

*DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment*

Minutes of the 50th Meeting of the CSAT National Advisory Council

*June 28, 2007
1 Choke Cherry Road
Rockville, MD*

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The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met in open session on June 28, 2007, at the SAMHSA Building, 1 Choke Cherry Road, Rockville, Maryland. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the meeting at 10 a.m. Members present included Anita B. Bertrand, M.S.W.; Kenneth A. DeCerchio, M.S.W.; Bettye Ward Fletcher, Ph.D.; Valera Jackson, M.S.; Chilo L. Madrid, Ph.D.; Juana Mora, Ph.D.; Gregory E. Skipper, M.D., FASAM; and Judge Eugene White-Fish. Also present were Richard Kopanda, M.A., Deputy Director, CSAT; George Gilbert, J.D., Director, CSAT Office of Policy Coordination and Planning; and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

Welcome and Opening Session

Dr. Clark welcomed the participants and expressed his appreciation for the service of the Council members and their commitment to the field. His request for a motion to adopt the minutes of the March 22 meeting was met with a motion from Ms. Jackson, which was seconded by Dr. Fletcher. The motion passed unanimously, and the minutes were adopted as presented. Dr. Clark formally welcomed Dr. Mora to the Council. He also welcomed Dr. Madrid back to the Council after successful bypass surgery.

Council members introduced themselves and discussed their recent activities. Dr. Madrid, the chief executive officer of Aliviane No-AD, Inc., mentioned his involvement in the Texas legislative session, where he lobbied for funding for people who are addicted and involved in the criminal justice system. Ms. Bertrand, the executive director of the Northern Ohio Recovery Association (NORA), announced that NORA recently signed its third lease to open a resource center in Akron and has been working with local funding bodies and their executive directors to ensure that recovery support services are linked to professional treatment services in the northern Ohio area. Judge White-Fish, a tribal judge in the Forest County Potawatomi tribal court and the president of the National American Indian Court Judges Association, reported that the Indian court judges are concerned about the impact of the methamphetamine problem across Indian Country. Ms. Jackson is the executive director of New Century Institute Systems, Inc., which is a collaborative of six human resource agencies in Florida working to affect the quality of services in the community. Dr. Skipper, medical director of the Alabama Physician Health Program, mentioned that he is working internationally to promote physician health in Switzerland and Austria. Dr. Fletcher is the president and chief executive officer of a research and evaluation firm in Jackson, Mississippi, that helps foundations evaluate and design initiatives and works with the local treatment program to strengthen its outcome evaluation for services provided in a homeless shelter and in a treatment program focused on women. Mr. DeCerchio, Assistant Secretary for substance abuse and mental health in Florida, reported on the recently passed Substance Abuse and Mental Health Criminal Justice Reinvestment Act, the Brief Referral Intervention Treatment for Elders (BRITE) initiative, and his new position at the National Center for Substance Abuse and Child

Welfare. Dr. Mora, a professor of Chicana/o Studies at California State University, Northridge, engages in participatory action research with communities, in particular, in the areas of violence, substance abuse, and environmental health; she also is beginning a new initiative on substance abuse issues along the border.

Director's Report

Dr. Clark welcomed new SAMHSA staff and interns to the meeting and apologized to Council members who experienced delays in their reimbursements due to the establishment of a new accounting system.

Dr. Clark reported on some CSAT activities from the last quarter. CSAT funded grant and contract continuations throughout the period of continuing resolutions. New grant opportunities are currently being prepared for awards, including a new round of Access to Recovery (ATR) grants, Targeted Capacity Expansion (TCE) grants, TCE/HIV grants, and Addiction Technology Transfer Center grants. At this point, both the House and Senate have completed markups and restored the cuts to a number of Science to Services programs. Furthermore, the Senate has endorsed increased funding for the Pregnant and Postpartum Women program and criminal justice and drug courts. The executive and legislative branches will negotiate and resolve these matters. Dr. Clark stated that the Council should be thinking about 2010 and the activities it will entail.

In terms of administrative matters, two divisions have been reorganized: the Division of Services Improvement (DSI) and the Division of State and Community Assistance (DSCA). DSI now comprises three branches: Health Systems, Target Populations, and Quality Improvement and Workforce Involvement. DSCA's reorganization consolidates CSAT data collection, reporting, and analysis of grantee and State block grant data into one organizational unit - the Performance Measurement Branch.

