

**Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment**

**Minutes of the
52nd Meeting of the
CSAT National Advisory Council**

October 17, 2007

Rockville, Maryland

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The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met in open session on October 17, 2007, at the SAMHSA Office Building in Rockville, Maryland. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the meeting at 8:43 a.m. Members present included Anita B. Bertrand, M.S.W.; Bettye Ward Fletcher, Ph.D.; Ken DeCerchio, M.S.W., Melody M. Heaps, M.A.; Valera Jackson, M.S.; Chilo L. Madrid, Ph.D.; Francis A. McCorry, Ph.D.; and Juana Mora, Ph.D. Also present were Richard Kopanda, Deputy Director, CSAT, and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

Welcome

Dr. Westley Clark welcomed participants to the meeting.

Consideration of Minutes

Council members voted unanimously to adopt, as presented, the minutes of the June 23, 2007, CSAT National Advisory Council meeting and the Council meeting held on August 23, 2007.

Opening Remarks and Introductions

Dr. Clark emphasized the value of Council members' advice to SAMHSA, as well as their contributions in monitoring the environment in the community. He also highlighted the important role of States in facilitating delivery of services to people in communities.

Members introduced themselves and identified activities in which they have been involved. Dr. Frank McCorry stated that he has a new role (Director of New York City Operations) in the New York State Office of Alcoholism and Substance Abuse Services (OASAS). OASAS, whose treatment and prevention system will be tobacco free by July 2008, partners with the Department of Health to provide nicotine replacement therapy and offers training and learning collaboratives to providers. OASAS also is working with the Office of Mental Health on co-occurring disorders, Mental Retardation, and Substance Abuse to work toward coordination of cross-system care. Dr. McCorry reported that the Washington Circle is developing performance measures in screening for alcohol, medication-assisted treatment, and continuing care. The National Quality Forum, which sets standards for the health care industry, has endorsed 11 evidence-based practices in substance abuse treatment. Ms. Melody Heaps requested that Council members receive copies of the National Quality Forum report.

Ms. Heaps stated that Illinois' Treatment Alternatives for a Safe Community (TASC) has formed the Center for Health and Justice, a policy and advocacy wing, and that TASC published a "No Entry" report on alternatives to incarceration. She noted that the Sentencing Project's report, "The Quagmire: The War on Drugs," analyzes issues related to incarceration, including disproportionate minority confinement, particularly of African Americans.

Dr. Chilo Madrid reported that collaboration between substance abuse and criminal justice in Texas has improved. His work addresses trauma in the children of alcohol and substance abusers,

as well as post-traumatic stress and substance abuse among returning military from Iraq. In addition he has been involved on the role of violence and drugs in contemporary music.

Ms. Anita Bertrand explained that the Northern Ohio Recovery Association sponsored 12 events in three counties for Recovery Month. The association has received funding for targeted outreach into a poor community to motivate women and children to enter treatment earlier, and is advising Cuyahoga County in the merger of its mental health and substance abuse advisory boards.

Mr. Kenneth DeCerchio has joined Children and Family Futures, which runs the CSAT-funded National Center for Substance Abuse and Child Welfare, to manage a new contract with the Administration for Children and Families (ACF) to provide in-depth technical assistance to grantees for a \$30 million program targeting methamphetamine and other substance abuse in families of children in the child welfare system. This program represents the first uniform and integrated data collection/outcome measurement system at the national level for child welfare and substance abuse. Mr. DeCerchio noted that Dr. Madrid's organization is a new grantee.

Dr. Bettye Ward Fletcher serves as chief executive officer of Professional Associates Inc., a research and evaluation firm that works with foundations, nonprofits, and other programs in design and evaluation. Her group emphasizes facilitating meaningful participatory evaluations and capacity building among community- and faith-based organizations and nonprofits.

Dr. Juana Mora, professor in the Chicana/Latina Studies Department at California State University–Northridge and currently on sabbatical, is writing a report of a community-based research project on children's health in Los Angeles and developing a new graduate course in Latino health issues that will focus on disparities and substance abuse. She also works toward developing new scholars in the substance abuse field. In addition, she is starting a new substance abuse prevention project along the U.S.-Mexico border.

Ms. Valera Jackson serves as chief executive officer of NCI Systems, which represents six not-for-profit agencies that provide substance abuse treatment and prevention services to more than half Florida's counties. NCI Systems has instituted a "Tag, UR It" contest/marketing campaign that challenges 11 to 17 year olds via text message to design a logo for T-shirts that promotes a healthy, drug-free lifestyle. She stated that advocates are urging Florida's legislature to designate National Outcome Measures (NOMs) to measure outcomes. An anticipated reorganization may outsource contract management and enable government employees to focus on policy issues.

Director's Report

Dr. Clark reported that CSAT/SAMHSA operations remained under a continuing resolution in the absence of congressional budget action for FY2008. Since the last Council meeting, SAMHSA awarded nearly \$32 million for substance abuse treatment and HIV/AIDS services; more than \$5 million for family-centered, substance abuse treatment grants for adolescents and their families; and \$2.8 million for eight peer-to-peer recovery services grants.

Dr. Clark stated that the first cohort of ATR, a presidential initiative designed to expand consumers' choice of clinical and recovery support services using a vouchers, is approaching the end of the grant period. SAMHSA has awarded \$96 million to 24 new ATR grantees, with \$25 million earmarked for methamphetamine services; SAMHSA will evaluate the process and impact of ATR II's introduction. The 15 original ATR grantees exceeded the targeted 190,000 total clients served. CSAT has provided sustainability trainings to ATR providers. The ATR program scored "moderately effective" in the Office of Management and Budget's (OMB) PART Analysis, a good score. Phase II ATR grantees include four tribal organizations or tribes.

