# SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

## CENTER FOR SUBSTANCE ABUSE PREVENTION

## NATIONAL ADVISORY COUNCIL

Tuesday,
February 14, 2006

Room 204B
Washington, D.C. Convention Center
801 H Street, N.W.
Washington, D.C.

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# C O N T E N T S

PAGE

Welcome, Opening Remarks, and Introductions

Richard T. Kopanda, M.A.
Acting Director, CSAP 6

Dennis O. Romero, M.A.
Deputy Director, CSAP 7

Consideration of the August 16-17, 2005
CSAP Council Meeting Minutes 13

Comments from the Acting Director

Richard T. Kopanda, M.A. 13

SAMHSA Administrator's Report

Charles G. Curie, M.A., A.C.S.W.
Administrator, SAMHSA 21

Discussion 45

Preventing Underage Alcohol Use:
A National Meeting of the State:
"An Overview"

Stephen G. Wing, M.S.W.
Associate Administrator for
Alcohol Policy, SAMHSA 56

Discussion 65

Drug-Free Communities Update

Richard A. Moore
Branch Chief
Division of State and Community
Assistance, CSAP 67

Discussion 73

C O N T E N T S

PAGE

National Outcome Measures

Augusto Diana
Public Health Supervisor
Division of Knowledge and Systems
Improvement, CSAP 77

Discussion 95

Appreciation of Beverly Watts Davis
as Former CSAP Director 102

Hurricane Katrina Deployment Experiences

Robert L. Stephenson, II, M.P.H.
Director
Division of Workplace Programs, CSAP 105

Charles E. Williams
CSAP Disaster Response Coordinator
Division of State and Community
Assistance, CSAP 108

Discussion 117

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 119

Susan B. Pearlman
Director
Division of Contracts Management
Office of Program Services, SAMHSA 126

Christine L. Chen
Director
Division of Grants Management
Office of Program Services, SAMHSA 136

Discussion 142

Council Roundtable Discussion 144

P R O C E E D I N G S (12:19 p.m.)

MR. KOPANDA: Let's get started, if we could. We'd like to get started. I'd like to just tell the members all the mikes are on, and if you could just keep one in front of you for when you speak.

Our first order of business is going to be lunch.

(Laughter.)

MR. KOPANDA: It seems that there's no food in this building. Dennis and I took an exploratory trip around the area and found a decent sandwich shop. So we're going to pass around a form here for food. Basically what they have is sandwiches: roast beef, turkey, ham, on different kind of rolls, bread, Kaiser rolls with all the various fixings. So if you want that, and they have chips and drinks. So if Council members would like to put just what they'd like there, we'll charge it to one of our charge accounts, and then maybe we could all work out later what that would be. But they're fairly decent and fairly large sandwiches. Dennis and I split one, just to let you know.

MR. DeWISPELAERE: We thought Tia put us on a diet.

(Laughter.)

MR. DeWISPELAERE: Although I need it, I wasn't planning on that today.

MR. KOPANDA: We are a little bit behind this

morning, so we'd like to get started. Mr. Curie is supposed to be here at 12:30, but I'd like to start with introductions, and since this is my first time with the Council, I'll just start very briefly with myself.

For those who don't know me, my name is Rich Kopanda. I've been around with SAMHSA and ADAMHA since 1976, served most recently 10 years as executive officer of the agency. My permanent job is deputy director of CSAT, Treatment, and I've been here a little over two months in CSAP. I found this to be quite an enjoyable but quite a different job being the acting director, as compared to the deputy director, but quite fulfilling. I'll talk a little bit about the staff later.

I'd like, then, to introduce Dennis very briefly, have him say a few words about himself, and then maybe if the members could very briefly just introduce themselves.

MR. ROMERO: Thank you, Rich.

Good afternoon. My name, again, is Dennis Romero. I am, from what I've heard, the newest SAMHSA member, and it's good to feel young again.

(Laughter.)

MR. ROMERO: I am from the field. I've been in the field for over 20 years, actually. I counted last night after I've been saying it's 18-plus. It's actually

20-plus years in the field, and I am really honored to be working with folks who I've admired for many, many years being a clinician and a practitioner in the front lines. My work has included working both in community-based organizations in the South Bronx to working in upstate New York in a community mental health sector, as well as in hospital administration. My most recent position, I came from the Alcoholism Council of New York, the oldest prevention agency in New York State. I held the position of deputy director of the Council.

I started here just under six to seven weeks, so thank you for having me.

MR. LOZANO: Good afternoon to all. It's good to be here today. Welcome aboard.

Rich, thank you for the hard work you've invested.

Henry Lozano. In fact, for Senor Romero, if I don't give my full name, then I'm in trouble. Enrique Eduardo (Spanish spoken).

MR. ROMERO: Muchas gracias.

MR. LOZANO: And that's for a CSAP future investment.

(Laughter.)

MR. LOZANO: Good to be here and good to be part of this Council. Thank you.

MR. KOPANDA: Thank you.

MS. GERINGER: My name is much simpler. I'm just Sharyn Geringer. I'm the former First Lady of Wyoming and have had a longstanding interest in substance abuse prevention, particularly with children.

MR. KOPANDA: Thanks for being here.

MR. SHINN: Allan Shinn. Aloha. I'm with the Coalition for a Drug-Free Hawaii. We have community and school-based prevention programs, and we're part of the Drug-Free Communities grantee group. I'm happy to be here.

MR. KOPANDA: Thanks for coming.

MS. RUSCHE: Sue Rusche, president and CEO of National Families in Action. We have two major projects. One is the Addiction Studies Program for journalists, and now the Addiction Studies Program also for state legislatures, which we do in collaboration with several universities and the National Conference of State Legislatures. The one that's dearest to my heart is the Parent Corps, which is a pilot program to hire and train parents and employ them as leaders in their schools to mobilize all the other parents in drug prevention. Our 20 parent leaders in 20 schools in 9 states have recruited 4,700 parents in their schools into the Parent Corps as members, in this age when parents don't do anything.

MR. KOPANDA: Thank you. Very impressive.

MR. DeWISPELAERE: Welcome Dennis, Richard. My name is Jay DeWispelaere. I'm the president and CEO of PRIDE, Inc. We're in 500 locations in the U.S. We were just recognized recently by the United Nations as a non-governmental organization. We're recognized in 60 countries for the work that we do.

MR. KOPANDA: Thank you, Jay.

MR. COYHIS: My name is Don Coyhis. I'm a member of the Mohican Nation. I was born for the Turtle Clan on my mother's side and the Coyote Clan on my father's side, and my Indian name is Tatonka Wombley. That was given to me by the elders. I am the president of White Bison. We have been in existence 16 years and we are currently implementing what we call a well-briety movement among the Indian Nations. It includes both treatment and prevention grants. We have something we implement in communities. We actually do seven trainings simultaneously. We do a 12-steps for men, for women, we have a Daughters of Tradition, Sons of Tradition, Children of Alcoholics, and the Family Series. It's a very grassroots change program.

Our current one, we're piloting a reentry program called Warrior Down. In Boise, Idaho, we have 36 inmates that have come out of the prison system. We started eight months ago and not one has gone back to

prison, and not one has drank again. But we find that the more we turn to the culture and use that type of approach, the stronger it is.

I'd like to welcome you, Dennis. I'm glad to see you. Any way we can support, you just play the drum.

MR. ROMERO: Absolutely.

MR. COYHIS: Thank you.

DR. TELLERMAN: Welcome. Glad to be joining with you, and hello to everyone here today. I'm Judy Tellerman, and I'm a clinician. I'm a clinical psychologist and clinical professor at the University of Illinois College of Medicine, and I am best known for a structured group program that I developed for middle and high school for prevention and intervention. I'm also a board examiner for board certification in group psychology.

I'm very happy to be here. I love this Council. I think we do good things, and I'm glad to help support everything that SAMHSA is doing. Thank you.

MR. KOPANDA: Thanks, Judy.

MR. SAHN: Hi, everybody. My name is Mitchell Sahn. Not to be outdone by Allan or Henry greeting in the Native tongue, I have to say "How you doin'?"

(Laughter.)

MR. SAHN: I hail from New York.

(Laughter.)

MR. SAHN: I want to welcome both of you. Dennis I had the opportunity to meet several months ago when I was working as a senior advisor to NCADD on their restructuring plan. I think it's a great plan, and I hope you're very happy here.

Rich, I've heard nothing but good things.

My specialty is connecting the dots. I ran a very large health and human service vertical in Nassau County. I served on the U.S. Conference of Mayors Task Force, and I developed a no wrong door paradigm which connects the human services with the social services through a single port of entry for the first time. My background is on Wall Street, but I went into public service because we're supposed to do these things back in Ann Arbor.

I guess what I'm trying to say is prevention has become such an important part of the paradigm, but we've been unable to really quantify it. We've gone through the struggle of empirical evidence versus anecdotal evidence, and as funding has become more constricted it's become a larger and larger struggle to get our share of the pie. I feel that it's our job to be as supportive to Rich and to Dennis and help them achieve that. So thank you.

I have to go out for a conference call, but I should be back.

MR. KOPANDA: Thank you.

MR. ROMERO: Thank you.

MR. KOPANDA: Our first order of business is to approve the minutes from the last Council meeting. Hopefully you've had a chance to review them, but I wonder if there are any comments on the minutes from last time.

MR. DeWISPELAERE: Richard, so moved that we accept the minutes as presented.

PARTICIPANT: Second that motion.

MR. KOPANDA: It's been moved and seconded that we approve the minutes from the last Council meeting.

Any opposition?

(No response.)

MR. KOPANDA: Ayes?

(Chorus of ayes.)

MR. KOPANDA: We'll consider the minutes from last time approved.

I'd like to begin very briefly before Charlie gets here, and we do have a very interesting agenda for today, and a full agenda I might add. I'd like to begin with just a few overview points as to what's going on in the Center right now. Hopefully you've had an opportunity to participate in some of the CADCA events and attend some of the grantee breakout sessions we've been having.

I'll start with our 2006 appropriation. As you

know, we do have an appropriation now. It's a slight reduction from that of fiscal year 2005. However, we do have a number of new announcements coming out, I'm pleased to say. The Strategic Prevention Framework State Incentive Grant, or SPF SIG, announcement has already been out. The applications are due May 1 for that announcement. The Drug-Free Communities we expect to momentarily send out the announcements for both the support program and the mentoring program. The mentoring would be much smaller than the core support program for the DFC grants, but they should be out within a month or so, but I'm not sure exactly the timing of that.

MR. DeWISPELAERE: Do you know the turnaround on that?

MR. KOPANDA: I'm sorry?

MR. DeWISPELAERE: Do you know the turnaround?

MR. KOPANDA: Well, I'm not sure. May 1 for that. That's the plan right now.

Conference grant announcement is out, and the methamphetamine grants, as you know, the Hill added funds for methamphetamine this year. We're working on that announcement. That will be out a little bit later as well. Hopefully, applications are due May 1 for that program.

We have no change in our FTEs this year. Fortunately, unlike some of our sister components in

SAMHSA, we've had very few retirements among the staff. I know in CSAT they've had quite a few retirements, but we've been fortunate this year.

The 2007 budget is now on the Hill. We have about a $12 million reduction in the CSAP core budget. There's no cut in the block grant proposed, and there's no reduction in FTEs or staffing proposed. The reduction in our discretionary funds is primarily in the SPF SIG program. Our plans right now are not to eliminate any grants in any area in 2006, any ongoing grants. That reduction will be accommodated through possible slight reductions in the funds for the current grantees and reductions in some of the support costs that we provide as part of the program.

We've straight-lined many of the other programs, like the CAP program. The methamphetamine program will be straight-lined. HIV/AIDS, straight-lined, which means there will be basically no reductions in any of those programs in 2007 in the President's budget.

I'll just mention briefly that within SAMHSA as a whole, and Charlie might get into this a little bit, there are some proposals for the Access to Recovery program. If you're familiar with that, that's the CSAT treatment voucher program. The proposal for 2007 will be to take the majority of those funds, a little over $70

million, and make it into a voluntary incentive program that would leverage block grant dollars to be voucherized for treatment purposes only. That does not include prevention. It's only for treatment.

MR. DeWISPELAERE: So explain that again. I'm confused about that.

MR. KOPANDA: Okay. The funds in the voluntary incentive would be a discretionary grant program. I'm just going to go as far as I've been given to understand, okay? There will be applications accepted from the states for those funds, and if states apply for those funds, they agree to voucherize part or all of their substance abuse treatment part of the block grant funds. Up to 30 percent of the three-year VIP program could be used for developing the infrastructure for treatment vouchers in the state.

MR. DeWISPELAERE: And do the state associations support that?

MR. KOPANDA: I can't answer that.

MR. DeWISPELAERE: I don't mean to put you on the spot.

MR. KOPANDA: The 30 percent development of the infrastructure could be done over the course of the three-year grants. In other words, it could be 90 percent in the first year and then zero percent in the other two years, in order to develop the infrastructure up front. It

would be 30 percent of the three-year cost of the VIP program.

MR. DeWISPELAERE: So if they apply, they automatically agree to voucherize their block grant dollars as part of that.

MR. KOPANDA: Not all, yes. States that have had an ATR grant must voucherize a larger percentage of their block grant than those which are coming in for the first time and proposing vouchers.

MS. RUSCHE: That's a very nice way of beginning to coax some change.

MS. GERINGER: Richard, if I may interrupt please, I am not part of the government and I do not understand letters. So instead of using just the acronym, if you could give us the whole name, I'd appreciate it.

MR. KOPANDA: Okay. Thank you very much.

There will be one other main part of the Access to Recovery, which is about $100 million, and $25 million would be used of that amount for a separate program, which would be a methamphetamine voucher program.

MR. SAHN: Excuse me, Rich. When you were talking about that $12 million cut, is that from the core operating budget?

MR. KOPANDA: No, it's not from our operations. It's in our grant and contract budget.

MR. SAHN: So that will not impact the grants that you just mentioned. Which grants will that impact?

MR. KOPANDA: Well, primarily it will impact the SPF SIG. Sorry.

MS. GERINGER: That one I understand.

(Laughter.)

MR. KOPANDA: The Strategic Prevention Framework State Incentive Grants. But it will not result in the elimination of many of those grants.

MR. DeWISPELAERE: So if a state is getting $3 million, everybody across the board will get (inaudible)? Is that the idea?

MR. KOPANDA: We will have to work out how that would work. At this point we will wait and see what the action is on our appropriation before we became too definitive as to exactly how we would implement that, how much grants, how much contracts, what percentage. We would wait and see what the final appropriation is first.

MS. RUSCHE: This is certainly something that Council members should be concerned about in advocating for CSAP. No cuts, please.

MR. KOPANDA: So noted.

MR. DeWISPELAERE: In our SPF SIG, how many -- maybe you can't answer this, but how many states are there currently? I think there are 24 or 27 states now?

MR. KOPANDA: Twenty-four states.

MR. DeWISPELAERE: And with the new batch of money, how many do we intend to add?

MR. KOPANDA: Well, we're talking about 40 in total, which would be about 16, but a large part depends on how many tribes apply and are funded as well. But we're thinking about 12 to 14 more, possibly up to 40 total by the end of this year.

MR. DeWISPELAERE: Impressive. Thank you.

MR. KOPANDA: Those are the major aspects of the 2007 budget. There are some significant changes in mental health as well in terms of their block grant. I'll just tell you they're talking more about moving forward the mental health transformation aspect of their block grant in 2007.

Within the agency, we're approving the National Outcome Measures across the board, and CSAP's National Outcome Measures, eight National Outcome Measures, or NOMs, were approved for us for our use. One of those includes the use of cost bands in our programs. Now, we have not communicated this broadly and we intend to do so in the near future, but we will be developing internally an online system for the reporting of NOMs data from our projects. We hope to have that ready by about May of this year.

MR. SAHN: Excuse me, Rich. The methodology

behind the cost bands, are you going to bucket different programs and then assign parameters around them so you are able to compare oranges to oranges, apples to apples?

MR. KOPANDA: Yes.

MR. SAHN: That's good.

MR. KOPANDA: In particular whether a program is universal or indicated. Cost bands are very different for the different types of programs.

We're also working internally on the new drug testing guidelines. The staff have done a tremendous job putting together the comments in terms of the very, very large document that's wending its way through the Department, and we expect to have the new guidelines out shortly.

Charlie has joined us just in time.

There's just one other thing I'd like to say. I just want to express my appreciation to the staff of CSAP. Since I've been here, you couldn't want a more cooperative, knowledgeable and helpful group. They have been just incredibly supportive and easy to work with, and as you go forward and talk to the staff and work, you just know that someone coming from a different center and working with them found it so easy to just get up to speed on so many different issues in a short period of time, and it's really due to their efforts.

With that, I'd like to introduce our first speaker, Charlie Curie. You know him so well that I'm not going to go through his bio, but I'll read the whole thing if you'd like, Charlie.

MR. CURIE: No, please don't.

(Laughter.)

MR. KOPANDA: We're very pleased to have him with us this morning.

MR. CURIE: Thank you, Rich. I just want to say, Rich, I want to thank you for the tremendous job you've done as acting director of CSAP.

I'm going to be pleased to give my report today, but I know that with the updates that have occurred, there's been a real strengthening of the structure of CSAP. Rich, I think, represents the epitome of senior executive staff. I think he represents what the SES is all about in the federal government. He is seasoned, knows the system, adheres to the highest principles of professionalism, and just has been a trusted advisor. Again, one of the aspects of an SES person, when you reach senior executive service level, is to be able to place them anywhere in the federal government to manage and to move situations ahead, and I think Rich is a fine, fine example of that.

I want to thank you for your work.

MR. KOPANDA: Thank you, Charlie.

MR. CURIE: It's great to be here today with you. I have to tell you, I'm extremely excited about what CSAP has accomplished and what has been accomplished in partnership with the many folks that I see represented in this room. I think it's been an exciting time for prevention and will continue to be, as I feel substance abuse prevention in particular is coming more and more into its own. I'm feeling that we're less on the defensive than we were, that we're making the case, and again the only way we can do that is through the efforts of everyone involved in the field, all of our partners.

At the outset I would like to announce to the group, and I'd be interested in hearing when I'm finished with that and my remarks any feedback, and it's also just great to see everyone here. Sharyn, it's great to see you. Thanks for joining us. I just see a lot of good friends here, everybody. In fact, I think I have more friends on this council than my own.

(Laughter.)

MS. RUSCHE: It's because you're a preventionist at heart.

MR. CURIE: I think so.

As I mentioned earlier, Rich has just done a tremendous job. I also want to clarify that Rich agreed to accept the acting director of CSAP for basically a 90-day

or so period, a three- to four-month period of time. Again, I think we can say mission accomplished with what he's done. As we wrap up that period of time, it's important for us to consider what's the next phase for CSAP and its management.

