

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

**Center for Substance Abuse Treatment
National Advisory Council Meeting**

1 Choke Cherry Road
Sugarloaf and Seneca Conference Rooms
Rockville, Maryland

Thursday, March 20, 2008

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C O N T E N T S

| | <u>Page</u> |
|--|-------------|
| Welcome | 3 |
| Consideration of 10-17-2007 NAC Minutes | 3 |
| Introduction of Members | 6 |
| Director's Report | |
| Westley Clark, M.D., J.D., M.P.H. | 21 |
| Overview of ACYF Regional Partnership Grants | |
| NAC Member Ken DeCerchio, M.S.W. | 39 |
| Council Discussion | 61 |
| CSAT's 2000 Budget and Priorities for 2010 and Beyond | |
| Westley Clark, M.D., J.D., M.P.H. | 67 |
| Council Discussion | 91 |
| Public Comment | 106 |
| SAMHSA's Process for Developing Grant Announcements | |
| Jennifer Fiedelholz, M.P.P. | 117 |
| George Gilbert, J.D. | 131 |
| Recovery Month | |
| Ivette A. Torres, M.Ed., M.S. | 158 |
| Overview-Recovery Oriented Systems of Care | |
| Catherine D. Nugent, M.S. | 178 |
| Shannon Taitt, M.P.A. | 182 |
| Council Discussion | 201 |
| Council Roundtable | 220 |

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P R O C E E D I N G S

Welcome

DR. CLARK: Welcome. Good morning. I welcome you to the CSAT National Advisory Council Meeting.

Today, March 20th, is an exceptional day. We were informed by Rita Vanderborg of DSI that March 20th is Spring Equinox. It is also Milad an-Nabi, the Muslim birthday of the prophet Muhammad, it is the Feast of Esther for the Jewish faith, Maundy Thursday commemorating the institution of the Eucharist by Christ.

It is also the 53rd meeting of the CSAT National Advisory Council.

It will also be known as the day we formally welcome four new council members, and last but not least, it is the first day of March Madness. So, it is an auspicious occasion.

Consideration of October 17, 2007 NAC Minutes

DR. CLARK: Our very first item of business on the agenda is to vote on the minutes of the October 17, 2007, meeting. Hopefully, you have had an opportunity to review the minutes.

I would like to point out to the new members

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that although you were not members of the Council at the time of the meeting, but that you are now members and present today. You have the right to vote on the minutes, as well.

I would entertain a motion to adopt the minutes.

Is there any discussion of the minutes?

DR. McCORRY: Just one change on page 1. There is a line, seventh or eighth line, and with the Office of Mental Health, Mental Retardation, and Substance Abuse, no such agency exists, so that phrase could be stricken from it, and it would be an accurate statement.

DR. CLARK: Any other clarifications?

MR. DeCERCHIO: I am not listed as a member present, but I was here, and I did give comments in the body of the minutes.

DR. CLARK: Okay. We want to acknowledge Ken's presence. Elizabeth says you were present. We want to make sure that there is no contradiction. Ken was present throughout the meeting.

Any other suggestions, modifications?

[No response.]

DR. CLARK: If there is no further discussion, may I get a vote?

DR. McCORRY: Move.

DR. CLARK: Second?

DR. HOWELL: Second.

DR. CLARK: Frank McCorry moves and Elizabeth Howell seconds to adopt the minutes as amended.

Those in favor, let it be known by signifying aye.

[Chorus of ayes.]

DR. CLARK: Those opposed?

[No response.]

DR. CLARK: The minutes are adopted. I thank you for that. I can never say enough about how much I appreciate your service on this very important council, for your commitment to the field and the service you provide to this council, and I will say it again, thank you.

Introduction of Members

DR. CLARK: As is customary, we always like to hear what our members have been involved in since we last met. However, before we turn the floor over to members

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who have been here, we want to formally welcome our new members.

I will start with Elizabeth Howell, immediate past president of American Society of Addiction Medicine and Associate Professor of Psychiatry at the University of Utah. Dr. Howell, welcome aboard.

Do you have any comments you would like to make?

DR. HOWELL: I am just happy to be here. Should I make a comment? What is customary?

DR. CLARK: Customary is short.

DR. HOWELL: Thank you.

DR. CLARK: We also welcome Reverend John Castellani, former President and Executive Director of Teen Challenge in Pennsylvania.

REV. CASTELLANI: Thank you for allowing me to be here.

DR. CLARK: Again, welcome. And Mr. Abdelwahhab Alawneh, former Prevention Team Leader of the Public Health Division of the Arab Community for Economic and Social Services Community Health Research Center in Dearborn, Michigan.

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MR. ALAWNEH: Thank you. Good morning. Thank you for allowing me to be here. Also, I want to add there is tomorrow a very auspicious occasion in the Middle East. Tomorrow is the Mother's Day in the Middle East, so Happy Mother's Day for all mothers here. I am glad to be here.

DR. CLARK: Last but not least, Mr. Gib Sudbeck, Director, Division of Alcohol and Drug Abuse, South Dakota, Department of Health and Human Services in Pierre, South Dakota.

MR. SUDBECK: It is a pleasure to be a member of this committee.

DR. CLARK: We will give you a little more time after acknowledging your presence. On the handout table is a bio document I encourage you to pick up a copy of this document if you haven't done so already.

I am also delighted to have SAMHSA CSAT staff along with members of the public present at this meeting and I want to take a couple minutes to allow council members to introduce themselves as a group or as individuals, to let us know what interests you have and whether they have been working on any new projects since

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we last met, or simply let us know what you have been doing with current projects.

We will begin with Reverend Castellani and proceed around the table.

REV, CASTELLANI: A little background, is that what you said? The bottom line is I graduated Valley Forge Christian College and I married my wife of 49 years this June, had two daughters, five grandchildren 7 to 17. They play soccer and I know it's good because the ball goes in their net. Otherwise, I have no idea what they are doing.

Pastor 27 years, been with Teen Challenge since 1989, as the Executive Director of the entire organization nationally, at Springfield, Missouri, for 7 years.

I met a lot of great people across the nation.

It is an honor for me to be here and I thank you for the invitation and welcoming me.

DR. CLARK: Thank you.

Anita.

MS. BERTRAND: Good morning. My name is Anita Bertrand. I am the Executive Director of Northern Ohio

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Recovery Association. We are located in Cleveland, Ohio. For the last three years I have been working with three large cities and the local government entity to integrate peer-driven recovery support services throughout the systems in those counties, and most recently working on a conference coming up in May titled Building Bridges where we invite individuals from the treatment provider networks, some faith-based community and prevention organizations together for a weekend of looking at how we can better work together in those systems and just develop a comprehensive system of care.

Most recently opened up a residential treatment program for women with their children, and it was very timely because the other organization in the county that was providing those services actually closed down, so we are sort of trying to merge over the services that they had, so that is a interesting twist having those children on the unit with those mothers.

It has been quite a bit of work, but I enjoy what I do. Also, I want to say I am a product of recovery for 17 years and so I just want those in the audience who work here and those around the table to know

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that the work that you do really does matter.

MR. ALAWNEH: Good morning. My name is Abdelwahhab Alawneh. I was born and raised in Bethlehem, Palestine and got by Bachelor's Degree from Bethlehem University, majoring in psychology.

Came to the United States in 1993 with my three boys and we have another one here. I got my Master's Degree in organization, government, and management. I am very close to finish my Doctorate Degree in Health Administration. I worked in the area a few years, also, substance abuse prevention. Also, I was involved in many areas of research, such as domestic violence, substance abuse.

The last research I am very proud of was about psychology which I will be presenting during the ABA conference in Boston. At this time I am Director of ACC Network Clubhouse in Detroit, which ACC is the largest Audubon, nonprofit organization in North America, and I am very glad to be here and I look forward to do any contribution part of this work.

Thank you so much.

DR. CLARK: Thank you.

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MR. DeCERCHIO: Good morning. I am Ken DeCerchio from Tallahassee, Florida, been in the field 28 years. I am going to do a presentation in a few minutes, so I won't duplicate that.

I work for the Center for Children and Families Futures, which operates the National Center for Substance Abuse and Child Welfare, which is funded in large part by the Center for Substance Abuse Treatment.

I am from Florida, the state that in the year 2000 we couldn't count votes, and it looks like in 2008, where votes won't count. So there will be no other jokes about that the rest of the day. Thank you.

MR. SUDBECK: Once again my name is Gib Sudbeck and I am Director of the Division of Alcohol and Drug Abuse in South Dakota. I have held that position for 18 years.

I have been working in the chemical dependency field for 28 years. I have operated inpatient programs for adults and adolescents within the psychiatric setting, operated outpatient treatment programs for a private nonprofit, and did establish alcohol and drug treatment programs within all the adult and juvenile

Krexler facilities in the State back in '88, which continue today.

I am a certified chemical dependency counselor and I have been certified probably for close to 25 years at this point in time.

In regard to the activities going on in South Dakota right now, we do have a COCE grant which we are working on. We have an FASD grant through the Center for Substance Abuse Prevention we are working on.

We just recently got done with my legislative session. This is my 18th, wound up getting a 25 percent increase in the Division's budget this year, which was a miracle in the State of South Dakota. With those monies we are setting up a system of care for meth addicted clients, as well as working on enhancing fees or repaying providers for the services they deliver.

One of the other areas we are working on is work with the travel programs on trying to get more of a worker relationship with the tribes in the State, which is an ongoing process. We do have two tribes out of nine at this point in time that have a formal relationship with us, and have contracts through either Medicaid or

our Division funds for services.

I am also a NASADAD board member, treasurer for that organization.

DR. CLARK: Thank you.

Frank.

DR. McCORRY: Good morning everyone. I am Frank McCorry. I am the Director of the Commissioner's Office in New York City for the New York State Office of Alcoholism and Substance Abuse Services. It is a single State Agency for substance abuse prevention and treatment.

I want to fill you in on a number of items, just do it very quickly, very briefly. I see that recovery-oriented systems of care is on the agenda here today, and New York is moving very aggressively in terms of establishing recovery centers across the State.

We have an RFI currently out leading to the establishment across the State of recovery centers. We have been in touch with our colleagues in Vermont and Connecticut that have led the way in developing recovery centers. We are very excited about that.

Also, I am involved directly in a process we

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call the "methadone transformation." We have over 40,000 people on opiate agonist treatment using methadone in New York, and the modality has fallen into some disrepair, and there is a need to reinvigorate the modality and to make it more relevant and more patient centered.

I had a great meeting with Bob Lubran last week about it and we hope to change the way services are conducted in that modality to be more patient centered, more of an outpatient system of care that uses medication-assisted treatment as the first step in moving medication-assisted treatment available in all our outpatient settings.

Both of those initiatives speak to this issue of a chronic care model in New York held its own session with Columbia University, and we invited Connecticut and New Jersey to help us,. Connecticut is also working a chronic care model, which speaks to this issue of recovery-oriented systems of care.

So New York is looking very actively at how does a system, a substance abuse treatment and prevention system begin to adopt the principles of a chronic care model, which means both extending the continuum of care,

as well as becoming much more consumer-oriented and consumer-friendly in the work.

It is a very exciting kind of initiative as we continue to deliberate and try to find our way through adopting this new paradigm for delivery of services.

Lastly, I am also the Chair of the Washington Circle on Performance Measures, and I just wanted to mention of things very quickly about that.

We have completed a survey with the development of a client perception of care survey with the performance measures, another group that has been working on performance measurement, tremendous science behind it, and I don't know whether it's 11 or 12 or 13 items, but that had been shown to be very effective in reaching out and hearing from clients, not just on what their satisfaction is, but what their perception of the experience was, which is a different kind of construct from simply oh, I liked it or the food was bad, much more so, how was I treated here, was I shown the respect, did I feel a partnership with my counselor.

In addition, we are working on a medication-assisted treatment performance measure in

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partnership with the National Quality Forum, a screening and brief intervention, and a continuing care performance measurement.

If we were to complete this work, which we hope to complete, some of it by September within this fiscal year, and some next year, we will have a continuum of measures that runs from identification, initiation, and engagement through client perception, right through continuing care as a kind of stable of process measures that have good science behind them, that could be used both in terms of helping states that are trying to improve their outcome measures.

To improve outcomes, you have to improve the processes, and this will allow for the measurement of those processes to improve the outcomes that will be measured by CSAT.

All in all, it has been a pretty exciting time in New York, and it is always great to be here.

DR. CLARK: Thank you.

Dr. Howell.

DR. HOWELL: That sounds great, Frank, I can't wait to hear more about a lot of those initiatives. I am

Beth Howell. I am a psychiatrist, board certified in Addiction Psychiatry and General Psychiatry, and also certified by ASAM.

As Dr. Clark said, I am the immediate past President of the American Society of Addiction Medicine.

I am still on the board as the immediate past President, but I don't have to do much, which is really nice. It's so much better.

I am soon -- you are so out of land of conference calls for ASAM, which will be great. I have been in the field about 25 years, started out not really planning to make this a career, but that is how it ended up. I have worked in all different kind of settings, for profit, hospitals, nonprofit, methadone state director in Georgia, blah-blah-blah, you know, a lot of different things that I have done through the years.

It has been really rewarding. I guess now in my current position, I am Associate Professor of Psychiatry at the University of Utah, School of Medicine, and I am in the trenches. I am an inpatient doc, I am working with people who are in crisis, and that are coming in the hospital to get stabilized.

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A lot of my patients are addicted only, but really more of them have co-occurring disorders. Occasionally, I get a psyche patient that I have to treat, that doesn't have addiction issues. That is rare, because they want me to be able to do the treatment.

Utah is the land of not too much alcoholism, but a lot of prescription drug addiction and a lot of overdose deaths from prescription drugs.

Since I have gotten there, I think there are a lot more people using buprenorphine. I don't see as many of my former patients or our former patients in the obituaries, which is really nice, because when I first got there, it was a regular occurrence that at least once a month we would have somebody die that we had treated, who had gone out and relapsed.

That is really important. Right now my new chairman wants to start a Division of Addiction Psychiatry. I would like to start an Addiction Psychiatry fellowship. There is a lot of interest among the residents at our place, which is really cool.

The students are another matter, fairly judgmental and until they hit the clinical wards, they

don't really realize how devastating addiction is and how people don't really choose it.

I guess what I am doing now is I am academic medicine and I am treating patients. It is a lot of fun, and I guess that is all I have to say. Also, I was the medical editor for the TIP on buprenorphine and, I don't know, I have done a lot of different things, but I am happy to be here. Thanks.

Director's Report

Westley Clark, M.D., J.D., M.P.H.

DR. CLARK: Thank you all.

I am delighted to have this opportunity to address you today. I want to thank our staff for making this meeting happen. I want to acknowledge Cynthia and Julie and other staff, Doug and others, who contribute to the administrative aspects of this meeting. Too often, people who work on the infrastructure of a meeting don't get acknowledged, so I want to thank Rich for taking the lead yesterday, I was clinically indisposed.

As you know, SAMHSA began the fiscal year operating under a continuing resolution. Congress passed the Consolidated Appropriations Act of 2008. The

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President signed it into law in December. CSAT funding levels were virtually straight lined, therefore, 2007 levels, both Programs of Regional National Significance are PRNS line and the SAPT block grant.

This resulted in a \$399.8 million appropriations for PRNS and \$1.758 billion for SAPT block grant, which then left George and his crew, Doyle and Bob Termin [ph] and others with the delightful task of assisting us in how to allocate the money to various programs.

Most of the programs that have been recommended for elimination or reduction of FY '08 requests were restored by Congress in the final appropriations act. In addition, CSAT received a total of 6.2 million in congressionally earmarked projects that must be funded in FY '08.

Looking ahead to FY '09, in February, we submitted our '09 budget justification of estimates for appropriations committees, supported the FY 2009 President's budget, which, of course, was announced in February.

It reflects a reduction of almost 63 million in

PRNS line for FY '08, and the block grant was increased by approximately \$20 million. The additional funding is for a new provision that provides supplemental awards to the top 20 percent of State for performance, and I will talk about the budget later in detail.

The FY '09 budget will bring with it challenges for CSAT and I am confident that we are up to those challenges. Council should be aware of those and as I mentioned, I will talk about that.

We are beginning the planning process for FY 2010 and beyond, and for new members of the Council, this is a great opportunity to begin to provide us with input.

I know this is FY '08, but 2010, the budget process starts to roll along.

In October 2007, SAMHSA awarded a total of \$11 million over four years for eight peer-to-peer recovery support services grants. In addition, 67 grants totaling nearly \$159 million over five years were awarded by SAMHSA under the Target Capacity Expansion grant, the substance abuse treatment, and HIV services.

Substance Abuse Treatment and HIV Services under these grants target African-American, Hispanic, and

other racial ethnic minorities. My written report to Council includes a listing of all of our '07 grant awards in Appendix 2.

CSAT has a number of funding opportunities in FY '08. We will be funding a new screening brief intervention referral to treatment grants to States, new expert medical residency training program grants, new target capacity expansion grants, and new substance abuse treatment and HIV services awards.

We will also be funding new homeless grants and grants for the benefit of homeless individuals. We will also have a focus on services and supportive housing environments, and we will be funding new grants for residential treatment for pregnant and postpartum women, new adult treatment drug court grants, and new grants for community-based treatment services for adults under criminal justice supervision.

In addition, we will be making a final round of opioid treatment accreditation grants, and we will fund a new initiative for physician clinical support system for the use of methadone to treat pain and opioid addiction in response to concerns about the increased

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methadone-related mortality.

Our initiative with historically black colleges and universities is also being recompleted. A complete list of our grant announcements for FY '08 is included in Appendix 1 of the Director's Report to Council.

Most of our announcements have been published and applications are or will be flowing in. We have a large number of new announcements this year including a number of programs added or changed by Congress. Given the lateness of the appropriation this year, it has taken a great deal of hard work and cooperation by CSAT staff and our counterparts in other SAMHSA components to prepare our funding announcement.

I want to thank George again and his team, also the Division Directors and their respective teams at CSAT for working on this. This has been very taxing. We can anticipate a similar process again this year given that this is a political year, a presidential election, and from all evidence, things are going to be delayed in terms of the appropriations process.

I want to express my appreciation to those who have worked so diligently to get the job done and the job

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done well. We have been busy supporting our continuing grant activities particularly our Access to Recovery Initiative. I updated you on the ATR status at our last council meeting and we have continued our focus on these activities since then.

In November, the 24 newly awarded ATR, two grantees met in Bethesda. At the meeting, eight forums were hosted by new grantees from grass-roots provided networks. We built upon that foundation.

I have traveled to nine new ATR grantees in February and March. I was just recently in Rhode Island.

At those meetings I spoke to representatives of the community and faith-based providers about the important role that they play in ATR programs, spoke to the SSAs, and also got a sense of what is happening in a number of jurisdictions.

Rhode Island, for instance, since I was just there, announced that they were having financial problems at the State level with cuts in State budgets. These are the kinds of things that we need to recognize at the federal level, the State budgets are somewhat precarious.

We know we have got strained economic times at

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this point, so our resources are playing a more important role at the State level.

We have promoted what we believe is a unique organizing concept, which we refer to as recovery-oriented systems of care, or ROSC, or ROC. This approach has been woven into many of our activities.

A ROSC approach emphasizes that recovery is a process. To be effective, substance abuse treatment must be person-centered, self-directed, all sources of support working with the person in recovery, recognizing the family and the community are also the direct beneficiaries of the recovery process.

You will be hearing a presentation on CSAT's ROSC approach and activities later today.

In December, CSAT hosted directors of the newly-awarded ATTCs. One result of that meeting was the creation of a five-year strategic plan focusing on the promotion of recovery-oriented systems of care, which I also want to stress fits intimately with the administrator's public health orientation for SAMHSA.

CSAT also held the last two Recovery-Oriented Systems of Care regional meetings in October and January.

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These meetings provided participants an opportunity to discuss planning and implementation of ROSC at the State and community level.

We have had internal meetings on Recovery-Oriented Systems of Care meeting with our staff, so that indeed we have got the discussion, and our staff will be contributing to the dynamics of ROSC. We don't see this as a static construct. We want to rely on the experience, faith, knowledge of not only external communities, but also internal communities.

The abuse of methamphetamine continues to be of great concern. Planning is underway for the national summit to promote public health partnerships and safety in critically affected populations.

The meeting is planned for the winter of 2008, and it will bring together participants from State Health Authority, Single State Agencies, State HIV, STD directors, and other community-based agency and research organizations.

SAMHSA/CSAT is the lead agency for the summit.

It is collaborating with multiple federal partners, such as other operating divisions in the Department of

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Justice. Ed Kraft from the Division of Services Improvement is the key staff person working under the supervision of his division director Jack Stein.

Another subject that continues to capture media attention is the debate surrounding buprenorphine. In February, SAMHSA and NIDA co-sponsored the buprenorphine summit. At the summit, we had the opportunity to focus on CSAT's buprenorphine activities and data with particular emphasis on the positive impact buprenorphine has had on opioid treatment.

Because of the media attention on the subject, a media roundtable was also held to answer questions about the summit. As of February 29th, SAMHSA has certified 13,462 physicians to use buprenorphine in office-based treatment of opioid abuse and dependence.

7,669 or 59 percent of these are listed, and our buprenorphine physician okayed the system. Over 17,000 physicians have been trained, and 2,460 have indicated they intend to treat up to 100 patients each.

It is very encouraging to note that more physicians were certified in 2007 than any previous year. Bob Lubran and his team, which includes Nick Reuter and

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others, has been active, working with both external groups and making sure that we are kept apprised at what is happening in this arena.

We have also been continuing our activities focused on co-occurring disorders. CSAT's treatment improvement and exchange was expanded to include an electronic discussion list called "Co-occurring dialogs," focusing on issues related to co-occurring disorders.

In addition, SAMHSA's Co-Occurring Center for Excellence, COCE, continues its outreach to States, the dissemination of information and resources to each single State Authority. COCE is also providing training to States and sub-State entities in collaborations with our Addiction Technology Transfer Center.

Ann Herron and her team were working on this activity with Charlene Lefoge [ph] being the branch chief that has the COCE contract, but the other issue is that co-occurring disorders is percolating, not just through our COSIG AND COCE activity, but through the use of the block grant throughout each jurisdiction.

So Ann and her team, the various state project offices are working closely in this arena.

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I am proud of the contribution that CSAT has had with the National Alcohol and Drug Addiction Recovery Month program. The 2007 Recovery Month activities resulted in 767 events, 146 proclamations, 68 voices for recovery posted on the 2007 Recovery Month website.

We are looking forward to the 2008 Recovery Month celebration. The theme for this year is Join the Voices of Recovery, real people, real recovery. SAMHSA will sponsor 50 Recovery Month activities in 2008, allowing each State to hold a SAMHSA-sponsored event.

In addition, many activities will be sponsored by local organizations and communities, not just our SAMHSA-sponsored activities.

Ivette Torres and her team are working very closely on this, making sure that we have the information available and materials available to show that Recovery Month is an important theme.

I am stressing the importance, not just of people in recovery and especially organizations, but also the involvement of other organizations in the communities like the Red Hat Women, the Daughters of the American Revolution, the Daughters of the Confederacy, the Elks

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Club, or they call them the Animals Club, and Eagles Club, the Elks club, the Rotary Club, et cetera.

We have to have the whole community to own recovery. We can't just rely on people who have alcohol and drug problems who are in treatment or their specialty providers. The problem is much larger than the single individual and the benefit is much greater than to the single individual and that individual's family. It is to that individual, that individual's family, the City, County, Tribes, State and to the Nation.

So if we don't outreach other groups in Recovery Month to participate and celebrating recovery, then, we, in effect, have a de facto stigma in a sense, that we don't promote dignity, we deal with stigma, and this is an issue for us.

