for these recovery support services.

25 About 25 percent of the dollars paid were to

1 faith-based organizations, again a big goal of what ATR is
2 all about.

3 And faith-based organizations accounted for 23
4 percent of the recovery support services and 35 percent of
5 the clinical treatment providers. So I think it's a very
6 nice breakdown of that.

7 But in terms of what we're actually seeing in
8 outcomes which, of course, is what's most important, and
9 again preliminary data, and this data reflects really
10 changes reported only among individuals who came in with an
11 existing problem at intake. What we're seeing to date is a
12 64 percent increase in abstinence rates, an almost 28
13 percent increase in stability of housing, a 30 percent
14 increase in employment, an almost 67 percent increase in
15 social connectedness, and an over 80 percent reduction in
16 criminal justice system involvement. Very impressive.
17 Again, very early, difficult to make comparisons, but it's
18 quite impressive. Again, I need to really recognize how
19 the staff have worked to compile such information in such a
20 short period of time.

21 I think I'm going to stop at that point. This
22 was a very quick overview. I thank the staff for compiling
23 it so quickly for us.

24 Dr. Clark, if we wanted to entertain any
25 discussions, I think myself or some of the staff here could

1 help.

2 DR. CLARK: Council members?

3 (No response.)

4 DR. CLARK: Will the SBIRT staff stand up? Tom
5 is back there and Eric. Those are SBIRT staff.

6 Will the ATR staff stand up, those who are back
7 there? Natalie Lu, and contracts. All right. Very good.

8 I agree with Jack that our staff has been doing
9 yeoman's duty in both areas, both SBIRT and ATR.

10 In regard to SBIRT, one of the original
11 conceptual thoughts was that it was to reach nondependent
12 users, but as I pointed out with the big red slice, the
13 fact of the matter is dependent users don't show up for
14 substance abuse treatment. So they've got to show up
15 someplace. They're more likely to show up in emergency
16 rooms and community health centers and alternative settings
17 than they are to show up at a substance abuse treatment
18 program. So I think we are picking up dependent users in
19 alternative settings since the data point out that we've
20 got 20 million people who meet criteria for abuse and
21 dependence requiring treatment and we're only treating a
22 minority, 3 million of those.

23 So where are those other people? We know when
24 you are having physical and psychological problems, they're
25 going to be manifested and you're going to seek help

1 someplace else, even if it's a headache in the emergency
2 room at the primary care setting, as a substitute for
3 dealing with the real issue, as it were.

4 So that's the exciting part about it is it's
5 much broader than its original conceptualization, and it's
6 been welcomed by the community, which is also an appealing
7 aspect. It's not as if people feel that this is being
8 thrust down their throats. So both SBIRT and ATR are doing
9 a good job, and ATR, of course, is reaching a broader
10 population and involving alternative practitioners.

11 We had Donald Kirk at one of the council
12 meetings present his model, his conceptualization for ATR,
13 which is a very good conceptualization in terms of
14 normalizing the experience of a person in treatment, not
15 simply relying on acute intervention, but by using
16 community support, stretching out the period and decreasing
17 the need for acute intervention because the person stays in
18 the continuum of care longer, you just don't need the more
19 expensive, higher professional treatment. What you do is
20 you normalize that person's experience. That is, again,
21 what we're also trying to do is to delay relapse, if not
22 eliminate it.

23 So these two programs are quite appealing and
24 very successful. As Jack pointed out, while the ATR
25 program is not a research program, but when we look at SAIS

1 data, the results are satisfactory. If we can be modest in
2 talking about ATR, the results are satisfactory, and it
3 isn't just to say which treatment is the best treatment.
4 It is to say, given the goals and objectives of ATR, and
5 when it's meeting those goals and objectives, those goals
6 and objectives from a policy point of view are important in
7 and of themselves. Therefore, ATR is a justifiable
8 strategy.

9 So then we will move to the council roundtable.
10 Before we get into other topics, Melody, do you want to
11 give us a fentanyl update?

