SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

41st Meeting

Wednesday,
March 7, 2007

Sugarloaf Mountain and Seneca Rooms
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, Maryland

IN ATTENDANCE:

Chairperson

Terry L. Cline, Ph.D.
Chair/Administrator, SAMHSA
1 Choke Cherry Road, Room 8-1065
Rockville, MD 20857

Executive Director

Daryl W. Kade, M.A.
Executive Director, SAMHSA National Advisory Council
Associate Administrator for Policy, Planning,
and Budget, SAMHSA
1 Choke Cherry Road, Room 8-1083
Rockville, MD 20857

Executive Secretary

Toian Vaughn, M.S.W.
Executive Secretary, SAMHSA National Advisory Council
1 Choke Cherry Road, Room 8-1089
Rockville, MD 20857

Members

James R. Aiona, Jr.
Lieutenant Governor
Executive Chamber
Hawaii State Capital
Honolulu, HI 96813

Gwynneth A. E. Dieter
Mental Health Advocate
U.S. Embassy Belize
Unit 7401
APO AA34025

Faye Annette Gary, Ed.D., R.N.
Professor, Case Western Reserve University
Frances Payne Bolton School of Nursing
1099 Euclid Avenue
Cleveland, OH 44106-4904

Barbara Huff
Consultant
The Federation of Families for Children's Mental Health
2837 North Plumthicket Circle
Wichita, KS 67226

IN ATTENDANCE:

Thomas A. Kirk, Jr., Ph.D.
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor
P.O. Box 341231, MS #14 Com
Hartford, CT 06134

Kenneth D. Stark
Director, Transformation Grant Division
Department of Social and Health Services
111531 Washington Street
Olympia, WA 98504-53311

Kathleen Sullivan
Journalist
Four Mission Court
Rancho Mirage, CA 92270

Ex Officio Members

Laurent S. Lehmann, M.D.
Chief Consultant for Mental Health
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

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P R O C E E D I N G S (9:08 a.m.)

DR. CLINE: Good morning, everyone. My name is Terry Cline. I'm the Administrator for SAMHSA. I'd like to welcome you to the meeting. I know that some people are worried about the weather and I appreciate you braving the storm. It's not quite a storm yet and hopefully won't be, but I appreciate you being here.

I also would like to thank Lieutenant Governor Aiona as the vice chair today. If at any point I'm called out, you'll be in capable hands with the Lieutenant Governor. So I appreciate your stepping up to the plate for that, as well.

I also would like to welcome our council members and would like to ask the council members at this point to introduce themselves so that most of you know each other but also for our audience today.

Barbara, if we could start with you and the council members, and then we'll do other introductions after that.

MS. HUFF: Hi. I'm Barbara Huff. When I started on the council I was the executive director of the Federation of Families for Children's Mental Health. I since have semi-retired and moved home to Wichita, Kansas, where I still work part-time for the Federation, and I also do some consulting work part-time as well.

I'm happy to be here and happy to see Terry. Thank you.

DR. CLINE: Thank you, Barbara.

MR. STARK: Ken Stark. I'm from Washington State. I'm the director of the Mental Health Transformation Grant, a grant from SAMHSA, and the grant is through the governor's office. We are working very hard to do what transformation we can around mental health in our state. It's a very, very busy year this year with legislative stuff going on. We've got over 22 pieces of legislation around mental health, so it's really, really hopping.

DR. CLINE: Wow. Thank you.

We're going to do other introductions after the council members.

DR. LEHMANN: Thank you. I'm Larry Lehmann with the Department of Veterans Affairs. Again, I'm very pleased to be here. We've really based our mental health strategic plan on the President's New Freedom Commission initiatives, and we're very pleased to participate in a number of the work groups, including those for disaster, suicide prevention, and primary care integration.

It's a pleasure to be here.

DR. CLINE: Welcome.

MS. DIETER: Hi. Good morning. I'm Gwynneth

Dieter, and I have a family member who has a co-occurring disorder. So I'm a family advocate, I guess I would say. When I began on the council we were from Colorado. We were living in Colorado. Right now I'm living in Belize, so I'm also becoming more interested in international efforts in which SAMHSA is involved.

DR. CLINE: Thank you.

DR. GARY: I am Faye Gary, professor at Case Western Reserve University. I am a psychiatric nurse. I do research and also teach medical students and nursing students. My area of specialty is child mental health psychopathology and working with families and children in the communities. I've also just been invited to join the National Board of Directors of the National Mental Health Association, which is now Mental Health America.

DR. CLINE: Great. Thank you.

DR. KIRK: My name is Tom Kirk. I'm the commissioner of the Department of Mental Health and Addiction Services in the State of Connecticut, a psychologist by training. Similar to Washington State, we're one of the mental health transformation states. The major things that I'm particularly interested in are focuses on the whole aspect of recovery and the recovery service system, co-occurring disorders, services for women, trauma, things that will truly result in improved quality

of life or quality of services for the people we serve. Our legislature is in session and we're going to be finished in June.

DR. CLINE: Thank you, Tom.

MR. AIONA: Aloha. My name is Duke Aiona. I'm the Lieutenant Governor for the State of Hawaii. In my former life I had the honor and privilege to start up the first drug court in the State of Hawaii. Currently, the governor has charged me to lead our state in developing a strategy for our drug abuse and alcohol abuse in the State of Hawaii, and we're doing very well.

DR. CLINE: Thank you.

We also have Ms. Sullivan on the line. Ms. Sullivan, would you please introduce yourself?

MS. SULLIVAN: Good morning, Terry.

DR. CLINE: Good morning.

MS. SULLIVAN: My name is Kathleen Sullivan. I'm a former broadcast journalist, and I have bipolar disorder.

DR. CLINE: And I understand you're a little bit under the weather today.

MS. SULLIVAN: Yes. Interestingly enough, I know that you are all suffering the effects of the very cold storm, but I was borderline pneumonia in 85-degree weather. So go figure.

(Laughter.)

DR. CLINE: We appreciate you joining us today. Thank you.

I'd like to go ahead and move to the introduction of our center directors as well, or their representatives.

Kathryn, if we could start with you, please?

MS. POWER: Good morning, everyone. I'm Kathryn Power, the director of the Center for Mental Health Services, and I've been here for a couple of years. So I know most of you, and it's nice to see everyone this morning.

MR. KOPANDA: Good morning. I'm Rich Kopanda, deputy director of CSAT. Dr. Clark sends his regards from Vienna.

DR. CLINE: Rose?

MS. KITTRELL: Good morning. I'm Rose Kittrell. I'm the acting deputy for CSAP, and I'm representing Dennis Romero, who is the acting center director. He'll be here this afternoon.

DR. CLINE: Thank you.

At this time I would like to recognize, as the new Administrator here -- obviously, there was a period of transition, so I'd like to publicly recognize the contributions of Dr. Ric Broderick, who stepped into the

fray and has done a remarkable job during that transition, as well as assisting me in this part of the transition. So if we could all join in thanking Ric for his contributions.

(Applause.)

DR. CLINE: And, of course, any time you have a transition like that, it tends to disperse the responsibilities not just to the person who is filling in in that position but also to a number of other people. So I would like to thank the rest of the leadership team who all stepped up to the plate and contributed during that time. That meant that they had additional hours, additional responsibilities, and have carried that out beautifully, as well as their own responsibilities that they carried on with.

So thank you to all of you who did that as well. Thanks.

At this time I'd like to make note that we have two more members who were not able to be here because of prior commitments. One is Ms. Holder, and the other is Ms. Bush. So we look forward to seeing them at our next meeting.

We also had one resignation from the council, Ms. Racicot. I had the good fortune of talking with her on the telephone and also meeting her last weekend at a Leadership to Keep Children Alcohol-Free board meeting here

in D.C., and I can tell that that will be a significant loss to the council. She obviously had a lot to contribute. Hopefully we'll still be able to get a little advice from her on the side. I think that she'll be more than happy to stay engaged with us.

At this time I will ask our vice chair if he has any comments he would like to make.

MR. AIONA: Very briefly, and good morning, and thank you again, Dr. Cline. Nice to meet you.

Thank you, Dr. Broderick, for what you've done in the interim.

I just want to remind the members that we serve as advisors and ambassadors of SAMHSA. So as we proceed in the next day and a half, if you could just, as we discuss various issue and items here, could you think about what your roles as ambassadors and advisors are, and also think about future agenda items or agenda items for our future meetings.

That's it, Dr. Cline. Thank you.

DR. CLINE: Thank you.

At this time we will move more into the business, and hopefully you had an opportunity to review the minutes. So I will entertain a motion to approve the minutes for the April 26, 2006 SAMHSA National Advisory Council meeting.

PARTICIPANT: So moved.

PARTICIPANT: Second.

DR. CLINE: And second. Any comments, changes, edits that need to be made?

(No response.)

DR. CLINE: We have a motion and a second, and I'm not sure if we actually take an official vote. This is where I'm walking through the process. Or do we just do this through consensus? Consensus.

All those in favor, please say aye.

(Chorus of ayes.)

DR. CLINE: Anyone opposed, please say nay.

(No response.)

DR. CLINE: Okay, the motion has passed.

We also have a call for a motion to approve the minutes for the June 29 meeting of the National Advisory Council. Do I hear a motion to approve those minutes?

MR. AIONA: So moved.

MS. HUFF: I'll second it.

DR. CLINE: Okay. The motion has been moved and seconded. Any comments, changes, additions, edits?

(No response.)

DR. CLINE: Hearing none, all those in favor of the motion, please say aye.

(Chorus of ayes.)

DR. CLINE: Anyone opposed, please say no.

(No response.)

DR. CLINE: The motion has passed. Thank you.

I am going to move into my Administrator's report, and as part of that I'm going to start by providing you with a little bit of background information about myself. I know a couple of you fairly well over the years, but some of you I'm brand new to the scene, so I'd like to just tell you a little bit about my background and then move more fully into my report.

I think this is my sixth week on the job as the SAMHSA Administrator. I'm starting to lose track of the weeks, so that's a good sign I think.

(Laughter.)

DR. CLINE: I think it's a very good sign.

I have come to this position from my previous position in Oklahoma, where I served in two different capacities. One was as the Secretary of Health for the state, appointed by the governor, and the other hat was as the commissioner for the Oklahoma Department of Mental Health and Substance Abuse Services. I held those positions for about six years.

Prior to that, I actually had completed the Health Care Policy Fellowship here at SAMHSA, which was an APA/SAMHSA fellowship. I'm very pleased to have been able

to do that really looking at organization and financing of mental health services across the country as part of that.

Prior to that, I lived in Cambridge, Massachusetts for about 15 years where I was a clinical director of a community mental health center, as well as chairman of a governing board for a teaching hospital, very involved in public health issues. The hospital system was also responsible for the Department of Health, the city health for Cambridge and had merged with several other hospitals in the area. So I'm bringing that bit of experience as well.

I've been very active in both the National Associations, NASADAD and NASMHPD, which were wonderful experiences just to get that breadth of exposure with the other states, and then hearing about what other issues states are grappling with, and that I think has been a helpful experience in coming into this position, having that broad base of experience.

So that's enough about my background. I'm going to move through my report. I'm going to encourage you, rather than waiting until the end of my report, if you have questions or if you have comments or there's anything you'd like to discuss that's triggered by my comments, I would encourage you to please just jump right in there, rather than trying to keep track of your questions and

saving those until the end. I think that, too, will make the flow a little bit more consistent.

One of the very first questions I was asked when I came on board was what are your priorities? What direction will we be going here at SAMHSA? My response was that I don't know and that I was not walking in with a pre-formed agenda that was based on whatever priorities I felt were most important. I believe it's important to establish those priorities as part of a process, and that process is much broader than just my perspective. Obviously, I'll bring my perspective into the mix as well, but for me that process includes hearing from you all here or other advisory councils, hearing from the various constituency groups, hearing from consumers and other stakeholders out in the field. So we have been on a very aggressive schedule of meetings over these last five weeks, and we are continuing to gather information, and it has been a very interesting process and I think a very important process.

Certainly my experiences are limited, so it is reassuring to me to know that we are gathering input from many other sources rather than having to rely on what may be my somewhat narrow scope. So that really is the process that we're following in terms of establishing those priorities.

What is in place and what will continue to be in place -- and I don't know if everybody's packet had it. I always get a few chuckles from this. Has everybody seen this before? This is the matrix.

MS. HUFF: We all have it as placemats.

DR. CLINE: Do you? Okay. This was at one of Charlie's going-away receptions. Actually, there were kind of masks that were made out of the matrix, and when Charlie walked out, everybody pulled out the mask and put it in front. The matrix is something that will continue. I think it was a groundbreaking effort to really cut across some of those silos that we've seen and some of those somewhat superficial barriers that many people have experienced within SAMHSA and external to SAMHSA. So having the crosscutting principles and programs I think has been very helpful, and we will continue with that.

Knowing that this has been a document that is in development and evolution, there may be changes over time, but there is no plan at this time to do that other than making those adjustments as we see fit, which was the case before. So I'm pleased to say that we're continuing with that. Again, I think that keeps the issues front and center for us. It keeps us focused on why we're doing what we do, and these are the issues that are closer to the source of people who are actually receiving services in

communities and neighborhoods across the country. So I wanted to let you know that that will continue. It continues to guide our budget discussions, and it continues to guide our priorities in terms of resources within SAMHSA. So I'm pleased to let you know that we will be continuing with that.

The other thing, and this is again having come from a state, I am a big fan of SAMHSA's vision and mission statements. I particularly enjoy the notion of a life in the community for everyone. I think that it is straightforward, to the point, and it's something that rings true for everyone who has received services or been struggling with recovery in communities or anyone who has been involved in providing and supporting people who are living with mental illness and serious emotional disturbance and addictions and substance difficulties.

So I think that having a vision statement that you can internalize, that we can all internalize, is not something that is three paragraphs long but is something that we can take to heart I think is very meaningful. So we are keeping the vision and the mission, which keeps that focus on resiliency and recovery, which is what we're all about. As we make decisions moving forward, we can simply ask the question does this support the mission, does this support the vision for SAMHSA, and if it doesn't, then we

need to question why in the world we're considering moving forward with something if it doesn't support that mission and vision.

So again, I know there was a great deal of work that went into those efforts for both the matrix and for the vision and mission, and I think it's important to continue with those. So we will be continuing.

I don't know. Were there any kind of similar responses or responses that were different as this process rolled out in the past? Does anyone have recollections of the matrix development or of the conversations around the vision and mission? I'll just put it back to you with a question mark. Anyone care to make any comments on that? Ms. Dieter?

MS. DIETER: Barbara has been here a little longer, I think. The vision hasn't changed, but the matrix has changed in response to recommendations here at the advisory council and input from other places. There have been several changes. Suicide prevention, criminal and juvenile justice was added. I'm trying to think. Has homelessness been there all along? Yes.

DR. CLINE: And the workforce development?

MS. DIETER: Workforce development was the most recent, I think. In terms of the crosscutting principles, help me. I'm trying to remember. Disaster readiness and

response was added.

MS. KADE: It was moved from program priority to crosscutting.

MS. DIETER: Crosscutting. Well, the science to services, that was a huge push in that direction, and what I can't recall is whether that was already in the crosscutting or was added to it. I remember that effort took quite a bit of time and work. I'm not sure of other additions. Does anyone want to add? Barbara? Daryl? Kathryn?

DR. CLINE: That's helpful. That really speaks to the evolutionary nature of the document, a living document that's responsive to needs and one that integrates our current thinking.

MS. DIETER: Right, and that I think that was the concept, that we have this formulation which can respond to additions, changes, adjustments as you go along.

DR. CLINE: Thank you.

Any other comments? Barbara?

MS. HUFF: I think for those of us in the field, and especially when I was the director of the Federation, I think that we were really excited and thrilled about all of this, because we could kind of see some of our work on paper, and that's always fun. But I think the problem, the most trouble we've had, but we've

worked around it -- Kathryn probably knows this, and that is the sentence that a life in the community for everyone by building resilience and facilitating recovery. We weren't sure how that fit for kids, were we? I mean we, not you. We. But Kathryn was really good at kind of helping us work through that, because that was really difficult. I think we've made due with this okay. I mean, at first it was like, no, this wasn't going to work for us around children, but we've kind of figured out that recovery is bigger than adults and that building resilience is always important. We just weren't sure that those were exactly the right ones, but we've made it work.

DR. CLINE: Thank you for that comment. I would love to have more conversation with you at some point about that. Thanks.

MS. POWER: I think, Terry, that Barbara really highlights the fact that when it comes to children and families, recovery really grew out of the adult population with mental illness, and resiliency had really not taken on a life of its own relative to an application across many of the children and family programs. So I think with the definitions of family-centered and youth-guided and all of that clarifying language, I think we've really moved toward, as Barbara indicates, a broadening of both recovery and resiliency in a wellness approach, in a total health

integrated approach, in a family approach and in a community approach, which I think has been really from the guidance of members like Barbara.

DR. CLINE: Thank you.

Any other comments? Dr. Gary?

DR. GARY: I certainly appreciate the comments of Barbara and Ms. Kathryn Power. I just wanted to comment that from a child psych community health perspective, I think we could really use children as the model to look at resilience if you frame it in terms of growth and development. That's where we get our data, our clinical issues regarding resilience, because that's what you see given their age, their growth, development, the support systems from families, communities. Being a child psych nurse, I think I see resilience and recovery there more and quicker many times than I see in adults. It's just neurologically programmed to happen with a few other extra supports from organizations such as SAMHSA. So I truly embrace that for children and families.

DR. CLINE: Thank you.

DR. KIRK: I think as state director what I find very, very valuable about this is this is a great communication document. One of the challenges I have is that people in the field will say some particular initiative is the flavor of the month, the project du jour,

and they don't see how things tie together. So in terms of trying to move the system, something such as this helps people to see how these things tie together, and whatever I do in my next job in life, these things stay in place and become embedded. So you build on the things that went on before. But like you're saying, I think the word that used to be used was "matrix reloaded" or "recharged." It changes, and it should change based upon experience. But in terms of a communication document for what we do and all the different elements and how complicated it is for people, legislators and others who don't necessarily pay attention to this, I think it's a great, great approach. So I applaud you for keeping it on the table.

DR. CLINE: Thank you. That's very helpful feedback, and I appreciate the comments. Thank you.

I am going to talk just a little bit, and we have a couple of other presentations on the agenda, one talking about some legislative actions as of late, and also more time on the agenda talking about the budget and appropriations. But I'm going to just reference both of those as I conclude my comments.

I had the pleasure of participating in the House Subcommittee Appropriations meeting last week, and it was a very interesting process for me. It was my first Congressional hearing. I snuck into one the day before

just so I could see how it actually worked and make sure there were no surprised for me, and there were a lot of similarities to what I've experienced at the state level. So there wasn't a complete shift.

But what I would like to say is that prior to that Joe Faha, who you'll hear from later, had worked very hard at getting me in the door with a number of our Congressional members. So I had met with quite a few people prior to that. We had a little bit of a time crunch because this was scheduled so early in the legislative session. I think one day we had five visits back to back with Congressional members, and that's a real testament to Joe's relationships on the Hill that he was even able to get that many scheduled that tightly as members were preparing for the hearing committees. So thank you very much for that work, Joe.

One of the comments I would like to make, and then I'm going to just run through some of the basics of the President's proposed budget, and then Ms. Kade will go through more specifics with that in her presentation, but it was very clear that there is strong interest for issues from our Congressional members. The questions were well informed questions, both in the individual meetings and at the hearing. It was clear that many of the members are very passionate about particular issues and are strong

supporters of the work that SAMHSA has done, and I believe they will be strong supporters of SAMHSA moving forward. So I think it's important that you know that, that there is strong support, I believe, from our Congressional members.

In looking at the budget, and I know this is information that you've heard in the past, at least some of this, but I'll talk about some of the specifics for that, the President's budget was proposed at $3.2 billion. I believe that that budget sets an aggressive agenda that again supports our vision and mission, tying back to our vision and mission. As an overarching principle, there was the drive to be wise fiscal stewards of taxpayer dollars while also advancing our nation's health. So we have these two dynamics that are in motion with the President's budget. So you can kind of overlay that to everything.

In doing that, there were many decisions to invest available resources in priority areas, and what that may mean in some situations is that we have core programs that are being supported at the same level they were supported before. It may mean that there are core programs that we've kept on the radar screen but are not funded at the same level that they were funded in the previous year, and those areas include children's mental health services, suicide, school violence prevention, prevention services, HIV/AIDS, screening and brief intervention, and criminal

and juvenile justice. Again, you will hear more specifics in Ms. Kade's presentation.

We also saw support for the administration's priorities, which are expanding choice through the Access to Recovery Program, transforming the mental health system, and also creating a healthier U.S. through the Strategic Prevention Framework. I'm assuming that these are programs that you all are familiar with and have heard about from either your work here or your work back in your communities.

Another guiding principle for us is making sure that as these decisions are made, that they tie back into SAMHSA's strategic plan, and that strategic plan has three core areas which are easy to remember as this ACE mantra, which is looking at accountability, capacity, and effectiveness, and again trying to tie in decisionmaking around programs to these strategic pieces of SAMHSA's overall plan, with accountability to items. Again, if you have questions, feel free to ask them. There may be some more information coming later.

One is around our data strategy. The second, which is related, is around the National Outcome Measures, referred to as NOMs. Both of these are critical for multiple reasons. Although they're in this accountability category, this information is helpful in terms of also

gauging effectiveness of programs. It's also important in terms of SAMHSA being able to demonstrate to multiple stakeholders, including Congress, states and others who are interested, the effectiveness of programs. Also, as we need to make adjustments, and we're looking at performance measures so that we can make informed decisions with that, then we're actually basing that on data rather than basing decisions on either the crisis of the day or the loudest voice in that particular moment. I think that anyone who has administered a program knows that that can be a dangerous way to make decisions, because it will be a different voice or a different crisis next month. If we want to maintain a course that moves us toward that vision and mission, we can't afford to make those detours along the way. So we want to make informed decisions as we move forward.

Has there been much discussion here about the National Outcome Measures data strategy? No? Okay. We'll make certain that there is much more discussion and presentation here. These are very important and reflect an incredible amount of work that flows out so easily to talk about it here, but it's years worth of work that is pretty remarkable because it speaks to levels of collaboration between SAMHSA and multiple stakeholders in terms of the NOMs, especially with NASADAD and NASMHPD in finding

measures that have some consensus support from those associations given that the states are the primary gatherers of data through the systems. So you can imagine trying to find 10 measures or 8 measures or 15 measures that everyone would agree on, not an easy task. There is great variability between the states, and some states have wonderful data systems that have been collecting information. They use that data to manage their systems and inform consumers in terms of choices. Then there are some other states that have not made that investment in data systems and are not in the same place. So trying to pull all that together has been a huge task, and everyone here at SAMHSA who has been involved in that is to be commended for that work.

MS. HUFF: I just wanted to say that the Federation served on a committee around outcome measures. I haven't been the one who served on it, but Trina Osher has, and others from the Federation, and it's been enough to just give a person a nervous breakdown. It's so hard. So I think what you're saying about the differences in coming up with 10 or 15 or whatever the number is of outcome measures has been really an amazing challenge.

DR. CLINE: And it's a monumental task.

MS. HUFF: Yes, ongoing.

DR. CLINE: Ongoing, but one I think that

people will be quite pleased to see the results. Again, we'll have more discussion about that. There are, again, multiple reasons that's important. One is for the data and decisionmaking for SAMHSA, but also decisionmaking for states as they make determinations about their programs and have data that may indicate whether they're able to move the ball down the field or move the needle in the right direction. So that is an important accomplishment.

The other piece of the strategic plan is around capacity, and we have a couple of things I would like to note. Of course, you've heard some conversation already about Access to Recovery and expanding choice through Access to Recovery, looking at the Strategic Prevention Framework and infusing that kind of general principle, which includes a lot of the public health framework and actually fits in very nicely with the resiliency and risk factors and things like that.

Another critical piece is around the Federal Mental Health Action Agenda. That action agenda is really historic in terms of pulling together nine Cabinet-level departments around these 70 action items. There's been a huge amount of work and attention to the commitment to transform the behavioral health system, the mental health system across our country. I don't know that I'll be able to do this publicly, but I would like to thank Kathryn

Power for all of her work on this effort and her continued work on this effort. Again, I know from that state perspective that Kathryn was the face of transformation as it first emerged, and I think was often swimming against the tide and was a real champion who was out there.

I think you've done an incredible job on that front and you have brought that vision to a lot of hearts. I know it hasn't been an easy task, and we're just at the beginning of that. So I appreciate all of your work, Kathryn.

(Applause.)

DR. CLINE: The last piece is around effectiveness. Even as we increase capacity and we have this level of accountability and data, how do we know that what we're doing is as effective as it can be? When we're making decisions with limited resources, that dollar that we spend, that limited amount of time that one individual has, has to be as effective as possible. We don't have the luxury of being ineffective in what we do. Again, people's lives are at stake, and SAMHSA has that commitment to move the field forward, to move the country forward in providing the most effective care possible to individuals, and the most effective services possible. You've heard already some discussion about the science and service, so I know you had some discussion about that in the past, and you

will hear more today on the National Registry of Evidence-Based Programs and Practices, which we believe is a very important tool that will really help spread that. I won't say anymore about that because you'll hear more about that later.