So I want to thank Council for hearing my comments and I will open the floor for any discussion and comments.

DR. McCORRY: Dr. Clark, when you mentioned the use of the block grant for Co-Occurring Disorders, is there anything more specific around that? You had mentioned that in addition to COCE and COSIG, the use of

block grant funds.

DR. CLARK: We don't have anything more specific. The idea, though, is dealing with co-occurring disorders. What we are doing in our discussion portfolio is now making sure that people, when they do their assessments, they ask questions about co-occurring disorders.

You know, it's one thing for us to say epidemiologically, it is the expectation, not the exception, but if we don't collect data on that, if we are not inquiring about that, then, we don't know much about it. As I pointed out, other jurisdictions have acknowledged the importance, so we are moving to integrate co-occurring disorders as a part of the business practice.

We still have to acknowledge that alcohol and drugs are properly reinforcing psychoactive substances, so we have to deal with the substance abuse issue, but we are also dealing with the co-occurring issue, and we are working with the limited resources as was pointed out.

The block grant gets to play a larger role in some jurisdictions than in others, so that this is a

focus and we will continue to come up with strategies, and we need to work with NASADAD and State Authorities, as well as the public health authorities on how to address co-occurring disorders without abandoning our commitment to deal with alcohol and drug use.

Any other questions? Elizabeth and then Ken.

DR. HOWELL: One question I had, it's encouraging how many people have been trained and waived for prescribing buprenorphine. The one issue that I am really aware of is that the training opportunities are dwindling at this point, and for those of you that don't know, the drug will go off patent I think next year sometime, late next year.

I was just wondering what plans, if any, CSAT had to sort of pick up the ball as far as training for buprenorphine, because I am afraid that, you know, this whole wave will just sort of pass and then we may not have people trained.

That was one of my questions.

DR. CLARK: Our goal is to continue to work with the community, which includes nonprofit organizations, for profit organizations, pharmaceutical

industry, and patient advocacy groups, so that we can figure out how to address that.

As you know from our '08 budget and the '09 President's budget, which we will discuss, the resources are limited, so we can't promise any specific initiative, but we recognize the importance of being able to address this issue.

So, what limited resources we will have, we will commit to that process, but we need to be able to mobilize the input from a wide range of supporting entities. You are correct this is an ongoing issue especially with the expansion of prescription drug abuse among a large number of entities.

When initially conceptualized, buprenorphine dealt with heroin, most practitioners discovered, whoops, we have got a major prescription drug abuse, a problem when you look at epidemiology, you said whoops, all these people using prescription opiates, and a small number of people relative to the number of people using prescription opiates, so this is a much broader, more complex issue.

But we will continue to work with the community

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to see what best strategies we can employ.

Ken.

MR. DeCERCHIO: I am looking on page 3, the programs targeted for elimination, so I had two questions related to that in the '09 budget.

One is, is there a ballpark figure about how much of the 63 million are services, are direct services versus other support activities?

The second question is what is the dialog like going on in Appropriations around the potential elimination of these activities?

DR. CLARK: I am going to talk about the budget at greater length at 11:00, so why don't we postpone your question, and don't let me forget it, and I will address those then.

Any other? You are next on the agenda, so I don't want to let you off the hook by taking up your time.

Any other issues, questions?

[No response.]

DR. CLARK: All right. We now move to an overview of the ACYF Regional Partnership Grants, and Ken

DeCerchio.

Overview of ACYF Regional Partnership Grants

Ken DeCerchio, M.S.W.

MR. DeCERCHIO: Good morning, everybody. I appreciate the opportunity to present fairly briefly, I think, a very exciting initiative.

For the record, I am Ken DeCerchio, a member of the Council. I am also work for the Center for Children and Family Futures out of Irvine, California, which is a nonprofit agency that has been doing work for over the last 15 years particularly around the area of bringing together collaboration between substance abuse system of care and child welfare system to assist States and communities to improve outcomes for children and families affected by substance abuse who are engaged or at risk of being engaged in a child welfare system.

I am going to speak today about a funding initiative that was authorized by Congress, and we have entitled these regional partnership grants, and they are regional partnership grants for methamphetamine and other substance abuse to improve outcomes for children and families in the child welfare system, authorized by

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Congress by this Act in 2006, Child and Family Services Improvement Act.

It also reauthorized promoting safe and stable families. The Regional Partnership Grant appropriation is funded through the Administration for Children, Youth, and Families, which is in the Department of Health & Human Services, kind of analogous to SAMHSA for the Child Welfare System.

There were 53 grants awarded in September 2007, and these grants are just getting up around the country.

Under the support contract, the Center for Children and Family Futures was awarded a support contract, and we were tasked with these three areas in developing a final set of performance indicators.

Interestingly, the congressional appropriation and the authorizing legislation required a consultative process to identify performance indicators that could measure the impact of this collaboration and these partnerships. I am going to speak in a little while about those performance indicators.

So there was an interagency federal work group put together. SAMHSA participated in that work group to

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identify indicators both in terms of child welfare systems indicators, as well as substance abuse.

Part of our task was to take what had been laid out in the program announcement and to work through a consultative process with grantees, primarily grantees, as well as the children's -- Sharon Amatetti is integrally involved representing CSAT on these activities, and finalizing those performance indicators.

The other thing that we are doing, we are developing a data collection system for the submission of the information and data around these performance indicators, and we are providing technical assistance, the Center for Children and Family Futures are providing technical assistance to grantees on evaluation and programmatic technical assistance.

Now, we have got two partners with us, Planning and Learning Technologies out of Rosslyn, Virginia, whose background is around child welfare and evaluating court improvement, and Macro International who has done a lot of work with SAMHSA, Center for Substance Abuse Prevention, to help develop the data system.

This is a scatter, if you will, of the 53

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regional partnership grants. You will see a heavy proportion of grants in the West Coast.

This authorization, this program is not limited to methamphetamine, but it is a primary focus area in communities and families affected by methamphetamines, so you see a high number of grants awarded on the West Coast, the central part of the country, and upper central, if you will, part of the country, and then moving eastward, if you will.

I will talk a little about the potential national impact of the regional partnership grants, NCSACW, the National Center for Substance Abuse and Child Welfare. It was funded by CSAT in 2002 for the first time.

CSAT funding with some participation from the Children's Bureau and ACUIF, funded the National Center for Substance Abuse and Child Welfare through Children and Family Futures.

Florida, I was a State Director in Florida at that time. We were one of the first, what is called IDTA, or In-Depth Technical Assistance. Among the activities of the National Center is to work with States

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and communities on a prolonged basis, usually a year to a year and a half engagement to strengthen the collaboration across substance abuse in child welfare systems.

What you see here are the 11 in-depth technical assistance sites. They are starred, and the big stars that were funded in the first round of funding of the National Center for Substance Abuse and Child Welfare.

The technical assistance for the regional partnership grants on the programmatic side of the implementation of the grants, really, the National Center with the support of CSAT and the Children's Bureau really has the lead in providing programmatic oriented technical assistance to the 53 grantees, and at the same time, our team is providing technical assistance around performance measurements, data collection around the indicators, and the reporting of those indicators.

Now, in the second round that was just funded October 1, 2007, the second round of funding for the National Center, there will be four more additional in-depth technical assistance sites being implemented, and then another eight over the course of the five-year

grant.

So all told, with the 53 RPG sites, there will be 76 total sites around the country will have worked to strengthen the collaboration between substance abuse and child welfare systems.

So when we look at the potential impact over a 10 to 12 year period of linking the two systems of care in order to improve outcomes for children and families, you know, collectively, look at this as really a program of national significance, and those of us that have been doing this work since probably the mid-to-late '90s, and part of that work in trying to link the two systems, it has really seen I think significant changes in the integration and the coordination of these two systems.

We are seeing some effects now that we hadn't seen 10 years ago, and you kind of see that reflected in these applications and the approach of services.

There are, as I mentioned, 53 grants, and the grants have been organized pretty much for, to some extent for management purposes to help facilitate our work with the grantees and to these six clusters, if you will, and these six clusters represent the 53 grantees

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and kind of the array of activities that they propose in their partnerships.

I am going to show you where these are, but we have five tribes participating. We have a drug court cluster whose primary focus is implementing or expanding, implementing new drug courts or expanding existing drug courts, agencies that are more child focused in terms of their interventions and activities, emphasis on collaboration on an array of services, connecting with other community agencies.

Then, there is a treatment focus cluster, but it is pretty hard to discern or to separate out a treatment focus cluster from a drug court cluster, so treatment is really scattered throughout all of these grants in terms of their approach to these services.

I am going to walk through these really quickly. You can see where the scatter is of the different clusters and who the grantees are. FPO is the Federal Project Offices for the Children's Bureau. PML means Performance Management Liaison.

We have a performance management liaison, kind of a consultant, if you will, assigned to each of the

clusters to work with those grantees in the implementation of those grants, to assist them with the identification or the indicators they are going to be selecting -- I will talk a little bit about that in a few minutes -- as well as other kinds of technical assistance to each of the grantees.

You see there are 10 drug courts, child-focused agencies, systemwide collaboration, treatment focus, and an array of services, geographic areas served by the 53 grantees. You can see that most of the grantees, regional partnership grants are focused on serving a region or a county.

Requirement of the grant is that the State or local child welfare agency had to be a partner applicant, and that there were a number of other agencies including substance abuse agencies that also weren't required to be a partner, but were strongly graded on the extent of that partnership, if you will, in evaluating the grants.

You can see 85 percent are serving regional or county areas. Lead agencies for the 53 grantees, had to be designated lead agencies, and you can see that about 45 percent of lead agencies were child welfare agencies,

either at a State or local level.

As I mentioned earlier, most of the grants are at a county level, and almost 23 percent are substance abuse agencies in terms of being the designated lead agency for the partnership.

There are four significant systems represented in these member agencies - State, county, tribes, and providers for both regardless of who the lead agency is.

A very strong representation of those four systems, as well as the courts, and you can see here almost 61 percent have the courts as partner agencies.

Those of you certainly that are familiar with this work know that really in order to improve outcomes, you have really got to have all three core systems working together, both substance abuse, child welfare, and the courts in order to do the kinds of innovations and more enlightened intervention and treatment approaches for families in the child welfare system.

What was surprising to me, you see the 47 percent had mental health services as a provider partner, which is encouraging. I don't think we would have seen that a number of years ago, and I think it reflects the

growing recognition we talked a little bit earlier about co-occurring disorders and the prevalence of co-occurring mental health disorders among this population.

Many of the grantees are targeting both children who are in home, but at risk of being removed from their homes, and children who are in out-of-home care, as well.

As I mentioned earlier, the grant has a focus on methamphetamine, but it is not exclusive to methamphetamine, in fact, the title of the authorizing legislation included methamphetamine and other substance abuse, but almost 70 percent of the grantees have a specific focus on methamphetamine, and a large part, once the grants are up and running, we are working with Sharon's office right now and the Children's Bureau to schedule a grantee meeting next January.

To a large extent we will be focusing on treatment strategies for methamphetamine, as well as family-centered treatment.

In the program announcement, there were broad project focus areas that grantees could propose, and these are the five areas. There were three service areas

that were identified in the program announcement as issues highlighted across the two systems, child welfare and substance abuse.

They were recruitment engagement and retention of parents in substance abuse treatment, the different perspectives in policies between the two systems, child welfare and substance abuse, and chronic service shortages in both systems.

What the grantees are proposing here really do a nice job of responding to those three practice and policy areas identified as systemic challenges and issues across these systems of care.

Training in coordination and collaboration comprise the majority of activities around systems collaboration and improvement. As with most, if not all, federal grants now, there is a strong emphasis also on sustaining the projects after funding terminates, and we view one of the key elements of sustainability of these projects is the collaborations, not unlike access to recovery, it's the collaboration and partnership that will really sustain these projects after the funding ends.

So it is a pretty important element, and a lot of our emphasis early on with the grantees, in addition to performance measurement, which has been a primary emphasis early on, is the whole concept of collaboration that is really the major focus, one of the major focuses, if you will, of the National Center on Substance Abuse and Child Welfare and the strength that we bring to all of the grantees.

Substance abuse treatment linkage and services project. Almost two-thirds are engaging in strategies to increase access to treatment, either increasing capacity or the timeliness of access to treatment, or the prioritization of families in the child welfare system.

I didn't mention these grants are three- and five-year grants. They are either \$500,000 grants or million dollar grants with decreasing funding in every progressive year, so each grantee is required to increase the local share or the local match, if you will, as these grants are expiring, or as these grants progress.

So you can see that the infusion of those funds, a major focus is in standing treatment capacity and access to care, as well.

What grantees are proposing to do in that are significant areas in screening engagement and outreach, co-location of staff, putting addiction staff either at a drug court or in a dependency court or co-located in child welfare offices, as well.

Eighty-one percent are providing developmental screenings, assessments, and services for children, or early childhood intervention. That was surprising to me, as well. It's another thing I think we wouldn't have seen that degree of identification for community agencies as recently as probably seven or eight years ago.

We know that housing and transportation, child care, i.e., you know, support services in our world, viewing those as recovery support services are major barriers to families accessing treatment.

So you can see that the second highest focus area in this area is to provide those kinds of support services for families, really pretty critical and what we are finding out and we all know was as critical as traditional treatment, as well.

This speaks for region's capacity for family treatment services and nearly two-thirds are implementing

strategies to expand services to families, as I mentioned.

Now, I will talk briefly, we have got a few minutes around the performance. It has been a major emphasis through this legislation. Congress required the Department to develop a set of indicators, as I mentioned, through a consultative process, and an annual report to Congress is required on the activities of this initiative, as well as its impact as identified, as measured through these performance indicators.

I think it is somewhat unique in that respect, but requiring the Secretary to submit an annual report to Congress. There are four outcome domains that are being measured - child, youth, adult family relationship, and regional partnerships, and there are a total of 23 indicators and 15 demographic variables for each of those indicators for the folks from the data unit, there are data elements for each of those.

The majority of these indicators, although not all of them, are going to be case specific, not unlike a GPRA instrument, if you will, but the client specific measurement of most of these performance indicators where

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they are relevant and applicable.

You will see as we do through this area of local evaluations, there are certain indicators that didn't lend themselves to uniform measurements, and so grantees will be measuring those on an individual basis using local evaluations. Every grantee is required to have an evaluator assigned to this project. Many have independent evaluators doing this work.

I am going to walk through the indicators fairly quickly just to give you a sense of just the breadth and depth of these indicators.

I mentioned there is four domains. There is nine child/youth indicators, most of which are indicators that are reflective of child welfare outcomes of the kinds of indicators we see in a child and family services review in a child welfare system with a couple of exceptions, and you see C7, prevention of substance-exposed newborns and measuring the recurrence, if you will, of any children who were born after entering the regional partnership.

Children connected to supportive services, there are a range of supportive services that grantees

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are proposing, and when we want to assess, we want to measure to the extent that those children are being connected, and this last indicator is percent of children who show an increase in functioning.

It is a tough area to measure. Certainly, there will be standard instruments to do that, but we are leaving a lot of flexibility to the grantees in terms of which particular instrumentation they want to use to measure child well-being.

Again, the critical outcomes in the child welfare system are child safety, improved child well-being, and improved permanency for children either in terms of reunification or through adoption or guardianship.

Now, the adult indicators will look very familiar to all of you, and in many respects, reflect and parallel natural outcome measures for substance abuse treatment.

We see access to treatment as a big issue, not only in this initiative, but certainly throughout the country, but to the extent that families are able to access treatment both in terms of the appropriateness of

treatment and the time it takes to access treatment, those grantees that are using ASAM for patient placement criteria will collect data around what those levels of care are and how they align with assessment.

Retention and treatment, admission and discharge looks around measures around use, and then parents who are connected to supportive services, and then these three measures look very familiar - employment, criminal behavior, and mental health status.

To the extent possible, we are using TEDS data elements and the data elements that are embedded in the National Reporting Systems for Child Welfare, the AFCARS reporting for foster care, and the reporting system for child maltreatment, the abuse and neglect data reporting systems.

So to minimize either primary data collection on the part of grantees, we are trying to modify these indicators to reflect existing data elements and existing reporting systems, and as you can see, as we speak in the number of indicators and the potential reporting burden is fairly substantial.

There are five family relationship indicators,

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F2 will be challenging indicators and again showing improved parent-child relationships, risk and protective factors associated with parenting, coordinated case management.

Now, the alignment of these indicators, we spent a lot of time working, aligning the indicators of the program strategies, and so the final measures that grantees are selecting or that the Children's Bureau is approving is being driven by the program strategies being proposed and how they align, whether these indicators will be moved, if you will, or impacted by those strategies.

Then, regional partnership service capacity, these are going to be aggregate measures in collaboration being a core element, as I have talked about.

For the collaborative capacity, we are going to be using the collaborative capacity instrument, which is an instrument developed by the Center for Children and Family Futures with support from the CSAT, and, as a tested instrument, that measures 10 elements, if you will, of systems collaboration including practice elements, as well as systems integration and systems

coordination.

I will just run through quickly, these are the demographic variables that are being collected, and then we are developing a data system that will look something like this, client-specific case level data, partnership data, kind of process data, if you will, and contextual data coupled with progress reports, semiannual progress reports, as well as submission of local evaluation reports, trying to get our arms around all that information and be able to report what we intrinsically believe, what has been some evidence to indicate that these types of interventions, these types of strategies, i.e., connecting good substance abuse assessment, intervention, treatment, and recovery support.

The family is in the child welfare system, that those families have better outcomes, more children are able to stay at home, greater reunification, shorter lengths of stay in foster care where those interventions are connected.

We see that in dependency drug courts, but really I think for the first time perhaps on the scale that we are talking about, the ability to actually show

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the impact of these interventions through a fairly rigorous, this isn't across system, across site evaluation project, sometimes it feels that way, but fairly rigorous measurement of a fairly robust set of performance indicators.

Thank you. Questions?

Council Discussion

MR. SUDBECK: I have a question, Ken. When you are looking at the different States or different projects, has any of the States implemented reporting statutes related to use of methamphetamines under the child welfare laws, in other words, have you used methamphetamines that is considered a condition to have your child removed?

MR. DeCERCHIO: A number of States have enacted laws around exposing under drug endangered children, work groups have enacted laws that make a child's exposure to the production of the methamphetamine felony offenses, in some cases, a prima facie, if you will, of abuse and neglect.

Most States don't identify parental substance use as prima facie for child abuse and neglect, but many

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states have moved toward what I just said about exposing children in methamphetamine situations, and as you know, there have been a number of activities around drug-endangered children, as well as legislation around precursor minimizing access to medicines that have had a significant impact on the reduction of clandestine labs around methamphetamine.

So, that is pretty much what we have seen in recent years.

MR. SUDBECK: Just a follow-up, when they implemented these projects, what has been the impact on the specialized treatment programming for pregnant women, women with children within those regions?

MR. DeCERCHIO: Which projects in terms of the impact?

MR. SUDBECK: You know, if you are looking at identification linkage to treatment, it sounds like that is a major focus of, what, 71 percent of all the projects, what is the impact of the treatment system in that locality?

MR. DeCERCHIO: A lot of the funds are being used to expand capacity, but not all. So, in part, this

funding is expanding capacity in part. In other situations, a number of the grantees have proposed accessing existing treatment by strengthening case management and outreach in co-location of staff.

So, there is an impact there, but they have identified that they can handle that capacity. Other grantees are doing other creative types of interventions, more in-home services and more wraparound services that tends to not be as traditional in the substance abuse field, and a number identified using transitional housing with kind of wraparound services, as well.

So there is an impact, but most of the funded activities are going to expand that capacity.

MR. SUDBECK: Thank you.

DR. McCORRY: What makes this a regional partnership? I was trying to understand. I see the two New York programs in the child-focused area, and I wanted to understand better what it means to be a regional partnership in the child-focused area.

MR. DeCERCHIO: Well, at a minimum they are countywide, and in many of the partnerships are multiple counties. I am not sure, you know, in Westchester

County, you know, how broad that is, but that is really what we are talking about, Frank, as well as kind of the breadth of who is involved in the partnership.

As you could see, child welfare, substance abuse in the courts, but other community-based agencies.

In Iowa, for instance, the State Supreme Court is the lead agency. They have five sites that are implementing expanded drug courts or new drug courts throughout the State.

One of the sites in California is involving five counties, five contiguous counties. Now, each county in California is operated, has an AOD, an administrator, has a child welfare administrator, so not only are they collaborating within the county to strengthen that collaboration, but they are looking across those five counties for joint practices, so that as families are getting kind of, not just equal access, but the practice and the collaboration between child welfare and substance abuse kind of raising the bar, if you will, for all five counties.

DR. McCORRY: A follow-up. The performance measures, are there core indicators, core measures, or

are they particular to the strategies that the grantee is employing?

MR. DeCERCHIO: They are particular to the strategies. We kind of started out with a discussion around core indicators and we moved away from that, and linking to the strategies, but when you look at those, quote, unquote "core indicators" around substance abuse treatment, and around the child welfare outcomes, and they are pretty identifiable when you look at them, you know, our view tends to be that it is pretty hard to do just partnership without impacting those.

So almost all the grantees are collecting most of those indicators.

Thank you.

DR. CLARK: Thank you, Ken, for an illuminating presentation. We appreciate your comments.

This gives us our 10-minute break. We will start back at 11:05.

[Break.]

DR. CLARK: We will move to the next item on the agenda. I want to thank Ken again for his quite illuminating discussion. I raised the issue with him

about the relationship between his grants and our ATR grants, the grants that ACF is managing, and I suppose the same question would apply to our Adolescent and Drug Court grants, so we will continue to work in collaboration with ACF.

I know that we are doing that, but in an environment of the program assessment rating tools and GPRA, those opportunities where there is overlapping activity, we want to be able to establish that our respective entities are in communication with each other. So this is an important thing.

**CSAT's 2009 Budget and Priorities for 2010
and Beyond**

DR. CLARK: Next, we want to talk about the budget. We always start off with the challenges. We know that the perceived need for treatment and efforts made to receive treatment among persons age 12 and older, but not receiving treatment continues to be an issue.

The waiting list for treatment is only about 314,000 people. The fact is that from our point of view, there is a larger issue, and that is that we have roughly 20 million people, a little more than 20 million people

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who meet criteria for alcohol and drug abuse, but who perceive no need for treatment, and as a result, are not presenting for treatment.

My suspicion is that this contributes to the stigma associated with substance abuse in terms of parity and other issues, because the demand, if you will, really isn't as great as it should be given the data that we have from our household survey.

This is an important point that I always like to make because I tie Recovery Month activity to this, that if the large community perceives no need for treatment, then, that is reinforced in part by friends and family until harm occurs.

I would venture that harm is the largest motivating force, and that occurs in the small number of people, the 2 to 3 million people who seek treatment, and the 314,000 people who believe they need treatment and weren't able to get it, but not the 20 million people that sufficient harm has not occurred, and that creates a problem.

In the '08 and '09 guiding principles in priorities, the thing that will influence this

administration, both in '08 and '09, the notion of a balanced budget by 2012, the theme of no new taxes, emphasis on delivery of direct services versus infrastructure, difficult choices being required in order to achieve the first two principles, and funding decisions involving multiple factors beyond those two things, it is an important point for us to keep in mind.

This is what is going to influence the budget process.

This is the overall aggregate budget of CSAT from 2007 to the 2009 requests. As you can see from this summary, that in '09, the request is \$19.9 million over the enacted in '08, and the difference between '08 and '07 is basically the same budget.

But if you look at the programs of regional and national significance, from '08 to the budget requests for '09, there will be approximately a \$48.5 million reduction in the CSAT budget with a \$2 million increase from '07 to '08.