The continuing resolution was to extend until November 16. Although both the Senate and House provided reports, only the House had a passed bill. Dr. Clark alerted Council members to the possibility of a Presidential veto. SAMHSA sent its FY2009 budget proposal to OMB; the President will make public his FY2009 budget proposal in February 2008.

Regarding CSAT's discretionary portfolio, Dr. Clark reported that activities for American Indian/Alaskan Natives (AI/AN) have included working with the Department of Health and Human Services (DHHS) on listening sessions, an Indian Health Service/SAMHSA National Behavioral Health Conference that offered a forum on best practices in substance abuse treatment, and a Policy Academy on co-occurring disorders. CSAT also cosponsored two Hispanic and Latino national conferences.

CSAT is addressing the methamphetamine problem in a public health approach that includes vulnerable populations. Initial planning for a national summit has begun, and a planning session was held on issues related to individuals who are lesbian, gay, bisexual, and transgender.

CSAT's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program held a conference with the National Institute on Drug Abuse (NIDA) to promote research. The Centers for Medicare and Medicaid (CMS) approved HCPCS billing codes to permit primary care providers to be reimbursed under Medicaid. In addition, American Medical Association-approved CPT codes will take effect in January 2008, once States approve the codes, to allow insurance companies to reimburse for screening and brief intervention. These developments will facilitate sustained primary care involvement, beyond expiration of SBIRT funds, in the behavioral health arena, particularly with reimbursement for emergency rooms and community health centers. This development demonstrates that SAMHSA has managed a program to engage the larger community in addressing addictions. Talks with the Office of National Drug Control Policy (ONDCP) have begun on educating State Medicaid directors and governors.

Representatives of 30 States have participated in Recovery-Oriented Systems of Care meetings. CSAT convened a media roundtable on strategies to reduce deaths associated with methadone, an issue on which CSAT is working with the Centers for Disease Control and Prevention (CDC), NIDA, ONDCP, Drug Enforcement Administration (DEA), other agencies, and the toxicology community. By the end of FY2007, SAMHSA had certified 11,906 physicians to use buprenorphine in office-based treatment for opioid abuse and dependence; 62 percent are listed in the Buprenorphine Physician Locator, a 5 percent increase. Almost 15,000 physicians have been trained, and more than 2,000 physicians have indicated their intent to treat 100 patients.

Recovery Month activities included a SAMHSA fun walk, 92 proclamations, 66 Voices for Recovery posted, and 54 SAMHSA-sponsored Recovery Month activities in the States. Many jurisdictions organized their own activities as well. Preparations for 2008 have begun.

Discussion. In response to a question from Mr. Ken DeCerchio, Mr. Jack Stein stated that SBIRT services may be delivered in physician-supervised settings. CSAT will work with ONDCP to disseminate implementation information and with State Medicaid directors to promote acceptance of the new codes. In response to Dr. McCorry's question, Mr. Stein offered to inform Council members when States adopt CPT codes. Dr. Madrid asserted the usefulness of a State-by-State analysis of Medicaid substance abuse services. Mr. Stein stated that SAMHSA has not yet prepared such an analysis, but SAMHSA will issue a document that describes the status of UPPL laws in each State. UPPL laws permit insurance companies not to reimburse for alcohol-related accidents.

Dr. Fletcher requested an update on the status of the Historically Black Colleges and Universities (HBCU) program. Dr. Clark responded that in the absence of a FY2008 budget, the HBCU program continues. To Dr. Mora's question about the effectiveness of the ATR and ATTC initiatives, Dr. Clark responded that CSAT makes it a practice to make initiatives work.

Fentanyl Update

Dr. Theodora Binion Taylor, Director, Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (DASA), discussed the issue of heroin laced with fentanyl, a major crisis in her State and others. Between 2005 and May 2007, Chicago/Cook County recorded 345 fentanyl-related deaths, including the teenaged son of an Illinois sheriff. The young man's death made headlines and raised consciousness about fentanyl, which helped to marshal resources and participation from others in the State. Medical examiner reports showed that 37 percent of fatalities had fentanyl only in their toxicology reports, while others showed fentanyl in combination with a range of other drugs.

Understanding of the extent of the fentanyl problem was delayed, and Dr. Taylor acknowledged Dr. Clark's alert to the issue. By second quarter 2006, 119 people had died. Dr. Taylor noted that overdoses in general represent a major public health issue. Most planning for the fentanyl outbreak occurred in June 2006, when Cook County's medical examiner began to provide monthly reports on confirmed fentanyl deaths. A public meeting brought together State and municipal agencies, DASA advisory board members, hospitals, professional organizations, consumers, outreach programs, and treatment providers. By June 2006, Illinois had expanded access to ATR funds to provide additional methadone treatment capacity and also had begun planning for focus groups. DASA's analysis showed that not as many fentanyl victims had been in treatment or on wait lists as anticipated. DASA convened an interagency work group to address the problem. Originally some believed the problem existed only in Chicago, but data showed that some victims had come from neighboring cities and towns.

By July 2006 advisories were sent to Illinois hospital emergency rooms, intensive care units, and primary care providers. By August 2006 CSAT had authorized DASA to use some SBIRT carryover funds to provide interim methadone services, hoping to increase capacity. DASA held focus groups and press conferences, and met with ATR ministers and other grassroots groups to help spread the message developed by focus groups. Coordination with Illinois State Police increased at this point as well.

