SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE PREVENTION

NATIONAL ADVISORY COUNCIL

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

IN ATTENDANCE:

Chairperson

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P R O C E E D I N G S (9:05 a.m.)

MR. ROMERO: Good morning, folks. Before we get started, I want to apologize. I was on a conference call since 8 o'clock this morning and it was hard to get off that call.

But I would like to officially bring this meeting of the SAMHSA Center for Substance Abuse Prevention National Advisory Council to order.

First of all, I'd like to welcome back our members and ask, are there any questions before we get started of yesterday's activities?

(No response.)

MR. ROMERO: I would like to acknowledge at the front end that Ms. Hope Taft is on her way here from the airport and she should be here maybe around 9:30 or 10 o'clock from Ohio.

I would also like to acknowledge that we have two NAC members on conference call, and I will ask them to also acknowledge and introduce themselves.

Yesterday we had a full day of information sharing, as well as overviews, of both the work of CSAP, the work of the Center for Substance Abuse Treatment, and the work of the Center for Mental Health Services. We also had the privilege of learning or getting an overview of the priorities of the Center for Substance Abuse Prevention, which are underage drinking, older adults, vulnerable populations, and workforce development.

Today on the agenda is to afford you the opportunity to hear and be exposed to, in a more realistic fashion, the four priorities as operationalized in the prevention field.

At this time, I would like to also acknowledge that Ms. Rose Kittrell, the Acting Center Deputy Director, is on her way down. She was at the conference call with me, and I asked her to stay just a couple extra minutes while I scooted out. So she will be here in a few minutes.

For those that are on conference call, Ms. Tia Haynes is present, as well as other CSAP staff, members of the prevention community, and certainly our prevention partners are present here as well.

Before we get started, I would like to invite the council members to introduce themselves. I ask that you give your name, your current professional position, as well as the expertise that you believe you bring to the National Advisory Council. And we'll start with our newest member.

MS. ARES: Thank you, Dennis. Good morning, everyone. My name is Karel Ares. I'm the Executive Director of Prevention First, which is a statewide drug prevention, training, and resource center located in Springfield and Chicago, Illinois. I've been with Prevention First for 17 years and in the field of

prevention for 20.

I feel that with this background I bring quite a bit of experience and knowledge about certainly what's worked and what hasn't worked in drug prevention over the past 20 years. I also bring with me a good understanding of the kinds of training and technical assistance and support that local communities need in order to implement what we know are best practices in prevention, and I also have an appreciation for the challenges of the state and federal bureaucracy in trying to do its good work and looking at that from a systems approach.

So I'm very humbled and honored to serve on the advisory council and look forward to working with my fellow members to help CSAP advance its agenda. Thank you.

MR. ROMERO: Thank you, Karel.

Sharyn?

MS. GERINGER: Good morning. I'm Sharyn or more friendly known as Sherry Geringer.

MR. ROMERO: Sherry. Good. I like that.

MS. GERINGER: I'm the former First Lady of Wyoming. I was one of the founding members of the Governors' spouses' initiative, Leadership to Keep Children Alcohol-Free, and then subsequently one of the founders of the foundation, which is working to support that work of the Governors' spouses.

I'm mostly a volunteer. That's what I consider myself professionally now, having retired from the political arena. As the mother of five and grandmother of 10, my main area of interest is prevention of underage drinking.

MR. ROMERO: Thank you, Sherry.

Jay?

MR. DeWISPELAERE: Good morning. My name is Jay DeWispelaere. I'm the President and CEO of PRIDE Youth Programs. I have served on the advisory council now for a while. I have the privilege of working with these folks and the wonderful staff here at SAMHSA.

My background is in law enforcement. I spent 25 years as an officer working with young people. I was a volunteer working with peer-to-peer prevention groups, high school mostly. Now I would say my area of expertise -- I have a background in serving the mentally ill as a board member and state board member. I have a background working with people in treatment, and of course, my work today is in prevention. So I find a lot of interest but probably the number one drug of choice is underage drinking and alcohol, and that's probably what I spend the majority of my time on.

I'm here to make sure that young people's voices are heard across the country. We support young

people that live a drug- and alcohol-free lifestyle, and I really believe that until which time as we grow as a council to the point that we add a young person with that background on the council that I'll make sure their voices are heard. Thank you.

MR. ROMERO: Thank you, Jay.

And Alan?

MR. SHINN: Aloha kako, everyone. My name is Alan Shinn, Coalition for a Drug-Free Hawaii. We're a primary prevention agency in Honolulu, Hawaii, but we serve the entire State of Hawaii. So we have some interesting challenges in Hawaii because of the physical isolation of the various islands. We're separated by water, of course, and some distance, but also each island actually has a different culture of its own in terms of its political and demographic makeup. So we do have some challenges. But it is paradise, let me tell you. It's nice to live there.

Our agency just celebrated its 20th anniversary, and we had a great fund raiser and celebration aboard the NCL ship, Pride of America. It's one of two ships the NCL fleet has in Hawaii. So it was a great celebration. Dennis was there. He was on our 20th anniversary video. The theme was 20 years of excellence in prevention, and I think that the agency really deserves that celebration and recognition for all the good work that

it's done. I just feel very proud to be representing it.

By the way, Allen Ward, how come you weren't at our fund raiser? I'm just kidding. I'm kidding, Allen. He's out in Hawaii. He's our project officer for our SPF/SIG and state. A great guy.

And John, you weren't there either. How come? You weren't authorized to travel.

MR. ROMERO: There may be a conflict of interest when it comes to fund raising activities, but we won't go there now.

MR. SHINN: On a serious note, we still have a serious problem with ice and crystal meth in the islands, and I believe we're either number one or number two, competing with Oregon State around this issue. I believe that the solution really lies in agencies like ours pulling people together, communities to really mobilize and to take action against not just ice but underage drinking and other drug-related issues in the islands.

So thank you very much, Dennis.

MR. ROMERO: Thank you, Alan.

I should also acknowledge that we're in the process of getting Mr. Henry Lozano and Mr. Don Coyhis, who will be on conference call in a few minutes for the remainder of this NAC meeting. Again, Ms. Hope Taft is on her way from the airport.

Today we will have the opportunity, as I said earlier, to actually bring some life to the priorities of prevention. My charge to the NAC members is to listen to the presentations of our four priorities and to really think critically from your vantage point how this can be further enhanced and be able to reach to all the communities that are in need of the prevention presence.

At this time, I have the privilege of introducing Mr. Arne Owens. Arne Owens is the Senior Advisor to the Administrator in the Immediate Office of the Administrator, representing today Dr. Terry Cline, our Administrator, and on behalf of our Deputy Administrator, Rear Admiral Ric Broderick. Arne?

MR. OWENS: Well, thank you, Dennis. Again, as I mentioned yesterday, it's really a pleasure to be here with all of you and we're glad that you all are here advising us and providing us your input and your counsel and your advice. That's extremely valuable.

Dr. Cline regrets that he cannot be here. He is on travel, along with Dr. Broderick, on an adventure that began somewhat last minute. Otherwise, he would have been here.

I will have to depart right after I deliver some comments here because I'm also chairing an Executive Leadership Team meeting here at SAMHSA. So I'll need to

scoot on up to that. But I did want to take just a couple of minutes here to hit some key points that I think are very important.

We do a lot here at SAMHSA. I mentioned yesterday how we are primarily a resource provider, a provider of funding, and also a provider of knowledge-based resources, information, evidence-based practices, things that will help you do your job better, more effectively. So we're very pleased to be doing that. It's really the core of what we do. We have some great people here at SAMHSA that are delivering those services. But again, as I also mentioned yesterday, we don't deliver direct services to people out of SAMHSA. You all do that and the states and the communities, community providers actually come into daily contact with people. But the folks here at SAMHSA care very much about this mission, and so they like to stay connected to you and it's important that we maintain that connection.

As you know, we have three centers here that provide the resources out to the states. Of course, in addition to CSAP, we have the Center for Substance Abuse Treatment and the Center for Mental Health Services. They provide the resources in their appropriate areas.

We'd always like to do more, of course. There are some limitations. But also -- and I think I mentioned

this yesterday -- when it comes to prevention, quite frankly, I think prevention is the most important thing that we do. It's the most important mission we have. Yet, at the same time, it's the area -- well, treatment gets most of the money, quite frankly. CMHS gets a big chunk of money because they have some very important resources they need to provide to the mental health community throughout the country. But in my own mind, prevention is the most important of the fields, quite frankly. Again, that's my subjective point of view, but I think that's true.

But I think we probably also agree that the primary deliverer of prevention services is not necessarily a government entity at the federal level or at the state level. It's primarily families. It's primarily churches. It's communities, community groups and organizations.

I still remember back to when I was growing up and in my high school years and was at the point in my life when I could be getting into trouble. I remember the little town I grew up in. Actually it wasn't quite as -- well, we had more than 3,500 people. We had about 95,000. So we were actually a small city I guess. But our local police department sponsored an Explorer Scout post. They also sponsored a youth band, and we got to wear the police uniforms. We started identifying with the good guys. As I look back on that, I realize that in my own life that was a

fairly effective prevention program. Both of those programs were sponsored by the local community, and that was outside of my family. Now, I had a very positive family experience, which was really the ultimate prevention story in my life, and I had a very supportive church. But all of those things combined kept me on the right track. Not everyone has that, but that's the heart of what we do, to try to provide that as best as we can in our communities throughout the country.

How are we doing? Well, it's very difficult to measure the prevention effort. I guess I look at it in terms of the big picture. We do what we call the Household Survey. We do a national survey of drug use in American households throughout the country. And it's pretty darned good data. I think it gives us a fairly accurate picture. Some folks say maybe it under-reports in certain areas. I don't know if that's true or not.

But from those surveys, we believe that there are probably 23 million or so Americans with a substance abuse problem that's so serious that they need some form of treatment. That's 23 million. Now, that's a lot of people. And they're really our priority. They are our priority of effort. They are our focus. About 20 million of those, by the way, don't think they need treatment. They do but they just don't think they do. So our

challenge is to convince them that they do need some sort of help. But that's the scope of the problem.

Now, I guess the good news is on the flip side of that, there are 270 million Americans out there who don't need treatment. So I kind of like to look at that positive side as well. So the more we can do on the prevention side, we just encourage and support that 270 million. So I just really appreciate what you all do in that regard.

As you know, here in CSAP, we've got some major programs, and I've been involved with at least one of them, Drug-Free Communities. The Office of National Drug Control Policy will tell you it's their program. It is their money. No question about that. But the people that actually make it happen and get it down to the communities are the people right here in the Center for Substance Abuse Prevention. I see Peggy Quigg back there. She's the division chief that makes all of that work. And we have project officers down there who are connected to communities and do, in fact, help enormously with that. There are 750 grantees around the country, $70 million or so per year that goes toward this effort, maybe more in the future. We'll see. But it's a great program.

It's coupled with another great program, the Strategic Prevention Framework. As you know, there are a

lot of folks out there that want to do good. High-functioning families are out there engaging in what we would call prevention anyway. Communities are doing some good things. But a lot of times there are disconnects and there's no organized approach. There's no integrated approach with community leaders focusing on what needs to be done within their communities because communities are different.

In the area where I live right now down in suburban Richmond, Virginia where my family is located out on what we call the west end of Richmond, there's a problem with underage drinking, and it's an issue of suburban kids being a little rebellious and getting a six-pack and going out drinking and throwing the beer cans off the side of the road and that sort of thing. It's a problem there.

Other communities have problems with drugs. So it varies based on the community you're in. So we need approaches tailored to those communities. And that's the great thing about the Strategic Prevention Framework. It provides a whole mechanism on how to achieve that. I'm very supportive of it and I'm glad the folks at CSAP are moving that forward.

I mentioned underage drinking. We did a roll-out of the Surgeon General's report on underage drinking a month or two back and gave some attention to that issue,

and we're helping with roll-outs in states around the country, again providing an opportunity to deliver a very positive message of what can be done and to raise the visibility of that issue because it is an important issue that affects communities that may not have been the focus of much attention prior to this.

I know in the part of Richmond I live in, the drug problem is probably minimal. Folks figured, well, there just aren't any problems out there in the suburbs, but there are. There are teenagers out there that are dealing with two parents working. They may be making a lot of money, but the kids feel neglected and they can get into trouble. So everything you do is important in that regard.

I wanted to talk about budget just briefly. Dennis will go into the details here of the CSAP budget. We're in an interesting environment. For fiscal year '08, the President has proposed about $156 million to go toward prevention. Most of that is within -- well, that's for SAMHSA. Most of that is in the CSAP area. Not all of it. I guess some of it is counted as prevention, but some of the programs are in some of our other centers. That's a lot of money but it is a decrease from what we had had before, and I felt it's important for me to place that in context and explain some of the background for that.

We're in a challenging budget environment right

now. You need to know that. I think if you read the papers, you can understand that. The President has actually announced in February of this year that he wants to balance the budget by 2012. So he's proposing over five years to do just that. Now, there are a lot of factors that work into that. If the economy continues to do well, then the revenues received by the federal government will increase at a higher level than what the Office of Management and Budget projects, hopefully. So maybe we'll achieve that sooner. Maybe there will be more money to spend. We'll have to see. But that's one of his goals, to balance the federal budget.

We're doing that at the same time where we're fighting a war in Iraq, and I don't need to explain that to anybody. It's in the newspapers every day. It's a very important matter, a very important issue. The President feels very strongly that we need to do what we're doing over there and try to bring some -- well, a new form of doing business, a new form of government to that part of the world. Whether you agree or disagree with that, that's the priority that he has set. And folks who disagree will, of course, have the opportunity to vote on it next year. All that will take care of itself with time. But that's the environment we're in.

In this restrictive environment, however, we

feel that we have here at SAMHSA identified the priorities that we need to follow. We believe we can do everything that we need to do with this $156 million and move forward and continue to advance these great programs. Now, this is $156 million of discretionary funding for SAMHSA. Now, in addition to that, of course, 20 percent of the substance abuse prevention and treatment block grant goes out to the states. It has to be used by the states for prevention. On top of this $156 million, of course, we have this Drug-Free Communities money, this $70 million or so, which comes from the Office of National Drug Control Policy. So we believe the resources are there to do what needs to be done and we want to just press forward with this mission.

Now, I will also state that the number I just gave you was the budget number that was sent to the Appropriations Committees on Capitol Hill. That's the budget presented to them by the President. As you know, the process doesn't end there. The Appropriations Committees go to work. We're told that in some of the markups they have done, dollars have been added to the SAMHSA budget.

But that then begs another question. If they add too much money overall and the proposed discretionary spending of the federal government exceeds the target level that the President has established, then we face the threat

of a presidential veto. If that happens, there aren't enough votes to override a presidential veto in the Senate. So that then leaves us with the possibility that there may be a continuing resolution, and if that happens, then things continue at the 2007 level. So that's kind of the convoluted process and the environment we work in here. Nothing is ever settled in this town, it seems like, but those are the realities that we have to deal with.

Now, here at SAMHSA, we have to consider all these ramifications, and we have to do our planning based on the environment and the possibilities that we see occurring. All I can assure you of is this, that we will take the resources that we're provided by the American taxpayer and we will do our level best to expend those resources wisely, as efficiently as possible certainly, but as wisely as we possibly can and do everything that we can to support your efforts as you carry the prevention message and do the prevention work around the country. That much I can guarantee you.

Thanks.

MR. ROMERO: Thank you, Arne, for those wonderful remarks.

As you hear from Arne, we truly have both a challenge to try to meet the needs of the prevention community, attempting to strike a balance with the

resources made available to us, the taxpayers' dollars. It is my contention that we need to ensure that every penny that is loaned to us be used in the most responsible manner as possible. And that is the charge that is before me, and I truly welcome and challenge the NAC members to embark on this quest with me to ensure that the responsibility -- the public trust and certainly the need to ensure that all citizens' hard-earned money is truly put to the best use as possible.

Now I have the privilege of affording you the opportunity to hear from Peggy Thompson who is the Director of the Office of Program Analysis and Coordination in CSAP, also known as our budget office. I'm not sure why we have this long-winded name when it really is a budget office, but someone will have to explain it to me at some point. Peggy will offer you a brief presentation on the CSAP budget. So, Peggy?

MS. THOMPSON: Well, good morning, and I see all of you made it back from lunch and from yesterday's evening. That's the first test. So congratulations. You passed.

(Laughter.)

MS. THOMPSON: The second test is not going to be on the budget. I didn't realize, when I started preparing my remarks, that budget was going to be the topic

du jour. So as a result, I'm going to keep my comments and my briefing very brief. It's a brief briefing, but I'm available for any kind of questions you might want. I just don't want to pound you to death on the budget because it's a topic that can be detailed, tedious, and important. So let's see how fast and how interesting we can make this.

I wanted to do my presentation in terms of personalizing the budget, not just SAMHSA-wide but specifically prevention-wide. I'm going to try hard not to repeat Mike's remarks. A couple of Arne's I am going to repeat, but I'll really skim through them quickly for you.

So I wanted to focus the presentation on three aspects: past, present, and future. So my first slide has to do with where we've been. Prevention Funding History. Where have we been? This is one of my favorite slides. Some of you may have seen it before, but it bears repeating because it keeps things in context. It shows where we've been and what the general trend in prevention funding has been. It's a nice chart that goes from 1998 to the present and it shows a nice, general, gentle increase in prevention funding cumulatively across the years. It does break it down into Drug-Free Communities funding, which is the little greenish bars; our ever so popular PRNS, or Programs of Regional and National Significance, funding which is the yellow bars; the block grant funding, which is that part of

the prevention and treatment block grant, that 20 percent set-side in the black bar; and then the happy red bar is the total of all of those different funding streams come together. So you get the picture. It's been increasing historically over time and shows a nice, consistent progression and continued increase and continued interest.

This is my second-favorite slide, probably your least favorite slide. It's a complicated slide but I'm going to make it really easy for you. This is the entire federal budget process. Basically it shows you that at any given time we are working in three fiscal years. The first multi-colored line is FY '07. It could be any year, but for the purposes of where we are right now, it's FY '07. The second multi-colored line is FY '08, and the third would be FY '09.

Each year, as you can see, is divided into five sections, the first section being budget planning in which we're thinking conceptually about where are we, where should we be going, what are our interests, what are the needs of the communities. This is the phase in which the National Advisory Council can play a really strong role in terms of helping us to understand from your perspectives where we should be going, what's real, what's out there. You are a reality check. You can give us ideas. You can help guide us as to where we should be going. So the red

bar of each year is particularly important in terms of National Advisory Council roles and functions.