If you look at our Science and Service portfolio, there was a slight reduction between '07 and '08, but a \$14.5 million reduction between '08 and '09.

The '08 appropriation provided level funding

for the block grant as you saw in the previous slide, restored nearly \$50 million in a large number of discretionary programs proposed for reduction, reduced drug court funding from 31.8 million proposed to 10.1 million, reduced SBIRT funding from 56.1 million proposed to 29.6 million, maintained the minority HIV-AIDS funding, added 3.5 million for tribes and tribal organizations, and added 6.3 million for 25 earmarked projects.

Key '08 activities and initiatives, we were able to implement Cohort II of the Access to Recovery initiative with 18 States, 5 tribes, and the District of Columbia. This is 24 grants which is up from the 15 grants in the Cohort I.

We were able to broaden the availability of the Screening, Brief Intervention programs, able to enhance the treatment services for American Indians and Alaskan Natives including an ATTC supplement and Pacific Islander jurisdictions, and then promote recovery support services in recovery-oriented systems of care, and continue to address methamphetamine treatment needs including through our ATR program.

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We were able to promote HIV Rapid Testing and Discretionary Grants and SABT block grants. Some of you may be aware that CDC has promulgated new guidelines with regard to HIV testing, favoring now a policy of very aggressive testing in the health care delivery arena, I call it test first, ask questions later.

But the idea is that with the advent of rapid testing, we can do testing, a homily I came up with is a cup of coffee and two donuts in 20 minutes, and I can tell you your HIV status.

It is an important point that we no longer have to wait two weeks to get results. We have fairly accurate results or at least screening results in less than half an hour.

We are in the process of conducting our own part assessment of drug courts program assessment rating tool. As you know, the OMB periodically examines various programs to determine their efficacy, accountability, utility, and we are working, our staff is working on that. That is within Jack Stein's shop. He is working with his team, the Criminal Justice team with Ken Robinson, Holly Rogers, and -- who else -- George Samoa.

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Who else is working on that, Jack? Ken Robinson, George Samoa, and Randy Muck, oh, yes, because juveniles are also involved.

That process has gone, and DEPA is working with our Data Branch to help coordinate this and make sure that we give the appropriate answers and have the appropriate numbers. DEPA, VULA, out of DISCA, working under Robert Alanda's shop under Ann Herron.

We are trying to address prescription drug abuse including methadone-related deaths and develop a substitute treatment workforce and adopt a public health approach to service delivery.

As I mentioned, Bob Lubran working on the Prescription Drug initiative, and the workforce, we have several entities within CSAT working on the workforce initiative, George Gilbert's shop, as well as Jack Stein's shop, Cathy Nugent, and Shannon Taitt, and many others who are working on the workforce issue.

The public health approach is tied to our overall recovery-oriented systems. This particular slide shows some of the activity in '08 and '09. As you can see, SAMHSA is not the only one that has suffered a

proposed reduction in appropriations for FY '09.

In order to meet those criteria, decisions have been made across agencies within HHS. SAMHSA overall will have a reduction of 5.9 percent in the '09 budget or \$198 million. The budget funds the presidential initiatives, ATR, and other priority areas like SAPT block grants, Criminal Justice, SBIRT, Minority AIDS initiative, while making targeted reductions in areas where grant periods are ending, activities that can be supported through other funding streams or efficiencies can be realized.

The '09 President's budget, PRNS funding is for SAMHSA by center is listed on this particular slide, and again you see reductions in all three centers. The reduction for CSAT is actually less percentagewise than the reduction for CSAPT and the proposed reduction for CMHS.

The '09 President's budget, CSAT continues to support, as I mentioned, drug courts in SBIRT. It maintains funding for the block grant with the \$20 million for performance incentives, supports direct services over infrastructure, savings achieved in lower

priority areas eliminates funds for congressional earmarks, and there is no proposed reduction in SAMHSA staffing.

The issue that we need to keep in mind, as I go through this, is that the 09 budget is the President's proposed budget, and the Executive Branch will have to negotiate with the Congress in the upcoming months about what the budget is going to be.

There seems to be some debate about that, that is articulated in the media, and that debate is going to have to be resolved. It is possible, given that our most recent budget, the '08 budget was not consolidated and passed until after the first of the year, that this budget may not make it through because as you know, this is a transition year, this administration ends on January 20th of '09.

There is an election in November, of course, and then how that resolves and what the Congress decides to do and what this administration or the next administration decides to do is something that we have to work with.

Those of you who worked in State Government

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understand periods of uncertainty that are generated by these kinds of transitions. We will work with whatever the administrations and the legislative branch achieves.

For the '09 budget, Access to Recovery would change by about 3 percent, Treatment Drug Courts would change about 280 percent. SBIRT would increase about 93 percent, Minority AIDS Initiative would remain the same. There would be an increase in the National Registry of Evidence-Based Practice, and the SHIN contract would remain the same.

The budget would include \$99.7 million for Access to Recovery, an increase of 3.2 million for '08, and that includes \$25 million targeted for methamphetamine. It continues that effort.

The proposed would be \$37.8 million or 60 percent increase over '08 for Treatment Drug Courts, together with funds from other Criminal Justice Grants that are naturally ending, 25 million would be available for new Drug Court Grants. This increases the total grants provided substance treatment for people referred by the Drug Court from 22 in '08 to 104 in '09, so there would be a substantial increase in the '09 budget in the

drug court activity.

Our Screening and Brief Intervention, as I previously mentioned, there will be an increase in '09 over '08. That will be a 93 percent increase, and together with funds from grants that are naturally ending, 28 million would be available to fund eight new grants to States, 18 new campus grants, 3 new grants to medical schools.

Early identification of substance abuse decreases total health care costs by preventing a progression toward addiction, and this would be a substantial effort in this direction. Remember the big red slice that I showed you. Our assumption is that if we don't go to where the clients are, we would have a long wait for them to show up in the specialty programs.

So, we don't want to diminish the importance of specialty programs, but we also want to reach people elsewhere in the system. The referral to specialty program will be enhanced, if you will, by identifying people else in the delivery system.

Minority AIDS will be at the same level of \$63 million, will fund all grant continuations, technical

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assistance, and program evaluation, and it provides substance abuse treatment services in racial and ethnic communities. It supports pretreatment services including HIV testing and counseling, provision of literature and other materials that support behavior change, and facilitation of access to treatment services.

Those of you who looked at the announcement will note that we are now requiring HIV testing as an integral part of both outreach and treatment, again consistent with the CDC approach. You really can't have a contemporary HIV program without at least facilitating the knowledge of HIV status.

All the meetings we have attended in addition to the CDC recommendations emphasize the importance of knowing your status as an integral part of intervention, and we are going to rely on projects that have some sensitivity to the whole HIV status issue, but at the same time we have a public health obligation to make sure that status determinations are made.

It is no longer sufficient just to hand somebody a brochure and tell them to engage in risk management activities. Knowing your status is a key

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issue associated with that.

Appearing on PRNS line, we are going to have programs obviously eliminated. Some \$55 million in capacity arena, \$14.8 million in science and service arena under the proposed budget with a total of \$70 million eliminated. We would also have some 74 grants terminated early, \$29.1 million worth of grants.

The factors considered in making the '09 program reductions and eliminations, one-time expenditures that don't need to be replicated, completed functions and commitments within the grants, scrutiny of automatic renewals. The point is that simply because you have done it for the past 10 years doesn't mean you have to do it again for the next 10 years.

Programs with purposes addressed through other places, under-performing programs and programs without solid performance measures, and proposed reductions in the past that were not enacted.

The '09 programs proposed for elimination are on this list. As you can see, our Co-Occurring State Incentive Grant is proposed for elimination, our treatment for pregnant and postpartum women is proposed

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for elimination, our Strengthening Treatment Access and Retention program is proposed for elimination. Our Recovery Community Services Program is proposed for elimination.

Our Treatment for Children and Families, which was substantially our adolescent portfolio, is proposed for elimination. Under Science and Services, Minority Fellowship Program, which is a modest \$500,000, is proposed for elimination. Our Knowledge Application Program is proposed for elimination. Partners for Recovery Effort is proposed for elimination. Consumer Education and Recovery Month Activity will be proposed for elimination.

Under Children and Families, this gives you the specific breakdown of the various activities that would be eliminated. Our Children State Incentive Grant would be eliminated. Our State Adolescent Substance Abuse Treatment Coordination Supplements would be eliminated.

Our Family Therapy Grants would be eliminated.

Our Family Therapy Grants for '07 would be eliminated. Our Women, Youth, and Families Task Force would be eliminated.

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Our National Center for Substance Abuse and Child Welfare would be eliminated. Our support for adolescent programs would be eliminate. The TAPS would be eliminated, and the contract for the IAGs under this rubric would be eliminated.

Our activity in Seclusion and Restraint would be eliminated. Minority Fellowship Program would be eliminated. Our special initiative outreach efforts would be eliminated. Information dissemination, which would include TIPS would be eliminated, and our program coordination and evaluation would be eliminated.

Specifically, for our special initiatives outreach, that would include our HBCU and our Lonnie Mitchell conference would be eliminated. DSI scientific, technical, and logistical support would be eliminated.

Our Performance Measurement contract and Logistics contract would be eliminated. Enhancing Practice Improvements and Community Care for Prevention and Treatment would be eliminated, and the Office of Director's special initiatives effort would be eliminated, and our analysis of the AHRQ healthcare costs effort would be eliminated.

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Program decreases. Opioid Treatment Program would have roughly a \$2.9 million reduction. Our TC general activity would be reduced by \$11 million. Our treatment system for homeless would be reduced by \$9.9 million. Our service accountability, which include our SAIS activity and TAPS would be reduced by \$13.6 million, and our Addiction Technology Transfer Centers would be reduced by \$478 million.

The entire SAMHSA FY '09 budget can be found on the SAMHSA internet for staff to be aware of.

Our 2010 budget context. So that leads us to 2010. 2009, the President has already articulated his budget that is before the Congress. The Congress will have to decide how it is going to address the proposed budget, and the Administrator has already testified in support of the President's budget, and the idea is that indeed that needs to be hammered out.

Of course, we are in the bureaucracy at the level of the center, so we have very limited contact with the congressional process. We defer to the legitimate approaches to that.

Interest groups are being consulted, I am sure

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by the Congress, and others that have an interest in the budget, so that process is going on even as we speak, but we don't know whether there is going to be an '09 budget based on this transition year issue and the fact that it is an election year and many people are going to be focusing on the election process.

If that is the case, then, we will probably have some kind of continuing resolution which we have had in the past until it is decided when the budget will be addressed.

But the issue for 2010 is something that we should start thinking about, and we can use Council to start thinking about that. We have four new members. This is an exciting time for you because this is the time when you can look at budget issues and make suggestions about programs, and we know that there is going to be a continuing need to address the nation's economic conditions, so we shouldn't expect a windfall to show up.

As you know, we keep reading in the newspaper about this entity or that entity, and this inflationary measure and that interest rate cut, so there is a large concern in the public about the budget and the economic

conditions.

The change in administration's turnover in Congress and possible change in the committee membership, so all of these things will influence what decisions are being made in the legislative level.

We know the President is going to change. We know members of Congress and some have already indicated that they are not running, and other people will be running. So it does mean for 2010, organizations in the community may have a lot of influence on the process.

So this gives people an opportunity to think about, gee, what would a good budget look like. This will be the administration's 2010 -- the final budget proposal, the 2009 final budget proposal -- 2010 budget is just in development.

If it is adopted by the next administration, it will be announced during the routine time, in February of next year. If it is not, then, the new budget will be adopted or announced.

There is likely to be continued emphasis on screening, brief intervention, and drug courts, and there is likelihood of a long-term continuing resolution, as I

have mentioned, but in the interim, we need to also think about issues of accountability. Performance, GPRA, and the process is actually, shall be say, nonpartisan.

The Congress has been long interested in what we do with our money, how we spend the money, and are we spending it well, and what results are we getting, which is one of the reasons infrastructures grants have not done as well, because they are often unable to show that people are served. On one hand, people say, gee, we can't get treatment, and on the other hand, if we don't spend money in the services arena, we don't have any evidence that we have helped people get treatment.

We have noticed from some of our infrastructure grants, that changes in the political arena just don't occur at the federal level, they occur at the State level. Those changes then can often create a cascade of consequences in terms of philosophies and approaches.

So the services approach allows us to at least highlight that people are being seen, services are being delivered despite the monumental changes that occur based on local and regional and federal politics.

We know that performance management and

management issues will continue to be themes, so as you think about how you think CSAT's budget should look for 2010, think about that as the principal issue. We will have evaluation results for ATR, for block grant, we believe for SBIRT, and Drug Courts by the time this budget matures.

In terms of being able to modify it in the future, in 2010, we believe it will have information that we will be able to put on the table to influence how programs are allocated.

We should think in terms of service integration within the primary care system, as I mentioned, Screening, Brief Intervention. The issue recovery-oriented systems of care as a part of a public health paradigm, I would encourage you to think about that, and we will have more to talk about later today, as that paradigm is presented to you.

We need to keep in mind the need to have evidence-based practices to be able to address health disparities. The issue of prescription drug abuse continues to be a concern, workforce development continues to be a concern, and that is not just a concern

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for CSAT.

Anna Marsh from the Center for Substance Abuse Prevention is the Acting Director of that Center, and Katherine Power, the Center for Mental Health Services, both of those directors have acknowledged the importance of workforce development, and Terry Cline, the Administrator, obviously, has also articulated that, so workforce development issues continue to be an effort, and we would benefit from your being able to suggest what priorities that we should have.

We will be outreaching nonprofit organizations, community groups to help us with this as a theme, what should 2010 look like given the budget context of, shall we say, a constrained economic environment and the considerations that I have already mentioned.

These are the key development dates. We can have both internal and external discussions of potential 2010 budget proposals. We are expected to refine and discuss with SAMHSA the various proposals starting now through late April. By May, our proposals for 2010 have to be finalized. Once they are finalized and the budget documents are developed, then, we cannot have external

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discussions. The embargo kicks in.

Right now there is no embargo. So right now we can turn to you as external entities to say, okay, given these constraints, how do you think we should be prioritizing our funding, what should we be looking at in terms of limited new activities.

Then, in June, the SAMHSA budget is submitted to HHS on June 2nd. So once that budget process moves forward, then, it moves off the table, but we have some time now, a month and a half or almost two months to get these things developed, so when you return home, would you think about it, when you talk to those individuals in your community, would you think about it, because indeed what we do in the long run turns upon what resources we have and how we dedicate those resources to those activities.

With that, I will entertain some discussion.

Ken.

Council Discussion

MR. DeCERCHIO: What are the budget parameters for 2010? In other words, does it come with a reduced budget from the '09 proposal, or an even budget, or is

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there some discretion on the part of the Secretary or Administrator to propose?

DR. CLARK: As I said on the slide, on the 2010 budget content, we can anticipate continued adverse economic conditions. We also know that this administration will undoubtedly link its 2010 proposals to 2009 and 2008, but the other issue, though, is the legislative. We don't know what the 2009 budget is going to look like. We know what the proposal is, and we support the President's proposal, but as in '08, the Congress and the President disagreed and there was a restoration, it was \$50 million over the proposal.

So, we can anticipate continued strains in the budget, so even though the Congress restored \$50 million, it wasn't \$150 million. It was only \$50 million. So, in thinking about these things, if we will assume that given the continued budgetary crunch, we will probably assume either even for '09 or 2 percent reduction for '09. We won't be given the mark until a little later.

For the community, you can assume either the same budget for 2010, between '09 and 2010, or the same thing, a reduction, or the community, based on its

context with the Hill since our processes don't allow the bureaucracy to have access to the Hill, but through their summoning us through the Administrator.

If I were an external entity, I would assume no more than a 2 to 4 percent increase. We are assuming a 2 percent decrease, either the same or a 2 decrease. But again there are these processes that suddenly converge. I know that teachers of geometry would argue that parallel processes don't converge, but these parallel processes will converge and then they need to be resolved. The White House will negotiate with the Congress on the federal issues.

Rich and George, do you have comments?

MR. KOPANDA: Just one thing I would note. As what is mentioned, this is a very unusual, well, it's an atypical year in the sense that we are going to have a change in administration for sure.

The proposals that you might propose, the considerations we might put forward in terms of programming initiatives, even if they are not adopted within a no-growth or tiny growth budget, they will remain kind of within CSAT and on the table, and

sometimes I have seen in the past a new administration comes in, they have an entirely different view of SAMHSA, CSAT, and our program.

So, it is handy to have available some initiatives, some ideas of what you would do, because you also often have a rapid turnaround in terms of producing them for a new administration that wants to go in a different direction.

DR. CLARK: George, any thoughts?

MR. GILBERT: I just wanted to say that in terms of thinking about 2010 and beyond, that oftentimes what is helpful to us is not necessarily specific program proposals as much as it is kind of the lay of the land, what are the key issues out there that we should be trying to address within our program capabilities, you know, are we missing something that we should be focusing on or are we concentrating too much in some area and should we be thinking of realigning what we are doing.

I mean it is both, you know, specific program initiatives, but also just broad policy issues that we should be attuned to.

DR. CLARK: Frank.

DR. McCORRY: I have a couple of comments I would like to make. The first was just on this last point that Dr. Clark and George was making, and whether this council, what role it might play both in informing or advising CSAT as you develop your 2010 budget, and as George was saying, what are the issues that we really would want to highlight for your consideration as you put a budget together and whether there is a process to do that since we have chock-full agenda today.

That is one issue. Related to that, there will be a new administration and we are an advisory council to an important center within the Executive Branch, and whether this council would want to have something to say to that new administration.

It might be the same thing we would say to CSAT in terms of 2010 budget, but maybe not. Maybe it's a broader document that introduces the administration to issues of importance.

I know there will be 1,000 of these kinds of things both from within government, as well as outside government, but just as a consideration whether this council would want to put something together for the new

administration to consider as the advisory council to the center.

Those are for the future. I want to make some comments about the current budget and whether again since we have the responsibility, even knowing which I think because I believe, it might not have been at this meeting, but it was a meeting that some of us were at, and people put up the budget, and the sense was, well, it is going to be a lot of work done on this budget before it was passed since there will be a new administration.

Even given that context that we might end up in continuing resolution or something other than what is currently present, whether some of the cuts that are proposed here are either worth commenting on in general or in specific.

One I would point out is all of these, of course, will do damage, I mean, so there is no picking among very important areas, I don't mean to do that, but some perhaps more damage than others.

The Recovery Community Support Services Program, for example, which really speaks to where we are going as a field, I think, or at least in terms what I

was talking about earlier, the Chronic Care Model, the role of the consumer in extending the model of care to beyond this acute phase that we currently have, and putting the consumer, the person in recovery, the recovery-oriented systems of care right at the center of this work, and then saying that to eliminate that, since it is really in its kind of incubator stage, you know, it is very, very new, to eliminate it just really kind of flies in the face of where we ought to be going.

So it might be more of death knell to that kind of process than all these other worthy areas, that might at least have some been around and kind of well established.

I am only picking at one area as a topic for discussion, but whether this council should be on record around these cuts, whether opposing or supporting or making advisory comments about them, whether we should be saying something publicly about things like the loss of the recovery community support services and what that means to where we want to go as a field or where we have to go as a field is a question I think we should at least consider communicating with either the Administrator, you

know, Dr. Cline, or someone else at the HHS level about the impact of these as we see it from our seats on this council.

DR. CLARK: As far as the '09 budget is concerned, since this council essentially advises the CSAT director, the Administrator, and the Secretary, and since the Secretary and the Administrator and the CSAT director are in line with the President's budget, there really isn't much effort at least within the Executive Branch to discuss the '09 budget. It is what it is.

We are soliciting your input for the 2010 budget, because again no decision has been made about the 2010 budget, and even in the context we are speculating. Ostensibly, the economy could change, the war could be over, money could be flying, or not.

So, we allow you to, in your eminent wisdom, to do what you are saying in terms of how should we prioritize as both Rich and George suggested, how should we prioritize from a policy point of view what is important and what should we do.

As individuals outside of this context, working with your respective jurisdictions, entities, you might

take another approach because indeed when you are off the clock, if you will, i.e., when you are not on the council, you go back to your respective lives and you can use what other venues and strategies and approaches to communicate to the other entities your views about '09, but the 2010 budget is again an open story.

The branding issue is something that does happen between administrations, new administrations like to have their own brand, not because the old administration is bad, but because, you know, this is what I did when I was here.

So, you might think of, gee, what should this new administration look for, and substance abuse treatment and venue can make recommendations about a new brand, if you will, for the new administration. That seems imminently reasonable.

Frank.

DR. McCORRY: I am not so much in agreement that because the Secretary and the Administrator and the center leadership is aligned, that the Advisory Councils have to be aligned in the same way, at least in terms of saying something back to the people we advise about the

inadvisability of this budget.

DR. CLARK: Thank you, Frank.

Anita.

MS. BERTRAND: I just want to say that I support the idea of having the Council put something together whether it's '09, preferably '09, and in 2010, so that we can help educate our administration here and the new individuals that are coming into offices, because a lot of times they don't understand addiction and know the value or the number of individuals who have benefited from the work that you all and that we do every day.

So, I really support that if there is a way to make that happen. I mean I would even be willing to sort of put together something. I don't want to overstep my boundaries or anything like that, but I would be willing to put something together and solicit information from the council members about what we value as important, so that if you have any room to look at what is important to us as an advisory council, that that can be heard and moved forward.

DR. CLARK: The only thing that I could say about '09 is a statement perhaps that should the

administration and the Congress reach a compromise where additional funds are available, how you thought those additional funds might be spent.

That is the only thing that would come to my mind. I think as an advisory council, we are essentially bound by the process for '09. The only exception is this awareness that some \$50 million were restored between '07 and '08, and the difference between the President's budget.

So, the argument could be that additional funds might be made available and should that happen, this is what this council would think. But for 2010, other than the context that we articulated, you are in a much better position. That, I think would be the more appropriate position to have.

Ken.

MR. DECERCHIO: Two questions. What would be the time frame if we were going to, Anita, put something together in the form of a correspondence with recommendations, whatever that may be for 2010, what would be the time frame that we would need to have that by, if we were going to, say, as an advisory council,

looking to 2010, here are some parameters or some priority areas, some considerations?

DR. CLARK: I would say by May 1st, because our budget proposals need to be finalized, and any information or thoughts that you have as soon as possible you can contribute either as individual members of the council or the council as a whole for 2010, the key issue being that we just want to make sure that we have your input.

MR. DeCERCHIO: Related to that, too, I think we can make a statement about the 2009 budget by what it is we point to in the 2010 budget. So, we can accomplish both things I think with that kind of strategy, you know, so if we want to identify recovery-oriented systems and say, look, you know, that is a priority for 2010, it just so happens to be it was recommended for elimination in 2009, we have made a statement about the 2009 budget without saying, gee, we have a problem with the 2009 budget or we consider it or whatever.

So, I think that can work as a strategy, as well. In these times, you know, one of the policy kind of frameworks tends to be limit on new services, but

let's look at if we are going to expand, look at expansion in those areas that have demonstrated some effectiveness and expand its penetration.

You know, it is a greater part of the community, if you will, or of the country as one kind of principle in these tough times, so it's first do no harm, and then it's second, you know, strategically looking at that which is out there and having demonstrated some effectiveness and how do we penetrate further in other parts of the country.

The idea, you know, Frank, you mentioned a topic here, the idea that both treatment for pregnant and postpartum women, and treatment, although not everything is direct service related, but treatment for children and families at a time when we know that economic stressors create an increased demand for social support, for social interventions, for activities is problematic, I mean just to be diplomatic about it, and perhaps short-sighted that at a time when families probably need more support, are under increasing stress, economic and otherwise, that those particular areas would be targeted.