12 MS. HEAPS: With the knowledge that you know
13 what's going on in the nation and I know what's going on in
14 Illinois.

15 DR. CLARK: Illinois was the bellwether. It's
16 the only state that signaled to the rest of us that there
17 was a problem.

18 MS. HEAPS: Really?

19 DR. CLARK: Yes, because Illinois, it turns
20 out, collected the basic data and other states did not
21 collect that data until Illinois pointed it out.

22 MS. HEAPS: I didn't realize that.

23 In the late fall and early winter, the press,
24 the state, and providers were noticing an increase of
25 overdose deaths, as well as admissions to our hospitals,

1 with the new compound substance of heroin and fentanyl.

2 Fentanyl, as most of you know, is a major,
3 major pain killer that is used in surgery. It is X times
4 more powerful than morphine, et cetera. It reacts with
5 heroin and has almost an immediate suppression of the
6 cardiopulmonary effects.

7 So on the street, it was being known as a
8 fabulous high. It was the bomb of all bombs. People were
9 flocking to certain distributors, at least in Chicago,
10 because that's where it was centered, who were supposedly
11 supplying this fabulous high.

12 The progress of both deaths and hospital
13 emergency room admissions increased so that within a period
14 of five to six months, we had over 100 deaths due to
15 heroin/fentanyl. The press started to pick it up and it
16 crescendoed. You know me. There's nothing like media
17 pointing out a drug problem to get people talking. It
18 crescendoed with a terrible tragedy of a police officer in
19 one of our wealthy suburbs. His son, two days after
20 graduation, died in a car having just shot up with heroin
21 and fentanyl. That then blew it out of the box for the
22 press.

23 Luckily our state administrator, Theodora
24 Binion-Taylor -- and I'd like to ask that the council
25 invite her next time to talk about her response and

1 continued response -- realized the importance of this and
2 called both the state public health officials and the
3 county public health officials with some of the leaders in
4 our treatment agencies together to talk about what we might
5 do. There were some mobile methadone units, some AIDS
6 community outreach people, and other treatment outreach
7 people that went to the streets to try and get the word out
8 that this was a dangerous drug and that addicts should be
9 absolutely careful about what they were doing.

10 The problem occurred from the street standpoint
11 and from the consumer standpoint that while the press was
12 talking about this, then the police and the DEA began to
13 talk about it. There came to be a natural paranoia with
14 the population that said, oh, this was all just made up,
15 that this wasn't true. This was just a way to get us as
16 addicts, that the police really are lying about it.

17 So we saw, for a brief few weeks, even more of
18 an increase. Some of the hospital emergency rooms that had
19 seen on any given day three to five admissions for
20 overdoses were up to 15 to 20. It was amazing. It
21 continues today, although we've seen some indicators that
22 it's subsided.

23 We went on two tracks. The state was doing its
24 public health piece. Then I contacted Congressman Danny
25 Davis, who has been very active in the area of demand

1 reduction both nationally and in Illinois, and we convened
2 a press conference of public officials, treatment agencies
3 to talk, to warn the community about it, to appeal to
4 public funders to increase treatment.

5 It's my understanding the Illinois delegation
6 sent a letter to SAMHSA asking for more money for
7 treatment, partly because our methadone treatment programs
8 have 8- to 12-week waiting lists. So while we're saying to
9 everyone, come to safe harbor, come to treatment, we're
10 also saying, oh, by the way, you can't get into treatment.

11 There was a real mixed message and concern for what we
12 were doing.

13 The newspapers have diminished their attention,
14 as they will on any idea. There has been a slight
15 decrease, to my knowledge.

16 In addition, while this was going on, the DEA
17 was calling people from around the country for a DEA
18 conference in Chicago, local police and DEA agents. One of
19 our TASC vice presidents attended it to look at where the
20 source of the heroin and fentanyl was. There was a major
21 lab in Mexico that actually had been taken down, but it was
22 appearing in other areas. It was coming out of Mexico in
23 many ways but also in other parts of the country. So the
24 DEA has been very active in this.