The second bar, which is the yellow, talks about budget formulation, and that's one in which our office gets very closely involved in that we prepare plans for the upcoming year. That is, each fiscal year we do three sets of plans. The first set goes to the Department of Health and Human Services. The second set goes to OMB. I'm sure you've heard of them. And the third set becomes the President's budget. So we do those three different versions for each budget year that we have to go through.

The third bar, which is purple, is congressional action, and that is the action in which the House and the Senate make their recommendations and the combined committees come together and do a final recommendation for any given year's budget.

The green represents budget execution, some people's favorite part because it's where we actually get to spend the money. That is when we actually award our grant and contract programs. So that occupies a lot of our time and attention.

The last bluish, I guess it is, bar is the audit and review section. We don't have a whole lot to do with that, but what we do is scrutinize by various folk in the government to make sure that we have spent our funds

appropriately.

So the real question is where the heck are we now. This nice little line shows where we are. We're in August in terms of FY '07. This is hard to see upside down, but I'm trying. In FY '07, we have spent almost all of our money. You'll notice it bisects the green. We're finishing up our fiscal year. It does end officially the end of September, but because of the various financial systems that all actions have to go through, we'd like to close down the books a little earlier if we possibly can. In fact, we have to. So we are basically almost through spending all of our money in '07.

If you go to the second cross-wise line for '08, Congress is acting on the budget proposals that we have submitted. So as you've already heard, the House and Senate have already made their recommendations for what kind of funding we should have. It's not quite through all the purple because we haven't had final congressional action yet.

If you look at the third cross line for '09, it's in the budget formulation process. Again, that means that we've thought through where we would like to be going in '09. We have made some recommendations to HHS. We have just now submitted our recommendations to OMB, and we are still in the process of finalizing what '09 will look like.

So hopefully that's not too much detail, but it gives you the overall picture about what the process is and where we are right this minute in each of the three different years.

This slide captures what Arne was just talking about in terms of the '08 process, where are we going. It shows, or I tried to make it show, the historical trends between the different parts of the budget formulation process. To put that a little bit more simply, it starts with where we are right now, or how much money we have been appropriated. The legend didn't come out quite right on this one. The red line is FY '07. The bluish line is FY '08. I put them both on there so that you could get a feeling about normal cycle changes instead of, oh, my gosh, look at '08. We're going to die, which really isn't the case.

So in '07, we started with a level that we ended '06 with. We submitted the President's budget. The House acted on it. You can see the line went up at that point. The Senate acted on it and it went up even slightly more. And then we had our final funding level, which ended up being in '07 a continuing resolution. That meant that the House and the Senate did not finalize our spending level. So they did not make any changes to it, and the fall-back position is that we are allowed to spend funds

this year at the same rate that we spent them last year. That's the really layman's definition of a continuing resolution. So that's kind of what happened this year.

In '08, the blue line, we started again with the '07 actuals, which is the current level. The President's budget you've heard too much discussion about already, being $156 million. But you can see how that does look pretty dramatic as the line goes down in terms of money available. But the House and Senate, you may notice, have proposed higher amounts or differing amounts. And then there is no blue final because we're not there yet. But even though you hear pretty scary suggestions about where we'll be in '08, what I wanted to leave you with is that these fluctuations are part of the normal budget process. They are not necessarily dire predictions of the future.

Indeed, for '08 we do have recommendations from the House and the Senate as to what we should be doing, as well as the funding levels. I wanted to just capture a few of the programmatic highlights or lowlights, but I think highlights, about where the House and Senate think we should be going.

Basically the House level continues to support the SPF/SIG at about the same level that it is now. It also continues to support the HIV grant program that we

have. In fact, it proposes a $4 million increase over this year's levels. It continues to support the meth grant program that we currently have available, and it continues to support workplace programs at about the same level that we have this year.

The new things that the House would like to see us tackle are a $7 million increase to help support more funding for underage drinking. As you heard from Mike yesterday, that means $5 million worth of grants, $1 million for the Ad Council, and $1 million for the ICCPUD. Don't ask me to spell that acronym. I can't do it. But it's I-C-C-P-U-D. It's the interagency group. So there is definitely an interest in underage drinking, and it is supported with funds at the House level. That's good news.

And the other good news is that the House has recognized a need to continue funding the CAPTs technical assistance, Center for Applied Prevention Technology systems. So those funds were restored in the House level.

The Senate level looks a whole lot like the House, which is really good news. It means there are fewer compromises to be worked out and fewer problems between the two groups. It also continues the SPF/SIG grant program, but it provides $7 million more within that program for funding. It continues the HIV, the meth, and the workplace programs at about the same funding level. It also wants to

see more funds go to underage drinking, but they have proposed only $4 million. And it also restores the CAPT.

So you see huge similarities between the two funding levels, and basically what that means is although we really don't know what the '08 final will look like, there really are only two options. Those of you who were at lunch with us yesterday may appreciate this slide more than others.

(Laughter.)

MS. THOMPSON: Basically there are two things that may happen for '08. One is that the House and Senate subcommittees may come to a compromise. Because they are already so close, that seems like a strong possibility, and we'll have a final budget that looks approximately like those two levels.

The other possibility is that they won't come to an agreement or the President won't sign it or something horrible will happen that we can't even foresee today, which I'm not even going to worry about. And then the worst case scenario that will happen from that is that we will, once again, be under a continuing resolution, meaning basically that we will have the same level of funding that we have right now. That's not such a horrible scene either because right now you may recall or may not that right now we have $192 million, and the House proposed $194 million

and the Senate $197 million. So there is a slight difference between those numbers, but percentage-wise not a huge difference. So no matter how you look at it, '08, while there may be a big question in your mind, does have some stability and a likely direction that we will be going in.

And '09. Okay. Why did I say "back to the future"? My daughter asked me that when I told her what I was going to do, and I had a beautiful explanation. It sounded so good last night.

Today all I can tell you is that we are always projecting in the future and we're always doing it at the current. So there is a circular relationship between the future and the present, and we cannot tell you exactly what the future will look like, but we are working on it. We are planning for it. A lot of things will happen between now and then, as you may recall from that incredibly complex slide, and we anticipate building on what we've done, taking your recommendations into account, and moving forward in '09.

That's it. You've heard enough about budget, but I'm happy to answer any specific questions or general questions you may have about the process or the content of the CSAP budget. You would have let me down if you hadn't said something.

MR. DeWISPELAERE: No, I couldn't do that. You know that. I'm going to be nice today. So I want to say, Peggy, that you make the budget process, although sometimes not the most easy thing to understand, simple and colorful, and that makes it nice. So with that said, thank you, Peggy.

MS. THOMPSON: Well, thank you.

MS. GERINGER: Peggy, I really appreciate that slide with the process of the three years because I've not understood how it works at all, and that at least clarifies some of it. So thank you.

MS. THOMPSON: Great. Thanks.

MR. ROMERO: Peggy, thank you for your presentation. Always good.

What's the CAPTs funding level? It said, "restores CAPTs." What would that funding level be for the House and the Senate, do you know?

MS. THOMPSON: Well, it would be approximately the same as it is currently. Let's see if I can give you a good number. It's --

MR. SHINN: Nine.

MS. THOMPSON: Nine? I was going to say $7 million to $9 million, approximately.

MR. SHINN: No, $9.2 million.

MS. THOMPSON: The funding for the CAPTs is

distributed between two different budget lines, which you really don't need or want to go into at this point. But the bottom line is about $9 million.

That's too easy, guys. Great. Thank you.

MR. ROMERO: Well, Peggy, thank you very much. You do make this look and feel like it's manageable and attainable. To me, still it's a very, very foreign topic. Trying to translate this information into English is, in and of itself, a daunting task. So thank you, Peggy.

As you know, the SPF, the Strategic Prevention Framework, is CSAP's major flagship, and it truly affords us the opportunity to challenge the prevention field to really begin to think strategically about the issues that confront their community. The SPF is taking hold across the nation and I am proud to say and report to the council that we are making tremendous headway across this land. The SPF is, in fact, challenging folks within the allied health field beyond the walls of prevention and into other areas of the allied health field.

To that end, this morning we have Allen Ward, the project officer within the Division of State Programs, who will present on the SPF, or the Strategic Prevention Framework, program within the discretionary grants and also give you an overview of some good news as to how the SPF is permeating across other areas of the substance abuse field.

I will preface this -- and I don't mean to take some of the wind off your sails, Allen, but this is something that occurred to me not too long ago to really begin to look at this piece and see better ways to manage and measure the effectiveness of the Strategic Prevention Framework within the substance abuse field.

So, Allen, thank you for coming this morning. I should also acknowledge that Allen is the project officer of the Pacific jurisdictions, which is an area of tremendous interest and of concern to CSAP and to me as well. So, Allen, thank you.

MR. WARD: And don't forget about Hawaii also, project officer for Hawaii.

Alan, to answer your question earlier, I didn't get the invitation in time. It was sort of late when I got the invitation from the Lieutenant Governor. I would have loved to have come. Looking at the big waves on the north shore is really great. Of course, we get a lot of work done when we're in Hawaii also.

I'm going to my best impersonation of Mike Lowther because this is actually Mike's presentation. So if I don't sound exactly like him and don't get the little movements down exactly right, let me know, and if I do, don't tell Mike.

This is probably going to be a repeat for a lot

of people when I start talking about the SPF process, but I'm just going to give a slight overview of the SPF process for some of you here who don't understand exactly what we're talking about with the SPF.

The SPF is a five-step process. It's really a planning process that we look at. But underneath the SPF, you have to realize that there has to be infrastructure in place in order for you to address the SPF. There's a certain infrastructure that a state or community has to have in place in order to address each one of the steps. So the model itself is a planning model to help you get from point A to point B and to also determine whether or not your programs are working. If they are working, what is causing them to work, and if they're not working, why aren't they working and how can we change that?

So the first thing we're going to look at is the assessment process. The assessment, when we look at the SPF/SIG grants, is a totally different process from when we're looking at communities. The SPF/SIG grant -- we have in place what we call an Epi Workgroup. The Epi Workgroup is a group of individuals from different agencies and organizations throughout the state that have access to data that's going to look at consumption and consequences associated with substance use. So that can include many different organizations and agencies that work with

families, children and work throughout the community, police enforcement, and different sorts of agencies. So the assessment part is to take a snapshot of your state, determine what the problems are around substance abuse, the consumption patterns of those problems, and also where they are located throughout the state.

The next part is the capacity part. You want to be able to address those issues. So you've got to assess your entire system to determine what capacity do you have to address the needs in your state. You're going to look at things like resources associated with knowledge, skills, abilities. You're going to look at financial resources, human resources. So there are a lot of different resources you're going to assess when you're looking at capacity.

The next thing you're going to look at you're going to develop a plan. The plan is going to include addressing the need, but it's also addressing the capacity. How are we going to build that capacity that we don't have. So you're going to have goals and objectives around addressing the need and goals and objectives around addressing the capacity.

The implementation process is where you're going to look at evidence-based policies, practices, and programs. What do we need to put in place in order to

address the need? So in the implementation process, you're going to look at that, and you're going to look at how are we going to operationalize our policies, practices, and programs. So in the implementation process, you're going to look at the programs you're going to put in place. You're going to look at how you're going to operationalize it. Operationalize can be we're going to use grants, contracts, whichever means we have to use to put this particular action in place.

And evaluation and monitoring is something that's going to be inherent throughout all five steps of the SPF. So you want to evaluate and monitor. You want to look at process evaluation where you're looking at everything that you put in place. How it's done, when it's done. In outcome evaluation, you want to look at what you put in place and how it affects the overall baseline that you're looking at of behaviors, attitudes and perceptions, norms, so forth.

Inherent within the whole process, in the center you see sustainability and cultural competence. Throughout the process, you want to determine how are we going to sustain those outcomes that we're trying to achieve. That has to be thought of at the very beginning. The cultural competence -- we want to work with individuals not only just race, creed. We want to look at

all those different subcultures. We want to look at the cultural aspects that are conducive to using substances within the community also and how you would address those needs.

So that's the quick and dirty overview of the SPF process.

As Dennis said, I work for the Division of State Programs. In the Division of State Programs, we look at the SPF/SIG grants, which are discretionary grants that we give out. Right now we funded three cohorts of SPF/SIG grants and I'll talk about how many funded in each cohort.

We also look at the block grant. We work with states who received a 20 percent portion of the block grant. That's all 50 states, the District of Columbia, and we have jurisdictions and territories that receive those block grants. Six of those jurisdictions are actually the ones that I work with in the Pacific, but we also have jurisdictions in the Caribbean with Puerto Rico and the Virgin Islands.

Also I have to mention Synar, too. We work with the Synar Program, and that's another issue that a lot of states don't want to hear about, but it's an important part of our job.

The structure of the SPF/SIG, or the Strategic Prevention Framework State Incentive Grant, first off is a

five-year cooperative agreement. A cooperative agreement is a little bit different from a grant in that we get an opportunity where we work more closely with the states when it comes to making decisions. With a grant, we usually just give them the money and say we want you to achieve these outcomes and basically monitor their implementation of the grant. With the SPF/SIG process, we're actually a member of the advisory council. So we advise them on every step of the SPF/SIG. The SPF/SIG is guided by the SPF/SIG advisory group, which is a group of individual organizations within the state usually appointed by the Governor. In the case of Hawaii, the Lieutenant Governor works pretty closely with the SPF/SIG and he is also the chair of the advisory group.

The other part of that is also the Epi Workgroup. The advisory group has to work very closely with the Epi Workgroup to make decisions around what are the priority needs that need to be addressed and the locations within the state or areas that need to be addressed. Eighty-five percent of the funds have to go to the community. What we look at is a 15 percent/85 percent split. Fifteen percent of the funds go towards administration, evaluation, and epi work. We have to do a cross-site evaluation also. That's part of the evaluation piece. But there's also evaluation of the implementation

at the state level.

The Epidemiology Workgroup looks at all the data related to consumption and consequences within the state. When you look up there, you see state/tribal and we also have jurisdictions. We also forget about the jurisdictions. There are three jurisdictions that have SPF/SIG grants. The tribal Epidemiology Workgroup is going to be somewhat of a challenge to us right now because a lot of them don't have the data that the states have and not even the data that the jurisdictions have. So that's something that we're going to have to look very closely at and work very closely with the tribes. This year we funded five tribes, which is the first cohort in which we funded tribes.

The SPF/SIG program is made up right now of 42 grantees. Twenty-one were funded in Cohort I. Five were funded in Cohort II, and we had 16 funded in Cohort III. Of the 16 funded in Cohort III, five of those were tribal grantees, and we had one territory which was American Samoa.

If you take a look at the map -- I believe you have this map in your handout. I know you can't see it very well. But it shows the location of the different cohorts and where they're located throughout the country. So in fiscal year 2004 and fiscal year 2005 was Cohort II,

and 2006 was Cohort III. We haven't funded a Cohort IV yet. We're not sure how that's going to work out.

The updates for Cohort I and II. Since they've been in the works for a while, they had an opportunity to do some of the benchmarks that we look at. One is the epidemiology profile. So they did an epidemiology profile which actually looked at the consequences and consumption throughout the state, and they broke it down by not only race, sex, and different areas, but they also broke it down by different areas of the state where there are priority needs so they can determine the priority areas of the states that they need to address.

The second thing that they did -- once they completed their prioritization process based upon their epi profile, each state is required to develop a strategic plan, and that strategic plan is one that we at CSAP have to review and approve before they can fund the communities. Most of the states in Cohort I and II -- in fact, there is a list of the information that's available, some in the handouts. I will hand those out later. We also have some of the handouts on the table. The handouts will show you the priority targets that were selected. This one will show you the priority targets that were selected. I'm not sure if everybody has this. If not, I have copies here.

The first handout will show you the priority

targets that each one of the states have selected so far. What you see in the handout will be Cohort I and II. Cohort III has not gotten to the point yet where they have selected a priority target. I think actually that was handout 2. I need to hand you this one which has the priority targets.

Handout 2 shows you the communities that have been funded, how many have actually funded their communities.

If you look closely at handout 1, you'll see that a lot of the individuals selected alcohol in some form or fashion as their priority target. In fact, when you do analysis or actually looking at that -- and I was talking to one of the project officers this morning about the underage drinking. She pointed out that all except one had selected some form of underage drinking. So underage drinking looks like one of the priority targets that most states have identified that is a problem within their state.

The second handout will tell you which states have actually funded the communities. If you look out to the side, there's a number in parentheses, and that number tells you how many communities that they actually funded.

So I'm going to move on and talk a little bit about the block grant next. The SAPT Block Grant, as you

know, is a block grant that gives funding to prevention and treatment. At least 20 percent goes towards prevention, addressing primary prevention. Some states target more than 20 percent of the funding, but 20 percent is required.

For fiscal year '08, which is the fiscal year coming up, states must report on NOMs in their application. The NOMs are the National Outcome Measures. The NOMs P1 through P11, which is the first 11 forms -- most of that information is pre-populated information which would come from the National Household Survey. Although states have an opportunity to substitute that information, there's a process that they must go to if they like that that information does not truly capture what's going on in their state.

Now, on forms P12 through P15, the states are required to report on that each fiscal year.

States are encouraged by the SPO, which is the state project officer, and site visits to embrace SPF as their planning mechanism for the block grant.

If you look at the next slide, we have a breakdown of the number of states and also we have a handout that has the summary information too. But we have the breakdown of the number of states that are using the SPF in some form. According to the information that we have, 48 states are using the SPF process of assessment in

their block grant planning. Forty-two of the states are using capacity in their planning for the block grant. The SPF step 3 of planning, 52 states are using that. The SPF step 4 of implementation, 34 states, and the SPF step 5 of evaluation, 22 states.

As for the last block grant applications that we got in, all 60 applications for the prevention and treatment portion of the block grants were approved. What we do each year, each state has to complete their block grant application. This year the block grant application is going to be a little bit different because we're not requiring states just to do the six strategies. They're given an opportunity to choose whether or not they want to do the six strategies or look at the Institute of Medicine model, the IOM model, where they're looking at selected, indicated, and universal programs.

Since January 2007, CSAP has conducted so far -- when we talk about the system reviews, we do system reviews with every state to look at their system. When we look at their system, we also look at the way that they plan for their block grant. A lot of the information that we got about the states using the SPF in their block grant process came from the system reviews. Since January 2007, we have conducted combined prevention and Synar system reviews. Last year we decided to do Synar system reviews

as part of the normal prevention system reviews. So we look at their Synar system, as well as their prevention system. So far this year, calendar year 2007, we did seven states and three territories.

