

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR SUBSTANCE ABUSE PREVENTION NATIONAL ADVISORY COUNCIL

Minutes
Tuesday, February 14, 2006

801 H. Street N.W.
Washington, D.C. 20001

Call to order of the Open Meeting

The Center for Substance Abuse Prevention (CSAP) National Advisory Council convened on February 14, 2006, at the Washington, D.C. Convention Center. The meeting was chaired by Richard T. Kopanda, M.A., Acting Director, CSAP.

Council members present: Don Coyhis, Paul J. DeWispelaere, Sharyn Geringer, Henry C. Lozano, Sue Rusche, Mitchell E. Sahn, Alan Shinn, and Judith Tellerman, Ph.D.

Council members absent: Karen Allen, R.N., Ph.D., FAAN, Sylvia Rodriguez Andrew, Ph.D., J.D., G. Douglas Bevelacqua, and the Rev. Marcus W. Harvey

Committee management specialist: Tia Haynes

Welcome

Mr. Kopanda welcomed participants and new CSAP Deputy Director Dennis O. Romero, and members of the CSAP Council introduced themselves.

Minutes

Council members unanimously approved the minutes of the August 16-17, 2005, meeting as presented.

Director's Report

Richard T. Kopanda, M.A., Acting Director, CSAP, presented an overview of CSAP's recent activities. Mr. Kopanda noted that the Council meeting was held in conjunction with a conference sponsored by Community Anti-Drug Coalitions of America (CADCA).

Mr. Kopanda stated that Congress passed the FY 2006 appropriation with slightly reduced funds from FY 2005. Program announcements have or were to be issued soon for the Strategic Prevention Framework (SPF) State Incentive Grant (SIG), Drug-Free Communities' (DFC) support and mentoring programs, conference grants, and a new methamphetamine initiative. No funding is available for additional employees (FTEs), but few CSAP employees have retired. Mr. Kopanda noted that the president's FY 2007 budget calls for a \$12 million reduction in discretionary funds, but no reduction in the block grant or FTEs. Reduction in CSAP's discretionary portfolio would occur primarily in the SPF SIG; CSAP has no plans to eliminate ongoing grants in any area in FY 2006, with funding cuts accommodated through slight reductions in funds to current grantees. CSAP has proposed no reductions for FY 2007 in such programs as methamphetamine, CAPTs, or HIV/AIDS.

A proposed format for FY 2007 for CSAT's treatment voucher program, Access to Recovery (ATR), would allocate most of the \$70+ million funding to a voluntary incentive program to leverage block grant dollars for states that offer vouchers for part or all of their substance abuse treatment. Up to 30 percent of the three-year VIP program's cost could fund development of infrastructure for a treatment voucher system. As part of ATR, \$25 million would fund a separate methamphetamine voucher program. Mr. Kopanda noted that significant changes also will be made in the 2007 mental health block grant in moving forward mental health transformation.

Eight National Outcome Measures (NOMs) have been approved for use by CSAP, one of which includes use of cost bands in CSAP's programs. An online NOMs reporting system is expected to be operational by May 2006. Mr. Kopanda also noted that CSAP is working on new drug testing guidelines.

Discussion

Ms. Rusche observed that the ATR concept would offer an incentive for systems change. She suggested that Council members advocate for no funding cuts for CSAP. In response to a question from Mr. DeWispelaere, Mr. Kopanda responded that approximately 40 states will have SPF SIGs by year-end, depending on how many tribes also are funded. Mr. Sahn observed that universal and indicated programs should be measured using different parameters.

SAMHSA Administrator's Report

Charles G. Curie, M.A., A.C.S.W., Administrator, Substance Abuse and Mental Health Services Administration, stated that at the end of Mr. Kopanda's tenure as acting director, Mr. Romero will step into that role; Rose Kitrell will serve as acting deputy director; and Peggy Quigg will serve as acting director, Division of State and Community Assistance. Mr. Curie noted that former CSAP director Beverly Watts Davis now serves as his senior advisor on substance abuse prevention.

Mr. Curie asserted that substance abuse prevention is coming more into its own as stakeholders make the case that prevention works and with the advent of the SPF. Based on science, transparency, empowering community leaders, and leveraging dollars, the SPF equips states and communities to make the right investment decisions regarding effective prevention efforts. SPF enables setting baselines to demonstrate progress when communities bring resources together, form leadership committees, assess community protective and risk factors, and decide which program to implement to address both types of factors. Over time it is expected that communities will reach out and engage diverse resources, enlisting such community organizations as CADCA drug coalitions, United Way agencies, Scouts, faith-based organizations, and juvenile justice.

