

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR SUBSTANCE ABUSE PREVENTION

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MEETING OF THE
CENTER FOR SUBSTANCE ABUSE PREVENTION
NATIONAL ADVISORY COUNCIL

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MARCH 26, 2012

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The meeting of the National Advisory Council of the Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA), convened at SAMHSA headquarters in Rockville, Maryland, at 10:00 a.m., Frances Harding, Director, CSAP, presiding.

MEMBERS PRESENT:

Frances M. Harding, Chair
John Clapp, Ph.D.
Michael Compton, M.D.
Eugenia Conolly, M.Ed.
Michael Couty, M.A.
Steven Green
Jane McGrath, M.D.
Michael Montgomery
Mary Ann Taifa'asai Tulafono

DIRECTOR, CSAP: Frances Harding

DEPUTY DIRECTOR, CSAP: Michael Etzinger

DESIGNATED FEDERAL OFFICER: Tia Haynes

1 P-R-O-C-E-E-D-I-N-G-S

2 (10:00 a.m.)

3 CALL TO ORDER

4 MS. TIA HAYNES: Good morning, everyone, and welcome.

5 My name is Tia Haynes, and I'm the Designated Federal Official for the CSAP National
6 Advisory Council. I would like to officially open the meeting, and I'll turn it over to Ms. Fran
7 Harding, who is the Council chair.

8 WELCOME AND OPENING REMARKS

9 MS. FRANCES HARDING: Good morning, all the Council members, SAMHSA staff,
10 and public attendees. We welcome you to the Center for Substance Abuse Prevention's National
11 Advisory Council. My name is Frances Harding. I am Director of the Center for Substance
12 Abuse Prevention and the chair of the Center for Substance Abuse Prevention's National
13 Advisory Council.

14 If you thought you were here for that, stay. If you meant to be at the substance abuse
15 treatment or mental health council, we can direct you to the appropriate room.

16 We are very grateful for all of you to travel in and to help us in the work of CSAP, and
17 we're hoping to have a very lively discussion. Since we last met we have had several changes,
18 both in the aesthetic of our Council membership and in CSAP in general.

19 The first person I would like to introduce you to, before we go around and introduce all
20 ourselves— For those of you who were here the last time, I kept telling you that by the time we
21 met again we would have a deputy for the center. And we do. Let me introduce you to Michael
22 Etzinger. He is our permanent Deputy Director for the Center for Substance Abuse Prevention
23 and, going along with my personality, I'm going to ask Michael to say a couple of words about

1 himself. He truly does not want me to do it. So Michael, if you could just let the Council know
2 who you are and where you came from and anything else you feel they should know.

3 MR. MICHAEL ETSINGER: Okay, great. My name is Mike Etzinger. I was fortunate
4 enough to be selected by Fran to be her deputy. Career: federal employee 26 years prior to being
5 here, all spent with the Department of the Army. Programmatic background: running programs
6 of all shapes and sizes. I'm very familiar with the whole process itself, so I came in intrigued by
7 the opportunity to be a part of another organization that is focused on doing good things for
8 constituents out there, making wise decisions, and spending the dollars wisely to get the most
9 bang for the buck.

10 I've been here just about 9 months now, so I'm starting to pick up more and more as I go
11 through and have been absolutely thrilled to be working with Fran. From an expertise standpoint,
12 I try to soak up absolutely as much as I can. We have an excellent team of directors that I work
13 with every day to execute the Center's mission.

14 That's why am and where I'm from. So it's great to be here, thanks.

15 CONSIDERATION OF THE MINUTES OF THE MEETING OF AUGUST 17, 2011

16 MS. HARDING: Okay, so for those of you who are new, we usually try to get through
17 business first and then we will go on. I'm required to do certain things at certain times. So what
18 we will immediately go to is, because we are a quorum, we will approve the minutes from last
19 meeting. You should have all received a copy of the minutes.

20 It might have been a little different for several of you, considering it was your first time.
21 And if we could have a motion to accept the minutes as written?

22 MR. COUTY: Motion to approve.

23 MS. TULAFONO: Second.

1 MS. HARDING: Thank you. Comments? Corrections? Or any of the above? Did we get
2 those down?

3 MS. HAYNES: Yes.

4 MS. HARDING: Okay. Thank you.

5 INTRODUCTIONS AND EXPECTATIONS

6 So, as I mentioned, there have been several changes to CSAP and to this Council in
7 general. We have tried to make the Council as wide a variety of talent and expertise. I am feeling
8 very confident that we have finally achieved that with both our former members and many of our
9 new members who have joined us.

