

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

**Minutes of the 49<sup>th</sup> Meeting of the CSAT National Advisory Council**

**March 21, 2007  
Hilton Washington DC North/Gaithersburg  
Gaithersburg, MD**

**Center for Substance Abuse Treatment National Advisory Council**  
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**Gaithersburg, Maryland**

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met in open session on March 21, 2007 at the Hilton Washington DC North Hotel in Gaithersburg, Maryland. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the meeting at 8:50 a.m. Members present included Anita B. Bertrand, M.S.W.; David Donaldson, M.A.; Bettye Ward Fletcher, Ph.D.; Valera Jackson, M.S.; Francis A. McCorry, Ph.D.; Gregory E. Skipper, M.D., FASAM; Judge Eugene White-Fish; and Ex-Officio Member Terry L. Cline, Ph.D., SAMHSA Administrator. Also present were Richard Kopanda, Deputy Director, CSAT; George Gilbert, J.D., Director, Office of Program Analysis and Coordination, CSAT; and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

**Welcome and Opening Session**

Dr. Clark welcomed everyone to the meeting. He explained that CSAT has laid the groundwork for some substantive changes that are important to assist the Center in accomplishing its immediate and long-term goals. These will be shared with the Advisory Council during the meeting. Dr. Clark also introduced Dr. Cline who has recently begun his new position as Administrator of SAMHSA.

Council members introduced themselves and discussed their recent activities. Mr. Donaldson is working with Convoy of Hope and living part of the time in Africa, where his organization is doing relief and development work in Kenya, as well as relief and disaster response in the United States. Dr. Fletcher, after 30 years in higher education, is currently president and CEO of Professional Associates, Inc., a research and evaluation firm in Jackson, Mississippi, which works with indigenous communities on evaluation issues. Dr. McCorry is working on quality and performance improvement and co-occurring disorders at the New York State Office of Alcoholism and Substance Abuse Services. He is also chair of the Washington Circle Group, supported by SAMHSA to develop performance measures, and co-chair of the National Quality Forum, which will be issuing a report soon on evidence-based practices. Ms. Jackson is executive director of NCI Systems, a collaboration of six of the largest agencies in Florida that is dedicated to developing Centers of Excellence. She is also chair of the South Florida Provider Coalition, a managing entity that manages all of South Florida's substance abuse block grant funds and money. The Coalition is currently seeking approval by the Florida Legislature to develop a managing entity privatization of the funds and funding for the entire state. Dr. Skipper is on the faculty at the University of Alabama School of Medicine, runs the Physician Health Program in Alabama, and is engaged in different national research projects. Ms. Bertrand, in recovery for 16 years, runs the Recovery Community Services Program in Cleveland, Ohio, working with individuals and churches. Judge White-Fish is a judge for the Potawatomi Tribe in Crandon, Wisconsin, as well as the president of the National American Indian Court Judges Association. He praised SAMHSA for becoming increasingly involved in substance abuse issues in Indian Country, particularly methamphetamine. The National Congress of American Indians will be addressing this issue at their mid-year conference in Alaska in June.

Dr. Clark noted that Chilo Madrid, Ph.D. a faithful member of the Council member had quadruple bypass surgery four weeks ago and would not return to work until the following week. Dr. Clark wished Dr. Madrid a speedy recovery.

Dr. Clark then introduced Dr. Cline, who served as Oklahoma's Director of Health from 2004 until he was appointed Administrator of SAMHSA. He served concurrently as Oklahoma's commissioner of the Department of Mental Health and Substance Abuse Services, a position that he had since January of 2001. Dr. Clark noted the significance of Dr. Cline, a psychologist working mental health and substance abuse becoming the Secretary of Health.

### **SAMHSA Update: Administrator's Report**

Dr. Cline thanked the members of the Council for their service and commitment, and thanked Dr. Clark for his leadership of CSAT. He said that his experience in Oklahoma was a unique opportunity to have someone with a behavioral health background at the helm of the health cabinet; it was the first time that had happened in the history of Oklahoma, and it speaks to the importance of our issues in the overall health picture.

Dr. Cline highlighted issues that reflect some of trends that SAMHSA is seeing in the United States based on current data. One of these trends, using data from SAMHSA's National Survey on Drug Use and Health, deals with inhalant use among young people: About 1.1 million adolescents between the ages of 12 and 17 reported using inhalants in the last year. Use among young males held stable between 2004 and 2005 at about 4.2 percent, but increased from 4.1 percent to almost 5% among girls.

President George W. Bush is proposing \$3.2 billion for SAMHSA in Fiscal Year 2008. There are several areas where there will be a continued investment in services that include children's mental health, HIV and AIDS, screening and brief interventions, suicide, school violence prevention, criminal and juvenile justice, including a significant increase proposed for drug courts, and Access to Recovery (ATR), a very innovative program that had full support. The proposed budget provides about \$2.3 billion for substance abuse prevention and treatment activities. Of that, \$1.8 billion is requested for the substance abuse prevention and treatment block grant, which is the same level as Fiscal Year 2007. However, this is a budget with several programmatic reductions and elimination of various programs. The overall message behind this budget was the need for a balanced budget by 2012, which required very difficult decisions.

**Discussion.** Ms. Jackson raised a concern about the elimination of discretionary funding as it has led to many innovative new treatments, such as the Women with Children and the Family treatment initiative. In her view, discretionary funding is necessary to move from science to service. Dr. Cline concurred that discretionary funding is needed to achieve program improvements. He noted, however, that the discretionary programs are more vulnerable because they lack longstanding data to demonstrate the outcomes of their initiatives. SAMHSA has worked collaboratively with the states during the past few years to develop recovery-oriented outcomes measures, such as the National Outcome Measures (NOMS). Dr. Cline suggested members of Congress need to be educated about the importance of these programs, and grantees need to be educated about the importance

of evaluation. When funding is limited, dollars will be invested in programs that have a demonstrated track record.

Dr. McCorry commented that the budget is project driven, e.g., there may be an investment in Access to Recovery or SBI because of their value, but most programs within a state don't benefit from specific projects. Project-specific funding doesn't answer the basic, fundamental question of how we improve quality systemically. Secondly, there are issues of readiness and performance measures that will drive adoption of evidence based practices. A specific project may be quite successful, but it doesn't necessarily change the actual service delivery system. Using NOMs to measure outcomes is insufficient if there is not a strong capacity to help programs improve and a structural capacity that makes states and other entities accountable to not simply measure but also to work with programs to improve based on those measurements.

Dr. Cline responded that Dr. McCorry's comment addressed multiple levels, including the use of data and outcome information. He agreed that data isn't helpful if it doesn't get used. He emphasized the use of a public health model to effect change on a population basis. An example is the Screening, Brief Intervention and Treatment (SBIRT) approach. It's using a public health strategy to improve the quality of life for people across communities, states and the country. Being able to instill a performance or process improvement culture is critical, especially in a period of limited resources where investments are being made based on demonstrated effectiveness.

Mr. Donaldson stated that the increase in young girls using inhalants was alarming and pointed to the impact of the media on young girls' self-images. He asked Dr. Cline for his perspective on how negative images in the media could be combated. Dr. Cline described ways in which SAMHSA is working constructively with the media. One initiative is the PRISM Awards, which recognizes those areas of the entertainment industry that are addressing issues of substance use and mental illness to make sure that they present accurate depictions that do not glamorize substance use. SAMHSA has also collaborated with the Ad Council to disseminate Public Service Announcements that have been very powerful.

Dr. Cline concluded the discussion by reminding Council members that they may not lobby Congress in their specific role as Advisory Council members.

