

HEROIN AND OPIATE EPIDEMIC ADVISORY PANEL

OF THE

SUFFOLK COUNTY LEGISLATURE

VERBATIM TRANSCRIPT

A meeting of the Heroin and Opiate Epidemic Advisory Panel was held in the Clerk's Conference Room of the William H. Rogers Legislative Building, 725 Veterans Memorial Highway, Smithtown, New York, on September 1, 2010.

MEMBERS PRESENT:

Jack Hoffman - Eastern Long Island Hospital
Jeff Reynolds - Long Island Alcoholism and Drug Counseling
Cari Faith Besserman - Phoenix House
Elaine Economopoulos - Horizons Counseling Center
Ed Ehmann - Superintendent of Smithtown Schools
Art Flescher - Suffolk County Division of Mental Health
Lisa Lite-Rottmann - New York State OASAS
John Venza - Outreach
Pamela Mizzi - Prevention Resource Center
Janine Logan - N/S Hospital Council
Kristie Golden - South Oaks

ALSO IN ATTENDANCE:

Susan Eckert - Aide to Legislator Nowick
John Paul DiMartino - Aide to Legislator Horsley
Kara Hahn - Presiding Officer's Office
Phil Enright

MINUTES TAKEN BY:

Donna Catalano - Court Stenographer
Lucia Braaten - Court Stenographer

(*THE MEETING WAS CALLED TO ORDER AT 3:10 P.M.*)

MR. REYNOLDS:

So welcome. This is our third meeting. Because there is a stenographer here, much to the relief of Cari Besserman, we've been asked not to talk over each other. I know that comes as a big disappointment to everybody. Although we all know each other, the stenographer does not yet know who you are, so you use the name tag to the extent that you can. Try to speak slowly and clearly so that we can get everything for the record. We do have the stenographer for this particular meeting and for public hearings.

There's been an ongoing issue related to the creation of minutes. And Cari was nice enough to volunteer and step up at our first meeting to take minutes. But as you see it's pretty voluminous, it required a lot of work on her part. And the other downside to doing it in this way is that Cari doesn't have the ability to participate fully and bring some of the perspectives that she has. So we do need to think about and potentially talk about a longer-term solution to dealing with the minutes issue. But for this meeting, I think we are good.

There's an attendance sheet going around, please make sure that you sign it. You got several documents via e-mail and you have another set of copies in the folder that we passed around. Today, our game plan is to pick up where we left on the prevention conversation, move quickly ahead to the treatment conversation, and then you'll find in your packet as well that you got via e-mail, a proposed roadmap for getting this done. With the end of summer it means that our timeframe is beginning to close. Needs we probably need to accelerate the frequency of our meetings in order to meet our initial charge. So we will spend I think probably the last 20 minutes or so of the meeting talking about that. Everybody had a chance to look at the minutes? Any corrections? Elaine, you are okay with the way that your words were this time?

MS. ECONOMOPOULOS

If I bring it up again, it will be three times in the minutes. We are fine.

MR. REYNOLDS:

Again, thank you, Cari, for all your hard work on this. I know it was a big task. We appreciate it.

MS. BESSERMAN:

It was actually really interesting to reread it. I was hearing it as I read it.

MS. LOGAN:

You did a great job.

MR. REYNOLDS:

So I don't know if we need a formal motion to approve the minutes. We can just say that we unanimously approved the minutes from the last meeting. Everyone's got an agenda. Does the agenda look reasonable to everybody? Pretty much what we agreed upon at the last meeting? So with that, I would suggest we jump right into the prevention conversation. I'm glad that Pam's here this time, because we are right up to your kind of bailiwick, and that is there's a list of prevention questions that we have prepared ahead of time. And we used that as a discussion guide, I think it actually worked pretty well. And we're up to the question on the page that say, "What are success stories in Suffolk? The drug-free community coalitions and model schools and evidence-based interventions and the like." You know, we just couldn't go on last time without your input so we stopped and agreed that we'd pick up conversation here today.

So I would suggest we go through kind of these last three questions. We have about 30 minutes to do, and then I think we should jump into the treatment conversation. You'll find a treatment -- some treatment questions in your packet as well. But the last three questions,

although we've worked around some of them, really need to be answered on the prevention side of it as well. So success stories and coalitions. Pam, could you give us kind of the lay of the land in terms of the coalitions in Suffolk?

MS. MIZZI:

Well, the drug-free communities, federally funded, have as their focus the reduction of underage drinking. That's their primary purpose. They are meant to develop strategic plans for communities to work together with schools, to identify risk protective factors and identify people who will be able to mitigate risk factors and enhance protective factors whoever they are. They have to report monthly. And one of their primary goals is the reduction of underage drinking. Every different community can add to that goal, but everybody has to have that goal. There are eight drug-free communities in Suffolk County.

MS. ROTTMANN:

I don't think they're funded. You're talking about East Hampton and them or others?

MS. MIZZI:

I'm talking about DFCs only.

MS. ROTTMANN:

Right. Okay. I don't know how many there are. Amityville, West Babylon, Southampton, I don't remember them all off the top of my head. There might be more.

MR. REYNOLDS:

We can get a list, right?

MS. MIZZI:

Right. I could provide that.

MS. GOLDEN:

Were there any new ones that were just announced yesterday?

MS. MIZZI:

Islip is a new one. The DFC funding cycle, the notifications came out last night for this year's year-one grantees. So Islip is a new one. Islip and Amityville.

MS. GOLDEN:

Amityville has their compass funding for a long time. This is a renewal or something?

MS. MIZZI:

No. They're on the list of brand new grantees, which means that their compass status previous must have been as a mentor-mentee with PAD.

MS. ECONOMOPOULOS

As is Commack.

MS. MIZZI:

Commack is a continuation, but it was part of the coalition.

MS. ECONOMOPOULOS

They're stand-alones.

MS. MIZZI:

They're in year two -- year three. So in terms of success stories, that's what they're going for.

The DFC funding is going for underage drinking. Then you have community coalitions who have a variety of priorities, including underage drinking, but they have taken on the issue of heroin for Sachem. Sachem Aware, for instance, has taken on the issue of heroin. And different community coalitions have very different flavors to them. And their successes are not immediately identifiable, because they often don't use measurable instruments. So no they don't have a pre and a post. The best they can do is use the youth development survey to have a baseline and then work against that baseline.

MS. LITE-ROTTMANN:

And there are four out on the East End that did the 2008 survey and will do it again in 2010, so they're have some measure -- I don't know how much of a difference it will make, but they'll be able to see if there's any difference in whatever they've done over the last couple of years.

MS. GOLDEN:

That goes back to the issue that we talked about last time about the idea of data collection and how data is used in making sure that whatever we're looking at is measurable.

MR. HOFFMAN:

When you talk about the coalitions, you said that they are specifically addressing underage drinking.

MS. MIZZI:

Those are the drug-free communities, Federal grantees.

MR. HOFFMAN:

And so when you said underage drinking, it's very limited specifically to that.

MS. MIZZI:

Yes, in terms of their reporting responsibilities to the Federal Government, they must report on that measure. However they ascertain that measure, that's one of their responsibilities in terms of reporting back how they use the money and how they've changed that parameter. Then they are challenged to develop the logic model for their community to include any other local conditions that they would like to work towards changing. And they have to show the data as it stands in the present and how they plan to change it; what evidence-based program or practice they use as an intervention, and they'll hopefully get a change.

MR. HOFFMAN:

And I am correct in hearing that they branch from drinking to expanding to heroin?

MS. MIZZI:

If they so choose in their individual community.

MS. GOLDEN:

They're focusing on reducing underage drinking because that's the precursor for the use of other drugs. Is that what you're getting at?

MR. HOFFMAN:

I'm trying to know if we've gone from drinking to heroin with no stops in between.

MS. ROTTMANN:

No. It might be helpful to just kind of give a picture of the landscape of Federal funding just so some people understand. So there are Federal grants for underage drinking specifically. These drug-free community support grants are targeted. And those are -- communities can apply for those grants and be funded to address certain issues. So that's a Federal grant specific to a particular issue like underage drinking.

Then you have individual communities who get together, form a coalition and identify their own priorities, such as Sachem, and in this case, it was heroin, that's what triggered the whole development of Aware Group. And then there are other community coalitions that have been in existence for three or four years now, maybe four or five years, based on a community mobilization effort on the East End. And they also have identified their own priorities, and most often based on some data that they've collected; either archival data or survey data.

So there's a gamut of issues, priorities that are addressed by any given individual coalition in the community depending on what the issues are, or if they have Federal funding to address -- that's restricted to addressing a particular issue. Does that help?

MS. GOLDEN:

If you take all the DFCs and all the former CTCs and all the new community coalitions, how many coalitions are there on Long Island? Probably about 20 or so, 25?

MS. MIZZI:

Well, there are 15 funded prevention providers.

MS. GOLDEN:

I mean coalitions, not providers, coalitions.

MS. MIZZI:

Twenty is a good working number. We can get you that out of the directory. Once you use coalition, you're not exact anymore, because there's the Recovery Coalition that really doesn't have anything to do with prevention, there are coalitions that, you know, aren't really doing prevention specifically.

MS. ROTTMANN:

And the other issue is that if they are a Federally funded coalition or not funded at all, then their choice to identify what their issues are obviously, their priorities based on -- whether it's based on data or not. I mean, they just, as a community, will choose their own priorities. And it's not a system that's cohesive across the County, which is one of the problems that, I think, we face.

MS. LOGAN:

Well, could there be coalitions or these communities of coalitions that you don't even know about.

MS. ROTTMANN:

Oh, yes.

MS. LOGAN:

Okay. So there are some identified people out there that are perhaps doing some prevention work in their local communities that we're not aware of at this point.

MS. MIZZI:

Well, that goes back to your definition of prevention as well. You know, I mean, Girl Scouts and Boy Scouts do prevention on a certain level, PTAs are very good at being -- you know, looking at things from that perspective. But organized coalitions --

MS. LOGAN:

Well, I know in my own community, we had a young man, a high school student, died from alcohol poisoning, I guess, and that kind of mobilized the whole community to come together and form --

MS. MIZZI:

What community is that?

MS. LOGAN:

Babylon Village.

MS. MIZZI:

That's one of our coalition sponsors.

MS. LOGAN:

I'm on the hospital end, so I don't know a lot about this, so if I appear ignorant, please forgive me.

MS. MIZZI:

The Babylon Community Coalition has been in existence for just over a year now. Actually, I think they are extending an invitation to Good Samaritan Hospital to be a partner in that coalition work. We have seen these industry-community partnerships be very productive in other communities.

