

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

40th Meeting

Thursday,
June 29, 2006

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

IN ATTENDANCE:

Chairperson

Charles G. Curie, M.A., A.C.S.W.
Chair/Administrator, SAMHSA
Rockville, MD 20857

Executive Director

Daryl W. Kade, M.A.
Executive Director, SAMHSA National Advisory Council
Associate Administrator for Policy, Planning,
and Budget, SAMHSA
Rockville, MD 20857

Executive Secretary

Toian Vaughn, M.S.W.
Executive Secretary, SAMHSA National Advisory Council
Rockville, MD 20857

Members

James R. Aiona, Jr.
Lieutenant Governor
Executive Chamber
Hawaii State Capital
Honolulu, HI

Faye Annette Gary, Ed.D., R.N.
Professor, Case Western Reserve University
Frances Payne Bolton School of Nursing
Cleveland, OH

Diane Holder
President
UPMC Health Plan
Pittsburgh, PA

Barbara Huff
Consultant
The Federation of Families for Children's Mental Health
Wichita, KS

IN ATTENDANCE:

Thomas A. Kirk, Jr., Ph.D.
Commissioner
Department of Mental Health and Addiction Services
Hartford, CT

Theresa Racicot
Former First Lady of Montana
Arlington, VA

Kenneth D. Stark
Director
Mental Health Transformation Project
Office of the Governor
Olympia, WA

Kathleen Sullivan
Journalist
Rancho Mirage, CA

Ex Officio Members

Laurent S. Lehmann, M.D.
Chief Consultant for Mental Health
Department of Veterans Affairs
Washington, D.C.

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1 P R O C E E D I N G S (9:20 a.m.)

2 MR. CURIE: Good morning, everybody. I know
3 that there are a few members about five minutes away, so we
4 thought that we would at least start the process. They're
5 not really going to miss a whole lot, but at least we get
6 our process moving.

7 I want to, first of all, again welcome
8 everybody here this morning, and I'm pleased to announce
9 that while we're disappointed that Lieutenant Governor
10 Aiona from Hawaii, who is the co-chair, could not be here
11 in person, I'm pleased to say he was by phone most of the
12 day yesterday, and right now he's with us.

13 So welcome, Duke.

14 MR. AIONA: Thank you.

15 MR. CURIE: I want to acknowledge your presence
16 by phone and your commitment.

17 Clearly, it was a situation out of his control.

18 I think anyone who was traveling this last week by air,
19 around here even by car it can be tough, but recognizes
20 that the weather patterns and the air traffic control has
21 been really tough, and when you're coming from Honolulu and
22 you get delayed several hours, and then you've got to turn
23 around and come back within a day, you're going to be
24 spending a lot more time in the air and in the airports
25 than in the actual meetings. So I appreciate Duke's

1 participation here.

2 I also want to acknowledge and wish Tom Lewis
3 well. I think, as you know, our fellow council member, Tom
4 Lewis, has resigned his seat to devote more time to his
5 health and his family. Tom was very dedicated, had been a
6 very dedicated member of the council and is just one of
7 those people who is very special in terms of his value
8 system and what's important to him, and being a strong
9 advocate for people with mental illness and people with
10 addictive disorders, and we will miss him. But I
11 definitely want to acknowledge and wish him well and thank
12 him for his service on the council.

13 I also want to note as well that the First Lady
14 of Florida, Columba Bush, is unable to attend due to a
15 prior travel commitment. The great news is that I think
16 everybody else on the council is in attendance, which is a
17 great turnout. Gwynneth at the last minute was not able to
18 come, but she was planning to. But again, I appreciate
19 everyone's commitment and everyone's participation.

20 I understand that yesterday the council
21 orientation was a success. Actually, Faye, I know this is
22 your second meeting, and I think the orientation was
23 actually put in place for you, primarily. But the great
24 news is I want to thank the council members who came, the
25 rest of the council members who came and attended, because

1 I think not all of you had an opportunity for a full
2 orientation when you first came aboard. I'll be anxious to
3 hear more, that it gave you a lot of opportunity to gain
4 more insight into SAMHSA programs and meet also some of the
5 new individuals that are part of the leadership of SAMHSA
6 and have an opportunity for that interaction.

7 I know that SAMHSA's new acting deputy
8 administrator, Admiral Eric Broderick, provided you with an
9 overview of SAMHSA, our current priorities. I want to
10 thank Ric in absentia. He's unable to be with us today
11 because he is representing me downtown at a couple of
12 events that conflicted with the calendar today.

13 Also, I know you heard from Larke Huang. As
14 you know, Larke is our new children's czar. Again, when
15 Sybil Goldman left, I think we were concerned about who
16 could fill those shoes. Well, I'll tell you, Larke Huang
17 is one individual who definitely can and does, and I think
18 hopefully you had a chance to get a feel for her. She's
19 just among the top children's mental health folks in the
20 country.

21 Also, I don't know if you had a chance to meet
22 Arne Owens yesterday. Arne has come aboard SAMHSA. He's
23 the newest member of the SAMHSA executive leadership team,
24 and he's senior advisor to the administrator. His
25 portfolio, out of the chute he's taken on some big issues,

1 issues which are very important and near and dear to what
2 we're doing now, the veterans issues. Again, I want to
3 recognize Wes Clark and the work CSAT did in organizing and
4 making sure we had a great conference in March in which we
5 pulled together 1,100 people representing providers, as
6 well as in partnership with the VA and with the Department
7 of Defense, to equip providers and local communities to be
8 enabled to meet the needs of returning vets, especially
9 with National Guard and reservists being primary forces.

10 We're going to have a lot of people returning
11 to hometown communities in their capacities of their
12 regular jobs, and it's a somewhat different circumstance
13 than we've seen in the past, and we want to make sure
14 community-based providers are hooked into that. Arne is
15 going to be working with that, as well as with our
16 community- and faith-based initiatives, working with the
17 HHS faith-based office as well as with the White House
18 faith-based office. So again, thanks, and I'm just so
19 pleased Arne came aboard.

20 I also want to thank Daryl Kade, who is the
21 executive director of this body, but also her day job is
22 director of SAMHSA's Office of Policy Planning and Budget,
23 along with the center directors who are joining us today.
24 I already mentioned Dr. Westley Clark. Westley accompanied
25 me, by the way, to yesterday's hearing and did a great job

1 representing, as he always does, the programs of treatment.

2 I also want to recognize Dennis Romero, the
3 acting director of CSAP, who is here today, and Ted Searle,
4 who is representing Kathryn Power from the Center for
5 Mental Health Services.

6 Also, I want to extend a warm welcome, as
7 always, to our federal colleagues and guests here this
8 morning. I think it's indicative of the interest our
9 constituency groups have in SAMHSA that we have such a
10 generally very good turnout for these advisory council
11 meetings, and I want to thank you and recognize
12 representatives from the Office of Minority Health that are
13 here today, friends in the National Institute of Mental
14 Health, the National Institute on Alcohol Abuse and
15 Alcoholism, and several guests again from our constituency
16 groups.

17 So again, welcome and good morning, everyone.

18 Before I begin my detailed report this morning,
19 we must take care of an important order of business, and
20 that's to make sure you have reviewed the minutes of the
21 December advisory council meeting and have a motion for
22 approval. Is there a motion to approve the minutes?

23 (No response.)

24 MR. CURIE: We will hold that until we have an
25 official quorum. I've just been informed we need seven

1 people, right? We'll have a quorum in a moment.

2 Does Duke count?

3 Duke, my heart just stopped. I asked if you
4 count, and Toian said no. I wouldn't take that personally,
5 though, Duke. You do count, Duke.

6 MR. AIONA: I do? Well, thanks.

7 MR. CURIE: I'm pleased to hear you count.

8 Thank you, Toian.

9 Let me begin my report, then, and we'll take
10 care of that order of business as we move along.

11 As I begin my report this morning, I think I'm
12 going to be making an announcement that all of you have
13 heard by now, and that is that the end of my tenure as the
14 administrator of SAMHSA is going to be occurring on August
15 5th. I did submit my resignation to the President. The
16 decision to resign my post, as always, those decisions are
17 always tough when you come to that point. While I'm
18 excited about moving into the next phase of whatever I'm
19 going to do, which is remaining to be determined, I just
20 want to say it's been the highest privilege being in this
21 position. The past five years have been profound for me
22 and it's been extraordinary working with this National
23 Advisory Council, our constituency groups, just people who
24 are committed and have a value system of being invested in
25 something outside of themselves, giving voice to people who

1 have no voice and helping people find their voice, people
2 who many times are shoved to the margins of society, people
3 with mental illness, people with addictive disease, people
4 who again many times, because of stigma, because of
5 perceptions that aren't based on fact, don't have the
6 opportunities to have that full life in the community.

7 Again, I'm continually inspired by the
8 participation of people in this group and in the groups
9 that we're dealing with ongoing who have the energy, the
10 passion, the concern of assuring that people find their
11 voice. I think there have been changes that in my view
12 will be lasting changes that have occurred over the past
13 five years.

14 I know you can take kind of a cynical route, if
15 you'd like. After I announced my resignation, the dynamic
16 is put into place. People begin to think who is coming in
17 next, and okay, now we don't have to worry about that
18 matrix anymore. Now a new administrator is going to come
19 in, and maybe none of this is going to count for anything.

20 We have a quorum now. I'm pleased. Barbara
21 and Kathleen, welcome. I'm glad you could make it.

22 My thought, though, as we take a look at -- and
23 again, to let Kathleen and Barbara know, in terms of me
24 giving my report, I just announced that I gave my
25 resignation as we look ahead. I'm hopeful and I'm

1 confident that many of the things that we have
2 accomplished, many of the things that we have in place are
3 things that are in place not because of me but because of
4 the field, because we've made informed decisions, because
5 directions we've taken have been directions in which there
6 has been ownership from a wide range of folks that we're
7 doing the right things.

8 As we take a look at the vision of a life in
9 the community for everyone, I think people understand that
10 that begins to depict the end game, that what we're about
11 as a federal agency is more than just thinking about
12 developing some new programs or developing and funding
13 programs and people participating in programs, and as long
14 as we get the GPRA information and whatever we need from
15 that, we're doing our job as a federal agency, but the work
16 we're doing is real work to impact the lives of people and
17 to make sure people have that life and that opportunity for
18 a life in the community.

19 It's more than just alleviating symptoms. It's
20 more than just getting people off of drugs and then we're
21 done. It's understanding the nature of the chronic,
22 devastating aspects of the diseases we deal with and that
23 we truly have an important, fundamental part of the public
24 health mission, and that we don't accomplish our mission of
25 building resilience and facilitating recovery until we see

1 outcomes in people's lives in which they have found their
2 voice, in which they have found not only their place but
3 they have found their life in the community.

4 Either those things ring true or not, whether
5 I'm here. If they don't ring true and we just went through
6 the motions because you had an administrator here who
7 talked about it a lot and staff was just wanting to appease
8 the administrator, then it is going to fall aside. I don't
9 happen to believe that's true. I happen to believe that
10 people throughout SAMHSA, the reason we've made progress is
11 because we have dedicated staff and leadership and people
12 who really do want to make a difference, and we have people
13 on this advisory council and the other advisory councils
14 who believe in this, and we have constituency groups. As I
15 look around the room, again I want to thank people. I'm
16 not going to name everybody, but people like Henry Lozano,
17 Rob Morrison, Linda Crawford, or the people I see in this
18 room who are committed through their various associations
19 to making a difference, that that work is going to be
20 carried forward because either that vision is valid or it
21 isn't.

22 As I'm going to review some of the
23 accomplishments that we have made together, we need to look
24 at it in the context of are those accomplishments truly
25 based on doing the right thing that people agree to, and

1 this will be carried on or not. I happen to believe that
2 we have been very thoughtful and open. We've modified
3 thoughts and ideas we had, fully changed some things based
4 on input from the field, based on being informed, and
5 hopefully those things I'm confident will stand.

6 Again, the overall goal we have is to build a
7 healthier, more hopeful America, and we focused here at
8 SAMHSA on what I refer to as the redwoods, brought them to
9 life as achievable goals through the SAMHSA matrix. I'm
10 convinced one of the things that we have been able to
11 accomplish that's been significant is alignment, aligning
12 our resources around priorities. We have pretty powerful,
13 potent, influential centers within SAMHSA. CMHS makes a
14 profound impact on the mental health field, in partnership
15 with NIMH and our other federal partners. People look to
16 the federal government for direction. People look to the
17 federal government for funding grants to see what direction
18 they should be going. That influences things.

19 CSAT. When I take a look at what CSAT does,
20 and again this applies to the other centers, because each
21 of them has their technical assistance centers and ATTCs,
22 as I travel across the country and I see the treatment
23 improvement protocols on the desks of providers, and
24 they're actually worn, the pages are worn, so you know that
25 they're used, and I'm being told, whether it's

1 co-occurring, whether it's the treatment improvement
2 protocol we talked about yesterday, number 33 that deals
3 with methamphetamine and synthetic drugs, that these things
4 are of value, and CSAT in many ways and in many dimensions
5 shows leadership through dissemination of information,
6 through technical assistance, through developing grants and
7 putting goals in grants that help focus people on the end
8 results we're looking for.

9 CSAP, profound changes there with the Strategic
10 Prevention Framework. I think we can say in complete
11 confidence that CSAP is the lead federal agency for
12 substance abuse prevention in the nation and that it does
13 more than just fund an array of prevention programs. Now
14 it is actually funding and focusing on, under the
15 leadership of Beverly Watts Davis and now Dennis Romero
16 and, again, the capable prevention professionals that make
17 up CSAP, we truly have a Strategic Prevention Framework
18 operationalized, and I'll talk about that in a little more
19 detail in a moment.

20 But again, I can point to all three centers. I
21 can point to our Office of Applied Studies that still comes
22 through with what I call the Household Survey. I know it
23 has a different name now, but the Household Survey every
24 year, DAWN, the emerging drug issues that are coming out of
25 emergency rooms, TEDS, the Treatment Episode Data, all of

1 that data which is used to inform the field, and as you
2 find a range of not only federal agencies but private
3 sector folks to help inform is invaluable stuff.

4 Again, as I talk about it, it makes me proud
5 that I've been a part of that operation and that SAMHSA, I
6 know, will continue to deliver over and over again.

7 Without question, I think SAMHSA has embraced
8 the direction that's been set forth by this council and
9 constituency groups. We talk about consumer- and
10 family-driven systems, and I think SAMHSA has tried over
11 the past year to be more consumer-driven, to be more
12 constituent-driven in the sense of meeting the needs and
13 understanding the needs of the field that have been
14 identified in the data, and at the same time understanding
15 we've got to be in a position to synthesize all of that
16 into a direction because not all constituency groups come
17 together all the time and speak with one voice. So the
18 responsibility we have is to sort that out and to begin to
19 find where we can best invest our resources.

20 Again, we listen to Congress. I listen very
21 carefully to the White House, listen very carefully to the
22 Secretary, listen very carefully to the administration, and
23 I feel that we've been able to chart courses where we've
24 been able to be consistent with the goals of the
25 administration, and I think we're viewed that way in

1 everything that we've done. I think we're viewed by
2 Congress -- again, the hearing was very positive yesterday
3 in terms of what they had to say about SAMHSA and the
4 directions we've been going.

5 I view Congress as a customer. A customer is
6 who pays for what you do. Congress appropriates money, so
7 they pay. I view the President as a major customer, my
8 major customer, along with the Secretary, because they make
9 sure we get paid for what we do. Again, I view our
10 constituency groups as a major part of that, and I think
11 we've been able to respond effectively.

12 I also believe that this council, when we talk
13 about moving ahead, when we talk about consolidating the
14 gains that have been made and continuing to build on the
15 direction, will continue to make a major impact. I think
16 perhaps my leaving is even more in your hands right now, if
17 you believe the directions that we've charted are the right
18 directions, to assure that the advice and directions that
19 are given remain strong in that direction. I know you will
20 continue because I know many of you on an individual basis,
21 and I've known many of you for even several years will be
22 committed and are committed to that.

23 Resilience and recovery are the focus of
24 dialogue now. You turn the clock back five years ago
25 before, recovery was a concept. Very much I call recovery,

1 again, from the substance abuse field and the mental health
2 field, because recovery has been around for a long time in
3 the substance abuse arena. It's been more of an
4 individualized process as people talk about being in
5 recovery and trying to understand recovery. We have tried
6 to bring recovery in two ways. One, an understanding of
7 how it can be applied to the chronic, severe, devastating
8 illness of mental illness and how people can use recovery
9 concepts in understanding how you manage your illness as
10 you begin to manage your life, and most importantly we
11 tried to operationalize recovery from a public policy and
12 public finance standpoint, that this is what we want to see
13 as the outcome in people's lives.

14 In substance abuse prevention and treatment, in
15 mental health care, I think in terms of using recovery as
16 the focus and as a common ground in resilience, I think
17 that there is stronger collaboration than ever before among
18 the three centers. I think the silos increasingly have
19 been diminished in terms of functioning as silos. I will
20 go on record -- I shocked folks at NASADAD a few weeks ago.

21 Silos serve a purpose. You never have heard me talk
22 structurally about let's destroy the silos because they get
23 in the way, and I know people take that approach. Silos
24 help you keep count, and we have a substance abuse
25 treatment field, a substance abuse prevention field, and we

1 have a mental health field, and it's important to those
2 constituency groups to be able to track resources and how
3 are we doing and are the resources going toward these areas
4 and arenas. I think we can't discount that very important
5 purpose of silos, that very important purpose of having --
6 I mean, you hear all sorts of schemes and all sorts of
7 ideas of people who come into positions. I think any of us
8 who have been commissioners at the state level, any of us
9 who have been around know that certain times leaders come
10 in and say, you know what? I want to just merge everything
11 and get all the money integrated together so I can just
12 meet people's needs.

13 I think we've found that while that may be
14 appealing conceptually at a certain level and in a certain
15 notion it's like, oh wow, that makes sense, I'd better use
16 the public dollar, I think we know that for so long people
17 have labored in the fields to bring substance abuse
18 treatment to a priority and having people understand that
19 treatment works and recovery is real. Prevention has had
20 to make its case and will continue to have to make its case
21 over and over again because it's a tough thing to prove,
22 but I think we are proving that it works; and mental
23 health, again, is its own illness. I mean, we're talking
24 separate disorders and illnesses. We're talking aspects
25 where we have people who are strong advocates who are

1 speaking on behalf of others. So we need to keep count.

2 But then operationally we need to function, as
3 I feel SAMHSA has functioned with the matrix model, that we
4 need to leverage all those resources in a way that helps
5 each center achieve its goals in even better ways together.

6 There's much more collaboration, partnership
7 and conversation, much firmer resolve to shift the focus
8 from ourselves, from our own unique agendas, our turf and
9 our budget to be focused more and more on what truly is
10 important to the people we serve and the families and the
11 individuals.

12 In some cases, a paradigm or a position shift
13 like this I think can take decades or longer. I think
14 we've been able, due to the commitment of leadership, of
15 staff, of people rolling up their sleeves -- I know when
16 the matrix first came out about four and a half years ago,
17 people grappled in an honest way without SAMHSA like what
18 is this matrix? What is matrix management? We embarked on
19 a process of actually having concrete sessions and training
20 on how matrix management can work, and people I would say
21 were innovative throughout SAMHSA in terms of developing,
22 because there aren't too many books out there, a cookbook
23 approach, but in terms of creating it, and that's one of
24 the most gratifying things for me, is to see how people
25 have taken hold of that and see how people have made it

1 work within SAMHSA and created it within SAMHSA.

2 Also, when you turn the clock back five years
3 ago, there were a lot of tasks that were kind of hanging
4 around, some things that were being done, a lot of good
5 initiatives, but they weren't necessarily being leveraged
6 to systemic change necessarily, and I think we've been able
7 to more and more look at systemic change and taking on some
8 things.

9 Today we have more community- and faith-based
10 providers engaged than ever before. Access to Recovery has
11 helped that tremendously on the substance abuse treatment
12 side. I think the New Freedom Initiative has been
13 profound, and again the Mental Health Commission. Again,
14 we tailored our prevention programs for producing results
15 at the community and family level through the Strategic
16 Prevention Framework. One thing we can't forget is we
17 created and implemented a data strategy, including National
18 Outcome Measures and State Outcome Measures and Management
19 Systems to track success, and also identifying areas of
20 improvement where we need to move ahead in different ways,
21 hopefully serve as an early warning system too of emerging
22 trends as we move along in looking at such things as
23 methamphetamine use, prescription drug abuse.

24 Today we have a much clearer focus on
25 science-to-services agenda. Again, our partnership with

1 the institutes is stronger than ever, and I think the stage
2 has been set to really shorten that period of time of
3 bringing scientific research findings to the front lines of
4 service. It's going to be an ongoing challenge. It's
5 going to be a process that can be never-ending, but we've
6 got to continue it. We've worked to reduce that time lag.

7 The National Registry of Evidence-Based
8 Programs and Practices, we've worked to improve that and
9 make it relevant not only in the prevention side but also
10 the treatment side. Again, that's been a long process of
11 getting input from a wide range of providers and
12 associations and folks, as well as consumers and families,
13 and I think we have a platform that's developed for
14 informing the field about science-based programs and
15 practices.

16 Each of these initiatives have opened the door
17 for SAMHSA and our constituency groups to, again, help
18 people achieve meaningful, real-life results as they strive
19 to attain and sustain recovery, build resilience, work,
20 learn, live and participate fully in their community. I
21 think overall our ability to focus on recovery as the
22 common ground has produced some key results. We more
23 clearly defined recovery from mental illness. We created
24 the National Consensus Statement on Mental Health Recovery,
25 which identifies 10 fundamental components of recovery. I

1 want to commend CMHS for that endeavor and how they engaged
2 the constituency groups. I also want to commend Kathryn
3 and CMHS for the Federal Action Agenda for Mental Health
4 System Transformation, which identified recovery as the
5 single most important goal for the service delivery system.

6 Through that action agenda, never before have
7 we had nine Cabinet-level departments, including over 20
8 federal agencies that touched the lives of people with
9 mental illness, have agreement around 70 specific steps of
10 action that the federal government can begin to take to set
11 the stage for transformation. That overall goal is to
12 empower states. As I look at Tom, as I look at Ken, as I
13 look at folks who represent states here, one of the
14 frustrating things is when states try to embark on an
15 integrated agenda, whether it's around mental health,
16 whether it's around substance abuse, or both, trying to get
17 agencies within a state to agree and take it seriously and
18 make it a priority is tough, because we know many agencies
19 touch the lives of the people for whom we're responsible.

20 But then trying to get the federal government
21 to speak with one voice on issues when there are different
22 agendas makes it almost virtually impossible, and that's
23 why for years I think it's been difficult to move ahead. I
24 think we have clear hope now that there can be clear
25 direction of a unified way from the federal government in

1 working with states to empower states to move ahead.

2 One of those steps, of course, in
3 transformation on the mental health side was the State
4 Incentive Grants for Transformation. Last year we awarded
5 \$92.5 million to seven states over five years. Two of
6 those states are represented right here at this table.
7 Ken, I think you're very much engaged in the process in
8 Washington State, and Tom in Connecticut. Also Ohio,
9 Oklahoma, Maryland, New Mexico and Texas are blazing the
10 transformation trail, and more and more Americans with
11 mental illness hopefully will step out of the shadows of
12 hopelessness, stigma and exclusion and receive access to
13 the care they need with the dignity, respect and belonging
14 they deserve.

15 Again, transformation, I think the stage has
16 been well set. Substance abuse treatment has undergone
17 significant changes and fundamental changes. I think now,
18 and I hope I'm not too presumptuous, but hopefully there's
19 an acceptance that we understand that there are many
20 pathways to recovery, that there's just not one cookbook
21 approach or treatment intervention that works, one or two,
22 but that recovery is an individualized process. Recovery
23 from addiction includes people who have gone through a
24 range of programs and maybe have relapsed. But what's
25 interesting to hear consistently is people who ultimately

1 attain and sustain a long-term recovery talk about how they
2 gained something from every program they were in, that
3 every program they were in was a step toward their
4 recovery, and I think we need to keep that in mind.

5 Many times it's characterized as just out and
6 out failure, and I think we need to frame that in terms of
7 what it really means in terms of the recovery process. I
8 think we need to recognize that there are very effective
9 science-based clinical programs, medical-based programs.
10 We're learning more and more. When I hear Nora Volkow talk
11 about the frontiers of what we're finding out more and
12 more, it's actually overwhelming in a positive way to think
13 about where we can be five years from now, ten years from
14 now with addiction treatment services.

15 Also, we recognize that the transforming powers
16 of faith play a critical role in recovery for thousands of
17 people in this country, and we need to make sure we're not
18 cutting off any pathway for recovery and that we're opening
19 up more pathways, that the federal government is not an
20 impediment to it but that we're a facilitator of recovery.