The block grant is undergoing transition right now. So that's where the opportunity for them to start looking at the IOM model comes into play this year and also the requirement for them to report on their NOMs comes into play this year, or the National Outcome Measures.

Finally, the SPF has been integrated into other programs as part of our Division of Community Programs, which is headed by Peggy Quigg. Methamphetamine prevention, they're looking at the five steps of the SPF and using the five steps of the SPF. The HIV/AIDS program, they're using the five steps of the SPF, and also Drug-Free Communities Support Program, they're looking at five steps of the SPF. So the five steps of the SPF are actually being integrated into all of our grants, and we're looking for states to integrate it more and more into their block grant as they're normal operating procedures.

Do you have any questions?

MR. ROMERO: First of all, thank you, Allen, for that wonderful overview of the SPF.

Before we open up some questions, I'd like to publicly welcome and acknowledge Hope Taft, former First

Lady of Ohio, and another newest member of CSAP's National Advisory Council. So I'm glad you were able to make it here, and great to see you again.

Are there any questions?

MR. DeWISPELAERE: Welcome, Hope. Nice to see you again.

Allen, I want to clarify a couple things that we talked about yesterday. Sometimes we get confused with the budget, but I get a lot of questions as I travel in different states as it relates to the SPF/SIG process. And, Dennis, you might want to chime in here too.

For the '07-'08 budget year, how much money do we anticipate will be available to fund new states or territories, depending on who is on the list? Do you know that?

MR. ROMERO: I'm going to ask Peggy to help me out with this question.

MR. DeWISPELAERE: I didn't mean to put you on the spot.

MR. ROMERO: No, no, no.

MR. DeWISPELAERE: I just want clarification of that.

MR. ROMERO: It's a bit of a quandary. We have to remember a couple of things. As we are preparing our budget or as we are submitting our proposed budget to OMB

and ultimately to the President for his authorization, we have to take into consideration not only funding new efforts but do we have enough money, first of all, to fund the continuation of the already existing efforts. So that's a balancing act in and of itself.

It is my understanding -- actually, Peggy, could you just chime in and provide us with a quick overview of where we are with continuations into '07?

MS. THOMPSON: Okay. The answer always depends exactly on how the question is asked. So do you want to ask it one more time so that I can give you what you need?

MR. DeWISPELAERE: I sure do because I get confused. I was just taking it easy on you up there. I was waiting for this one, Peggy.

MS. THOMPSON: Thanks.

MR. DeWISPELAERE: I get confused when I ask about -- because we talk about the '08 budget. Does that start in October of '08 or does it start on a continuation from October of '07?

MS. THOMPSON: The latter. The first day of the FY '08 budget period starts October 1st, 2007.

MR. DeWISPELAERE: So my question is, of the monies that we anticipate, will there, number one, be enough money to continue to support the current funded SPF/SIGs, and number two, will there be any money to add

any new states or any new territories?

MS. THOMPSON: There's limited money depending on which scenario actually ends up being the case. We talked about the different budget levels. We talked about the House level, the Senate level, the potential compromise committee, and potential CR. Each of those pictures has a slightly different answer, but the general answer to all four is that there is very limited money for a new SPF/SIG grant, which I think is your real question, under the Senate mark level and no money for a new SPF/SIG grant under the House, the continuing resolution, or the President's budget.

MR. DeWISPELAERE: So that answer is there probably in this budget year won't be any new grantees.

MS. THOMPSON: It's still a guessing game. That chihuahua isn't just a cutesy little placeholder. It is a real thing. It isn't over till it's over.

MR. DeWISPELAERE: Oh, I understand that.

MS. THOMPSON: We do not have a final appropriation, and even when we get it, the actual funding picture for each specific grant or contract program does undergo some minor shifting during the development of the year, as the year goes on. So I can't say with absolute finality that there will be no new SPF/SIGs. All I can tell you is under the currently proposed scenarios, it's

not likely.

MR. DeWISPELAERE: Okay, thank you.

The other thing, Allen, is I want to -- because I do a tremendous amount of work in the states -- I work with a number of SPF/SIG states and I work with a number of people that operate within the block grant. I think the key word there is cooperative agreement in the places that I've seen the SPF/SIG working best, the capacity that they're building throughout that state. As I think back, when we voted on starting the SPF/SIG, that's exactly what we were trying to do because we know how effective that is.

That said, good job on that to you and your shop, but I want to encourage the states. I know our friend from NASADAD is here, and not to pick on him either, but I want to encourage that the states take the same approach. I realize we can't require it. The law doesn't allow us to do that, but we can certainly encourage them to look at the states that are being successful because of their cooperative agreements and things that they have employed in their states and take that same approach with the block grant even if that changes systems that have been in place for years and years and years. Let's get all of these talking together so that the communities can access the most services that they can.

With that said, thank you for your

presentation.

MR. WARD: And I appreciate that comment also because what we tried to do with the last SPF/SIG meeting -- I think we did it a little bit too late -- was we opened it up to the states that didn't have a SPF/SIG for them to come to the meeting and hear some of the good things that the states are doing that have a SPF/SIG. And we're also hoping and we're pushing as project officers the states to look closely at the SPF/SIG process and use that.

I worked in a state system for 20 years before I came to CSAP. I worked for the State of Louisiana, and I did work with the block grant program there. In fact, I oversaw the block grant program. I also was the legislative liaison for my agency. One thing that I realized in working in a state system that had something in place for many, many years is that it's a political thing. And a lot of times it's hard to uproot that political structure when you're looking at dollars that have been in place for many, many years, but it can be done. It's a process that takes a while.

MR. ROMERO: Thank you, Jay. Thank you, Allen.

Any other questions?

MR. SHINN: I'd add a comment. I just want to thank Allen for working with us in Hawaii. I think he's shown a lot of patience with us, but also he brings a lot

of expertise and we appreciate that. He's very calm for some reason. He doesn't get upset with us or he doesn't get stressed out. So thank you, Dennis, for sending Allen.

MR. ROMERO: You're welcome.

MR. SHINN: I had a question and that was New Mexico keeps getting brought up as a model. Why is that, Allen? I mean, what's going on in New mexico that we need to know about?

MR. WARD: Actually New Mexico was first. Well, this last SPF/SIG meeting we tried to involve more states in the process because there are a lot of good things that are going on in other states. In New Mexico, they grasped the SPF/SIG process and they moved forward a lot quicker than a lot of states. It doesn't mean that they had anything special or anything different from a lot of other states, but they did have the lead and they could show states some of the problems that they encountered and how to overcome those problems.

And we're learning more and more with each cohort. In fact, the last SPF/SIG meeting, I think we had just about everybody from Cohort I to present on lessons learned and do a different presentation. In fact, we had a really good presentation from Guam and Palau, the way that they addressed the SPF/SIG issue. One of the states made a comment that instead of having Palau on a panel, next time

we should let them go for the whole 90 minutes because they enjoyed their presentation that much.

MR. ROMERO: And just to reiterate, of the first two cohorts of the SPF/SIG grants awarded, 25 of the 26 states have received an approval for their state plans. With one state, we're in the draft. This sort of equates to approximately 305 communities that have already received an SPF/SIG within 34 states. So the process is starting.

What you heard Allen speak to today is how the SPF as a planning mechanism is permeating again across other areas of the substance abuse field and certainly with the block grant. That to me is a real important sign that we are making headway in beginning to think strategically about the problems of substance abuse.

Yes, Hope.

DR. TAFT: Is the process being used by any states or any communities to leverage non-federal dollars, i.e., private money?

The reason I ask is Ohio has developed a system that's very similar to your SIG program, but we have found that the communities are using the information that they gather from the assessment and the other steps to really be able to leverage Community Chest, United Way monies, foundation monies, those kind of things.

MR. WARD: I really want to defer to Alan about

that because they did something in Hawaii where they've gotten state monies dedicated to prevention. I don't know the process that they went through to get that done.

MR. SHINN: You got me there, Allen. I'm trying to think of how we did that or what we did. Maybe it will come to me.

MR. ROMERO: I think, for example, that Nevada did leverage some monies from the state from other coffers to support prevention efforts.

In my opinion, it goes to the heart of what the SPF is about, which is sustainability. So long as we are not perpetuating or participating in an immoral, unethical, or illegal activity, I think sustainability is a good thing for a community.

It has to involve the leveraging and cooperation and collaboration of other systems, whether it's not-for-profit or for-profit entities that will contribute to the sustainability. That's the only way that it's going to work because if not, then we are creating in my opinion a very dependent relationship between the federal government and the communities and the states. So we have to strike a balance.

I would be very curious, Hope, to hear more about what Ohio is doing, and this may be something that we may want to explore, making sure that this message gets out

to other states as well. So we'll work on something. You bet. Thank you.

MR. WARD: Actually that is our hope, that states will look at sources in their community, as well as within their state, that they can leverage and pull in and bring in. That's the whole premise behind the advisory council, is we bring these groups together and we get them on board with a common vision, common mission, and looking at their resources, to dedicate their resources towards that goal, that one mission, one vision.

DR. TAFT: I think the more you can encourage that at the community level, the more effective the program will be and sustainability will be long-term.

MR. ROMERO: Thank you, Hope.

Karel?

MS. ARES: That was kind of a nice little lead-in to one of my questions around what kinds of barriers have you observed with states and their ability to use this process thus far, recognizing they haven't completed it yet. But what are some of the things that you've seen, and what is being done then to help them overcome those barriers?

MR. WARD: Well, from the very beginning, some of the first barriers, of course, is that it's a new process to them, and they have to put a totally different

system in place that they're normally used to working with. Many times, if they have a close relationship with the Governor, a lot of those barriers are easily overcome. In states that they don't have a close relationship with the Governor, they have a lot of problems getting organization agencies to cooperate and provide data. Data is one of the first barriers that I've seen that we've run into, trying to get access to data, trying to go through different processes that are put in place in order to get that data released. That's one of the main barriers.

The other barrier that I've seen is getting communities to actually want to look at the data to determine their need because a lot of times what we're used to doing is going straight to planning without actually looking at a data-driven method for planning. So our planning doesn't tie back to our data. So those are just a few of the things that we see.

MR. ROMERO: Thank you, Allen, again. This is such a vital piece to the work that we do.

We are running just about 30 minutes late. So I have been given the order -- and I follow the order quite well -- that we need to try and get back on time. So thank you, Allen.

As a quick point of housekeeping activities, we had scheduled a 10-minute break, and I think we will just

do a quick stretch, maybe 2 minutes, if it's okay with the council members, and we'll then continue. Thank you, Jay, for your support on that one.

(Laughter.)

MR. ROMERO: I have the privilege now of beginning to present to you where we are with our four priorities. As I said yesterday and I began earlier this morning, we have identified four priorities under the umbrella of CSAP and prevention. The first one that I'm pleased to present to you is on youth but particularly on underage drinking, and I know that there are a couple of members on the council who truly have their heart in this area of importance.

So Ms. Gwyn Ensley is the Senior Public Health Analyst in the Division of Systems Development in CSAP. Gwyn will be presenting on underage drinking activities, and with her, we have two additional guests present today. First is Meg Baker, Program Coordinator for Health Promotion and Substance Abuse Prevention, "Drawing the Line on Under 21 Alcohol Use," and Kathie Durbin, Division Chief Licensure, Regulation and Education, Montgomery County Department of Liquor Control. Gwyn, we'll start with you.

MS. ENSLEY: Good morning, everyone. It's a pleasure to talk with you and present to you this morning. It's been a pleasure because I've worked with a couple of

you, Mrs. Taft, in the past with the Reach Out Now Program, and I always work with Jay. He's been one of our best community people to work with in helping us get our programs out there for Reach Out Now and Too Smart to Start.

Dennis has already presented to you our two community leaders. However, before I get into my presentation, sometimes we can always talk about how successful we are, but sometimes the proof is in the pudding. We have people from the community. So today I want you to hear some individuals who have worked with us and have used our programs and how they have used our programs to help sustain underage drinking prevention activities in their community. So I'm going to let Meg and Kathie present to you first, and then I'm going to come back and tell you what SAMHSA and CSAP are doing around underage drinking.

MR. ROMERO: Thank you.

MS. BAKER: Good morning. My name is Meg, and we thank you very much for allowing us to present to you. This is really very exciting.

I guess with Drawing the Line on Under 21 Alcohol Use, there's a long history there. It goes way back. Actually it goes way back to 1990 when the Montgomery County Community Partnership was brought

together under a CSAP grant, and it is now sustained under the Drug-Free Support Grant.

Drawing the Line is a community coalition made up of public and private agencies that focus on reducing adolescent access to alcohol and also promoting the message that under 21 alcohol use is illegal, unhealthy, and unacceptable. And I'm going to stop here for a minute because we've made copies of the PowerPoints so you can kind of keep up with us.

MS. DURBIN: My name is Kathie Durbin, and I'm the Division Chief for Licensure, Regulation and Education at the Montgomery County Department of Liquor Control. We are a controlled jurisdiction here in Montgomery County which really makes life easy for us when we're working on prevention issues. We have some put in place automatically. There are liquor stores. We run them. We close them at 10 o'clock at night. There are no spirits sold in Montgomery County after 10:00 p.m at night. So there are things that are already put in place here, and we've never really talked about it. So we're talking about it now.

I actually used to be the coordinator for Drawing the Line on Under 21 Alcohol Use before Meg, and I worked as a prevention specialist for HHS as well. So it's really nice to be able to have this role as regulator as

well. I'm not really sure who I am. I actually also worked in the hospitality industry for many years and was Executive Director of the Montgomery County Restaurant Association in the '80s. So it's been very exciting for me to work through these processes and to use these materials to move forward with our community efforts.

MS. BAKER: We have a variety of partners, as you can see: Safe and Drug Free Schools. I'm not going to read them. You can read them. Whenever we'd develop a project in Montgomery County, we call on our partners, we develop work groups, and a plan of action follows.

MS. DURBIN: And then also, which I'm sure Mrs. Taft is very familiar with, Parents Who Host, Lose the Most Program -- we took that model on, I guess, three and a half years ago working with Ohio, and it was very exciting. We're actually moving that program right now into the Adults Who Host, Lose the Most program. So we're starting a new program in several languages with highway safety funding as well.

With that, we created a SAFE line to use with all of our partners, and the SAFE line is a call-in line for the community and for the police and any enforcement agencies that would like to talk about any issues they see might be arising, whether it's an underage drinking party that's coming up and maybe a mom found it in her son's

backpack or anything. It's really a SAFE line. They can call in and give us any information. We also offer the brochure and materials on how to have safe events that are alcohol-free.

MS. BAKER: Actually, let's see. What was it? About a year and a half ago, we accepted the challenge of offering a town hall meeting to our community. We gathered all our partners together. The packet that you have shows you our materials, ranging from flyers, as Kathie said, that were developed in different languages. What we did was we partnered with public schools. They have five official languages. So those are the languages that we focused on. You'll also see some media release in there and our agenda.

We also partnered with the local alcohol and other drug advisory councils.

And we publicized the materials in a variety of ways. In fact, one of them was the cover of the Department of Liquor Control newsletter. So that went out to all of their establishments. The PTA inserted a copy of the flyer into their bulletin that went out. So we tried many, many different ways to get the information out and to get folks there.

Our evening consisted of not just speakers, but we also involved local resources. So they had tables of

their materials on display and for handing out. We used the Ad Council's PSA that was developed at that point in time. We decided to have a door prize, and we took some of the stipend to purchase that. Actually we purchased a cell phone. The winner was one of the attendees, a Boy Scout in the Boy Scout troop. So it was really quite appropriate so that he could keep talking. Then we also gave out certificates to the participants as well.

One of the activities -- the police department has what's called fatal vision goggles, and they had a display. This demonstrates what limited abilities take place when you're under the influence of alcohol in the goggles, usually around .08. But it was to make a point, and it did.

We also developed calendar of opportunities when adolescents could have access to alcohol, and that's the single sheet that's around there. Folks were quite surprised that every day of the week, every month, every year there's always an opportunity when youth could have access to alcohol. Our youngsters that participated came from the State Teen Advisory Council, and one of our partners, Safe and Drug-Free Schools, was very influential in getting the teens to participate as well.

MS. DURBIN: We also worked with the police on this event, and Chief Manger was there to introduce an

expansion of our safe line to SAFEnet. So Keeping it Safe in Montgomery County is really our umbrella, and the SAFEnet goes out monthly from the Department of Liquor Control, but all the partners send their information. We send out to PTAs. We send out to anybody. Anytime we get their email, it's sent out to them. it's all information on what's happening in prevention, tools and materials they can get, especially the free materials, anything that we are doing to educate the businesses as well with underage drinking efforts and educating the businesses.

MS. BAKER: Our feedback came in the form of the attendees filling out an evaluation, and then further along, as we were working on other projects, folks who had attended that event offered community comments as well. So that's the unofficial evaluation.

Montgomery County Public School instructional TV filmed it and then broadcast it on their local TV stations. The materials were requested. So we were able to fulfill that. And to help the evening move along, we also had a few planted questions as well to get group discussion, and we had good audience participation with that.

I guess one of the challenges was with this material is not getting it in an early-enough fashion so that this could take place in the month of March. This is

my opinion. If something like this is offered again, the materials need to be out at least three or four months, way, way in advance so that it allows communities to find their partners, get them together, plan, figure out where it's going to take place, how everything is going to take place. Otherwise, the materials were quite helpful.

MS. DURBIN: The next thing we're going to talk about is our teach-in in Montgomery County. To lead into the teach-in, I'll tell you a little bit about what we're doing now.

Right after our town hall meeting, I received a phone call from the Century Council who we work with for the liquor control, and they said they were doing an event downtown in D.C., a media event, for their Girl Talk Program. And I happen to be a troop leader as well. I have three daughters. So it was perfect for me to bring the girls down by Metro. They go to school in Rockville, and we just hopped on Metro, 14 girls and I, with permission of the principal of their school. They were a little too young to be part of that program, but it was really exciting for them to see a press event downtown and to be part of it. Not to mention, there were soccer players and other people that they can really look up to.

So I kind of found that the girls liked, first of all, T-shirts. They like gifts. They were really

excited about the whole program and they learned something that day. This is when the young people are really forming their opinions about alcohol and drugs. So one happens to be my daughter. I was very happy she could be part of that as well. But we were really pleased about it, and they talked about it forever and ever and ever.

So when the teach-in came up, I asked them if they wanted to plan the teach-in themselves. So Troop 2060 -- at that time they were in sixth grade -- planned the teach-in and they actually helped to create the agenda. They were speakers as well, and we worked around them and actually used the materials from the website as well.

