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

Minutes of the 53rd Meeting of the CSAT National Advisory Council

March 20, 2008
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 March 20, 2008, at the SAMHSA Building in Rockville, Maryland. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the closed session of the meeting at 9:00 a.m. to review grants. The closed session adjourned at 9:25. Dr. Clark convened the open session of the Council meeting at 9:45 a.m. Members present included Abdelwahhab Alawneh**.** M.A., Anita B. Bertrand, M.S.W., Rev. John D. Castellani, Kenneth A. DeCerchio, M.S.W., Elizabeth Howell, M.D., Francis A. McCorry, Ph.D., and Gilbert Sudbeck, M.A. Also present were CSAT's Richard Kopanda, Deputy Director; George R. Gilbert, J.D., Director, Office of Program Analysis and Coordination; and Cynthia A. Graham, M.S., Designated Federal Officer, CSAT National Advisory Council.

Welcome
Dr. Westley Clark welcomed participants to the open session of the meeting.

Consideration of Minutes
Council members voted unanimously to adopt, as amended, the minutes of the October 17, 2007, CSAT National Advisory Council meeting.

Opening Remarks and Introductions
Dr. Clark welcomed to the Council new members Elizabeth Howell, John D. Castellani, Abdelwahab Alawneh, and Gilbert Sudbeck. Council members introduced themselves and described their activities.

Rev. Castellani has served as Executive Director of Teen Challenge for 7 of his 20 years with the organization. Ms. Bertrand, Executive Director of Northern Ohio Recovery Association (NORA), works with three large counties to integrate peer-driven, recovery-oriented support services. Her agency recently opened a residential treatment center for women with children. Mr. Alawneh, Director of ACC Network Clubhouse in Detroit, will present on his psychology research at the upcoming American Psychological Association annual meeting. Mr. DeCerchio, a 28-year veteran in the chemical dependence field, works for the Center for Children and Family Futures, which operates the National Center for Substance Abuse and Child Welfare. Mr. Sudbeck, also a 28-year veteran, reported that South Dakota has COSIG and FASD grants. South Dakota's legislature has raised the division's budget by 25 percent, the State is establishing a system of care for clients addicted to methamphetamine, and is working to enhance the rate of reimbursement to providers for their services. His division also is working to improve relationships with tribes in the State. Dr. McCorry serves as Director, Commissioner's Office on the New York State Office of Alcoholism and Substance Abuse Services. He reported that New York is adopting a chronic care model, moving aggressively to establish recovery centers across the State, and transforming methadone treatment to become more patient-centered and more of an outpatient-oriented system of care. Dr. Howell, board certified in addiction psychiatry and general psychiatry, is the immediate past president of the American Society of Addiction

Medicine. She has worked in the field for 25 years in a variety of settings, including as Georgia's state methadone director. Dr. Howell now serves as Associate Professor of Psychiatry, University of Utah School of Medicine.

Director's Report

Dr. Clark acknowledged CSAT staff's preparatory work for the meeting. He reported that Congress passed and the President signed into law the FY 2008 budget in December, with all CSAT funds appropriated at virtually the same levels as FY 2008 -- $399.8 million for Programs of Regional and National Significance (PRNS) and $1.758 billion for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Congress restored most program cuts proposed in the FY 2008 budget, and included $6.2 million in congressional earmarks.

The President's proposed FY 2009 budget reflects a reduction of almost $63 million in PRNS funding and an increase in the Block Grant of approximately $20 million for supplemental awards to the top 20 percent of States for superior performance and submission of NOMs. Planning has begun for FY 2010, which offers Council an opportunity to provide input.

In October 2007, SAMHSA awarded $11 million over 4 years for eight peer-to-peer Recovery Support Services grants, and $159 million over 5 years was awarded to 67 grantees under the Targeted Capacity Expansion (TCE), Substance Abuse Treatment and HIV Services programs. Dr. Clark called attention to the written "Director's Report," which provides details of FY 2007 grant awards and other programs. Funding opportunities for FY 2008 include new Screening, Brief Intervention, and Referral to Treatment (SBIRT) grants to states, SBIRT Medical Residency Training Program grants, TCE, Substance Abuse Treatment and HIV Services, and Homeless grants. New programs will focus on: services in supportive housing environments; new residential treatment for pregnant and postpartum women grants; Adult Treatment Drug Courts; a new initiative for a physician clinical support system for the use of methadone to treat pain and opioid addiction (in response to increased methadone-related mortality); and a final round of Opioid Treatment Accreditation grants. CSAT's initiative with Historically Black Colleges and Universities will be re-competed.

CSAT has been working diligently to support its continuing grant activities, including Dr. Clark's participation at meetings with new Access to Recovery (ATR) grantees that included community- and faith-based services providers and Single State Authorities (SSAs). The meetings offered an opportunity to learn, for example, that strained economies make Federal resources more critical at the local level. CSAT is promoting recovery-oriented systems of care (ROSC), an approach that emphasizes recovery as a process which is person-centered, self-directed, and positively impacts families and communities. CSAT hosted a meeting in December 2008, of newly awarded directors of Addiction Technology Transfer Centers (ATTC). They developed a 5-year strategic plan focusing on promotion of ROSC. CSAT also held the final two ROSC regional meetings in October and January, where participants discussed planning and implementation of ROSC at the State and local levels.