Under Department of Health and Human Services (HHS) directions, SPF SIG plans must address underage drinking in every community. Since FY 2001, SAMHSA has awarded SPF SIG grants to 26 states, totaling \$288 million; the goal by the end of FY 2006 is 40 states and all states by 2010. Mr. Curie stated that the success of the framework depends on the ongoing work of grassroots community coalitions and building on existing infrastructure and commitment. SAMHSA will continue to work with ONDCP to support DFC grantees.

Mr. Curie announced updates to the SAMHSA Matrix (www.samhsa.gov/Matrix/Matrix_Brochure_2006.pdf):

- Disaster response and readiness, formerly a priority program, has now become a cross-cutting principle. Mr. Curie noted that the Hurricane Katrina response revealed the need to attend more to continuity of care of persons with serious mental illness, addictions, and severe emotional disturbance, including SAMHSA's special populations.
- Suicide prevention has been added as a programmatic priority. With 30,000 annual reported suicides in the U.S.—an acknowledged underestimate—compared to 18,000 homicides, SAMHSA believes that governments should put forth at least as much effort in addressing suicide as homicide. Emphasis will be reflected in additional federal funding, formal launch of the National Suicide Prevention Strategy, partnership activities with states, and ties to the mental health systems transformation agenda.
- Workforce development has moved from cross-cutting principle to programmatic priority, with a commitment to developing a workforce plan that will focus in a multidimensional way on recruitment, incentives to work in underserved areas, and cultural competence. Work to date has produced considerable data, and models have been identified for evaluation to bring this priority to the systems level. Additional activities include looking at degree programs, working with community colleges to do training, and addressing retention as well as recruitment.

The 2 percent reduction in the president's proposed FY 2007 budget will call for difficult choices in spending cuts. SAMHSA's \$3.3 billion appropriation represents a net increase of \$67 million from FY 2006. SAMHSA typically avoids cutting grants in mid-term and reallocates funds from grants coming to a natural end. In FY 2007, SPF SIG funds will be realigned to include no new grants, but \$95.3 million to support continuation grants and contracts. For CSAP's programs of Regional and National Significance, almost \$181 million will support 344 grants and contracts, including 335 continuations and nine new competing grants. CSAP will continue to manage 20 percent of the prevention set-aside of the Substance Abuse Prevention and Treatment block grants; the FY 2006 set-aside totals \$352 million.

Mr. Curie highlighted the Access to Recovery (ATR) program, about which he expects first-year data to reveal a great deal. A presidential initiative in its third year of funding, many positive stories are emerging from ATR's 14 states and one tribal organization. SAMHSA has worked with states to fine tune their efforts. ATR focuses on expanding the provider base, including recovery support services, which include services to begin employment, keep jobs, and connect to communities. ATR has helped to expand faith-based providers and clinical treatment services. The FY 2007 ATR program incorporates an incentive to states to consider using block grant monies for choice and vouchers. Non-ATR states that elect to use the lesser of at least 20 percent of their block grant or \$20 million for vouchers would receive extra points in the scoring of their applications and also could use funds for infrastructure. ATR states and tribal organizations also can apply for these funds. SAMHSA has begun dialogues with states.

Discussion

In response to Mr. DeWispelaere's question, Mr. Curie stated that a hiring freeze has impeded staffing at appropriate levels, but an updated plan will be implemented when the freeze is lifted. SAMHSA and CSAP staff have focused increasingly on DFC grantees and continue the

commitment. Mr. DeWispelaere observed that DFC ties SAMHSA/CSAP to the grassroots movement, which has enhanced the agencies' image, and urged enhancing that relationship. Mr. Shinn noted Hawaii's problems with ice and crystal methamphetamine. He also questioned the rationale for cutting short ecstasy grants, which many grantees felt provided a platform to address emerging drugs and test a single-drug strategy. Mr. Curie responded that concerns that drove the decision were a difficult budget environment and changes in the data on the problem.