10 I would like to welcome all of our new members to the first Advisory Council meeting,
11 and I'm sure that the partnership of your appointment to the CSAP National Advisory Council
12 will allow you to provide valuable advice to CSAP and SAMHSA in general today and
13 throughout the future.

14 You will learn a lot about the Council today. You will learn your role as ambassadors for
15 CSAP and SAMHSA in general, which I find to be the most exciting part of your job. On that
16 note, let's begin to get to know the people who are around this table. And once we go around, if
17 you could give not only your name but your affiliation and maybe a quick, very quick, Michael
18 Couty, I'm looking at—too many Michaels—I just want a description of what brought you here
19 and, if you are a veteran, meaning you have attended at least one meeting, what keeps you
20 coming. I think that would be helpful.

21 So I'll start at my left with Matthew, who also is new to the Council and will be taking
22 over Tia's role in running the Council in the future.

23 Housekeeping for those of you who are not comfortable with this little device in front of

1 you we're sharing, microphones. We are recording the proceedings, so you have to speak into the
2 mic when you want to say something. You push the button until you see the red light go on, and
3 then please push the button again when you're through speaking or it drains the power for the
4 next person.

5 MR. MATTHEW AUMAN: Hello, Matthew Auman. I work in the Center for Substance
6 Abuse Prevention in the Office of [inaudible]. Tia has been helping me so well. She's done a
7 fantastic job trying to train me to be the next DFO. So I have been working with many of the
8 Council members over the last few months, and it's been a phenomenal experience to see you all.

9 As far as my background, I was in the Army for 4 years, intelligence analyst, and then
10 college at Penn State, bachelor's in political science. Three years after that, a prevention analyst
11 at NASADAD, National Association of State Alcohol and Drug Abuse Directors, and then the
12 last 6 or so months here.

13 I appreciate having the opportunity to be here and to help out with this Council. Thanks.

14 MS. EUGENIA CONOLLY: I'm a veteran. I'm Eugenia Conolly, and I am the Director
15 of Statewide Projects with the Maryland Alcohol and Drug Abuse Administration. Good
16 morning, everyone. I am responsible for the provision of prevention services, services for
17 women, women with children, and also in working with the criminal justice population. In my
18 spare time I am also engaged in work dealing with gambling issues, working also with the
19 colleges and universities to address underage drinking.

20 I have served for over 10 years as the Maryland representative to the National Prevention
21 Network. My time there was spent not just as membership, but also various leadership roles. So I
22 have been involved and engaged in this particular body since 2010, and time certainly flies when
23 you're having fun!

1 [Laughter.]

2 MS. CONNELLY: I will say that I was a little hesitant in the beginning to join this
3 esteemed group, but what I have found since coming and being involved is that there is indeed
4 strong advocacy support for prevention and wellness, and that the folks here are energized and
5 really anxious to do what we can to assist our federal partners in terms of advocating and
6 promoting wellness and prevention across all disciplines. Thank you.

7 MR. MICHAEL COUTY: I'll be shorter.

8 [Laughter.]

9 MR. COUTY: I'm a veteran, but Fran might call me a dinosaur. I was with the State of
10 Missouri. Retired after 32 years with the state. I was State Director for Alcohol and Drug Abuse,
11 and now I'm the court administrator for juvenile court for Cole County.

12 I guess the reason that brings me back here is working with Fran. I worked with Fran
13 when I was with the state as state director, and Fran was out of New York, and we work together
14 very well.

15 As for prevention, I truly think that when you look, typically the first thing that goes
16 when it gets tight is prevention services. And I think it's real important that we maintain that,
17 especially in the position I'm in right now, working with kids.

18 When you think about juvenile court, you think about kids who are in trouble, and you
19 have to look at it from the other perspective. We deal with a lot of neglect and abuse issues, and
20 there are a lot of things you can do that is preventable. It takes a little bit of funding in order to
21 do that, and that's what brings me back here every time.

22 MS. MARY ANN TAIFA'ASAI TULAFONO: Good morning. Hi, Fran, good to see
23 you. My name is Mary Ann Tulafono. I'm from American Samoa. I'm the First Lady of

1 American Samoa.

2 What keeps bringing me back here? The last time we met, I had shared with you the
3 recognition that the program that I run to prevent underage drinking initiative and the recognition
4 through the OJJDP, and in that particular meeting in Florida last August, I had conveyed to the
5 group from all the 50 states and territories that I was going to take it to the National Governors
6 Association. Two weeks ago, there was a National Governors Association conference here in
7 Washington, DC, and lo and behold, the chair of the NGA Spouses—because when we come to
8 Washington, DC, there’s only one First Lady—we’re all spouses, and rightfully so.