The implications, the long-term implications of

not providing services or quality services to children and expectant and postpartum moms in terms of all kinds of things for kids and families, we all know it.

So, perhaps, Anita, we could maybe in the form of a motion put a work group together to look at crafting recommendations. I appreciate you giving this opportunity.

I mean I think we have talked about this over the years, getting ahead of the curve, you know, you responded to us and giving us that opportunity for 2010, so, you know, we appreciate that, and I think it is incumbent on this to take advantage of that opportunity in a responsible way and maybe, Anita, you could put a motion together to put a work group together to look at it and come back with some recommendations in the form of written recommendations to the Administrator.

DR. CLARK: What I am going to do is ask that you continue this discussion this afternoon at the roundtable, because we have three people thus far who signed up for public comment, so we will do that.

Why don't we continue this discussion this afternoon at the roundtable. Rich Kopanda will chair the

meeting then.

In the meantime, we are always delighted to have a variety of persons attend our meetings, be they members of the field, members of the public. We have some public members desiring to address the Council, they are invited to come to the standing mike in the center of the floor.

We have got three names thus far, the first one being Jean Govoni from SAARA.

Public Comment

MS. GOVONI: Good morning, Dr. Clark, and good morning to the Council. My name is Jean Govoni. I am the Center Administrator of the SAARA Center for Recovery. We are one of the 2007 RCSP grantees. We consider ourselves extremely fortunate to have been granted one of the grants since there are 140 other people who applied for it, so we thank you very much for supporting SAARA Virginia.

We have a partnership with Chesterfield County and they were the ones who really came to SAARA Virginia asking for help. The Community Services Board cannot keep up with the demand of people coming, looking for

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substance abuse treatment.

At the time that the grant was originally applied for, people had to wait 47 days on a waiting list. The wait now is down to about 20 to 30 days, but we all know what can happen, you know, in that period of time.

So, Chesterfield County is extremely excited that the SAARA Center for Recovery has opened and as a matter of fact, we just opened on Monday, on St. Patrick's Day, and, you know, we have been open for three days and in just those three days, we have had people coming back twice in three days, which is pretty good. We had press, the newspapers covered it, the radio picked it up, as well, and as a result of some of that coverage, people walked through that door, not only once, but twice.

We had one gentleman come in at the end of the day, spoke with a recovery coach, found himself crying, you know, finally was able to sort of get real about his addiction. The next morning we came to work and we found this case of Kleenex sitting at our doorstep, unmarked, sent anonymously.

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There is another thing. We could never have gotten all of this up and running without technical assistance, which is extremely important to us in many, many kinds of ways, and so we felt that we really couldn't do it without them and wanted to acknowledge that.

I do want to read you an e-mail that I received yesterday from someone at my home computer. It says, "Congratulations on the opening of the SAARA Center for Recovery. What a noble and humbling event in your life. One day when I grow up, as I sit here at work dreading the thought of going home to my apartment and my Percocet-addicted jobless daughter, the article in Monday's paper, moreover your organization, has brought a ray of hope to my heart and a tear to my eye, or maybe a couple."

I think one thing that this lady didn't know was that you all were responsible for this happening. So, on behalf of the SAARA Center for Recovery, the community of Chesterfield County and metropolitan Richmond, of everybody in the recovery community, and anybody who suffers from addition, we hope that you would

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reconsider and reinstate funding for 2008, so that other communities who have reached out like Chesterfield County has could also benefit from this, as we have seen in three days, this extremely important program.

Thank you.

DR. CLARK: Thank you.

Walter Ginter from NAMHA.

MR. GINTER: Thank you, Dr. Clark, members of the Council. Actually, today, I am speaking on behalf of the National Board of Faces and Voices of Recovery. I am a project director of an RCSP project. Mine is a Medicaid Assisted Recovery Support Project in Bronx, New York, which is a collaboration of the National Alliance of Methadone Advocates and the Albert Einstein College of Medicine.

I am also here to speak about the lack of support for the RCSP funding. One of the things, in the 2009 budget, there was a comment on the discontinuation of RCSP that hinted that RCSP wasn't an evidence-based project, and I want to read something to you that comes from CSAT.

"The services are based on evidence-based

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practices for recovery and grantees are meeting performance measures. Recent data collected by SAMHSA in 2007 demonstrate the effectiveness of RCSP grantees in achieving successful outcomes.

"For example, the target for abstinence for all SAMHSA programs of regional and national significance is 63 percent. RCSP grantees reported actual abstinence rates of 85 percent. The most significant achievement was in the area of social consequences.

"When the PRNS target was 67, RCSP grantees were able to demonstrate a 94 percent rate. Other GPRA measures included employment with RCSP grantees reporting 10 percent above the PRNS target of 52 percent, and no Criminal Justice involvement with RCSP grantees 1 percent above the PRNS target of 96 percent.

"In the area of housing, RCSP grantees reported 61 percent success in securing housing far above the 52 percent PRNS target."

I think as far as evidence-based, those SAMHSA figures speak for themselves. We are hearing a lot of talk today about recovery-oriented system of care. Now, peer recovery support services are not treatment. They

are an adjunct to treatment, not a replacement for it.

At my project, I can remember three to four months into the project, and we worked very closely with the treatment provider, being contacted by a counselor who said what kind of voodoo are you using over there, I have had this patient for four years and she has never had two weeks in a row with positive toxicologies, and now she is clean for three months straight.

It is not voodoo, it is peer recovery support. There is a kind of support that professionals, not matter how well intentioned, and no matter how talented, cannot provide, that can be provided by peers. It is not a replacement for treatment, it's an adjunct to it.

Thank you.

DR. CLARK: Thank you, Mr. Ginter.

Our next speaker is Pat Taylor from Faces of the Voices of Recovery.

MS. TAYLOR: Thank you, Dr. Clark, and Council Members. What we are passing out here is a description about the Recovery Community Services Program, as well as the article that Jean referred to, that ran in the Richmond Times Dispatch about the opening of the Recovery

Community Center just on Monday in Richmond.

I wanted to talk a little bit more about the Recovery Community Services Program. As you can well imagine, we were extremely disappointed when we saw that the administration had proposed zeroing out this incredibly effective program in the FY 2009 budget.

As Walter mentioned, I think over 140 organizations applied for the last round in which only 8 grants were made, and the critical role that recovery community organizations and faith-based organizations are playing in terms of building strong communities of recovery across our country, I think needs to be acknowledged and hopefully supported by the administration and also by the Council.

What these recovery community organizations and faith-based organizations have been able to do incredibly effectively is to build environments, communities of recovery that support families looking for help for children, spouses, and others who are struggling with addiction, but also a place, a safe place for people who are leaving treatment or incarceration to go to.

We would like to strongly urge the Council to

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pass a resolution this afternoon, asking Administrator Cline to identify \$2.5 million to reinstate, to issue a new round of funding in FY 2008.

I know you have been talking about 2010 and looking to the future, but this is a critical problem which for a very little amount of money, relatively speaking, is doing an awful lot to change the environment, so that there is a public understanding that people can and do recover.

In addition to that, I would just like to also bring to your attention, a totally unrelated topic, the SAMHSA data strategy that was recently released. One of the things that we don't know about in our country is how people really do get into long-term recovery.

One of the ways that we can do that is include questions in the National Survey on Drug Use and Health about people's recovery experience. This is something that we met with Rich Kopanda and some other people about three years ago, and we were really pleased to see that SAMHSA's new data strategy includes a plan for asking people about their recovery experiences, because without that information, number one, we can't tell the public

how many people are in long-term recovery, but more importantly, I think in terms of understanding the criticalness of peer recovery support services, a policy environment that supports recovery without that information, it makes it more difficult to build a case for public support for these programs.

Also, just one other last thing, in terms of your discussion about 2010, I think it is really exciting for the Advisory Council to take a role in terms of discussing what it is the public wants to see happening in terms of public policies and programs.

Thank you very much.

DR. CLARK: Thank you, Pat Taylor.

Anybody else, any public commenter?

Okay. If there is anyone out there who would like to submit a written comment, they can give them to us Iesha Walker at the registration table.

We have made it through the first half with grant review and interesting discussions and a break, and now it is time for us to get some nourishment for our physical bodies.

We will break for lunch and the meeting will

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resume at 1:30. Rich Kopanda will chair the meeting for this afternoon as I won't be able to be here.

The shuttle is waiting for Council members to take you to the Sheraton, and will be joining you.

[Luncheon recess taken at 12:10 p.m.]

MR. KOPANDA: We are temporarily missing one of our members, Dr. Howell. We lost her between the hotel and here somewhere, but she should be joining us. We have sent out a search party, so she should be joining us shortly.

We are fortunate to have with us Jennifer Fiedelholtz, who is from our Office of Policy, Planning, and Budget. She and George Gilbert are going to jointly present our Process for Developing Grant Announcements. I see that we have about 20 minutes scheduled for this. If this process can be described in 20 minutes, that will be pretty amazing.

SAMHSA's Process for Developing

Grant Announcements

MS. FIEDELHOLTZ: I work in the Office of Policy, Planning, and Budget, and my team includes a couple of people who coordinate the RFA development

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process for the agency. I thought I would come and just talk a little briefly both about the content, how do we decide what RFAs we are putting out, what drives the content of the RFAs, and then how do we handle that process internally.

Obviously, the first thing we have to do, and we start about this time of year, is to figure out, well, what grant announcements do we think we are going to put out next year, and the very first clue is the President's budget, which is released in February.

We can look at the President's budget and we know which grant programs we anticipate having funding for new grants in and can start developing a plan based on that. Obviously, the President's budget is not the appropriation, so we monitor what is going on with the appropriations committees on the Hill.

Over the summer, there is usually a House report and a Senate report, and we start to get an idea of how the Congress is reacting to the President's budget, what types of things are they retaining, what are they adding, what do they not seem to be interested in, and we start getting an idea, and updating our schedule,

there are a list of grant announcements in the fall based on what we saw happening on the Hill over the summer.

If both the House and the Senate added funding for a particular program, we can probably guess that we would need to do a grant announcement for that, even though we don't have a final appropriation.

Then, obviously, at some point, after the beginning of October, we get the final appropriation. The last few years, that has been a bit of a challenge. There have been a lot of changes in the list of grants or in the design of the programs based on the appropriation, so we usually do some adjusting again after we get that appropriation. Sometimes that can be quite late in the process, as late as February sometimes.

Once we have got that list of grant programs, there is usually some information in the budget or in the appropriation's language about the program, but it is pretty basic. I forgot to include on the slide the authorizing statute. Some of the programs that we find have very specific authorizing statutes, and that obviously would dictate certain things.

Sometimes it is eligibility, sometimes it is

required activities. Sometimes it can even dictate things like review criteria or prioritization. Frequently, the appropriations language would indicate priorities within a program, so that has to be factored in as well.

Then, there are grants requirements that dictate some of what goes into the grant announcements. I think probably the one that would be most obvious to the field is a required OMB format for all grant announcements. It was issued four or five years ago and we must follow that outline. I will go over that in just a minute.

There are also a series of grants policy requirements. You can access those on the HHS website. Some of SAMHSA's specific grants policy requirements are on our own website.

Obviously, we have to factor those things into grant announcements, as well, and that can range from things like funding restrictions to required reimbursement rates, that we have an indirect cost rate, for example, that we factor into our grant announcements.

Because there are lots of grants policy

requirements, we have over the years developed boilerplate that we use for all of our grant announcements. We don't start fresh every year. Each year we kind of go through a lessons learned process and send it out, take comments on it, and update it.

We have had that boilerplate cleared by the Department to make sure we are doing the right thing, and that obviously is something that is a building block for developing the grant announcement.

Finally, we have developed some standard grant announcements around typical grant topologies across the agency. We did this three or four years ago, kind of looking at all of our grant programs and determining there are really, you know, three or four central types.

Services grants are the most frequent grant type within CSAT.

We also fund a number of infrastructure grants and then, to a lesser extent, we have funded some programs that we call best practices planning and implementation grants that are more smaller planning or evaluation type grants, and science and service grants.

So, we have developed standard grant templates

that are tools both for the staff who are writing the grant announcements and also a tool for the field. The two that we use the most, the services grant and the infrastructure grant templates are available on our website as a tool for the field.

If you are interested in a SAMHSA grant, you can look at those templates and get a pretty good idea of the types of things you are going to be asked to put or include in your application.

Those are kind of the starting points. That is the raw material that we start with in developing grant announcements. I will run quickly through the OMB required format. As I mentioned, this is something OMB issued I think in 2003.

It was an activity that was part of a federal law that required OMB to head efforts to streamline financial assistance. You may have heard of the grants.gov website. That is another part of the initiative to increase access to information about funding opportunities.

The standard outline for discretionary grants is another part of that initiative, and the idea was that

whether you came to HHS, or SAMHSA within HHS, or HRSA, or you went to the Department of Justice, that the information in a request for applications would be organized the same way and the basic content would be provided in the same place, across federal agencies.

We are required to use this outline. All of these headings must be in our grant announcements. We can add to the subheadings, but we can't take anything away, and we can't change the headers, and there are certain things that we have to cover in each one of these categories.

Some of it is pretty mundane. You have to put a CFDA number in on the cover of the grant announcement, you have to reference Executive Order 12372, which requires States to have the opportunity to comment on applications, so applicants are required to notify States that they are applying for a SAMHSA grant. That has to be put on the cover of the RFA and included later in the RFA.

Some of it is very substantive. We have to discuss cost sharing, is it required, and what happens to your application if you don't meet the cost-sharing

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requirement, is it something that we consider in scoring, would it result in your application being screened out, what is the implication of cost sharing.

Within the Eligibility Section, we must indicate anything that would result in an application not being considered. It may be cross-referenced elsewhere in the grant announcement, but we have to include it in Section 3 of the RFA, so it's the funding opportunity description, what is this program about.

We include performance measurement requirements there, as well, award information, how much money do we have, how much per grant do we think it is going to be. It can be a set amount, it can be a range, but how large are those awards expected to be, how many awards will there be, how long will the grants last.

Obviously, for SAMHSA, we can't guarantee funding beyond the first year, but we will still have to indicate what the maximum project period can be.

Eligibility information, that is pretty basic on the surface, but again you have to say anything that would result in an application not being considered, so screen out, we have some formatting screen-out

requirements, you have to reference those there.

Application and submission information is how you put the package together, how you get it to us, what happens if you don't get it to us on time. The application review information, that is both how we score each application and then how we make decisions, how we make decisions about which ones to select.

Section 6 is kind of standard award administration, how you will be notified about the award.

There are some miscellaneous administrative and national policy requirements, what your reporting requirements to us would be if you were funded, contact information, who do you contact to find out more information about the program. Then, there is a catch-all, if there is anything else you want to throw in there, that goes in the Section 8.

That is mandatory. We have to follow that. While I might quibble about the order and the headings, I actually think it's a really good thing that this is standard across the government.

These are the four standard grant types. The two that we fund the most are services grants and

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infrastructure grants. Again, those are available on our website.

Those are the building blocks for content. Beyond that, it is kind of our best professional information. So, what is the process that we use?

This is a very involved process. I don't think there is a part of the agency that is not involved in grant announcement development in some way, and everybody brings a different perspective and a different body of information, a different expertise to the table.

You have agency leadership, which includes the center directors, the deputies, the OPAC directors, the senior advisors to the Administrator, the Deputy Administrator, providing guidance with regard to priorities and broad overall leadership.

They review and clear all of the RFAs. Program staff, who are involved in the grant programs on a day-to-day basis, they know a lot about the programs based on historical information.

They know what has been problematic for grantees in the past. They know what has worked well, and they bring that to bear. They drive the programs

from a program content perspective.

My office coordinates the RFAs. We have done this for a long time and have some experience about what works in the grant announcement and doesn't. Similarly, the people in Grants Management and Grant Review are involved from their own perspectives.

If you have run many grant reviews, you can look at review criteria and anticipate where applicants will be confused and where we might need to say something more clearly or where we have articulated a requirement, but not told applicants how they have to demonstrate that they have met the requirement, so they are involved in it.

We start out about this time of year. I have actually reviewed a draft, an internal draft of guidance for FY '09 grant planning. We know what is in the President's budget, and we start thinking about how did last year's process go, you know, what can we learn from that, what do we want to do differently.

We will consult with each of the centers and with Grants Management and Grant Review. We will develop guidance, I have to have that done, you know, within the

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next month or two, and we will develop a tentative schedule.

We try to publish all the grant announcements by March 1st, so that there is ample time for applicants to submit applications for the review to happen and funding decisions to be made.

Then, we will start what we call a policy review of the initial planning documents, and that may just be a mark-up of last year's RSA. If you are reissuing the RSA, and you don't want to make a lot of changes, you can just mark it up and send it forward with a cover memo explaining what you want to do differently.

If it is a brand-new program or something that we want to change dramatically, the centers will develop what we call a decision memo. That really outlines the key components of the grant program, what the center would like to do, what the rationale is, and we send that out to the senior advisors, we send it to Grants Management, Grant Review, and Policy Coordination staff within OPPB.

People review it, they will send us comments. If they are minor things, we will transmit the comments

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in writing. If there are a lot of comments, particularly if it is a new program or a complex program, we will sit down. We will have what we call a policy review meeting, and we will all sit down around the table and try and reach agreement about how we want to move forward with the RFA.

Once we have reached agreement, we put together the RFA. It typically involves a number of back and forth, things can happen with the appropriation that causes us to go back and change something, but that is it in a nutshell.

I will turn it over to George to talk a little bit about how the center handles it.

MR. GILBERT: Cynthia is going to bring up the few slides that I have, which are the ones that I had in your package yesterday for those of you who were here at the orientation, and I didn't really cover them very much because we are going to talk about it today.

I am going to try to just fill in some of the gaps, tell you how the center fits in with the overall agency process. I want to talk a little bit, you know, we talk about RFA, RFA, what is an RFA. Well, it doesn't

mean anything except Request for Application, a grant announcement. So for those of you who are new, you hear us talking about RFAs, you know what an RFA is.

What are the sources for our RFAs? Jennifer has talked about how the starting point is really the President's budget in any given year, and really, you know, what is in the President's budget, that is going to determine what announcements we initially start planning for, but obviously, the ideas -- Cynthia, if you just scroll down, I think the slides are in this one, too -- as I said, the President's budget is the starting point, but we get our ideas for things that we think are important to be done from a lot of different sources.

Certainly, the Advisory Council gives us a lot of ideas about areas that we need to focus on, and as I said earlier this morning, it isn't necessarily the council saying you should do a grant on this, but it is more or less a policy area or an issue that is out there that maybe you all, in looking at our portfolio and the discussions you had, you are telling us maybe you need to spend a little more time here, or maybe you need to back off here and do something over there.

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The Council is definitely a source for us. Our grantees, through the grantee meetings that we have with them every year, other sources, other meetings, we get feedback from them. We also hear from our constituency groups in meetings that we have with them throughout the year, but we will also be doing a meeting probably in April to review with them, like we did with you, what is the '09 budget, what is the outlook ahead, and where do they think we need to be focusing our efforts.

Congress obviously plays a big role in this. Just to give you a couple of examples, this year we didn't request anything new for PPW or homeless, but we got new funding in both of those areas.

They also can change what the President submits in his budget, so they limit it, for example, this year what had been requested for treatment drug courts and for SBIRT.

Then, we are just trying to be responsive to emerging and urgent needs in the field. Methamphetamine, for example, is an area where even before there was a lot of public attention being given to the issue, we had picked up on this through our various sources, and we

started funding some methamphetamine grants, and now, of course, it is built into ATR.

Methadone is another area. This year, for example, we are announcing a new physicians clinical support system mechanism for methadone to respond to the rise in methadone-related mortality.

So, we are always trying to see what are the issues out there that maybe we need to be responsive to in developing programs to address them.

Jennifer mentioned the authorizing legislation. For us, each of the centers really has a generic PRNS, programs of regional and national significance, authorization. Ours is Section 509. That gives us broad authority to do targeted capacity response type activities, training and technical assistance, and knowledge development and application.

We don't do a lot of that anymore, because we are a services agency these days, we are not research, so most of what CSAT does is services grants. We also have a specific authority for homeless programs called Grants for Benefit of Homeless Individuals, or GBHI. That is Section 506 in our authorizing legislation.

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Then, we have a specific authority for residential treatment programs for pregnant and postpartum women. The section should be 508 actually.

Then, we have some other specific authorities for adolescent treatment, methamphetamine, and also for American Indians and Alaska Natives. We use these rarely because oftentimes they are written very specifically, very specific requirements, and Congress doesn't appropriate money for those specific authorities.

So, if we are doing programs that are addressing methamphetamine or tribal populations, often we are trying to provide more flexibility for grant recipients to design programs that are going to really be responsive to their needs, so we use our generic authority where we can.

We have used the adolescent treatment authority a couple of times, but again, you know, we have these very specific authorities, and then we have the more generic authority.

Then, in terms of how we go about developing the RFAs, Jennifer has really given a pretty good overview of that. We work very closely with OPPB. We

work very closely with the other components of SAMHSA in developing our RFAs. Danielle Johnson, who is here in the front row, is our RFA coordinator, and she works closely with Jennifer's staff and with our own staff to develop either the mark-up of the previous RFA, if we are doing a re-announcement or to develop a concept paper for a new program.

Then, we meet with Jennifer's staff, go over the issues. They gather the comments from all over the agency. We may resolve that either back and forth through meetings or we might do it through e-mail or memos, but it's a collaborative process and really, as Jennifer indicated, it really involves a tremendous amount of coordination all across SAMHSA to pull together the announcements.

We also work with Grant Review once the announcement -- even really before the announcement is published, we sit down with Grant Review and we talk with them about the particular issues in a program.

For example, in some programs, we will target the available money to several different categories of respondents, and we will talk about what the implications

are for the review and make sure that we are on the same page with them, so that when the review is completed and we get scores, we have what we need to be able to fund a program in the way that we said we were going to fund it in the announcement.

Of course, there is also the Advisory Council review, and you have all sort of had initiation to that today. After the grants have been reviewed, we develop funding plans. Again, we work with our program divisions to do that, to develop the recommendations that Dr. Clark makes to the Administrator for funding.

Hopefully, it all gets done before, I guess in these days it's September 1, August 31. So it's a lengthy process, it's a complicated process. It involves a lot of coordination and a lot of input both internal and external.

I guess I will stop there and leave some time for you all if you have questions.

MR. KOPANDA: I just want to thank both representatives. This is a very complicated process and I think OPBB, Jennifer, and her staff have done just a marvelous job of simplifying and standardizing many of

the procedures that go into this. They have been very helpful.

We occasionally complain about the level of comments, but it has been incredible. Also, George and his staff, Danielle, we can't speak highly enough about Danielle Johnson and the work she does in getting these RFAs out. It is just really incredible.

Comments? Ken.

MR. DeCERCHIO: Question. To what extent does past performance on a specific grant part of the application process? We review grants where there are new grants and there are competitive grants, but an applicant might have done that activity in the previous grant cycle, and yet I don't recall how they did on that previous grant cycle as part of either the scoring or a reference to that.

Is that not included or is it included and I am not aware of it?

MR. GILBERT: Past performance has been kind of a tricky issue. It is easier to deal with that in Contracts than it is in Grants. We have struggled with that issue off and on over the years, and it is really

difficult to try to build something into the review criteria that would allow you to award points or deduct points based on past performance.

Really, we sometimes have grants that, for various reasons, may be put on what we call the watch list. You know, they may have difficulties administering grants, and that is not a disqualifying factor.