MS. LOGAN:

I mean, they really mobilized after that incident. There were some beginnings of a coalition before that, but it really took off after that.

MS. GOLDEN:

I think what this speaks to too from the prevention standpoint is that the County and the State came together to fund the PRC to try to help identify all of those things that are going on and to create some uniformity in how the communities get approached. So that's the very first step in trying to figure out how to leverage all those coalitions as a whole in terms of Suffolk County.

MS. BESSERMAN:

I think it's important to note, this actually goes back to part of our discussion at our last meeting, was we kind of jumped to the question of do we think the communities are ready, what is readiness and all these things, we said there were things out there, but we don't even know based on this without the PRC doing the type of work they're doing and the initial trying to figure out what grants are out there, what coalitions are out there. So we kind of asked a question about readiness and moving on, and this is really giving us baseline information of assessing even a readiness kind of thing.

MR. HOFFMAN:

So to go back to the specific questions regarding success, funding models, goals, evidence-based, we can draw more of that information when we have a good sized collection what the collectives are and a full list of the programs so then we can look at them and go, "Who is successful?" And we're and going to have to beg the question then, "What's success?" And that's a wonderful question we'd all love to have around.

MS. ECONOMOPOULOS

Not to backtrack, but again, it goes back to the first question, "How are we defining prevention," which we did spend a lot of time on. And we all threw our thoughts on the table. I don't know if we came to a consensus as to what this committee going to be working with. What is your working definition in regard to how are we measure it all if we're all talking about something else?

MS. ROTTMANN:

I was not here last meeting, but it seems to me that the Federal -- the Feds have defined a strategic framework, the State has issued a strategic prevention plan, and it seems to me that the defines, if you will, the boundaries of work that at least we as a State would support, not that there's nothing else you could do, but certainly, that is pretty comprehensive. So it just seems like that might be an easy way of defining the work of this group.

MS. MIZZI:

That includes community assessment. One of the requirements, one of the baseline requirements is a community assessment of resources and needs to get to that baseline. You know, you add whatever data you can in terms of solid survey data, but without survey data, school survey data, you still need a community assessment to develop needs, further needs.

MR. HOFFMAN:

So we begin, therefore, by using -- do we want to go to the point of saying which one we are using?

MS. MIZZI:

No, that would be mistake.

MR. HOFFMAN:

No, I don't mean assessment data. I'm sorry.

MS. MIZZI:

Which model.

MS. GOLDEN:

You know, why? There's a whole host of different models that different providers choose to use, different coalitions choose to use. And there's a list of a variety of them that are seen as evidence-based. So there's no one particular model that fits any one coalition or any one community.

MR. HOFFMAN:

I think I was talking about the definition of prevention.

MS. GOLDEN:

I am sorry.

MR. REYNOLDS:

I think we can come up with that based on the kinds of the things -- we can throw out some characteristics of good prevention and use some of the existing definitions. I mean, I think we have to do that. I don't know that -- I feel that we have, at least in Suffolk, so far to go that that shouldn't stand in our way, that we kind of know intuitively where things are working and where they are not.

MR. FLESCHER:

Well, I think we know the core ingredients regardless of which evidence-based program. Some addressed different aspects of what you're trying to accomplish. But the core ingredients including how to mobilize a community, the need that schools can't do it alone, a variety of different things we're going to build as a framework, you know, because --

MS. ROTTMANN:

I don't know if it would be helpful to share the strategic prevention plan with the group so that everybody has an idea of at least what that framework is.

MS. MIZZI:

The states?

MS. ROTTMANN:

Yes.

MS. MIZZI:

All right. So I'm going to come up with the directory and I'm going to come up with the list of coalitions.

MS. ECONOMOPOULOS

I have it, if you want to refer to it and make copies.

MS. MIZZI:

I will not copy unless I'm sure that it's the most updated copy.

MS. ECONOMOPOULOS

It may not be. I don't know that.

MS. ROTTMANN:

I'm talking about the OASAS strategic prevention plan itself. The other thing I think I promised at the first meeting, which I neglected to do, was send you the archival data guide. I will do that.

MS. GOLDEN:

I'd be interested in seeing that as well. Maybe you could send that to everyone. You have it in an electronic file?

MS. ROTTMANN:

Yes.

MR. REYNOLDS:

Can we move along away from the coalitions piece really to the -- what's going right in terms of model schools, evidence-based interventions, that kind of thing? We've like another 10-15 minutes on this conversation.

MS. MIZZI:

So school-based intervention.

MR. REYNOLDS:

Last time we talked about some of the barriers. I think a lot of them are the minutes and are pretty well known and have been identified and have actually added a lot of texture to that conversation. But we should kind of talk about, you know, are there things that we have seen that are working real well that could be potentially replicated in other places? And if not, are there barriers beyond what's already been identified, whether it be financial or otherwise?

MS. MIZZI:

Well, this County really has never used a evidence-based program for long enough to show a measurable change. You know, we know that -- we know from research in the past that the one across-the-board program that had been used most frequently in Suffolk County schools was not effective. So, you know, we know what's on the list of nationally reputable evidence-based program and practices. And we have been encouraging schools across the board to engage in those prevention programs.

MS. ROTTMANN:

I don't think we -- I have to keep going back to the data piece, because I don't think we could talk about success or outcomes without pairing the -- you know, in the conversation pairing model -- discussions -- discussion about models with the data, because that's the only way that any of us will know whether any intervention is effective, whether it's community-based environmental strategy or individual district intervention.

MS. GOLDEN:

I agree that because of the fact that there's no -- there hasn't been this uniform data collected for a

long time, it's difficult to say which -- this is what I thought you were talking about before when you were talking about framework -- that there's different evidence-based model that might be suitable in different communities, but we have no way of saying, "Well, this one works for this school district, great, and this one works for that," because they haven't been done. People have shied away a lot from evidence-based practices also, because you can get trained in them, but the implementation process and the mentoring process of actually implementing them with fidelity is time consuming. So people go, "Oh, that's great," and then they take it back and they go, "Well, we'll do these three pieces of the ten."

MR. REYNOLDS:

Right. Instead of a ten-session intervention, can you do it in two sessions.

MS. MIZZI:

Well, except -- I have to put in my plug for Student Assistance Services. There's a model program that I think we can be relatively sure that it does work. Now, how much of it is prevention and how much of it is intervention is decided, you know, on the ground with how that school uses that SAS counselor, but they do use evidence-based programs and practices. You know, and depending on how they are deployed in their school district, we know that that's a successful program.

MS. ROTTMANN:

And Eastern-Suffolk BOCES does keep their own data. So even though it's not a youth development survey, they keep their own information. I don't know what it is off the top of my head, but they collect a lot of data.

MS. MIZZI:

In terms of programs and practices, Student Assistance Services has to get a gold star across the board.

MR. REYNOLDS:

So when we do our public hearings and we identify folks we want to invite, Barry would probably be an important person to have in the room. And I think, you know, of the things to really home in on -- and you said it, Pam -- is that nexus between prevention and intervention. And it might be those two things working in tandem and the immediate availability of those things provided by somebody from outside the district that makes the difference.

MR. ENRIGHT:

Excuse me. May I just intervene about this school question if I may?

MS. CATALANO:

Can you just state your name, please.

MR. ENRIGHT:

My name is Phil Enright, I live in Port Jeff Station. I've been involved as a volunteer for over 35 years working with parents and schools doing this for quite a while. But anyway, this particular question about what are the schools doing; which is successful, which is not successful, I'll just throw out a suggestion. If you were to contact every school, maybe a questionnaire to ask them, "We have this task force and this is what we are doing; we're trying to accumulate a lot of information to come up with a good plan that's going to help solve the epidemic. If you could maybe answer some of these questions, it's very simple; well, what have you folks been doing, what do you find that really works in your district?" And if we get that letter or whatever it is, in a nice non-official, get it to every single school district and see who responds. And then you're going to get a picture of really the school districts that -- you know, what they are doing, you may get some that don't respond, and then you'll have list of the school districts that maybe you ought to take a look at. Just a suggestion.

MS. MIZZI:

Just in response to that suggestion -- thank you, Mr. Enright -- I just want to put it on the record that the prevention resource center did send over 300 e-mails to Suffolk County schools in the spring and then again in fall of 2009 --

MS. GOLDEN:

A questionnaire.

MS. MIZZI:

-- about prevention services, about how prevention is utilized in their school district, what would they like to see, what do they do now, what would like to see, and we got very disappointing results.

MR. REYNOLDS:

Can you say more about that, like what percentage or what did they say?

MS. MIZZI:

Not off the top of my head. What did I put in that e-mail to you?

MS. GOLDEN:

It was 12 schools or something like that.

MS. MIZZI:

Well, we followed up with US Mail to the prevention providers. So OASAS funded prevention providers all responded in the end, but their response was maybe 20 answers out of 300. Now perhaps this advisory panel would have far more weight.

MR. REYNOLDS:

If you remember, the fact that those who are doing pretty well were the ones who responded or not necessarily?

MS. MIZZI:

It just wasn't their issue.

MR. REYNOLDS:

No, but I'm saying the ones who did respond, I would imagine those are the ones that are doing pretty good stuff.

MS. MIZZI:

They had either a student assistance counselor that did answer.

MR. HOFFMAN:

It's something to point to.

MS. ROTTMANN:

But then the other question is -- and I don't know what the responses were -- again, how the school district defines prevention; you know, Health Education Class to them might be preventions versus an evidence-based. It is that continuum anywhere from that to an evidence-based practice.

MR. REYNOLDS:

So would you be willing to share what you sent out? Because maybe we could polish it or even not change it and sent it out kind of with our name on it and see if we get a different result.

MS. MIZZI:

Well, we could look at it anyway, sure.

MS. ROTTMANN:

You know, that School Board Association Conference is coming up in the fall, and that might be something that we could distribute at the conference as well at least for the Long Island School Districts.

MS. GOLDEN:

That's a good idea.

MS. ROTTMANN:

Let them scan or e-mail the results, send it or mail it to you.

MS. GOLDEN:

I remember you shared this with me about how it went to various people in the district itself.

MS. MIZZI:

Yes. We originally sent it to the Superintendent and Guidance, and then we went to Superintendent-Assistant Superintendent, Chair of People, Personnel Services out of the scope book as well as Guidance, Head of Guidance. You know, we put in five different titles for each school district.

MR. FLESCHER:

Hoping somebody would bite.