Dr. Taylor explained that experience shows that the best way to convey a message is to provide the message in a way that appeals to the target audience by someone the audience considers trustworthy. General revenue funds paid for peer outreach workers, people identified in treatment programs in areas where most of the deaths occurred, to talk to people in communities where people were suspected of buying the drugs. DASA and the University of Illinois School of Public Health provided training for the workers, including CPR training. (Dr. Taylor noted that DASA has talks underway with the Red Cross about providing broad-based provider training to teach consumers how to do rescue breathing.) The strategy was to use information from focus groups in targeted areas and craft a message about the outbreak of fentanyl that would make an impression on the target audience.

Focus groups were held in public housing, provider sites, and other areas where drug users could hear the message. Participants fell generally into three categories: 40 years old and older, predominantly African American, Vietnam veterans; age 25 to 39, mainly Caucasian users for 10 to 15 years; and age 24 and younger, mainly males and mainly from outside Chicago. Participants were asked about their using practices, whether they sought heroin or fentanyl, awareness of media coverage and whether it affected them, safety practices, trustworthy sources of information, and knowledge and experience with Narcan. The focus groups revealed that most participants used two to five bags of their substance daily. The heaviest users were older. All but one participant stated that they attempted to avoid fentanyl. Almost everyone knew about the problem except people in the women's group who were unaware that fentanyl was mixed with cocaine. Most participants had witnessed or experienced overdoses, and most had heard about Narcan and expressed interest in learning more. Fentanyl outreach efforts involved five to ten peer outreach workers who submitted almost 4,100 hours. They reported high referral rates, which remain to be substantiated.

Next steps include determining how to use lessons learned in expanding the SBIRT methodology, continued efforts to secure medical examiner information from other counties, seeking legislation to make Narcan more available to outreach workers and others, and securing resources needed for community outreach, medical facilities, and education on opiate treatment.

Dr. Ken Hoffman, Medical Officer, Office of Pharmacologic Therapies, CSAT, described the responses of government and private-sector organizations at the Federal, State, and local levels to fentanyl overdosing deaths. He explained that the highly potent narcotic, with 30-50 times the potency of heroin, has a safety record if used as prescribed. When produced illicitly and mixed with heroin, fentanyl can result in rapid lethal effect without one's knowledge. Fentanyl also can be weaponized. One of fentanyl's precursor products may be tracked within the U.S., and classification of the other precursor is anticipated.

Dr. Hoffman explained that the Federal poison control center in New Jersey alerted CDC to concerns about fentanyl in April 2006. CDC initiated a conference call in May 2006. CDC established a case definition and began to accumulate data. While the initial effort focused on Camden/Philadelphia, Chicago and Detroit had been affected months earlier and DEA had bought a contaminated sample in August 2005. In June 2006 SAMHSA, NIDA, and the National Drug Intelligence Center issued alerts. CDC documented 583 confirmed deaths from 2005 to 2006. Later reporting attributed approximately 1,000 deaths to fentanyl overdose in 10 jurisdictions by November 2006, probably an undercount. Dr. Hoffman illustrated that the pattern of deaths resembled an infectious disease outbreak. DEA took over the reporting of fatalities since August 2006. Epidemiology revealed the highest peak among people ages 45 to 54, with many deaths in the age 16 to 24 group. Eighty percent of victims were male, 53 percent white, 40 percent Black, and 4 percent Hispanic.

The Federal effort involved ONDCP; DHHS's CDC, SAMHSA, NIDA, and the Food and Drug Administration; Department of Justice's DEA and National Drug Intelligence Center; and the Department of Homeland Security, all of which triangulated their information in regular conference calls; representatives of State, county, and municipal agencies also participated. The Delaware Fusion Center also was involved, which brought law enforcement, High Intensity Drug Trafficking Area (HIDTA) personnel, and others together. The need to improve the continuum of care became evident: Many people who overdose on the street do not go to emergency rooms because they fear law enforcement; emergency rooms do not link consistently to treatment; and treatment centers do not confer priority status for treatment on people who have overdosed. Collaboration is improving with law enforcement's shift to support treatment and prevention. Dr. Hoffman stated that Federal agencies worked well and openly together, with appropriate information sharing among agencies and community organizations. The ONDCP Synthetic Drug Workgroup discussed creating an early warning prevention mechanism.

Discussion. Dr. McCorry described New York State's evidence-based overdose prevention effort to train "shooting buddies" by issuing single-use syringes with Naloxone and suggested a presentation on opiate overdose prevention models at a future Council meeting. Dr. Taylor explained that legislative changes would require authorization of treatment programs to provide access to Narcan, in addition to physicians, and that good Samaritan legislation would be needed to avoid liability for people who administer Narcan in attempt to save a life. Dr. Taylor responded to Ms. Bertrand's question that DASA engaged experienced street outreach workers active in needle exchange, HIV, and sex worker programs. DASA identified key points for each outreach worker to make in his or her own way. DASA staff provided training on the technical aspects of fentanyl and statistics, and medical staff provided CPR training.

Ms. Heaps suggested that CSAT/SAMHSA engage with DEA to discuss improving the timeliness of communication with States and local jurisdictions on overdose data. Dr. Clark concurred in the need for rapid communication. Ms. Heaps also recommended that CSAT/SAMHSA engage with DEA about sharing its data with States to provide early warnings on drug emergencies, perhaps using the Illinois model. Dr. Clark stated that he will make efforts to put this item on the agenda for CSAT/SAMHSA's work on disaster-related strategies. Mr. DeCerchio suggested developing a 90-minute webinar targeted to Single State Agencies (SSAs) on the Illinois model of response to substance-use emergencies. Dr. Hoffman responded that

each city and State worked with agencies with their own interests in responding, and the configuration differed in each area. The need for types of information was consistent.