Concern about methamphetamine abuse continues, and planning is ongoing for the national summit in winter 2008 to promote public health partnerships and safety in critically affected populations. SAMHSA/CSAT, in collaboration with Federal partner agencies, will convene

participants from State Health Authorities, SSAs, State HIV/STD directors, and other community-based agency and research organizations. The National Institute on Drug Abuse and CSAT sponsored a Buprenorphine Summit, which emphasized the medication's positive impact on opioid treatment. At a media roundtable, Dr. Clark answered questions about the summit. By February 2008, SAMHSA had certified 13,462 physicians to use buprenorphine in office-based treatment of opioid abuse and dependence, 59 percent of whom are listed in the buprenorphine Physician Locator System.

CSAT has continued its activities on co-occurring disorders with the expansion of its Treatment Improvement Exchange to include Co-occurring Dialogues, an electronic discussion list. SAMHSA's Co-occurring Center for Excellence disseminates resources to each SSA and provides training to States and sub-State entities in collaboration with ATTCs. In addition, attention to co-occurring disorders is being addressed through the Block Grant in each jurisdiction.

The 2007 Recovery Month campaign resulted in 767 events, 146 proclamations, and 68 Voices for Recovery that were posted on the Web site. In 2008, SAMHSA will sponsor an activity in each State, plus locally sponsored events. Dr. Clark highlighted the importance of the involvement of a broad spectrum of community organizations in Recovery Month.

Council Discussion. Dr. McCorry asked for clarification of Block Grant activities related to co-occurring disorders. Dr. Clark stated that CSAT, through our discretionary portfolio, is requesting that when assessments are conducted, questions about co-occurring disorders are asked in an effort to incorporate attention to co-occurring disorders as part of the business practice. He observed that CSAT must work with NASADAD and SSAs, as well as public health and mental health authorities, to address co-occurring disorders without abandoning the commitment to deal with alcohol and drug use.

Noting that training opportunities to treat persons with buprenorphine are dwindling and that the drug will go off patent in 2009, Dr. Howell inquired about CSAT's training plans. Dr. Clark stated that CSAT will continue to work with nonprofit and for-profit organizations, the pharmaceutical industry, and patient advocacy groups to determine how to address the issue. Because of limited resources, no specific initiative is planned. He pointed out that the numbers of people affected by the epidemic of prescription opiate overdose and misuse are far greater than those affected by heroin.

Administration for Children, Youth, and Families Regional Partnership Grants: Overview
Mr. Ken DeCerchio, Program Director, Center for Children and Family Futures (CCFF), described the Administration For Children, Youth and Families (ACYF) Regional Partnership Grant program. Authorized by Congress to improve the safety, permanency, and well-being of children affected by methamphetamine and other substance abuse, the program awarded 53 grants in September 2007. Under a support contract, CCFF works to refine and develop performance indicators, develop a data collection and reporting system, and provide programmatic and evaluation technical assistance to grantees. CCFF's subcontractors include Planning and Learning Technologies and Macro International.

The National Center for Substance Abuse and Child Welfare (NCSACW), under a contract with CSAT (joint funding with the Children's Bureau) works with States and communities to strengthen collaboration among the substance abuse, child welfare, and court systems. The In-Depth Technical Assistance Program of the NCSACW is supporting 4 new sites, with another potential 11 sites over the next 5 years. Together with the 53 RPG sites, by 2012 there will have been 78 sites implementing strategies to strengthen the collaboration among the 3 systems to improve outcomes for children and families.

The 53 active grants are organized by cluster: tribal, drug court implementation or expansion, child-focused agencies, system-wide collaboration, an array of services within communities, and treatment-focused agencies. Most grantees serve a region or county. One requirement of the grant is that a State or local child welfare agency has to be a partner applicant, and for 45 percent of grantees the lead agency is a state or local child welfare agency. A number of other agencies, including substance abuse agencies, were not required as partners; however, the applicant was strongly graded on the extent of their partnerships. Almost 23 percent are substance abuse agencies at the county level, and are the designated lead agencies for their partnerships. Four significant systems are represented in the partnerships: States, counties, tribes, and providers. In addition, courts are well represented, with almost 61 percent of grantees partnering with courts. Mental health services provider partners were 47 percent of grantees, which is a new development in recent years that recognizes co-occurring disorders in this population. Many grantees target children in the home who are at risk for out-of-home placement, as well as children in out-of-home care. Almost 70 percent of grantees specifically address methamphetamine with a major focus on treatment strategies for methamphetamine and family-centered treatment. Grantees can develop their proposals in the following areas: improvement of engagement and retention of parents in substance abuse treatment, different perspectives in policies between the two systems (child welfare and substance abuse), and chronic service shortages in both systems. Mr. DeCerchio described key activities in specific focus areas, including systems collaboration and improvements, substance abuse treatment linkage and services, children's services, other services for parents/families, and expanding the region's capacity for family treatment services. The program emphasizes sustaining projects after funding terminates, especially by promoting continued collaboration and partnership. The grants are for 3 and 5 year funding periods and for $500,000 or $1 million, with decreasing funding in every progressive year so that each grantee will increase the local share of funding by requiring local matching funds as grants are expiring.