MR. REYNOLDS:

Did Ed send his back?

MR. EHMANN:

That was Number 326 on the e-mail list. I was going to suggest that one of reasons I was happy to serve on this is to represent the Suffolk County Superintendent's Association. And the conversation today is leading toward gold star programs. You said this was a gold star program and you mentioned there were others that could be effective in various communities.

Once we are done looking at programs that work, I'd like to put together a presentation to the Superintendents, "these are programs that work rather than what's your issue, because all districts have issues. And if you start to survey us on what are our issues, it gets overwhelming. There's not a district that's immune from the issues. The extent might be greater in one community than another on a specific issue, but all issues are there. So if we can bring to them some research-based programs that have proved effective, it will take away a lot of the effort on their part to implement, and then they'll identify key people. We can do Western BOCES -- I'm a Western BOCES member, Eastern BOCES -- we can do workshops where we ask every district to send a rep, whoever it might be; Guidance Director, Superintendent, right on down, and just spend a couple of hours to present things that work and help them implement it in their district. I think that might be a more effective use of our information, because I think we know what the issues are.

MR. FLESCHER:

I think to piggyback on point at, I mean, at some point, there's going to be a report coming out. Part of what's going to exist in this report is what's recommended in prevention, what's recommended for schools, and we're going to try to tie some of this together so it is practical for people as well. That maybe would be a good tool to work off of in terms of that type of presentation.

MR. EHMANN:

I probably get, without exaggeration, five e-mails a day from private individuals who are looking to create a character education program, drug prevention programs, and you just get overwhelmed by the volume of information that's coming through.

MS. ROTTMANN:

Forward them to Pam.

MS. GOLDEN:

That's probably a good idea.

MR. EHMANN:

But if you have some gold star programs, to me that helps a lot. And so I think -- I recommend we go there.

MS. ROTTMANN:

The other thing is that there's not going to be any one strategy for reaching out to various community or schools. And while I think that all of these are good ideas, the report, I would imagine, would compile all those strategies.

MR. HOFFMAN:

I think this catapults us forward to the last question from last week about if we could make new laws and change existing legislation, what changes on prevention efforts would we encourage, because that's the final wrap up question for this section?

MS. MIZZI:

Right. Because how can schools be compelled to do anything?

MR. HOFFMAN:

So your point is some legislation has to have a piece in it that compels schools to participate.

MR. REYNOLDS:

Kara.

MS. HAHN:

Yes. I'm just curious. This is my first meeting. Did anyone address the lack of mental health services in the schools? Because as you all I'm sure you do know, alcohol and drug use could be a way of medicating mental health issues. I know at least in my school district, my daughter is 17, there are, you know, three mental health providers for 2100 students. There's no way they can, you know, even touch upon some of the issues. Has that come up at all? I'm just curious.

MR. REYNOLDS:

I think it will in the treatment conversation. This has been so far limited to prevention. There is crossover, and kind of one of the things we agreed upon is that there's a connection between all these things and that as we do the report, we should try not to silo them as they have been in the past.

MS. HAHN:

I absolutely would think as prevention, because when students have problems that they may be deal with early on --

MS. MIZZI:

Also, there's screening of intervention.

MS. ROTTMANN:

Screening for both mental health and substance abuse is --

MS. HAHN:

They don't want to do it. They don't want to admit it.

MS. BESSERMAN:

Then they have to do something about it. That kind of goes back to one of the standing points that we started with, that -- not that they necessarily don't want to, but there's such pressure to do so many things, that if there's a way to not be compelled to have to it, if they are not compelled to actually do it, there are so many other things that they are pressured to do right now.

I think you used a great word before when you used the nexus between two components. All our components have to be tied in. And there will be that part of -- prevention might prevent that next level. If you catch someone early, you can do an intervention and perhaps when you turn around it may not even be a required treatment. All those pieces are together.

But this is also one of things that I think from last week and one of the questions from our last meeting is if we had money. We all talked about resources and not just the financial but legitimized individual alive person resource, not just the manualized person -- a manualized resource or curriculum, but it's the deliverer. It's the relationship, it's the engagement, it's the investment in the wellbeing of that individual. In most cases, here we are talking about the children.

MS. HAHN:

So student are ready to learn. One of things that the school needs to determine is that students are there and ready to learn. And when there's mental health issues --

MR. HOFFMAN:

So screening is a big piece that we wanted to include in our recommendation in terms of legislation, correct? Okay.

MS. GOLDEN:

Just to piggyback on that a lot, there's a lot going on Statewide on the Office of Mental Health side that is targeting schools and looking at the social and emotional development piece of children. And there's a lot happening on the mental health side in terms of their coordination with schools and trying to help schools to integrate mental health services into the schools to a greater degree. And there's number of mechanisms --

MS. HAHN:

So ten years from now.

MS. GOLDEN:

Well, I think it will probably be sooner than that.

MR. FLESCHER:

It depends on which school you're involved with.

MS. GOLDEN:

There's things happening; OMH is changing its reimbursement system, and there's things that are going to make it a little easier for services to be provided in a variety of locations, including the schools. And that's actually happening as we speak. So you are on target, and I think there's larger effort going on that's moving people in that direction.

MR. HOFFMAN:

On prevention, is there anything else that we want to note at this point that's a real Legislative recommendation?

MR. REYNOLDS:

Prescription, diversion and misuse. That's an area that Dr. {Chauncy} raised on a number of occasions. And there are some things that have happened in other states which bring them up to

where New York is. But there are some very concrete recommendations we can make around access to that database; the updates that happened through the Statewide registry and that kind of thing. I think that should be on our radar screen. John.

MR. VENZA:

I just think one of basic principles that we could incorporate into the legislation is that it's continuous throughout a child's school career. You know, I mean, a lot of times schools that are even -- that they try to do it and they'll do their seminar or their assembly in Grade 4 and they'll do they're -- you know, they're for the wrecked car on the school grounds in Grade 7, and they'll have the other assembly in Grade 11 and folks will cut out of it. You know, I'm being a little bit jaded. But I think we want to look at -- if we're going to make a recommendation, that we're not going to prescribe the specific model, because of a lot of the resource issues. But clearly I think that we want to say, the principles, the federal and state principles of effective prevention say quite clearly, it starts when you are young, and every year, like your Measles, Mumps and Rubella, you get your booster shots each and every year. And then they could be the right size each year. That may be, you know, a nice recommendation.

MR. EHMANN:

There's other issues. I mean, there's not a school, I believe, in Suffolk County that isn't concerned about the social, emotional development of their kids. And we are constantly being asked to do more and more in the values clarification area and the character education development area, so it gets a little bit overwhelming. I think what you hit upon before is the key; we introduce the programs, we talk about the K-12 continually, because the assemblies don't work we know that. I mean, it looks nice, but it just doesn't have a shelf life.

But you have to have teachers trained well enough to incorporate lessons into their everyday routine. And we talked about this at the last meeting, whether it's a Math teacher or an English teach, a 2nd Grade teacher -- of course they do the interdisciplinary approach -- but it's got to be part of the culture, it's got to be part of the kid's development as well as the academic piece. Schools are making progress in that area. The challenge is which program should we engage in? Because it takes a districtwide effort to train everyone.

So just to give Smithtown as an example, we had a great body shop, and then it started to dissipate. The kids obviously participated in DARE, and that was proven to not be that effective, so that went. Now we have reached out coincidentally, and thankfully, Jeff is helping us with Too Good for Drugs with training every Physical Education and Health teacher so that from K-12, the kids will get the Too Good for Drugs curriculum, the teachers will be educated to what's happening, leader and we're bringing in the Leader in Me, Covey's Principles for Children. The teachers are excited about it.

We've done five different presentations, they like the Covey the best. If you've read the book, it takes children and tries to develop leadership-type behavior out of them, to get them to make positive decisions. It's going to take a while for it to be ameliorated into their personalities, but the challenge is, while all that's happening, the State revenues are diminishing, State aid is declining, districts are forced to make decisions about staffing; who are they to make folks go, maybe the social worker and the counselor, because they just aren't in the classroom to face the pressures coming from the State assessments and the like.

You know, we were disappointed to lose the Title 4 grant money. I mean, for Smithtown it was 39,000 a year. And we did a lot of really good stuff with \$39,000 a year. When that money goes away, it's hard to replace within your budget. Again, I come back to, this committee can do tremendous work in this area identifying proven programs so we can advertise those to communities through the Superintendants and then the PTAs and the youth advisory groups. I mean, then it starts to filter out. But the challenge is to identify the ones that work so they have a little bit smaller menu from which to choose than the overall menus that we get each day.

MS. ROTTMANN:

I'd like to say that it sounds like you're expressing the responsibilities the schools have. And I'd just like to remind everybody -- I'm sure you know this -- that the community has a larger responsibility. And if we include recommendations for using environmental strategies in the community, then that really supports the schools in whatever efforts the school may decide to implement. Community coalitions and environmental strategy is critical in any community. And I know Smithtown has a coalition.

MR. EHMANN:

We have a coalition. We are also so big. I mean, Babylon, it's a little tighter, but at the end of the day, it's the same process. That's what is so good about this particular advisory group, because the minutes contain such good information for me as a Superintendent. I learned so much at the last meeting and I'm learning more today. And this is the type of information that we have to bring to people so they are aware of what they can do to get help.

MS. LOGAN:

You see this as a community, the community responsibility. Obviously the hospital community is a big part of this. And certainly establishing relationships with the local community schools with the hospitals, I think will help further it along. And in addition, on discharge, there's a lot of counseling, opportunities for counseling about medication use and making sure your medication is in a safe place so that your child cannot hold of it and it gets on the street and all of that. So it does all tie together. But absolutely bear in mind that the hospital, I think, plays a big role in this too.

MR. REYNOLDS:

JP has been very, very patient.

MR. DIMARTINO:

I was in high school six years ago. It seemed as I went through and progressed from freshman to senior year, competition was removed, physical fitness tests got easier, gym class became a joke. I really think -- even in all classes, as far as goes, I feel as competition is removed from the school place, kids need to expend their energies in other ways. I think that's really where harder drug use comes into play. I think as a basic -- you know, I'm just throwing it out there -- maybe regular competitions in art, regular competitions in writing for English class, you know, get serious with physical education again.

I mean, a 17 year old kid has a ton of energy. If they don't expend that energy during the school day, what are they going to do at night? It makes them more apt to make destructive decisions. I've seen it -- you know, I was an athlete in high school and college. I know plenty of kids that once the competition was removed from their life they turned to drugs, because that gave them the same high they got from the sport's feelings. I'll tell you that, you know, playing in front of 5000 people for a game, it's awesome and playing on TV is awesome. And then you go from that to real life and you're like, "Well, I just finished work, now I have to go home."