I'm going to close now simply by saying that you can tell there's a huge amount of information, a huge amount of guidance in terms of strategic plan, in terms of the matrix, the mission statement, the vision statement. But part of what keeps that fresh and part of what keeps all of this alive and evolutionary is the input from our constituent stakeholders and the advisory council. So I again want to thank you for your commitment to be here today, traveling great, great distances for many people, and all of you are leaders in your respective fields who are in great demand. I recognize that your time is very limited and very precious, and there are many ways that you could be volunteering your time, either in your communities with your families or nationally. So I'd like to thank you for that. Your participation here is greatly valued.

I think I'm about to get a note here. Ms. Sullivan, I'm being prompted. I hope I'm not neglecting you.

MS. SULLIVAN: No.

DR. CLINE: I'll see if there are any comments

you'd like to make at this point.

MS. SULLIVAN: No. First, Ric, I've been meaning to compliment you and thank you so much for what you did in the interim. I think you looked at the matrix and you kept the matrix going, and thank you for all of the programs. Kathryn, what you've done ongoing for the past couple of months especially, and your attending to all of the programs that I care so much for has meant so much. Terry, how you're addressing the matrix, it's just all good, good, good from the West Coast.

DR. CLINE: Thank you, Ms. Sullivan.

Dr. Gary?

DR. GARY: Thank you, sir. Thank you for your report. I just had one or two questions and probably comments.

Could you also just make comments about how the New Freedom document, the President's New Freedom document might have driven the decisions regarding budget? And also, the Healthy People 2010, where the specific goals that the nation should be able to meet, address, measure that relates to healthy people in the United States, were those documents integrated into the discussion, and how will SAMHSA continue to address those issues, which in many ways the matrix is subsumed under a lot of those different areas?

The third issue is would you also include comments, observations about the next step in helping the Katrina victims? We know that children are still not in school. There are a lot of mental health issues, housing issues, general public health kinds of issues. Will SAMHSA have a specific role with regard to how we could look at this, the matrix, and apply it to the Katrina population? I think if we're not careful, the people who were in that hurricane in Louisiana, Texas, Mississippi, I think we have to continue to advocate for them. So I would just like to hear a bit of discussion about your future thinking about those populations as well.

DR. CLINE: Okay. I see Kathryn's hand at one time was moving close to the mike, so I'm going to ask Kathryn if she would take the first question. I'll take the 2010 question. Ric, I'm giving you a heads up that I'm going to ask you to address the last question.

MS. POWER: I can probably add a couple of things about the others as well.

The President's New Freedom Commission did inform, Faye, the budget process, as it has in the past several years since it came out, and particularly it informed the process because we're continuing under the Federal Action Agenda, those 70 steps that the Administrator mentioned. One of those steps, obviously, is

to continue the Mental Health SIG Program in the states that are getting the Mental Health Transformation grants, as well as a variety of other initiatives, including our continuing work with all of those departments and agencies. So those departments and agencies derived those 70 action steps from the six goals that are in the Commission report.

So it is continuing to inform them, along with the guidance from the executive order. They were cross-walked, and that document, as far as I am concerned, will continue to be informing what we do and where we go in terms of the direction as the federal partners interpret it. For example, the Department of Labor will make decisions about their activities based on one or more of the six goals and the five executive order principles.

So yes, it's a living document. The agenda which we're about ready to come out with in terms of an update to the Federal Action Agenda -- it should be cleared, hopefully, fairly soon -- will show you evidence of how the New Freedom Commission report has continued to resonate across successive budget years.

I'll just add, Terry, for purposes of Faye's question, that the Healthy People 2020 issues are really, from a mental health perspective, being reflected because we are taking in '07 a much more integrated wellness approach. In looking at the morbidity and mortality of

individuals with mental illnesses, looking at an integrated approach in terms of not only their mental health care but also wellness and looking at that primary care/behavioral health care integration. So that is really a reflection, I think, of the Department's Healthy People 2020.

I can add something to Katrina, if Ric would like me to.

DR. CLINE: I'm going to just give you a heads up, both Rich and Rose, to jump in on this, too. But I'm going to give you a little time while I make one comment about the public health piece of this.

I think one of the most significant movements that's taking place is SAMHSA's embracing of the public health model and really looking at the public health approach toward improving overall health of communities and understanding how our issues impact that overall health. One of the places I think where that's most apparent -- and, Rose, you may want to say something about it -- is through the Strategic Prevention Framework, which is really a concept I think that has been well received by the field that is embracing this kind of public health approach. What that allows us to do is to back up a few steps and look at things that we have typically had difficulty looking at population-based data. A lot of the data that we've looked at has been driven by our service system, and

that's not population-based data. It's important data, but it's not population-based. Then we've had some of the larger surveys, like the National Survey, the old Household Survey, and now the National Study on Drug Use and Health, which only recently has started to look at some of those mental health issues.

So you can see the kind of step-wise progression closer to getting that type of thing. If we're looking at impacting, again it goes back to that kind of broader based resiliency, and our system has been so incredibly reactive out of necessity and limited resources. How do we ever expect to get ahead of the curve and impact the population at large? That public health approach I think is essential to that.

Rich, would you like to make a comment? And then Rose, and then we'll move to Dr. Broderick.

MR. KOPANDA: Well, I was just going to mention a little bit about the Katrina effort. In terms of our assistance in CSAT with the State of Louisiana, Anne Herron had previously worked very closely with their state substance abuse treatment system to kind of, at first, recast the system and see how it might be redesigned to more or less reestablish the treatment system to make sure it was well integrated with behavioral health in general, and also the primary care system.

Recently they've asked for additional assistance both in terms of reestablishing the system and in terms of looking at how to bring more providers, substance abuse treatment providers, back into the system. We're in the process right now of developing a response plan for that. We're also going to engage some of our contractors who assist us with the block grant generally to really focus on Louisiana, and that's kind of in process right now.

DR. CLINE: Thank you, Rich.

Rose?

MS. KITTRELL: As Terry has said, we are working with the Strategic Prevention Framework. We have funded some SPF/SIGs, states as well as travel organizations throughout the country, and through this process, through this five-step process, we are helping states to identify their resources, to identify the gaps in services, and strategically place our resources in areas of greatest need. As Terry indicated earlier, we are not catering necessarily to the group that has the loudest voice or to areas where they have excellent grant writers and they're able to draw down the funds. We have epidemiological outcome work groups that are working in concert with the states to really strategically place our resources so that we can drive down our numbers.

If the money is in the wrong area, if it's going toward a population that's not in the greatest need, our substance abuse numbers will not be driven down.

DR. LEHMANN: One of the things that SAMHSA is involved with is an interagency group on workforce support in the case of pandemic flu. I mention that because I've got to absent myself from the committee for a moment to take a call for that group, along with Terry Spear from SAMHSA. It's been an opportunity for me to meet her. So that's by way of explanation for why I'm scuttling off right now. Thank you.

DR. CLINE: Thank you.

Dr. Broderick?

DR. BRODERICK: Thank you. Thank you for adding that, Rich, and I know Kathryn has something to add here too.

I guess the first thing I would say, Dr. Gary, is that as you know, as I'm sure you know, half of the people in this building, 250 people from SAMHSA, actually physically went to the Gulf States to respond. So there are personal connections that were established among those folks that remain. I think that serves as a basis for a clear understanding here among our staff that much remains to be done.

The second thing I would add is to reiterate a

name that you just heard that I was going to mention as well. Terry Spear recently joined Daryl's staff in OPPB. She is our new emergency coordinator. We're very fortunate to have her. She came to use from HRSA, and she is actively engaged in emergency response in general and pandemic flu in particular.

With regard to Louisiana and the Gulf States in general, the Secretary, as you probably know, has engaged with those states to endeavor to rebuild the health system across the board. We participate closely in that effort. There's been an opportunity for us to contribute to the overall planning process within the Department, which we have done. We've met on several occasions with the staff from the Secretary's office that have created that response plan with Louisiana. Specifically, you heard Rich mention efforts from CSAT. I'll ask Kathryn in a minute to talk about efforts from CMHS. But suffice to say in general that we have a number of grant programs that are currently in process around suicide prevention, and our efforts continue to help the states with their rebuilding efforts of both their substance abuse and mental health systems.

Kathryn, would you talk a little bit about our emergency response?

MS. POWER: Sure. Admiral Broderick mentioned what is really a broad recovery plan approach to the

hardest hit areas in Louisiana relative to the infrastructure. So there's a tremendous amount of effort going into the planning on the rebuilding of the infrastructure and the capacity. In addition to that, the disaster response staff inside CMHS is responsible for the Crisis Counseling Program. We call it CCP or the Crisis Counseling Program, which is a program that we basically implement. It is FEMA money, but we are the implementers and the overseers of that program, and there is a massive amount of funds that continue to go to those states, particularly in Louisiana and Mississippi, under the Crisis Counseling Program, and we continue to have a tremendous response to the use of those funds for the needs of the people in the Katrina devastated areas.

DR. CLINE: Thank you.

Dr. Kirk?

DR. KIRK: Two questions, and maybe one is to solicit a comment. In looking at the matrix and the kinds of things that SAMHSA and the field as a whole are involved with, I've been involved in the field for a long time, but what is particularly exciting and I think very evident is the opportunity for extraordinary system change. Maybe this is a question for Kathryn. What I find is that the leadership required to support and sustain this type of system change is different from operational leadership.

Within the workforce development piece, can you share any comments about SAMHSA's initiatives to support the development of more transformative leadership?

Let me go to the second question. Whether you look at the Freedom Commission's report, the Surgeon General's report, Access to Recovery and so on, I think some really exciting things have been brought to the table. Again, from a systems change point of view, I'm interested in your read, Terry, and the leadership of SAMHSA. Do you still sense a sense of urgency in that larger choir? And how do we make sure that sense of urgency to follow through on these things stays on the plate and doesn't get diverted because of the latest crisis of one type or another?

So the Freedom Commission, the Surgeon General's report, things on addiction, to me there's extraordinary opportunity for major system change that will outlive many of us, but the sense of urgency has to be there to say we can't stop now, we have to continue to move it. So I'd be interested in comments on those two points.

DR. CLINE: Kathryn?

MS. POWER: Well, I'll start, first of all, with the fact that Tom's question I think comes from the fact that he is a transformational leader and understands that transformational leadership requires a very different kind of approach and a very different kind of set of skills

and competencies in not only being able to build that sense of urgency yourself within your state but also being able to express it. So I will be talking tomorrow about the workforce development issues that SAMHSA is approaching, and leadership development is a key component of that. We have had a variety of different experiences in terms of supporting leadership development programs across SAMHSA over the last several years, and I think everyone really resonates with the fact that we have a responsibility to inculcate and incorporate leadership and leadership principles and leadership competencies across these systems, and transformational leadership which has really changed management leadership is a special and unique requirement.

We are going to be looking more closely, particularly over this year, in '07, at what are the nuances of that, what are some of the specialized approaches that are derivative of some of the prevention training, derivative of some of the treatment training, derivative of some of the mental health services training that has gone on in the past, and yet apply another level of change management work.

So there are really two pieces, Tom. The first is that we are working on workforce development broadly, and we do see leadership as a component part of that, and

our experiences at SAMHSA have been that we really need to step out further and step out more deliberately and assertively about promoting the kind of transformational leadership that is necessary and needed over the long haul to build that very sense of urgency that you talked about.

DR. CLINE: Any other comments or questions?

(No response.)

DR. CLINE: All right. Well, thank you all very much.

At this point I'm going to go ahead and conclude my comments, and we're a little bit ahead of schedule, which I think is almost always a good thing. It means we have a little bit longer for break.

I will go ahead and turn it over to Joe Faha for legislative updates. Joe, have you presented to this group before?

MR. FAHA: Yes, I think so.

DR. CLINE: Joe is the director of legislation for SAMHSA. As I mentioned earlier, he does an incredible job.

MR. FAHA: I think most everybody here recognizes me as being the best looking man east of the Mississippi. I think that's how I last introduced myself.

(Laughter.)

MR. FAHA: I just saw Rich's eyebrows go way up

in the air. Boy, is that a stretch.

In the next couple of minutes I want to kind of quickly go through a summary of what is going on legislatively so that you're aware, and if I go quickly enough you'll be able to have time to ask some questions.

The first thing. Since Terry started out talking about appropriations, you're all aware that the President entered a budget request on February 25. We have been over the past couple of weeks in a what I refer to as a perfect storm. Several things have come together all at the same time, including both reauthorization and appropriation, and has made our lives as far as legislation and Congress' concern very busy. But I must suggest that while dealing with Congress is a lot different than dealing with your state legislatures, while it's in Washington or Oklahoma or Connecticut, the skills that go into dealing with those legislatures are very much the same. Fortunately, Terry has a lot of very good skills for dealing with all of them.

We have had so far nine visits, and we have one tomorrow with another appropriator. We have met with the appropriations committees in both the House and the Senate to go over the budget request and to hear their remarks, which were typically what one would expect. It went something like "dead on arrival" kind of comments. So our

efforts between now and the time in which we get House and then Senate action, which will probably be early this year considering the pace they're on right now and the number of hearings, is to try and make what comes out what we would like it to be. I'll just leave it at that.

That will be quite an effort, but I assure you that from our vantage point we will be working very hard to effect a good budget.

I told you reauthorization as well. SAMHSA has been up for reauthorization since 2004. This has not affected our ability to get appropriations since it is not necessary to be reauthorized to receive funds. The fact that you get funds actually legally reauthorizes the program for the year in which you receive the funds. So it's not been a difficulty in terms of getting appropriations.

However, what it means is that the last time we had a substantive expansive discussion about mental health and substance abuse issues with Congress was back in 1999. Now, that's eight years ago, because that's when the discussions happened in preparation for a reauthorization in 2000.

DR. CLINE: Could you just say a word about what reauthorization is?

MR. FAHA: The first point is that

reauthorization does not mean that the agency itself is being reauthorized. It's referring to our programs as being reauthorized. If you were to go into the statute, say, for children and violence, Section 581 of the Public Health Service Act, at the bottom it would say something along the lines that there are appropriations for carrying out this section $50 million for fiscal year 2000, 2001, 2002, 2003. I'm just making that up.

What that's saying is that Congress is authorized to spend money through 2003. Literally, reauthorization means you change those years to something that might say 2007, 2008, 2009, 2010. That's literally what it means. So reauthorization in and of itself doesn't mean that much unless it is that you have changes you're looking for in statute that prohibit you from carrying out the activities that you'd like to carry out, and if indeed it's time to have a serious conversation about mental health and substance abuse issues with Congress.

So that's what we will be trying to achieve in reauthorization. We have a hearing that will likely come up the first week or second week of April. It first was set for March 29 and March 23. Now it's the first or second week in April. The important thing is that it's going to be soon, and we are finishing the touches on what proposals SAMHSA is looking for. Dr. Cline, in his

comments to the committees, has been talking about four different things. One is inclusion in primary health care; secondly, a systems approach which Tom was just talking about and how we need to be able to address these programs through systems. The third is mental health promotion and the prevention of mental illness, and the fourth is accountability. So those are the things that we're walking into reauthorization wanting to talk about.

There are other issues on the table, as you can expect. There are a lot of constituent groups out there who have ideas of their own about what they'd like to see in reauthorization. Much of that comes from the fact that we've made the point that we really don't need any more authority. We have plenty of authority to do anything that we want to do. What we really need is money, and their comment is yes, but two responses. One, by promoting some of these provisions, this is one way that we get Congress to focus on some of these very important issues. Secondly, by doing this and then seeking money is the only way that we can get you to spend the money the way we want you to spend it. So there's that dialogue that goes on and will continue to go on.

But some of these issues that are on the plate include custody relinquishment where parents have to give up custody of their kids in order to get the mental health

services that they need, care for older adults, methamphetamine, FASD, workforce development. These are just some of the issues that have been raised typically by members of Congress themselves by introducing legislation that we know will wind up being considered in the context of reauthorization.

The final one that I'd like to report on is parity, not that anybody here is interested in that issue, but you probably know that the Senate Committee on HELP did pass a bill for parity several weeks ago that was a compromise, not just between Republicans and Democrats but also a compromise amongst insurers, employers, mental health groups, and substance abuse groups. No one in the Senate is suggesting this is the be-all and end-all, but it was a compromise that managed to get passed out of committee.

The House, as of today, is going to be introducing their own bill, authored by Mr. Ramstad and Mr. Kennedy. While it addresses many of the same issues, it takes a different view on some of those. For example, two things that come up are that it would require that employers have mental health coverage in their plans, and it would also place restrictions on the ability of insurers and employers to use medical necessity and utilization reviews to limit services for individuals. There are

several other differences between the bills. The difficulty is that many of the senators who bought into the Senate legislation indicated that they do not want to have to conference this with the House. They bought into this compromise bill and that's what they want the House to do, to buy into that conference. So the mere fact that the House has decided to go differently does not bode well for the passage of a parity bill any time soon.

I'm going to stop there and offer you an opportunity if you have any questions.

One other thing that I mentioned in there is that methamphetamine, it was very startling to me that the issue never came up in any of our visits to members and was not a topic at the hearing. So it would seem as if much of the emphasis on methamphetamine seems to have dissipated a bit.

Having said that, Barbara?

MS. HUFF: Well, since we have the time, I've known Joe for a lot of years. He gets real tired of this, but he's going to have to sit through it one more time. I just want to go back in history a little bit because Joe and I have been around for so long. I'm not going to say we're so old. We've just been around a while.

MR. FAHA: And we look it, right?

MS. HUFF: Yes, we're beginning to look it.

I want to go back in time and say that in the mid-1980s, when the Federation of Families for Children's Mental Health hadn't even started yet but we were kind of in our development stage in the late '80s, the mid to late '80s, and I went out to NIMH before there was SAMHSA as it is now, I went out to NIMH and I met with Dr. Lew Judd, who was the director at that time. He came out in his white coat, like a doctor, a doctor-doctor. It's so interesting how things have changed. I asked him for enough money to fund some family organizations in this country, and I left there not knowing for sure if he would do that or not, but he did, and he funded five, five states.

He had a certain amount of money, funded them all at about $10,000 apiece, and one of them was Hawaii of the first five. After going to advocate from Kansas for that, I didn't get any of the money. Isn't that the way it goes? Yes, that's the way it goes. Anyway, I hadn't written such a good grant either. I was an interior designer trying to be an advocate.

Anyway, I want to give you that history because it started very modestly, and over the years it turned into 10 grants, and then 15 grants, and now there are 42 family organizations funded with about $60,000 to $70,000 each. Even Guam has applied this year, I know, for a family organization grant. I think South Dakota does not have a

family organization, and Arkansas currently does not have it. Most states do have it. It's 42 of them, and quite a few were funded. Their funding is basically -- well, let me go back and say that the family organizations do a variety of different things. They provide information, support, training and advocacy to families in their state who have children and adolescents with mental health needs, and $60,000 to $70,000 is not a whole lot of money. If they get $70,000, there's a requirement that they put together an organized effort around youth. So that's the extra $10,000 that 10 of them, I believe, get now.

So that's a little bit of background. Of late, since I would say the New Freedom Commission, and maybe even before that, most of them are funded -- this amount of money gives them the ability to sit in decisionmaking places and pay for their time, effort and energy for families to sit at the table on mental health planning councils, on transformation efforts across agencies, which I think is phenomenal, that SAMHSA has been visionary enough to fund an advocacy effort. We may not call it that, but it is around helping to plan for systems change.

Now, a number of years ago we ended up getting enough money, also in that line item -- and I'm going to talk about that line item here in just a second -- to fund consumer organizations as well. So now there are family

and consumer organizations both funded. Since I'm not as up to date on the consumer ones, I'm not sure how many they fund. I'm not sure how many organizations get funding for consumer organizations, which really meet the needs more of adults.

So when we got this money, it was kind of hidden away, and we did that on purpose because we didn't think anybody would like us well enough to keep us funded. But what has happened now is it's in jeopardy all the time where it is. It sits in Projects of Regional and National Significance, and you can see that it's taken this huge hit, and in the '08 budget the consumer and family organizations are gone.

Now, I know I don't have to say it to you, Joe, and I know that I don't have to say it to you, Terry, or Kathryn, or probably any of the SAMHSA folks here at this table, but it is a lifeline for most families, and we have got to figure out how to keep it safe, maybe even give it its own line item so that families can advocate for this in a different sort of way, because now they have to advocate for it through something that people go when they call their legislators. "Where is that, and how much money is that?" It would be really nice to just be able to point to the line item and say, okay, the consumer and family organizations are funded right here, and we'd have

something different to fight about with Congress, or not to fight about but to advocate around.

So we're family driven, kind of on the move out of Kathryn's office, which SAMHSA has totally supported, the whole notion of family-driven and youth-guided, and with all the transformation efforts happening at the state level, with things funded to help states transform themselves, how are we going to do this without the family and consumer voice sitting at the table? This is what funds that to happen.

So we've got all the values in the right place, but now we're going to have to have the dollars that reflect those values, and this is a minute amount of money in the big scheme of things.

So, Joe, I'm done, and I know I'm preaching to the choir here, but I'm getting too old for this and, I've got to tell you, it just breaks my heart in many ways. I mean, this is not big money. Sixty thousand dollars to try to manage transformation efforts for 42 family organizations, and many of them it really is their lifeline, and many of our family organizations are taking a huge hit right now at the state level. Jane Adams in Kansas has lost $300,000 in state funding. So we're going to need for people to be underneath this. NAMI also lost their money in Kansas. So it wasn't just Keys for

Networking. It was NAMI as well. Some states are moving forward and some aren't, and I'm amazed at how far backwards things can go.

MR. FAHA: Can I comment? Would that be all right?

MS. HUFF: Yes, Joe.

MR. FAHA: Barbara, we do go back a long ways. One of the things is that as we both have gotten aged over time, your enthusiasm and support has not wavered in years, in all those years. You are as much the advocate today as you have always been.

A couple of points, though. You say line items, and I want to clarify that it was Congress that created the single line item back in 1996 that pulled all of our specific programs. Prior to that, there used to be a listing for every program in our report, and then a dollar amount. It was in '96 when we took a heavy hit in terms of all of our funding, when they went to a single line item for discretionary grants so they could basically say that they can spend as much money on pregnant addicts, for example, as they did last year, in essence. So it didn't show that they were reducing. I just wanted to clarify that.

Basically, we're responding to Congress' insistence. We tried to offset that, however, in our own

budget justification by putting in what they refer to as a SLOA table, where it lists all the different programs. Number one.

Number two, and this is very important. Dr. Cline has met with the constituent groups and will continue to meet with the constituent groups. For example, the Campaign for Mental Health Reform has several members from the family and consumer networks who made sure he understood the same concerns at that meeting, and he will be meeting with those groups again, and with substance abuse groups, by the way, to talk about budget and reauthorization. He has also indicated that he is expecting that the constituent groups will play a role in the development of the '09 budget and has indicated to the center directors that that should be part of the process.

So I'm trying to get at the fact that Dr. Cline is ensuring that there will be a voice at the table from all of these groups.

I'll leave the justification for why those are being zeroed out to Daryl's presentation on the budget, but I would point out that despite the fact that there has been an ongoing debate about funding for consumer and family networks, I do not believe that they have never not been funded, even when the administration continues --

MS. HUFF: (Inaudible.)

MR. FAHA: I know, Barbara. I know, I know.

MR. STARK: Kind of keying off that, Joe, I'm not sure if you would be the one to respond, or maybe Dr. Cline might be the one to respond to this. But given that all of those programs got lumped into Programs of Regional and National Significance, when you do get your budget, once you get it, you mentioned that SAMHSA is going to be looking at whatever process that you might use around planning for this next year, what are those timelines? I'm not asking you to identify any of the priorities, but what are the timelines that you kind of perceive both relative to developing your list of priorities for the upcoming budget as well as once you get a budget, going back and revisiting, depending on how much money you got and what cuts you might be taking, how you'll establish the priorities within that sort of grouping? How do you see, if you've had time to think about this, this body playing into giving input around that?

DR. CLINE: I'm going to ask Daryl to take part of that, and I'll add to that.

MS. KADE: With regard to '07, we actually developed an operating plan that had to be submitted to OMB last week, and then submitted to the Hill. That operating plan is based on budget lines and also the significant items identified in the Congressional justification.

Although OMB looks at what we call the SLOA table, which is the summary listing of activities, which I have in the handout for my presentation, it basically goes to the program level. So OMB has been looking at us very closely so that there's a great relationship, direct relationship between what we plan to do in '07 and indeed what we told the Congress we would do based on those SLOA tables.

Now, if there are changes, we have to negotiate them with the Department and OMB. So that's happening right now, and I can get into that a little bit in my presentation.