ATR grantees are in the final year of a 3-year grant period, and CSAT has been conducting a series of sustainability trainings for providers. Up to \$96 million will be available for ATR programs, and 18 grants will be awarded. It is expected that \$25 million will be spent to address the methamphetamine issue. Dr. Clark represented CSAT at a crosscutting breakout session on methamphetamine abuse at the Department of Health and Human Services (HHS) 9th Annual Tribal Budget Consultation session, where he emphasized SAMHSA's continued commitment to creating healthier tribal environments. In terms of electronic health records, CSAT staff members have been actively involved in developing an improved strategy.

A joint SAMHSA/Centers for Disease Control and Prevention (CDC) work group on HIV and methamphetamine met in Atlanta to consider privacy, security, and other relevant health information technology standards. A new Web site for the National Registry of Evidence-Based Programs and Practices was launched on March 1. The Recovery Community Services Program convened on May 30 to address organizational infrastructure, peer practice, ethical framework, and guidelines for peer practice and evaluation of peer recovery services.

The 2007 Request for Applications (RFA) for TCE grants was posted on March 29 and closed May 25. Projects to be funded have been categorized in four major areas: Native American/ Alaska Native and Asian American/ Pacific Islander populations, e-therapy, grassroots partnerships, and other populations' emerging substance abuse issues. Total funding will be \$8 million, and 16 grants are expected to be funded. CSAT also has carried out training initiatives in faith-based communities. Participants have developed program sustainability plans and have been able to effectively market their program services to potential donors. Dr. Clark highlighted the Progress for Recovery initiative, which is a collaboration of communities and organizations mobilized to help individuals and families achieve recovery. Dr. Clark concluded his report by commending CSAT staff for their excellent work on award-winning public service announcements (PSAs).

Council Discussion. Judge White-Fish expressed his thanks on behalf of the Native American communities for Dr. Clark's participation in the tribal consultation sessions. Dr. Clark clarified that CSAT's role is to provide subject matter expertise about substance use and mental health to tribes and tribal organizations. Dr. Madrid commented on the issue of sustainability and noted that service providers need more direction and technical assistance. Dr. Clark noted that the Office of Management and Budget (OMB) is concerned about what happens at the end of a program and that new technologies adopted by local communities will facilitate service delivery.

Methadone Misuse/Abuse/Mortality

Mr. Bob Lubran, Director, CSAT's Office of Pharmacologic Therapies (DPT), and Dr. Kenneth Hoffman, Medical Officer, DPT, presented on methadone use, misuse, and unintentional mortality. Mr. Lubran explained that in 2003, SAMHSA convened a multidisciplinary group for a national assessment of methadone associated deaths. In 2001, authority had been transferred from the Food and Drug Administration (FDA) to SAMHSA for responsibility and oversight in regulation of methadone in treatment in the United States. There was some question about whether the new regulations had an effect on the change in mortality.

The Methadone Associated Mortality Assessment Report was published in 2004. The findings from the report showed that nearly all narcotics, including methadone, were increasingly associated with diversion, abuse, and deaths; both respiratory depressant effects and/or cardiovascular effects at high doses of narcotics can be fatal; and methadone treatment for narcotic addiction has a proven safety record and actually reduces mortality in this population. Mr. Lubran stated that 4 years after the report was issued, the problem continues to be serious because of misuse, diversion, and abuse of methadone. Significant increases in methadone-related deaths are being reported.

Dr. Hoffman highlighted information from the Drug Abuse Warning Network (DAWN), CDC, and the Florida medical examiners data. According to DAWN, methadone ranks third among all of the opioid analgesics, fourth among all of the controlled pharmaceuticals, and eighth among all of the controlled substances. Dr. Hoffman reviewed the CDC ranking of States with the highest number of methadone deaths in 2004; Florida was ranked number one. He also cited a study of deaths of clients in

methadone treatment in Texas from 1994 to 2002. The study found that opioid-addicted patients remaining in treatment generally had much lower mortality rates than those who left treatment.