21 I believe that through the Access to Recovery
22 program as a key addition to the demand reduction
23 infrastructure, thousands of people are now seeking
24 treatment or finding it, that because of that capacity
25 being in place, they have that hope and opportunity. I'm

1 pleased to say with the data coming in on Access to
2 Recovery, again we have two states here that are
3 implementing it, that the data is looking very, very good
4 overall. I know there have been people who have been
5 impatient that the data wasn't coming in fast enough, but I
6 think we cannot forget that we're talking fundamental
7 infrastructure change in which we had to set up a voucher
8 system in states, a new way of doing business, an awesome,
9 overwhelming task, and I don't know if you would disagree
10 with me, Ken or Tom, on that, but not easy to pull off at
11 all, probably one of the most challenging things.

12 But states and the tribal organizations have
13 done it, are doing it, and I think we're going to learn a
14 lot more from Access to Recovery.

15 As you know, ATR is based upon choice, states
16 having the flexibility to use these dollars to focus on
17 their emerging trends. I might point out that Wyoming and
18 Tennessee, for example, chose methamphetamine being a major
19 problem and issue with their states, and they were able to
20 direct those dollars. Again, fundamentally federalism, the
21 federal government telling states you know best what your
22 needs are, and we need to work with you in partnership and
23 not dictate where those dollars should be ultimately
24 directed.

25 Wes will bring more details, Wes Clark, on ATR

1 after lunch, and we'll also hear from our own council
2 member, Tom Kirk, about Connecticut's success with ATR as
3 well, and I would welcome Ken to participate and make
4 observations about Washington's experience.

5 Clearly, recovery from mental illness,
6 addiction and co-occurring disorders is no longer the
7 privilege of just a few individuals, but I think more and
8 more we're seeing that the access has been increased. I
9 think we do stand -- and depending on whether you read the
10 book "Tipping Point," I think we're standing at a tipping
11 point in which they call this the "magic moment" in which
12 minds and hearts are changed, and radical change is more
13 than a possibility; it's more of a certainty. I think
14 we've experienced that on many levels, not only the things
15 I've just been talking about but also with regard to
16 co-occurring disorders.

17 In the landmark 2002 report to Congress from
18 SAMHSA, we recognized that people in need with co-occurring
19 disorders should be the expectation and not the exception,
20 and that we have better data than ever before in
21 recognizing the levels of co-occurring disorder, the type
22 of interventions that are appropriate depending on what's
23 presented, understanding we need to do an assessment for
24 both when people come to the door, and that it's just not a
25 small subspecialty population but that many of the people

1 who have gone through our systems and have been seen as
2 failing many times have had co-occurring disorders and only
3 one of the disorders have been treated, and so recovery
4 can't be sustained or attained unless it works.

5 Again, Treatment Improvement Protocol Number
6 42, co-occurring disorders. I think CSAT again needs to be
7 commended for informing the field, and I know it's being
8 used, and there have been policy academies held to
9 encourage the development of state action plans. I want to
10 thank, again, the staff of SAMHSA. I want to thank the
11 field. I want to thank NASADAD. I want to thank NASMHPD.

12 I want to thank the trade associations who have found the
13 common ground around co-occurring disorders and have been
14 able to move that agenda ahead on behalf of the citizens of
15 this country.

16 Another major change, with the backing of the
17 First Lady, is to increase prevention efforts and bring
18 prevention to scale on a national level. The First Lady,
19 Laura Bush's Helping America's Youth Initiative is becoming
20 more and more an umbrella which pulls together multiple
21 federal prevention programs, including SAMHSA's Strategic
22 Prevention Framework. It involves juvenile justice and the
23 Justice Department. It involves Education. It involves
24 virtually every department that was represented at the
25 first Helping America's Youth Conference. I'm pleased that

1 SAMHSA's approach with implementing the Strategic
2 Prevention Framework is recognized as part of that and very
3 consistent with what they're striving to do with Helping
4 America's Youth, and that's find a science base and an
5 evidence base for what can work to prevent juvenile
6 delinquency and substance abuse and those negative,
7 destructive consequences that exist in communities
8 throughout this country.

9 We will be implementing the Strategic
10 Prevention Framework in 40 states. So it's really being
11 brought to scale. The SPF is putting into place, again,
12 that science-based approach. Now with SAMHSA owning
13 Communities That Care and that approach and other
14 approaches, we have tools available to states and
15 communities to embark upon a process to assess risk
16 factors, to assess protective factors, and then to make
17 decisions in terms of what programs should be implemented
18 in a community based on the risk factors in those
19 communities, evidence-based programs from NREPP, from the
20 list with Communities That Care. There's a range of
21 science-based decisions that can be made.

22 We also recognize that the best solutions to
23 substance abuse problems typically come from local
24 communities. Local people solve local problems best, and
25 we want to empower them with knowledge. We want to empower

1 them with resources to make those decisions.

2 Looking toward our nation's future, the 19
3 percent reduction in illicit drug use among our youth over
4 the past four years is truly an inspiration and tribute,
5 and I think we need to continually recognize the hard work
6 of families, schools, anti-drug coalitions, communities and
7 faith-based organizations that have been speaking more and
8 more with one voice, more and more with a unified approach.

9 We know that when we push back against the drug issue and
10 drug abuse, it works. It's in the future that we're going
11 to see the benefits unfold as a result of the many new and
12 growing initiatives that are underway. The future of
13 substance abuse prevention, substance abuse treatment and
14 recovery support services looks remarkably different and
15 exciting.

16 I want to stress, too, that one of the things
17 we learned in ATR, we're learning that recovery support
18 services play a critical role in helping us realize the
19 outcomes in people's lives and that we are looking at a
20 framework beyond providing treatment programs, but also
21 what do people need to achieve recovery.

22 I believe part of the success can be attributed
23 to the message said over and over again, loud and clear,
24 that prevention and treatment work, and recovery is real.
25 I think each of you, I know, believes that. Over the past

1 few years I know we've had some convincing to do at times.

2 It's no longer enough to show evidence of a need. We must
3 be able to demonstrate results in order to assure that
4 funding for our services that we know work is going to take
5 place. It's public accountability, and public
6 accountability requires proof.

7 The most direct route to proving and
8 demonstrating success has been through SAMHSA's focus and
9 renewed commitment to performance measurement and
10 management. That commitment yielded the National Outcome
11 Measures and the State Outcome Measures and Management
12 System.

13 The National Outcome Measures are really about
14 putting people first. It's about reporting on our
15 performance in helping people attain and sustain a life in
16 the community. The domains that we've identified all
17 capture the meaningful, real-life outcomes which combine to
18 create a life in the community.

19 The thing about it is it's not only outcomes
20 that people who are seeking recovery are looking for, but
21 every person in this room want to see those outcomes in
22 their lives. I think that makes it real to all citizens in
23 this country.

24 The data collection thus far reflects strong
25 partnership in an enormous undertaking and demonstrates

1 solid, early progress. As we know, it's not easy to come
2 to a consensus around what data we should be gathering.
3 It's a burden. It's a burden on states. It's a burden on
4 providers. It's a burden on systems to be gathering
5 outcome data. I'm not saying burden in that it's an
6 unnecessary burden, but it is work, and it's not easy. We
7 as a federal government have a responsibility to be very
8 clear on what we want to see, because if we just throw out
9 a whole bunch of measures that sound nifty or are different
10 from grant to grant because we're looking for things or
11 exploring things, we aren't painting a comprehensive,
12 consistent picture of what our dollars are doing, and we're
13 making it even more unnecessarily hard on the states.

14 But if we try to give a focus around let's have
15 a few domains that we all agree reflect recovery, and let's
16 consistently get those measures on everything that we're
17 funding, we have a better shot at painting that picture.
18 Again, I know it may not feel this way at times because
19 it's very difficult, but the goal has been to lessen the
20 burden as we go along. Again, that's hard in and of
21 itself.

22 We will also continue to rely on data provided
23 through, again, the annual surveys, the National Survey on
24 Drug Use and Health, the Household Survey, DAWN, and the
25 Drug and Alcohol Services Information System, along with

1 other data sets. Yet we know data alone is not enough.
2 The data will only guide the way. It will not improve
3 systems. Improving systems requires strengthening and
4 reinventing the workforce that delivers care. I want to
5 stress workforce development. We've added that to the
6 matrix. We know that approximately 80 cents of every
7 mental health and substance abuse dollar is spent on our
8 workforce. We also know that increasing the workforce
9 capacity has a direct link to quality improvement. Yet
10 little progress can be shown on the workforce development
11 front because it's a tough issue.

12 Again and again, individual strategies are
13 developed to tackle the issue, but the complexity of the
14 issues themselves creates a moving target. To put this
15 issue front and center, we've revised the matrix to include
16 workforce development. There's been a lot of work through
17 the Annapolis Coalition, a lot of work out of CSAT and CMHS
18 and CSAP to identify what are the problems and not only
19 focus on recruitment but retention in the field and what
20 type of training needs to take place in the academic
21 institutions, how do we prepare a workforce, what type of
22 incentives do we need to put in place, what type of people
23 and professionals need to be in place in frontier, remote,
24 rural areas, where the challenge is just overwhelming with
25 workforce development in terms of trying to find the

1 resources that people need there.

2 Again, we've identified models, models that are
3 working in certain areas that we're getting information on,
4 behavioral health aides, for example, working in the
5 villages in Alaska Native villages. We see a model
6 emerging out of the University of Alaska in Fairbanks in
7 examining how can we bring some of those things to scale,
8 what can we learn from that. That's just one example of
9 many.

10 So we need to bring a force of focus. We need
11 to bring resources around workforce development and really
12 come up with a plan that's cohesive and gives results.

13 The same will happen with suicide prevention.
14 Again, that's a state priority in the matrix now. Data
15 from our Household Survey again indicates that 900,000
16 youth had made a plan to commit suicide during their worst
17 or most recent episode of major depression, and 712,000
18 acted on that plan by attempting suicide. When faced with
19 the fact that the number of suicides outnumber homicides by
20 3 to 2 in this country, the urgency and immediacy of the
21 need to take action I think speaks for itself.

22 I've often said my role as administrator is
23 that of being a temporary steward, and I view my
24 responsibility as administrator to make solid program and
25 management improvements that will last beyond my tenure.

1 You've got to think beyond where you are if you're really
2 going to make a difference. I'm hopeful, as I look around
3 this room and see the many stewards of these changes, that
4 the progress made will far outlast my tenure.

5 A lot has been accomplished. Much more remains
6 to be done, obviously. I feel like we only scratched the
7 surface in terms of the needs that are out there. I
8 believe strongly that SAMHSA should continue its service
9 also to the international community, as we've been working.

10 It's interesting that in the developed nations that have
11 been coming together around working together, the United
12 Kingdom, Great Britain, Scotland, New Zealand, Australia,
13 Canada, as we've been sharing and exchanging ideas among
14 countries, recovery, remarkably, is a common ground.
15 Recovery is guiding policy development in those countries.

16 There's an emerging commitment to really work with
17 post-conflict countries, where people are traumatized in
18 ways perhaps beyond our comprehension, in Third World
19 countries. I think we being part of that process is very
20 important, and later this morning you'll hear more about
21 SAMHSA's international initiatives.

22 Other areas that deserve continued focus and
23 attention are our efforts to continue reducing and
24 eliminating coercion, seclusion and restraint practices.
25 We need to combat underage drinking in this country and

1 really see the progress made with that that we've seen with
2 tobacco and illicit drugs. In a few minutes you'll hear
3 more on underage drinking with regard to the Leadership to
4 Keep Children Alcohol-Free. Our own Theresa Racicot will
5 be participating in that, as well as Michele Ridge, who is
6 here with us today.

7 Again, the past five years have given me the
8 privilege and opportunity to lead an agency that I think in
9 many ways, while it may be that historically SAMHSA is not
10 recognized as central to public health, I believe it is. I
11 believe mental health and substance abuse is very central
12 to public health. Again, I'll be forever changed and
13 grateful for the experience.

14 I wish you all the best in success as
15 ambassadors of SAMHSA. That concept developed with this
16 council. I appreciate your efforts, and I'm going to look
17 forward to SAMHSA's continued evolution in seeing the
18 individuals we serve and the families we serve benefit from
19 that as well.

20 Now I'd like to open my comments for
21 discussion. Thank you once again for your partnership,
22 your leadership and support in everything we've done in
23 achieving the priorities.

24 I'll open it up to the council. Thank you.

25 (Applause.)

1 MR. CURIE: Ken?

2 DR. STARK: Well, Charlie, I wish you the best
3 wherever you're going. You have shown really strong
4 leadership with SAMHSA. You know as well as I do that
5 there were a number of issues. Although we didn't always
6 agree on everything in terms of the states or SAMHSA, one
7 of the things that I know I personally believed was that
8 SAMHSA needed to show some leadership to sometimes drag us
9 along in making certain decisions, and I think you did that
10 in a number of areas. I think probably the biggest legacy
11 at least I believe you will leave that will be
12 longstanding, even after you're forgotten, are the issues
13 related to the data, the NOMS, being able to really start
14 measuring what we're doing. That is what's going to have
15 an effect over the long, long term to help people in the
16 community. I think that's a key. I think that's what puts
17 SAMHSA in the leadership role now that you can truly talk
18 to the other federal agencies and give them some clarity on
19 what you're trying to achieve, and that they can begin
20 adopting those same measures so you can have across the
21 federal government, as we need in states across state
22 government entities, consistency in those outcome measures.
23 So I really applaud you for that and I think you've done a
24 great job there, and in a number of other areas too.

25 I do want to encourage, in your short tenure

1 that's left and whoever takes over after you leave,
2 encourage the collaboration particularly with NIMH and the
3 other institutes, because it's absolutely critical that
4 because SAMHSA doesn't have either the authority or the
5 resources to do the kinds of research and evaluation that
6 we need to truly continue to validate both the programs
7 that we're currently doing, as well as adopt other
8 innovative research-based projects and implement them in
9 the community, we need the resources of the institutes to
10 be directed to coordinate with the programs that are funded
11 through the states. The states clearly can be
12 laboratories, as you know. If we collaborate at the state
13 level and at the federal level in terms of the service
14 dollars and the research and evaluation dollars, we can
15 truly maximize the credibility, if you will, of the field
16 that's going to be needed as dollars continue to get
17 tighter and tighter.

18 So I appreciate what you've done. I wish you
19 the best in the future. I hope to talk to you again
20 sometime, wherever you land. I plan on hanging out here
21 and doing the best I can to continue to give input.

22 MR. CURIE: Thank you, Ken. I appreciate very
23 much your kind words, and I appreciate personally our
24 collaboration and partnership and debates and different
25 things that have occurred through the years, which I think

1 all have been constructive and to the greater good.

2 I do really strongly believe that an area that
3 needs much more further clarity is the area of services
4 research. I do own the fact that I made the decision when
5 I first came aboard that SAMHSA was not a research agency,
6 we're a services administration, and we were doing some
7 research-oriented types of things that should be done in
8 the institutes. OMB loved that clarity, by the way, but I
9 think it opened up a challenge to make sure we don't lose
10 sight of a services research agenda. I think all three
11 research entities have responded to that at various levels,
12 and I appreciate it.

13 I think the partnership and collaboration among
14 NIAAA, NIDA and NIMH is stronger than ever. I do think
15 there needs to be more concrete effort to clarify that, and
16 also to make the distinction, and this is going to be an
17 ongoing process, between program evaluation and research,
18 because I do believe program evaluation, in terms of
19 effectiveness of programs and what we learn, is part of our
20 mission, and that should not be confused with research. So
21 that, I think, is an ongoing dialogue and does need further
22 clarity.

23 Thank you, Ken.

24 Kathleen?

25 MS. SULLIVAN: I'd just like to thank you, for

1 those of us who were sick. Thank you for respecting us,
2 and thank you for honoring us.

3 MR. CURIE: Thank you, Kathleen.

4 Barbara?

5 MS. HUFF: Kathleen, you were so short, I can't
6 believe it. I'll have to try to follow suit.

7 I've been around at this for a long time,
8 Charlie, and I just have to say thanks for your leadership,
9 because I would say in all the years that I have been
10 talking as an advocate, I've not had an administrator
11 that's ever listened in the same way and acted on it. I
12 remember some very emotional conversations we had as a
13 council around the issue of suicide, and it is now in the
14 matrix. So I really feel like you have allowed us to make
15 a difference as advocates. You've heard us, and I will
16 always say that I think it was really brave to have put me
17 on this council, knowing that it would be hard at times.

18 Anyway, I thank you, and I hope that it has --
19 to put a family member of a child who has struggled with
20 mental health and substance abuse problems, I mentioned
21 this yesterday too, that I hope it has set a precedent and
22 we can follow suit next time when my tenure is over.

23 Again, thank you for a tremendous journey.
24 It's amazing to actually do this work and see a difference.
25 Thanks.

1 MR. CURIE: Thank you, Barbara. That does mean
2 a lot coming from you, and I appreciate it very much.

3 MR. AIONA: Charlie, can I say something?

4 MR. CURIE: Hello, Duke. Faye will go, and
5 then, Duke, we'll have you go.

6 Faye, go ahead.

7 DR. GARY: Faye Gary. I, too, would like to
8 thank you and to thank you for a very thorough and
9 impressive report. I looked at the minutes and could
10 concur that our discussions have been very in-depth, very
11 pithy and very worthwhile. The follow-through is much
12 appreciated.

13 This is just my second council meeting, and I'd
14 like to thank you for making me feel welcome and for
15 allowing my voice to be heard, and also respected. Thank
16 you very much.

17 I want to also just reflect for a moment on
18 some of the initiatives and acknowledge the addition of
19 suicide and workforce. I want to reinforce workforce,
20 because workforce will make the difference in terms of how
21 all of the other principles and priorities in the matrix
22 are addressed, the three domains, whether it's the systems
23 issue, how we communicate with patients, or whether we are
24 providers. So I would like to really, really reinforce the
25 provider and workforce issue for sure.

1 The other piece is that what troubles me deeply
2 is the antecedents or the risk factors that people are
3 continually exposed to that lead to mental illnesses, and
4 also to substance abuse. Of course, in my mind's eye, I
5 think one of the greatest variables that influences
6 people's mental health is poverty. I would ask that SAMHSA
7 and perhaps the other institutes give more attention to
8 poverty as an issue that forces and shapes the lives of
9 people, especially children, and look at perhaps how there
10 might be some intervention on the front end.

11 While we are thinking about paradigms and
12 visions, I would also ask that all of us begin to think
13 about a cure for mental illness and add the word "cure" to
14 our vocabulary so that we can be hopeful that there can
15 indeed be a cure as well as prevention, as well as
16 appropriate, prompt treatment and recovery. But to the
17 vocabulary I think we also need to add "cure."

18 MR. CURIE: Thank you, Faye, and thank you for
19 your comments. I think you've articulated well why
20 workforce development is fundamental to the future and why
21 if we don't have a focus on that, no matter what we plan,
22 it will be to no avail. Thank you.

23 Duke, go ahead.

24 MR. AIONA: Thank you, Charlie. First of all,
25 I want to add my thanks to you for giving me the

1 opportunity to serve on this advisory council. It's been a
2 great experience for me. I've learned a lot. I've had
3 great colleagues to work with, and I thank you very much
4 for the opportunity.

5 I think you know as well as I do that when you
6 do work in this field, and also the systems that you're in,
7 that it's very difficult and it's a very, very big
8 challenge, and it has been a challenge for you. As you can
9 see, as everyone can see from this very brief report, that
10 much has been accomplished, and it's been accomplished in
11 the right direction.

12 I maintain, based on my experience, that if
13 we're going to make a difference in our communities, our
14 individual communities, our states, and of course our
15 country and the world, that we're going to have to do it
16 within, that the changes will have to be inside of people.

17 The environment is not going to change. Better homes,
18 nice clothes, those are not going to change us as a
19 community and as people. We're going to have to do it
20 within.

21 So what SAMHSA has embarked upon is truly
22 exciting, and I think I will stay with it as long as I can.

23 When I say as long as I can, that means until my last
24 breath is taken on this earth. Our lives are temporary,
25 but we're hoping that we're going to make life much better

1 for those who follow us, which means our children and our
2 grandchildren and everyone else. So I applaud everything
3 you've done up to this point in time, no doubt about it.
4 The only way that we're going to make improvements is that
5 we're going to have to have dialogue. We're going to have
6 to have collaboration. But most importantly, we're going
7 to have to have conflict and we're going to have to have
8 challenges. If we have that, we'll always be better in
9 what we do, and we'll always make improvements.

10 I just want to emphasize prevention. I think
11 you've done a great thing in regards to the Strategic
12 Prevention Framework. It's done a lot not only for my
13 state but I think for everyone who has had a chance to look
14 at the model and to do what it has to do with it to see a
15 tremendous difference within their state. That is probably
16 the toughest thing that we can do because of the collapse
17 of what I would call a measurable and something that's a
18 concrete outcome. But that is the key right there, and
19 that's where my emphasis is going to be in our
20 administration.

21 So again, Charlie, I just want to thank you for
22 everything that you've done. My only regret in all of this
23 is that I'm not there personally to shake your hand and to
24 give you a hug and say how much I appreciate what you did
25 and wish you the best of luck for you. Thanks.

1 MR. CURIE: Thank you, Duke, for those kind
2 words and for, again, being co-chair of this advisory
3 council and just your passion and undying commitment to
4 have a lieutenant governor to take our issues on. Last
5 night I had the opportunity to be with NAMI, the National
6 Alliance for the Mentally Ill, on the Hill, and they had,
7 Mark, I don't know, 10 members of Congress who dropped by,
8 which is a great turnout for any group. To see members of
9 Congress speak to the issues around mental illness, speak
10 to addictive disorders, speak to our issues, again I put it
11 in the category to have governors and to have a lieutenant
12 governor who take these issues on in the forefront, we know
13 our issues are such that typically elected officials don't
14 lead with mental health and substance abuse as their issue
15 to get the attention of the electorate and to get elected.
16 So you know when these issues are taken on, it's because
17 it's a true commitment and there's a level of courage, I
18 think, so we don't take that for granted.

19 So I just want to thank you for that, Duke, and
20 for your participation.

21 Tom?

22 DR. KIRK: Charlie, amen to what all others
23 have previously said. I think probably, at least in my
24 view, the most significant thing that your legacy
25 represents is change (inaudible) the choir. The vision

1 that you've set and the things that you tied together
2 brought people to the table who talk about mental health,
3 who talk about substance abuse, who never talked about it
4 before.

5 So I use the example of my next door neighbor
6 who may have little if any interest, but the way you
7 presented the agenda, the way you talk about it can get a
8 person like that to understand why this is so very, very
9 important. Part of the reason why that is so critical is
10 that I think the kind of efforts that have been made that
11 have resulted in more partnerships empowering people who
12 have mental illness, empowering people with substance abuse
13 disorders, the message of recovery empowers them, gives
14 them hope, and they represent a natural advocacy. So when
15 I'm going to my local representative in such and such town,
16 I don't have to talk about these things because he or she
17 sees that in the people within that particular community.

18 What's the advantage of that? A couple of
19 things. One of them is that mental health and substance
20 abuse issues become part of the agenda. They're just core
21 to the agenda. They're not something else. The people
22 that I have to deal with in terms of legislatures
23 understand that these are my citizens, these are in my
24 community, and they see it in a different way. The
25 president of the senate up in Connecticut, a conversation I

1 once had with him was that he said your primary challenge
2 is, frankly, to get all the different constituency groups
3 or stakeholders not to form circular firing squads, because
4 we don't understand what they want. One wants this, one
5 wants that.

6 I think a lot of that has served to be muted,
7 if you will. So I think that your vision and the way
8 you've communicated that has reinforced a lot of what these
9 folks said, but in many ways there is somebody named Joe
10 Smith, and Joe Smith lives in Stamford, Connecticut or
11 someplace else, who knows nothing about Charlie Curie, who
12 knows nothing about SAMHSA, but the emphasis on a life in
13 the community, that's a benefit to him. So to me, your
14 biggest legacy in many ways is all the things that I've
15 mentioned, but the thousands of people in this country who
16 somehow have resulted from the message that you've given
17 have a new hope, that they understand they don't need to be
18 ashamed of their mental illness or substance abuse issues,
19 and that that change is the kind of thing that after you're
20 gone and the rest of us move on to whatever it is we do,
21 Joe Smith is going to continue to move on with his life,
22 and that's an extraordinary legacy. You will never see Joe
23 Smith, but he's out there. He doesn't know you, but that's
24 the biggest difference in my mind. That, in my judgment,
25 came about because of the agenda that you set and the way

1 you communicated that whoever the audience was they could
2 understand what you were saying.