Again, you've all now met Dennis Romero, the new deputy director for CSAP. I also want to say, going back to SES, Dennis is probably one of the newest SES individuals to the federal government, and I think between Rich and Dennis also a model has evolved. Rich and I were talking about this the other day. I think it's the first time we've actually seen it play out this way, and that is to have a seasoned veteran SES person, if you will, take under his wing or mentorship a new SES person who is coming in, and really I think that typifies the last two months of work between Dennis and Rich.

The great news, what I hear from Dennis and what I hear from others and what I hear from Rich, is that I think it's been a real win of a situation and, again, a model that can be used throughout the federal government in terms of how SES is supposed to work and senior executive staff. So with that said, Dennis is getting a firmer and firmer hold on becoming deputy director or being deputy director of CSAP.

I'm pleased to announce that in one month from

now, within 30 days, as Rich wraps up being acting director of CSAP, Dennis will be stepping into that role as acting director of CSAP. Rich will go back to being deputy director of the Center for Substance Abuse Treatment. It was kind of tough for me to ask Rich to stay on when he accomplished his mission. It's like, do you want to keep doing this? No, not really. Rich has really enjoyed his tenure there.

But Dennis has accepted being acting director for CSAP. I'm also pleased to announce that the acting deputy director for that period of time will be Rose Kittrell. I think many of you know Rose. She's very seasoned and competent, and we're pleased to have her.

(Applause.)

MR. CURIE: A federal employee and manager, one of the best managers that we have within SAMHSA, and I'm just pleased that she was willing to step into that position and take the helm, working with Dennis, and I'm so pleased that Dennis said yes in terms of being acting director of CSAP.

With that, I'm also pleased to announce that Rose, she actually manages the largest division within CSAP, and we need to have someone at the helm there during that period of time. Again, this is consistent with the CSAP reorganization as well. We are asking Peggy Quigg to

please step into that acting director role.

(Applause.)

MR. CURIE: So I think with those people firmly in place, and I'm so pleased that Peggy accepted as well and I thank her for that, and everyone being willing to set up, I think we have a good strong structure right now in place to manage the situation and to continue to move CSAP forward.

In talking about CSAP moving forward, one person that I want to continually recognize is the person who has led CSAP for the past two and a half years, and I'm now very fortunate that she's my senior advisor for substance abuse prevention and treatment, Beverly Watts Davis.

(Applause.)

MR. CURIE: And I think with that team in mind, with Dennis as acting director of CSAP, with Rose as acting deputy director, with Peggy as acting division director, and with Beverly as senior advisor, I think we have a strong, if not the strongest, team around CSAP and our prevention activities that SAMHSA has ever known. So I'm just really pleased to see everyone being willing to step up into the positions that we have right now.

I think what's evident when I talk about why I think we're in a very good place is I think we just need to

take a hard look at the Strategic Prevention Framework and where we are. Many of you have heard me talk about Strategic Prevention Framework for well over four years. The great news is that with Beverly coming aboard, SPF became a clear reality, and I'm just so appreciative that she was able to bring that vision and that concept to a reality. I want to applaud all of CSAP for what CSAP has done over the past two and a half years.

For the first time, bringing a framework based on the science, based on transparency, based on empowering communities, community leaders, based on the principle of leveraging dollars to put into place a framework that equips states and, most importantly, communities to be able to make the right decisions for their community as to where they should be investing their dollars in order to have effective prevention efforts put forward. For the first time, SPF gives us the opportunity to have a baseline in place so that we can truly make a case as we go ahead, whether it's to OMB, whether it's to Congress, whether it's to the taxpayer in general, that we're able to sit down and say here is the progress communities are making who have brought all the resources together, have formed a leadership committee, have embarked upon a process of assessing the risk factors in their community, assessing the protective factors in their community, and then

determining with the dollars that they have what programs they're going to fund that represent the protective factors to address their risk factors, and hopefully over time more and more engaging federal resources, state resources, local resources, private resources, foundation resources, having together hopefully in communities not only the CADCA drug coalitions, which is always an exciting week when they're in town, never a dull moment, and I'm just pleased again that we'll be able to touch base firsthand with so many coalitions around the country.

But not only with CADCA coalitions but also bringing together other United Way agencies, bringing together Boys and Girls Clubs, 4H, Scouts, YMCAs, YWCAs, bringing together youth development efforts, bringing together the faith-based communities, have them come together, bring together city government, local government, law enforcement, the juvenile justice system, bring them all together around an effort in the community is a powerful, powerful concept, and I think again it's going to set a long-term foundation.

SAMHSA will support ongoing efforts to implement this framework with an emphasis -- I want to remind everybody that not only are we addressing the issue of illicit drugs, but we are also expecting an emphasis on underage drinking in each of those endeavors around

Strategic Prevention Framework.

Again, the reason we're looking at that, and I'll be talking a little more about it -- you're going to be hearing a lot about underage drinking. It's a major initiative right now. It's an initiative that's been embraced by the Secretary. It's an initiative that has been embraced by the Surgeon General. It's an initiative that for the first time we have an interagency coordinating council, which I have the privilege of being chair, which brings all the agencies together around an underage drinking strategic plan for the federal government. We have a report in the Congress.

I want to recognize Steve Wing, too, by the way, who is the associate administrator for alcohol within SAMHSA, and he's just been invaluable for being the point person and lead person as we pull together those underage drinking efforts.

Steve, why don't you stand?

Let's recognize him.

(Applause.)

MR. CURIE: And the great news with the Strategic Prevention Framework is every community will need to address underage drinking in the plan. My point would be, first of all, alcohol is the most abused substance of youth, number one. Number two, show me a community where

underage drinking isn't the number-one substance problem. I want to visit that community and find out what they're doing so we can incorporate it in the Strategic Prevention Framework, because literally every community in this nation has to address it. That's why it has to be a national effort.

Twenty-six Strategic Prevention Framework grants, so $288 million over five years, have been awarded, and we expect to fund a total of 40 Strategic Prevention Framework grants by FY '07. So in other words, really literally all but 10 states are going to have an SPF grant. It's been our goal to see over the next three years to have an SPF grant in every state. I'll talk about the '07 budget. In the '07 budget we're not going to be adding any new ones because of how tough the budget is in terms of the plan, but I still think it's within reach as we move along to have it in all 50 states within a three-year period. But 40 states is tremendous. I can't think of too many efforts that we've put forth where we have that type of tremendous systemic activity going on in that many states.

We just announced the availability of funds for the grant program. In fact, for the awards coming up yesterday, it's expected that a total of $33 million will be available to fund approximately 12 to 15 SPF SIGs, state incentive grant cooperative agreements in fiscal year '06.

The annual awards are expected to be about $2.3 million or less per year in total costs, depending on the size of the geographic area and the population being served.

The success of the framework is very much determined in large part by the tremendous work that comes from the grassroots community coalitions. That's the other thing that's really, I think, the beauty of SPF, that all the hard work that has gone on with anti-drug coalitions through all the years, they're prepared for this. We're not starting from scratch. We're building on the infrastructure and commitment that's in place of anti-drug coalitions across this country. It would be wrong to try to start something from scratch when we have that committed core of grassroots individuals available in so many communities across the country. So that's another reason I'm so optimistic about the success of this, is that we're not just building it from scratch.

SAMHSA expects to continue also to work with ONDCP to support approximately 720 grantees funded through the Drug-Free Communities grant program, again combining the efforts of DFC with SPF. These acronyms just flow at the federal level. It really gives us a great opportunity to say yes to substance abuse prevention, to move the agenda ahead.

Some other updates as we take a look at some overall things, and then I'm going to talk a little bit more about the '07 budget. If you're not familiar with the SAMHSA matrix, I'd like to meet with you after this meeting.

(Laughter.)

MR. CURIE: Thank you. Dennis qualifies greatly. He also carries (inaudible.)

(Laughter.)

MR. CURIE: As you know, we use the matrix to delineate our vision of a life in the community for everyone, our mission of building resilience and facilitating recovery, and we do that by having axes of programmatic priorities, blue axis, which I call the leadership axis, and that's really specific programmatic priorities that we look at which we need to address. Each one of those areas has a matrix workgroup within SAMHSA. Each one of those areas has a two-year plan up on our website so you can take a look at what we've done.

I just saw Sue looking at me. That's the easiest way to (inaudible) on the screen.

The cross-cutting principles. That's how we do what we do. Again, the leadership axis is doing the right things. The management axis, the red axis, is doing things right. These cross-cutting principles are those things,

those elements that we want to see at play in everything that we do. So you see data there driving our decisions. You see cultural competence. You see using community- and faith-based approaches. You see trauma, violence and sexual abuse needing to be something we consider in all that we do because of the pervasiveness of that type of condition and situation with the clientele we serve. Recovery driving what we do; reducing stigma. We need to be thinking about those things as we implement programs, making sure we're not perpetuating stigma, because sometimes inadvertently that happens. So we need to keep that front and center.

I'm pleased to say, and I've called this because we've updated it two or three times, the matrix reloaded, and I'm pleased to say we're going to reload it again, and I want to share with you what we're planning on doing, and this is after consultation with the field, with constituents, with consumers, people in recovery, with states, with people on the Hill, Congress. We tried to really get a handle on what's emerging, what the data is telling us.

We are going to make a move of disaster readiness and response which is, again, I cannot say enough good things about SAMHSA's response to Katrina, Wilma and Rita. It was phenomenal in my mind what staff did, the

sacrifice, seeing them come forward, and I can say in all perfect honesty that literally 100 percent of the SAMHSA staff was involved with the Katrina response. We had over 60 to 65 percent involved either with being deployed there or serving in the SAMHSA Emergency Response Center. All the others had to fill in double-time to cover people who were there. I mean, everyone worked hard. We needed some people back to keep the trains running on a regular basis, and they did that and did that well without missing much of a beat on anything. I mean, it was challenging at times.

But basically, as we look from August 29 through currently now, we had the SERC running full time to, I believe, about the end of November, beginning of December, in that period of time. That's a long period of time, and we still have a virtual SERC running at this point in terms of the numbers are alive and people are still calling up. We've been responsible for deploying over 700 people to the area, and that's for mental health and substance abuse issues. We've also been involved with other types of deployments. But those are the ones that we were directly responsible for.

But all the hard work after 9/11, when we first put that up there, disaster response as a priority, I think we saw how much it paid off in the response to Katrina. We just did a hot wash, what we call a hot wash, this week on

Katrina, to look at lessons learned, and are really doing a lot of debriefing around that. The White House has been doing a lot of debriefing, taking a look at lessons learned. SAMHSA has participated fully in that. In fact, I'm pleased to say that in that review it was pointed out that the relationship between SAMHSA and FEMA is viewed as a potential model for how federal agencies should work together, because we do facilitate the application process for the crisis counseling program and the regular support program that goes on, and we work very closely together on deployments, FEMA as the coordinating agency and we as the implementing agency around mental health and substance abuse.

So that was exciting. I mean, there are some real bright spots, a lot of bright spots in the federal response that you don't hear about in the media, but people who really did an excellent job.

But with that said, we also learned in the Katrina response that we need to think in terms of more than just crisis counseling. We need to think in terms of more than just continuity of care for people with serious mental illness, people with addiction, children with serious emotional disturbance. We also need to think about the different populations for whom we're responsible all the time, the homeless population for example, the older

adult population, the criminal justice population, children and families very much. We began looking at this, co-occurring, again the continuity of care issues. We had to make sure methadone treatment continued. There were 1,300 people in New Orleans who were on methadone treatment. They began showing up in Houston and other places, and we had to make sure states were equipped with dollars as well as with resources. Again, it was an effort among the whole system.

The field, the providers, Mark Perino and his folks working with the states and working with us. It was a team effort to provide continuity of care. NAMI was very much homed in on people with serious mental illness and their loved ones. We worked with them and the states to make sure there was continuity of care. That tells us that we need to continue to make disaster readiness response a priority, but it's now being moved to a cross-cutting principle, because we need to make sure that it's involved with everything that we do, and that's the next phase, bringing it to the next level.

We'll continue now the two-year matrix work plan on our website with it. So I want to assure you we're not dropping it as a major focus and priority, but we are viewing it now as bringing it to the next level, that we've got to think about all the populations in a disaster.

Katrina brought that face to face reality to us, that we need to be consistently thinking of all that we do.

With that move, we're going to be adding two priorities to the programs and issues, because I also believe that when we add programmatic priorities or issues on that axis, that leadership axis, not only is it a statement of long-term systemic change but it also can be a statement of maybe we need to really take a look at focusing on an area to jump-start it and really get the field around it and move it ahead, and that's where this next one really fits there, and that's suicide prevention.

So again, it's a prevention item, a prevention agenda. It's one that CSAP and CMHS have worked very closely on. CSAT has also been involved with it.

But when you take a look in this nation and there are 30,000 suicides a year, and we're confident that's a low count because a lot of deaths that are ruled accidental are probably suicide, and we know that that's the reality -- those of us who have been in the field who have dealt with it know that's reality. But 30,000 is a count that we have, and just take that number and compare it to 18,000 homicides a year. I think that's a staggering figure, that more people kill themselves than kill each other in the course of a year, and the government does a lot to try to bring down the murder rate, and I'm all for

that. We need to keep bringing the homicide rate down. I'm not saying we should stop our efforts in that area.

But I'm also saying we should put forth at least as much effort in addressing suicide in this society. Again, talk about trying to address an issue that's steeped in stigma, that's steeped in discrimination in terms of let's don't deal with it or talk about it. Suicide is one tough issue to address, and if SAMHSA doesn't put it in the forefront, no other federal agency will. That's our responsibility.

So we are stating it as a programmatic priority. You're going to see it appear on the blue, and what's going to be involved with that, and I'll talk a little bit more about this in the budget in a moment, is some added dollars that we have in that area to look at that, launching the National Suicide Prevention Strategy in a more formal way, beginning to move that ahead and really doing a lot of activity and partnership again with the states.

It's also very much tied to mental health systems transformation. That's going to be a part of the transformation agenda. So it's a very timely thing to do.

The other priority we're going to be adding is workforce development. I think it's been a cross-cutting principle. We're moving it from a cross-cutting principle

down to a programmatic priority to really commit ourselves to coming up with an actual workforce plan in the fields of substance abuse treatment, substance abuse prevention, and mental health services, because as we know, it's been an issue for years that we've struggled with. In fact, I can't think of a year -- I've been in this field 26 years at this point, 27 years, and I remember first entering the field. I was in a rural area, a community mental health center that later also became a drug and alcohol center as we emerged. But I recall the difficulty with recruiting people back then. It never seemed easy, and it's always been difficult for a rural remote area or a frontier area in this country, and I think we need to take a look at workforce development in a very much multi-dimensional way. We need to look at not only recruiting people to the field but we need to put incentives out there for people to go to areas that have been underserved historically. We need to have a focus on cultural competence and the diversity issue to have a viable workforce that's going to be relevant in meeting the needs.

I'm pleased to say that the work that's been done in the centers already, and all the work now has been focused on the Annapolis Coalition effort that started at CMHS but we've moved the activities from CSAT and CSAP into listing CMHS into that activity. There is a foundation of

a lot of data that's been gathered on what the issues are, what we need to begin to look at doing, some models that have been identified in different parts of the country that we need to evaluate to bring it to a systems level, again taking a look at various degree programs, collaboration with community colleges and also academia to do the ongoing training, and also not only to think about recruitment but retention in the field. We have to think about both. In fact, some can make the argument that maybe retention should be focused on as a priority and then recruitment instead of the other way around, and I think there's some value to that.

The other thing I want to say is we all recognizing making this a priority is not an easy thing to do because workforce development is a tough, tough issue to address. But again, I'm confident as we engage partners.

So those are the major changes to the matrix that you're going to be seeing that I think help bring our efforts to the next level.

The budget, the '07 proposed budget. I think there are opportunities for innovation in every budget that we've put forth. That's how we tried to approach it. I think this is proving to be another tough budget years that calls for more tough choices in reductions. Overall there was a 2 percent reduction in discretionary spending. Our

budget is all discretionary, and we're seeing about a 2 percent decrease overall.

The good news is, without going into detail, I think as we started out in the process it could have been a lot worse. I think as we went through the process we held our own in terms of what we needed to do. So again, I compliment the management throughout SAMHSA and the staff who helped us formulate the budget and make our case.

Overall, the President's '07 budget proposal is $3.3 billion for SAMHSA. That's a net increase of about $67 million from the FY '06 appropriation. Again, the rule of thumb we used this year and we use every year is we take a look at reductions. We look at those grants that are coming to a natural end. In other words, we really work hard to avoid cutting grants mid-term, unless we see a grant is totally ineffective, of course. But if we're seeing that a grant is coming to an end, we want those grants that we just awarded the year before and the last couple of years to be able to continue to realize the full fruits of their labors. So that was the rule of thumb we used this year.

In '07, the Strategic Prevention Framework Fund will continue to be realigned. It's important for the framework's implementation. While this grant, the proposed grant, does not have new Strategic Prevention Framework

grants awarded in '07, we still have $95.3 million proposed to support the continuation of the SPF grants and contracts that we have out.

CSAP's programs of regional and national significance funding in '07 of almost $181 million will support 344 grants and contracts consisting of 335 continuations and 9 new competing grants.

CSAP and CSAT will continue to manage 20 percent of the prevention set-aside of the Substance Abuse Prevention and Treatment block grants. The '06 set-aside for prevention, that totals around $352 million. I encourage you to make a note of how much money out of the block grants will go to prevention. That's what we need to be focused on and hopefully continue to see it and see it come to a realization.

I want to highlight one aspect of the budget which is not directly in CSAP but it's very critical to substance abuse, and that's the Access to Recovery Program. Again, we've had Access to Recovery now implemented. We're in the third year of funding. We'll be entering the third year of funding, and the good news is we have a lot of positive stories to tell out of the 14 states and one tribal organization that have implemented Access to Recovery, and we're learning a lot already through the process. We're now just coming upon beginning to get the

first year of data in completely. It's going to be telling us a lot. We've been working very closely with the states to fine-tune their efforts.

We obviously are very, very focused on assuring that there's an expansion of the provider base with Access to Recovery, which includes recovery support services. I think one of the most profound things about Access to Recovery is never before have we been able to fund to any great extent with governmental dollars recovery support services which helps people sustain recovery. It really is focused on a life in the community.

It includes self-help support. It includes those types of services that people need in order to begin to get employment, in order to keep a job, in order to begin to get connected to the community. Again, I think it's had a profound impact. Also, we've seen expansion of faith-based providers in both recovery support services, very much in that area, as well as in the clinical treatment services. So again, progress is being made.

One note I will mention on Access to Recovery, it's been a Presidential initiative. It continues to be a Presidential initiative. If we would have had appropriated to SAMHSA what has been proposed in the past several budgets for Access to Recovery, we probably would have had close to $350 million more dollars in the SAMHSA budget for

treatment. But unfortunately, we've been held at $100 million for Access to Recovery. 2007 would represent a new grant cycle, and we are proposing almost $100 million, around $99 million, for continuing Access to Recovery effort. This year what we've incorporated is an incentive to encourage states to consider using block grant dollars for choice and for vouchers. How this would work is that states can choose whether they want to pursue this or not. So it's based on federalism. We're not telling states that they have to use their block grant for vouchers or have to use any dollars for vouchers. If they apply for the Access to Recovery dollars in this budget, we'd set aside $70 million out of the $99 million for this voucher incentive program.