25 I had requested of the DEA and it didn't --

1 partly because I didn't follow through enough, maybe, but I
2 intend to do it -- that the DEA sit down with a treatment
3 provider to talk about this and to give some indication
4 about what we can expect. Is this going to increase? Is
5 this going to decrease? Where is this?

6 And I would like to recommend that, in general
7 -- not just about heroin and fentanyl -- we ask
8 periodically that the DEA come here to talk to us about the
9 latest trends on what drugs are coming in, what drugs are
10 on the street, what they're anticipating, and also how some
11 of the routes of transportation go. It's a fascinating
12 discussion and I think it's a real alert to those of us in
13 the community who need to prepare for this. So I really
14 would like to suggest that at least once a year the DEA be
15 brought in not to describe what they're doing that's so
16 good, which may be fine, but to describe what the problems
17 are, where they're seeing it, and what's coming down the
18 pike.

19 And I'd like to have a briefing on the
20 heroin/fentanyl because it was not only Illinois. It was
21 Philadelphia, Detroit, New York, and on and on.

22 DR. CLARK: We have Bob Lubran and Ken Hoffman
23 who can help you flesh out the specific jurisdictional
24 spread, and they've been actively involved. When you
25 finish, I'll ask them.

1 MS. HEAPS: I've finished.

2 DR. CLARK: So, Bob, Ken, do you two want to
3 say anything about this matter?

4 DR. LUBRAN: Yes. I'm actually going to ask
5 Ken to give you an update on what we've been involved in.

6 We got involved early on in the process. It
7 was originally CDC that sort of was spearheading the
8 effort, and then they asked SAMHSA to really take over the
9 responsibility for a more integrated federal response. So
10 what we did was engage DEA, Department of Justice, ONDCP,
11 CDC, and then state and local officials to get involved.
12 So we've been holding a weekly conference call with -- I
13 don't know the number. It's over 50 public health and law
14 enforcement officials to really give a weekly update on
15 what is happening around the country.

16 Ken has been asked to chair that effort on
17 behalf of SAMHSA, and we are starting to discuss and
18 discuss with Westley and others some ideas for what we
19 might do to extend the effort beyond what we're currently
20 doing. So I'm going to ask Ken to give you a little bit
21 more background on some of the details.

22 DR. HOFFMAN: I'm not sure where you began, but
23 in terms of the activities in Chicago, I'm well aware.
24 Actually I attended that DEA meeting. It was basically
25 geared towards law enforcement. It kind of exponentially

1 grew, I think, even from what their expectations were.

2 But basically, as I can pull things together at
3 this point, there are drug buys that go on kind of for the
4 sense of what's happening in the world today. Somewhere
5 this past October, there was actually a detection in
6 Detroit of some fentanyl-laced heroin, and it turns out
7 that Detroit and Chicago are probably the ones that first
8 received this kind of unwanted supply, which turns out to
9 be surprisingly deadly in the sense that what would be a
10 little dime bag of heroin, which you could actually see in
11 terms of 100 milligrams, converts to about 125 micrograms
12 of fentanyl in terms of equivalency, which is actually like
13 literally three grains of table salt. So the mixing of
14 that can actually be quite deadly quite rapidly, to the
15 point that death can literally take place as fast as it
16 takes to inject the contaminated.

17 So, anyway, the Epi-X system that CDC has,
18 which is for public health, picks up a message in April
19 from the New Jersey poison control. So initially we were
20 looking at a locus of problems in the New Jersey, Camden,
21 Philadelphia area. CDC then launched the first of several
22 telephone calls, which we've carried on weekly after that,
23 which has incorporated people at the state from poison
24 control, emergency response systems, actually fusion
25 centers, which is a Department of Homeland Security effort.