3 I remember you came to Connecticut and sat and
4 listened to the governor a little bit, and you walked out
5 of the office and you said she gets it. She gets it not
6 because of anything I've done as much as it is the kinds of
7 things that you put on paper and the way you spoke with
8 her. She understood it in such a way that she said mental
9 health may not be my agenda, or substance abuse, but I now
10 understand how it fits into my agenda, and that's an
11 extraordinary institutional change that you have much, much
12 reason to be proud of, and I thank you for what you've done
13 for us. Thank you.

14 MR. CURIE: Thank you. Thank you, Tom. Again,
15 coming from you, who I consider a preeminent leader in the
16 country and has used recovery to shape things in
17 Connecticut, thank you. Thank you so much.

18 One more? Larry.

19 DR. LEHMANN: Thank you, and I will be brief
20 but do have to very much thank you for your leadership,
21 your openness to working with other agencies such as the
22 VA. I think the President's New Freedom Commission and its
23 orientation towards recovery and rehabilitation really
24 helped us to move our agency along in that direction, and
25 really three things that to me have defined your

1 leadership, one being the President's New Freedom
2 Commission, but before that, in October and November of
3 2001 in New York City, the conference for community mental
4 health and state mental health leaders and how one deals
5 with disasters such as terrorist attacks. Most of those
6 folks have spent their lives dedicated towards working and
7 improving traditional mental health services. A lot of
8 them had never thought about these kinds of issues. That
9 was number one.

10 Number two, the New Freedom Commission. Then
11 after that, most recently, this March 2006 conference on
12 meeting the needs of returning veterans, where I think a
13 tremendous opportunity is offered for us in VA and the
14 Department of Defense to collaborate with our community
15 colleagues in helping to take some of these recovery and
16 rehabilitation-oriented concepts in dealing with this
17 newest generation of veterans, dealing with their problems
18 in a way that isn't just focused on pathology but focusing
19 on strengths as well as problems, and helping them to work
20 through that is really just a terrific opportunity for us
21 to emphasize and implement recovery and rehabilitation and
22 help people improve their functioning and their return to
23 civilian life. Thank you.

24 MR. CURIE: Thank you, Larry, and thank you for
25 your consistent support, participation, and leadership with

1 this council and with the collaboration with VA. I know
2 that Fran Murphy was there. Just her serving on the
3 commission and you supporting that process, again I think
4 it's as strong as it's ever been in terms of our
5 relationship there, and I appreciate that.

6 The other thing, you know, it's interesting
7 that one thing I've not mentioned and really should,
8 because again I think SAMHSA staff demonstrated just a
9 tremendous response, is after 9/11 the ongoing work with
10 New York, with New Jersey, with Connecticut, with the
11 states that were impacted directly by 9/11, and also
12 working with every state to develop a mental health and
13 substance abuse consequence module to their disaster plan
14 is significant, and staff worked very hard with that, and
15 then our response to Katrina. I'm going to have to begin
16 incorporating this in my remarks more. Maybe it's because
17 Katrina is just so recent, but it was a tremendous effort
18 on the part of individuals, and we're still engaged in the
19 Katrina effort because we know that mental health and
20 substance abuse consequences will emerge more and more over
21 time as we look over the next one to two years, and we've
22 got to be in it for the long haul.

23 But SAMHSA's response, its partnership with
24 FEMA in terms of being out there, we got the reputation of
25 the orange shirts, and the folks that we deployed -- I

1 think over 700 people were deployed down there under
2 SAMHSA's auspices, providing support wherever people were
3 appearing too, in grocery stores, on the street, in parks,
4 as well as providing over 75,000 clinical sessions in the
5 process. Again, I can't say enough good things about all
6 the centers' responses. In particular, it was centered in
7 CMHS, and we have the leadership of Anne Mathews-Younes,
8 Seth Hassett, Brenda Bruun, just to name a few key people,
9 who just really came through. I know the Secretary in the
10 Department viewed SAMHSA's response as just stellar, and
11 that goes to the credit of people who worked hard after
12 9/11 to really strengthen what a SAMHSA emergency response
13 center should look like, how that's hooked into the
14 Secretary's command center, and made us agile and
15 responsive. I don't want to forget that because I think
16 that's going to be ongoing in terms of capacity at SAMHSA.
17 Again, it brought mental health and substance abuse to the
18 fray.

19 Now that we have a quorum, we can approve the
20 minutes. Is there a motion to approve the December
21 minutes?

22 MS. HOLDER: So moved.

23 MR. CURIE: So moved, Diane.

24 DR. GARY: Second.

25 MR. CURIE: And Faye seconded.

1 Any discussion on that?

2 (No response.)

3 MR. CURIE: If there's no objection, the
4 minutes will then be approved. Thank you. That was
5 burdening me.

6 (Laughter.)

7 MR. CURIE: I wanted to get that out of the
8 way.

9 I now have the privilege of introducing two
10 individuals.

11 I'd ask Michele if you'd come to the table,
12 please, and Theresa.

13 First of all, Theresa Racicot, who you all know
14 is a member of our National Advisory Council. She's former
15 First Lady of Montana and has just been an unwavering
16 advocate in terms of addressing this issue of underage
17 alcohol use and stopping it and preventing it. Again,
18 she's been a strong voice on this council. She's been a
19 strong voice. She's worked very closely with NIAAA, has
20 really put a lot of her own time and effort day to day into
21 it, and really I think we've been privileged to have
22 Theresa's involvement in this and ongoing advocacy. She's
23 taking it to another level with her partner here, Michele
24 Ridge, who again it's a special privilege for me to be
25 introducing the former First Lady of Pennsylvania. Again,

1 I worked for her husband, Governor Ridge. I actually blame
2 him for giving me my start in public service directly back
3 in 1995.

4 When I talk about governors and elected
5 officials who take stands that aren't necessarily stands
6 they take because it's going to gain them more points in
7 the polls, Tom Ridge is somebody who I point to, and he did
8 that at many levels in Pennsylvania. I think people look
9 back at his tenure that his focus was good policy that was
10 reinforced over and over again. Secretary Houston, the
11 folks that worked from the governor's office said they
12 wanted sound public policy based on data. They made a
13 carveout decision for mental health and substance abuse,
14 which Diane is very familiar with, and it's still alive and
15 well today. It was a legacy of that period of time. It
16 was not a popular decision among some really key people,
17 but it was the right decision that was made.

18 I also want to recognize Mrs. Ridge for the
19 fact that she brought Communities That Care to Pennsylvania
20 in her legacy as First Lady. It was just an ongoing
21 passion and tenacity in assuring that 142 communities,
22 somewhere in that vicinity, implemented Communities That
23 Care. I'm not sure that any other state came close to
24 having that many as a concerted effort. But a
25 science-based approach to prevention which again informed

1 me a lot as I came to SAMHSA in terms of where we needed to
2 be moving and growing. So I credit that process and the
3 education Michele also gave me in terms of introducing me
4 to that process and what really worked, having a profound
5 impact in why we have Strategic Prevention Framework today.

6 Also, both of these leaders, again I think
7 you'll hear from them today about their passion in going
8 beyond the First Spouses' Initiative into another level of
9 ongoing support to assure we finally move underage drinking
10 in the same way we've moved tobacco use and we've moved
11 illicit drug use and getting society to take it seriously.

12 So I want to thank you for your ongoing leadership and
13 commitment, and it's my privilege to turn the floor over to
14 you.

15 MS. RACICOT: Thank you, Mr. Curie, for letting
16 us present this morning. Michele is going to give you just
17 a brief history of what the Leadership Initiative is.

18 I realize that we're preaching to the choir a
19 little bit, but this initiative is very important at this
20 point in time. So we're delighted to have the opportunity,
21 and I'm going to turn it over to Michele.

22 MS. RIDGE: Thank you, Theresa.

23 I just want to provide a little context for the
24 Leadership to Keep Children Alcohol-Free Initiative.
25 There's a Dr. Putnam from Harvard who wrote a book called

1 "Better Together: Restoring the American Community." I'm
2 sure most of you are familiar with it. He talks about
3 creating social capital and bridging social capital, and
4 when he talks about social capital he's referring to social
5 networks, norms of reciprocity, mutual assistance,
6 trustworthiness, and all of this takes time and effort.

7 When we talk about social capital at a national
8 or regional level, we're really talking about a network of
9 accumulation of mainly local concerns. How this dilemma
10 can be resolved is by creating networks within networks,
11 and I think that's the context for what's happening here.
12 Relationship building is a way of looking at the world, not
13 just a strategy.

14 In 1994, the National Governors Association
15 spouses group, in '93, decided to take on the issue of
16 breast cancer. So for two years the governors' spouses
17 voluntarily took on that issue in their respective states.

18 As a result of that, the folks at NIAAA were looking at
19 this model and decided that one of the things that they
20 thought would be good would be if they could get the
21 governors' spouses to be interested in not just underage
22 drinking but childhood drinking, the 9- to 15-year-old
23 children, that particular group.

24 So in 1999 the Robert Wood Johnson Foundation
25 and NIAAA of NIH started to invite governors' spouses to be

1 a part of this unique coalition of spouses, federal
2 agencies, and public and private organizations to prevent
3 the use of alcohol by children ages 9 to 15. As a result
4 of that invitation, there were approximately about 20, a
5 little less than 20 spouses that took this on. We know
6 that alcohol is the number one drug of choice of America's
7 youth, and we know that with every decade that passes the
8 age of onset of drinking drops a whole year. A lot of us
9 at that time had children in that age grouping, and we
10 heard lots of anecdotal stories. This was an important
11 public health issue that affected children and families in
12 our respective states.

13 So in March of 2000, the Leadership to Keep
14 Children Alcohol-Free Initiative was launched here in
15 Washington, and the governors' spouses took a pledge at
16 that time, and they made a public commitment: "To promote
17 the health, safety, and maximum potential for the success
18 of our nation's youth, we hereby commit ourselves to the
19 goals of the Leadership to Keep Children Alcohol-Free
20 Initiative. We solemnly pledge to do everything in our
21 power to ensure that the prevention of early alcohol use by
22 children is recognized as a priority concern for our
23 nation, educate the public about the many dangers posed by
24 early alcohol use."

25 In 2000, most journalists that these spouses

1 encountered were totally amazed at the statistics and at
2 the early onset of drinking.

3 "Encourage the use of research-based strategies
4 to combat underage drinking at local, state, and national
5 levels. Foster broad-based community involvement in
6 prevention activities. Cultivate a coordinated statewide
7 approach to the prevention of underage drinking by
8 fostering the cooperative action of relevant state and
9 municipal agencies, health care and service providers,
10 civic organizations, parents, teachers, and our young
11 people. Engage the energy and experience of young people
12 in alcohol prevention efforts, and encourage the media to
13 portray and report the negative consequences associated
14 with underage drinking and promote positive images of
15 non-use."

16 So this was the pledge that was taken, and it's
17 really essentially the pledge that's taken by all of the
18 spouses that are involved in this particular initiative.
19 The initiative's appeal, I think, to governors' spouses
20 was, first of all, the science that accompanied it. Most
21 of us -- I'm a volunteer. I'm a public librarian by
22 profession. I am not an expert in substance issues or in
23 mental health issues. But I do know from looking at my own
24 state and that it reflects pretty much what's happening in
25 the rest of the country, that this was an important public

1 health issue. Alcohol use by 9- to 15-year-olds is an
2 overlooked but very serious problem in this country, and
3 the one area statistically that we haven't been able to
4 crack is that middle school, the 6th, 7th and 8th grade
5 group, and it isn't just the alcohol use. It's the risky
6 behaviors that accompany the alcohol use.

7 So having the science backing this initiative
8 was very important to spouses, because it gave the spouses
9 credibility and it gave them the opportunity to go back to
10 their respective states and to recruit the state agencies,
11 to recruit advocacy groups, to recruit parents groups, to
12 recruit whomever they could get to the table to get
13 involved in the prevention of childhood drinking.

14 So the launch of the Leadership has also meant
15 that we've had a lot of conferences and regional meetings,
16 but we also have a very impressive website. On that
17 website, the Leadership funders and participants, we've had
18 a lot of partners. When I talk about creating networks
19 within networks, I think part of the success of the
20 Leadership Initiative has been just that, creating networks
21 within networks, and also in listing the health care field,
22 the American Academy of Pediatrics and the American Bar
23 Association, the American Medical Association, and using
24 scientific advisory groups to work with us.

25 I think one of the strengths of this initiative

1 and the uniqueness of it is that it has survived changes in
2 leadership at the top, and party changes, which is an
3 extraordinary testimony because that doesn't usually
4 happen. I think you can look at Wyoming and Hawaii as two
5 great examples of that, where the governorship changed
6 parties and changed leadership. It has bolstered state
7 infrastructure and produced concrete strategies to combat
8 the issue, and you can look at states like New Hampshire
9 and Florida, Wyoming and Ohio.

10 I think part of the strength of the initiative
11 also has been its non-partisan basis. We set the
12 initiative up with four co-chairs. I was one of the
13 original four co-chairs, but we picked two Democrats and
14 two Republicans because this is not a partisan issue. This
15 is a very important public health issue. So we modeled our
16 leadership on that same sort of non-partisan model that the
17 National Governors Association uses.

18 I think there are so many results that have
19 come about as a result of the initiative itself in the
20 states. I mean, you can get on the website, look at the
21 weekly updates, look at how active these spouses have been
22 and what they have been able to get other people to do.
23 They don't do it themselves. They get other people to do
24 it and provide leadership and a very public kind of face on
25 this issue of childhood drinking.

1 There's also been an impact on the national
2 level. The initiative has been able to have meetings with
3 Secretary Leavitt, and also with the Surgeon General, and
4 that has been important in our pressing the case that
5 childhood drinking needs to be an American public health
6 priority.

7 So the initiative exists today. You can see on
8 the screen there is a slide of the governors' spouses
9 leading the way. Those are the current spouses. There are
10 40 states participating in the initiative, and it is the
11 issue that drives people's participation. It is resolving
12 the issue that transcends maybe our different philosophies
13 and certainly our different regions, but we all are dealing
14 and grappling with the issue of children drinking alcohol
15 at the ages of 9 to 15 and the great peril that it places
16 them in.

17 I will turn this over to Theresa.

18 MS. RACICOT: Thank you, Michele.

19 As you can see, I always say this. I think
20 it's remarkable that there are 40 sitting spouses
21 represented on one particular issue, because on any given
22 day when you're a governor's spouse, you have the
23 opportunity obviously to partner with many things, from the
24 arts, a lot of people see governors' spouses as major
25 leaders of health issues for families, because

1 traditionally until recently they were always women. So
2 for them to choose this and stay with it -- as Michele
3 said, they did breast cancer, there was a wonderful
4 nationwide Habitat for Humanity women's bill that they did
5 at one time, they did literacy, they've done domestic
6 violence, but never have they stayed with anything, and
7 we're talking about six years now, with changes, as we
8 said, in parties. So that's remarkable in itself.

9 The other piece is we now have 18 emeritus
10 spouses. When you leave office a lot of times, like
11 Charlie, he's probably thinking this is a fabulous
12 experience, but I'm done for a while, and to have these
13 people stay involved at the level that they have -- and
14 they're all involved. You see Michele and I a little more
15 because we live in Washington, D.C., but we have a group
16 behind us that is very involved, very committed, and very
17 powerful.

18 Because of the emeritus group that came out of
19 the initiative, we realized that when the federal funding
20 went away, which is going to happen in September of '07,
21 this initiative would disappear. So we formed our own
22 foundation, the Leadership to Keep Children Alcohol-Free
23 Foundation, in October of '04, and we have 11 board
24 members, and we have bipartisan officers. I'm the
25 president, a Republican. Vicky Cayetano from Hawaii is the

1 vice president. She was a co-chair and is a Democrat.
2 Mary Herman from Maine is an independent. So that's an
3 interesting mix that we have going right now.

4 We are trying very hard to promote the work of
5 the Leadership, and our great hope is to get funded and
6 absorb the Leadership initiative into the foundation,
7 because there's no place else for it to go when the funding
8 drops off the table, and the bottom line is it's the only
9 group addressing 9 to 15, and we all know the importance of
10 what I call intervention, which is a treatment and
11 prevention when you get in early. So it's very important
12 that we don't lose this group.

13 They've addressed underage powerfully, but a
14 lot of times when you say underage to people, they're
15 thinking 17 to 20. Most people, when you say 9-year-olds,
16 they look at you like you've lost every cent you've ever
17 had. One of our spouses in Wyoming, the partner in her law
18 firm, she said I'm going to be gone the next few days, I'm
19 doing an alcohol conference, and he said, well, what's it
20 about? She described it, and he said why would you be
21 bothering with alcohol and 9-year-olds? I think that's a
22 powerful public opinion. These are children, and they're
23 not involved with alcohol.

24 So to keep the science going, which as Michele
25 said has been the driving force for recruiting the spouses

1 -- I have to tell you, whenever we can get them to a
2 conference and present the science, they sign on without
3 one hesitation. We have a scientific advisory board made
4 up of Enoch Gordis, who is the former director of NIAAA;
5 Dr. Alex Wagenaar from the University of Florida College of
6 Medicine; Dr. Richard Hyman, who is the chair of the
7 American Academy of Pediatrics Section on Adolescent
8 Health; Dr. Edward Hill, who is the president of the AMA;
9 and Stacia Murphy, who is the former director of NCADD.

10 With the sitting spouses, as Michele said,
11 we've been responsible and we pushed the General Surgeon's
12 Call to Action. I know our sitting spouses were very
13 helpful in the success of the town hall meetings that
14 SAMHSA did last fall. They've been supportive of the IOM
15 recommendations, trying to incorporate them in their
16 states. We're trying to push them more on the national
17 level. They maintain strong relationships with some of the
18 people that we've mentioned, the AMA, the AAP, the National
19 Association of Attorneys General. We were involved with
20 them in a meeting in San Francisco last year, and they're
21 looking at this issue very strongly, obviously from the
22 legal side and the cost to law enforcement and justice.

23 So currently we are working programmatically
24 with this pediatrician in Ohio who has a program out that
25 may actually change the screening of children in a

1 pediatrician's and a family practice doctor's office. He
2 has come up with a set of five questions to ask that would
3 open the door to whether children between 9 and 12 are
4 being exposed, are walking around the area with peers or
5 with influence in those kinds of ways. We're trying to
6 partner with him.

7 Let me tell you what our uphill battle is,
8 which is everybody's, and that's money. We're trying to
9 find money publicly and privately, but it's difficult. I
10 mean, it's not a popular issue, and it's a hard one to
11 sell, and obviously everyone is desperate for money. So
12 Michele and I, who have become known as the R&R team, are
13 knocking on every door we can find that we think possibly
14 might be willing to help this foundation move forward.
15 Frankly, as I say to people, it's not SAMHSA's problem,
16 it's not NHTSA's problem, it's not the American Academy of
17 Pediatric's problem. It's the community's problem. It's
18 all of our problem, and it's a major children's health
19 issue in this country and one that needs to be addressed.

20 So I thank you for the time today, and if you
21 have any questions, we'll be happy to try to answer them.

22 MS. RIDGE: I just wanted to add to Theresa's
23 comments that the CDC just came out with their 2005 Risky
24 Behavior Surveillance Survey. Seventy-one percent of
25 Americans between the ages of 10 and 24 die from car

1 crashes, injuries, homicide and suicide, and then they
2 listed the substances that are involved in that.
3 Forty-some percent of those incidents, alcohol is somehow
4 involved. So for our young children, it isn't just the
5 drinking of alcohol, although the pediatric research, the
6 brain research that's been done now helps to undergird our
7 efforts and certainly gives us some strength in raising
8 this issue with policymakers at all kinds of levels and
9 communities.

10 The fact that children who drink regularly
11 under the age of 14, 40 percent of those individuals will
12 have alcohol addiction issues to deal with as adults.
13 That's a tremendous gamble to take with people's lives. So
14 we really thank you for the opportunity to be here and
15 present at your council.

16 MR. CURIE: Thank you.

17 MS. RIDGE: Any questions?

18 MR. CURIE: I want to note that Duke Aiona, a
19 member of this council, on behalf of Governor Lingul, is
20 the representative on the First Spouses' initiative.

21 MS. RIDGE: Yes, some of the nation's governors
22 don't have spouses and they delegate that, and the
23 Lieutenant Governor has been leading the way in Hawaii, and
24 I think that's a great example because Benjamin Cayetano
25 preceded Governor Lingul in office. That's a great example

1 of this issue transcending party.

2 MR. CURIE: Any questions? Diane?

3 MS. HOLDER: I'd just like to commend you for
4 your work. It's so important. It was only about 15 to 20
5 years ago where people used to say that children actually
6 couldn't be depressed. There was a literature that said
7 childhood depression didn't exist. Over the last 20 years
8 we've learned a lot in terms of the fact that it does
9 exist, and I think in the same way that you're confronting
10 sort of an idyllic national perception that somehow
11 children are protected or that children actually don't
12 experience the kinds of things they really do experience,
13 because most of us actually don't want to believe it.

14 So I think that the kind of education you're
15 doing, the ability to get to pediatricians, is really
16 critical. One of my questions is how, with your networks
17 within networks concept, have you been successful in
18 engaging education in terms of a methodology in the door to
19 the schools where the kids are spending a huge percentage
20 of their time?

21 MS. RIDGE: Well, I think that that really
22 varies, Diane, between -- it depends on each state. If you
23 go onto the Leadership website and research that, I think
24 you're going to find some examples. A lot of it depends on
25 the structure of each state and how active the advocacy

1 groups are. I think usually the education model goes
2 through parents and some of the parent organizations into
3 the schools.

4 MS. RACICOT: The initiative is set up and has
5 to be set up this way, obviously, so that each spouse who
6 signs on signs on with their degree of commitment. Some
7 are very, very involved. Others, as I said yesterday, when
8 the spouse puts their name on it, it immediately raises the
9 level, and just doing that in their states is valuable,
10 opens them up to all the prevention and education
11 materials. But it is not a set format that if you sign on
12 you have to do X, Y and Z. So they all are doing different
13 things, very interesting, very unique, and when they come
14 together at the meetings that we've had, they share and go
15 back.

16 Mical Hoven, for instance, in North Dakota,
17 partnered with Appleby's to put table tents on their tables
18 because it's considered a family restaurant, even though it
19 does serve alcohol, and they helped to raise money for
20 billboards in her state, and that was just one of the
21 things that a spouse came up with that was unique and not
22 done by another state, for instance.

23 We need to mention, too, that Columba Bush is
24 one of the co-chairs of the sitting spouses' Leadership
25 initiative.

1 MR. CURIE: Absolutely. The council is well
2 represented in this process.

3 Barbara?

4 MS. HUFF: This was a little before your time,
5 Theresa, but --

6 MS. RACICOT: (Inaudible.)

7 MS. HUFF: I know. I keep saying that to
8 myself since I have such a history anymore.

9 There was a group of Congressional spouses who
10 came together around children's mental health in about
11 1990. The National Mental Health Association kind of
12 gathered them together, and they became the real advocates
13 for systems of care and the legislation that passed around
14 systems of care years ago. Without them, I don't know that
15 that would have happened. It might have, but it might have
16 taken a lot longer. Just the fact that this group of
17 individuals promoted children's mental health in the way
18 they did, it just rose to the surface.

19 So first of all, I'd just say thank you both
20 for your time and energy as volunteers in this effort. I
21 certainly want to say that if there's anything we can do to
22 be supportive, we would want to do that. So thank you very
23 much.

24 MS. RACICOT: Did the spouses group not
25 continue as an advocacy group?

1 MS. HUFF: I don't know. There's been talk
2 over the years about trying to kind of reinvent that. The
3 National Mental Health Association is going to be under
4 some new leadership, and that might be an exciting time to
5 try that. But no, they took that on and I don't know if it
6 wore them out, and they may have taken on other issues, but
7 not children's mental health after that. That was their
8 big thing, and being from Kansas we had Jim Slattery's wife
9 very involved, and Tipper Gore. That's when she really
10 first started in the area of mental health. So she chaired
11 it. It was a phenomenal effort, so I know great things can
12 happen when people have perceived power.

13 MS. RACICOT: Barbara makes a very good point.
14 They came together, they did it, but they didn't sustain.
15 Think of where you could be today if you had that group
16 behind all the time. The challenge, of course, with
17 political people is the recruitment. I mean, we're facing
18 a huge recruitment session coming up here because we're
19 going to lose a lot of these spouses. Some of them are
20 term limited and some of them are up for election. So the
21 other piece of this that we are working very hard on that I
22 should have mentioned is keeping the numbers up, because
23 the power is in the numbers. I just hate to see this
24 group, who can bring so many different people from so many
25 different walks of life, power, advocates, treatment

1 givers, prevention and education together, slide off the
2 table and leave this issue with no one voicing it.