States, if they're a non-ATR state currently and they choose to put a portion of their block grant, they will get extra points in the scoring of their grant. Plus, any awards that are made, they're able to use dollars for infrastructure with this block grant, 30 percent of the dollars over three years, and that can be higher the first year as long as it averages 30 percent over the three years. That's very liberal, if you will, for infrastructure dollars than we typically have. But again, we want to show that we're serious for states that want to develop the infrastructure and move in a process for using

vouchers and choice.

ATR states will have the opportunity, and the tribal organizations will have an opportunity to apply for these dollars, which again typically in a new grant cycle we don't necessarily have the old grantees be able to apply for new grant money because you want to spread the wealth, so to speak, and give other states an opportunity. But because we want to build on choice and vouchers, if an ATR state wants to apply for these dollars, they need to put up at least 20 percent of their block grant dollars, or $20 million, whichever is less, into a voucher program. Then they will be eligible to apply. They'll continue to get extra credit for higher proportions of their block grant being moved or migrated to a voucher system, and then again the other aspects would apply. They can use 30 percent for infrastructure. Again, we think ATR states and CRIB out of California could be best poised throughout the country to be able to build on choice because they already have a very firm foundation in Access to Recovery.

So it's a way of leveraging more dollars for choice, leveraging more dollars. We'll be looking for states to expand recovery support services, to expand choice, including faith-based, and realize the outcomes that we've hoped all along for ATR, but be able to turn that $70 million into perhaps $100, $200, $300 million of

vouchers, depending on how it could come about and what the applications look like. So we're excited about it. We're encouraging it. We're starting a dialogue with states to begin exploring interest in how they might do this. But I think it's a great opportunity.

With that said, let me open it up just for a few questions.

MR. KOPANDA: Thank you, Charlie.

I just wanted to point out that I think Sue said earlier that Charlie might be considered a preventionist. If you had seen Charlie behind the scenes on this budget, I think you'd really believe that that was true. He was very, very supportive of our work.

Are there any questions?

MR. DeWISPELAERE: I have a comment.

MR. CURIE: Yes, Jay?

MR. DeWISPELAERE: Or a question, Charlie. Welcome and thank you for taking the time to come. Actually, two of them.

First, the Council at our last meeting sent the joint letter to you in regards to not just staff at CSAP, although that's what we're mostly concerned about. I assume it would be staff across SAMHSA, that we have the adequate staff to manage all these additional responsibilities. Can you give us an update on that? Are

you comfortable with where we're at now?

MR. CURIE: No, not necessarily. One thing we've tried to do throughout all of SAMHSA over the last few years is keep the balance of the required ceilings that we have and at the same time filling as close to those ceilings as possible. Historically, I think there have been times when SAMHSA has stayed quite a ways from the ceiling, and what we've tried to do is take advantage of filling up toward those ceilings.

Now, it's been particularly challenging over the past two or three months that we had a mandatory hiring freeze throughout the federal government. So that crimped our efforts. But the good news is I think we've submitted a plan, and I'm optimistic that's going to be lifted soon, because each OPDIV has to do that. With that being lifted, we're working very closely with the centers to see what their needs are. Again, prioritization is real critical to make sure that we gear the staff toward where they need to be, and as we assess things such as Drug-Free Communities in particular, for example, making sure we have the adequate staffing to do that.

I think the great news with Drug-Free Communities is I think SAMHSA and CSAP have particularly done a tremendous job having a greater amount of staff focus on the grantees in Drug-Free Communities than maybe

they've really ever had, and we're committed to continuing to do that.

MR. DeWISPELAERE: The other comment is with regard to Drug-Free Communities, since you're on that subject. I think you and I have had this conversation, not publicly, but I would like to say that I was in 70 places last year across the country, and in many, many different states Drug-Free Communities ties us directly to the grassroots movement in this country. I can't emphasize how important that move was to SAMHSA, to CSAP, and what that does for the SAMHSA/CSAP image out there in the country, because what's different with that block grant money is the block grant money, for whatever reason at the local level, is still considered state money. As much as we tried to get that recognized, and we made great strides, the Drug-Free Communities really puts us in touch with what's going on, and accessing that commitment locally is what this is all about. I want to congratulate you on that and encourage you, whatever it takes, to continue that relationship moving forward. Thank you.

MR. CURIE: Thank you, Jay.

MR. KOPANDA: Allan?

MR. SHINN: Hello, Charlie.

MR. CURIE: Hi, Allan. How are you?

MR. SHINN: Thank you for spending time in

Hawaii. I know that you've been out quite a bit. I wouldn't say quite a bit. Twice.

(Laughter.)

MR. SHINN: We won't tell them about the times you just came out. Sorry. But we're going to get you on a surfboard sometime, next time you come out.

MR. CURIE: Thanks for encouraging me to come back, Allan.

(Laughter.)

MR. SHINN: But I think it's important because I know Charlie understands the problem in Hawaii with the serious problems around ice and crystal meth that we're having there. So I appreciate you coming out and spending time with us.

MR. CURIE: Thank you.

MR. SHINN: I also wanted to echo your compliments on your staff because I think my experience has been with project officers and administration that they've been both knowledgeable and professional in their work, and I really appreciate their contribution. So thank you for that.

I have to bring up, though, this abandoned child syndrome. That has to do with the ecstasy grants being shortened, the five-year grants being shortened to two years. I spent all day yesterday with ecstasy grantees

because Hawaii has one, and we're involved in that also. I think some of the main points that came out, I think one was the lack of clear rationale of why ecstasy grants were sort of singled out and eliminated just when they were started to get up and going. Many of the ecstasy grantees felt that the ecstasy initiative and other club drug initiative provided a very flexible, versatile platform to address emerging drug needs, as well as ecstasy and cocaine and other drugs that we know are used on the party scene and among our youth.

The other was that there seems to be this feeling that it was uncompleted business, that there wasn't enough time to really establish good evaluation marks and work on the outcomes so that we really will never know whether the single-drug kind of strategy really works or not. So that, again, was very disconcerting to a lot of the grantees.

Then I think the third point was that this model really seems to fit into the specific strategy on how you could work with diverse groups and organizations within your community to really put together a very meaningful prevention strategy. It seemed to really fit in.

You're a social worker, Charlie, so you know that we're going through a grieving process here. So there's anger and disappointment, but also questions that

have come up, and I wanted to ask you to address that, if you could.

MR. CURIE: Well, I totally understand the disappointment, the anger whenever a decision like this is made. Clearly, those people who have committed themselves in those agencies and entities to really build an approach, it's extremely disappointing, and that's what makes the decision a really hard, tough decision when you're prioritizing where to put dollars. I think the questions are all very legitimate questions.

What really drove this decision was I'd say two primary things. One, a tough budget environment in terms of making some decisions in terms of where we're really prioritizing. Secondly, the data that's coming in showing that ecstasy and other types of drugs, when these grants were first envisioned and first developed and came out of Congress, the data was very different then than it is now, and in terms of trying to take a look at where we need to gear resources based on where it may be increasing overall. So that really was a major underpinning of the decision, along with the tough environment that we're in.

I encourage the grantees that were teed up and beginning to do this, that we stay engaged with them to see what we can do, especially as SPF does take off. Our goal with SPF, in fact, is for all communities to really, where

possible -- this is probably one of the tougher parts of SPF -- put all their dollars on the table in a community and kind of say these dollars, let's look at them initially as uncommitted dollars, even though everyone is going to have their string tied to them as they put them on the table. There will still be a string back to the entity that threw them on the table. We understand that. But let's pretend for a moment that they're uncommitted dollars, and then when we develop our strategy for the community and determine what programs we need to be investing in, determine if where those dollars came from, if that's where they should continue to stay or whether we should be moving those dollars to programs because we have more information now of what the issues are and the risks are and what the drug use is in that community.

So I would encourage all those grantees to be at the table in that process, but I certainly understand it. That's what drove the decision. So thank you, Allan. I appreciate that.

MR. KOPANDA: I think we have time for maybe one more.

Sharyn?

MS. GERINGER: I appreciate your time, too, Charlie. It's good to have you here with us.

MR. CURIE: Good to see you, Sharyn.

MS. GERINGER: As you know, underage drinking is really the thing that's closest to my heart, and I'm wondering about the funding for this new initiative that the Secretary is really very interested in, obviously. Is that actually taking more money out of our budget or are we getting more money coming in to deal with those, or how are we doing that?

MR. CURIE: That's a wonderful question, and probably not a real straightforward, easy answer in terms of money actually coming in. Clearly, Sharyn, you're exactly right. The Secretary has embraced this, and we had our first national conference on underage drinking in which we brought all the states together and also rolled out the PSAs and announced the Surgeon General's Call to Action. We're conducting a series of town hall meetings across the country.

The money that we're really looking to invest in this, we do have dollars set aside in SAMHSA for this type of activity. We're prioritizing to be funding these with those dollars. I believe, Steve, some of the other agencies have put up some dollars, too, for some of the process?

MR. WING: They contributed to the website and the national meeting.

MR. CURIE: Okay, for the website as well and

the national meeting.

So the good news is, Sharyn, while we might not be getting a lot of newly appropriated dollars, there's been a reallocation of dollars around this priority from members of the ICCPUD, the different federal agencies and us. Also, the Strategic Prevention Framework, those dollars again each year that are being placed into that, we've received some appropriations specifically for that, were geared toward underage drinking.

So I think it's as robust a funding in this tough budget environment as we have. Obviously, I'm there and I encourage everyone to advocate for more as we move along, because I really believe that we're starting a groundswell of support and attention to this issue. It's been gratifying for me as I've traveled across the country and stayed in, I believe it was Nashville. I see Sherri Nolan, my senior advisor for juvenile justice and criminal justice. She was there. I was there with the commissioners of corrections across the country, and I turned on the TV in my hotel room, and "David" came up, the underage drinking PSA. So it's always great to see the PSAs that you've been a part of playing, and I know it's getting a lot of attention.

I think it's the type of topic that's going to continue to receive great sympathy on the Hill, great

sympathy within the administration as we continue to move ahead. As the town hall meetings take hold, and as outcomes come from that, as each state has their own plan, I think we really set the stage to be able to garner more support, and I anticipate that when we look at attitudes across the country in five years, we're going to see different attitudes about drinking, and underage drinking in particular, than we see today. It's going to be better.

Thanks for your ongoing support.

MR. KOPANDA: Charlie, do you have time for one more question?

MR. CURIE: Yes.

MR. KOPANDA: Judy?

DR. TELLERMAN: Thanks. Hi, Charlie. Thank you for being here with us. I just wanted to just mention that years ago I was a suicidologist, and I was doing research for the psychological autopsy study of teen suicide in Cook County, and I then was asked by the State of Illinois to be the prevention person for suicide prevention and wrote a number of things, curricula, and after a needs assessment they then asked me to develop this group counseling program for middle and high school. When I was working on the program, we found that it was impossible to go into schools and communities and work with children with anything with the name "suicide prevention"

in it, that it was so stigmatized that it was just not going to happen.

At that time I developed this model, which I then wrote about, in which I described this program that we developed, not using the word "suicide," although it was in the research part, but I talked about the continuum of self-destructive behaviors, and it fits really well with SAMHSA. We have prevention on a continuum, and self-destructive behaviors are also on a continuum, whether it's substance abuse and the various things that kids could do, and then the end of that continuum is suicide. So I conceptualized the group program as being one to prevent self-destructive behaviors, and of course if you're intervening at any point along that continuum, you're ultimately preventing suicide. That seemed to work and was more acceptable to the community and the parents and people who found it just too upsetting to say this is a program called suicide prevention for our kids. I'd be glad to be quoted on that or have whatever -

MR. CURIE: I think we'll be following up with you, Judy.

DR. TELLERMAN: Thank you. There's a whole history here.

MR. CURIE: I think it's very good, and I think what I'm hearing you say is when we look at efforts on the

ground level, the front lines, if we're going to be addressing the stigma issue, we need to think very carefully about the message, and I appreciate that. Thank you very much.

MR. KOPANDA: Thank you, Charlie. We really appreciate your time and being here, spending time with the Council.

(Applause.)

MR. KOPANDA: Moving our agenda along, we need to have our next presentation, and that's Steve Wing from the Office of the Administration, our Office of Policy, Planning and Budget. He's going to present to us on underage alcohol use.

We're going to dim the lights here because Steve does have a PowerPoint presentation.

If I could just interject for a minute, we will probably cut back the amount of time on the break. We have a half hour scheduled for the break. When our Council members' sandwiches arrive, we will distribute them and maybe we can eat as we go here, because it is getting a bit past lunch.

MR. WING: I'm a little technologically challenged, so I'm getting some much needed help here.

Has everyone here seen the PSAs that Charlie mentioned? You haven't? Well, let's look at one really

quickly and then move from there. Let's do "David."

(PSA shown.)

MR. WING: There's also "Lisa's Story." Why don't we show that one, and then we'll go on.

(PSA shown.)

MR. WING: These PSAs are being shown across the country. Many of us have seen them, and they actually won an award from the Ad Council last year for the best PSA that they've developed. I'm getting a bit ahead of myself, but one of the things that I found very interesting in being part of a process as really an observer in the development of these was how engaged everyone was at the Ad Council. The reason is that most of the people involved in the creative end and in reviewing these and so on are somewhere between their mid-30s and their 50s, and they all have kids in this age group. So the first thing that happened was they started looking at the statistics and they said, "Oh my heavens, we didn't know this stuff." Then they started going and actually practicing on their children and talking to them, and they actually said in one of their meetings that they were far more -- the Ad Council people said to a review board of distinguished ad agency executives in New York that they were pleased that they were so engaged, and one of them came back and said, "Well, you know why? Because we all have kids this age."

I was asked to tell you about the national meeting that we had last fall, and I'll spend a little time on that. But I thought, both in the interest of time and also because I'd rather talk a little about the future as well as the past, that I'd highlight certain other things for you that we're doing in underage drinking.

The first thing I want to mention, though, is that we have this new government website, which we're looking at right now, that brings together resources on underage drinking from all across the federal government. As Mr. Curie mentioned, each hair is an interagency committee on underage drinking, and that committee jointly supports this website, and there's the membership. So the government is working in an increasingly coordinated way on this topic.

One of the things that has very recently been released is a report to Congress on underage drinking. It just went up on the website a few days ago. You can go to this button to take a look at it. It's going to be printed, but we wanted to get it up in the fancier version, but we wanted to get it over to the Congress as soon as we could. So we went ahead and put it up in electronic form, and there will be a printed version later.

The thing that you'll find interesting about this report, I think, is that it has, for the first time,

federal targets for reducing underage drinking. There's a five-year target on prevalence, there's a five-year target on binge drinking, and there's a goal of increasing the age at first use. It also has three overarching goals around which we're designing and planning what we're doing.

What this report mentions is that there's a brief thing on looking forward. Just for your information, one of the problems in the federal government is that when a report process is a little disconnected from the budget process, you can't get out ahead of the President's budget. So there were some constraints there. But when we talked about looking forward, we said that we thought there were several things going to be happening over the next year that were going to be pivotal in advancing this issue in a positive way.

The first one was the release of the Ad Council campaign, which took place last fall, and those, as we've talked about, those PSAs are getting good marks. The second one was the national meeting that we had. The third was town hall meetings, which will be held in March. The fourth was the Surgeon General's Call to Action. So what I'm going to propose to do is to give you a quick update on all of those and then commend you to the website in the interests of time when, at your leisure, you can click around in here and find more detail on every one of them.

The national meeting. Last fall, on Halloween and the day after, we brought teams in from every state in the United States except for four states -- Mississippi, Louisiana, Arkansas, and Texas that were unable to come because of the aftermath of Katrina, and we're going to do a special meeting for them later this spring. The Secretary, as Mr. Curie mentioned, is very engaged in this issue. He personally wrote to every governor and asked them to put together a team, and they did, and we asked those teams for the state officials representing a variety of different groups such as prevention, law enforcement, highway safety, alcohol control, and so on. So we had teams from every state and several territories. They met for a day and a half. The meeting was opened by Mr. Curie and the Secretary. There was a talk by T-K Li on the science and epidemiology of underage drinking, and there was a talk by Ralph Hingson on solutions. The PowerPoint for both of those are on this website under "Resources" if you're interested. There was a panel discussion on various states that have taken positive and organized action on the subject, and there were breakout meetings held by various ICCPUD members. So, for example, the Department of Education had a breakout meeting for the education folks that were there. There was a breakout meeting for the criminal justice people, and so on.

The second day was devoted to starting to plan the town hall meetings, and it was at that meeting that Beverly Watts Davis announced that Mr. Curie had approved stipends for up to 1,500 communities across the country to just help out with these town hall meetings.

Following the meeting last fall, we worked with the teams from every state and asked them to identify communities that could receive the stipends. First of all, we heard Jay talking about Drug-Free Communities. It was important to both Charlie and Beverly that all the Drug-Free Communities get a stipend for a couple of reasons. One is they have the infrastructure. So when you're only giving a modest amount of money, common sense says you want to build on something. The second thing is that it encourages perhaps the occasional Drug-Free Community for whom this is not at the top of their list to think about the issue.

In addition, we went out to each of the state teams and asked them to select communities, and depending on the size of the state they got 20, 15 or 10, to nominate that number. They sent in their nominations, and CSAP is now giving the money out to the communities. We said we have a target of holding these town hall meetings on March 28. It's not a rigid target. If a community has an important basketball game and they know nobody is going to

show up, they can certainly do it some other time, but we tried to have as many of them as possible on one day so that we could say this was a national event, and that is the way it's turning out.

Now, you may not have noticed what I did, but at the very top of the website there's a little button that says "Town Halls," and that's where we are right now. We're going to go down here, and there's the town hall locations, and that tells us that right now 523 communities have not only been named but they sent all the paperwork back. It won't shock you to know that we're a bureaucracy too, and so we're not putting the names of the communities up until they've sent their papers back, but we expect that we'll have near our target number, if not our target number.

Now, what this does is allows us to go and click on a state, and you can look at where these town hall meetings are going to be held. I thought you might be interested when you go home to take a look and see what's happening in your state or your community.

The town hall meetings are each community that's receiving a stipend and, for that matter, any community that's interested is receiving a package of information that includes a DVD that shows "David" and "Lisa" at the beginning and the end, and it has some

information, an introduction provided by Mr. Curie, a much shortened version from Dr. Li and Mark Goldman at NIAAA, and it has some clips from the Surgeon General's speech and closes with Charlie encouraging communities in the short run to use our "Reach Out Now" materials, which all of you know about, and to use the Ad Council materials, but more importantly to, as a community, develop a comprehensive plan reducing underage drinking that looks at both reducing demand and looks at reducing availability and access to alcohol by youth.