With regard to '09, I know that Dr. Cline has asked us to start thinking about '09 now because traditionally our request to the Department is due in June, and then our request to OMB is due in September, and then there are a lot of negotiations around the major holidays, Thanksgiving and Christmas, and then of course we get into a production mode, and then you have the budget going out in February. So now is really the time to start talking about '09. Then, of course, in the middle of this process, after our budget goes to the Department and before it goes to OMB, we have the House and Senate marking up the '08 budget. So we look at what the '08 markups are in the summer to influence some of the decisions that may be made as the Department submits its request to OMB, and then OMB

looks at the projected or reasonable outcomes. Sometimes we have a budget on October 1 and sometimes we don't, and that also plays into their decisions.

DR. CLINE: Ken, I would expect that we will have a budget discussion here, and I can tell now that you would be willing to share your thoughts on that, which is the whole purpose of having an advisory council, to be able to advise us on that process.

We don't have all the specifics in terms of that timeline, but it is clear that we want input from multiple stakeholders, and the reason we're starting that now is, as you know, that process is more labor intensive and it takes more time to do that. So I want to make certain that doesn't slow us down in doing what we need to do, and that we're being as strategic and as informed as possible as we move forward.

MR. FAHA: Are there any other questions? Gwynneth?

MS. DIETER: Yes. In terms of the parity bill in the Senate and the one the House is going to propose that actually you think will come to nothing because of the disagreement, but what role does SAMHSA have in that? Does SAMHSA have a role? Do you have a role?

MR. FAHA: Yes, we have a role. It's the role that the President gives us, and that pretty much is we

march in tune with what the President wants. The President, as you may know, back in 2002 in Albuquerque, New Mexico, he echoed his support for parity legislation, and as of yesterday he's not wavered on that. He states that he is in support of parity as long as it doesn't wind up being too costly and that it doesn't result in limitations on access to care. So if you add mental health benefits, you don't lose other kinds of benefits that may be helpful to people.

The administration is currently looking at the Senate bill and will be looking at the House bill so it can make its comments. But so far there has been no administration position with regard to Senate bill 558, which is the parity legislation.

MS. DIETER: So then if there is a comment by the administration, do you have the opportunity to speak when these bills are coming up for votes and so forth?

MR. FAHA: We always have an opportunity to speak about bills that come up, but what we speak is always what the administration wants us to say. Dr. Cline is going to be testifying on Monday out in Greentree, Pennsylvania at a field hearing that is basically about parity, being hosted by Congressman Tim Murphy and Patrick Kennedy and will echo a lot of his personal and administration thoughts about the need for access to care

for mental health and substance abuse services. However, when it comes down to taking a position with regard to the bill itself, we will refrain from commenting about Section 1, Section 2, Section 3, and just give the Presidential current position of the administration with regard to the bill, which I just stated.

MS. DIETER: So you mean you don't comment on certain sections of the specific bill, you just reiterate the position --

MR. FAHA: That's exactly what we're going to do on the 12th, because to enter into a dialogue about the provisions means you're talking about the bill when Dr. Cline has not been empowered to speak on behalf of the administration. So what, in essence, we will do is leave it to the White House to carry out that dialogue.

MS. DIETER: Could he be empowered to speak on behalf of the administration?

MR. FAHA: He could be, but that would literally take the Domestic Policy Council to make that decision to empower him. It's like any other ladder. It goes from the DPC to the Secretary, from the Secretary to Dr. Cline. That's how we got to the position of testifying on Monday.

MS. DIETER: So that does happen. I mean, I'm not that familiar with this. I'm sorry.

MR. FAHA: It does happen, but more often than not, most of the stuff that's being considered in Congress is of limited interest to the Secretary, nevertheless to the Domestic Policy Council, and the less interest it is to the Domestic Policy Council and the Secretary, then the more latitude Dr. Cline has. The more important it becomes to the Secretary and/or the Domestic Policy Council, then we have to bow to the wishes of those people, and parity is one of those. The parity legislation is one of those. I don't know if that thoroughly answers your question.

MS. DIETER: Yes. It's an area I personally think is really important, and it's been going on and on and never -- I mean, states have parity rulings in some sense, but it's an issue that isn't resolved.

MR. FAHA: It certainly hasn't stopped us from talking about the need for access to care and the fact that there are problems and limitations in insurance. What we are limited in talking about is the actual fix that Congress is putting together. We cannot talk on behalf of the administration on that fix, other than to echo what it is they just said.

MS. DIETER: But they're there talking about it.

MR. FAHA: They don't exactly call me up, or Dr. Cline, to say we're going up to visit to talk about

this, but yes, the Domestic Policy Council is talking about this issue. Politically, to understand this, right now there isn't much for them to have to worry about because you've got the divergence between the Senate and the House, so there is a logjam that's caused. So there's no real political need for them to enter into the fray. As it gets closer, then they will.

MS. DIETER: Okay. Thank you.

MS. HUFF: Also, I just might add that like Mental Health America and other advocacy organizations, I believe they're holding briefings on the hearings on the Hill. Am I right on that, Joe?

MR. FAHA: Yes.

MS. HUFF: So there's a lot of good advocacy work going on.

MR. FAHA: Yes, and I can attest to that. Barbara is absolutely correct. There have been briefings given by Senator Kennedy and Senator Domenici's staffs at which maybe 100 individuals representing every mental health and substance abuse group that I certainly have known about have attended, and they're all being very vocal about what's going on in the bill.

DR. KIRK: I don't know whether this is a question appropriate for Joe or for Daryl, but what seems to be the spirit in Congress relative to block grants, as

to whether block grants should be combined and so on? I thought I saw something that Congressman Kennedy was oriented to, for example, combining the mental health and substance abuse block grants, but maybe I'm wrong.

MR. FAHA: You're referring to a question he asked Dr. Cline at the hearing. First of all, Congress has typically been very supportive of block grants. I can't remember the last time that they were ever reduced. The worst that seems to happen is that they're level funded, but I can't recall either the SAPT or the CMHS being reduced in any one year. So obviously they're very supportive of those programs.

With regard to your second question, there has been for some time, as you know, a dialogue amongst mental health and substance abuse groups about the opening of the SAPT to pay for mental health services, direct mental health services, and I think that's what Congressman Kennedy was referring to in his question, not so much about the combining. I don't recall that he mentioned the combining of the two grants.

Thank you very much. I appreciate it.

MS. HUFF: Was there some conversation not about combining -- now this is just a rumor. Was there some conversation about eliminating the block grant?

MR. FAHA: Absolutely not. I've never heard

anyone say anything about that, Barbara.

Again, thank you very much. I always enjoy this visit. Thank you.

DR. CLINE: Thank you, Joe.

At this point, Joe, you've gotten us right back on schedule and in the other direction, and we will take a 15-minute break and reconvene at 11:00 sharp. Thank you.

(Recess.)

DR. CLINE: I'd like to call the meeting back to order, please. Thank you very much. I know we'll have a few other people who will still be coming back into the room.

It's my pleasure now to turn the mike over to Ms. Daryl Kade, who is the executive director of the SAMHSA National Advisory Council and is also the associate administrator for the Office of Policy, Planning, and Budget.

So, Ms. Kade, the floor is yours.

MS. KADE: Thank you. Due to the unusual budget situation this year, I'll be talking about two budgets, '07 and '08. You have in your handout or in your book some handouts on the 2007 budget. The first page of the handout is what we call an APT or all-purpose table. This is what it looks like. I wanted to note that the joint resolution for '07, which was effective mid-February,

provided $3.3 billion for SAMHSA, which was slightly more than what we had in 2006. I would refer you to the bottom line. If you're looking at this table, look at the third to the last row. That's where you see the bottom line for SAMHSA. The amount provided in the joint funding resolution was slightly more than the 2007 President's budget, about $66 million more, but somewhat less than the summer House and Senate marks.

I wanted to also draw your attention to the next handout for '07, which looks like this, which identifies significant changes relative to the 2007 President's budget. I would point out that CMHS receives an additional $35 million. You can see the various increases, and I would point out the largest increase was for the school violence program. CSAP received an additional $12.3 million, and the significant increase here was for the SPF/SIG. CSAT received an increase of $23.6 million, and the two largest increases were for the PPW program and program coordination.

I also wanted to point out some significant changes with regard to the summer and the House Senate marks. In CSAT, I think the most notable change was that ATR had been zeroed out in the summer, and the SAPT block grant had been increased by $75 million in the House and $30 million in the Senate. However, under the joint

resolution the block grants were level funded, and we will be going ahead with the 2007 announcement for the ATR program for a new cohort, with a goal of $25 million for treating people with methamphetamine addictions.

What you do not have in your package is a list of 2007 funding announcements as a result of this budget. At this point we're reviewing them. For CMHS there are over a dozen, I would say, funding announcements, and a handful for CSAT. At this point, with the 2008 budget out, along with the 2007, a number of the programs, as you know, have been eliminated in 2008, and a number of the programs have less funding in 2008 than in 2007 to support the new grants in 2007. So at this point there are ongoing discussions, especially with regard to CMHS and the issues of multi-year and one-year funding announcements for various programs that are funded in 2007, and with CSAT in terms of the same issues, do we go for multi-year funding if a program is no longer continued in the 2008 budget, or indeed skip a new round of new grants. That's an ongoing discussion within SAMHSA, and we'll get back to you. If you want a list of announcements, we can get that to you as well.

As I mentioned earlier, an operating plan was submitted to the Department last week in preparation for submission to OMB, and at this point the operating plan

assumes that we are in sync with the 2007 column in the 2008 budget, which includes all the specifics with regard to the SLOA tables, which is the lining out of the programs in the listing of Programs of Regional and National Significance. Again, that's not a hard and fast rule. If we need to make changes, we'll present those changes in a packet to the Department, and we will need to negotiate them with OMB. To the extent that they affect CSAT and CSAP, we'll probably need to negotiate with ONDCP as well.

So I'm going to shift to the second attachment, which is 2008. I wanted to make sure you knew that at the back of the package we do have a copy of Dr. Cline's testimony from last week at the House hearing, which included the three institutes. I also wanted to make sure that you saw these SLOA tables. At the back of this section you have a summary of listings for each PRNS program for each of the centers. So if you want any specifics with regard to the reductions, with regard to the eliminations, they're here specifically in these tables.

I wanted to just note some general specifics. There was a question earlier about how various planning documents influence the decisions in '08. I would point out that all of our major programs or major initiatives, although not increased and maybe slightly reduced, are continued in this budget, and the block grants are level

funded. So in essence, although SAMHSA experienced a $159 million reduction from the base, most of our programs remain intact. Of the $159 million reduction, $76 million was associated with CMHS, $36 million for CSAP, and $46 million for CSAT. Again, if you look at the individual SLOA tables, you will see that breakdown.

I also have in this section a handout that reflects the statements made by the Secretary with regard to how difficult budget decisions were made this year, not only in relationship to the various planning documents that were mentioned before, but he had criteria that he used to make difficult budget decisions. I would note bullet 3, looking for programs that emphasize the delivery of direct services, not just replacing infrastructure. I would also note the last two bullets, eliminate programs whose purposes might be addressed in other places, that is to say alternative sources of funding, and also looking for underperforming programs, and then specifically programs where there is no measurable way of determining whether they succeed or not. I think that gets back to the earlier discussion with regard to the data strategy and NOMs and how to communicate how effective or ineffective our programs are, or if ineffective, changes and monitoring the effect of those changes on the performance of those programs.

MR. STARK: Can I ask a question?

MS. KADE: Sure.

MR. STARK: Just a quick question. On those criteria for elimination, is there any way, not necessarily today but at some point, of getting a handle on which of those criteria were applied to the programs, or which of the criteria are the criteria that caused the programs that are on the list of eliminated programs to be eliminated? Like are there some where there truly was a belief, the next to the last bullet, there truly was a belief that some of those eliminated programs clearly could be funded through other resources?

MS. KADE: I believe this is the type of analysis we're trying to do now in preparation for '09, to see where there were weaknesses in our presentation and where we can strengthen that presentation and also deal with gaps in funding.

MS. POWER: Daryl, I can just add that one of the things that we're doing is going back and looking at that, and one of the examples that was used in the budget presentation was the older Americans mental health piece. I don't know if it was the Secretary or somebody who said we know that there are services for older Americans that are funded by CMS, we know there are services for older Americans that are funded by HRSA, and so that was used as

an example of one of the areas where the Department said what are we doing? Now, our argument obviously would be that specifically there are needs for older Americans from a mental health perspective and from a behavioral perspective, and I think that's what Daryl is getting at. We need to kind of be clear about the ways in which we're working with those other agencies but there might be some unique aspects to the program.

MS. HUFF: A couple of things that concern me. Bob Bernstein from Bazelon Center for Mental Health and I offered a lot of volunteer support, all volunteer support, to the consumer aging group. You could say that about children, about everyone, because children are supported over in CMS probably at a much greater level. So I don't want us to think that we can eliminate a program because somebody else is funding some too. So that concerns me because older adults are people just like children. They just don't have the voice, and the organization that they formed didn't make it because they were old and they just didn't have that energy related to some of the things that needed to be done to keep an organization going. So their money is kind of sitting in the Federation's bank account right now on hold, and SAMHSA worked with us on that, to get us to a place of just kind of hold on their consumer organization.

But I think the thing that alarms me even more as we go through this in those bullets is that -- Kathleen, are you there?

MS. VAUGHN: No, she's not. She must be on another line.

MS. HUFF: Okay, because Kathleen will remember, and maybe some of you folks will, too, when they funded some of the suicide efforts, the efforts around the issue of suicide, and we asked the question, the council asked the question, if there was a strong evaluation piece with this, because we felt like how will we know if putting a lot of money into this, if we don't have a good evaluation with it, that we won't know unless people have committed suicide or attempted suicide or whatever.

Do you remember that when we asked that question? And Charlie said we don't, we don't have what we really ought to have. So we don't have that. So if we go back to these points here, that whole suicide prevention thing could be unfunded if we don't have what we need to prove that it's working.

Am I right on that, Terry? I mean, I say that just out of concern. There's nothing we can do about it as a council, but I say that to you as a concern that if we don't have a good evaluation component with some of these things that we are funding, under this criteria we'd lose

the program.

DR. CLINE: Well, consider your concern registered. There are two points I would make in response. This does speak to the need for a data strategy, and it speaks to the need for that level of accountability. Our programs that do not have strong performance measures are vulnerable, and they're vulnerable whether it's this year or next year.

I mean, first of all, I think we're all in agreement that there will never be enough money in our system. There will never be enough money to address all the needs. So we want to do everything we can to get back to making sure that we're funding programs that are most effective. One way to demonstrate that is by having those performance measures and those outcomes. So as other people chime in in terms of the budgeting process and they see two programs and one has good outcome measures and one doesn't, then the one that doesn't is vulnerable, and it's harder for us to defend that particular program.

Certainly this was true for me at the state level, too. I loved it when I could go up there and I had strong outcomes. I mean, it's just an easier argument to make. So it behooves us to work aggressively to try to get those types of measures.

Back to the earlier conversation and point

about funding through other agencies, first of all I'm not of the belief that simply because the money is there we can say it's already funded, so it's okay and we can rest easy on that. But I think there is an opportunity for us, and sometimes scarcity moves us toward that. The adage of necessity being the mother of invention, we get more creative when resources are scarce. The example that was given for older adults, if we look at that and the hundreds of millions of dollars that are being spent across this country in the overall President's budget, not just our budget but the overall President's budget, hundreds of millions of dollars, very few of those dollars are focused on behavioral health for older adults. So the opportunity here, I think, is to drive us to say we don't have the money in our budget or may not have the money in our budget to do that, so part of the tradeoff is that we want to be certain that as those dollars, as those programs, as those services are being delivered, hundreds of millions of dollars, we want to be sure that behavioral health has a seat at that table so those dollars are being leveraged in some way to address our needs.

That's a big challenge. I think, again, that the Federal Executive Steering Committee is a great opportunity to have all of those agencies and departments at least talking about behavioral health and

transformation. That's one of the take-home messages for me from that whole initiative. It's not just about getting people to buy into our agenda and support it but how can we get them to buy into it to such a degree that they want to help transform their agenda and their budgets to address these needs.

So I don't want to be superficial in terms of somehow thinking that just because someone else is funding some of that with the big label of older adults or children's services or any of those things, that somehow that will automatically make that happen. I'm saying there's an opportunity to build on the work that has begun to get ourselves on those agenda, and homelessness is another example. I mean, literally there are hundreds of millions of dollars that are being spent on homeless services in the President's budget. How much of that really focused on behavioral health, whether it's substance abuse or mental health services? Very little of that, and there's a risk of SAMHSA being the only agency that's owning responsibility for those types of services out of those hundreds of millions of dollars.

So the opportunity is how can we infuse it, again, into those other agencies? It's not an easy task, and it's not going to happen in one year or two years. It's going to take a long time to really get that embedded.

Ken?

MR. STARK: Just as a quick comment, and I'll get off my shtick on this.

MS. HUFF: Me, too.

MR. STARK: But, Terry, since you're new in this position, I haven't done this with you at the helm. It gets back to language and how we tend to stigmatize ourselves. If we're clearly talking about trying to look at mental health and alcohol and drugs on a par with physical health, then we really need to, I believe, focus on the concept that we are part of health when it comes to the human being. I hate the term "behavioral health" because I truly believe that it stigmatizes mental health and alcohol/drugs by using that term, seeming to give the perception that mental health and alcohol/drugs are about behavior, not about physical health and mental health. When I say "mental health," I'm not talking about mental illness but a physiologic mental health issue.

So I really encourage us to try to think about not setting ourselves aside from the health agenda by labeling ourselves behavioral health and try to generalize and use the generic term that we are a health system, mental health, alcohol and drugs, all part of this broader health agenda. I think that behavioral health again just stigmatizes us. It negates the physiologic, biologic,

genetic predispositions that are part of mental illness, as well as alcoholism and drug addiction. Even within the physical health system, when they think about mental health and alcohol/drugs, they use the term "behavioral health," which then sets us aside from their inner core in physical health. So just a shtick, wanting to pay attention to how we use terminology that tends to stigmatize ourselves, and I encourage us to get away from that term.

DR. CLINE: Thank you.

Dr. Gary, and then Dr. Kirk.

DR. GARY: Thank you very much. I was looking also at the guidelines that were used for program elimination, and I wanted to ask if there was any discussion given to programs that were eliminated based on these particular guidelines. For example, if you look at grant activities that have been essentially completed and no automatic renewal, I think at first glance that sounds pretty solid, but in many instances where grants are given and there's no renewal does not mean that there's not the public health need for prevention, treatment and rehabilitation. If we do not look at the second phase of what happens in the individuals' lives, then I could argue that that's money that was not well spent, because sometimes after services are no longer available to people, they again fall through the slats. Whatever we have

invested up front, there's no evidence for two or three years later. So even though a program has run its course, it does not mean that the needs of the individuals do not still exist and that we ourselves are not participating in a subliminal kind of process, if you will, where we too are creating health disparities.

So another way to look at this, I would think that if we would look at the programs that have met these criteria, to the extent that they are not being funded, could we look at them to see what populations are at risk because they are not being funded? That would be number one.

Number two, then why weren't these programs evaluated to the extent that there was feedback earlier about their non-productivity or their inability to meet the needs of individuals? I think that's back to your idea about evaluation and having evidence base. So that could go on on a yearly basis rather than when there's a budget crunch, because that was not a good investment in the first place.

So I as a council member would be interested in those programs that will not be funded and what happens to the human beings with regard to their opportunities for resilience and for life in the community, because I don't want us to lose any ground, especially in those areas that

we have invested in earlier.

DR. CLINE: I of course appreciate your commitment and your passion about the issues. One of the overarching principles here was moving toward a balanced budget by the year 2012. So that then puts the pressure on the budget in terms of how will you actually get there, and these were really guidelines. There were many programs that may have come to a logical end, but that doesn't mean automatically that that program was eliminated. So it wasn't an automatic process because that was coming to the end of a grant cycle. That was basically the red flag that said, well, we should really look at that, we should scrutinize that, instead of just automatically renewing that.

DR. GARY: I think the second part is could that information be shared so we can look at lessons learned from those programs that did not meet the criteria so that we can protect, to the extent that we can, those individuals who need our services. That's my point.

DR. CLINE: That is part of the discussion that we're having around how can we better prepare ourselves for next year to make sure that our programs and our people are not vulnerable.

DR. GARY: In other words, we don't want (inaudible). Just a short way of saying this is that we in

no way want to create vulnerabilities, set the stage for vulnerabilities in people's lives. We want to make sure that we do everything we can, but we do know that when services are withdrawn, are not available for a variety of reasons, there is or can be an exacerbation of conditions that lead to high mortality/morbidity in people's lives.

DR. KIRK: A couple of comments. I'll make my comments and then I'm interested in finding out from you how can we help you on this.

One of the things that concerns me as I look at these numbers and as we look at what it is we need to do -- and I appreciate, Dr. Cline, one of your points, what I call trying to make sure mental health and addiction issues are part of every agenda, as compared to being just our agenda. One of the experiences we're having is that if you're talking about true system transformation change, it's not just a matter of taking the folks that we currently have in the service system, the staff and so on, and doing more of the same, as much as it is to hit the infrastructure, and I'll use a couple of examples.

One of them is that in Access to Recovery, we formed a partnership with our judicial branch, probation, parole, prisons, and it set up a framework in which I think something in the range of 40 percent of our resources related to Access to Recovery made significant impact in

our whole criminal justice system. So Connecticut, in terms of its overall approach, says we are not interested in building more prisons. We want to make sure that we can keep people in the community, and so on, and that has been supremely successful.

So, for example, something called technical violations, the rate of technical violations, people just missing appointments and that kind of stuff and being reincarcerated has been reduced to the range of 40 percent, and that was because the judicial branch has taken some of their probation officers and parole officers and provided some training for them to help them recognize mental health and addiction issues, but also provide services. That, to me, is infrastructure. Yes, it's services with infrastructure this other part of the service system.

As we sit here now, every 17 minutes there is a successful suicide in this country. The largest proportion of those suicides, successful ones, are in the senior population. I forget what the statistics are, I'm sure Kathryn knows this, but a very large percentage of those persons were seen by a primary care physician within 30 days of the successful suicide. Now, if I talk to my commissioner of public health, Dr. Galvin, and he says my people do not know how to successfully screen for these kinds of issues, that's an infrastructure issue.

So when you talk about mental health transformation or moving the service system, what concerns me about the numbers is whether we're going to move to a focus that we can't afford infrastructure changes that will go back to your point about being part of a transformative agenda, and we just need to keep throwing more money towards services. That, to me, is what I call an acute care delivery system, and it's crisis oriented, and crisis oriented types of systems are expensive. In Connecticut we'll pay a thousand dollars a day for a person for acute psych state, detox and so on. I'm trying to get away from that and keep people in the community.

So a long story short, I'm interested in how much of what it is we have here in the budget relates to what I would call infrastructure development that would involve me helping my primary care docs in Connecticut, helping people in the judicial system, helping people in the child welfare system not to become specialists in this area but to play off of a greater degree of understanding so that it's clear that by partnering with us, they truly result in a transformed system.

I think the other point is just a question. Based upon this, are we moving away from infrastructure development? And if so, what can we do to help you either in terms of -- I looked at the book as to what our ethics

are and that kind of stuff, and I'm not interested obviously in getting us in trouble. How can we help you to continue to get across the message that services are important, but if you don't pay attention to these other things, it's just simply the same thing over and over again. We never get there.

DR. CLINE: Rich?

MR. KOPANDA: To maybe just touch on a couple of these issues, we talked about the evaluation components of some of our grants and whether we're doing kind of a process evaluation that's done within the grant or a cross-site evaluation that tends to be very expensive. In fact, as we've discussed, many of the non-service activities were not prioritized in this budget. Unfortunately, in some cases, that included our technical assistance and evaluation dollars. Technical assistance, of course, is working to help grants to perform, and evaluation is working to document that good performance.

So in terms of, Tom, your question in terms of how can we move toward documenting the performance, I think taking our National Outcome Measures, NOMs, and developing them to the point where all of our programs, including our infrastructure programs, are reporting on NOMs which can document how well the grants are performing serves us very well. We're moving, of course, in that direction for the

substance abuse block grant for next year. We have done that in quite a few of our CSAT programs, but not all, but it's very difficult to do in the infrastructure area.

We were talking to our co-SIG grantees just recently about the need to develop our performance measures for infrastructure. It's a little bit easier to do for the direct service delivery. But that helps us when we go through a process like we're doing right now, the OMB PART process with the Access to Recovery, where we do have pretty good performance measures, probably as well as we have on any of our programs, but we need to have that for basically all of our activities. To the extent that you can work with us to develop those measures, that would be very helpful.

DR. CLINE: Ken?