### **Director's Report**

Dr. Clark thanked Dr. Cline, Mr. Kopanda who helps him manage CSAT and Ms. Graham who organized the meeting. Dr. Clark noted that there were many SAMHSA staff members in the audience because the Council's comments influence the way the staff thinks about what SAMHSA does.

Dr. Clark summarized the President's proposed budget, by noting that SAMHSA is one of the 11 grant making agencies of HHS. The goals are accountability, capacity and effectiveness. SAMHSA's data focus is a critical aspect of meeting the accountability goal.

CSAT's proposed budget for FY08 is \$3.168 billion. Under the 2007 continuing resolution, the budget is \$3.3 billion. So there is a reduction proposed between 2007 and 2008.

A comparative analysis of discretionary funding by major activity reveals that Health and Human Services (HHS) will experience a 0.29 percent increase in budget relative to other departments, e.g., Labor, a 9.4 percent reduction; the Environmental Protection Agency, a 4 percent reduction. Some departments like Education have no change, and there are modest increases in others.

Looking at SAMHSA relative to other operating divisions within HHS, the Health Resources and Service Administration (HRSA) received a 5.61 percent decrease. The Centers for Disease Control and Prevention (CDC) has a 0.86 percent decrease in the FY08 proposed budget. SAMHSA would have a 5 percent decrease. The Administration for Children and Families (ACF) would have a 3.9 percent decrease.

Within SAMHSA for FY08, the proposed decrease for the Center for Mental Health Services (CMHS) is 29 percent. For the Center for Substance Abuse Prevention (CSAP), the proposed decrease is 19 percent. For CSAT, the proposed decrease is 12 percent.

The guiding principle in making these budgetary reductions is a balanced budget by 2012. There is also an emphasis on direct services. Several factors were considered in making program reductions and eliminations: 1) including one time expenditures that don't need to be replicated; 2) completed functions and commitments within grants; 3) the scrutiny of automatic renewals (there is an assertion that programs should not continue in perpetuity); 4) the elimination of redundancy between programs with purposes that are addressed in more than one place, 5) underperforming programs and programs without solid performance measures; and 6) proposed reductions in the past that were not enacted. These guiding principles influenced decisions made for the FY08 budget; they represent a key shift for SAMHSA as it moves toward a more performance oriented environment.

The SAMHSA decline is about 5 percent or \$159 million. The budget funds Presidential initiatives such as Access to Recovery and other priority areas such as block grants, the criminal justice portfolio, SBIRT, and the Minority AIDS Initiative, while making targeted reductions in areas where grant periods were ending, activities can be supported through other funding streams, or efficiencies can be realized.

The proposed block grant is a reduction from FY05 levels. CSAT's Programs of Regional and National Significance have two components: Capacity, with a reduction from \$386 million in 2005 to the proposed \$339 million in 2008. CSAT's Science to Service line item is reduced from \$36.7 million in 2005 to \$13.1 million in 2008. CSAT's total budget goes from \$2.198 billion in 2005 to \$2.11 billion in 2008.

The President's budget includes \$98 million for Access to Recovery with \$25 million targeted for methamphetamine treatment. For drug treatment courts, \$22 million is available that will more than triple the number of current grants. An additional \$12 million is earmarked to support Screening and Brief Interventions in general medical and community settings. \$25 million is available to fund three new grants to states, 18 new

campus grants, 8 new grants to medical schools, and 12 new grants to school districts and community health clinics serving Native Americans.

Dr. Clark noted that programs like SBIRT are critically important because 73 percent of the people who meet criteria for abuse and dependence of illicit drugs and 86 percent of the people who meet criteria for abuse and dependence of alcohol do not perceive a need for treatment, and so they're not knocking on the doors of the substance abuse treatment programs. SBIRT allows the screening and referral to treatment of a large number of individuals at community health centers, student health services, and emergency rooms.

There are also programs in the FY08 budget that SAMHSA will have to eliminate. The proposed budget would eliminate a number of programs in CMHS, including children's programs other than the children's block grant. Mental Health Transformation activities would be eliminated. Older adult activities would be eliminated. Adolescents at risk would be eliminated. Consumer and support technical assistance would be eliminated. Disaster response and some of their homeless activity would be eliminated.

At CSAT, the Strengthening Treatment and Access to Retention (STAR program), both grants and technical assistance, would be eliminated, as would the special initiatives outreach program. State Service Improvement activities would be eliminated, as would information dissemination, program coordination and evaluation, some technical assistance, and CSAT's contribution to the Minority Fellowship Program.

Among CSAT's Special Initiatives/Outreach program, Technical Assistance Publications (TAPS), the Historically Black Colleges and Universities (HBCU) and the Lonnie Mitchell conference, and the planning and special initiatives out of Dr. Clark's office would be eliminated. In addition, the performance measurement contract in Disability Service Improvement (DSI) would be eliminated, as well as analysis of the Agency for Health Research and Quality (AHRQ)'s health care costs study, and CSAT's scientific, technical and logistical support. Within State Service Improvement, HIV/AIDS cross-training would be eliminated, along with confidentiality training. Within Program Coordination and Evaluation, Partners for Recovery activity would be eliminated, as would CSAT's consumer affairs and education activity, including Recovery Month. The Knowledge Application Program (KAP) within Information Dissemination would be eliminated. Within Technical Assistance, printing and clinical technical assistance would be eliminated.

CSAT would experience decreases in the following areas: State Incentive Grants for Treatment of Persons with Co-Occurring Substance Abuse and Mental Disorders (COSIG); opioid treatment programs; Targeted Capacity Expansion grants; Pregnant and Post-Partum programs; the Recovery Community Services program; Children and Adolescent programs; treatment systems for the homeless; and program coordination and evaluation.

The FY08 budget is a very tight budget, and CSAT will operate within that budget, making whatever adjustments are needed.

SAMHSA will begin planning for the FY09 budget shortly. The amount of money that will be available is not yet known. Therefore, the agency will probably plan for several potential funding scenarios using the FY08 budget as the base. These possible scenarios include a flatline (no change from FY08) request, as well as reductions from or increases to the President's 2008 budget at different levels, such as plus or minus 2 or 4 percent. The Administrator would like to get input from all stakeholders on what the priorities should be and Dr. Clark would like to hear from the Council members during the Roundtable discussion about their thoughts about where resources should be allocated. Should CSAT focus on expanding the availability of treatment services or on improving treatment quality through the dissemination of evidence-based treatment practices? Should the Center focus on how it disseminates information? If there is a budgetary increase, what are the priority areas that should be addressed first? Are there new programs or activities that CSAT should be focusing on, or should the Center expand current efforts such as ATR or SBIRT? If faced with additional cuts, how would the Council recommend that CSAT reduce, eliminate or refocus its current programs?

Dr. Clark stressed that the budget could change as it moves through Congress. SAMHSA will operate within the final appropriated budget.

With the focus on performance and a constrained fiscal environment, there is an emphasis on data to demonstrate the utility of programs. The Administrator referred to data about inhalants from the National Household Survey and to data about prescription drug abuse from DAWN data. He is also interested in the Treatment Episode Data Set (TEDS) data. SAMHSA is interested in taking the large data sets that it has and integrating them into how the agency functions. As a result, the Administrator has approved a proposal that affects two CSAT divisions, the Division of Service Improvement and the Division of State and Community Assistance (DSCA). CSAT plans to restructure its activities by consolidating data activities currently spread across those two divisions into a new performance measurement branch that will be located in DSCA. This new branch will be responsible for coordinating all program performance activity and analysis of national data sets so that CSAT can be much more aggressive in using these data. When the Office of Management and Budget (OMB) examines program performance, it wants to know what the evidence is and where the data came from. In addition to the National Outcome Measures and the Government Performance and Results Act (GPRA) data, CSAT also invests in collecting other data. There is a need to integrate all of this data collection activity into Requests for Applications (RFAs), technical assistance and assessment.