SAMHSA's Science & Service Award Presentations

Dr. Kevin Hennessy, Science to Service Coordinator, Office of Policy, Planning, and Budget, SAMHSA, explained that the Science & Service Awards recognize organizations for outstanding work in expediting new science into practice in community settings. The inaugural awards to 20 recipients around the country represent visible national recognition that they have successfully implemented one or more evidence-based practices in their communities. Award applications required brief information on how applicants addressed their programs' implementation, sustainability, implementation with fidelity, and outcomes. Brief summaries and contact information on all 20 award winners are available through a new Science & Service webpage on SAMHSA's website. Six recipients described their programs.

Ms. Bobbye S. Gregory accepted an award on behalf of Central Clinic/Court Clinic in Cincinnati, Ohio, in the treatment of substance abuse and recovery support services category, for Helping Women Recover and Integrated Dual Disorders Treatment (IDDT). Court Clinic developed a cross-system collaboration that assessed the needs of women who are incarcerated and their treatment options. Joint assessments are conducted by representatives of criminal justice, probation, mental health therapists, and substance abuse counselors. Evaluations completed at a jail site revealed that most women with co-occurring disorders were never diagnosed, misdiagnosed, or fell through cracks. After 3 years of foundation funding, Hamilton County funds have supported the ongoing Alternative Interventions for Women Program, an intensive outpatient program for women mandated to treatment. Treatment for up to a year incorporates two evidence-based practices, Helping Women Recover and the Dartmouth Model States of Change. With help of Pre-trial Services, the program tracks recidivism for 3 years after program completion. More than 70 percent of the women were not convicted within 3 years.

In response to questions from Council members, Ms. Gregory stated that the program originally was planned for 12 weeks of therapy, but the unrealistic timeframe was extended to 12 months. As a jail diversion program, the program has enabled families to stay together. An onsite child care specialist and case management to arrange child care vouchers prevent out-of-home placement. Few mothers have been involved in the child welfare system. Many women have lost custody of their children, and many are working toward regaining custody.

Ms. Arienne Fauber accepted an award on behalf of Scioto Paint Valley Mental Health Center, Greenfield, Ohio, in the co-occurring disorders category, for implementing the Criminal Justice Substance Abuse/Mental Illness (SAMI) Assertive Community Treatment (ACT) Re-entry Program. Ms. Fauber explained that the agency began implementation in 2002 with a foundation planning grant. Local stakeholders assessed the area of greatest need and chose to implement SAMI/IDDT services for individuals ages 17 to 20 with specific mental health diagnoses, substance abuse, and involvement in the criminal justice within the previous 6 months who were returning from secure confinement. In 2004 72 percent of clients avoided permanent confinement, and in 2005, the number rose to 90 percent. In 2004 82 percent had stable housing; in 2005, 86.4 percent. Good outcomes and funding enabled the clinic to incorporate the ACT model, to double the number of clients served, and to add three staff members. In 2006 no

participants returned to permanent confinement; 56.8 percent reported not using their primary drug of choice; 78.4 percent lived in stable housing; and 40.7 percent had full- or part-time employment. Lessons learned included the need to maintain high fidelity to treatment models, develop good relationships with the criminal justice system and other community stakeholders—good relationships with probation officers especially help reintegration into the community—and maintain client-centered treatment with enduring support for clients.

Dr. Michael DeBernardi accepted an award on behalf of The Life Link of Santa Fe, New Mexico, in the treatment of substance abuse and recovery support services category, for implementing Community Reinforcement and Family Training (CRAFT), a program to support significant others in motivating loved ones to enter treatment. Dr. DiBernardi explained that Life Link is a community not-for-profit focused on effective models. Santa Fe County applied successfully for CSAT funding to demonstrate the effectiveness of CRAFT in a community setting. After a 3-year study with 107 concerned significant others and intense supervision, the loved ones of 65 percent went into treatment, and decreased quantity and frequency of drinking in the home were reported at 6 months for those who did not enter treatment. Moreover, significant improvements in the areas of anxiety, depression, and anger were identified. Life Link joined the Southwest node of NIDA's Clinical Trials Network to participate in formal research and created the Life Link Training Institute, which has offered 300 providers to date technical support, training, and ongoing supervision on implementation of evidence-based practices. In response to a question from Dr. Fletcher, Dr. DeBernardi responded that Life Link recruited heavily for the program, with most referrals from the ad on the back cover of the newspaper's TV guide. Most Life Link's referrals take place via word of mouth.

Mr. Harry J. Cunningham accepted an award on behalf of the Mental Health Center of Greater Manchester, Manchester, New Hampshire, in the co-occurring disorders category, for implementing IDDT. Mr. Cunningham stated that CSAT's efforts have enabled even the smallest of mental health centers to implement state-of-the-art evidence-based practices with high fidelity. He cited the challenges of staff turnover, shifting attention span of State mental health authorities, and complexity in implementing and sustaining multiple evidence-based practices. Dr. DeBernardi urged SAMHSA's continued assistance in managing the challenges, asserting that regional centers of excellence could provide training and technical assistance to grow and sustain the progress made.

Mr. Emmitt Hayes, Jr., accepted an award on behalf of the Travis County Juvenile Probation Department, Austin, Texas, in the treatment of substance abuse and recovery support services category, for implementing the Juvenile Justice Integrated Treatment Network. This child-centered, family-focused program serves youth in the juvenile justice system who are recidivists. The program works with entire families in all aspects of their lives. Beginning with a single rapid assessment upon entry into the Probation Department, a multidisciplinary staff determines best practices. That information is provided at the initial hearing to the judge, who orders the child into certain types of programs. After resolving complex challenges regarding confidentially across disciplines and other issues, and achieving measurable successes, the program has expanded programming into the Texas counties that include Houston and Dallas. Mr. Hayes explained the team-based nature of the program, whose case management approach links families to all the ancillary services they need, all within existing funding mechanisms.