Mr. Curie responded to Ms. Geringer that the Secretary has embraced the issue of underage drinking; a national conference brought states together, rolled out public service announcements (PSAs), and announced the Surgeon General's Call to Action; and communities are conducting town meetings. SAMHSA has set aside funds for the initiative; other agencies have contributed funds; and some SFP funds are earmarked for underage drinking. He identified the need for advocacy for additional funds and anticipates support from other partners.

Dr. Tellerman explained that in the process of developing a suicide prevention program for Illinois, the inadvisability became apparent of using the term "suicide" with children and adolescents because of the associated stigma. The program used the construct of "a continuum of self-destructive behaviors," including substance abuse and, at the end of the continuum, suicide. Intervening at any point on the continuum also prevents suicide. Mr. Curie concurred with the need to address the stigma issue and to think about terminology.

Preventing Underage Alcohol Use: A National Meeting of the State

Stephen G. Wing, M.S.W., Associate Administrator for Alcohol Policy, SAMHSA, presented nationally broadcast PSAs on underage drinking, winners of the Ad Council's Best PSA Award, and introducing a new interagency website (www.stopalcoholabuse.gov), where a new report to Congress may be accessed. For the first time, the report includes federal targets for reducing underage drinking in terms of prevalence, binge drinking, and age of first use.

In October 2005 SAMHSA convened a national meeting of teams of state officials representing a variety of groups, including prevention, law enforcement, highway safety, alcohol control, and others. The agenda included presentations on the epidemiology and science of underage drinking and possible solutions, a panel discussion on states' positive actions, and break-out meetings designed for team members from like disciplines. On the second day, participants began to plan town hall meetings, for which stipends were approved for 1,500 communities.

Following the meeting, SAMHSA asked state teams to identify communities to participate in the town hall project. All DFC grantees were anticipated to receive stipends because of their existing infrastructure and to provide incentives for communities to raise the priority of underage drinking. The target date for the town hall meetings is March 28, 2006. Each participating community received a packet of resources to help plan. Writing the Surgeon General's Call to Action involves staff from the offices of the Surgeon General, SAMHSA, and NIAAA. A notice will be placed in the *Federal Register* seeking input on content.

Discussion

Ms. Rusche suggested linking the website to the *Federal Register*. Mr. Wing responded to Ms. Rusche that states have nominated specific communities; not all funds have been distributed for

the town hall meetings; and he will compile a list for her of the state teams. Mr. Wing stated that tribes were eligible for funds.

Drug-Free Communities: Update

Richard A. Moore, Branch Chief, Division of State and Community Assistance, CSAP, briefed Council members on the Drug-Free Communities Support Program, which provides grants of up to \$100,000 to community coalitions that mobilize to prevent underage drinking and youth substance abuse. On behalf of ONDCP, SAMHSA/CSAP manages, monitors, and supports capacity building in communities in the DFC program. Through a competitive process in FY 2005, SAMHSA issued 756 DFC grants, including 176 new, 24 new mentoring, 543 continuing coalition, and 13 continuing mentoring awards. Staff worked with 87 continuing awards to address high-risk issues associated with direct services, and all grantees surmounted their high-risk status. FY 2006 program priorities include establishing SFP as the operating system for all DFC coalitions. Project officers provide technical assistance, support program compliance, and ensure that all projects can convert to the SPF framework.

Mr. Moore announced that SAMHSA has launched the Coalition Online Management and Evaluation Tool (COMET) for DFC and other SAMHSA-funded coalitions to monitor conversion to SPF, report program achievements, serve as the data collection system, and foster the national evaluation on DFC. He noted that 80 percent of DFC coalitions have committed to participate in the town hall meetings.

FY 2006 new noncompetitive continuation awards will be evaluated for compliance and progress. Approximately 100 new coalition awards and 20 new mentoring awards are anticipated to be made. Five DFC application workshops are scheduled across the country, with emphasis on improving DFC awards in tribal communities. (See www.dfc.samhsa.gov.)

Discussion

To Mr. DeWispelaere's questions, Ms. Quigg, Director, Division of Prevention Education, CSAP, responded that CAPTs, which typically provide technical assistance to states and not community-based organizations, have been called upon to assist with logistics for the COMET training. The Drug-Free Communities Coalition Institute will provide technical assistance. Mr. DeWispelaere suggested that CSAP reconcile conflicting standards for training requirements between block grants and DFC. Mr. Kopanda assured that efforts will be made to integrate technical assistance to avoid mixed signals.