MR. REYNOLDS:

How could I duplicate that high?

MR. DIMARTINO:

I hit the gym, but, I mean, other kids don't make that decision.

MR. EHMANN:

That's Dr. {Dewey's} presentation with the affects of the brain under those types of stimulants. He taught about the natural highs versus the artificial highs. It's hard to bridge that gap. Our challenge is to get kids from kindergarten through 7th-8th Grade to stay away from risky, because there are other things to try to do. So I will bring your thoughts back to the school.

MR. REYNOLDS:

Phil, 15 seconds then we're moving on to treatment.

MR. ENRIGHT:

Fifteen seconds. I just wanted to mention to that gentleman in the corner who talked about -- before we get off prevention -- what any kind of legislation might be involved or looked at in terms of that. Long Island schools do not screen for drug users in their preemployment drug screens. Possibly some legislation may be put in place, but it really doesn't need to be put in place. The court of public opinion will get it in place. Parents all over the County have no idea that the school districts do not screen for drug users in their preemployment tests.

MR. REYNOLDS:

Okay. We got you on the record.

MR. ENRIGHT:

It is not against the law, it is not illegal, and it's never been contested. In light of that, in light of the drug epidemic, in light of several employees in school district dealing drugs both on and off the property, I would think that would be something the task force may want to add when they put in their report.

MR. REYNOLDS:

Got it. Treatment. You have in front of you a discussion guide with some questions related to access of treatment. Just a few kind of -- it doesn't mean we need to stay on this but it should give us kind of a starting point a sense of questions that will follow a similar flow to prevention questions by kind of getting us to first identify some of the characteristics of good treatment and timely treatment and that kind of thing. So it's a logical point to start. If we think about now kind of how this report shakes out, each section will start with the ideal and this is the standard and then some assessment as to where we're at and some recommendations about how to fill whatever gaps might exist. So we can just kind of proceed with this document in a kind of lockstep way and brainstorm until we feel we're done and then move on to the next one. We've got probably 45 minutes to kind of run through this, maybe 50 minutes to run through this and kind of start forming a framework. We're going to deal with this in the next meeting as well, but if we can get, you know, at least half of it out of the way, it will get us down of road in terms of dealing with the treatment questions.

MR. VENZA:

Leading off, I mean, the characteristics -- I know the drug strategies for adolescents they did in, I think it was 2003-2004, came out with nine core essential elements with good adolescent treatment that was a national survey that they surveyed programs around the country. You know, they did a pretty good job. Some of their -- there were inaccuracies in some of the reporting and coding, but I think overall they came out with nine core things that made kind of the backbone or support some of our dialog here as a reference document.

MR. REYNOLDS:

Can you get that to us?

MR. VENZA:

Yes, sure.

MS. GOLDEN:

What is that?

MR. VENZA:

Drug strategies. It was nine effective elements of adolescent treatment. I think OASAS actually replicated it in that bulletin too recently I think.

MS. MIZZI:

Are we focusing on adolescent treatment?

MR. REYNOLDS:

It kind of varies. And John had raised a question at our very first meeting, which I thought was a good one in terms of how we define adolescents and kind of our willingness to put kind of 12 to 17 in the same category kind of thing, so we should get to that, but we can talk about it, I think, both adults and adolescents.

MS. ROTTMANN:

I would like to say that I think we need to frame the discussion of good treatment in terms of accessibility to the program itself and the services and how welcoming, if you will, the service provider is either in terms of the setting of the facility itself or the staff who meets the individual as they come through the door. I think that's a critical piece in terms of good treatment.

MR. FLESCHER:

To some degree good treatment is a service in which people want to return to and that people feel as if it's a place where they can help get well. And where you go from there is a lot of different issues. I mean, people need to -- good treatment is adaptive to people's needs, yet is consistent in terms of what the expectations are. And how you balance that is, I think, a part of the challenge in doing the work.

MS. BESSERMAN:

I think -- I mean, excuse the pun, but there is an art to effective treatment, because there are so many different dynamics of people. And that part, I think, is a standard. As far as adolescent or adult, I don't think that's an issue, age group. I think the methodology that's used and the skill sets that are brought to it. It's not enough -- similar to what you were talking about earlier with the schools, it's not enough to say, "Here's a curriculum, go do it." It's not about, "Okay. I got trained in MI now, boom." There had to be a thread that brings it through. You can have a great program and lousy people running it, and you now have a lousy program.

And then you can have a mediocre program but you have phenomenal people, and that will rise the program up, because that connection will make the success, because in the ends, the common denominator, whether it's adult or child, it doesn't really matter, we're dealing with people. You know, we're not talking about widgets. So the successful relationship is what changes -- helps someone to make a risk to make that change. That's why sometimes we say, "Oh, there's a few good curriculums that we would recommend or some evidence-based or some gold standards, but it goes beyond that. And I think good treatment is something that flows with the art of the human mind and the human being.

MR. HOFFMAN:

I think the other thing, especially if you're treating -- talking about adolescent treatment is your modalities and approach has to be current. You know, we can't be using outdated material with adolescents. You know, adults will bear up to a video of 20 years ago. Adolescents won't. And the more that we also learn how to bring treatment into an electronic age which speaks to them, the more -- because then we're speaking on their platform on their terms, which makes me uncomfortable, because I am out of date. You know, that's why I don't specialize in adolescent treatment.

MR. REYNOLDS:

You couldn't even open the Google document I sent you.

MR. HOFFMAN:

That's true. That's another piece that we need to help emphasize.

MS. ECONOMOPOULOS:

And the level of care has to be appropriate. It has to be on target.

MR. VENZA:

The match for services, absolutely.

MS. ECONOMOPOULOS

Because that's one of the, I think, biggest problems that we face is when someone is being treated in the wrong level of care.

MS. ROTTMANN:

Cultural competence is another one.

MS. BESSERMAN:

A couple of things, the elements that we're just discussing right now are no different than the elements that we said is what we needed to have --

MS. ECONOMOPOULOS:

Prevention. Yes, I agree.

MS. BESSERMAN:

So we have another core theme. You know, we know we have to take into all those accounts.

MS. GOLDEN:

A couple of things that I think are really important too in good treatment is integrated care that I don't think we involve or talk to the primary care physicians as much as we should or could. And I think that treatment providers reach out to primary care practitioners, but this was another thing that Dr. {Chauncy} was bringing up as well is that lack of coordinated care leads to duplicate prescriptions, issues that come as a result of the lack of that integrated care. And integrated care is the -- is the, you know, gold standard in terms of where the whole country is trying to move with the medical overhaul concept and the direction of health care in general.

And secondary to that, to speak of what you were just talking about current approaches is that you have a real conflict between providers who focus solely on an abstinence model and others who focus on a harm reduction model, which really are at odds. They don't have to be at odds, but a lot of providers perceive them in that way, especially if you're working with adolescents, that if you get an adolescent who went out on the weekend and had a couple of beers or has had a problem and they get involved in treatment and now they're talking total abstinence, people will perceive that as unrealistic for certain populations. So the fact that there's these conflicting opinions within the field itself about what model needs to be followed --

MR. VENZA:

It is true. I mean, I think anybody that, you know, runs a program by day or maybe doing private work by evening -- that's myself -- with adolescents, I almost find myself feeling hypocritical, because here I am in a residential model by day and then I'm working with kids that could be eight months between pre contemplated and contemplated decision making around reducing how often they're smoking pot. I agree, I think it's really -- it's really not neither or, but getting folks to begin to embrace both in a predominantly abstinence sector. You know, I think --

MS. GOLDEN:

Well, that speaks too to regulation if you think about it as well that I -- and, Lisa, you can correct me if I'm wrong, but I think one of the expectations of OASAS in any of the OASAS-licensed

programs is that abstinence has to be the primary goal.

MS. ECONOMOPOULOS

Right. Yes. Right. I don't know --

MS. ROTTMANN:

In regulation? You're asking me if it's in regulation?

MS. ECONOMOPOULOS:

It is what is measured on your IFMS reports. You can't go for partial completion, it has to be abstinence.

MS. ROTTMANN:

I want to correct you. Unless -- I mean, I haven't -- I don't remember that work being used in the revised regs, I don't believe it is. I don't think that OASAS stipulates what -- certainly there are harm reduction strategies that can be used in the context of working towards somebody becoming drug free. And when I say drug-free, that doesn't mean somebody who needs medication, etcetera. But I don't believe that OASAS anywhere stipulates abstinence. Now, what you are saying is you can't check somebody off as having completed treatment if they're not --

MS. ECONOMOPOULOS:

Successfully.

MR. FLESCHER:

It depends what your goals are.

MS. ECONOMOPOULOS:

You cannot put it into the computer. I don't want to get that, but I am telling you, I know, you cannot.

MS. ROTTMANN:

That's a data reporting issue you're talking about.

MS. ECONOMOPOULOS

Either way, that's how it gets reported. That's our outcome study. So what they say and what is reportable, you cannot enter a successful completion if you have less than an abstinence goal.

MR. HOFFMAN:

She is correct.

MS. ROTTMANN:

I think she is in term of the reporting.

MS. ECONOMOPOULOS:

That's the part that really counts for us.

MR. FLESCHER:

But is it abstinence from all substances, or is it abstinence from the primary substance?

MS. ECONOMOPOULOS:

The primary.

MS. BESSERMAN:

There's other conflicts, because now we're talking about every -- if we look into a little bit and say,

"How do we actually get some of our folks that are in treatment," they are compelled by external sources, largely courts or diversions or, you know, family guidelines. But anyone that has a legal component, whether it is adult adolescent, they don't send us a referral saying -- the judge doesn't say, "Okay. You work on it -- right. There's no reduction, there's no minimization, "Okay, you used crack, but now you're smoking pot, yeah on you." It doesn't happen that way. So there's also a conflict.

So I might be trying to use engagement and movement and readiness and all the MI and MAT and all those wonderful things, but I work with Kristie on working on some of those things and Kristie says to me, "I don't know, I'm just not ready," and she is making progress, but then she drinks and I have to report that she drank. So already there's a negative to it. So it kind of builds into that. So I think part of the treatment component and what our expectations are is making sure that we have some level of flexibility. And I think in some cases we don't, because we need an outcome, how do you count -- I think it was just easier to say yes or no abstinence for primary, yes or no to a secondary. So there's different levels.