3 MR. CURIE: Ken, and then Faye.

4 DR. STARK: Just a quick question. I haven't
5 tracked all the stuff you guys have been doing. I know
6 you've been doing great stuff. I just haven't tracked it
7 in detail.

8 How much have you gotten involved in looking
9 at, especially given the tie-in with the governors'
10 offices, around legislation, model kind of legislation,
11 beer taxes, other kinds of things in order to promote
12 prevention activities and to reduce access?

13 MS. RIDGE: I know that some of the states have
14 actually had their keg registration legislation go through.
15 I think governors' spouses generally fly under the radar,
16 and most times that's more effective. But I know that
17 Nancy Freudenthal in Wyoming has been very active on the
18 legislative front. She's an attorney and was involved with
19 the legislature even before she became first spouse. So I
20 think it just depends on each state. But there has been
21 legislative advocacy both within states as well as at the
22 national level. We worked very hard -- we'd have to go
23 back to the drawing board, I think, but we worked very hard
24 to get a postal stamp to get research. Part of the goal of
25 the initiative is also to encourage pediatric research and

1 the effect of alcohol on children, and we need to do more
2 research on that, the impact of alcohol on the brain, not
3 just on young children but how plastic the brain is.

4 So that's a long answer to your question, but
5 there have been some spouses who have actually been
6 successful at getting legislation passed, especially as it
7 relates to keg registration.

8 MS. RACICOT: Nancy Freudenthal was actually
9 very successful with that particular piece of legislation
10 with a group of high school kids from Cody, Wyoming. They
11 pushed that keg registration. When you're lobbied by young
12 people, it's a very difficult thing to walk away from.

13 MR. CURIE: Faye?

14 DR. GARY: Thank you very much for your good
15 work. I am most appreciative for the written brochure that
16 you've given. It's very informative and it's very well
17 presented. Thank you for that.

18 I wanted to get back to the comment that Diane
19 had made about a model, because I think as I see and hear
20 this discussion, it seems to me that your model or your
21 method, your paradigm if you will, would be very, very
22 useful for other people to be included in your network.
23 That's the part that's very intriguing to me, these
24 inter-networks. I wanted to ask, for example, a network
25 with the juvenile justice system where a lot of children

1 who are seen as typically hard to reach and
2 disenfranchised, isolated. So I would see that perhaps
3 given this model, that the juvenile justice system, as well
4 as Diane's observation about the school system, and also
5 faith-based organizations would be a part of this network
6 that I'm envisioning in my head.

7 So I'd just like to ask about that -- Girl
8 Scouts, Boy Scouts, where children congregate, recreation
9 centers, the YWCA. I see evolving a model that would
10 include many, many community organizations, but I don't
11 know if that's what you have in mind. So I'm intrigued
12 about the possibility of the model that could just paint
13 the community, if you will, and involve all of these
14 different segments, because I think the advantage that you
15 have is that you do speak from a position of power, a
16 position of visibility, a position of authority, and you do
17 have access, not only in the state but you have access to
18 power in the entire nation.

19 The other question that I wanted to ask is do
20 you have in place a process whereby your good works will be
21 evaluated so that you will know the impact that your good
22 work and the good works of other people and this network
23 system have on this problem that is very problematic for
24 all of us?

25 MS. RIDGE: I think in the individual states,

1 and I think Theresa maybe can also answer this, I think
2 your suggestions are wonderful. I think in the individual
3 states, a lot of spouses have brought together -- we
4 basically leave it up to the spouses, but we also provide
5 them with a lot of information about science-based
6 programming, research-based programming, and most of these
7 spouses are very good at bringing together all the elements
8 of a community, because I think you really don't get
9 change, especially at the local level, unless you really
10 get all the stakeholders at the table. So I think some of
11 the spouses have been successful.

12 The initiative does that individually by state.

13 The initiative tries to provide as much technical support
14 and resources for those individual governors spouses.
15 That's what's really going to be the mission of the
16 foundation, to continue that support, to continue providing
17 governors spouses with the resources.

18 Part of the incentive for people to sign up and
19 to participate in this initiative is also the fact that
20 there is an umbrella organization. Right now it's the
21 initiative. Our foundation is very new. It's fledgling as
22 a way to deal with the end of the federal contract in
23 September of '07. So the foundation itself is finding its
24 way, but its primary mission is to support the initiative.

25 MS. RACICOT: You know, Faye, on the evaluation

1 question, we haven't really had -- this is a novice here
2 saying this -- a programmatic process going that would
3 maybe speak to the kind of evaluation that I think you're
4 saying. I guess I would evaluate the work if you look at
5 the amount of materials that have been requested, and out
6 of the United States. I think our materials are in 40
7 countries, and I know they were printed and distributed in
8 large numbers around the town hall meetings. So in that
9 respect I think the materials and the information is very,
10 very valuable, and I would base the evaluation of that on
11 those numbers.

12 MR. CURIE: Any last comment or question?

13 Duke, do you have any comments or questions?

14 MR. AIONA: No, other than I thank Theresa and
15 Michele for the work that they're doing as a foundation.
16 What they said about sustaining it is very important. I
17 could go on for days about what we're doing in Hawaii.
18 Like I said yesterday, we're making tremendous progress.
19 We've got an aggressive campaign going on right now from
20 the governor's office, and it's all because of Leadership
21 that kind of spurred us on. I'm just proud to be a part of
22 it. It is a great model. It's something I think everyone
23 can learn from. So thanks again. Great presentation,
24 Theresa.

25 I'm sorry I'm not there. I had some nuts for

1 you, but I'm not there.

2 MR. CURIE: Thanks, Duke.

3 I want to thank you both for coming and
4 presenting, informing the council. It was an excellent
5 presentation. Again, thank you for your leadership and
6 commitment, which is truly making a difference.

7 (Applause.)

8 MR. CURIE: Now let's take a break, a 15-minute
9 break.

10 MS. VAUGHN: Fifteen minutes, with one comment.

11 MR. CURIE: Toian has a comment.

12 MS. VAUGHN: In front of you we've placed menu
13 selections for lunch. If you would circle the item, place
14 your name on the menu and give me the money, and then we
15 will place the order. Thank you.

16 (Recess.)

17 MR. CURIE: If everyone would gather back to
18 the table, we'll reconvene. Thank you.

19 I am pleased to introduce the next topic, but
20 first of all, one person I want to recognize, Craig Love,
21 who is a former National Advisory Council member, here
22 visiting us today and still very active as an advocate in
23 the field.

24 Thank you for being here, Craig, and for your
25 years of service on the council.

1 He was on the council when I first arrived, so
2 I feel like part of a full circle is being accomplished
3 here.

4 We want to focus now on SAMHSA's international
5 activities. Again, I want to stress that SAMHSA's mission
6 is primarily the focus is domestic. All of our
7 appropriation is geared toward domestic programs, and by
8 law we do not fund treatment programs or programs
9 internationally. So I want to go on record that our
10 international focus has not undercut in any way our mission
11 here in the United States and what we're to be
12 accomplishing, but we think it has helped augment our focus
13 by being able to be exposed to not only in our
14 international focus learning from other countries what's
15 working there, but also being in a position to help provide
16 technical assistance, help bring teams together of experts
17 in this country from academia, from various fields, to
18 provide the consultation, support and facilitation as
19 countries look to develop further their substance abuse
20 treatment delivery systems, their focus on prevention or
21 their mental health services delivery system.

22 We've had an international focus for many years
23 at SAMHSA. I would say that it has increased dramatically
24 over the past two or three years. Winnie Mitchell, who is
25 the team leader and policy coordination team in Daryl's

1 office, actually, is our international officer, and again
2 has been I think in that capacity for several years and has
3 seen things emerge.

4 Two of the areas that we want to focus on today
5 is the work that we have done both in Iraq and that we're
6 beginning to do more and more in Afghanistan. Over two
7 years ago I had the privilege of going with Secretary
8 Thompson to Baghdad. The coalition, the provisional
9 authority, as well as the emerging at that time Iraqi
10 government and health ministry had identified the three top
11 health priorities of infrastructure that they wanted to
12 build and address in Iraq to be, one, infectious disease
13 management; two, oncology, addressing cancer; three, mental
14 health. Actually, it was quite remarkable to see one of
15 our issues land in that top three, and I think it showed a
16 lot of insight on the part of Iraq. They were concerned
17 not only about assuring people with serious mental illness
18 in that country receive the care they need, and children
19 receiving intervention and care they need, but also
20 recognizing that they're a post-conflict society, that
21 they've been under tremendous trauma, if you will, under a
22 dictatorship and a violent situation for more than three
23 decades, and coming out now, of course, under a very
24 challenging time.

25 Fortunately, SAMHSA has done work with Project

1 One Billion, which is part of WHO, and Harvard has been
2 very much involved, Harvard University very much involved,
3 Richard Mollica in particular, in developing interventions
4 and approaches and working with health ministries of
5 post-conflict countries around the world. So there are
6 some ready models that we can begin to use in working with
7 Iraq and Afghanistan.

8 The approach that Iraq is taking -- and again,
9 one nice thing about the approach we've taken in Iraq as we
10 got engaged is the United Kingdom already was beginning to
11 engage Iraq at about the time that we were involved. An
12 individual by the name of Dr. Sabah Sadik, who is an
13 expatriate from Iraq who landed in England and was a
14 practicing psychiatrist at West Kent Trust in England, very
15 much got engaged back with colleagues that he had left
16 behind in Iraq to help build the infrastructure.

17 The way we approached it is we looked to
18 England, the United Kingdom, to be the lead partner in
19 rebuilding the infrastructure in Iraq, and we being a
20 partner helping to facilitate that process and enabling it.

21 It's been very inspiring to see how the individuals in
22 Iraq who are mental health professionals -- there are
23 approximately 90 psychiatrists in Iraq. Probably half of
24 those psychiatrists have been actively engaged in the
25 rebuilding of their mental health infrastructure. But some

1 key decisions that they've made in terms of their approach
2 is, one, they want to integrate mental health with primary
3 health care. As they build the primary health care centers
4 and systems there, instead of having a separate mental
5 health system developed and engaged, do it kind of in the
6 direction we're trying to do it now in the United States.
7 The disadvantage we have is we're not starting from
8 scratch. We've got to overcome structures that are already
9 in place to some extent. In Iraq, they're starting anew.

10 The second decision, which was a very
11 courageous decision that they made, I believe, over a year
12 ago in Amman, Jordan, in the way that we structured things
13 with Iraq is while I was in Baghdad initially because of,
14 obviously, the circumstances in Baghdad and various hot
15 spots in Iraq, we're not sending our teams to Iraq to meet
16 with folks, but we're bringing folks out of Iraq to come to
17 Amman, Jordan, where we did training over a year ago, as
18 well as strategic planning sessions, and then this past
19 March in Cairo. So we've had that ongoing process.
20 They're making good progress in Iraq.

21 The other courageous decision that they've made
22 is deciding to close Al-Rashad Hospital, which has been
23 their major mental health institution, if you will, for
24 decades in Baghdad. Unfortunately, it was used also as a
25 place to put political prisoners under Saddam Hussein, and

1 basically the conditions were just atrocious and
2 unimaginable. But they had the foresight, thinking in
3 terms of while a quick fix would be let's fix up the
4 institution and let's do an institution-based approach,
5 they recognized that if they did that, the institutions
6 would be sucking all the resources and there wouldn't be
7 dollars left for a community-based system of care and the
8 integration of primary health care. So they made a
9 commitment over the next few years to actually work towards
10 closing that hospital as part of their plan.

11 Afghanistan approached us last year. I think
12 partly they saw and heard what we were doing in Iraq, and
13 Dr. Fatimie, the health minister from Afghanistan, met with
14 me and Dr. Kakar, his deputy minister, who has a real
15 interest in mental health and I think helped put mental
16 health on the radar screen with Dr. Fatimie as well,
17 basically came and said we know what you're doing in Iraq,
18 can you do some of the same things for us in Afghanistan.

19 So again, we pulled together a team of folks,
20 had an initial meeting in Kabul a couple of months ago, and
21 basically began to set the stage for more of their
22 planning. They have I think a 10-point plan now that they
23 had developed. We put more meat on the bones of that plan.

24 Again, the approach we take here is they need to own the
25 plan. It needs to be their plan, and truly I can say with

1 confidence that both in Iraq and Afghanistan they don't
2 view this as a plan we developed or this is how we do
3 things. They truly do view this as their plan, and it
4 legitimately is.

5 Again, we have a long way to go in both
6 countries. Afghanistan doesn't even have close to the
7 infrastructure that Iraq has to begin with, so they're
8 really starting at a whole profoundly different level. To
9 give you an idea, I mentioned that there are 90
10 psychiatrists in Iraq. There are two in Afghanistan. So
11 again, there's a whole process of beginning to think about
12 how do you begin to build professional workforce, how do
13 you begin to really have mental health available. Again,
14 the approach of integrating mental health with primary
15 health care is also the approach being looked at in
16 Afghanistan.

17 Both in Iraq and Afghanistan we're also
18 engaging the institutions that exist in their communities.
19 We also recognize that much of the culture there is very
20 tribal. We also recognize that we need to think in terms
21 of cultural competence, as we do here in the United States,
22 and also engaging their religious leaders and faith-based
23 leaders, who are viewed as an important resource in their
24 communities. They are all actively engaged in both Iraq
25 and Afghanistan. So it's a very exciting venture. It has,

1 again, been a profound experience for me to really see the
2 commitment that folks make.

3 One thing that struck me in this past Iraqi
4 consultation in Cairo -- and my heart really goes out to
5 the Iraqi doctors and professionals. In Amman there was a
6 lot of hope you could see over a year ago, and they're
7 moving ahead in excitement. Cairo, because, as we follow
8 the news, we know the insurgency has just been brutal in
9 Iraq to a large extent, that has taken a toll in terms of
10 how they view things because of what they're experiencing.

11 I think they view that it's going to come to an end at
12 some point as the Iraqi government takes hold, so they're
13 still very hopeful, but you can tell the trying times does
14 have an impact on the process.

15 The other thing, most of them being
16 professionals and doctors, they're also targets of
17 kidnapping. This is something I've learned goes on over
18 there that we may not hear about in the news quite as much,
19 but it's not unusual for someone who is viewed as having an
20 income or some means to be kidnapped off the street, be
21 held for ransom once the terrorists or whoever are
22 kidnapping, get the money, they release the person. But
23 it's still just an added stressor, obviously, that it's
24 hard for us to comprehend in our day to day life.

25 Of course, very much their families were on

1 their minds as they were in Cairo. As they got into the
2 conference at Cairo, they very much I think benefitted from
3 the process. But again, it just reinforced some of the
4 challenges that are involved.

5 I would like to now introduce to you Winnie
6 Mitchell, our international officer. Again, she works in
7 Daryl's shop. She'll share some of the details of what
8 we're doing internationally.

9 Winnie?

10 MS. MITCHELL-FRABLE: Thank you, Charlie, and
11 I'll just stay up here if it's okay with everyone.

12 I just personally want to say, and I've said
13 this to Charlie, that it's been an honor to be with him the
14 last couple of years on this. I've never been so excited
15 about my professional career and just felt like it was a
16 magnificent opportunity, thanks to Charlie.

17 I just wanted to go back to what Charlie said
18 about him getting involved internationally in such a big
19 way and going to Baghdad with former Secretary Thompson. I
20 think that both Charlie and he talked about health
21 diplomacy, and I think everyone in this room, and certainly
22 all the members of the council, understand that when you're
23 focused on the common good of improving mental health,
24 behavioral health, the health of children, the health of
25 people, the goal is bigger than one conflict and one

1 approach. So it's really common ground for us to go out
2 and work with our partners and colleagues in the developing
3 world.

4 What we've also learned is there's a real
5 yearning to know what we in SAMHSA, what you around this
6 table know. The developing world wants to know about how
7 to do services. They think that research is important,
8 they think evaluation is important, but in the first
9 instance what they're asking for is information about how
10 to address the needs of the people they see right in front
11 of them, and how to get the services going.

12 Where we work, as Charlie said, I want to just
13 show you on the map. Where we work is in Iraq, which is in
14 green; Afghanistan, which is in yellow. The Central
15 American countries, we've just started a very exciting
16 collaboration, again under Charlie's leadership, with the
17 U.N. Office on Drug Control and their work in Central
18 America to improve substance abuse treatment in all the
19 countries, and I might add Belize, including Gwynneth
20 Dieter, is now responsible for getting Belize as part of
21 that network. So the brown is where we're working there.

22 I also want to just tell you that Russia is now
23 back on the radar for SAMHSA's international work. Thomas
24 Christina is in the background there, but we are working
25 through the President's AIDS work to really resurrect some

1 work that we did in Russia in the late '90s on substance
2 abuse prevention and screening based on our TIP 24, with an
3 important component of that TIP 24 being a module on
4 helping primary care workers screen for substance abuse as
5 an HIV prevention tool. So all of that work is kind of
6 coming back, and we're working very carefully to resurrect
7 that work.

8 I would also tell you that you'll see in red
9 that there's Vietnam, and there should be red over in
10 Geneva. As you may know, Carl White from CSAT is on detail
11 to Vietnam right now, working again on AIDS activities, and
12 we also have a detailee, Dr. Tom Barrett, to Geneva working
13 on mental health activities. WHO Geneva and WHO in many of
14 its regional offices has become a very important
15 collaborator with us in our work in both Iraq and
16 Afghanistan, certainly in Central America, and really all
17 over the world.

18 Now, the purple, you might ask, what's the
19 purple? The purple are the countries that are the members
20 of the International Initiative for Mental Health
21 Leadership that Charlie co-founded with his colleagues in
22 England and New Zealand, and Charlie mentioned this
23 organization to you before. It's the organization that
24 really has put innovation and life to recovery, and it's
25 given Charlie an opportunity to really share innovation and

1 different kinds of how-to's with his colleagues in these
2 English-speaking developed countries that are members of
3 the International Initiative for Mental Health Leadership.

4 Now, let me turn to Iraq and give you some of
5 the more bureaucratic details to really flesh out what
6 Charlie has already told you. As Charlie said, one of the
7 first things we did was to establish a planning group, and
8 the planning group includes not only folks from SAMHSA but
9 also our colleagues from the National Institutes of Health.

10 Both NIDA and NIMH are members of this council. We have
11 ongoing participation from HHS Office on Global Health. We
12 also have membership from our Department of Defense and the
13 State Department. This planning group also, most
14 importantly, the members include Dr. Sabah Sadik, who
15 Charlie told you about, the national mental health advisor
16 for Iraq, and our colleagues in Baghdad, his deputy Dr.
17 Mohammed Lofta, and Dr. Ronika Growley. You'll see
18 pictures of them soon.

19 But we have a conference call with this working
20 group, which includes the folks in the United States and
21 the folks in Baghdad and the folks in England, at least
22 every two weeks. I'm saying this only because at least
23 what I have learned is that a device like this, a tool like
24 this is critical when you're working with developing
25 countries where things are so difficult on the ground.

1 Having a regular meeting every two weeks gives them hope,
2 gives them something to sustain, helps them over things.
3 It's basically become kind of a mentoring group, an ongoing
4 support and technical assistance group, if you will, for
5 our colleagues in Iraq, and it's been really an important
6 device.

7 So this planning group is alive and well, and
8 we still meet every two weeks. We held the 2005 Action
9 Planning Conference in Amman, as Charlie said, and
10 significant progress on the recommendations made there:
11 closing Al-Rashad, as Charlie said; developing a code of
12 practice for mental health; and instituting a referral
13 system, which was really a trick in Iraq given all the
14 different kinds of things that are going on. But we were
15 very grateful to hear when we got to 2006 that they've
16 already institutionalized this referral system in three
17 provinces, three governances as they call them, and they're
18 going to be expanding them to 12 governances by the end of
19 this year.

20 In 2006, as Charlie said, I wanted to tell you
21 personally what I saw. The first day that the folks
22 arrived in Cairo from Baghdad, they were nervous, they were
23 angry, they were yelling at me. I hope they didn't yell at
24 Charlie. They may have. But everybody was like this, just
25 really, really anxious and full of dread and kind of tired.

1 Well, after they had gotten a couple of good nights sleep,
2 they'd had some really good food, they all of a sudden saw
3 people over the table they'd never talked with in Iraq,
4 Shi'ia talking with Sunni, Shi'ia talking with Kurds, all
5 this kind of stuff. They were at a professional conference
6 for four days. They did magnificent work. Charlie led a
7 group on mental health services that came up with
8 extraordinary recommendations that built on what they had
9 done in Amman. I saw the same thing in the mental health
10 policy group, extraordinary work. They were professionals
11 at a professional conference and they had a good time.

12 Then we had some problems at the end which took
13 them back to what they were facing when they went home, and
14 it all kind of came to an end, and they were nervous, and
15 they were frightened for their families. The only thing
16 that it evoked in me was the way I felt about my children
17 when we had the sniper incident here in Washington, D.C.
18 That was the way they were feeling when they had to go back
19 to Baghdad.

20 So I just want to show you some pictures. This
21 is our poster. This is the emblem of the National Mental
22 Health Council in Iraq. The man at the podium is Dr. John
23 Bowersox, who is the health attache in Baghdad, who has
24 been really instrument to our work. The gentleman by
25 Charlie is Dr. Sabah Sadik, and behind Charlie is our

1 collaborator in the United Kingdom, Irville Miller. Here
2 are some of the key Iraqis. These are expatriates and
3 people who actually work in Iraq. The gentleman
4 immediately right there is Dr. Santooma, who many of you
5 may recognize. He's been with the National Institutes of
6 Health for most of his professional life. He's an
7 expatriate and has been critical to our work in helping
8 Iraq reestablish its research capacity. Next to him is Dr.
9 Mahmoud Tumor, who is a leading cardiologist from Johns
10 Hopkins who is intimately involved in our work and goes to
11 Iraq every chance he can. Next to him is a gentleman that
12 Dr. Tuma and I are meeting with this afternoon, Dr.
13 Khalili, who is the cultural attaché for the Iraqi embassy
14 here in Washington, D.C. and is very instrumental to the
15 collaborations between the Institutes of Higher Education
16 and the training activities that we're going to be
17 subsequently doing. Next to him is the inspector general
18 for the ministry of health, Dr. Otil, who was very
19 important to me the last couple of days in making sure that
20 all the people got home safely to Baghdad. Importantly,
21 the woman there who is on the panel is Dr. Naima Al-Garsea,
22 who is in charge of Iraq activities for the World Health
23 Organization and has been our real partner in all this.
24 WHO has very effectively administered \$6 million of

1 training money for Iraq from Japan, and we've been working
2 with WHO in the U.K. every step of the way.

3 This is another scene of the conference. We
4 were in this room for quite a long time, so I just wanted
5 everybody to see that.

6 Now, we did have fun. The point of showing you
7 these is that the pyramids in Egypt are really in the
8 suburbs of Cairo, so I just wanted you to see that you
9 could really see that they're there.

10 These are two of my friends. These people do
11 not speak English. The gentleman is Dr. Tamar, who is a
12 judge in Baghdad, and the woman is a social worker from the
13 ministry of labor, and they've become two of my closest
14 colleagues even though they don't speak English. They're
15 wonderful. So I just wanted to show you that.

16 Here are the Iraqis having fun on the bus.
17 This is in the middle of the week when they were
18 professionals at a conference.

19 Then I also want to show you that our two
20 colleagues from Iraq, Dr. Mohammed Lofta, who is the
21 gentleman with the red tie, and Dr. Ranak Agroui, the woman
22 in the purple jacket, are the two that join us every week
23 on the planning group call. But we have expatriates from a
24 whole variety of communities in Washington, D.C. The
25 gentleman in the red shirt is Dr. Hussan Al-Atari, who is a

1 practicing psychiatrist from Fairfax, and right here is a
2 gentleman from NIDA, Dr. Al-Kashef, who does the work on
3 medications from NIDA and is intimately involved in all of
4 our work with Iraq.

5 Here's Charlie with our colleagues from Iraq,
6 Dr. Sadak in the light shirt, Dr. Lofta, and Dr. Agroui.
7 Here he is again with some more of our colleagues. I just
8 wanted to point out the young man in the brown jacket right
9 here is Dr. Nazar. One of the things we're going to be
10 doing over the coming years is supporting emerging leaders
11 in Iraq like Dr. Nazar and giving them extra opportunities
12 for training.

13 Here are our colleagues from the U.K. and from
14 Egypt. The gentleman with the tie on the far end is the
15 minister of health from Egypt, and then here is Dr. Sadak,
16 and then our two colleagues who have been intimately
17 involved with us, Mr. Miller and Mr. Wilkes from the U.K.
18 with Charlie. Here we are with our key collaborators from
19 Iraq.