So, you can't say, well, if this grantee is on a watch list, we are not going to give them award, because it doesn't necessarily mean that they are disqualified. It is just you need to work with them and provide PA and help them do whatever it is to take the corrective actions needed.

But it is just not really a factor that we can lay out there as a criteria for making grant awards.

MR. DeCERCHIO: I sit and review. For some reason, it is like, well, some of them are performance based, in other words, we are going to so many, whether it's accreditations or whatever it is, and yet there is nothing in the summary that says, well, yeah, we performed that way last time.

I know it's tricky. Do you have the

discretion, though, if there is a wonderful grant, but actual performance on the prior round fell far short to act accordingly?

DR. CLARK: We really don't or at least if we do, we don't exercise it. With respect to contract, there is a formal process of taking past performance into account. Within grants, as George mentioned, it is pretty much you have to treat each announcement and applications as they are.

If a reviewer happens to have particular knowledge, a reviewer might take that into account in terms of their scoring, but once they are scored, unless they have been designated high risk, in which case it's the organization that is designated high risk.

For example, consider a grantee like a State. The State, as an entity, may have not performed very well on one of its grants, but it may be an entirely different unit of the State that comes in with another grant application. We cannot take the action against the organization per se being a State or a county or any larger organization, university.

MS. FIEDELHOLTZ: One other thing that I did

want to add, I think George and Rich are absolutely correct, it has been very difficult. We have talked about it has been very difficult to figure out how we would do that fairly and objectively.

But when the RFA requires that you have experience in doing something, there are sections of the review criteria that ask you to document what you have done to show what you have accomplished, to show how you are building on it.

You know, we not only want to make sure that you are experienced in doing it, but that you are not going to duplicate the effort and use the money to do something you supposedly have already done, but that would have to be factored into the review criteria.

MR. GILBERT: Ken, performance very definitely figures into the administration of the awards once they are announced, and CSAT has created a very careful process to monitor grants and to review their progress annually through the Project Officer Review Board, thank you.

They look at the performance and they look at whether or not the grantee is meeting the targets that

they spelled out in their application, whether or not they are serving the number of clients they said they were going to be serving, looking at the data that comes back through our SAIS system, looking at how they are spending the money, et cetera, and then they make recommendations every year for the amount of continuation funding or whether or not a grantee should get any continuation funding.

You have to build a pretty strong case if you are going to yank somebody's award, but frequently, there are recommendations for funds to be -- I can't come up with the terminology, Rich -- we will offset an award if a grantee maybe has money that they haven't spent, we might say, well, okay, we are going to offset the next year's award, or we might say, you know, you need to come up with a corrective action plan and demonstrate to us before we make a decision what you are doing to meet these areas where you seem to be deficient, so we do have a pretty solid process in place to monitor performance during the award, during the administration of the grant.

MR. KOPANDA: I would just add very briefly that over the course of the last four years, five years,

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some period of time like that, as I think I mentioned yesterday, we are much more emphasizing performance and we are much more taking these kind of actions than we ever have in the past.

If you look at previous 15 to 20 years, we did very, very little with respect to grantee performance.

MR. DeCERCHIO: It just strikes me that in a narrow sense, in other words, doing the same activity they had done on a previous funding cycle, so it is not related, but it is the same organization doing the same activity, and they have a grant score.

It is like, well, how did they do the first time, did they meet, you know, and that that can have, in essence, no influence on the review process, not the management process, but the review process. In the era of performance, it just seems to be kind of a gap in connecting the dots.

DR. HOWELL: Just out of curiosity, what is the average number of RFAs that go out every year and how many applications do you get? I mean I know that is hard to say, because every year is going to be a little bit different.

MS. FIEDELHOLTZ: I can talk about RFAs, I am no sure I can talk about applications. I would say for the last three or four years we probably put it around 20 to 25 RFAs a year. This year it will be 31.

When I first started doing it, we were putting out more like 40. I think we are putting out RFAs for larger grants. The State infrastructure grants are a much larger amount of money than some of the previous discretionary grants were, and therefore there are fewer RFAs, but 25 to 30.

MR. GILBERT: We have I think 12 or 13 just in CSAT this year, and I don't know the exact number of applications. Danielle, do you remember what we got last year by any chance? How many?

MS. JOHNSON: 900.

MR. GILBERT: 900 applications. The number of applications that SAMHSA has received over the years has increased dramatically, and has contributed to sort of the stress at the end of the process of reviewing them and getting awards made, but there has been an enormous increase in the number of applications.

MR. KOPANDA: I might just add that it depends

on the nature of the RFAs, as well. Some of our RFAs are limited to tribes and States. The pool of applicants is smaller. We have some RFAs that even though they are not very large in terms of the number of grants we are going to award, we get hundreds and hundreds of applications from them.

MR. GILBERT: And you heard this morning some of the folks who talked saying how there were 140 applications for RCSP for eight awards or something.

DR. HOWELL: The other thing is occasionally, you will do a sole source, and how does that get determined if you do a sole source RFA?

MR. KOPANDA: Well, we need to justify internally, as well as through the Department, any sole source grant announcement or contract. It is always based on the fact that a single organization in the country is supposed to be the only one capable to do the work that we have embedded in that RFA.

It is usually published, grants are published, and any other organization that feels that they are equally capable of performing that work is eligible to come in and let us know that.

If they make a strong enough case, then, we have to open up the competition.

Frank.

DR. McCORRY: In October, we spoke about the possibility of CSAT spreading its grants over a year's time to allow for I think it was both better responses from people who write multiple grants, as well as perhaps increasing the possibility of on-site review with some other greater in-depth review than currently is practiced.

Any thoughts about any movement on trying to change the timelines on your grant announcements?

MR. GILBERT: I will just say something quickly. I mean when we plan the process for the year, we try to stage the announcements usually in three cohorts, those things that we know we are going to have to do, those things that we are likely to do, and then those things that most likely or could be affected by congressional action being the last ones we do, kind of the case of the best laid plans.

You know, you try to spread them out, but congressional action on the budget has been so late these

last couple of years, and there have been so many issues that have been kind of hanging up in the air, you have to kind of weigh the pros and cons of publishing an announcement early before congressional action in expectation that Congress is going to say yeah, we agree with that versus they are going to put something in there that is going to make you go back and change it or withdraw it and have people in the field having spent a lot of time and money developing applications that all of a sudden are just not appropriate anymore.

So, that is the kind of balancing test we do.

MR. KOPANDA: Just to add that that is what happened this year, and actually very likely happened last year, if you remember Dr. Clark's slide about the fact that we will have a continuing resolution, and that will just delay our ability to issue the announcements.

Also, this year we did see kind of a change in the way under the omnibus continuing resolution, the way we approached our announcements.

Rather than doing the programs all at the same level as they did in the previous year, which is pretty much the way we operated up until this year, we basically

looked at them and went ahead with some, and not others.

So, there was some policy decisions that happened kind of at the last minute that changed things, and had we actually issued some earlier, we would have had to actually retract them.

Anita.

MS. BERTRAND: Has the administration discussed how they could support community-based organizations? I know back in October, we talked about just trying to level the playing field for the organizations who may not be able to hire the best writers, but are in the trenches delivering services in the community versus the organizations that have top-notch writers from universities and things of that nature.

I was just wondering where you all stand and if you have talked about that at all.

MS. FIEDELHOLTZ: Well, I think there are two grant programs included in the President's budget that are targeted capacity expansion programs focused more on localities than on States. I think that is one thing we have talked about.

There are a variety of technical assistance

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manuals that are available on the web. In recent years, we haven't had the funding to go out and do a lot of in-the-field technical assistance going at writing. I don't know if CSAT has been able to do that this year or not.

Limited resources, but lots of applications coming in already. You know, how much do you encourage people to apply when the chances of getting a grant are about the same as getting into Harvard. So, it's a dilemma.

MR. KOPANDA: This issue came up during the SAMHSA National Advisory Council when they met just recently, not only the ability to compete, but the dedication of funds and the targeting of more service delivery of funds to smaller communities that have community-based services which are not able to compete, maybe not as eligible, or they can't identify as many evidence-based practices on our list or something, so the services are lost to the community.

That council has come up with a number of recommendations. I have the draft recommendations here, but they are only in draft form. Some of them deal with,

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for example, our NRAP program and how practices get on there and how representative they are of different communities and such.

So, we are taking a look at this, and we want to see if that might be an issue for us to consider, and also work with NIH, making sure that a wider variety of organizations and populations are included in the evidence-based practices.

We are also looking at the size of our awards and whether we might want to target some of our grant funds to smaller community-based organizations, but they are eligible for most of our grants other than the very large State grants.

MR. SUDBECK: This may be a silly question, but I have to ask it anyway. You don't limit the number of grants a State can get, do you? In other words, you don't limit the number of grants a region is eligible to obtain, do you?

MR. KOPANDA: No, not in any way. In some cases, we do try to encourage geographic diversity within a grant announcement, that is, they are not all clustered in one state or one coast, you know, but no, no formal

limits whatsoever.

We do sometimes give, if we are announcing, well, our TCE/HIV program, for example, the eligibility for that announcement for the grants that -- well, this year's announcement that went out soliciting new applications would limit eligibility to organizations that don't currently have a grant. We don't want to fund multiple grants in a series of years in one program. We really do want to try to spread out the funding as geographically dispersed as possible.

MR. SUDBECK: The reason I bring it up, I was approached several years ago by a grants writer who basically said, well, she had six of them funded already this year, six different grants that she had written for six different areas.

You know, that is fine and dandy, I think the person obviously needs the language and what to put in, but I think it goes back to Ken's piece. Now, you may have an excellent grant writer, somebody that can dot every i and cross every t, but it has nothing to do with the performance of the grant.

Just because you have somebody that can write a

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good show doesn't mean they can produce anything. I think that is an issue. You probably can't address it, but it is a concern, because soliciting drafts based on being able to write a grant is a good PR thing, but it has nothing to do with what that grant was able to produce.

MR. KOPANDA: We understand that is a problem and you are right in terms of the way our objective review process is conducted, we can't deal with it in that way, but we can deal with it through the performance side.

If they are awarded a grant and they can't deliver according to what they said they were going to do, you can take performance action. We have discussed some of them here.

We also have terminated in the last year or two, some of our grants, and we terminate when they really can't deliver. So, that is what we are going to have to continue to focus on.

MR. SUDBECK: I think that is helpful to point out that just because somebody is able to write something doesn't mean that money is tied up for five years while

whoever they wrote it for is trying to figure out how to do something.

MR. GILBERT: I might just say in terms of performance, one of the things that we have started incorporating in some of our grants is an incentive for high performing grantees. There are supplemental awards based on performance. It is in our ATR program, it is in our treatment drug court program.

Danielle, have we got it in anything else? Of course, the block grant proposal you heard about today, but I am talking discretionary grants. That really grew out of a conversation or a series of conversations that SAMHSA had with OMB a number of years ago where they were saying, you know, what are you doing to penalize grantees that aren't performing or to reward grantees that are performing.

It is almost easier to penalize than it is to reward, and I am not going to get into all the ins and outs of that, but we worked on it for a couple of years and we came up with a way to provide an incentive for high performers, and it is still kind of being piloted.

We incorporated initially in the Drug Treatment

Court program. Our experience was that we kind of set the bar too high in some areas, so we have revised it, we are trying it again.

MR. KOPANDA: If there are no more questions, I think we need to get a little bit back on schedule.

MR. SUDBECK: Just one quick question.

MR. KOPANDA: Sure.

MR. SUDBECK: Has the funding for Drug Courts been all transferred to SAMHSA? Does Justice do funding for Drug Courts at all now?

MR. KOPANDA: The funding has not been transferred to SAMHSA. Justice still has the Drug Court program.

MR. SUDBECK: They still have, but SAMHSA is expanding Drug Court?

MR. KOPANDA: Yes, the budget proposal although I understand that for the 2009 President's budget, the President did not request any new funds for the Justice program.

MR. SUDBECK: That is why I brought up the question, because I thought Justice was cut out.

MR. KOPANDA: They have continuations, but they

don't have any new funds recommended by the President for this year. By the process that we talked about, that is looking at our program, is also looking at the Justice program.

Thank you very much.

We next have Ivette Torres, who has a presentation on Recovery Month for this year.

Recovery Month

MS. TORRES: Good afternoon, if everybody is awake. I am going to plow through this, because we need to get back on track, and I have got some interesting areas that I want you to take a look at.

National Alcohol and Drug Addiction Recovery Month for 2008, the theme is Join the Voices for Recovery, Real People, Real Recovery. Of course, many of you know that we support the ONDCP goal of demand reduction, and we try to enhance the knowledge, improve understanding, and promote support for addiction treatment all over the country.

We might take that lightly and say yes, yes, yes, Recovery Month does that, but, indeed, when you start looking at communities and you start seeing what

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happens in September in many of the States and the type of events and activities that are generated and undertaken by community groups, by State SSAs, and by others, you really begin to understand that it is a significant part of getting the broader community, the business sector and everyone else to understand the importance of addiction treatment and hopefully, in turn, they will support it when it comes to their legislative process within the State, their municipality, or the broader national scope.

Our costs have not risen. If you take a look at from 2002 to 2007, we are still pretty much flat line, which really is a testament to the planning partners and the support that they provide. Anita Bertrand and Abe both participated in our planning process. If any of you are interested in joining us, our next meeting is going to be next week on the 27th, and we would love to have you. Like I always say, we never turn anyone away.

But it is important because I think both Abe and Anita sort of bring the link between the process of the Advisory Council to the broader, you know, groups that participate in Recovery Month, and when we are

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talking about being flat line and appearing in outyear budgets, I think, if you get my drift, I think it is tremendously important to have the link that we have with the Advisory Council.

The costs of Recovery Month, of course, we are still doing 75,000 kits, 10,000 posters, fliers, and 20,000 giveaways. We have got some beautiful, Rich, you will love it, some new name tags for travel coming up this year.

We still do public service announcements, we still do web casts and the community events, and we are still hosting three meetings a year. One of them, of course, in June, is done through teleconferencing because we felt that we needed to save people's time and resources.

Eight shows in 2008 airing in 50 States. We have grown since my report to you last year. We are up to 17.8 million households generating about \$10 million in free air time every year with the web cast show.

We are continuing our partnership with the National Cable Television Association, and they will be doing a public affairs kit to all of the cable television

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associations, the local community channels, and hopefully, that will continue to generate more people to come into our service.

I forgot to mention in that last slide, we are looking at the radio series. We are taking the audio from the television and we are turning it into 30-minute spots, and we will be doing it through cable TV, radio, and through broadcast radio because the National Association of Broadcasters is also interested in the radio show.

They are also, I forgot to put them on the slide, they are also very interested in continuing their efforts to distribute our public service announcements, which you will see in a minute. You are going to see the rough cuts for 2008.

The same thing with the number of stations airing us every year. As you know, we started in 2004, which is the 129, and we are up to 363 stations in 2007. According to PMAP, we have to grow by 10 percent, so that is our goal for 2008, is to grow it by 10 percent.

Number of households you can see increasingly, you know, roughly 2.8 million from last year, which I

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think is quite significant. There is the dollars on the free air time just for the Road to Recovery series.

These are the topics that we did this year. Join the voices for recovery, of course, we get everyone in February and March to get ready for Recovery Month and to go on line and begin to download whatever the theme is, the flyers, and so on, and so forth.

We did a show on Medication and Assisted Therapies, providing the whole patient approach to treatment, addiction and PTSD, combatting co-occurring disorders. We focused a little bit of that on the returning vets.

Recovery in the family, extending treatment to everyone, real people, real recovery, effectively delivering recovery-oriented systems of care. You are going to get a presentation on recovery-oriented systems of care, and we thought it would be very important for the broader community who is not in Illinois or Connecticut where some of these systems are already taking place, to really learn about it.

We had a really excellent show. Dr. Clark was on the show, and we had a very dynamic dialog about

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recovery-oriented systems of care.

Accessing prevention, treatment, and recovery on line. We wanted to do that particularly because a young population now, and we wanted to make sure that the general public knows about the access to on-line resources both for prevention and for direct services, accessing direct services.

We haven't taped that one yet. If any of you have a particular interest or knowledge in this particular area, let me know and I will put you on the panel.

Recovery in the United States, Past, Present and Future. That is really sort of like a policy look at everything that has happened, a sort of forward look in terms of where we think the field is going, and then the Road to Recovery 2008, a Showcase of Events. That is the wrap-up show and we take video and photographs from everybody all over the country who did events in 2008, and we show it in November.

We are not going to see the promo because I think many of you have seen it. Any of you want to see the promo? You saw it yesterday. Everyone has seen it?

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We will skip through that one.

Community Events. We are growing in the total number of SAMHSA-sponsored events, as well as the number of attendees to the SAMHSA-sponsored events. We are up to about almost 100,000 people and a total of about 108 events.

Now, mind you we contract out only for about 50 per year, and people get so excited that they are working and whatever, and then they do more events than what we contract for. So we are very pleased.

Number of community events nationwide, again, we are growing, 665 in 2006, and 767 in 2007.

This is what is interesting, is the number of organization that are involved. We want on line and we actually did a survey of -- we didn't survey -- we took a look at the number of people that were actually on line that had not been on there, so we did a graph and for every single event, going back to 2004, we wanted to know how many entrants were coming in every year that were new.

You are going to be very surprised. The percentage of new organizations per year coming in as

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participants of Recovery Month and putting their events on line, in 2007, you can see it is pretty consistent, hovering now around 70 percent of new.

We have to do another, further analysis and say okay, so what is happening to the old folks that used to do events, why are they not doing events, you know, are we getting new people because the old folks say, oh, my God, I did this Recovery Month last year and I am whipped, you know, let somebody else do it, which is something that, you know, we certainly hope that is not happening, or is it that they are creating coalitions within communities and people are taking turns at being the leaders of each one of the events, and they are taking turns each year, which is of course my theory.

The types of organizations that you can see, 78 percent are nonprofit, 5 percent are faith -- this is in 2006 -- 7 percent county, and 3 percent city. So, I would consider it a pretty health mix.

The most popular events that they are doing is, of course, the walks and the runs, health fairs, lunch or picnic or family celebrations, conferences and meeting. We are getting a lot of conferences, people are taking

advantage of Recovery Month to host recovery conferences and training sessions. They are posting it all on the web.

It is a phenomena that people, even when it is not a September event, people are coming onto the web and are actually listing activities within their community that are recovery oriented.

We are this year collaborating with Sharon Amatetti. You heard this morning about the women's conference, and they will be hosting it during Recovery Month, and we are going to be having a Recovery Month event during that conference, so that we are listing it, it is right on our web page, and hopefully, many people will take advantage of linking to that activity through Recovery Month.

Types of organizations in 2007. As you can see, we have grown a little bit in the federal, State, and county, grew in the faith area, and the nonprofit sector pretty much remaining around 75 percent.

The types of events haven't changed much. They are still pretty much the same list that you saw the year before. Proclamations, we are not at 100 percent, so we

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have May presentations through NASADAD, and we are going to be talking to the SSAs in August, and hopefully, this year we are going to get 50 States to issue 50 proclamations. That is my hope.

This is our new website, www.recoverymonth.gov. I urge you, if you have not gone to the website, just to go, because it has got some great information. We will be having challenges, and I have to say this because if things start happening and people start saying well, you are not posting my event immediately, I have to wait two weeks, you know, or whatever.

We are going to be in a transition mode this year between vendors of the web. That last time that happened, it happened fairly seamless, and we are hoping that the same thing happens this year.

The number of hits have grown tremendously. We still are getting more and more people. We are having a meeting with Daphne Vale from TASC to take a look at -- and that will happen this coming Thursday -- to take a look at all the new technologies and how we can actually expand and broaden into groups and electronic systems and marketing opportunities that we haven't looked into yet.

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I think it is important, I mean My Facebook, You Tube, and take a look at all those site sectors and say okay, so how can we generate interest, how can we get in there, even in Wikipedia, you know, I am going to go to Wikipedia, I am going to make them list Recovery Month, so if people go to Wikipedia and they look up Recovery Month, it is going to pop out, so look for that feature forthcoming.

It is all in the interest of really keeping up with the younger sector and keeping up with the technologies that are emerging and making sure that we are making the best use of them.

The public service announcements, we have two television and radio, and I am going to go to them. Lock and Key is the first new one for this year, and I am reminding you that these are rough cuts. These are not the voices that we are going to see, and not the complete imagery, but you are going to get almost a complete PSA.

[Video shown.]

MS. TORRES: Okay. That is one comment. The second one is Butterfly.

[Video shown.]

MS. TORRES: Those are our two public service announcements, and we have been very lucky. Every year the stations are waiting for our two treatments. We do them in Spanish and in English. The challenge for 2008, of course, is that everybody is buying up time for the election, and we are going to have one heck of a time trying to place free ads, but we are still very lucky, even four years ago, it was not a total catastrophe for us, let's put it that way.

Why? Because we are still playing them during the cable shows that we do, and some of these shows that we are doing on cable are running, you know, maybe 10 to 12 times a month, so we are still getting played, but what we want to get played really is during broadcast prime time as well as cable.

So, we are hoping for the best, folks. I am not making any promises on the PMAP on that one.

MR. DeCERCHIO: Do you rely totally, for what you just said, on donated public service announcements?

MS. TORRES: Yes, we do not buy air time. That would be ONDCP with their millions, but we do very well.

I mean really we do extremely well. We have talked to

the Ad Council, I have gone to some AD Council meetings and people are raising their hands and saying well, we are getting placements in for free and blah-blah-blah, so I am sitting there in the back, and particularly when they are talking about the length of time that people are on the web, you know, looking at the web.

We average 21.2 minutes per visit as an average, which is absolutely unheard of, and why. Before we started distributing the programs, people were coming on line and watching for like an hour until the show was over, and now we are back down.

Since we started cable, of course, a lot of people view it on cable, and they don't go on line to view the show, so we are back down to about I want to say 14 or 15 minutes average per visit, which is still very good.

People see it there. They see it on line, they see it everywhere else, and that is really all the distribution channels that we use.

The PSAs for previous use are still in rotation, which is another thing I wanted to say. NAB, National Association of Broadcasters, keeps sending them

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out, and we keep making money on them, on free air time.

This year they will be doing a kit, and they will be distributing it to all of the broadcast stations about Recovery Month.

They take our Recovery Month kit and they turn it into a kit for broadcasters. I don't know how to capture all this. I mean the results of what we get in exposure and everything else through the NAB collaboration, it is really hard for us still, and that is something we are going to be looking at next Thursday, too, is how can we really get the numbers from this particular activity to add to the already great results that we are providing you today with, so we will see what happens.

The National Help Line 1-800-662-HELP is a result of the PSAs, of the web casts, and of everything else that we do. It is still getting about 28,500 average calls per month for 2007.

As you can see, we have grown considerably from the 22,000 we started with in 2002, when we started getting the numbers. The awards are many. I wanted to tell you closing about two new campaigns.

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This one is talking to parents and teenagers about medicine and abuse. We are doing this with NCPIE, National Council of Patient Information and Education, and it is a very inexpensive campaign.

NCPIE has done a great job. I want to take a moment, if I can. Do I still have a few seconds? All right. I want to show you, hopefully it will come up, technology willing. Cannot open the specific file. Nope, I didn't see it up there. I will show it to you next time, how's that?