With the consolidation of the performance measurement activities in the new branch, the plan also affords the opportunity to restructure three Division of Service Improvement (DSI) branches. This restructuring will improve the Center's ability to accomplish its mission. This new performance-based environment in which CSAT is expected to manage for performance and demonstrate solid outcomes and results is a critical environment. With the 2008 budget deliberations, all emphasis will be on documenting SAMHSA's performance. For 2009, SAMHSA wants to be able to document the utility of the various programs that it has so that there's no debate about how important or useful programs are.

The Program Assessment Rating Tool (PART) may expand and drive future budget decisions, so the data will have to be of sufficient quality that it can survive PART reviews. The Administrator's expectation regarding CSAT's use of data, including national prevalence and trend data to guide and manage programs, will be a challenge, and the Center will work with Dr. Cline.

On March 29-30, the ninth annual Lonnie Mitchell National Historically Black Colleges and Universities (HBCU) Substance Abuse and Mental Health Conference will be held in Washington. The conference honors the work and legacy of the late Dr. Lonnie Mitchell, and is designed to educate students at our nation's HBCUs, Historically Black Colleges and Universities, about substance use and mental health disorders, and to bring to their attention information and strategies used in coping with the problems of substance abuse and mental health in African American communities. In addition to Dr. Cline, Mr. John P. Walters, the Director of the White House Office of National Drug Control Policy, will participate in the conference.

Dr. Clark noted that he appreciated Judge White-Fish's comment about SAMHSA's participation with the American Indian and Alaskan Native communities. The Center is trying to address the needs of each of the populations in the United States. In addition to working with HBCUs, SAMHSA has also been active in reaching out to the American Indian and Alaskan Native communities and addresses the needs of Hispanics through an Hispanic work group. Dr. Clark recently presented at an Asian American and Pacific Islander research meeting in Los Angeles. CSAT also works actively with rural America, in Appalachia and other communities.

SAMHSA will also address the issues of the electronic health record and e-therapy. As the Agency moves toward a performance-oriented culture, it needs to make sure information gets uplinked to the largest systems, and the electronic health record is going to play a major role in doing that.

**Discussion.** Dr. Fletcher asked about the impact of the culture of performance on expectations for discretionary grantees and how those expectations will be communicated. Dr. Clark responded that the expectation that grantees will perform according to their goals and objectives will be communicated through technical assistance and project monitoring.

Dr. McCorry sought clarification about issues surrounding data sets, the restructuring the Agency and the culture of performance. Dr. Clark explained that SAMHSA has aggregate data from the National Household Survey, as well as the Treatment Episode Data Set (TEDS). CSAT needs to reflect how it spends its money relative to the magnitude of the problem as reflected in those data sets. It also needs to have better information about how much money treatment programs are costing so as to support a "Ford Taurus" rather than a "Cadillac" program. There are also program management issues; CSAT needs to understand and respond promptly when programs are underperforming or future funding levels may be reduced. Mr. Kopanda added that OMB is looking for a SAMHSA data strategy that provides a broad look across the three centers and how national surveys like the Household survey provide data useful to programs and simultaneously integrate with data collected from those programs. The

data strategy has to be integrated with direct program performance; this will be related to the new organizational unit.

Ms. Jackson noted that most states are investing substantial monies in data collection in an effort to become performance-based. There are many challenges, however. For example, in Florida, the Legislature has mandated a set of outcomes that have nothing to do with NOMS and require data collection. How can SAMHSA help states and other localities align their data collection requirements with national ones? Dr. Clark concurred that there are going to be conflicts in operability. SAMHSA is trying to work with jurisdictions to resolve those conflicts. The electronic health record is a potential mechanism by which data can be aggregated without operability conflicts. However, states are going to have to address NOMS because Congress is spending money based on these measures and there is a proposal for penalties if NOMS data is not collected at the state level. SAMHSA's objective is to work collaboratively with states and community-based organizations to collect the needed data. Some of the hardware issues have been addressed and now attention needs to be paid to software issues. However, the need to move forward is serious.

Dr. Skipper asked if there were provisions in this policy for programs such as Alcoholics Anonymous and Narcotics Anonymous whose effectiveness is difficult to prove? He also cautioned that more money could be spent trying to prove performance than in providing services. Dr. Clark responded that the performance culture mandates less interest in the nature of the intervention and more interest in what happened as a result of it. Funding decisions will be based on program effectiveness as demonstrated by positive outcomes.

Ms. Bertrand asked about the GPRA data for CSAT initiatives that are currently in place in terms of consumers staying in recovery. Dr Clark responded that CSAT currently has insufficient data to answer that question, but wants to address it through better data and a longitudinal analysis.

### **Legislative Update**

Dr. Clark welcomed Joseph D. Faha, SAMHSA's Director of Legislation, who joined the meeting to provide a legislative update to the Council.

Under the Continuing Resolution for FY07, SAMHSA received the same amount of funding that it had in FY06 with an expectation that funds would continue to be spent in the same way as they had in FY06. In early February, President Bush submitted his FY08 budget to Congress. SAMHSA testified before the House of Representatives on March 12 along with its sister agencies within the National Institutes of Health (NIH) (National Institute on Drug Abuse [NIDA], National Institute on Alcoholism and Alcohol Abuse [NIAAA], and National Institute on Mental Health [NIMH]) in a collegial environment; the Agency strove to create a dialogue on the relationship between science and service.

In addition to the appropriations, SAMHSA is up for re-authorization this year. The re-authorization addresses changes in or continuation of SAMHSA programs. This provides an opportunity to engage Congress in a discussion of mental health and substance abuse issues; the last time this discussion was held was during the last reauthorization of

SAMHSA in 1999. It allows the Agency to obtain greater authority to make changes, such as requiring collection of NOMS data as part of the state block grant program. However, Congress may have issues that it also wants the Agency to address. Some of those issues may be custody relinquishment, services for older adults, methamphetamine, child welfare related to methamphetamine, supportive housing and services, workforce development, mental health promotion and the prevention of substance abuse, mental health in the schools, accountability, and suicide prevention. Those issues and others will be debated, beginning in a Senate hearing that is likely to occur in early May. The Health, Education, Labor and Pensions (HELP) Committee is already working on them. So now is a good time for those interested in substance abuse and mental health to have conversations with their Congressional representatives about the issues that are important to them. Except for the state block grant formula, it is not anticipated that it will be a contentious debate and the odds are good that the Senate will write the bill and the House will accept the Senate version.

Dr. Skipper asked who was on the reauthorization committee and if any controversial issues could be anticipated in a Presidential election year. The Committee is chaired by Senator Ted Kennedy. Mr. Faha listed other members he could recall. Mr. Faha noted that three of the members, Senators Christopher Dodd, Barak Obama and Hilary Clinton are running for President. This provides the opportunity for mental health and substance abuse issues to gain the attention of the press and the public.

Dr. McCorry asked for an example of how issues such as wellness or accountability get translated into reauthorization language. Mr. Faha responded that reauthorization is the process of amending existing statutes. SAMHSA's statutes are Title 5 and Title 19 of the Public Health Service Act and Protection and Advocacy for Individuals with Mental Illness. Dr. Clark interjected that proposed provisions may also not get funded. Mr. Faha said that SAMHSA currently has 14 unfunded authorities and one goal of reauthorization is to eliminate them because SAMHSA has the authority to accomplish the objectives of these provisions without the unfunded provisions themselves being on the books.

Mr. Donaldson asked if SAMHSA is exploring innovative ways to engage corporate partners and leverage their resources through private-sector partnerships. Mr. Faha remarked that this would be a lose/lose strategy because private sector funding would encourage Congress to reduce federal funding. This would put the Agency in a precarious position.