20 Now I'll move on to Afghanistan. I just wanted
21 to tell you that it's all about people for me, and I know
22 for Charlie, and those are the wonderful people that we're
23 working with from Iraq.

24 In Afghanistan, as Charlie said, an
25 instrumental meeting about a year ago with Minister Fatimie

1 and Deputy Minister Kakar. We established a similar
2 workgroup on Afghanistan mental health, actually almost the
3 same cast of characters from the National Institutes of
4 Health, DOD, the State Department, our Office of Global
5 Health Affairs, and most importantly some expatriates
6 Afghan Americans on the workgroup, along with the embassy
7 of Afghanistan.

8 We held a meeting at the embassy in December to
9 further our plans, and I'll never forget when Deputy
10 Minister Kakar asked Charlie, well, do you want to come to
11 Kabul? And Charlie said, sure, why don't we do it in a
12 couple of months? Anyway, we did get the conference going
13 and we had the Partners' Conference on Behavioral Health in
14 Kabul recently.

15 I'm sorry this is such a dense slide. There
16 are handouts that will give you all the background. I just
17 want to tell you briefly about the handouts. There are two
18 pages on Iraq and two pages on Afghanistan. One of them is
19 a summary of the overall effort, and one of them is a
20 summary of the highlights from the conferences that we just
21 had. But this partners' conference was really interesting.

22 It was the first time people across Afghanistan working on
23 mental health had come together. The non-governmental
24 organizations that are doing all the service provision
25 there had never met up with each other. This is the first

1 time they ever came together. The funding partners who are
2 sponsoring all these activities in Afghanistan had never
3 met up with each other. So the real significant thing is
4 that all of them came together in one room.

5 The lessons learned are obvious. Short-term
6 training is not enough. They need ongoing support and
7 supervision. Finding and keeping staff is a challenge.
8 Women and children are the most vulnerable groups, and
9 everyone in Afghanistan has experienced violence and
10 trauma.

11 The challenges are how to define standards for
12 interventions, how to screen, how to provide substance
13 abuse services, another challenge for Iraq as well, and
14 limited public awareness of substance abuse and mental
15 health problems.

16 Recommendations are obviously to build human
17 capacity, to integrate behavioral health into primary care,
18 and to increase public awareness.

19 What we're going to do in Afghanistan is very
20 much like what we hope to do with Iraq, targeted support
21 for the implementation of their national strategic plan and
22 support for training, both in Afghanistan and training here
23 for emerging leaders.

24 Here's what it looks like. This is Dr. Kakar,
25 the Deputy Minister of Health, and Charlie. One of the

1 things they do in Afghanistan is they hire local painters
2 who make these big banners, and they put them in the front
3 of the hall in the Ministry of Public Health so everybody
4 knows that there's a big conference going on there.

5 Here are the people who came. I would say that
6 the young women in back are very interesting. The woman
7 with the glasses in white is a psychologist who was trained
8 very elegantly in Southeast Asia and gave a really
9 important presentation on PTSD and trauma in Afghanistan.
10 She's going to be an emerging leader, clearly, there.

11 The gentleman right here in front has
12 participated. His name is Dr. Tim Moshamosham. He runs
13 the one mental health hospital in Afghanistan and has been
14 a participant in the Project One Billion Harvard Program on
15 Refugee Trauma master classes for the last three years. We
16 sponsored him to go there, and he'll be going back.

17 I would also tell you that I'm showing another
18 picture because the gentleman right in front of the picture
19 is Dr. Azimi, who is the WHO lead in Kabul, Afghanistan and
20 will be very instrumental in the work that we're going to
21 be doing with Afghanistan because we're going to be working
22 very carefully with WHO. We've already had offers from
23 both the offices in Geneva, the offices in the Middle East,
24 and then offices in Kabul. So they will be very
25 instrumental to our work.

1 Now, here are some of the people, the emerging
2 leaders, and you'll recognize Dr. Anita Everett on the end
3 there. Dr. Rahula Nasiri is the mental health coordinator
4 who is our key person and who is on our calls with the
5 working group every week. Next to him in the red shawl is
6 Dr. Nahid Aziz, who is an Afghan American professor at
7 Argosy University here in Washington, D.C. She's our
8 ticket. She's the person who can teach us how to be
9 culturally appropriate in everything that we do, and she
10 has just been an amazing person. She's a clinical
11 psychologist.

12 Next to her is Dr. Peter Ventavogel, who is
13 with HNI, an NGO. He was the person who really taught Dr.
14 Nasiri everything about mental health and how to set up
15 institutions, and Dr. Ventavogel is now doing this kind of
16 work in Africa but came back for our meeting.

17 Next to him is Dr. Monsouri, who works for an
18 NGO in northern Afghanistan, and he was just an amazing
19 leader. I just do this to show you that there's really
20 amazing potential and talent in Afghanistan.

21 Here's Charlie with key actors, Dr. Kakar on
22 the end, Minister of Public Health Fatimie, who I know as a
23 real colleague of Charlie's and a wonderful man, and then
24 Dr. Nasiri. There's Charlie giving him his certificate.

25 Then I end with the one thing that I was able

1 to do in Kabul, which was visit a women's hospital. I
2 attended a very impressive case conference there. I think
3 you would all have been amazed at the standards of care and
4 supervision and clinical team work that goes on in that
5 hospital. I just wanted to show you the women who
6 participated in the morning case conference that we had.
7 It was very significant and important what they were
8 talking about, disease and infection control, the mental
9 health kinds of interventions they would do with the women
10 who are at this women's hospital.

11 Then just as kind of a way to leave you on the
12 key point about Afghanistan is there's hope. This was one
13 of the most beautiful babies I ever saw. They let me take
14 pictures of these gorgeous babies in this women's hospital,
15 and I just wanted to share that with you because that's
16 kind of the way Afghanistan felt. No matter what we hear
17 on the news right now, these people are amazing, and the
18 opportunity they have to overcome a lot and not make the
19 mistakes that we had as they integrate mental health into
20 primary care is really significant with their talent and
21 with their hope.

22 I just wanted to tell you briefly about the
23 International Initiative for Mental Health Leadership,
24 because this is a significant effort that Charlie really
25 brought to SAMHSA that I think really has potential for all

1 of you, and it is really our professional organization for
2 mental health leaders in the developed world. It's just
3 really significant what they were able to do.

4 The innovation shared -- Charlie has really
5 brought the elimination of seclusion and restraint to these
6 countries. We've talked about mental health systems
7 transformation. Kathryn Power talked to them. The peer
8 support and employment programs, the programs for native
9 and indigenous peoples, it was really amazing. They used
10 these things called exchanges in open spaces, and when I
11 went to their conference I was going what do they mean by
12 that? Exchanges are people like you. You would meet your
13 colleagues in these countries and really see what they do
14 on a daily basis. It's just extraordinary. The open
15 spaces gave everyone an opportunity to talk about what was
16 really important to them, who had participated in this
17 conference with their colleagues.

18 One thing that happened to me, all of a sudden
19 I was in a room with a bunch of people who do the same kind
20 of work I do in developing countries, and now we have our
21 own little workgroup. I'm going to learn from them really
22 a lot. So that was just truly amazing for me.

23 But I just wanted to tell you that the whole
24 thing was made possible by Charlie and his commitment and
25 leadership in this. It's been an extraordinary opportunity

1 for me personally, and I think for all of us in SAMHSA.
2 We've had amazing help from Wes Clark and his folks on
3 substance abuse treatment, and I'm really looking forward
4 to continuing working with them.

5 I would go back to Richard Mollica, who Charlie
6 mentioned from the Harvard program on trauma, for the
7 lessons that I've personally learned. I know that I've
8 learned from Charlie and I've learned from Dr. Mollica and
9 others that what you need to do is provide small, targeted
10 support -- I wouldn't even say dollars -- support over a
11 long period of time. The problem in the past with many
12 things that we've done is we've gone in with a lot of money
13 and we left, and what we've learned is you just go in with
14 a little bit of money every year and you sustain the
15 effort. You also go in on a regular basis. You have
16 regular meetings. You give people things to do. You say,
17 okay, we're going to meet in two weeks, we're going to have
18 this meeting in a month, we're going to come back in a
19 year. So you structure the effort so it gives you a way to
20 do things, a way to accomplish things, and you provide
21 hope.

22 Charlie, as I've heard you all say, has left an
23 enormous legacy in this area, and I'm really hopeful that
24 we can continue to do it. I don't know, without his
25 leadership it's going to be tough, but we're going to try.

1 I just thank you personally for this, Charlie.

2 Thanks.

3 (Applause.)

4 MR. CURIE: Thank you, Winnie.

5 I think you can see she has a lot of passion.

6 We try to get her more excited about it.

7 (Laughter.)

8 MR. CURIE: But Winnie has just done a
9 tremendous job in bringing focus and structure around this
10 and the ongoing efforts.

11 Let me open it up now for our council
12 discussion. Any thoughts, comments? Barbara?

13 MS. HUFF: You might know I'd have to ask this.
14 Winnie, are there advocacy organized efforts forming?

15 MS. MITCHELL-FRABLE: Yes.

16 MS. HUFF: Yes? All right.

17 MS. MITCHELL-FRABLE: And Charlie can tell you
18 about that. We have seen that be a critical recommendation
19 in both Iraq and, interestingly, Afghanistan. You know, we
20 made an effort to have a consumer in Cairo. He was a
21 psychiatrist, but he was also a consumer. So it was really
22 interesting.

23 I don't know, Charlie, if you want to add
24 anything to that.

25 MR. CURIE: Clearly, I think where we're seeing

1 the impetus for that occurring is for the International
2 Initiative for Mental Health Leadership as we partner with
3 them. Again, the United Kingdom is a partner with us in
4 Iraq, and I'm anticipating also Afghanistan, and Italy. We
5 have other partners there as well.

6 But at the International Initiative for Mental
7 Health Leadership, this was the third or fourth conference
8 that we've had. We had over 600 people, which is
9 remarkable. I still consider IIMHL a fledgling
10 organization, that we're still at the beginning, but this
11 year really took hold. I want to say over 80 matches, but
12 we have family members and consumers as part of that 600.
13 In fact, they're developing their own tracks in terms of
14 sharing among those countries how the consumer and family
15 movements are -- how they've developed, how they're
16 emerging. Clearly, that's going to be a major part of the
17 discussions as we continue to work with Iraq and
18 Afghanistan of empowering consumer and family voices in
19 participation in the policy development process, and then
20 ultimately in the treatment that occurs.

21 Any other thoughts, comments or questions? Oh,
22 Kathleen.

23 MS. SULLIVAN: Winnie, thank you. Did the
24 health workers find themselves to be security risks? Did
25 they find themselves in danger?

1 MS. MITCHELL-FRABLE: Well, as Charlie
2 mentioned, they clearly do.

3 Charlie, I'm sorry to tell you this, but
4 there's been increased violence against doctors these past
5 couple of weeks, to the point that there have been some
6 murders. They haven't been just held for ransom.

7 Dr. Khalili, the cultural attache that I showed
8 you, was the target of a kidnapping effort, and he and his
9 wife had to flee Iraq with nothing but the clothes on their
10 backs. So, yes, they're in significant danger.

11 MR. CURIE: It's very sobering. When you're
12 talking to them and working with them, it's actually hard
13 for us to be able to relate to that when we hear it, what
14 they're up against.

15 MS. MITCHELL-FRABLE: The only thing, as I
16 mentioned, was the way I felt about my children during the
17 sniper episode in Washington, D.C. a couple of years ago.
18 That's the only thing that evoked the kind of terror that
19 they feel.

20 MR. CURIE: Other thoughts, comments or
21 questions?

22 MR. AIONA: I'm just curious about that.

23 MR. CURIE: Yes, Duke.

24 MR. AIONA: Are they a target of attack because
25 the terrorists have identified them as a key part to

1 rebuilding the country or rebuilding the community, or is
2 it just because everybody is a target basically?

3 MR. CURIE: No, I think they're strategic
4 targets. I think two things. I think they are viewed --
5 anyone who is helping rebuild the government in a
6 constructive way is viewed as an enemy of the insurgency.
7 So clearly, again, the folks we're working with are very
8 much engaged with the health ministry of the current Iraqi
9 government, trying to be constructive and really build a
10 new future for Iraq.

11 Secondly, I think it also goes back to the fact
12 that these folks have means and are viewed as having more
13 of a solid income and way of making a living than a vast
14 percentage of the Iraqi population. So it makes them also
15 targets in that arena. I think it's both, but probably,
16 based on what we just heard from Winnie and what we're
17 seeing, I think the fact that they are viewed as part of
18 the establishment of the new government trying to really
19 make things work and bring stability -- and they do
20 represent stability there. I mean, they're a professional
21 cadre. They're very excited. Keep in mind that these
22 psychiatrists, many of them that stayed there and that are
23 in Iraq who are in their 30s and 40s, they were forced to
24 be officers in Saddam Hussein's army. There was no real
25 civilian or medical doctor workforce. So these folks,

1 that's been their life and professional career. Now
2 they're looking forward to having a civilian professional
3 life and developing that for themselves and Iraq.

4 So that's been very exciting for them, and
5 they're very excited about democracy. When you meet with
6 them, you become enthused about democracy all over again
7 because it's very precious to them.

8 MS. SULLIVAN: Charlie, I saw that the World
9 Health Organization was at the table, but I didn't hear --
10 should UNICEF, or should there have been an arm of the
11 United Nations -- was there representation at the table, or
12 should there have been?

13 MS. MITCHELL-FRABLE: Well, in essence, WHO is
14 the health arm of the U.N., and we work with WHO in very
15 close collaboration, and when it's appropriate they bring
16 in other entities. We also work with UNODC, the U.N.
17 Office on Drug Control. So we work very carefully with
18 Geneva and WHO, and they kind of bring in UNICEF. So
19 they're kind of our lead partner.

20 MR. CURIE: And they're both active in Iraq and
21 Afghanistan as well.

22 Well, Winnie, thank you very much for the
23 presentation. Thank you for the discussion.

24 I believe we're ready for a lunch break.

25 Let me have Toian guide you now. I'm not going

1 to assert anything right now.

2 MS. VAUGHN: We are ready for a lunch break,
3 but the food has not arrived. So maybe you want to go to
4 the restroom, or there are some little appetizers in the
5 back. As soon as the food arrives, then we will distribute
6 the meals.

7 MR. CURIE: Thank you.

8 (Whereupon, at 12:15 p.m., the meeting was
9 recessed for lunch, to reconvene at 1:15 p.m.)

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AFTERNOON SESSION

(1:25 p.m.)

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MR. CURIE: Let's reconvene for the afternoon session. Welcome back, everybody.

6

Duke, I know you're there as well. Correct?

7

MR. AIONA: Yes, I am.

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MR. CURIE: Great. Thank you for hanging in there with us. That's always challenging teleconference-wise.

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MR. AIONA: No. It's okay.

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MR. CURIE: This afternoon in our session, I think we have a very interesting session planned. It's an opportunity to really focus on a presidential initiative that SAMHSA has been responsible for implementing, and that's Access to Recovery. We're going to be hearing first from our Director from the Center for Substance Abuse Treatment, Dr. Westley Clark, the center which is responsible for the implementation of Access to Recovery for the development of and implementation of the RFA and, after the awards, the ongoing monitoring of Access to Recovery.

23

24

25

Then we'll be hearing from Tom Kirk, our own advisory member, who is the Director for Mental Health and Substance Abuse Services for the State of Connecticut, and

1 ATR was awarded to Connecticut.

2 Again, I would encourage Ken to share his
3 perspectives from the State of Washington as well in this
4 process. Ken is a veteran of the beginning implementations
5 of Access to Recovery as well.

6 I might mention here at the outset that I want
7 to remind folks -- and I shared this yesterday in the
8 hearing that Congressman Souder held yesterday around
9 methamphetamine treatment and approaches in discussing
10 Access to Recovery. The President originally proposed \$200
11 million for Access to Recovery and came the second year of
12 Access to Recovery at the \$200 million level and for the
13 third year, asking for \$150 million. I point that out
14 because Congress appropriated \$100 million each year for
15 Access to Recovery in the first three-year cycle. Again, I
16 think the context is many questions have been raised about
17 the fact Access to Recovery is only in 14 states and one
18 tribal organization. It's very limited. There are 66
19 states, territories, and tribes that applied. So there's
20 great interest in it. How can we do more?

21 Again, I want to remind folks that I think we
22 received \$200 million the first year, and the original plan
23 was the President had made a commitment to increase
24 substance abuse treatment capacity by close to a half a
25 billion dollars over a four- to five-year period, and

1 Access to Recovery and some dollars in the block grant were
2 a way of doing that. And there have been some increases in
3 the block grant along those lines as well. But,
4 unfortunately, we didn't realize that full amount.

5 That said, I know there's great interest on the
6 part of members of Congress and others in the field to see
7 the results of Access to Recovery. Overall, you'll be
8 hearing more about the data today. The data is very
9 encouraging in terms of more people receiving access to
10 treatment, to care, to recovery and recovery support
11 services.

12 Again, the future of Access to Recovery is kind
13 of in question right now if you take a look at the House
14 mark currently where the President's proposed budget was
15 for \$98 million, about \$100 million, to begin a second
16 cycle of three-year grants. Again, there was a goal set in
17 this Access to Recovery model, the second one, to give
18 incentive to states to leverage block grant dollars for
19 vouchers, and I think that whole issue, again, kind of
20 compounded and complicated people's perception of Access to
21 Recovery.

22 Ultimately the House mark ended up keeping the
23 money in the SAMHSA budget, but putting \$75 million in the
24 block grant and setting aside the \$25 million. And we did
25 have \$25 million set aside in ATR for methamphetamine

1 exclusively for use of vouchers. They kept the \$25 million
2 for methamphetamine but says it doesn't have to be
3 voucherized. It can be; it doesn't have to be. So they
4 really made it more of a Targeted Capacity Expansion
5 typical grant for us. So the money is there for treatment
6 capacity, but not in the context of ATR.

7 So I just kind of lay that out that I think
8 there are concerns that even, as we find successes with ATR
9 and lessons learned with ATR, there would remain a question
10 mark whether ATR is going to continue to be as it has been,
11 as one leg on the stool of financing which uses vouchers.

12 In any event, I'm excited about the fact that I
13 think there are a lot of lessons we can learn from Access
14 to Recovery. I'm excited about the fact that for the first
15 time we have funded recovery support services in a real
16 meaningful way, meaning not just treatment services of
17 treatment interventions, but helping pay for individuals to
18 access supports and services, pay for individuals in terms
19 of vocational areas and educational areas and housing areas
20 and ways of assuring they have the supports they need to
21 sustain recovery. Again, I think we're going to learn a
22 lot of lessons from that and we have a lot to learn today.

23 So with that type of background, I'd like to
24 now turn it over to Dr. Clark, our Director for CSAT, to
25 discuss SAMHSA's Access to Recovery program. Wes.

1 DR. CLARK: Thank you, Charlie. I want to
2 commend Charlie for his support for the Access to Recovery
3 initiative and for leading the effort on this presidential
4 initiative, which, of course, as he stated, the Congress
5 approved only \$100 million for this program.

6 We have discussed ATR before. It is a voucher-
7 based program that emphasizes consumer choice,
8 accountability, and effectiveness, which fit very nicely
9 within the SAMHSA paradigm of accountability, capacity, and
10 effectiveness.

11 The issue with Access to Recovery is, again, a
12 focus on recovery. Research shows that providing holistic,
13 community-based support services enhance treatment
14 outcomes. We recognize that substance abuse disorders are
15 often chronic, relapsing diseases, and we recognize then we
16 need something in addition to an acute episode of
17 treatment. Experience shows that ongoing community support
18 is important to sustaining recovery. We've learned that
19 lesson not only from the mental health consumer and HIV
20 peer communities support focus on recovery, but also
21 research on and lessons learned from nearly 65 years of
22 12-step groups and other self-help organizations in terms
23 of support.

24 AA would often say if you avoid slippery
25 places, it helps you avoid relapse. In many cases when I

1 ran an acute substance abuse, a 28-day program, when I
2 worked for the VA, I would wonder what happened to the
3 clients on day 29. And then when I ran an intensive
4 outpatient program and I would see people three, four times
5 a week, Friday would be the last day I would see them. I
6 would wonder what would happened to them on Saturday. The
7 key issue is that community support is inextricably linked
8 to recovery.

9 As Charlie is fond of pointing out, there are
10 many pathways to recovery. Treatment helps facilitate.
11 Some people have solo recovery. Others require medication-
12 assisted treatment, peer-to-peer recovery support services
13 often facilitate recovery. There is faith-based recovery,
14 12-step and other community-based recovery, and court and
15 criminal justice facilitated recovery. It's important
16 thing for us to recognize that there is no cookie cutter
17 that applies to all individuals. In fact, some people may
18 wind up having a number of these items in their recovery
19 portfolio that helped to facilitate their recovery. As
20 Charlie pointed out, you hear people saying, I tried this,
21 it set the stage for that, I tried something else, and I
22 was able to build on that, and eventually I arrived at a
23 point where I was in recovery.

24 In fact, I was in San Francisco doing a
25 conference on chronic inebriates, which is a small group of

1 people who consume a lot of resources as a result of their
2 alcohol problem, and they had a little skit. In the little
3 skit, they had some gentlemen doing the presentation, and
4 one of the gentlemen, before he went on to do his
5 particular role, pointed his finger at me and said, I know
6 you. Okay. So he got up and he announced, I am in
7 recovery. I am seven years in recovery, and I want to
8 thank Dr. Clark, which was of course me. He said, 10-15
9 years ago -- it's been that long -- Dr. Clark tried to help
10 me, and I want him to know that even though I did not enter
11 recovery right away, as a result of his efforts, I have now
12 been clean and sober for seven years.

13 In other words, you never know when you have an
14 impact, and the recovery process is not simply a model
15 where you go into a treatment facility or you get exposed
16 to a counselor or a psychiatrist or whomever and, bingo,
17 you're recovered. So I was quite impressed by that
18 because, indeed, it captures the notion that there are many
19 pathways to recovery.

20 What are recovery support services? They're
21 services designed to help people in recovery and/or their
22 family members and significant others initiate and/or
23 sustain recovery from alcohol and drug use disorders and
24 related problems and the consequences by providing social
25 support.

1 The Access to Recovery program goals were to
2 increase treatment capacity by expanding access to
3 treatment and support services critical to recovery; to
4 ensure genuine, free, and independent client choice for
5 clinical treatment and recovery support services at the
6 appropriate level of care; and to ensure that assessment,
7 clinical treatment, and recovery support services funded by
8 ATR are provided pursuant to a voucher being given to and
9 presented by the client.

10 So we empower the client by giving the client
11 the ability to purchase services. That's a key issue, and
12 we often talks in terms of recovery being an individual
13 responsibility or "this individual needs to get it," but
14 financing actually is not given in such a way that the
15 individual does have the power to make the decision.
16 Voucher programs permit that.

17 The Access to Recovery goal is to increase
18 treatment capacity by expanding access to recovery. Again,
19 recovery means that I'm participating in that process if
20 I'm the affected individual.

21 We expect that the administration expects the
22 program to address the treatment gap in other substance
23 abuse treatment programs, and the administration is
24 committed to expanding access to care to ensure that faith-
25 based organizations are utilized. And the administration

1 is cognizant of the need to intervene and address concerns
2 of fraud and abuse. It's a new program without precedent.

3 This was a bold, new experiment. We think it has been a
4 successful experiment, but it's a bold, new experiment to
5 reach out and bring an individual who is affected by
6 alcohol and drugs into a critical period in the decision-
7 making process.

8 Community- and faith-based organizations are
9 expected to be participants in this program as clinical
10 treatment and recovery support service providers. If we
11 talk about expanding the realm of care, the number of
12 participants, we need to make sure that we expand the
13 opportunities for care so that when we empower the
14 individual, there are those entities within the community
15 which can play a critical role in the recovery of that
16 person. I saw this when I visited some of the mission
17 programs.

18 I visited one in Santa Barbara and they were
19 offering all sorts of care. What they were saying is we
20 can't get state funds because we are a faith-based
21 organization. We handle detox. We handle job placement.
22 We handle literacy training. We handle skills development,
23 but we are shut out of state funds and block grant funds,
24 for that matter, because we are a faith-based organization.
25 I thought, gee, that just seems unfortunate because,

1 indeed, they were offering a full spectrum of
2 interventions, interventions that would assist a person.

3 And I particularly liked their focus on
4 literacy because it reminded me there's an operating
5 assumption, especially in a cognitively oriented strategy.