MR. STARK: Kind of keying off of what Tom had mentioned, that if we're truly looking at systemic change and we're looking at trying to maximize our dollars across multiple program areas, including the thing that you talked about relative to looking at other programs, whether that be looking at the CMS and their stakeholder systems, or as Tom mentioned looking at the criminal justice system and their stakeholders, if we're truly going to maximize resources and continue to be effective at working with folks with mental illness, as well as with alcoholism and

other drug addictions and problems of alcohol and drug abuse, that the whole leadership of SAMHSA around training some of those other systems to be able to screen and recognize alcohol, drug and mental health issues, and to see the value to their system of doing that and the impact, the cost impacts -- and you know this from all your Oklahoma stuff and doing the administrative database analyses across systems -- if we don't get these other systems committed to both recognizing alcohol and drug issues and mental health issues early and being part of helping those folks get stable, then we will continue to do nothing but an acute care system, and that gets back to looking at programs not unlike the Minority Fellowship Program of trying to identify folks and training them in schools, and not just the students but also the instructors, so that we get in the schools of psychology, in the schools of nursing, in the schools of medicine, and in a number of these other schools, this new group of professionals that are going to be coming into the field as we all fade into the sunset, getting them trained to at least recognize and do screening around alcohol, drug and mental health issues.

It also goes in line for me to think about the contracts that SAMHSA has with NCSL in trying to ensure that state legislators and their staffs begin to recognize

the impact of mental illness and alcohol and drug addiction on their other systems within the state and the value of these services.

So I hope that we truly do have, as we move forward, a balance of the infrastructure things, as Tom referred to them, as well as the service things, because, as you already said, there's never going to be enough money, but there are resources in some of these other systems, and to the extent that we can get those other systems trained to pay attention to these issues, I think we can maximize some of those resources. But that's going to take leadership from SAMHSA because those other systems aren't necessarily going to recognize it on their own. So I hope this leadership group that I know you guys have with the other federal agencies continues to move forward and over time those other agencies begin to put some requirements in their funding flows that go to states.

But in the end, it really is going to be the collaboration at the state and the local level that's going to make this stuff work. You guys can drive the policy. You can influence at that level. But whether it's going to get initiated and implemented is going to be the states' responsibility and the locals' responsibility. So I just want to be sure that we don't throw the baby out with the bath water on this, that everything goes to services and

nothing goes to infrastructure and policy change and the whole idea of collaboration.

DR. KIRK: Two quick comments. One of them is that I asked about the sense of urgency to the issues that are important to us. I forget the specifics, but there's a review of eight states looking at the life expectancy of persons with serious mental illness, and currently it's 15 years less. That just screams for attention. Go back to Ken's point. The relationship between their needs, the fact that they're living 15 years less than others. They're not dying of suicide, they're not dying of drug overdoses. It's things related to obesity, cholesterol, et cetera. So that's one point.

The second point is -- I forgot it. As my staff says, when I say I lost my train of thought, they want to know is it a slow train?

(Laughter.)

DR. KIRK: I forget it. I'm sorry.

MS. KITTRELL: I want to go back to what Tom and Ken are both saying about infrastructure development. SAMHSA recognizes the importance of that, and that's one of the reasons we have funded the Strategic Prevention Framework State Incentive Grant Programs. I don't want you to think we're just a one-note agency, but this is very important for infrastructure development. The federal

government does not provide direct services. States do not provide direct services. Communities do that. So through the Strategic Prevention Framework, we are funding states. We are working with states. We are training states. We have prevention fellows, prevention fellows, in state systems working with communities so that they can deliver effective services to be able to do the screening.

As a part of the SPF/SIG planning process, we have to have more people at the table other than just substance abuse treatment and prevention people. We have mental health. We have education. We have criminal justice. So we have a broad spectrum of people that impact children and families. As I was talking with Barbara Huff earlier, when we did the Starting Early, Starting Smart program together, we recognized that in order to help the individual, you had to have a holistic approach. So we are doing that with the SPF/SIG.

DR. GARY: I wanted to pick up on the theme that Ken and Tom and now you, Rose, have brought up. If we look at, let's say, infrastructure leadership, leadership is not only position but leadership is knowledge and skills. One has to have knowledge and skills about leadership but also knowledge and skills about what one is leading, which is mental health and substance abuse. If we look at programs such as the Minority Fellowship Program,

which is directly tied to the President's New Freedom Commission report that discusses cultural competency throughout that document and many, many other documents, just suffice it to say that, for example, in nursing, 3 million nurses in the United States and only 13 American Indian nurses have Ph.D.s in anything, and 10 of those 13 American Indian nurses have gotten their doctorates through the Minority Fellowship Program.

I make the case that there's no other agency that picks it up. The Minority Fellowship Program is probably the most successful federally funded program in the history of the United States. I would think that if we would look at infrastructure, if we would look at service, and if we would look at the populations who are most affected by substance abuse and mental health, I don't have all the statistics in front of me, but we know co-occurring disorders and people who have to come in at crises are primarily minority people and poor people. We know that substance abuse, people who do not get care are primarily people of color. We know that seclusion and restraints occur primarily with Hispanic and African American young adult males. That history, that kind of data has been in the literature now for about 50 years.

We know that children and families in foster care, children and families who have no infrastructure are

primarily people of color. We know that the suicide rate of African American men has increased by 110 percent in the last five years.

MS. SULLIVAN: Faye, excuse me. Which color? I know this is rude, but when you say people of color --

DR. GARY: I'm talking primarily about American Indians, people of African descent, Hispanics, and to some degree Asians. That's the nomenclature for people of color.

MS. SULLIVAN: All right.

DR. GARY: It's not rude at all. Ask me anything you'd like.

MS. SULLIVAN: No, because when you say that, it's nice to be specific when you say that.

DR. GARY: Thank you, ma'am. Of course, we know HIV/AIDS, we know that African American and Hispanic women are affected by HIV/AIDS more than any, and we know that the prisons are filled with black men and now Hispanics. We also know that the least represented groups in the workforce are African Americans, Hispanics, and American Indians almost don't exist there. There is not one doctorally prepared nurse who is Alaska Native in the whole world, not one.

So we have some serious issues as we move any one of these agenda items forward, and I would ask that we

look very, very carefully at who is providing the care, how that care gets provided, how that care gets implemented, and if it makes any difference that one gets care if it's not the right kind of care for that particular population-based group of people. So I think we really need to take a look at workforce.

DR. CLINE: Well, we are taking your message to heart, and there is a full presentation on workforce development that is taking place tomorrow. So you'll hear a lot about that, and there's been a lot of work on that front.

DR. GARY: Good. Thank you.

MS. SULLIVAN: Dr. Cline, may I mention something?

DR. CLINE: Certainly.

MS. SULLIVAN: There's an elephant in the room here, and we've danced around this for years. Larry, I've emailed you on this numerous times at Veterans Affairs, but I think it's sitting right here, right in front of us now, and it's an opportunity. It's now something that we can look at as an opportunity because it's not only on the front page of the Washington Post but it is now front and center in the front of every American's mind, the disaster that's going on as far as the lack of treatment for our veterans that have come back from Iraq and from Afghanistan

across this country.

I believe the number, Larry, and you can help me with this, is 62,000 who are suffering from post-traumatic stress disorder. As you see that as an issue that we can step into and just scream SAMHSA. I see now such an opportunity for SAMHSA to step in, especially as former Senator Bob Dole and former Secretary Donna Shalala are now heading up the group that the President has put together to study what has gone on at Walter Reed and what has gone on with the ailing within the Veterans Administration as far as what has happened with the treatment of these veterans.

For SAMHSA to be able to walk in, and possibly for Kathryn and for you, Dr. Cline, to walk in and to say, hey, we are here, we can come in in greater force than what you've been able to do. We are here with resources, and possibly also that we are able to get a bit of the budget so that maybe we can get some resources as well, and maybe there is a new partnership to be formed with the Veterans Administration.

We've danced around this for years. We've said, no, that's their problem, they should deal with that. I think it's time for us -- on our matrix, we don't see veterans, and it's always been Veterans Affairs, Veterans Affairs. I think that that's something that we've

overlooked for way too long, and I think the country is demanding that we do something.

MS. POWER: Kathleen, this is Kathryn. Larry had to step out of the room for a conference.

First of all, thank you very much for your comments, and I appreciate your concern about this issue. A couple of things come to mind, and I can reflect back on some of the activities that SAMHSA is actually involved in.

First and foremost, as you know, last year we had the returning vets conference, and subsequent to that the Administrator has created an internal SAMHSA working group that is devoted to looking at the future of SAMHSA's role in supporting veterans issues, and that is a very active and very assertive outreach, and if Larry were here I'm sure he would say to the VA and to the Department of Defense that's being led by Arnie Owens at SAMHSA, under Terry's direction, and many of the folks across SAMHSA are sitting on that working group. We have done some very deliberate reviews post-conference to take a look at just where can we build on our connections with our grantees, with the programs, with the states, to make sure that mental health issues, mental illness, substance abuse and addiction issues are front and center for us in terms of that particular community.

Secondarily, I am the personal representative

for SAMHSA on the DOD Mental Health Task Force, which was created basically out of a piece of legislation that Senator Boxer from your state created, and it was created under former Secretary Rumsfeld, and now we report to the new Defense Secretary Gates, and that report is going to be coming out probably in April or May, and that is specifically composed of DOD active-duty military psychiatrists, family members, and I'm the person who represents the public health SAMHSA perspective, as well as being a reserve officer.

Our task is to take a look at the current mental health and substance use response system for three populations: the active-duty military, the returning vets that are involved in the VA system -- that is, that are getting their care from the VA -- and their needs within the Reserve and Guard community, which is very distinct from the active-duty and from the VA. It's been a very powerful experience. We've done over 35 site visits to military installations across the globe, and we are clearly coming to the conclusions that you have elicited, and that is that it's time for the military, for DOD and for VA, all of us, in SAMHSA, across DHHS, everywhere, to bring the attention about behavioral health, with apologies to Ken, about broadly the issues around mental health and substance use and addictions and bring it to the forefront.

So we are very actively involved in those discussions. We are very actively pursuing, with Terry's leadership, the federal partners connection with both DOD and VA around specific areas, particularly suicide prevention and particularly focused on that under our Federal Action Agenda. So we resonate with your suggestion and your recommendations and we are working, I think, very assertively to make sure that these issues are paid attention to even though, as you know, we are not the agency that is required by law to respond to or promote those services. DOD and VA are the first line, and then we I think come in as policy shapers and policy informers. The notion about a public approach to mental health and substance abuse is very different when you look at military medicine.

So all of that dialogue is going on and I really appreciate your interest in it.

MS. SULLIVAN: Once again, Kathryn, I'm just awed by the amount of work you're able to do, and to do so handily. Congratulations and thank you for putting that under your umbrella.

DR. CLINE: Thank you for raising that issue, as well.

We have just a few more minutes, and I know Ms. Kade has a couple of points she would like to make before

we close out for lunch.

MS. KADE: Very, very quickly, I did want to point out some of the very positive features of this budget, that the 2008 budget does maintain funding for the Presidential initiatives and priorities, including ATR, the MTH SIG. It does maintain funding for other major activities, including the Children's Mental Health Services, the PNA program, and both block grants. It does maintain an overall level of funding for PRNS at 95 percent, and there are increases for the SBIRT and drug court programs in CSAT, and it does maintain funding for National Minority AIDS Initiative activities.

Now, it does require the submission of NOMs for both block grants, we think as part of the block grant application, and we're working with OMB and the Department to clarify that. Obviously, we do have a $159 million reduction. I've included in your handout what I'm sure you've already seen, which is the list of programs that are already reduced. There are 18 programs that are eliminated, and that does not include the additional programs for which there is reduced funding and thus not enough funding to continue new awards from '07 to '08.

I did want to point out the 5 percent incentive/penalty for states providing or not providing NOMs through their SAPT block grant. We'll be working

again with the states, as well as OMB and the Department, to assure that states do comply. We'll be working on those criteria together.

As a result of the '08 budget, there are a number of programs that we will be announcing in '08. I would point out the handout that you have in your packet. For CMHS we will go forward with youth violence and youth suicide prevention, for CSAP National Minority AIDS Initiative, for CSAT SBIRT as well as TCE general, AIDS as well as drug courts, and again we'll be working with OMB and the Department to clarify what it means to require the NOMs submission along with the block grants.

I think today we've actually started a conversation on 2009. I would point out that we did make commitments to OMB to provide a data strategy to them by the summer, and I think the discussion about NOMs not only in terms of individual client outcomes, which has been the focus, but also infrastructure, may be things that we talk about in terms of identifying action steps that we can proceed with even before the summer.

I don't think anyone has anymore questions? Barbara?

MS. HUFF: I see the amount. It says "Children's Programs." What all does that include? What was cut? What was eliminated? Not cut, but what was

eliminated in the way of children's programs?

MS. KADE: If you would look at this handout for CMHS, it is what we call the Summary Listing of Activities, and you'll see the various deltas by the programs. So if you have any questions about any of the programs, the details are in these three center tables in your handout.

DR. CLINE: Ken?

MR. STARK: Mine's just a quick comment. As you're looking at 2009, I would really encourage you to have discussions about the feasibility of looking at SBIRT models and ATR models on the mental health side as well, and particularly SBIRT given the fact that you've got so many individuals with mental illness who also show up at hospital emergency rooms and what not. It gets to that whole issue of trying to do early screening and interventions by engaging other systems where individuals are showing up.

DR. CLINE: I've just been reminded that we have one person who has signed up for public comment. So if we could be patient for a bit in case she's not here this afternoon, I'd like to give her an opportunity to go ahead and come up to the microphone to make her comment. Marcie Granahan.

If there's anyone else who would like to make

public comments, please sign up on the sheet and do so this afternoon.

Is Marcie still here? Marcie, there's a mike right there for you. Thanks.

MS. GRANAHAN: On behalf of the United States Psychiatric Rehabilitation Association, I'd like to thank SAMHSA for allowing me to present public comment today, and I'm very short. Thank you.

USPRA has been a long-time supporter of SAMHSA and the Center for Mental Health Services, as we both share similar missions to help facilitate the recovery of people with mental illnesses. For those of you who don't know, USPRA is a 501(c)(3) organization of psychiatric rehabilitation agencies, practitioners, researchers, educators, consumers, and interested individuals dedicated to promoting, supporting and strengthening community-oriented rehabilitation services and resources for persons with psychiatric disability. We believe that, as a government agency, SAMHSA is uniquely positioned to advance the transformation of our nation's mental health system.

From its funding of progressive state programs to its investment in identifying evidence-based practices to anticipating future workforce needs, SAMHSA and CMHS have been at the forefront of change. SAMHSA has played a

significant role in how society thinks about and cares for individuals with psychiatric disabilities. However, there is still much work to be done to realize the 10 fundamental components of recovery and ultimately transform the mental health system. Reauthorization of SAMHSA, and probably more importantly adequate funding for CMHS programs, are essential. Although USPRA is pleased with the 2008 budget that will continue to fund programs that are critical with the mental health delivery system infrastructure, we're very concerned about the $78 million in funding cuts to the Programs of Regional and National Significance, which also support the states in carrying out activities that improve services for adults with psychiatric disabilities.

While admittedly difficult at times to measure, these programs have no less an impact on transformation. In fact, the comparatively small amount of resources spent on Programs of Regional and National Significance deliver significantly higher yield in grassroots efforts to transform the mental health system through training and technical assistance. These programs speak directly to SAMHSA's fundamental component of recovery that states "Consumers have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, that will affect their lives and are educated and supported in doing so."

Through knowledge dissemination and training, many of these programs provide individuals with psychiatric disabilities a voice in the delivery of mental health services. While not a direct recipient of CMHS funding, USPRA has witnessed the benefit these programs provide. Consumer and consumer-supported technical assistance centers have brought self-directed tools such as WRAP, which is the Wellness Recovery Action Plan, into the mainstream. The Rehabilitation Research and Training Centers, also known as the RRTCs, have been instrumental to mental health policies, programs and systems, as well as to the development of innovative services, and have allowed for the mass dissemination of mental health research. Many of these technical assistance centers use USPRA, as well as other associations, as conduits to ensure a trained and educated mental health workforce. The Statewide Consumer Network Program provides support so that innovative delivery services, such as Georgia's Peer Specialist Program, can flourish. Elimination of programs such as these would be a terrible loss for the entire mental health community.

USPRA understands the difficult and oftentimes unpopular decisions the administration must make in presenting a realistic and balanced budget. However, the extent of the cuts to SAMHSA, and specifically to CMHS, is

disappointing. USPRA hopes the administration will reconsider its position on the Programs of Regional and National Significance and the value that these programs bring.

Thank you very much for letting me speak today. I appreciate that.

DR. CLINE: Thank you for your comments.

At this time we will adjourn and reconvene at 1:45. Thank you.

Oh, one more comment from Daryl.

MS. KADE: Yes, just with regard to lunch. Lunch has been arranged at the Sheraton Hotel, and a shuttle should be outside waiting for you now. See you back here at 1:45.

(Whereupon, at 12:10 p.m., the meeting was recessed for lunch, to reconvene at 1:45 p.m.)

AFTERNOON SESSION (1:50 p.m.)

DR. CLINE: Welcome back, everyone. I hope you had an enjoyable lunch, and I appreciate your presence back at the table to my council members, and welcome back to our members of the audience as well.

At this point I am going to turn over the microphone to Dr. Kevin Hennessey, who is our science to service coordinator in the Office of Policy, Planning, and Budget, for his presentation on the National Registry of Evidence-Based Programs and Practices.

Kevin, the floor is yours.

DR. HENNESSEY: Thanks very much, Dr. Cline. I appreciate the council's invitation to come and speak with you about SAMHSA's National Registry of Evidence-Based Programs and Practices.

Let me take you back to April 25, 2003, which was the date of my last presentation to SAMHSA's council, and it was really a broader presentation in terms of emphasizing SAMHSA's emerging science to service initiative. In the course of that presentation, I made note of the fact that SAMHSA was poised at that point to begin expansion of its National Registry of Effective Programs to all SAMHSA domains, so mental health treatment, mental health promotion and substance abuse treatment. I am very pleased to say that a little less than four years

later and one name change later, here we are with the new National Registry of Evidence-Based Programs and Practices.

(Applause.)

DR. HENNESSEY: I was going to say there are probably a few council members here today who weren't council members then, but I for one may be the happiest person in the room for that blessed event. I am pleased to report that it was a healthy delivery and the baby is poised for tremendous growth and development in the months and years to come.

MS. HUFF: We hope without any mental health problems.

DR. HENNESSEY: Exactly.

(Laughter.)

DR. HENNESSEY: SAMHSA's vision for NREPP is that it becomes a leading national resource for contemporary and reliable information on both the scientific basis and the practicality of interventions to prevent and/or treat mental and substance use disorders. NREPP really represents a major activity within SAMHSA's science to service initiative, and it has been reformulated as a decision support tool and a valuable resource, we hope, for state and community-based organizations seeking to identify and select interventions to meet their needs, and you'll hear that more of the emphasis really is on

meeting the needs of these states and localities. What it is not is a list of approved or accredited programs or practices. I'll also have a bit more on that later.

A little bit of the history of NREPP. It began in 1996, again as the National Registry of Effective Prevention Programs. Between '97 and 2003, the system was very active. It reviewed over 1,100 substance abuse prevention programs. Over 150 of those programs, or about 15 percent or so, were designated as either model, effective or promising programs, and information on those programs was posted on the old NREPP website, which was called Model Programs.

Again, back to that April 2003 date in which the decision was made to expand NREPP to include all SAMHSA domains.

The new system. Part of the reason it has taken four years is that there has been a tremendous amount of thought and effort given to how to redesign the system to better suit the needs of particularly end users of the systems, consumers, providers, purchasers of services. So we began with a convening of several different kinds of review panels in 2003 in the various areas of expansion. We wanted to get their best thinking at the time of how we should expand the registry to address the needs in each of those expansion areas.

One of the strong recommendations that emerged from each of those panels was that evidence should be rated at the level of outcomes targeted by a particular intervention. The old NREPP system really was a global rating and a global label of the intervention that this is a "model intervention." Even though perhaps it was modeled for achieving certain outcomes, it may not have been modeled, or even promising, for achieving some other outcomes. So the redesign of this system really is a much more targeted effort to specify and be very clear and transparent about what the intervention does accomplish and perhaps what it doesn't accomplish.

We piloted -- "we" meaning the agency and the contractor -- different criteria over this time and have redesigned the system, and we felt that as we had this new system ready to launch that it actually would be very important to begin to engage the public, that we thought we had it right, but truly the true test of this was getting comments from the public, people that were going to be using the system that were influenced or impacted by the system. So in August 2005 we issued a Federal Register notice saying here's what we think the system should look like but, importantly, what do you think it should look like. We did get a number of comments back, well over 100 comments to that Federal Register notice.

Some of the recommendations emerging from that process, to make the assessment of behavioral outcomes a priority, not to say that we're not interested in changes in thought or changes in attitudes, changes in risk and protective factors, but that the primary emphasis -- and again, this is from the public comments -- the primary emphasis should be on actual behavioral change outcomes, be they in individuals, in communities, or in populations.

Another comment that was fairly consensus was to provide more importance on the emphasis dimension that we now call readiness for dissemination. It's one thing to have a strong evidence base for a particular program that has been tested in randomized controlled trials or been tested in various research-based settings, but it's another thing for that intervention to have been tested in generalized populations, to have the kinds of materials and training and other ongoing support that's needed to really take an intervention from a one-site or several-site intervention to something that would be applicable statewide or nationwide. So the public really did want information on how ready is this intervention to be disseminated more broadly. We're trying to do that with our new system.

They encouraged us to avoid a system that limits flexibility and innovation, to develop a system that

is fair to interventions with limited funding, and I think that was born in many regards from the fact that an unintended consequence of the old system was that purchasers began to restrict their purchasing to only interventions that were listed on the old NREPP system, and in some cases it was even to only model interventions, and the reality is that while those interventions in many cases were quite good, they were limited and there weren't interventions to address all of the needs in all of the settings among all of the populations. So we really did want to build with the new system an opportunity to promote innovation and to encourage the development of an evidence base for many interventions so that they had an opportunity to move into the registry.

Other recommendations were to recognize that multiple streams of evidence are important and that these multiple streams are really what address stakeholder information needs; to establish policies that seek to prevent the misuse of information on NREPP, again trying to protect against that notion that NREPP was an exhaustive or comprehensive list and you should feel comfortable in just selecting an intervention from NREPP even if it doesn't quite meet your needs; and finally, providing a summary rating system that reflects the continuous nature of evidence, that somehow with the use of the labels under the

old system, the "model," "effective" and "promising" programs, you lost a lot of information in that process. Again, as I noted before, it might have been a model for certain outcomes and perhaps not a model for others. So we really have moved away from the labels in this new system.

What I'd like to do now is actually move to the podium and give you kind of a whirlwind tour of the new NREPP. We did launch the system last week, on March 1, and are pleased with some of the initial feedback we're getting from the system. So I'm going to move to the podium.

Can everybody hear me if I speak up? Is it loud enough? Okay. I'll just try to speak loudly into this mike.

I did want to publicly acknowledge the hard work and outstanding effort of the NREPP contractor, Manila Consulting Group. Representing Manila today are the project director, Gary Hill, and the deputy project director, Anna Hodgson, if you guys can just stand up, because they have done tremendous, tremendous work on this project --

(Applause.)

DR. HENNESSEY: -- leading a staff of extremely dedicated, talented and incredibly responsive people. We've thrown them lots of curve balls over the years, including the fact that they've now, I think, become

experts in helping us to issue Federal Register notices, because we had three of them in the process. But they really have put in long hours, and I think that we have lots to thank them for in terms of the development of the website and the running of this system.

I do want to give you a whirlwind tour of the National Registry of Evidence-Based Programs and Practices. You can see that we're going with a fairly in some ways bold website in terms of the colors, but more importantly we tried to present it very clearly, not to have a lot of information on any of the pages, because we know that people really want to zero in on what the most relevant information is as quickly as possible. People are busy. They want to have something that they can easily access, that they can easily understand. So that's really what we're trying to do here.

Let me click on the About page first to give you a little bit of context about what NREPP is and, in some cases, what it's not. You can see the second paragraph under "What is NREPP?" "The purpose of the Registry is to assist the public in identifying approaches to preventing and treating mental and substance use disorders that can be scientifically tested and that can be readily disseminated in the field. It's one way that SAMHSA is working to improve access to information on

tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field." Again, it's this translation of science to service or reducing the research to practice gap that many reports, including the Institute of Medicine's seminal report, "Crossing the Quality Chasm," had identified.

What we're really about at SAMHSA in many respects, or at least one of our central missions, is trying to deliver on the services that have been developed and tested through the National Institutes of Health and other research bodies, to get those out and more broadly adopted in the public. We hope that NREPP is one important way now that the public will be able to get access to that information in timely ways.

What information does NREPP provide? Several important factors. One is descriptive information about the intervention and its targeted outcome. There are two rated dimensions. One is the quality of research, and that is really the quality of the research behind the intervention, how rigorous was the testing of the intervention in terms of achievement of specific outcomes. So there's a rating in that regard, and then the second rating is readiness for dissemination that I already talked about.