What we had to do when we went into the school -- it's a small, private school. It's about 300 students in the school, kindergarten through eighth. But it took me four years to get a principal to finally say, working with the archdiocese, yes, we can do something like this. Last year we really opened it up. So it took a long time. This is not an overnight process. So you're really building relationships with teachers who don't think it's their kind of issue that they should be doing this at some point. They're already tapped out. Working with the school, working with the administrative system, the whole support system in getting that approval took a while.

But once we did get approved, it was really

exciting and we worked closely with Bill Beard and Meg and I worked together. We produced a media release and we put it out there, and it was really exciting.

So since we already found out the girls love shirts, we ended up using some of the money that we had from the troop. I didn't realize we had like $700 since kindergarten. They're in sixth grade now. So we used money and we purchased T-shirts that said "Start Talking" --

MS. BAKER: No, "Keep Talking."

MS. DURBIN: I'm sorry. "Keep Talking Before They Start Drinking." We asked the girls what they wanted, and they kept it as "Keep Talking." At the end of the day, we were wishing it said "Stop Talking."

(Laughter.)

MS. DURBIN: It was fifth and sixth graders and we took them for pizza afterwards and they talk a lot.

So it was very exciting. We had Captain Fascinelli, who used to run our alcohol unit here in Montgomery County, came and spoke, and we worked some scenarios that we had gotten from the website and used the scenarios with the kids. As you can see, two of the scouts actually wrapped up the program for us. The principal couldn't be there, so the vice principal was part of it, which was great because she's never, ever been part of any

of this. And we have the principal's buy-in already.

So it ended up at the last minute being fifth and sixth graders. We thought it was just going to be sixth graders. So it was exciting. We had a room full of young people, and as you can see, they like the lime green shirts.

MS. BAKER: We started the morning off by using the alcohol true/false quiz, and that was a real good place to get started from. Then as Kathie said, we developed into some of the scenarios that took place.

MS. DURBIN: Right.

I guess the feedback we did get from the teach-in was really exciting because only a couple of parents came to the event, but we had lots of emails because the kids were going home telling them exactly what they learned that day. They were talking about it. They did have a conversation with their parents about this event, and it was very exciting for them.

It went through the school. We also had a lot of pictures to put on our website. We've got a lot of play out of both of these events, and it's been wonderful for us because the parents have really responded in a positive way.

We've also empowered the youth and they are wanting to play in another event this year of the same

sort. So it's very exciting and we'll get them whatever color T-shirts they want because that's what they like. I forgot the T-shirt.

So, anyway, we're really excited about doing these programs. We use the material. I'm always on the Stop Alcohol Abuse website and we're always pulling off the materials because we don't have a lot of money to spend. So this has been very exciting to not recreate the wheel again.

MS. BAKER: Right. And also with the SAFE line, our online newsletter, we're able to reach out to the community parents and refer them to the different websites too so that we don't have to recreate a lot of our material. It's been wonderful.

MS. DURBIN: That's it. If you have any questions.

(Applause.)

MS. ENSLEY: Thank you. Thank you. Don't go away. Have a seat.

MS. GERINGER: I do have a question for you, if I could, Kathie. You mentioned that your liquor stores in Montgomery County close at 10:00 p.m. Was that done through the county legislative body or how was that enabled?

MS. DURBIN: No. Actually that was done years

ago through the Montgomery County Department of Liquor Control. It's their stores. They run them. I'm sure if they wanted to keep them open, then they would have to go to the county council at this point. When prohibition ceased, we became a controlled jurisdiction. The State of Maryland went to the counties. There are 18 other states that are controlled. We actually have three additional counties in the State of Maryland that are controlled, but they control spirits only. In Montgomery County, we control beer, wine, and spirits. So we have the complete control over who gets the alcohol, when they get it. So it comes really from our agency.

MS. GERINGER: Wow, that's terrific.

What about bars? Are they also controlled?

MS. DURBIN: The alcohol they purchase has to be purchased through the county system, and then that money goes back into a general fund which goes into substance abuse prevention programs and highways and roads and such. We transferred $24 million last year into the general fund. But it is a state licensing system. So we work through the Comptroller's Office under the state licensing.

So if they have a license that it goes until 2:00 in the morning, if we're seeing issues in Montgomery County, when those businesses are now up for renewal, we ask them to work with us, and we put restrictions on their

license but they have to agree to it. If they don't agree to it, then we work with them in other ways, whether it's enforcement or more education. So we do have a handle on it.

MS. GERINGER: I see. Thank you very much.

MS. ENSLEY: I want to thank Kathie and Meg for presenting on two of the programs that we do, and the programs that they talked about is Reach Out Now and Reach Out Now teach-ins and town halls.

And we want to thank Mrs. Taft who is the one who first started. She did the very first teach-in when she was the co-chair of the Leadership to Keep Children Alcohol-Free.

So after that, SAMHSA took the ball from Mrs. Taft. And we have now been in our sixth year, and hopefully in fiscal year 2008, we are going to do teach-ins again, along with town hall meetings. We did over 1,500 town hall meetings in 2006. So it is proposed to do town halls in 2008 based on the budget, along with Reach Out Now and Reach Out Now teach-ins.

Real quick, because I've been asked to cut it short and move it along, upcoming, as I just said, we're doing the town halls and the teach-ins. Allen mentioned to you earlier about the SPF/SIGs. We have about 42 SPF/SIGs now. But out of the 25 that we have gotten approved plans,

24 of them have underage drinking as their major target, and about 15 of them are specifically spending their SPF dollars on underage drinking. So that's a good one for us.

I looked at a report from Texas this morning, and some of the things that they are doing in terms of working with all the types of different groups, parents, and communities, well, that gives us hope that the states now are definitely increasing their focus on underage drinking in the states because we know that there is a big problem.

SAMHSA/CSAP will be also participating in a DEA museum where we'll have a piece that's going to be presented, I believe, in California in November. So we also have an opportunity to address underage drinking there, along with the Surgeon General's Call to Action. He has visited some states, and he did one of his roll-outs in Hawaii and, I understand, has been very successful. He has North Carolina and a couple more states coming up. He's working with the Leadership Foundation to continue to push this effort. So we have new publications, materials that are coming out, and we're definitely trying to keep underage drinking sustained within the community.

You heard about what Congress has proposed in terms of their budget with the STOP Act, which has to do with underage drinking, in terms of the money for grants

and for the Ad Council's new PSAs that they're developing for this upcoming year. So we're trying to definitely keep it on target and keep it focused in the communities.

I want to thank Jay and Mrs. Taft for their efforts for definitely helping us keep this at the forefront.

I hope this was quick and short.

MR. DeWISPELAERE: That was short, wasn't it?

MR. ROMERO: Thank you very much, Gwyn, and also Meg and Kathie for your wonderful story. This is what prevention truly is about, and the more we can share the promising actions that communities make to really bring attention to underage drinking -- to me it's a personal charge. I have two young children. My daughter is 2 years old. My son is 1 year old, and I want to see a healthier tomorrow for them, certainly a better one than the one I had. So it really is very personal to me and I know to the members of this council. We're all here not because this gives us tremendous aspirations but, rather, because this is the right thing to do. It's doing the people's work. For that, I thank you very much for your work, for your continued support for this effort.

Underage drinking remains an important priority for me, as I stated. It remains a major priority for CSAP and for SAMHSA. Terry Cline and Ric Broderick are very

much aligned with our focus on focusing our attention on underage drinking. Youth will remain a top priority for prevention in the years to come as well.

So once again, thank you very much.

Before we break, we are close to back on time. So we will have a five-minute break, a little stretch. Just two quick points before we break for five minutes.

Because we had changed the meeting of the NAC, there were some preexisting meetings that I am unable to change. So I will not be back after the break. I will be attending some meetings with other HHS and federal folks. So Rose Kittrell, the center Acting Deputy Director, will chair the remainder of the meeting. I hope to be back as soon as I can. I do have to leave a little early because I have a flight out to, I think, it's Michigan, if I remember correctly. The last time I checked --

MR. DeWISPELAERE: You better check that because I think it might be somewhere else. You can fly with us to Michigan, though.

(Laughter.)

MR. ROMERO: But let me just, in my minutes here, just say thank you to the council.

I also need to acknowledge the CSAP staff who are present here today. Really, there is no better group of people to shoulder yourself with, folks who are just

truly committed to this work from the division directors, Peggy Quigg, Mike Lowther, Kevin Mulvey, Peggy Thompson, and certainly the staff of CSAP. But we don't do this alone. We have a wonderful family. We call this family SAMHSA. SAMHSA truly is engaged in addressing and creating a healthier community. So to the CSAP staff who are present and certainly to the SAMHSA folks who are also present, I thank you very much for your attendance at this very important meeting.

So we will break for five minutes and we will resume at that point. Thank you very much.

(Recess.)

MS. KITTRELL: We're going to go ahead and move right along here. We want to be flexible with our agenda to meet the needs of our council members and, at the same time, provide all of this information that I think will help you during your tenure on the council. So what we're going to do is to move right along with the "Minority, Vulnerable, and Diverse Subpopulations" with Claudia Richards, and then we also have Peggy Quigg, who is the Division Director, and she will talk with you about the returning veterans initiative. Then Dr. Kevin Mulvey will be joining us, and he will do a presentation. I'm sure it's the data strategy. That's what he's going with us about that, after which we have a council member that's

going to need to leave, and there are some recommendations that she wants to share with us. What we would like to do at that time is just take recommendations from the council.

I also want you all to be thinking about recommendations for new members for the council. It's about a 9- to 12-month process. So it's not too early to get started on that. So we would like for you to share with us some of your recommendations and give that information to Tia.

So we'll now start with Claudia Richards. She is the Branch Chief, HIV Behavioral Health Issues Branch.

MS. RICHARDS: It gives me great pleasure to speak to you council members today with regard to CSAP's Minority AIDS Initiative programs and looking at the Programs of Regional Significance, the Secretary's Emergency Fund for the Minority AIDS Initiative, and last, talk to you a little bit about the methamphetamine abuse project.

Through several Minority AIDS Initiative grant activities, we at CSAP are working to prevent and reduce health disparities and substance abuse and HIV for at-risk minority and disadvantaged populations in all sectors of the communities. The Minority AIDS Initiative grew out of the Congressional Black Caucus initiative reflecting their leadership in creating a framework and providing and

securing new federal funding. The Minority AIDS Initiative is also designed to strengthen organizational capacity and expand substance abuse and prevention-related HIV services.

The creation of the Minority AIDS Initiative is reflected in a broader focus on disproportionately affected racial and ethnic minority communities and also involves efforts taken on by the Congressional Hispanic Caucus. We pretty much target five racial and ethnic groups within the Minority AIDS Initiative programs that include African Americans, Hispanic Latinos, Latin Americans, Native Americans, Asian Americans, and Pacific Islanders.

First, I just want to make you aware that under the Minority AIDS Initiative, it began in 1999 when CSAP initiated its first Cohort I. We currently have six cohorts at this time. So we have been quite progressive in terms of getting funding out in the communities of color to address this impact of substance abuse or to prevent or delay the onset of substance abuse, as well as to prevent HIV infections.

CSAP currently has 148 HIV grants. That would include currently three cohorts. That would involve Cohort III, Cohort IV, Cohort V, and Cohort VI. We currently have 22 active grantees in Cohort III. We have 48 in Cohort IV and 81 in Cohort VI.

At this time, Congress has created this

initiation simply because of the spread of HIV in the minority communities, and as a result, has targeted appropriated funds within the Department of Health and Human Services. SAMHSA is one of several federal agencies that receive Minority AIDS Initiative funds over the course of years. That would include CDC, Health Resources and Services Administration, Office of Minority Health, Office of Women's Health, and other federal agencies, Indian Health Service, all receive Minority AIDS funds, as well as each of the centers within SAMHSA receive appropriated dollars for minority AIDS services.

What we attempt to do is to continue to reinforce the idea with the President's State of the Union address that was made in January of '06 to continue to fight against HIV and AIDS in America, also to continue to stop the spread of the disease. This is very important to the field of prevention. We continue to embrace rapid testing as a mechanism to continue to identify new HIV-infected individuals.

Looking at the infusion of the Strategic Prevention framework, we have afforded an opportunity for 81 grantees within Cohort VI that involved implementation of the SPF. Eighty-one grantees were awarded in fiscal year 2005 that initiated their first three steps of the SPF, assessment, capacity, and planning, during fiscal year

2006. These grantees have been awarded $254,000 over the course of five years, and they will continue to implement services starting this year and the remaining years of their grant.

This map illustrates our current active portfolio within the area of minority HIV and AIDS grants. As you can see, to the right is a distribution by our five CAPT regions in terms of how the funding is being distributed across the states. You can see, in terms of proportion of the HIV rates and prevalence, it's pretty much more predominantly on the east coast area, as well as across the southern states. Then it goes across and then it goes to California and up.

In terms of the metropolitan statistical area, primarily these particular communities of color have been identified to meet the CDC case rate in terms of 50 cases or greater with a population of 500,000 or 20 cases per or greater with a population of 100,000. Or they may have been identified to have a case rate of 10 cases per 100,000 that would include those states and communities.

Next, I'd just like to give you a brief update in terms of some of our current demographics of Cohorts IV and V. Currently you can see, in terms of race and ethnicity, a proportional amount of target population are African Americans' followed by Hispanic Latinos; third,

American Indians and Native Americans; and last, Asians and Asian Americans and Pacific Islanders.

Next is targeted groups by gender. We continue to see serving males more than females, but preliminary data have shown, in terms of some more recent information, that this is shifting a little bit in terms of serving more females. So we want to continue to outreach to both genders because of the importance of prevention.

Next is the category, age range. You can see we continue to serve adults. Also we serve adolescents and youth and, more importantly, children. We also connect these people with their families.

Intervention methods. It's very important that our grantees identify evidence-based intervention models not only for substance abuse prevention, but also for HIV. We afford the flexibility for them to identify these intervention methods as they begin implementation of services. You can see the distribution across the various types of intervention models that are being used under the Minority AIDS Initiative.

Next, I'd like to give you a couple updates of some other special projects. We have a recipient of two types of funding for this project. Under the PRNS line, we're line-item appropriated. You can see our funding has been flat consistently. It was good to hear that on the

House side, that we potentially may get an increase, and that really will be refreshing.

You can see, in terms of 2007, that particular funding amount continued to support Cohorts IV, V, and VI. IV and V will be in their last years starting fiscal year '08 that we'll be ending. We will continue to fund the 81 grantees that are responsible for implementation of the SPF, which are five-year grants.

The next slide illustrates another source of funding that we receive from the Department of Health and Human Services. This is called the Secretary's Emergency Fund. This is a departmental fund, approximately $50 million, that are available to federal agencies that have been designated to receive Minority AIDS Initiative funds that I had mentioned earlier. SAMHSA is one of those agencies. As a result, SAMHSA submits a request to the Department and CSAP is a recipient of these funds, looking just at a three-year window from 2005 to 2007. As you can see, we have received a significant amount of increase for two of our projects regarding Minority Education Institution and the Drug-Free and Faith-Based Partners Initiative, which I'll speak about briefly.

The first project is the Minority Education Initiative project. This particular project was initiated with funding in '05 and started implementation in '06. We

initially awarded 13 schools in '05, and in '06 we awarded 12. We anticipate adding additional minority institutions starting this fiscal year. Hopefully, we anticipate making these awards by the end of the fiscal year.

But the main thing about this project is that it focuses attention on increasing minority students' awareness about risk factors associated with substance abuse. We're looking at underage drinking on college campuses. We're also looking at sexual risk behavior associated with the use of illicit substances or alcohol and just the importance of using student peer educators as a mechanism to get the information out to do a lot of reaching out to their students. We have had a lot of success rate in terms of training our young workforce, if you will, as well as having the ability to allow them to continue to encourage people to get tested. A lot of our schools do HIV rapid testing or some kind of arrangement with a public health entity on campuses to encourage students to get tested. So we have had a lot of success rate in those increased numbers.

But more importantly, I'd like to note that this year with the 12 existing minority education institutions, they're currently adopting the Strategic Prevention Framework, which is a different animal because it's actually being implemented in an academic institution.

We do have, for example, on our discretionary side another academic institution that's currently doing SPF, and we're learning a lot about that project to transfer that knowledge to this project. So we've had a lot of success rate in terms of schools having the opportunity to not only work within the walls of their schools, but also to engage the proximity of their community in terms of looking at those stakeholders that are key people that would have some influence and some involvement in terms of their participation in the project.

Also, we look at it from a sustainability standpoint. So we have had continuously success because, as you know, on college campuses proximity of the community -- there are liquor stores. There are drug activities going on outside of the walls of the schools, and you have to engage the community. So this is the first opportunity where a lot of schools are taking that opportunity to actually interface with people outside the walls of the school.

Next, I'd like to just mention the other project under the Secretary's Emergency Fund is our Faith-Based Partners Initiative. Again, this project also started at the same time the Minority Education Institution project started that I spoke of earlier. It has pretty much a twofold approach. This particular initiative is

underway, which is part of our 2007 funding, to continue to fund or at least establish funding for 12 to 15 new awardees that will receive $50,000 that have some affiliation and partnership with a community-based organization such as a drug-free coalition, partnering with a faith-based organization to address the needs of the reentry community, partners that come back from the prisons. Reentry is very important to the faith-based community, and they're doing a lot of work. So we want to engage them, along with the drug-free coalition partners and to begin that collaboration to address the needs of minority prisoners who are reentering into the community.

David Wilson is the government project officer on that particular contract. He's not available today, but hopefully we'll get a chance to tell you more about that because he's doing a lot of exciting work with faith-based partners across the country in terms of doing PSAs and a lot of educational and social marketing.

Next, I'd just like to shift gears. The other project that our branch manages is the methamphetamine. Who is using methamphetamine?

Well, in terms of 101, for those council members who may just want to have just a quick synopsis, methamphetamine is a synthetic stimulant drug which induces a strong feeling of euphoria and is highly addictive.

Meth, of course, can be eaten, smoked, injected, and snorted.

These are some of the slang terms for meth that you will see, folks.

These are some of the short-term side effects of meth users. These are other short-term side effects.

This picture depicts a woman who has been using meth for about 1.5 years. In terms of some of the long-term effects on meth users, they are listed. With regard to rotten teeth, the National Dental Association is quite interested in looking at ways to work with meth users to address meth mouths. That's what they're calling it. So SAMHSA is showing some leadership in working with the National Dental Association to looking at meth users across the country as they begin to treat these individuals.