6 Many of our treatments are cognitively oriented, keep a
7 record, keep a log, keep a diary, read the big book, read
8 this, read that. And it's all predicated on one
9 assumption, that you know how to read, you know how to
10 write. If you can't read and you can't write, a lot of the
11 interventions will be lost. So this was a faith-based
12 organization that says, look, we realize that this is an
13 issue and we're putting something in place to address that,
14 and that was one of the first times that I had seen that
15 issue addressed so aggressively.

16 So the summary of ATR requirements include
17 assuring client choice of service providers; implement a
18 voucher system for clients seeking substance abuse clinical
19 treatment and/or recovery support services; and to conduct
20 significant outreach to a wide range of service providers
21 that previously have not received federal funding,
22 including faith-based and community providers. Even though
23 this is not direct funding, it allows the individual to
24 purchase care from providers who traditionally did not get
25 funding.

1 Examples of services that could be paid for
2 using the vouchers included detoxification, which is a
3 traditional service, brief intervention, group counseling,
4 case management, family services, sober housing, employment
5 coaching, 12-step groups facilitation, recovery coaching,
6 spiritual support, traditional healing. This again opens
7 the door for a wide range of strategies.

8 Now, as the council knows, ATR grantees are
9 some 14 states and one tribal organization, the California
10 Rural Indian Health Board. These are the states, and as
11 Mr. Curie pointed out, we've got Tom Kirk from Connecticut
12 and Ken Stark from Washington, but the other states are on
13 this list, as you can see on the slide.

14 We're requiring data. We want the grantees
15 responsible for quarterly data reporting to SAMHSA,
16 including financial data, performance, and outcomes data.
17 We have a requirement in this for seven domains. The key
18 issue is by focusing on outcome measures, we allow the
19 grantees greater diversity in their choices because the
20 focus is not on did you use this specific intervention, but
21 as a result of the intervention that you used, what were
22 the outcomes.

23 We required some provider-level data.
24 Participating providers will be reporting GPRA data to the
25 grantee, as well as performance and outcome data, so that

1 we have from the contact list the client by the provider,
2 up through the grantee, back to us.

3 We expect that the grantees are managing their
4 ATR programs based on performance. The whole focus is
5 outcomes. ATR grantees report financial and outcomes data
6 to SAMHSA on a regular basis, monthly reports and quarterly
7 reports. There is considerable targeted technical
8 assistance to grantees on this issue. Plus, we have site
9 visits and grantee meetings when necessary. We have an
10 upcoming grantee meeting in July addressing the next year's
11 expectations for ATR.

12 The GPRA performance and outcome data are
13 collected at baseline, i.e., admission to the program; and
14 then every two months during the treatment episode, that
15 is, between admission and discharge; and then finally again
16 at discharge. Our hope is to be able to characterize what
17 we're doing in this program.

18 Let me give you a quick overview of the current
19 state of ATR programs, where we are now, the status of ATR.

20 For the first time, all grantees have been able to
21 successfully upload all data through March of this year.
22 All technical problems related to upload into the Services
23 Accountability Improvement System have been resolved.

24 While we have our ATR team here, can the ATR
25 team stand? There's Roula. There's Andrea. Anybody else

1 back there at ATR? Well, Andrea Kopstein is the lead CSAT
2 staff person on ATR. Deepa is our lead SAIS. Is Pat Roth
3 back there? Did you stand, Pat? Trying to get data from
4 programs, as many people know, can be, shall we say, an
5 interesting experience, and the ATR team has worked very
6 closely. The states have been pitching in to make sure
7 that we get this information so we can tell the story.

8 The ATR program has exceeded its target of
9 clients served of 50,000 clients by this particular
10 juncture in time. As Mr. Curie pointed out, for the life
11 of the three-year grant, we expect to see 125,000 clients.
12 We're supposed to see roughly 50,000 clients by this point
13 in time. However, we've seen over 62,000 served by the
14 program since its inception. This represents 26 percent
15 more clients than originally projected. So the key issue
16 is that we are seeing people.

17 And you get variations and you'll see
18 variations in the structure because we're actually dealing
19 with 15 different projects. That's something I'd like to
20 remind people. 15 different projects. It's a nightmare to
21 try to harmonize data from 15 disparate projects. We've
22 got an adolescent program over here. We have a criminal
23 justice program over there. We've got all parties over
24 there. When you say, well, how are these programs similar,
25 the fact is they are similar based on a few basic points,

1 and then the similarities disappear.

2 Over 56 percent of the clients for whom status
3 and discharge data are available have received recovery
4 support services. As of March 31st, 43 percent of dollars
5 redeemed were redeemed for recovery support services. So
6 we've got a strategy which in a sense we've pilot-tested
7 with our RCSP program that we've integrated into the Access
8 to Recovery program, and we're seeing the results of that.

9 On average, 70 percent of those who use
10 substances were abstinent at discharge. 31 percent of
11 those unemployed were employed at discharge, and an average
12 of 62.2 percent of those who were socially not connected
13 became socially connected by discharge. An average of 81
14 percent of those involved in the criminal justice system
15 were not involved at discharge. An average of 30 percent
16 of those without stable living became housed by discharge.

17 So you can see that we are having an impact,
18 particularly in the area of abstinence and social
19 connectedness. We're working to get people through our
20 efforts employed and housed although, again, each program
21 is different. So we can't say, the program has got to have
22 a major housing component or a program has got to have a
23 major CJ component. We are working on our GPRA efforts.

24 Some people ask, well, what about the faith-
25 based component? As of March 31st, SAIS data indicates

1 about 30 percent of the dollars redeemed for clinical and
2 recovery support services provided by ATR had been redeemed
3 by faith-based organizations. That's roughly \$48 million.

4 And faith-based organizations accounted for
5 approximately 21 percent of all recovery support service
6 providers who have redeemed vouchers.

7 Faith-based organizations accounted for
8 approximately 33 percent of all clinical treatment
9 providers who redeemed vouchers. For example, let's just
10 use one faith-based organization example. Teen Challenge
11 providers are enrolled in 9 of the 15 ATR programs. The
12 total amount of ATR monies that have gone to this
13 particular faith-based group of providers is about a half a
14 million dollars.

15 Again, one of the things the council needs to
16 be aware of, there's a delay in the voucher redemption. So
17 these data are always a little behind what's actually going
18 on because of the reporting delay

19 But the fact is we have met our target in terms
20 of serving clients. We've expanded the number of
21 providers. We've expanded the involvement of community-
22 and faith-based organizations. So we are achieving what it
23 is that we set out to achieve.

24 In the start-up months of ATR, CSAT contracted
25 with nine faith-based liaisons who offered the grantees

1 technical assistance for recruiting faith-based providers.

2 These efforts made a significant impact on the program as
3 evidenced by the percentages of faith-based providers that
4 had redeemed vouchers.

5 In the upcoming months, CSAT will begin a new
6 contract aimed at improving clients' access to faith-based
7 treatment and recovery support services through the use of
8 faith-based transition coordinators. They will become
9 available for each grantee to assist in client care,
10 transition from assessment to treatment or recovery support
11 services, and other duties such as following up on client
12 referrals. So what we are attempting to achieve is
13 broadening the strategies that we employ.

14 Now, some people ask about, well, what about
15 methamphetamine, Dr. Clark? Tennessee and Wyoming deal
16 with methamphetamine. When they competed for the grants,
17 they made specific reference to this. But other
18 jurisdictions are encountering methamphetamine as a part of
19 their efforts, and so we don't want to minimize even though
20 they did not list methamphetamine as their target. I think
21 Idaho clearly points that out. A lot of the people that we
22 see suffer from methamphetamine abuse and dependence.

23 So let us look at ATR grantee-specific
24 activities. California has client satisfaction surveys
25 that indicate a high degree of satisfaction with their

1 particular model, their CARE services. The developed a
2 process to connect youth in juvenile facilities to recovery
3 support services during and after incarceration, as you can
4 see from the chart, the target, which is in yellow, and the
5 clients served, which is in green.

6 The California Rural Indian Health Board has
7 been enrolling clients and requesting vouchers online using
8 an updated voucher management system that significantly
9 reduced the time requirement for these activities. And
10 recovery support service provides and faith-based
11 organizations have been solicited in rural areas of the
12 state.

13 We look at Connecticut. I won't dwell on
14 Connecticut. We have Tom Kirk here who is going to talk
15 about the Connecticut experience. But it's excelling at
16 maximizing the funding resources it's received, and the
17 state is on track with expending its unobligated funds.
18 The program initiated the matrix model of enhanced
19 cocaine/methamphetamine intensive outpatient treatment, and
20 CSAT is providing technical assistance to the state in
21 preparation for this initiative.

22 Florida continues to conduct aggressive
23 recruitment in the following 10 counties: Charlotte,
24 Collier, Glades, Hendry, Lee, Citrus, Hernando, Lake,
25 Marion. This recruitment aims to build a more diverse

1 provider base which will facilitate choice for clients.
2 Florida reports that expenditures for direct services are
3 continuing to increase, and the state anticipates hitting
4 its monthly expenditure targets by the end of the summer of
5 this year.

6 Idaho has exceeded by 53 percent its target
7 number of clients served. Residents of many rural
8 communities can now receive services without traveling long
9 distances outside of their community. Idaho ATR has
10 facilitated access to culturally sensitive services for
11 Native Americans and increased access for Hispanic
12 communities.

13 Illinois is working directly with recovery
14 support services providers to refer individuals directly
15 into ATR assessment services and has increased and
16 expedited referrals for recovery support services
17 providers. The program has restructured its electronic
18 system by turning off unnecessary functions and adding new
19 functions supportive of ATR. Providers have been trained
20 on the system and have begun entering their own data,
21 reporting, and billing.

22 Louisiana has exceeded its target number of
23 clients served by 38 percent, and it recently added
24 outpatient treatment with buprenorphine services as another
25 clinical treatment service.

1 In Missouri, the provider meetings have
2 resulted in a significant increase in the use of recovery
3 support services vouchers. Joint meetings with clinical
4 treatment providers and recovery support providers continue
5 to facilitate cooperative working relationships.

6 New Jersey will use carryover funds to offer
7 small funding opportunities to the New Jersey AI community
8 and faith-based providers struggling to get started or
9 expand services. New Jersey has developed internships for
10 four undergraduate students to interview clients, collect
11 GPRA data, and spot-check for completeness and accuracy in
12 collected data.

13 New Mexico has increased the recovery support
14 service voucher value and expanded the services offered
15 under the voucher to include housing. A system-wide case
16 management structure has been implemented to enhance
17 outreach, retention, and follow-up for ATR clients. In its
18 third year, the state plans to use innovative strategies
19 for meeting its target client number.

20 For Tennessee, through a contract, the
21 University of Memphis is conducting client satisfaction
22 surveys six months after a person's admission to ATR, and
23 Tennessee has exceeded its target client number by serving
24 4,783 clients as of March 31st.

25 Texas. A brochure of providers contains

1 descriptions of each provider, hours of operation,
2 languages spoken, religious orientation, if any, and other
3 information about the program. Texas has conducted
4 training for all enrolled providers, as well as
5 participating courts.

6 The State of Washington, which Ken can comment
7 on. One of Washington's ATR counties, Clark County, has
8 recently added two new points of entry, allowing the
9 program to reach more clients. Washington has established
10 a strong collaboration with faith-based providers and
11 partners who provide points of entry, housing, drug-free
12 activities, and many more services. It has also exceeded
13 its target number of clients.

14 Wisconsin. The Governor's liaison to faith-
15 based organizations and community organizations held
16 meetings to educate the community about ATR. Its faith-
17 based Community Advisory Council developed a Web site as a
18 resource to faith-based organizations, and to encourage new
19 treatment and recovery support providers, Wisconsin has an
20 open and ongoing application process.

21 Wyoming ATR has effectively integrated with
22 existing mental health and substance abuse providers, thus
23 expanding capacity. And it streamlined the approval
24 process for new providers.

25 There are, obviously, ongoing challenges,

1 ongoing support for peer leaders. There are, of course,
2 ongoing issues of ethics and risk management. We're
3 working with jurisdictions on these issues of coordination
4 and collaboration with other systems of care. Monitoring
5 and evaluation. And, of course, as we enter the third year
6 of this project, it's the issue of sustainability. Those
7 will be some of the themes that we'll be discussing at our
8 next meeting.

9 SAMHSA has been a resource to the grantees.
10 They're not out there by themselves. We've provided
11 technical assistance on screening assessment, ASAM training
12 and software, ASI training and software, development of a
13 recovery support service screening instrument, and on
14 recovery support services in terms of rate-setting,
15 screening for these services, and eligibility criteria.

16 We are trying to make sure that we increase
17 faith-based and community-based organization participation
18 through outreach, recruitment, and marketing.

19 We are also providing to our grantees financial
20 management on expenditure management, the burn rate of the
21 grant, fiscal management, and of course, the issues of
22 fraud, waste, and abuse, which we have not had any
23 significant issues of fraud, waste, and abuse, but it's
24 always an ongoing issue in large grants. So we continue to
25 stress the importance of this.

1 We're providing general technical assistance,
2 in short, to our grantees, including client follow-up,
3 clinical services, cultural competence, developing provider
4 networks, GPRA, motivational interviewing, Native American
5 and Alaska Native issues, performance incentives,
6 performance management and quality improvement, and other
7 things that you see on the list on the slide.

8 ATR in the future. Mr. Curie has made
9 reference to the Choice Incentive Program and the
10 methamphetamine program. I won't dwell on that at length,
11 given the time. But as we know, the President proposes
12 using \$70 million for a Choice Incentive Program that would
13 provide up to 25 grant awards of \$1 million to \$5 million
14 to applicant states and tribal organizations to expand
15 choice through vouchers. The grants would be up to three
16 years, and it's intended to accelerate the progress
17 achieved by ATR.

18 Priority to the states that voluntarily commit
19 to using a portion of the SAPT block grant funds would be
20 prioritized. Grant award recipients would be able to use
21 up to 30 percent of their award for technical support to
22 convert their treatment systems to vouchers. And states
23 and tribal organizations that previously received an ATR
24 grant would be eligible only if they commit the lesser of
25 20 percent of the block grant or \$20 million to vouchers.

1 Now, again, Mr. Curie pointed out that the CIP
2 program did not fare well in the House in the full
3 committee. This issue still is on the table. Our hope is
4 that the CIP program will get some support from the House
5 when the full House votes, and then also from the Senate.
6 We'll just, obviously, have to wait and see, but the key
7 issue is this \$70 million.

8 If we do get this program, when the
9 applications come in, applicants will receive additional
10 points during the review process according to the
11 proportion of their SAPT block grant dollars and/or other
12 state funds that they agree to redirect to vouchers. We're
13 trying to leverage funds so that we can make this program
14 even more successful than it has been.

15 The funding criteria would align the award size
16 with the size and complexity of the state, territory, or
17 tribal organizations to be funded.

18 We expect outcomes. Applicants will have to
19 identify and commit to milestones and a three-year goal.
20 Data will be collected documenting block grant funds that
21 have been redirected toward voucher systems or other state
22 funding toward the new systems. And the results of the
23 changed system will be documented through our NOMs.

24 We are trying to promote innovative drug and
25 alcohol treatment and recovery through our CIP program,

1 should it be funded, and provide a wide array of treatment
2 provider options, and introduce into the substance use
3 disorder treatment system greater accountability and
4 flexibility.

5 And Mr. Curie also made reference to the
6 specific methamphetamine voucher program which would fund
7 up to 10 grants, roughly \$2.5 million each. The program
8 would focus on applicants from those states where
9 epidemiologic data and treatment data indicate high
10 methamphetamine prevalence and treatment prevalence. The
11 state data would be used. Community Epidemiology Workgroup
12 data would be used, and our NS data would be used.

13 Now, the House full committee has supported a
14 program of \$25 million for methamphetamine. In that
15 program that they've supported, the use of vouchers is
16 optional. So we'll see how that works with the full House
17 and then the Senate, and then we'll, obviously, have to
18 develop guidelines for grants under this program, should
19 both the House and the Senate approve of a program and the
20 President signs it.

21 We're going to use the methamphetamine funds to
22 support clinical treatment, support recovery support
23 services, and increase focus on participation of community-
24 based and faith-based organizations.

25 Thank you.

1 (Applause.)

2 DR. CLARK: Do you want to let Tom Kirk give
3 his presentation and let Ken Stark comment, and then I can
4 answer questions?

5 MS. VAUGHN: Kathleen has a question.

6 MS. SULLIVAN: It's just a quickie because,
7 Wes, I've always wanted to know this. Natrona, Wyoming and
8 in Appalachia, just explain to me why the methamphetamine
9 epidemic in those two areas.

10 DR. CLARK: Well, actually, if you look at the
11 epidemiology of methamphetamine, it's essentially swept
12 across western and midwestern states. Those jurisdictions
13 just chose to write their applications on that. Idaho, for
14 instance, did not choose to write its application, but is
15 providing methamphetamine services, and other jurisdictions
16 are seeing people with methamphetamine. We can probably do
17 methamphetamine the next time we have a council meeting,
18 and we can review the epidemiology of methamphetamine.

19 Tom.

20 DR. KIRK: Good afternoon. We are one of the
21 AtoR states. But what I'd like to do at the beginning is
22 give you a brief idea why we went after it, why it fits
23 into our larger vision.

24 My term as Commissioner began in May of 2000,
25 and prior to that I was Deputy Commissioner for Addiction

1 Services. One of the things that we did was that we went
2 to the mental health advocacy community. We went to the
3 addiction advocacy community, people in recovery, and said,
4 tell us what the system should look like. Tell us what the
5 values and design of the system should be. They gave us
6 what we call recovery core values, and those recovery core
7 values, in terms of programming, direction, and so on,
8 financing, we've used as a template to measure, if you
9 will, what we do. So that was one of the pieces.

10 The second piece is that I'm very much of the
11 opinion that we should be thinking of substance abuse and
12 mental health issues as health care, but I would put quotes
13 around health care, health care in the broadest sense, and
14 I'll tell you why in a minute. So if you come into our
15 agency, we are a health care service agency. Our
16 prevention services are geared toward promoting health and
17 recovery and sustained health through the treatment and
18 recovery support services.

19 I'm a psychologist by training. I worked in
20 the addiction area for a long, long period of time, as well
21 as mental health. Frankly, I think some of the messages we
22 use, we are responsible for some of the stigma that is
23 often associated with the field. We use these kinds of
24 terms. We talk about serious, persistent mental illness
25 and so on. And the basic message to Joe Q. Public is,

1 doesn't anybody get better? And I think we have to move a
2 different agenda. That's why I was particularly interested
3 in going toward the health care framework, but it also ties
4 in with why Access to Recovery was very important to us.

5 If you've seen one state, you've seen one
6 state. If you've heard this from one state director,
7 you've heard it from one state director. I think as a
8 field, sometimes as a funder, as well as a service
9 provider, we are treating a health care condition which
10 requires continuing care as an acute care model. So as one
11 lady told me, when I get too functional, I lose my
12 services. So in my view this is the way our system has
13 been funded, and what we need to do is move it towards
14 something like this.

15 Sorry. This is the way it is now. So I go
16 into detox. It's a crisis service. You pay X number of
17 dollars. It's relatively expensive. I go into the
18 hospital. I get through there, and then there's a slope.
19 We don't bridge between the two episodes of care. As a
20 result, we have this type of cyclical piece. Furthermore,
21 if I go to a detox program at this point of the state and
22 then I discharge and I move to another part of the state,
23 there's no continuity of care. There's no one who owns my
24 care, and that doesn't give us good results.

25 A rule of thumb that I use -- and it's very,

1 very oversimplified, but we've looked at some of the data.

2 In our system, we were spending probably 80 percent of our
3 resources on 20 percent of the population. It's high,
4 expensive, inpatient and residential detox types of care.

5 This is what I was interested in moving us
6 toward. The gaps between the acute care, between the
7 crises, find services that will link people to appropriate
8 follow-up care in the community such that we don't have
9 those repeat episodes. So one of the things we had done
10 was we looked over X number of years of data and said, let
11 me find out those persons who have gone into detox more
12 than X number of times within three months. Let me find
13 those persons who have gone into inpatient psych admissions
14 acute care X number of times within a certain number of
15 months. Those are very, very significant numbers. Our
16 view was that we were undertreating or possibly poorly
17 treating those folks and we wanted to find ways to give us
18 more effective responses.

19 As Dr. Clark mentioned, many paths to recovery.

20 Some people can have a substance abuse issue, never went
21 to formal treatment, whether it's a spiritual community,
22 whatever the avenue is, but there are any number of people
23 who never went into treatment but they're in a path toward
24 recovery.

25 The overall, single overarching goal of our

1 agency is toward what I call a value-driven recovery-
2 oriented system. "Value," as used in this term, is not
3 things like honesty and faithfulness and all that sort of
4 stuff. "Value-driven" means the highest quality of care at
5 the most reasonable cost. So when we look at services and
6 someone comes in and says, I want to add a new service, my
7 question to them is, show me the value added that's going
8 to come from this particular service as compared to just
9 throwing money at an issue. So there's a strong quality
10 component. Are we as sophisticated in that as we would
11 like to be? No, but that's part of the vision.

12 The recovery-oriented. My view of recovery
13 orientation is I am responsible for my own recovery. I've
14 managed my own recovery. It is a process. How I handle
15 that is my responsibility. My responsibility as a funder
16 or as a provider of service is to offer the person in
17 recovery the tools that they can use to move on and stay in
18 recovery.

19 The collaborative tools. Collaborative tools
20 means partnerships with the recovery community,
21 partnerships with other state agencies, partnerships with
22 collaborative funding sources. Those are the three drivers
23 that support our overall strategic goal.

24 My point is to us AtoR is not just a program.
25 We're not just interested in chasing dollars to support

1 services unless they fit into the larger vision. So the
2 major focus has been what I tell the staff working on this:
3 tell me how we can use AtoR to mesh it into the rest of
4 the service system based upon the things that we learn from
5 that. So it fits in our overarching goal. Recovery or in
6 the service system, AtoR is supposed to drive that.

7 The second thing was building on previous
8 infrastructure types of activities. One advantage we had
9 was that there's a carve-out of dollars from the social
10 service agency, something called a general assistance
11 program. It's about a \$70 million pool of funds for
12 persons who receive general assistance, and we're
13 responsible for the behavioral health care. One of the big
14 advantages -- what does that have to do with Access to
15 Recovery? Built into that model is something known as the
16 Administrative Service Organization that we fund. They do
17 the authorizations. They pay the bills and other kinds of
18 things based upon our standards. That clearly gave us a
19 step up when we moved into Access to Recovery.

20 The Connecticut system, as far as substance
21 abuse, oversimplified, maybe 165 agencies of one type or
22 another around the state. The state is really divided into
23 five regions. We don't have counties. We have 3.5 million
24 people. So when we went into the AtoR, we said, we will
25 fund a single network in each of the five regions, and we

1 did it based upon an RFP. So these providers had to come
2 together, sign agreements, and clearly show their options,
3 in terms of choice fitting in with the voucher approach,
4 and the other kinds of things in accord with AtoR. Two of
5 the provider networks that came through we would not accept
6 their proposal at first glance. They didn't seem to
7 reinforce choice. They didn't seem to have some of the
8 qualifications. We said we will put it back out to bid
9 unless you can come up with these other qualifications, and
10 they eventually did.

11 Part of the reason why I mention that is that
12 as we go through funding over the next couple years, we're
13 being mandated by our legislature to take our entire
14 service system and rebid it. This may well give us the
15 opportunity to use AtoR principles as a driving force and
16 rebidding of the service system.

17 Five networks. Notice 135 recovery providers,
18 including peer and faith-based, as well as the clinical.
19 One lead agency in each of those networks, if you will,
20 owned the network, and they had responsibility for
21 management, if you will, of the overall piece.

22 One of the things we did was that we looked at
23 what are the agencies or portals where the folks are that
24 we would like to engage, particularly those who are not in
25 the service system. They're earlier in their substance use

1 and we would like to reach them. So we identified these X
2 number of agencies.

3 I particularly would like to have you look at
4 the DMHAS-funded Outreach & Engagement Urban Initiatives,
5 particular in the New Haven area, which is what you call
6 the south-central area. It's in the other areas also.
7 There's very strong outreach and engagement efforts for the
8 chronic homeless. These are persons sleeping under bridges
9 and all those sorts of things. They are heavy users. They
10 are heavy users of emergency departments and other types of
11 services. We already fund the case management services and
12 outreach for them, but we wanted to bring to them types of
13 services, recovery support, which would maybe move them
14 into stable housing, move them into other kinds of services
15 which would have sustained value.