Mr. DeCerchio explained that Congress required development of a set of performance indicators through broad consultation with the field and grantees, and mandated an annual report of progress to Congress. Using 23 indicators and 15 demographic variables, four outcome domains are measured: child/youth (for example, percentage of children who remain at home, occurrence of child maltreatment, improved child well-being), adult (access to treatment, substance use, parents or caregivers connected to supportive services), family/relationship (parenting capacity, risk/protective factors, coordinated case management, substance abuse education and training for foster care parents), and regional partnership (collaborative capacity, capacity to serve families in the child welfare system). Project evaluators will measure some items on an individual basis. The data system will include client-specific, case-level data; partnership (process) data; and contextual data. Grantees submit semi-annual progress reports and local evaluation reports.

These types of interventions and strategies have the goal of providing better outcomes for families in the child welfare system, such as more children remaining at home, greater rate of family reunification, and shorter terms in foster care. For the first time on a national scale, rigorous measurement using a robust set of performance indicators will demonstrate the impact of the program strategies to provide early intervention and treatment services to families in the child welfare system affected by methamphetamine and other substance abuse/addiction.

Council Discussion. Mr. Sudbeck inquired whether States have implemented statutes related to methamphetamine use under child welfare laws. Mr. DeCerchio replied that several States have enacted laws making it a felony to endanger children by exposure to methamphetamine and other drugs. Mr. DeCerchio added that the impact on specialized treatment for pregnant women primarily is to expand capacity. Some grantees strengthen case management, outreach, and co-location of staff, while others provide more nontraditional in-home and wraparound services.

To Dr. McCorry's question about what constitutes a regional partnership, Mr. DeCerchio responded that at minimum, the partnership is county-wide; some incorporate multiple counties. The important feature is the breadth of the partner agencies. In large part, performance measures link to individual strategies, rather than core indicators. Almost all grantees collect most indicators. Dr. Clark stated that CSAT will collaborate with the Administration on Children, Youth, and Families on performance measures.

CSAT's 2009 Budget and Priorities for 2010 and Beyond

Dr. Clark described the challenge posed by the roughly 20 million people who meet criteria for alcohol and drug abuse, but who perceive no need for treatment. If the larger community perceives no need for treatment, this is reinforced by friends and family until harm occurs; harm is the greatest motivating force for treatment.

For the FY 2008 and 2009 budgets, guiding principles for this administration include the goal of a balanced budget by 2012, no new taxes, emphasis on delivery of direct services versus infrastructure, and other funding decisions based on multiple factors.

The Block Grant budget remained stable in FY 2007 and 2008, with a $19.9 million increase in the budget request for FY 2009. The proposed PRNS budget would decline in FY 2009 by $48.5 million from FY 2008, following a $2 million increase over FY 2007. For the Science and Services portfolio, there was a slight reduction between FY 2007 and 2008, but a $14.5 million reduction between FY 2008 and 2009. The FY 2008 appropriation set level funding for the Block Grant, restored $50 million in many discretionary programs proposed for reduction, and reduced funding for drug courts and SBIRT. It maintained funding for Minority HIV/AIDS, included funds for tribes and tribal organizations, and included funding for 25 earmarked programs.

Dr. Clark enumerated key FY 2008 activities and initiatives, including: implementation of a second ATR cohort in 18 states, 5 tribes, and the District of Columbia; broadening availability of screening and brief intervention (SBI) programs; enhancing treatment services for American Indians and Alaskan Natives; and promoting recovery support services in recovery-oriented systems of care. Other activities include: promoting HIV Rapid Testing; conducting a PART

assessment of the Drug Courts program; addressing prescription drug abuse; developing the substance abuse workforce; and adopting a public health approach to service delivery.

Under the FY 2009 proposal, SAMHSA's budget would decline by $198 million, a reduction of 5.9 percent. The budget would fund Presidential initiatives, including ATR, and other priority areas, while making reductions in areas where grant periods are ending, activities can be supported through other funding streams, or efficiencies can be realized. The budget maintains funding for the Block Grant, plus $20 million for performance incentives; eliminates funds for congressional earmarks; and proposes no SAMHSA staff reductions. Dr. Clark described proposed funding levels for specific programs, all subject to final budget negotiations between the White House and Congress in the coming months. He stated that CSAT will work with the final outcome and will contend with the present uncertainties. Highlights include a small increase in ATR funding, a 280 percent increase in Treatment Drug Court activity, and a 93 percent increase in SBIRT, with $28 million available for new grants to States, campuses, and medical schools. Dr. Clark emphasized that preventing progression toward addiction can decrease total health care costs, and widespread screening increases early referrals to treatment programs. Level funding for the Minority AIDS initiative will enable continuation of grants, technical assistance, evaluation, and provision of substance abuse treatment services in racial and ethnic communities. Dr. Clark stated that the public health approach calls for people to know their HIV status, not just to be generally informed.