In terms of methamphetamine kills, it causes heart failure. It causes brain damage. It causes stroke. It exposes children to hazardous chemicals. Fires and explosions and, more importantly, aggressive and violent behavior.

In terms of CSAP's response to methamphetamine prevention, first of all, what we have been able to do is partner with a lot of federal people. We are now partnering with the Centers for Disease Control, the Indian Health Service, Department of Justice, and also the

National Native Law Enforcement Association.

In terms of some of the history for meth, as you can see in the previous slide -- I'm not going to read it, but in terms of statutory authority, we continue to address this authority in terms of our grant portfolio program, and we have a very exciting program because it's a different approach that we're using in terms of addressing meth. We're addressing meth in several ways. We're addressing it from infrastructure, also for service delivery.

In terms of the historical funding, you can see the project is maybe on a smaller scale, but it's making major impact in the community. More importantly, we recently received additional funding of $588,000 to award two additional methamphetamine abuse grantees, and they will be active October 1st. We currently have 10 active grants with a budget of $3.3 million. So that's our current portfolio. These grants are three years, and again, they provide infrastructure and service delivery intervention services.

In terms of the types of expectations, the grantees provide community-based prevention programming with these funds. They assist local government entities to conduct appropriate meth prevention activities. They continue to do workforce development and training and

educating state and local law enforcement officials and other key community stakeholders. Also, they continue to monitor and evaluate the meth prevention activities and report and disseminate results to the public. Again, all of our grantees are reporting on the NOMs measures, so we anticipate having some additional data to be able to report out next year.

In terms of our interests in the area of meth, what we are attempting to do is to build capacity in the community in terms of infrastructure and also community-level support for interventions. We also want to help communities to initiate and develop interventions, to design change in attitudes and norms about meth, particularly young people, and going into the schools. Again, we want to prevent or delay the use of meth.

The vulnerable populations that we serve and also the diverse subpopulations that we serve under this initiative require intervention services. We have very unique programs in terms of a wide spectrum of array of services that are being carried out under this initiative, working with meth mothers and their babies, as well as going into the school systems, the school-aged children, and addressing from a prevention standpoint. We also look at it from the community standpoint in terms of infrastructure development. We continue to work with those

individuals in the community to continue to educate and make positive change.

Some examples of our infrastructure projects. Again, training is very, very key. Capacity building, workforce development. Also to establish a prevention referral linkage system is very, very key. Many times a lot of the individual meth users lack the support in terms of the type of level of service that they will need in order to sustain or to prevent themselves from reoccurring any use of meth. So we provide these wraparound services as needed.

Examples of prevention intervention projects. Again, school-based programs about the dangers of meth and inhalant abuse. Replicating, developing, implementing and adopting evidence-based effective prevention interventions.

This is just a map that illustrates several of CSAP's programs, the SPF/SIGs, overlaid with the methamphetamine grantees, as well as the Minority AIDS Initiative grantees. As you can see, the overlay is pretty much targeting communities of need. In my case, my MAI program targeted minority communities of need because these providers are either minority-serving organizations or organizations that serve minorities. So it's very good to see the overlay in terms of the geomapping and see how our funds are distributed across the country, looking at

various aspects of prevention services.

The next slide I'd like to share is just methamphetamine laboratory incidence in 2006. As I mentioned, CSAP is partnering with the National Native Law Enforcement Association, as well as the Indian Health Service, and we're partnering with them in terms of putting on a meth track along with the Center for Substance Abuse Treatment in November in Memphis, Tennessee. As you know, Memphis is one of the leading states in the area of methamphetamine laboratory incidence, as well as meth use.

Last, but not least is my staff. I could not have done all of this without my staff. And if they are here, could you please stand?

(Applause.)

MS. RICHARDS: I'd just like to give kudos to my staff every opportunity.

So it gives me great pleasure to just give you a synopsis of what we're all about in the Behavioral Health Branch, and I will entertain any questions you may have.

MS. KITTRELL: For the sake of time, if you could hold your questions.

Peggy, because we are operating under a very tight time frame here, because we do want to get the recommendations from the council members, if you could hold your presentation to about five or six minutes. Do you

have it available for the notebook? And you all can chat over this at lunch as well.

MS. QUIGG: Well, thank you, Rose. My presentation is a very short presentation. We had actually taken this presentation out of your schedule, but due to the questions that were raised yesterday by, I believe, you, Sharyn, about what we were doing about veterans, we put it back in for you. So I'll be very brief.

We continue to work as a result of the Returning Veterans National Forum that was held almost two years ago now by SAMHSA where we brought together groups from all over the country to look at the emerging issues around returning veterans. We continue to work with a variety of agencies, groups to look at this not only from the returning veterans aspect, but across the spectrum of what are we doing pre-deployment, during deployment for families, and post-deployment activities across the board. We know now that this war effort is not a short effort, that no matter what happens politically, we're still going to be involved in this for the next couple of years, and the numbers just keep expanding and growing.

I've provided for you the most recent report from Congress looking at what are the issues. This is the report that was the joint commission by Elizabeth Dole and -- I can't remember the other person, but it's called the

Dole Commission report now. It was released in July as a draft. It really gives you a quick snapshot of kind of where we are at current day.

Last week the Pentagon released a second report on suicide rates for returning veterans. The most significant finding out of that is a fairly alarming finding I believe, that the suicide rate is almost double that of the normal population, and the attempt rate is even higher than that. So suicide has become probably the next major emerging issue that we're looking at, in addition to substance use.

On the National Guard side -- and, Sherry, I think that's probably more what your comments were asking about yesterday -- we've been working nationally with the National Guard Bureau to try to help them build up some of their own programs internally. They came to CSAP and SAMHSA asking for us to help them bring evidence-based findings to their programs, and they also wanted to make a shift in their programs to do more in-reach into some of their own military families and dependents. And that's not been a typical mission of the National Guard counter-drug program.

There are three components to the National Guard counter-drug program in the States. The first is the counter-drug supply reduction, which is the typical mission

they've done forever around helping law enforcement reduce the supply of drugs in enforcement activities.

The second piece is the drug testing and control program within the National Guard. It's their own monitoring and maintenance system of their soldiers. That program has been around for a long time, about 15 years, within the Guard. They actually do random drug testing of their soldiers and drug testing for deployments has become an even higher need.

In addition to that, because of where we are today and I think because of the long-term work that the Guard has done in communities, there's an increased awareness now that they needed to expand that program much more in an area of prevention and not just only limit it to drug testing and control. So the expansion has been a program they've done through an interagency agreement with SAMHSA to begin to bring one of our workplace model programs into the Guard called Team Awareness. They've adapted that to a program called Team Readiness, and readiness is certainly the issue that they're concerned about most for their families and soldiers.

So the program is a great program. It's been tremendously supported by workplace environments. It is one of our model programs. It is an intensive program.

The developer has worked with the National

Guard to help break down the modules so that they can do it however they need to do it to work best within their training schedules. Normally they would come into a workplace and do two or three days' worth of intensive training time. They don't get that luxury with the Guard. So the developer has worked with them to figure out how they could break it down into one-hour modules, four-hour modules, how they could do family program pieces along with it.

They're currently in a pilot project with 26 states fielding that program now, and by the end of the year, they hope to expand that to all 50 states and the territories that the National Guard serves.

The Demand Reduction Program also took a little bit of a change this year and last year using a model to really look at how can they measure the work that they're doing. They too, like all the rest of us, are held to accountabilities and outcome measures. The program that they had was 50-plus different programs all across the country with no good measures for outcomes. They have good outputs if you're talking about the number of people reached and number of programs done, the number of volunteer hours, but no good outcomes. And Congress was challenging them to show outcomes like they're challenging the rest of us in prevention.

They worked with us on some recommendations on a prevention curriculum. They saw a need to do a standardized curriculum. With the turnover rates that they have in deployments, their Drug Demand Reduction folks now have less than two years' experience, and they needed something that they could give them in a kit to go out and do a viable, evidence-based service to the communities. That's way different than what they've done in the past.

There are a lot of communities and even a lot of the folks in the Guard that have not been happy about that transition, but I think given the current state of affairs, they made a good choice in moving in that direction for standardization for their own survivability and sustainability and to get some measurable outcomes going.

They also complement that with a production made by Motivational Productions called Freedom Calls. So they go into school, show that piece. It is about motivation and it has two parts. It leads kids to think about what's going on in their heads, what's going on in their hearts, and what do they need to do about it. It is designed to really target kids that are having some problems not just about substance abuse, but all of the kid behavior issues, to seek some help, to go find somebody to talk to about some of these issues, to talk to their

parents, to talk to their teachers, counselors, whoever.

And then they inserted within that production a piece specifically designed for military kids to heighten both awareness of the school environment, the counselors, teachers, that, my gosh, you might have kids here whose family members are deployed through the Guard and Reserve and also to tap into those kids who may be feeling lonely and left out and different now that their family members are deployed or the risk of being deployed. It's not a matter of if you get deployed now. It's a matter of when. So there's a lot of increased anxiety with these kids. So this production was designed to help bring some of those things to light, make the school think about some of their environment and what they're doing and target those kids.

That production and the curriculum is now being fielded in, I think, 46 states across the country. They did a pilot last year with 10 states. The states had the chance to adopt both programs, and 46 have now gone on and adopted those not only with the federal resources they get, but with some additional state resources and making their own state plans adopt that.

It's also about doing community outreach and in-reach for the military youth, trying to educate communities that these kids who used to be in our lowest at-risk populations have now become part of the highest at-

risk populations.

Then lastly, there are several ongoing special emphasis work groups and efforts here at SAMHSA, combined with other federal agencies. I mentioned the Dole Commission report. The veterans focus groups continue to work on an ad hoc basis and around certain issues that come together. Most importantly right now and most intensely right now, Kathryn Power has been a part of a mental health work group that released an intensive report about a month ago that also fed into this report as well. As a result of that initial report, HHS has brought together an intense work group. One of Claudia's team leaders is detailed right now from CSAP down to work on that work group to make recommendations around mental health concerns, mental health capacities, and the mental health response for both returning veterans, as well as their families.

I mentioned the Pentagon Workgroup on Suicide Prevention. We now have on our SAMHSA website a host of things about veterans initiatives and linkages to the VA and other sites about veterans issues. So if you want more information on what we're doing, please refer back to that website. It's a fairly intensive group of things that are going on.

So that's brief. How was that, Rose?

MS. KITTRELL: You did good, Peggy. Thank you

so much.

MR. DeWISPELAERE: Peggy, aren't you a veteran too?

MS. QUIGG: Yes, sir, I am.

MR. DeWISPELAERE: I thought so. Thank you for serving.

MS. QUIGG: Thank you.

MS. KITTRELL: All right. Do you have any questions for the last two presenters?

MR. DeWISPELAERE: Good job.

MS. KITTRELL: Sharyn, did you have any questions?

MS. GERINGER: No. I think my questions were very well answered. Thank you.

I am concerned about the children of our Guard -- well, the active duty, as well as the Guard. And I'm glad to see that there is some focus on their needs because when members serve, it's not expected that the children will have a consequence, and yet, we're finding that that's happening in some of our communities. So thank you for helping with those people particularly.

MS. QUIGG: We're also working, Sherry, a lot with our Drug-Free Community coalitions. The coalitions need heightened awareness that they need to be doing more outreach for those Guard and Reserve families. And that's

working. They're coming on board with a big interest, that it's more than just collect the boxes and the things to send overseas and the cards. Those are all important.

MS. GERINGER: Right.

MS. QUIGG: But the coalitions have a lot more to do.

It's also been helping the National Guard understand that they need to let other people come in and bring the communities in to help them. The military has a pretty strong attitude of it's their job to do it for their own and not real open to that. So we've partnered a lot with Community Anti-Drug Coalitions of America. A lot of the training that the National Guard has done has been in conjunction with other CADCA venues, the Mid-Year Institute, the National Forum, so that we can help blend that and make them a little more aware that coalitions are standing ready to do that.

MS. GERINGER: Right. And that's a good point.

The other thing is that not all of our National Guard troops are going to combat, and I think that there is some confusion among our community members about that as well. So no matter how they feel about war situations, the Guard members are serving in other venues, as well as on the battlefield.

MS. QUIGG: Eighteen months away from home is

18 months away from home.

MS. GERINGER: Exactly.

DR. TAFT: Peggy, you probably know about the effort in Ohio where mental health and alcohol and drugs have combined together to provide support through the Guard situation. Those single state agencies -- maybe in other states are doing that. I don't know.

I also have heard of a program. I think it was in Florida where they are providing so many hours of pro bono service. The President's Council on Service and Civic Participation is having a conference on pro bono service that you all might want to connect into as a way to heighten these two professions giving service to families.

MS. QUIGG: Yes. Thank you for that, because I think NPN and NASADAD have done also some great outreach efforts to help their folks better understand that they need to be at that table. Ohio Cares has been a leader. Vermont has had a fabulous program. Those two have presented nationally at several of the NASADAD and NPN venues to kind of make them more aware of what's going on. Thank you.

DR. TAFT: And then you know about the program in Wyoming that's at the air force base out there. It seems to be getting good results.

MS. QUIGG: Actually we invited Penny Norton to

present to the internal prevention and control work group at their last training last month to talk about the Warren Air Force Base experience because it did shift the culture, and we wanted them to see that they can shift the culture as well. And it was a great experience.

MS. KITTRELL: All right. Thank you so much.

Alan, you had a question?

MR. SHINN: Thank you. Just really brief. Peggy and Claudia, thank you for the presentations.

I just wondered what the effort was with our military in the Pacific region because I know we have a lot of Samoan and Micronesian troops out there. The losses have been heavy disproportionately for their populations. I wonder if you could address that.

MS. QUIGG: I think we still struggle with the same issues we do to outreach to that population as a whole. There are probably more efforts going on within the active duty components because you've got substantial active duty military components both in Hawaii and Guam and the build-up activity that's going on in Guam.

The active duty always does much better than the Guard and Reserve in terms of they are their own community. They have all the resources. That's what puts the Guard and Reserve at greater risk.

My previous experience and the work that I

continue to do particularly with the Hawaii National Guard is that they have always tapped in very well to their active duty components just because of the isolation factor, whereas that doesn't happen so much in the States. In most states, the military is a unique entity of its own and the bases are very isolated with the exception of the surrounding communities. Because of the geographic pieces of the islands, the military base is a huge part of those islands. So the Guard naturally works very much hand in glove with those active duty components much better than what we see in the States.

But I'll continue to raise that issue with the Guard.

MS. KITTRELL: Thank you.

All right. We've made these revisions to the agenda, and I hope you all are okay with it. From 11:40 till about 12:05 or 12:10-ish, around in there, we will have our roundtable discussion instead of having it this afternoon. That way you'll be able to give your input at that time.

Then from about 12:10 till about 1:05, 1:10, somewhere like that, you all will have lunch, and we changed the venue for lunch. Tia is working on that to be able to bring it back here and eat it. Then that way we can start at 1 o'clock.

Dr. Kevin Mulvey will return. He's agreed to come back after lunch. Then that way you can have your full time here to be able to do your roundtable.

Okay. We're ready for the roundtable discussion.

Thank you, Peggy and Claudia.

MS. HAYNES: It's open to the floor, council members.

MR. DeWISPELAERE: Rose, we've had a lot of discussion the last couple of days and a lot to absorb and take in. We appreciate what you guys have done to keep that moving and keep it going.

I want to encourage -- I didn't get a chance to because of the quickness to turnaround -- that as an organization we get the Reach Out Now and the Teach-In and the town hall meeting information out earlier. Groups are getting that information probably through the contractor too late, and so we're missing out across the country on a lot of organizations. Planning is essential to what we do. Please understand I'm not being critical because I think the program -- and I've been involved with Hope and others here to help move that out there. But the sooner we can get the information out, the better, and I would encourage that we do that.

MS. KITTRELL: Good. You know, one of the

things that Dennis was talking about is to develop the infrastructure internally to CSAP, the same thing that we're encouraging states and communities to do. We're trying to internalize that process ourselves, and that is, we're going to develop a calendar, a time line, if you will, of events and to build in it the time that it will take to get the information out to the communities so that we won't be sending you things at the last minute. I mean, every year we have the same thing. We know when Red Ribbon is going to occur, FASD, HIV Month, all of these things. Let's put it up on the calendar. Let's let everybody know about it ahead of time so that everybody can build it into their local calendars. So that's a good point.

MS. ARES: While we're on that initiative -- and this, again, may just be my newness. So please take that into consideration. But I know that in Illinois we had a lot of town hall meetings and some of the teach-ins. I would concur with Jay's recommendation to get that information out earlier than in the past.

And even in the presentation this morning, I didn't really see if there is a consistent or standard evaluation process for that initiative. So I guess I would recommend that we look at developing some kinds of information or resources or tools or supports that would help grantees evaluate these initiatives and tie that

evaluation to progress toward NOMs. In Illinois and I know in many other states, these National Outcome Measures are taken very, very seriously, and the states are implementing a lot of their directives to their grantees to tie into NOMs. So when you add an additional initiative that you're going to ask a state to help coordinate or a local community, at least in Illinois, to implement, the more that we can help them understand how it ties into the NOMs and give them the resources and tools that they can evaluate these efforts in relationship to that, I only think that helps present a bigger, better picture about the work that CSAP is really doing and progress toward those outcomes.

MS. KITTRELL: So noted.

MR. DeWISPELAERE: An example of that is the PRIDE conference is in April, and obviously all my staff are tied up for a couple months prior to that. Then we get the information out in March. We have 500 groups that would like to participate, but all their focus is on getting to our national event at that time. I think being more open to the timetables involved and getting the information out earlier, you will see the involvement increase dramatically.

MS. KITTRELL: Okay.

DR. TAFT: In regard to the Reach Out Now and

Teach-In, some of the schools tell me that they don't get the material in a timely manner either directly from the supplier/provider or that they don't come at all. So you might want to double check to make sure that they're still going out in a systematic way.

MS. KITTRELL: Okay. I hate Gwyn is not in here because she's our guru.

MS. GERINGER: On a different subject, one of my concerns is the size of our council. As I look at those of us around the table and the number of people actually listed, I see just from the list that we are four members short even with our new members listed. That's a concern to me because I think this is a really important thing for people in the substance abuse prevention community across the country to be part of. So I understand from what you said, Rose, that it does take a while to get through the process. We know that. So I guess maybe, hopefully, we can start earlier so that there aren't big gaps like we have right now.

One of the things that I would like to consider, given the four priorities that Dennis has, I would like to see some sort of a representative from the aging population be included as a member of the council. I know we used to have someone from the military or military/National Guard as a representative. I think that

that's important too.