Electronic communications management solutions move data across providers and counties, and have enabled the network to provide treatment and other services to more than 9,000 children and their families, around 200 at a time.

In response to questions from Council members, Mr. Hayes stated that his program uses Title IV-A funds. In order to engage parents other than by court order, the program meets families on their terms, often in their homes. Independent case managers do not work for Probation, which relieves families of an element of fear when case managers appear at their homes. The process of breaking down resistance begins with conversation with families and linking them to an essential service, such as rental assistance or food. When parents report their children to Probation, they do so with the understanding that help will be forthcoming, not immediate punitive action. Mr. Hayes stated that although insufficient numbers of professionals are bilingual, the program uses interpreter services available through the courts and also provides training about the populations' cultures. He stated that evaluation has been a major challenge, but the University of Texas has helped the Probation Department with process evaluations to help develop the integrated system. He has engaged with the Robert Wood Johnson Foundation's (RWJ) Reclaiming the Future program to learn how to market the network's program and its outcomes.

Dr. Linda Lee Gertson accepted an award on behalf of Ventura County Behavioral Health Department, Oxnard, California, in the co-occurring disorders category, for implementing a SAMHSA-funded grant to demonstrate full implementation of IDDT by four California counties. In an evaluation with California's version of the fidelity scale, the program earned near-perfect scores on every component. Dr. Gertson's agency developed a series of outcome measures for its clients with serious mental illnesses and severe addictions; preliminary data show a direct correlation between participation in the program and decreased symptom acuity, abstinence or decreased use, and decreased incidents of re-hospitalization and re-incarceration. The agency also developed an instrument to assess trauma, which revealed a history of trauma for 80 percent of clients; the agency runs trauma and dialectical behavioral therapy groups. SAMHSA awarded a \$2 million grant to include the homeless population in the program. If the program receives Mental Health Services Act (MHSA) funds, the agency plans to expand IDDT throughout the balance of clinics in the county. Dr. Gertson plans to take steps to adapt the program into a randomized controlled trial and to publish results.

Discussion. Dr. Hennessy stated that leveraging the Science & Service Awards was a hoped-for consequence. He observed that recipients echoed recurring themes: a core vision of meeting clients where they are; commitment to the client, family members, and consumers; and commitment to providing multiple services backed by the best science. Dr. Clark noted that many recipients are advising SAMHSA, which has a vested interest in evidence-based practices and providing adequate services for those in need. Council members commended recipients on their achievements. Dr. Mora expressed concern about the lack of evidence-based practices for various language and cultural groups. Dr. Gertson described the diverse minority populations of Ventura County, including 25-35 percent Hispanics. The agency has a bilingual staff; as part of the JCAHO-approved Ventura County Medical Center, staff train annually in cultural competence and must provide culturally competent services.

Ms. Jackson inquired about recipients' experience with implementation with fidelity and sustainability. Mr. Cunningham identified the need for senior administrative attention, making time for staff to learn and implement practices, and embracing and making time for monitoring and fidelity visits as a quality assurance effort. Dr. Gertson anticipated that MHSA funds will provide sustainability, enable expansion, and promote the recovery model for substance abuse and mental health. In addition, MHSA funds would fund construction of a dual-diagnosis residential facility and support workforce development. Ms. Fauber linked sustainability to a good relationship with stakeholders and to good outcomes and fidelity to evidence-based practice models. Dr. DiBernardi asserted that program sustainability requires ongoing training and supervision, and funds. Through education and lobbying, his program enlisted a major insurer to create a CRAFT CPT code and worked with the State to cover CRAFT through ATR. He awaits establishment of a CPT code for supervision, an expensive challenge.

Mr. Hayes identified the challenge of creating an experimental design to measure program outcomes and the difficulty in measuring the effect of the paradigm shift from deficit- to strengths-based approaches. Dr. Mora recommended pursuing community-based participatory research. Mr. DeCerchio inquired about IDDT's influence in other areas of the agency. Dr. Gertson responded that her agency received approval to replace its Medicare-driven master treatment plans with client-centered, recovery-oriented plans of care that address IDDT fidelity concerns. The agency's alliance with NAMI and other community-based organizations facilitates education, and the agency runs dual diagnosis groups in every site in the county. Mr. DeCerchio suggested that programs establish connections with ATTCs and the National Implementation Research Network (NIRN). Dr. Hennessy noted that NIRN conducted the awards process. Ms. Gregory stated that the National Institute of Corrections recently visited her program to learn about cross-systems with pretrial probation and the courts. Program success was instrumental in spawning, a new program for women who engage in prostitution to address trauma issues.

SAMHSA's Grant Review Process: Mystery of Review Revealed

Mr. Stanley Kusnetz, Senior Review Administrator, Grants Review Office, SAMHSA, described the intricacies of SAMHSA's grant review process. He itemized tenets of the review, including the requirement for each application to receive a thorough and impartial peer review, considered and scored only in accordance with the funding announcement's published review criteria, reviewed solely on its own merits and not compared to other applications. Review committee members are chosen for the expertise required; conflict of interest standards are strictly followed; and confidentiality and a level playing field are maintained. Whether or not an application "should be" funded is not considered.

SAMHSA outsources its grant review process, beyond four Federal employees, and review staff and Centers' program officers consult with each other before and after an announcement is issued. The Review Branch reviews grant applications for all Centers. The process begins with submission and screening of applications for format, screen-out criteria, and programmatic eligibility; program staff screen for other published programmatic requirements. Reviewers are chosen for their required expertise based on suggestions by program staff and review administrators.. Conflict of interest, diversity, geography, and review experience are considered. Review and program functions are separate to avoid a perception of conflict of interest.