The current bill primarily gives funding and amends laws that pertain to the Department of Justice (DOJ), not to SAMHSA, but the Agency is interested because CSAT has a lot of reentry programs. A SAMHSA employee will become involved to give technical assistance and promote more cooperation between DOJ and the Department of Health and Human Services (DHHS) on reentry legislation. In response to a question from Dr. McCorry, Mr. Faha stated that the level of funding for this legislation is wide open.

### **Public Comment**

There was no public comment.

Following the public comment period, the meeting was open to consider the minutes from the September 20, 2006 meeting. Dr. Skipper moved to accept the minutes; Ms. Jackson seconded the motion. The motion was passed by a unanimous voice vote.

### **Substance Abuse Treatment Services for Individuals with Disabilities Update**

Dr. Clark introduced Ruby Neville, CSAT's lead on substance abuse treatment services for individuals with disabilities, to update the Council on what CSAT has been doing to address this issue since her presentation at the September 2006 meeting.

CSAT staff have been having monthly conference calls with experts on co-existing disabilities. These experts include Ken Perez from the New York Office of Addiction and Substance Abuse Services; Cynthia Graham; Jacqueline Hendrickson from OPT and CSAT; Dennis Moore from the SARDI program with Rice State University in Ohio; Debra Guthmann from the California School of the Deaf; Deborah Larson-Venable, executive director of the Granada House in Massachusetts, and also a consumer; Harry Kressler, the director of the Pima County Partnership in Tucson, Arizona. There is also a potential participant, Dr. Francis Sparadeo, from Rhode Island who specializes in traumatic brain injury. One of the issues that emerged from the conference calls is that of traumatic brain-injured (TBI) individuals who have substance abuse needs, and treatment providers need to learn how to provide evidence-based treatment for these individuals.

CSAT continues to assist youth with co-existing disabilities to access substance abuse treatment services. SAMHSA is collaborating with the Administration for Children and Families (ACF) through ACF's Family Support 360 Program and the Substance Abuse Prevention and Treatment (SAPT) block grant.

**Discussion.** Dr. McCorry commented that Mt. Sinai conducted a TBI study as part of New York's practice improvement collaborative. There were tremendous positives on the TBI screen that they were developing and validating, which led providers and CEOs to get really concerned that there were no psychologists available to do the follow-up assessment on the positive screens. They felt vulnerable about having something in the record that they weren't able to address in the treatment plan. He recommended development of a basic fact sheet for providers about simple practices that can be implemented to be more sensitive and response to people with cognitive impairments. Ms. Neville responded that there are people with expertise who can provide guidance to others in the field through communication vehicles such as listservs and newsletters, as well as through technical assistance when funds become available.

Dr. Clark closed the discussion by noting that TBI is an evolving issue as the troops return home. CSAT is seeking to understand the issues better so it can collaborate with the Department of Defense (DOD) and the Veterans Administration (VA) on serving this population.

### **Council Roundtable**

Dr. Clark invited the Council's comments on priorities for CSAT as it begins to plan for the FY09 budget.

Ms. Jackson asked if SAMHSA was planning to propose any changes to the block grant formula, including set-asides. Dr. Clark responded that this is an issue that Congress deals with; their resolution reflects competition between states. The Agency in the past made some recommended changes to the set asides, but this year SAMHSA is not recommending any changes to the formula or the set asides.

Dr. Skipper stated that he appreciated the advisory about alcohol markers that has had a tremendously positive impact. He asserted that drug testing is a very effective deterrent.

Dr. McCorry reflected on the culture performance, noting that there are three element of performance improvement: delineation of quality, process improvement, and measurement. NOMS is the measurement part. The quality and improvement aspects, however, are not included in this budget. That sets an expectation on providers and states without addressing the capacity to meet the expectation. In a block grant environment in which whole state systems are limited to or defined by the money that CSAT gives them in terms of treatment, to assert one element of the three without developing a capacity for the other is short sighted and not in keeping with the kind of relationship that has to exist between provider states and the federal government to actually improve care. Dr. Clark agreed that quality improvement and process improvement are important parts of performance improvement. SAMHSA supported NIATx and STAR; those efforts enhance the ability of programs to operate in a cost-conscious environment. Part of the NIATx effort was learning how to keep people engaged so that they remain in the program long enough for it to have an impact instead of continually assessing new or returning participants; otherwise, the cost bands become distorted and the average outcomes will become depressed.

Dr. Fletcher noted that CSAT has heretofore assumed a leadership role in terms of addressing substance abuse and higher education, particularly among the HBCUs. With the demise of the Lonnie Mitchell program, she asked if there will be a continuing involvement with HBCUs? Dr. Clark replied that the HBCU initiative would not be continued in FY08, nor would the Minority Fellowship Program, which goes beyond HBCUs to also include the Hispanic community, the Asian communities, and the American Indian and Alaska Native communities to support those who are interested in careers in mental health and substance abuse disorders. There may be other places within the Federal government where some of this work can be continued.

Ms. Bertrand sought clarification about the two programs proposed for elimination, Recovery Month and Partners for Recovery (PFR). Dr. Clark stated that Partners for Recovery facilitated a number of activities, including leadership institutes and outreach. Mr. Gilbert interjected that PFR also supported the Recovery Summit a couple of years ago, and is now rolling that out through regional meetings; these would have to be discontinued. It supported the development of the "Know Your Rights" brochure, which was used for some very successful meetings at the state level to make people aware of rights under federal law and corresponding rights available under state law to people that

are in treatment or with histories of substance use disorders in terms of employment discrimination and housing, etc. It also sponsored briefings for state legislators on performance measurement with regard to treatment that were well received. Overall, PFR has tried to promote notions of recovery and recovery oriented systems of care, worked on anti stigma efforts and leadership training and workforce development efforts, such as the production and the development of the CSAT Workforce Development Report. In the consumer affairs area, the annual Recovery Month campaign would be eliminated under the 2008 budget. Ms. Bertrand noted that local communities may be able to continue celebrations of Recovery Month but that the SAMHSA will need to look at creative ways to continue its workforce development efforts.

Ms. Jackson asked the use of methadone as a painkiller among returning veterans and whether this is a VA or a SAMHSA issue. Dr. Clark said that the care of veterans is the jurisdiction of the VA, but that SAMHSA has a supportive role. SAMHSA is working with DOD and the VA to establish an appropriate role. Some veterans go to community providers for services, and those providers need to have adequate resources to address the unique needs of veterans.

Mr. Donaldson asked for clarification about what consumer affairs activities beyond Recovery Month are being cut. Mr. Gilbert responded that other campaigns include involvement in an annual Inhalant Week, campaigns on prescription drug misuse aimed at older adults and youth, and the Patient Consumer Support Education Project. CSAT staffer Bob Lubran explained that this is a group of patients and families who are involved with methadone treatment and come together periodically to talk about educational initiatives focusing on patients and consumers. Mr. Donaldson stated that he agreed with Ms. Bertrand about the importance of Recovery Month. Not only does it educate the general public, it also highlights the accomplishments of CSAT. Further, it has been a great entry point for faith-based, community-based groups that are not going to get involved right away but will participate in some kind of public affairs campaign. He believes that Recovery Month has been highly successful and is disappointed that it is being cut.

Mr. Gilbert confirmed that the TIPS publications, part of the CAPT budget, were also being eliminated in response to a question from Dr. Fletcher.

Dr. Clark closed the roundtable discussion at 12:02 p.m. so that the Council could adjourn for lunch. He noted that he would not be available for the afternoon discussion, but that Mr. Kopanda would be present.