Mr. Lubran described a number of CSAT initiatives that are under way: improvement of education of OTP physicians and patients through continuing medical education courses and the Patient Community Support and Education Project. Another initiative will improve the education of physicians managing pain with methadone, with specific attention to the identification of addiction problems, recommended actions in primary care and emergency room settings, and continuing medical education courses. An open discussion with medical organizations involved in medical education and residency training will improve substance abuse disorder treatment competency for future physicians. Finally, CSAT intends to coordinate actions with the Office of National Drug Control Policy, DEA, FDA, and the National Institute on Drug Abuse. Two consultation meetings in July will review the impact of accreditation on the OTP standard of care and the impact of the recommendations made in the 2003 assessment.

Council Discussion. Dr. Skipper referred to the importance and complexity of the issue of methadone misuse and abuse, which have resulted in more than 3,000 deaths per year. Improved training for doctors, perhaps even mandatory training, and better surveillance of OTPs are needed. He recommended that SAMHSA (1) support the idea of a medical specialty designation for chronic pain management, with oversight and standards for treatment, and (2) disseminate the findings on the hazards of methadone misuse and abuse in the popular media. Dr. Madrid reported that in the past 10 years the supply of heroin has increased to the extent that what once cost \$100 per day now costs about \$2 to \$4 per day and speedballing injection (a combination of heroin and cocaine) has become popular. His recommendations are for more training of clinicians, determining methadone dosing on the basis of the extent of the addiction, training doctors about simultaneous abuse and multiple diagnoses, revisiting the take-home concept, and examining problems related to the purity of the substance. In response to a question from Ms. Jackson about Florida's high death rate, Mr. DeCerchio explained that in 2003–2004 significant increases in the prescription of oxycontin by doctors in a number of Florida counties resulted in a change in prescribing practices, including an increase in the use of methadone for pain management. Methadone misuse and abuse are part of a prescription drug problem, and deaths from prescription drugs far exceed deaths from heroin and other illicit drugs. Mr. DeCerchio called for mandated training by State boards of medicine for physicians prescribing opiates. Furthermore, laws should be passed regarding prescription fraud, and a prescription drug monitoring validation program should be established. In addition, a public health outcry is needed from chief medical officers in departments of health and State surgeon generals, as well as at the national level. Ms. Jackson responded that this information must be disseminated and discussed at conferences. Clearly, physicians need training in prescribing long-acting pain killers. Dr. Clark stated that SAMHSA presented on this topic at a recent conference in New York. Some practitioners are attempting to address this issue, but more work is needed to solve the problem of methadone misuse and abuse.

Substance Abuse Treatment Services for Individuals with Disabilities

Dr. Dennis Moore, a professor in the Department of Community Health at Wright State University, briefed the Council members on issues related to substance use disorder and persons with disabilities. Dr. Moore described a program called Substance Abuse Resources and Disability Issues (SARDI), which is one of the few research and demonstration programs in the country focused on persons with disabilities and behavioral health problems. Since 1990, SARDI has examined a number of issues related to substance use disorder, mental illness, and other stigmatized conditions such as HIV and hepatitis.

One SARDI program involves Rehabilitation Research and Training Centers (RRTCs) and focuses on substance abuse, disability, and employment. A number of projects nationwide work with vocational rehabilitation systems to deal with these problems. The Center for Mental Health Services (CMHS) funds or co-funds four of the RRTCs through the National Institute on Disability and Rehabilitation Research (NIDRR). Some of the funding that goes into RRTCs results in high-quality research.

SARDI has examined health and disability issues that adversely affect minority populations. A program called Brothers to Brothers/Sisters to Sisters focuses on people who are living with or who are at high risk for HIV and/or a substance use disorder. Dr. Moore explained that a number of people with severe disabilities do not understand that functional impairments affect many aspects of their lives, including their recovery. Sometimes SARDI's mission is to help people understand the barriers they face. SARDI runs a mobile van and uses a church as a primary outreach site in Montgomery County, Ohio. SARDI accounts for about 25 percent of the HIV testing in the county and is now beginning hepatitis C testing. Dr. Moore asserted that the model suggests that in 15 years hepatitis C will outstrip HIV in terms of morbidity and mortality. The Consumer Advocacy Model (CAM) program is one of the few programs in the country that was established to provide substance use disorder and mental health treatment to people with disabilities.