For each funding announcement, review staff develop a template that identifies each item in the review criteria, assuring a degree of uniformity and consideration of every element. The template forces reviewers to review the entire application according to the RFA and to make both objective and qualitative assessments. SAMHSA conducts field reviews, telephone reviews, and onsite reviews. Field reviews, conducted by mail, are used most commonly, particularly for RFAs with large numbers of applications; three to six reviewers are assigned to a committee and review about six applications. Telephone reviews are held to resolve differences identified by the review administrator in completed field reviews. Onsite reviews involve meetings of 12 to 15 persons per committee, plus a chair, divided into triads of individuals with diverse and relevant expertise; each triad reviews five or six applications to develop consensus for each element in application; if consensus cannot be reached, members vote and the disagreement noted. The full committee discusses each application's triad review, section by section, and each reviewer scores each section independently following discussion. For all reviews, the priority score is the mean of the individual reviewers' scores on a 1-100 point scale.

For field and telephone reviews, program officers may prepare language, approved by the review administrator, that addresses for reviewers the intent and history of the funding announcement. The program officer also participates in orientation of reviewers and may attend onsite reviews to serve as a resource for the review administrator.

Summary statements are the objective reports of reviewers' assessments of an application's merits. For field reviews summary statements are developed from a composite of the structured review templates and assess each bullet of the funding announcement. Summary statements for telephone reviews are modified by the discussion. In addition to reviewers' assessments, summary statements include the application abstract plus assessments of the budget justification and participant protection. In onsite reviews, the summary statements incorporate the triads' enumerations of strengths and weaknesses, as modified by the full committee. A cultural competence section is appended to almost every review criterion. Summary statements are distributed to program staff, applicants, and Council members.

Council Discussion. Ms. Jackson observed that onsite review is the favored, although most expensive, approach; that most applications are subject to field reviews; but that non-onsite reviews omit comprehensive, interactive, holistic reviews. Mr. Kusnetz explained that decisions on review type depend on the volume of the response. He stated that efficiency, more than cost, leads to field reviews; onsite reviews are time-consuming to organize and conduct, particularly in the context of a short review season. He stated that review staff are developing a mechanism to enable reviewers to discuss applications online. Templates were developed to ensure that all reviewers carefully examine all aspects of the applications from their own perspectives. Field reviews were instituted due to the uncertainty of air travel immediately following the events of September 11. He asserted that the way to create best opportunities for onsite reviews is to schedule applications throughout the year. Review staffer Ms. Crystal Saunders explained that two onsite reviews are provided to each Center and that SAMHSA must consider implementation alternatives upon expiration of the current review contract. Dr. McCorry stated that spreading applications over the year will generate a more competitive process and result in a better product; time-pressed applicants would respond with better applications, and onsite reviewers could challenge each other's opinions.

Dr. Mora explained that Council wants to provide wider access to CSAT funds to effective community-based programs, regardless of their grantsmanship skills. To do so, she asserted, the mutual educational value of discussion at onsite reviews is critical, particularly in the adequate scoring of cultural competence issues. She pointed out also that program comments may be weak in cultural competence but have high scores nevertheless. Mr. Kusnetz explained that rounding scores sometimes raise an application to the next level. He also stressed the need for funding announcements to reflect the aim to support community-based organizations in order to achieve that aim in the review process; the RFA for ATR produced grantees with characteristics that reflected the applicant pool. Ms. Bertrand stated that leveling the playing field for community-based organizations is difficult when SSAs and county governments can compete with them for funding—especially when the governmental agencies hire grant writers.

Dr. Fletcher noted that in earlier days most reviewers were academics. Mr. Kusnetz responded that review committees now represent greater diversity among professionals and populations.

Ms. Jackson suggested that SAMHSA solicit comments from reviewers and experts in the field about improvements to the grant review process; Dr. Mora added that SAMHSA should consult with Council. In order to maximize the quality of both applications and peer reviews, Council members unanimously recommended that CSAT/SAMHSA distribute RFA submission dates throughout the fiscal year in order to facilitate greater opportunity for face-to-face reviews and to permit applicants to avoid grant-writing crunch times that impinge on application quality.

Dr. Mora suggested continuing the discussion of accessibility to grant programs, the development of RFAs, and the feasibility of more onsite reviews at the next Council meeting.

Evaluations at CSAT

Mr. Richard Kopanda, Deputy Director, CSAT, explained that program evaluations have been helpful at the program level in the past, although they may have had little visibility or use elsewhere. More recently, with increased emphasis on outcome measures and program performance, policy makers and have had greater interest in program effectiveness. In its recent restructuring, CSAT has established the Performance Measurement Branch to manage its evaluations. Both cross-site and local evaluations are critical to justify spending.

Addiction Technology Transfer Centers (ATTCs). Dr. Jack Stein, Director, Division of Services Improvement, CSAT, explained that the ATTC Network aims to develop and strengthen the addictions treatment workforce, and to raise awareness of and improve skills in using evidence-based and promising practices in recovery-oriented systems of care. From its inception in 1993, ATTCs have grown to cover all 50 States, territories, and commonwealths; 14 regional centers and a national office coordinate activities. Services and activities include developing partnerships with SSAs, provider organizations, recovery associations, addiction educators, and other stakeholders; training, technical assistance, research dissemination, and other technology transfer activities and initiatives, including a NIDA Blending Initiative, which provides resources to ATTCs to develop training packages that reflect research findings; Leadership Institutes; workforce surveys; activities to upgrade practice standards for addictions workers, including Treatment Improvement Protocols (TIPs); and development of materials and strategies to enhance recruitment and retention.