9 The chair of the NGA Spouses, Sally Ganem of Nebraska, actually had on the agenda a
10 whole morning of speakers on preventing underage drinking. It was very well attended by all the
11 first ladies.

12 I was able to share with them the concept of how a lot of the people who do the kind of
13 work from public health, within the respective states, they are of the opinion that first ladies are
14 unreachable. I shared with them, and it was just an overwhelming response, because there are
15 quite a few of them who are new to the NGA. We had a speaker from the president of MADD.
16 Also there was a gentleman there—and I didn’t bring his card with me, I forgot—but he is with
17 SAMHSA and he’s with the WHO but a wonderful response in terms of substance abuse and
18 prevention. Everybody is on board, and I can say that with all conviction, because in spite of all
19 the initiatives that the first ladies have, nobody is exempt from it, if you will.

20 It is a problem for everyone, and just my role on the SAMHSA counsel, it is well
21 recognized among the first ladies. I’m honored to be here. And I tout your leadership, Fran,
22 thank you very much. It’s from a territorial perspective and also I’m probably the only Pacific
23 Islander sitting on the Council. It’s being able to touch base with a lot of resources and also to be

1 able to get the word out from west of the Mississippi on. Yes, it's beneficial, and I really, truly
2 am honored to be on this board. Thank you very much.

3 MS. HARDING: Thank you.

4 MR. STEVEN GREEN: Good morning, everyone. My name is Steven Green. I serve as
5 the Executive Director of Behavioral Health Services for the Gila River Indian Community,
6 which is in Sacaton, Arizona, which is about 25 miles southeast of Tempe, Arizona. I'm
7 responsible for all the mental health, drug, and alcohol prevention services for the community
8 that I serve.

9 Clearly the prevalence rates are very high for drug and alcohol in Indian Country, and
10 prevention is a very serious focus our program has. In addition to that, the Gila River Indian
11 Community has the highest prevalence rates of diabetes in the United States, and we're really
12 focusing on integrated healthcare.

13 So, thank you very much.

14 MS. HARDING: Thank you.

15 CAPT. NEAL WALKER: My name is Neal Walker. I like to do this because it has a long
16 history behind the O, but you don't want to hear the history.

17 [Laughter.]

18 CAPT. WALKER: I am one of the directors in Fran's Center for Substance Abuse
19 Prevention, in which we house the programs for Drug-Free Communities, support STOP Act,
20 and HIV branch programs. I will have more to say later on, I'm told. I'm glad to be with you and
21 I'm glad to have met you.

22 MR. RICHARD MOORE: Good morning. My name is Richard Moore. I'm the Director
23 of the Division of State Programs in CSAP. Our division has the responsibility for the program

1 administration of the 20% set-aside portion of the Substance Abuse Prevention and Treatment
2 Block Grant. We also administer discretionary grant programs to states, the Strategic Prevention
3 Framework State Incentive Grants, as well as the Partnerships for Success Grants and the
4 Strategic Prevention Enhancement Grants to states.

5 MS. CAROL REST-MINCBERG: Good morning. I'm Carol Rest-Mincberg, and I'm the
6 Director for the Division of Workplace Programs. It sets the standards for federal drug
7 workplace testing, and every time I get one question, and that is, "Do we give money to states or
8 communities?", and we don't. I'll answer it before anyone asks the question. We are the only
9 regulatory division within CSAP.

10 MS. VIRGINIA MACKAY-SMITH: Good morning. My name is Virginia MacKay-
11 Smith, Ginger MacKay-Smith. I answer to both. I'm also a division director. I direct the Division
12 of Systems Development, and the systems that we develop are those that support the work of
13 grantees and the prevention field in general, having to do with providing information and support
14 for evaluation programs, materials development, and technical assistance.

15 DR. JOHN CLAPP: Good morning, John Clapp. I'm new to the Council. I'm currently
16 Director of the U.S. Department of Education's Higher Education Center for Alcohol, Drug, and
17 Violence Prevention, which is a mouthful. I'm also the director for San Diego State University's
18 Center for Alcohol and Drug Studies, professor of social work and public health there as well.
19 I've done research on underage drinking, SBIRT, drunk driving prevention, and a number of
20 things that are related to things we are interested in here.

21 MR. MICHAEL MONTGOMERY: Good morning. I'm Michael Montgomery. I'm
22 retired. I was the AIDS Director for the state of California for a number of years and spent the
23 last 20 years of my career working primarily with HIV/AIDS issues. Early in my career, and

1 were talking about the early 1970s when I got out of graduate school, I did do alcohol and drug
2 counseling specifically with gay and lesbian populations, and that's a strong interest of mine.