1 So there's been a conglomerate from the law enforcement
2 side, DEA of course, and then from the treatment side,
3 you've had some treatment providers, Detroit, Chicago,
4 Philadelphia. Actually Delaware has been engaged and now
5 New York. Then with that, you also bring in the public
6 health departments. So we've had a real conglomeration, I
7 think, of people with different information sources. NIDA
8 with its Community Epidemiology Work Group has been
9 involved with it, along with FDA.

10 Bob Lubran mentioned the other organization,
11 ONDCP. This actually led recently to an ONDCP fentanyl-
12 laced forum that was in Philadelphia for a day the end of
13 July. And the activities, I think, of what people had been
14 involved with were presented at that, with the idea of how
15 do we continue to kind of look at this in terms of an early
16 warning detection and response mechanism, which was
17 something that came out of the Synthetic Work Group about a
18 year and a half ago. In the context of what Dr. Clark
19 talked this morning about, the methamphetamine problem, but
20 actually a lot of the same issues have arisen in the
21 fentanyl.

22 So I'll shut up now, and if there are any
23 questions, I'll be glad to answer.

24 DR. CLARK: Any questions?

25 MS. HEAPS: I just hope CSAT would support the

1 efforts of our single state agency director who jumped on
2 this with all hands on deck, and whatever that support
3 means, whether it's official recognition or including her
4 in some of the discussions, et cetera, she really did grasp
5 this issue as a singularly dangerous issue and really has
6 tried to mobilize around it. I think inviting her here to
7 talk about it would be a good idea.

8 DR. HOFFMAN: And in fact, the public health
9 officer, the medical officer from the Chicago health
10 department was at the DEA meeting. And certainly the
11 single state authorities I think have all been made aware,
12 and as you say, some have been very actively participating
13 in the conference calls.

14 DR. CLARK: I've talked with Theodora on this.
15 She was convening a meeting from the public health end of
16 the spectrum, recognizing that law enforcement tends to
17 focus on the public safety end of the spectrum, but also
18 recognizing there needs to be ongoing communications from
19 both ends at the middle. So focusing on the unique needs
20 of the public health community while recognizing the
21 importance of the public safety community was her
22 objective.

23 So with our staff, working closely with DEA,
24 ONDCP, and others and with the single state authority,
25 Theodora, and other jurisdictions, we're trying to come up

1 with practical solutions that we can contribute.

2 We did note that in some jurisdictions, the
3 single state authorities were not aware of some of the
4 issues. That was one of the things that we're trying to
5 help foster, is increased awareness. The non-substance
6 abuse public health authorities were aware that there was a
7 problem, but were not communicating to the substance abuse
8 public health authorities. So they were not aware. I
9 called up several. Did you know there was this problem?
10 Oh, it's not a problem in our state. We haven't heard
11 anything about it. These were two different jurisdictions.

12 Yet, we had data that adverse events were occurring in
13 both jurisdictions.

14 So part of our role inherent in DSCA and the
15 other divisions is, when we get this kind of information,
16 we want to involve the single state authorities as quickly
17 as possible. Just as with other disasters, if you will, we
18 can ask what role we can play, what kind of technical
19 assistance we need to provide and be a part of that net of
20 information.

21 So I appreciate all the work that Bob and his
22 crew are doing, and of course, DSCA and John Campbell also
23 responding to this issue in terms of TA.

24 In terms of client reaction and my big red
25 slice, as you pointed out, it's a killer drug. Where do I

1 find it and try to figure out how to communicate the
2 message it's not a killer drug. It will kill you. But the
3 notion of a killer drug is different in their minds. So we
4 have to figure out how to communicate that in such a way
5 that it's not seen as hysteria or an exaggeration because,
6 as Ken pointed out, the problem with the fentanyl is that
7 it doesn't homogenize and it only takes a small amount. So
8 if they're used to homogenizing drugs so I can inject it
9 and I just get a buzz, well, if you get those three grains
10 all in the same bolus, you're gone. Those three grains are
11 really quite powerful, and if they concentrate at one end
12 of the syringe, you're dead. That's what was happening.