National Outcome Measures

Augusto Diana, Ph.D., Public Health Advisor, Division of Knowledge and Systems Improvement, CSAP, explained that National Outcome Measures (NOMs) will be required of all SAMHSA grantees by fall 2007, including recipients of CSAP block grants, SIGs, and other discretionary grants. SAMHSA uses the new NOMs to operationalize its data strategy to ensure that services are driven by data.

Dr. Diana enumerated the eight (of ten) NOMs domains relevant to CSAP's work and described the discrete measures and sources of data. Domains include abstinence from drug use/alcohol abuse; increased/retained employment or return to/stay in school; decreased criminal justice

involvement; increased access to services; increased retention in service programs; increased social support/social connectedness; cost-effectiveness of services (by cost band); and use of evidence-based practices. He noted that for the block grant, states will report all NOMs through existing sources of data with little additional reporting burden. Discretionary grants, such as the SPF SIG, will report on all domains, but they may also have unique reporting requirements. DFC grants, need only report on the abstinence domain in NOMs.

NOMs data sources include surveys, archival data, and grantee reports. The primary source of survey data is SAMHSA's National Survey on Drug Use and Health (annual Household Survey), with which states are performing statistical estimation. Grantees use tracking software to derive access-to-services and other data, and archival data will come from public records. To indicate readiness for NOMs implementation, at least 23 states and jurisdictions currently use SAMHSA-developed tools, 15 use commercial tools, 11 use self-developed tools, and 11 use manual systems that must be converted to enable electronic data submission. To facilitate data collection, State Epidemiological Outcome Workshops (SEOW) are to be funded in all states and jurisdictions without SPF SIG awards through separate contracts for up to \$200,000 each.

SAMHSA plans to establish an online National Outcome Reporting System (NORS) to generate standards for data collection and reporting by states, ensure consistency and accuracy, create definitions, provide NOMs reporting templates, and design standard NOMs reports generated for delivery to SAMHSA. SAMHSA has been in contact with users of non-CSAP developed systems to ensure reporting capability. The State Outcomes Measurement and Management System (SOMMS) will feed data generated through NORS to SAMHSA's centers.

CSAP is creating the Prevention Platform as a central portal for such resources as understanding the SPF, interactive tools and readiness assignments, and evaluation measures specific to NOMs. States can map their data with free GIS tools. SAMHSA also will make public-use data files available to grantees and the public for grant writing, reporting, or other purposes.

Dr. Diana discussed NOMs timelines. NOMs was vetted with states and approved in December 2005. NORS will be in place by May or June 2006. All SEOWs will take place during summer 2006. Some states and discretionary grantees will begin test reporting on NOMs during summer 2006. Full NOMs implementation will be in place by the end of FY 2007.

Additional forms of assistance include CAPTs for technical assistance and support, the SOMMS contract, and the block grant. SAMHSA's training and technical assistance plan calls for technical assistance to states in April 2006, with states most ready to report a priority.

Discussion

To Ms. Rusche's questions, Dr. Diana explained that for each type of program or intervention—universal, indicated, and selected—states will capture the 25 to 75 percent range of costs in “cost bands”; data already in the public domain will be provided back to the public; restrictions will be imposed on certain data not yet defined; and state data will be provided without state identifiers. Mr. DeWispelaere asked whether all entities regardless of size will use the same reporting instrument, and Dr. Diana responded positively. Mr. Kopanda explained further that DFC grantees will report only on abstinence, and other discretionary programs will report on only

those NOMs relevant to the program. Dr. Diana clarified that grant programs define reporting requirements, but states can nominate other methods for measurement. Mr. DeWispelaere expressed concern about communities' loss of decision making on data collection. Mr. Kopanda responded that Household Survey data is used for state grants, but grantees in discretionary programs might opt to use another survey. If a state reports on all communities, the state makes the decision.

Mr. Shinn inquired about how data will be disaggregated under the new system to reveal culture-specific information. Dr. Diana responded that some NOMS measures will not be broken out by demographic groupings, although data on numbers of persons served will be. Mr. Kopanda stated that the Office of Applied Studies (OAS) is concerned with this issue.

Council Presentation to Beverly Watts Davis

On behalf of the National Advisory Council, Mr. Coyhis presented a special gift to Beverly Watts Davis in appreciation for her leadership at CSAP.