16 Clinical services, self-explanatory in terms of
17 the range, the usual types of pieces.

18 Brief treatment was really something new for
19 us. I know in some other states it's much more the rule,
20 but we're particularly interested in trying to get to the
21 college population who is early-stage use, the EDs,
22 emergency departments also, where there's earlier-stage
23 substance abuse. Most of the others are fairly part of our
24 usual, but we wanted to put a greater emphasis on them.

25 You'll notice here no residential treatment was

1 part of our clinical services. Why? Because our funding
2 sources through other funding sources already supported
3 that particular type of approach.

4 Recovery support services. Self-explanatory,
5 but let me give you some more specific examples.

6 Transportation. We're talking about folks who any number
7 may not have transportation. They can't get to various
8 kinds of appointments. They don't have the resources to go
9 for employment opportunities. They don't have resources to
10 buy tools and so on. Transportation, housing,
11 vocational/educational services and those basic needs were
12 very, very important pieces. I'll give you an example.
13 It's not evidence-based, but it's anecdotal. But it struck
14 me as extremely important.

15 One of the things that our director of research
16 did in looking at women with children and coming into care
17 was that she noticed that women with children coming into
18 care, in late August and September, the admissions dropped
19 down. Why would that be? Kids are going to school. One
20 of the things that they built into that particular research
21 project was buying a backpack for the child, buying a
22 decent set of clothes to go to school. Those two things
23 were more important to those women than telling them that
24 they could have an appointment next Tuesday for services.
25 Were they in services then? No. Where they identified for

1 services? Yes. That type of approach, what might be
2 called a recovery support service, was more meaningful to
3 those persons than, if you will, treatment on demand.

4 So we played off of that. So food, clothing,
5 personal care. You get a voucher. If I was getting a
6 voucher, it would come from a provider. I would go to my
7 provider. They would say that I would get a voucher for
8 food or clothing or personal care. I would be told to come
9 on Tuesday between 1:00 and 4:00 to pick up the voucher.
10 Literally, it's a real thing. I'd take that voucher to
11 vendors that we had pre-authorized to provide these things,
12 Target, all the bigger stores. I go in with my voucher for
13 clothing, for example, which was worth, I think, 50 bucks.
14 I could get one of those one time a year. I present the
15 voucher, buy the clothing that I needed. That vendor then
16 takes the receipt for the purchase tied to the voucher and
17 sends it to our administrative services. They get paid for
18 that. So that's the way we control it. The personal care
19 items the same way.

20 Faith-based services, peer-based services. The
21 faith-based services -- my own point of view -- were one of
22 the most significant -- not so much the services. The
23 faith-based community was one of the most significant
24 sources of new persons coming into services as compared to
25 our usual system. Sometimes it was because my wife may

1 have said to her spiritual leader, he has to get into care,
2 and the route came through that. For other people,
3 whatever the reason was, but it was an extremely important
4 part in reaching a whole new group of people that we had
5 not reached before.

6 Peer-based services in Connecticut is a very
7 strong recovery community. Some of it falls under
8 something known as the Connecticut Community for Addiction
9 Recovery, as well as the larger group. They are great in
10 terms of mentoring. They are great in terms of community
11 types of services. They clearly say we are not in the
12 treatment business. We do not want to be in the treatment
13 business. But those particular services are critical to
14 the sustained recovery. Notice two-thirds of all of our
15 money in Access to Recovery goes to the recovery support
16 services, not to the clinical services.

17 If you can read this from where you are, what
18 are recovery support services? It's an important piece.
19 There's another slide that probably gives you a better
20 definition. But it goes back to, again, my view of
21 recovery. If I have a substance abuse disorder, it is the
22 provider's responsibility to help to decrease the symptoms,
23 to put the symptoms in remission so I don't use. But in
24 addition to that, it's also their responsibility to offer
25 me the opportunity for things that will sustain my

1 recovery. We call those recovery support services. The
2 recovery community calls it recovery capital. We'll come
3 back to that in a minute. Very important.

4 Bill White, recovery capital. "The quantity
5 and quality of both internal and external resources that a
6 person can bring to bear on the initiation and maintenance
7 of recovery."

8 Natural recovery, natural supports. In the
9 recovery community, the 12-step recovery community, what's
10 one of the most important pieces? Giving back. From the
11 Bill White point of view and from our point of view, giving
12 back earns recovery capital. It builds up recovery
13 capital. It furthermore, reinforces the person's self-
14 worth.

15 Look at these examples. Here is probably the
16 one slide that I would say pay particular attention to
17 because it demonstrates the efficacy and the true value of
18 recovery support services. Child care transportation. The
19 lady cannot come to care because of what's going on in her
20 life. As one lady told me when she was in an intensive
21 outpatient program, she says, I like the program, but you
22 need to understand my life is so dysfunctional back where I
23 live and trying to get here, I simply can't fit this into
24 my life. So providing child care, transportation to get
25 her from point A to point B is extremely important. That

1 was a personal barrier, an environmental barrier to her
2 coming into care and staying.

3 Participation in the recovery community.
4 Connecting people to treatment, 12-step, and other mutual
5 support/recovery-oriented groups. There is a group in
6 Connecticut I mentioned, CCAR, that in the Willimantic
7 area, on Main Street, Willimantic, there's something called
8 the Recovery Community Center. People go to the Recovery
9 Community Center, family members and others, a variety of
10 things related to how to fill out job applications, putting
11 together resumes, and so on, all the kinds of things. But
12 in addition to that, there's a whole social component
13 that's built into it. When you look at the NOMs or other
14 things, being reintegrated with the community is an
15 extremely important piece. That builds into that. A
16 person's recovery capital, giving back to the community and
17 gaining employment, represents an energy that takes its
18 place after the formal treatment is no longer there.

19 Overall, over 10,000 people unduplicated were
20 served through the first two years. I guess we're about a
21 month or so away from the first piece. Year 1 total, a
22 total of 106 people. I would imagine if you talk to some
23 of the other AtoR states, to implement such a major, major
24 system change in the way we provided services is, in the
25 words of one of my staff, a megillah. And getting it

1 straight from an implementation point of view so that it's
2 well managed was probably the most significant piece in the
3 first year. So I'm sure from the Feds' point of view,
4 you're moving too slow. You've got to get it going. Well,
5 the reality was if you want it done right, you've just got
6 to work with us and help us to get through this. We
7 continue to fine-tune, if you will. Sometimes it's more
8 than a fine-tune.

9 Year 2, after only having 106 in the first
10 year, we moved up to 10,000 in the second year. I think
11 our goal, according to the grant proposal, is something
12 like 16,500, and we would expect to meet that by the end of
13 the third year.

14 75,000 service level. That's not 75,000
15 different people. You'll see in some of the vignettes
16 about \$10 million put into claims.

17 These are not data directly related to AtoR.
18 They're from another piece, but I offer it to you because
19 it's one of those examples of why do we pay attention to
20 housing and employment. The housing piece here, if you
21 notice -- I can't read it, but supportive housing that we
22 have in Connecticut where good supportive housing decreases
23 the inpatient mental health and substance abuse costs,
24 increases employment. Good return on investment.

25 Why pay attention to vocational types of

1 services? Another piece of the study we had done. Give
2 people vocational training, you double the rate of
3 employment among them. Is that part of the usual substance
4 abuse clinical picture? No, at least not what I'm used to.

5 So investing in that particular piece is one of those
6 things that will decrease the likelihood of those acute
7 care episodes or high repeat admissions.

8 Let me give you some examples of what has been
9 done. York Correctional Institute is one of the women's
10 prison facilities in Connecticut. What happens here is
11 that we have a couple case managers who are part of Access
12 to Recovery that literally go into York and meet with the
13 women. So they're up there a couple days a week.

14 So this is one particular lady that they saw.
15 This is a real example. The name is not real. So they saw
16 her a couple months before she was supposed to go. In
17 concert with the correctional staff, they identified what
18 she needed. In accord with the choice, you can go to this
19 particular program; you can go to this particular program.

20 Those programs were not there to market, if you will.
21 These are the two programs. We're not recommending one
22 over the other.

23 She says, well, I can't go back to my usual
24 home environment. I need a housing situation. So we will
25 give her up to two months of housing support when she first

1 comes out. The other piece is food, clothing, personal
2 care items, bus passes, and she goes to the IOP program.
3 It's a wraparound type of approach, clinical as
4 appropriate, where it's not being funded by other sources,
5 wraparound the other services, but she walks out of York
6 not with a pass in her hand, but she knows exactly where
7 she's going to go, how she's going to get there. She's got
8 the transportation. And that in our judgment not only
9 promotes access to care, but also effective engagement
10 care.

11 Judicial branch. History of substance abuse.
12 Wanted to return to his work as an electrical contractor.
13 I think this was a situation where he was already in actual
14 treatment, and we funded that from another source. But
15 what he needed was equipment to go back or tools to go back
16 to his trade. That's a recovery support service.

17 Another lady, a non-AtoR. She was getting her
18 treatment from other funding sources we had. She was
19 interested in classes, going back to Dr. Clark's piece that
20 some of these types of treatment, cognitive-behavioral
21 approaches, if you can't read, if you can't write, some of
22 these types of things, it's a short circuit to say the
23 least.

24 Frank. Faith-based men's retreat. This
25 particular individual had more of a spiritual orientation.

1 That's what he wanted to choose. So here again, options
2 were given to him.

3 The last lady. I think she was getting her
4 services already in the system from other funding sources.

5 Her treatment was being funded by the general assistance
6 funds. So whenever she was in outpatient, whatever the
7 care was, it was already being taken care of. What she
8 wanted was vocational types of services.

9 What are the challenges? Real quickly. The
10 administrative infrastructure tied up with this is a
11 megillah. And we've gone through the first two years, and
12 even with all the infrastructure that we had built into
13 providers, it still was a major, major piece.

14 The voucher program. The voucher program for
15 us was probably easier than some other states because we
16 already were using a voucher type of approach in something
17 known as the Basic Needs Program as part of general
18 assistance. So if you were a general assistance eligible
19 candidate, which dollars we had set aside, we were used to
20 providing some money for housing, we're used to providing
21 to some money from other kinds of pieces for those persons.

22 This gave us an opportunity to really amp it up to a
23 totally different level. So in other states where you
24 didn't have a provider system or a state agency that had
25 some of that infrastructure, it was much more of a

1 challenge.

2 Grassroots organizations, faith-based. The
3 paperwork, GPRA, and that type of stuff for these folks was
4 a whole different ball game. They were not used to billing
5 for services, and this was a challenge for them.

6 Some of the lessons learned. Self-evident.
7 System change. Recovery support services, building
8 infrastructure, getting the data that we want. So we've
9 invested quite heavily in technical assistance to
10 particularly the faith-based community. You cannot get the
11 dollars unless you go through the training. We didn't do
12 that in the beginning and that was our mistake. Now we've
13 gone through a whole recertification process of all of our
14 providers, and they have to get that as part of that.

15 Some recovery support service providers over-
16 extended themselves. As far as they were concerned, these
17 dollars were going to be forever. We think they got
18 themselves in a situation where, God help us, when the
19 recovery support dollars are not there and they can't pay
20 their mortgage. But we'll see how that turns out.

21 Impact. Broaden the clinical care system by
22 the pieces we just mentioned. Recovery support services,
23 much broader. Non-traditional provider base.

24 Third and fourth were probably the most
25 important, at least from my perspective. It offers us the

1 opportunity to take AtoR and some of the principles that
2 are built into that and infrastructures and look at the
3 rest of our service system that's funded through GA, look
4 at the rest of the service systems funded through grant
5 funds, and see how the three of them can be matched. So as
6 we go to the next stage and the question is, well, what's
7 going to happen after you run out of AtoR dollars, we are
8 looking at how the same types of processes and procedures
9 and so on could be applied to some parts of our block
10 grant, some parts of our general assistance dollars to make
11 more sense, not to replace the dollars so much as play off
12 of the things that effectively engage people in care and
13 decrease this high volume of readmissions to care.

14 Improve the continuity of the care. Let me
15 give you one example of that last one here. It's a
16 provider in Hartford that runs a detox program. I think
17 he's got a 20-bed program. He was complaining about
18 relatively low utilization because our contracts require a
19 certain level of utilization, and there were lots of
20 reasons why. We said, okay, let's load you up, the whole
21 Hartford region. We will provide 24/7 access by phone.
22 Somebody can call us and say, I need care. Secondly, we
23 will provide transportation as part of it. Thirdly, there
24 was a couple of other pieces. We also focused on the high
25 volume readmissions into that detox program. Without

1 changing the total number of beds that he had in his
2 program the year after we implemented those recovery
3 support services, he had a 50 percent increase in the
4 number of people being admitted to the program.

5 Why did that occur? Because those people of
6 the high-volume readmissions, we tied them up with what we
7 now call recovery support services. They were not going
8 back. That gave us a better investment in our dollar from
9 our point of view. We've maximized the capacity of the
10 system without actually putting in new dollars.

11 What I call the challenge of all this is to
12 move people into a recovery zone. We had the conversation
13 before about -- I think Dr. Gary mentioned this. Our view
14 of recovery is not necessarily equivalent to cure. We're
15 not saying recovery results in a cure. What we're saying
16 is that recovery moves the person in a stage of their life
17 where they can manage their disorder despite the condition
18 of the disorder. Some people then have difficulty with
19 that. So my view is that the challenge is to keep the
20 person within a recovery zone.

21 Let me give one other example. A couple in the
22 New Haven area, married, five years into recovery or
23 thereabouts. Their child died, the infant. Their first
24 child died. Devastating, devastating effect on them. Part
25 of the stress of that, frankly, was that their finances,

1 their life simply was falling apart. The recovery support
2 part in terms of housing support was critical to them to
3 keep them in their recovery, so to speak, to keep them in
4 the recovery zone. So despite the enormity of having lost
5 an infant and the effect on that, their first child,
6 providing the recovery support so they did not lose their
7 house was an extremely important piece. You call that a
8 relapse prevention strategy. We see it in that fashion.

9 Next steps. We are recredentialling all of our
10 service providers, particularly those from the faith
11 community, paying attention to the points that we mentioned
12 here.

13 We are looking at possibly using the network
14 approach as the basic framework for the other funding
15 sources that we use in our system. We'll see whether that
16 will work out.

17 A very important part is the third one.
18 Charlie has mentioned that. Clearly, Dr. Clark. Does this
19 represent a cost effective model? So one of the questions
20 I ask my folks is that this recovery support services seems
21 to represent a good investment. Does it represent a good
22 investment over a longer period of time, or are we simply
23 just moving dollars from one side of the table to the
24 other? So we're working with some folks out of Yale to
25 take a look at the cost model that's associated.

1 The last piece, expanding recovery support
2 services into other funding sources. Some other options
3 here that come back to us.

4 So that's what it's about, but as I said, if
5 you've seen one state, you've seen one state. I'm sure Ken
6 can add some points.

7 The enormity of the challenge from an
8 implementation point of view is an extraordinary one. But
9 from our point of view, if those efforts can result in
10 someone not going back into high-volume repeat admissions
11 with whatever the care is -- we use the example if you or I
12 had a family member that was in inpatient acute stays for a
13 supposedly psychiatric condition five times in six months,
14 or if you had a family member that was into a detox program
15 for X number of times within three or four months, we would
16 be going to whoever the health care provider is. At least
17 I would be. I would be raising holy hell. What is it
18 we're missing? Why does this person keep going into the
19 hospital? It's not that the care is ineffective or
20 inappropriate as much as it is we must have been missing
21 something. And our view is that tying these recovery
22 support services to it, number one, results in a
23 stabilization of that, and instead of paying \$600-\$700 a
24 day for an inpatient hospital bed or \$300 a day for a detox
25 bed, I'll take \$50 of that or these others, tie it to the

1 recovery support services, and we have fewer readmissions.

2 Thank you for your attention.

3 (Applause.)

4 MR. CURIE: Thanks so much, Tom, and thank you,
5 Wes.

6 I just wanted to say I think we can all
7 recognize and see how Tom Kirk is just exceptional at
8 operationalized recovery. What he's done with Access to
9 Recovery in Connecticut I think is profound. I'm going to
10 ask in a moment Ken to reflect and make some comments based
11 on his experience in Washington State. But I just want to
12 say, Tom, thank you for what you've done there. I think
13 the presentation really gets at what was envisioned and
14 some of the very things the President was looking for in
15 some of the discussions early on in terms of how do you
16 truly operationalize recovery, make access to recovery real
17 for people's lives, not just access to another program, but
18 truly impacting all aspects of one's life.

19 I also want to just stress real quickly that I
20 appreciate what you had to say about the implementation of
21 ATR and, probably for the record, just stress that I know
22 on SAMHSA's part, we tried over and over and over and over
23 again to clarify with a range of other federal agencies and
24 offices the notion of implementing a voucher program,
25 especially if you didn't have the infrastructure in place,

1 was going to take quite a bit of time and focus that first
2 year. And while there were targets set and it was
3 anticipated that 50,000 individuals a year could be served
4 with Access to Recovery, based on \$100 million, the reason
5 we came up with a three-year goal of 125,750 was we were
6 able to make the case that no one should anticipate a
7 voucher being even issued in the first six months in any
8 state. Some states did get some issued in the first six
9 months, but the first year would be a very low year because
10 of what you described. I appreciate you pointing that out.

11 I do think it's something we have to stress again even now
12 over and over.

13 I am pleased to say OMB is one office that
14 understands it and gets it. So that helps us out
15 tremendously. I won't mention any other offices. But I am
16 pleased that OMB understands it.

17 And actually ONDCP came out with a very
18 positive letter about Access to Recovery, and I appreciate
19 it. They did their own site visits, came back I think more
20 impressed than they thought they were going to be. I know
21 Connecticut and Washington absolutely got visits in that
22 process. So I appreciate their, what I consider, fairly
23 objective opinion going out because they weren't really
24 going out to prove that it was good or bad. They just
25 wanted to see what was there. So ONDCP on Access to

1 Recovery came through.

2 So, again, the data that's coming in now looks
3 very promising overall.

4 Ken, I'd like to give you a few minutes to just
5 reflect and share your perspective.

6 DR. STARK: Well, I'll try to keep it brief,
7 and I will keep it brief. I won't try.

8 I think Tom covered it in a very comprehensive
9 and clear way. Even though each state is truly different,
10 there were some commonalities among the states relative to
11 the concern on the administrative structure to be able to
12 carry out a voucher-based program, as you already
13 mentioned, Charlie, and as Tom stated quite clearly.

14 In Washington State, because much of the money
15 from the state outside of residential treatment goes from
16 the state through counties and/or tribes, we have a second
17 level governmental structure that we also had to deal with
18 when passing money down to direct service providers.
19 Governments are typically used to things like contracts and
20 requests for proposals and those kinds of things. That's
21 what generally keeps them out of trouble around ethics
22 issues and around abuse and fraud or at least the
23 perception of abuse and fraud.

24 And a voucher program created a whole new
25 opportunity, if you will, one that I think on the one hand

1 most states and their local sub-state agencies were
2 interested in, but also one that they were challenged with
3 through their contracts offices, their prosecuting
4 attorneys, and other legal folks that had some worries
5 about how are you going to do this, how are you going to
6 keep control, how are you going to ensure accountability,
7 and also just having the staffing to be able to change the
8 systems on both your billing and payment structure
9 mechanisms.

10 That aside, I think people in Washington State
11 were truly excited about seeing the ATR money as an
12 opportunity for more flexibility than we had ever seen
13 before, the kind of flexibility we would hope for the
14 future for the Performance Partnership and block grant.
15 But that will be a challenge to get there, but we would
16 hope that we could eventually see that kind of flexibility
17 in the block grant.

18 So in Washington State's mind, we saw this ATR
19 as twofold: one, to be able to fill some of the treatment
20 gap where we had those major gaps; and two, to be able to
21 provide those services that essentially could be recovery
22 support services or, put another way, relapse prevention
23 kinds of services, services that could, in fact, help
24 people who started treatment complete treatment, and two,
25 those that completed treatment to stay out of treatment in

1 the future and retain their recovery.

2 The second year, the State of Washington
3 actually got a bunch of new money for treatment expansion.

4 So we shifted the focus of what we saw ATR for, and it
5 continued to be the relapse prevention and keeping people
6 in treatment and spending a little bit of the money on
7 treatment. But it became a major focus for doing outreach,
8 looking at providing recovery support services in the
9 community even before people got into treatment and then
10 using that intervention and engagement as a mechanism for
11 those that either wanted to or needed to to go ahead and go
12 into other treatment that was funded by the new money. So
13 it filled a lot of gaps.

14 We used it for a ton of unique things, things
15 that might raise eyebrows in some people's minds if they
16 didn't understand the need for recovery support services.
17 We used it for one individual to fix his car. It was
18 cheaper to spend the money to fix his car so he could
19 commute back and forth to his treatment provider and other
20 services than it was to pay for bus service and that sort
21 of thing.

22 In another case, a person had a bad, bad
23 toothache and needed some dental work done and wasn't
24 eligible for any of the other public programs, and getting
25 that dental work done was a major priority. I mean, you

1 and I both know if you have a major toothache, you're not
2 going to be able to benefit from treatment or any other
3 recovery support service. You're going to be focused on
4 that pain. So getting that service was something that
5 helped this individual stay focused on the rest of his
6 recovery plan.

7 And, of course, we used it for some child care
8 and the traditional transportation and employment and some
9 transitional housing. Those are very, very important
10 issues.

11 But the main thing that Access to Recovery
12 provided was choice, as you talked about, Charlie, choice
13 that wouldn't otherwise have been, in many cases, available
14 through traditional funding sources, although in some cases
15 I think the other thing we have to be careful of is to not
16 take the government source and fund something that other
17 people are already providing and now, all of a sudden, they
18 see money available. So they stop providing that and then
19 take this money. And that's a danger. That's always a
20 danger. So you've got to pay attention to that.

21 But having increased flexibility among all of
22 the fund sources would certainly be a desire of, I think,
23 anybody administering dollars. I worry about the loss of
24 ATR if it goes away in the future, and I assume it probably
25 will. I hope that as it goes away, other fund sources get

1 more flexible to be able to continue some of those
2 services.

3 MR. CURIE: Thank you, Ken, and I appreciate
4 your caution at the end. I find myself wondering very much
5 now will this first three years be all we see of ATR. If
6 that's the case, then I think what we need to do is learn
7 lessons.

8 Tom, I appreciated your mentioning the
9 evaluating aspect of really taking a look at the efficacy
10 and cost effectiveness of recovery support services. I
11 think as we talk about certain levels, I think we're
12 finding investing dollars in those areas very well may be
13 more cost effective than what our regulations allow in
14 other kinds of situations in terms of getting results. I
15 know it's thinking out of the box. I know it makes people
16 who are traditional auditors maybe a little fearful in
17 terms of should "treatment program" dollars be spent on
18 things like car repair or equipment for electricians. On
19 the other hand, ATR is going to give us the opportunity to
20 evaluate that and determine these may be shorter pathways
21 to actually one's attaining and sustaining recovery because
22 we truly are helping them achieve the goals they need to
23 prevent relapse and to attain it. I think that's an
24 exciting feature that's there.

25 I guess I would also encourage constituency

1 groups, SAMHSA, the advisory council to really keep its eye
2 on Access to Recovery, not forget Access to Recovery,
3 advocate. I think there's openness on the part of Congress
4 as I talk to members of Congress who are very interested in
5 seeing the outcomes of ATR. I know Chairman Regula of our
6 appropriations subcommittee has made no secret. He talks
7 publicly about the fact he doesn't like vouchers and he's
8 open about that. Though, even at that, he still has
9 supported \$100 million for ATR for three years. His
10 comment has been let's see what the data tells us, what we
11 learn. It may be a very good thing. And I think that's
12 reasonable, and I think it's important for us to listen
13 carefully to that type of feedback and really take the
14 outcome data from ATR and see what we can learn and apply
15 and the issue of where do we need further flexibility.

16 Let me open it up for council discussion,
17 questions, or feedback. Barbara?

18 MS. HUFF: Hopefully, I didn't just miss this
19 along the way, but is there a comprehensive evaluation that
20 goes with this that somebody is contracted to do, or is
21 everybody doing their own evaluation?

22 MR. CURIE: Wes?

23 DR. CLARK: There was no comprehensive
24 evaluation planned for ATR. We did ask for some funds in
25 '07 to do an evaluation, but it wasn't built into the

1 original program. We're using our GPRA data to monitor,
2 and in a sense, the GPRA data becomes a tool for
3 evaluation, but not in the classic evaluation context.

4 MR. CURIE: The other thing I might mention is
5 ATR really is our first treatment program that we
6 operationalized national outcome measures, along with the
7 GPRA data, the 10 domains. So that will be a form of
8 evaluation in terms of are people really attaining and
9 sustaining recovery as defined by those 10 domains.