It's interesting, because here I am saying how do we compel to have to be engaged in a prevention or how do we compel to make sure that we can transition successfully to treatment if necessary, but we're also handcuffing ourselves in some case for making individualized treatment.

MR. HOFFMAN:

We're talking about barriers now. And this is bridging over to our next question, the issue of barriers. Now, part of the barrier is an adolescent comes to you largely not really interested in the conversation, there are one or two. So how do we engage them when we are set up with an abstinence model? And we can play at it, but you know that in the end, you've still got to get down there to that nitty gritty line. And that's one of the big barriers, because you know -- and not all parents think that abstinence is the outcome. They want to go, you know, "Just get John to smoking less pot. I smoked pot and I'm fine. I own a big, you know, Fortune 500 Company. What's the big deal?"

MS. MIZZI:

And leave the drinking alone.

MR. HOFFMAN:

"He drinks with us, we watch him, it's fine. But you know, the cocaine, you know, we are not too happy with that." So it's moderation is what they want to hear about.

MS. ECONOMOPOULOS:

Or as long as they don't get into trouble. One of things that -- I don't know if you want to look at it as a barrier or as an enhancement -- but adolescents much like our adult population, we have the greatest success with those who come in maybe resistant, but mandated. Get me somebody who's forcing that --

MR. FLESCHER:

There's been some consequences also.

MS. ECONOMOPOULOS:

Consequences or they just can't decide to walk, okay. So that buys us enough time to make the kinds of changes in, you know, what's happening for them to see positive outcomes. And with adolescents, we lack that mandate. I wish -- you know, we get referrals with strong recommendations, I wish we could get more of a mandate from the referral source.

MS. ROTTMANN:

Back in the day of the PINS petition.

MS. ECONOMOPOULOS

They can choose to walk. We're invested and we're working and we're seeing positive change often with {APY} with the kid, not with the family, and they leave. But if the schools had a stronger role in -- and I know there are barriers to doing that, I understand that -- but if they had a stronger arm in mandating or, you know, keeping this kid in some kind of a program, we have a better shot at really making a change.

MR. VENZA:

I think to the point with the legislation and with the schools, I think with that legislation change, that expeditious process for a school-initiated, you know, PINS is really removed. I mean, you could speak better to this, but I think a lot of schools that would like to expedite and kind of collaborate with a Family Court or what not, have they had in the past, who don't have the resources and the time or the personnel to do it the way they need to do it now. So I think you're looking at that mandate, it's multi-level, the mandate has disappeared.

You talk about treatment going from compliance to commitment to congruency in three big chunks, and I think that compliance piece is critical for the adolescent. And it's not there. And compliance can be distilled down to, you know, do your homework or no TV. I mean, that's a basic level of child rearing. So now we're talking about treatment in young folks. The levers are gone. I mean, we're talking about legislation. There was a Legislative shift that was not the end-all, be-all or the answer all, but certainly a significant piece that I think Elaine is speaking to that anybody working with these young folks, including the school systems feel like is -- there's a big void there.

Unfortunately, the leap goes from family intervention with some kind of compliance through a family-oriented court that the next time you see and type of involvement of court is Criminal Court. So there's dissidence there. You talked about a Legislative revisit, that is certainly one that is prime. It doesn't have to be in place, it could be -- it doesn't have to be either/or. I think, you know, the diversionary program, diversionary efforts are important. I think that took care of the parents that wanted to abdicate the role the first time the child didn't do something on demand.

But I think there's a lot of kids in family systems that are passed that, you know, diversion as mandatory versus diversion as discretionary, I think is the language in the law that should be revisited. I think that's also what prevents us from getting kids with the mental health issue -- the woman is not here any longer -- but these kids who have the double-edged sword with the mental health piece, I've sat and participated and helped them at the PINS diversion hearings and sat on committee. And a big obstacle there is if you want to get a child in for an extended evaluation through Sagamore, you can't get there until you get the PINS petition, but you can't get the PINS petition until you do the PINS diversion, which, you know, nine years and six feet under can occur first. So I think to answer the other question on a different topic, I think that would be a huge one that would give us some parameters to help do our work in that treatment.

MS. MIZZI:

And I was just going to follow that up with that's the legislative piece, but if there was also a policy piece on the school level, because this is a multifaceted problem, because we're all in this together, it's not schools alone, it's not communities alone, it's not treatment providers alone even though we're just talking about treatment now, the congruence of school policies that had requirements of mandated treatment or strongly recommended treatment, but -- so he was talking to the legislative piece, but it needs to be backed up with the policy piece, the small policy piece in the schools so that -- so that --

MR. EHMANN:

You have to remember in treatment though it's considered corporal punishment, so they need a whole other level of legislation to change that.

MS. MIZZI:

But school policies can be changed on that community level, correct?

MS. GOLDEN:

Right. The drug use policies, you mean.

MS. ROTTMANN:

If a child is identified --

MR. EHMANN:

We have that. We have all those. We do the best the best we can through superintendent's hearings to strongly suggest that counseling occur before the student would be allowed back into the schools. We have athletic policies that if students are, you know, ever caught, there's a whole disciplinary thing, but it's hard to force people to get treatment. It's very hard.

MS. LITE-ROTTMANN:

Or to withhold education until such --

MS. MIZZI:

It could extend to extracurricular activities.

MR. EHMANN:

We don't do urine tests yet, that might be coming down the road. I know in some states they do these random tests.

MR. REYNOLDS:

Phil wants that.

MR. EHMANN:

We do fingerprint our staff before we hire them. We don't fingerprint them every year --

MR. HOFFMAN:

I think the piece here is, especially with adolescents, with youth, it's the issue of consequences. And, you know, what we are all going around is it's very, very hard to have consequences for adolescents. The families don't -- inherently don't want to follow through, they both work. You know, there's reasons for that. Legislatively, you know, we either have the hammer comes down and you're in drug court, which is abstinence. And, you know, you'll sit with me in drug court until hell freezes over or else you go to jail, Southampton specifically.

And schools can only push it so far. And youth know very good and well that most consequences don't apply to them. They know that their parents have to provide a home, they know that corporal punishment doesn't exist, they know that they have tremendous ability to do what they want to do. And this is a huge problem in terms of -- we all know mandated leverage and a hammer is a great tool in treatment.

MS. ECONOMOPOULOS:

You need to be able to depend on external support. You know, we recognize it as a family disease, we recognize the parents are in as much denial as the child is in. We are appealing to the parents, they're buying into the lying, they're not seeing it until we have crossed some other barrier, until now we are in deeper, until now, perhaps, we are not even in the right level of care anymore. And we can't necessarily blame them, they are as affected by the disease as what's going on.

But others from the outside see what's happening, and we know an intervention is required, and we know that we need some leverage to make it successful. And we sometimes, you know, stand by helpless and watch what's happening and have to wait until the judicial system jumps in. You know, it's a criminal system that now can mandate something.

MS. GOLDEN:

You're kind of pulling it all together for me from the standpoint that we're talking about -- we started talking about measurable outcomes and how we measure success in what we're doing. And perhaps we need to come up with alternative measures of success other than abstinence or in addition to abstinence. And those measures of success can drive the complex change in terms of what the school does, what the community does and what everybody in terms of what those measure of success are.

But just to take it a step further, part of the issue that you're bringing up is treatment access, right, the barriers; how do people get to it if there's two working parents; the compliance issues are partly because of the way the family systems run. So it brings me to the fact that on the treatment end, OASAS and OMH in particular have been talking about authorizing delivering treatment in the home, which makes a difference then in term of access, in terms of seeing what goes on in the home and what's occurring, and we're almost there. I mean, they have pilot projects, people do deliver services in the home, but right now it's not necessarily something that's pushed or funded. This is a whole other thing that's coming down the road, hopefully that would be the case soon. I don't know under the new OASAS regs, are they going to allow services to be delivered in the home when that's --

MS. ROTTMANN:

No. There are discussions about what we're calling off-site services that you can count as a unit of service versus that you can bill for. You cannot bill for any service that's in a non-certified setting. That doesn't mean that at some point we won't allow off-site services just in terms of being able to do an assessment and count the service as a service, deliver it, but not for billing purposes.

MS. GOLDEN:

Is that tied to the CMS regulations about allowing Medicaid -- (inaudible). They're hoping that's going to change. But the whole evidence-based is pushing toward being able to deliver services in the right environment at the right time. So if that should go through, that opens doors for greater access to treatment.

MS. MIZZI:

School-based.

MS. ROTTMANN:

Now, school-based treatment is a different issue, because a school setting can certainly be certified, and they are. I mean, Elaine has --

MS. ECONOMOPOULOS:

I have services delivered in school.

MR. HOFFMAN:

So one barrier is location of treatment, so another barrier is financial coverage, which is --

MS. ROTTMANN:

Speaking of the schools, it is location of treatment, but if we can get schools such as William Floyd is interested in -- you know, I don't know, Kings Park, if we can try to get schools to accept services on the premises, that would be a huge, huge, huge step towards reducing barriers to access to treatment.

MS. GOLDEN:

And now that -- to take that a step further for me, some schools express interest in that and want that. And on the OASAS side, can you currently bill for the services delivered in a school?

MS. ROTTMANN:

No, but you can get funded to -- I mean, you know, obviously money is always an issue, but you can get certified -- any school setting with a provider can get certified to deliver treatment services at any setting that falls within the standards have to be met. So it doesn't matter if it's a school or whatever. The issue is if you cannot bill for it, well then funding has to -- somewhere funding has to come, whether it's from the State or district -- you know, tax levy money or County money, whatever the case may be, you deliver the services through funding of some kind, revenue.

MS. GOLDEN:

So it's the Medicaid -- well it's for Medicaid cases.

MS. ROTTMANN:

On Long Island, 50, 60% are not Medicaid anyway.

MS. GOLDEN:

Well, that's the interesting thing is we just had a conversation that speaks to this whole treatment access issue. We had a conversation with United Behavioral Health, which is one of the larger Behavioral Health Providers that South Oaks deals with, and we were talking to them about our ability to provide services in the primary care office or in the home or in any location off site. And they were so excited about the idea that we were interested in doing this for their beneficiaries that they were open to the idea.

So I think it's a dialog that's beginning and has potential to decrease barrier issues.

MS. LITE-ROTTMANN:

I just want to say one thing though. I would -- there are ways of creating services in other settings right now today. If a provider is willing and let's say for example a school is willing to partner, you can get certified without any problem, and then you could bill, you could do whatever you want if you're certified.

MS. GOLDEN:

If you get a satellite location?