Dr. Moore described substance use disorder treatment barriers for people with disabilities. One barrier involves the attitude of people who lack exposure to disability issues and tend to jump to inaccurate conclusions about potential clients. Other barriers involve discriminatory policies and practices and communication difficulties, in particular, involving people who are deaf. Also, architectural barriers can compromise accessibility to treatment venues, funding barriers affect the acquisition of treatment, and some existing disability statutes are a low priority for State agencies. Another problem involves the minimal level of advocacy from the disability community itself because of the fear of stigma.

SAMHSA has undertaken several actions over the past 15 years to address the issue of substance abuse treatment services for people with disabilities. It has sponsored issues forums and training, and a number of its conference agendas have included the disability issue. Treatment Improvement Protocol 29 involves substance use disorder treatment for people with physical and cognitive disabilities. SAMHSA also has required grant

applications to include disability issues and has provided States with technical assistance in mental retardation, developmental disabilities, and deafness. In addition, an informal, voluntary advisory group has been formed at CSAT to deal with the issue of substance abuse treatment services for individuals with disabilities.

Regarding future directions, Dr. Moore commented that SAMHSA offers a 1-day training for staff to sensitize them to the issue. He also urged SAMHSA to consider the National Advisory Committee's comprehensive strategic plan and encouraged CSAT to seek out interagency partners, in particular, NIDRR, the Administration for Children and Families (ACF), and CDC, to help address some of the issues involved in substance use disorders and persons with disabilities. He also urged SAMHSA to use social marketing to generate momentum on the topic within the disability community. Most important, SAMHSA should ensure that the data systems within CSAT represent people with disabilities. In addition, SAMHSA should encourage State-level compliance.

Council Discussion. Ms. Jackson concurred with Dr. Moore's statement that many substance abuse treatment center professionals do not understand issues involving individuals with disabilities. Ms. Bertrand asked Dr. Moore to explain his assertion about the predicted increase in the number of individuals with hepatitis C. Dr. Moore stated that the increase in morbidity and mortality is related to people who acquired hepatitis C several decades ago. As these individuals age, they progress to an acute condition. Mr. DeCerchio referred to Dr. Moore's description of a treatment approach that involves less intensity over longer duration. He mentioned that this approach is linked to the problem of funding and an opportunity to use home-based treatment or out-patient treatment instead of 24-hour residential treatment. He asked Dr. Moore to identify models or cite his observations about substance abuse services and less reliance on cognitive approaches. Dr. Moore stated that out-patient treatment is the preferred modality and that home-based treatment might be an alternative. However, for many people with disabilities, the nexus of the problem is the home. Because other family members create the problem or "feed the fire," home-based treatment would have to be family based. A Medicaid waiver would allow billing at higher than the standard Medicaid rate for persons with physical and cognitive disabilities.

Public Comment

Ms. Patricia Taylor, the executive director of Faces and Voices of Recovery, spoke about recovery-oriented systems of care. She emphasized ways in which to raise the profile of and develop a stronger leadership role at CSAT for creating a recovery-oriented system of care. In addition to the report from the Recovery Summit, regional meetings have taken place around the country and interest is mounting for a more recovery-oriented research agenda. More information is needed for people to achieve long-term recovery. A tremendous interest in peer-recovery support services around the country results from the realization that a recovery-oriented system of care is more than treatment; it includes ongoing support services and other opportunities to sustain recovery. CSAT can play a leadership role in this regard at the national level by proactively creating an action agenda for the establishment of a recovery-oriented system of care.

Mr. Walter Ginter, the project director of the Medication-Assisted Recovery Services project in New York, spoke about methadone-related deaths and medication-assisted recovery. He stated that the issue involves, not control, but education. Perhaps methadone needs an X number. Physicians should be trained before they can prescribe methadone for addiction or pain. Regarding dosage guidelines, Mr. Ginter pointed out that dosage guidelines lead to dosage caps and therefore should be presented very carefully.

Ms. Martha Hottenstein, the founder of the National Diversion Department of Helping America Reduce Methadone Deaths (HARMD), told the Council members about her deceased son, who unsuccessfully sought treatment for a Percocet addiction. After her son's death, Ms. Hottenstein became involved with HARMD, where she founded the National Diversion Department. Through HARMD's Web site, she has been informed about 20 cases of diversion deaths. Ms. Hottenstein stated that she is not against methadone but she is against methadone deaths and methadone abuse. Sales of take-home doses acquired through diversion from clinics and other means must be stopped. Ms. Hottenstein called for more education for doctors, public safety, and safety for patients.