You'll also see a list of studies and materials that were submitted for the NREPP review, and finally contact information for the intervention developer. We're encouraging the public to go directly to these intervention developers. So we're providing full contact information for them. We want to provide descriptive information in some of these ratings, and then the public can make decisions on their own about what interventions best meet their needs given their resources, their organizational structures and various dynamics that they're facing. We want them to have as much information as possible, and then they can go right to the developer to learn more if they need to.

There's lots of discussion about what is evidence based, and I think that the way we're really putting that in the context of NREPP is really emphasizing that NREPP does not attempt to offer a single or authoritative definition of evidence-based practices. It's one way that we're really operationalizing what an evidence-based practice is. It doesn't mean that there aren't other very valid and very important ways of defining and implementing evidence-based practices. The second paragraph does capture it as well. We recognize that there is a wide spectrum of possible definitions of evidence. With this in mind, the agency has attempted to make the

NREPP rating criteria and processes as transparent as possible. This is really one of our guiding principles. We want people to understand how NREPP is rating the interventions, and so we're trying to be very transparent about that.

A few other contextual setting sorts of comments. Part of our education of the field is really providing some important notes about what NREPP is and what it's not, how it should be used and perhaps a caution or two against how it should not be used. So we put this important note to NREPP users. Let me go back just to show you. We make that a click off the homepage, because we really do want people to hopefully go there as one of the first things that they do.

In light of what we've done with NREPP in terms of the redesign, we do provide this information that we encourage NREPP users to carefully weigh all information provided, that it's intended to serve as a decision support tool, not as an authoritative list of effective interventions. We don't really approve, recommend or endorse specific interventions. That's up to the public to be the judge of that. Being included in the registry doesn't mean that an intervention is recommended or that it has been demonstrated to achieve good results in all circumstances. Certainly, many of the outcomes are

positive. That doesn't mean that they're positive in all cases. That's a very important distinction.

Finally in that paragraph, policymakers in particular should avoid relying solely on NREPP ratings as a basis for funding or approving interventions. That's a very important note, because in many cases other registries are oftentimes used to limit the funding in decisions that are made. So we want to make sure that we're very clear to the public that NREPP is an important tool but, again, not an exclusive or exhaustive list. You may want to go here to begin your search for effective programs, but your search may or may not end here as a result. Again, it's not a comprehensive list of interventions, but it is a good place to start to look.

Let me go finally into if you're actually going to the system to find an intervention. It's a searchable database, and it's searchable in many cases by some key factors. You can see that it's searchable by topics. It's also searchable by area of interest, searchable by the type of study design, some of the population factors, age, race, ethnicity, gender, setting, whether the materials are proprietary or public. That's an important distinction in many cases for community-based organizations that are making decisions in some cases with very limited funds. It may be a very important factor in whether or not they

choose a specific intervention, whether the materials are proprietary or public.

At this point there are 25 interventions on the registry, but this is poised for some pretty significant growth because we have over 200 interventions in the queue for review. Many of those are interventions from the old NREPP system, but a number of them are expansion areas as well. In response to the first period of an annual open submission period, we got about 50 interventions in response to that. We anticipate that that will be probably something that we do every year and that we'll continue to populate the registry with a number of those interventions. So at this point it looks like we'll be increasing the numbers on the registry, probably 5 to 10 interventions per month that we'll be adding. So it's a growing registry and it's something that we're encouraging users to check back frequently.

You can do a keyword search. You can put in the name of an intervention, the name of a program developer, a particular area, and interventions will pop up. Let me just, for example, click on older adult interventions. Again, you can use the check boxes as well. If I search, it provides the quick overviews of the interventions. We're really in Version 1.0 of NREPP, and like Microsoft we'll be coming out with 1.1, doing some

updates, things like that. One of the things we'll do is as the search is conducted, we'll print across the top how many interventions met that search criteria. So the end user will know right away how many interventions are meeting their initial search characteristics.

If I were to click on one of the interventions, you really get at the heart of what NREPP is, and this is the program summary or intervention summary. There is some descriptive information, the topics, the populations, what the outcomes are, the abstract, settings, area of interest, whether or not it's been replicated formally through independent study, whether or not the information and materials are proprietary or public domain, important information about cost, whether or not the program has been adapted.

Moving down, adverse effects, again an evolution from the old NREPP. It's important for the public to know whether or not the intervention has any harmful side effects or whether or not there have been any concerns that have been raised about the particular intervention.

The implementation history; again, this is really from the program developer, but in many cases that's a very important feature because it could be that an intervention has been implemented in two settings with

exposure to about 100 people, or it could be that it's been implemented in 100 settings with exposure to over 2 million people. So that may be important in weighing some of those decisions.

Again, moving down the page, you'll see outcomes, and there's a description. Each outcome, each targeted outcome has a box associated with it where there's a description of the outcome, what some of the key findings are, the studies that measured that outcome, the research design that was used to measure within that study, and then the quality of research rating, which is again on that 0 to 4 scale.

Let me move down to a kind of summary table of the ratings. Again, these are the quality of research ratings. It's really how strong, how rigorous was the study design that evaluated whether or not these outcomes were achieved by the intervention. So you can see the various criteria across the top, the reliability, validity, fidelity move across. Again, all of those are rated by independent, expertly trained reviewers, and it yields the various scores for each outcome on the 0 to 4 scale.

The readiness for dissemination ratings again are done by experts as well. The quality of research is scientific experts, people with not only a knowledge of the content area but also expertise in statistics, methodology,

study design. The readiness for dissemination reviewers I'm pleased to say are people with expertise in implementation. So in some cases they would be Ph.D.-level researchers, and in some cases they would actually be consumers and providers that have an expertise in implementing particular interventions. So we're really engaging a variety of stakeholders on the front end of this NREPP system. Again, they produce ratings which reflect the quality of the implementation materials, the training and support, the availability and the ongoing nature of that, as well as quality assurance. Are there fidelity scales? Are there other support sorts of materials that can help to kind of assess in an ongoing or continuous way the quality of the intervention and the quality of the implementation?

We provide some strengths and weaknesses in each of those dimension areas. So there are strengths and weaknesses on the quality of research and strengths and weaknesses on the readiness for dissemination. This is really, I think, in many ways the most useful information in terms of what the public may be most interested in, in helping them to make some decisions about the interventions.

Moving on down in the intervention summary, the study demographics. Again, people may want to know has

this intervention ever been tested in the population that I'm most interested in. So this is a quick table that would at least give you some basic information in that regard.

The studies and materials reviews. Remember that NREPP really is a snapshot in time. It's a review that's conducted in a particular time period, and so the NREPP reviewers have the benefit of all the information that has preceded that, but we want to make sure that the public understands that the review was conducted in November of 2006 and it could be that additional information is available on that intervention in 2007. So we actually do put that important note at the top of each summary, that all information below was current as of the date of review. To request more information or to see if new studies and materials are available, please contact the program developer. Again, we're seeing NREPP as an information tool, but we really do want to begin to have NREPP begin to direct people to the program developers so that if you're thinking about implementing that intervention, you go right to the source.

The way you would go to the source is the fact that we provide the contact information at the end of each program summary, so again encouraging people in many ways to go directly to the program developers to get the

information.

That is kind of a quick summary of how you may find an intervention. Let me just give you a little bit of an overview of a couple of the other NREPP pages just so that if you're in a position of needing to talk about NREPP or directing people to use of the system. The review process is fairly straightforward. Again, it begins with an application. There's an open submission period that is going to probably be tied to the beginning of each federal fiscal year, what is now a four-month open submission period from October of the beginning of the federal fiscal year to February, four months later.

Because each of SAMHSA's three centers is an important part of the NREPP system, they are really the ones who are weighing in very carefully about what kind of priority content areas they would like to see move into the registry. So if there are particular areas that are in need, if the center directors and the center staffs identify particular gap areas where they would like to see more interventions come in and be identified as evidence based and available to the public, they would identify those areas.

Because I'm seeing Kathryn, I'll pick on that area. Kathryn and her staff identified several key areas last year for NREPP priority review, and some of those

areas were consumer- and family-operated or consumer- and family-run services, alternatives to seclusion and restraint, diversion programs for individuals with serious mental illness or children with SED, diversion programs from the criminal justice or juvenile justice system, and I believe the fourth area was suicide prevention programs for all ages. So some very targeted areas, and we did actually receive some important submissions in some of those areas. So far, the system is working well.

The process is that interventions submit during that open submission period and some determinations are made about whether or not they meet the minimum requirements of the NREPP system, and let me just highlight what those three minimum requirements are. It's that the intervention demonstrates one or more positive outcomes in mental health or substance use behavior among individuals, communities or populations. The second minimum requirement is that the intervention has been published in a peer-reviewed publication or documented in a comprehensive evaluation report. Again, we're not saying that it has to be published, but it certainly has to have some documentation associated with it.

And then finally, there is documentation in the area of manuals, process guides, tools or other training materials, and that the documentation of the intervention

and its proper implementation is available to the public to facilitate dissemination. Again, we're most interested in interventions that have the kind of documentation where somebody in Nebraska could pick up the phone and call somebody in, say, for example, Oklahoma and say I'm interested in implementing this intervention; what kind of materials are available to me to do so with a high degree of fidelity and a high likelihood of achieving similar successful outcomes? So we do have certain minimum requirements associated with the NREPP.

Then on top of that are priority points, and that's really around study design. If it's a more rigorous design, it gets an additional priority point. Again, if it meets one of the content areas that the centers have identified, it will get a second priority point.

So all of that information is put together and decisions are made about which interventions are then invited for the full review. The intervention developer works with someone called a review coordinator employed by the contractor, and this is an expert who serves as a liaison between the program developer and the actual expert reviewers. They provide all the information that's needed to conduct those reviews, and then they're very responsible at the end for developing the intervention summaries and providing all the information that then goes up on the

website.

NREPP is a voluntary system, and so the part about submitting the intervention is voluntary. The program developer has to decide to submit the intervention. But the program developer also agrees to the posting of that information after the review is completed. We're not posting any information that the program developer hasn't provided us with a signed consent that this is fine to post this information. Again, we're trying to be a very voluntary and a very transparent system.

In terms of the process for moving forward, I had noted that we had over 200 in the queue, and so we anticipate getting through those interventions in the next year or two and moving about 5 to 10 out per year. We anticipate publishing a Federal Register notice with SAMHSA priorities for review. We probably will do that every summer. We did the first one last summer at the end of June, and we have a process internally where we identify with the centers and their directors what the priorities will be for the subsequent year and then publish that information.

We're trying to make this a very consistent and predictable sort of process, as well as a very transparent process.

At this point I wanted to make sure we have

plenty of time for questions. Again, thanks for your support, and I'm glad to be standing here four years later.

MS. POWER: I just had a sort of exploratory sort of question. When we gave you the priorities last year, and you have a great memory because you remembered them very well, we also had a lot of other programs like, for example, the National Child Traumatic Stress Network, and they're sort of poised and ready to continuously be creating new interventions because they're a grantee and that's what they're supposed to be doing. As those five or six or whatever priorities we gave you last year, that will not inhibit folks from the National Child Traumatic Stress Network who might want to have NREPP review this from submitting that. Those are just simply guiding priorities for you and the staff to take a look at whether this fits, because things like consumer programs and consumer-related services and peer services is sort of an emerging, exploding field. So we're looking for interventions that are effective in that, but that will probably be an ongoing priority given transformation.

But there might be other programs specifically from this trauma network that we funded over the last several years where they come up with new interventions based on the science and based on the research. Though trauma may not have been on my priority list, every year

we'll have a chance to look at that and say we'd like you to consider some of these emerging things, and hopefully that will reflect what we think is coming out from some of the grantee programs that we're supporting.

Does that make sense?

DR. HENNESSEY: Absolutely. It really is striking a balance. The challenge is striking a balance between wanting to bring new and emerging areas into the registry and using the registry to really help build the evidence base for particular areas like consumer and family-run services that I think we all see as so important, but with areas that are already established, you continue to bring the new programs and the programs that in many ways have been tested more widely in some cases, you want to continue to populate the registry with those programs. So I think part of the challenge that we face within SAMHSA and the centers is making sure that we have a balanced portfolio every year as we move forward.

The other caveat I would mention is that we also are limited by the amount of resources, and these interventions and the whole process, as you can see, is extraordinarily detailed, and with that comes a price tag of between $10,000 and $20,000 per review. So the good news is that it's very predictable in terms of what we can do. If we know that on the front end if we put X number of

dollars into the system it will produce Y number of reviews, there's the ability to expand and hopefully not contract, so I'll emphasize to expand the system as we look to identify additional interventions.

Yes, Ken?

MR. STARK: I think it's a great tool and I applaud you all for doing it.

One of the questions that I have is that given the fact that we're going to always be wanting to add to the list with emerging and promising practices, is there any sort of strategic alliance between SAMHSA and the institutes, NIAAA and NIDA and NIMH, about looking at some common priority areas where you've got some emerging or promising practices, and given the split of roles where SAMHSA is not supposed to be doing research, that the institutes would focus some of their resources around doing some research on some of these emerging and promising practices so they can ultimately get on the list or prove that they don't belong on the list?

DR. HENNESSEY: Excellent question. I would note, and Dr. Cline noted in his testimony to Congress, that at this point even though it's a small number of interventions on the registry, 25, two-thirds of those interventions were supported by NIH research, either initially or in an ongoing kind of expansion sort of way,

and we anticipate that that percentage is going to be about the same or similar as we expand the registry. So we're really identifying the interventions that NIH has made investments in and bringing them forward hopefully in an accelerated way to the public.

But in terms of those strategic alliances, it's very, very important because I think that the registry ultimately will prove to be a very useful tool not only to providers and consumers and purchasers but researchers as well, because I think what it will clearly highlight, particularly in those sections around whether or not there have been adaptations or the implementation history, we all know that there are certain interventions that really don't have a particularly strong evidence base, or maybe it's more accurate to say a limited evidence base from the standpoint of they've been tested and proven to be very efficacious in the initial research-based interventions, but they haven't been tested more widely, the effectiveness trials; in other words, how well does it work outside of the lab or outside of this tightly controlled research setting with Native American populations, with Asian American populations, older, younger, whatever.

Having that be very transparent on this NREPP system actually could provide leverage to the outside communities to say this intervention looks great and it's

getting some high scores or it looks like it could be very effective, but we really don't know how well it works in these other populations or in these other service settings. So in many ways, the next logical step would be to maybe make some investments in some of those additional areas.

MR. STARK: If I could do a follow-up, I agree with everything you said, that many of the interventions that have been funded by the institutes do get on the list because they've already got the research from the institutes and they were driven from that arena. I'm also referring, though, to the other side, those that are practice based, meaning that they've already been developed, they're already working, and states and communities already feel they're effective and even have some level of documentation, but not the type of rigor that would come with an institute-funded study.

So I'm hopeful that in these strategic alliances between SAMHSA and the institutes, that the institutes can feel their way to fund not only new interventions that they've done in the lab, as you say, under those conditions, but rather to identify emerging and promising practices that were developed in the field, not in the lab setting, and that people do believe they're effective but what they're missing is the rigor of an institute-funded study to validate their existence, because

neither the programs not the states, nor SAMHSA for that matter, given the role that you're confined to, can fund those kinds of studies.

DR. HENNESSEY: There may be some alternative opportunities for some of those things. I agree with you fully that we need to look at ways that SAMHSA, even if it's not direct resources, ways that we can try to facilitate partnerships so that some of these practice-based interventions have an opportunity to build their evidence base. It may be through foundation support, it may be through state dollars. I know state dollars are limited, but there may be some limited state dollars for evaluations. I know that SAMHSA at one point, with our service to science academies, was playing in that area a little bit, and perhaps there can be some replications of those sorts of concepts by other funders. I've got to be careful what I say here.

MR. STARK: I understand. The reason I'm laughing is because you are being so careful and it sounds like there wasn't a whole lot of faith that the institutes would jump on that idea and be willing to fund those kinds of things. But then again, I think you're free to say that.

DR. HENNESSEY: I'm a glass half full kind of guy, so I'm going to emphasize that we can do some

strategic partnerships.

MR. STARK: Good.

MS. KADE: I would point out that this year we did have a hearing with the institutes, and we're hopeful that the creation and growth of NREPP will change and improve those dynamics, especially when the members want to hear about the dynamics and the collaboration between the institutes and SAMHSA.

MS. DIETER: You mentioned the priorities you used for the first 25 interventions. Are those our matrix priorities or are these priorities within each area, and if so, what were they?

DR. HENNESSEY: Well, quite honestly, the 25 interventions that were part of our initial launch were a combination of interventions that were already model programs on the old NREPP and some that were interventions in the expansion area. Perhaps the common denominator for those 25 was that they responded very quickly to the invitation given to them to be included in NREPP last summer, because again, we had 200 interventions, many from the new system and then some new interventions that were identified by the work of many of our center staff for interventions that should be brought into NREPP, but we had so many interventions -- the contractor really reached out, and because of our tight time frame in trying to launch the

system, and because of all the information that's needed to submit for a review, we really took those that responded most quickly. So some of those are the old interventions and some of those are expansion areas.

We ended up, of the 25, we actually have a fair amount of representation across the domains. About half of them are mental health interventions, and about half are substance abuse interventions. Within the substance abuse, a few more prevention than treatment, but we're working hard to elevate the substance abuse treatment interventions for priority review as well.

The contractor agreed with me that the best advertisement for getting additional interventions into the registry is to have a live website, and just in the last week since we launched the website, they heard from a number of the interventions that we hadn't heard from in the initial invitation. They're saying, well, where am I in the queue? I really want to be reviewed. So I think that's a good sign to us.

MS. DIETER: Have you gotten any calls from the field? I mean, I hadn't thought too much about it. I think that's a really important question, what Ken brought up, because as he said there are some practices that have been tried and been successful that don't have any data, haven't been written up anywhere, and that's one of our

huge problems in mental health and substance abuse, all this fragmentation all over the country where we have no idea what's going on, no one is in touch with each other. Maybe there's some sort of attempt on your part to offer -- I don't know how you can really do this, to say if you have someone in the field, that you have some way to do it, a short study, to give them the technical support of actually performing a study to collect some of the data that you might need before you can actually put it on board.

DR. HENNESSEY: Well, in thinking out loud a bit, one challenge that could be posed particularly at the state level is if there are interventions that are working well, perhaps within a state, but they don't have a strong evidence base, perhaps there could be a decision made at the state level by some of the funding agencies that we're going to identify between three and five interventions a year, or maybe it's only one or two interventions, but it's something that's working well at the state level where we need to build the evidence base and fund a more formal and a more rigorous evaluation of that intervention through state and/or foundation dollars with a goal of perhaps moving into the national registry. I don't think it should be the exclusive goal of doing that sort of evaluation, but it could be an important goal.

Another goal may be to fund a rigorous enough

evaluation that it forms a basis for pilot work where you would then go and get a larger National Institutes of Health sort of grant. But if people think about it, there are some different opportunities that might be available if people think creatively. Again, some of it is a matter of priorities. There are clearly going to be many, many dozens of interventions within each state where people could make the case that they deserve the investment, but maybe there are certain priorities that are established at the state level, or even a county level, and some of those limited dollars could go toward a rigorous evaluation that would build the evidence base and move them toward systems like NREPP.

MS. DIETER: Yes, because it just occurs to me more and more after Ken's comment that like anything, once you're a parent, you learn how to be a parent. Once you're a treatment center, you learn how to treat clients. I mean, a lot of it happens in the field, not because of a study or a more contrived, creative response to a situation that ends up turning out to be quite effective. I think there are some small places that are doing some fairly neat things that nobody really necessarily knows about. I shouldn't be taking so much time, but I'm just thinking about it. I mean, here's this national registry of evidence-based, but how do we promote more exchange of

information about good practices?

DR. HENNESSEY: They're excellent comments, and I think what it challenges me to think about is if something is occurring at the local level, or even within a particular agency, and it's working well, the challenge really not to just that agency but to the entire field is to begin to document it in a way that it's replicable, because if it's working well there, there are some secrets to success that maybe it can work well in other places. But unless it's documented and evaluated, there's really not that opportunity to replicate that in a successful way. So I think the registry is a vehicle to help people begin to identify that. But the step that needs to happen, or the many steps that need to happen before that is to get some sort of partnership between maybe a local evaluator or a university-based evaluator in that state or region to come in, and perhaps through an NIH grant or perhaps through state or foundation funds, and to begin to document that more formally so they can demonstrate those outcomes in a way that is potentially replicable in other places, because I agree with you. I'm a provider myself through emergency room practices, and there are a lot of things that go on that are great but don't necessarily have an evidence base. You really do have to create that evidence base so that you can get it out there more broadly.

MS. DIETER: Absolutely. Thank you.

DR. CLINE: Barbara?

MS. HUFF: I want to respond to you, Gwynneth. But first of all, I'd like to just thank you because I remember when you were here before and I gave you a really rough time.

(Laughter.)

MS. HUFF: I bet you can't imagine that, can you?

(Laughter.)

MS. HUFF: About not having families involved. Do you remember that?

DR. HENNESSEY: I do.

MS. HUFF: And before I even got back home that day, because I still lived out here, you had called Jane Adams, I think. I mean, you really took it to heart, and I just wanted to say thank you for that and for this work. I think it's absolutely evident that you've listened to people and done a really fine job. In fact, I think Trina Osher might have been involved in this last review process.

DR. HENNESSEY: Yes, she was.

MS. HUFF: Another family member. I had to convince you that there were family members who were also researchers that could be reviewers, but that was at the beginning, and you're obviously a believer now. So anyway,

thank you. I appreciate that.

In response to your concern and questions, I for years thought that we could move this system based on the fact that there were best and promising practices out there, and I still believe there are, because there are a lot of people who are never going to get into the evidence-based practices, probably, for whatever reason. I mean, it costs money. I mean, there are lots of reasons. But this is one way, I think, to begin to move practices to another level, and I think we have to get real about the fact that -- and I think we're seeing it today with the very things that are evidence of funding being cut, that there may not be the evidence we need to say they're worthy of keeping.

So I think whether we like it or not, the handwriting is on the wall that we're going to have to have data around things. I think, however, that we ought to figure out a mechanism, sometime, some way, to collect the information around best and promising practices. The Federation did their conference this year on evidence-based practice and practice-based evidence. The practice-based evidence is more of what you're talking about.

So there should be a way to collect it somehow, people who are doing really good work in the field, and where families and consumers say we like that work, whether

it's evidence-based or not, whether there's the data around it, we believe it's helped our family, it's helped our child. There ought to be a way to collect that, maybe in a little different way. But right now, we're several steps ahead of where we were several years ago, and I thank you for that. But your point is really well taken.

MR. STARK: Let's see. I almost had a senior moment there. It came back.

The thing I was going to mention, and this is more of a philosophical thing but it turns into a practical implementation thing, for the 17 and a half years that I was with the alcohol and drug office in Washington State, we struggled with all of this stuff around evidence-based practice and had talked with the institutes because many of the evidence-based practices were that, they had evidence based on a practice, and we don't fund practices, we fund programs, and almost all of our programs used a multitude of practices. The reason for that was because the program served a multitude or a diversity of consumers, whereas most of the evidence-based practices were limited and narrow in scope in terms of what they were evidence-based for, some only for African American males between the ages of 14 and 17, some for only females, and thus and such, and our programs didn't differentiate that way. Our programs served basically all comers.

So what we did is we decided to take the term "EBP" and apply it to programs, and instead of calling them evidence-based practices, we called them evidence-based programs, but we only called them that after we had done the research, and we did a lot of research, although in the beginning we weren't all that interested in publishing in a peer-reviewed journal, but over time we found that to have credibility you needed to do that. So we did get about 20 to 25 articles published on various prevention and treatment programs, not practices.

Now, I couldn't tell you for the life of me which practices within those programs made them effective or not. I could only tell you that as a total program, they were effective in the majority and that the struggle with that as a state is, under the guise of this kind of evidence-based practice, that people want to come back to you and say, well, what are the practices that make it effective, and that was something we were hoping to be able to do in the next step, that we didn't have everything manualized, for instance, we didn't have everything documented, except the outcomes. We knew the programs were working but we didn't know why, or why not in the case of the ones that weren't working, and that truly would be the next step.

So I think we're all challenged here with a

combination of how do we document practice-based evidence along with utilizing evidence-based practices in the context of a program that uses multiple practices to serve multiple consumers. Big challenges.

DR. CLINE: Just to say as part of that, too, that there are multiple goals in looking at that, and one of those might be to determine again the effectiveness of this program versus that program in terms of funding, but one of the challenges that I think we see here is that collective practices within programs would be difficult in looking at replicability. It would be very hard to replicate something if you didn't know what made it successful. It's important to be able to say it's successful, but then how can we really replicate and spread that if we don't know the ingredients that made it successful? So depending on your goal, and there could be multiple goals, the hope would be that you could achieve many of these things at the same time, but many challenges I would agree with.

