

SUBSTANCE ABUSE AND MENTAL HEALTH  
SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE PREVENTION

NATIONAL ADVISORY COUNCIL

Thursday,  
March 6, 2008

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

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P R O C E E D I N G S (9:05 a.m.)

DR. MARSH: Good morning, everybody. Welcome.

My name is Anna Marsh. I'm Acting Director of the Center for Substance Abuse Prevention, and I'm pleased to welcome you to our National Advisory Council meeting. So I'd like to officially bring the meeting to order.

I want to thank and welcome all of the advisory council members. We had our new members here yesterday for an orientation session, and I'm pleased to welcome Dennis Griffith, John Glover, Don Maestas, and Natalie Zaremba. I want to also acknowledge my boss, Terry Cline. I'm pleased to have him with us, the Administrator of SAMHSA. And there are some guests who will be receiving awards and Kevin Hennessy, who is a member of our SAMHSA staff, too. And we have a number of SAMHSA staff also participating with us today and perhaps members of the public as well. So we welcome all of you. I'm very pleased to be joining you here.

What we'd like to do first is just go around the table and have each council member introduce yourself, say who you are, where you're from, what organization, and a little bit about yourself and your interests in the council here.

MR. SHINN: Aloha kako. Hello out there, everybody. Alan Shinn. I'm the Executive Director for Coalition for a Drug-Free Hawaii, and I've come all this way to be at the meeting. It's been a good trip.

We learned a lot yesterday. We had an orientation session with new members, and I think the new council members will bring a new perspective and energy to the council. So I'm looking forward to serving my third year. My goodness. Thank you.

DR. TAFT: I'm Hope Taft. I'm with the Leadership to Keep Children Alcohol-Free.

MR. MAESTAS: Good morning. My name is Don Maestas, and I'm the Director of the Office of Substance Abuse Prevention with the New Mexico Department of Health of the State of New Mexico. I'm very happy to be part of this advisory committee. I've been working with prevention for over 25 years and I'm certainly looking forward to working with SAMHSA and this group. Thank you.

MS. ARES: Good morning. I'm Karel Ares. I'm the Executive Director of Prevention First, which is a nonprofit resource center specializing in substance abuse prevention in Illinois. So we have offices in Springfield and Chicago. I've been with Prevention First almost 18 years, primarily involved in the training and technical assistance and information dissemination aspects of our field.

I am married to a wonderful husband and I have two daughters who are almost 12 and 8. So please pray for me.

(Laughter.)

MS. ZAREMBA: Hello. I'm Natalie Zaremba. I'm from Boston, Massachusetts. I have a fairly long history in public health and behavioral health and, of course, the last 15-20 years really in substance abuse treatment and prevention. And I've dealt with CSAT and CSAP fairly extensively over those years. I'm now a consultant and I am working directly with a number of programs, particularly on their youth outreach. We're looking at college-age drinking issues. I'm very interested to be in touch with other people around prevention issues and hopefully I can offer some perspective from some of the things that I've been through.

MR. GRIFFITH: My name is Dennis Griffith, and I'm Executive Director for Teen Challenge of Southern California. We offer recovery support services and prevention services to young people. I've been with the organization about 30 years, and I've served the U.S.A. office in numerous capacities over the years and the global office as well in numerous capacities. I've been on various committees and groups here in D.C. I represent Teen Challenge here in D.C. as well. It's good to be part of CSAP.

MR. GLOVER: Good morning. My name is John Glover. I'm the Deputy Director of the Alcoholism Council

of New York. It's a citywide prevention agency for the City of New York. I think all of you know New York has approximately 19 million people that we serve.

I'm delighted to be asked to sit on this council, and I'm going to try to participate, but more importantly, I'm going to try to learn a great deal from you. Thank you.

MS. GERINGER: I'm Shary Geringer from Wyoming. I'm also on the Leadership to Keep Alcohol-Free. Hope didn't mention that she's the former First Lady of Ohio and I'm the former First Lady of Wyoming. Hope has got some great credentials. Visit with her sometime.

This is my last meeting of the National Advisory Council, and it's been a real pleasure to serve on it. I wish all of you new folks well. It's a great organization. Don't hesitate to speak up and ask questions and make your opinions known because it sure does make a difference.

DR. MARSH: We have some awardees here today. So if you'd just like to introduce yourself and say where you're from and we'll have more about you in a few minutes.

MS. PATTON: Good morning. My name is Brenda Patton. I'm with the Council on Alcohol and Drugs Houston. I manage our middle school prevention services, and I'll speak more about what we do later on during the

presentation. Thank you.

MR. ARLT: Good morning. My name is Tom Arlt.

I'm the Prevention Coordinator for Granite Falls School District which is located in Washington State about 50 miles north of Seattle. Our district serves about 2,500 students. One of our major programs is LifeSkills Training which we're implementing third through eighth grade for about 1,100 students each school year.

DR. PAGEL: Good morning, everyone. I'm Laureen Pagel. I'm with Sutton Place Behavioral Health, which is a community-based substance abuse and mental health treatment agency in Nassau County, Florida, also on lovely Amelia Island. I'm the Director of Operations and I supervise all of the prevention programs in every middle and high school in Nassau County, Florida.

MR. ROMERO: Good morning, everyone. Again, my name is Dennis Romero. I'm the Deputy Director here at the Center for Substance Abuse Prevention. And I just want to welcome not only the new members but the board as a whole and certainly welcome our visitors and our guests who will be attending and listening in on our conversations. So thank you.

MS. HAYNES: Good morning, everyone. I'm Tia Haynes and I'm the designated federal official for the CSAP National Advisory Council.

DR. MARSH: We're pleased to have you all.  
Welcome.

I'd like to introduce Terry Cline. He'll be giving some remarks about SAMHSA. I just want to say what a pleasure it is to have him here and to be working with him. I learn a lot from him. As many of you probably know, he's from Oklahoma, was the director of the whole health department there, the Secretary of Health for the State of Oklahoma, and is a psychologist, and has been here just over a year and I think brought the agency into a new era. Pleased to have you.

DR. CLINE: Thank you, Dr. Marsh.

Good morning, everyone.

PARTICIPANTS: Good morning.

DR. CLINE: It's a great pleasure to be here.

I am going to run through a little bit of a report to give you an idea of some of the things that we're involved with, some of the direction that we're taking as an agency. I welcome questions and inquiries and comments throughout. So please feel free to jump right in there.

I'm making available to you at some point today a recent report, and I am a big fan of this report. So I'm going to do a little spiel for it and try to encourage you to use it as well. It's "A Day in the Life of American Adolescents: Substance Use Facts." Really what it does is

it takes a slice of any given day in 2006 and describes a little bit of the picture in America for adolescents in terms of their substance use on that particular day. It is very, very compelling information.

I'm going to give you a few examples. This will mean more to you than it does to most people I think because you understand. For this particular piece, we have information about how many people are using different types of drugs on any given day. This information I'm about to share estimates how many people are using a particular substance or drug for the first time, and we're talking about 12- to 17-year-olds. So this is important information.

So on any given day -- you know, it could be today. It could be next Tuesday. It could be October 16th. It doesn't really matter what day it is. You just pick any day -- we would expect to have 8,000 12- to 17-year-olds who are taking their very first drink of alcohol.

Any given day. Just think about prevention, our work, the tide that we're swimming against. Approximately 4,300 are using an illicit drug for the very first time any given day. There are 4,000 who are smoking cigarettes for the first time on any given day. There are 3,600 who are smoking marijuana for the very first time, and 2,500 who are using a prescription pain reliever for the first time,

any given day, 12- to 17-year-olds.

So when you're out there making that argument about why our work is so important and why we need to keep pushing every single day and why we cannot hesitate, why we cannot pause, why we cannot rest, this is the information that speaks so clearly to me because every single day we have more and more kids who are lining up, and we need to do everything in our power to stop that.

One of the things that we're pushing very much here at SAMHSA is a public health approach and really using all of our resources in that direction. As you know, the fields associated with mental illness, the fields associated with substance use have really been on the margins of just about every single system. They've been on the margins of the health care system, if involved at all.

They've been on the margins of the public health system, if involved at all. And I think that we've paid a very big price for that. You can make the argument that there was a strong need for that in terms of our development as fields to really get our feet on the ground. But we're really pushing this approach.

This is where I think prevention is really leading-edge, leading the way for the entire agency. These are issues that are not new to prevention, but to a lot of the rest of the field, it is new, this idea of getting

upstream, this idea of moving ahead of the curve, really looking at issues comprehensively. So much of our system has been focused on the reactive, "pick up the pieces" part of this equation, and it's not been focused on the upstream piece of that. Prevention, of course, is all about that, and in that public health model, that really is the foundation. Everything else is built on that foundation. So as an agency we're moving that direction.

We had a hearing yesterday in front of the House for Congress, and that's the push really that we are presenting. And that's hopefully where we'll be able to get some additional support as we move forward as well.

I'd like to mention just a couple of programs.

You have several things on your agenda for today, and so I won't touch base on those because you'll have a lot more opportunity to hear and learn and to share your thoughts on that. But I wanted to touch base on some things that may not be on the agenda later on.

One is the National Guard Substance Abuse, Prevention, and Treatment Program that you may not have heard about. SAMHSA has recently been involved in working with the National Guard to help train their staff to provide brief interventions and assessments for substance use and mental health problems. This would be a peer-oriented program. Currently there are over 200 soldiers

who have been trained, but the most important piece of this I think is that there have been 26 prevention coordinators who have been trained as trainers. So they will then be able to go out and kind of spread that good work and bring other people on board for this very, very important initiative. So we're excited about that work. We expect to see that implemented throughout the National Guard.

Another initiative is the Minority Education HIV/AIDS Prevention Initiative which is a partnership between SAMHSA and 13 minority education institutions. The goal is really to increase awareness and testing and early identification of HIV and AIDS. With these 13 institutions, we have nine historically black colleges and universities. We have two Hispanic-serving institutions and two tribal colleges that we're working with as part of this initiative. This, again, is a peer-led education program that really emphasizes cultural competence in the delivery of these services and using peers to deliver this.

To date, over 121,700-and-some-odd people have been participants in this program. So, again, we're seeing some spread with that, and you can see the potential as that grows. So we're excited about that. As part of that, there have been almost 8,000 HIV tests that have actually been conducted as well.

The trends I'm sure you are all familiar with.

We should take great pride in seeing the declines in the use of illicit drugs that we've seen since 2001, about a 24 percent decrease in the rates of illicit drug use in our country. That is very, very significant and something that doesn't happen on its own. It's obviously part of a comprehensive plan in prevention, and all of the people who are engaged in this work across the country need to take credit and acknowledge that work and the payoff for that incredible work.

As I'm sure you've heard in your communities and your states, there are many people who said it can't be done. These issues are too ingrained. It's too much a part of our culture. We will not be able to turn the tide on this. Well, the facts tell us a different story, and the facts say that when we do engage in a concerted effort and a comprehensive approach, we can significantly reduce those rates. And, indeed, we've seen that since 2001.

But as I mentioned earlier, it's not time for us to pause or to rest on our laurels. We need to keep moving when we look at all those young people lining up and using drugs for the very first time.

Part of the work that I want to acknowledge is the work that's going on with the Strategic Prevention Framework, which has now spread across 34 states, 3 territories, and 5 tribal organizations. Again, this gets

back to that public health approach. That is a fantastic foundation, and I think many of the states that I visited with are finding that that conceptual framework has helped them not just for their prevention work but really a spilling over into all of the other areas as well, as it should. Again, it's foundational work that provides a conceptual frame and a blueprint that says here's what we need to do to fully understand, comprehend, engage in a strategic plan, assess the effectiveness of that plan, and then make modifications and move on. It's a very, very powerful model.

Again, this is a basic public health approach that any public health expert would say, of course, this is fundamental to this, but a lot of our states and areas have not utilized this framework, and I think it will help them in terms of gathering data. It will help them understand the importance of using data to tell the story and evaluating the effectiveness of programs as they're implemented across their areas.

Of course, the Drug-Free Communities program. Over 800 communities across our country. Certainly that's what I think about when I think about the declining rates of illicit drugs across our country. Where the rubber meets the road is at the local level, and when we see that kind of involvement from the grassroots level, including

local law enforcement and clergy and teachers and parents and everyone who's involved in communities, that's how we create that sustainable change. So that's exciting too. I know that many of you have been involved in that.

One initiative you may not have heard about and I just want to mention briefly is an initiative that's called Helping America's Youth. It's an initiative that's led by First Lady Laura Bush that is focused on forging connections between at-risk youth and caring adults and really with that focus in families, communities, and schools. The unique piece of this initiative is it cuts across 10 federal agencies who are participating in this.

One of the concrete outputs for this particular initiative is a community guide that you can access on the Web. So it's a Community Guide to Helping America's Youth.

You can actually go in and geomap what services are available in your particular area. You can geomap what funds are being utilized within your particular area from these 10 federal agencies. If you're looking for partnerships and strategic partnerships or you're wondering what's available in your area, you can actually go there, pull this up, and get a sense of that. That information is updated. So it's current. The website for that is [www.helpingamericasyouth.gov](http://www.helpingamericasyouth.gov). No spaces, no apostrophes. Just [helpingamericasyouth.gov](http://helpingamericasyouth.gov). So I would encourage you to

take a look at that.

Two of the challenges that we continue to face -- and I don't want to leave people with the impression that our work is done, again, with the progress that we've seen. As our Leadership to Keep Children Alcohol-Free folks clearly understand, one of those persistent areas that has been very difficult to budge has been the rate of underage drinking in our country. We're seeing that as an area where we're starting to see a glimmer of hope, but it's been very difficult to budge the needle on this particular issue. Again, you'll hear more about that, so I'll stop on that.

The other issue is around the misuse of prescription drugs. So both of those have been very concerning to us and really counter to the trends that we're seeing across the board in these other areas.

One of the things that we're doing in the area of misuse of prescription drugs is that we have engaged in a point of sale education effort which includes 6,300 pharmacies across the country, 26 states. We've distributed about 3 million fliers that actually go to the pharmacy and are provided with medications that are at high risk for misuse. The information that's provided talks about the risk for this particular medication and provides information on the appropriate disposal of that medication.

As you probably know, all the survey data, all the information tells us that most people are accessing those medications not from the Internet, which is I think less than 1 percent of medications coming from there, not from street sales. They're actually getting it from medicine cabinets. So it's unused medication that may be in your grandmother's medicine cabinet or your friend's medicine cabinet. You know, when we go to the dentist and we have that surgery and we have those three pills left and we don't dispose of those, we put them right there in the cabinet. Well, those are at high risk for someone going in and just grabbing those right out of there. Or back pain or whatever. So the point-of-sale effort is really focused on educating consumers about the appropriate disposal of those medications.

I think that I'm going to wrap up here as I go through here. We were talking earlier about some information that's available to you through our Health Information Network, and I would encourage you to access that information if you have not done so already, see what information is available. We have just incredible information that we can send to you, that we can send to communities that parents and teachers and others I think will find very, very useful. We receive about 50,000 inquiries a month, and some of those come through the

Internet. Some of those come by mail or phone. We have parents who are calling. We have teachers who are calling wanting to access it. So I would encourage you to take a look at that information. It's really very rich. This is part of our effort of getting information out to the public.

One of the other ways that we're trying to move the field forward and the nation forward is through NREPP, which is our National Registry of Evidence-Based Programs and Practices. I don't know if you're going to talk about that at all.

DR. HENNESSY: Not today.

DR. CLINE: Probably not today. Okay.

But it's a Web-based decision support system. It's really designed to help states and community-based organizations access evidence-based practices that may be relevant to you. One of the things that we're going to be talking about later is that gap between science and actually hitting the road in the service, and NREPP is designed really to help shorten that lag as well. We have about 170 now, I believe, interventions that are available on NREPP and about 120 that are in the queue waiting to be reviewed to also be released there.

So I'll go ahead and close with that. That's just a little snapshot of some of the things that we have

going on right now across SAMHSA. Again, you have several other things on the agenda.

I would like to close my comments by thanking you for your service. Those of you who are going off the council, those of you who have provided years of service, that is greatly appreciated and a warm welcome to the new members as well. I know all of you are here because you have expertise or experience which is valued by many people, but it also means that you're in great demand in other places. So we realize when you're here you're not doing many of the other things that you could be doing, and we know that's a sacrifice for you and it's a sacrifice for your families. So it's greatly appreciated, and I want to personally thank you for that.

With that, I'll turn it back over to Dr. Marsh.  
Thank you.

DR. MARSH: Let me ask first, are there any questions or comments that you'd like to address to Dr. Cline or any other thoughts you want to express at this point?

(No response.)

DR. MARSH: The next item on the agenda is presentation of the Science to Service Awards, and Dr. Cline will be handling that too.

DR. CLINE: Great. My participation in this

piece is very short. So let me start just by congratulating the 2007 Science to Service Award winners who are here with us today. You, of course, are representing a larger group and you represent those exemplary programs that we know are out there across our country, and we are most appreciative and proud actually to honor you with these awards.

As, again, I think most people are aware, there is an incredible lag that exists between the creation of science and knowledge and understanding and the actual implementation of that in the field which is anywhere from 15 to 20 years' lag between that evidence and then the implementation of that. So if you apply that to any other field -- you know, if I were going in for cancer treatment and someone told me that that the cancer treatment I was going to be receiving today was 20 years behind current knowledge, it would simply be unacceptable -- unacceptable -- to any of us. Or if you were going in for heart surgery and we were using techniques that were outdated by 20 years, it would be unacceptable. But in our field, we have had this lag.

So we're working hard in shortening that period of time in between and realize that there is a significant role to be played by emphasizing the uptake of this information at the community level and at the state level.

So part of this initiative is really to recognize those programs that have risen to the challenge and that also are providing us with outstanding examples of how to do that, how to shorten that lag so we can learn from those examples and we can help spread those best practices so that we can shorten that for others as well. So it's a real pleasure to have you all with us here today.

I am going to turn the microphone over to Dr. Hennessy who will make a few comments, and then we will have a brief panel presentation from the award winners, which I think you'll find fascinating. So thank you.

DR. HENNESSY: Thanks, Dr. Cline.

Let me add my congratulations and underscore how pleased I am to honor the organizations that are represented here today in the Science to Service arena.

As Dr. Cline suggested, often the most challenging aspect of reducing the research to practice gaps lies in successfully implementing research interventions in "real-world" settings where most of us live. Each of the organizations represented here has an important story to tell. They've learned a great deal that can assist SAMHSA and assist our stakeholders in translating these evidence-based interventions into communities so that individuals and families can receive the best substance abuse and mental health services that

our society has to offer, not the best services of 20 years ago.

The purpose of today's awards, as Dr. Cline mentioned, is to provide visible and national recognition to these community-based organizations and coalitions that have done really an exemplary job of implementing one or more evidence-based interventions, recognized programs.

And for the inaugural 2007 awards -- this past year was the first year we selected -- the agency received a total of 115 applications, and from this pool, 20 organizations were selected for recognition. Mind you that 115 applications were for an award that is non-monetary, and so it actually required the organization to designate time and resources with not really getting a lot in terms of money back. So we were thrilled that we had that many organizations apply, and I think it suggests that recognition from SAMHSA in this capacity really does mean something.

Representatives from three of the 20 organizations are present today, and representatives from the remaining 17 organizations have already or will be receiving their awards at a similar presentation, one of the SAMHSA National Advisory Councils. All 20 award winners were identified in a SAMHSA press release that was issued last September 10th, and that's available through

the SAMHSA website. In addition, brief summaries of all 20 organizations and contact information for all award winners is also available through this new Science to Service Web page. If you go to the SAMHSA home page and scroll down under browse by topic, if you click on Science to Service, it will take you right to that.

So without further ado, let's move to the presentation of the awards. I'm going to be calling out each of the awardees and then they'll go up to receive an award and commendation letter from Dr. Cline.

The first awardee today is the Granite Falls School District in Granite Falls, Washington. They are receiving an award in the substance abuse prevention category for implementing LifeSkills Training. Receiving the award for Granite Falls is Mr. Tom Arlt, the Prevention Coordinator.

(Applause.)

DR. HENNESSY: The next award goes to Sutton Place Behavioral Health in Fernandina Beach, Florida. It sounds lovely. It's receiving an award in the substance abuse prevention category for implementing Project SUCCESS, Schools Using Coordinated Community Efforts to Strengthen Students. Receiving the award for Sutton Place is Dr. Laureen Pagel, Director of Operations.

(Applause.)

DR. HENNESSY: And the final award today goes to the Council on Alcohol and Drugs Houston in Houston, Texas. The council is receiving an award in the substance abuse prevention category for implementing LifeSkills Training. Receiving the award for the council is Ms. Brenda Patton, Manager, Middle School Prevention Programs.

(Applause.)

DR. HENNESSY: Fortunately, we have some time today to really hear some of the stories behind the three award winners, a little bit about their organizations, and a little bit more about what their experience has been in implementing the particular program that they received the award for, and some lessons learned. These are things that I think we could all benefit from. In fact, I'm pleased to say that under the 2008 contract that we have for the selection of the award winners, we're also going to be doing some key informant work with the 2007 and the 2008 award winners to compile that information about lessons learned and how to do this well and make that available eventually through the SAMHSA Web page.

So with that, let me turn first to Tom Arlt from Granite Falls. And I think we are able to queue up the slides as well.

MR. ARLT: Hello. Thanks.

As I said, I'm the Prevention Coordinator for

Granite Falls School District. When I went to work for Granite Falls in the fall of 2000, one of my first jobs was to implement our state Healthy Youth Survey. Actually I was recruited to Granite Falls School District specifically to try to tackle some of the problems that they were having in the community. So I administered this survey in the fall of 2000. Results came back in the spring of 2001.