Again, our web page, our 1-800-662-HELP is there. I want to say something else in closing. We are trying very hard, as Dr. Clark mentioned this morning, we really have not engaged the civic center, you know, sort of like the Lion's Clubs. He mentioned the Daughters of the American Revolution. I don't know what kind of an inroad I am going to be able to make there, but certainly the volunteer organizations, certainly the civic organizations, and we are going to be looking at this year, at really beginning to make a list of at least five major ones, and going after them, you know, nontraditional groups to join the Recovery Month effort,

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because, you know, I think that will certainly help us, certainly Teen Challenge has been an incredible partner for us, and we hope to continue our collaboration with them, but there are other organizations that we need to bring in and hopefully, with your help, we will be able to do that.

Thank you.

MR. KOPANDA: Thank you, Yvette. I have to say that Yvette has a staff of two people, Carol DeForce and Michelle Monroe, and the three of them are pretty much responsible for all our consumer affairs, consumer education activities.

MS. TORRES: And Abraham Reese.

MR. KOPANDA: What?

MS. TORRES: Abraham.

MR. KOPANDA: Oh, and Abraham. It is just amazing the creativity, the energy, the enthusiasm they bring to this. Without them, I just can't see how this Recovery Month would come off the way it does involve this many organizations. It is really a nationwide effort here, and the three of them are the heart and soul behind it. So, thank you very much.

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[Applause.]

MR. DeCERCHIO: Excellent, really. This has grown over the years, you know, all the numbers, all the bar graphs are going up.

To what extent are the anti-drug coalitions kind of the target, at least one target of the outreach in terms of kits or whatever, or through CSAT, there are a lot of coalitions that have expanded beyond, quote, unquote, "community prevention activities?"

MS. TORRES: Well we have been very involved with CADCA, of course. They are our planning partners. PDFFA is also, as a matter of fact, they are coming in next week to do a presentation. We are trying to really get more engagement from the prevention side, and they have been there, but, you know, every time that we get them at the meetings, we say, you know, you guys really went through because of the coalitions, it would be really great if they took it on.

Many of them have. Can I say that all of them are engaged? At this point, no, but that is our hope.

MR. KOPANDA: Any other questions?

Thank you. We are a little bit behind, but not

too far. We have with us Shannon Taitt from our OPAC office and Cathy Nugent from our Division of Services Improvement. They are going to discuss something we have talked about a little bit here, Recovery Oriented Systems of Care.

Overview-Recovery Oriented Systems of Care

MS. NUGENT: Good afternoon. Shannon and I are going to sort of do a duet this afternoon, so I am delighted to start off. I wanted to begin with just a little caveat by saying that the framework we are going to be presenting this afternoon is very much an iterative ongoing evolving framework.

It is something that CSAT has been working on with our grantees, with others in the field, with our staff here in CSAT, and we are really happy to be able to talk about it with you this afternoon, and we will be welcoming your input and ideas, as well.

The second thing I wanted to say just as an opening comment is I don't think we could have gotten a better preamble this morning than we did from members of the Council themselves.

When we went around in the opening go-around

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when Dr. Clark invited people to make some comments, Ms. Bertrand talked about putting people in recovery at the center of the work that we do in CSAT and in the field, and clearly, that is a concept that you are going to hear sustained throughout our discussion of recovery-oriented systems of care.

Dr. McCorry talked about the innovative introduction of recovery centers in New York and how those are being introduced as part of a paradigm shift in the way that services are organized and delivered in New York, and that is another kind of concept that you will hear woven through our remarks this afternoon.

Mr. DeCerchio talked about a wonderful integration between the substance abuse and the child welfare system. So, again, you have got some foreshadowings of the framework that Shannon and I are going to be talking about with you this afternoon, and I thank you for those comments that really helped set the groundwork.

What we would like to do this afternoon is introduce the Advisory Council to the evolving ROSC framework that we have been developing here in CSAT,

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describe some of the particular activities and initiatives that are supporting our work around recovery-oriented systems of care, and then have some time for your questions and comments.

So, recovery is really at the heart of everything that we do at SAMHSA, because our vision is about facilitating recovery and finding a place, a life in the community for everyone, and enhancing the systems of care for those who want and need substance use services is central, as well, to CSAT's mission.

In going about that work of helping everyone find their place in their life in the community, we face a number of critical challenges.

Dr. Clark's slide this morning, the Big Red Slice, brought into sharp contrast or awareness the fact that there are 22 million people who meet the DSM criteria for substance use, dependence or abuse, that are not receiving treatment for a variety of reasons, when we know that our systems of care are woefully underfunded, and that we need to be sure that what we are doing is effective and that it is based on sound research, a research base or a practice base, and that it is

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culturally appropriate.

We are facing a critical shortage in the work force and we have an urgent need for recruitment and retention as people are aging out of the work force, and finally, I think one of the important contributions among many that Dr. Cline has brought to our agency is to help us reground what we do in a public health approach, and we believe that this ROSC model operationalizes the public health framework when working with substance use, conditions, and disorders.

The approach is population based, comprehensive, and holistic. It looks at the whole continuum from intervention through treatment, through recovery support and health promotion. It recognizes the need to work across systems and professions.

Critically important, it involves people in recovery and the community and the public and private sectors, and it is evidence based.

MS. TAITT: From there you could see how did we get to this point with recovery-oriented systems of care.

In 2005, there was a national summit held where guiding principles of recovery and elements of recovery-oriented

systems of care were developed and recommendations for advancing recovery-oriented systems of care emerged from the summit, and it was the first time that there was really a broad-based consensus on what these principles should be.

So, from there, a report was developed and an opportunity for multiple stakeholders to get together. Over 100 stakeholders had an opportunity to discuss this framework and what they would like to see in it.

Those stakeholders came from mutual aid groups, recovering individuals themselves, family members, and federal agents and also treatment providers.

Out of this summit came a working definition of recovery, and you will see there 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.

That was one of the major components of the summit and very proud that that came out of the summit, as well.

Another area that came out of the summit was a definition of recovery-oriented systems of care, and this

is a person-centered and self-directed approach to care that builds on the strengths and resilience of individuals, families, and communities to sustain personal responsibility, health, wellness, and recovery from alcohol and drug problems.

This definition of recovery-oriented systems of care supports the goals of the summit, and there are three goals that I wanted to highlight were the development of new ideas that would transform policy over time and that there was developing guiding principles to be used across programs, services, and systems, and also to generate ideas for advancing recovery-oriented systems of care in various settings.

So that is now the paradigm shift that we are in, the recovery-oriented systems of care shift, and what we are shifting to is a question from how do you get the client into treatment, to now we are saying how do we support the process of recovery within the person's environment.

Recovery-oriented systems of care support person-centered and self-directed approaches to care that builds on the strength and resilience of individuals. It

also offers a comprehensive menu and services of supports that can be combined and readily adjusted to meet the individual needs to those chosen pathways to recovery.

The recovery-oriented systems of care model also encompasses and coordinates the operations of multiple systems, providing responsive outcomes-driven approaches to care, and require an ongoing process of systems improvement as Cathy had mentioned earlier, that incorporate the experiences of those in recovery and their family members.

So now Cathy will take this opportunity to walk you through this, for what we are calling here at CSAT, the ROSC Cascade. This will give you more of a schematic approach to what we are talking about and break it down a little further for your understanding.

MS. NUGENT: What I am going to basically do are take all the words and put some pictures with it, and I have to laugh a little bit because once at a recent presentation, we presented the verbal definitions and then Dr. Clark did the slides that showed this graphically, and the folks in the audience said oh, no, we don't like the words, we like the part that Dr. Clark

did. In fact, it is really the same thing, but for those of you who are visual learners, hopefully, this part will help a little bit.

In the first slide that you have in your handout and that is up here on the PowerPoint, I would just like to point out a couple of important things that I think are the critical elements of this slide.

First of all, the individual, the family, and the community are at the center of this picture. We know that along with the individual, the family and the community suffer with addiction, and likewise, the individual, the family, and the community all benefit from recovery, so we are placing the individual and the family and the community at the heart of this recovery-oriented system of care.

The other thing I would like to highlight is the idea of bringing strengths and resources into the picture. We see a recovery-oriented system of care as really building on the strengths that exist within the person, within the family, within the community, and we also look at the idea of an individualized and self-directed approach, so that it is really the person

in recovery who is choosing the route, the path to recovery that they want to take and that we are helping them to build a system of services and supports around their chosen path.

Finally, I wanted to highlight that what we want, the outcomes that we are looking for, for the individual family and community, go beyond the remediation of symptoms or the absence of problems and really move toward holistic health, not just abstinence, but also health and wellness.

So, in order to achieve abstinence, health, wellness, recovery, the individual needs a variety of services and supports, and they need to be a mix of services that will help the person with their chosen path to recovery.

I wanted to mention that there are a wide array of services and support that can be important in the process and that in no way are we devaluing formal addiction treatment, Millions of people have been helped by formal addiction treatment, and that is clearly something that we embrace and support, but we are talking about adding other pieces that can support and complement

the formal route to treatment.

I also wanted to mention that within a ROSC model, we see peer-to-peer recovery supports as bringing in a particular value added.

So, to provide an array of services, many different systems need to be involved, and there is a need for collaboration and integration among those different systems, and we have listed some of the systems that a person in recovery and their family may engage with as they are moving throughout the process of recovery.

In the next slide, we are saying what are the outcomes that we expect to derive from a recovery-oriented system of care, and we are starting with the national outcome measures that we use in all of CSAT's grant programs, and those are where we are starting. As we continue to evolve this framework, we anticipate that there may be other measures that we want to add to the picture, but we know these are a good start.

Finally, we see a ROSC requiring an ongoing process that allows us to reflect on and to examine

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closely what we are doing, and to enhance the quality, and this involves eliciting the person in recovery and the family members' perceptions of care and having a continuous feedback loop, so that we can continue to enhance the quality of the ongoing system.

MS. TAITT: So, based on that, what are the benefits of recovery-oriented systems of care? Increased responsiveness to individuals, families, and communities. Not all principles apply to all people, and either in your packet for the Council members, or on the back table, you have a few handouts that will go a little further into some of the guiding principles and some of the elements of recovery-oriented systems of care, and you will see the working definition of both of those on the back table or in your packet.

Another area is also what is going on with research in recovery-oriented systems of care, so that is another handout that I would like you to take a look at in more detail when you have time, to talk about the different strategies that we would like to discuss, how outcomes can be improved as we improve upon the outcomes with recovery-oriented systems of care.

Also, another major component here for us at CSAT is the involvement in the systems change movement that is occurring not only here at the federal level, but also at the State and local level.

The last handout that I will refer to is the Lessons Learned from CSAT's regional recovery meetings. These meetings took place over the last maybe 15 months or so across 49 States. We had about 220 individuals that participated in this recovery meeting, and we had an opportunity for States to develop their plan.

Ms. Bertrand was one of the people from her region that attended and was on a State team there, so this is another handout that can get a little more detail for you on what the States are seeing and what they are saying about recovery-oriented systems of care.

Responsiveness to individuals and families. We know that there are many pathways to recovery, but our current system isn't as person-centered as it should be, and so if you look at this slide, we are going to give you some ideas here on what we think the shift should look like and what needs to occur with the change in the paradigm.

In ROSCs, treatment is viewed as one of the many critical resources needed for clients' success, integration into the community. Various supports work in harmony with the clients' direction. Systems and policies are established that provide client options and the ability to make informed decisions regarding their care, and that is very important being able to have buy-in from the client for their own direction of where their care is going, and measures of satisfaction are collected routinely and in a timely fashion from people in recovery and their families.

Again, these are some areas that we say should be happening if you are developing and implementing a recovery-oriented system of care. Each State, however, needs to develop their own needs assessment to determine what they need, because any models that are out there, any States that we talk about on a continuous basis are just wonderful approaches that we like to highlight because they really grasp this concept and run with it, and have had some great successes, but we are not all there yet, and we want to make sure that everyone is able to look at their own regulations, their competencies, and

also strategic plan what they would like to do with the system change.

Factors contributing to the shift towards recovery-oriented systems of care, there is many factors, but some that we would like to highlight today are growth and recovery communities, the fact that people in recovery have an opportunity to network with each other and to build their own advocacy groups, to be able to support the importance of having family members and people in recovery at the table when decisions are being made, emergence of recovery advocacy, advances in science and technology, just a different way of doing things, being able to use the technology that we have, and with the programs that Cathy will highlight momentarily here at CSAT, what we are trying to also promote here to make sure that people are getting the best treatment and therefore able to stay in long-term recovery.

The Institute of Medicine Report that gives some other details about the information necessary to bring different and multiple systems together to support this area and approach, focus on collaboration and accountability, and also federal and State initiatives.

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Now Cathy will give you some of those initiatives that we are working on here at CSAT.

MS. NUGENT: We have many programs. All of our programs are really supporting recovery, but we have several that have focused in a very specific way on recovery, the recovery community, and recovery-oriented activities, and I wanted to just highlight a few of them.

Ivette has already talked in great detail about Recovery Month. This is I think, what, our 14th year? 18th year. This is clearly something that has been building for years in the field, and I wanted to say again that I see CSAT's role as both reflecting and shaping what is happening in the field.

The recovery community's services program began in 1998 and clearly has been an important player in helping to move the field to embrace this recovery paradigm. The Access to Recovery Program, which started a few years ago, has brought the faith-based and the community-based recovery support services to the fore, and has clearly put the clients in the driver's seat with the vouchers in the area of client choice, and the Partners for Recovery Initiative has just had multiple

activities that are very much supporting recovery.

So, to say a little bit about some specific activities that are current and ongoing, I first wanted to mention that in January of 2008, Dr. Clark established a CSAT cross-cutting work group on recovery and recovery-oriented system of care.

Prior to the formal establishment of that work group, there was an ad hoc group that just developed organically here in CSAT of people who were very interested in recovery and wanted to promote recovery ideas and also wanted to promote collaboration across CSAT units.

Dr. Clark has really supported this work and established it as a formal work group recently, so we are very excited about moving the work forward. Along those lines, the framework that we have talked about today with you was just presented last Friday to all of CSAT staff. Dr. Clark held an all-hands meeting.

We had CSAT staff come. Dr. Clark presented the framework and then we had about an hour of small group discussions where CSAT staff members really grappled with some of the ideas in the framework, gave us

many things to think about as we refine it and move it forward, so it was a preliminary conversation that was very conceptual and stimulating and thoughtful.

We are going to follow that one large all-hands meeting up with some smaller sessions that the work group members will be having with CSAT staff organized by branches, so that we can really look more specifically and in more detail at how this framework plays out in different grant programs and grant portfolios.

There may be some issues or refinements that need to be made, so we are looking forward to having those kinds of discussions.

I wanted to mention Shannon had alluded to the five regional meetings that were put in by Partners for Recovery. These were really valuable opportunities for State teams to come together and look at some beginning strategic planning for how they can move to a recovery-oriented approach in their State.

Partners for Recovery has put out a number of papers on ROSCs and another unit in CSAT also developed a paper on recovery support services. The Recovery Community Services Program has done a report looking at

what are indicators of a good, sound, solid, peer recovery support program, and they came up with 12 indicators.

So, I think that is a very valuable tool that is available to the field, and we have a toolkit that is currently under development that is going to be an on-line toolkit that will be available for various audiences to use, and it is going to include policies, administrative rules, strategic plans.

There will be a very specific module that is going to look at infrastructure issues, such as regulatory issues, financing issues, quality assurance issues. The goal for this toolkit is that it would be very hands-on with lots of practical tools, models, case histories, lessons learned. We are envisioning this as something that people will really be able to take and use in a very practical sense.

We are working on a recovery self-assessment, and our vision for this at this point is there may actually be a couple of different tools. One would be for States and the other would be for organizations, and it would be a tool that would allow States to look at the

extent to which they are incorporating some of the elements of a recovery-oriented system of care, and our idea is that where they may see that they need to learn something or there is a gap between where they are and where they would like to be, they would be directed to technical assistance resources that could help them with that.

So, for example, if one of the items asked them about their competence in doing a recovery plan and they felt like they didn't have strength in that, they may be directed to a web-based tool that would give them examples and perhaps prompt them through that process.

I also wanted to mention that the Northeast ATTC with funding from CSAT and some additional funding is putting on a large meeting -- well, it's a medium-sized meeting -- about 150 people will be coming, and we are excited about the fact that representatives of some of the research institutes, NIDA and NIAAA, will be there, and the idea is a half-day will be focused on beginning to set a research agenda saying what do we need to know about recovery and how people recover, and the trajectory of recovery.

The second day will be more of a policy and practice meeting to really look at what States and providers need to do to begin to move toward recovery-oriented systems.

MS. TAITT: So, great. Now that you have heard just a general overview from us from recovery-oriented systems of care, we would like to give you some additional SAMHSA and CSAT resources.

Of course, you can go to the websites that are listed here that will give more information and detail about recovery-oriented systems of care and programs and services that support this approach, and also on the Partners for Recovery Initiative, I guess I have got to put in a little plug for that.

I can also give you some background documents that will help you. The summit document is actually located on the Partners for Recovery website, and we are also in the process of getting the white papers cleared that help support the regional meetings that we had, so that you will be able to look at those and see the case studies on State and local levels, some of the ATR programs, and also some other areas as far as the

research goes.

Here are some other CSAT recovery resources that will be helpful for you as you look into this a little further and need more explanation for some of the things that we sort of rushed through today to get you kind of in the mind-set of what is going on with recovery-oriented systems of care.

So, at this time, I just wanted to give many thanks to all of the people here in SAMHSA and CSAT more specifically that have supported this effort and really have help with the ongoing development of the ROSC framework.

I also wanted to thank any of you. I know that Mr. McCorry is on the Partners for Recovery Steering Committee and some others of you that have given information to us on how we can refine this and improve this for the field. So, I just wanted to thank you and the many stakeholders that have taken part in this.

At this time, we are just going to see if there is any general questions that you may have.

Council Discussion

MR. KOPANDA: Thank you, Cathy and Shannon.

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Before we get to the questions, I just want to mention that one additional activity we have going on is we have awarded some grants for recovery-oriented systems of care. I think we awarded five last year and we have an open announcement right now for under our targeted capacity expansion program for just a few more recovery-oriented systems of care grants.

These grants would involve more or less you might think of a hub organization coordinating a system, small or large, of recovery services in that area.

So, thank you. Questions. Ken.

MR. DeCERCHIO: The recovery self-assessment, is that an instrument per se or a series of probes, and what level is that? I am a little bit familiar with -- I forget, I always call it the ROSIE or the ROSI in terms of recovery-oriented systems inventory in mental health.

I am just wondering is there something similar to that, that communities or providers could be looking at their own systems to determine how recovery-oriented they are.

MS. NUGENT: Yes, I think it is going to be something similar to that. It will be a sort of

inventory that you will kind of walk through and what it will do is kind of operationalize the elements of a recovery-oriented system of care that we identified through the summit.

MR. DeCERCHIO: What is the time frame for that being available to communities or providers or States?

MS. NUGENT: Well, I am hopeful that may be in the next six month.

MR. KOPANDA: Anita.

MS. BERTRAND: The event that the ATTC is hosting, is that information going to be available after the 1st and the 2nd of May? That is one question. Then, the toolkit availability.

MS. NUGENT: Okay. I guess I will say that I know the May 1st and 2nd meeting, because they are pretty limited in space, it is primarily invitational, but they do have information about it on the Northeast ATTC website, which I would be happy to get to you.

I can tell you if you go to www.nattc.org and then just click on Pennsylvania, that will get you right to the Northeast ATTC, and you can check and see whether they still have space available.

MS. TAITT: And in addition to that, with the toolkit, again, we are hoping within the next six months that the toolkit will be available. We are going to try to pilot some of this information at the State grantee meeting that will take place this summer.

For those of you that had an opportunity to participate in the regional meetings where we started the State dialog where we started developing State recovery-oriented systems of care plans, that this will be a follow-up that we promised, the TA opportunity for you to really be able to look at the different components of recovery-oriented systems of care and see which ones fit for your State, for your organization, or your program.

So, really stay tuned within the next six months to see what we are coming up with. We are also planning some additional stakeholder meetings with federal level people, with other community and faith-based organizations, so that we can really hear from every angle on what we need to do to improve the systems overall.

MR. KOPANDA: Frank.

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DR. McCORRY: The white papers, they are not available yet, is that what I heard, Shannon?

MS. TAITT: The white papers are in the clearance process, and hopefully, they will be available soon. We did have a draft available that people could see at one time, but since we are in the middle of the process right now, we are hoping in the next month or so that those will be available.

They will be available on the Partners for Recovery website. We are not doing any hardcopy distribution of it. It will all be web based.

DR. McCORRY: Second question. In terms of services and support in your graphic here, I see you mentioned spiritual, number 13 slide, spiritual and peer support, but you don't mention mutual aid or Twelve Step, I was wondering, since peer support really is in Twelve Step and spiritual isn't necessarily Twelve Step, I was wondering if that was a conscious decision to not use that as a service in support.

The second question related to that, I see alcohol and drug services. It doesn't specifically mention treatment. I was wondering if that was a

conscious, you know, like it was important to say it that way for some reason.

MS. NUGENT: The reason that we said alcohol and drug services is because we were trying to convey the idea that it would include prevention, intervention, treatment, recovery support, the full gamut. That was the thinking there.

MS. TAITT: And that was intentional.

DR. McCORRY: And that would include medication, as well?

MS. NUGENT: Yes, it would. One of the thoughts that we have had about this is that as we refine it, we may want to even do pop-ups on some of these particular segments. I think it would be really good to make explicit some of the points that you are making, so I thank you for that.

DR. McCORRY: I think particularly for that, I think since that is such a broad range, it would be great to have some kind of drop-down or pop-up kind of capacity, to be able to point to some of the elements within it.

MS. NUGENT: Also, to really explicate the idea

that we do include medication-assisted treatment and recovery as one of the paths.

DR. McCORRY: But not mutual aid or Twelve Step as a separate --

MS. NUGENT: There was no conscious decision on that. I think we thought that the peer support again was a very broad category that covered it, but I hear you and we may want to really pull out Twelve Step and mutual aid.

DR. McCORRY: I think given its role in this field, and peer support can be something, because more recovery coaches, and Walter was talking today, it's a different kind of role than the Twelve -- it doesn't necessarily work in the Twelve-Step framework.

MS. NUGENT: Correct.

DR. McCORRY: In the peer support. So, given the role of AA and those kind of mutual aid kinds of processes, it is probably worth listing as a distinct service in the recovery paradigm.

MS. TAITT: And as we move forward with the toolkit and the resources that are available for that, we will take those little sections and be able to explain

how they are integrated into the systems, and what other systems might need to be brought in, that we just couldn't fit in this poor little circle here.

So, we definitely understand that and are looking at those as we develop the narrative concept, as well.

MS. NUGENT: Thank you for that, though. I think it's an oversight that we need to fix.

MR. SUDBECK: Are these the programs we were talking about being reduced in FY '08 and FY '09 this morning?

MR. KOPANDA: Yes, well, the new funds for RCSP have been eliminated from 2008, and the entire program has been eliminated in 2009. With respect to the other, the recovery-oriented system of care grant under targeted capacity expansion, that program has not been eliminated, but there are no new funds in 2009 to do anything other than HIV/AIDS, I guess we have TCE in 2009.

MR. GILBERT: As Rich mentioned, we did recovery-oriented system of care last year in the TCE announcement, and this year we didn't anticipate that we were going to have enough money in TCE to do it again,

but the budget process was really pretty convoluted this year, and it was an interesting negotiation, shall we say, once the budget actually came through, because Congress changed the priorities, and we engaged in negotiation with the Department and OMB about what we were going to be able to fund and what we weren't given the congressional direction.

We wound up having more money in targeted capacity expansion that we thought we were going to have, and less than we want for RCSP. So, the recovery-oriented system of care component of the TCE grant this year really was a way for us to try to provide an opportunity for current or expiring RCSP grantees and other organizations, community-based organizations, to have a way to address recovery issues within their communities, because we couldn't do it through RCSP.