So that's where we are with the town hall meetings. The final thing I want to talk about for a minute is the Call to Action. There's a committee that's made up of the Surgeon General's office and SAMHSA and NIAAA that's kind of working on this on a day to day basis, and it's two-thirds written. In the next day or so there will be a notice going out in the Federal Register saying that we are reiterating what the Surgeon General announced last fall, that he will be issuing a Call to Action on underage drinking and asking any interested parties to send comments in on what they might like to see included. I don't have it in front of me. I believe it's limited to 500 words. We do have to read these things. We will not be sending replies, and that's stated in the Federal Register notice, but I thought you might like to know about

that. So we're writing and we're also seeking input. The goal is to have that released later this spring.

MS. RUSCHE: Can you put a link on your website to that notice in the Federal Register when it's published?

MR. WING: That's a good idea. Yes, sure. I'm getting old and I forget things, so let me write that down.

So that's where we are. As Mr. Curie said, there's a lot going on right now and it's very exciting, and I think that I'd like to close with mentioning a few people from CSAP who have been very involved in this.

Beverly, of course, who is working with Mr. Curie now. She has been very supportive of these efforts and was key to getting the funding for the town hall meetings. We had planned the town hall meetings, but we didn't have the funding identified, and I daresay without the funding it wouldn't be likely that we'll be doing nearly as well as we're going to be.

The idea of the town hall meetings came from Mike Lowther, who, like me, is old enough to remember Chemical People, and I think that we're very grateful to him for that idea. He's been a key part of this process. Peggy Quigg and Gwen Ensley, who works for Peggy, have also been really important, Gwen in particular. I don't know how many of you know her, but she's a very committed person and has done tremendous work on all of these projects.

So that's where we are. Do we think we're going to end underage drinking next week or in a year as the result of some of these efforts? No, but we do think that we have a chance to at least significantly raise the visibility of the issue, stimulate discussion, get parents and communities to start thinking about the issue, and maybe most importantly as part of that to get the information out that we know now that we didn't know 10 years ago, like the fact that you're more likely to be an alcoholic if you start drinking young. It strikes me that there are a lot of parents that, oddly enough, are saving big chunks of money for their kids to go to college, and yet they don't realize that if they start drinking early that money isn't going to be used very well, and we need to get that information out to them. I think we've got a good start on that.

MR. KOPANDA: Thank you for all your work on this.

We do have time for some questions. Any questions from the Council?

MS. RUSCHE: Have all the funds been distributed for town hall meetings or are those still available?

MR. WING: Well, each state has nominated their people. They haven't all been distributed yet.

MS. RUSCHE: And are the state teams listed somewhere?

MR. WING: The state teams, we don't have them on the website, and I'll tell you why. Mrs. Bush from Florida brought her husband's cabinet with her. We have state contacts. If you would like to know who they are, they were printed in the program for the meeting in the fall, but we haven't put them up electronically -- you understand why. Our goal, which we succeeded in in many cases -- I mean, we had the Attorney General of Maine there, we had governors' cabinet members, and our goal was to push this issue into the highest reaches of state government that we could get it pushed into. Our secondary goal is to not do something that makes them wish they'd never heard of the topic. But we can get you the list.

MS. RUSCHE: Thank you.

MR. KOPANDA: I think Don had a question.

MR. COYHIS: Maybe I can find this out from the website, but do you know if the tribes were eligible for this also?

MR. WING: They certainly would have been eligible. A coalition or a tribe would have been eligible. I don't know what tribes have or have not been nominated.

MR. COYHIS: Okay. Thank you.

MR. KOPANDA: Any other questions for Steve?

(No response.)

PARTICIPANT: Good job.

MR. KOPANDA: If not, thank you very much, Steve.

MR. WING: Thank you.

(Applause.)

MR. KOPANDA: Tia, do we have sandwiches here? Should the Council members go to the back? I think we'll do that. As you all know, while you're here, you're federal employees. So this is what we do, pay your own way. So thank you very much. We want to appreciate Peg and Will and Eliza Jones, who all helped.

If it's okay with you, we'll go along with our next presenter then. Richard Moore is going to give us an update on Drug-Free Communities. Richard Moore, as you know, is one of our branch chiefs in our Division of State and Community Assistance and our lead on Drug-Free Communities.

MR. MOORE: Thank you, Rich.

Good afternoon, Council members, and members of the audience. My name is Richard Moore. I'm a branch chief in the Division of State and Community Assistance, and I'm the CSAP management lead for the Drug-Free Communities Support Program. I'm going to provide you a brief update on the Drug-Free Communities Support Program.

I'll provide you with a summary of the 2005 Drug-Free Communities grant awards. I'll also go over CSAP's 2006 Drug-Free Communities program priorities, and lastly I'll outline the 2006 Drug-Free Communities funding process.

Before I get started, I'd like to ask that the Drug-Free Communities project officers in the audience stand up. I'd like to take an opportunity to publicly recognize these individuals. They do an exceptional job in terms of supporting CSAP's efforts to provide technical assistance in support to those grantees, and I just want to give them a hand.

(Applause.)

MR. MOORE: The Drug-Free Communities Support Program provides grants of up to $100,000 to mobilize community coalitions to prevent underage drinking and youth substance abuse. The Drug-Free Communities grants support coalitions of key community providers and stakeholders and other partners that build capacity within communities.

The program enables Drug-Free Communities to support coalition development, to promote community planning and decisionmaking, and it also promotes evidence-based prevention programs to reduce underage drinking and substance abuse. The program is a collaborative between the Office of National Drug Control Policy and SAMHSA, and its mission is to achieve two goals.

One is to reduce alcohol and substance use among youth, and the other is to strengthen collaborations among communities and other partners in their efforts to prevent substance use and alcohol use among youth.

Through an interagency agreement, ONDCP contracts with SAMHSA to manage, monitor, and support capacity building with all of the Drug-Free Communities programs. CSAP is the main point of contact between the Drug-Free Communities programs and the Drug-Free Communities. Through a competitive process in 2005, SAMHSA issued 756 grant awards. There were 176 new awards, 24 new mentoring awards, 543 continuing coalition awards, and 13 continuing mentoring awards. The staff worked with 87 of the continuing awards to address high-risk issues associated with direct services, and over a 30-day period these grantees were able to submit revised budgets, and we were able to take them off of high risk. I want to give these guys a hand because that was a tremendous effort on their part.

(Applause.)

MR. MOORE: The map that you're looking at right now shows where all of the Drug-Free Communities are located across the country. If you're interested in getting additional information on the grants in any state, you can just go to the SAMHSA website at www.samhsa.gov and

go to the Grant Funding Map and get information on any of these grants.

CSAP's 2006 DFC program priorities are to establish the Strategy Prevention Framework as the operating system for 100 percent of the Drug-Free Communities coalitions. We recognize the SPF as the management system that best allows communities to do planning, community assessment and prevention-based, evidence-based programs that have outcomes. As part of that, project officers will conduct 300 site visits this year to support technical assistance, to support program compliance, as well as to make sure that all of these projects are able to convert to the SPF framework.

We're very pleased to announce that today the Coalition Online Management and Evaluation Tool has been launched for Drug-Free Communities programs, as well as other SAMHSA-funded coalitions. COMET is a web-based data management system that is designed to support programs in their efforts to do conversions to the SPF. In addition to that, the web base will allow project officers to go into the system and monitor program achievements. It will also support and serve as the data collections system for program reporting requirements. That includes the semi-annual reports, it includes ONDCP's GPRA measures, and it also includes CSAP's NOMs measures. Lastly, COMET will

allow the national evaluation and the contract with Bechtel to accomplish the national evaluation on the Drug-Free Communities.

Now, as Steve indicated, CSAP is also supporting the Drug-Free Communities, your participation in the town hall meetings. At this point in time, we have about 80 percent commitment on the part of the Drug-Free Communities to participate in this, and our goal is to get 100 percent participation. So we'll continue to work on that.

In addition to that, we will continue to support coalition training and TA provisions to all of the Drug-Free Communities.

The last thing that I want to talk to you a little bit about is the 2006 award process. In 2006, we will have a new non-competitive continuation award process. The applications for the continuation awards are due April 15. I didn't have anything to do with having those being due when the income taxes are due.

MR. DeWISPELAERE: When are they due again?

MR. MOORE: They're due April 15.

MR. DeWISPELAERE: Thank you.

MR. MOORE: The process for the continuation awards this year will be that they will be evaluated for compliance as well as progress, and we hope to be able to

have those identified well before we get the new grant awards in.

This year we'll have a new competitive announcement going out, and as Rich indicated we anticipate that award will be going out very shortly. The due date for the coalitions will be April 15 as well, subject to change, depending on when the awards actually come out. For the mentoring, they will be announced a couple of weeks later, and right now the due date for the applications will be around April 30. We anticipate having approximately 100 coalition awards, new awards, and about 20 new mentoring awards. When I say new awards, those awards are to organizations that have never received DFC funding or they've had a lapse in funding and can reapply in the competitive process, or if they're going for their second round of awards.

We plan to have and we've scheduled five application workshops. There will be a workshop in Washington, D.C.; there will be a workshop in Oakland, California; there will be a workshop in Houston, Texas; there will be one in Detroit, Michigan; and we also plan to have one in Denver, Colorado. The application workshop that we will put on in Denver, Colorado is specifically designed to work with American Indian and Alaska Native programs. We will be working with our American Indian and

Alaska Native TA center, One Sky, as well as White Bison, to try to improve the representation of Drug-Free Communities awards within tribal communities. So we're very pleased about that.

If you want to get additional information about the RFA announcements or the planned application award workshops, please go to our website at www.dfc.samhsa.gov, and that will give you information on this process. You'll know when the awards will be due, due to our not being able to tell you that they're actually announced right now.

At this point in time, I've covered the main information that I wanted to share with you. If you have any questions or any discussions, I'll be glad to entertain them.

MR. KOPANDA: Jay?

MR. DeWISPELAERE: Richard, welcome. As you can tell, I'm a big fan of Drug-Free Communities.

MR. MOORE: So am I.

MR. DeWISPELAERE: I've been around long enough to have been involved in helping to write that legislation years and years and years ago. But one of the issues I see in the field, and as you know I work with many communities that are Drug-Free Communities sites -- can you back up a slide while you're there?

MR. MOORE: Which one?

MR. DeWISPELAERE: Technical assistance through the Institute.

MR. MOORE: Sure.

MR. DeWISPELAERE: Can you elaborate on where does the CAPTs fit in there and where does states that choose to use assistance other than the Institute or the CAPTs fit in there for technical assistance to the coalitions?

MR. MOORE: I can describe to you one specific area where the CAPTs are working with CSAP, and that is in terms of providing training, the Train the Trainers in the COMET system. The COMET system, we're very excited about the COMET system, and it's going to be a resource tool that will be available to the DFC grantees. The CAPTs are working with us to train the trainers, and they will also work with us to do 16 regional trainings across the country for Drug-Free Communities grantees to become familiar with the COMET system. Peggy Quigg is in the audience and she may also be able to give you some additional information on what types of support the CAPTs are providing to Drug-Free Communities.

MS. QUIGG: At this time, the CAPTs provide very little technical assistance directly to the Drug-Free Communities coalitions. Their contract is to provide technical assistance primarily to the states. For this

instance, we called upon them to use their contract as a mechanism to do the logistic support for these meetings because they have the contacts in the regions to know where computer labs would be available. But the Drug-Free Communities Coalition Institute will be providing the actual technical assistance, and we try to make sure that we keep that a fairly clean line between the roles, that there is a $2 million direct grant for the National Coalition Institute to provide TA for that grantee pool, and that is not a primary mission of the CAPT contracts.

MR. DeWISPELAERE: Okay, and that goes back to my concern that I'll share with you, and I'll leave it at that, which is if you're a coalition and you're receiving block grant monies and you're receiving Drug-Free Communities money, there are different standards for training, different standards for requirements for both of them that makes it conflicting for community coalitions. I'm asking if they're all out of SAMHSA or all out of CSAP especially, that we work internally, Dennis and Richard, to have less of a gap in that and bring them together closer so that we're talking one language, which is easier, especially for requirements coming from block grants or Drug-Free Communities. They should be the same thing in terms of what's required.

MR. KOPANDA: Jay, if I may, I think we on the

staff understand that issue pretty well. Right now we have a program kind of -- I won't say in transition, and I won't say in limbo, but somewhere in between us and ONDCP here. So we don't have complete control all the time as to how this gets provided, but we will continue to work internally to make sure that, as much as we can, the TA is integrated to the extent that we're not giving two different signals or two varying signals to the DFC projects from the different sources of TA being provided to them.

MR. DeWISPELAERE: Thank you.

MR. KOPANDA: Any other questions for Richard?

MR. MOORE: I want to make one correction. I indicated that the continuation awards would be due April 15. In fact, they are due March 15.

Thank you very much.

MR. KOPANDA: Thank you very much, Richard.

(Applause.)

MR. KOPANDA: We're at a point on our schedule now where we can actually take a break. I'd like to take maybe a 15- to 20-minute break and come back at 2:30. We'll be back on schedule. Thanks.

(Recess.)

MR. KOPANDA: The Council will come back to order.

MR. DeWISPELAERE: Richard, how many trips to

Hawaii have you taken since you've been -

MR. KOPANDA: Two states I haven't been to, Hawaii and North Dakota. But I have a priority order for visiting them.

(Laughter.)

MR. DeWISPELAERE: I'll invite you to go hunting with me in North Dakota.

MR. SHINN: You can come surfing with me.

MR. KOPANDA: Okay, next on our agenda for today we have a discussion of the National Outcome Measures. Wil Hardy is not with us today. Instead we're going to have Augie Diana, who is detailed to our Division of Knowledge Application and Services Improvement, KASI, presenting on our National Outcome Measures.

MR. DIANA: Hi, everybody. As Rich said, I'm Augie Diana with CSAP. Wil Hardy is our lead at CSAP on NOMs, and he was scheduled to be here, but he had a bit of a misadventure with ice yesterday, and so he's recovering today.

I tell you that, not about the ice but about Will being the lead, because he put this together. So I'm going to try to make as much sense of it for you as I can, and hopefully I'll be able to answer. We have a team of five people who work on the NOMs effort at CSAP, and two-fifths of us are here, Mike Lowther and I. So

hopefully if you've got questions, either one of us can help answer them.

The most important thing about NOMs is that they are going to be required of all SAMHSA grantees. So in CSAP's case, it covers at a minimum the block grant recipients, the state incentive grant recipients, any of our other discretionary grant recipients such as HIV, meth, ecstasy, et cetera. The NOMs are SAMHSA's way of operationalizing its data strategy and ensuring that as much as possible any services that are provided are driven by data. You'll see another slide later about the implementation plan, but SAMHSA's intent is to have NOMs be fully operational in all its centers by fall of 2007. So it's really right around the corner.

Now, the slides, as I look through them, that Will put together appear to be divided into a couple of sections, and that's the way I'm going to try to present them. The first set is what the actual NOMs are, how we came about them, what they are. The second set have to do with implementation issues regarding the NOMs. Hopefully that will be clear in the presentation.

So here they are. There are 10 domains for NOMs in SAMHSA. Eight of those are relevant to CSAP's work. Depending on the grant program, all eight are a subset of the 10 and are the responsibility of grantees.

So the first domain is called abstinence from drug and alcohol use, and CSAP has four measures within this domain. Use in the past 30 days of substances, we have narrowed that to four categories of substances: tobacco, alcohol, marijuana, and other illicit drugs. Age at first use for those same four; perceived disapproval of use for those same ones; and perceived risk or harm for those same ones. This measure and some of the others that you'll see are captured through survey data, and you'll see a little bit more about that shortly.

The second domain is increased or retained employment, return to state and school. This domain was actually at the SAMHSA level about employment. We felt it was important because of our focus on youth to build a school dimension into it. There are three measures here: perception of workplace policy; substance abuse-related suspensions and expulsions; and school attendance and enrollment. These three are all captured from different data sources, each from a different data source, perception of workplace policy through surveys, substance abuse-related suspensions and expulsions through school records, and school attendance and enrollment also through school records but somewhat different kinds of school records.

Two other domains on this slide, decrease

criminal justice involvement and increased access to services. Two measures within criminal justice involvement, alcohol-related car crashes and injuries. Given what Steve Wing presented earlier, the focus on alcohol is really quite important. So we want to see what inroads we're making in this area, and alcohol and drug-related crime. Those are both measured from existing data or archival sources, Uniform Crime Reports, National Highway Traffic Safety Administration data. So the expectation here is we'd collect those from the existing data sources.

Increased access to services, which is our measure of service capacity, is measured by the number of people served. This would be captured by yet another data collection mechanism, which would be grantee reports. Again, you'll see that shortly.

The next two domains, increased retention in service programs, substance abuse, and increased social support and social connectedness. We had to be fairly creative about this first one, increased retention. The intent was to measure whether people stayed in program services, and that's principally from a treatment perspective. Largely through the brain power of Mike Lowther, we came up with this total number of evidence-based programs and strategies because, in a sense,

from a systems perspective, prevention is doing its work well if we're getting people involved in the right things. If we're doing that right, they tend to stay in those evidence-based curricula through the life of the curricula. Also, as a measure of more environmental kinds of exposure, percent of youth who we know are exposed to prevention messages in some form.

The second of those is a survey measure. The first is measured through grantee reporting systems.

Social support and connectedness, we went around and around about this and came out on family communication about drug abuse, and that is also a survey measure.

I think this is the last two domains, cost-effectiveness, which is a fairly strict requirement from the SAMHSA level. We talk extensively about this, but the services provided within cost bands is intended to capture the actual cost to service participants out in the world. Because our services are so varied, we've chosen to break this out by the three Institute of Medicine model categories: universal, selective, and indicated services. We expect there to be differences in the costs for each, and so we're going to create ranges of cost.

MS. RUSCHE: Can you tell me what a cost band is? Several of us don't know that term.

MR. DIANA: If you think about it as, for example, a universal service like a media campaign, that's environmental and I think it fits in universal for us. What does it cost in any particular state? Generally speaking, our reporting entities are states. What does it cost in any particular state or in any particular community within a state to implement that type of campaign? What we're going to do is we're going to take that range of costs and we're going to create a band or a lowest to highest cost, and I believe our measure of this -- we say average cost, but the way we're going to capture that is we're going to take the 25 to 75 percent range of scores, but Bev Fallik on the team could tell you for sure about that. Does that help?

MS. RUSCHE: It does. Thank you.

MR. DIANA: And evidence-based practices, this is the same as the measure we saw in retention. It will be captured the exact same way. We're just going to use it to report on two different domains.

There are a couple of more that are measure-specific-related, and then a lot of implementation kinds of issues.

Substance abuse and prevention treatment block grants, for the block grant, all of these will have to be reported. You'll see again, I'll explain in a later slide

that the majority of these will be reported through existing sources of data. There will be very little, if any, burden on states to report, at least that's what we hope. Discretionary grants tend to fall in the same category, except we can set somewhat different requirements. We've done that already for the SPF SIG. They've got a slightly different level of reporting requirement than the block grant does. Methamphetamine and HIV would have a program level reporting requirement. The others might not have. So they will report on all eight domains, but they may have either more restricted emphasis -- for example, the HIV and methamphetamine, we're going to need to know something about other drug categories that we wouldn't get from the measures, and we may need to know some things about HIV that we don't need to know for the general block grant. So we set those as they're appropriate to the grant program.