Melissa Zuppari, the president of HARMD (www.harmd.org), explained the genesis of the organization. A group of parents and family members began to communicate with one another about what they could do about methadone deaths. Her fiancé, who was addicted to Percocet, died in his sleep at an in-patient treatment center after being treated with methadone and other drugs. Ms. Zuppari addressed the assessment and monitoring at treatment centers and clinics of individuals addicted to pain pills in terms of the doses of methadone they are given. After recounting a number of stories of methadone deaths, Ms. Zuppari stated that people who continue to abuse drugs while at clinics pose a danger to themselves and to society as a whole. The clinic system must change in regard to assessment, regulation, and monitoring of take-home doses and doctors should be required to hold a special license in order to prescribe methadone.

Council Discussion. Mr. DeCerchio thanked Ms. Hottenstein and Ms. Zuppari for sharing their personal tragedies and for their advocacy surrounding the issue of methadone diversion and abuse.

Physician Health Programs: Blueprint for Lasting Recovery

Dr. Skipper discussed pre-publication data from a national study that he believes could be influential in improving outcomes for addiction treatment. Drs. Robert DuPont and Tom McLellan contacted Dr. Skipper because of their interest in studying physician health programs (PHPs). Physicians have about the same rate of addiction in substance abuse as the general population; therefore, looking at physician treatment affords an opportunity to discover successful aspects of PHPs. The study found that the concept of contingency management (CM) can be very effective. CM entails the use of drug testing following treatment; negative drug tests are rewarded with a positive reinforcement, and positive drug tests are followed by a therapeutic consequence.

The objectives of the study of PHPs were to describe them and to provide a national assessment of the treatment, monitoring, and outcomes of substance-abusing physicians. Only two States (Nebraska and North Dakota) do not have PHPs. The study surveyed 49 PHPs regarding their structure and function. Much debate occurred about how to describe the function of PHPs; most PHPs strongly resist the notion that they provide treatment. Dr. Skipper described PHPs as doing “glorified employee assistance program work” or long-term case management and treatment supervision. PHPs attempt early detection, provide referrals to evaluation and treatment, and monitor individuals’ long term. PHPs have agreements with State regulatory licensing boards. Some PHPs have legal authority to operate, which provides immunity from liability, and most of the programs are nonprofit foundations, with about 50 percent of funding from regulatory boards.

The study asked the programs to provide chart reviews and paid the programs \$20 per chart review received. A chart review instrument was developed for 16 programs to obtain data over 5 years; 904 charts were included in the study. Dr. Skipper described the client characteristics derived from the charts and noted that 14 percent of the physicians in the study had a history of injection drug use as compared with 9 percent of the general population. Seventeen percent of the doctors had been arrested for drug-related incidents as compared with 13 percent of the general population. Certain specialties were overrepresented in the study—anesthesiology, emergency medicine, psychiatry, and family practice; other specialties were underrepresented—pediatrics, surgery, and pathology. The most common source of referral was the regulatory board. A high percentage (63%) of the doctors received residential treatment; only 1 doctor of the 904 received methadone. Naltrexone was used in 46 of the individuals as an adjunct to treatment, and 32 percent were placed on antidepressants.

Dr. Skipper summarized the study’s most important findings: 78 percent of the participants remained totally abstinent over an average of 7.2 years of the study; there was only one report of patient harm; and the most consistent service provided by PHPs to their participants was drug testing (100%). Dr. Skipper pointed out that physicians in the programs did not necessarily suffer from a milder variety of substance abuse than the general population, and he emphasized that virtually all treatment was abstinence based.

Dr. Skipper concluded his presentation by remarking on the potential for transferring the positive outcomes of PHPs to other ATPs through the use of long-term testing, case management, and contingency management. Monitoring through drug testing, with support and consequences, might be the key to treatment success for the public at large.