There are some handouts in the back, and I'll have kind of a blown-up slide of some of the results that I will give you at the end so you can see those a little bit better.

I'll go through some of the numbers for you. When we got those results back, as everyone's concerns were validated by the survey, risk factors and 30-day use numbers were astronomical. Also, I think something to point out is these results actually -- we're not a very big community. About 2,500 kids in our entire school district.

So third through eighth grade. That's about 1,100 kids, which is the age of kids at LifeSkills Training is implemented for. So these are all of our kids in our community, and some of our risk factors numbers for eighth grade ranged from the high 40s to over 60 percent of our kids at risk on those peer and individual risk factors.

Of course, as we all know, when risk factors are elevated to those levels, you can expect that 30-day

use rates are going to be through the roof, and you can see some of our 30-day use rates there. For eighth grade, tobacco, 24; alcohol, 36 percent; marijuana, 26. Meth use was creeping up to almost 5 percent of our kids were involved with methamphetamines at the time. Tenth grade numbers were, of course, significantly higher. Forty-six percent of our tenth graders at that time said they had been using alcohol regularly in the last 30 days. That's half of our kids. So you can imagine how that's impacting our community.

So, of course, the next thing -- I'm going to try to cover as quickly as I can for you kind of the whys and then get to the outcomes. So one of my first jobs then was to take those results and start to look at research-based programs and what could we do about that. We had to start somewhere. So two of the risk factors that we decided to prioritize were two of the higher ones and more elevated ones, and that was favorable attitudes and friends' use of drugs on the peer and individual scale. And we started to research best practice programs. Of course, we prioritized both risk factors.

Along the way, something that happened that was very important was the Granite Falls School Board basically mandated that by a certain number of years we would have a comprehensive prevention program K-12 in our district. And

when I say district, that really means our community because our school district really encompasses the entire community of Granite Falls. And that was a big support for the program to have that kind of top-down buy-in from the school board, and the school members basically are the key stakeholders in our community. We're not a very large community.

So we went to work researching programs and getting ready to implement. Of course, all of this is in the handout. I'm skipping. This is about a 40-minute presentation.

(Applause.)

MR. ARLT: So we chose LifeSkills Training as a program that impacted two of our highest risk factors and then went about pursuing funding. And we would not have been able to do this without federal prevention funding basically that comes through our state and then through our local county health department. And that money really got the program going. Of course, LifeSkills Training is a best practice. And we had a lot of support from NHPA and Dr. Botvin's organization on that.

A little bit on the program. Of course, you can do your needs assessment and you can align the appropriate program that meets the needs assessment, but if you aren't able to implement that program with fidelity,

you're not going to get the outcomes.

One thing that happened along the way is we got involved with a Blueprints Replication project through the Office of Juvenile Justice that the University of Colorado was running at the time, and they came in and did all of our fidelity monitoring and observations and stuff. So we had pretty strict guidelines along the way for implementation.

Of course, the bottom-up buy-in from our teachers and the actual professionals that would be implementing the program was very important along the way.

Those are our implementation ratings along the way compared to what implementation ratings were for the other 126 Blueprints Replication sites around the United States at the time. The program really only ran three years. We were extended a fourth year because of our implementation ratings and then into a fifth year. And you can see what our implementation ratings were, up around 95 percent at the time. I think Dr. Botvin's original research fidelity ratings were in the mid-80s when he first started working on LifeSkills and some of the initial research, so just to kind of give you a comparison.

There are some other numbers. About 550 students in grades six through eight, and about 550 in three through five. So about 1,100 students a year go

through the program. It's a cohort group, so they actually receive the program in sixth grade with booster sessions in seventh and eighth grade. So it follows them for three years. Residual effects should be out four to six years post, and when I show you the results, I'll kind of show you where those kids are right now as to the first cohort group, and you'll kind of see those results still following the kids.

So that leads me to outcomes. I wanted to give you a little bit easier-to-read sheet with our outcome numbers. So at the top of the sheet are basically our 2000 Healthy Youth Survey results that I showed you in that first slide. And then in the middle section where it says "Washington State Healthy Youth Survey 2006," those are obviously our 2006 results, the same risk factors and the same 30-day use rates for the same substances. And at the bottom, those are the net changes in risk factors and the net changes in 30-day use between our results and our norming group, or our state results. You can see risk factors were down I think fairly significantly for eighth and tenth grade.

And then you can see the 30-day use rates down, alcohol 30-day use down 27 percent. And those are straight percentages. Those aren't based on like if we have 60 kids and then down to 30. Those are just straight percentages.

Meth use for eighth grade went from 4.5 percent -- as you can see, minus 4.5 percent. We had 0 kids reporting methamphetamine use in 2006, which is pretty significant.

The 2006 results, the tenth graders -- those were the first full cohort to receive all three years of the program. Our twelfth grade numbers in 2006 were still pretty elevated, but we'll be taking our 2008 Healthy Youth Survey this next fall, and I fully predict to see those same plunges at twelfth grade as we've seen at eighth and tenth over the last couple years. So we're coming into our eighth full year of implementing the program third through eighth grade.

And actually LifeSkills just added a ninth grade component that talks more about family issues and communication with ninth grade students as a fourth year or a third year booster for the program. So we've just begun that too to try to push those results out even farther.

Thanks.

(Applause.)

MR. ARLT: Any questions?

DR. HENNESSY: We have time for a couple questions, I think, if people are inclined.

MS. ZAREMBA: I only have a comment. I think this is wonderful, and I think it's the publicity of these kinds of results that need to get out to the communities to

support programs that really are potentially lacking in fidelity or just talking about initiating it. It's excellent. Thank you.

MR. ARLT: Something that was in one of the slides that I skipped over was keeping that data in front of the community. Actually the results that we've gotten along the way have been of great benefit to the community in implementing other programs. We have a community resource center. And it just has given the community hope that we can do other things to impact other risk factors in other domains and that has been a big positive. Thank you.

DR. HENNESSY: Other questions?

MS. ARES: I do have one. I'm sorry.

MR. ARLT: Oh, sure.

MS. ARES: I went to your last slide, "What we learned," and I saw that you have "Mechanism to deal with staff turnover." Can you elaborate on that a little bit?

MR. ARLT: Yes, definitely. I'll be tactful about this next thing I'm going to say. A lot of the research-based programs are -- LifeSkills is owned by a private company basically, a very expensive program. The training is very expensive. The first couple years, if we wouldn't have had the federal prevention funding and that support, we wouldn't have been able to do it. It's about \$4,000 basically to bring a trainer out from New York to

the west coast to train our teachers.

So the mechanism that we put in place is we convinced Dr. Botvin and NHPA to allow us to conduct a trainer of trainer trainings on the west coast. So all of our LifeSkills teachers are now registered and licensed LifeSkills trainers. So basically we can provide our own training. So if we have a new teacher, especially elementary, you're talking about almost 30 teachers implementing. So you're going to get teachers coming and going. So we can provide our own training so as to not miss a beat, so to speak, as far as having everybody implementing.

DR. TAFT: Of all the parts of the LifeSkills program, what are the kernels, what are the key elements that you think are the most important?

MR. ARLT: Well, you know, drug and alcohol prevention -- you would assume that there's a ton of drug and alcohol information in there. Actually the LifeSkills Training program is very interesting. There's very specific information about tobacco, alcohol, and marijuana at very specific times, but the majority of it is social skills, communication skills, anger management, how to deal with situations, just boosting the kids' ability to deal with kind of real-world and school issues so that they don't turn basically to drugs and alcohol as a way to deal

with problems or things that they can't handle. It's about 18 lessons at sixth grade that take about 45 minutes to an hour.

DR. HENNESSY: Thanks very much, Tom.

Our next presenter is Dr. Laureen Pagel from Sutton Place Behavioral Health.

DR. PAGEL: Thank you very much. It's just a pleasure to be here. It's very exciting. Even though it's a little cold, it's okay.

(Laughter.)

DR. PAGEL: I'm going to provide a brief overview about the agency in general and then talk specifically about the Project SUCCESS program which won the award.

Sutton Place Behavioral Health. "Help for today. Hope for tomorrow" is our motto. We are a community-based substance abuse and mental health treatment agency. We are not-for-profit. We are the only community-based substance abuse agency in Nassau County, so we serve everybody who cannot otherwise receive services anywhere else. We're CARF-accredited. We're licensed by the State of Florida, and we contract with the State of Florida to provide services.

Our mission is to provide the highest quality mental health and addiction services for all the residents

of our county which is about 65,000 people in the entire county. We're a rural county in north Florida.

Our organization. And it doesn't show everybody on there, but I have about two-thirds of the people that report to me. It's a little unbalanced.

Just talking about operations, these are all the programs that we serve: adult mental health, children's, all substance abuse, case management, emergency services, psychiatric services, prevention, and socialization. We run the full gamut, the spectrum, ages 0 on up, at the agency.

For adults experiencing mental health problems, individual group therapy, all different locations available throughout the county day and evening. The same with children. The parent and guardian must work with us when we work with a child because we work with some young children, ages 3 and 4, and you're not working with the kids. You're working with the parents at that age, which is part of our prevention.

Substance abuse, adolescents and adults diagnosed at risk, providing a full array of services, individual, group therapy, on both sides of the county. It is a rural county. So it's difficult for people to get from one side to the other.

Our prevention program, Project SUCCESS, is

offered at every middle and high school in Nassau County. We also were a winner of the best Rural County Prevention Program by the State of Florida in 2006. We're also very proud of that award. And I'll talk a little bit more about Project SUCCESS at the end.

These are all the schools that we provide services for.

We provide services based on the need. We look at what does the data say. We use our Strategic Prevention Framework and not just for prevention, but we look at it for all levels, the needs assessment, capacity building, implementing strategic planning, implementation, then evaluation. We serve many different women and so we have some very specific issues here addressing what are the women's needs for mental health and then working with domestic violence and then specifically a women's substance abuse program. And I say we work with kids 0 on up because we work very specifically with pregnant women. So we work with them before the children are even born. So I say 0. People look at me and I say yes.

Parenting. We have three specific parenting programs that we run because it's very different.

We work with curriculum, including child development especially for those parents who have been ordered through our Department of Children and Families --

they're kids have been taken away -- dealing with those issues.

We have a specific group for parents of teenagers. I have a 7-year-old and 12 and 15 stepchildren.

So, yes. When you're working with teenagers, you're focusing on different issues.

Then we have a separate group for parents who are in recovery because when you're substance abusing parents, there are guilt and shame issues that go along. So we really try to target all of our programs looking at the specific needs of our population.

These are our adolescent groups. So we work with children, again specific needs, those who have behavior problems, substance abuse issues, and then adjustment disorder. These are the treatment programs that are offered in the office with our adolescents.

And these are all the different evidence-based practices that our agency implements: Project SUCCESS; Seeking Safety, which is another SAMHSA model program working with women with trauma issues; cognitive behavioral; the CYT/MET with our adolescents; DBT training; and Partners in Parenting from TCU, which is what our parenting program is based in.

Project SUCCESS is the program which we're recognizing today. It's a SAMHSA model program, evidence-

based. It's on the list for NREPP currently. As Tom said, we purchased it from the developer. We had the developer come down for about \$5,000/\$6,000 and provide training. I could tell you two of the most key factors in fidelity is training and supervision. Without that, none of these evidence-based practices can be implemented with fidelity. And it's not easy to do and it's expensive to implement evidence-based practices.

Turnover. We have to retrain. Training of trainers. We rely on other agencies in our area. We belong to a network with 12 other agencies who also use similar evidence-based practices, so we can share these resources.

We work closely with our drug coalition. In the State of Florida, out of the Governor's office, they have identified underage drinking as the number one priority for prevention. Every county in the State of Florida must implement a drug coalition using SPF/SIG money. We are a partner with our drug coalition working together collecting the data. The data that we have for the last five years for Project SUCCESS is what the coalition is using to target the adolescents in the county and looking at that data. We have ADAS surveys and Florida Youth Substance Abuse Surveys back to the year 2000.

Project SUCCESS works very well in our school

system. We have level one/level two prevention. We provide education in the classroom and then from there, identify those children who need individual and group. And then they're topic-specific groups. So we serve an average of 200 kids per school. And in the State of Florida, we're the only agency who has been able to get into the school system and have a full-time counselor in every middle and high school in their county, and that has a lot to say about our school system and our superintendent and the relationship that we have with them. It's very, very important to be able to do that and to work together.

And Project SUCCESS is a great program. Being that it's topic-specific groups, depending on the school and the need, we can identify which groups are needed for which schools depending on the problems that the kids have.

Transitions and mobility has always been the highest risk factor for Nassau County. One of the groups for Project SUCCESS is called the Newcomers Group. So you work with those kids coming into the community, and then there's a Seniors Group for those kids who are leaving the community.

It's absolutely a wonderful program. We've been doing it for six years. So I really like it and it works very, very well in our community, along with the other evidence-based programs.

And I talk fast. I'm actually a New Yorker

originally.

(Laughter.)

DR. PAGEL: I can't get it out.

DR. HENNESSY: Thank you very much, Laureen.

Are there any questions?

MR. MAESTAS: I have a question.

DR. HENNESSY: Sure.

MR. MAESTAS: Congratulations on your program.

I think you're running a great program and I certainly hope you continue to put it out there and the successes. I think that's exemplary.

But I had a question regarding the cost of implementation. You said it was expensive. And second, following up on that, how many kids did you touch directly with the program?

DR. PAGEL: As I said, we began implementing Project SUCCESS six years ago and that was through a Drug-Free Communities Grant with one school. At that time, another agency was implementing it, and so they brought the developer down and had her train. And so we've been training over the last five years with this one person. Well, that person actually left the agency. So I worked this past September to bring the developer down again, and I actually coordinated with five other counties in our area so we could all cover the cost. But it cost about \$6,000

for the trainer, the flight, the hotel, everything, and then it was three full days, eight hours each day with all of my staff out of school for those three days. So you look at that time. So it is costly to implement that, but it's important to do that for fidelity purposes. We were able to cover some of those costs with our Drug-Free Communities Grant.

One thing I didn't say about the program is we have four different funding sources. We have general revenue dollars from the state. We have a state Drug-Free Communities Grant. We have a state Department of Juvenile Justice grant, and then we have some block grant dollars coming through the state. So we're able to put some of those training costs into some of the grants to cover that.

We serve through our level one, which is education, around 150 kids per school, and then the topic-specific groups and individuals, 50 to 75 children per school and we're in seven schools. So it's around 1,500 kids a year we are able to serve with Project SUCCESS, which is a large number, I perceive.

MR. SHINN: Thank you for your presentation. Congratulations.

What are the demographics of the students you serve and the families in Nassau County?

DR. PAGEL: Nassau County is a very interesting

county. There are about 25,000 people that live on Amelia Island, and it is considered a wealthy part of the county.

On the south end you have the Amelia Island Plantation, Bausch & Lomb. Once you get off the island and you head west towards the county, it's the working poor. It's considered very rural. There are more unpaved roads on the western side of the county than paved roads. Most of the people don't have transportation and they don't even have phones. So it's two very separate worlds in Nassau County, east and west. There really is quite a divide between the two.

In the western part of the county, we have a lot of issues with tobacco. There's a very high rate of tobacco use, marijuana use, and then the alcohol use. On the eastern side of the county, you're getting into more of the prescription medications. So very diverse populations.

And that's why the program fits so well with looking at the small groups because you can tailor those to the need of the specific school in which you're working and those children. But it is difficult in the county because there's quite a divide with wealth. It's considered a poor, rural county.

DR. HENNESSY: Thanks very much, Laureen.

(Applause.)

DR. HENNESSY: And our last presenter is Ms.

Brenda Patton from the Council on Alcohol and Drugs Houston. Thanks.

MS. PATTON: Good morning. Thank you. I am truly honored to be here today.

I'm going to talk about a program that we're presenting there, implementing of the council. But if you don't mind, I would like to acknowledge one of our program managers. Cynthia Sequeiros is accompanying me on this trip and she manages the elementary portion of the LifeSkills Training program. So it is a joint effort and as our programs are funded, it's a combined effort with our middle school and elementary school. But we had to choose, and so I'm sitting at the table.

DR. HENNESSY: Did you want to point Cynthia out in the audience?

MS. PATTON: Would you stand, please?

(Applause.)

MS. PATTON: So, again, I'm Brenda Patton and Cynthia Sequeiros is with me and we are with the Council on Alcohol and Drugs Houston.

Our organization is a nonprofit organization. We were founded in 1946. Our mission is to keep our community healthy, productive, and safe. We want to provide services to a number of individuals and we do so by providing programs and information, referral services,

counseling, treatment, as well as our prevention programs, for infants and women, children's program, to the senior citizens. So our programs cover a large number of people.

Our prevention department directly serves over 30 communities and 15 schools. So we're pretty spread out throughout the Houston area.

One of the things that we looked at, in terms of community need, was to address the issue of deterring the use of substance use, and so we do know that if we can keep kids from using before age 21, then they're less likely to develop dependencies later on in life. And so we're trying to interrupt that in the elementary and middle school years.

According to the 2004 Texas School Survey, what we saw was a doubling of use of alcohol between fourth and sixth grades, and then, of course, with all substance use increasing, that was pretty troubling for us. Of course, despite our efforts -- and we've been providing these services for some time -- we still see that there's some use going on.

The table here just basically shows what we were looking at from the Texas School Survey, and that's a survey that's done throughout the state and it's self-reporting by students. So the use of alcohol, tobacco, and inhalants, as you can see, the 21 percent with elementary

students and secondary students, a 50 percent increase, as well as the lifetime use. So those are pretty troubling statistics.

So we chose the LifeSkills Training Program, one, of course, it is a science-based program. Of course, at the time our funding source was requiring that all of our programs that we write grants for were science-based programs. And so we had a charge from the state level as well.

But, of course, we chose LifeSkills Training because we found that it was a successful program in terms of the implementation and the research that had been done on it in terms of cutting marijuana use, reducing smoking, pack-a-day use, and the fact that it could be delivered across the elementary and middle school programs. When we initially started to implement the LifeSkills Training program, we were only doing it with middle school students, sixth through eighth grade, and then we later on brought in the elementary component, and now we're doing it third through fifth grade.

It was also a program that we found to be effective with different ethnic groups and can be beneficially implemented in either rural or urban areas. As most of you know, Houston is a very large metropolitan area and real urban. Of course, we really were pleased

with the fact that it addressed a lot of the issues that we find our kids are having issues with, which is the social, personal self-management skills.

The other benefit for using this particular curriculum was the fact that it was a universal curriculum and it allowed us to serve more students with fewer dollars. So we could train our health professionals, prevention specialists through our agency to go into the schools and implement these programs.

So how do we do that? Generally we're implementing our LifeSkills Training program in various school districts. Houston Independent School District is one of those, as well as Alief, Aldine, Spring Branch, Pasadena. The Houston area or the council is located within region 6, which covers 13 counties in the greater Houston area. Houston Independent School District is one of the largest school districts in Texas.

We choose our schools based on feeder pattern strategies. Our goal is to try to provide a continuum of care for our students. So we look at elementary, middle, and high schools where we can serve students continually across the board with our programs.

Of course, we also look at community needs and risk factors and what their concerns are as we go into these particular schools. A lot of the schools or the

communities just don't have the resources to provide it. The schools don't have the funds to do it even through the Safe and Drug-Free Schools Communities Grants and programs.

And then, of course, a demonstrated support that we get from the school administrations and the district-wide support.

We do have a district-wide agreement with the Houston Independent School District to collaborate with their schools and provide these services. Of course, the great thing is that they're allowing us to implement the program with fidelity as prescribed, and that's very important.

Another one of the things that we do that makes our program, I believe, successful is that we're able to provide comprehensive services, and so we also include alternative activities, fun, recreational, social activities for the students, as well as for their parents.

This allows for other bonding opportunities, gives the students an opportunity to bond to the community and to the school. And so still working with the 40 developmental assets, we're able to still really stress the importance of these programs. We also provide parenting classes for parents and guardians of the students that we're serving in those communities and in the schools.

We've provided the LifeSkills Training program,

as I mentioned earlier, for at least 10 years now with the middle school students and then now with elementary for four years.

Our program has been sustaining those strong community relationships. They are very important to us, establishing the relationships with the schools, as well as the community organizations that we work with, and then retaining experienced managers and staff. As the other people at the table have mentioned, that's sometimes a challenge.

One of our biggest challenges is having our staff recruited by the school district. Of course, being a nonprofit organization, we can't compete in terms of salaries with that. But one of the things that we have done also was to get with National Health Promotions, and I have become a trainer of trainers. So I train the staff as they come in and go out because turnover is a problem for us as well.

Of course, all of those community relationships. We collaborate with a lot of organizations in the Houston area to implement our programs and support them.

With our elementary students, some of the outcomes that we obtained in 2005 and the '06 school year was that 77 percent of our students increased their

knowledge about alcohol and tobacco. We saw a 75 percent increase in life skills overall, knowledge. You can see all the stats there. One of the things that we found was really significant was the significant change that we saw in knowledge about alcohol and tobacco from pre- and post-tests, where we actually looked at the pre-tests, looked at the post-tests of the students that we were serving, and found a significant difference from pre- to post-test. So it wasn't by chance that these students actually increased their knowledge in these areas or their life skills. It was actually from the implementation of the curriculum. So they really did get it, and so we were really pleased to see that significant statistical difference.

With our middle school pre/post change outcomes, again we saw increases during the 2005-2006 school year. Middle school students are a little more challenging. Even when we go into the schools, we find elementary kids are just so easy and eager to get this information. Middle schoolers, sixth, seventh, and eighth-graders -- especially our seventh-graders -- already know it all. So it's kind of hard. But nonetheless, we still get some good results from the things that we're doing with them, and so we saw a 58 percent increase in their knowledge about alcohol, tobacco, and other drugs, and then a significant change in knowledge about alcohol, tobacco,

and then the life skills knowledge as well.