### **Afternoon Session**

Mr. Kopanda reconvened the meeting at 1:35 p.m. He announced a deviation from the agenda because the Council still had a number of questions about the President's proposed budget. Mr. Gilbert reviewed Dr. Clark's slide presentation from the morning session. He noted that \$352.1 million for CSAT's Programs of Regional and National Significance (PRNS) is just for discretionary programs. Of that \$352.1 million, \$339 million is slotted for the capacity programs, which are the major services programs, like Access to Recovery, drug courts, SBIRT, etc. There is \$13.1 million allocated for Science to Service programs, such as the ATTCs and the CAPT program. Among the

slides showing eliminated programs, the dollar amounts are in thousands so the eliminations amount to millions of dollars. For CMHS children's programs, there's \$8.2 million in program activity that's being eliminated. On the CSAT slides, the various lines equate to lines that are in SAMHSA's budget document that goes to Congress. As an example, the proposed eliminations for the STAR line include both grants and technical assistance. In 2008, the budget proposes to eliminate funding for the STAR program, and this means that CSAT would have to terminate grants that would otherwise be getting their third year of funding in 2008. Mr. Kopanda added that STAR is the only grant program that would have active grants terminated.

Under Special Initiative/Outreach, the HBCU and Lonnie Mitchell initiatives are supported by both grant and contract dollars. This activity comes to a natural end at the end of 2007. It will not be continued in 2008 if this budget passes, but it wouldn't be terminated early.

In this state service improvement line, the HIV/AIDS cross training and confidentiality training programs would be lost. Mr. Gilbert suggested that the decision makers at OMB may not have understood what some programs state service improvement, special initiatives/outreach, program coordination and evaluation actually were, whereas programs with more specific titles, criminal justice, drug courts or SBIRT were more clear. This is speculation. Dr. Fletcher asked why evaluation funds would be eliminated in a culture of performance. Mr. Gilbert replied that the title was misleading because the funds were not actually used for evaluation.

In response to a question posed by Ms. Jackson, Mr. Gilbert described the budgeting process. SAMHSA prepares a budget that is first reviewed by DHHS, then revised and submitted to OMB. It also gets reviewed by the Office of National Drug Control Policy because it's part of the President's drug control budget. Mr. Kopanda noted that many budget lines are aggregates of multiple activities and may not contain a very descriptive title that conveys the importance of the activities contained within it. Evaluation activities are also often built into programs, rather than appearing on a budget line entitled "evaluation." Access to Recovery, for example, has about \$3 million for evaluation built into the ATR grants. Nonetheless, evaluation was probably not given the priority in this budget that direct service received.

Ms. Bertand asked what type of activities were conducted under the planning and special initiatives program. Mr. Gilbert confirmed that this program, which was eliminated altogether, included the HBCU grants, the Lonnie Mitchell conference, Dr. Clark's special reserve for special conferences and events, a performance measurement contract, and logistical support for some programs. Ms. Bertand asked if SAMHSA has a department that analyzes how the funding is distributed into the community, e.g, who is responsible for RFAs and how they're worded? Mr. Kopanda responded that such work begins in the program division. The grant program initiates an RFA and has an internal discussion about the best target population, what CSAT has done in the past in this area, what kind of grants it has received in the past, what statute is going to be used to fund the program, etc. and it makes a recommendation that is reviewed at various levels before it is sent to the Administrator. From there it may go as far as OMB and the White House, but most stay within the Agency.

Dr. Fletcher observed that many of the programs being cut are very small. She noted, however, that even small programs have the potential to impact a significant population. An example is the HBCU initiative. There is no other program that speaks to substance abuse at the 107 HBCU's. How can you rationalize eliminating this program? Mr. Kopanda responded that the program is valuable but that difficult budget decisions had to be made. Further, some programs may be able to be restored once the House and Senate take action. Mr. Gilbert referred Council members to the Congressional Justification (CJ) that was submitted to Congress for the 2008 budget. It was distributed to Council members and is available online. Examining the document, it becomes apparent that the line items are aggregates of individual programs and provide no fine detail. SAMHSA may want to reconsider how these line items are displayed and explained in future CJs. The Agency finds out about the cuts after the decisions have been made so it doesn't have the chance to argue on behalf of key programs, such as TIPS.

The technical assistance (TA) being eliminated includes both printing and clinical TA. Traditionally, CSAT budgeted TA within individual program lines. During the past year, a decision was made to put all the clinical TA on one line. OMB looked at the budget and saw roughly \$1.2 million per year for clinical TA and then a sudden jump to \$10 million; that raises questions and the entire \$10 million was lost. Dr. McCorry queried which area of clinical TA was being cut; Mr. Kopanda explained that it was primarily TA for discretionary grants in the DSI division.

Mr. Kopanda also noted that CSAT experienced the least reduction among the three SAMHSA centers and these budgetary discussions go beyond SAMHSA to many other federal agencies. Mr. Gilbert reiterated that most grant programs would not be prematurely terminated but that existing cohorts of grants would not be renewed. He also pointed out that CSAT's cuts were sustained by the discretionary programs and the block grants were essentially protected.

#### **ATR and Recovery Support Services Update**

Mr. Kopanda introduced Anne Herron and Jack B. Stein to report on Access to Recovery and Recovery Support Services.

Ms. Herron began by reporting on a Recovery Support Services conference held on January 22-23, 2007 in Ft. Lauderdale, FL, that was designed to take some lessons learned from some CSAT grant programs and to share them more broadly with states and other providers. This occurred during one and a half days that were added to a meeting for Access to Recovery program grantees. CSAT brought together the ATR grantees, some Recovery Community Services Support grantees, some RCSP grantees, regional directors from NASADAD, and members of the CSAT faith-based expert panel that was developed to support ATR. Altogether, there were 65 people.

This was a forum to discuss the experiences of the grantees, both looking at the evidence that supports the ongoing development and support of recovery support services, what recovery support services are, the definitions, how they were implemented and some of the procedural issues both from the community provider side as well as from the state side, and the experiences from the provider perspective with providing these kinds of services as part of an existing continuum of care.

Some of the lessons learned that emerged from the meeting is an understanding of what the role of recovery support services is and continues to be. Overwhelmingly, what the group was saying and reasserting is that recovery support services function as a way to expand the continuum of care; that they allow the system and the field to focus on strength based services; and the relationship between recovery support services and treatment services is very much complementary and compatible.

Another theme that emerged was the importance that the addiction field has developed in relation to the ongoing treatment of chronic illness, the provision of wraparound services, of treating an individual and family holistically and providing the kinds of things that people need in their ongoing development and life.

Challenges and the barriers included how some of the recovery support service providers new to the system lacked the necessary business infrastructure. Clearly, many of the states were encountering this issue and many of the providers were experiencing issues around financing, around clinical documentation, and around the ability simply to fill out all of the paperwork that is necessary. Another issue had to do with a lack of consistent direction and agreement on how to establish rates for recovery support services. Some of the discussion from the states really talked about how they would go into the phone book and find out what the going rate was for transportation. That's how they set their rates. There was no other information to use. Sustainability is another concern.

From the state perspective, there are issues around fees and reimbursement, and issues of workforce quality and credentialing. Some of the states were looking at credentialing or acknowledging individual providers. Others were looking at credentialing a program, rather than individuals, which is a change for this field. Other issues had to do with how states conducted their outreach and how they brought new providers into the system, and then the kinds of training that they developed and are continuing to provide around business practices, for both treatment providers and recovery service systems.

From the provider perspective, a challenge was the difficulty of continuing and sustaining their marketing of the strength based approach, that there is a tension about focusing on not talking about the deficits of individuals but talking about their strengths. Another challenge is trying to support a paradigm shift within the continuum: Instead of talking about treatment planning, talking about recovery planning and really developing formal relationships and partnerships between the treatment programs and the recovery support service programs and thus expanding the continuum of care.