MR. STARK: I would agree with that, Terry. The only thing I would say back is that we did know the ingredients, but we didn't know which ingredient made the difference because we didn't study it by ingredient. We studied it in the context of the whole cake. But we did know what the ingredients of the cake were.

DR. GARY: I just wanted to also thank you for such excellent work. That certainly has great utility for many different stakeholders in America. I guess the other part of the challenge is to make sure that individuals know that this exists. I'm talking about consumers, advocacy groups, providers, as well as researchers.

My other comment is that I've been in some discussions and meetings at the federal level about requesting, perhaps even requiring, that individuals who get federal monies provide a brief abstract, a brief description of the program or the outcomes of their research or their service program or whatever their research is that could be written at the level where the consumers or the general lay stakeholder public could understand it. Frequently right now, we know when we look at peer-reviewed journals that it's written in a language that we call scientific writing, and it's difficult to decipher without having the background for that kind of reading. I mean, even if you're good, sometimes you miss the point.

So I'm wondering if there is any discussion about having -- I guess the issue is dissemination of information to a much broader audience through several media. It could be newspapers, newsletters, the Internet, public service announcements, so we can make this a living,

breathing organism for people, and improve and increase the utility of it so that we can get the outcomes that we want, and also we can find out what programs work for which particular groups and really have the data to substantiate that. That's how we move the science forward, because I think science informs practice, but practice also informs science.

DR. HENNESSEY: Absolutely, and a couple of thoughts in response. One is that we have actively worked and are continuing to actively work to try to achieve the right balance with the NREPP system in terms of providing the information in an accurate and transparent way and an accessible way, and yet maintaining truth to the interventions. We don't want to oversimplify a finding and have that be misunderstood or misrepresented. So part of the challenge is how do we represent the key findings within each of these summaries in a way that's accessible to a variety of audiences without needing a Ph.D. to understand it, but at the same time realizing that we don't want to oversimplify it, the fear of misrepresenting the findings of an intervention. So we're continuing to struggle with that. I think we've achieved somewhat of a balance, and we'll be continually challenged as we move forward.

DR. GARY: I guess my observation from a policy

perspective is that the people who get the funds to do the interventions to do the research should have that responsibility. I think that should be a basic part of the requirement. We know that they all do abstracts. If you get research funding, you have to have an abstract to go with your proposal, but it's scientifically written. I'm just suggesting that same information be translated for a wider group of stakeholders.

DR. HENNESSEY: I think another thing that we're actually in development with at this point is something that would take the accumulated body of research in a particular area -- NREPP is really about identifying a specific application of an intervention. So it's not cognitive-behavioral therapy for trauma. It's a specific application of that that has a package and has implementation materials and training materials. But there are those who are interested in just in general what does the research say about the effectiveness of cognitive-behavioral therapy for trauma. So part of that is taking the research that has accumulated primarily through systematic reviews, the reviews that meet certain high standards, and translating that or at least portraying that in a very accessible manner, almost in some ways a journalistic manner, where there are key findings that are portrayed in ways that are easily accessible to the public.

That's a project that we have in development currently, and I'm happy to come back and talk about that one. It's one of the other activities in our science to service arena that I anticipate will probably take about another year or so to fully develop.

But it's really taking that whole body of systematic reviews for interventions that prevent or treat mental or addictive disorders and getting that information and putting it into a database where it's very accessible and you can drill down as far as you want. So if you really just want the overall finding, you'll have that. If you want the original study that was the basis for that finding, you can have that. If you want additional SAMHSA resources that are related to that particular type of intervention, you can get that through another web click. So again, trying to design tools that are going to bring this information to the public in an accelerated and yet accessible and accurate fashion.

DR. CLINE: I think we have one more question we can take before we move to the next session.

MS. DIETER: I wanted to apologize because when I asked my question earlier I was so distracted by my thought that I forgot to say congratulations and thank you for this work. I was here also when you started, and I think I was so excited the other day when I got that email

and I popped it open, I think I mentioned to Terry right when we first were talking, when I came in, how excited I was to see this, and you've done a great job.

DR. HENNESSEY: Thank you, but it's truly been a large team effort. I have the privilege of sitting at the top of that effort.

MS. DIETER: Well, thank you.

DR. CLINE: That's a nice note to conclude on. Thank you very much. Dr. Hennessey, thank you for all of your leadership and your work in this area. Thank you.

DR. HENNESSEY: Thanks, Dr. Cline.

DR. CLINE: We will now move to a presentation from Dennis Romero, who is the acting director for the Center for Substance Abuse Prevention.

Dennis, the floor is yours.

MR. ROMERO: Thank you very much. Dr. Cline and members of the National Advisory Council, it is my pleasure to present to you a relatively large sector of our prevention efforts, and that is the Strategic Prevention Framework, and in this case the State Incentive Grants.

I apologize. I'm trying to recover from a second cold. I'm not contagious.

Some of the discussions that took place with Dr. Hennessey really go in line with what are the efforts of our SPF/SIG. As you probably already know, SAMHSA's

vision is a life in the community for everyone, and that mission is guided by building resilience and facilitating recovery. That is the hallmark of what we try to do throughout SAMHSA. The prevention side of the SAMHSA is to create communities where people can have a life in the community, and that quality of life is so important in that process.

We do this through ensuring that healthy environments are at work and in schools, that supportive communities and neighborhoods are supported, and that drugs and crime are minimized or erased from the local community. That's really the basis of what we're trying to accomplish through the focus of prevention at CSAP. We truly believe that substance abuse cannot be seen as a national epidemic but rather it is a series of local epidemics, and we need to treat it as such, because in doing so we can really tailor both the needs and the services in such a way that they truly complement one another, as opposed to being given top-down information as to what you are going to be looking at.

In one word, the role of the federal government, the role of CSAP is to support the communities and the states in this effort. We truly want to support communities, states, tribal entities to ensure that they have the necessary skills and tools to be effective as they

try to address this devastating issue which we call substance abuse. Every community needs a comprehensive communitywide plan, and the reason is very simple. Where change has to be measured is at the community level, not at the state level, not at the regional level. It's at the community level. It's where the rubber meets the road in my opinion, and that's where we truly focus our prevention efforts through the SPF.

The SPF in a nutshell really is simply a planning tool, nothing more than a planning tool to help galvanize the community to truly address the problems that they foresee in their community, and I'm going to walk through these five steps very briefly, very quickly.

The first step is assessment. What do we mean by this? Simply that we need to use data to help us drive our decisions. If data tells us that there is a high prevalence of marijuana, then that might be the issue that the community needs to address. But they will not know that. We cannot use simple anecdotal information. But when we look at the data that tells us through our epidemiological workgroups to tell us what is driving the problems in our community. Once we've identified and made that assessment, we need to begin to explore capacity.

Through the capacity building will allow us to begin to form a planning effort, and with that planning

effort we will then begin to explore what makes the most sense, knowing what the problems are, knowing what the data are telling us about the problems in our community, what mechanisms should we implement in the community to help us reduce, drive down the problems that have been identified in our assessment phase.

So we then implement programs with fidelity in the hopes that the program will truly address the problem that is so pervasive in our community. When we've gone through that phase, we then enter the phase of the last step, which is the evaluation phase, and here it's very simple. We evaluate how our program data in our community that drive down the problem that we assessed in the assessment and capacity phases, and if it just so happens that the evaluation comes back to report that the problem still exists, then part of that evaluation component would then be to revisit what other mechanisms, what other tools do we want to implement and try the process again, or it just might mean that we need to tweak what already is in place to make it more effective, and the process continues.

Throughout this process, in order for this to be successful in any community, at any level of the community, it requires that the key stakeholders truly keep in mind at the forefront of their discussions, keep in mind that cultural competency and sustainability have to be

paramount, truly the common denominators throughout every step of this process. As a decisionmaking planning tool, you are not going to be effective if you are not conscious of the cultural implications of your community. You are not going to truly address the problems if you are attempting to address a problem that does not fit with the community that you are trying to work with. So we need to have sustainability and cultural competence as key common denominators throughout this entire planning process.

I am happy to say that this map represents where our Strategic Prevention Framework State Incentive Grants are located throughout the country. We currently have 42 SPF/SIGs across this nation, and of them, it includes 34 states, 5 tribes, and 3 territories, and I am happy to say that I had the privilege not too long ago, actually in mid to late December, to be in Hawaii and be part of the kickoff celebration of the SPF that Hawaii recently was awarded.

It has been said, first of all, that today's philosophies are tomorrow's common sense. The SPF process, we are trying to bring a new paradigm to the way in which we deal with substance abuse, no longer using just anecdotal data, no longer just using what may seem to be the compassionate approach to take, but rather we want to do that but we want to make sure that we are successful in

our approach, and therefore it makes sense that we use data to help us drive our decisions, and we are moving forward in that effort.

We started in 2004, as I said, and this year I was extremely proud to report that we have five tribes and three territories already on the road to SPF, as I call it sometimes.

That's a quick nutshell that I wanted to report. I did not really want you to hear me, even though I know you were all just dying to hear me, and I love to hear myself, frankly. But I think who you need to hear from are from people who are truly making this operationalized, who truly are successful in their own way, and there's no better way to do that than to invite people who are where I call where the rubber meets the road. But I would first like to introduce Michael Lowther, who is the division director in the Center for Substance Abuse Prevention as the director for the Division of State Programs.

Mike?

MR. LOWTHER: Very quickly, by way of introduction, let me just say that there are 34 SPF/SIG grants. There are five tribes, three jurisdictions. The grants, just so you'll understand the context of how it works, I know Dr. Kirk that you know you have one in

Connecticut, and you know about the one in Washington. The grants are awarded to the governor or the chief executive of the organization. They're five years in length. Eighty-five percent of the money has to go to communities for infrastructure and/or services. So this is sort of the context. There must be an advisory council that the governor appoints and chairs, and that advisory council should be made up of agencies involved in drug abuse, public health, public safety, communities, people from, if you will, a coalition at the state level to try to provide guidance and assistance to the implementation of the program.

They're required to have an epidemiological work group, and they're required to do the five steps of the process that we've described here. That has to happen at the state level so that you build a state prevention system. You transform a state prevention system into a system that sees its goals, its role as serving communities in reducing problems related to substance abuse, so that you really are about building systems at the state level whose job it is to help communities, whose job it is to reduce substance abuse, because as Dennis so appropriately said, substance abuse is local.

That's the purpose of the grants, to provide the states with the dollars to build the infrastructure at

the state level and the community level. That's the first goal. The second goal is to reduce problems related to substance abuse, traffic deaths, emergency room visits, overdoses, those kinds of things, and to reduce the onset and progression of substance abuse, that is those patterns of use that drive those problems. The notion is that if you use data and you find the areas where it's the highest and you concentrate the resources, you can do this work. You can drive it down. The prevention really does work.

So with that, let me say that it's a real pleasure to introduce our real partners in the State of Kentucky. Connie Smith, who is the director of the SPF/SIG project for the Commonwealth of Kentucky, is here to talk about sort of the state level, and then her colleague, Diane, who works at the community level, will also be involved and can describe that, and you all can ask them some questions. But I wanted to give you some context. And I would be remiss if I didn't acknowledge Clarice Holden, who is a state project officer. She's the real federal partner with Connie. So Kentucky's success is really about Clarice and Connie and the folks at the local level.

Take it away.

MS. SMITH: Thank you very much. We were so excited when Clarice called. I mean, I just didn't even

know what to do, but I'm so happy to be here. What we'd like to do is, first of all, just give you a little overview of how we got where we are, and I'll talk about our state grant, and then Diane is going to link that with her Drug-Free Communities because Diane is also one of our master trainers who is involved with a county grant, and also she's Drug-Free Communities, Ohio County is. Then after that I just wanted to tell you a little bit how the Strategic Prevention Framework has really changed Kentucky's look at prevention and how we're looking at prevention. We are changing it, and it is because of the framework, and we're pretty excited to do that.

We have chosen the Commonwealth Alliance for Substance Abuse Prevention to be our logo for the State of Kentucky. We have eight counties, and if I say community or if I say county, they're interchangeable. We chose to look at counties. Kentucky has 120 counties, so our communities are the counties. The first thing we did was we had our epi work group look at Kentucky as a whole, and they did all kinds of research and finally identified Kentucky's ATOD priorities.

The second thing we did is we brought the results of the epi work group to our strategic planning committee, and the strategic planning committee then drilled down to identify the communities or the counties

that have the highest usage and consequences of state ATOD priorities. So we started out looking at 120 counties, and then we began to drill down.

After we looked at those counties that had the highest usage and consequences, we began to drill down some more. At this level, at level 2, we identified that Kentucky really had five priorities that we needed to look at. We needed to look at methamphetamine use, we needed to look at inhalant use, we needed to look at prescription drug diversion, folks that are sharing their drugs or selling their drugs. Also, obviously, with Kentucky we looked at tobacco use, and then of course CSAP would like us to look at underage drinking, so we did that. So those were the five targets that we looked at.

What we did, then, to choose of these high counties which ones, because we couldn't look at 19 and do a good job, we sent out a site review team, and the site review team consisted of about five sub-teams, and they went to each of these counties that had these problems, and we had a survey that we used, like a community norms survey. We talked to each of these counties to look to see if that county had a coalition that could support this project for the next five to seven years. We looked to see which of these counties had low resources because we felt that there might be high readiness and there might be a lot

of substance abuse problems in this county, but if they didn't have high resources then they couldn't do anything about it. So we wanted to look at those counties that did not have high resources.

What these site visit groups did was they interviewed all these counties. They came back once again to the strategic planning committee and they said out of the 19 counties that we looked at, we feel that these counties should be considered as grantees. The strategic planning committee then -- it took us almost all day. We talked about it and talked about it and talked about it, and we drilled down to eight counties that had the highest readiness, the highest use, and the lowest resources. So that's how we ended up with our eight counties.

One of the things I'd like very briefly to tell you because it's very, very important to implementing this grant is that Kentucky is very fortunate to have regional prevention centers. We have 14 regional prevention centers that cover all 120 counties, which means that not only are we looking at the SPF/SIG projects but we're also looking at any other drug prevention project or drug abuse project in any county. For example, if I were in Ohio County, I could go to the River Valley Prevention Center and ask the folks there for help. If I were in Franklin County, I could go to the Bluegrass Prevention Center and ask for

help. So there's always a person, a regional prevention center and a regional prevention center director who is extremely familiar with prevention that can help anyone in that county that needs assistance. So overall, Kentucky does have regional prevention centers, and you'll see in just a little bit how they really play an important part in our SPF/SIG.

What this map attempts to show -- and we didn't know how to get rid of the little lines, so just kind of pretend they're not there. I'm okay with prevention, but when it comes to clickers, I'm really not very good.

So let's just look at the yellow. The yellow are those counties that we have given the awards to. Muhlenberg County and Ohio County, we're looking to them to target methamphetamine. We have Monroe County and Clay County. They're going to be looking at inhalants. We're looking at Letcher County and Clinton County, and they are looking at prescription drug diversion. We're looking at Owen County for underage drinking, and we're looking at Owsley County for tobacco use and abuse.

One of the things I'll mention very briefly is that Kentucky has wet and dry and moist counties, and when you produce a lot of bourbon, you have to break it down into who is going to sell it and who isn't. But anyway, wet counties are allowed to sell alcohol all over the

county. In dry counties you cannot sell alcohol, and moist counties you can probably sell it in the cities but not outside the city limit. But, of course, what you do is you go to the county line with the wet county and you buy there.

Anyway, what I'm trying to say is that Owen County, who we're targeting for underage drinking, had the highest problem with underage drinking, and they are a dry county. So that's going to be a challenge for all of us on there.

Tying the communities and the state together using the SPF/SIG process. Now that we have got those eight counties, we wanted to show you just a little bit how our counties mirror our state plan. Each of our counties or our communities were given a guide to do their strategic plan modeled after the state's strategic plan. So each of our counties had to go through the five steps of the Strategic Prevention Framework. We were able to give them a good start. For example, we were able to give them a good start on methamphetamine use using the KIP survey and using some other bits of information, but it's going to be up to those counties to drill in deeper. For example, some of our counties are going to the coroner's, they're going to the emergency rooms, they're having focus groups. So it's up to them on that first step to drill down into their

county to look at more of their needs assessment, and then they have to also follow the next step and all five steps.

The state is helping each of our counties with step five. It's pretty tough for folks to be able to do a good job of evaluation without some help. So Regional Louisville, who are our partners, are one on one helping each of these counties with their evaluations.

Our state agencies are also linked to the Strategic Planning Framework through local affiliates. These counties are all expected to have advisory councils or advisory boards. For example, we have what's called home teams. So we have folks at the state level in the Department of Education, in the Department of Juvenile Justice, Mental Health and Substance Abuse, Family Resource and Youth Service Centers, and I mentioned the Department of Education at the state level. But we also have these folks at the community level. So we have the community folks that are -- for example, the Department of Education. We have two people who are at the state level, but at the Department of Education also in our SIG communities, it has the board of education that's helping them. So we're drilling down from the state to the community level.

We also have community project coordinators, meaning that in each of these eight counties that are funded, we have a coordinator that must have an office in

that county. This person is in charge of keeping that county in line. That's not a good way to use that. They're keeping the county focused. They're charged with looking at the strategic plan of each of those counties and helping those folks in the community implement that plan effectively, and they are there five days a week. They are there so that the county can reach them at any time. They're also in charge of having board meetings and making sure that everything is running as smoothly as possible with their logic models.

We also have master trainers. Master trainers are comprised of regional prevention center directors or regional prevention center staff. These folks have gone through a very intensive training that the state gave to them on the five steps of the framework. This training lasted almost a year, and each of our master trainers understand very thoroughly and have presented the Strategic Prevention Framework to their counties, and they work in conjunction with the project coordinators. Our project couldn't be successful without the master trainers and the regional prevention centers.

The communities are also required to do quarterly reports to us. In other words, the county coordinators need to give us a quarterly report on what they're doing as far as their strategic plan. Are they

staying with their logic model? Are they consistent with their timeline as we have to report to CSAP?

We also have site visits. Our site visits are beginning next month and our Frankfurt folks that are SPF folks, myself and our coordinator, will be going to each of these eight counties and having a site visit, and the site visits are not for the purpose of gotcha, you're doing this wrong. The site visits are let's sit down now that we have a chance to really talk and see what you're doing, see how we can help. So one of our philosophies in Kentucky is that you can't stay in Frankfurt and implement the SPF. You've got to get down there with them, you've got to be a partner with them in each of these counties. So we really talk to almost all of them at least weekly.

They have to have bi-annual meetings of all granted counties. What we're going to be doing is to bring them all to Frankfurt or bring them all to Lexington or bring them all somewhere where they can all meet and have all of our counties meeting at the same time where they can talk with one another, they can dialogue with one another, we can talk about common problems, we can talk about common successes, and we can just exchange ideas. Instead of us exchanging ideas with them on a one to one basis, they can also start exchanging ideas with one another. One of the things we're also planning, I was also with the first

incentive grant, and one of the things they wanted was to open it up to community members, too. So we're really excited that in May we're going to open it up in a big room and the community members can come. So if I'm a community member from Clinton County, I can talk with someone else and learn, with just the folks in the community and not worry about what's going on as far as the logic model.

We just put "TA is just a phone call away" because we always, always encourage that if the community coordinators or the master trainers are having problems, we encourage them to call us, or if they just want to sit and talk and tell us what's going on, we encourage that also.

The last slide is to talk to you about our funding streams. We'd like to just show you a little bit how our money is distributed in Kentucky. We have the federal block grant money, and we have Prevention Enhancement Sites. As of two days ago, the Prevention Enhancement Sites are not three but they're five, so I'm really excited about that. A Prevention Enhancement Site is a site that's located in a regional prevention center that really concentrates on one substance, and they're open to any county in the state that would like to go to them for help. We have a Prevention Enhancement Site that really focused on alcohol. We have a Prevention Enhancement Site, the same site right now, that is focusing

on fetal alcohol spectrum disorder. We're having a Prevention Enhancement Site that allows the faith-based communities to get in on prevention, to help with prevention. We have a Prevention Enhancement Site that's going to be focusing on methamphetamine use and abuse in the state, and finally we have one that's focusing on tobacco use and abuse.

Once again, these are located in the regional prevention centers, but they really are experts in these fields and anyone in the county is welcome to go to them. Of course, our federal block grant also supports all 14 of our regional prevention centers.

The SPF/SIG dollars, of course, go to the state. We have eight counties, and we have some carryover funds this year, and what I'm excited to do is with part of our state dollars that are carryover that we didn't use, what I would like to do, what we were planning on doing -- we haven't gotten the RFP written, but we're hoping to take 25 new counties at $50,000 each, write a simple RFP, and these are counties that are not funded already, and have them do a little RFP following the Framework, saying what they would like to focus on, look at the database, our data warehouse for example, and say we believe our county has a problem with marijuana, the data warehouse says we do, and we have a coalition that would like to follow the SPF/SIG

process. So we would like to give them $50,000 to begin steps 1 and 2, counties that aren't already funded.

So this is the way that we can build capacity with the state and get that SPF out to the other counties that aren't funded through the regular grant.

We also have some state general funds, and whenever we have some leftover state general funds, we try to get those to the prevention centers.

We have some tobacco settlement funds through the Office of Drug Control Policy. The Agency for Substance Abuse Policy was one of our partners on the -- excuse me. I'm sorry. The train just left the station without me. I guess that's my senior moment. Our strategic planning committee. The Agency for Substance Abuse Policy is also in there, and they said, well, you know, you had 19 counties, and you only funded eight, and we feel that these counties that were so close need to have something rather than just say sorry about your luck, you don't get anything. So they came up with $500,000, and they are giving nine more counties -- they're taking that money and dividing it between nine more counties to also implement their framework in steps 1 and 2, basically. So we're excited about that. They're also looking at their own strategic plan, and their agencies are now looking at taking their strategic plan and modeling it after the five

steps of the framework.

Then, of course, we have our Safe and Drug-Free Schools and Communities funding that funds our early intervention program and our Champions for a Drug-Free Kentucky Coalitions.

Dianne?

MS. McFARLING: Thank you. It is a pleasure to be here today. Greetings from Western Kentucky, particularly from the County of Ohio. We are excited to have this opportunity to speak to you all and to share some of the things that are going on in our region and the things that are happening.

I wanted to start by showing just a basic organizational chart. I am a part of the regional prevention center, a certified prevention specialist, and also a master trainer for the SPF/SIG. So I was one of those people who went through the extensive training that Connie was talking about, and from the receiving end of it, it was very good for us to have the opportunity to really learn even though it incorporated the things that we had been using to a degree. But it was much more intensive and much more results oriented than what we had been doing in the past. So it was a very good opportunity that we had to do that.

When we look at the regional prevention

centers, our scope, our roles that we have follow basically the funding pattern that Connie just spoke about. The early intervention program is a part of the Safe and Drug-Free Schools money. It's a program that's designed to work with at-risk youth who maybe have begun using but are not yet at the point of addiction, to intervene early to show the risks and the consequences to encourage them to make different choices in their lives. The referrals to that program come through our district court system, court designated workers, schools, a multitude of places that have opportunities to be with these at-risk youth.

The Prevention Enhancement Site, River Valley, is one of those RPCs that just received the Prevention Enhancement Site for methamphetamine. Being a part of Western Kentucky, it is a very heavy farming community. So because we have the accessibility to the anhydrous ammonia and farmers put those tanks on their properties, we have some issues with methamphetamine. We have realized that over several years and have worked to decrease the labs. We have decreased the labs. I would like to say that we have decreased the problem, but we have found that now there is coming a new way of importing the drugs from other countries. So we're constantly faced with how we're going to approach this problem.

So that is what the Prevention Enhancement Site

will do, particularly for our seven counties, but the Prevention Enhancement Sites are for the statewide community. So it will cover all 120 counties with regard to methamphetamine. What we found is that things that happen on the west end of the state have a tendency to move toward the east as well.

On the right-hand side are the county coalitions, and these coalitions are involved with policy advocacy. They're also involved with providing an outlet for people to work to counter the problem and to deal with the problem. I have listened to seven counties that currently my regional prevention center operates, and this is by no means to say they operate through us. We are there to provide technical assistance and help and support for them.

We have the Champions for a Drug-Free Kentucky. We have five counties that have those grants and that work on encouraging science-based curriculum, encouraging strategies to use for community members to combat the problems of all types of drugs, not just one specific drug.

We have three counties that we serve that are drug-free communities: Ohio, McLean and Hancock. Again, I serve the Ohio group, and they are very committed, and you will see their names up there under everything because they are really working hard to impact their community to make

it a safer place for youth and adults.

The third bullet down there is the Kentucky Agency for Substance Abuse Policy that Connie spoke about. These are groups that we have in all seven of our counties that work at looking at policy and how policy can impact the use and the consequences and trying to look at system policies, not just local law enforcement policies but school board policies, workplace policies, and trying to impact those to reduce the accessibility, provide information so that our community knows. Part of what we do with the policy we cannot do unless we have the education that goes along with it. Sometimes we try to enforce policies or implement policies, but if you don't have the community support -- so there is education that goes with that as well.