Council Discussion. Dr. Mora asked about the co-occurring psychiatric disorders seen in doctors in PHPs. Dr. Skipper explained that the most common of the disorders was major depression. He added that two doctors in the study were schizophrenic due to stimulant abuse. Bipolar disorder, ADD, and narcissistic personality disorder were prominent. Mr. DeCerchio asked about the cost of treatment. Dr. Skipper responded that the main cost was borne by the doctors and varied considerably depending on the length of time in treatment. The doctors diagnosed with drug dependency received 4.1 years of monitoring on average, and drug tests cost about \$30 each. In response to a question from Judge

White-Fish, Dr. Skipper replied that the average length of stay for residential treatment was about 63 days and for out-patient treatment about 4 months. The question is whether the follow-up (required attendance at groups with drug testing) should be called treatment. Ms. Jackson mentioned a similar treatment for impaired lawyers and expressed an interest in the outcome data on that treatment. In response to her question about the transferability of the treatment, Dr. Skipper reported on a study of CM data involving teenagers, which included depositing \$5 in an account for negative drug tests and emptying the account for positive drug tests. This 60-day treatment study resulted in a high success rate. The question involves what can be used as leverage in similar programs.

Promoting Safe and Stable Families (PSSF) Partnership Grant Programs

Catherine M. Nolan, M.S.W., ACSW, presented information about targeted grants to increase the well-being of and improve the permanency outcomes for children affected by methamphetamine or other substance abuse. Ms. Nolan explained that she is the director of the Office on Child Abuse and Neglect within the Children's Bureau of ACF at HHS. After presenting some of the history and describing the functions of the Children's Bureau and her Office, in particular, Ms. Nolan's presentation focused on the PSSF legislation, the purpose of the grants, the development and content of the program announcement, and the review process.

The PSSF program was reauthorized in September 2006 and renamed the Child and Family Services Improvement Act of 2006. Several major changes occurred during the process of reauthorization. Title IV Subpart 2 PSSF Section 437f authorized the Secretary to make competitive grants to regional partnerships to provide, through interagency collaboration and integration of programs and services, services and activities designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children who are in out-of-home placement or are at risk of out-of-home placement as a result of a parent's or caregiver's methamphetamine or other substance abuse. Permanency in this context refers to the idea that every child deserves a permanent and safe home. The legislation defines "regional partnerships," requires that the State child welfare agency be a partner, specifies that at least one non-tribal entity must be included in a tribal partnership, and outlines the authority of the grant awards. The legislation also lists the application requirements, use of funds, matching requirement, performance indicators, reporting requirements, and required reports to Congress.

The purpose of the grant program is to provide funds to assist regions in building the capacity to address issues related to child permanency, safety, and well-being occurring because of parental methamphetamine or substance abuse. In consultation with SAMHSA and other Federal partners, the Children's Bureau worked to implement the legislation and draft the program announcement. Thirty people from a variety of agencies worked on the development of the program announcement. Ms. Nolan described the history of partnering with SAMHSA, which included the 1999 report to Congress on substance abuse and child welfare, creation of the National Center on Substance Abuse and Child Welfare, child welfare waiver demonstrations, and May 2006 Conference on Methamphetamines: Child Welfare Impact and Response. She also supplied a number of

details about the development of the program announcement, including the establishment of subgroups to work on the performance indicators and funding structure, creation of a conceptual framework, and writing, submittal, and posting of the program announcement on May 4, 2007.

The key components of the projects are that the applications must represent regional partnerships formed by a collaborative agreement and must designate a lead agency. Ms. Nolan explained how discussion of the possible funding schemes led to the development of four program options with two possible Federal award amounts and two possible grant periods. The program announcement stipulates that the partnership must select one of the program options and justify the selection in terms of accomplishing the project goals. The money declines over time; the \$1 million awards decline in the out years, and the \$500,000 awards remain fixed. All awards have an increase in percentage in the match over time.

Potential applicants received technical assistance through a Webinar on May 22. Ms. Nolan noted that grant applications are due on July 3, 2007. A panel of experts will review and score the grant applications during the week of July 30. In August 2007, a decision meeting will be held with the Administration on Children, Youth and Families Commissioner, and final grant award letters will be sent to successful applicants by September 30, 2007.