So we're very pleased knowing that we're still impacting, the fact that they are learning drug refusal skills. Certainly I think that's a tribute to our staff and the way they implement the program with creativity, keeping it according to the curriculum as it's laid out, but it still allows an opportunity for the staff to be creative in terms of implementing those lessons with the students where they will be more interested in getting it.

So that's about it. Do you have any questions?

DR. HENNESSY: Thank you very much, Brenda.

(Applause.)

DR. HENNESSY: Any questions?

(No response.)

DR. HENNESSY: Well, I want to thank all of our award winners today and the other award winners we've been honoring throughout the year. We're really hearing some pretty common themes around what leads to success for some of these programs, particularly the implementation with fidelity, the funding available for training and the retention of staff. These touch a number of other different areas, including workforce development and other important areas. As I had noted earlier, we're going to try to do our best to really cull these pearls of wisdom from the 20 award winners for 2007, as well as our future

2008 award winners, and make that information available to the general public through our website.

But thank you so much for joining us today. We're really very honored to honor you.

(Applause.)

DR. MARSH: Thank you so much, Dr. Cline and Dr. Hennessy and our awardees. It's been a wonderful presentation. So I really thank you and congratulate you.

We're actually running a little ahead of schedule. So is there any other matter anybody would like to bring up at this point?

(No response.)

DR. MARSH: I wanted to mention one thing, which is I have to apologize, but I'm going to have to leave toward the end of the morning. A few of us have an engagement at the Department, which is a review of the success and performance of our major programs at SAMHSA. So we didn't want to miss that. That would be important. But I will leave you in Dennis Romero's capable hands when I go, and I do apologize for having to leave toward the end of the morning.

Well, I think we can take a break now. Steve Wing is our next presenter and we'll try to get him down a little ahead of schedule. So if you could come back about 10:30, I think we'll be good to go. Thank you.

(Recess.)

DR. MARSH: The next item on the agenda is a report on the Interagency Coordinating Committee on the Prevention of Underage Drinking, otherwise known as ICCPUD, and the Surgeon General's Call to Action, which is right here. We'll have an overview on these activities from Steve Wing, who is Associate Administrator of SAMHSA for Alcohol Prevention and Treatment Policy. He's also in the Division of Policy Coordination in the Office of Policy Planning and Budget. And I've had the privilege of working with Steve for a number of years and know that he is extremely well informed and will be, I'm sure, informative about this topic. So I welcome Steve.

MR. WING: Thank you, Anna.

I'd like to start -- I was thinking as I was coming down in the elevator -- to just do sort of a little overview. As Anna pointed out. We've worked together for some time, and I was thinking back to when I was first at SAMHSA, and frankly, we could have been probably more accurately called the Illicit Drugs and Mental health Services Administration. But alcohol was almost never discussed even though our block grant was going to treat and, to some degree, prevent alcohol problems.

The other thing is, thinking back, that David Musto, who is a historian of alcohol use in the United

States up at Yale, has published a number of books. In one of them, he said that some documents that came out of OSAP back in the '80s were fully consistent with the positions taken by the Women's Christian Temperance Union and the Anti-Saloon League and had, not surprisingly, encouraged some push-back because the country, as you know, had decided that prohibition was not our policy.

So where we are now -- I'm speaking to this as my alcohol policy hat -- is that for both reasons of science and law, if you're under 21 you shouldn't drink. If you're pregnant, you shouldn't drink. If you're a recovering alcoholic, you shouldn't drink. But if you're over 21, it's up to you. If you choose to drink and it isn't counterindicated, we hope that you will follow the moderate drinking guidelines, and we take no position on whether someone should drink or not except to say that if you choose to do it, we hope you'll do it in a healthy way.

So there are two major differences that I look at over the past 15 years that I've been here.

Now, there's another one that ties back to the Illicit Drug one. You may have already talked about this and I'll mention the SPF/SIGs. We're in a position now -- well, let me go back five years.

When we started working on the underage drinking issue, we didn't have a whole lot of funding

addressing that issue. It was in the low millions of dollars, and that's probably being generous. We're now in a position because of the SPF/SIGs, the majority of which have either decided to focus on underage drinking exclusively or to focus on preventing alcoholic problems, including underage drinking. We're in a position where this agency and CSAP's single largest discretionary grant program has a heavy emphasis on alcohol in general and underage drinking in particular. And that is seismic shift and one that I think many of us are very happy about because it's a serious problem.

Now, I'm going to be covering a lot of material that many of you already know. So I'm going to slip over some of these slides. If you have questions, I'd be happy to field them.

I'd like to start by just pointing out, which I always do, that this is not a new problem. This comes from T-K Li at NIAAA. It's our most primitive intoxicant. Barley beer goes back to 4200 B.C. They had it in China in 2000 B.C. Plato mentions underage drinking in one of the dialogues and says that the young men that were coming into the academy to discuss philosophy had to start late because they had always gotten drunk the night before -- this is an archaic translation -- "as young men are wont to do." So they were all hung over and they had to start late. This

is not a new problem.

Back several years ago, as you know, the Congress asked the Institute of Medicine to take a look at this issue, which they did. They convened a group to look at it. And in 2003 in the fall, they released "Underage Drinking: A Collective Responsibility," really a watershed document.

One of the things that that report recommended -- first of all, let me just say they recommended an overall strategy that would create a national commitment to underage drinking prevention by engaging states, communities, parents, and other essential components. And here's the strategy goal: to create and sustain a broad societal commitment to reduce underage drinking and to pursue opportunities to reduce the availability of alcohol to underage drinkers, the occasions for underage drinking, and the demand for alcohol among young people.

Although that was a private document and we were not charged with implementing the IOM report, that's a pretty good summary of where we've all been going. We see this, and I understand Dr. Cline earlier this morning talked about this, how underage drinking is seen as a right of passage, that it's sort of deeply embedded in American society. So our approach, along with our partners across the government, has been to try to create and sustain a

broad societal commitment to reducing underage drinking.

One of the things that they did was ask the federal government to start an interagency coordinating committee, known as ICCPUD. That's the acronym. It's kind of an ugly acronym, but it has the advantage that no one forgets it. It's so sort of peculiar. And in 2004, the then-Secretary, Tommy Thompson, asked the then-Administrator, Charlie Curie, to convene the ICCPUD, which he did. And in the fall of 2006, the Congress passed the STOP Act which established the ICCPUD in statute.

And these are the ICCPUD members. You'll notice that SAMHSA is up there on the top left. That's because it's chaired by Dr. Cline. There's a principals group that has representatives from each of these agencies, and there's also an agency representatives group.

From the STOP Act, the purpose of the committee is to guide policy and program development across the federal government with respect to underage drinking provided, however, that nothing shall be construed as transferring regulatory or program authority from an agency to the coordinating committee. Both are very important. It means that we are a coordinating committee, not an administrative body. Dr. Cline can ask his colleagues to try to work together. He cannot tell them what to do and neither can our Secretary tell the Attorney General, for

instance, what to do in his programming.

We have a group of agency representatives which I chair across the federal government, and we talk at least once a month, usually a couple times a month. And that has really been a valuable thing. It's helped us to avoid duplication in services, and it also means that, for instance, with the town hall meetings -- I'll use NHTSA as an example. They have gone out to the state highway directors in all the states and asked them to support the town hall meetings. The Office of Safe and Drug-Free Schools has gone out. When the Office of Safe and Drug-Free Schools put out their request for proposals for their grants to reduce alcohol abuse programs in the schools, the ICCPUD agencies all sent out notices to various groups suggesting to flag that. So we don't run each other's programs, but we try to support each other.

This ICCPUD has done several things. Back in 2005, we convened a national meeting of the states, and that was here in Washington. It was known as the Halloween meeting because that was the only day we could get the hotel. And high-level teams came from each state. We have a searchable website called [stopalcoholabuse.gov](http://stopalcoholabuse.gov), which is I think a very valuable source for information, and it brings together information from all the agencies across the government, sort of one-stop shopping.

As you probably know, we've worked with the Ad Council developing a public service announcement. Those of you have seen "My name is David and in eight years I'll be an alcoholic" ads know about that.

We sent a report to Congress in 2006. This report included measurable targets, a plan of action, inventory of federal programs, extensive data on the problem. The second annual report to Congress has been drafted and is currently in clearance. I've heard we're getting it back from the Department today actually for revision.

And there's an annual state report called for in the STOP Act that's been partially funded, and there's not enough funding in there to do this whole report. But we'll be working with interested parties to plan and develop the report within the constraints of the funding provided by Congress. So we're going to do what we can. We'll get a start on that.

One of the things that the ICCPUD has supported -- SAMHSA has paid for but has worked with the ICCPUD on -- are town hall meetings, as you probably know. And Gwyn is going to be talking about these in a lot more detail. There were more than 1,200 of them back in 2006, and we're doing another round of them here in the next few weeks. I'm going to leave that to Gwyn. That has really turned

out to be a very important part of our sort of comprehensive approach, I think, trying to create a broad societal commitment, as the IOM said.

Now, I'll switch over to the Call to Action. This is on calls to action in general. The Surgeon General uses them to focus the nation's attention on important public health issues, and when the Surgeon General's office talks about this, they say it's related to the level of the science and the seriousness of the problems. So if the science is beginning to suggest that there's a serious problem but it doesn't rise yet to the level of a call of action, they may have a consensus meeting or a meeting of scientists and sit around and talk and decide where the threshold is. I didn't say that right. Sort of decide what action is appropriate.

Once the science is at a point and the epidemiological data is sufficient to justify the Surgeon General calling the issue to the attention of the country, then they issue a call to action. And those differ from Surgeon General's reports which are created when the science is more robust. Thank heavens I haven't had to work on one of them. They're really quite fat documents and definitive. So a call to action is the sort of second level in the process. That's where we are.

And as you have them in your packets and you've

seen these, that was issued last March. In this case, it's a science-based call to every American to join with the Surgeon General in a national effort to address underage drinking early, continuously, and in the context of human development. Admiral Moritsugu, who was the previous acting Surgeon General, used to say underage drinking is everyone's problem and its solution is everyone's responsibility, and I think all of us working on that agree with that.

The slides have more detail and, of course, the Call to Action itself has lots of details. So I'm not going to do a lecture on the Call to Action.

I did want to point out, though, obviously it's taken seriously. There's a message from the Secretary and from the acting Surgeon General in there. It's divided into four sections, and I'm going to talk about those just briefly.

The first one, section 1, talks about the scope of the problem, and I just have a few things here to give you a flavor of what's in there. It talks about the fact that alcohol is the most widely used substance of abuse of America's youth, widespread public health -- persistent public health problem deeply embedded in American culture, et cetera.

It has a number of charts and graphs. This

one, for instance, shows that alcohol use ramps up dramatically during adolescence. This one shows that alcohol is the substance that kids choose most to use, more than cigarettes or marijuana, way more than cigarettes and marijuana. And this one focuses on the fact that while adolescents drink less often than adults, when they do drink, they drink more than adults do. So that's kind of a sense of the data that's in there.

It also talks about the direct adverse consequences and the longer-term consequences of underage drinking and points out, for instance, that it's a leading contributor to death from injuries, which are the main cause of death for people under 21, associated with academic failure, alterations in structure and function of the developing brain, et cetera.

Here are some more direct consequences, a range of physical consequences, hangovers to death, and so on. Risk factor for heavy drinking later in life with its associated medical problems.

I'm going to divert for a moment. One of the most interesting things that NIAAA has come up with in their review of the science is that alcohol is somehow almost uniquely equipped to fit certain of the needs or the desires of adolescents. That's one of the reasons that we find dealing with it so challenging. And let me give you a

couple of examples, and these come from animal studies. Actually before I go to the animal studies, let me back up.

I think we can all agree that peer relationships are very important to adolescents. It's a period of risk-taking and so on. Well, it turns out that the positive effects of alcohol, at least in animal studies, are stronger in adolescents than they are in adults, those effects that facilitate peer interaction, for example. So the very things that kids are wanting to do developmentally are addressed by alcohol more powerfully than they are, if I may presume to include all of you in my age group, for us.

But to the contrary, the negative effects of alcohol, the hangovers and the problems with small and large motor coordination, and that sort of thing, affect them less so that whereas if we all sat down and drank, we might get a hangover and say, well, I don't want to do that again, the young are not as prone to that.

So they get the positive stuff more and the negative stuff less, and there's a fit with their developmental stage. And, of course, the country is awash in it. So is it any surprise that they use a lot of it? Probably not.

One of the things that the report to Congress does is talk about secondhand effects of underage drinking.

We think is very important in trying to change attitudes across the country, and here's some data on that. It mostly comes from Ralph Hingson, who is now the head of prevention over at NIAAA. I want to say that one of the really positive things about the whole ICCPUD process is that SAMHSA and NIAAA are working like this on it. We worked on the Call to Action. I was over there. Mrs. Taft and I were over there virtually all yesterday afternoon, and I met with Ralph Hingson. And we actually now do each other's presentations. One of the reasons he wanted to see me is that they couldn't do a presentation, and we help each other out a lot. It's been an extremely valuable collaboration, and I think it's exactly what we're all trying to do in moving science into services.

Section 2 talks about underage drinking as a developmental issue. We believe it's best understood and addressed within a developmental framework. Just a couple of examples.

I think we all know that we don't want to do the same prevention messages or the same prevention approaches for 13-year-olds and 20-year-olds. They're very, very different. It also recognizes that there are certain key transition points during adolescence and growing up where alcohol use ramps up. One is from middle school to high school. Another one is when you get a

license and have independence. Another one is from high school to college. So this focuses on those sorts of transitions and challenges us to think about that fit between the characteristics of alcohol and the characteristics of adolescents.

Here is just a little chart that shows the sort of systems that influence adolescent behavior. This is discussed at some length in the Call to Action.

Section 3 talks about preventing and reducing alcohol use and alcohol use disorders and some of the goals of interventions. They're listed down here. First of all, this chapter talks about the fact that prevention and reduction efforts must take into account the dynamic developmental processes of adolescence, building on chapter 2 or section 2, as well as the environment and the role of the individual. And it talks about some of the goals of interventions, for instance, again, changing societal norms, going back to the IOM report, change societal acceptance, prevent adolescents from starting to drink, delay initiation, intervene early especially with high-risk youth, reduce drinking and its negative consequences and identify adolescents who have developed alcohol use disorders, and develop additional interventions, including treatment.

And this talks about scaffolding. When we put

a building up, we build a scaffold around it, and we gradually take it down as the building can stand on its own. It's a metaphor that we've been using more and more.

You have a different type of scaffold around underage drinking for a 12-year-old than you do a 20-year-old, and it challenges us again to think of these in developmental terms.

Here we go. I forgot I included this slide. Scaffolding is used as a metaphor for the structured process through which parents and society provide adolescents with support and protection as needed from their natural risk-taking, sensation-seeking tendencies to ensure the adolescent's safe and healthy maturation to adulthood. We had a great writer working on this thing.

Now, section 4. There are two parts to this. One is that it lays out the principles that the Call to Action is based on, and these are the principles, that underage alcohol use is a phenomenon directly related to human development. We keep pounding this because we wanted to kind of get that out. Factors that protect adolescents from alcohol use, as well as those that put them at risk, change during the course of adolescence, again related to development. Three, protecting adolescents from alcohol use requires a comprehensive developmentally based approach. Four, prevention and reduction of underage

drinking is the collective responsibility of the nation. Underage drinking use is not inevitable. As both Mr. Curie and Dr. Cline are fond of saying, when we pushed back against tobacco use and marijuana use, it receded, and we can expect that if we push back against underage alcohol use, it will as well.

The Call to Action has a number of goals. I'll quickly highlight them. Goal one, foster changes in American society that facilitate healthy adolescent development and that help and prevent underage drinking. We wanted to cast this not so much in anti terms but in positive terms and say our goal here is to facilitate healthy adolescent development and that we think that is more likely to take place in a world that isn't awash in alcohol or where kids are. That doesn't mean that adults can't drink, but if adolescent life is awash in alcohol, then it's less likely to happen.

Engaging parents and other caregivers, really the entire range of folks that interface with youth, and youth themselves -- it's important to engage them in a coordinated national effort to prevent and reduce underage drinking.

The third goal is to promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account

individual adolescent characteristics, as well as environmental, ethnic, cultural, and gender differences. We think a lot of the problem with this is the lack of understanding. I think most parents don't realize the implications of the research that's out there, and one of the reasons is that when we were all growing up, it wasn't out there. So we grew up in a different world, and I know I have a hard time sometimes. I had to call someone actually who works for me and ask her to turn this thing off when I was on a plane several weeks ago. So you can tell where I am on some of this stuff.

Goal four. Conduct additional research on adolescent alcohol use and its relationship. I mean, we are where we are because of the research. We need to do more of it.

Work to improve public health surveillance of underage drinking and on population-based risk factors. It's from the Household Survey and from a national survey done by NIAAA that we know that you're five times more likely to have alcohol problems as an adult if you start drinking before you're 15. Without those surveillance surveys, we would not know that. So I think that shows why that's so important.

Then finally, work to ensure that policies at all levels are consistent with the national goal of

preventing and reducing underage alcohol consumption.

Now, the Call to Action describes the rationale for each of these goals and the challenges associated with its achievement. You'll be relieved to know I'm not going to go into all of that. It contains a list of strategies and action steps for various segments of society under each goal so that if you go to goal 1, for example, you'll be able to see the rationale, you'll be able to see the challenges, and then you'll see recommended strategies -- excuse me. We don't make recommendations. We have identified a number of steps or strategies that parents and other caregivers might consider, schools might consider, colleges and universities, communities, criminal justice, health care, alcohol industry, entertainment, governments, and policy makers.

Now, let's talk for a minute about how we're rolling this out spreading the word. It was released at a national rollout on March 6, 2007. Since then, there have been state rollouts in a number of states, and I'm going to ask Hope to chime in here. She has been key to this. SAMHSA and the Surgeon General's Office and NIAAA have been working closely with the Leadership to Keep Children Alcohol-Free on these rollouts, and I'm going to show you a couple of examples here.

This is a chart from the Leadership to Keep

Children Alcohol-Free. As all of you know, it's an organization of Governors' spouses who are interested in preventing drinking by 9- to 15-year-olds, and Mrs. Taft is now the president. Are you the CEO as well? Mrs. Taft is it, and thank heavens she's it because without her, I don't think we would be anywhere near where we are.

Lieutenant Governor Duke Aiona, who is on the SAMHSA Advisory Council, hosted the first of these rollouts out in Hawaii. Mrs. Taft and I were both privileged to be there. It included a meeting with the Governor. It included a visit to a school where they did a teach-in. It included a number of press events. It included a luncheon that brought together folks from all across Hawaii who are interested in the prevention issue, and it included a meeting between the Surgeon General and the Hawaii equivalent of the ICCPUD, the folks at the kind of upper middle bureaucratic level who are doing this work on a day-to-day basis.

I'm going to fast forward to the one that we did in Ohio. Was it last week? It feels like it was three weeks ago, but I think it was last week. These have evolved and we've learned from them. That visit included a meeting of the Surgeon General with key doctors at a children's hospital in Columbus, including the head of the Pediatric Society for Ohio. It included the Secretary of

Health for Ohio where he talked about the importance of preventing underage drinking. Before that, incidentally, he did some press stuff.

After that, we went out to a luncheon at Denison University where he met with college presidents and various college staff from across Ohio. He came back into Columbus where he sat down and talked with the ICCPUD counterpart for Ohio. Then he and the First Lady of Ohio and the SSA there -- well, actually the SSA and the First Lady introduced him at a meeting of prevention leaders from across the state, and then he went across the street and met with the political leadership of the state. Hope, you know better than I do who was there, but I mean, a lot of the cabinet were there, the supreme court. So he had a chance to talk one-on-one.

So this is a good picture of how these are evolving now. The First Lady is involved or the First Spouse is involved and the Surgeon General, which gets great press. We reach out to the medical leaders to try to get this to the pediatricians. We make sure that he sits down and not only has a chance to thank but learn from the state ICCPUD group. If possible, he speaks to a major event like a prevention meeting, and we try to arrange -- sometimes it's a reception at the Governor's mansion. In one case, it was a sit-down breakfast at the Governor's

mansion. In other cases, it's the statehouse. But he has an opportunity to meet one on one with the leadership of the state.

The Surgeon General's Office says this is the prototype that they would like to use for all rollouts of all calls to action in the future. It's just a terrific thing. I don't think they're going to be able to because they don't have the leadership of Mrs. Taft to work with.

Now, here are some others. In Maine there was one, and you have a picture there of Admiral Moritsugu. And that's the First Lady up there on the right, and there's a picture down here in the middle on the right of a press event.

On the left, he joined North Carolina introducing a media literacy curriculum, and there he is with First Lady Mary Easley on the right.

In New Mexico, there he is at a town hall meeting with a whole theater full of people with First Lady Mrs. Richardson and the Surgeon General. So that's one of the ways that we're promulgating them.

But the other thing I want you to know is Dr. Cline and the Secretary see this as, at least during this administration, our policy statement on underage drinking.

That means, for example, when we're doing the town hall meetings, we ask them to use the guide to the Call to

Action, which I think you have. There are some guides that are sort of popularized versions of this.

You'll be hearing more about the STOP Act this afternoon. When Dennis Romero convened a group to talk about how to implement the STOP Act grants to Drug-Free Communities grantees to address underage drinking, we decided to require that they use policies that are either listed in here or that are congruent with them. So we're using this in a variety of ways here at SAMHSA and outside SAMHSA to not only raise the visibility of the issue, but to push people toward using science-based policies that we all agree are a reasonable way to go.