The SPF/SIG, we have one county, and that is Ohio. We are charged to look at the methamphetamine problem that's there, and from the data that we received from the state we know that we have a significant problem with methamphetamine, and it is up to us now to have the initial data that we received from the state, but then also to move and gather new data and look at different ways to drill down, absolutely, as Connie said, to really determine how significant the consequence data is.

So if we did a job description for prevention

specialists, we might be tempted to look at it from that fashion. But I would say that really the fashion that we should look at it from is this fashion. The regional prevention center serves as a part, and Together We Care is the name of the county coalition in Ohio County. When they say together we care, that is absolutely what they mean. They work together. They are hard working. They are very committed to making these things work, and their readiness certainly was noted when we did the readiness surveys. When the site visit came for them, they were found to be up to the task to do this.

They are a county that has over 1,500 square miles. They're the third largest geographical region in our state but a much smaller population. To cover that territory, they only have 18 law enforcement officers. That is a big territory given the problems with farming and anhydrous ammonia. There we have some problems.

Also, when we look at Together We Care, these are the 12 sectors that support the Drug-Free Communities, they are a drug-free community or a (inaudible) of their Drug-Free Communities grant. They have these people who are at the table. So when we looked at the diagram, we thought that this was the perfect way to represent exactly what they did. You could pull one of those circles out and you would still have a functioning group. But I think the

way that we assess readiness and abilities to look at the problem is to say that all of these things are there and working together we can address them much more rapidly and with more effectiveness.

We look at all of the people that are at the table, and one of the things about Ohio County, when they walk through the door, they check personal agendas at the door. They do not carry what they want to get accomplished to make them look good. They really are there to focus on the needs of Ohio County and how that works.

So we are there with them. We provide technical assistance. I don't really see that it's the regional prevention center and Ohio County. We are one and the same. We serve other counties, and this would not be the way that we see each and every county in our region, but this is certainly the way we see Ohio County.

When we look at the bottom, we see the Drug-Free Communities. They are a recipient, again for five years. The Champions, they have consistently been awarded Champions grants, and those are grants that they use to implement science-based curriculum in their schools and provide those opportunities, Kentucky ASAP, and now the SPF/SIG. We have a coordinator. We have completed our strategic plan. The strategic plan was not just a document that we put together quickly. It was something that really

took about six to eight months, and we have truly appreciated the support that we have had from the state. They have been very beneficial. It was not just go out there and you do it. They have been with us, working with us and in constant communication, and it has been a tremendous help to us.

We are excited about the implementation stage, but we realize that the implementation stage is not where it stops. The evaluation stage is not where it stops. We are continually having to assess the needs. Again, as the problem moves, then we have to adjust our strategies, and then also as we move the needle, we need to adjust our strategies as well.

So that is a few words that we have to say from the regional prevention centers and for this particular county. The Strategic Prevention Framework is something that each of our counties are encouraged and trained to use. We see this as the move of the future and a very good move using the data and drilling down and helping everyone identify exactly where they are and how they can build the capacity for their communities. You can come up with a strategic plan, but if you do not have the capacity to implement that strategic plan, it's a piece of paper.

MS. SMITH: Very briefly, I just wanted to go over how the Strategic Prevention Framework has really

changed prevention in Kentucky. First of all, we are working very, very hard to participate in the National Outcome Measures. Our prevention data system we've had for quite a while, and some of the questions that are asked of the National Outcome Measures we can already answer with our prevention data system. So we continue to ask our counties that are funded by the SPF/SIG and the regional prevention centers to enter data. Data is essential. We are also applying this and also asking Regional Louisville, our evaluators, to help us with the National Outcome Measures as well.

Each of our regional prevention centers are charged with having a blueprint, what are you going to do this next year, and they give that to the state and we look at them. The blueprints are also based on the five steps of the Strategic Prevention Framework so that all regional prevention centers are implementing this.

We mentioned the master trainers. The Agency for Substance Abuse Policy is now having their own strategic plan around the framework, and they're also helping us with funding those runner-up counties that didn't get the initial funding.

I mentioned the mini-grants, the 25 mini-grants of $50,000 each. We're also in the process that starts next week, Kentucky offers Prevention Academy, and that is

open to -- we're having to close it down because there are so many people that want to do it, but Prevention Academy is open to anyone in the field. We ask that the new staff that are employed by the regional prevention centers to go to Prevention Academy. It's a two-week academy where, once again, each step of the framework is taught. So anyone from the field can go, and also the folks from the regional prevention centers can go. It's open to anyone who would like to learn about the Strategic Prevention Framework. We're focusing on that.

We have a data warehouse that Regional Louisville has constructed for us, and that means that if I were in, for example, Ohio County, I could go into the data warehouse, I could click on Ohio County and I could get all kinds of information. Then from that I could do graphs, I could do PowerPoints, I could do all kinds of presentations, and the work has been done for me. That's when I mentioned those mini-grants. What they need to do is go into that data warehouse and say not that we think we have a problem with marijuana, but the data warehouse with consequence data shows us that we do. So we're making them use the data warehouse also to begin their implementation.

We also use our state portion of the SPF dollars to offer trainings. We're really excited that in the near future we're having a two-day cultural

responsiveness or cultural competency training. We're insisting on it. It's required for all of our community coordinators to attend, and it's required for one other person from their coalition to attend, but then we're opening it up to all the regional prevention centers also. For anyone in the community who would like to come to that, we're offering that.

Because of the SPF, our state is forming new linkages with other agencies. We're looking at a system that looks at prescription drugs that doctors record. For example, if Dianne were to get a prescription for OxyContin, the doctor would enter that into the computer. When she went to pick up her prescription for OxyContin, the pharmacist would look and say yes, okay, it's not a false prescription. She indeed does have a prescription. He would enter that he did give her that prescription for OxyContin. If Dianne wanted to go to another county, for example if she wanted to go clear to eastern Kentucky and try again to get that prescription filled, then all they would have to do is go into the computer and say sorry, Ms. McFarling, you have already filled that prescription. So we're working with KASPER. I don't know if I can remember what KASPER stands for, but I wrote it down and didn't realize it. Kentucky All Schedule Prescription Electronic Reporting. So we're trying to link with that, and we're

very excited because we'd like to link that with Tennessee, because some of our folks in eastern Kentucky are trying to go across the border to Tennessee to repeat their prescription.

I think that that's all we have right now.

MR. ROMERO: Thank you, Connie and Dianne.

This is truly a wonderful example of prevention in practice, operationalizing the impact that prevention can have in a community by really galvanizing and certainly empowering the community to take the lead on addressing problems. Again, thank you very much for presenting today. You guys are awesome.

(Applause.)

DR. CLINE: Thank you, Connie. Thank you, Dianne.

We have some time for questions and comments from the council, and if you wouldn't mind if you'd stay at the table and be available for any questions.

Dennis, I know you need to run, so feel free to do that. Thank you for being here.

Mike, if you could stay, that would be great.

Ken?

MR. STARK: Great presentation. Thank you.

One of the things I wanted to ask you, having made the conversion myself in terms of employment from

working in the alcohol/drug field for a long, long time and then shifting over to mental health through the transformation grant, which is also a SIG grant but not a SPF/SIG, although Washington State does have a SPF/SIG, have you seen in Kentucky any buy-in, if you will, at either the state level or the local level from the folks in mental health around the prevention framework, given the fact that there's so much interrelationship, as you all know, from the prevention side between academic achievement, juvenile delinquency, runaway, teen pregnancy, alcohol and drug use, that sort of thing?

MS. SMITH: Yes, we have. One of our home team leaders is a representative from mental health and substance abuse, and they were also part of the team that went around to interview these counties that were potential grantees. What they learned is that there's a whole other world out there. So our director is really pro-SPF. We also have folks on our strategic planning committee who are from the mental health field, and on our advisory committee. So slowly but surely, yes, it's taken on, and we're excited about that.

MR. STARK: I would just make a comment that I think it's another one of those areas in terms of the whole framework that alcohol/drug prevention is really something that can be a lot more generic than that and is very, very

appropriate for the mental health field. Obviously, we know it's appropriate for the education field and some of the other arenas, child welfare.

MS. SMITH: And our Office of Drug Control Policy is on there, too.

MS. McFARLING: I'd also like to add that the regional prevention centers are actually attached to the community mental health centers. So my office actually sits in the community mental health.

DR. KIRK: Impressive process. Very good.

Let me ask a question from a SAMHSA point of view. The kinds of approaches that are inherent in this effort, they're systemic, if you will. From the experiences you've had so far, what are the critical components or bridge elements, if you will, that after the SPF/SIG is over stay embedded, so the dollars stop but, frankly, the processes and components that you've built in have a lasting value that 10 years from now someone says I don't remember what SPF/SIG was about but people such as you can go back and see how that was an element? I think this was a question, actually, for SAMHSA as a whole, for all of your grants, how you build them in such a way that the effect doesn't end when the dollars end but somehow they become embedded. So based upon your experience at this point in time, what are the components, that homegrown

Kentucky flavor, that would stay in place over a period of time?

MS. SMITH: One of the things that's really, really important is sustainability. In the diagram you've got sustainability in the center, but what we ask our counties to do is to show sustainability for all five steps. In other words, we've got some folks who will help them write grants, but money is only a part of sustainability. So hopefully the folks will stay on board. What are you going to do to keep your coalition going? What are you going to do to make sure that when the money runs out, how are you going to continue with this?

So in partnership with the regional prevention center, they're doing the SPF process. Their blueprints have been doing that. They've been modeled around that. So hopefully the name "SPF" might be gone, just like we've got KIP, and everyone associates that with the survey. So the term "SPF" might be gone, but the process won't. So what we're trying to do is get this process out and show them that each step relies on the other and it works. Once you evaluate and once you see, you either go on with what you've been doing, you change what you've been doing, you modify what you've been doing, but we keep the process going. Hopefully with the regional prevention centers continuing to do their blueprints around that, each of our

counties is going to be more and more adept at doing this process, and that's how we're going to sustain.

MR. LOWTHER: I think at the practice level that's exactly right, that it is about people learning how to solve problems, and it works when they keep solving problems the way they've learned how to solve them. That's what the SPF process is. It's simply planning and about executing it in the right order.

I think for the state, what it boils down to is figuring out what their role is and supporting that ongoing process in communities so that the state understands that there's going to be turnover in communities, so we're going to continue to have to teach them assessments and how to do them, that communities won't always understand what evidence-based means, and so we have to have a training system that will do that. That's one of the glorious things about Kentucky, that they have embraced it and they've trained all the prevention centers to start with the same language, all the time, over and over again. So as that staff turns over, that won't change because it will be embedded inside that training system, and they will be training the communities to think that way about it.

The leadership at the state level, to continue to support and push the idea that it should be a state coalition, that it should have all the players at the table

together at the state level is a critical piece. The places where I've seen this break down would be in states where we've gotten what you've seen here in Kentucky going, but quite frankly there will be a change in the governor, or there will be three administrative heads change, or something different occurs and the folks at the state level that have the authority and the ability to keep things alive maybe for no reason -- not that they want it to be bad, they just don't know, and so they don't support the continuation of what's been going on, and things can die.

So I think at the state level it's about leadership and about institutionalizing these ideas. If you can do that reasonably well and embed it in the training structure, then the communities will embrace it and use it, and they won't forget how to solve problems once they've learned how.

MR. AIONA: This sort of goes back to your question before about practices and programs. I think the challenge for any number of us is that based upon an experience such as this, do we learn from this what might be called evidence-based or experience-informed system change? What are the components that tie together so that it's not just a matter of giving you money and so and so is not funded anymore? What are the elements that give you evidence-informed system change? Otherwise the grant runs

out and you have to figure out how to do another grant application. I don't see that as getting us where it is we want to go.

MR. LOWTHER: I think you're absolutely right. I couldn't agree more. When the grant runs out, you've helped a few people and they're a little bit better off for the time that you were there with them, but you haven't changed anything permanently, and that has to be institutionalized somehow at the state level and be appreciated, and it's difficult.

DR. CLINE: Part of what happens with this is you're changing the way you approach problems, you're changing the way you think about the work you do and the challenges you face, and I think that's where that gets embedded. You're actually changing the culture of how you approach issues in your communities. In some ways there are a lot of similarities with the NIATx problem, just that kind of process improvement, that kind of plan/do/study/act kind of cycle. That is changing that culture and approach, and it's not associated with any one specific problem. It can be applied to everything you do. So I think that sustainability does get embedded.

MR. LOWTHER: One of the things that's really different about this grant is that we're not telling people what problems to solve. We're funding them to solve the

problems that they see. So we're not saying to implement a program. We're saying figure out what's wrong and then figure out what causes it, and then fund strategies that will drive that change, rather than looking to the federal government to say, hey, go do mentoring, or go do this, or go do that, because we don't know, we don't live there.

MR. AIONA: If I can, I think this is a part of the discussion, and I can talk offline maybe with you, but it seems like in your presentation -- by the way, very good presentation. It seems like a key element of this whole thing is your regional prevention centers, and that was actually created out of your block grants. Is that correct?

MS. SMITH: Yes.

MR. AIONA: So that means that the people in the regional prevention centers are employed by the state, they're paid by the state?

MS. SMITH: They're paid through the block grant and they're using the community mental health centers as the fiscal agents.

MR. AIONA: And that was started before you go this grant?

MS. SMITH: Oh, yes. They've been in place for a long time. I couldn't give you a date, but in the early '90s, I believe, they were created. Yes. We couldn't do

it without them, and they've done wonders for prevention.

MR. AIONA: Do you know what percentage of your block grant is used for these regional prevention centers?

MS. SMITH: I want to say it's the governor's portion. I wish I could tell you, but I don't know. I'll be glad to find out and let you know, but I don't know.

MR. AIONA: Thank you.

DR. CLINE: Any other questions or comments?

Dr. Gary?

DR. GARY: I wanted to thank you for certainly an insightful and innovative way of looking at things. I can tell that you've toiled for long hours.

When I look at your relationships and collaborations, I wanted to ask you if you would just talk with us a bit more about your notions of the use of self-help groups that are known to help to inculcate and change the culture that Dr. Cline mentioned in communities, a very powerful force in doing that. I'm reminded of the research that comes from the University of Vermont where they have a prevention research center and they frequently write about self-help groups and teaching people how to do self-help, which would include the consumers, parents, teachers, organizations, et cetera. I would be interested in how is it that you've addressed that very important group of stakeholders, please.

MS. McFARLING: We have embraced that, actually. They have recently come to the table, in Ohio County particularly. We did not have a lot of self-help groups that were there, but within the last six months they are actively participating. Ohio County is also a recipient of the Drug-Free Mentoring Grant, and some of the mentoring counties that they've used have become very vital, and then Ohio County has also embraced those. They are definitely at the table, and we could add another circle for that collaboration and partnership.

They are vital, they're helpful, they provide a place in the community for others who may need help to be able to access that.

MS. SMITH: Also, each regional prevention center has a library, and they are charged with if someone with a self-help group would like to learn more about prevention or if they would like a prevention center to come and speak with them or help them integrate it, the regional prevention centers also are a resource for that as well.

DR. CLINE: Last question to Dr. Kirk.

DR. KIRK: On your graphic there, religious and fraternal organizations, what are you finding in terms of how critical is the role that they're playing? Coming from an Access to Recovery state, for example, we've found the

faith communities, the spiritual communities to be really, really important players in terms of getting messages out and access to the system so that any number of folks -- my spouse may not go to our doctor to tell that I have an alcohol/drug problem, but our spiritual community, she may well go there. Can you talk a little bit more about what you're finding as far as the role of the spiritual community/fraternal organizations as critical to this prevention framework?

MS. SMITH: We have known that the religious community is extremely important. I guess we didn't have the right approach to get them on board. With the Strategic Prevention Framework, we can show that right in the church itself they can implement the framework, and in their own little microcosm and macrocosm, they can do it.

Then I think we see that a lot of folks that maybe won't go to a county meeting or won't join a coalition but are really strong in their faith and in their church, when they see that implemented in their church and they see what an important part prevention plays, they'll go ahead and take part in it. In fact, now that we are implementing the framework and we're seeing how important the church is, we have now got the faith-based PES. We've got four in one county. We've got 40 churches right now that are interested in joining the coalition, and we need

their input. There are a lot of things that we can learn about prevention, but we need the faith-based input because it's a whole other field out there that we've not been able to reach. I believe they are beginning to -- in fact, I know they are. They are beginning to take part in it. So it's very important.

DR. CLINE: Great. Connie, Dianne, thank you very much for being here. We enjoyed the presentation and we wish you the best of luck as you carry on the work back home.

MS. SMITH: Thank you so much for having us.

DR. CLINE: Thank you.

(Applause.)

DR. CLINE: We will take a 15-minute break and reconvene at five after 4:00. Thank you.

(Recess.)

DR. CLINE: We're going to jump right in here. We're into the home stretch. We have saved one of our most engaging presenters for the last up today, so everyone will be fully engaged with him and with us.

At this point I will turn it over to Rich Kopanda, who is the Center for Substance Abuse Treatment deputy director.

Rich, the floor is yours. Thank you for being here.

MR. KOPANDA: Good afternoon. I understand the council actually asked for this presentation on methamphetamine data. I'm not sure you asked for it at 4 o'clock in the afternoon, and I do have quite a few slides, but I'm going to try to go through them very quickly and only point out one or two of the highlights of each one.

I'm not sure if you're like myself, but I sometimes get confused by the various survey results that come out. We hear about the Household Survey, and for us we have the Drug Abuse Warning Network, DAWN, and then there's TEDS, and then there's Monitoring the Future. I tried to look at our surveys, our information that we have here on methamphetamines and put them together in some kind of logical order such that we could compare, in this case, three: our National Survey on Drug Use and Health through the Household Survey, which gives us information on prevalence; our TEDS survey, which is a survey of the state treatment providers, basically, that we receive from the states, and that gives us information on admissions, basically, admissions into treatment; and the data we have from our CSAT treatment programs, from our discretionary programs or from all our programs, and to compare them where we have data that are fairly comparable or similar from the three programs.

TEDS and Household Survey data are from 2005.

The discretionary program data, the GPRA data you'll see on the slides, is as of December 31 of last year. So I'll go through them fairly quickly and then leave some time at the end for some questions.

First, prevalence and admission rates. This is Household Survey data. What we see on methamphetamine and lifetime use, a statistically significant decline between 2002 and 2005. We have a little over 10 million Americans who have used methamphetamines over the course of their lifetime. There are declines also in past year use and past month use. So in a given month we have slightly over 500,000 Americans using methamphetamines. Also from the Household Survey, this is new initiates. We see also a statistically significant decline in new initiates between 2002 and 2005, 299,000 to 192,000. That's on the left of this slide. The age in years varies. We'll get to age a little bit later. So in terms of overall prevalence and new initiates, we're seeing a decline over the past four years.

This is TEDS treatment admission data where we don't see that kind of decline. In fact, we've been seeing an increase. You might have seen a similar chart to this in terms of the Household Survey where we show how it moves from west to east over the course of the past few years. Here we have over 10 years between 1995 and 2005. We see

the same with respect to treatment, where it's particularly in the west, and I'd also note that we focus on the west a lot here because they look darker and redder in our slides. But if you also look at the central part and the eastern part of the country, you see the same trend. Now, it doesn't get up to the same level as the western part, but what we're seeing is that all states really are seeing many more methamphetamine clients in their treatment system.

This is methamphetamine admissions from the TEDS data from 1995 to 2005, once again the data that was shown by state in the other chart, a 172 percent increase. I'd also note that that's about 8 percent of the total treatment admissions. In this slide from the Household Survey, we see methamphetamine as the primary drug of abuse is about 4.3 percent of those who have a substance abuse problem. So while it's about 4.3 percent of those with a problem, it represents about 8 percent of those in treatment. So what we see is a higher than expected treatment utilization rate for those with methamphetamine as their primary drug, and of course when you're addicted to meth, it has such significant addictive properties that it's probably your primary drug of abuse.

Compared to all our discretionary programs in the second bullet, we have a little over 9,500 of our clients from several of our discretionary programs who

report methamphetamine abuse when they enter into the treatment in our programs. They represent about 5.2 percent of our discretionary clients. This is a little bit higher than the 4.3 percent that we see for the whole nation. This may be because we have some dedicated methamphetamine programs, and it's about a 20 percent increase, but it's fairly comparable.

The other thing about it is it's still a fairly small percentage in terms of all of those using drugs. Methamphetamine is a small percentage. On the other hand, those who use methamphetamine, of course, create additional problems, as you know, environmental problems, family problems, problems with law enforcement. So the problems that are created by these clients are not necessarily proportional to the percentage of those using drugs.

Where did those who use methamphetamine get their drugs? The third column there, methamphetamine, you see it's a little bit different than the others, fairly comparable in terms of the red and the yellow, that is those who either bought it or got it free from a friend or relative, which is about close to 80 percent. So for most of the drugs, they're getting it from friends and relatives. What you see for methamphetamine, though, is that none of the white, from a doctor, as you would expect, and almost none bought on the Internet. You don't buy it

on the Internet as with other stimulants. So it's either coming from a friend or relative or a drug dealer, pretty much.

With respect to age, if you look at the various cohorts in the Household Survey, the 18- to 25-year-olds are the ones who have the highest percentage use rate of their group. If you add the percentages up here, you will not come to 4.3 percent because they're percentages of that age group. But the highest percentage of the age group is in the 18- to 25-year-old range. Age 12 to 17 is about 0.7 percent, and 26 and older is 0.3 percent, still relatively low percentages but highest in the 18- to 25-year-old group.

I tried to compare here several of the surveys. The Household Survey is the first column. Monitoring the Future is a NIDA survey in the second column. Youth Behavioral Survey, which is a CDC survey, is in the third column. What you see is that the methamphetamine reduction in use is approximately comparable among the three surveys. The Household Survey comparison is from 2002 to 2005, so it's missing a year, if you will, compared to the others, so the percentage there is a little bit greater. But in all cases, the reduction in methamphetamine use is greater than any of the other substances on here, including and especially alcohol and cigarettes over the time period.

The treatment admissions by age differ from the utilization data. What you see here is that if you take the 25- to 44-year-old group, the two middle sets of bars, if you will, that's where you see the greatest treatment admissions. If you remember, the other one was 17 to 25. So it's about eight to twelve years after initiating use and using at your peak period that you actually enter into treatment based on these TEDS data.

The data from our group, from our CSAT treatment data, is basically about the same. So more than half, about 60 percent of the clients, are between 25 and 44 years old.

The demographics of the methamphetamine-using population. Overall from the TEDS data we see slightly over 50 percent male, slightly under 50 percent female. We think of it basically as about 50/50, which is a very high percent of females, by the way, compared to many of the other drugs of abuse. When you look at our CSAT data, it's about 60/40. So we have more males than females in our CSAT program, and this is a very unusual finding for us because CSAT programs generally, if you look across all our discretionary programs, we have a much greater percentage women than men when compared to treatment across the nation, compared to TEDS data, our data. So it's different for the methamphetamine population. I've been trying to

find out why that is. I thought maybe some of it was because our drug program might be a higher percentage male, but I'm not really sure of that. More referrals to treatment -- I'm not exactly sure, but this is something we need to look at because it's unusual.

By race and ethnicity, we have -- and this is the TEDS data, national data -- slightly over 70 percent white using methamphetamine. The second group is about 18 percent Hispanic, and then very small use rates in the other populations. From our CSAT data, I'm not exactly sure why we don't capture directly in the pie chart the Hispanic population separately, but the white population is about comparable, almost 70 percent, comparable to the national population, and we have about 25 percent reported being Hispanic. So that is the second largest group, but it's shown differently on this chart.

By referral source, the criminal justice DUI court referrals represent nearly 50 percent of the total of those in treatment nationally for using methamphetamine. Those who go into treatment by themselves as individuals represent about 25 percent. So 75 percent are either going into treatment on their own or being referred from the criminal justice system in some way or another.

MS. HUFF: Richard, how is the (inaudible)?

MR. KOPANDA: They're from the criminal justice

system drug courts or they've been picked up for some criminal activity and they've gone into treatment through that.

MR. AIONA: Can I ask a question?

MR. KOPANDA: Sure.

MR. AIONA: I just wanted to know from what age this is.

MR. KOPANDA: This is all ages.

MR. AIONA: All ages. Okay.

MR. KOPANDA: Let me show you the next slide. Here it is by age, okay? By age it differs, and it changes at about age 30 or so. The young folks, up through age 30, are predominantly being referred by the criminal justice system. They're getting into trouble. They're getting into trouble and they're being referred into treatment in that way. When they start getting older, over about age 30, and they've been using for a while, because remember that they started using when they were younger, then they start referring themselves to treatment, and they're less likely to get into trouble and be referred to treatment in that way, or compelled to treatment I should say. All the others are fairly low, relatively speaking, and all stay about the same over the age range.

By route of administration, as you'd expect, methamphetamine is not really taken on an oral basis by

most people. I guess there are some. It's either smoked, inhaled or injected, injection being second to smoking.