The next step is the development and dissemination of a white paper which will be a guidance document for providers and for states and others who are interested in implementing recovery support services.

Dr. McCorry noted that the National Quality Forum (NQF) is coming out with a consensus on evidence-based practices. One of the domains being addressed is continuing care management, because the Forum discussed addiction within a chronic care model. There is no specific practice listed within this domain. The work that Ms. Herron describes ties very nicely into the NQF document because continuing care is seen as the extension of the treatment model into a continuing care/recovery management kind

of domain. If the report gets endorsed by the Forum, it is used by the Centers for Medicare and Medicaid Services (CMS) in the development of Medicaid funding and Medicaid performance measures.

Dr. Stein provided the Council with an update on the Access to Recovery program, which represents a shift in paradigm from an acute model of care to a recovery oriented system of care. Access to Recovery was established in 2004 as a presidential initiative, with the goal of providing clinical treatment and recovery support services to people identified as having an alcohol or other drug misuse or dependence problem. The goal was to serve 125,000 clients over a three year period with approximately \$3 million funding. Beginning in August 2004, grants totaling approximately \$100 million were awarded to 14 states and one tribal organization. Overall, these 15 awards are slated to end on August 2, 2007. More than half of the grantees will ask for a no cost extension until August 2008.

ATR is a discretionary voucher based grant program designed to expand capacity, support client choice, and to require the grantees to manage performance based on outcomes that demonstrate patient successes. The voucher based component of ATR is one of the most unique aspects of ATR, an alternative approach to how treatment and recovery support services can be administered, managed and delivered. It is a very unique experiment in how best to improve and expand treatment services.

Five major objectives governed the program: to expand treatment capacity; facilitate the pursuit of recovery through many different personal pathways; increase the number and types of providers, including faith-based providers who deliver clinical treatment and/or recovery support services; utilize vouchers as a means to obtain services; and manage performance based on outcomes that demonstrate patient success.

The governors' offices that were the recipients of funds in the state-based grants had the opportunity to determine, based on need, how they'd like to spend the dollars. Many of them chose to implement ATR on a statewide basis while others focused the program on a more regionalized basis.

ATR has been a resounding success in meeting its goals. The three year target of 125,000 clients has already been attained; to date, over 137,000 clients have been seen through this system. Recovery support services have truly played a large role in the program. About 64 percent of the clients for whom status and discharge data are available have received recovery support services. Nearly 50 percent of the dollars redeemed were redeemed for recovery support services, and over 50 percent were for clinical treatment services. About 30 percent of the dollars redeemed for clinical and recovery support services have been redeemed directly by faith-based organizations, one of the objectives of this initiative. Over half of the clients seen to date were males, about 32 percent females. Approximately six out of ten were white, one third African American and 13% Hispanic. Some of these numbers will probably shift as the remainder of data is collected over the next couple of months.

Clinical treatment services accounted for about 35 percent of the services delivered, but case management and other services that really fall under the recovery support services complete the complement of services that are provided through ATR. About 64 percent of the clients received recovery support services. Almost \$150 million worth of services have been redeemed to date. Forty nine percent of the dollars paid were for recovery support services, and 34 percent of the dollars paid were to faith-based organizations. Lastly, faith-based organizations accounted for 22 percent of recovery support services and 34 percent of clinical treatment providers.

Some really significant changes are apparent, based on GPRA data. From intake to discharge, nearly 70 percent of individuals who came in with a problem with substance use report abstinence at discharge. About 22 percent increased in stabilized housing. Nearly 30 percent increased in employment. Over 50 percent increased in social connectedness. Over 80 percent of individuals reported a reduction in criminal justice system involvement. The majority of people coming into the system did not have a criminal justice background, so it's actually a very small number that represented in this percentage. Nonetheless, these are remarkable changes, and Dr. Stein attributes them to the fact that a continuum of care is being provided.

Technical assistance has been a critical component of Access to Recovery. Many of the organizations that are part of Access to Recovery are very small grassroots organizations and need a lot of assistance. In January, CSAT held a technical assistance conference for ATR grantees called "Optimizing Outcomes Through Sharing Knowledge." It focused on grant closeout issues, how to keep on collecting follow-up data, and sustainability.

In regard to sustainability, some states have implemented what they call transition coordinators over this last year and a half to ensure that the legacy of ATR continues. Some states have literally transformed their treatment systems so that ATR has actually become more of a model for them. Many of them have also reported linkages with other health care systems and other types of systems, such as the criminal justice system.

Mr. Kopanda noted that CSAT is working on the RFA for a new round of ATR grants that will total almost \$100 million.

Dr. McCorry asked how to interpret the outcome data presented about ATR. Dr. Stein replied that the measure looks at the status (e.g., abstinence) of the individual within the past 30 days. Individuals are also tracked over the course of six months, as well as at time of discharge. Discharge could occur before or after that six month period of time as well. Dr. McCorry also asked about the average length of stay in an ATR program. Dr. Stein replied that he didn't have that information immediately at hand, but it should be easily located.

Mr. Donaldson said that CSAT has been a vanguard in engaging the faith community, and ATR is an example of that success. Dr. Stein cited examples of faith-based efforts that he had observed. He also recounted his experience to NIDA's Clinical Trials Network Steering Committee about a recovery oriented system of care, because the concept of recovery is narrowly viewed at NIDA, more as a concept of after care rather than an ongoing concept of recovery support. He challenged the NIDA researchers to

help build the science base behind recovery support services. The evidence is there, but it needs to be expanded.

Mr. Kopanda stated that ATR has been one of the most intensely managed programs within CSAT. A great deal of data is collected from grantees and reported.

### **NREPP Update**

Mr. Kopanda introduced Kevin Hennessey, SAMHSA's Science to Service Coordinator in the Office of Policy, Planning, and Budget and Frances Cotter, CSAT's Science to Service lead.

Dr. Hennessey provided screen shots of the new NREPP website, which is accessible from SAMHSA's homepage. NREPP is a searchable database for interventions for the prevention and treatment of mental and substance use disorders. Its purpose is to assist the public in identifying approaches to preventing and treating mental or substance use disorders that have been scientifically tested and that can be readily disseminated to the field. The system was launched on March 1, 2007 with about 25 interventions representing the full array of SAMHSA domains, including mental health treatment, mental health promotion, substance abuse treatment, substance abuse prevention, and co-occurring disorders. There are over 200 interventions in the review queue at this point, and about five to ten interventions per month will be added for the foreseeable future.

Interventions can be searched by topic, area of interest, evaluation design, target population and/or whether it's proprietary or public. Key word searches are also available. When printed out, intervention summaries run 10 - 12 pages in length. Information is organized into Descriptive Information, Outcomes, Ratings, Demographics, Studies/Materials, Replications and Contact Information. Each outcome is described, including how it was measured and some key findings. The research design is included so that users can make judgments about the rigor of the evaluation design. Ratings include a research rating that measures the quality of the evidence about the intervention on a scale from 0 to 4, and a readiness for dissemination rating about the general quality of the resources available to support the use of the intervention.

There are three requirements for interventions to meet for consideration for NREPP review. The first is that the intervention demonstrates one or more positive outcomes at the conventional statistically significant level of  $p > .05$ , and those outcomes have to be in mental health and/or substance use behavior among individuals, communities or populations. The second requirement is that the intervention has been published in a peer reviewed publication or is documented in a comprehensive evaluation report. The third requirement is resources, such as training or materials, which are available to the public to facilitate dissemination.

SAMHSA's Science to Service Awards are designed to publicly recognize community based organizations that are implementing evidence based programs. Beginning in 2007, three awards are given each year in each of four areas: substance abuse prevention; substance abuse treatment and recovery; mental health promotion; and mental health treatment and recovery.