13 As DEA points out, it's very difficult to mix,
14 if you will, fentanyl unless you know what you're doing.
15 They know how to make it, but they don't know how to
16 distribute it in such a way that it's not fatal. And it's
17 poor business if you kill off your customers.

18 Val?

19 MS. JACKSON: One thing Melody said I thought
20 was really important, and that is, it seems like it would
21 be very beneficial for us to hear, perhaps on an annual
22 basis, whether it's the DEA or whoever you would deem
23 appropriate, to take a look at, hey, what's coming, what's
24 new, what's increasing, what's decreasing. The National
25 Household Survey is a wonderful instrument and, of course,

1 we all hear things, but it would be a great report I think.

2 DR. CLARK: Well, we've heard from the DEA
3 before. They've been willing to participate. I'm sure
4 that we can make that request and we could couple what we
5 find from DAWN, from the National Household Survey, the
6 National Survey on Drug Use and Health, and our TEDS data
7 with their arrest information. So that would be useful.

8 I also commend you to the DEA's website. They
9 periodically update it on various jurisdictions and they
10 have state-specific information about what drugs are
11 popular in a particular community. You can see again the
12 regional variation in drug activity. Take methamphetamine.
13 In some jurisdictions, methamphetamine is the big drug;
14 others, prescription drugs; others, it's heroin; and still
15 others, it's cocaine.

16 So we work closely with other federal agencies
17 in the service of this information. So, yes, we'll put
18 that on there and make a request.

19 Any other matters that the council wants to
20 address? Did we finish EtG? I think we finished it.

21 MR. GILBERT: I was just going to say, I was
22 scribbling and I noticed both Cynthia and Westley were
23 scribbling this morning when Melody and Greg were giving us
24 your recommended changes. I didn't get it all down. We
25 probably have it in the transcript, but if you have written

1 out the changes you want, if you could make those available
2 to us before you leave, that would be very helpful to have.

3 DR. CLARK: Donna Bush has some of those
4 changes. Donna, do you want to read those changes to
5 council? Even though we no longer have a quorum, I think
6 we can get some consensus as to the acceptability of those
7 changes. Donna?

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

9 A bunch of us put our heads together with the
10 advice and good counsel of the advisory council and put
11 together, I guess, this almost like a black box notice, a
12 summary statement at the top.

13 Currently the use of an EtG test in determining
14 abstinence lacks sufficient proven specificity for use as a
15 primary or sole evidence that an individual, prohibited
16 from drinking in a regulatory compliance context, has truly
17 been drinking. Legal or disciplinary action based solely
18 on a positive EtG or similar unproven test is inappropriate
19 and legally and scientifically unsupportable at this time.

20 These tests should currently be considered as potential
21 valuable clinical tools, but their use in forensic settings
22 is premature.

23 DR. CLARK: Melody?

24 MS. HEAPS: That's very good. Do you want to
25 add criminal justice after you say professional regulatory?

1 There is a difference between that and the -- you may want
2 to just add that. It's a wonderful statement.

3 DR. CLARK: All right. Criminal justice is
4 added.

5 Any other comments? Val.

6 MS. JACKSON: This is not on that.

7 DR. CLARK: All right. Before we finish that,
8 that essentially captures the sense of council when you
9 made your vote earlier.

10 MS. HEAPS: Well, the vote had two parts. I
11 mean, it was the language but it was also what does it mean
12 to have a public education campaign about this. One of the
13 recommendations would be simply to have a conference call
14 among those of us on the board that are interested, as well
15 as your staff to suggest mechanisms for how to distribute
16 the advisory, et cetera, ways which may be revenue neutral
17 but would at least get the word out.

18 DR. CLARK: All right. We can follow up on
19 that. I like that phrase, "revenue neutral."

20 (Laughter.)