The FY 2009 budget request calls for elimination of discretionary grant programs that amount to $70 million, including $55.3 million for capacity and $14.8 million for science and service. Factors considered in making the FY 2009 program reductions and eliminations include: one-time expenditures that do not call for replication; completed grant programs; scrutiny of automatic renewals; programs addressed elsewhere; under-performing programs and programs lacking solid performance measures; and proposed reductions not enacted in the past. Programs proposed for elimination in FY 2009 include Co-Occurring State Incentive Grants, Treatment for Pregnant and Postpartum Women, Strengthening Treatment Access and Retention, Recovery Community Services Program (RCSP), Treatment for Children and Families, Minority Fellowship Program, Knowledge Application Program, Partners for Recovery, and Consumer Education and Recovery Month activities. About $24.3 million for programs to serve children and families would be eliminated and $4.5 million for special initiatives and outreach. Budget cuts for a variety of CSAT's continuing programs would amount to about $14 million.

Dr. Clark explained that the SAMHSA Administrator has testified before Congress on the budget, and Congress currently is consulting with interest groups. He anticipated that a continuing resolution will be enacted until a budget is passed.

Regarding the 2010 budget, Dr. Clark stated that the upcoming change in administration, turnover in Congress, and change in congressional committee membership will affect the budget's outcome and timing. Dr. Clark stated his anticipation that there will continue to be an emphasis on screening and brief intervention and drug courts. Accountability, performance measurement, and management issues will continue as priorities. Services provision, rather than infrastructure, will be emphasized to demonstrate that people are seen and services delivered. Evaluation results exist for ATR and the Block Grant, and by the time the budget matures, we

expect to have results for SBIRT and Drug Courts. This information will influence how programs are allocated. Budget proposals under consideration include: service integration within the primary care system; SBI; recovery-oriented systems of care; improving evidence-based practices; addressing health disparities; addressing prescription drug abuse; and promoting workforce development. Dr. Clark stated that internal and external discussions on potential FY 2010 budget proposals are ongoing, taking into account continued economic constraints. By the end of April, proposals will be finalized and budget documents developed. On June 2, 2008, SAMHSA will submit its proposed 2010 budget to DHHS. Dr. Clark offered Council members the opportunity to express their opinions on FY 2010 budget priorities.

Council Discussion. In reply to Mr. DeCerchio's question about parameters for the 2010 budget, Dr. Clark stated that one might assume a 2-4 percent increase or 0-2 percent decrease in the FY 2010 budget from enacted FY 2009 levels. Mr. Kopanda noted that the change in administration offers an opportunity for CSAT to develop a menu of initiatives that might take the Center in new directions. In response to Dr. McCorry's concerns about program cuts in the proposed FY 2009 budget, Dr. Clark suggested that the Council might suggest program priorities should the Administration and Congress compromise and make additional funds available.

Dr. McCorry suggested that the Council prepare a document for the benefit of the new Administration regarding priorities that should be reflected in CSAT's FY 2010 budget. Ms. Bertrand offered to coordinate Council members' input. Mr. DeCerchio suggested that a statement directed to the FY 2010 budget will reflect Council's views on the FY 2009 budget, noting that the FY 2009 budget cuts in treatment for children and families come at a time when increased economic stressors create increased demand for social supports.

Public Comment

Jean Govoni, Administrator, SAARA Center for Recovery, Chesterfield County, Virginia, a 2007 RCSP grantee, described the early successes in the center's newly opened facility and the importance of technical assistance in those successes. She urged restoration of RCSP funding.

Walter Ginter, National Board of Faces and Voices of Recovery and a project director of a New York RCSP project, refuted the FY 2009 budget comment regarding discontinuation of the RCSP program due to lack of an evidence base; he quoted a CSAT document that reports effectiveness of RCSP grantees in achieving successful outcomes.

Pat Taylor, Faces and Voices of Recovery, expressed disappointment over the elimination of this effective program. The RCSP grantees and faith-based organizations have built safe environments to support families and others struggling with addiction. She urged the Council to recommend that Administrator Cline identify $2.5 million to issue a new round of RCSP funding in FY 2008. She also commended SAMHSA on its plan to include questions in the National Survey on Drug Use and Health about people's recovery experiences.

SAMHSA's Process for Developing Grant Announcements

Jennifer Fiedelholtz, M.P.P., Director, Planning and Performance Measurement Unit, Office of Policy, Planning, and Budget, SAMHSA, described SAMHSA's process to develop grant announcements, or Requests for Application (RFA). Ms. Fiedelholtz stated that the President's

budget guides initial grant planning activity, and that these initial plans are updated once the House and Senate issue their budget reports during the summer. If both legislative bodies add funds for a particular program, work may begin on development of that grant announcement. The final appropriation is made after October 1, prompting further changes in the tentative list of grants and approaches.