In the case of the SPF SIG, we've said they have a responsibility to provide community-level data as well as state-level data.

For Drug-Free Communities grants, they have as part of their GPRA requirements to report the abstinence domain, and currently that's the only one of the NOMs where there's crossover for us. So at the moment, that's what the expectation or requirement is of them.

Data sources are also directly related. I mentioned to you I think of them as three different types of data that are being reported for NOMs. The first is survey data, which is captured exactly that way. Some survey is administered either routinely or regularly, or else grantees have some surveying requirement. The second is through archival data that's readily available through public records like police data and health data, that kind of thing. The third is what we call a peer grantee report, which is data we can only get by grantees providing it to us. So the prime source for our survey data is the National Survey on Drug Use and Health, or NSDUH. That is done by SAMHSA, and we have ready access to the data. What they have to do for us is they have to break the data down to the state level and provide us with estimates. They don't have good numbers across the states, so they have to do statistical estimations to do that, and they've already started to do that for us.

It does say grantee reports. Sorry. For grantee reports, we have provided systems such as Minimum Data Set and Database Builder, which are tracking systems for providers to tell us how many people they're serving and what services they're providing, those kinds of things. So we'll get the access to services domain that way. To the extent that they have to do program-level or

participant-level survey data, they can use Database Builder, which we provide to them free of charge. There also are systems out there that are in use in states that we have nothing to do with. They just developed them on their own or used a commercial vendor, and all those will be aligned. Then the external data source, as I mentioned is the archival data from public records, and those are the specific examples that we have named in there.

Currently in use, and this is to give you a sense that we're now in more the implementation phase, currently in use, for us to have an idea of how ready the nation is to report, what we know is that 23 -- I think it might be 24 at this point. But anyway, at least 23 states and jurisdictions are using tools we've developed, Minimum Data Set and Database Builder. Because we're developing those, there will be no reason for those states not to be able to report, at least technologically. That doesn't consider all the other potential problems with the data.

Other tools developed commercially and for sale, 15 states are using those. Eleven states have developed their own tools, states and jurisdictions, and the remaining 11 are doing work on paper and pencil still, which doesn't mean they can't report, but to get the information to us electronically there has to be some work. This shows you a picture of what that looks like. The

yellow/light green are our systems, the 23 or so states. The pink are commercially developed systems. We felt it was important to say commercially developed generally, because there can be lots of commercially developed systems, and others may emerge, but 12 of the 15 are using the KIT Solutions System out of the State of Pennsylvania. So that's predominantly how they report prevention information. The blue states have developed their own, and the gray are using pencil and paper. Bob Stephenson wanted me to remind the Council that all of the Pacific jurisdictions are using ours, and we know that they need extensive TA and training and site visits from us. So if you have any suggestions for how to do that. Bob wants to personally make those visits, if I understood correctly.

One other major funding mechanism for providing support around the NOMs is State Epidemiological Outcome Workgroups. These are going to be funded in all states and jurisdictions that do not have SPF SIG awards. The reason is, as you'll see up here, the SEOWs are funded either through the SPF SIG or through a separate subcontract. So SPF SIG awards are typically between $2 million and $2.5 million per state. They're expected to direct a portion of that money towards this process. I'll explain the process a little bit more in a second. If they don't have that award, then through a separate contract we're going to

provide them with up to $200,000 in funds for SEOWs.

The purpose of these, the driving purpose of these is to facilitate data collection in states and jurisdictions over and above what we know we can provide through our existing sources. So if we're providing NSDUH, they don't have any work to do. But NSDUH can't provide community-level survey data. So this is meant to facilitate that process. If we're providing crime data but we don't have it at relevant levels of geography, they're to use this to help break the information out.

Third and as importantly, we know that grantees are going to need additional data beyond the NOMs. So these are meant to help them collect whatever additional data they would need. This is going to help them implement the framework. There's a slide later showing that, which I'm sure you've all seen, but just to give you a reminder of it, and I think that's all on there.

There's the framework, very hard to see, so I won't walk through it. But the idea here is that the measures relate to all of the domains in some way. Access is a capacity issue. Assessment and evaluation are areas where we clearly draw on data directly, either to determine where to address funds for problems or to study the effectiveness of our services.

Our plan for collection of NOMs. The idea that

there are data systems in place, that there are technological approaches to doing this, is important because then you can ensure some consistency and accuracy in the information. But then once the data are collected through these mechanisms, we still have to get the data into CSAP and ultimately into SAMHSA.

We're creating, through a contract which you'll see I think on the next slide called the Data Coordination and Consolidation Center, the DC3, we're creating what we're calling what we're calling the National Outcome Reporting System, or NORS. This is going to do the things that you see there. It's going to generate standards for data collection and reporting. So it's going to be our way of communicating to the field that this is what that abstinence measure means. This is the correct way to collect it, and this is the correct way to report it, and we're going to ensure there's consistency in this, in how we communicate it, but also that SAMHSA is signed off on this message.

We're going to create definitions of each of those, and we're going to provide templates for the actual reporting. So if they're using KIT Solutions System, how do they then get the data to us? We will provide templates so there's consistency in how we receive the information. Then we will use the system to generate standard NOMs

reports that we deliver to SAMHSA that then get used in planning, et cetera.

We've already been in discussion with a number of the non-CSAP-developed system users or developers. So we're hoping that those templates that we'll have to cross over will happen fairly easily. We'll see. There's a system that was developed by CSAP called SAIS. I have no idea what that stands for, but we have a customized version of it in CSAP for HIV grantees as well, and that reporting model is what the NORS is being driven by.

I think we've said this. There's the contract I mentioned through which this is happening. The second bullet, "Operational by May 2006," I think I told Will it would be done by June. So probably to make it look better, he said May.

(Laughter.)

MR. DIANA: But I think we'll be ready to go with this by the end of May, early June. NORS is not the hard part. Those templates, transferring those data across, is what's really going to be the hard part. So we'll have something operational for sure around this time. Hopefully, the way the linkages happen across the systems can happen at that time as well.

This just repeats what I said. Even though MDS and Database Builder are created by CSAP, we still have to

create the linkage to the NORS so the data can feed from one to the other. The good news is MDS, Database Builder and NORS are all contained within that same contract, that DC3 contract, so there's no excuse for them not to create those linkages well. KIT Solutions I mentioned. Most of the pink states were working directly with Cheyenne John of KIT Solutions on those transfer protocols. The COMET system is the Drug-Free Communities data system, also being developed by Cheyenne and KIT Solutions. So we think that those solutions will be pretty comfortable.

On the other side, what we produce, what we generate through the NORS we have to feed up to SAMHSA, and SAMHSA has what they call a central service contract. I may get the Ms wrong, but it's State Outcomes Measurement and Management System, in one of those orders. That's what SOMMS stands for. We are creating this in conjunction with that contract, which is managed out of our Office of Applied Studies, which also does the NSDUH survey. So what we generate goes right to SOMMS as well, so that they can then compile the data for all three centers for SAMHSA. So if this sounds like a lot of technological goobledy-gook that you don't understand, know that I don't either. I oversee a lot of this, and I'm just really trusting that they know what they're doing. But I think the data transfer stuff should be reasonably straightforward from a

technological perspective, but much smarter people than me have to think about how to do that, and the good news is they're all talking to each other about it.

The idea that NORS is going to be provided through the prevention platform, as are all of these other things, the MDS, Database Builder, et cetera, is only important because the prevention platform is being created by CSAP as a central portal for a lot of things, including understanding of the SPF, providing interactive tools, providing what we call readiness assessments, so states that are ready to embark on this journey have a sense of just how ready they really are. But the relevance of the prevention platform really to this is that it's going to provide evaluation measures specific to NOMs. So if states have to use them in a customized way in surveys of their own, they can do through here. If they need other measures, they can do that through the prevention platform.

We can do mapping largely through the work of our Workplace Division that Bob heads up and Charles Reynolds leads. They can go into the platform and get access to free GIS tools, and they can not only generate the data that they need but they can see it in a way that tells them something about the geographic area that they're trying to study. So the platform will become the portal, as well as the mechanism by which the data gets spit out

wherever it needs to go.

Besides the access to SOMMS, we intend to make public use data files available to our grantees and others in the public so that they can also make use of the data for their reporting purposes or grant-writing and other things.

Timeliness. The NOMs have already been vetted and approved, vetted with states and approved. The NOMs that you saw reflect the latest agreement with states, not only supported by states but they actually narrowed the list down. They were the ones that told us the list shouldn't be any longer than this, and it shouldn't look different than this. So what happened in December, just two months ago, is what you saw in those first few slides.

For NORS, in May and June we should have the reporting system in place. The State Epidemiological Workgroup should be in place by the summer. Wil Hardy is leading that task. I think he's leading that task. He put that on the slide, and he should know. States that are ready to begin reporting on NOMs we expect that by the summer can start using these systems, and the good news about that is because NORS will be developed by then, we'll get a chance to see how it works really. Whatever you do in a testing environment doesn't really tell you what it's going to be like in the real world. So hopefully by the

summer we'll know more about that.

Similarly for any discretionary grants, our SPF SIGs should really be in a good position by the summer to deliver some data to us; at least we hope so. Full implementation by the end of FY '07, which is a directive from much higher than us.

Additional forms of assistance and resources around NOMs. We mentioned the SEOWs. The CAPTs, there are some CAPTs that are still here. If you don't know this, CSAP's position has generally been if you need TA and training, give it to the CAPTs. So the good news about that is they're really good at what they do. The bad news is they're getting a lot of things to do that they may not have the resources for, but they are seen as a major, major resource around this.

Our SPFAS contract is our main training and technical assistance one, and we just had a meeting a couple of days ago to talk about how to better utilize that contract for support to states on NOMs. The SOMMS contract, that will be a two-way relationship. Besides what we give to SOMMS, they will provide a lot of support to us in things like data definitions and standards and some other things, and there may be some other resources as well.

This slide says that we will begin providing TA

to states in April 2006. I don't know what that is going to look like. This is not an area that I've been all that directly involved in. But the thing that I can tell you about this is we are going to be kind of dividing up the states into their functional levels. So we're going to see those that appear to be most ready to report, which we think are going to be the green and the pink ones from the earlier slide. We may be proven wrong, but that's what we believe.

Based on that, we're going to try to define what kind of TA they need and then go start providing it to them, see how their systems currently report what we need and what their needs are going to be technologically and otherwise for the linkages that we saw earlier.

This is it, the NOMs team. I think Wil must have done this slide based on level in the organization, because Mike is the highest and Kevin is the next highest. The fact that he's on the bottom and he's the lead leads me to believe he's either trying to communicate to you that this is a bottom-up approach, or else he's being very strategic about when you're likely to call him.

(Laughter.)

MR. DIANA: But you have this in your handout. So if you do need to contact anybody, any of the five of us should be able to help you.

I think that's it. Yes, that's it.

MR. KOPANDA: Thank you, Augie.

Do we have questions on NOMs for Augie?

Sue?

MS. RUSCHE: I want to thank all of you for getting to this point, because it's something the field has been asking for for a long time. I want to know, though, how much public access there will be to the data that's compiled here.

MR. DIANA: That's a very good question and it's not one that we have defined yet. There are two sides to it, though. The first is much of the data we're providing is already public access data.

MS. RUSCHE: But you've pulled it together.

MR. DIANA: Exactly. So how we provide it back to them, organized by states for example, GIS maps and that sort of thing, is one of the things that we would certainly intend to provide back, but we don't know at this point what it's going to look like.

The second thing is the areas that are not public accessed already, such as participant-level data, we already know that there are going to be restrictions on what we can provide, but we haven't worked yet with the people in our Office of Applied Studies and OMB to determine what should and shouldn't be provided. But as an

example of something relevant to your question, we've asked for our Office of Applied Studies to provide us with the state data so we can do the mixing and matching as we need to for providing it, and we already know that they would give the data to us without state identifiers. So we couldn't even organize the data by states.

So we're not sure what direction it's going to go, but there may be some pretty severe restrictions on how much identifying information is available on those.

MS. RUSCHE: Thank you.

MR. KOPANDA: Other questions?

Yes, Jay?

MR. DeWISPELAERE: This is a lot to comprehend. Good job on that. You guys have worked awful hard on it.

If you're a ma and pa operation providing prevention in rural country somewhere, am I understanding this to say that you'll report the same in Hawaii as ours would report in Michigan, the same instrument, down the road everybody will be trained or at least have access if you're receiving CSAP funds, whether they be block grant, discretionary, or Drug-Free Communities?

MR. DIANA: That's correct. That's my understanding as well.

MR. KOPANDA: Right now, though, the Drug-Free Communities won't report on all eight. They'll only report

on the one, only on the abstinence one. For some discretionary programs there may be some additional reporting requirements. The NOMs are kind of standard and they would be reported depending on the nature of the programs. You might have, for example, an HIV/AIDS program that would not be -- I'm trying to think off the top of my head. One of the NOMs might be completely inappropriate to ask of those projects, so we would not ask that one. But by and large, if they are applicable to a program, we'd ask them to report them.

MR. DeWISPELAERE: I heard you mention the Household Survey, I think. I think that's what I heard you say. If a coalition somewhere is not using that survey currently, they choose to use some other instrument, that's okay. It's just that that information will need to be gathered from that, correct?

MR. DIANA: There are a couple of answers to that. One of the things I should clarify, not only have the specific requirements around the measures and the domains been developed internally and in consultation with states by our grant programs, but so has the level at which reporting is required. So, for example, one of the ways that states were willing to agree to these requirements for the block grant was if the expectation was that the requirement was at the state level. So at some point,

somebody is going to have to make a decision about what that means for their community providers. But if they are okay with the Household Survey being their measure of perceived risk, then they don't have any responsibility. We're going to provide the state estimate. If they would like to use an alternative source, which they can do, they have to write up a proposal, basically. They have to send the tool that they want to use and actually send the data so analysis can be done in-house, and in that case what becomes their state estimate would reflect also the communities that are included in there.

So the grant program somewhat defines what those requirements are, and states do have the option of nominating alternative methods for capturing the measures.

MR. DeWISPELAERE: But the state will be the final say on that. It won't be the community. So it's back to big daddy government making the decision for the local community. Is that right? It's just plain and simple not right. Those decisions have to be made locally, and I just can't emphasize that enough. I visit these places all over the country, and they want to pull their hair out at people making decisions for them when they have no experience in trying to gather that data. I believe in the data and I support the gathering of that data, but I just want to emphasize the fact that local decisions have

to be made in that regard.

I give an example of one community that's done a certain document for 14 years in their coalition the same way to gather that data. To throw that out the window and start over gathering two sets of data is just not practical. It's not fair for government to ask communities like that to do that, and I just really want to emphasize the fact that we need to give them options.

MR. KOPANDA: Well, let me try to clarify something here if I can. Augie, you can interject if I'm not stating this correctly. The Household Survey data will be used as a measure for state grants. In other words, the Household Survey will give us nothing lower than state data. So if we're talking about the state grant or we're talking about the SPF SIG and the state elects not to use any other measure, the Household Survey would give us the measure for that. If we're talking about a discretionary grant, which does not go to the state but it goes directly to a community, we would not then use the state measure, and then that project would have the option to use another survey rather than the state Household Survey, which would give us the state data reporting on that discretionary grant. But if a community is within a state and the state is reporting on all the communities, either it gives us another survey -- the state has to make the decision

because we're really reporting on the aggregate state program and not every sub-grantee, which may vary for the block grant or any other program year to year.

MR. DeWISPELAERE: I know, and I'm not blasting any of my state friends when I say that they're going to probably take the easiest way out to report, number one, and then blame it on us, on CSAP, number two. I've been involved quite a lot in certain areas that have caused these coalitions great concern as they try to gather these data for requirements that we set forth here at the federal level, and I just caution that that needs to be communicated very carefully. I know a lot of these states, especially the SIG states that are doing epi, things right now are underway with this stuff, and this is probably why it's coming up more, why we in the field know more than what we should in this regard. But they're struggling with it too, because they're trying with their advisory councils to be something for everybody, and I'm not sure we can ever be that. But at the same time, there are some real arguments out there with regards to this.

MR. KOPANDA: Thank you.

Any other questions for Augie?

Yes, Allan?

MR. SHINN: I'll make it quick. It's an old issue with SAMHSA, but the whole issue of ethnic and

language data and disaggregating the data, especially in the Asian and Pacific Islander communities. It's really not helpful just to say Asian or even Pacific Islander because there's so much diversity. So the question is how will we do that with this new data system?

MR. DIANA: Do you want me to try to answer that? There are measures that I don't think will be broken out at all by demographic groupings. There are other data such as number served which will be, and I know for a fact that in Hawaii, because Hawaii uses Minimum Data Set, that they've actually customized the Minimum Data Set to capture the various ethnic groups, the sub-Asian ethnic groups that they need to be aware of. The expectation of NOMs is that those would not be reported to us. It doesn't mean that our expectation is that you wouldn't need to capture that and use it for your own purposes, but there's not an expectation that you would report it through this system.

MR. SHINN: I think the question was broader than just Hawaii, because I think we do that pretty well. But I'm talking about other states that have significant API populations that don't report it and it's not helpful to us as a national kind of issue to just have those aggregated data.

MR. KOPANDA: I think that's also an issue for our Office of Applied Studies and some of the surveys they

conduct and data they collect there.

Thank you very much, Augie.

(Applause.)

MR. KOPANDA: We'd like to go off the agenda a little bit and have Don Coyhis give a little presentation here.

MR. COYHIS: I have been asked, on behalf of the Advisory Council, if Beverly is here I'd like her to come up front. There's a gift that we have for you for the leadership that you have given us for your time at CSAP. So if you could please come up front.

This is in our appreciation for your leadership. In my language, if I were to have this discussion, we do not have a word for leader or for boss or for manager or subordinate. Those words do not exist in our culture. If I were taking her to the elders and I wanted to explain that she was a manager or a director, what I really would tell this elder is how strong she is respected in the circle in which she walks. That's how I would say it.

(Applause.)

MR. COYHIS: Since she has been at CSAP, with us at the Advisory Council, that's what she has always done. She has maintained our respect.

Then if she got promoted and she came back,

what I would say then is not only how strongly she maintained the respect in the circle in which she walks, but she was also tested, which means a senior leader, somebody who has maintained the test of that. So we can't say boss or leader. That's the way we say it in our language.

So on behalf of the Advisory Council, I'd like to present you this. It's wrapped in yellow. That was very specific in our culture. You have red in the east. That's the new sun, new day. Yellow is the south, the time of growth. Black is the west and white is the north. So if you will open it up, this is something we give to very special leaders. They are snow shoes. In the middle of each one is the dreamcatcher. What that means is that during the day, things happen, and the web will catch those things that are day, and in the center is the hole to only let the things that are good go through. These are always picked special because, once again, you have to walk and make footprints, and the dreams come true, and then we'll come and follow behind you. But we know you can do it because you have been tested and earned that respect.