Ms. Cotter explained that each Center contributes about a half million dollars to the NREPP initiative and is part of a decision-making group. She encouraged Council members to share their thoughts about NREPP as it continues through its rollout to the field. She also emphasized that the new tool is very different from the old NREPP. Therefore, it will be important to educate the field around the fact that this is a decision support system and tool and not simply a comprehensive list of programs and practices. She also emphasized the full pool of evidence based practices currently within CSAT. These include not only NREPP but also TIPS, which are a consensus based rather than a peer review based set of protocols that are at the core of the treatment field's evidence base. In addition, under the Knowledge Application Program, CSAT has put a number of evidence based practices that evolved through CSAT initiatives into training manuals and materials. The most recent one is the Matrix Program for Stimulant Abuse. There is also the ATTC program that has a full series of online and other kinds of training materials and products. Finally, there are the blending products, such as the Clinical Trials Network. Both the ATTC program and NIDA are developing awareness and training materials for the findings that are coming out of the NIDA Clinical Trials Program through this initiative.

**Discussion.** Ms. Jackson congratulated the presenters on the improvements in NREPP and the hard work that went into making the new system usable. Mr. Kopanda stated that NREPP is fully funded in the 2008 budget. He also noted that grant applicants for a service program are required to use an intervention from the list of effective programs and practices that Ms. Cotter circulated. Mr. Gilbert clarified that applicants could use other programs, but had to justify them by providing evidence about their effectiveness.

Dr. Fletcher noted that the TIPS are a valuable resource for the field. They are used as a training tool for those who are planning careers in the substance abuse field and some credentialing agencies reference TIPS as a primary resource for those who are preparing themselves for credentialing. Ms. Jackson stated that she is opposed to eliminating funding for the TIPS, as proposed in the President's 2008 budget, because they are such a valuable resource for the field.

### **1993-2003 National Expenditures for Substance Abuse Treatment**

Mr. Kopanda introduced Rita Vandivort, acting branch chief in CSAT's Organization and Financing Branch. The National Expenditures for Substance Abuse Treatment report is a cross center project between the Center for Mental Health Services and the Center for Substance Abuse Treatment to look at what United States is spending on mental health and substance abuse care, both in the private sector and the public sector. It includes all mental health and substance abuse diagnoses that are usually covered by health plans. It does not include dementias, tobacco dependence, developmental delays, mental retardation, prevention services or the burdens and costs of illnesses. The data comes out of SAMHSA spending estimates, going back to 1986.

Dr. Vandivort also discussed trends and issues in Medicaid funding. In 1986, Medicaid accounted for only 10 percent of all spending, but in 2003 it accounted for almost 20 percent, at 18 percent. There are some audits going on by the Office of the Inspector General, OIG, looking into Medicaid spending. As a result, CMS is eliminating reimbursement for services that were covered in the past. Examples cited included the

elimination of bundled rates for wraparound services for children and adolescents; bundled charges for residential treatment; the definition of what is considered rehabilitation (reimbursable) vs. habilitation (not reimbursable); and family therapy unless the child beneficiary is in the room. It's also important for states to understand CMS requirements to have specific treatment goals, to document every service date, and to be sure that providers have Medicaid status. States are being required to reimburse Medicaid for services when they were found in violation of CMS rules.

*Discussion.* Dr. Fletcher asked Dr. Vandivort to discuss the implications of declining private sector funding, level public funding support and tighter Medicaid regulations. Dr. Vandivort replied that the field needs to look more broadly at private payers. There has been a huge decline in spending from employer sponsored health insurance. The field needs to think of strategies by which to make its case more compelling to employers. Almost 90 percent of those employed have some substance abuse coverage, and yet there are declines in spending. Some of it is utilization management controls that are part of the managed care arena. However, if the employer says it needs to have access to substance abuse treatment, utilization management guidelines can be loosened.

Dr. Fletcher reflected that the field has changed little over the past 20 years, continuing to struggle with the same issues. Dr. Vandivort concurred, noting that there has been a huge shift away from inpatient care. Commercial insurance tends to have inpatient and outpatient coverage, with nothing in between. She suggested that the field needs to look at reimbursement for community based intensive outpatient models so that there is a continuum in benefit structures.

Ms. Jackson encouraged SAMHSA to educate Congress and the public about these issues, at the same time noting the large percentages of individuals without health insurance.

Dr. McCorry asked how service providers can construct a sustainable program of services in light of the constantly shifting dynamics around funding within particular localities and how such a state by state patchwork of funding arrangements can work. Dr. Vandivort replied that grantees should begin to plan for sustainability from the first day they receive a discretionary grant, as well as diversify their funding sources. Dr. McCorry queried whether CSAT, NIDA and NIAA could undertake a study to create state profiles of support for services. It should be a protocol that provides a view within a particular political district or division of how monies flow in and out to create the substance abuse treatment system. Dr. Vandivort agreed that this kind of data is needed. Mr. Kopanda stated that he recently attended the SAMHSA National Advisory Council and there was discussion there about the need to develop some kind of an overall construct for where the SAMHSA and others want the system as a whole to go in light of significant changes in the field. But within that mix was the reality of cuts in Medicaid funding, the changes in the whole funding structure and the fact that Congress may or may not pass parity legislation. In response to a question from Dr. McCorry about how to describe the financing model of addiction treatment in the United States, Mr. Kopanda responded that state and local funding is the core of support for treatment. Dr. Vandivort noted that the field needs to use data to make a better case for how much private insurers are actually spending on substance abuse treatment currently shown only as "medical services." Ms.

Jackson pointed out that some service providers such as her organization juggle 25 to 30 funding streams at a time. Few referrals come in from Health Maintenance Organizations to her facility.

Ms. Bertrand commented that her agency's clients are struggling with housing and family issues and so providers need to have a sturdy infrastructure and build partnerships with other departments. She also posed a question about the IMD rule in terms of providing a central facility for clients. Dr. Vandivort clarified that IMD stands for Institutes of Mental Disease; it's a rule that Medicaid funds can't go to an institution that is primarily directed at mental illness and other conditions listed in the DSM-IV. In the late 1990's, some states were able to waive the IMD through an 1115 waiver, but CMS has indicated that when those 1115 waivers come up for renewal, it will no longer continue them.

Dr. Fletcher asked Dr. Vandivort to comment on the programmatic impact of CMS' redefinition or reinterpretation of support services. Is it redefining what constitutes treatment? Dr. Vandivort said that there are a number of regulations from the Deficit Reduction Act that should be coming out soon to clarify this. SAMHSA is trying to make a case that since CMS says that it supports community based living what substance abuse clients need for that community based living are these types of supports and flexibilities. Substance abuse spending accounts for a little over 1 percent of Medicaid's budget so it's challenging to focus CMS' attention on this issue.

### **E-Therapy Update**

Ms. Jackson introduced Captain Stella Jones from CSAT's Division of Services Improvement to update the Council on CSAT's e-therapy initiative. Ms. Jackson noted that the contract period was nearly over for the initiative and that a publication was forthcoming. She noted that e-therapy would continue to evolve and invited Council members to play a role in its evolution.

Capt. Jones reported the findings of a literature review about e-therapy that revealed that this modality can potentially provide treatment to underserved and hard to reach populations. Providers must be knowledgeable of issues related to cultural and linguistic competence. Successful implementation of e-therapy, however, requires more providers to be trained in online counseling, possibly additional languages and cultural nuances within special service populations.

The review also indicated that more research is needed on the efficacy of e-therapy within diverse populations. What is critical is that licensure and regulations for e-therapy must be clarified, particularly for treatment provided across jurisdictions. Implementing e-therapy requires a certain level of technological savvy for both the providers of services and for clients.