Council Discussion. Dr. Clark mentioned that Sharon Amatetti, who works very closely on a variety of issues with the Bureau of Alcohol, Tobacco, and Firearms, has been instrumental in helping CSAT become involved in this new program. Ms. Jackson noted that the program announcement bridges differences in perception between people who work in child welfare and people who work in substance abuse. She asked about continued work on this issue. Ms. Nolan explained that the work group was convened specifically to write the program announcement and help with the launch of the grant program. A series of meetings will take place over the next 5 years with program directors, evaluators, and key partners. Dr. Madrid commented on the program announcement's funding options and the notion of sustainability. He asked how the Children's Bureau is planning to take advantage of Medicaid dollars to begin efforts for sustainability on day one. Ms. Nolan explained that the new program is Section 437f of Title 4B Part II. Title 4E pays for cost of care. The match must be non-Federal dollars; therefore, Medicaid cannot be used as the match. She pointed out that Medicaid is complicated because it is different from State to State and that the question of sustainability and the use of Medicaid funding deserve consideration.

Recovery Month Update

Ivette A. Torres, M.Ed., M.S., Associate Director for Consumer Affairs in the Office of the Director of CSAT, explained the goals of Recovery Month, which include supporting demand reduction goals and building momentum for holding State, regional, and national events to assist individuals in recovery and convey the message that addiction treatment works, recovery is possible, and funding is needed to accomplish these goals. Ms. Torres reviewed the costs of Recovery Month (i.e., the kit, commemorative posters and

materials, PSAs, multimedia materials, and meeting logistics) and noted that the package is relatively inexpensive given the exposure received. She encouraged all of the Council members to participate in the Road to Recovery series, which is televised in 27 percent of U.S. households.

Recovery Month includes 54 events. Local communities and coalitions are encouraged to tap private sources and other resources to assist in the observance of Recovery Month. Various events target adolescents, African Americans, American Indians, Asian and Pacific Islanders, and Latinos. Events include a Fun Walk at SAMHSA, Addiction Professional Day, Recovery Rides, and numerous community events nationwide. Attendance at these events has increased significantly since 2002, as have visits to the Recovery Month Web site (www.recoverymonth.gov). Ms. Torres showed two PSAs that carry the message of recovery. She noted that Nielsen rated the 2006 campaign in the top 10 percent of national campaigns in terms of quality and number of plays. However, Ms. Torres noted that the campaign's success should be measured not in the awards it receives but in the significant increase between 2002 and 2007 in the number of calls from individuals and families to SAMHSA's national helpline.

Partners for Recovery

Shannon B. Taitt, M.P.A., CSAT's Office of Program Analysis and Coordination, is the new Partners for Recovery (PFR) coordinator. PFR's cutting-edge initiatives include a series of briefings on the outcomes of addictions treatment and approaches to monitoring performance. PFR developed the Know Your Rights brochure, which provides individuals in treatment and recovery and their friends and allies with information regarding Federal anti-discrimination law related to employment, housing, public benefits, and other domains. The brochure is available in English and Spanish at www.pfr.samhsa.gov. PFR activities in the area of workforce development focus on recruitment, retention, and professional development. The PFR initiative resulted in a report titled *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce*, which catalogues major addictions treatment and recovery workforce challenges. PFR is currently funding activities related to improving workforce recruitment and retention.

Council Roundtable

Ms. Bertrand requested that the administration of CSAT take a proactive approach to "set the stage" for States' activities regarding a change to a recovery-oriented system of care. Ms. Jackson suggested that the National Advisory Council use its roundtables to discuss its priorities for 2008–2010. A discretionary grant or a pilot might set the stage for examining the way in which recovery applies to the medical and legal professions. She also noted the difficulty that men have in getting treatment and the lack of progress in increasing funding at the State level. Perhaps the Council can set priorities and formulate policies and ideas for the future. Mr. Kopanda noted that the budget picture has changed since the March meeting, Dr. Fletcher's letter to Dr. Cline, and the House and Senate markups. Restoration and even growth are now in the picture. CSAT would value the input of the Council in the form of comments and suggestions regarding recovery and other areas.

Dr. Mora declared that she supports recovery efforts and will follow up with her congressional representatives regarding funding in that area. If the Council's role is to advise on policy and priorities, one way to do so might be in the writing of RFAs, where priorities are set and identified. Dr. Mora asked what input the Council can have in that process and suggested that this topic be discussed at the next meeting. Mr. Kopanda responded that CSAT will ask the Council for suggestions on the distribution of discretionary funds for the coming year and a strategic framework regarding longer term priorities. Dr. Mora asked whether a strategic plan is available that delineates the long-term goals of CSAT and SAMHSA. Mr. Kopanda responded that SAMHSA's strategic plan does not cover fund allocation. Dr. Mora expressed a desire to understand the general plan and future direction. She commented that the Council might be able to have some input in terms of targeting special needs.