21 DR. CLARK: The people who write the checks
22 will be very glad that we think in those terms.

23 But, yes, we'll talk about the distribution
24 subsequently after we finish.

25 If there are no other issues on EtG, Val, you

1 had something you wanted to discuss.

2 MS. JACKSON: I had something a little bit more
3 on a personal note. Many of you knew a person who I think
4 was very important to this country and has passed from us.

5 The Miami Coalition was known as the first coalition that
6 really gathered steam across the country, and of course
7 now, through ONDCP and CSAP, there are I don't know how
8 many coalitions, but there's a lot of them funded, as well
9 as those that do their own.

10 In the early 1990s, I had the pleasure of
11 meeting Marilyn Culp who came to Miami from Oregon or
12 Washington -- I'm not absolutely sure -- and took over the
13 job for the Miami Coalition, which was funded by
14 businessmen. When I first met her, I was working for the
15 Florida Alcohol and Drug Abuse Association, and I walked
16 away and said there's no one that I know of who could
17 possibly organize or get all of the Miami providers to even
18 talk to each other.

19 Through the years, Marilyn Culp was probably
20 one of the only people who I knew that somehow could bring
21 people together and get things done and yet not alienate
22 folks. She was a remarkable woman and battled cancer for
23 the last six or seven years until she passed in early June,
24 I believe it was.

25 Just to let you know, her husband happened to

1 be the trainer for the Miami Heat and she was at the Miami
2 Heat game when they beat -- I'm sorry, anybody from
3 Michigan -- Detroit and got themselves into the national
4 championship and won the national championship.

5 On a lighthearted note, Marilyn, of course,
6 knew that she was going to die, and she left her husband a
7 note. All around the house, she left him notes, and she
8 left him one note that said to open on, I believe it was,
9 June 20th. It said congratulations, and it was the day
10 that the Miami Heat took the national championship.

11 She was a great asset to our country, to our
12 world, and to the coalitions, both treatment and
13 prevention. So I wanted to mention her. Thank you.

14 DR. CLARK: And thanks for taking the time to
15 acknowledge the passing of a contributor to the field. I
16 think that's very important.

17 Anybody else?

18 (No response.)

19 DR. CLARK: We at SAMHSA did lose a staff
20 person in the crash of the Lexington, Kentucky airplane
21 crash at CSAP. Steve MacElray, who worked for CSAP, was
22 coming home from the NPN meeting there and had taken that
23 flight. So we do lose people. What we did here for Steve
24 was have an in-house ceremony and discussion. Staff people
25 were, obviously, affected by that.

1 The point is that we need to take time to
2 acknowledge the contribution and the passing of people who
3 are laboring in the trenches. Unfortunately, death occurs
4 at all ages for our members, but while we soldier on, we
5 can pause to reflect on their contributions so that we can
6 remain energized. So thank you.

7 Any other issues for council? You can discuss
8 any issue that you wish to pursue, whether related to
9 today's presentations or other matters of interest. Any
10 questions? Val?

11 MS. JACKSON: I just wanted to mention I was
12 fortunate enough, Melody and I and Matt had lunch with Jack
13 today. He was very exuberant and actually opened doors for
14 us to say, well, I'd really like to hear your thoughts on
15 discretionary grant funding. He probably got the two
16 people in the country who have a whole lot to say about
17 discretionary grant funding.

18 MS. HEAPS: (Inaudible.)

19 MS. JACKSON: Well, yes, true.

20 But we focused on that one and gave him a
21 number of thoughts. Among those -- and you may have some
22 insight on this -- the thought occurred to me that perhaps
23 in the future one of the things that we need to do is to
24 tear apart that big red circle that you have that shows
25 that 95 or 94 percent, whatever it is, of those people who

1 don't seem to access treatment. And we kind of know. We
2 expect that they're probably some trauma people and some
3 disabled people and there are some folks like that. But
4 perhaps we need to start looking at what targets are in
5 there that might be folks that we can reach if we target
6 particular populations that you could discover through, as
7 Jack said, mining.