Hurricane Katrina Deployment Experiences

Robert L. Stephenson, II, M.P.H., Director, Division of Workplace Programs, CSAP, served on a multi-agency team deployed to Mississippi by SAMHSA in September 2005. Mr. Stephenson presented a slide show that depicted the extent of the damage and how the team dealt with first responders and their needs. He explained that many conditions as documented in September still exist and are likely to persist. He noted that the disaster brought about recognition for the need for better preparedness.

Charles E. Williams, CSAP Disaster Response Coordinator, Division of State and Community Assistance, described his deployment experiences following Hurricane Katrina. Mr. Williams explained that SAMHSA activated the SAMHSA Emergency Response Center (SERC) to track the disaster and manage the agency's response and resources (see www.samhsa.gov). For three weeks he worked with the SERC, which set up phone hotlines for state personnel, and in October he met in Mississippi with persons focused on prevention. In December he deployed for two weeks to a cruise ship in Pascagoula that housed 1,200-1,600 people who had lost everything. On the ship, Public Health Service maintained a health clinic, FEMA had its offices, and armed guards protected against security risks. SAMHSA staff wore orange shirts and called themselves the "stress managers."

Mr. Williams stated that SAMHSA provided stress training to FEMA staff, many of whom were contract employees who had been impacted by the storms. Many referrals followed that training. Buses took kids from the ship to their own schools, and many people went to work. People were referred for services off the ship when necessary. Mr. Williams presented a slide show of his "disaster tour," which featured evidence of the destruction as well as inspirational signs. SAMHSA's Ad Council mental health awareness campaign provided ongoing support for folks in various areas of the country and for various populations.

Discussion

Ms. Geringer stated that many New Orleans residents remain dejected and depressed—but determined—about their recovery prospects. She commended SAMHSA staff's efforts.

Panel Discussion: Roles of the Project Officer/Grants Management Staff/Contracts Management Staff

Rose C. Kittrell, M.S.W., M.Div., Acting Director, Division of State and Community Assistance, CSAP, noted that the panel responds to a Council request for information on the role of federal government project officers (GPOs). Ms. Kittrell set the context in terms of CSAP's mission and SAMHSA's strategic goals. The goals are to build, sustain, and enhance a national substance abuse prevention infrastructure and capacity at the state and local levels, and internally in SAMHSA; enable all states, communities, and providers to deliver effective prevention; and establish systems to assure program performance measurement and accountability.

Ms. Kittrell explained that GPOs develop program initiatives, write RFAs, provide technical assistance to prospective applicants, and work with grants management staff on budgets. GPOs serve as the government's representative to grantees, conduct new grantee workshops, ensure that agencies' programmatic requirements are met, follow up with grantees on compliance issues and complaints from the field, and provide or arrange for technical assistance.

Under cooperative agreements (for example, the SPF SIG), GPOs serve on governors' advisory committees, provide guidance and technical assistance to help grantees achieve their goals, participate on grantee workgroups, monitor collection of process and outcome data from grantees, review and approve grantees' strategic plans, review and approve grantees' community funding mechanisms, and keep grantees apprised of new directions and policy.

Susan B. Pearlman, Director, Division of Contracts Management (DCM), OPS, explained that DCM supports SAMHSA's three centers and OAS, project officers, contractors, or potential contractors, and introduced her team. Ms. Pearlman described procurements made through DCM, which include programs for communities, training and technical assistance, and public information campaigns—but not service support, information technology, facilities support, equipment, goods and services under \$100,000, or food under federal contracts. The technical assistance contract includes the www.grants.gov website.

SAMHSA leadership approves and transmits concept papers to DCM. The goal of each acquisition is to negotiate a task order or contract that achieves the contract objectives at fair and reasonable cost. Contractors are responsible for performing, compliance, marshalling and controlling resources, and their profits. It takes 90-195 days for an award, including peer review, depending on the mechanism. Ms. Pearlman stated that in the pre-solicitation contracting phase, program staff provide DCM with an RFC package, and DCM staff advertise opportunities, issue solicitations, receive and review proposals, negotiate, and make awards.

To improve personnel security, all contract employees who work more than two days at SAMHSA have fingerprints taken and undergo a background check. SAMHSA spent \$325 million in contracts in FY 2005, including 27 percent to small business's, just shy of the 30 percent HHS requirement. DCM uses the GSA schedule to identify small businesses.