Grants management requirements dictate basic components of grant announcements, including a required OMB format, grant policy requirements, and boilerplate language. SAMHSA has developed standard grant announcement templates for services and infrastructure, for example. The OMB-required format for discretionary grants mandates a standard outline that includes specific headings with certain information covered under each heading. RFAs must include a description of the funding opportunity, award information, eligibility information, application and submission information, application review information, award administration information, and agency contacts.

Ms. Fiedelholtz explained that the RFA development process is conducted as a partnership between SAMHSA leaders and staff. The Office of Policy, Program Coordination, and Budget (OPPB) coordinates RFA development, and the Office of Program Services conducts grant management and review. The process begins in winter, immediately following the release of the President's budget, when OPPB begins to draft guidance and a tentative schedule for grant planning for the year. OPPB tries to publish all grant announcements by March 1 of each fiscal year to facilitate timely funding decisions. Planning for each grant announcement typically begins with policy review of either a marked up RFA (i.e., if the Center plans to reissue a previous grant announcement) or a grant planning decision memo (i.e., if the Center is planning a new grant program or significant changes in an existing program). This policy review allows staff from across the Agency (e.g., program, policy coordination, budget, grants management, and grant review) to come together and reach agreement on the key elements of the program. Once consensus is reached, the RFA is developed. After all the RFAs for a given year are published, staff conduct a lessons-learned analysis of the RFA development process to identify improvements for the next year.

George Gilbert, Director of CSAT's Office of Program Analysis and Coordination (OPAC), noted that program ideas come from the National Advisory Council, grantees, constituency groups, Congressional appropriations, and emerging and urgent needs in the field, as in the case of methamphetamine treatment and the current RFA to establish a physician clinical support system for methadone. He explained that each SAMHSA Center has a generic Programs of Regional and National Significance (PRNS) authorization that gives authority to do targeted capacity response activities, training and technical assistance, and knowledge development and application (although these activities are emphasized less currently at CSAT due to the focus on services). In addition, he noted that there are specific authorities for homeless programs and for residential treatment programs for pregnant and postpartum women. Other specific authorities are provided for adolescent treatment, methamphetamine, and American Indians/Alaskan Natives. However, Congress does not appropriate funds for these specific authorities and CSAT programs, for example, on methamphetamine or for tribal populations try to build in more flexibility for recipients to design programs for their needs, so the generic authority is used wherever possible.

Mr. Gilbert emphasized the close collaborative relationship among SAMHSA components to develop RFAs and funding plans, including CSAT staff, OPPB, and grant review, as well as the National Advisory Council, to meet the deadline funding decisions by September 1.

Council Discussion. Mr. Gilbert responded to Mr. DeCerchio's question that past performance on other grants does not affect scoring on new applications. Some grantees that may have had difficulty administering their grants have been placed on a watch list. We work with them by providing technical assistance. Mr. Kopanda added that contracts provide a formal process to deal with that issue. Ms. Fiedelholtz added that RFAs require applicants to document previous accomplishments and how they build on them. Mr. Gilbert stated that CSAT has created a careful process to monitor grantees' progress annually and to approve continuation funding or not, or to develop a corrective action plan to meet deficiencies. Mr. Kopanda added that attention to performance has increased over the past several years. Mr. DeCerchio expressed concern about not using past grant performance in the review process.

In response to a question from Dr. Howell on the average number of RFA annually, Ms. Fiedleholtz said that SAMHSA has issued 20-25 RFAs over the past several years; in 2008 it will issue 31. Some grants are larger than in the past; for example, the State Incentive grants (SIGs). Mr. Gilbert added that CSAT issued 12 or 13 RFAs in FY 2008 and SAMHSA received 900 applications the previous year. Mr. Kopanda noted that RFAs limited to tribes and States receive fewer applications because of the smaller pool of applicants, but others attract hundreds of applications despite limited numbers of grants to be awarded. He explained that any sole source grant or contract must be justified on the basis that it is the only entity in the country able to do the work embedded in the RFA. If other entities make a strong enough case, SAMHSA opens the competition.

Dr. McCorry inquired whether SAMHSA has extended grants' timelines in response to Council guidance at an earlier meeting. Mr. Gilbert responded that although SAMHSA tries to spread RFAs throughout the year, continuing resolutions and late congressional action on the budget have impeded those intentions.

Ms. Bertrand asked whether the Administration has discussed how to support community-based organizations to level the playing field regarding grantsmanship. Ms. Fiedelholtz responded that the President's budget included two TCE grant programs focused more on communities than States and that a variety of technical assistance manuals are posted on the Web. Mr. Kopanda noted that SAMHSA is considering recommendations submitted by its National Advisory Council to dedicate funds to smaller communities to deliver more evidence-based services, to incorporate programs with evidence-based practice in NREPP, and to work with the National Institutes of Health to incorporate a wider variety of organizations and populations in research on evidence-based practices.

In reply to Mr. Sudbeck, Mr. Kopanda stated that although generally SAMHSA does not limit the number of grants a State may obtain, geographical diversity is encouraged within grant announcements, and sometimes eligibility might be limited to new applicants. Mr. Sudbeck expressed concern that excellent grantsmanship does not necessarily relate to grantees' performance. Mr. Kopanda responded that SAMHSA can terminate grants for inadequate

performance. Mr. Gilbert added that SAMHSA has begun to pilot test incentives for high-performing grantees, including supplemental awards in ATR and the Treatment Drug Court program.