MS. ROTTMANN:

Yes. So that can happen right now. And even before the discussion about approving off-site services that can or cannot be billed for, you right now can create a broader range of settings that can be certified and you can bill for services. So I think the low-hanging fruit is getting other settings certified right now, because there are lots of providers who would love to provide services in schools.

MR. VENZA:

I just want to throw out there -- you know, I know nobody's -- not anybody's doing this with an intention, but -- and I don't know if this has changed, you may know, but I think Floyd lost their four student assistant counselors. So I think that somehow if we did this collaboratively, if we're adding services in one corner of the building and pulling them in the other, I think we want to make sure we do this as -- because I think unfortunately that -- you know, that's a financially great move for Floyd that they lost money (inaudible), but I don't know if they've been restored or not. I don't know.

MS. ROTTMANN:

No. But they're supposedly working on a partnership to deliver treatment services on site.

MR. VENZA:

Right. But what I'm saying is they're bringing it in, but they also lost four very available FTEs there that were doing -- we said, it was a gold star programs earlier. So I mean -- going this way and

that way, ending up in the same starting place, I think we'd want to do in addition to rather than in place of.

MS. BESSERMAN:

Actually, I wanted to jump back for a second. We kind of took a tail off on the coercion thing and then we did PINS and schools. And it all made sense. The issue with if we use coercion or mandates or whatever, there are two things; there's a mandated compliance, which I think is somebody giving me -- a lot of times we get a lot of lip service, so where is that really leading us? It might get them through a nine month, six month, 12 week curriculum, but where is the change element and how do we actually maintain a moderation of legitimacy to did it really happen.

John and I can both speak to people who have done really well even in our residential care settings who we actually would turn around and think had a good shot, completed aftercare, moved on, and the day they completed or the judge completed for them, you know, they go out and celebrate by using whatever it is that we spent all this time -- I mean, you know, sometimes it's as painful as graduating from high school? What do you do after graduation? You go out and have a beer, you know, they have these parties. The same thing from treatment can happen.

You know, we have people doing really well. We have them under a requirement. And they seem to be making progress, and they're actually making progress outside what we thought they would. They go and the judge is very proud and their treatment court team is very proud because they've made such progress, and as a reward, lift the coercion element of it, and then they are done. So there's no -- although coercion sometimes is helpful for me, because I can at least have somebody there and I might have a starting point, but even with coercion, it's open door, you still can leave. Your punishment might come from a court. So we have to do the ongoing maintenance of data to see if this is really a positive outcome.

MS. ROTTMANN:

I have a question in drug court. Is it just a program that's represented, or do you have representation from, let's say in the case of an adolescent, from the school, the from family, from any other provider that may be involved with that person or is it just the program?

MR. HOFFMAN:

It depends upon the court.

MS. BESSERMAN:

It's case by case and court by court nuance. I know that we do our best to try to engage the family in the process to work with the treatment court. It's not just send a note and see what happens. Because we have school on-site, we can try to engage the process for that school. Our discharge planning talks to the school about people going back. So yes and no.

MS. ROTTMANN:

I'm not talking about the process and the planning, I mean being literally present face to face in the court. I guess my point is the more stakeholders that are --

MS. BESSERMAN:

They're not mandated.

MS. ROTTMANN:

That's my point, that maybe there's --

MS. BESSERMAN:

One of the things we were talking about is environmental change.

MS. ROTTMANN:

Some recommendation that could be made around that issue.

MS. GOLDEN:

That's a good idea.

MR. HOFFMAN:

If I can speak from my experience with the two drug courts I work with, we encourage providers to come and they're invited to come to meetings before we go sit in. We do meet with parents, we do meet with specific providers, schools are repeatedly invited, schools do not participate. So there is access for that, and it's very useful. Now we have a very high contact with the treatment provider about what are treatment goals are and what their treatment goals are to make sure that we're aligned. You know, we are getting the right feedback back and forth. You know, like, if we are saying, "You know, we want this guy to go get his high school diploma," that they're on the same page so we are both headed down the same road. But it's not always -- there's not a lot of community response for stakeholders to participate.

[Substitution of Stenographer - Lucia Braaten]

MS. GOLDEN:

And that's it, That if you can say that -- and I'm just making up this scenario, so don't shoot me for saying this, but if you have a kid that has to go to court, then the, you know, whatever, the Judges' performance is based on "X" and the school doesn't get -- the school gets additional funding for having a staff member present, And the treatment provider gets to bill for that hour. You know, all of those things have to have the incentive to show up and that doesn't exist right now; it's a time factor. I don't have time to go show up in court for three hours. And the Judges base -- the judges do what --

MR. FLESCHER:

The Judges aren't paid.

MS. GOLDEN:

-- what they need to do based on what they perceive the situation to be, and -- you know, and that's -- there's so many different things that affect it.

MS. ROTTMANN:

Maybe we can think about some incentives. You know, in terms of a recommendation. You know, how can we incentivize various stakeholders to participate in the support of treatment services for --

MS. GOLDEN:

That collaborative care.

MS. ROTTMANN:

Whether it's just youth or, you know, people in general. And I'm not sure what those incentives would be.

MS. GOLDEN:

Yeah.

MS. ROTTMANN:

But, certainly, that -- you know, that's something that I agree with you, I think we should think about.

MR. FLESCHER:

Can I just piggyback on a point that Cari made before that I think I don't want to lose. You know, when I started providing treatment a number of years ago, the -- a large percentage of people that

came into treatment were not mandated by any legal system, okay, really significant percentage. And I just don't want to fall back on the idea that leverage is the key to good treatment, because it's not. What's key to good treatment is the internalization of the desire to change. And however we make that appetizing to somebody, you're absolutely right, that leverage is useful when everything's telling them, "I don't want to be here," it sometimes can keep them there. But there's a lot more to it than that, and the idea that although, yes, maybe some of the changes made with the PINS law haven't worked out as well, the old PINS law was bad, and there were a zillion people that ended up in the very adversarial situation of Family Court and mandated into services that really destroyed families because of the power of that. But if you can avoid -- I know you agree with that.

MR. VENZA:

Absolutely, I do.

MR. FLESCHER:

And so I just want to put that out there, because I don't want to -- I don't know that we want to turn back the clock with a lot of things. I think we need to say, "Well, have we gone too far in certain ways?"

MR. VENZA:

Exactly.

MR. FLESCHER:

But, overall, how do we develop recommendations as part of this process that help everybody look at here's the problem that exists, it's multifaceted in its causes, and also solutions are going to require stakeholders to want to be involved. And, yes, it would be great to provide in-home services. I have to tell you, we provide them through the MST Program, they're incredibly expensive and they're not practical. They're not going to have it on a regular basis. And you could also argue with treatment; substance abuse treatment in particular.

MS. MIZZI:

It's not a good form of treatment.

MR. FLESCHER:

It's not a good form of treatment --

MS. MIZZI:

You don't want to be in that position.

MR. FLESCHER:

-- Because you want that group focus. You want peers working with peers and breaking through some of that denial and all the other things that we know work. So it's just an -- it's been an interesting discussion to hear, because on the one hand we're talking about, well, maybe we need to embrace harm reduction a little more because people don't change in the same way, you know, at the same pace, but, on the other hand, it's like let's have more of a leverage so we can force them to change and I think we --

MS. MIZZI:

Well, in all fairness I think it's both.

MR. FLESCHER:

Yes.

MS. MIZZI:

I think we're looking at having incentives, which I don't think we have very many right now with adolescents, and having consequences, which we don't have a strong fallback position, you know. I

think what we're looking for is to provide both, maybe in some of the environmental changes we're looking to make. Those are areas to see if we can build them in when we're talking about that population.

MR. VENZA:

Yeah, I think it is a combination of both, because you know what my views on this are.

MR. FLESCHER:

Yes.

MR. VENZA:

And I think the old legislation, you know, you lost too much control. The new legislation, you know, we've created a -- you know, a black market for orders of protection, you know. And I think we have to really come out of denial with that and realize that, you know, we can't have no leverage either. And I agree, good treatment is not all about the consequences. I mean, you hope that when you need that in the beginning that there's that level of help to get them to comply, Because all you're going to get in the beginning is smile and saluting in treatment, We know that. There's a, "I'm here because I have to be here," Even from motivational -- "I'm here because my mom made me come here."

MR. FLESCHER:

Yes.

MR. VENZA:

But that's where the program's that have --

MR. FLESCHER:

There may be some --

MR. VENZA:

That's where the programs have to try and get them to go from compliance to some level of commitment and that's when those mandates start to peel back.

I think one of the things that would also be helpful, and I think that we're looking at legislation and we're looking at collaborations, and I don't know if this is OCA or what it is, but, you know, I don't think it's unique to any one court, but treatment courts, you know, in the name of collaboration very often are not collaborating with treatment riders. You know, when the kid comes back and tells you that they're done with Treatment Court, or they're graduating Step Court, or they're graduating this court, you know, and you have this kid and this family in a very critical place in the final month or two of treatment and, you know, that -- you know, then they don't avail themselves of the six months of continuing care or the stepdown process.

So, I think these are also pieces that -- you know, it is multifaceted and there's a lot of levels. And, again, I think we can't get away from the fact that there's a certain amount that we need to kind of hold these kids accountable in that --

MR. FLESCHER:

I guess what I'm saying is, yes, treatment -- leverage exists in a variety of different ways, and let's not shortchange the leverage that exists from educating parents from using whatever other influences there are. And, yes, law enforcement and courts are important, hopefully, at a later stage that -- rather than at an earlier stage, because there are other things we can do.

MS. MIZZI:

Again, my point was I wish there were some leverage at a lower level need, you know, because I get kids -- in one of my school-based programs, I've got kids -- I see about 50 of them annually,

self-referred, unknown to their family, unknown to the school, self-referred. Okay? But that's not -- that's not the kid I'm talking about. I'm talking about the kids we all know need to be in a program, need some education, need a relationship and nobody can get them in the door. I just -- I'm not saying leverage for the rest of their life, I'm saying just how can we get them in a door so we can begin to educate, we can begin to talk to them and look at what's going on?

MS. ROTTMANN:

See, but I also think that speaks to the other points at which that kid is touched. Doesn't have to be the court, although --

MS. MIZZI:

Right.

MS. ROTTMANN:

-- hopefully, they don't end up there. But, again, the school and youth boards and other -- I don't, you know --

MS. MIZZI:

Community ball teams, you know, anything that this kid could be involved in that would have an impact.