So next steps of the Surgeon General. We're going to continue the rollouts. As I said, SAMHSA now routinely recommends that its grantees and others align their programming with the strategies. Sometimes we don't just recommend; we require. And we're supporting town hall meetings. We've talked about that, working with the Ad Council. All that's the same.

This is something that we've been using in some of the talks and it's a little off topic, but I like it pretty much. It's sort of a conclusion of where I think we are. Underage alcohol use in America is a public health problem because of the number of children and adolescents who drink, when and how they drink, and the negative

consequences that result from that drinking. Although progress has been made in reducing the extent of underage drinking over a multi-decade time span and several national surveys have shown modest declines over the past several years, the rates of underage drinking are still far too high and its negative consequences are too serious to ignore.

Underage drinking is deeply embedded in American culture. Therefore, to make a change, we will have to rethink our cultural attitudes about underage drinking. We will have to stop seeing it as inevitable and as a right of passage and start pushing back against it as we have pushed back against tobacco and illicit drugs.

Underage alcohol use is everyone's problem and its solution is everybody's responsibility. Each of us has an important role to play in the prevention and reduction of underage drinking through our individual and collective efforts, ensuring that the future America offer its youth is neither shortened nor impaired by the consequences of alcohol use.

So if you have any questions, I'd be happy to entertain them. Hope, do you have anything to add?

DR. TAFT: No, thank you.

MR. WING: I just want to say what a great pleasure it has been working both with Mrs. Taft and the

Leadership. Really, these rollouts are just amazing.

I also I want to pay tribute to CSAP's efforts.

The town hall meetings, in particular, are one of the great successes, I think, of SAMHSA, not just CSAP over the last five or six years in addressing a major public health problem. And you'll be hearing from Gwyn more about that, but I want you to know that Gwyn has been an important part of making sure that those happen and that they're done well.

DR. TAFT: I might add that it's been a pleasure to work with the ICCPUD group and with NIAAA and the Office of the Surgeon General and SAMHSA, in particular, on making sure that the Surgeon General's Call to Action gets some publicity as we go around the states. And it's the strong support that we get from the Governors' spouses in all those states that really makes a big difference. Even the former Governors' spouses such as Shary are a big part of that effort in that support system.

MR. WING: Can we take a minute and tell them about Prevention Day? Do you mind?

MR. ROMERO: Oh, absolutely. I'm sorry. You know what? Actually Peggy will be talking about that later this afternoon as well, I believe, after Gwyn.

MR. WING: Okay.

MR. ROMERO: But stay tuned. That should

create some excitement for this group now and anticipation.

Are there any other questions for Steve Wing?

MR. SHINN: I had one, Dennis.

MR. ROMERO: Sure.

MR. SHINN: Thank you, Steve.

Where are we with the alcohol agency? I think Hawaii likes Bud Lite more than it likes water sometimes. I don't know if I should say that. But you know what I'm saying. Alcohol is popular anywhere. So where are we with the alcohol industry?

MR. WING: With the industry. First of all, the Congress has been very clear that we should seek input on our programming and everything else, the STOP Act stuff, for instance, from all interested parties, including the industry. So we do discuss what we're doing with them.

The Call to Action is fairly clear -- I'll see if I can find the page on it -- about the responsibilities of the alcohol industry, for example, with regard to advertising. It's on page 43 and you might want to take a moment and look at that. It basically says the alcohol industry has a public responsibility related to the marketing of its product and goes into a little further detail there.

It also says, incidentally, the entertainment and media industries have responsibilities because the

perception of underage drinking is certainly affected by marketing and advertising, but it's also affected by movies and TV and video games and everything else.

As far as advertising is concerned, we can't regulate it. The FTC does monitor it and they're monitoring it now.

A lot of community groups have pushed back against various products. And there's concern right now about energy drinks, and a lot of the community groups are pushing back on that.

We don't partner really with them. The ICCPUD does not have industry on its membership, nor does it have MADD. It's entirely a government agency. We view our role as taking the best science we can and making people aware of that and trying to foster a change in attitude about underage drinking, but we don't directly partner with any groups, including the industry.

DR. TAFT: You might want to mention that the National Association of Attorney Generals has a standing committee on underage drinking, and it is more forceful in its approach to the industry than anybody else I know.

MR. ROMERO: If there aren't any other questions, Steve, thank you very much for your wonderful presentation. I also want to say that Steve, as the Associate Administrator for Alcohol Policy -- really it's a

pleasure to collaborate from CSAP's perspective because of the great work that we have embarked on with underage drinking and certainly with Ms. Hope Taft as well. So this is just wonderful. So thank you again, Steve.

Next on our agenda we will have a presentation from Ms. Gwyn Ensley, who is our Senior Public Health Analyst in the Division of Systems Development, and who is really going to provide us with an overview of the town hall meetings and afford you information and answer and entertain any questions that you might have. I believe we're going to do a slide presentation or video presentation.

MS. ENSLEY: I'm going to talk to you about the town hall meetings in terms of what we're doing for 2008. As Steve alluded to in his presentation, we did town hall meetings in 2006 which was a result of the national forum that we had in 2005. As he said, in 2006 we had over 1,100 communities that conducted more than 1,200 town hall meetings.

So this year in 2008, we set a goal to do 1,500 town hall meetings. I will tell you that this number is changing. As of this morning, when I first opened this up, this was at 1,594, and as you now can see, we're at 1,595 communities who have confirmed their participation to conduct a town hall meeting. However, I will let you know

it will be more than 1,595 town hall meetings because we have many communities who are doing multiple town halls. So we can definitely end up well over 1,600 or 1,700 town hall meetings for the month of March. We have communities who have committed to doing town halls all the way up into the month of May.

We have set the town hall meetings for the end of March, March the 31st through April the 4th. This is in conjunction with Alcohol Awareness Month, which is April. We have had some town halls that are taking place. I think one at least this week and some next week. We tried to make sure that we find a week that is conducive nationwide because, as you can see, the colors -- gray -- some people call it blue, but it looks gray to me. If you will notice, we're having town hall meetings in every place of the United States and its territories except American Samoa and Puerto Rico. In 2006, everybody participated except Puerto Rico. American Samoa is still trying to decide on how and who is going to conduct a town hall, but once we get that information, then the territory will be color-coded.

Also, you will notice on the color code -- you see stars like here in Maine and Rhode Island and Alabama and Nebraska. That means that a participating Governor's spouse will be also involved in conducting a town hall meeting. For instance, in Maine, my understanding is Mrs.

Baldacci has said that she is going to try to attend a majority of the town halls that are in her state. They're working very closely with their communities in the town hall meetings.

The stars also indicate that the First Spouses have produced a video that we are also passing out to the states where the spouses are participating.

One of the things that is different this year than in 2006 is we had the SSA and the NPNs to do recommendations for all of the participating communities. And I would have to say the NPNs stepped up to the plate. I mean, the number in terms of confirmation is 1,595, but we had over 2,200 recommendations. What happens is that a state -- and I will just pull up Hawaii for Alan here. We were trying to get Lieutenant Governor Aiona's video on it that will showcase. But what I want to show you is that when we contact a specific organization, they end up getting their password, and they come in and they fill in all of the information in terms of the name of the coalition, the location, and the date. And as you can see right now, in Honolulu, you have two on there that have already submitted their information, their profiles. We send out emails every couple of days to ask the communities to please put in your profile and let us know where you're going to hold your town hall meeting.

In your packet -- I think it's right behind Steve's presentation -- I gave you some information and some of it is state-specific in terms of the number of communities that have confirmed to do town halls. But I also gave you a list in terms of the professions that are leading in a specific state, and I won't call the state's name, but I will say it has parishes. You have four mayors in that whole parish who are going out and conducting the town hall themselves. You have a juvenile court judge. You have a county news editor. We've got nurses. We've got the SPF/SIG coordinators, especially in the State of Washington, stepping up to the plate. Washington recommended over 100 communities, and I believe we had 98 that are confirmed to do town hall meetings in the State of Washington. You've got superintendents, and you even have a sheriff's department.

Also on your list that I gave you is a list of the materials that are going in the packet that we're sending out to all of these communities, and also the SSA of your state and the NPN will get a packet. We are mailing out -- we started last week -- to these different communities a packet of the Surgeon General guides. It's the community guides and the family guides. And the educators are getting like 100 of the community guides, 50 of the families, and about 25 of the educators guides, and

if they need more for the community, they can always come back in. The State of Maine asked for 1,000. We were able to negotiate and only send them 200, but I told them they can always come back and ask for more.

What we also did that I want to showcase, since they put it up, each spouse that sent us a video we also have downloaded on the site and we are going to have those available.

(Video shown.)

MS. ENSLEY: So what we will be doing for Hawaii is all of the communities in Hawaii will get that DVD of Lieutenant Governor Aiona, and it will be the same thing for Utah, same thing for Maine, same thing for Oklahoma, Nebraska, Alabama, South Dakota. And I think in South Dakota she is now a co-chair.

DR. TAFT: North Dakota.

MS. ENSLEY: North Dakota, okay.

So that's what we're doing for the town hall meetings. We've been very busy. We're uploading today all of our information on the sites.

I'll show you one more and this is the First Spouse from Utah, and it just gives you a flavor.

(Video shown.)

MS. ENSLEY: So we're working hard and the states -- the leadership has just come together to make

sure that we have success this year just like we did in 2006.

SAMHSA has put on their plans to do this every two years, and Steve is going to make sure that CSAP has the money. CSAP's funding is supporting this, and I just want to thank Anna and Dennis for their support in providing the funding to make sure that we were able to do this. I do know we did have to cut our support in half from what we did in 2006, but I tell you, the communities are wonderful. This is important to them and some of them said, hey, we're going to do town hall meetings whether we get the funding or not.

And so I just want to thank all of you who are working out there in your communities and who are CBOs, Drug-Free Communities grantees who are definitely stepping up to the plate and helping us make sure that we keep this message out in the community about our kids and about the issues and the problems of underage drinking.

Do we have any questions? None? Oh, I love this.

Yes, Hope.

DR. TAFT: Do you have a list of those communities that would like to have funding but don't have funding?

MS. ENSLEY: No. Before we had made a decision

about supporting the town hall meetings, some of them were saying, well, are you going to do it this year? And I had to tell them, I don't know. This was before we got a budget passed. And they said, oh, well, we're going to do one anyway. We would take their names and when we found out what we're going to do, then we let them know.

MR. ROMERO: Gwyn, thank you very much.

Are there any other questions or comments?

(No response.)

MR. ROMERO: I certainly would like to reiterate some of the comments I'm sure Gwyn mentioned. First of all, I apologize. I needed to step out for an important call.

Gwyn and I and Steve had the opportunity to go down to Florida to do the videotaping for this year's town hall meetings, a videotape that will be providing some direction to the communities that plan to do a town hall meeting. It was an incredibly fruitful event. Gwyn and certainly Steve Wing played a crucial role in the success of that effort.

Again, we'll ensure that our town hall meetings this year will be productive and certainly continue to raise the awareness of the devastating impact that underage drinking has not only on our youth, but also on our economy. And we have to continue to connect the dots in

those areas that alcoholism, alcohol, underage drinking has an ultimate consequence in our national economy. That's where we need to continue to pay more attention.

Now I have the privilege of inviting up to the microphone Ms. Peggy Quigg, who is the Director of the Division of Community Programs in the Center for Substance Abuse Prevention. Peggy is going to give us an overview of Prevention Day and afford you the opportunity to get a better glimpse of the work that we do throughout Prevention Day and answer questions regarding the Division of Community Programs as well. So, Peggy.

MS. QUIGG: Thank you, Dennis, and good morning, everyone. It's nice to see all of you again.

How many of you have had the chance to come to Prevention Day this year?

(Show of hands.)

MS. QUIGG: And how many of you have had the opportunity to come to a Prevention Day over the last four years, attended at least one?

(Show of hands.)

MS. QUIGG: Good, great.

Well, my intention this morning, as Dennis said, is really to just do a brief overview for you, and for those visitors and guests in the audience, the agenda sheet that I just passed out is available on the back table

as well for you. Just a brief overview of this year's Prevention Day and more importantly to get feedback from you about how we can strengthen this effort and what recommendations and ideas you might have of how we can better meet the needs of our grantees.

The purpose of Prevention Day began four years ago with the thought in mind that many of our grantees in the Drug-Free Communities program in particular have had a challenge connecting with our state systems. Because the funding for Drug-Free comes outside of the state network, a lot of those relationships were not happening on the ground. The CADCA National Leadership Forum provides a national venue where many of the Drug-Free Communities coalitions already attend the national conference. We started Prevention Day as an add-on to that venue just to see if we could bring the state systems to bear at that place and also some of our other discretionary grantee programs, HIV and methamphetamine, because what we find, by and large, is all of our discretionary grant programs fall outside of the boundaries of the scope of work of the prevention systems within the state. And many times those people don't know one another. So the purpose of Prevention Day was to help foster networking between our discretionary grantees and the state system providers.

The second purpose of Prevention was just to

provide an opportunity of networking and sharing and information and leadership from CSAP to a large pool of our grantees. It replaced some of our old, traditional annual grantee meetings in stovepipe silos of we're going to have a grantee meeting for the HIV grantees, one for the meth grantees, one for the DFC grantees, and one for our SPF/SIG grantees and never would those groups come together to meet. So Prevention Day provided a forum where the hope and the goal was to bring those groups together, introduce them, let them have some dialogue, and feed them some leadership information from the top levels here at SAMHSA and CSAP.

So with that in mind, that's what really sets the stage for these agendas. So this year's agenda, in the morning session, was a brief overview starting from Dr. Cline, very much like what you heard today from his remarks. He released some of those same statistics out to the audience to set the stage for the day, reiterating the importance of underage drinking in particular and some of the other behavioral problems we have with young people every day in this country.

What didn't happen this year -- and this was the draft agenda. I'm sorry we picked up the wrong one this morning -- is we didn't end up doing the YouTube-style question and answer session, and that was unfortunate

because we had a good plan for that. But some other things prevailed and we didn't get to do that.

We had the fortunate addition of Dr. Cline who, when we were initially planning, wasn't available. His schedule cleared up and he was able to start that morning for us.

The real key part of the meeting to me -- and excuse me, Dennis, if I overstep our leadership with this -- was having Mrs. Taft present to the audience because she plays an important leadership role for this field, being first and foremost that of a former First Lady and someone who has been a champion and leader in her own state, also a recognized prevention professional and someone who really understands the same issues and challenges that the grantees in the room face every day in their own communities, but brings that leadership perspective on a very large scale. So her remarks were exciting and challenging to the grantees, and we heard tremendous comments throughout the day about having her be a part of that morning.

Now, for some reason, grantees get tired of listening to bureaucrats talk. I'm not sure I understand that anymore, but that is what we hear.

Then we broke the group down into some priority areas. As you know, Dennis has led CSAP for the last two

years around looking at reaching vulnerable populations and finding ways to really connect our grantees to more outreach efforts and to keeping these vulnerable populations in mind as they do their work. So the purpose of the workshops was to provide more insight and depth of knowledge of what we're looking at and seeing at this level about those vulnerable populations and spark some interest and ideas in grantees. Most of those sessions were actually done by people from communities already working on these vulnerable population issues, not just some of our folks here with ideas about what might be done. But we gave the participants real-live examples of things that they could take home, and we know that that's what many of the grassroots coalition folks really want to hear when they come to these sessions.

At lunchtime, we did regional breakouts, again with that idea to meet our first goal of trying to connect state systems with our grantees and let people in the room know other people from their own states and many times from their own communities that they've never had the opportunity to meet and greet and share business cards with. So our lunch provided a somewhat facilitated process but, more importantly, an informal time for networking and sharing to occur. We continue to get good feedback about those type of venues.

The afternoon session breaks down in a couple of different ways. Simultaneously the CADCA Leadership Forum begins its preconference workshops in the afternoon.

So we have to find a little bit of a balance because many of our Drug-Free Communities coalitions really want to take advantage of those venues and attend those preconference workshops. So we try to find a middle-of-the-road, so to speak, agenda for the afternoon to allow people the flexibility and freedom to do what they need to do with their time here with us on this day.

We also provided, in addition to those workshops, some facilitated breakouts, and we repeated the workshops from the morning. So people had a chance to attend two workshops. But the facilitated dialogue was a chance to talk about and bring home some of the ideas presented in those vulnerable population workshops and share ideas and try to spark interest of what people could do to go home to better work on those and also served as a focus group for us. We had staff conducting those breakout sessions so that our staff got a chance to hear from the people in the communities what they were thinking about reaching those vulnerable populations, what they might need in terms of services and programming and support from us to better to do that. And it turned into some very rich dialogue.

The unfortunate part for that was that the workshops that were held this year were great workshops and virtually all of those rooms that I went into were packed.

So a lot of our attendees chose to do that rather than come to those feedback groups. But it is what we said. It's about trying to meet people where they are and what their needs are so they get the richness of the day for themselves and not necessarily for our own pleasures or needs.

What we got back from the feedback group, even though it was small in attendance, was rich feedback, and the people that came had a need to share that information, had a desire to do so, and the comments that we got were very beneficial and helpful to us.

We also did host those other special meetings at the bottom as special priority projects and programs going on within SAMHSA, some other leadership venues that needed some attention, and this just provided an easy way to get that done. We did an HIV grantee meeting. The National Guard was hosting training for themselves. We didn't actually participate in that training, but they were on site, again, to network their folks better with the community folks that come to town. And we also did a Native American track and a faith-based track for some of our projects and programs in those areas throughout SAMHSA.

So that was an overview of the day.

What I'd really like to do is turn it back to you and ask you about your thoughts, comments, suggestions, ideas. There are three things that come to our minds as we look at this conference every year. What is the benefit to the field? How beneficial or not is the connection of doing this in conjunction with the National Leadership Forum? And what are some future Prevention Day activities that you might like to help us build an agenda with? So thoughts and ideas from you.

Thank you, Mrs. Taft. You wouldn't let me down.

DR. TAFT: You know that I'd have some ideas.

First of all, I want to thank you for letting me participate on behalf of the Leadership to Keep Children Alcohol-Free Foundation in your morning session. I too got a lot out of it and liked the fact that we were there to help, again, network a different set of people with your CSAP grantees because in conjunction with your Prevention Day, the Leadership hosted an education day for our membership and participated in the evening reception and then also hosted breakfast for the state breakouts for the spouses that were in the state. Our membership found it very worthwhile to get to know the people that were really on the ground working hard on this issue in their states.

So I want to thank you for that. And any way we can tighten that relationship, any way we can keep the focus on underage drinking, since it is a SAMHSA priority, I think would be a great advantage.

MS. QUIGG: How many First Ladies actually ended up attending?

DR. TAFT: We had 15 states represented.

MS. GERINGER: Peggy, I would add that it was useful as a former First Lady to have that connection again. But I know, from my time in office too, having Prevention Day be in conjunction with the CADCA conference really does help. So many of our programs can't really afford to do a lot of travel, and to be able to have one plane fare instead of trying to come twice really is very helpful. So I would urge you to continue to tie the two together.

MS. ARES: I would echo that. Also, I know that I wasn't able to attend the Prevention Day this year, but I did the year before. As a NAC member -- and maybe this is just me personally -- I feel like I need to have a charge or a task while I'm there. If we are truly advisory to CSAP, I feel in my capacity as an advisor, though, I also need to be able to hear the multiple issues and needs of the people that I think I kind of represent.

So I guess two thoughts. Give us a specific

charge. Maybe we help co-facilitate some of those feedback sessions. If you didn't have good turnout, then don't compete with really good workshops.

Secondly, if there's a way that you could also coordinate this meeting with that meeting, then again you're saving a lot of time and resources so that maybe we have part of our advisory council meeting conducted during that time frame. So we're already there. Then we can participate in Community Prevention Day, and if we need to then be involved with some of the CADCA work, then we can do that as well.

But I think it's definitely a worthwhile effort, and when I attended, I met with the Illinois contingent, and I'm like, I didn't know that you had that funding. There were people around that table that didn't know one another. So it's sad that you have to fly people across the country in order for them to get together, but it does serve a useful function in that regard. So I think you're on target with that.

MS. QUIGG: Great. Thank you.

MS. GERINGER: I would echo what Karel said about having a NAC meeting at the same time, and perhaps the time that is Capitol Hill Day, which we don't do as National Advisory Council business, would be a good time to host that. That way we'd still be available to go to the

CADCA meetings and the Prevention Day but would have time to have at least a half-day meeting.

MR. SHINN: Hi, Peggy.

MS. QUIGG: How are you, Alan?

MR. SHINN: Okay.

I didn't attend the Community Prevention Day, but I understand that grantees were not mandated to attend.

So I want to check that with Dennis. If that was so, I think there should be some charge to come to this important event. I understand the silo issue and they expect to meet grantees. I don't know if that affected attendance or not.

So I was going to ask if you thought that had any impact.

MR. ROMERO: I think we had a very good attendance for Prevention Day. Peggy may know better than I. Last year we had an incredible number of attendees, I think a little bit more than this year. There were a couple of logistical factors that impacted on this year's both Prevention Day and CADCA.

But I echo and I 110 percent support the comments made by both Sharyn and Karel. You're absolutely right. And I think this is another avenue, another leveraging tool that we, CSAP, have in terms of connecting ourselves with the community through the NAC board. So this is very good information.

I will say that one of the emphases in the last

couple of years has been to ensure that we're getting the kinds of attendees who normally just do not have the financial capacity or capability of getting to something like this because it really is worthwhile. Unless you've been to the Prevention and the CADCA conference, anyone could tell you about it, but it's another thing to go and sit and take in the wealth and richness of the presentations and the topics to see the value and what you're able to take back to your organization.

The first year that I was here and I attended it, I was absolutely mesmerized at the fact that this is available, and I was simultaneously saddened by the fact that this was the very first time in my career -- and I've been in the field of substance abuse and mental health 24-plus years -- that I had been exposed to something like this. And I think how wonderful, yet how sad, and how many other organizations are in that same boat. They don't have that access.