Recovery Month

Ivette Torres, M.Ed., M.S., Associate Director for Consumer Affairs, CSAT, reported that the National Alcohol and Drug Recovery Month theme for September 2008 is "Join the Voices for Recovery: Real People, Real Recovery." Recovery Month enables significant parts of the community to understand the importance of addiction treatment. She noted that costs associated with Recovery Month have remained stable.

Ms. Torres noted that Ms. Bertrand, as a Council member who also participates actively in Recovery Month, provides a link in the planning process. For 2008, SAMHSA will produce 75,000 toolkits, 10,000 posters, flyers, and giveaways. SAMHSA also produces public service announcements (PSAs) and Web casts, and sponsors community events in each State and four annual meetings. SAMHSA will produce eight shows for the Road to Recovery Series in 2008 that will air in 17.8 million households in 50 States, representing $10 million in donated airtime annually. SAMHSA continues its partnership with the National Cable Television Association, which will distribute a public affairs kit to its constituency. In addition, SAMHSA will turn the audio broadcasts into a radio broadcast series. SAMHSA continues its efforts to distribute the PSAs and to increase the audience by 10 percent in 2008. Communities are encouraged to prepare for Recovery Month in February and March by downloading materials from the Web site (www.recoverymonth.gov). The Road to Recovery series included shows on returning veterans, medications-assisted therapies, and recovery-oriented systems of care. An upcoming show will air on accessing prevention, treatment, and recovery online. Ms. Torres invited Council members to participate in the shows by joining the panel discussions.

The numbers of SAMHSA-sponsored events and attendees are growing. From 665 community events in 2006, 767 were held in 2007. More than 70 percent of the events held since 2004 are sponsored by new organizations each year, and Ms. Torres plans further analysis of the organizations' participation pattern. Recovery Month activities in 2006 were run by nonprofits (78 percent), faith-based organizations (5 percent), and cities (3 percent). Walks and runs, health fairs, lunch or picnics or family celebrations, conferences and meetings, and training sessions are among the most popular activities, all of which are posted on the Web site. Organizations now are listing recovery-oriented activities on the Web site that are not connected with Recovery Month.

Ms. Torres stated that the Women's Conference, hosted during Recovery Month, will feature a Recovery Month event. Participation in 2007 events grew among Federal, state, county, and faith-based entities, with nonprofits accounting for 75 percent. The same types of events are to be held in 2008, and it is hoped that all 50 States will issue proclamations.

The Web site soon will transition between vendors. The number of hits has grown, and new technologies are under investigation to expand into new electronic systems and marketing opportunities such as FaceBook and Wikipedia. Ms. Torres presented the two new PSAs, to be broadcast in English and Spanish. She advised that securing free air time during election years is

more difficult. SAMHSA makes no expenditures for air time, the length of Website visits is high, and people view PSAs online and on cable. Previous years' PSAs are still in rotation, courtesy of the National Association of Broadcasters, which will distribute a kit with Recovery Month 2008 information to all broadcast stations. Ms. Torres stated that CSAT is looking into capturing data from this activity to demonstrate its excellent results. She reported that the National HelpLine, 1-800-662-HELP, noted on all media, receives on average 28,500 calls per month.

Two new inexpensive campaigns, in partnership with the National Council of Patient Information and Education, involve talking to parents and to teenagers about medications and abuse and a new Steroids Youth Initiative which will host 10 high school assemblies on the harm of steroid use. Ms. Torres noted that CSAT will work in 2008 to engage civic organizations in Recovery Month. She responded to a question from Mr. DeCerchio that the Coalition of Anti-Drug Coalitions of America (CADCA) is a planning partner in Recovery Month, and efforts are underway to engage Partnership for a Drug-Free America.

Recovery-Oriented Systems of Care: Overview

Catherine D. Nugent, M.S., LPC, CP, Acting Team Leader, Workforce Development, Division of Service Improvement, CSAT, stated that the framework for recovery-oriented systems of care (ROSC) is evolving and that she appreciated Council members' comments on their involvement with recovery-oriented programs and activities. She explained that recovery is at the heart of SAMHSA's activities, reflecting SAMHSA's vision and mission. The challenge is to reach the 22 million people who need treatment services but do not receive them, to ensure that interventions are effective and culturally appropriate, to address the critical shortages of a qualified workforce, and to frame SAMHSA's efforts in a public health approach. The ROSC model operationalizes the public health framework for substance abuse disorders. The ROSC approach is population based; comprehensive and holistic; incorporates the continuum of early intervention, treatment, recovery support, and health promotion; works across systems and professions; involves people in recovery, the community, and the public and private sectors; and evidence-based.

Shannon Taitt, M.P.A., Coordinator, Partners for Recovery, Office of Program Analysis and Coordination, CSAT, explained that Recovery-Oriented Systems of Care (ROSCs) emerged from a 2005 National Summit on Recovery, which developed the guiding principles of recovery, elements of ROSCs, and recommendations for advancing ROSCs. The summit generated a working definition of recovery: Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. ROSCs support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to sustain personal responsibility, health, wellness, and recovery from alcohol and drug problems.