SAMHSA's peer review is based on statutory requirements. External experts review and rate proposals. DCM then determines competitive ranges and negotiates. Some administrative work

is not subject to peer review. Ms. Pearlman asserted that procurement integrity is important to the fairness of the process, and contractors in possession of leaked information may be precluded from bidding. Potential contractors can contact Ms. Pearlman or SAMHSA's small business coordinator, Lynn Tantardini.

Christine L. Chen, Director, Division of Grants Management, OPS, explained that her division is responsible for all business management matters associated with the administration of all SAMHSA grant. Staff work with GPOs responsible for grants' programmatic aspects. SAMHSA's mandatory grants are required by statute to be awarded if the recipient submits an acceptable application and meets the eligibility and compliance requirements of the grant program, include the Community Mental Health Services block grant, Substance Abuse Prevention and Treatment block grant, CMHS Path Program, and CMHS PAIMI Program. Mandatory grants of almost \$2.2 billion were awarded in FY 2005, almost two-thirds of SAMHSA's budget. Ms. Chen's division participates in the grant application package review, provides technical assistance to grantees, issues notices of grant awards, signs the awards, and resolves audit findings.

SAMHSA's discretionary program awards grants according to specific authorizing legislation through a competitive process. In FY 2005 SAMHSA issued about 2,000 awards for a total of \$770 million, including \$70 million for 700 awards in the DFC program, and about \$26 million for 30 grants in response to Hurricane Katrina.

Ms. Chen noted that management of discretionary grants is more complicated and diverse than managing mandatory grants. Some discretionary programs, for example, feature matching requirements and others require accounting capability reviews to ensure proper management of federal funds. Discretionary programs have two renewal grant mechanisms, new and competing renewal grants, which must go through a competitive process, and noncompeting renewals or continuations, which are subject to availability of funds and satisfactory progress.

Council Roundtable

Mr. Kopanda invited Council members to submit suggestions for agenda items.

At Dr. Tellerman's request, Mr. Romero introduced himself by telling his personal story of immigration to New York City and then of experiencing academic difficulties because of his English deficiencies. On his own initiative he asked the principal of a private school to evaluate him for admission based on his enthusiasm, not his records or grades. Although he was discouraged at that point, he later graduated with two degrees from that high school and served on its executive committee. His applications to college again met with rejection, but he advocated to the dean of his first-choice school to judge him by his enthusiasm, not his SATs, and four years later Mr. Romero graduated with two degrees and went on to graduate school. He stated that his real calling is to help others, and enthusiasm has been a major lesson.

Ms. Haynes responded to Ms. Rusche that CSAP will provide Council members with the various versions of the FY 2006 and 2007 budgets. To Ms. Geringer's question about "acting" leadership, Mr. Kopanda explained that dramatic program changes in CSAP have resulted in many changes in the agency beyond leadership, but that CSAP is working to stabilize the entire

internal organization soon. Mr. Sahn noted the value of an agency director with experience and relationships on Capitol Hill, and asked how Council members can help support CSAP aims. Mr. Kopanda stated that communicating the effectiveness of their work, making use of NOMs and outcome data, is helpful in their private capacity.

Ms. Haynes responded to a question from Mr. Sahn that the selection process of Council members is going forward with appointing new members and reappointing others, and invited members to contact her with specific questions. SAMHSA's Toian Vaughn added that although some appointments have ended, Council members have continued to serve until they are reappointed or replaced. She welcomed recommendations for positions on all SAMHSA councils with vacancies.

Mr. Romero invited Council members to meet with him to enhance collaboration. Ms. Rusche urged scheduling Council meetings a year in advance to enable members to save the dates. Ms. Haynes stated that the next meeting will be held on July 25-26, 2006, the only meeting remaining in FY 2006. Mr. Kopanda noted that CSAP hopes to have all applications approved by July, but if that does not happen, Council members also will participate in a teleconferenced meeting.

Dr. Tellerman raised the issue of members attending external meetings in an official capacity and reporting back to the Council. Ms. Vaughn suggested that the Council chair might evaluate the usefulness of that process. She noted that roundtable discussions are an ideal time for Council to decide on the need for subgroups or for the agency to discuss particular matters. Mr. Kopanda suggested summarizing Council members' activities in the past. He invited Council members to make recommendations for participation in external groups to Ms. Haynes.

Public Comment

Time was set aside for public comment, but no one stepped forward to speak.

Adjournment

The meeting of the CSAP National Advisory Council was concluded at 5:00 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.