Mr. DeCerchio remarked on Dr. Clark's mention of SAMHSA's internal discussions regarding the 2009 and 2010 budgets. He suggested that in an upcoming session the Council could be informed of the agency's thoughts and expresses its own thoughts in a constructive dialogue. Ms. Jackson agreed that the Council could benefit from a guided and structured discussion of the topic. Mr. Kopanda stated that this suggestion will be added to the next Council agenda.

Mr. Kopanda reminded Council members that if they talk to their contacts about the 2009 budget, they should not do so as Council members.

Mr. Kopanda remarked that a confluence of elements affects CSAT's programs, priorities, and budgets. The Government Accountability Office is examining the OMB's Program Assessment Rating Tool (PART) process to determine how managers use information from evaluations and other aspects of their programs to determine future program priorities. The PART process was completed recently for the Access to Recovery program, and CSAT is looking at the application of PART principles to many of its other programs. Dr. Mora commented on the complexity of the grants and the fact that many community-based organizations do not have the technology, support, or resources to compete even though they have the trust of the community. She would like to have a dialogue about this problem. Mr. Kopanda agreed that this issue deserves attention.

Mr. DeCerchio asked about any proposed changes to the block grant formula for 2008 or 2009. Mr. Kopanda stated that the reauthorization process is currently under way and thus far no changes have been proposed to the block grant formula, except for possible changes in the minimum State allocation. The question that usually arises concerns the relationship between the formula and the need for funding and services. Mr. George Gilbert added that some thought is being given this year in the reauthorization of SAMHSA to include a provision that would mandate a study of the formula and options to change it to better reflect need. Mr. DeCerchio commented on the tenuous nature of consensus regarding modifications to the formula. Dr. Madrid added that on the House side as of June 21, an additional \$35 million has been proposed for the block grant and discussion involves how that amount will be allocated based on the present formula.

Dr. Madrid recommended that the Council discuss border issues related to the problem of double medication. The Federal Government spends millions of dollars to affect the supply side of illegal drug trafficking on the border but invests zero dollars to affect the demand side. Lowered prices mean that more and more young boys are becoming addicted to methadone and heroin. Dr. Madrid stated that border issues deserve study. He suggested that in the coming year the Council discuss the possibility of collaboration to work on the demand side problem. The Council also could discuss a PFR national plan. Mr. Kopanda stated that future discussions will focus on border issues.

Ms. Jackson pointed out that Congress funded ACF last year in a very complicated system. One of the problems with match money is the difficulty faced by agencies in matching funds. Nonprofit organizations must survive through grants, foundations, third-party payers, and insurance, but sustainability is impossible given the dwindling resources from these funding sources. The Council should discuss sustainability with an eye to the match issue. Mr. Kopanda asked whether match requirements encourage grantees to seek outside sources of support. SAMHSA has not conducted a systematic examination of whether match programs are sustained at any greater rate than any other programs. Another key issue involves the dollars in the system as a whole. It is difficult to increase capacity when the dollars do not increase. Ms. Bertrand pointed out that match alienates smaller community-based organizations because they cannot match, whereas larger hospitals, foundations, and universities can.

Mr. Gilbert returned to the issue of formulas. He reported that a proposal in the Administration budget this year would withhold 5 percent of the reward to a State if it failed to report using the National Outcomes Measurement System (NOMS). The Senate has said that it will not support this provision, but this issue could be raised in the appropriations process. Dr. Clark stated that a key issue is the expectation of performance data to ensure accountability. Most jurisdictions in the substance abuse community have been responsive in submitting data that show the money is being well spent.

Dr. Clark announced that a teleconference meeting for grant review has been tentatively scheduled for August 23. The next face-to-face meeting of the Council is tentatively scheduled for mid-October. He encouraged Council members to visit the OMB Web site to learn about PART, which will be applied to SAMHSA's entire portfolio.

There being no further business, the meeting was adjourned at 4:30 p.m.

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

12/03/2008
Date

/s/
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Chair
CSAT National Advisory Council