The next steps for the project are to develop an e-therapy guidance document, now that the review and synthesis of the literature is completed. The development of guidance document is in progress.

**Discussion.** Mr. Kopanda noted that within CSAT's Targeted Capacity Expansion Program, there is a program called Targeted Capacity Expansion General. There will be a focus area on e-therapy within that program for the first time this year and CSAT expects to make some e-therapy grants. Ms. Jackson noted that members of the e-therapy subcommittee have received a copy of the draft guidance document and need to get comments back quickly.

**Council Roundtable (begin)**

Dr. Kopanda opened the floor for general discussion, including any further discussion of the 2008 budget.

Dr. Skipper recommended that SAMHSA take responsibility for overseeing drug testing in schools, by licensing boards, and from homes. There's a growing body of evidence regarding the benefits of drug testing both in improving outcomes of treatment and in prevention of substance abuse. Both ONDCP and NIDA support the expansion of drug testing. SAMHSA currently oversees drug free workplace rules. However, there is currently no agency that oversees drug testing in these other venues. Specifically, he suggests that SAMHSA take three actions: 1) promote an increased use of drug testing; 2) promote training of licensing boards, schools, courts, parents, etc., in the proper use and interpretation of the drug testing; and 3) promote increased training of Medical Review Officers (MROs) who operate under federal testing guidelines for the drug-free workplace. MROs get one day of training and certification, and they don't have the training or knowledge to really interpret tests properly.

Mr. Kopanda stated that drug testing in SAMHSA is primarily done within the Division of Workplace Programs for federal drug testing in the Center for Substance Abuse Prevention. Dr. Skipper's comments would be provided to them. Dr. Skipper responded that he believes this is also a CSAT responsibility. Mr. Gilbert noted that CSAT has addressed the issue because the appropriate use of drug testing is covered in a number of TIPS; a more cohesive response may also be needed. Dr. Skipper proposed that educational programs for medical boards and drug courts about proper testing procedures, as well as literature for home and school testing, be developed.

Ms. Bertrand stated that she would like to see CSAT continue to support community based and faith based organizations in some manner. She also recommended that language be put into RFAs that limits administrative costs in favor of service delivery, and that TIPS and Recovery Month be continued. Mr. Kopanda responded that these recommendations and the discussion from earlier in the day would be used to inform SAMHSA/CSAT's discussion of the FY09 budget. He also noted that with this year's Targeted Capacity Expansion grants, CSAT is going to have a focus area on recovery oriented systems of care in which small organizations, including faith-based organizations, would be supported to operate a system of care. Ms. Bertrand suggested that CSAT invite project officers to suggest what they think would be a good initiative to invest in, as opposed to having an outsider that knows absolutely nothing about a particular system. She noted that some organizations that are in the trenches doing very good work may get overlooked because they can't write wonderful grant applications.

Dr. Skipper recommended that, in light of the growing abuse of prescription drugs, SAMHSA needs to take a little more active role in talking with the Food and Drug Administration (FDA) about drugs that may be the most risky, whether their availability should be reduced and, if they are available, to encourage training of the doctors who prescribe these drugs. Doctors must currently be trained to prescribe buprenorphine, but not Dilaudid, Demerol, OxyContin and so forth. On behalf of addicted or potentially addicted patients and those that will relapse because of all these drugs out there, SAMHSA should be making strong recommendations to the FDA. Mr. Kopanda responded that Dr. Ken Hoffman from the Division of Pharmacologic Therapies was present. The Division will be holding a meeting on methadone and will take up this topic at that meeting.

Dr. McCorry asked for a future presentation from the Office of National Drug Control Policy (ONDCP) at a Council meeting to address how outcomes data is related to supply reduction given the one-third/two-thirds split between demand reduction and supply reduction. Specifically, he is interested in the policy question about why the Nation is spending so much money on supply reduction when there seems to be a greater need for demand reduction. Mr. Kopanda indicated that CSAT would invite ONDCP to an upcoming council meeting.

Judge White-Fish expressed sadness about the budget cuts. He noted that addictions have not decreased in Native American Country. If there is a program that is working, those programs should be continued rather than starting new programs. It's hard to accept that budgets are being cut so drastically and all on the basis that decision-makers didn't understand the program. There are people that are suffering from this disease, and the monies need to take care of our people at home.

Dr. Fletcher observed that the budget cutting process did not use evidence-based principles. First, the reductions do not reflect efficiency. Consider the HBCU program as an example. It has an expansive scope but requires very few dollars. Secondly, the budgeting decisions have the potential of retarding our progress in the field of substance abuse. An example is the TIPs documents that have become a major reference source and a knowledge dissemination tool that advances the field. She concluded by asking her colleagues whether or not the Council, as a collective body, shares a need to express its concerns regarding the budgeting process.

Judge White-Fish asked for clarification on the question of lobbying in light of earlier comments that the Council members are prohibited from lobbying in their role as advisors to CSAT. Mr. Gilbert stated that although they could not lobby while in their role as Council members, they are free as private citizens who also serve as council members to express their opinions to legislators. Mr. Kopanda stated that it is possible for the Council members to put together a statement to provide to Dr. Clark or Dr. Cline. Ms. Graham noted that a quorum of Council members is not present at the meeting, which would prohibit the council from passing a motion..

Mr. Donaldson stated that he believes SAMHSA needs to do a better job when the budget is presented on defining what the line items are and their value. He noted that faith-based programs were being cut, even though they were a Presidential priority.

Dr. McCorry proposed that one point the Council might make could be around the closing of programs versus a reduction in programs as a way to reduce the budget. Most of the \$46 million being cut is in the Programs of National Significance, despite concerns by Dr. Fletcher about the HBCU's, by Mr. Donaldson about faith-based programs and his own concerns about performance management. At the very least, a reduction in funds in light of a curtailed budget could be argued. The Council could say it opposes the elimination of programs, much as it understands the need to balance the budget, and that it encourages Dr. Clark and Administrator Cline to look to restore these funds within the context of their budget, and that it endorses the introduction or the reintroduction of funds to keep these programs whole. Dr. McCorry volunteered to draft a letter if there is consensus on this issue and send it to all Council members. Mr. Kopanda suggested that Ms. Graham be the contact person to work with the Council on this. Dr. Fletcher stated that she supported the Council drafting such a letter. She asked for guidance on appropriate procedures to move forward. Ms. Graham responded that a motion would be inappropriate because a quorum was not present. However, the Council may draft a letter addressed to Dr. Clark, and she would coordinate getting the document to all of the Council members to sign off on it. From there, it would go to Dr. Cline for his consideration.

Dr. Skipper said he would like a chance to review and possibly edit the document, not simply sign it. Dr. McCorry said he would do a first cut and send it to the members present at today's meeting for comments. He will incorporate the comments and then it can be sent to the larger Council for signature. But everyone present would have a chance at the early level of writing. He offered to let someone else be the primary writer, but no one accepted his offer. Therefore, he agreed that he would write the first draft and circulate it to the others present before sending it to their colleagues for approval.

Mr. Gilbert emphasized that the budget that has been submitted to Congress is the first step in the process of Congressional consideration of the budget. In response to a question from Dr. McCorry, Mr. Gilbert agreed to respond to questions about the budget so that information in the Council's statement would be correct.

Mr. Kopanda thanked everyone for their participation in the meeting. Dr. Fletcher made a motion to adjourn the meeting. Dr. McCorry seconded the motion, which passed unanimously. The meeting adjourned at 5:11 p.m.

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

7-26/2007  
Date

/s/  
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM  
Chair  
CSAT National Advisory Council  
Director  
SAMHSA's Center for Substance Abuse Treatment