So I made a commitment, on behalf of CSAP and coordinated with CADCA, for CSAP to provide a scholarship for community organizations that cannot afford to come, that we would defray part of the cost. CADCA was very supportive of that. This year they even went so far as to say that they would also, from their own end, support the already existing scholarship that we were providing to

further entice and increase the number of people that could attend who otherwise would not be able to attend. So we certainly are making inroads.

I hope you all know that I do have a soft spot.

Many people don't realize that I have a soft spot, but I do have a soft spot. My soft spot is working with those who are voiceless, those who do not necessarily have the resources to shine in ways that they already do because of their lack of resources. So getting them to places like Prevention Day -- SAMHSA's, CSAP's Prevention Day -- is a national opportunity to be connected with other key people of the prevention field. So we are moving more in that area.

Alan, to answer your question specifically, again, because of some logistical pieces, it made things a little bit different, but in conversations that I had with Hope in Oregon, in both the NPN and the rollout for Oregon, we discussed the opportunity of making the Leadership organization be part of it because underage drinking has to be central to our raising awareness. And I certainly am extremely proud to say that CSAP is collaborating with Hope Taft and the Leadership to Keep Children Alcohol-Free because it truly is a synergy there. So we need to continue to foster that collaboration, as well as with others, but underage drinking has to be part of it. So we

will continue. Certainly on our part, Hope, CSAP will continue to collaborate and continue to make this an annual activity.

MS. ARES: I have one more question. Sorry. Is it always mid-February? Yes? Okay.

DR. TAFT: It's always right around that time.

MS. ARES: Well, the last two have been mid-February. Valentines Day is not an issue for me. Don't tell my husband. But my board of directors meeting is an issue for me, and I can schedule around that. So if I know that this is happening --

DR. TAFT: Next year, the dates have already been set.

MS. QUIGG: It will not cover Valentines Day. It's the 9th through the 12th. So Prevention Day, if we would do it in the same venue, would be on the 8th.

MS. ARES: Are you sure it's not the 9th? That's all I need to know because I think the 8th is a Sunday.

MS. QUIGG: If the 8th is a Sunday, then Monday would be the Prevention. So it would be the 10th through the 13th.

DR. TAFT: And they've already got the location. It's here in Washington. It's at a brand new Gaylord Nelson Conference Center.

MR. ROMERO: It's going to be in a larger venue, as Hope mentioned. It actually will afford everyone to be in the same hotel at the same conference. So it's minimizing the commuting from one hotel to another.

But the other piece, Karel, you should know is that when both CADCA and CSAP coordinate the data of our national conference, we have to look at the overall big picture of the other national conferences. We don't want to inundate or saturate an area. So it's a juggling act.

MS. ARES: As a conference planner, our organization does a lot of that. So I fully appreciate that. I just really wanted to know the date so that I would have it on my calendar and not schedule anything around it. So mission accomplished. Thank you.

MR. ROMERO: I will make sure that Tia will send to you with your packets the dates for both Prevention Day as well as CADCA. I am going to seriously take into consideration the notion of making our NAC meeting for the winter right around that same time and see if that works. I think that meets several purposes.

MS. QUIGG: Well, thank you all very much for your support and your ideas. I appreciate it.

MR. ROMERO: Peggy, thank you very much.

Any other questions for Peggy?

(No response.)

MR. ROMERO: I do thank you very much, Peggy. Thank you for your commitment to the work of prevention.

Certainly I know when a presenter comes up, we hear that presentation and then we afford all of you the opportunity to ask any questions, but I'm sure that there may be other questions that may pop later on. Please don't hesitate to forward those questions and any inquiries you might have to Tia, and then we will funnel them appropriately and get answers back to you. So this is not the only opportunity to ask or to inquire or to seek information.

We are running 10 minutes ahead and I'm very proud. That means we all have an extra 10 minutes to stretch and fetch. So we will meet again at exactly 1:30 when we will begin our presentation on CSAP's budget. So we will reconvene at 1:30. Thank you very much.

(Whereupon, at 11:50 a.m., the meeting was recessed for lunch, to reconvene at 1:30 p.m.)

AFTERNOON SESSION

(1:35 p.m.)

MR. ROMERO: We will now resume our National

Advisory Council meeting. I hope everyone had a delightful lunch and mini-break. I hope you had the opportunity to meet with one another and sort of connect the network because that's also vitally important.

But before we get started, Karel, you had a comment.

MS. ARES: I just wanted to mention that as a result of my lunch discussion, I never want to become a first lady.

(Laughter.)

MS. ARES: Shary and Hope deserve a lot more accolades doing important public service and definitely not getting the rewards and recognition that they deserve. So I just learned that from my lunch, that that's not part of my plan.

MR. ROMERO: Well, thank you, Karel. But it's that wisdom and that experience and the opportunities that these two fine ladies bring to the council that really enhances our purpose and our focus. So again, Sharyn and Hope, thank you for your continued support and involvement here.

Now I would like to present to you Peggy Thompson. Many of you know Peggy. Peggy Thompson is the director of our OPAC office. Essentially, she will go over with you today the budget overview for both 2008 and 2007,

and then we will entertain some questions. I'm sorry. Did I say 2009? I meant 2009.

Peggy?

MS. THOMPSON: Thanks, Dennis, and hello again to all of you I didn't get to say hello to earlier. To those of you who I just met over lunch, it's good to be here with you.

It's a tough spot to fill. First of all, you've already heard two budget presentations and you're probably thinking, oh no, not another budget presentation, but I'll try to keep it informative and yet move quickly enough that you won't fall asleep, especially right after lunch, and I'm also going to try to link it into what you've already heard from Joe Faha, who talked about the appropriations process, and then Michael Finucane, who talked to you yesterday about the different steps in the budget. I'll try to make that a little bit more programmatic and bring it into what we are actually doing and what we hope to be doing, and what the budget allows us to do.

And I also thought that, since spring is coming and I have spring fever, when I started the slides that I'd try to make them a little bit more seasonal for you. So perhaps this will wake you up after lunch and make you feel all warm and happy. So this is my spring budget overview.

This slide you've seen before. I'm not going to go into it in detail but just as a reminder about what Mike talked about yesterday. At most times of the year, we're working on three different budgets at the same time, the year that we have finished and is being audited, the year that we are actually spending the money in, which is 2008, and the year that we are planning for, which is 2009.

So these colorful bars represent those three years.

Then, of course, within each of the three years, there are five key activities that go on, the planning, the formulation and Congressional action, execution and audit and review. I'm not going to go over each step because you've heard it before and you don't want to hear it again, I'm sure, but it's up there as a reminder.

Just in case you were wondering where we are right now, the line that just appeared magically on your slide shows about where we are. We have finished 2007. There are some various audit and reviews going on as to how we actually spent our money, but we are pretty much out of that picture at this point. The middle bar for FY '08 is the execution, the green part, and it slices right through that, showing that we are busy trying to spend our money. And then for '09 we are in the process of we finished the President's budget, and the next step that will occur is

Congressional action on the budget. So that's just an overview and a reminder about the multiple steps and the fact that for 2009, at least, it's not a done deal. It is one of many steps in the process. So just keep that in mind as we go through the slides.

So here we are in fiscal year 2008. What are we doing? We are spending our money. This is a summary list of the things which we are able to have been instructed by Congress to spend our money for. Our budget is actually divided into two key parts. Our discretionary funds are divided into two parts. So this slide represents the first of two parts, called capacity. You don't have to worry about that because there is no test on that either. But it has some key elements that you might like to know about. This is kind of the overview. I can answer a lot of questions on a -- I won't say a superficial level, but there are people on staff who know these programs intimately, and I can just kind of give you an overview about what they are and what they look like and what their funding levels are.

So the first program that you are probably familiar with, I know some of you are, is the SPF/SIG line.

In 2008 we have -- all these numbers are in thousands. So we have \$104 million for the SPF/SIG SLOA line all together. The next activity that we are invested in is the

mandatory drug testing, and that includes both some Youth in the Workplace grants and also the lab tests that you heard briefly referenced the other day, and a couple of contracts that support that effort as well.

The next line refers to our minority AIDS grant program primarily, and there's \$39 million worth of minority AIDS grants. You may be interested to know that in fiscal year 2008, this year, that we have some of that money available for new grants. So I believe that RFA is currently on the street, and there should be about \$18 million available for new grants. I can talk a little bit about the grant program and what it looks like. Other people can talk a great deal about it. So let me know what you are interested in.

The next one talks about our meth grants. We are basically finishing up the existing 12 meth grants for \$2.9 million. Slow me down if I'm going too fast.

The next one is the program coordination line, and basically this is our data collection and analysis capability. This is the money that supports our ability to collect data from each of our grantees and to report out on what they are doing with their funds. So that's about \$6 million this year.

You have heard and will hear more about the new STOP Act Grants that Congress has given us money to fund

this year for \$5.4 million. These are small grants that have to do with underage drinking. Again, since you'll get a presentation more on those following mine, I will let that person go ahead and describe them more for you.

And last but not least on this slide, everybody's favorite, the Congressional projects for \$3.6 million. Those are the infamous earmarks or bacon or whatever term you choose to use on them. There are about 15 projects that various Congressional representatives have indicated that they believe are exemplary and want us to continue to fund. I have noticed that several of those were focused on meth and a huge range of topics. So you can't really categorize them all, but I did notice that.

So that's kind of the big picture about our capacity or our treatment activities.

The second category -- I mentioned there were two -- is called Science to Service, and that includes related activities. That's kind of support or supplement in some way for the main capacity programs. The first of those is our Fetal Alcohol Spectrum Disorders Program, which has been ongoing for quite a few years at \$9.8 million. I think last year was the first year for the new contract, but previous to that we had a five-year contract supporting this activity. So it's an ongoing activity with a new contractor.

The next one down the list is the CAPTs, and they have been supported by Congress, and they have requested that we support them in the amount of \$8.5 million this year out of this particular budget line. There is a supporting budget line that augments this one. So the total amount that is going to the CAPTs is larger than that. It's actually more like \$12 million. But typically, we discuss the discretionary funds line separately. So that's what this is.

The next one is the program coordination line, and it has to do with underage drinking. I think the Native American TA Center is there, perhaps probably the border initiative is there, logistics contracts are there, things like that, for almost \$5 million.

The next on the list is the SHIN, which you've heard about before. It's our SAMHSA Health Information Network. That's the clearinghouse where you can get all kinds of interesting publications for free of charge, for \$2.7 million.

And last but not least, the Minority Fellowship Program, which is a very small contribution that we make towards the overall program of \$60,000.

Okay. That was our discretionary program line.

In addition to that, we do have funds coming in from other areas that help us to do our programs, and the one that is

on everybody's minds a lot lately is the Drug-Free Communities Program line. As you probably remember from previous discussions, this program is actually authorized through ONDCP, but they don't have grant making authority.

So we actually make the grants and manage the grants, and a large number of our staff are responsible for ensuring that these grants are managed very well.

There are two types of DFC grants, the support grants, which are the ones that most people think of, and then the mentoring grants, which are somewhat smaller grants, usually \$75,000 grants in which an existing DFC coalition mentors a new DFC grant. Altogether, these grants total about \$80 million, and there are about 750 of them. So it's a pretty good-sized program in terms of numbers of grants.

The last significant funding stream that we have and get to manage is the Substance Abuse Prevention and Treatment Block Grant. Honestly, this is the largest amount of money that we receive. Our grantees are directed to spend 20 percent of the total funds on prevention activities, and that 20 percent equals \$351 million. So it is a substantial amount of money for this particular program, and it's formula driven. It's not discretionary.

So there is an extremely complex formula based on all kinds of things like population and emergency room visits

and 10 other factors that determine how much each state and territory receives from this program.

This is one of my favorite slides because it shows, in a nutshell, historically and cumulatively what we have to spend and what we have been spending. So from 1998 all the way through 2009, the red bar, the tall bar, represents the total amount of funds that we have had to manage here at CSAP. As you can see, it represents a nice, steadily growing picture. 2009 is a little lower. It represents the President's budget, and as I will show you in just a couple of minutes, that bar is likely to increase. But in general, you can see that there is a nice, gentle, but effective increase in our budget for most years, historically speaking, over the last 10 years.

The little sub-bars, the yellow one is the discretionary grant program we were just discussing. The purplish one is the block grant program. The green one shows the Drug-Free Communities Program, which we were just talking about. As you can see, we just started managing that in 2004. And then again, the red bar is the total amount of money we have to spend.

Okay. That pretty much closes out 2008. I also want to talk briefly about the 2009 President's budget and what we, at this point in time, think we will be able to do with those funds. Again, there are many people who

weigh in on these decisions. Some of them are our staff. Some of them are our NAC members. Some of them are on the administration level, and then there's Congress and the President. So it is a work in progress. It is not a final budget.

But at this point in time, it looks like our 2009 President's budget is going to be about \$158 million out of the PRNS, and that is a decrease of \$36.1 million from this year's level. That sounds kind of scary, but it does allow us to maintain some things, to add some things, and it takes advantage of the fact that certain activities are naturally ending.

This is a rather complicated slide, or at least a rather dense slide, but I will go over it briefly and perhaps it will be pretty clear, I think. The new activities that we will be able to do in 2009 is a brand-new Prevention Targeted Capacity Expansion Program. This is a new grant program, somewhat undefined as of this point in time, but there is a similar existing program in Treatment, and there is also a similar proposed program for Mental Health. So the idea behind this program is to provide funding opportunities that fill in the gaps that the SPF/SIG grants have left or that have emerged since the SPF/SIG is over. So again, it's relatively undefined, but at this point in time it looks like it might be a \$7

million program, and we look forward to doing that.

There are a lot of things that we will be able to continue that we are doing at the same or even slightly increased levels, and they would be the FASD that I mentioned earlier. It's still \$9.8 million. It's been \$9.8 million since before I started here. So that's a nice stability factor. The HIV/AIDS grant program, the same story on that, \$39.4 million, pretty much the same level for the last five years at least.

The NREPP that you heard a little bit about earlier, the National Registry of Evidence-Based Programs and Practices that works to document the effectiveness of various programs, including prevention programs, with various populations. The SHIN, the Health Information Network, again is fairly level funded.

There are some programs that are going to have reduced funding. The first one that everybody is going to be alarmed about is the SPF/SIG program, but the good news is that although there is a \$7.9 million reduction overall in that budget line, a lot of our SIG grants will have received their last year of funding in 2008. So in 2009, a lot of them will be ending. In fact, approximately, and this is always approximate because the budget is not done, but approximately \$38.1 million of grant money will be available for new grants. So even though it is a little

scary that the total amount is decreasing, it still does represent an opportunity for more new SPF/SIG grants.

The web cert is going to be currently under the President's budget decreased, but still maintain. The Data Coordinating Center, that's the data collection and analysis contract series that we have, will also be decreased.

Finally, the last column, the programs that will come to a natural end or that will be eliminated in 2009, right now, the Workplace Youth Grants Program will come to a natural end. Those were five-year grants, and 2008 will be their last year. So they will simply have their normal grant period ended.

Meth grants, same thing.

The STOP Act Grants were new in 2008. Because they were new in 2008 and the 2009 President's budget was based on a time period that preceded our appropriation for 2008, it did not include the STOP Act Grants. So we will see what Congress has to say about either restoring them or not restoring them. But as of this point in time in the 2009 President's budget, it looks as though they will be eliminated.

The CAPTs, the Centers for the Application of Prevention Technology, again, a significant reduction in those, although there is still a \$4.4 million piece of them

that will be retained under a different funding stream. I just want to let you know that that does not mean that they are totally eliminated at this point in time.

And last but not least, the program coordinating cluster of activities is also eliminated, and that does include the alcohol underage contract and the Native American Resource Center. So that will be something that I'm sure Congress and we will be looking at very carefully in the future.

More flowers.

Earlier I gave you the summary listing of activities for 2008. I just wanted to put the comparison numbers for 2009 next to them in this slide so you got a better idea about how the budget looks in the future right now.

For the SPF/SIG, as you can see, we kind of already went over this, but this puts it in a different format that might be easier to remember. The SPF/SIG is going down in 2009 currently. But again, remember that there are those new grants because the old ones are falling off. Drug testing is going down. Some of those grants are ending, so that's not as dire as it appears. HIV/AIDS and substance abuse are maintaining at the same level.

The meth grants, there are actually two grants that are out of sequence with the other 10, so they will

just simply receive their last year of funding in 2009. The DCCC will go down significantly. The new Targeted Capacity Expansion program will begin in 2009. The STOP Act Grants will not continue, and the Congressional projects right now are not identified. So they are not indicated in there.

And the second category -- again, we're doing the same two categories we did earlier. The FASD is maintained. The CAPTs are eliminated, except under a different funding stream. The program coordination activities are eliminated. The SHIN is maintained, and the Minority Fellowship Program, small as it was, is not going to be even visible.

So that is the current look at the 2009 President's budget. Again, we will have to see what Congress does. We will have to see what the President signs or doesn't sign. We'll have to see which president we get. There are a lot of unknowns at this point in time.

This slide is kind of out of order, actually. This is supposed to talk about new increased initiatives. Well, it's not totally, because this initiative is not one that I have talked about at this point in time. But there is proposed in the 2009 President's budget a \$20 million increase in the SAPT block grant, and it is supposed to be awarded to the 20 best-performing block grant recipients.

Best-performing is not defined, so it's going to be interesting to see how that is implemented, but it is an attempt to incentivize block grant recipients to be more responsive, to use their funds perhaps in more evidence-based ways, to be more responsive to NOMs reporting. Whatever parameters are decided are still undefined, but that's kind of what that is all about.

As I said before, there's \$37 million for new SIG grants, \$7 million for the new Targeted Capacity Expansion Program to states and local communities, and that's all for that slide.

But this one I like particularly because it puts things in perspective for us better. The magenta colored back profile shows the enacted amounts from fiscal year 1998 through 2008. The lighter color is the President's budget for those same years. So it shows kind of in a profile or a picture way how and how much our final enacted amount has historically been as compared to the President's budget, which I think helps keep things in perspective. As to what our final numbers will look like?

No one knows, but at least from an historical point of view, you have a clearer picture of the significance of what you are now hearing and how it might impact programs that you would like to support.

In summary, the 2009 President's budget

actually provides 94 percent of our funding from the same amount that we received in 2008 from across all funding streams. So if you combine the PRNS, the block grant, the block grant that aside and the DFC funding streams, you will find that we will actually be receiving 94 percent of what we did receive this year under the current President's budget. It does sustain our major program initiatives, and it does allow for new and increased initiatives.

So that kind of provides the link, I hope, between the overall appropriations process and just a really quick overview of what our programs are and how they look. Did you have any questions about either the budget process or about the programs contained in 2008 or in 2009, or detailed information about whatever?

MS. ARES: I have a few questions. One of the questions I had is you made reference earlier that the budget was prepared by, of course, CSAP staff and others. How did the NAC weigh-in on the budget request again? I know you said some NAC members had input, but --

MS. THOMPSON: Yes, we had a nice conversation about a year ago. I didn't bring a date with me. It's been a little while ago, but not all that far where the NAC was actually asked for their recommendations as to where they thought CSAP should be going, both specifically and generally.

MS. ARES: Okay, great. Because when I look at the little federal budget process beautifully colored chart, thank you very much -- as a visual person, I appreciate that -- and I see that budget formulation and budget planning, I just wanted to see when the National Advisory Council met, if that fell into the appropriate time for when we would have an opportunity as a group to have another discussion around budget stuff.

MS. THOMPSON: There is never a bad time. Anytime that you feel it's appropriate and that you would like to express your thoughts and focus us about where we should be going, we would love to hear from you. The best strategic time would also vary. As you've heard, the 2009 President's budget is pretty well developed, and the next step is up to Congress. So it is just a tad late to weigh in on where we should be going in 2009 from that point of view.

MS. ARES: Yes.

MS. THOMPSON: But certainly Mike Finekin mentioned the other day that we are already starting the planning process for 2010, hard as it is to believe.

MS. ARES: Oh, right now?

MS. THOMPSON: So perhaps you would like to touch base with Dennis or with Anna and have a conversation later on today or another time about it.

MS. ARES: Okay. Thank you. I think it would be great if we as a council actually had a group discussion rather than a couple of us individual members contacting Dennis or whomever with our ideas. I would like to have more of a group discussion around that. Maybe we have some consensus. Maybe there are some things that we would prioritize in terms of what we think budget priorities and program priorities would be. This is only my second meeting. I know we didn't have that opportunity in my first meeting in August, but as we are moving forward for the next federal fiscal year, if this group could have maybe more of a facilitated discussion around that, I would appreciate the opportunity.

MR. ROMERO: Sure, Karel. I think that's well noted, number one. But just to give you some background information, the last two years we have been under a CR, which essentially has placed some limitations on the way in which we operate our budget. I'm sure that Peggy Thompson can be more eloquent in explaining that whole process and how that works.

But because we were having some very quick turnaround opportunities to provide input back to the Department, SAMHSA as a whole, and CSAP cannot take credit for this, but SAMHSA as a whole, SAMHSA leadership felt that it would be best to weigh in and get additional input

from the community, as Peggy mentioned. So I sought the advice of and invited all of the council to be part of a conference call regarding the budget, and that included some other folks as well.

I know that this is not necessarily a standard operating procedure, but it certainly began to set the tone that the input of the council is vital as we begin to explore from a general standpoint, get your advice, get your input, what do you see from where you sit. What are the priorities? And then take that information into account as we begin to deliberate and begin to put on paper what do we propose. As Peggy mentioned, it's a dance, a five-step, six-step process, and we are in 2010. Don't think of it outside of the federal government, how far we have to project, not knowing the circumstances we will be under in those years.