I don't know how the invitations are structured in terms of are we looking for people to represent certain areas of concern that CSAP addresses or is it just kind of a shotgun approach. But having a youth representative -- and I know it's hard to define youth, but I guess I would think that in terms of someone who's college age that maybe is majoring in a field, something along the lines of what we do for our fellowship program perhaps. And then someone from justice or law enforcement I think would be appropriate.

I don't know what other people would think of in terms of the kinds of experience that would be useful on the National Advisory Council, but it seems to me that if we could get representatives from various areas of interest, it might be helpful for the council.

MS. ARES: I would also like to add that when we're looking at additional council membership, that we look at the diversity of the group. I'm not aware of anyone from the African American community serving. There has been, but I would encourage that kind of diverse representation in addition to the other areas that Sherry just mentioned.

MR. DeWISPELAERE: I know that the Administrator is looking into the youth representation on

the councils because he's asked if our organization would send some names forward, and I know he's recruiting other names throughout the country to do that. So we'll be providing them just as quickly as we can. That request was made to me. And I know he defines -- Tia, you might know more about that, but he defines youth I think that he's looking for to be hopefully college age, if I understood that correctly.

MS. HAYNES: Well, I guess 18 to 21. We would have to get more of a definition of what "youth" is defined as. But, yes, Dr. Cline did express that he wants youth on the council, as you heard from Toian Vaughn, who you met yesterday at the orientation meeting. So that's one thing that we can look into.

In terms of the balance of the council, it's such a long process. We do have four new members, but they won't be on until September the 15th. So we have four names that are on, but we can't announce their names. It's a very long process. So we have four new members. So we're looking for three more. We are only short three members.

In terms of diversity, Marcus Harvey was on the council. He was an African American male, faith-based. He recently went off. He just went off.

When you look at diversity, it doesn't go by

ethnicity. It goes by your expertise and the state that you're in. We try to look at all of it, including ethnicity, everything. So we are taking that into consideration.

When you make your recommendations, I think what we need to do is really focus -- since we have three slots, we need to look at who is represented on the council now and the three slots that will be filled, like who will be recommended because it really doesn't help if we get 20 names and then we have to narrow it down. Out of the three slots that we needed, if we could get 10 strong names that would cover the areas that we need to cover to make it a balance. I think the areas that we do want to cover are the four priorities that CSAP wants to focus on.

MS. ARES: So if anyone knows a retired chaplain who's African American, over the age of 65 --

(Laughter.)

MS. ARES: -- give their name to Tia. Right? There you go.

MR. DeWISPELAERE: And a male. Right? You did say that?

MS. HAYNES: On a serious note, there will be emails coming from me. We will be communicating in reference to this because packages take typically four to six months once a name is submitted. It takes a long time.

They have to be vetted through the White House. You know, it's a long process. So the sooner we get it done, the sooner we can replace the three slots that are left on the council. We try to keep a smooth flow.

MR. DeWISPELAERE: Along that line too, I think that as we continue to look for creative ways in the states to get the good name of SAMHSA out there, I know as a council member I'm not the most senior council member on here in terms of age, Alan. But I've been on the council a long time and I can tell you that I attend state SPF/SIG meetings. I attend other state collaborative meetings, and I not only attend in the occupation that I have, but I attend as a representative of the NAC council. I'm often asked about, everywhere I go, what CSAP or SAMHSA is doing on this issue or that issue or another issue. I think you'd be surprised, especially the new members, just how often you are asked what the direction is and what the priorities are. The more we can get that information out, I think the better position it puts SAMHSA as a whole.

DR. TAFT: Since I was not here yesterday, can you report the four areas?

MS. KITTRELL: Okay. It's youth, older population, vulnerable populations. I think he had a subset of that. Underage drinking and workforce development.

DR. TAFT: So it's really basically the tabs in the book.

MR. DeWISPELAERE: Right.

In the old days of the council, the Administrator would appoint certain members to participate in different national events around the country. Like one would be appointed to CADCA. One would be appointed to represent at NASADAD's meetings and the NPN, of course, meeting. I think that's coming up pretty soon, if I'm not mistaken.

PARTICIPANT: I'll be there.

MR. DeWISPELAERE: The PRIDE conference. Other events like that, they would appoint members to attend on behalf of the council and actually cover their cost of travel.

I would recommend, Tia and Rose, that when you go back and discuss with -- I think it would probably be inappropriate today with Dennis not here to appoint them -- that you seek out what these members are interested in and get back from them their best area of expertise.

MS. KITTRELL: Yes, most definitely.

MS. ARES: One of the things that I guess I would like to hear more about maybe at a major council meeting is the degree to which CSAP works with the U.S. Department of Education and the Safe and Drug-Free Schools

and Communities Program or any other type of prevention-related programs that might fall under its purview. We're seeing an increasing interest and a lot of strong evidence about the value of student assistance.

And given that so many prevention providers do their work in schools or with schools, it would make a lot of sense to look at models that not only help meet CSAP's priority areas but also help meet schools' academic goals. A lot of the things around school violence and mental health and even the program that Peggy was talking about earlier that the National Guard is using, these things have value. There's absolutely no doubt. But through some kind of student assistance framework or collaborative framework, I think schools and communities need help kind of making sure that they don't trip over one another and that they work together to really provide the full range of support that students and their families need.

MR. DeWISPELAERE: The Under Secretary would be a good one to invite. It's Deborah -- maybe you remember, Hope. I can't think.

DR. TAFT: Price.

MR. DeWISPELAERE: Deborah Price. To invite to the council and ask her to come, give us a report. She's a great spokesperson and would encourage more of that. I know that CSAP works with several different government

agencies. I've not seen those folks at our tables in the time that I've been involved.

DR. TAFT: In fact, there might be some way that you could get everyone that's on the Interagency Coordinating Committee on the Prevention of Underage Drinking, the ICCPUD group, to come and talk about how they're all trying to mesh their programs together.

MS. KITTRELL: Okay. Did you have something?

MR. SHINN: Yes, I just wanted to bring something up.

MS. KITTRELL: Okay.

MR. SHINN: All good stuff, Jay, especially from you. I'm impressed.

MR. DeWISPELAERE: You didn't think I could do it.

MR. SHINN: No, I didn't think you could do it at all, Jay, but you really impressed me. Thank you.

The issue of problem gambling, I guess, is something that's been coming up a lot. I just don't know where it fits. I don't want to give CSAP another issue here, but how it relates to substance abuse I think is very interesting. I think we need to look at that.

I know in many casinos and card clubs in California -- it's not legal in Hawaii, but I'm sure in other states -- a lot of Asian/Pacific Islanders frequent

those casinos and card clubs. There are projects in California, NAPAFASA, our national organization, has a contract with the California State Office of Problem Gambling to do prevention and outreach not just to Asian/Pacific Islanders but to the general population.

So I don't know if it's a cutting edge issue. It's been around for a long time, but I just want to know how we might incorporate that into our base of knowledge and connect the dots on that issue with substance abuse because I think there is one.

MR. DeWISPELAERE: I know CMHS does some things with that because we worked with them last spring on a youth problem gambling track at our event, and it was a combination of a couple of states and CMHS, as I remember it.

MS. KITTRELL: What I have done, I have taken your comments and I have put them into five categories. I want to go back over this with you because we need to reach consensus. If we're going to take something forward, I need to know this is the consensus of the council.

So the first I pretty much think we've reached consensus on, but I still want the group to let me know. As it relates to getting to materials out, Reach Out Now, the teach-ins, town hall meetings and everything, we have consensus on that. I see the heads. Okay, now, very good.

There was concern that was expressed by Sharyn concerning the advisory council, the representation. She had put forth some categories for consideration. Representation from the aging population. Are we in agreement that this should go forth? Okay.

Military/National Guard? Jay, are you with us?

MR. DeWISPELAERE: My concern is the statute is very clear about appointments. My history on this council is that we've always had good representation from almost every -- you know, I'm for it. If it's consensus, I'll go along with it. But I want to say that I think SAMHSA as a whole has done a marvelous job with that over the years, and I just think that that's important to point out here.

MS. ARES: I'm sorry. Does that mean, Jay, that you would -- I guess I'm asking for clarification -- that you would recommend that we not specify particular categories and just let them do what they think is best in identifying new members?

MR. DeWISPELAERE: I'm not sure we can. I see the general, as I call her --

(Laughter.)

MR. DeWISPELAERE: -- the nicest lady in the world, up at the microphone. Maybe she can give us some direction there.

MS. VAUGHN: With regard to the military, the

councils are to have a representative from the Veterans Administration and the Department of Defense. All the councils. We don't have them and that's on me because I need to communicate with the assistant secretaries of those agencies to have them appoint individuals. But dealing with your military issue, we'll move on that.

And I didn't hear all of your recommendations. I heard the ethnic and diversity person that you wanted. You can make the recommendations of looking at certain types of individuals. The law is very clear on the expertise that we're looking for. What we really would like are names of individuals and then looking at them within the constraints of the law and then the departmental policy, looking at diversity, the geographical issues, the gender, and all those other variables. But we really need some names that will make the process move faster.

MR. DeWISPELAERE: Toian really isn't a general. I just like to call her that.

DR. TAFT: Is there a way you could communicate with us what your parameters are for names and then we could submit names to you when we have our databases with us?

MR. DeWISPELAERE: An email reminder would be wonderful.

MS. VAUGHN: Well, the law states a national

leader. What I look for are people who are serving on national boards, who are leaders of organizations, associations. Then looking at the law itself in the behavioral and social science area, the law even talks about lawyers. But you don't have to look for a lawyer, a media person, but people from the law area, the social science area. But just people that you interact with that are national leaders in the prevention, treatment, mental health field that you have encountered through your movement through this system. You have the charter and you can look at the charter for those particular expertise, but what you're looking for are people that you feel would best represent the agency and provide advice to the center director and the Administrator, as well as the Secretary.

MS. KITTRELL: The other areas, Toian, were justice or law enforcement, college age youth representation. And Jay has already indicated that he had been approached about providing the names of some youth. So that was it.

MS. VAUGHN: So justice is in the law. It's in the legislative authority. So that takes care of your parameters, your categories. So now help the agency find the individuals that meet those criteria.

I've already spoken to Jay and he's going to search for some individuals who are young people. The

Administrator is very interested in having young people on these councils, as well as consumers, who will self-identify, who are experts in the prevention, treatment, and mental health fields.

MR. DeWISPELAERE: Oh, man, the young people that we work with in our organization have 10, 12, 15 years' experience doing this. They're probably are more experienced than most of us here. And it's not just our organization. It's the field. I know Hope knows many. They look to her leadership. There are just a ton of kids that have a tremendous amount and can talk data and can talk science-based and can talk all the strategies that you want to talk.

MS. KITTRELL: Another area -- and Jay brought this out -- had to do with creative ways to get SAMHSA's name out, and he was talking about conferences and meetings wherein the members would identify an interest, and if it was a meeting that SAMHSA would want them to represent us at, they would attend at our expense. It seems like Dennis said something about that maybe at a couple of previous meetings that he does want that type of representation.

MR. DeWISPELAERE: Right.

MS. KITTRELL: It's really incumbent upon you all to identify what you're interested in and then we can get this information in to Tia.

MR. DeWISPELAERE: Can I make a recommendation?

MS. KITTRELL: Yes.

MR. DeWISPELAERE: Could Tia send an email out to the council members on which events that SAMHSA supports and their location and when they're going to be, which will help you guys get together that national calendar that you're working on, and email that out to us for an area of interest because I can tell you right now that there are three of us sitting right here that have a strong interest and a lot of expertise on underage drinking. And there was just an underage drinking conference in Florida. Did you get to go? I didn't have the opportunity. It didn't work out. But I don't know of another member from the NAC council that got to go to that. Did you get to go, Alan? No. And that's just an example.

I think you'll get several interests from members for certain categories. The chairman appoints who goes to what. Just do it as fair as you can, and I'm sure nobody on the council is going to argue.

I think the key to that, though -- what's happened in the past with those appointments, if Sherry is appointed to the PRIDE conference and she can't make it because of her previous commitments, then that should come back to Tia for someone else to attend that will certainly represent the council.

SAMHSA supports some pretty cool initiatives out there, and it's neat to watch that happen.

DR. TAFT: And then, Jay, did they have any official role in the conference, or did they just kind of wander around with a name badge?

MR. DeWISPELAERE: Well, I could tell you at our event they had official roles. I can't say what happened at others, but I can only imagine that if council members went to CADCA -- I think I was one of the appointed members there -- General Dean introduced them. And they had a number of folks come up to them -- I know I did -- asking questions about the council. That's another good way to look for people from the field to help serve on the council down the road.

I know NASADAD has two events, the NPN and the state one, and they're usually always around the same time. Is that correct? I myself would love to serve on that one, but I think you need to put them out fairly.

DR. TAFT: I'll be at the NPN one in Oregon for a short period of time, if you want to put me down for that one.

MS. KITTRELL: I gather from various ones that you want some more information about the collaborative work that we're doing with the Department of Education to look at some educational models, perhaps some of the models that

they have, as well as what we have in NREPP. You wanted to invite someone named Price?

MR. DeWISPELAERE: That's Under Secretary Deborah Price, the Safe and Drug-Free Schools Program.

MS. KITTRELL: And someone from the ICCPUD, underage drinking group. So we'll see if we cannot contact them and see who would be available to come.

DR. TAFT: Steve Wing is the chair of the ICCPUD group, and it might be nice for this council to learn all the prevention activities that are going on throughout the federal government and how they relate to what CSAP is doing or the overall picture.

MS. KITTRELL: Yes. Steve will be more than willing to come.

And then also more information about problem gambling and a nexus with substance abuse prevention. You said at CMHS, they have been doing something in this arena as it relates to mental health. We could certainly have them to come, and if you have a speaker that you would want to hear from, you could certainly send that person's name in.

MR. SHINN: There was a John Vierras from Illinois who is working on that, and actually John is from Hawaii. I missed his presentation because I'm here. But he was in Hawaii just presenting on that just last week.

MR. DeWISPELAERE: There's a national organization for problem gamblers right here in the Rockville area that works with a number of the states. I have that information back in the office. I'd be glad to send you that. I just don't have it with me.

MS. KITTRELL: Okay.

Did we get consensus on that as well?

MR. DeWISPELAERE: Sure.

MS. KITTRELL: Okay, then. Well, I think I've covered all your issues.

MS. HAYNES: One more thing. One last thing just to clarify something. This is on the attendance of meetings. What I'll do is -- and let's put this on the table. I can't send you a list of things that will come up. As things come up, I'll develop a letter and send it out and ask you. I know that you're interested in this issue if it's a meeting on underage drinking. And in your return, let me know if you're interested in going. The purpose of you attending the meeting is, one, to follow up on something that Dennis is interested in or the Administrator. So if you'd attend, then you would have to report back to the council. So you'll come back and give us a briefing.

Toian, is that clear?

MS. VAUGHN: Yes.

MS. HAYNES: So just to clarify that.

MS. GERINGER: We're not going on a vacation. We're going there to work.

MS. HAYNES: Right. So we're in agreement to move forward.

MS. KITTRELL: Is there anything else?

(No response.)

MS. KITTRELL: If not, we'll go ahead and take a break for lunch and we'll get back at 1 o'clock. Thank you.

(Whereupon, at 12:18 p.m., the meeting was recessed for lunch, to reconvene at 1:00 p.m.)

AFTERNOON SESSION (1:25 p.m.)

MS. KITTRELL: We're going to go ahead and get started and we're going to start with the data strategy with Dr. Kevin Mulvey.

MR. MULVEY: Good afternoon.

MS. KITTRELL: Good afternoon.

MR. MULVEY: As you know, data strategy has been an activity in SAMHSA for a couple of years now, and it was revitalized, if you will, and a new group got together about six to eight months ago from each of the centers and pulled all the previous material together. To try to cull it down into about a 20 to 25-page document was the goal.

You have the data strategy as it currently exists in your notebook. Just briefly, I'd just like to say there are essentially three goals the way the data strategy is laid out: a goal of looking at national information including incidence and prevalence, a goal of looking at performance information, and a goal of promoting the electronic health records and health information technology. The rest of the data strategy essentially walks you, as you read it, through each of those goals in terms of the objectives that were set for those goals, current progress having been made or underway on those goals, and then future activities for those goals.

It went out for review for a variety of folks,

and we're currently reviewing the responses or the comments that we received. In fact, the comments that I reviewed were all positive. There were some specific questions about some elements, about whether or not we'd be collecting and looking at those elements. Currently what's under process is again that clearance process in SAMHSA to address the comments, create a document that shows that the document addressed those comments, and then to create a two-year action plan that would bring to life milestones and markers based on those activities listed within the document.

So I was asked by Admiral Broderick to thank you all for commenting, that the comment period is currently closed, that we're currently addressing the comments that were received, and that we will have a final document, the expectation is I believe, by the end of next month.

The two-year action plan, once developed, will be shared again with each of the centers. It's a very center-driven, office-driven activity. Hopefully by the time that you all meet again, we'll have the cleared version and we'll have the two-year action plan, which you would have had time to take a look at and provide input.

That's the update on where we are with this current version of the data strategy. It very much is in

line with, if you've read it, the strategic plan of SAMHSA, which is in line with, obviously, the HHS strategic plan.

DR. TAFT: Judging from the second paragraph under 1.0, I am assuming that there's no statutory mandate to provide national data on mental health and substance abuse prevention services?

MR. MULVEY: There are statutory requirements to collect depending upon how the program was funded. So, for example, PRNS activities, Programs of Regional and National Significance, might have specific data collection and reporting requirements for prevention activities such as the MAI program you heard about before lunch, the methamphetamine program that you heard about. There's a report to Congress that's due as a result of that. So there are certain programs that are funded with certain legislative mandates that prescribe the report to Congress.

DR. TAFT: And this is just for SAMHSA programs. You're talking about the Household Survey or are you talking about other kind of surveys that you do?

MR. MULVEY: This is in fact for SAMHSA. What we're planning to do is you'll notice under the performance measurement activity, which is where each of the three centers are focusing on right now with GPRA, the Government Performance and Results Act, and PART, the Program Assessment Rating Tool -- under goal 1, we're expecting for

prevention specifically to begin looking at developing a prevention survey similar to the inventory of treatment and mental health services facility survey and then to create a framework for collecting that information. That was one of the major outputs that would affect prevention activities.

MR. SHINN: Hi, Kevin.

MR. MULVEY: Hi.

MR. SHINN: How are you?

MR. MULVEY: Good.