Ms. Deepa Avula, Public Health Analyst, Performance Measurement Branch, CSAT, stated that the ATTC evaluation aims to identify Network strengths and areas for improvement, to share lessons learned within and across the Network, and to distinguish between region-specific (for example, methamphetamine treatment) and cross-regional processes and outcomes. Methamphetamine treatment coordination may differ from region to region. The evaluation has incorporated the ATTCs in a participatory approach, particularly in the design and implementation phases, and includes process and outcome perspectives and quantitative and qualitative analysis.

The ATTC evaluation is funded in two phases, a 2-year design phase (through December 2007) and a 3-year implementation (through September 2010). In concert with ATTCs and diverse stakeholders—including SAMHSA, NIDA, SSAs, and ATTC directors—the evaluation elicited the history and context of ATTCs' work. Evaluators developed a logic model that outlined resources, funders' goals, and mandates; regional, State, and national needs; ATTC Network activities; objectives of the activities; and outcomes and outputs for each objective. Technology transfer objectives include awareness raising, skill building, and changes in practice and policy using lessons learned. ATTCs urged adding "mediating factors" to the logic model, which include geography, cultural diversity, and training of professionals, as context critical to understand ATTCs' activities, objectives, and outcomes.

Evaluation questions involve setting priorities and collaborations across the ATTC Network and with local, State, and Federal partners. The essence of the evaluation is its assessment of ATTCs' effectiveness in meeting customer needs, changing the substance abuse treatment delivery system, and enhancing skills and competencies. The ATTC evaluation is composed of three sub-studies. Data on planning and partnering by ATTCs will be elicited during site visits and small focus groups of ATTC staff. The evaluation of customer satisfaction and benefit to the consumer will use GPRA data already collected, customer satisfaction data, and customer interviews. The evaluation also will study outcomes of ATTCs' technology transfer activities, including changes in clinical practice and treatment systems and enhanced clinical and cultural competencies of the addictions treatment workforce in the areas, plus a NIDA Blending Initiative on treatment planning. The timeline for the ATTC evaluation will depend on OMB clearance.

Access to Recovery (ATR) Evaluation. Ms. Avula described Phase II of the ATR initiative, for which CSAT has allocated \$96 million for 24 grant awards to States and tribal organizations, including \$25 million for methamphetamine-related services, and \$2 million annually for the 3-year evaluation. Five tribal organizations, 18 States, and the District of Columbia received ATR II grants; 11 of these jurisdictions also had ATR I grants.

OMB's PART review of ATR, completed in August 2007, revealed the need to conduct the evaluation of the program's effectiveness. SAMHSA awarded the evaluation contract to RTI International. The evaluation aims to understand how ATR has implemented its voucher management system to promote recovery support services and enhance consumer choice by expanding the network of providers, and to use outcome data to manage and monitor program performance. The evaluation also will focus on ATR's impacts on clients, providers, and the treatment system. The evaluation will include extensive literature reviews on implementation of substance abuse and other health care system activities, and will incorporate an in-depth review

of the implementation process. It also will look at expansion of the treatment network, whether faith-based providers were recruited appropriately, and whether or not NOMs indicate improved client outcomes after receiving ATR recovery support or clinical treatment services. The evaluation also will focus on numbers of clients served, vouchers redeemed, implementation of the voucher management system, and how implementation of voucher management systems by State affects client outcomes. The evaluation also will look at the costs of ATR implementation to States, providers, and clients in terms of funds, time, and energy spent.

Data collection methods will include visits to all sites, a document review, review of administrative records, and surveys of providers and clients. Data collection tools will be developed and then submitted to OMB around March 2008. Year 2 of the contract will involve data collection and preliminary data analysis. The last half of the third year will be devoted to completing formal final reports. CSAT intends to involve grantees in the evaluation.

Council Discussion. To a question from Mr. DeCerchio, Ms. Avula responded that the ATR evaluation will not specifically analyze Cohort I outcomes, but lessons learned will be revealed in changes that repeat grantees make to their programs. Mr. DeCerchio urged CSAT to forge a stronger connection between grantees and ATTCS, including grantees who did not receive continuation funding, to bring implementation success to national attention. Dr. Stein stated that technical assistance contractors have been capturing such findings in their final assessment.

Mr. Stein stated that target customers are the clinicians who provide substance abuse treatment services and their supervisors. Two-way dialogue is fostered through ATTCS' partnerships with State-based organizations that represent treatment providers, and by encouraging ATTCS to include stakeholders in their decision-making processes. Dr. Fletcher urged CSAT to implement a proactive mechanism for ATTCS to engage stakeholders and grantees to establish a participatory approach to maximize learning from and dissemination of grantees' experiences. Dr. Mora urged CSAT to incorporate questions in the ATTCS evaluation that investigate ATTCS' level of effort and success in reaching out to provider organizations that serve minority populations. Ms. Avula stated that the evaluation will address that issue.

Ms. Avula explained that ATR Cohort II grantees must collect NOMs data on seven major domains. A decision will be made on whether to collect outcome data for longer than 6 months.

Dr. McCorry highlighted the need to compare ATR's success with treatment as usual, in addition to comparing community-based versus faith-based outcomes. Ms. Avula stated that such a comparison is not part of the proposed design.

Dr. McCorry observed that ATTCS have not yet focused on bringing to scale the science of knowledge adoption and the implementation of new practices at the program level; he expressed concern that ATTCS will be evaluated on a task they are not designed to do. He stated that not enough ATTCS are established or sufficiently resourced to penetrate at the individual level in large communities such as Los Angeles or New York. An elusive piece of the equation continues to be knowledge adoption and implementation, which has not been moved successfully beyond pilot programs such as STAR-SI or NIATx. With Ms. Heaps' concurrence, he asserted that systems will not change until CSAT adopts that as an ongoing core strategy.