MR. SUDBECK: So it's being done through the treatment capacity expansion grants?

MR. GILBERT: Yes, and that is something I think the field hasn't totally picked up on.

MR. SUDBECK: I don't think so.

MR. GILBERT: It was a tradeoff. I don't want

to go into all the ins and outs of it here.

MR. KOPANDA: It also relates to the discussion we had earlier about Council recommendations when we get to the roundtable, which may impact us or we may be able to take into consideration when things like this happen, if they happen next year, and it turns out that we are not doing some things and we have funds to dedicate elsewhere.

The elsewhere is something we can have some flexibility as to where to put those monies.

DR. McCORRY: I want to be clear, Rich, in terms of what Pat Taylor suggested, this 2.5 million, asking for resolution from the Council in '08 to be able to fund more RCSP projects, and you saying that there is no money for RCSP, but there is money for RCSP-like structures under TCE, projects that are currently on the street, but there is still a window for people to apply for that, is that correct?

MR. KOPANDA: That's correct.

MR. GILBERT: What happened is that, you know, very briefly, the congressional language, the report language was very specific about certain programs and

certain funding limits that they expected us to do, and certain programs that they expected us to cut back, et cetera.

RCSP was not one of the programs that was specifically mentioned by the Congress in the final appropriation and language, whereas, things like Drug Courts and SBIRT were, so funds, even though money was restored, funds go shifted from some priorities to others.

There was not request in the budget, the President's budget, to do new RCSP programs in 2008, only to do continuations, and in the discussions with OMB after the appropriations, that was an area where they did not want us to do new programming. Although we wanted to do it, they said no.

So, we wound up having to not do programs in some areas, but then we had other money, new money that we had, and we put it into targeted capacity expansion, because that's a place where we could put it, where we had flexibility to put it.

DR. McCORRY: So what would be available, then, George, this year, and time frame for submission, what

would be available under TCE that could be an RCSP submission?

MR. GILBERT: I think \$3.5 million under TCE general for recovery-oriented systems of care applications.

MR. KOPANDA: 7 or 8 grants.

DR. McCORRY: And when are they due?

MR. GILBERT: Somebody said 8 out here.

MS. TAITT: April 11th. We will check on that and get that information.

MR. GILBERT: Hold on just a second. It's right here, it's right in the report. I forgot I had this. 3.5 million, up to 8 awards. The program was announced on the 14th of February. The applications are due on April 18th, so it's about a month away.

MS. BERTRAND: When I guess the RCSP, it was announced that it would not be announced, I received a lot of phone calls from people in recovery and different individuals about their concern regarding that, and one of the things that I heard is that the concern is that they want to make sure that the peer recovery support services remains funded as much as it can be, because

sometimes what happens when we change things is that we open the door for other entities to be able to apply.

That's okay, but the peerness is I think what they are really concerned about making sure that it's very clear that individuals in recovery are designing and delivering the services, because when we look at the number of labor volunteer hours that individuals in recovery give back, it offsets a larger budget that we have here.

That would be something I would be interested in looking at measuring, what is the impact of the volunteer hours that the Clubhouse and other places is providing and how much economically is that saving our system.

I do want to say that, you know, from what I was hearing, because I even said, well, you know, ATR, and they said no, don't get confused about ATR, because in Ohio, ATR has taken the peerness out of peer services and it is open to individuals.

To be honest with you, organizations like mine is not involved in ATR in Ohio, so that is a concern.

MR. KOPANDA: You raise an important point.

Recovery-oriented systems of care grants are not RCSP. They don't have a requirement that there be peer services involved. They are intended to establish a system rather than support just a single organization providing recovery support services.

So, in that sense, they are different. As George mentioned, the situation was that we were attempting to implement as much as we can the administration's priorities, and it was not included in the President's budget, and it was not specifically identified by Congress RCSP as a program to continue.

We moved the funds to recovery-oriented systems of care. It is something we had done before, so we had some history with the grant announcement. We were able to do it.

MR. GILBERT: I will just say I think the field did a really marvelous job in terms of letting Congress know what the needs and concerns were. I think that earlier on, when the discussions were going on, we were looking on a process where we faced probably getting an appropriation without too much language in it directing us what to do.

I think the field really did do a good job of educating Congress about what the concerns were and what the needs were, and as a result of that report language we got was far more specific, but there were obviously some areas where things just didn't get picked up, and this is one of them, so we are where we are as a result of that.

MR. KOPANDA: Yes, Frank.

DR. MCCORRY: I just wanted to review it one more time to make sure I understand it correctly, that the 3.5 million for ROSC projects can include RCSP submissions.

MR. KOPANDA: That's correct.

MR. GILBERT: It can certainly include submissions by RCSP organizations, and it can include peer-led, peer-driven recovery support services, but they need to address, as Rich has been saying, the underlying notion here of working to establish a broader kind of a recovery-oriented approach to the system within the community.

MR. KOPANDA: Gib.

MR. SUDBECK: I think that is a pretty novel

idea. I congratulate you. But I think you also need to look at some of the information that put out. Treatment capacity expansion, the intent of it was to expand treatment.

Looking at some of the information put out on the RCSP or ROSC, they distinctly say, and this also goes to the issue of AA and NA, you are going to get pushed back on it, because we did something similar in a State where we hired mentors to work with recovering people, and the AA and NA community went nuclear.

But anyway, as you look at this, the fact sheets put out, Alcoholics Anonymous, Narcotics Anonymous, and other neutral support groups, professional inpatient and outpatient treatment are not recovery support services.

So I think once you get into working with the recovery community as an entity, they don't like this idea. At least in the Midwest, they didn't originally, it took us five years to get people from clubs to finally come forward and consent to work with us.

So, just a caution as you get into this, the literature cuts them out as you are not part of this,

okay, and in reality, I think they feel offended in some ways in the recovery community. So, that is my intake from South Dakota.

MS. BERTRAND: One more comment. I think now that we have individuals at the table who can come before us and speak about, you know, be able to say that they are in recovery, that is a big deal, because I know 15 years ago, people were not come in here and say I am in recovery.

Maybe they feel a little bit more comfortable before this group, but they wouldn't go to a lot of other places. So, now that we have them at the table, I think we want to try to encourage that, because those are the same individuals who do some of the things that we are talking about, like speak, educate those in the community about the different work that we do.

I real want to commend CSAT and SAMHSA for the work that you have done over the years in terms of engaging individuals because that is a really big deal. I mean I have been in recovery for 17 years, and I was telling someone at lunch that I remember a time where I didn't want to say that publicly, but today I can say it.

So, now that we have made this transition, we want to keep the momentum moving forward, and I really would like to see us support the concern that they had.

MR. KOPANDA: Thank you, Anita.

MS. TAITT: I just wanted to comment back on what you were saying, and I think that as we move along with the development of materials, the development of this dialog even further, that we really are looking for any concrete information to show how we can work better with those other organizations and other entities.

I think with the main goal that came out of the summit, of there is many pathways to recovery, we are not trying to exclude anyone. We want to make sure that we are able to include them all, and that they all have a fair spot at the table.

Now, the issue is how to do that and make everyone comfortable, and not have the pushback that you are talking about.

MR. SUDBECK: I think part of it is reviewing the literature put out. It says right here you are not included. Something in writing makes goals a lot longer and it sticks in people's minds more than just

statements, so if it is in writing, says you are not included, you are not included.

MR. KOPANDA: Any other comments on this subject?

If not, we thank you very much and we really appreciate it.

I would ask the council whether you would like to take a short break, 5-minute break, and then come back for our Council Roundtable. Okay. Five minutes.

[Break.]

Council Roundtable

MR. KOPANDA: We would like to get started. A couple administrative items. Next meetings. August 21st, we are going to have a teleconference to approve grant applications, and that is going to be a major number. That is going to be the rest of our grant applications for this year, so there will be a substantial number of applications.

Cynthia will be in touch with you when they are available for you to review on the web, those applications, so that will be August 21st, teleconference.

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October 16th will be your next full day meeting here. If you have any suggestions for agenda items, you might want to let us know today. We can plan for that. Of course, you can submit them later also if you would like.

The last thing is for your notebooks, if you would like us to send them to you rather than have to carry them home yourself, just leave them at your place here, and Cynthia and the staff will send them to you.

With that, any administrative questions?

We would like to open it up. We are free, as much time as you would like to take here for our Roundtable Discussion. Gib.

MR. SUDBECK: I think this has been a very informative last couple of days. I never really understood all of the inner connections between all the different entities with SAMHSA, so I find it very interesting.

We are looking at the future items and I don't know if this is the time to talk about it or not, but I think as we get into 2010, a couple areas that I have been around a while and have been involved in, and I

think on a national level, there is still a major, major gap, and that is the whole issue of a treatment for people within the juvenile and adult correctional system in the country.

At this point in time, South Dakota, it is not like I am pitching for more money, because of what we have done since '88, is we have developed a programming within our adult and adolescent systems in the State, and we have basically treatment on demand within those two systems.

At this point in time, of all the parolees, which is about 2,000 a year adult parolees going out into the community, only 11 percent do not get treatment while they are in prison, and all parolees who leave the system are connected with our community-based providers for continued care of services.

I think nationally, this has been talked about since I have been division director and at least since the mid-'80s, the whole idea about treatment for inmates, either adult or adolescent is doable. My operational budget is about \$4 million a year for that population, which isn't, in fact, much considering the cost to

society, and I really think that is something SAMHSA needs to look at in the future.

MR. KOPANDA: Right now we limit our treatment and our services to outside the walls other than we have done some reentry programs where we begin a bit before release from prison or jail, but we have pretty much stuck with that policy, leaving that for the Department of Justice. We could take a look at that.

MR. SUDBECK: It is not going to happen if it's left to the Department of Justice, because it has been with Department of Justice for over 20 years, and still, if you are looking at the federal system, for example, only about 5 percent of inmates get any type of treatment on a national basis.

I think it is something, you know, something to look at, something to study.

MR. KOPANDA: Yes, Ken.

MR. DeCERCHIO: It triggered a thought, I will throw it out there, that Council of State Governments has been working with a couple of States, Kansas, Texas, around alternatives to incarceration for persons with addictive disorders as part of a strategy to reduce

populations.

The alternatives include drug courts and I believe community-based services, not just in-prison treatments, because the whole goal is to reduce the number of beds. In fact, there is an article I think in today's Washington Post, the governor of Kansas and the governor of Texas talking about other options and alternatives, and they mention drug courts in order to reduce the prison population.

So, while not exactly what Gib is talking about, we might want to have staff take a look at that and maybe invite the Council of State Government to give us kind of an overview. They have got some hard data around a couple of the States that are looking to reduce population by doing community-based interventions, and it is not exclusively substance abuse, but a lot of their strategies in a couple of States that they have worked with, as well as some additional communities are essentially substance abuse treatment.

I have two things around potential agenda items.

MR. KOPANDA: Let me just comment on that.

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That is something we could look at for a future agenda to have them present. Do the programs deal with serious and violent or just non-violent populations?

MR. DeCERCHIO: Mostly non-violent. I don't want to overly generalize, but hard sentencing associated with crack cocaine, so mostly things like possession and non-violent, not unusual for most drug court populations.

Two agenda items. I don't know if the Administrator, I can't recall if the Administrator -- to my memory, he hasn't just come and visited with us and given us kind of his view of the State of the Union around substance abuse.

I don't recall, I may be wrong about that, but I am not sure I am.

DR. McCORRY: He came and introduced himself when he was first appointed, that one time.

MR. GILBERT: Actually, Dr. Clark does want to invite the Administrator to the next meeting. We decided not to do it at this one just because there were a number of members who we knew weren't going to be able to be here, so he said let's see if we can get Terry to the next meeting.

MR. DeCERCHIO: It's a request, not a criticism.

MR. GILBERT: I understand.

MR. DeCERCHIO: The second area, Rich, you mentioned earlier that the timing of the evaluations for Access to Recovery and a couple other initiatives, maybe pregnant and postpartum women would be ready to kind of potentially influence the 2010 budget, so if those evaluations are vetted and ready to go, and if the agenda would permit it to get a report out on what those outcomes look like.

MR. KOPANDA: That would be excellent. I think at the October meeting, we could have an agenda item to go over those evaluations. In some cases, it may be preliminary finding, but I think in at least a couple we will have our final evaluation report.

Yes, Frank.

DR. McCORRY: I would like to expand on a couple of the ideas presented just to throw them out to see if these fit or not.

One is around the Criminal Justice and something that is going on in New York, which I think is

problematic nationwide, but also it might be a State issue, so I am not sure whether it's a Council issue, but the fact that treatment takes place outside of certified settings, or if, for example, the Criminal Justice system might be conducting drug treatment or alcohol and drug treatment without any involvement of the State Agency, without any certification, and that this has various iterations of it around the country.

In one state, Texas, it might be very prominent, in New York it might be more mixed, and in another state, the single State Agency has perhaps oversight in a way that isn't as true in another state.

So, I am not sure. Getting a handle on that, assuming that the federal treatment agency has a stake in whatever is being call treatment, whether it is paid for or not, whether you have a dollar, you know, because it might be, say, you have federal Medicaid dollars, it might be a federal DOJ dollar, but a group like CSAT would have a stake in whatever the conduct of that treatment is to understand nationally how different States have come to address Criminal Justice needs, addiction-related needs of the Criminal Justice system

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and the role of the single State Agency or the federal agency and its counter parts in overseeing, monitoring, certifying, collaborating on those services, whether that might be worth some exploration.

Staying with that theme and picking up on Ken's idea, so much of this business is in other people's systems. We are doing it in New York all the time, and we are getting more effective at it, but it is just an endless, endless need to educate other systems about their role in addiction services, whether it is prevention or treatment.

I think as the Administrator coming, as the head of SAMHSA, how that plays out across the federal agencies and how SAMHSA's role with DOJ and the need to educate, their relationship, I am not looking so much for a list of things we are doing together, I am not looking for that.

I am looking for a much kind of franker discussion about how SAMHSA or CSAT see themselves as in educating and collaborating with these other systems of care, whether it's Center for Disease Control, whether it's DOJ, whether it's other parts of HHS, in their

coming to understand how central they are to treating addiction.

While it would be interesting to hear all the projects that are going on, that is interesting, but I am not looking for kind of validation that you are doing something, I understand that.

It is more what more has to be done, what is the state of the relationship within the federal hierarchy around the recognition of addiction as central to the work of these agencies, whether it is Public Welfare, whether it's Criminal Justice, whether it's Public Health, have they come to understand it in a way.

Or is that really something with the new administration coming in, that this council and other councils from SAMHSA should be advocating, that that become first and foremost the task that these other agencies come to appreciate and endorse and start to plan around and implement services that it treats addiction-related needs in their populations.

MR. KOPANDA: I think that is a very important point. I haven't looked at ONDCP's statutory authority recently, but I think normally, I would turn to ONDCP as

the agency with the responsibility, they primarily coordinate budgets and program plans, but this would seem to fit within their role of making sure that all the agencies that fit within their purview are aware of and support the mission of the others.

I would note one thing not exactly on point, but the SAMHSA National Advisory Council, one of the recommendations from Tom Kirk from Connecticut was that SAMHSA grants, but we can think of it as CSAT grants, include some requirements for service grants that go beyond basically, say, the NOMs.

Right now the NOMs deal with the outcomes and/or outputs for an individual or an individual going through treatment or being in the system, that we include some performance measures that go beyond that and say beyond those you are treating in your program, what impact are you having on other systems within your area.

The area may be a city, state, county, whatever, how are you impacting the justice system, how are you impacting the child welfare system, and to have them include, this is me kind of explaining something that was mentioned very briefly, but to have them explain

in their application how they intend to impact other systems and possibly develop some measures, you know, a few measures as to how that occurred or didn't occur during the term of their grant.

So, it kind of gets to your point, but at the local level, not at the federal level.

DR. MCCORRY: But perhaps then, Rich, it would be good to hear from ONDCP about that rather than asking for the administrative on my original point, to have them give a state of the art of federal agencies' relationships around addiction and how are they and what remains to be done.

I am just throwing it out. I am not saying it has to be done, but I just thought it might be an interesting area to explore given the new administration coming in.

MR. KOPANDA: I think we would certainly be able to invite them.

MS. BERTRAND: I wanted to just encourage the Council to consider the request that was put before us earlier regarding peer recovery support services, one, and then, two, the work plan that we talked about. I

think it will be a good idea.

MR. KOPANDA: Would you like to make a motion on that?

MS. BERTRAND: Sure. I am talking about the peer recovery support service and work plan. Those are two different things.

MR. KOPANDA: I am sorry, Pat Taylor had suggested, not suggested, requested that the Council adopt a resolution calling for the use, you know, encouraging the Administrator to find funding to support the expansion of recovery support communities within this current budget year.

I think that was her specific recommendation, and I think that is what Anita, you are suggesting here, is that the Council endorse something like that.

DR. McCORRY: Didn't we just hear of a way that they were going to go about supporting --

MR. KOPANDA: It is basically a different program than Pat. Pat was talking I think pretty much about the RCSP as it had existed.

MS. BERTRAND: And what I am thinking is if we put the resolution forward, then, at least we have done

what we sort of can do. Then, the administration will decide what they want to do, but at least we have done what we can do.

MR. KOPANDA: You might consider incorporating that with any 2009/10 budget recommendations, because that could certainly be factored into that kind of a recommendation or it could stand on its own.

DR. McCORRY: The suggestion would be for 2008 that we recommend or encourage the Administrator to look towards expanding recovery community support programs within the existing budget, and then also follow up. It would be separate resolution on a work group for 2009/2010 priorities.

So, the question is whether the Council wants to endorse such a resolution I guess.

MS. BERTRAND: Also, I think the resolution, if we could '09 in Pat's resolution, because we may miss that opportunity. Maybe we could just go ahead and say '09 for moving forward if the administration could consider that, if there are discretionary dollars available, that we have already done that, so we don't have to come back.

MR. KOPANDA: 2008 is impossible. I mean there is a lot behind this RFA and the announcement process including as much time, giving applicants sufficient time to get their application together and going through the review process.

We are way behind now. If it is not announced now, we couldn't possibly do anything for 2008. I am just saying that in terms of reality. '09 would be the earliest we could do something at this point.

DR. McCORRY: Perhaps then we should roll that into the other resolution then, or not the other -- the idea of the work plan, the work group. Ken's suggestion, I thought it was great, and it shows Ken's experience in government I thought.

When I was saying we should be a little more critical of the '09 submission, and Ken said, well, we don't have to deal with that separately, let's look at 2010, but then the recommendations we made around 2010 back to Dr. Clark and the leadership here, will reflect what we see as lacking in '09, so it would be indirect, but we could tie it to '09.

We don't have to say, we are not going to say

anything about '09, but we can say gee, this is missing in '09, and this is really important and we want to see it in 2010 as a way of bridging the gap between being critical of a budget we can't right now.

So, as a resolution, I am not sure we need to resolve it as much as just set up a work group to say who would like to work on a set of series of recommendations to CSAT that will capture the Council's ideas on 2010 priorities with the understanding that 2010 priorities will be reflective of our perceptions of the '09 budget.

Shall we move that?

I move that the Council set up a work group chaired by Anita and -- Ken, were you volunteering, too -- co-chaired by Anita and Ken to develop recommendations to CSAT for the 2010 budget submission.

I further recommend that the work group review the '09 budget for gaps and for deficiencies that should be addressed in the 2010 budget.

MS. BERTRAND: Second.

MR. KOPANDA: It has been made and seconded.

Any comments?

MR. DeCERCHIO: A friendly modification would

be that it culminate in a letter from the Council and that is the output, that is the product, is that it culminates in a letter with recommendations.

I will ask Rich a question as to the most appropriate place to direct the letter. My inclination is to direct it to the Secretary, but I am really asking for some guidance there as well.

MR. KOPANDA: I think directed to the Administrator and Dr. Clark at this point in the process. That would be most effective. We are at the point where both SAMHSA and CSAT can put something into our budget that reflects your recommendations.

If they are going to be ready by, say, early to mid-April, the timing would be perfect. I mean once the budget gets beyond us and we have this May 1st submission, then, the Secretary recommendation, it is out of our hands, so the recommendation would go there.

DR. McCORRY: So, we would adopt that friendly amendment that this will culminate in a letter from the Council to the Administrator and Dr. Clark enumerating our recommendations.

MR. KOPANDA: Any other comments?

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All in favor?

[Chorus of ayes.]

MR. KOPANDA: Opposed?

[No response.]

MR. KOPANDA: It is carried.

MR. GILBERT: Are we done with that?

MR. KOPANDA: Anything further on that? Okay.

REV. CASTELLANI: It has been interesting for me to be here the last few days. I understand much of what we discussed because I have been in this for about 20 years, so I get all this material.

Being on the faith-based side, the best thing that has happened to the faith base is the ATR. It is incredible what that has done. The difficulty with ATR, it is limited to the 24 groups that can get it. I understand it's a pilot program.

What does it look like for the ATR to be advanced to all 50 states at some point?

MR. KOPANDA: The issue is kind of open for 2010 right now. Obviously, 2009, we are locked into, just a continuation for the current 24, but the 24 end at the end of 2010, and then we would have, as Dr. Clark

noted on his slide, we are going to have the turnover.

So, the \$100 million becomes free money. So, the question at that point is going to be in part of our discussions, what happens to that \$100 million, actually, it's \$98 million I think.

Is it going to be continued with ATR another round of ATR programs, that we have policy issues such as do we allow the current grantees to compete, do we just target new grantees, how do we do that?

The last round, we allowed the previous grantees to compete and 11 of the 15 were successful. So 11 of our 24 now are, first, Cohort I, that continued to Cohort II. But the 98 million will be available, and this administration will have an opportunity in the 2010 budget to propose to do something with that money.

So, you can make a recommendation in your 2010 recommendations as to what happens to the ATR money. The administration will have to decide, I mean us being part of the administration, but the administration as a whole will have to decide what they want to propose, and then that, of course, will go to the new administration.

Sometimes, you know, in my experience I have

seen everything possible happen to whereby the budget proposal is adopted just as it is, to when President Reagan came in he said no, we are going to change things, and we had all kinds of changes happen at the last minute, and we basically threw out the previous administration's budget, to everything in between.

So, it would be helpful to have a recommendation as part of your recommendation, what happens to the ATR program and what you would like to see happen to it, expand, continue another round of grant applications, but that is a big chunk of our discretionary grant money, so somehow or another that will have to be disposed of over the next period of time.

A continuing resolution, if we have an omnibus continuing resolution, one would presume that normally, we would continue all these program and we would continue ATR, that is what we did the last time, however, this year set a precedent of not necessarily, you know, officially, a continuing resolution only continues your total dollar level, it doesn't necessarily continue every program in there.

So, even decisions on whether you are going to

pay your continuation grants are up in the air, and you saw from Dr. Clark's slide that 74 grants are proposed to be terminated in the middle of their program, in the 2009 budget. So, I mean even that is an option.

That is a long answer to your question, but I do think it would be helpful to have a recommendation as to what happens to the ATR program. It could be an expansion or you could recommend that we set the goal of getting a grant in every State.

But the question would be then whether we use the turnover to address only those states that have not gotten an award or whether we expand, double the dollar amount, if you will, to go to all the states or anything in between.

So, the issue is open, what happens to ATR.

REV. CASTELLANI: How do we go about that, what you just said?

MR. KOPANDA: Well, I think the Council should consider that as part of your recommendation. That would be an appropriate point, and it is something that we are going to have to, when we go forward to the Department on May 1st, we are going to have to say something about what

happens to the \$100 million that turns over in ATR.