MR. SHINN: Again, just about data and the need for disaggregated data especially among Asian/Pacific Islanders, I know I'm going down to the very narrow, but I think within the data sets, there needs to be that breakout. It's not useful for us in the Asian/Pacific Islander community unless we have some disaggregated data on ethnicity and the use rates and all for different groups. That would be most helpful. It's not a new issue, as you know. I just want to know how we are doing on advancing that issue.

MR. MULVEY: What SAMHSA has done is put into place a process whereby specialized reports get generated or can get generated, and one of those specialized reports might be looking at subpopulations such as African Americans or Asian/Pacific Islanders, et cetera, across all the data sets that we have access to. The Office of

Applied Studies, through Beatrice Rouse, is primarily responsible for the special reports and those types of publications. So we're moving towards the direction of having subpopulation type reports out.

Thank you. I apologize, but I have to now go to another meeting.

MS. KITTRELL: Thank you so much, Kevin, for your patience.

MR. MULVEY: Sure. You're welcome.

MS. KITTRELL: Our next presenter is Ms. Jennifer Solomon, and she's a public health analyst. Jennifer is very passionate about her work. She's going to share with us information on the older adults.

MR. DeWISPELAERE: Madam Chairman, can I make a comment before she starts?

MS. KITTRELL: Yes.

MR. DeWISPELAERE: The gal leaving, Beatrice, with Kevin's shop --

MS. KITTRELL: She stopped.

MR. DeWISPELAERE: You can go ahead and leave. We're just going to talk about you. You've got another meeting to go to. She's the one that sends us out information. I know I've found that very helpful and I get a chance in a less rushed atmosphere to read that. We appreciate getting that information from her on the updates

on the data collection. Thank you.

MS. KITTRELL: Excellent.

Go ahead, Jennifer.

MS. SOLOMON: The presentation objectives for this afternoon are to discuss the demographic imperative, share CSAP's Older Americans Technical Assistance Center experience using the strengths, weaknesses, opportunities, and threats assessment with Louisiana and Mississippi around emergency disaster planning for older adults.

This is about our third meeting. This is the first one we had around disaster planning. We had with the Asian/Pacific Islands last fall. We've worked with Ohio, Maryland, and Connecticut, and we're working our way across the country. We've been taking them in groups of twos and threes.

And we're going to discuss the Get Connected! Toolkit, which is here. I'll leave this in the back of the room so if you'd like to look at it after. It's available in our clearing house, and it's free and you can order multiple kits. But I just wanted to bring this to show you, and we'll also discuss it within the presentation.

The demographic imperative. Thirteen percent of the U.S. population is 65 and older and expected to increase to up to 20 percent by 2030. Eighty-three million baby boomers born from 1946 to 1964 were counted in the

U.S. Census of 2000, and 78 million baby boomers turned 65 turned in January 2006. So we're really seeing a real increase in the older adult population. I'm sure you've been seeing it now, especially on TV in terms of commercial ads. AARP has also lowered their age range to 50. So you're really starting to see a change in how America is looking at what we call the graying of the population.

There's an enormous pressure on retirement systems, health care facilities, and other services. What we're seeing now in the workforce is that people are retiring. They're coming back. Some are staying retired. Some are taking part-time jobs. So there's a real difference in people just going out and retiring. Some are getting second careers. Some are moving into the volunteer area.

Major implications for substance abuse and mental health on prevention and treatment. So what's happening is now as people are getting older, there are more chronic conditions. People who have been drinking their whole life went through body changes. You're seeing that alcohol -- especially women are staying intoxicated longer. So what you're seeing is more medications being taken, differences in health conditions, and more medication and alcohol staying in the body longer.

An estimated 1 in 5 older Americans, 19

percent, may be affected by combined difficulties with alcohol and medication. The number one abused substance in older adults is still tobacco. While the rates do go down now for older adults, the baby boom generation is going to be changing that. So you're going to see what now are lower rates going up. There's also more of an acceptance of marijuana, alcohol, medications in the baby boom generation versus this cohort of older adults.

MR. DeWISPELAERE: Can you identify the age of which you're talking?

MS. SOLOMON: Yes. It depends on who you're talking about. Still, it's 65. We've dropped it down to 55. AARP is setting new standards now for 50. So you're really getting almost like a 30- to 40-year group of older adults which are being broken out into separate cohorts of 10 years at a time. They dropped it down to 55 to capture the baby boomers. Sixty-five is still Social Security. That will be changing. It will be up to 72. The age rate for women is up to the middle 70s. For men to pass away is in the lower 70s. So you're really seeing a change in those. The laws just have not caught up with the system, but they will be changing.

In 2004, CSAP created the Substance Abuse and Mental Health Older Americans Technical Assistance Center. The center is an experimental center. There is no

substance abuse prevention field for older adults. There is no coordinated effort across the country. This center is set up to find out what states are doing, to look at information through data, to find out where the gaps are, where people are making progress. So the overarching goal is to create sustainable changes in the field of geriatrics around substance abuse and mental health so that these issues are recognized and planned for.

There's a lot of retrofitting within states. They'll come up with a plan and then they'll say, oh, yes, but the older adults. They'll try to retrofit them into a use system.

Older adults have very different needs than younger children. They found that through the Hanley Center in West Palm Beach. They tried putting them in the same treatment center, and they had to divide them out. Older adults in treatment will tend to parent the younger cohort.

Also with prevention, they found out when you give prevention messages to older adults, they will actually listen and change their behavior. So prevention really does work for this group.

The Older Americans TA Center priorities. Technical assistance with respect to prevention and early intervention of substance abuse, medication misuse and

abuse. It's not just substance abuse. It's misuse. There's a whole lot of misuse going on with older adults. They can't read the medication bottle. They don't understand what they're taking. They're taking multiple medications that look alike. They don't know what a standardized drink is. Since the drink level goes down, NIAAA has set out guidelines for what a standard drink is, and it's a neat kind of experiment to do to find out what people think a standard drink is. It's kind of like the Weight Watchers and what a serving size is. It's really interesting to see what people think.

Co-occurring. We do not go into serious mental illness. We only go as far as anxiety and depression. As I was saying before, it's very interesting. The new Medicare laws do not cover anxiety medication, only medication for depression. One thing older adults have is anxiety. So it's very interesting to see. It was written into the legislation. So it's not covered.

As I spoke before, state planning with Louisiana and Mississippi. Louisiana had a state planning meeting in Louisiana on May 17th and May 18th. We partnered with the Center for Mental Health Services and their Crisis Counseling Peer Program. We took on the second day and a half of the meeting, and the Older Americans Technical Assistance Center used the strengths,

weaknesses, and opportunities and threats assessment. Are you aware of -- basically it states what you have, what you don't have, where do you need to go. We found that tool to be the best tool for working with this group, especially with state and community and health and social service providers. It provided a way of getting to information that we could formulate and give back in a reporting format.

So we gathered the information using conference calls, and we really wanted people to talk between state and community leaders and the stakeholders. What we're really finding is once people get in a room and start discussing, they really are starting to pair off. We saw that in Connecticut and we saw that in Ohio, that they're really starting to pair off and they start working together and they start linking.

We did more than 20 conference calls. We made an integrated report from the responses, and we reported back on that day. Then we did breakout groups so they could further discuss what we found in the reports.

What we found from the strengths was the Division of Aging is the centralized state contact for aging services and the Area Agencies on Aging, which are run by the Administration on Aging, provide a majority of the services. In the makeup of the Area Agencies on Aging,

they have 44,000 people across the country, health and social service providers and different types of community providers. So they're a real strong network for us to get the information out.

Project Recovery is in Louisiana and they provide services through 15 individuals who are familiar with older adults' needs and resources. What we are finding is that there are teams approaches, especially Louisiana and Mississippi, especially after Hurricanes Katrina and Rita, and older adults are one of the best resources. They tend to rally around each other and they tend to volunteer.

Gaps. Need to conduct more outreach to older adults regarding substance abuse and mental health issues. Trauma causes increase in medication and alcohol use. There was a lot of displacement.

Lack of screening tools for substance abuse and mental health for older adults. There's the CAGE and the Michigan Alcohol Screening Test, which are contained in this kit. But a lot of the screening tools are not tailored for older adults.

The need for home-delivered meals, transportation, and socialization services are very important. There's a huge isolation factor with older adults, especially people who are 80 and over, and it's

even worse now in places like -- if you go to New Orleans, they're not staffed. Some have left and there's just not a lot of staff and a lot of people have been displaced and moved around the country.

The need for a statewide needs assessment focusing on state agency resources for older adults especially around substance abuse and mental health. They get a good picture in their SWOT assessment when we give the report back. They end up seeing a really good picture of what their state looks like.

And there's a lack of dedicated full-time staff to address older adult issues. Also, we checked. Only about 3 percent of medical schools had any kind of geriatric-specific training program. So there are really a lot of professionals that do not have any training even like you would take the extra credit, you know, continuing education credits that specifically are targeted for older adults.

Opportunities. State agencies have the opportunity to partner on grant applications. There's an environment of mentorship and training exists due to varying levels of staff experience. They build on stronger relationships between state agencies and the participation on state work groups, epidemiology and advisory groups, to provide a platform to launch an assessment for state agency

resources aimed at older adults.

This is the Get Connected! Toolkit. We worked with the National Council on Aging to develop this toolkit, and it's targeted organizations that provide services to older adults. It provides materials necessary for training staff who work for older adults.

The Get Connected! Toolkit helps aging services providers learn how to incorporate substance abuse and mental health issues into their ongoing health promotion and health education activities.

How to identify and partner with local substance abuse and mental health organizations. There's actually a resource matrix in here that we've been finding very helpful about connecting with substance abuse and mental health, what you have, where do you need to go, what type of professionals you have within your own organization, and who you can link with, and it's contained in the notebook. The notebook is also contained online. So if you just wanted to download the notebook, you could go and download just the pieces.

Collaborating with NCOA to provide the Get Connected! Toolkit training. We held a training in Boston, Washington, D.C., Orlando, Baltimore, Birmingham, Lexington, and West Palm Beach. We've had a wide range of audience service providers from mental health and substance

abuse, aging nutritionists -- actually that's a very interesting group to provide this training to -- public health officials, and state program administrators. State program administrators have taken this and actually have had statewide trainings.

Here's one. The State of Washington held a training for 150 clinicians and paraprofessionals in the fall of 2005 and administrators from mental health and substance abuse and the aging fields in Seattle and Spokane. The technical assistance center, along with the National Council on Aging, did about 75 people per day and a two-pronged training approach addressing health literacy, which is a very big component of this, and behavioral health resources.

Then we have a new level on the training called Increasing Provider Comfort. That's actually a training which teaches you and that talks about doing activities like how much alcohol an older person should have. It includes how to read labels, what older adults actually see. Do you know what the labels actually mean? So it's a very good partner to this training.

I guess that would be it.

MR. DeWISPELAERE: Can I ask you a question?

MS. SOLOMON: Sure.

MR. DeWISPELAERE: The Get Connected! thing.

Can I get you to send me one of them?

MS. SOLOMON: Sure.

MR. DeWISPELAERE: I'd take it today, but --

MS. SOLOMON: I have extra copies upstairs.

MR. DeWISPELAERE: -- I would have to haul it on the airplane. I would appreciate it.

MS. SOLOMON: Yes. I'll get your address from Tia and we can put some in the mail to you.

MR. DeWISPELAERE: A lot of the coalitions that we talk to -- as a matter of fact, I'm serving on a statewide committee and a local committee on services to older adults.

MS. SOLOMON: Oh, great.

MR. DeWISPELAERE: There's very little data in the state that I'm from in regards to that, and what I'm hearing, there's very little data --

MS. SOLOMON: There is.

MR. DeWISPELAERE: -- across the country. As coalitions struggle to work on different issues within the community and there's a lot of attention on it, very little is known about it. We appreciate what you're doing.

MS. SOLOMON: Thank you.

On the SAMHSA website, if you go down on the left side, there's a section that says "older Americans" under the matrix. You can click on that and there are

policy documents on older adults that talk about the state of the knowledge. So there are different pieces. But we can also get you some kits as well.

MR. DeWISPELAERE: Good. Appreciate that.

MS. KITTRELL: Tia brought it to my attention that it would be good if we could have some kits for all of the members.

MS. SOLOMON: Okay.

MS. ARES: I just have one question. To what degree are pharmacists engaged in this initiative?

MS. SOLOMON: For the Increasing Provider Comfort, pharmacists were involved in developing the training for the professionals. Actually CVS was involved in providing labels, what the labels look like. On the side of the older bottles, you would see those little strips, and they would have a picture on them. So we involved them in the Increasing Provider Comfort to make sure that we had gotten the appropriate information to them that they would understand.

Now, for doctors it's a little bit different. We have a scientific team, Dr. Blow and Dr. Bertells, and they have helped us with more of the academic side. Not everybody is involved in every piece, but for the specific audience we're trying to target, we've brought in the appropriate expertise to help us along with that.

MS. KITTRELL: Thank you, Jennifer.

At this time I'd like to introduce Ms. Nel Nadal. She is a public health analyst in the Division of Systems Development. She will present on the workforce development plan that we're putting together and talk about our collaboration with CMHS. Nel?

MS. NADAL: Good afternoon. Glad you all are still here and hanging in.

MR. DeWISPELAERE: Some of us stayed.

MS. NADAL: In our time together, I just want to go ahead and share some information about SAMHSA's workforce development initiative which is a matrix priority. Then we'll go over some of the specific activities that CSAP is implementing.

The action plan that I think is yet to be posted on the SAMHSA website -- its basic purpose is that across all of SAMHSA, looking at all the key issues within both the substance abuse prevention and treatment fields, as well as mental health, as to what are the things we need to do in terms of bolstering our workforce and also retention and recruitment. These are issues that pretty much cut across the entire country regardless of field.

Also for the SAMHSA action plan, the matrix is actually currently headed up by the center director for CMHS and the Special Advisor to the Administrator. So that

would be Beverly Watts Davis and Kathryn Power.

The challenges. SAMHSA has identified four major program challenges. The first one, basically we need more people to do the work that you need to do in the fields of prevention and treatment, as well as mental health, and we need to ensure that all areas of the country have the expertise accessible to them. Obviously, you have the transitions between rural and urban and even within urban settings, you may not necessarily have the kinds of resources you need to go ahead and implement those kinds of activities.

The diversity and cultural expertise. It's nothing new. It's meeting people where they are. Do you have the staff that know how to do what they need to do with the various audiences, whether you're talking age, you're talking different kinds of geographic communities, SES, you're talking about working with military populations? Are our folks not necessarily going to become experts in knowing every kind of culture there is, but are they good at going ahead and working with the populations that they're working with so that they learn about what it is to implement things appropriately? Because you can't be an expert in everything, but there are ways that you can talk to everyone and be able to work with them.

Education and training. Everybody strives to

keep their workforce up to date with the latest research, but all of us here, whether you're at the community level, state level, or whatever, it's difficult to go ahead and keep up. Even if you do keep up, how do you necessarily bring it to the application side? So these are things that will be ongoing. So SAMHSA is working on trying to go ahead and strengthen as many of the channels that we can possibly affect to improve some of those systems.

Then the consistent and high-quality implementation. How do you we know we're doing a good job as prevention folks? It's basically what it comes down to. We know things differ across states. That's not necessarily bad or good, but to the extent that we can go ahead and bring everybody's capabilities up to a higher level in using the things that we know in terms of the evidence base, that's what we're shooting for.

In terms of performance measures, there is a web portal that is under construction. So one of the things, once that is fully developed, is having that as a major tool for states to go ahead and use and bring to all of their planning processes and to the extent too that national organizations can make use of it or even just individuals in finding resources for their own continuing education, hopefully that will be kind of like the one-stop shop.

In terms of other performance measures, the idea is that it's not just the professionals. You have a lot of paraprofessionals. You have a lot of consumers. How do we go ahead and provide opportunities for training or whatever level of involvement people want to be involved with prevention? How can we bring them in and then how do we track that to the extent we can?

In terms of SAMHSA's workforce development activities, the cartoon there -- you can't really see the team work picture there, but the idea would be Dr. Cline wants to make sure that all the centers are working together. It's not that the centers don't try to do that, but he's emphasized that piece. Pretty much in looking at this particular picture, we decided that prevention is kind of the foundation. So that would be the dog on the bottom, that you really build on prevention and kind of move up from there.

So it's a broader focus than what the centers have traditionally done because there's a lot of individual work that each of the centers has pursued. What we're doing through a single contract is working so that we've got a more comprehensive approach and we don't just have parallel efforts going on. So it's beyond just communicating that we actually struggle through trying to figure out what each of these tasks are and applying them

to each of the centers, but making sure that it really represents behavioral health.

In terms of those first three activities, it's kind of the basics, what's out there in terms of the inventory, what are people doing for recruitment and retention, dissemination, training, education. What are different groups doing? How do they tell how their workforce is doing in terms of strengths, gaps, weaknesses?

And then the behavioral health core competency development. Going across all the centers, what core competencies currently exist? So in doing a needs assessment, sort of an environmental scan, the contractor is collecting on SAMHSA's behalf a number of different competency sets. Then from that compendium, what we hope to do is to have a single set that would be broad enough to cover all three of the centers.

Then the other activities that are also covered in sort of the global thing is looking at accreditation and credentialing. So we're looking at all of the different standards that all the different accreditation and credentialing bodies have, and for prevention, a lot of it is the ICRC. The idea there is that understanding what from those can we draw when we do our core competencies and then figure out how do we promote the adoption and implementation of the standards.

And then as I mentioned before, the website is under development.

In terms of CSAP specifically, workforce development pretty much is integrated across CSAP whether it's called that or not because it's integral to all the work that's going on with our discretionary grant programs and technical assistance and training. The bullets that are up here really are just highlighted because they're more intensive workforce development efforts. I'm not entirely sure all the staff are here, but the folks who have been working on the Learning Communities are Alaina Harris and Erica Pearson. Erica Pearson actually is going to be leaving us shortly to go to the Bureau of Health Professions at HRSA. So we'll still have a connection in terms of that cross agency working together since the training issue is a big deal over there.

Prevention Fellows. Daniel Bailey is the project officer for that, and Nancy Kennedy is working with him as well. Mary Joyce Pruden is my CSAP co-lead for workforce development, and so she's working with me initially on our prevention core competencies, as well as the Prevention Leadership Academy.

Very briefly I will go through kind of what these all are.