(Applause.)

MR. COYHIS: So on behalf of the Council, we wish you the best journey as you set the new footprints in the snow. The dreamcatcher will allow the good dreams so

that our communities and our children and our families are able to heal and to prevent from getting into those things which we know that you're a fighter for. So on behalf of the Council, please accept this.

MS. DAVIS: Thank you all. Thank you, Council members. You have been an amazing group. We could not do -- and I say the we plural. I thank you all when you gave us the wisdom we needed. You refused, as you said, to be a rubber stamp council. You will be involved and engaged. We have Council members that went to conferences and trained with us.

Is Toian here? Toian, this is absolutely the best Council ever in the history of SAMHSA, and I say this because when you look at the activities they've done, the fact that they were here, that they trained, that they give advice and give counsel when we need help, they remind SAMHSA of our obligations to our staff and those kinds of things, they were there.

I just cannot thank you all enough. You have been an incredible group to serve with. Thank you very, very much.

(Applause.)

MR. KOPANDA: Thank you. Thank you, Don.

Our next presenters are Bob Stephenson and Charlie Williams. They're going to present on Hurricanes

Rita and Katrina disaster response.

I should also mention Bob is director of our Division of Workplace Programs, and Charlie works in our Division of State and Community Programs.

MR. STEPHENSON: First of all, this presentation will take about five minutes. Please look at the images and don't look at me. Just listen to my words. Each one of these images will show for about four or five seconds and will tell a much more powerful story than I possibly could.

I was part of a team that was deployed by SAMHSA early on after Katrina had hit. We went down into Mississippi. I went there not as a photographer but I took almost 800 pictures over the next 15 days to try to document what it is we saw and to bring back some of those images for others who we knew would come later on and be deployed into these same areas.

The team had been developed specifically to deal with first responders and their needs that had come from the emergency response and the crisis that they were undergoing at the time. They were non-federal leaders. One was Tom DeMaria from New York, who led the home ground response team after 9/11 in the Twin Towers incident, and Rand Baker from Oklahoma, the deputy commissioner for mental health who had been involved with the Murrow Office

Building bombing situation and had just come from Oklahoma helping to prepare some response shelters for the Katrina victims.

We had individuals from CSAP, the Center for Mental Health Services, the National Institute for Mental Health. We had volunteers from non-government agencies. We went out from September 12 to 26, although most of us were ready to go from about September 4. But it took a while to evolve the mission and understand exactly what would be required.

We went across Mississippi. We started by driving almost 360 miles a day just to get from where we were quartered to provide some services. We worked up to 22 hours a day. The 77 example images are just a subset of the almost 800 that had been taken during the time we were there. They were intended to show the extent of damage and the nature of the problems and how we as an agency fit into the disaster response and recovery situation. Our team worked with the State of Mississippi, the Department of Health and Human Services, Federal Emergency Management Agency, the National Guard, counties, Red Cross, churches, and numerous communities. Many of those who had already seen these images deployed later in the recovery process in November and even December and January. They told me that when they looked at these slides again, it's as if the

disaster had just taken place yesterday in Mississippi, that many of the conditions and problems as were documented in September still exist today and are likely to exist for some time into the future.

What these changes have brought to us is our recognition that we need to be better prepared and to understand how to quickly and appropriately respond in future disasters, and that certainly Katrina and the other related disaster responses that triggered right along that were a part of our lives now and will not leave us. These images are in my mind. I don't need to look at them to be reminded of them. I know Charlie will have the same kind of experiences when he shares with you.

There is no narrative here. These are places and snapshots of what had come out at the time. Some of these places were almost totally destroyed, and half the populations died in the floods and the tidal surges that came ashore.

9/11 was here. This came out of New York City and it was a response team that had been generated by the 9/11 group.

This is in a place that's called Perlington, which is in the Delta. It's about two feet above sea level. Half the people who were there died. There was only one real building that was left.

We were quartered, luckily, in a place that was a game preserve, but it didn't have lights or power or game. It was there for us. This was the place we were allowed to stay, and by the time we left we had brought over 30 FEMA staff into this area to give them a place to get a hot shower and a hot meal.

This is the expression of what's going on. "If God is willing and the creek don't rise," but unfortunately the creek did rise, and this was Rita that came right on the heels of Katrina.

We were able to make contacts that one would never believe you could, and they accepted the information appreciatively. We put together a team that represented volunteers and people from other places in a way that we all worked together. We were proud to have been there and honored by the opportunity to serve.

Thank you.

(Applause.)

MR. WILLIAMS: Thank you very much. It's an honor to be here. I'm just going to give you an overview of my deployment experiences in Hurricane Katrina, which I was asked to do. This is the first time SAMHSA ever activated the SAMHSA Emergency Response Center. In our new building we have an area that's set up. It's actually Mr. Curie's conference room that's set up so that we can track

things, disasters and things, and we did activate that response center. Some of the resources that are on the SAMHSA website are there today, and please make sure that folks you know are aware of that because folks have been displaced all over the country.

The hurricane made landfall on August 29. We had a meeting in the SAMHSA Emergency Response Center. I represented CSAP at that meeting on the 30th, and on the 31st the center was activated. I then spent about the next three weeks pretty much every day working with the emergency response center. During that period of time there was a lot of chaos, a lot of things to work out with the Department of Health and Human Services, and basically we did whatever it took. We had telephone hotlines for folks from the states to call in. We recently just had a hot wash list on Friday. I know Bob participated in that. That was the review of the roles that various people had in the hurricane response. Of course, it wasn't just one hurricane, but Katrina was the one that initiated all this.

In mid-October I was asked to go down to the State of Mississippi with our state prevention project officer, Donna Sims, to Alameda to meet with the state prevention person and staff, and they also brought their state prevention people from the Gulf Coast of Mississippi up to meet with us, and I think probably one of the

beneficial things of that is it got those folks away from the devastation for a couple of days, because all of them, besides trying to do their job and run their program, they were obviously very devastated by that.

Then later, in December they asked if I would go down and do a two-week deployment in Pascagoula, working with the homeless people that are housed on the cruise ship, and I did that.

This is pretty much that deployment, flew into Mobile, driving over to Pascagoula. We forget how hard it is for people down there. Many of them have lost everything, lost their homes, and some have lost their loved ones.

I was getting off the Interstate and I noticed the signs there, and they kind of tell the story of what was going on. This was in December, several months since the hurricane made landfall. I love this: "Superior Roofing," "Mold Removal," "God Bless America," "Free Estimates." There were stories of folks who weren't so ethical in their repair work. Another big problem is getting people who can do the work.

In Pascagoula, as in other communities, there are trailer parks that have been set up. There's a very large shipbuilding plant there, Northrop Grumman, and that is operational and working today. They went into

partnership with FEMA and Mississippi Power to set up housing for people.

This is the beautiful Gulf Coast there in Pascagoula. This is what it looks like on a nice, calm, serene, warm and sunny day in December, which probably is today. This is what it looks like coming in to the other side of Pascagoula. You can see that big cruise ship sitting there, a little unusual. It normally sits in Mobile, Alabama. As we get closer to the cruise ship, it's kind of weird going to a cruise ship, but we had anywhere from 1,200 to 1,600 evacuees on that cruise ship. We had the ship staff. They staff the ship under contract until the beginning of March of this year with a full staff, especially maintenance staff and people taking care of things. We had a health clinic with doctors, many coming from the Commissioned Corps, Public Health Service, and then we had the FEMA staff and the FEMA shuttle transition team, lots of security, armed guards, which is kind of unusual coming in and having people carrying AR-15s. Everybody is thoroughly checked out. They say there are security risks there. The SAMHSA team, too.

This is looking at the cruise ship. There's a fellow right there carrying his AR-15.

One way in and one way off the ship. That's Imagene, our good lady who took care of all the health

issues on the ship with FEMA. She's an emergency medical person from Oklahoma and spent most of the last six months there.

This is a sunny day on the deck. This is a fellow I worked with. I'm just going to call him John. He was a shrimper and said he didn't mind having his photo taken. He was a shrimper. He was homeless, and one of his buddies found him and brought him into the ship. This just happened in December. So he had been out living on his own, and he'd been living pretty hard on his own. So it's good we got him.

This is the SAMHSA orange shirt. People who were deployed with SAMHSA, whether they were contract or SAMHSA employees, we were given orange shirts. We called ourselves the stress managers. This was in the FEMA part of the offices of the cruise ship where we had our daily meetings. We had pretty good access to computers and equipment and things for printing out materials.

Everybody is from all over. Rashid, the fellow on the right, was from New Orleans. He had been displaced and was trying to get his home rebuilt, so he was working with us. He did not lose everything, but he could not live in his home. So this was at least a change for him and a chance to help and work with us.

I was really blessed. When you work with an

emergency response team, you never know. Most of you come together for the first time, having never worked together before. It's not the most ideal situation, and I was really blessed. We all got along, we all worked really well together, and that's not really the norm all the time. So it was really a great experience that way.

The kind of things we dealt with, this pretty much explains it all. One of the things we did was stress training to the FEMA staff. Nobody had ever done that. The FEMA staff were contract employees who came onto the ship every day working the shelter transition team, working security. They were folks who had been impacted greatly, going home to trees still laying on the porch of their house, and many of them had unbelievable stories to tell about what they went through just to survive the hurricane.

After we did that, we got so much business. The people were sending people to us all the time, including themselves.

We worked with the ship's purser and crew, which was interesting, because everybody had to go through I.D. checks on and off the ship. So if we didn't see somebody, we were worried about somebody, we could go to the ship's purser and find out if they were on the ship, if they're not, if they went off, when they went off, things like that.

We did have buses taking kids to school, to their own schools, which was good. One reason the ship came from Mobile was that many of the people on that ship were from Jackson County, Mississippi, and we had many folks going out to work. So part of the recovery process if normalization. If we found folks who needed more help than we could give them on the ship, we'd try to connect them with a local community mental health center, substance abuse provider, hospital, and all the local resources which were still pretty limited at that time, but it was getting better.

Across from that nice area where I showed you earlier on the coast was what you start seeing what people have to go back to, so I just saved a few of these pictures. I got off the ship one day during the two weeks we were there, I got off and was able to do what we call the disaster tour. Interesting sign there: "Cleaned by T&T Demolition."

I'm sorry. I jumped to the bottom and I didn't mean to.

This area of the coast got hit with 40-foot waves, unbelievable winds, 150 mile-per-hour winds. That actually had steel structures on it. It's funny that the ones that were saved seemed to be the ones that were caught at a different angle. They didn't take a direct hit, or

they were blocked by the houses in front of them that were wiped out.

As power came back, if people could get a trailer or had insurance, then they could have the trailer put on their property so at least they could live on their property while they were trying to figure out, and many of them are still trying to figure out what they're going to do next as far as rebuilding, code issues, things like that.

This goes on for all up and down the coast and Mississippi. It goes for blocks and blocks in Pascagoula.

"State Farm" is what it says there. A lot of times they would put signs in front of their house for their insurance company.

You can see a piece of somebody's roof or wall up in the tree there. It still hasn't come down yet, snagged up there.

The reason I put this here was because the little sign here in front of all the rubble says, "Do Not Allow Katrina to Steal Your Joy."

I drove down to Biloxi, to Gulfport. This is not the Interstate but I think Route 90. You can see how the wind and the storm had just ripped it apart. I mean, these were tremendously large pieces of concrete. This is the frontage of the casino in Gulfport, and the casinos

there have to be on the water, and that was on the water on the other side of the street. When we drove past it, we didn't even notice it. We thought it was an apartment building until somebody said, oh, you passed it on the way over. On the bottom you can see barnacles because that's what used to sit in the water. They said it could never be moved no matter what hurricane because it's weighted down so much and all that, and it just picked it up and carried it a couple of blocks across the street and set it there.

I put this there because if you didn't know what I was talking about, this could have been an earthquake scene.

As I said, if you had power, that's where you put your trailer down.

When I left Mobile, Alabama, they had Christmas trees up in the airport, and this was a Christmas tree made up of the different headlines from the paper. If you go down there today or check the local papers online, most of the headline articles are still about the recovery process.

One thing that is happening is that SAMHSA has this Ad Council Mental Health Awareness Campaign, and that's in your handout. There are handouts over here. They're to provide ongoing support for folks.

DR. TELLERMAN: I saw that on TV in Chicago.

MR. WILLIAMS: Good. That's good. There are

different toll-free numbers there, one for first responders.

Okay, thank you very much.

(Applause.)

MR. KOPANDA: Thank you, Bob and Charlie.

Any questions? Do Council members have any questions?

MS. GERINGER: I don't have any questions, but last week I was in New Orleans, and what Bob and Charlie have said about those areas and the devastation is equally true in New Orleans. One of the people that was on the tour that we were given said that he was last in the lower Ninth Ward in October and it was the same last week as it was then. We had the opportunity to talk to people from several different organizations that were trying to work on recovery. We were given our tour by the assistant adjutant general of the Louisiana National Guard who had been involved in things from the time before Katrina actually came in. It's remarkable I would say that the people there are dejected, they're pretty depressed because recovery is taking so long, because they don't know what recovery is going to be, but they're also very determined.

I think that what SAMHSA is doing, all three of our centers, is so terribly important to the people, and I just have to commend you for being willing to take the time

away from your homes and your families and go there and tend to the needs of these people who are just devastated by what's happened to them, and not just what has happened but that they have no vision of what their future is going to be. Leaders can't decide whether they can rebuild or not. People don't know if they're supposed to make payments on a home that's gone, their house payments. It's just incredible.

New Orleans, the average or usual population before Katrina was half a million people. There are 130,000 people living there now. The rest of those people are dispersed.

So anyway, my congratulations, my kudos, and my great appreciation to all of you who are involved with helping the people who were touched by these storms.

(Applause.)

MR. KOPANDA: If there are no other comments on that, I think we do need to move along in terms of our agenda. We have three people with us to talk about the role of project officers and grants management and contract management. Susan Pearlman is director of our Contracts Management unit in the Office of Program Services, OPS. Christine Chen is director of our Office of Grants Management, in OPS also. You know Rose Kittrell, director of our Division of State and Community Assistance.

Rose, are you up first?

MS. KITTRELL: Yes. Thank you.

I think I was at the Council meeting where you all wanted to know about the role of the project officer. I think it was the one before the last time. I felt that I could certainly do this because, truly, I started out as a project officer in the federal government. In fact, I was with Sue Rusche's program. She was my grantee, and also Allan Shinn. So I felt that I could handle this.

I wanted to discuss this within the context of CSAP's mission and the role of prevention. Our mission is to decrease substance use and abuse by bringing effective prevention to every community, and to create healthy communities in which people have a quality life. We're talking about healthy environments at work and school, supported communities and neighborhoods, connections with families and friends, all of this in drug- and crime-free neighborhoods.

I also want to talk about ACE. I think Mr. Curie mentioned it earlier. But we're talking about capacity, SAMHSA's strategic goals, to build, sustain, and enhance a national substance abuse prevention infrastructure -

(Feedback from sound system.)

MR. KOPANDA: It doesn't like that phrase

there.

(Laughter.)

MS. KITTRELL: To build the infrastructure and capacity not only at the state and local level but also internally within SAMHSA. We do this with our CAPTs, the Center for the Application of Prevention Technologies, CAPTs, and we also do it with our contracts that provide technical assistance to our grantees, and we also want to build it at the local level as far as training and building that type of capacity that will help us to bring effective prevention to every community.

We're also looking at effectiveness. That enables all states and communities to deliver effective prevention.

Accountability: establish systems to assure program performance measurement and accountability. When Augie was doing his presentation, he was essentially talking about the National Outcome Measures, the state outcome measures and management systems. All of this helps us to be accountable.

I also want to talk about accountability in a different way, and that is that we're all accountable to one another. The federal government is accountable to you as grantees. The project officers, when they are out conducting their site visits, they are really

representatives of the government to you. They're ensuring that you're really carrying out the approved scope of work. Then you're accountable to us in the sense that you are providing us with the data that we need, as well as the progress reports, and that you are delivering effective services out in your communities.

The role of the government project officer is critical to the success of SAMHSA's programs. Government project officers play a vital role during pre- and post-award. Quite often we only think about the during post-award, but I want you to know that during pre-award they also play a vital role. They're involved in developing program initiatives and writing the Requests for Applications, providing applicant TA.

I want to go back just a little bit to developing program initiatives. What I'm saying here is we develop concept papers or decision memos for the Administrator to review and for the policy office to review. These are developed by project officers, and then they're engaged in writing the RFA or the Request for Applications, and then they provide applicant technical assistance for prospective applicants.

Now, we normally have Qs and As, and we set up a technical assistance hotline so that applicants can call in if there's something that's not clear about the RFA.

They can raise questions, and the project officers man those lines.

They also work collaboratively with grants management to ensure that application budgets meet project needs and program requirements. During post-award, the project officer serves as the government's representative to the grantee, as I said earlier. They conduct new grantee orientation workshops, they ensure that the agency's programmatic requirements are met through ongoing monitoring, site visits, conference calls, and written feedback on progress reports. They work collaboratively with grants management on budgetary matters. For instance, if a grantee has unexpended funds and they want to carry them over into the next year, the project officer works with the grants management specialist on this, or they have come to the end of their project period and they have money that remains and they want to have, say, a no-cost extension. That means we don't give them any additional money but we may grant them three, six, or nine months to bring their program to a logical conclusion or for them to gain bridge funding to continue their funding. Well, grants management and the project officer will work together on that, or if they have some re-budgeting needs. We work together.

The project officer does follow-up with

grantees on compliance issues. For instance, with the submission of their progress reports, their annual reports, if they don't get them in, the project officer will call them up and find out what are the issues, and they can give them an extension to get their report in. They follow up on complaints from the field concerning fiscal improprieties and any other programmatic issues that come up. We actually have people that will call the IG hotline and they will say that money is not being expended appropriately. Sometimes I think it's people who have applied for funds and they didn't get funded and someone else got funded. So they really watch these programs, and they will call and make reports. But it's incumbent upon the project officer to follow up on all of these because we never can tell. We have followed up on them and we've had some funds that were not being expended appropriately.

They provide on-site technical assistance when they're out conducting monitoring visits, and if they don't have the wherewithal to provide the TA, they arrange for technical assistance, and they do it with our CAPTs in the instance of state programs, like the SPF SIG, the Strategic Prevention Framework State Incentive Grant program, or if there is a technical assistance provider that's part of a grant program, say like with the HIV/AIDS program. They had a TA provider.

Now, I want to share with you a little bit about cooperative agreements, because we have project officers for those funding mechanisms as well. There are four ways in which the government puts money out so that recipients can help the agency to carry out its mission. You do it by way of contracts, cooperative agreements, contracts, and interagency agreements. So the cooperative agreement is a funding mechanism when the government knows that it's going to have a significant role in helping to carry out the program's mission. In the past we've had a number of cooperative agreements, and I want to share with you the SPF SIG.