So this is something that we will continue to -- and I appreciate you making it for the record a desire for the council to be more involved in it today. I would welcome that.

MS. ARES: And I do recall participating in that conference call that you convened. I think it was soon after I joined the council. So I really did appreciate being part of that conference call. I do also appreciate, having witnessed this in Illinois, that the

budget dance is not always clearly lined out and follows proper timing and sequences as we would like it to. So I really do appreciate and understand the dynamics under which you are trying to do this. I realize that fiscal year 2010 is coming up, and if there's an opportunity for us to have maybe a group discussion around planning for future years, it might be something that you have in hand so that when those last-minute opportunities present themselves, you have already obtained feedback from at least one source. I recognize that you will want to get others. Thank you.

I think I had another question. It was related to the block grant supplemental performance awards. Who defines performance?

MS. THOMPSON: Well, that's one of those amorphous, if that's the word, terms that has not yet been defined.

MS. ARES: Right. Who defines it?

MS. THOMPSON: Who will define it in the future?

MS. ARES: Well, yes. I mean, who is going to be the one who decides what performance is? Not who gets it, but what performance is.

MS. THOMPSON: I think that will be an ongoing discussion, probably involving quite a few people, probably

above our level, probably at the SAMHSA Administrator level, probably with OMB, almost certainly with OMB, possibly at the HHS level.

MS. ARES: I see. Okay.

MS. THOMPSON: So I don't have the answer to that. We did kick it around once or twice at a meeting, trying to figure out what the parameters might even be, and realizing that it's a highly charged and very challenging definition, whatever it is.

MS. ARES: Right. Okay. Thank you. I'll probably just reserve comments on that later when we have our roundtable.

MR. ROMERO: Sure, sure.

Any other questions? Yes, Don.

MR. MAESTAS: I have a couple of questions. With regard to the \$20 million, you said that there would be 20 grants given out to the best performers. I know a lot of this has not been defined, but at the same time, how long will those grants be for? Is that for a one-year period?

MS. THOMPSON: Yes. They are annual grants.

MR. MAESTAS: Okay. And then related to the SPF/SIG, \$37 million will go to new states I assume, right? To new grantees? With the goal being to see how many states we can fund over the time period?

MS. THOMPSON: \$37 million will go to new award recipients, whether they are states, territories, or tribal organizations.

MR. MAESTAS: But the first three courts will not be part of that process. Is that correct?

MR. ROMERO: Well, no, because they already have received a grant.

MR. MAESTAS: So my question then has to do with life after SIG, SPF/SIG. Will there be additional discussion for fiscal year 2010, I guess, for discretionary dollars that may or may not be available?

MR. ROMERO: Well, as you remember, at the last NPN meeting, the Division of State Programs, Mike Lowther, the director of that division, and I challenged the NASADAD leadership, including the NPNs, to provide us with their input. We need to have input from outside the federal walls in terms of what ought to be. This has been a question that I have been raising for a couple of years, what is after the SPF/SIG?

We have received some thoughtful comments from both NPNs and from other interested parties, and we are planning to have an internal discussion and weigh in on the merits of the recommendations, and then we will certainly pursue in due course. So the short answer is we are having a conversation about this, and we are getting input from

both the community as well as our key prevention partners as well.

MR. MAESTAS: Thank you.

MR. ROMERO: Let me just say one thing, Don, that this is something that I think that the council really needs to have on your radar as well, because your input and your participation in this and your guidance will be taken into consideration as well. I cannot stress enough the importance of us putting this and keeping this on our radar.

MS. GERINGER: So will you put this on the agenda for our next council meeting?

MR. ROMERO: We can certainly do that at your request.

MS. GERINGER: It is a request, even though I won't be here.

MR. ROMERO: That's okay.

MS. GERINGER: I think it's a good idea.

MR. ROMERO: You can certainly do that.

We are running a little bit out of time. So if there aren't any other pressing questions, I want to thank Peggy Thompson for --

MR. SHINN: Can I just quickly --

MR. ROMERO: Sure.

MR. SHINN: Thank you for your scintillating

presentation. On the SPF/SIGs, can you break it down, 2008, 2009? How many grant awards would be possible in 2008?

MS. THOMPSON: Well, in 2008, we are continuing the existing awards, and there are 42 of them.

MR. SHINN: Right.

MS. THOMPSON: In 2009, we have approximately \$34 million. If each one was \$2 million, that would be 17 additional awards.

MR. SHINN: Okay, 17.

MS. THOMPSON: Sixteen or 17. But all those things are not set in stone. It all depends on who applies, how much money their requests, what the total budget looks like, et cetera, et cetera. But that is a general ballpark.

MR. SHINN: So in 2008 we will have --

MS. THOMPSON: The same --

MR. SHINN: No new awards, then.

MS. THOMPSON: Correct.

MR. SHINN: Okay. Thank you.

MS. GERINGER: And I have one question for you too, Peggy. Given that we don't know what's happening with the STOP Act, are there any rumors out there as to whether or not Congress will do something about it? And then going beyond that, since alcohol is one of our major focuses,

what is SAMHSA doing to try to encourage some funding there?

MS. THOMPSON: I don't know that I have the answer to your question, in all honesty. The STOP Act grant were proposed for 2008, as I said, after the 2009 budget was formulated. So there was like a leapfrog effect in which they were not considered in the 2009 budget. Historically speaking, it seems quite likely that Congress will be looking hard at them in a very positive way. But it's about as hard to predict what Congress will do as when my teenagers will get jobs. So we can't make promises to anyone about what they will look like. But since they were a relatively recently emerged program, it seems likely that they will be reconsidered, and that's about as far as I can take that.

MS. GERINGER: Is SAMHSA looking at a funding request for that work in 2010, since you are just starting 2010?

MS. THOMPSON: We are looking at a lot of things for 2010. But yes, we will be looking at that for 2010, along with all required continuations and all new ideas. I think that's an idea that has a lot of support. So I would expect that we would look at it very strongly.

MR. ROMERO: Okay. Again, Peggy, thank you very much for your presentation.

Along those lines, Sharyn, our next presenter is Jayme Marshall. Jayme Marshall is the branch chief in the Division of Community Programs. She has had the lead in the implementation of the STOP Act or writing the guidelines for the STOP Act, how the STOP Act will be implemented. As you know, the STOP Act was a Congressional directive for us to use this money particularly to address issues of underage drinking. In the legislative language, it clearly stated that we are to use this in coordination with our Drug-Free Communities Grants.

So this is a bit of an interesting dance because many of you heard this yesterday, and now I will repeat it again today. We coordinate with ONDCP on the Drug-Free Communities Grants, and ONDCP has the authority of the grant. Therefore, they address issues of policy and direction. We at CSAP, SAMHSA, we manage the actual grants. So our project officers work directly with the 840-plus DFC grantees.

The STOP Act -- and Jayme can speak more to this -- creates a bridge between the Drug-Free Communities grantees at the community level and an activity that will be the responsibility of CSAP/SAMHSA to oversee because this came directly from Congress to us.

So, Jayme, the floor is open to you.

MS. MARSHALL: Thank you and good afternoon.

I'm very pleased to be with you today and bring good news.

Just in the last couple of hours, Dr. Cline did sign the RFA for the STOP Act. So it has not gone live yet on the web. You have the first copy, so that was pretty exciting for us.

But before I get started with the briefing, I do want to introduce a couple of the staff who are on the STOP Act team. Captain Gil Rose, who just passed out some documents, came to us about a year and a half ago from the Surgeon General's office, and he is very knowledgeable in the Call to Action and is working closely on this.

Another member of our staff came a couple of years ago from Illinois, Ms. Costella Green, who is trainer extraordinaire and an expert in environmental prevention strategies. So we've put together a very good team here at CSAP and are very excited about the prospects for this program.

You had a one-page fact sheet in your packet. I did not think I would be able to go into very much detail this afternoon because the RFA had not been released, so I did not have a PowerPoint. So I thought I would cover just a few brief points, but we can go into a little bit more detail now that you have the RFA in front of you.

But as you know, this program was not in the President's budget. It came directly from Congress, and it

is to prevent and reduce alcohol use among youth, and it will be tagged onto the current Drug-Free Communities applicants, as well as those who ever had a Drug-Free Community grant. So we're excited to see what kind of pool of applicants do apply for this. We expect there will be available about \$3.9 million, and that will fund up to 80 grants. They are small grants, \$50,000, but for the community coalitions, that's a nice chunk of money that they can do a lot with. Hopefully, if the money is restored for next year, it will be a project period of four years. Of course, that's in the RFA that it is dependent upon funding availability. I want to take a minute to go through the approach.

We worked very closely with Steve Wing, who I know you heard from earlier today, in coming up with what would be a feasible approach, what would make sense for these grants. We relied heavily on the environmental strategies that are outlined in the 2007 Surgeon General's Call to Action, and we also wanted to make sure that we incorporated the SPF process. So we're not asking the grantees to go through the entire SPF but to build on their existing strategic plans. So that should result in a number of their initiatives being strengthened or expanded.

The evaluation criteria that we're going to be using in the RFA is on page 15 of the RFA that we just

passed out, the RFA, and it's a shortened form. We're getting a pretty quick turnaround on this. Thirty days is all they will have to prepare for this, but it should be fairly easy because we have gone with what traditionally has been more of a supplemental approach, especially for those coalitions that are currently in existence. So you can see that we've got just a couple of pages for the narrative that they will have to put together.

I think the tricky part is going to be for the former DFC grantees that are no longer funded by us. They are going to have to come back and explain how they are going to -- hopefully, their coalition is still in existence and they are doing prevention work, explain how they're going to kind of ramp back up if they don't have something currently in place.

So let me stop there for a minute and see what questions or comments you might have.

MS. GERINGER: Will you be providing some help for former grantees if they need it to get through this process?

MS. MARSHALL: Well, that's a good question. We do have a hotline number that's posted in the RFA, both for e-mail and phone, but we can't go into a lot of extra assistance for them. So it will be interesting to see what kinds of questions come in. But we will try to be as

thorough in the answers that we post to the web so that everybody will have the same information. The Coalition Institute is available. They can obtain technical assistance through that arm of the program.

MR. GLOVER: You mentioned that Ms. Green is a trainer extraordinaire in environmental strategies. Does that mean that she will be able to help coalitions?

MS. MARSHALL: Well, we anticipate that we will be putting together materials and probably doing some workshops around the country, not in terms of technical assistance pre-workshops but after the fact at different conferences and related things. So yes, she will be very involved in that.

MR. ROMERO: And I'd just like to stress, and I don't mean to get too much into the weeds of things but this is an important piece to appreciate, and that is that this opportunity for grantees who had or have a Drug-Free Communities Grant currently will have the access to really be involved in this STOP Act. The way that we've written the language here is to ensure that we don't burden the grantee as much as possible with following particular planning models.

So the SPF is what we want them to use, but we may find that they use similar means of collecting the necessary data. So we are consciously becoming much, much

more focused in the last few years in SAMHSA, certainly in terms of are we creating too much burden on the potential applicant when they apply for grants. This has really been a collaborative effort of both Jayme, Peggy Quigg, Steve Wing, and grants management from SAMHSA. So it's been a very, very positive collaborative effort from all parties, CSAP and certainly from other parts of SAMHSA. So for that, kudos to the CSAP staff in this area.

Are there any other questions?

(No response.)

MR. ROMERO: Okay. Jayme, thank you very much.

MS. MARSHALL: Thank you very much.

MR. ROMERO: Well, we seem to be running a little bit ahead of schedule. We are about eight minutes ahead of schedule. Let me pose a question to the council members. Would you like to take a five-minute break now or should we just proceed? Continue? Okay. Fantastic.

Well, now it's my privilege to introduce to you Dr. Beverlie Fallik, who is the acting branch chief in the Division of Systems Development, which pretty much oversees and looks at all of our prevention data-related activities.

Dr. Fallik will be talking to you today and providing you with an overview of our data accountability report and what that entails, and what that means for the rest of us in this room.

Beth?

DR. FALLIK: Thank you. Hi, everybody. I'm really glad to have this opportunity to show you a little bit about what CSAP is doing to promote accountability across our programs and performance-based decision-making, which is a priority in the department. So this is just the tip of the iceberg.

I know there are a few new members here, but certainly -- I don't want to say the older members, but the more experienced council members have probably heard about the SAMHSA data strategy, which is relatively new and where CSAP's data activities are focused in this data strategy is in the provision of data to show the effectiveness of our programs and to use the data to help improve our programs where we need to do so. SAMHSA has a strategic plan. There are three goals in the strategic plan, accountability, capacity, and effectiveness. So our data activities focus on providing evidence to show how we're doing in terms of accountability. For example, is the quality of the data we're getting good? Are we getting data from all our grantees? Are the measures we are using appropriate for our programs? Capacity is how many are we serving, the types of services we are providing, and effectiveness is are our programs working?

We have federal data requirements, which

probably started all of this. In 1993, GPRA came to be, and every year when the President presents his budget, in that budget integrated with the proposals are the performance data. So Congress can look at our budget requests and see how that program has been performing according to our GPRA data. They use that in deciding whether or not they want to fund us anymore or up or down.

We get a lot of questions back and forth in the whole process. As Peggy said, Congress is looking at our 2009 budget now. We are getting a lot of back-and-forth about the data that they have received.

The Performance Assessment Rating Tool is something that OMB came up with about five years ago that is a much more stringent examination of our performance, looking at our data. We have to update these data twice a year. It's on an OMB website called [www.expectmore.gov](http://www.expectmore.gov). Anybody can look at it, and our programs also get reviewed by OMB, and those reviews are also on the web. And then the National Outcome Measures, which I think everybody here knows about, which is SAMHSA's effort to have common measures as much as possible that are aligned with SAMHSA's vision, which is to improve life in the community for everybody.

Now, you may ask how do we do this. Well, Peggy mentioned the two data contracts that we have that

you saw in the 2008 and 2009 budget that she presented. There are two major contracts. They are the DITIC and the DACCC. It's a standing joke in the center, like Mutt and Jeff, Tweedle Dum and Tweedle Dee. I am the project officer of the DACCC, which is the Data Analytic Coordination and Consolidation Center, and Charles Reynolds is the project officer of the DITIC, which is the Data Information Technology Infrastructure Contract. So the DITIC is where all of our grants and contracts submit their data to, and it has some online data entry and a lot of neat system stuff for data. And then the DITIC gives the data to the DACCC, and we do the data cleaning and the analysis, and produce the reports.

Now, these are some of the accomplishments that we've made to date. We have the NOMs OMB-approved surveys for all of our programs to use. We have online data collection for HIV Cohort 6 and Meth Cohort 3, and in September we will have it for SPF/SIG Cohort 3. We have management and reporting tools so our project officers can monitor compliance with the data requirements for their portfolio of grants.

We produce analytic reports, and most of what you are going to see here can be found in the accountability report, which is looking at our data requirements by all different kinds of perspectives, by

gender, by race, by ethnicity over time. We look at trends and directions for constructs of particular interest to prevention that maybe are not tracked somewhere else over time, like perceived availability, for example.

We do annual state NOMs trends reports, and I'll show you an example of that, and we do special reports, one-shot deals, depending on what the field and/or the steering committee and CSAP thinks is important for us to do; and many, many, many ad hoc reports, and I'll give you an example of that. But it's at the request of CSAP/SAMHSA, the Department, OMB, Congress. Somebody asks for a particular analysis that we have the data to do, we will generate it. So that's how we got the data that you are going to see; not this one, though. This is just providing you with a national context. Dr. Cline said before that there is good news, we are doing pretty well over time for certain substances. We are seeing a decline, and this is from the NSDUH, showing that especially for marijuana for 12 to 17-year-olds, we are doing a great job.

So how do CSAP program outcomes compare? This is one example from the accountability report. This is something that we have recently been trying to explain to people. Prevention means stopping people from using before they start. So even though to the right side of the screen you see user decrease, much of our targeted population has

not begun using. So we want to have non-user stability, people who are in our programs continue not using by the end of the program and over time.

So this shows you how we are doing in non-user stability, and we are doing pretty well. We have gotten a little better actually over time, about 91 percent non-user stability in our programs.

User decrease is interesting. We are trying to be honest and open, and it looks like last year we did a little better than we did this past year. So is that an aberration or is it because perhaps the HIV program was missing from that analysis? We have to look further into why that decrease, but that's what the data are for.

One of the things we look at and that I like to look at a lot is are there any differences by gender. And here again we are seeing non-user stability and user decrease by gender. This is aggregated across all our programs for whom we have gotten data. I find this kind of interesting, and this is a typical result in that even though male rates tend to be higher, our programs tend to be more effective with males than with females. Why is that? Well, I think that is something our programs need to investigate. So these data can be really, really helpful.

Here is looking at our data by race, and this is not a pre/post match. This is just on exit. What we

see here is that alcohol doesn't look too great for Native Americans, and here is another thing that I've noticed, and I don't know if it's meaningful or not but I sure would like to investigate it, and that is that use at exit seems to be least often for the Asian population. This comes up frequently. Now, is there some kind of resiliency factor that we should be trying to model? I don't know, but I think it's important information.

Now, again, we are prevention, so we don't just look at use. We look at risk factors. How are we doing in reducing risk and increasing resiliency? Here is another analysis that we did by gender looking at perceived risk for particular substances, and this is again pre/post matched, and I think we are doing a pretty good job because we are talking about many hundreds or over a thousand people. So an increase of one percent means that we have touched the lives of hundreds of youth.

I was really impressed with the presentations this morning by the awardees about how their implementation of evidence-based programs had very positive outcomes. One of the things we track, one of our NOMs, is the implementation of evidence-based programs by our grantees.

This shows that about 68 percent of the programs implemented by our grantees are evidence-based. So it would be nice to be able to assume that there are a lot of

good programs being implemented out there with good outcomes.

Now, this slide troubles me, and I thought about taking it out, and I figured, no, we are all here for the same purpose, so you might as well see it. What you see here, again, is that we did better in 2005 in a number of instances than we did in 2006, and we need to look at why. Again, I think it's because we are missing the HIV data in 2006. Our HIV programs are doing really well in terms of outcomes, I have to tell you. The accountability report has outcomes aggregated the way you are seeing it, but also by program, and sometimes even by cohort.

So the concern is why did we not have a good effect in perceived risk for trying marijuana once or twice? This is something that we need to think about in our programs and use to improve it. I have a great example for you. It's a little older example, but how we can use these data to improve our programs.

A few years ago, I don't know if you remember the Family Strengthening Mentoring Program. We were not getting good outcomes and it was very troubling. So the program investigated in more detail, and what they found was that even though the cross-site showed poor outcomes, if you looked at it by dosage, there seemed to be a threshold so that the programs where the mentoring was much

more intense did great. The programs that were below that threshold of hours of mentoring did badly. So the aggregate did not look good, but we could figure out why, and in the next iteration of the RFP and we had a minimum number of hours. So that's how we can use these data to improve the program.

This is an example of our SPF/SIG outputs. As you all know, the SPF process takes a long time. So for a SPF grant, they have to go through the SPF steps at the state level, and then again at the community level before we can reach any outcomes. So we won't have any outcomes until this fall. So what we are doing is tracking outputs.

And again, if you look at the aggregate, it may not look that great. But if you look at it by cohort, we are doing great. Cohort 3 just started this past year. So they can't be doing as well as the others. So I think this is a good outcome, good output.

Another report we produce is the NOMs Trends Report. We look at the NOM for each state and we compare each NOM against the national median for that NOM, and we produce these graphs for each state, as well as explanatory tables with the actual numbers and the trends over the past three years. So each state gets this, and they can see how they are doing compared to the nation. So, for example, the state might want to look at what they are doing with

the illicit drugs because in all three NOMs they are worse than the national median. But they are doing pretty well -- I can't read from here. I believe it's the second one.

They are all on the low risk side compared to the national median. It's hard to read. I'm sorry. Tobacco. So they are doing pretty well on tobacco but not so well on illicit drugs. So maybe they might want to rethink their future efforts.

This is some data from the Drug-Free Communities. As Peggy Quigg and Jayme mentioned, this is an ONDCP program technically, but they allow us to get a copy of their data. So we are trying to figure out how to look at it. One of the things we are thinking about doing is looking at their outcomes in relationship to the SPF/SIG community outcomes once we get them. So that will be kind of interesting.

This is an example of an ad hoc report. This was requested by the advisory council in 2001. There was a concern at that time that states were not putting much effort into smoking prevention because they were making so much money off of cigarette taxes. So we were asked to do a cost/benefit ratio of the money that is spent by the states on healthcare related to smoking compared to the money that they are getting from the taxes, and we shared this with them. I don't know whatever happened to it, but

we produced the report.

Now, the rest of the slides are from a publication that is going to be coming out. It's gone through all the clearances. It's in print. It's called "The Cost/Benefit of Substance Abuse Prevention: Dollars and Cents." We are always asked about is it worthwhile spending money on prevention, and I think this really shows that it is. The data came from a variety of primary sources, Jonathan Culkin, Rick Harwood, CASA, Ted Miller, who is the primary author of this publication, actually. So this is an example of the cost to the nation of underage drinking. This is an explanation of the methodology that was used to figure out the cost/benefit of implementing substance abuse prevention programs.

The premise here was if we implement substance abuse prevention programs nationwide in the schools and we delay age of first use by two years, what would the benefit be? The bottom line is that the thinking is that we would save almost \$4,000 per pupil if we did that. What they did was they looked at a lot of the very well-known programs to see the cost/benefit per student, and it was really very interesting because the most expensive programs didn't necessarily have the best benefit/cost ratio. But this is all explained in the report. I don't want to go through all of it with you, but I'm hoping the report comes out

soon.