10 But Wes is right. In terms of comprehensive
11 evaluation, we look to '07. As we looked at the second
12 cohort of ATR, we actually had proposed \$3 million of the
13 dollars to be set aside for that type of evaluation.
14 Again, that's not realized at this point in the House mark.

15 Ken.

16 DR. STARK: Well, one of the things I would
17 mention -- and it sounds like Tom and Connecticut are
18 looking at the same thing -- is at some point in Washington
19 State, as Washington State does with virtually all of its
20 programs, they will be looking at outcomes, comparing
21 administrative databases and trying to look at these
22 consumers who received services through Access to Recovery
23 to similar clients who didn't receive the recovery support
24 services and see what the difference in outcomes are
25 relative to arrests and relative to hospital emergency room

1 recycling and associated costs and employment. How
2 comprehensive that evaluation will be will be dependent
3 upon the resources that the state has at the time.

4 But clearly, Washington State will be looking
5 at those kinds of outcomes to see whether this makes a
6 difference because the other issue that Washington will
7 face, as will Connecticut and the other states, and the
8 rural Indian tribal program in California, is if they are
9 going to sustain any of these services, we're going to have
10 to be able to justify that.

11 MS. HUFF: I know.

12 DR. STARK: Nowadays, you don't justify it
13 based on popularity. You justify it based on cost
14 effectiveness or value as Tom referred to earlier in terms
15 of being that nexus with quality and cost.

16 DR. KIRK: Barbara, one of the things that
17 we've focused upon is what we call continuity of care, and
18 by that I mean that a person discharges out of, let's say,
19 a detox program. How long before they're hooked up with
20 the next level of care? We had done some data separately
21 from Access to Recovery that demonstrated that if the
22 person was admitted or linked to the next level of care
23 within 7 to 10 days of discharge from that, the results in
24 terms of decreased readmission to that instability were
25 extraordinary.

1 So, let's say from our evaluation point of
2 view, one of the things we would be looking at -- I didn't
3 go into it, but on the housing piece, there are four
4 different levels of housing that we supported. One of them
5 would be what we call a recovery house where I'm leaving
6 the detox program and I can't get a residential bed for two
7 weeks. I go to the recovery house, which is a little bit
8 more peer and light staff. It's not a treatment program.
9 And I stay there in a stable, drug-free setting, and then I
10 can go to my residential treatment program two weeks from
11 now.

12 Those recovery house beds cost something like
13 -- I don't know -- \$28 a day. That promotes continuity of
14 care because if you didn't have that, I'm going to get
15 readmitted to detox within a relatively short period of
16 time. So it's the cost/benefit type of approach that I
17 think we need to make sure we pay attention, as well as
18 quality of life.

19 MR. CURIE: Thank you.

20 Any other questions? Faye.

21 DR. GARY: I wanted to just say thank you for
22 these very, very actually inspiring and hopeful kinds of
23 programs that are in place. I'm most appreciative for
24 that.

25 My question is I didn't hear much discussion

1 about the overlap between mental health, substance abuse,
2 and forensics, especially given the fact that many people
3 who are very poor and underserved might be in jails and in
4 prisons. Is there any way that you have access to those
5 populations, or when those populations are discharged from
6 prisons or jails, how can they access your service? So
7 it's either way. Do you go to the jails, prisons? I'm
8 talking about juvenile centers as well as for adult
9 services.

10 I know one of the major concerns is that when
11 people are discharged from prisons and jails, who have
12 substance abuse problems, they frequently relapse and get
13 involved too. So I'm just wondering how that comes full
14 circle.

15 DR. KIRK: I'm glad you brought it up because
16 that's what I forgot to mention. The largest pool of
17 referrals into Access to Recovery for us are from
18 corrections and probation, the criminal justice system.
19 One of those levels of housing, the one we call Recovery
20 House, is particularly geared toward persons who have
21 special needs, i.e., could be special medical needs,
22 criminal justice involvement, and need a different level of
23 supervision.

24 Furthermore, in Hartford, there's something
25 known as the Hartford Community Court, and the court is run

1 by the judge who operated the first drug court in
2 Connecticut, Judge Simone. We located a person who would
3 be an outreach person for Access to Recovery in his court
4 and said we were going to give him one day. He now has him
5 there three days a week. These are folks with nuisance
6 kinds of offenses, often with co-occurring mental health
7 and substance abuse issues. So I think the clearest answer
8 to your question is that that's probably more of a focus in
9 our portals than any other areas.

10 Part of that ties to a larger agenda in
11 Connecticut that Connecticut decided they were not going to
12 build any new prisons. So we went through this spending
13 billions of dollars on prisons. So over the last three
14 years, through the legislature, there's something known as
15 the Prison/Jail Overcrowding Commission. Maybe as a result
16 of that, Connecticut has been in the top three in the
17 nation within the last couple years in decreases in its
18 prison population, but some of it's based upon diversion
19 and some of it's based upon what some people call "back
20 door." So this was consistent from a policy point of view
21 with a focus on those particular populations.

22 Can we do better? Yes. If I was going to
23 express a disappointment, where we really have not been
24 able to have as much inroad as we'd like is actually the
25 child welfare system, and I'm not sure why. I don't know

1 whether it's because if the referral comes from the
2 Department of Children and Families through a person, that
3 somehow that just has such a stigma to it. I don't want
4 your services if it's coming from DCF. But probation,
5 corrections, parole have actually been the largest sources
6 of our referrals, but our juvenile population is not part
7 of the mix at this point in time.

8 MR. CURIE: Ken.

9 DR. STARK: I would say that's historic in
10 virtually almost all of the alcohol-drug programs
11 regardless of fund source, whether it's ATR or otherwise.
12 Even if you don't target that population group, those
13 referral sources target you if they know you have
14 resources. So you'll get a lot of them. As Tom said, does
15 that solve the problem? No, because we never get enough
16 money to reduce or eliminate the gap to the extent that we
17 would like to.

18 But clearly, I don't think you can find any
19 alcohol-drug programs across the country on the public
20 sector side that won't have criminal justice as one of its
21 major, if not the major referral source.

22 Referring to ATR in Washington State, we
23 actually targeted the child welfare system as part of our
24 population group in that grant, as I recall, when we first
25 wrote it. I got to tell you that is a tough nut to crack.

1 The child welfare system is very, very difficult to work
2 with for a variety of reasons, not the least of which are
3 the pressures around lawsuits and litigation on child
4 welfare to either make a darned decision and put the child
5 in foster care or reunify in a short period of time, and
6 that short period of time is not always consistent with the
7 faith that people have in people getting into recovery.

8 And this being a chronic, relapsing condition,
9 I think that's one of the -- Tom, again, alluded to this in
10 his presentation. We tend to stigmatize ourselves.
11 Although addictions are, in fact, a lifelong condition and
12 recovery is lifelong, and as I've heard Tom say before,
13 treatment is a point in time, but sometimes when we say
14 this is a chronic, relapsing condition, we take all the
15 faith out of anybody outside of our system believing that a
16 referral to us is not a risk. So I think that's the
17 biggest challenge we have with our child welfare system,
18 whereas the criminal justice is desperate for resources.
19 They'll refer anybody to anybody. It's a very different
20 situation.

21 MR. CURIE: Wes, and then Barbara.

22 DR. CLARK: I just wanted to point out that we
23 have Texas and California and Wyoming that are involved in
24 either the criminal justice system or juvenile justice
25 system as grantees. As a larger number, when we look at

1 the referral source for substance abuse treatment, as Ken
2 pointed out, roughly 50 percent of the people who are
3 referred for methamphetamine treatment to the substance
4 abuse treatment delivery system come from the criminal
5 justice system. So in the aggregate for all substances,
6 the criminal justice system is the largest point of
7 referral. So as Ken pointed out, there's a well
8 established partnership and relationship. The only
9 question is availability of services.

10 MR. CURIE: Ken, and then Barbara.

11 DR. STARK: This is not related to ATR, but I
12 want to throw it in because I know we're about ready to
13 leave. It's related to the medication that's out there
14 that's being promoted by some folks called Premeda.
15 Because there are some fairly well-known, nationally
16 recognized folks who have gotten into promoting this
17 treatment approach and promoting it strongly with
18 legislatures and drug courts and others around the country,
19 I think it's really, really important that SAMHSA take a
20 look at the evidence-based practice data that's out there
21 because there's going to be potential political pressure
22 that's going to be put on states to look at that
23 medication. For states who don't have a strong knowledge
24 base or strong relationships, they could easily be pushed
25 into spending some resource that may or may not be the

1 appropriate way to go at this point in time.

2 MR. CURIE: Thank you, Ken, for that.

3 Wes, do you want to comment? And then Barbara.

4 DR. CLARK: Back to the criminal justice
5 system, with regard to ATR, Cheri Nolan is working out a
6 deal with the Department of Justice and the Department of
7 Labor with regard to ATR making sure that we pair up some
8 of our ATR grantees with some of the discretionary grant
9 programs that Labor and Justice have dealing with the issue
10 of reentry into the community. So we'll be discussing that
11 at our July meeting. So, again, this partnership that Ken
12 mentioned. We've got SAMHSA staff working on all aspects
13 of it, doing the best we can with the resources we have.

14 MR. CURIE: In terms of, Ken, your
15 recommendation, I would ask that CSAT take this under
16 advisement, the working partnership with NIDA in
17 particular, to evaluate to how we might inform. I see this
18 as part of our responsibility with ATTC technical
19 assistance, and I think we can offer an economy of scale of
20 that information. So thank you, Ken.

21 DR. STARK: Thank you.

22 MR. CURIE: Barbara.

23 MS. HUFF: I just can't help but wonder, not
24 like this is going to be a surprise that I'm asking this.
25 What percentage of the grantees are serving young people?

1 I heard you mention college-age students. I was thrilled
2 to hear that. That was neat. I think it was you that
3 mentioned it. Are most of them serving young people coming
4 out of juvenile justice, or are any youth being served?

5 DR. CLARK: Yes. The ATR program is fairly
6 diverse. So California has targeted adolescents. Wyoming
7 has targeted adolescents. Others have targeted outcomes.

8 MS. HUFF: I knew they have that ability to do
9 that.

10 DR. CLARK: And then we should also mention
11 that we do have a separate portfolio for adolescents. So
12 with the SAPT block grant, adolescents receive care. We
13 have some of our TCE grants that target adolescents, and we
14 have a specific adolescent portfolio. So, again, while
15 some may say there's not enough money going to adolescents,
16 we are committed to that at SAMHSA.

17 MS. HUFF: I wasn't questioning that.

18 DR. CLARK: And then we work in partnership, of
19 course, with CMHS and CSAP to address both our prevention
20 and treatment needs in adolescents.

21 MS. HUFF: Thank you.

22 DR. CLARK: So we have the age range for ATR.

23 MR. CURIE: Again, I think that's, if you will,
24 the double-edged sword of state flexibility. On the one
25 hand, I believe fully states are flexible to address what

1 populations that they prioritize and what needs they
2 prioritize. Theoretically, it could end up, though, that
3 no state identified necessarily adolescents or youth in a
4 particular program, but that doesn't mean it's not a
5 priority. So that's why we have a diverse portfolio to
6 make sure there is some focus on adolescents and youth and
7 some direction in that area, as well as a balance of state
8 flexibility.

9 Any other closing thoughts or comments on what
10 I think has just been a remarkable presentation with,
11 again, tremendous approaches in leadership on the part of
12 Tom, on the part of Ken. I've appreciated Wes and his
13 staff.

14 You have to keep in mind for all these people,
15 including the CSAT staff, this is new territory. This is
16 forging into the unknown. This has not been easy. There's
17 been blood, sweat, and tears through implementing Access to
18 Recovery. The gratifying thing is we're seeing outcomes
19 beginning to occur in a positive way, and I think we're
20 going to have a rich field of data in which we can learn
21 about how choice, recovery support services, and truly
22 operationalizing recovery can really work and work better.

23 So thank you.

24 It's now time to have a time for public
25 comment. I will say I think this is the first National

1 Advisory Council meeting which no one has signed to make
2 public comment, but that does not preclude the opportunity
3 for spontaneity, for people who want to come up to the
4 microphone, introduce themselves and who you represent to
5 make a public comment. So I would now open the floor to
6 the public for anyone who would like to step up to the
7 mike.

8 Oh, Art Dean did raise his hand, but we have
9 someone else first, and then we'll ask Art. Okay, go
10 ahead, Art. Go ahead. Okay, don't worry, Art. You'll go
11 second. Thank you.

12 MS. THIEL: I'm Thelma King Thiel. I'm the
13 Chairman and CEO of the Hepatitis Foundation International.
14 I'm really here today to thank Dr. Clark and Beverly Watts
15 Davis for embracing our Liver Wellness approach as a good
16 strategy for promoting prevention and recovery. We have
17 trained over 2,000 of their grantees and we have many more
18 planned and scheduled to come up. We're just getting
19 tremendous response.

20 There are a couple of studies that are going to
21 be reported soon that involved injection drug users and
22 also homeless children that are really identifying and
23 supporting the fact that the Liver Wellness concept is
24 actually changing people's behavior. So we're very, very
25 excited about that, and we're looking forward to working

1 more with SAMHSA.

2 But we've done some of our own studies doing
3 evaluations of each of our presentations. We found that 89
4 percent of those who attended learned new information about
5 the impact a damaged liver can have on one's health. 77
6 percent were more concerned about their own risk of
7 infection with hepatitis B and C, and of course, with our
8 Liver Wellness, we always talk about hepatitis. 62 percent
9 were alerted to the fact that they themselves need to be
10 tested for hepatitis C and B. So we're really motivating
11 people to assess their own risk behaviors and to act upon
12 that.

13 Again, you can't change what you don't know,
14 and the information about the liver has been missing for
15 many, many years in schools, et cetera. So we feel that it
16 is the missing piece. As a matter of fact, we're going to
17 be training 50 methadone counselors up at the Rhode Island
18 School of Medicine, their addiction program, and there is
19 interest with the Yale University Medical School, their
20 rehabilitation program.

21 So we're very excited about having this kind of
22 support and interest in what we're doing, but I feel the
23 urgency to do so much more, and we're really looking for
24 easier ways to reach more of the people that are working on
25 the front line that really need this information to enhance

1 their programs. Right now, there are no RFAs coming down
2 that support training with SAMHSA. They're all to the
3 community organizations. So what it means is we have to go
4 out and try to plug our program to your grantees to get
5 them to pick up on it, and it's just a circuitous route
6 when I think that we know we have something that is
7 effective and we would like to make it much simpler. So we
8 really need to collaborate with you on a better basis.

9 Thank you.

10 MR. CURIE: Thank you, Thelma, and thank you
11 for your ongoing work, a very important priority on our
12 matrix, and I appreciate collaboration and you specifically
13 pointing out Dr. Clark and Ms. Watts Davis in terms of your
14 key lead collaborators. Thank you for what you do.

15 Art, would you like the floor? Please.

16 GENERAL DEAN: But something did go wrong
17 because about three weeks ago I officially asked to give a
18 public comment. So I'm not sure what happened, but that's
19 perfectly okay.

20 MR. CURIE: Toian owns responsibility. She's
21 the big person that she is. So we apologize.

22 GENERAL DEAN: Not a problem.

23 But it's really great to have the opportunity
24 to speak to such an important group of leaders that are
25 providing significant leadership and support for this

1 important field. I wanted to come by just to give you a
2 short update on things that are going on particularly in
3 the community coalition field.

4 I hope that you would agree with me that our
5 collaboration and work with SAMHSA and our community
6 coalitions is one of the reasons why we believe that we've
7 had this tremendous reduction in substance abuse over the
8 last three years. We believe that community coalitions
9 have directly contributed to that, and we give SAMHSA, its
10 centers, and their support a great deal of credit for
11 providing that kind of assistance to us.

12 I want to give you just a short update on some
13 activities and events that I think are important to you,
14 and I won't be very long. But I did bring some
15 publications along that we will share with you, and Dr.
16 Hernandez, who works with the National Institute, will
17 share those with you.

18 One of them is our summer newsletter that
19 highlights the National Leadership Conference that we had
20 back in February. Fortunately, we had over 3,000 attendees
21 at that. It was, as it is every year, supported
22 significantly by SAMHSA and its centers, and without their
23 support, I can tell you that we would not have 3,000
24 coalitions here because they would not be able to come.

25 We have started a few years back having a mid-

1 year institute, which is designed to give one-, two-, and
2 four-day-long seminars versus our National Leadership Forum
3 is built around workshops that are two hours in length.
4 The one this year is going to be August 14th through the
5 17th at the Hyatt Regency Lake Las Vegas Resort and Spa in
6 Las Vegas, and we will be in training there for four days.

7 We've just recently put out our call for
8 proposals for the National Leadership Conference that's
9 going to be in February 2007, and I know that SAMHSA and
10 its grantees and other agencies will be submitting topics
11 for us to consider. We just recently had some discussions
12 with Dennis Romero in the Center for Substance Abuse
13 Prevention and we will again be hosting as a part of our
14 National Leadership Conference SAMHSA's Community
15 Prevention Day, which has turned out to be a wonderful
16 addition to the National Leadership Conference.

17 Also, I will report to you that I take great
18 pride in this and I'm generally a very humble kind of guy,
19 but during our watch over the last few years, we have had
20 participation from all three of SAMHSA's centers in the
21 National Leadership Conference. I will say to you about
22 seven years ago, it was very heavy CSAP. A few years back,
23 three, four, five years, CSAT became a significant player.

24 In the last two years, the Center for Mental Health has
25 been a significant player as well, and we are very pleased

1 that the whole family is a part of that activity and we are
2 quite pleased about that.

3 Something that is very new for us is we have
4 been doing some international work, and we've actually
5 started some coalitions in South America. But in August,
6 in San Diego, we're going to have our first training in
7 Spanish and we're going to have foreign attendees in that
8 training, as well as those community coalitions that have a
9 heavy concentration of those that speak Spanish as a
10 language. We're excited about that taking place August
11 21st to the 23rd.

12 The National Coalition Institute, which is our
13 first grant that we got from the federal government going
14 back three years, is administered, along with the Drug-Free
15 Community program, by SAMHSA. We trained over 5,000 people
16 last year. We currently have 100 coalitions in a yearlong
17 training program, and that's in coordination with the
18 National Guard. And we're very excited about that.

19 What we've done is, working with our friends at
20 CSAP, we have published the first primer on the framework
21 for the Strategic Prevention Framework. We started with
22 evaluation, and we will be publishing this year the four
23 remaining ones. So by the end of this year, we will have a
24 primer with great details that covers each of the steps of
25 the Strategic Prevention Framework in all of our training,

1 to include the Coalition Academy uses as its basis for
2 training the Strategic Prevention Framework. We are very,
3 very excited about that.

4 We are working closely with the underage
5 drinking initiative that SAMHSA has. We support that. We
6 supported their town hall meetings. And working with our
7 friends at the National Institute on Alcoholism and Alcohol
8 Abuse, we just published an evidence-based practical
9 theories on underage drinking, and it's called "Using
10 Science to Combat Underage Drinking," which is something
11 that we care very dearly about and will continue to partner
12 with SAMHSA on that issue.

13 The last thing that I wanted to say is that we
14 will continue to work with SAMHSA in the interagency
15 coordinating committee to make sure that this effort is, in
16 fact, worked. Substance abuse in its totality is having a
17 tremendous impact on our communities. Illicit drugs,
18 illegal drugs are having a tremendous impact. But I would
19 be remiss if I didn't tell you that alcohol is causing the
20 greatest problem out in our communities. So it's important
21 that we work that issue together and we will continue to do
22 that.

23 As I close, Charlie, can I get you to come up?
24 I don't know if Charlie will agree with me or not, but
25 since he arrived at SAMHSA back in November of 2001, not

1 only has he been a leader that has cared about this total
2 field and has worked diligently to cause people to have a
3 life in the community, but he's reached out to CADCA, to
4 our board of directors, to our advisory committee. He's
5 been involved with community coalitions. He's supported us
6 in a very dedicated, professional way. But beyond that, we
7 have established, I believe, what is an outstanding
8 friendship and partnership.

9 I wanted to give him this on behalf of the
10 board of the directors, on behalf of our advisory
11 committee, our staff, and the more than 5,000 community
12 coalitions that have benefitted significantly from his
13 leadership, from his dedication and his professionalism.
14 I'm convinced that coalitions are stronger today and in
15 more numbers today because of Charlie's leadership, and I
16 wanted to come by and personally, in front of his advisory
17 committee, thank him for that and say we're going to miss
18 you and thank you for your great work.

19 (Applause.)

20 MR. CURIE: Thank you so much. That means a
21 lot.

22 GENERAL DEAN: Thank you all very much. Well,
23 again, thank you all for your leadership and your support.

24 MR. CURIE: Thank you, Art, for those kind
25 words and the recognition. It means a lot coming from

1 CADCA. I think CADCA is foundational and is truly the
2 backbone of grassroots anti-drug efforts and prevention in
3 this country. I appreciate very much our friendship and
4 partnership.

5 Henry, would you like to have the mike? Henry
6 Lozano.

7 MR. LOZANO: Thank you, General Dean, on behalf
8 of the board of the directors of CADCA.

9 I'd like to just take you back for one moment,
10 Charlie, to September 4th, 2001. And all of us were
11 sitting with Dr. Clark and the National Recovery Month
12 Program, Ivette Torres in the room with Secretary Tommy
13 Thompson, and we were all in there dreaming a dream. It
14 was a critical week, a complex week for this nation, for
15 this world, and that dream from that point in juncture till
16 today has been an incredible adventure. As just one of
17 those many folks out there in this field that had the
18 privilege to work with all these fine folks, it's been an
19 honor, sir. A true honor. Thank you.

20 MR. CURIE: Thank you, Henry.

21 (Applause.)

22 MR. CURIE: Any other public comment?

23 (No response.)

24 MR. CURIE: If not, just in terms of making a
25 couple closing remarks, I first of all just want to one

1 last time thank this council for its ongoing commitment,
2 dedication, support. It personally has meant a lot to me
3 on both an individual basis, as well as a council as a
4 whole, the way you've taken the business of SAMHSA so
5 seriously, moving the agenda ahead on behalf of people in
6 this country with addictive disease, with mental illness,
7 children and youth who are at risk. It, again, has been a
8 true honor.

9 I wish continued success for the council. I
10 absolutely want the best for SAMHSA as it moves forward in
11 the future.

12 I want to recognize a couple folks, Daryl Kade,
13 who is the Executive Director of this council, and also,
14 again, Director for Policy and Budget Development, playing
15 the key role on the executive leadership team. I give her
16 tremendous credit for helping synthesize and integrate and
17 helping develop the concept around matrix management and
18 helping weave that full integrated picture that we have
19 today. I just appreciate her support and leadership.

20 (Applause.)

21 MR. CURIE: And, of course, the council knows
22 Toian Vaughn quite well. Toian is the one that toils on
23 the logistics, striving to keep all of us organized and on
24 track. I don't know of anyone who takes her job more
25 seriously than Toian in terms of really wanting to put

1 forth the best. I just want to thank you for your ongoing
2 efforts and what you do.

3 One last person I'm going to surprise right
4 now, I think, to recognize. He's been sitting quietly out
5 there, and actually his issue was addressed earlier by
6 Theresa Racicot and Michele Ridge. But one of the unsung
7 heroes I think of SAMHSA -- and there are many, probably
8 525, which is about the number of our employees -- is
9 somebody who, again, toils day in and day out, many times
10 in his very quiet way but a very effective way, pressing
11 the issues around alcohol abuse in this country and
12 underage drinking, and again, the town hall meetings, the
13 Interagency Council for the Prevention of Underage
14 Drinking, moving ahead with the Surgeon General's call to
15 action -- I can just go on and on and list the types of
16 things that he's been instrumental in really helping us
17 pull off and lead and advise. And that's Steve Wing.
18 Steve, would you stand up?

19 (Applause.)

20 MR. CURIE: I have appreciated his counsel.

21 When I first came aboard, one of the things
22 that really wasn't real active with SAMHSA was the alcohol
23 agenda. It was there. There were some things occurring
24 and going on. I think we have a real life and priority
25 now, and it's my hope that five years from now we're going

1 to be able to look back and say, there's a decrease in
2 underage drinking like we've seen in illicit drug use and
3 tobacco. I know that's very, very possible. It's a
4 societal change that's going to occur. And I think with
5 the help of everyone in this room -- and this is where
6 CADCA is going to play a critical role, the Strategic
7 Prevention Framework, Steve, and of course, you heard all
8 the commitment today earlier from folks.

9 But anyway, thank you, everybody, and may God
10 bless you in your ongoing efforts.

11 (Applause.)

12 MS. VAUGHN: We are adjourned.

13 (Whereupon, at 3:20 p.m., the meeting was
14 adjourned.)

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