The state project officer participates as a member of the governor's SPF SIG advisory committee. They provide guidance and TA to grantees to help the grantee achieve the SPF SIG goals. They participate on policy, steering, or other grantee workgroups. They monitor the collection of process and outcome data from grantees. They review and approve the grantee SPF strategic plan, and they review and approve the grantee's community funding mechanism; that is, when they have these sub-grants that they put out in their communities.

As I mentioned earlier, the project officer has a viable role, and especially during this period of transition within SAMHSA, within CSAP specifically, the

project officers will keep the grantees apprised of policies, new directions that we're going in. So they play a meaningful role.

As I conclude my presentation on the project officer, I want to say to management and to Rich and Dennis, and to all of the people here who have supported me over the years in my various roles within OSAP and now CSAP, as many of you all have known, I have been in an active capacity for at least 11 or 12 years. I was in one position for -- I think it was a little over a year that I was not acting. So I'm acting again, but I thank all of you. I could not do this without the project officers, without my management team, my branch chiefs, my team leaders. Beverly Watts Davis really put together a great group of people. My Peggy, Peggy Thompson and myself -- who did I leave out? Yes, both Peggys, Peggy T. and Peggy Quigg.

We all work together very collaboratively. We don't get caught up into turf issues. In fact, as I was just saying to Mike jokingly what Peg said: "Be careful what you put out, Rose." I told Peggy, "I have served my time over at DSCA. It's a very challenging division." I said, "It's time for you to come over." I said, "Mike has put in his time, I've put in my time. Peg, it's time for you to put in your time." I was just saying this.

(Laughter.)

PARTICIPANT: When Rose speaks, things happen.

(Laughter.)

MS. KITTRELL: So this happened. But I thank all of you.

(Applause.)

MS. PEARLMAN: Well, I want to thank you all for inviting me here today. As you know, I'm Susan Pearlman. I'm the head of the Division of Contracts Management. One of my main goals is that when you think of the Division of Contracts Management, you also think of me as dedicated to our customers' mission.

So I want to begin. I want to welcome you to SAMHSA. I got here a year ago, and I think my first week here Beverly brought me over to a meeting, and it was the CAPTs meeting, and it was my first induction here into SAMHSA. She said does anybody have any questions for Susan, and there were probably a million questions, and I'm writing down I'll try to do this, I'll try to do that, and I think I've really tried to do what the contractors as well as program has wanted me to do to make this a collaborative effort.

Our vision. Well, obviously if you are part of this council, you know our vision, a life in the community for everyone. I've kind of tailored this to not only the

people that I'm supposed to speak to, which is the Council, but now that I see all these project officers and contractors here, I'm going to put a few words in for you as well.

Who are our customers? Well, Mr. Curie is my main customer, and as you can see, Kana and Beverly. We start at the top. Whatever our mission is and they give to the Division of Contracts Management to do, I will try my best legally to do it. I not only service the Center for Substance Abuse Prevention but also Office of Applied Studies and Center for Substance Abuse Treatment and Mental Health Services.

So what does this mean? "You had me at hello." Well, basically I'm completely devoted to customer service. Who are my customers? My customers are everybody in this room. You have a question, you don't have to know the answer, you just have to know who to call, and I'm really here. I publicize it everywhere that if you are somebody who wants to do business with us, if you're somebody that has a question about what we do, if you're a project officer, or if you're already a contractor, me and my staff are ready to help you.

So basically I thought we'd kind of put some faces and names together. James Witt is the team leader, and he services the substance abuse mental health services

team, and also the Office of Applied Studies. We have a lot of new faces here, but we do have some people who have been here, and Hildy Pollard is one of his senior contract specialists. Mary Farrell is new. I came from FDA. Mary came from FDA. Andrew Maine is pretty new, and Linda Tillery has been here for a while.

Then we have two other teams, substance abuse prevention and substance abuse treatment. Janet Mattson is the team leader, and she's fairly new as well. Lynn Tantardini, I'm sure a lot of you know her, and she's been here for a while, and she's also the person who is going to keep a record of all of our small business dollars that we spend. She did that last year as well. Susan Dawson is pretty new. Andrew Payne has been here for a while. Tracy O'Neill is also new to SAMHSA, and she came from FDA.

Office of Program Services. The woman in the blue suit to the left is Anna Marsh, and these are her direct reports.

Just as you all maybe want to be contractors -- I see some contractors out here -- I value my contractors, and that's how I know that I try to support my program, because we want to give you the best contractors, and the Advisory Council wants us to have the best contractors. So I have two 8(a) contractors that actually support me. EXCEED Corporation is an 8(a). They do my admin support.

NEW-BOLD does the admin support, closeout, and peer review, which I'm sure you're all aware of as far as peer review.

So what don't we buy? Well, we are not a buyer of service support, information technology, facilities support or equipment buys. Also, my office does not procure for goods and services that are under $100,000. Those are procured through the Program Support Center. We do not have statutory authority to charge registration fees. So here's an example. Because we are a small OPDIV, our IT services are through the Department of Health and Human Services, and it's through Unisys Corporation. Also, we do not provide food for feds or non-feds. Basically, you know if you're a SAMHSA contractor or sitting here in this meeting today, unfortunately it's not under our statutory guidelines to buy food under federal contracts.

So what do we buy? Well, we buy all the programs that were talked about here today, which are incredible, and I just want to say that the pictures from Katrina, we did a lot of support for that with our contractors, and I just think it shows right there what we do and how we really reach out to the community.

We also buy training, and this includes our technical assistance training, and campaigns such as Race Against Drugs. There was actually the racecar out in front of our building.

As part of our technical assistance contracts, we have grants.gov. In order to be able to get our grantees to be able to understand how to get under grants.gov, we've made it a requirement on all our contracts that if they are having more than 100 grantees come to one of their meetings, they will contact grants.gov and someone that works for Christine Chen to come out and give information about how it's so easy to get onto grants.gov.

The planning process. We've talked about this. We have a great planning process here at SAMHSA. I actually do get contract plans, and as we talked about, these concept papers so that we do know what we're doing for the year. I haven't gotten them all yet, but I'm getting them.

Daryl Kade is the director for OPBP.

So how does this work? Well, people from the program meet with OPBP and they bring their concept papers, and according to appropriations and ELT, Executive Leadership Team, whatever they determine should be bought this year, they all work together to do these concept papers and then give them to DCM, which is me.

Those are our concept papers this year. I haven't gotten all of them yet, but those are the ones that are actually going to come to me. So those aren't major

RFC packages. Those are each a piece of paper that's work for our division to do, and we only have 11 people, as you can see, and two of those people are team leaders.

Here's Anna Marsh that I work for, and she works closely, and so do I, with the budget officer for SAMHSA, Anita Swedeman.

So who does DCM support? We support everybody from Andy Knapp, the acting deputy administrator, to all of our acting and directors. There's Rich Kopanda, acting director of CSAP, and Dr. Clark for CSAT, to our project officers. Anybody who needs any kind of work that has to be done over $100,000 for SAMHSA goes through us, DCM.

So now you know who we are and what we buy, so what is the process? The nuts and bolts of federal procurement. Don't worry, I won't bore you, because I figured you just kind of wanted to know the generalities of it. But basically, the goal of each acquisition is to negotiate a task order or contract that achieves the contract objectives for a fair and reasonable cost. What is the contractor responsible for? Well, they're responsible for performing, for compliance, for marshalling and controlling resources, and for their profits. Although I want them to get profits, I want their profits to be fair and reasonable.

So how long does it really take to have a

SAMHSA procurement to be awarded? These dates look staggering. However, we do have peer review, which is required, and that is one of the reasons why it does take so long to get something through, because we have a peer review process that's required, and we have to get people from all over the country, just like you Council members are, to come in and help us review our contracts.

Last year we spent $325 million in contracts.

So what is our partnership? Well, I have a partnership between project officers and contractors, and we're all part of a team, and I think we can see that today. We collaborate together to work together to get the mission of SAMHSA done.

We have basically four steps in the procurement process. Step 1 is the pre-solicitation phase. The project officer has a vision. His or her content paper is approved. What do they do? They give us an RFC package. From that we advertise, we get the solicitations out, we get proposals in, we review, negotiate and award.

So what gets publicized, and why? Well, all new procurements, unless 8(a), which are minority business set-asides, under $3 million, under our indefinite delivery or indefinite quantity contracts, or GSA, are required to be advertised in the Federal Business Opportunities, which is a single source of entry for government actions.

A little bit about what we've done this year about personnel security, which has to do with our contracts. When I first came to SAMHSA, I was signing all of these papers for contractors to get their red badge. That means they can work in our building, they can have access to our Internet. So I was thinking to myself, okay, what am I signing here? Who are these people? How are they getting into our documents and into our server? So we met with the Program Support Center, and actually now all of our contract employees that work more than two days at the SAMHSA One Choke Cherry have got to have fingerprints at level 5 and a background check. Also, if you're a contractor and you work off-site but you're into our service and things like that, you will be required to get that as well. What that has really done is it's really protected the contractors because they could never get this kind of clearance, and it's protected us as well.

So what am I committed to? Well, last year we actually did award $325 million and got 27 percent small business. We are required from the Department to make 30 percent, so that's my goal, to even hit higher than that, and that's the reason for the way that we do a lot of the procurements that we did last year and that we're going to continue to do this year.

GSA. We use GSA a lot. I don't know if all of

you know what that is, but under the GSA schedule there's a lot of contractors, and a lot of them are small businesses, and in prior years we used our indefinite delivery indefinite quantity contract which had a lot of large businesses. In order to make the small business goal, we actually did a lot of contracts under the GSA schedule this past year, under the Mobis schedule. These contractors still get reviewed under the peer review, but it's just another way of getting to small businesses.

I'll talk a little bit about the peer review. You may know that we do peer review based on statutory requirements. The reviewers are from outside of the agency, and they are called in to review our proposals, rate, and then we do competitive ranges from them and negotiate. Dr. Hui is our peer review administrator. He does work for me but really independently, and he works with our contractor to do the peer reviews.

We also have administrative and work that's not subject to peer review, and those are the IDIQs, because when they were originally awarded they were peer reviewed. So now each task order only has to have an objective review, which are in-house reviews. Also, we don't do IT but things like that that would not be programmatic, we also do objective reviews.

Procurement integrity. I just wanted to talk a

little bit about this, and basically my saying is I don't want the contractors to ask and I don't want us to tell. Any kind of information that is leaked out or given to potential contractors does not make it a fair acquisition process. It hurts the government and it hurts contractors. If we find out a contractor found out about something, they could be actually precluded from bidding.

So what can they do? What can contractors do or offerers do to get business with the federal government and with SAMHSA? Well, we have a small business coordinator, Vivian Kim. They can contact her. They can contact me. A lot of times we have been doing this, very regularly, calling in contractors, bring in your capabilities, meet with program, but meet with program with a contracts representative.

What may occur? If we have interest in someone's organization, if they're an 8(a) contractor, we might just go to them. We might say, okay, we've got four or five good GSA contractors, they came in and did good capability statements; we go to them. We want to get the best contractors for our mission, and this is how we do it, this is how we reach out to the public.

So basically the end of my presentation is that last year -- and I was very fortunate to be a part of this -- we had everybody from Mr. Curie to Beverly Watts Davis

to our contractor doing the CTC that we bought, down to our contracts, and we worked together collaboratively to get what SAMHSA's mission needed.

That's it. Any questions?

(Applause.)

MR. KOPANDA: If you understood all that, we have a job for you.

(Laughter.)

MR. KOPANDA: It is quite complicated.

MR. ROMERO: Susan, thank you. Actually, it was great for me. It was a great orientation. I feel like I'm in my orientation phase again.

(Laughter.)

MR. ROMERO: Great.

MS. CHEN: Compared to Susan's presentation, mine is going to be boring.

(Laughter.)

MS. CHEN: But on the other hand, I'm going to take advantage of all those vivid pictures she was presenting still lingering in your mind, and here's my presentation.

Division of Grants Management. What's our function? Very straightforward. The Division of Grants Management is responsible for all business management matters associated with the administration of all SAMHSA

grants. Just like Rose said, our office works very closely with the Centers Program project officers, who are responsible for the programmatic aspects of the grant. So we work together to monitor all of SAMHSA's programs.

We have two kinds of grant programs. One is the mandatory programs. We call them mandatory grants, and then the discretionary grants. Mandatory grants are those grants we are required by statute to award if the recipient submits an acceptable application and meets the eligibility and compliance requirements of the statutory and regulatory provisions of the grant program. In SAMHSA we have four different mandatory grants. Those are the Community Mental Health Services block grant, the Substance Abuse Prevention and Treatment block grant, and also we have two formula grants. They are also mandatory grants. Those are the CMHS PATH Program, the Projects for Assistance in Transition from Homelessness, and also CMHS PAIMI Program. Sometimes we refer to them as the P&A program. That's the Protection and Efficacy for Individuals with Mental Illness.

In fiscal year 2005, the total mandatory grants we awarded close to $2.2 billion, and that's almost two-thirds of SAMHSA's total budget based on some of the functions of grants management involved with the mandatory programs. To begin with, we participate in grant

application package review, and also all the mandatory grant applications come to Grants Management Office. Of course, we also provide technical assistance to grantees.

The most obvious and visible function we have is we issue all the notice of grant awards, and also we sign the grant awards. In our division we have three people, three individuals who can sign SAMHSA's grant awards. I myself can sign the mandatory grants, as well as the discretionary grants, and we have a grants manager and officer for the mandatory grants, Llewellyn Rice, and she is the one who signs all the mandatory grants. We also have a grants management officer for the discretionary programs, Kimberly Pendleton, and she will sign the discretionary grants.

Actually, I think I left out another important function we do, which is to resolve the audit findings. In our office we have three accountants, and they work with the project officer and also with the grantee, either state or the grantee organization, to resolve any audit findings, because all the mandatory grants are required by OMB Circular 133 to be in compliance with the independent audit. The audit requirements are any organization that receives $500,000 or more federal funding, it's mandatory to have an independent audit.

So this is basically what our function on the

mandatory grants is.

The other program is the discretionary grants. A discretionary grant is defined as a grant awarded according to specific authorizing legislation and through a competitive grant process. In fiscal year 2005, we issued about $770 million and over 2,000 awards. This number includes the Drug-Free Communities program, for about $70 million and 700 awards. But this does not include some of the emergency and disaster programs we issued. For instance, in responding to the Katrina hurricane disaster, we issued the disaster emergency grants. In 2005, I think we issued about 30 grants in the total amount of about $25 or $26 million.

Comparing the discretionary grants with the mandatory programs, we can see that the discretionary grants is about one-third of the dollar amount of the mandatory programs. However, the management of the discretionary grants is much more complicated. The mandatory programs are more uniform. The grantee organizations don't change from year to year. The majority of them are state agencies. Three out of our four mandatory grantee organizations are the state. The P&A or the PAIMI program, the grantee organization was designated by the state government. However, the grantee organization don't change from year to year, and also the dollar amounts

are fixed because the dollar amounts were mandated by Congress according to a set formula.

On the other hand, the discretionary grants for the 2,000 awards we issued were covered under about 30 different programs, and each program may have different requirements. For instance, some of our programs have matching requirements. The Community Coalition Program does have required matching. The matching sometimes, let's say for five-year programs, they change. The first year may be $1 to $1, and the second year they change to $2 for $1. So in order to manage the discretionary programs, they are much more complicated. That's why in our division our staff time and effort spent is much greater in the discretionary grant than in the mandatory programs.

Another issue in the discretionary grants, because the grantee organization varies, covering the big state agency to the local community agencies, so that's one thing in our office we have to do, conduct accounting capability review of many of our grantee organizations to ensure that they have the proper accounting system in place, they have the adequate policy and procedure in place in order to manage the federal funding.

I'm not going to read all the functions we perform. The last slide I'm going to show you, and this is just another presentation of the discretionary grants

process, and also our functions. There's one thing I do want to point out, that we have two types of discretionary grants, and those are the new and competing renewal grants, which are the grants that have to go through the competitive process. The applicant has to submit an application to respond to our RFA, and then based on our funding decision, we make awards. The other side are non-competing renewals. Those we actually call continuation awards. Once the application is approved for multi-years, and actually many of our programs now have five-year project periods, in order to receive the continuation award, they would not have to go through the competitive process anymore.

However, the continuation award is not automatic either. The grantee has to submit an application, and in the application they have to present a report on their prior year's progress, and then in the application they have to submit their coming year's work plan with a budget to support their work plan. Basically, we're saying the continuation application is subject to availability of funds and the satisfactory progress of the program. The application, when they come in, the continuation application is directed to our office, and we will have the application go through program project officer's review and approved, and also the Grants

Management Office has to review the budget and also the comprised assurances. After that, then the continuation award will be issued.

So this basically is what is the Division of Grants Management's function. I was told I should go through this in five minutes. I think that's just about right. Okay. Thank you.

(Applause.)

MR. KOPANDA: Thank you all very much.

Now our panel is available for questions either on project officer, contracts management, or grants management questions.

MR. DeWISPELAERE: Susan, did you leave anybody at FDA, or did you take them all with you when you went?

MS. PEARLMAN: I'm sorry. What?

MR. DeWISPELAERE: I wondered when you said all those people came from FDA, if you left anybody there.

MS. PEARLMAN: Not really. I took all the good ones.

(Laughter.)

MS. PEARLMAN: I forgot something key to my speech. When you think of my division -

COMPUTER VOICE: That was easy.

MS. PEARLMAN: That of "That was easy." You just have to know who to ask the question to.

PARTICIPANT: That's your easy button.

MS. PEARLMAN: Yes, that's my easy button from Staples.

MR. KOPANDA: Any questions?

(No response.)

MR. KOPANDA: These are actually some of the more complicated processes we go through. It's very difficult to do it in this time period. There's a lot to this, and the staff who have been working in this area, many of them have been working for years, and they still can learn a lot about the processes and how they really work. Every time you turn around and you think you've got it down, something changes somewhere in the process, or the emphasis changes. Susan was mentioning, for example, the emphasis on small businesses. That's a relatively recent thing for us, and our project officers are constantly engaged, and we appreciate the work that the servicing units do in helping us out to navigate through the waters of contracts and grants management. So we thank them as well.

MS. GERINGER: I was just going to say that I sure am glad that there are people like you who like to live here and do things like that.

(Laughter.)

MR. KOPANDA: With that, thank you to our

panelists.

(Applause.)

MR. KOPANDA: We're now at the point where we have the Council roundtable discussion. I would open it up to any issues that the Council wants to bring up, and also ask you if you have any ideas either now to discuss in terms of agenda items for future meetings, or also if you think of any after this time you can send an email to myself or to Tia Haynes and we will think about that for the next agenda for the Council meeting.

MS. RUSCHE: I would like to begin by asking Dennis to please tell us a little bit about yourself, because I know your bio is in here and I just read it, but I thought maybe it would be nice to just hear about you personally because we're all getting to know you, so please do.