The paradigm shift to ROSCs moves the conversation of how to get the client into treatment to how to support the recovery process within the person's environment. ROSCs offer a comprehensive menu of services and supports that can be combined and readily adjusted to meet the individual's needs and chosen pathways to recovery. In addition, the ROSC model encompasses and coordinates the operations of multiple systems, providing responsive,

outcomes-driven approaches to care, and requires an ongoing process of systems improvement that incorporates the experiences of those in recovery and their family members.

In supplementing Ms. Taitt's discussion with a visual presentation, Ms. Nugent highlighted the fact that individuals, family members, and the community are at the center of ROSCs; they all suffer as a result of addiction and, therefore, all can benefit from recovery. ROSCs capitalize on strengths and resources that emanate from the person, family, and community, based on an individualized and self-directed approach with a variety of services and supports from others. The outcomes sought extend beyond symptom remediation or absence of problems toward holistic health and wellness. Ms. Nugent emphasized that considering services and supports as part of the process in no way devalues formal addiction treatment. She noted that the ROSC model particularly values peer-to-peer supports, and stated the need for collaboration and integration among support systems, for example, social services, child welfare, addiction services, and mental health systems. We are starting with the National Outcome Measures to determine the outcomes that we expect to obtain from a recovery-oriented system of care. ROSCs' ongoing systems improvement process will elicit individuals' and family's perceptions of care.

Ms. Taitt enumerated the benefits of ROSCs: increased responsiveness to individuals, families, and communities; application of knowledge gained from recovery-oriented research; and involvement in a systems-change movement at all levels of government. CSAT's regional recovery meetings have produced lessons learned from ROSCs in States. Each State should develop its own needs assessment and strategic plan based on their own regulations and competencies. Contributory factors in the shift toward ROSCs include: growth of recovery communities; emergence of recovery advocacy; advances in science and technology to ensure getting the best treatment and sustaining long-term recovery; an Institute of Medicine report on systems integration; focus on collaboration and accountability; and Federal and State initiatives.

Ms. Nugent explained that while all CSAT programs support recovery, those that focus specifically on recovery, the recovery community, and recovery-oriented programs and initiatives include: Recovery Month, RCSP, ATR, and Partners for Recovery. Recent ROSC activities include the following: Dr. Clark established a CSAT Cross-Cutting Workgroup on Recovery and ROSCs; a roll-out process on ROSCs for CSAT staff has begun; regional recovery meetings provided opportunities for State teams to begin strategic planning processes; several reports have been issued on ROSCs and recovery support services; a comprehensive, online ROSC toolkit is under development; a ROSC recovery self-assessment tool for States and providers is under development; and a meeting is planned to establish a recovery research agenda and to set an agenda for how diverse stakeholders can play a role in ROSCs. Mr. Kopanda added that CSAT has just awarded ROSC grants and has an open TCE program announcement for additional grants.

Council Discussion. Ms. Nugent replied to Council members' questions, informing them that the recovery self-assessment will be an inventory that operationalizes ROSC elements, to be made available within 6 months, as will the online toolkit, following a pilot test by States and input from a variety of sources. In addition, white papers currently in the clearance process will be available soon on the Partners for Recovery Web site.

Dr. McCorry suggested listing mutual aid, 12-step programs, and medication-assisted treatment and recovery as distinct services in the ROSC paradigm. The presenters acknowledged the need to itemize and explain specific services as ROSC materials are developed. In response to Mr. Sudbeck's question about funding reductions for recovery oriented programs, Mr. Kopanda explained that new funds for RCSP were eliminated for 2008 and the entire program is eliminated in the 2009 budget. Mr. Gilbert clarified that unanticipated funds available for TCE in FY 2008 will enable $3.5 million for up to 8 new awards in the recovery oriented systems of care component of the TCE announcement. The program was announced in February and applications are due in April. Applicants may include current and former RCSP grantees as well as other community based organizations. Applicants must address the underlying notion of working to establish a broader recovery-oriented approach within the community.

Ms. Bertrand stated the need for continued funding for peer-designed and -delivered recovery support services. She stated that it would be interesting to measure the economic impact of volunteer hours that the Clubhouse and other programs are providing and how much money is saved in the system. In Ohio ATR has removed peer support from the initiative. Mr. Kopanda responded that recovery-oriented systems of care (ROSC) grants are not the same as recovery community services programs (RCSP). The systems grants do not require peer services since they are intended to establish a system rather than direct support such as a single organization providing services. Mr. Sudbeck stated that he anticipates pushback on ROSC in that the materials published to date are not inclusive of certain support groups such as Alcoholics Anonymous and Narcotics Anonymous since they are not recovery support services.

Ms. Bertrand asserted the need to encourage self-identification as recovering persons and advocacy by those persons. Ms. Taitt solicited input from Council members on concrete information on working better with recovery organizations. Mr. Sudbeck suggested that Council members review written ROSC materials.