MR. DeCERCHIO: Those grants are in their second cycle, are in their first year right now?

MR. KOPANDA: They are in their first year of operation, but they are actually in their second year. 2008 is their second year of funding, 2009 will be the third year of funding. Of course, they get their grant like September 1st, so the grant period, the performance period goes out a year after that.

So, functionally, sometime during 2010 it will be the end of the fiscal year, the grants will actually be awarded, and that will be the time that the Cohort II grants theoretically end, but the decisions on what happens with the money has to be made well before those grants are actually made.

MR. SUDBECK: Has any of the ATRs secured sustainability after the end of the federal funds?

MR. KOPANDA: Yes.

MR. SUDBECK: They have.

MR. KOPANDA: Uh-huh, some of the Cohort I, some of the ones like Wyoming, Wyoming State is continuing their ATR program without any federal funds.

They were not successful in the second cohort.

Several other states added some money.

Connecticut added some money, but, of course, they have got a Cohort II. Louisiana did, as well, but they both got Cohort II grants.

MR. SUDBECK: It would be nice to see that type of information as to the support. When those things first came out, it was adamant about you have to demonstrate financial capability to fund the programs after I think it was three years at that point in time.

So, it would be nice to see how many became financially independent of the federal dollars, as well as some outcomes. They are doing NOMs, they are doing GPRA, which one are they doing?

MR. KOPANDA: Basically, kind of a subset of GPRA, if you will. They are doing the NOMs basically.

MR. SUDBECK: It would be nice to see some of the NOMs add on those projects, too.

MR. KOPANDA: The evaluation results should be in by the time of your October meeting, so you will have some information. Now, the ATR evaluation is focusing mostly on the Cohort II, prospectively on the Cohort II

grantees, but there will be some information there on Cohort I, as well. That would be a great time to discuss that.

MS. BERTRAND: If Congress puts a budget in place, does that mean that the administration has to -- I mean I would think that they would have to follow what is put before them. I am just wondering how much discretion does the Council have.

I mean we can make recommendations, but if we are getting something from our new leadership saying this is what we want to see, isn't that how it is going to go, or is there some discretionary portfolio, you know, the X number of dollars where the Council has the discretion to say, well, we really want to see -- because I thought ATR was a presidential initiative, so I am just trying to make sure I am understanding how dollars are earmarked for programs and things like that.

MR. KOPANDA: I am not sure. All of our dollars, when we submit a budget like in May to the Department, and then in subsequent budget requests, the Department will make a cut and it goes to OMB, and then OMB will make a final determination. That will be the

President's budget that goes to Congress right at the end of January.

All of our programs and all of our dollars are pigeon-holed, if you will. They are identified by program, by area, with specific performance measures. We don't have basically any flexibility. Now, Congress is free to reject it. The new administration is free to reject it, because we have that kind of change, and Congress is free to reject it.

But depending on the outcome, the final determination will be made by some kind of a bill that Congress will come up with in terms of an appropriation that will have more or less flexibility.

As we were discussing for this year, we didn't have any flexibility with, say, drug courts and SBIRT, you know, where they said this is a specific, but then we did have a little bit of flexibility within that total, but up until that point, when we get it back, when we get it back from the Hill once our budget is set, you know, anytime you ask us what is the budget, of course, we can't discuss it, this is administratively confidential, so we can't discuss it.

I am not sure if we can discuss it with Council members while they are federal employees. It gets a little bit -- traditionally, it is not even widely shared within the agency usually, because the administration's priorities are in there, and there is concern that they would be leaked to the press or whatever.

So, just the few of us know that inside, so like I say, this is the time. We will do what we can to reflect the priorities we can, but then the only flexibility we might have after that would be during the preparation.

MR. GILBERT: As Westley pointed out this morning, and Rich has alluded to it, I mean we are going to go through a major transition. One way or another, we are going to have a new administration come next January, and new administrations look for new ideas, so it is a good time for Council to be kind of laying out what you think the priorities should be, because you don't know what opportunities might arise to put forward new proposals.

But this is a key time when it is likely that we will be getting asked what are your ideas in this

area, what do you want to put forward.

DR. HOWELL: This is going to be kind of a general topic, and I hope I can explain it. It is sort of forming in my mind here. It is related to some of what Frank was saying about the initiatives in New York about the methadone programs.

I guess the way that I would look at this is discussing more the role of medical providers in treatment because, in general, a lot of addiction treatment has evolved without us medical providers, and we all know, although it is not supposed to happen, it still does, about -- and I will pick on methadone for a second -- methadone programs where the counselors may decide what the dose changes are going to be.

A lot of times I think the people who go to work as physicians in methadone programs are really not the most highly qualified in the world. They are often doing it very part time. That is a medication assisted treatment and I think it is one that is -- the more I learn about methadone, which I mean I worked in methadone for several years, but now there is more coming out about its dangers especially with its overdose problem, and

even through that is not so much of an issue from the clinics as opposed to from pain prescribers, I have a bigger respect for methadone as a potentially, you know, dangerous drug.

I think a lot of times one of my problems with methadone treatment wasn't the medication part, but it was the non-recovery orientation of methadone treatment.

It is like, well, you are just opiate addicted, but you can drink, you can, you know, take Alprazolam, you can do whatever, and that is different because that is another addiction.

Unlike the brain, there is only one brain up here and I would like to sort of bring these two aspects of addiction treatment, the more recovery oriented closer to methadone and medication, and I am picking on it, but just medication assisted closer to the recovery model.

I don't think that they are mutually exclusive, I use them together all the time, and realistically, I think they all fit together. I was talking with Jack Stein about how -- he wanted to know how do I see spirituality with biologically based theories. Well, I have no problem integrating those two together.

So, it is more trying to set a model for a holistic approach, which I think is a lot of what is being done, but maybe we need to specifically include things like medication like you mentioned, and make that a very overt part of the holistic model.

It is not going to be for everybody, but a lot of people can benefit from it. I just would like to sort of bring the medical community together more with what is going on with CSAT, and I think a lot more of that has happened in the last 10 years than before.

But I do remember when I was a State director having some people say to me why would a physician be interested in addiction, because they couldn't understand what the role of a doctor or physician or any kind of medical provider would be in addiction treatment, and that just blew me away.

I think we are a little bit better off than we were then, but maybe not as much as we need to be.

MR. KOPANDA: There may be an issue that you have hit on there, the role of the medical provider in some of the opioid treatment programs, I mean how much time are they dedicating as they move to more for-profit

organizations, are the minimizing the time and saving money, and is this having any kind of an impact.

I am not sure we have looked at that.

DR. HOWELL: I think it would be worthwhile to look at. I think in some parts of the country, the physicians or some program, they are very involved.

I mean I have friends that work in methadone, and I know that they are very involved, and then there are other programs or parts of the country, or maybe it's for profit, but I think even nonprofit programs at times, there is very little physician involvement, and the patients often don't even really know the doctor except there is somebody that sort of passes through and does the perfunctory physical year or whatever they have to do now.

MR. KOPANDA: Frank.

DR. MCCORRY: I think that is a great idea, Beth, and I would shape it a couple different ways. Just New York now is passing its regulations to have all medical directors who have methadone programs to be ASAM or what is the other group?

DR. HOWELL: American Board of Psychiatrists.

DR. McCORRY: Yes, credentialed, but they are going to grandfather the folks that are in, but there is this issue of the standard, you know, the quality of the medical provision within methadone programs, but within all programs might be worth some discussion.

I would also frame it up in terms of the role of the medical provider in recovery-oriented systems of care, then, the role of medication-assisted treatment in recovery-oriented systems of care, and then the third one is the quality or the standard qualifications of the medical provider in treatment.

It is a really interesting idea because as was presented in the graphic, the medication-assisted treatment isn't broken out, and Walter was here. Walter and I were having some discussions around methadone in New York, and he is convinced that we are going to set up these recovery centers and that people on methadone will be excluded, not intentionally, but that they won't be welcome there, because that is the way recovery doesn't embrace medication particularly methadone patients.

So, this view of the role of the medical provider, the role of medication-assisted treatment

within this paradigm of recovery-oriented systems of care, and then the qualifications of those individuals in delivering that care, I think is a great topic that really I don't think has been touched at all in the recovery or I haven't heard any discussion around ROSC and the medical provider.

MR. DeCERCHIO: The other potential opportunity, we just approved the second round of accreditation for medication-assisted, so kind of look at those standards. Before I left Florida, we were rewriting, you know, we had a group to rewrite the licensure standards to make them more recovery oriented, get rid of treatment plans and recovery plans, and reduce kind of the emphasis on time frames for when things got done as opposed to what is your overall goal in helping people achieve recovery, and what do you feel as a provider agency, you know, how do you organize your system of care in order to enhance recovery and go more in that role, more moving toward that model as much as you can, which is pretty heavily regulatory. You know, it's licensing, it's not even accreditation.

But it seemed like a potential opportunity in

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this next three years to look at those accreditation standard to see how at least at a minimum introduces, provides opportunities for folks, exposure to recovery in accredited programs, and in what capacities do they have, I mean there are certain standards that could be developed very easily.

They say you have got to be able to provide this -- I am not sure of the right word, exposure is not the right word, but access to certain information, opportunities, you know, what are your referral agreements. This is not my area, but I think there is an opportunity, looking at that accreditation, can recovery be advanced in this next round.

MR. KOPANDA: Right now our standards of care for accreditation is only something that we develop here, but there are only suggestions. I mean they can include the suggestions and we can promote that, but the accrediting bodies each have their own actual standards. We do encourage them to incorporate our suggestions.

DR. HOWELL: One other thing, just to expand on this a little bit, I have had this discussion with several people in the field that are physicians, and I

would have to say that overall, I think that treatment programs see, I am going to make a gross generalization, but they see physicians as a necessary and expensive evil that they have to incorporate.

I have experienced this at public, private, you name the different settings, and many of my friends have experienced the same thing. One problem is that until you have really worked with somebody who specializes in addiction medicine or psychiatry, you don't really know what we have to offer.

I think there is a real bias in the field, but think that -- and I don't know if this is true -- but it's a hypothesis that would be worth testing, that if you have an expert physician involved in your treatment process, that you would probably do better in some ways.

At least this is what patients tell me that happens for them.

Now, maybe it's because they are finally getting their psychiatric symptoms diagnosed and treated appropriately, or medical, or whatever, but I think that, you know, if you want, I think the agency is really interested in approving treatment than it was the old

name, you know, treatment improvement.

I think that having physicians really involved as a member of the team in programs could benefit patients quite a bit. Until we are more involved, I think you are going to have a hard time getting medication-assisted treatment accepted fully at least.

MR. KOPANDA: Thank you. Do you have any suggestions? I mean would you do that through our suggested accreditation standards? Maybe we should have Bob Lubran here -- oh, do you have any comments, Bob?

MR. LUBRAN: Actually, I have heard a number of good suggestions and I should point out that last summer we updated the accreditation guidelines after almost 10 years. So, that is not something we do every day, however, it would be not a difficult task to take a look at certain aspects of the guidelines, such as the qualifications of medical staff, training, any other aspects of it, and do an update. We do that from time to time.

On the training side, we have several initiatives, most of which I can't really talk about because they are in the contracting procurement stage,

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however, we did announce in the Federal Register the physician clinical support network proposal for methadone that sort of complements the one for buprenorphine.

That is one activity that has been added, and there are a number of other educational efforts underway both for the physicians who work in the medication and treatment and also physicians who are working in the pain world, who are causing some of the problems that we have to deal with, and maybe for the next council meeting we could just get a list and description of some of those activities, give you a sense for how we have really put an emphasis in this next couple of years on better educating physicians or medical staff I should say.

MR. KOPANDA: I think you said this would be perceived, I mean if we tried to build in recovery as we review it, as we see it from a ROSC point of view, into OTP, I think that would kind of be viewed as a sea change in terms of their operation for the most part, because I don't think they really perceive things on a recovery type of basis, but at least through specific guidelines.

I think there might be some other ways where we can communicate this and begin the discussion without

going to the point of saying, well, here is our guidelines, here is what we would like you to be doing tomorrow.

MR. LUBRAN: The other thing is that I did meet last week in New York with some folks from New York State, learned a little bit about what they are doing, and we are interested in learning more about how the recovery-oriented systems of care might fit into the models that we have been working under.

Certainly, as they develop, I would like to know more about it, and we would like to see how it can fit in and absolutely would want to work with people in the field including grantees, such as we heard from earlier today, to try and maybe test out some models and see how it could work. So, you know, we would be interested.

MR. KOPANDA: Great.

REV. CASTELLANI: You wrestle with these things for a lifetime almost and then you get an opportunity to be here, and you don't know how much you should express.

What I heard her say about methadone, that is kind of where we are at in our end of the spectrum.

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For instance, in our State of Pennsylvania, we handle about 300 people on a daily basis. it's residential, and we are licensed by the State, and so we have to have one counselor who is a certified counselor for every 8 clients, and we meet all that, but even though we meet all that and do all the things that the State requires of us to be licensed, we don't qualify for anything except the students then are qualified for like food stamps or maybe welfare for a certain period of time for housing.

But that is all that we can get, and I understand it. When I come to Washington, I have been to Washington many times, I have been doing this now for about five years, and it seems like you come here and you get this message, you know, we are here to help you, and you go back home and you talk to your single county authority and you talk to your State person, and it sounds good, but they smile and, you know, away you go.

So, obviously, the public is interested in who we are, because they support us, you know, I mean or else we wouldn't survive. We get supported we have to raise all of our support that way.

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The only way we can circumvent some of these things, and you hate to say it this way, but you go to your local congressman and you go to your local senator, and then he goes and gets an earmark for you for something he likes you are doing, and then here, people running for president, and I understand they have to do this, we are not going to have any more earmarks.

I guess where I am coming from is somehow if this august body SAMHSA could have some standards that are generic for States to embrace, and maybe we can't do that, maybe States have their -- you know, you keep hearing separation of federal and State, and I understand the complication, but I also understand the pain.

I talk to Ken, and he kind of has operated differently in his background and embraced the Teen Challenge in the area where came from. I am not going to say anymore, it's just that, you know, we are doing everything they are doing, but then I see the doctor point, I don't have a problem with the doctor point, I really don't because I think that is probably not a bad thing, but when you are doing everything else that everybody else is doing, and they don't have doctors, and

they are at the table, but because of one of your little caveats, which is not methadone, but which is faith, you can't be at the table. I will just leave it there.

I don't know how else to say it, because, you know, it doesn't matter if we win or if we don't, because we are going to keep doing what we are doing, but the fact is that if we are doing the same thing as somebody else is doing, but we have one little caveat that they don't have, you know, I just don't have the answer for it, and I am not asking for an answer, I am just saying those of you who go to these other kinds of meetings where you really get in the trenches, you can just bring it to the table if you desire.

MR. KOPANDA: That is an interesting observation. Clinical treatment licensure is really, it's obviously done at the State level, and I don't remember CSAT ever having gotten into making suggestions, recommendations, or anything on State licensure. We just kind of say it's a State responsibility.

When it comes to methadone, of course, we do regulate the program. We do accredit the organizations, but that is only kind of limited, as well. It would be a

significant leap for us to try to I think get more involved in State licensure.

REV. CASTELLANI: That's fine. You know, there is a thought going through my mind here like Evie Back [ph], you know, she and I are best of friends, and she pushes everything she can for us, but then she hits the grindstone. I know she comes here, and she is a great advocate for our State and does a great job for us.

I just, you know, you kind of say okay, should you even be licensed, you know, should you even go through the process and the pain of going through, it's pretty rigorous to go through an inspection from the State, very rigorous, in fact.

When you jump through all the hoops that everybody else jumps through and you can't come to the same tables they come to, it gets a little, you know, it gets a little tough. Anyhow, so much.

DR. HOWELL: Just one thing to clarify what I was saying. I don't necessarily think that everybody has to have a physician, but I think that when you by licensure or by need or whatever, you need to have medical care as part of your continuum of services that

you are giving, then, I think we all need to look at the role of physicians and other medical providers and treatment, and have less of this, us versus them kind of thing.

REV. CASTELLANI: Actually, in Pennsylvania, we have to have a contract with a hospital or a clinic for everything that goes on, so we meet all those standards, we just don't have a doctor on campus, you know, or anything like that.

DR. McCORRY: And I don't think that, I mean regardless of whether you are faith based or for profit or not for profit, community based, hospital based, essentially, if medication-assisted treatment is an evidence-based practice, which it is, and whether it's methadone, buprenorphine, naltraxone, whatever else is coming down the road, essentially, if clients can't get that in your facility, can't get what is an evidence-based treatment, what should be considered a standard of care as an option, and, in fact, National Quality Forum stated it that way, as an option, not that people have to take medication any more than if I went to my primary care doctor and he told me to lose weight for

my blood pressure and didn't offer me a medication, to say, well, perhaps you want to use medication while you lose weight, that can't be considered good practice.

Whether it is in a residential or an outpatient setting, and the problem is that our evidence outstripped our practice, so we regulate and we fund for a model that currently is outdated given what we know about the way to provide care, and that shouldn't be just for faith-based organizations. It shouldn't be any different, in fact, it isn't.

Medication is just a treatment, isn't available in many places across the country regardless of whether you are faith based, because it requires changing the clinical model and changing the financing model to support that practice. That hasn't happened.

Now, there is a role I think for CSAT in bringing up some awareness about that, that currently, States don't have a model that incorporates medication-assisted treatment. It doesn't have to be a doc, but there has to be prescriber, so that when I am in residential treatment, I am not excluded from the opportunity of using something that might benefit me and

my recovery, and that is something I think that CSAT will have to struggle with, and is an 2010 recommendation.

Most of this is paid for by Medicaid, but can we start to talk about using block grant dollars as an incentive to promoting evidence-based treatments that currently aren't available in Pennsylvania or New York or Ohio, because no one wants to kind of -- there is no funding stream and right now there is no mandate or emphasis that is driving the change in the clinical practice.

DR. HOWELL: For example, in Utah, Medicaid will pay for buprenorphine, but there are very, very few Medicaid providers who have a waiver. I can prescribe it for somebody, but I can't charge them for a visit, so I can't see them, because just the way things are structured, the Medicaid contract is with another entity, and nobody at that entity has been approved by the head of the entity to prescribe buprenorphine although he is shifting.

So, those are the kind of barriers that people run up against. They could benefit from buprenorphine, they could pay for it with their Medicaid prescription

benefits, but they can't get a provider to prescribe it unless they go to the methadone clinic, but then -- anyway it gets very convoluted.

MR. KOPANDA: Do you know why they haven't gotten -- they are not able to prescribe buprenorphine?

DR. HOWELL: Most of the people who have their waivers are not Medicaid providers for outpatient. There are probably two that I can think of out of there is probably 100 and something waived physicians in Utah.

MR. KOPANDA: That is interesting. First of all, I thought most States did not pay for buprenorphine with their Medicaid, or permit Medicaid -- it is possible, but I thought most States didn't participate because buprenorphine is so expensive.

MR. SUDBECK: Typically, in South Dakota, we still go to a total recovery-based abstinence model, and with our opiate people, they go through our treatment program with medication support.

It was interesting what you said before about what constitutes recovery, and within our State, you know, we treat probably 100 opiate addicts a year, but they go through a medically monitored or medically

managed level of care throughout their stay, so a different approach.

If you go in and mandate that a State follow a certain protocol for this type of population, that would tend to create a few ripple effects across the State, across the country, wouldn't like it, because this is evolving. So, what works tomorrow, something better may come up a year from now, and if you go out and basically set a mandate, it may take decades to change the mandate.

COSIG, I hope it continues. Is that going to be cut?

MR. KOPANDA: Well, you saw there is no COSIG in the 2009 request.

MR. SUDBECK: States like South Dakota, we actually believe in co-occurring disorder treatment. We actually have invested State dollars in putting together a plan and moving ahead. This would set back this type of initiative.

MR. KOPANDA: Do you have a COSIG grant?

MR. SUDBECK: We do now, we just got it, but we have been doing planning for two years with State dollars and we appropriated, had Dominkoff [ph] come into the

State and work with us, so it just blows my mind that at this point in time, actually States have got past the fighting stage are actually cooperating and making it happen, that we have cut it. What's the sense there?

Really, for 2010, I think it's something that I would hope would be supported and promoted again. I was involved in fights eight years ago on this whole issue. I don't want to go back to those days again.

MR. KOPANDA: Thank for the comment.

MR. DeCERCHIO: That reminded me, if the members of the Council, by the end of next week or early the following week, if you send Anita and I an e-mail, if you choose to, with -- I have got the notes about what we have talked about here, but if you have specific recommendations, it wouldn't hurt to just send us an e-mail and say oh, i am concerned about this or based upon what we heard about the 2010 budget, here is what I would like to see and then so that we can incorporate that into what we have put together.

You know, we will work based on discussion today, but if you have got specifics that you want to add, give us a paragraph or something, particularly if

there is a statement about how it impacts, whether it impacts your State or more importantly, how it impacts communities and people, you know, so, hey, if this goes away, this is what it means, not to my State budget or my agency budget, but this is what it means in terms of the changes in care that people are accessing in services.

MR. KOPANDA: Thanks.

MR. GILBERT: Can I just say one thing? I know that there are several members who aren't here today, who I am sure are going to be interested in this discussion.

I am wondering if maybe we can send an e-mail out to all the Council members with Dr. Clark's presentation with a note about the recommendation that was adopted, and I don't know, Ken or Anita, if you want to give us just a sentence or two, we could put in about sending the suggestions to you.

We could forward that or you could use that e-mail and then forward it on to the Council members, but let us know how we can help you with that.

MR. DeCERCHIO: I will write a couple of sentences and I will send you an e-mail, send it to Cynthia, that you can just incorporate and sending

something to the Council members. I will probably do it on the way home tomorrow or over the weekend. You will have it either tomorrow or Monday.

MR. GILBERT: Then, we will very early next week get something out to the entire council with Dr. Clark's presentation.

MR. KOPANDA: Any other discussion on any other subject?

MR. SUDBECK: Is that information confidential?

MR. GILBERT: Which information?

MR. SUDBECK: The information you are going to put out of Dr. Clark, asking for feedback from the Advisory Council members.

MR. GILBERT: Well, he is not asking for it, you guys made a recommendation to get together and develop some recommendations. All we are doing is giving you his presentation and letting all the Council members know what the recommendation was adopted by Council, so they will be up to date and be able to participate in those deliberations.

MR. SUDBECK: Is that recommendation confidential?

MR. GILBERT: No.

MR. SUDBECK: Are the activities that the Council brought up, significant issues, whether it's ATR, COSIG, so I could share that with --

MR. KOPANDA: It's a public meeting, everything discussed today is public.

MR. SUDBECK: Just double-checking. I don't want to cross that line.

MR. LUBRAN: Rich, remember that the morning session was confidential.

MR. GILBERT: The grant review session, right.

MR. KOPANDA: Any other issues on any other subjects?

MR. GILBERT: Just very quickly. In the discussion on performance, there was something going off in the back of my head, and I couldn't think of what it was at the time, but I remembered it afterwards.

I wanted to point out that in our TCE/HIV RFA this year, we included language that will put grantees or applicants on notice that if you have had a grant from us before, we will use your performance, your past performance to set terms and conditions of award if you

are selected for a new award.

That is about as far as we can go. I just wanted to let everyone know that. I mentioned it to a couple of you, but that is the language kind of where the cursor is there.

MR. KOPANDA: If there are no other issues, do I hear a motion to adjourn?

MR. SUDBECK: So move.

MR. KOPANDA: Approved. Any disagreement?

Okay. The Council meeting is ended. Thank you all.

[Council meeting concluded at 4:58 p.m.]

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