Ms. Heaps raised the issue of pressure on States to report ATR outcome measures before sufficient time had elapsed for real outcomes to evolve. She expressed concern about the degree to which the evaluation will offer information to the highest policy levels on the real issues that have emerged. Dr. Clark responded that the decision to pursue ATR was made at a higher level, and SAMHSA was designated to implement it. SAMHSA demonstrated ATR's utility, but it was not a research paradigm. ATR's side benefits include jurisdictions deciding to continue aspects of the program that appeal to them and adopting a recovery-oriented system of care. Dr. Clark explained that the Administration has urged Congress to adopt appropriations language that would improve accountability and results based on NOMs data for all service delivery programs. Congress expects a comprehensive transformation of the service delivery system that produces increased wellness. Dr. Clark asserted that recovery-oriented systems of care should transcend political imperatives and become a public health delivery system. ATR has empowered clients to make choices to suit their needs based on cultural competence and greater specificity. He expressed the hope that Council will help devise a recovery-oriented system of care that will be accountable and demonstrate an impact. Collaboration with NIDA, ATTCs, and States, along with the National Repository of Evidence-based Practices and Programs (NREPP), all will contribute to the transformation and diffusion of evidence-based practice into care.

Ms. Bertrand noted that the ATTC for Ohio's region has brought the State, three counties, and providers together to develop a strategy using NIATx principles to create additional treatment access and to document the process for replication elsewhere. The ATTC serves as an important resource for community-based organizations.

Dr. Madrid urged outreach to the Latino community for participation in ATR. Dr. Clark pointed out, however, that one initiative does not provide sufficient funding for the entire delivery system. With continuing education, jurisdictions can adjust their operations to reflect advantages of the ATR paradigm. SAMHSA can highlight the issue of cultural competence and ensure that as many academics and vendors as possible know about ATR II's existence. In addition Dr. Clark asserted that the Block Grant and discretionary portfolio also should be culturally responsible and accessible by specific groups. To Dr. Madrid's question about monitoring vouchers, Dr. Clark responded that grantees monitor vouchers and CSAT monitors grantees.

Adopting Changes to Impact Outcomes Now (ACTION) Campaign

Ms. Frances Cotter, Public Health Advisor, CSAT, described the new ACTION Campaign to promote adopting change in business and administrative practices that can improve substance abuse treatment providers' outcomes related to client access, engagement, and retention. The campaign aims to impact 500 treatment providers and a large number of partners. The Network for the Improvement of Addiction Treatment (NIATx) serves as coordinator of, and provides technical support to, a partnership of national organizations, including CSAT/SAMHSA. The campaign began in 2003-2006 with a successful CSAT-RWJ demonstration of process improvement methods under its own enduring NIATx brand. In addition to positive results, the project identified best practices. During the period 2006 to 2009, CSAT and RWJ supports Strengthening Treatment Access and Retention (STAR), a ten-State implementation program to learn how State systems can embed the strategy and, in partnership with providers, drive change.

To date the field-initiated ACTION Campaign has enrolled half of its goal of 500 treatment providers. Each will implement 1 of 12 access or retention interventions over an 18-month period, projected to enable an additional 55,000 individuals to receive treatment. Three actions make a difference: providing rapid access to services, improving client engagement, and creating a seamless transition between levels of care. A toolkit was developed for each best practice, and a website (www.actioncampaign.org) and other resources provide quick guides. The no-cost program focuses on organizational adoption and implementation, supported by a peer network.

Discussion. Drs. Taylor and McCorry both have STAR demonstration projects in their States. Dr. Taylor explained that Illinois has enjoyed a positive experience with process improvement and is endeavoring to disseminate the principles throughout system. Illinois reminds providers that in an environment of performance-based contracting and NOMs reporting, the process offers a specific way to address challenging issues. Dr. McCorry stated that New York State aims to create within providers an environment that allows for the adoption of innovation, and providers express enthusiasm for the menu of NIATx tools.

Public Comment

Thelma King Thiel, Chief Executive Officer, Hepatitis Foundation International, described positive feedback at the ATTC conference, particularly on the “Silent Killer” video about liver and heart risk. Her foundation provides training on liver wellness and helping people take responsibility for their own health care. She expressed interest in the ACTION campaign.

Council Roundtable

The Council unanimously recommended that CSAT staff develop approaches, for Council review, for a demonstration project, specific to areas of greatest need related to drugs and medications that support the implementation and evaluation of a model response-to-overdose prevention and intervention program.

Ms. Heaps stated the need for the ATR evaluation to document CSAT’s work to incorporate ATR into a recovery-oriented system of care. She also suggested inviting a NIDA representative to speak to Council about its blending initiatives. Ms. Jackson expressed appreciation for gearing the meeting’s agenda to the Council’s interests. Dr. Mora suggested including as an agenda item the substance abuse treatment issues of returning Armed Services members from Iraq. Dr. Clark responded that issues for community treatment providers of returning National Guard and Reservists are an appropriate focus for the Council.

Mr. DeCerchio stated that many child welfare regional partnership grantees are community substance abuse agencies and in need of technical assistance and support. He urged developing connections among CSAT, ACF, and the child welfare community, and linking with ATTCs. He also suggested investigating opportunities for linkage with the Department of Labor’s disadvantaged youth initiative. Dr. Madrid suggested as a future agenda item the relationship for adolescents of drug addiction and music. Dr. Clark responded that he will share information with Council on the phenomenon.

Adjournment

The meeting adjourned at 5:05 p.m.

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

06/19/2008
Date

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