Future Meetings

Mr. Kopanda noted that the Council will meet via conference call on August 21, 2008, to review grant applications. The next meeting, will take place at the SAMHSA building on October 16, 2008, with Council members welcome to submit suggestions for agenda items.

Council Roundtable

Mr. Kopanda chaired the Council Roundtable. Regarding areas of interest for FY 2010, Mr. Sudbeck identified the need to address treatment for people in the juvenile justice and criminal justice systems. Mr. Kopanda stated that SAMHSA has limited its support for treatment services to those who are not incarcerated, with the exception of some re-entry programs just prior to release. The Department of Justice is generally responsible for those within the prison system. Mr. Sudbeck responded that under the Department of Justice, only about 5 percent of inmates receive treatment—a situation worthy of study. Mr. DeCerchio suggested inviting the Council of State Governments to present on its work on alternatives to incarceration, including drug courts and community-based services. He also suggested scheduling a presentation at the next Council meeting by the SAMHSA Administrator and a presentation on evaluations of ATR and other programs.

Dr. McCorry suggested that CSAT explore how States and Single State Agencies (SSAs) variously address addiction-related services, and suggested inviting the Office of National Drug Control Policy (ONDCP) to provide an overview of Federal agencies' relationships around addiction and what remains to be done. Mr. Kopanda stated that the SAMHSA National Advisory Council has recommended that SAMHSA/CSAT services grants require addressing and measuring impacts on other local systems, such as justice or child welfare.

Council members expressed interest in expanding RCSP. The Council voted unanimously to create a workgroup co-chaired by Ms. Bertrand and Mr. DeCerchio to develop recommendations for FY 2010 for the next Administration, informed by gaps and deficiencies in the FY 2009 budget, to be expressed in a letter prepared for Dr. Clark and SAMHSA Administration Cline by mid-April.

Noting the great successes of the ATR program within faith-based communities, Rev. Castellani identified the need to extend it to all States. Mr. Kopanda noted that in FY 2010, $98 million for ATR-funded grants will end. He pointed out that Council members might offer recommendations to the next Administration regarding ATR future funding. In response to a question from Mr. Sudbeck, Mr. Kopanda stated that Wyoming continues its ATR program without Federal funds, and other States continue their programs with Cohort II funding. Mr. Sudbeck suggested scheduling a presentation on States that have sustained ATR programs and evaluation results.

To Ms. Bertrand's question on flexibility within SAMHSA's budget process, Mr. Kopanda replied that the formal budget development process provides little flexibility. Mr. Gilbert added that the present is a good time for Council members to express their views on priorities for the upcoming Administration.

Dr. Howell urged consideration for medication-assisted treatment to be aligned with the recovery model to establish a more holistic model of treatment, and to involve more physicians. Dr. McCorry also suggested consideration of the role of medical providers in facilitating a recovery orientation and of the qualifications of medical providers in treatment. He expressed concern that people on methadone, for example, would be unwelcome in recovery centers, because recovery does not embrace medications. Mr. DeCerchio suggested that accreditation bodies develop recovery-oriented standards in order to advance recovery. Mr. Kopanda stated that CSAT is responsible for standards of care for accreditation and can make recommendations for systems of care standards and encourage the accreditation bodies to take the suggestions. Dr. Howell stated that treatment programs typically see physicians as necessary and expensive evils to incorporate into their programs, but she hypothesized that including expert physicians on treatment teams may benefit patients considerably. She stated that until physicians become more involved, full acceptance of medication-assisted treatment will be impeded. Noting that not every program needs a physician, she stated that when medical care is on the continuum of services, the field would benefit by more inclusion. Robert Lubran, M.P.H., Director, Division of Pharmacologic Therapies, CSAT, responded that reviewing and updating certain aspects of the guidelines, such as qualifications of medical staff and training, would not be difficult. CSAT has several training initiatives in the works, including a Physician Clinical Support Network proposal for methadone and educational efforts for medical staff on medications. Mr. Lubran suggested that Council

members and CSAT consider how to incorporate ROSC into current treatment models by eliciting input from people in the field, including grantees, and then testing some models.

Rev. Castellani described frustration with the difficulties faith-based organizations encounter in finding resources at the local and State level to support people in recovery. Mr. Kopanda stated that licensing of clinical treatment facilities is handled by the States. Dr. McCorry suggested that CSAT has a role to create awareness of the lack of availability of medication-assisted treatment and that States do not have a model that incorporates medication-assisted treatment. Dr. Howell pointed out that Medicaid regulations pose barriers to medication-assisted treatment in her State. Mr. Sudbeck cautioned that setting mandates for States is not a good idea since models change and a mandate would embed these mandates for decades and not allow for change. Mr. Sudbeck expressed concern about lack of funding in the FY 2009 budget for COSIGs.

To assist the Council in executing its resolution to provide recommendations for the new Administration on the 2010 budget, Mr. Gilbert said that CSAT staff would e-mail Dr. Clark's budget presentation to all Council members, including those unable to attend today's meeting, along with a note outlining the resolution adopted by Council at the meeting.

Adjourn
The meeting adjourned at 4:58 p.m.

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

06/19/2008
Date

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