MS. ROTTMANN:

Right. So --

MS. MIZZI:

It doesn't have to be just, you know, the principal.

MS. ROTTMANN:

So the pathway -- I guess what I'm saying is the pathways, there are many pathways to treatment. And, somehow, if we could identify what the most common pathways are or the points at which that kid may be touched and then develop -- I don't even know, I'm thinking off the top of my head. Just there's got to be a way to educate the various stakeholder groups in any given community so that they can know what to look for, identify these issues, and understand what that pathway is to get that kid into treatment, and I know that sounds grandiose.

MS. MIZZI:

Screening and brief intervention for --

MS. ROTTMANN:

Screening and intervention for different stakeholder groups.

MS. GOLDEN:

You know what you're describing, though, what really struck me is, you know what a "jacks" is, right, you know, what you play with. Right? Inside of like -- the center is where you have someone engaged and each of those spokes on that jacks is one of those pathways. So, if you can align that whole -- every one of those pathways, whether it's -- I mean, not through coercion, I mean it could be just positive reinforcers, or whatever it is that's incenting a kid to enter that treatment point; all of those things have to be in align, everybody has to be on the same page.

MR. HOFFMAN:

Well, I think that's -- you know, we keep coming back to that, we came back to that when we talked about prevention.

MS. ROTTMANN:

Right.

MR. HOFFMAN:

We've got to keep people with some cohesive, you know, gold star pictures, and the same thing is true of prevention. I mean, certainly, when we talk about community, you know, churches and religious affiliations touch a vast number of lives and, yet, you know, we also know that we don't have many inroads there for conversation. You know, we have -- at a hospital we have a yearly breakfast, you know, and it's very interesting how few churches want to come and talk about behavioral health issues, you know, so -- but, still, this is a huge resource.

And the other piece in terms of barrier that is -- you know, it's kind of obvious, I don't know if it's even necessary to bring up, but we're dealing with a communication; television, video, audio, etcetera, that is really, really seriously working against us in the last significant numbers of years. The message is stronger and stronger and stronger about sex and the use of drugs and the frivolity of life, and, you know, we -- this is a huge impact that's working against us. You know, *I Don't Want To Go To Rehab* is a huge hit song; I think that's it.

MS. ROTTMANN:

See, I think --

MR. REYNOLDS:

Try To Make Me Go To Rehab.

MR. HOFFMAN:

Try To Make Me Go To Rehab. You are that much hipper.

(*Laughter*)

MS. ROTTMANN:

The community coalition plays a very active role in prevention, treatment and recovery. And I keep coming back to this idea of this community coalition and how we can, you know, build these groups to really address all of these issues.

MS. MIZZI:

Right, Because it's back to the swimming in the polluted pond issue.

MR. EHMANN:

How about financing not prevention, but treatment? We find that there are insurance issues sometimes. Families --

MS. GOLDEN:

Many, many.

MR. EHMANN:

-- are in economic distress right now. Are there any ways to fund treatment for families that don't have insurance so that we can get the kids and the families into the treatment?

MS. ROTTMANN:

Yes, State aid. The State funds many programs around the State, and those public funds are, in fact, to support those who are uninsured or where there are barriers to accessing insurance. But insurance is an issue in and of itself and a whole --

MR. EHMANN:

And do our guidance counselors have all those directories, like the resource -- like the resource directory that you sent around, I forwarded it to all the counselors.

MS. ROTTMANN:

Yes.

MR. EHMANN:

And I thought it was great because it just had such an overview. But those are the types of things that I can bring back to schools that will help, at least on a practical level, to get people funded for treatment.

MS. ROTTMANN:

Yes. And, Ed, I would say that one message is that no OASAS-funded program can deny anyone services the lack of ability to pay.

MR. EHMANN:

Okay.

MS. GOLDEN:

You know, you just made think, too, that this goes back -- when you talk about teachers, earlier on you were talking about educating the teachers, and part of it speaks to the curriculum that takes place when somebody becomes a certified teacher, that there's only so much that can be packed into a -- to an undergraduate or a graduate curriculum, but to touch upon these things and how they can fold that interdisciplinary piece into it when it comes to prevention and how to -- and really case management in the sense of making referrals to treatment providers and whatnot. It should be a piece of the pie of what gets taught to a teacher who becomes certified, So that goes to the university, to involving the universities.

MR. EHMANN:

It also goes to what Dr. O'Shouhanessy was saying, where the pediatrician has the kid from birth to five. We get the kids at five, six. A lot occurs between zero and five, as you know, and so it's important for those pediatricians to be working with the families to educate them, because it's got to start that early and then we can pick it up from there. So --

MR. HOFFMAN:

We've got about five more minutes before we have to go on to talk about scheduling, but -- so let's just begin touching on the discussion of bed slots and available treatment slots. Now, I know detox, I could speak to that one right off the bat. I will also say that I have brought it up and it is a discussion at the hospital about, you know -- about having an adolescent detox. Discussion; there's still discussion for me for that one, but we're there. And detox is a bad -- is a problem. You know, our license is 18 and over and most licenses are, so it's very hard for detox beds for individuals.

MS. ROTTMANN:

It's not an OASAS license that says 18 and over.

MR. HOFFMAN:

Right.

MS. ROTTMANN:

It's the -- if it's anything, it's DO-8.

MS. GOLDEN:

Yeah. You know what it is, too, is that nobody pays for detox. Nobody pays for adolescent detox, because they fail an outpatient treatment before the insurance companies will consider inpatient detox for an adolescent. It's just almost as difficult with adults nowadays, it's It's very hard to get treatment authorized.

MS. ROTTMANN:

I have raised this issue of insurance not paying for detox for adolescents with Debbie Eagle and others working on this issue and she's looking into it. I don't know why it would be any different for an adolescent than it would be for an adult, but --

MS. GOLDEN:

I think it boils down to the -- I mean, insurance companies have their own ways of getting around, in and out of things, but they portray that it has to do with the least restrictive environment for an adolescent. An adolescent shouldn't be in an in-treatment treatment facility first, that they should try outpatient treatment first, which makes sense, you know, in theory.

MR. HOFFMAN:

Detox is not treatment:

MR. VENZA:

For each kid has to enter a different level, that's the problem, essentially, that they want a linear approach.

MS. ROTTMANN:

Just putting that aside for a second, the other issue that we -- OASAS has is that we don't have data that separates the need for adolescent beds, and that's whether it's detox, intensive residential, or otherwise, from adult. The only data that we separate adolescent from adult is in outpatient. And so that's one of the issues, is that we can't wrap our hands around what the need for inpatient detox, regardless of what level, whether it's medically supervised, withdrawal or medically managed.

MR. FLESCHER:

Why is that, that you can't get that data?

MS. ROTTMANN:

The need methodology that we use, it hasn't been -- it hasn't been developed. The methodology hasn't been developed to collect the -- the prevalence information and the --

MS. GOLDEN:

Separate from adults, you mean.

MS. ROTTMANN:

From adults, except for outpatient.

MR. HOFFMAN:

We could at least do a total of the telephone calls that we get.

MS. ROTTMANN:

Yeah, and that would be very, very useful.

MR. HOFFMAN:

Seafield would be another very good resource, and I can talk to them about that.

MS. GOLDEN:

I was just thinking that, that's a good idea. That right now so many calls come in and they either get denied or you can tell by the medical -- medical necessity that they're not going to get approved. You know, you can tell right off the bat, and all of our admission staff take those calls constantly.

MR. HOFFMAN:

Adolescent is adolescent, you know.

MS. GOLDEN:

Yeah.

MR. HOFFMAN:

That's a really simple thing, that this is underaged, then we put a chit there.

MS. ROTTMANN:

Yeah. Kristie, regardless of the insurance, if some -- would you be able to collect information on anybody -- calls on -- for kids under 18; do you get calls?

MS. GOLDEN:

Yeah, our Admissions Department does all the time. I would have to ask them. They would just have to use some kind of tickler system, I guess, to collect that information.

MR. FLESCHER:

Just understand, though, it would be a duplicate account, because all the hospitals do that, they can call all around.

MS. ROTTMANN:

That's okay, that's okay.

MS. GOLDEN:

What I can do, I know, is I can ask them for historically what their experience has been as well. That if -- if they had to put a percentage on the number of calls of adolescents that are calling in for that, you know, in comparison to our overall calls or our overall admission, they could probably give us that.

MR. HOFFMAN:

I think I get a call at least once a week that gets referred to me, you know, that's my job, you know, they get referred to me and I get an angry, upset family screaming, "Why won't you take and detox my son?"

MS. ROTTMANN:

Yeah.

MR. HOFFMAN:

And a lot of times the detox isn't appropriate.

MS. ROTTMANN:

Yeah, yeah.

MR. FLESCHER:

See, that's the other question.

MS. GOLDEN:

Parents want to get them out of the environment, they want to get them out of the environment.

MR. VENZA:

And some has said they're going to detox them --

MR. HOFFMAN:

Put them in inpatient.

MS. GOLDEN:

Yeah, put them in an inpatient facility.

MS. ROTTMANN:

You know, and it may be that an inpatient rehab for adolescents would be suitable that incorporates, you know, induction, for example, services or some other medically assisted -- medication assisted treatment. But --

MS. GOLDEN:

You know what I could give you probably some numbers on is we have a lot of kids that come to us that are duly diagnosed, that come in and they may be, you know, mild -- mildly detoxing, if there is such a thing, but being treated on an -- in an OMH bed.

MS. ROTTMANN:

Yes. I'm sure that --

MS. GOLDEN:

Because of some other significant mental health issue.

MS. ROTTMANN:

Right.

MS. LOGAN:

Do you need -- do you know the number of beds that are available for inpatient detox and outpatient detox and all of that, All the hospitals on Long Island?

MS. ROTTMANN:

Yes, that I have.

MS. LOGAN:

That you have.

MS. ROTTMANN:

Yes. What I don't have --

MS. LOGAN:

So we're talking about the younger --

MS. ROTTMANN:

Yeah. What I don't have are kids that may be admitted into an adolescent psyche unit that may have co-occurring or scatter-bed, somehow -- I don't know if scatter-bed detox's is --

MR. FLESCHER:

Other medical means that get in and it's not noted.

MS. ROTTMANN:

Right.

MR. HOFFMAN:

They're in on a different diagnosis and at the same time they're detoxing.

MR. FLESCHER:

I think that's very common, well, fairly common.

MS. GOLDEN:

Yeah, because they go to emergency rooms and the hospitals hold them for 23 hours or, you know,

until the next day.

MS. LOGAN:

Right, right.