The CSAP Learning Communities. It's basically

CSAP walking the talk. It's like integrating educational experiences across the divisions, theory and practice. It's basically self-directed, self-organized, and Alaina and Erica have done a really nice job in piloting these different learning communities around the SPF. So looking at how can we do a better job of delivering effective TA. So you're looking at problem solving from a systems perspective, examining how do you deliver TA. So they're using case studies and simulations to have staff practice. It's not like everybody knows how to do these different kinds of things, and it's not that it's foreign to any of them. But the more you can interact with your other colleagues, I think you end up being a little bit stronger in your delivery.

Ultimately too, for those folks that want to pursue it in doing the learning communities and some of the other continuing education work, folks would be eligible for prevention certification.

Prevention Fellows Program. It's a three-year program basically promoting the SPF as a mechanism for delivering evidence-based substance abuse prevention. There are currently 36 fellows. It's currently in its second year. Awards are made of up to $35,000 being available to each state. The District of Columbia has a fellow, as well as CADCA and NASADAD.

MR. DeWISPELAERE: How did they get one and we didn't? Go ahead.

MS. NADAL: Another piece that I didn't list on this one was the Prevention Leadership Academy, and Mary Joyce has worked on that. It's an annual event that we do with the state prevention coordinators, and it really is to emphasize the leadership roles that states have in the prevention field. And ultimately through that annual event and other things that go on during the year, it's to really sustain a core of state leaders who can build effective state prevention systems.

The prevention core competencies. There's been a lot of work done within the field, and what we held at the end of June was a meeting of various state representatives. Alan Moghul from NASADAD was there. The idea was to come to some consensus at least on an initial set of core competencies which we're then going to go ahead and vet through the field just to establish some kind of baseline, and from there, we'll go further in terms of working with the field in terms of promotion and adoption of those.

Kind of that old team work thing. It's government. It isn't limited to government. There's a lot of times when you're working really closely with folks, and sometimes you can still end up in two different places. So

the whole idea with workforce development is that we're not trying to go there, and I think, because of the integration and the emphasis that the Administrator has put in doing this particular activity, that we're in pretty good shape.

And it's the end of the day. I'll give you something positive to look at.

MS. ARES: I have one question.

MS. NADAL: Yes.

MS. ARES: On the prevention core competencies, I know that you mentioned earlier ICRC. Have you looked at their competencies? Because I think they've kind of organized them into a domain.

MS. NADAL: We have.

MS. ARES: They have knowledge, skills and attitude sets under each one of those things.

MS. NADAL: We have, and basically we were also drawing upon work that's been done by California, Washington State, and we had somebody from ICRC involved with us, as well as some folks from Drug-Free Community coalitions. So we're not quite at the point where we need to actually negotiate all of these because part of the challenge is that everybody looks at it slightly differently and there isn't necessarily one answer for all of this. But we want to come to something that people are comfortable with, that they can work with, and hopefully

then do whatever they need to do, if they need to develop it further, to make it match up more so with their state or community.

MS. ARES: Have you seen a great variance across these groups?

MS. NADAL: No. There's a lot of similarities.

MS. ARES: Well, that's good to hear.

MS. NADAL: And it's terminology and it's the way that people choose to define things.

MS. ARES: Wordsmithing.

MS. NADAL: That's the big one that has held some of this discussion ongoing I think. So we're going to put something out. Hopefully it's something that folks can work with and kind of let them take it from there because it won't be prescriptive.

MS. ARES: I wish you the best in that endeavor because I know prevention people love to wordsmith. Or is it wordsmith? I've heard it both ways.

MS. NADAL: See. There you go.

MS. KITTRELL: Are there any other questions or comments? Alan?

MR. SHINN: Aloha, Nel. How are you?

MS. NADAL: Pretty well.

MR. SHINN: I was just wondering do you think CSAP will ever get to the point where -- CMHS has actually

implemented curriculum training for language and ethnic minority populations with mental health professionals. Do you think we'll get to that point with our prevention?

MS. NADAL: I don't know. I'd look to the senior staff in terms of where our budget planning is. I think it's one of those that if it was an important one for the field and you could make the case for it because it's always going to be an issue of sort of carving out the dollars for specific groups. If it makes sense, if it's something that we could pursue perhaps with other interagency type arrangements, just because HRSA has a large amount of money put into that kind of work and the Congress tends to look to them as the primary delivery system for training.

So it's something that I think SAMHSA leadership has taken a look at and we're not quite sure yet what direction we're going to go in terms of all of the interagency options that they can pursue. But we would definitely be behind having things that would support additional resources.

MR. SHINN: The other question is Hawaii -- you know, we have our SPF/SIG, and we're looking for an epi person. Are you willing to come to Hawaii?

MS. NADAL: I think we've made sure to go ahead and advertise all those jobs for you.

MR. SHINN: Can I recruit? No? We'll buy you a plate lunch every day. How's that?

MS. KITTRELL: Thank you very much, Nel. Oh, there was another one?

DR. TAFT: I was intrigued by your Prevention Leadership Academy, your one-day training. Could you go into a little more detail on that?

MS. NADAL: Is Mary Joyce here?

MS. KITTRELL: Yes.

MS. NADAL: Mary Joyce, you have to talk about details for the Prevention Leadership Academy.

MS. PRUDEN: We started it about three years ago. We've had three annual events, and we will begin planning the fourth one at the NPN conference. This is for NPN specifically. Many other people want to come to it, but this is really to develop our prevention contacts and who we see as a state prevention person in a state, as the lead prevention person in the state, so that we can help foster their leadership and hopefully have some sustainability too with some of the leaders.

We work in partnership with the NPN with the Executive Committee and also the Workforce Development Committee of the NPN. Last year they helped to choose -- they were even on some of our telephone calls when we interviewed some of the trainers. So they have a huge role

in this.

So what are some other things you might want to know about it?

DR. TAFT: What kind of things do you touch on when you're with them that day?

MS. PRUDEN: Okay. Well, each year they decide what they want to do. The first year we ended up with various people talking about various topics, and that didn't go over as well. They wanted one subject more in depth. So the second year we decided to look at leadership models, and we had Cambridge, Harvard University come and present adaptive leadership. So we got an orientation about that was about. Also, there was a lot of group process.

When we do this training and we look at this, we look at two things, and we want to strengthen the NPNs individually for each state. We also look at the NPN association and try to help them strengthen themselves. We want to make prevention more visible. You know how we're always kind of the last person that they think about when it comes to budgets, the first person that they think about when it comes to cuts. So we want to try to make the value of prevention so people can see that, and that's probably the underlying purpose of one of them.

DR. TAFT: Thank you.

MS. PRUDEN: You're welcome.

MS. KITTRELL: Thanks for coming down, Mary Joyce.

Any other comments, questions?

(No response.)

MS. KITTRELL: If not, I will open up the floor for public comment. Do you we have anyone from the public that wants to make a comment? Okay, Alan.

DR. MOGHUL: I bring you greetings from my association, which is the National Association of State Alcohol and Drug Abuse Directors, NASADAD, as well as its affiliate, National Prevention Network. My name is Alan Moghul, and I serve as the Chief of Prevention there.

In short, our association is very, very happy to be a partner in many of these activities that we talked about today. I just want to zero in on one particular topic that was talked about this morning and basically just give you accolades from our association.

In the SPF/SIG program, Director O'Meara was asked earlier will there be a SPF/SIG in every state, and of course, the answer is we don't know. I mean, if money were endless, sure. But we were able to prevent a situation of haves and have nots. There are about 30-some SPF/SIG states, but those that don't have the cooperative agreement right now -- you guys were able to put together

epidemiological work groups, and that proved to be very, very helpful. It leveled the playing field and allowed states to really do an effective needs assessment and capacity assessment and so on and start to move ahead on their own strategic prevention framework outside the actual SPF/SIG. So we just wanted to say thanks for that.

If the budget does prove to be very, very tight, again, we would hope that you'd continue to look into that model. Thank you.

MS. KITTRELL: Thank you, Alan.

Is there anyone else?

MR. BAILEY: I'm the project officer for the Prevention Fellowship Program, and Alan actually has a fellow working in your office right now. So just to give a little bit more visibility -- and I heard the question you mentioned earlier. Why doesn't my state have a fellow? Well, your state can have a fellow. We are looking. We're going to have a recruiting process the end of the year, and what we're trying to do is hit a lot of these conventions, letting the states know that this is free money basically. You don't have to pay the salaries of $35,000 a year in which you're able to use a fellow working in your state prevention office.

MR. DeWISPELAERE: That's more money than I get.

(Laughter.)

MR. BAILEY: Part of the reason why we wanted to have a flat fee of $35,000 is because basically, depending on what area it would be and so forth. But I thought also it would be a great opportunity for you to recruit because actually what we do is that we actually fund the $35,000, but you are the ones who are actually selecting the fellows. We don't actually select the fellows. So it gives you an opportunity to see -- if you want someone who has a strong epi background, it allows you the opportunity to say, well, you can come through this Prevention Fellowship Program that we have here.

MR. DeWISPELAERE: Sure.

MR. BAILEY: It's a three-year program. The first year, they go with the SPF model and they learn about the different steps, what it entails. So even with states that don't have SPF funding, it's a great opportunity to have a person understand how the system works, and it brings an asset into your state.

The second year, they go into a more concentrated area depending on what their interests are. Maybe it would be social marketing or epi work or substance abuse across the life span. They get to choose what they want, and then they'll get additional training in that area.

Then the third year, we're pretty much hands-off. We provide funding for them to present, write a paper, or to evolve what they've learned in the program in their state. So we're really trying to give back to the states and say here's an asset that you can use in the state and also work in the state as a future employee.

So we're really trying to use this opportunity to get these fellows out here, give them a chance to work in the field in a strong, supportive network, and meeting a lot of these goals that Nel talked about in the workforce development plan. We're trying to create resources. As you know, the federal government and also the field is going to have a brain drain, and this is very important that we support this program as much as possible because this is the way we can.

Also, another thing. They're all getting ICRC certification, and hopefully by the end of the three years, you'll have not only a person that worked in your state, but also a person that's certified to do the work and has had training and support in all portions of their development.

So I just wanted to mention that before you all got a chance to walk away.

MR. DeWISPELAERE: My question was a little more selfish than that being that NASADAD and CADCA are

national organizations and the organization I work with is too. That's why I asked. But trust me, I'll be seeing you before the meeting is done.

(Laughter.)

MS. KITTRELL: Thank you, Daniel.

You know what I'd like to do, because we have a little bit more time. I see CSAP staff. I see some of our interns out there. If you could just stand up briefly and say who you are and where you're working, if there's any special project that you're on, just quickly. Daniel told you the project that he's working with, the Prevention Fellows. And you met Peggy. Andrea?

MS. KAMARGO: I'm Andrea Kamargo and I work for Peggy Thompson in OPAC. I work on the RFAs, as well as Healthy People 2010 and soon to be 2020, and a variety of other ad hoc projects and work groups and committees and things like that. Nice to meet you all.

MS. KITTRELL: And could you come right on up behind Ron?

MR. ARMSTRONG: I'm Ron Armstrong from the Division of Workplace Programs, and I do policy oversight of the federal Drug-Free Workplace Programs in all the federal agencies. So it's about 120 federal agencies. And along with that, I do a lot of policy work with the Office of National Drug Control Policy, and we get our legal

opinions and a lot of coordination back and forth with the Department of Justice.

MS. KITTRELL: Thank you.

Nancy?

MS. KENNEDY: Hi. I'm Nancy Kennedy and I work in the Division of Systems Development. I've been in behavioral health for 35 years. I'm looking forward to retiring in two and a half years, and therefore, I'm trying to be in the background and let young people like Daniel and David Wilson and others step up to the plate as they do so well. Thank you.

MS. KITTRELL: Deborah?

MS. GALVIN: I'm Deborah Galvin. I'm in the Division of Workplace Programs. I have several interesting programs that I think are important. One is the Young Adults in the Workplace where we are trying to figure out the best ways of integrating young people into our workplace. As Jennifer shared, so many people are leaving, and we have a great influx of young people now. We're not sure our programs in the workplace work for these young people. So this grant program is looking at that.

We also have a workplace website, and on that website, we're having very shortly a brand new workplace kit that will be coming out. That will be for small businesses and large businesses across the country with how

to do a Drug-Free Workplace program.

We're also going to parallel that kit and have a health and wellness kit, and that is for places that may not like terminology like "drugs." It will be almost the same kit, but its focus is on health and wellness. What we found out in our Workplace Managed Care Program is that when you put substance abuse prevention within health and wellness, you have a very successful substance abuse prevention opportunity, as well as the health and wellness message still gets across.

In that vein, the last thing I work on is I'm responsible for our getfit@samhsa.gov, which is a health and wellness interactive website that can be adapted by communities, schools, workplaces. You put your own name in it. You put your own health care plan in it, and it provides government-oriented health and wellness information that can be counted on.

Thank you. I'm sorry I took so much time.

MS. KITTRELL: Thank you. That's all right.

Walt?

MR. VOGL: I'm Walter Vogl in the Division of Workplace Programs. Primarily we work on what's called the National Laboratory Certification Program. We have currently 45 labs that are certified around the country, and they do all of the drug testing for federal agencies,

for all of the industries regulated by the Department of Transportation, Department of Energy, Nuclear Regulatory Commission. Basically all of the regulated industries have their urine specimens tested in our certified labs.

I'm also involved with the website with Deborah. We both work on it quite extensively to keep it as current as we can. We have all of our guidelines on there and other records and information that people use to establish a workplace drug testing program.

It's been in existence since '87, and we really look at it as prevention. A lot of people look at drug testing as a law enforcement sort of activity, but we really look at it as prevention. We want to prevent people from starting to use drugs, and that's why we test them in the workplace, the job applicants for jobs. If they're clean, hopefully they'll be convinced to stay that way. So we really look at it as prevention, not law enforcement.

Thank you.

MS. KITTRELL: Thank you. Come on. Don't be shy. Interns, staff on the other side, come on. Thank you, Costella.

MS. GREEN: My name is Costella Green, and I'm a Drug-Free Communities project officer. I have the States of Washington and California and Illinois. I also work on the PRIDE program with Jay that I love because it's with

youth and I used to do direct service. My old supervisor is here at the table and she knows I love direct service. So I love what I do working with the coalitions.

MS. KITTRELL: Thank you.

MR. DeWISPELAERE: Good work, all of you.

MS. PRUDEN: Hi, and I'm Mary Joyce Pruden. I came back because to let you -- no, not Hope. Let's see. Who else? I guess she left. Right? Sharyn. Yes, because I'm the state project officer for Wyoming. I wanted to make sure she knew that.

But anyway, I have five states. I do many things here, many committees. I'm on the Workforce Development Committee with Nel. She and I do a lot of work together in the Leadership Academy, and we're starting our fourth year on that.

Other states that I have are California, Washington State, Nevada, Oregon, and Wyoming.

MS. KITTRELL: Thank you, Mary Joyce.

MS. STEINER: Hello. My name is Elizabeth Steiner. I recently finished my degree and came up here as a summer intern, and as of the last few weeks, I've transferred over to student appointment. I work in OPAC with Peggy Thompson. I'm learning the duties of personnel liaison and I'm going to start learning about the conference grants.

MR. DeWISPELAERE: Can I ask a question?

MS. STEINER: Sure.

MR. DeWISPELAERE: What is the difference between summer intern and student appointment?

MS. STEINER: Student appointment is more permanent. Summer intern, you leave, you're done. Student appointment transfers over into a job, hopefully.

MR. DeWISPELAERE: Good.

(Laughter.)

MS. STEINER: Hopefully. I look in that direction.

MR. DeWISPELAERE: Hey, that's the way we like it. Good job.

MS. HAYNES-BATTLE: Good afternoon, everybody. My name is Josefine Haynes-Battle. I'm brand new to SAMHSA. I'm working directly with Dr. Mulvey, along with Dr. Kennedy, Daniel, Nel, as well as Dr. McHale. And I'm primarily working on a couple of contracts. One deals with fetal alcohol spectrum disorders, and then the second contract that I'm assisting with is the Native American Center of Excellence which we hope to kick off early next month.

So welcome and have a safe trip back home.

MS. KITTRELL: Thank you, Josefine.

MS. CLARK: Good afternoon. I'm Jennifer

Clark, and I'm a new project officer in the Drug-Free Communities Program. I have the States of California and Nevada.

MR. ROSE: Hi. I'm Gilbert Rose. I'm also a new project officer at CSAP, Drug-Free Communities, and I have Missouri, Kansas, and Louisiana.

MS. KITTRELL: Thank you.

MR. VOKES: Hey, I'm Kevin Vokes. I'm a new intern here. I'm in a masters program in community counseling. I'm new here.

MS. KITTRELL: Thank you, Kevin.

MS. RUBIO: Hello. I'm Cynthia Rubio. I'm with Drug-Free Communities as well, and I have the State of Iowa.

MS. McHALE: Hello, everyone. I'm Carol McHale. I work with Kevin Mulvey in the Division of Systems Development. I'm a project officer for the Northeast CAPT contract, and I have several task leads. I am the task lead on a fairly new initiative that we launched this year with the HIV/MAI grantees where the CAPTs did two and a half-day regional workshops, and they were really very well received. We did them in all five regions, about 400 participants overall. So that was one major activity, which I believe will be repeated next year, we hope.

I'm also the task lead on a unique CSAP initiative called Service to Science, which is intended to nurture the development of local innovative, field-grown programs to develop stronger evidence of effectiveness and to be able to document it well.

I serve as a liaison with SAMHSA on the National Registry of Evidence-Based Programs and Practices, and I work with the state division and Mike Lowther on the development of CSAP's guidance around selecting evidence-based programs and practices for the SPF/SIG program.

MS. KITTRELL: Thank you, Carol.

Are there any other comments?

(No response.)

MS. KITTRELL: All right. If not, I want to thank all of you all for being here, for the CSAP staff, those of you who hung in here with us for two days, and I wanted to thank the National Advisory Council for you taking the time out of your busy schedules to be here with us.

As Mike Lowther likes to say, we don't deliver services at the federal level. We don't deliver them at the state level. They are delivered locally in your communities. You bring to us your experiences and you all become the arms and legs for CSAP for SAMHSA when you go out into the field, when you attend the meetings, the

conferences, when you're representing us because we can't be everywhere, but you all can take the message. You can take our priorities out into the field. The information that's in your new members' orientation packet -- you have that. You have the information that has been shared with you today. Plus, the recommendations that you all have given to us already we can begin to act on some of those, and hopefully we'll be able to report some things out to you. Tia will be in contact with you.

I thank you for all that you do, for your expertise, and you all have a safe journey home.

(Whereupon, at 2:22 p.m., the meeting was adjourned.)