What else is in the report is an explanation of how you can decide which programs to select, because your community may not have a whole bunch of money. So when you figure out the cost/benefit ratio, maybe that will help you. Also, what the report does is identify which programs are most cost beneficial for tobacco versus alcohol versus other drugs. That's what the TAD stands for.

So I'm really excited about this report. I hope it comes out soon.

This is where we are going and the kinds of issues we are confronting. We don't necessarily get all the data from all the grantees, or the data are not always complete, or sometimes they don't use the items the way they should, but we have developed a feedback loop so that our contractors now work with the grantees to help improve that. We do training. We produce training materials on meeting the data requirements.

These are some of the analyses that we are thinking of doing as we move forward. So we are trying. We are at the beginning, relatively speaking, and we hope we will improve with age just like people do. That's it.

MR. ROMERO: Thank you, Beverlie.

Are there any questions?

MS. ARES: Yes. I'm sorry, but I thank you

very much. This was really a fascinating presentation.

One question I have is that on the very first slide, the Program Assessment Rating Tool, PART, it says that 50 percent of the score is based on outcomes.

DR. FALLIK: Correct.

MS. ARES: What is the other 50 percent based on?

DR. FALLIK: Program management, program design, whether it is duplicative of programs in other agencies, those kinds of things. But if you go to [expectmore.gov](http://expectmore.gov), it will show you every question that is asked.

MS. ARES: Okay. And then I saw on the accomplishments to date that you have done kind of a NOMS training of trainers.

DR. FALLIK: Yes.

MS. ARES: If we're interested, can we attend one of those trainings when they come up? I would be very interested in learning more about this as a NAC member.

MR. ROMERO: Sure. I don't see that as a problem. You just need to understand that sometimes some of the trainings are specifically targeted to data people. Some of the rest of us, and I speak for myself, may find it over our heads some of the time. But yes, if that is of interest, we can certainly connect you to some of those

sources.

MS. ARES: I see that you have staff and contractors that have been trained. So maybe we can get that outstanding trainer that was referenced earlier, if she has been trained in it too.

DR. FALLIK: We can come to whatever advisory council meeting there is and do it here.

MS. ARES: Or maybe just like a crash course, "NOMS for Dummies" or something like that.

MR. ROMERO: Sure. I like that title already.

MS. ARES: Thank you. And then I just have one last question.

MR. ROMERO: Sure.

MS. ARES: And that is that I really appreciate the accountability graphs that you showed and the whole fact that we are actually now looking at non-user stability, because for many years we had always been saying, well, you can't measure something that didn't happen. Well, yes you can. So this is really, really wonderful. When you're looking at maybe the changes that the user decreases are not happening or they are shifting and not doing what we would hope they would do, and you are trying to then figure out why so you can make adjustments to your program, I applaud all of that.

My question is does OMB and Congress and other

people who make the decisions about funding understand that these data are being used for program improvement and they're not using it to say, well, they weren't effective, let's chop them?

MR. ROMERO: Well, the obvious answer is that data plays a vital role in the decision-making. I think where the continued challenge for us and certainly the Division of Systems Development have as one of their major challenges is to be able to translate that information in a way that is meaningful to policymakers and to those who finally make decisions. Our job is to attempt to translate sometimes very, very complicated pieces of information. OMB, as you are aware, I hope by now, has really moved. This current administration has made tremendous, tremendous emphasis to performance outcomes. So OMB has taken that as a major point of focus.

So we need to continue to focus on the outcomes, but at the same time we can't lose sight of, as Bev mentioned earlier, really our work is to prevent. So to assure that our data really translates and speaks to the worth and the value of prevention activities, and the worth and value of investing money at the front end for prevention activities is extremely valuable. That is why the report on the cost/benefit analysis of prevention dollars really is something that we began a year and a half

ago. We began to work on that, and it was a conversation that I started to have because I was concerned that when we went around the country, we have wonderful information about how much it costs to provide treatment to one individual, we know exactly how much money it costs to provide mental health services to one individual. We also know from the last report that was done in 1999 the total cost of substance abuse to our society, and that happens to be \$510 billion annually.

That's a lot of money, and it takes into consideration the cost of productivity, cost of emergency care, the whole nine yards. But what we did not have was the ability to say, okay, so we know how much it costs at one end of that spectrum, but what about at the front end?

How much does it cost to invest in prevention, and ultimately how much do we save by that? So this report, the cost/benefit analysis, allows us to do that, number one. But more importantly for me, I think, and for all of us in this council, is that it affords us clear, concise bullet points that we can take to our respective folks and use the same language, speak from the same sheet of music as to why we need to continue to invest in prevention. If we don't invest at the front end, we will be paying tremendously on health care costs.

Bev did not mention this, but under her

leadership, as well as Dr. Patricia Getty, the acting division director, they took on another project that was not discussed today but that I am very proud of as well, looking at the block grant, our \$351 million block grant portion, the 20 percent that is tethered to prevention services, and how are states utilizing that money. We have that report looking at 2007 as a benchmark, and we are going to be doing that in 2008 to see what kind of changes have occurred. We will then be able to have a way of comparing. Some states, some entities are investing more in education, just a whole host of areas.

That's important for us to know. How is the nation utilizing the funds? Because the reality is that there are a number of states where the block funding is the only source of prevention dollars. So we need to make sure we are attempting to do the best we can with the limited resources that we have and that we are using evidence-based practices where we know what the outcomes are going to be at the front end.

Dr. Bev Fallik has a tremendous task before her, and I cannot think of a better person to be able to do this work because she really puts things in perspective that is stuff that is just extremely complicated and challenging in many respects.

So thank you, Bev, for your great presentation.

I'm sorry. You are popular this afternoon, Bev.

MR. GLOVER: Thank you, Dr. Fallik. I know that in your work you have considered this question, and I have waited two days to ask it, actually, because I was waiting for this presentation. By the time the data gets used, or rather attenuated, and goes through a number of services, and as you said sometimes that data is incomplete, it is being submitted inappropriately, from my perspective, and I know that the analysis yields often more questions than answers and that that is part of the process, are we measuring increased knowledge? There's a value in doing that through these evidence-based practices, obviously. My question is are we preparing adolescents to give us the right answers? How do we know that we are actually changing attitudes? How do we know that we are actually changing behavior? It's a tough question but it's one I have, if you don't mind.

DR. FALLIK: The way we know is self-report. We give them a pre-questionnaire, a post-questionnaire, a follow-up questionnaire, and it is self-report. So they could lie. The statistics that I've seen, though, show that self-report seems to do pretty well. We are certainly not testing hair and urine. That's what we have to go on. You are right, that's what we have.

MR. ROMERO: Natalie?

MS. ZAREMBA: I am so happy to hear your presentation, and it's interesting just at lunch I was saying, you know, we don't know the cost/benefit in prevention. We have heard about some of it in treatment. So this is wonderful. But how do you account for the savings? What are you looking at when you have your savings per pupil? I know your cost per pupil, but when you are going out there, what public sources do you use? Hospitalization? Car crash? I mean, what do you do? What is it?

DR. FALLIK: It is the typical costs of use. So they are looking at all the health-related use costs, the juvenile justice costs, property crime, violent crime, drunk or drug-related car injuries, the typical costs associated with it.

DR. TAFT: Is it all those things in the pie chart?

DR. FALLIK: Actually, I don't think risky sex was included in the calculations.

DR. TAFT: But it's about those kinds of things.

DR. FALLIK: Those kinds of things, right.

MS. GERINGER: I was just going to ask if you would send a copy of this report when it comes off the

press to the council members, the cost/benefit of substance abuse prevention dollars and cents. I like that title because it really is something that we can use with state legislators as well. I think it's going to be very beneficial if we could have copies of it.

MR. ROMERO: Absolutely. We will make sure that we get you not only the actual document but the executive summary that comes with it, which summarizes the entire report, which is quite long. But it is a worthwhile effort. But yes, you can certainly get that.

MS. ARES: I'm sorry. I have one last question. In the data that you have collected, this is only on the CSAP discretionary programs, so this does not include an analysis of the block grant?

DR. FALLIK: I did not include it here, but we do that separately.

MR. ROMERO: Just a point of reference. We separate our activities, the block grants from the PRNS, the Programs of Regional and National Significance. You know that the block grant is pretty much a steady amount and it does not shift, except this year it's going to be an increase for those who are high performing. But this is all focused on our PRNS primarily.

DR. FALLIK: I just would like to add to my comment there. We were PARTed by OMB. PRNS, the

discretionary, we did very well. Block grant we failed. The reason we failed is because there was no outcome data.

This was several years ago. So we went through the whole process of coming up with the NOMs and getting OMB clearance for the revised block grant application. This year the accountability report will have outcome data for the block grant. So I'm very happy about that. I just wanted you to know.

MR. ROMERO: Yes?

DR. TAFT: Following up on some questions around the table on how you are going to use this information if you can share it, will it be shared with other departments, like the information you have on school-based programs? I think that would be very interesting to the Department of Education, Safe and Drug-Free Schools Office, and some of the information on the environmental approaches might be very interesting to those who are applying for your STOP grants, because that is what they are supposed to be focusing on.

MR. ROMERO: Sure. A lot of this will be coordinated first through our Office of Communications. Certainly as it goes through our clearance process, we can begin to disseminate it. But also, because of the prevention partners that we have within the federal government, this is something that allows us to share this

kind of information, but it does require a clearance process.

I'm excited about the cost/benefit analysis report. It has been in the queue to be cleared through the process for several months, actually. But I think we are at the tail end of it at this point, from the last I heard from Mark Weber, the director of the Office of Communications, who coordinates with the Department.

But yes, it is vitally important that as many people become aware, and we will certainly have a press release about the report so that all interested parties will at least know that it is out there, and we will make sure that you all get a copy of it as well.

DR. TAFT: So you're telling me that I really shouldn't go singing the praises of this effort from the top of the hill until the process is completed?

MR. ROMERO: I would not do that right now because I do not have a final go-ahead, go to the top of the mountain and let everybody know that you had this, not yet.

Well, thank you very much, Bev.

We will now break for 10 minutes, and we will start at 3:10 p.m. sharp.

(Recess.)

MR. ROMERO: Hope, thank you very much. Safe

travels.

We will now spend the next 10 or 20 minutes opening up the floor for a roundtable discussion for NAC members. This is the opportunity to ask one another, to ask me, as well as seek input from you in terms of some of the direction that the council needs to pursue and/or CSAP needs to pursue. So I open this up to all of you at this time.

MR. SHINN: Can you put me on the agenda?

MR. ROMERO: Sure.

MR. MAESTAS: I would like to talk at some point about the intended purpose of the block grant.

MR. ROMERO: Okay. Anyone else?

MR. GRIFFITH: I have a question.

MR. ROMERO: Sure. Okay, let's see how we do with time, if time allows us to get through all of them. Let's start with Alan, with your question.

MR. SHINN: Do you want us to go about two minutes, three minutes at the most?

MR. ROMERO: Let's do three minutes, and then we will do about two to four minutes for discussions so we can try to keep this at a reasonable place.

MR. SHINN: I'll try to keep this very brief. This has to do with the recent CSAP substance-abuse HIV prevention initiative, SP08001. It has to do with

substance abuse and HIV prevention, and this can be granted to nonprofit organizations. I'm not sure if government organizations can apply. But anyway, it's what we went over in the budget initiatives that you saw.

I think my comment -- I don't think the council should do any micromanagement with CSAP staff. That is obviously not our role. However, I think the concept I am trying to get out is that I think we should make CSAP as accessible to our communities as possible. So that's where I'm going with this comment.

My take on this initiative is that this RFA excludes certain states and localities from applying because the criteria is a CDC AIDS infection rates, and you have to be over 10 percent, 10 per 100,000. What that does, obviously, is it cuts out some of the states and probably many localities where there are subpopulations or ethnic groups that are new and emerging and may have increasing HIV infection rates and not necessarily reported AIDS rates. So I think that's my concern, that we not exclude these states and localities from applying.

Normally in the past, CSAP has allowed communities, states, whatever, to self identify and to make their case, and I don't understand the change. I don't think any other center is applying the CDC HIV infection rates that I know of, and I have an example. Dennis

received -- I did discuss this with Dennis and Claudia Richards earlier in a conference call before this meeting, and I know that Guam has responded and sent Dennis an e-mail which kind of supports what I'm saying. I didn't want to just speak for Hawaii because I think that is somewhat self-serving and a conflict of interest maybe. But Guam did say exactly what I'm saying, that they are experiencing an increase in HIV infection rates, about one case every two months, and in 2007 they had seven HIV-positive cases that were identified.

There are some cultural issues, I think, involved with Guam for the Pacific Islands. While they are implementing rapid testing for HIV infection, many of them -- and this is not just atypical to Guam -- people are not coming for the confirmation testing. And I'm not an expert in HIV. I'm looking at John because I think John is much more fluid in this and he can comment after me perhaps. There is also the issue of inaccessibility of testing. There is the issue of lack of outreach to the targeted populations that are high risk, on and on. So I just made some notes.

I'm sure that this affects other places, and I'm hoping that maybe council members have examples. For example, Native American tribes, I'm sure there are some that are going to be left out because they are not in the

right state or locality to apply. And this RFP does outline that African Americans have the highest AIDS infection rates. Then it's Latinos, and then it's Native Americans. So we do have to pay attention to that.

My recommendation is that CSAP not use AIDS infection rates. Instead, HIV infection rates might be a better way, or STDs. I'm looking at John again. Maybe he has some ideas on how we can do this to open it up a little bit more and make it more inclusive, and that's basically it. That's the issue, Dennis. Thank you.

MR. ROMERO: Thank you, Alan.

We will open this up for discussion

MR. GLOVER: I just want to add, I think you highlighted some of the pitfalls of the technology, particularly the rapid testing and things like that. The only thing that you did not add, and I know that we talked about this earlier and it's on your mind, is the cultural competence piece. Places that are remote, either by geographic location or just by being rural communities, also have the added obstacle of individuals who might want to come forward and get tested and just cannot because invariably they all know each other. So they would have to end up going to somebody who they know, or knows somebody they know. So I certainly support your concern about how the data is being used to drive funding.

MS. GERINGER: Do I understand that it is an actual number rather than a percentage?

MR. ROMERO: Yes. The RFA specifically states that the funding will go to regions or potential grantees where the population of infection is 10 or above per 100,000 people. There is a logic behind that, number one, but I'm not an expert in this. But I will share with you the information that I have about it, and that is that the Centers for Disease Control has established some clear guidelines as to how to have the most impact in a community, so they have based it on this threshold.

I am not well versed in justifying or providing information as to why 10 is the cutoff point and why the population of 100,000 or more is the cutoff point for the population group. But there is evidence that CDC has received the support of many medical and scientific organizations to support these guidelines. There is a lot of merit in what Alan says, but that doesn't just apply to the Pacific jurisdictions. It also applies to rural communities where lack of access makes it difficult and from a cultural perspective where there is still a stigma around self-identifying, self-disclosing that one has contracted the HIV virus.

So I do agree that there is merit, but I will say this for the record, that at least we are making

strides from a prevention standpoint to bring attention and increase the protective factors by providing funds to address HIV, not necessarily in every locality, in every place where we would like it, but at least this is opening it up. I don't have a copy of the RFA in front of me. If I did, I would be able to tell you exactly how much, potentially how many grants we are hoping to have.

But from a prevention standpoint, this is an important piece. You need to be mindful that here we are connecting substance abuse prevention and the impact of use and the risk of HIV. So this is a major bridge that we are embarking on through this effort. Is there more work to do? Absolutely. No question about it. I have placed the question that we discussed the other day, Alan, in front of the HIV work group in SAMHSA that is spearheaded by Beverly Watts Davis to really take this into account. This is another perspective that needs to be taken into consideration as well.

MS. GERINGER: I think, as I understand what we as a council do then, if as a council we agree with what Alan has said and with his recommendation, that we as a council should go on record as supporting that recommendation so that it becomes an official part of the record and part of the council's action.

MR. ROMERO: Absolutely, absolutely.

MS. GERINGER: So I don't know if you want to do it by motion or by acclamation.

MR. ROMERO: We would need to do it by motion at this point. So those in support of Alan Shinn's proposal, please show your approval by a show of hands.

(Show of hands.)

MR. ROMERO: By unanimous consent, it is approved as your recommendation, and we will take that and move that forward. Thank you.

Karel, you are next.

MS. ARES: Thank you. Totally unrelated to the previous item, one of the things that struck me during the presentations this morning, one of the common threads that seemed to be presented by our award recipients was the need for ongoing training and supervision to ensure that evidence-based programs are implemented with fidelity and can be sustained over time. One of the things that I don't see or I don't understand where it fits in the big picture is the dedication to providing cost-effective training to the workforce in what works and what doesn't.

We are struggling in Illinois with the constant turnover rate, as well as the need to reach a lot of providers and provide training when we are spread out all over the place. Illinois is a large state. So we are looking to the increased use of technology, online

training, more blended learning approaches, to help provide that training and technical assistance to folks so that they do implement these programs and strategies with fidelity and get the support they need over time in order to do that.

There is also a really, really fascinating article that I came across called "Digital Natives and Digital Immigrants." It basically talks about the fact that our young people and our future workforce are far more technologically savvy than we are. They even learn differently now because of their access to digital technology that didn't exist when we were born. So I feel like if we are really looking to the future and making sure that we have a prepared workforce, as well as looking to how youth get the information that they need, that we need to really start looking at how can we incorporate more technology into our workforce development practices, and even into some of our prevention program development. In my view, we're looking at trying to create management systems online, web-based instruction, a means of also addressing the travel costs for our providers and whatnot.

I understand that this will never take the place of face-to-face classroom-based instruction, particularly for some things. You can't learn interpersonal skills through an online course or get the rich feedback sometimes you can

get from a focus group. But we have to be more blended in our approaches working with our current workforce, working with our future workforce, and working with the young people who learn that way.

It's kind of like trying to change the wheel on a car while it's moving. It's kind of tough. I've never experienced that directly myself, don't care to, but I do think that it might be useful to help states or even the CAPTs. How do we look at building a technological infrastructure that can support prevention efforts as well as prevention workforce development needs? Maybe a little incentive, some seed money to help people invest in these online systems to get the ball rolling while we are still trying to provide training through traditional approaches. Thank you.

MR. ROMERO: Thank you, Karel.

Comments from the group?

MR. MAESTAS: I have a comment. Certainly, data systems are a big concern, I think probably across the country. In New Mexico, we used to use a minimum data set. We used it for several years with some limited success, and finally we had to move forward and develop our own data system, which certainly is very costly and continues to be costly. But certainly, it's very important to the work that we do to be able to have an online data system that

responds to the needs of the folks in communities. So certainly that's an area that needs to be addressed by CSAP to see how we can continue to improve those data systems.

MS. ZAREMBA: I just have a comment about that.

I think you hit on something that is very important. As we talked yesterday about the aging workforce and the fact that we are bringing in and will be bringing in more and more young people who are technologically savvy, primarily they are going to go where they have the opportunity to use some of that technology. I think it's really a workforce issue also, because they have learned to work that way. They are used to having the equipment around them, and if we as an area are not able to supply that to them, they are going to be looking elsewhere. It's part of a sophistication and it's part of a culture.

But I think for CSAP and SAMHSA, it's going to be a very important thing to look at this culture change for young people who are using technology just as a matter of course, and it also can be, fortunately, programmatically very powerful, certainly around online trainings. If CSAP have some dollars to look at how to do online trainings -- once again, it puts me in my age and place, but there were years when people would not use it, when we really were trying to get people to become more technologically savvy and we couldn't use online trainings

because people wouldn't use them. Today, we've got another population, and I think we can't miss the boat. I think it's a very good suggestion.

MR. ROMERO: Any other comments? I know we have one comment from a staff member. This is Bob Stephenson, the director of the Division of Workplace Programs.

MR. STEPHENSON: Hi. I'm just itching to get in here because you reached out and grabbed one of our sentinel program areas. It isn't so much just about prevention workforce training. It's about training for young people and for use of online systems. You have two documents that we have given to you. One is a print kit of a workplace kit for employers. The second is linked to that, which is the online version of that, which is available through the Internet and through our website as a constantly updatable version of that same process. It has tools in there to help employers address not only the issues of setting up comprehensive programs with much more of a health and wellness focus to them than some of the older systems that we had espoused years ago.

But the focus is on young people, and one of the things that we had with the grants program and with the purple-covered analytic document that you also got is an incredibly powerful set of statistics, tables, and analyses

that look at our workforce in terms of its aging, in terms of its composition by industry niche, and by incidence and prevalence. What we see consistently is that in some specific industry groups, there is a very high incidence and prevalence of substance use and binge alcohol use. But more importantly, across the board it's young people.

There is another bookend to that, though, and that is that some of us are aging, and only some of us --

(Laughter.)

MR. STEPHENSON: And as you get older, we are also seeing an increased incidence and prevalence of those over the age of 60. When you put all of these people back into a workforce, either the one today or the one that you are likely to see coming into force in the next two or three years, it's really important to us. So we focused on that, and we have given you these two documents to take home with you as a starting point to help you maybe become ambassadors of outreach to people in your local business community and your educators and the folks in your universities and junior-college areas to say, hey, these are all important issues, and here are some tools that are available.

We hope to get OAS, our Office of Applied Studies, to redo this based on the NSDUH analysis of data in future years. So please take it back and if you have

any information that you want to pass to us or any questions, I hope you will all know how to get hold of me, and I will follow-up with you or my staff will. Okay?

MR. ROMERO: Thank you, Bob. Certainly, the point of contact through Tia, Tia can certainly direct or funnel any questions or inquiries to Bob Stephenson. I should say that Bob and his staff have done a tremendous amount of work in the area of workplace, and specifically not only -- he's got a very technical component of his responsibilities in terms of the lab certifications, but in terms of workplace activities and having an emphasis and focus on the younger population entering the workforce and the impact of this unique setting. Really, there have been tremendous advances because of not only Bob but his staff. Deborah Galvin is also here. Could you just stand up for a second, Deborah? Deborah is also on his staff, who has worked very hard in this area as well.