MS. GOLDEN:

It's just an -- it's an ongoing complicated thing.

MS. LOGAN:

It's very hard, yeah.

MS. GOLDEN:

And I think part of that is, as you said before, the perception of the parents, that the parents are being told or people are saying to them -- they're reacting instead of proactively looking at it. They're reacting to a given situation, Johnny coming home trashed and what do we do, we take him to the emergency room and they tell us he needs detox and then there's no detox.

MS. LOGAN:

Where do they go. Where do we go from here?

MS. GOLDEN:

It goes this way and then it goes back, and then it goes --

MR. FLESCHER:

The question is does the emergency room even say he needs detox? You know, it's just that when they call -- they simply -- what they're saying is, "You've got to do something."

MS. GOLDEN:

Exactly.

MR. FLESCHER:

And he needs detox. And it's like, "Well, why does he need detox?" "Well, because he's using."

MS. GOLDEN :

Yeah.

MR. HOFFMAN:

Well, detox and rehab -- detox and treatment are two of the most misunderstood words.

MS. GOLDEN:

Right, yeah.

MR. HOFFMAN:

We all spend three-quarters of our time reeducating the public about the difference between detox, rehab and outpatient. They don't understand.

MS. LOGAN:

That might be a part of what we have to do.

MS. GOLDEN:

Yeah, that's a great point.

MS. LOGAN:

Because I didn't realize that there was such a difference.

MR. HOFFMAN:

Oh, they're entirely different animals.

MS. BESSERMAN:

And just to point out another caveat to the whole insurance, if a family happens to have insurance, that doesn't mean they necessarily have the financial wherewithal to even take advantage of using that insurance because of coinsurance and copay on it. So we keep struggling with even just the idea of the uninsured and underinsured. We have plenty of people who are insured who can't afford to use their insurance unless it's something catastrophic, like a medical thing. But an ongoing treatment where you have copays, we have that element all the time and people have to say, "Well, am I going to feed us this week?" "Am I keeping us sheltered, or am I paying this, you know, \$20 copay?"

MR. VENZA:

Copay, the deductible.

MS. BESSERMAN:

-- plus my 500 coinsurance, and do I meet my \$1,000 deductible? And I really hold onto the insurance element because what we all fear is all catastrophic illness, and what if I need to go into the hospital? You know, so we lose people even that way, and that's heartbreaking as well, because now you're actually losing -- the potential to lose someone who might really be at a readiness to change state, yeah.

MS. LOGAN:

Well, I'm not sure, but as the health insurance reforms kick in in a couple of years, hopefully, some of those problems will be solved. You know, we've got a few years to go.

MS. GOLDEN:

Payment reform.

MS. LOGAN:

You know, in 2014 and people have the ability to -- you're all looking at me.

*(*Laughter*)*

We're hopeful that, but, you know, more people will have the ability to access insurance and, therefore, hopefully, get the treatment --

MS. ROTTMANN:

Hopefully, behavioral health insurance is the important piece of that which, you know --

MS. LOGAN:

I know, I know. We'll get there, we'll get there.

MR. VENZA:

Just to go back to slots and treatment slots, we've talked about detox. I know in treatment, and, again, I'm going to come from the adolescent paradigm, and folks from the adult can contribute, but I think there's an ebb and flow that we have to factor into the mean number of slots. For example, Cari, I know I saw Mike the other day, he was like us, we were down a few, you know, censuses under, and I guarantee you by second week in October, when the first marking period comes in, we'll have a line out the door. But I think that -- you know, that extraneous variable needs to be factored into that mean number about what's really an appropriate number of beds because of those ebb and flows.

MR. HOFFMAN:

Very hard to determine.

MR. VENZA:

Yeah, yeah.

MS. ROTTMANN:

I think one of the issues in this region is that we have gaps in our continuum of care. So it's not just the detox, but, for example, even with intensive residential, we have only 100 beds out here in this region, and, as John said, very often you're above census, you have a waiting list. I don't know about Phoenix, but we have no inpatient rehab for adolescents, so there really is a lack of various levels of care and I think that's why a lot of adolescents end up in outpatient, because that's what's available; and it's not always the most appropriate level of care, but that's all that there is. And so that affects the outcome, obviously, you know, in terms of retention, and so there are --

MS. BESSERMAN:

And even taking that one step further, we both have IR levels, there's no CR level.

MS. ROTTMANN:

Yeah, there's no CR, there's no, community residents -- it's community residents --

MS. BESSERMAN:

So even in the -- they have no transition built in for --

MS. ROTTMANN:

Inpatient rehab.

MS. BESSERMAN:

So it goes even --

MR. REYNOLDS:

And that recovery support, which we're talking about, you know, starting on the next meeting. So that continuum, I mean, we've identified the prevention gaps, but those gaps exist throughout the entire continuum of prevention treatment and recovery.

So I gave you guys a copy of a proposed schedule that will help kind of move us ahead a little bit faster. Just a word on the public hearings; the legislation calls for at least one, enables us to do as many as we want. Most of the meetings or all of the meetings have been here in Hauppauge. It would be nice and I think important, and I think Jack would probably second this, we should have some meetings closer out to the East End.

MR. FLESCHER:

It would one meeting, at least we wouldn't have to travel so far.

MR. REYNOLDS:

To ensure some geographic diversity, and really allow for participation, because --

MR. FLESCHER:

Yes.

MR. REYNOLDS:

-- the legislation is very specific about who's a member and that kind of thing and somewhat limited, which enables us to get through our meetings in a reasonable amount of time and that kind of thing. But there are a whole bunch of people, including kids in recovery and parents who should be part of this discussion and be able to provide some input and guidance into the final documents, so I did kind of sketch out the potential for two public hearings.

But let's start with the next meeting, and I think we probably do need to meet a little bit sooner than the three weeks. You know, the summer's over and it's time for us to, I think, kind of tighten this up a little bit and work towards our final goal. So, if we could meet the weekend of -- the week, rather, of the 14th, I had proposed the 15th.

MS. ROTTMANN:

What time are you thinking, Jeff, because we have/there's an Advisory Council meeting in the afternoon, Suffolk County.

MR. HOFFMAN:

I can on the 16th in the morning.

MR. REYNOLDS:

I could do the 16th in the morning. The 16th in the morning at like 9:00?

MR. HOFFMAN:

Nine to -- the 16th, 9 to 11?

MS. BRAATEN:

Do you want to go off the record while discuss this?

MR. REYNOLDS:

Yeah, you don't need to type all that.

[DISCUSSION OFF THE RECORD]

[Return of stenographer - Donna Catalano]

MR. REYNOLDS:

So Phoenix House, can we do one for Phoenix House.

MS. BESSERMAN:

Offhand, I generally don't see why not. I'd like to talk about what the construct would be, and then so we have you doing -- are you --

MS. ROTTMANN:

What's the idea?

MS. BESSERMAN:

Yeah.

MS. ROTTMANN:

Because I wasn't here last --

MR. REYNOLDS:

The idea is to get some direct feedback from kids in terms of navigating the system, kind of the road they've been down, just to add some texture on I think some stuff that might not come up around this table.

MS. ROTTMANN:

Can I suggest that we do parents as well -- a separate?

MR. REYNOLDS:

Uh-huh.

MS. ROTTMANN:

A separate -- Okay.

MR. VENZA:

We talked about doing maybe a home and away, maybe going to both and doing it together. So, that was our --

MS. BESSERMAN:

We'll continue our conversation.

MR. VENZA:

Yeah.

MR. REYNOLDS:

So we could -- I mean, just in terms of comfortability, we could come up together maybe with a discussion guide --

MS. BESSERMAN:

Yeah.

MR. REYNOLDS:

-- to kind of structure the conversation.

MR. VENZA:

Yeah, I think we want to -- yeah, we wanted to collaborate on that a little bit first, yeah.

MS. MIZZI:

We need to all use the same questions.

MS. BESSERMAN:

Yes.

MS. MIZZI:

Yes, that's how focus groups works. Unless you call them listening tours and then you're off the hook, but a focus group you need all of same questions.

MS. ROTTMANN:

I just want to say that OASAS is working on developing a list of questions for focus groups that they want to run on the same issue around getting feedback on access to care for adolescents. So why don't we just steal their questions? I mean, I'll bring them in.

MR. REYNOLDS:

Sure.

MS. MIZZI:

When are they going to do it?

MS. ROTTMANN:

They're in the process now.

MR. REYNOLDS:

Are there parent questions, too? Okay.

MS. BESSERMAN:

That's going to save us time, yeah.

MS. ROTTMANN:

And there you can change whatever you want.

MR. VENZA:

Good. Not really looking forward to hours of more work, but since you made the suggestion, we'll take it.

MS. ROTTMANN:

It's already there. Why reinvent the wheel?

MS. MIZZI:

Well, it's bad enough getting the kids together and, you know.

MR. REYNOLDS:

So it is two minutes after 5:00. We are officially done for the day. Everybody happy with the way we're proceeding? Everybody feel good about it? I feel like we're just kind of touching on some of the issues, we're probably not going into them as in depth as we're used to. We will have a chance to circle back and connect some of the dots, so -- and as we produce the draft and comment on it, I think there'll be more ability to have some more substantial conversation on these issues. So it's not the only time we get to talk about the venture and the treatment as in this kind of 45-minute chunks of time we've set aside. Pam?

MS. MIZZI:

There are those, not in this room, but there are those who believe that there is a single answer that we, in our wisdom, are going to come up with an answer. And I just want to put --

MR. REYNOLDS:

Boy, are they going to be disappointed.

*(*Laughter*)*

MS. MIZZI:

I'm going to put a plea out there that we are on the same page, we have to say -- restate -- you talk about what Art says all the time; it's a complex problem and it's a complex solution and we're working together from all these different, you know, stakeholders or aspects, or whatever you want to call yourselves, but we're working together to look at the problem from various perspectives, and there is no one single answer. I mean, there are expectations that we will have an answer.

MR. REYNOLDS:

Really?

MS. MIZZI:

Oh, yeah.

MR. REYNOLDS:

Bring those people here.

MS. MIZZI:

No, no.

MS. GOLDEN:

Just one quick thing in the beginning to draft something, which I regrettably volunteered to do -- no, I'm just kidding. Next time we'll take two minutes to talk about a mechanism to begin looking at it

and reviewing it, you know, so that I'm not flying by the seat of my pants.
I think we're done.

[THE MEETING WAS CONCLUDED AT 5:10 P.M.]

{ } DENOTES SPELLED PHONETICALLY