8 I appreciate his getting input and I hope that
9 you continue to ask for input across the country. I think
10 not only Melody and I but many people across the country
11 have great insight as to some of the populations that need
12 to be treated. We support the discretionary grants,
13 believe that they're very innovative, and I just wanted to
14 make that comment to reinforce my belief, strong belief, in
15 the need for discretionary grants.

16 DR. CLARK: Thank you.

17 Any other comments? Dave?

18 MR. DONALDSON: I'm still trying to get my arms
19 around the ATR and exactly what happened. But I have
20 always tried to follow the course that you hope for the
21 best, you do your best, but also prepare for the worst. So
22 I think my question would be is there a contingency plan.
23 If the ATR goes away, how do we preserve this vision? It's
24 the right vision. This big tent approach to recovery
25 management services is right.

1 I know in the faith community, this has been a
2 wonderful entry point. It's a way that affirms the value
3 of the faith community. It shows us where we can serve in
4 this continuum of care, and I'd hate to see that go away.
5 I think we've got great momentum. How do we build upon
6 that? How do we continue to preserve the voucher approach
7 which I think certainly affirms a person's dignity? Also,
8 it protects faith-based groups that are concerned about
9 their identity and methodology being stripped away. So how
10 do we keep that going?

11 But I think the other is that the next time you
12 present a national plan and if this one is DOA -- and I
13 hope and pray that's not the case -- then it is much harder
14 to launch something new because people will be predisposed
15 to thinking how long is this going to last and they're only
16 going to get one leg on the bus. So what is our plan?
17 What is our strategy moving forward?

18 DR. CLARK: Well, I think the administration is
19 stepping back to consider what it needs to do to inform the
20 Congress of the utility of ATR and that process will
21 probably intensify over the next month or so. Our data
22 demonstrates that we're doing okay with ATR.

23 It's not just the faith community who has
24 benefitted from this. That's another point that we need to
25 make. It's community-based organizations and it's this

1 notion of empowerment. I'm glad you highlighted that. It
2 makes it clear that the person who has the problem plays a
3 role in the solution and that it's not a matter of
4 professional paternalism, if you will. So the
5 administration will continue to stress that and then we'll
6 see what happens.

7 We do have an ancillary program in terms of
8 recovery community support programs. It does not have the
9 voucher element. It is subject to charitable choice. So
10 it is not an ideal substitute for ATR, but we'll just have
11 to work with the wishes of Congress and the will of the
12 people. The President's agents will be trying to
13 communicate the administration's position on this matter
14 over the next month or so.

15 Melody?

16 MS. HEAPS: I just want to completely echo
17 David's response about ATR and its importance.

18 But I would like you to just inform us with
19 regard to the funding proposal for ATR that the
20 administration has put forth and how the block grant was
21 brought into that. I'm not sure we were completely clear.

22 What is the budget proposal with regard to ATR this year
23 from the administration's standpoint?

24 DR. CLARK: Oh, we discussed this at our last
25 meeting. Basically the proposal was to incentivize

1 jurisdictions to use a portion of their block grant in
2 order to be eligible to be competitive for ATR funds. That
3 is, shall we say, one of the sticking points for some
4 members of Congress who have made their concerns known
5 through the proposals in the House and the Senate. That's
6 an issue that is on the table being discussed.

7 Anything else?

8 (No response.)

9 DR. CLARK: All right. We've had a full day.
10 I thank you for your undivided attention and attendance.
11 Can I have a motion to adjourn?

12 DR. SKIPPER: So moved.

13 DR. McCORRY: Second.

14 DR. CLARK: It has been moved and seconded that
15 we adjourn. All those in favor?

16 (Chorus of ayes.)

17 DR. CLARK: Anybody opposed?

18 (No response.)

19 DR. CLARK: All right. Have a safe trip and
20 your comments and questions and concerns have been duly
21 noted and will be addressed. Thank you.

22 (Whereupon, at 4:23 p.m., the meeting was
23 adjourned.)

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