If I could just stop the process for just one second and make sure that we are following the right procedure. Irene, I would like to ask you if you wouldn't mind if you could just repeat so that we understand and that we all are in agreement on what are the two comments that have been made from the council and what we will pursue.

MS. GOLDSTEIN: If you don't mind, if you could

direct the questions to the original staters of the --

MR. ROMERO: Sure. Absolutely. Let's start with Alan. If you could please restate your comment in the most succinct manner possible.

MS. HAYNES: You can state it, and then what we can do is have Irene state it back so that it is just an accurate reflection of what you all as a council are trying to move forward as a recommendation.

MR. SHINN: I think specifically I was talking about our substance abuse HIV initiative and that in future RFAs, that CSAP explore or look at other ways of setting criteria for applicants for CDC AIDS infection rates in order to be more inclusive with our communities.

MR. ROMERO: Thank you, Alan.

Irene, can you -- I should give you a chance to finish typing.

MS. GERINGER: Alan, one of the words you used before was "exclusion," that some of our communities are being excluded, and that really struck me because it seems to me that one of our charges is to reach out to all communities.

MR. ROMERO: Sharyn, that's a good point.

MR. SHINN: Do you want to amend that, Sharyn? You can amend that.

MS. GOLDSTEIN: Shall I read back what I have?

MR. ROMERO: Please.

MS. GOLDSTEIN: The council recommends that regarding the substance abuse HIV initiative, in future RFAs CSAP should explore other ways of setting criteria for applicants than the CDC AIDS infection rates in order to be more inclusive of communities.

MR. ROMERO: Is the council comfortable with that language? Okay. Wonderful.

We'll go to the second comment. Karel, if you could just restate your comment, please, again in a succinct manner.

MS. ARES: It's a tall order. I'll do my best. I guess my recommendation is that CSAP would start looking at how technology online learning systems can be supported and used for current and future prevention workforce, as well as for young people who learn through this medium.

MR. ROMERO: Thank you.

MS. GOLDSTEIN: Got it.

MR. ROMERO: Can you please repeat that?

MS. GOLDSTEIN: CSAP should start looking at how technology online learning systems can be supported and used for current and future prevention workforce, as well as for young people who learn through this medium.

MR. ROMERO: Are we comfortable with that language?

MS. ARES: I can't make it any more succinct than that.

MR. ROMERO: That's wonderful. Okay. Fantastic.

Don, you're next.

MR. MAESTAS: Thank you. Just a couple of things regarding the block grant. For many years now the block grant, the minimum to be spent on the block grant is 20 percent on prevention. I think it's time that we recommend that it be moved up to at least 25 percent. I would like 50 percent, but that's probably unrealistic. But at some point, I mean, I think it's time to have that discussion. I don't know, Dennis, have any discussions been had in the recent past about that issue or not? But the block grant is critical to many of the states. As was stated earlier, for many of the states, that is their primary funding source for prevention. So it's really critical that the states that do have it are using it for that or for others that they really understand too the states -- and maybe this goes through CSAP, that part of the purpose in my mind of the block grant is to develop and maintain the prevention infrastructure within those states, which includes all the major components of the SPF grant. There has to be a strong assessment component that takes into consideration the school surveys, the data, et cetera.

There has to be a strong capacity building component.

Certainly workforce development, as was stated earlier, is one of the key foundations of the work that we do. We have to continuously build capacity within our states to do the prevention work. Certainly it was mentioned by Alan, I think, regarding staff turnover. So it becomes ever more critical that we have a strong continuous workforce development system in place. And then certainly planning is critical to what happens within the state, and then also as we convey to the federal government what we are doing with those resources or plan to do with the resources, and of course implementation and evaluation.

So those are kind of the comments I wanted to make regarding the block grant. Thank you.

MS. ARES: I would like to just make one addition to that, if I may. I think Don also raises an issue that came to my mind earlier, especially when we are looking at NOMs and GPRA and PART and all of that stuff. I hope that people understand that there are some things that are not going to be able to be tied to an outcome, like decreased use, 30-day use. The assessment work, the evaluation work, the workforce development work are integral and very important parts of a prevention system that may not tie directly to whether or not a student saw an increased knowledge of the harmful consequences of

alcohol.

So as these measures and outcomes are used to assess funding, I hope that they are going to keep in mind that you have to fund other parts of the system that may not be directly tied to an outcome.

MR. ROMERO: Comments from the council?

MR. SHINN: Dennis, on the block grant issue, I want to support what Don said. Can we call up -- Alan Moghul is in -- can we call up Alan? I did check on this.

I think it was Mike Lowry's shop that I called and asked about the block grants and how many states actually overmatch or use more than 20 percent for their prevention funds, and I was told that there were quite a few. But maybe Alan has some comments on that. Is that all right?

MR. ROMERO: If we could hold off on that until we open up the meeting to the public.

MR. SHINN: Okay.

MR. ROMERO: I do apologize, but we need to make sure that we are following our process here.

MR. SHINN: Sorry about that, Alan.

MR. ROMERO: I do have a comment. But before I make my comment, I want to make sure that Irene has captured Don's point.

MS. GOLDSTEIN: The council recommends that CSAP consider raising the minimum funds allocated under the

block grant to 25 percent.

MS. HAYNES: If it's not accurate, this is the time to have a conversation to ensure that what goes down is what you really want to move forward.

MR. MAESTAS: That's what I was saying. The only part that I would wonder about, she started out by saying the council recommends, and I just wanted to bring it up for discussion. I would hope the council would recommend that.

MR. ROMERO: Right. We would need to ensure that there is consensus from the council. The language as written, Irene, is pending the board's unanimous consent to this statement.

By a show of hands, could you please vote as to your approval of Don's comment?

MR. GLOVER: Could she read it again? Please, because I got a little lost there for a second.

MS. GOLDSTEIN: Honestly, I'm going to rely on the transcript. But the council recommends that the block grant minimum funds for prevention be increased from 20 percent to 25 percent.

MS. ZAREMBA: Just a comment. I didn't hear you have a specific amount that you wanted it raised by.

MR. MAESTAS: Well, I was hoping 50, but I think 25 is what I said.

(Laughter.)

MR. ROMERO: Okay. By a show of hands, those in favor of Don's request?

(Show of hands.)

MR. ROMERO: For the record, the entire council approves the motion made by Don Maestas.

The comment that I would like to make for the record is that the block grant, as you know, is a Congressional directive, and historically the block grant came into existence during the Reagan administration as a way to ensure that there would be funds clearly set aside to address particular issues. We have a mental health block grant. We have a substance-abuse block grant. Within the substance-abuse block grant, 20 percent of it is set aside for prevention activities. This year OMB and certainly Congress has been wanting to see an increase in performance. So there is an incentive, and I don't know the exact numbers or the figures, but there is an incentive for those states that show an increased performance rate to have an increase in their funds. So that is a step forward.

I want to remind you that the comments that you are voting on right now are recommendations. You are advising CSAP to present to its leadership the position of the council, and certainly we will take that and you will

see that in the official transcripts as well.

Yes, Irene?

MS. GOLDSTEIN: Did the council want to take action on the technology recommendation comment?

MR. ROMERO: We did, I believe. I'm sorry. We did not.

MS. ARES: I just restated.

MR. ROMERO: I am sorry. My apologies. Can you please restate Karel's position? This is a chance to show your skills, Irene.

MS. GOLDSTEIN: I'm daunted. CSAP should start looking at how technology online learning systems can be supported and used for current and future prevention workforce, as well as young people who learn through this medium.

MR. ROMERO: Irene, are you comfortable with that statement? Okay.

By a show of hands again, please express your agreement to the statement made by Karel.

(Show of hands.)

MR. GLOVER: I'm not sure what action we are taking here.

MR. ROMERO: Well, you are approving as a council a comment to be moved forward, in this case as a recommendation, in this case one made by Karel Ares, on the

importance of paying attention and emphasis on the utilization of technology tools to support not only our workforce but also to ensure that there is dissemination of information in a way that captures the unique workforce that exists or the workforce that is entering into the system. Wow, I said that.

MR. GLOVER: I certainly appreciate and understand your concern, but I thought Bob had addressed that issue with the materials and the resources he gave us. So are we saying that we want something over and above, not having looked at this?

MS. ARES: That's not the same thing.

MR. GLOVER: Okay.

MS. ARES: (Inaudible.)

MR. GLOVER: It's that time of day.

MS. ARES: That was certainly an informative piece but not my point. So I think it's great that we have those kinds of workforce prevention programs available online and in print, but I guess my point was that we have to be prepared for young people in a future workforce who learn and work through a technology that is currently relatively new and emerging. For many of us who are prevention trainers and workforce development folks, we do not have the infrastructure in place to support that. We need that. I think that separate from the resources that

were referenced earlier. It's really a broader issue than that, and maybe it's a strategic plan, maybe it's an assessment. I mean, if there was anything I could say that comes out of it in concrete terms, maybe we begin by following the Strategic Prevention Framework process and doing an assessment of the current and future workforce needs and how kids learn.

I mean, I don't want to be lengthy because I know we are pressed for time, but there was even a report on NPR that the kids' use of technology now is changing the way that they learn. It's actually wiring their brains in different ways than our brains work. If we are going to reach these kids and we are going to engage them to become prevention workers down the line, we have to look at this technology and put an infrastructure in place that reaches them and maybe even encourages them to join us in our work.

MS. ZAREMBA: Can I add one comment to that?

MR. ROMERO: We will add one more comment and then we will need to move on.

MS. ZAREMBA: Only that I want to make sure in that that you are talking about two things. One is the infrastructure, having a technological infrastructure. The other is that you need it as to tools now, in the future. It is also a tool for the workforce. So it is not just the infrastructure but it's the online training.

MS. GERINGER: So will the word "infrastructure" then be inserted into what we are voting on? Because that really clarified for me what you were saying.

MR. ROMERO: It will now.

Irene, can you --

MS. GOLDSTEIN: Can I come back to this in a minute?

MR. ROMERO: Sure. Absolutely.

Dennis, if you can do this in a succinct manner so we can move forward, because I would like to afford the public the opportunity to also, for the record, ask questions of the council and/or make comments to the council.

MR. GRIFFITH: No problem. I have a question about future meetings, or maybe even past meetings. Do you or Anna or the Administrator have any kind of topics that you would like this group to address? Has that been your custom in the past or does it interest you in the future?

MR. ROMERO: As I see it, the council is afforded the opportunity prior to the meeting to submit any topics that they would like to address at this forum during the open or roundtable discussions. But if there is a particular theme that you would like to have more focused on -- the date, for example -- that is certainly open to

explore. My only intent is that it becomes the most fruitful opportunity for the council. You come here, many of you from very difficult and distant places, and the last thing I would want for your experience to be is another meeting. I want to make sure that you are not only getting as much information from us but that you are also being fully utilized, and that is why we have the kind of meeting that we had today where you were given a lot of information not only from CSAT but from the rest of SAMHSA, so that you can begin to internalize that information and see how best to utilize it.

What if there is something that you would like to have an emphasis on, a couple of years ago we had a particular emphasis on having community providers who had been recipients of our funding talk about their successes and/or their challenges, and that was very fruitful at one point. So it is open to your desires and your interests. I would welcome the opportunity to add pieces or themes.

MR. GRIFFITH: My question mainly had to do with do you or does Anna or the Administrator, Terry Cline, have any topics? I guess if you do, you will bring them up. So if there are issues that you guys are dealing with or want to comment on, or even alerting us to what those questions or topics might be prior to a meeting, we might come better prepared to assist you in the decisions you are

making and the items that are on your plate.

MR. ROMERO: Sure. Point of clarification. The center director is the chairperson of the council in this case, in CSAP. That does not apply necessarily with all the other councils. So if there are particular items that SAMHSA, the Administrator, the director would like to have available, we would certainly provide that to you beforehand as well. But it is a two-way street.

Any comments?

(No response.)

MR. ROMERO: Irene, can you repeat Karel's comments, please?

MS. GOLDSTEIN: Yes. This is also subject to editing, of course. The council recommends that CSAP consider development and support for an infrastructure for new technologies for online learning systems to be used by the current and future prevention workforce, as well as to engage young people who learn through these new technologies.

MR. ROMERO: Is everyone comfortable? By a show of hands, those in agreement please raise your hand.

(Show of hands.)

MR. ROMERO: Once again, there is consensus on this point. Thank you, Irene.

We will provide all of you with a response on

the measures that were set forth during the roundtable discussion.

Okay. At this point I would like to open the discussions to the floor for a public comment, both to ask questions of the council or of the center.

Please, Alan, if you could just identify yourself.

DR. MOGHUL: Hello. I bring you friendly greetings from the National Prevention Network. My name is Alan Moghul. I am with NASADAD and the National Prevention Network. It is on their behalf that I would like to offer a few comments, a little bit of feedback on some of the topics that were discussed today.

Number one is the issue of the Community Prevention Day that Peggy Quigg presented earlier. First, on behalf of the NPN members, I really would like to offer our heartfelt thank you to Dennis and to Anna and to the whole agency for making travel support available for about 20 or so of the members to attend the Community Prevention Day. I would like to say that this is no small matter.

State government, unlike the federal government, is not allowed to go into deficit spending. And as the national economy starts to slide downhill yet again, state governments often have to cut a lot of things, and one of the first things that gets cut is travel of

state employees. So whenever we can identify an alternative funding source to get people to come into town or wherever to conduct this business of National Prevention Day and to do some of this great work, getting the bodies there is very, very important. So I would like to say thank you for making that happen. We hope that we can continue to allow that to happen given our funding challenges.

The other thing, too, on the same topic is that we would like to have more of a substantive involvement of some of our NPN representatives in formulating future Community Prevention Days. Since we are making this bridge now between the community programs and the state people in prevention, it would be perhaps very beneficial to allow more working of the NPN members together as we construct perhaps next year's Community Prevention Day.

On the issue of data, which Bev talked about earlier, just to say that we continue to work very passionately with you all as we work on the National Outcome Measures, the NOMs. There is certainly more work to do, and we will continue to do that with you. So we certainly do support your efforts in that.

Issues regarding workforce. Again, on behalf of the members, I would like to convey thanks to two apparently quite successful programs right now. Number one

is the Prevention Leadership Academy, which is geared toward my constituency, toward the NPN members, basically helping them with their workforce development and their professional development activities. I don't think Mary Joyce Pruden of your staff is in the room, but she has been the key point person on this project. This year I believe will mark the fourth iteration of this program. It is very good. It brings all the NPN members from all the states and the territories together, and as I said, it does embellish their professional development activities and has been quite a very beneficial program and has helped that organization really gain stature and become more of a professional organization.

The other great workforce development activity that I would like to add is the current Fellows Training Program. I think I saw Dan Bailey here earlier. This is a mentoring program geared to bring younger people into the prevention field in state government and, in fact, at our offices too. I am a mentor to a young lady who was a Master's candidate at George Washington University. She is entering her third year. So this has been also a very beneficial program, and we hope that that can continue.

Lastly, to Alan Shinn's question and the great discussion about increasing the set aside for the block grant, 50 percent might be a good target to hit, but we've

got to deal with reality here. But to the best of my knowledge, about 20 to 25 of those jurisdictions who receive the substance-abuse block grant actually add their own state funding from state resources to that 20 percent set aside. Typically, those will be your big population states such as New York State, California, Texas, Florida and so on, where they have a broad enough tax base to supplement the federal block grant. But many of those states are the low population states, the rural, the frontier states where it is only the federal set aside that can support their prevention infrastructure. So thank you very much.

MR. ROMERO: Thank you, Alan.

Any comments from the council?

MR. SHINN: So Alan, would NASADAD support our recommendation?

DR. MOGHUL: It's a little too early to say. But let's continue the discussion.

MR. ROMERO: Are there any other comments from the public?

(No response.)

MR. ROMERO: If there aren't any, I do have some final and closing comments. But prior to me making my final comments for the day, I would like to acknowledge National Advisory Council members who are stepping down

from their posts as members of this body: Jay DeWispelaere, who was not able to attend because of conflict with meetings with his board in particular; and Sharyn, who today would be her last official meeting with NAC and with CSAP. I would like to extend a heartfelt thank you for the record and publicly thank two great board members. I've had the privilege to work with both of them in different capacities, and certainly your dedication, your commitment is something that I know will continue beyond your time here in CSAP and in the NAC. So I want to extend a sincere thank you on behalf of the Center for Substance Abuse Prevention, but also on behalf of SAMHSA for the great work and your contributions and your dedication to truly ultimately address the needs of the disadvantaged and the voiceless, and that is ultimately what we were all here about.

So, Sharyn, thank you very much. Also, as a token of our appreciation, we have a plaque that will go out to Jay DeWispelaere, and I have a plaque for Sharyn here. Sharyn, if you could come up for a second.

(Applause.)

MR. ROMERO: Sharyn, allow me to read what plaque will read here. It says, "With appreciation for your outstanding tenure on the Substance Abuse and Mental Health Services Administration Center for Substance Abuse

Prevention, National Advisory Council, and gratitude for your tireless support, advice and insights to the benefit of SAMHSA, the United States Department of Health and Human Services, and the people that we serve. March 28, Dr. Terry Cline."

MS. GERINGER: Thank you very much.

(Applause.)

MR. ROMERO: I have asked Sharyn to make some final comments.

MS. GERINGER: Just to say thank you for the opportunity. I did a lot of work in the state, but I didn't have nearly the appreciation for what the federal government does as I do now, having spent this time with you, and I do appreciate you and all of the staff of CSAP and of SAMHSA for your tireless efforts on behalf of all of us out in the states who are on the ground and doing that work. We couldn't do it without you. So thank you.

MR. ROMERO: Thank you. Thank you very much.

As we close the council meeting, I just would like to just reflect briefly on what we are about and why you are here. You had the opportunity, those of you who were new to the council, you had the opportunity to hear yesterday what your role is, and your role is very clear. It's defined by law, and it comes with some clear privileges, and some clear parameters. It's been said that

you reap what you sow. And you sow what you reap. So to that end, there have been some very fruitful discussions in my opinion, and without singling people out, Karel, you are one who I hope will continue to voice and push the envelope, because this is how we make things happen. We can get stuck on the data, we can get stuck on the graphs and the bar graphs and the projections and 30-day, 60-day, 2-year and 5-year use and where we are. We are ultimately working to help people. You as council members are working to help and alleviate the suffering of people, and that's what we are all ultimately here about. So we will have and we should have disagreements. We should have differences of opinion. But as long as we are all clear as to where we are starting from and we have the same goal in mind.

It is with that that I thank you for your participation, I thank you for your involvement, and I thank you for your dedication to really raising your talent and your expertise and your voice to an issue that does not get, in my opinion, the level of prominence that it should get, and we need to collectively continue to do that. You in your respective roles and responsibilities have that opportunity. You now have, again, the opportunity to wear two hats. Make sure you know which hat you are wearing when you are saying what.

We are running out of time. I had something

that I was going to say, but I will not say it because we are running out of time. My point that I was thinking of making is what I said at the CADCA Forum. We had on the second or third day of the CADCA Forum the opportunity for the federal partners, which is the leaders of the different federal agencies who coordinate or work on the issue of prevention, to speak. We had the Department of Justice, the Office of the National Drug Control Policy, Department of Education and myself up on the stage to speak, and when I spoke I thanked the audience. I thanked them for their dedication and for what they do day in and day out.

The salary is not great, the recognition is not great, but that's not why you are here. But that does not mean that we should not work toward compensating you for what you do, and that is a piece that we need to be mindful of. Data is important, and we need to be able to continue to document the good work that we do, number one, but make sure that that information goes to the right place, to the place where it does make a difference, where it does matter, because when we send the good information to the wrong place, it just sits there, and you know this already.

The analogy that I use or the joke that I use is this lady is returning from a funeral service where her husband, a minister, had just passed away. After that, she went home feeling sad for her loss, sat down at the

computer and decided to check her e-mails to see whether or not -- just to see who sent her some nice comments of sympathy. So when she read her e-mail, her first e-mail, she screamed and fainted. Her son, who was in the house, ran upstairs to her room and realized that his mom was on the floor, went over to make sure that she was okay, and then he turned his head and realized that there was something on the screen. So he went over to the screen and began to read the e-mail.

The e-mail began with, "I have arrived." Just at the same time that this is happening, there was a gentleman in Florida who had just arrived in preparation for his 50th wedding anniversary. There was a travel mix-up, the husband and wife who were supposed to go down to Florida to celebrate their 50th anniversary. The husband arrived first. The wife was supposed to arrive second. They went to the same hotel where they had spent their first wedding anniversary. When the gentleman got to the hotel, he realized that the rooms, everything was the same as it was 50 years ago, with one difference, and that was that there was a computer in his room, and there was a complementary opportunity to send e-mails from your room. So he sent an e-mail to his wife, except that when he was writing the e-mail, the address, you misspelled the e-mail by one letter. So it went not to his wife but to a wrong

address. It went to this lady in Houston who had just come back home.

In reading that e-mail, this lady who was now a widow, the e-mail began with, "I have arrived." And it said, "My dearest love, just wanted to let you know that my trip was uneventful, and I have also learned that all the arrangements have been made for your arrival tomorrow."

(Laughter.)

MR. ROMERO: "Because I don't know how much this might cost me, I will not write too much. But you should know that they have computers here, and they do allow us to send out e-mails. Your loving husband. Can't wait to see you tomorrow. P.S. By the way, it's very hot down here."

(Laughter.)

MR. ROMERO: Thank you very much, everyone. We will officially end this council meeting.

(Whereupon, at 4:18 p.m., the meeting was adjourned.)