By employment status, if you take the last two columns, those who are unemployed and those who are not in the labor force, often forcibly not employed, that's the majority of those who are going into methamphetamine treatment. So they're basically not employed when they go into treatment in some way or another.

By type of service, as you'd expect, most are in outpatient or intensive outpatient care -- i.e., ambulatory care. For the last two columns it's kind of interesting, because for long-term residential, while the numbers are not high, percentage-wise many more of those in treatment for methamphetamine are in long-term residential than all admissions, which is the yellow, and only half of those are in detox in all admissions. So in that respect, they're slightly different than the general population of those in treatment.

MR. STARK: Question on that?

MR. KOPANDA: Sure.

MR. STARK: Do you have any data or any belief that one of the reasons why you see so many of them in long-term treatment is because of the fallacy, the myth that was out there where a lot of research was misinterpreted and people believed they needed longer-term

treatment, so a lot of folks are being pushed in that direction via the criminal justice contacts?

MR. KOPANDA: That's a possibility. I personally don't know that to be a fact, though. Wes would probably know that better than I would, but that's definitely a possibility. I mean, if you talk to anyone about methamphetamine abuse, they'll say oh, yes, you've got to get them into treatment forever. It doesn't appear to be the case based on our experience with the matrix treatment and other kinds of treatment programs.

MR. STARK: And it didn't appear to be the case in Washington State with the research that we did, either.

MR. KOPANDA: The outcomes, just very briefly.

Oh, yes?

DR. KIRK: Go back to the previous slide.

MR. KOPANDA: This one, or this one here?

DR. KIRK: That one. Tell me what, when you say long-term residential, the yellow is all admissions?

MR. KOPANDA: All admissions into TEDS. This is the TEDS data that we get from almost all the states and almost all the treatment capacity. So if you add up to 100 percent all the treatment, basically we look at it as all the treatment in the nation, basically. The percentage there would be, say, 18 percent, and there would be 14 percent for methamphetamine.

MR. STARK: If you can cross-reference that particular chart with your referral to treatment criteria, you might be able to get some sense of whether the majority of those who are in long-term treatment were the ones referred by the criminal justice system.

MR. KOPANDA: Oh, yes. We should be able to do that because they're both from the TEDS data, too.

Okay, just very briefly on the outcomes from our programs. This is a list of our programs where we have a fairly high number, a reasonable number of those who are in treatment for methamphetamine, Targeted Capacity Expansion generally speaking, and also some of the programs we initiated which were targeted to methamphetamine, the Drug Courts Program, Access to Recovery, which of course is open to all but some say it's focused more on methamphetamine than others. Those are discretionary programs. But as I mentioned, any discretionary program, different data than I'm showing here, come from all discretionary programs, even some others where the rates of referral to methamphetamine treatment may be fairly low.

We also address methamphetamines through our substance abuse block grant, of course, our states do. We have a collaboration with ACF on their child welfare program. It's a $40 million program that's being started this year to focus on child welfare with meth families that

are using methamphetamines.

We supported the governors summits in many states to address methamphetamine. We have begun some collaborations to address American Indian and Alaska Native meth use, and TIP 33 -- I'm not sure if it's 33 or 32 -- addresses stimulant use disorder, and it's very helpful for methamphetamine.

If you take all of our discretionary programs and you look at the outcome in terms of six-month follow-up use rates, you see a 54 percent decline in the use of methamphetamine. This is a very excellent outcome, we think. You'll see the numbers. Remember I mentioned over 9,000 before? This is significantly lower. That's because we don't have six-month follow-up data on all of the clients from all of our programs. But for those we do, we see a 54 percent reduction.

Some of the other NOMs that we collect with respect to those in methamphetamine treatment in our programs. Once again, 3,000 versus the 9,000 total, but we see increases in all these areas, improvements I should say. The rate of change here is basically improvement in all these areas, improvements in employment, housing. The housing, 5.9 percent. It's hard to get improvements in housing sometimes, but I'm not sure if that might reflect the fact that many meth users had housing before they went

into treatment. In other words, they're not necessarily a homeless population.

Arrests and involvement with the criminal justice system and social connectedness as we now define it -- we're still working on that as a NOMs measure, but we do have something we use now in our programs.

Yes, Ken?

MR. STARK: Well, there are states, as you know, that do report private pay clients on TEDS as well. So that whole employment thing and housing thing could be skewed by the fact that it is such a broad range of consumers, unless you only with this chart looked at those who are poor, like at 200 percent of poverty level and below, or whatever.

MR. KOPANDA: Well, this is not TEDS. This is from our programs, CSAT programs now.

MR. STARK: Oh, it is only --

MR. KOPANDA: This is only our CSAT programs.

MR. STARK: But even them, each state does differ in terms of where they have the cutoff of who you can serve.

MR. KOPANDA: Well, that's true. This is from our discretionary programs, so this is a compilation of ATR grantees, methamphetamine TCE grantees, drug court grantees.

MR. STARK: Then I would actually argue that that's even more so, because some of the grantee programs don't differentiate between people who are poor and people who have money when they fund them through the discretionary grants.

MR. KOPANDA: That's true.

MR. STARK: So unless you segregate that out by income level, you're going to get some things that -- it will underreport the positive issues around employment, although that one looks good, and housing, because a high number of those folks may have already had good housing and good employment from day 1.

MR. KOPANDA: That's true, that's true.

DR. GARY: Thank you. I wanted to ask a quick question about employment. That's a quite impressive figure, and I noticed in a previous slide that individuals who are employed are less likely to be users.

MR. KOPANDA: Yes.

DR. GARY: Is there any particular focus in the treatment program that helps with employment, any special training to help with employment, attaining employment, how to act when employed, et cetera, et cetera?

MR. KOPANDA: I would say generally not in our strict treatment programs, like our Targeted Capacity Expansion. What we have in our grant focuses on the

treatment aspect of that, unless the grantee provides that kind of service on their own. However, one of our big emphases now is on recovery support services. The RCSP program is basically not in these data because they don't provide treatment, but the Access to Recovery program, for example, Connecticut, they probably don't have a high methamphetamine use rate, but should any of the ATR programs where they do focus on recovery support services, which can include, depending on what a state wants to do, employment services, that would be included here. So it's kind of hard to say. We have kind of a mixed bag of programs. We'll have to look at it individually, but that would be something we would want to look at in terms of emphasizing our recovery support services, how much better outcomes do we get if we don't just provide treatment, which is what we have traditionally done, but if we also add recovery support services to that.

DR. GARY: Absolutely. I was just wondering if it happened serendipitously or if you programmed for it. Then again, another way to look at it is if it were not a part of the treatment package, if it were, how much more positive outcome could you get?

MR. KOPANDA: I would say some, but that would be a guess right now.

DR. GARY: Plus they'd be paying into the tax

base and be productive people.

MR. KOPANDA: That's a very good point.

Last slide here. I didn't want to go through all of our communications material and everything, but we do have some new tools that have come out recently, including what we use for our earlier methamphetamine treatment program, the matrix intensive outpatient treatment that was very successful in our treatment. We do now have that available for anyone's use. So people can access that through these and have that tool available for them, and that's pretty much it.

So any other questions?

DR. CLINE: I have one question for you, Rich. You presented a lot of data, a lot of information. I think it shows how rich the data system actually is, and I'm sure there are a lot of questions that people may be mulling around.

What couple of take-home messages, when you present all that data, what couple of big themes, big-ticket items would you like us to pay attention to or that were interesting to you? What are a couple of take-home messages from that data?

MR. KOPANDA: Methamphetamine use seems to be declining. I didn't really get into the issues here because it has to do also with everything from the lack of

availability to Sudafed to enforcement efforts and shutting down the labs and such, but it does appear on a national basis to be declining. It doesn't necessarily mean that in Hawaii or any individual state, or Kentucky, that it is declining, or in local areas, but nationally it is declining.

Treatment is not. Treatment is going up. But as we see, there's kind of a lag. I would expect treatment to continue to go up for a little bit and then start to decline in concert with the decline of the prevalence rate. Hopefully we can continue that. We have available the tools now to provide, as Ken was saying, effective treatment. We know how treatment can be effective. I think, as Faye was saying, we need to start analyzing the various components of this data, like employment and looking at it in terms of providing more recovery support services in association with our treatment services, in particular recovery support services that you might say are indicated for the kind of problem that you're seeing.

We have a lot of data. This is just a piece of our data. We need to also do a better job, I think, within SAMHSA and CSAT of analyzing the data we have and using it to help mold our programs as we look to the future.

MR. AIONA: I have a question. Do you have any data on the effect of methamphetamine on brain development,

long-term, short-term, or just brain intervention, if that's the right way to phrase it?

MR. KOPANDA: We have a lot of slides on that that we've gotten from Rick Ralston from California. We've worked very closely with him. He has an excellent presentation. We'll be glad to send it to you. It includes very graphic slides.

MR. AIONA: Can you give me a real brief summary on it? What are the findings up to this point, if they have anything definitive? Because I know it's the early stage and it takes a while to get to any type of --

MR. KOPANDA: Well, what he shows is that with continued use, methamphetamine has distinct and definite harmful effects on the brain. It actually changes your brain chemistry. Those effects, though, are reversible. It takes a while. I'm not sure how long it takes, but they are reversible with treatment and with abstinence. Then there are other associated effects, like meth mouth, and other kinds of things. But once you get to that addictive phase, you're almost compelled to continue your addiction unless you get some kind of help. That's what I've taken away from that. We talked before about whether this is a behavioral problem. It's really not behavioral. It's physiological after a while, and you need help to reverse those physiological changes to get to the point where you

can heal yourself.

DR. CLINE: Ken?

MR. STARK: NIDA has a lot of slides, too, and you can get those on their website around the brain changes. But one of the things that has always fascinated me is that when they, "they" meaning NIDA and their researchers, first started coming out with those slides, what they would initially say is that it causes a lot of brain damage, and I continually questioned that. What does that mean? I mean, I know there are brain changes, and if you're making the words "brain change" synonymous with damage, then I want to know what kind of functional impairment is caused by methamphetamine. I mean, we all can see the dental stuff. That's real clear. We can all see how one looks like they've aged 10 or 20 years when they haven't slept in weeks and they haven't eaten and that sort of thing. Chris, you can see that in a person who has chronic alcoholism, too, when they first go into detox if they've been living on the streets for years. They can age 10 years in a matter of a year.

But what I finally came to realize, and we went through this with crack cocaine with the crack epidemic in 1988-'89, that there was a lot of hype initially about this brain damage that was going to be permanent. Just like with crack cocaine, what we've discovered, at least thus

far, is that although there may be certain brain changes that might be very, very long term, that relative to functionality nobody has been able to demonstrate yet that this is irreversible brain damage that results in functional impairments that are irreversible, and most of the impairments that they've identified, from what I can see, are things like short-term memory and things around coordination initially. But then again, I remember seeing brain slides on even chronic marijuana users where you've had effects on short-term memory and on the ability to walk a straight line, just like with alcohol.

So I think there's a lot we don't know, but I do know there's a lot of hype, a ton of hype about this being the most addictive drug there ever was and the most damaging. I don't want to downplay how damaging it is, but we heard the same rhetoric with crack cocaine in the '80s, and if you go back, god knows how far back, we heard the same thing with reefer madness about marijuana; not to say there aren't serious issues here, but bottom line is that it's not as devastating and permanent as the hype might tell people.

DR. CLINE: Other comments or questions for Rich?

(No response.)

DR. CLINE: Rich, thank you very much.

Appreciate that. That was a great presentation, and you went through that at lightning speed. Thank you.

(Applause.)

DR. CLINE: For the last request of the day, I have one more request in terms of advice from you with the advisory council. Given that I'm new at this task and new to this advisory council, part of what I would like -- and this was also triggered by the presentation with the National Strategic Prevention Framework -- is to use just a few minutes to get some feedback from you about the process of this meeting, this particular meeting, focused on things that you thought went well with this meeting, in one minute or two minutes. I'm going to go around the room and ask if everyone would just quickly say what they liked about the meeting or what they thought could actually improve this meeting, and that will be important feedback from me. You have kind of a relative basis given your experiences with this particular format, and this is a structure that I've used many times in other meetings, and it helps keep our meetings focused and also helps that continuous quality improvement model stay alive in the meeting. Hopefully it won't feel too touchy-feely for the group, but it's also something that's widely used in a lot of business communities and other communities that are focused on quality improvement.

So I'm going to actually start. I normally would not start, but with the hope of kind of modeling a little bit, I'll put in one cautionary note. It's not a last opportunity to make a speech. It's not a last opportunity to make the point that you hoped that somebody would get and they never did get at the last part of the day, but to really focus on the process of this particular meeting, what you liked and didn't like. So I'm going to jump right in there, and we'll move quickly with this, and then I'm going to go around this way.

I found the discussion around the budget very helpful, really helpful for me, and having the feedback from you and being able to hear what was really a dialogue between council members very helpful. In the afternoon, every single presentation I enjoyed and I thought they were all very rich. I probably found it less helpful to have so many presentations because that took away from conversation and dialogue. I found myself needing to say "last question, last comment." So I felt like I was cutting the conversation short a little bit, and I would wonder about that balance, having more time for conversation and less time for presentation.

Daryl?

MS. KADE: I thought the change in dynamics in terms of inviting Q&As during the presentation as opposed

to waiting until afterwards resulted in a much richer discussion.

MS. HUFF: I really liked it. I liked everything about it. I liked the richness of the discussion around budget, too, but that's just because I had some questions I needed to have answered. So I appreciate your willingness to not be defensive about it when we kind of really approached it in a straightforward sort of way, because you easily could have been, especially your first meeting.

I felt very listened to in the sense that I told you on the phone when you called me that I really did like the idea of bringing in people from the field to have some SAMHSA input into subject matter and for them to bring in people who kind of backed up good programming.

Anyway, I was really impressed that that was heard, because I think several of us have said it over time, that we really like that style. Thank you.

MR. STARK: I think this is probably one of the meetings where I've seen more engagement than many of the other meetings. In a number of the other meetings I felt more talked at than talked with, and I thought this one truly did give an opportunity for much more dialogue. I agree that the mix of presentations with the dialogue and the opportunity to ask questions not necessarily at the end

of the presentation but during it added a lot, because some of us are having senior moments and we'll forget by the end of the presentation.

MS. HUFF: Almost all of us.

MR. STARK: Hey, you weren't the only one. It happened to me, too.

(Laughter.)

MR. STARK: The other thing I would mention, if I can stall just a second because I'm already having that senior moment I just mentioned, is that I liked the diversity of the topics that we had today. I think it's really important for us all to get a better understanding of the budget process and the limitations, and also seeing timelines and how we can fit in to giving SAMHSA input to truly be able to say that we had some opportunity to try to influence, if you will, the priorities. It may be that it's too late for 2007, it's too late for 2008, maybe we've got to be talking about 2009 right now to be able to give you the input to feel like we had that opportunity, and I think I heard that mentioned earlier today, that that's a discussion that's already going to go on. But I liked it, I thought it was good, but not too many presentations, because then it's like you said, you're going to have to end up cutting us off, because the minute we get warmed up, it's time to cut us off.

MS. KITTRELL: Well, I enjoyed the interactive dialogue as well, and to find out from you some of the things you're interested in, like the veterans initiative, mental health transformation, really transforming the field through the leadership, some of the things that you talked about this morning, cultural competency. It's important to know your thoughts as well as our thoughts.

I'll yield the rest of my time to the gentleman from -- where are you from, Larry?

DR. LEHMANN: From the VA.

MS. KITTRELL: I'm yielding the rest of my time to you.

DR. LEHMANN: This is not my good ear.

I thought this was very useful in terms of the fact that what I tend to get from these meetings is sort of picking up what other organizations and groups are doing and how that applies to some of the things that we're doing in VA, and also what's going on within the non-VA community that we can tap into. As a result, even though I'm not a substance abuse person, it was very interesting to see the process of how, for example, the funds from the grants were being used and the issues that were being raised and how they were addressing them in terms of the idea of how you sustain an evidence-based practice, which for me is really what the afternoon was about, evidence-based practice.

It's very, very important for us.

So it was quite useful, and it was the combination of the presentations and the discussion. I think it's very, very useful, though, as an organization or as an advisory committee to see some of the fruits of SAMHSA's investments. I think that's extremely useful, because it's quite reinforcing, quite frankly, to see the good that's being done from the investments that come down from on high.

MR. KOPANDA: Well, at the risk of repeating what others have said, I agree with the comments that you all have made. In particular for me, the interest and engagement of the council members, all the council members were engaged, jumped in and gave us comments on a number of different subjects. That's what I really enjoy most about this meeting, and I think it has been actually a greater involvement than I've seen sometimes, and maybe it's because of the nature of the mix of the presentations and discussion.

MS. DIETER: I thought it went really well, too, in the two points which have already been stated. I think the format of having the questions and having a dialogue during it has been extremely helpful for the first reason that we might forget, but also people carry on. I mean, Tom has been able to emphasize something. Now I'm

just thinking about all the time in terms of the systems change. I mean, because he's able to insert, it comes up at different times under different topics, and I can see how it relates to each one. I think that's really helpful.

I also agree that having a program visit had the same effect last time. It is wonderful to see the benefits of what's happening, but I think even more importantly it stimulates also other questions and thoughts about what to do with that, what further needs to be done here. We have all this great information. You know, it just stimulates a lot of other questions, conversations, thoughts on not just our part but everyone at SAMHSA. So I thought it went really well.

MS. POWER: In the three-plus years that I've been at SAMHSA, I've had the privilege of working with this council as member, and also have my own CMHS council. So it's interesting to see that process and this process and sort of compare and contrast, and one of the things that happened for the CMHS council was they basically demanded that this kind of process go on, that there be much more interchange, that there be less presentations, that there be much more dialogue relative to an investment in the process. From my perspective today, because all of the people around this table I've really worked with over the last three years and have watched my relationship with them

and your relationship with us grow together, we really are fortunate that this is a mature and highly sophisticated group of people who are ready and willing and able to step in and make comments and ask questions. So I think that's an advantage, Terry, that you've exploited, which I think is good.

The other thing that I observed is that at the end of our day and a half when we meet, or at the end of our two days of council, we found that we needed to go back and remember with our brains what were the nuggets that we came up with during the conversation. We learned we had to sort of capture those in a parking lot somewhere. So when Ken says I think we should do a mental health ESPIRT kind of thing in '09, we ought to capture that somewhere, and then that becomes the basis of the closing discussion tomorrow, when everybody can kind of reconnect with some of those ideas thematically. So that was a process that we've used, and I think that may be helpful, Terry.

DR. CLINE: We actually have that in place, and the staff has done an incredible job. I was already presented with a sheet that has all of those nuggets, which is very impressive when you look at it. You say how in the world did you capture all of that? So it's an amazing job. One option was to do that today, and I thought just to help inform the process a little bit tomorrow we would save

that parking lot and do that tomorrow, and actually I'll probably start with that in the morning just to connect today with tomorrow. Thank you.

DR. GARY: I always feel that I'm very fortunate to be here to meet colleagues who share the same passion that I do and who work hard every day to assure that everyone will have a life in the community.

I enjoy very much looking at the cutting-edge kinds of activities that SAMHSA is doing. For example, we learned today about the evidence-based data and the interventions. To tell you the truth, I had not checked the website to see that. I enjoyed the dialogue, but we could spend a whole lot more time talking about how that one program could impact mental health services utilization throughout the United States, a variety of ways, in universities and community mental health centers, self-help groups. I would love to have that kind of dialogue and that kind of sharing here so that we could look at new and creative ways to do that.

I know I enjoyed the discussion, and if we had more time I think there would be even more discussion and more nuggets of wisdom. One such nugget of wisdom would be if we could have discussions, predictive discussions, so we could predict what we need to do and how we could plan to do that, I think that would be very helpful for SAMHSA.

Otherwise I think we're always looking at the downstream rather than looking at the upstream, and to take some time to prepare what I would call concept papers that would relate to these specific kinds of areas on our matrix that we would want to take a look at, and how that might also drive budget, how program can drive budget and how numbers drive budget, and how we can come to some kind of agreement on that.

But I truly enjoyed the discussion, and I'm glad I had the opportunity to learn so much from my colleagues.

DR. KIRK: I thought the diversity of the topics today, I didn't find it too long, but let me tell you part of what I was thinking. I think you've already anticipated how to make use of this.

How do we take what we talked about today and all the give and take in terms of discussion, maybe in your roundtable discussion tomorrow? What's the opportunity for strategic thinking, not based upon projects but how some of this stuff ties together? I don't know whether you're comfortable with this, but from SAMHSA's point of view, what are the hard questions, if you will, or the challenges that you're looking at that you're comfortable talking about besides how much money?

I mean, you all go through your discussions

internally about how to do this, how to do that. So what I would think the opportunity is for, because I like the diversity and the give and take, but how do we take this? You asked Rich a question before. When we walk out of here tomorrow, what are the lessons learned, if you will, that will be of benefit to you as well as from the strategic thinking that we might have for a half hour, 45 minutes, would serve to be of benefit to you? And furthermore, as a council member, as I go back to my day job, as I think about things, as I see things that go on in my day job that I say why don't I send that to Terry Cline? We talked about that at the last session, and this might be of help to him.

You can only bring in so many programs, bring in the local programs, but it happens at the state level, it happens at the program level, and I think people such as us, particularly within the states, we can bring back to you things that are going on in an individual state not in a formal presentation as much as to tie things together that we have talked about here. So it's tying one session to another.

I think the other piece, and I should have thought about it before when Daryl was giving the budget piece, one of the things I heard today is that so many of the things that are important for mental health, substance

abuse prevention, all the components, are not necessarily within SAMHSA itself, like housing and employment and these other kinds of things. I'd be interested in hearing from you -- I presume you do something like this -- how do the budgets for these other federal agencies go generally that are likely to have an impact on some of these recovery support services and essential components? Housing, for example, is critical to so much of this. The employment stuff is so critical to this. Did HUD or whatever the agency is, did they take some heavy hits so that when we talk about services critical to the people -- yes, the things that are unique to SAMHSA are important, but some of these other things that any number of these folks talked about, in many ways they're more important than me getting an outpatient appointment. Do these other federal agencies take hits such that the service system, if you will, out there, that there are going to be breaks that we should be aware of?

I think the final comment I'd like to make is that I think in the conversation today and hopefully tomorrow, that you walk out of here with the impression and some suggestions to us as to how we can help SAMHSA. So it's not sitting here and doing dog and pony shows, go back and nothing changes. How can we be of assistance to you within all the ground rules for council members? Any

number of us in states, we have these councils, and sometimes, frankly, they're more trouble than they're worth. I don't want me or others to be more trouble than it's worth to you. How do we provide some assistance to you, and what comfort level would you have in saying I need some thinking about this and this? We're not struggling with it, but we're at that stage of our thinking. So the '09 budget may be one of the pieces. So you could say, okay, that's what we're going to concentrate on.

But all in all, I think it was very, very helpful, but I would look forward to that strategic discussion tomorrow. You know, you sat here for all day, you listened to these things, and can you identify what you see as the strategic questions or observations you could make from listening to that so that it's not projects but the larger picture?

MR. AIONA: I agree with Tom on what he said. I guess maybe I'll say it in a different way, but we are an advisory group, and so I look at our role much like I as a leader in the state government would put together a task force, or whatever you want to call it, to give me advice on something that we may be undergoing, some project we may be undertaking and making changes to or developing or implementing. So likewise with us, I would feel great to walk away from here knowing that I came with a purpose to

help you and SAMHSA, and we walked away and we did a better job of it.

I think you had a great discussion today because you had topics that people really were engaged with. It was interesting topics that everyone could engage with and had expertise in. You can see that you've got a great diversity of -- if you want to call it experts here in this room on this council. So I would just echo what Tom said and just say that today was a great meeting, it really was. Thanks.

MS. VAUGHN: Several things. I like the idea that we went out to council and asked them what were they interested in hearing about. So the agenda is a mix of what you wanted and what we thought you would be interested in because it was an emerging issue, and then some of the things that you asked to be on the agenda at previous meetings. So I really liked that effort on both of our parts.

I also like the idea of the handout presentations. We're calling these, in a sense, your homework. We gave you your books last night. We hope to get the information to you earlier. That's putting more pressure on me, but so you'll be able to read the material and then you'll come to the meetings with a better understanding of where we are with regard to these

particular issues.

The other part is a logistical issue. I like the idea that you're at the Sheraton, which we have the transportation back and forth and we've made it available, and they're very flexible with getting you here and moving you out.

One other thing. We talked about the grantees coming here. I would be interested in hearing tomorrow whether or not you're interested in maybe an onsite/offsite visit of a grantee.

So those are the things that came up for me.

DR. CLINE: Well, thank you all very much. That was extremely helpful, and I appreciate your candor and that spirit of contribution in being here, and your service to SAMHSA and to the country.

So with that, we will adjourn and reconvene at 9 o'clock tomorrow morning. Thank you.

(Whereupon, at 5:08 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Thursday, March 8, 2007.)