MR. ROMERO: Yes. Well, I'm trying to think. I'll tell you the personal piece first. I'm born and raised in South America. I'm from Keto, Ecuador. I came here to this country in my early teens, lived in New York primarily, went to school in New York. I got left back four times because of my English deficiencies. When the bilingual system came into place in New York City, I was placed in the third tier, the lowest tier level of the classroom work, and that was because all of the

standardized tests proved that I had a learning disability.

I should tell you that in those days my classmates were what we know today as the problem children, so I really wasn't learning much other than keeping my head down so that I wouldn't get hurt and getting out of the class literally 30 seconds before the bell rang so I wouldn't get stomped, because I was a small kid.

One day when I was on the New York City train, I noticed these kids would get off at a particular stop wearing ties, and I thought to myself I want to go wherever they're going because I think they're getting a better education. I went and told my mother and my father, and they said -- they don't speak English to this day, by the way. My dad said, well, I don't know what to do. Why don't you go and find out. So with my broken English, I went and I literally played hooky one day, and all I did was I followed those kids to their school. I let them in and then I went a half hour later back into that same school and I asked to speak to the principal. He met with me around 1:30 in the afternoon. I spent a few hours just sitting in the main office just waiting to speak to him.

When he did have time for me, I told him not to look at my school records or my grades but just look at my enthusiasm, and he said he couldn't do that for two reasons. Number one, he said that my family could not

afford this private school; and number two, the likelihood that I would be able to finish this high school was zero to none.

To make a long story short, I graduated from that high school with two degrees.

(Applause.)

MR. ROMERO: And I went on to be on the executive committee of the school, still with the broken English.

So then I applied to college. My SAT scores were so low, other than my name was correct, that no school of the 10 schools that I applied to would accept me. One school accepted me with the contingency of not going to their four-year school but rather to their newly-created vocational program. But I had to take a test to see if I could make it. I took that test and found out, according to that test, that I had manual abilities, which meant that I should be a good plumber or a good carpenter. I love to do those things on the side.

(Laughter.)

MR. ROMERO: I need to know those things on the side, but that's not my real calling. My real calling has always been to help others. So since no school accepted me, I did the same thing that I'd done for high school. I went to my number-one school that I requested to go to, and

I asked to speak to the dean. With better English, I advocated for myself. I asked them again to look at my enthusiasm and not at my standardized tests, look at the work that I did in school. Four years later I graduated with two degrees and two minors, and then I went to graduate school and moved on.

Enthusiasm has been one of the major lessons that my parents taught us. If you can imagine a family of nine coming to this country in the early '70s, having to live in a two-bedroom apartment, and learning to live with each other. Your best friends are your own brothers and sisters because you have a team right there, a basketball team, and you've got a good baseball team, and to this day we are as close as the next best family. To me, family is very important.

I love to work hard. I think I'm a workaholic. I think my whole family are workaholics. It's what our parents have taught us. But family comes first.

I hope that what you see is that I've worked very hard to get to where I've gotten. I have had the privilege of meeting some very wonderful people along the way who have taught me, who have shared with me their struggles and their lessons, and I hope to do that now, to give that back. All my life I've worked in the helping professions in one sort of way or another.

I'm really disclosing.

(Laughter.)

MR. ROMERO: I like what I do, and I am honored -- I said this to my family when I got the news that I was called for the position of deputy director. I was really humbled, and I remain humbled, and I know that I will need to sustain that humility if I'm going to be successful at what I do.

(Applause.)

MS. GERINGER: I'm really glad I asked.

MR. KOPANDA: I might just also add that I've worked with Dennis for the last two months, and everything that he said is accurate. He does bring that to this position. He has related extremely well to our staff. He's shown me the commitment he has to the job, and he has all the skills needed to do this job. He's just been honest, straightforward, and I think you all will really enjoy working with him.

Any other questions from the Council? Issues?

Sue?

MS. RUSCHE: You knew I would have one?

MR. KOPANDA: Yes.

MS. RUSCHE: I remember from the days when OSAP first got started. I served on the ADAMHA board, and one thing that was very helpful to us was that we were provided

with budgets of the agency so that we could become advocates for the agency. If it's possible and it's not an inappropriate request, could you provide the Council with both the '06 budget for CSAP and also the '07 President's budget so we've got a foundation to work from?

MR. KOPANDA: Yes, we can do that.

MS. RUSCHE: Great.

MR. KOPANDA: The '06 will be more or less summaries of our activities. There's not an actual document we produce. I mean, it's in a variety of different types of documents. For the '07 budget I think we have or can get copies of the more or less official document that's gone up to the Hill.

MS. RUSCHE: Good, and then also when it's time to submit your budget, if we could see that as well so we can compare the House, the Senate, what you have requested and what the President has recommended. It would be very helpful to us to have those documents.

MS. HAYNES: I have the FY '07 budgets, and I'll give them to all of you.

MS. RUSCHE: Wonderful. Thank you.

MS. HAYNES: And you want copies of the '06, too.

MS. RUSCHE: Right, as finalized.

And just so I'm really clear, you were level

funded this year. Is that correct?

MR. KOPANDA: No, we have a slight reduction this year.

MS. RUSCHE: A slight reduction this year.

MR. KOPANDA: Yes, of about $6 million.

MS. RUSCHE: Of $6 million, and the President's recommendation is $12 million less for '07?

MR. KOPANDA: Yes.

MS. RUSCHE: Okay. Thank you.

MR. KOPANDA: Any other questions?

MS. GERINGER: I have a question. Again, it's because I probably don't understand the federal process that well, but we have acting, acting, acting and acting people. When do we get permanent people? Or do we?

MR. KOPANDA: Rose, can you answer that?

(Laughter.)

MS. GERINGER: But to me, it's kind of like you hear attorneys practice. Well, when do they ever quit practicing and get to the real business?

MR. KOPANDA: Well, let me do a slight comparison, if I might. In the Center for Substance Abuse Treatment, we were really very stable. We had all stable leadership until we had a number of retirements, and then we had to put some people into acting positions. The difference is that in CSAP we have had such dramatic

program changes that we have not seen in CSAT. In particular, the addition of the Drug-Free Communities has really disrupted the way the staff were allocated. We have had to put so many different people -- we're talking the need for 25 to 30 new people, different people, to work on Drug-Free Communities. Internally, we're working on the Strategic Prevention Framework like we haven't before, and a number of other changes internally that have required us to detail people to different positions. This is apart from the leadership but this is internally.

So we have made a number of adjustments within CSAP to accommodate that. I would say that we are working internally to stabilize the internal organization, to put many of our staff into positions permanently, and that is one of my charges here. My time here is limited, so we hope that in the short term we are able to stabilize the internal organization and not have so many people in acting positions.

Now, that's separate from the leadership. The leadership in terms of the director, the deputy director, we have now stabilized a bit, with Dennis being the permanent deputy director. So I think we're going to get to the point fairly shortly where much of that will be resolved, but I think that's about all we can say about that right now.

MR. SAHN: Excuse me, Rich. Let me just follow up. This comes at a very politically inopportune time. The concept of having a director with the experience and the relationships on the Hill to be able to reverse some of the cuts usually is preferable to having acting people. Is there anything we can do to support your efforts when you go up there, or when Dennis goes up there?

MR. KOPANDA: I think just in terms of your general work that you do in communicating what you do, and I know many of you are skilled and that you do that on a regular basis, and I think communicating the effectiveness of your work, using as much as possible the NOMs and outcome data to report that prevention programs are actually delivering, I think that's very helpful.

As Toian so effectively points out, that is in your private capacity, not in your government capacity.

(Laughter.)

MR. DeWISPELAERE: As I said, here come the Council police. Do you want to borrow my badge?

(Laughter.)

MR. KOPANDA: No, that's a very good point. You do need to distinguish between the two.

MS. RUSCHE: We're good at that.

MR. DeWISPELAERE: Dennis and Richard, I want to welcome you. Dennis, Richard, thank you for all you've

done for us. We know in 30 days you're going to be gone, and I'm sure they did all your work back at CSAT.

MR. KOPANDA: Yes.

MR. DeWISPELAERE: Don't do what the contracts lady did, take all the good employees from CSAP over there.

MR. SAHN: The contracts lady?

(Laughter.)

MR. DeWISPELAERE: Because we will come looking for you if you do that.

(Laughter.)

MR. DeWISPELAERE: Thank you, though, again for all your work. We appreciate your hard work.

(Applause.)

MR. SAHN: Actually, we were going to give you a gift, but you have to be here longer than 45 days to get one.

(Laughter.)

MR. KOPANDA: Are there any other Council issues before we open it up to the public?

(No response.)

MR. KOPANDA: Why don't we do that now. Are there any members of the public during our public comment session who would like to provide any comments? I'm not sure I see any.

(No response.)

MR. KOPANDA: No public comment. With that, I guess I'll one more time ask if the Council have any other issues that you'd like to raise. This gavel must be here for a reason.

(Laughter.)

MR. SAHN: Before you put that down, a few of us are up for reappointment, and we're not sure if we're actually extended, not extended. We'd be curious to know what the process is. Are our names in the hopper? Are we going to wait for Dennis to come on to go through that? How does that work?

MR. KOPANDA: Do you want to address that, Tia?

MS. HAYNES: Yes, with the assistance of Toian Vaughn. We're in the process of redoing -- well, let me not say redoing. Appointing new members, reappointing some. I'm not sure if I can disclose the information or if everybody will want me to do that at this time. If you're concerned about your appointment, give me a call. I'm more than happy to discuss with any of you. You can email me, give me a call. You have my cell phone number, all my numbers.

MR. ROMERO: Or we could come over and talk to you.

MS. HAYNES: Or you can come and talk to me. If that's a concern, you need to talk to me, because we are

doing that. We have a package that's currently going downtown to be vetted. It was approved. So you know when your terms end. Look in the back of the Director's Report. You have the numbers there. Everybody is clear when your term ends, or if you have a question if you'll be reappointed, or if you do or do not want to be, talk to me.

MR. KOPANDA: Yes, I think that's very good advice.

MR. ROMERO: When you come by to visit Tia, please stop by and see me. I remember that this Council is as vital and needs to be utilized to its full potential, and through that collaboration we can aim for that. So don't forget the rest of us in there.

MS. GERINGER: Dennis, we appreciate your willingness to take this on. I know it's a step in a different direction for you, a different city, so it involves a move. We are willing to help. We're here. We're all busy people, but like you, we want to help other people, and we have something we think that we can give. So use us as you feel that we're best used.

MR. ROMERO: Thank you.

MS. VAUGHN: Let me just follow up on the appointments process. Several of you know that, as Tia pointed out, your terms have ended. They ended in November. We appreciate the fact that even though they

have ended, you will continue to serve until either you've been reappointed or your replacement has been named.

One thing that CSAP would appreciate is if you have anyone to recommend for positions on the Council or on some of the other councils, the SAMHSA National Advisory Council had vacancies, the Center for Substance Abuse Treatment has vacancies, the Center for Mental Health Services has vacancies, as well as the Advisory Committee for Women's Services. So we are looking for nominees for all our various councils. So we would appreciate, if you have recommendations, if you would make those recommendations to Tia, to Richard, to Dennis.

Mitch, you asked about extensions. Until your replacements are named, and if you've agreed to serve until your replacement is named, you are extended in your term until such time.

MR. KOPANDA: Thanks.

Anything else?

MS. RUSCHE: For those of us who are insanely busy, which is probably everybody around the table, it would be very helpful if we could schedule out the meetings for a year in advance, because then we can plan around them and make certain that we save the dates. It's very difficult when we are not given notice early enough to be able to clear our calendars because they're already filled.

It would be very helpful if we could have advance notice of dates out over a year. Thank you.

MS. HAYNES: Look on the second page of your agenda. The next meeting will be July 25 and 26. That's the only other anticipated meeting date because of the changes. But now that Dennis will be coming on in a permanent capacity, we may have another meeting in between. It might be a teleconference. I'm not sure. What would you all like to do?

MR. KOPANDA: You mean for this fiscal year.

MS. HAYNES: For this fiscal year, yes, because this is our first meeting of this fiscal year, and then July 25 and 26 will be the second one. We're only mandated to have two, but I'm sure you all would love to have more.

MS. GERINGER: Aren't we supposed to do some approvals on grants then?

MS. HAYNES: Yes.

MS. GERINGER: That wouldn't be until the fall, then, right?

MS. HAYNES: That was the July 25 and 26 one, but that date can be tricky if they get extensions. That's what happened last time in August.

MS. GERINGER: Exactly.

MR. KOPANDA: We will have to discuss that within the Center a little bit. Our intention initially

was that by July 25 and 26 we would have all the grants ready to be approved. There's a possibility that maybe some wouldn't be approved and we could have a teleconference to do them. But we'll have to see. If everything is sufficiently delayed, we might want to try to get something in. One of the problems is, as Christine would tell you, we're trying to move the grant awards earlier, at the end of the fiscal year. We can no longer go until September 30, like the good old days. It's really become more like September 1 that we have to have all our grant awards made. So it puts the Council meeting in the summer if you're talking about September 1. July and August is really not a good time to get people together.

So there are a number of things that would need to be discussed, but we'll probably want to wait and see when these announcements are all announced. If the major ones are announced and we're ready to go, we'll have this Council meeting and probably just do a quick teleconference if we need to, if there are just a few grants to be reviewed.

DR. TELLERMAN: Also, we might want to discuss subcommittees, too, because we had some active subcommittees and I'm not sure where we stand with that. I don't know if they're subcommittees or committees.

MS. HAYNES: Toian, the subcommittees that

she's talking about, and you probably can advise us more on this -- I don't want to put you on the spot, but you said in order to convene as a subcommittee, you had to have an actual meeting like an advisory council. You can't just meet off the record. So if we'd have to have a transcriptionist, post in the Federal Register, you would convene business just like you would do for a National Advisory Council meeting.

MS. VAUGHN: The subcommittee functions under the auspices of the full Council. When you have Council business and you feel as though there is a need to further research that particular topic area, then the Council itself, with the chair's agreement, set up a subcommittee.

DR. TELLERMAN: I was actually referring to something like, for example, Prevention Partners. Is that considered a committee, where some of us are assigned to that, and then we go to meetings?

MR. KOPANDA: It does not sound like that's an official subcommittee of the Council. That sounds more like that's an individual assignment of a member to represent the Council at an external group.

MS. VAUGHN: That's correct.

DR. TELLERMAN: Okay. I was just wondering about our assignments to those for this coming year. Maybe we can talk about that at the next meeting.

MS. VAUGHN: Let me get clarification. What you're saying is that the chair asked some of you to attend Prevention Partners meetings.

DR. TELLERMAN: Yes.

MS. VAUGHN: My question would be are you bringing this information back to the Council? Maybe it's just what Mr. Curie will do on occasion, ask a Council member to represent SAMHSA at these meetings. So I'm not clear on exactly what you were --

DR. TELLERMAN: Well, it was like a standing assignment. I was assigned to what used to be called an external workgroup, and then it became Prevention Partners, and I would be assigned to it. I would go to the meeting and --

MS. VAUGHN: Report back to home.

DR. TELLERMAN: -- and report back to the Council.

MS. VAUGHN: To the full Council.

DR. TELLERMAN: Yes.

MS. VAUGHN: I guess the chair will have to further investigate that to see how that's working, because that was a continuation of Beverly Watts Davis initially selected you to go to Prevention Partners. Correct?

DR. TELLERMAN: Yes, and prior to that it was Ruth selected me for what used to be called the external

workgroup. So I was selected prior to that, and then I was reselected again.

MR. SAHN: Toian, since this is procedural, can we take this offline to talk about it?

MS. VAUGHN: Rich can close the meeting, and then you can have your discussion, but this is not going to be a Council discussion and I'd rather that you just adjourn the meeting and, if you're going to go to lunch or dinner or something, you're going to have such a discussion, or you're going to have a discussion with Rich and Dennis later. But just to close the meeting with the public here, you'd be in violation of FACA for the purpose of having this discussion.

MS. GERINGER: I think what we're trying to do is just seek some clarification as Council members what beyond attending the two required Council meetings a year the expectations are for our involvement, particularly given that we have a new director. So whether that's done as part of this meeting or afterwards, I don't know that it makes a lot of difference.

MS. VAUGHN: During the roundtable discussion, that's the best opportunity to kind of outline what you as a Council see as your role with regard to advising the chair, advising the Administrator. Once you as a Council bond and you decide what you see as your role, you work

with the chair to decide whether or not you have a need for subgroups and whether or not you have a need for the agency to talk about a particular matter so you can continue to advise. Your role is to advise the chair, advise the Administrator and advise the Secretary. So you as the Council, when you have these roundtable discussions, and then when you have the individual presentations, that's your opportunity to advise.

MR. KOPANDA: I think one thing we'd like to do is maybe summarize or talk to Tia and summarize the kind of assignments that have been made in the past.

DR. TELLERMAN: Yes.

MR. KOPANDA: Who has been assigned to what purpose, especially now with my being fairly new, Dennis coming on board and being new, we'd like to look at that and see. But by the same token, if you have any recommendations for activities that you'd like to participate in on behalf of the Council, if you could make them as well to us through Tia, that would be very helpful. We would then review them and get back to you. We would need to discuss the issue as to whether -- I don't think it would be appropriate to be a subcommittee, but --

DR. TELLERMAN: I'm not sure what the title is.

MR. KOPANDA: The issue, then, would be we'd need to decide would that be something you would do as a

federal employee or as an individual whereby you could still do it as an individual, yet report back to the Council.

DR. TELLERMAN: It was done as a federal employee.

MS. VAUGHN: But it wasn't a subcommittee.

DR. TELLERMAN: No, I used the wrong term. I'm sorry. I'm just a little rusty there.

MR. KOPANDA: Because there would be limits on what you could do or couldn't do, whether we would reimburse your travel, if travel were necessary and such, and the requirements if you were a federal employee versus just doing it independently, such as you do for your own home organizations.

DR. TELLERMAN: This was definitely a function as a Council member and reimbursed the same way.

MR. KOPANDA: Then we would definitely need to review that.

MR. SAHN: Maybe to clarify, I think we were each tasked with different assignments throughout the year in which we acted as government employees, as ambassadors to go here or there, usually within a certain theme, so we had an area of expertise. But Dennis is new, so maybe we can have the opportunity afterwards to just bounce all this stuff off of him.

MR. KOPANDA: Okay. Anything else?

MR. DeWISPELAERE: Thank you.

MR. KOPANDA: Before we close, I'd just like to thank Tia for her fine work in getting this together.

(Applause.)

MR. KOPANDA: And also a few people in the back: Eliza Jones.

(Applause.)

MR. KOPANDA: Our interns, who also helped. Would you like to stand up for a minute?

(Applause.)

MR. KOPANDA: Thank you very much.

Also to Peg Thompson and to Dave Robbins, who also helped with this meeting.

(Applause.)

MR. KOPANDA: So is there a motion to adjourn?

MR. DeWISPELAERE: I so move.

MR. SAHN: I'll second that motion.

MR. KOPANDA: Made and seconded. We're adjourned.

(Whereupon, at 5:00 p.m., the meeting was adjourned.)