3 DR. JANE McGRATH: Good morning. I'm Jane McGrath, and I'm a pediatrician from
4 the University of New Mexico. I'm very happy to be here. I hardly think of myself as a veteran,
5 but I have been here before.

6 I have a background in school health and I'm very pleased with the topics that we are
7 going to be talking about tomorrow, that we are really going to get into that topic area a little bit.
8 Good morning.

9 DR. SUE FIALKOFF: Hello. I'm Dr. Sue Fialkoff. I'm with the Center for Substance
10 Abuse Prevention. I'm the Director of the Office of Program Analysis and Coordination. We
11 handle the budget activities and coordinate the grants and contracts and other center-wide
12 activities that go on.

13 DR. MICHAEL COMPTON: Good morning. I'm new to the Council and it's a real
14 pleasure to be here. I'm Michael Compton. I'm a professor at the George Washington University
15 in downtown Washington, DC. I'm a psychiatrist, but I'm also double boarded in preventive
16 medicine. I mainly do schizophrenia research, but my real passion, aside from schizophrenia, is
17 prevention psychiatry, and I'm interested in helping my field move toward prevention since
18 we've been so focused on treatment for so many years.

19 It's a pleasure to be here.

20 MS. HAYNES: Good morning everyone again. I am Tia Haynes and, as I stated before,
21 I'm the current DFO for the Council, and I'm training Matthew Auman to be the DFO for the
22 Council. I hope to move on to provide human resources needs for the center. I'm pursuing my
23 master's in public administration with a concentration on human resource administration.

1 Welcome.

2 MR. RICHARD LUCEY: Good morning. I'm Rich Lucey. I'm the Special Assistant to
3 the Director in CSAP.

4 And John and I have actually come full circle, I think. I started at the Department of
5 Education's Office of Safe and Drug Free Schools back at the end of 1999, and in 2000 I took
6 over our grant program that dealt with high-risk drinking and violent behavior among college
7 students, and that's where my background lies. And John's was one of the first projects that I
8 monitored. Now we're both at the same table instead of me monitoring all his activity.

9 MS. HARDING: Well, thank you very much.

10 We have a couple of Council members who could not join us today, but for the most part
11 we will have plenty of time during breaks, during lunch, and then of course overnight into
12 tomorrow, when you have a joint Council meeting and hopefully that will give us some time to
13 get to know each other—the veterans, the dinosaurs, and the newbies at the table.

14 So before we get into a real discussion and dialogue about what it means to be a member
15 of the National Advisory Council, if I could ask, and it's not a mandate, people who have joined
16 us around the room, if you would like to introduce yourself by name and affiliation or whatever
17 is most comfortable for you.

18 Unfortunately, you'll have to come up to the table, and speak into one of the mics. Wait a
19 minute, I stand corrected.

20 MS. KATHRYN TUPUA: Good morning everyone, my name is Kathryn Tupua. I serve
21 as Chief of Staff to the First Lady from American Samoa.

22 MS. TONIA SCHAFFER: Good morning. My name is Tonia Schaffer, and I sit in the
23 Division of State Programs with Richard Moore. I'm a new employee, and I have responsibility

1 for five southern states—Alabama, Arkansas, Louisiana, Georgia, and Florida. I’m attending this
2 meeting so I can learn more. Thank you.

3 MS. STEPHANIE ZYDECK CHANDLER: Good morning. My name is Stephanie
4 Zydeck Chandler, and I, like Tonya, am a new employee with SAMHSA. I just arrived from
5 Juneau, Alaska, a couple of weeks ago, and I’m on Richard Moore’s team as a state project
6 officer, and my states will be the Northwest Region 10, primarily. I’m excited to be part of this
7 team and learn from all of you.

8 MS. MEREDITH WILLIAMS: Good morning. It’s a pleasure to be here. My name is
9 Meredith Williams. I’m with Abt Associates. I’m a government contractor supporting a lot of
10 communication activities for CSAP as well as the SAMHSA Office of Communications. Thank
11 you.

12 MR. ALAN WARD: Good morning. My name is Alan Ward. I’m a Branch Chief with
13 the Division of Community Programs. I wanted to come to this meeting also to see some of the
14 old faces that I’ve worked with in the past in prevention. It’s always really good to see you guys,
15 and it’s good to see you from American Samoa. I wish I was there right now . . .

16 [Laughter.]

17 MR. WARD: . . . having a relaxing time. But it’s good to see you here. Thank you.

18 DR. CHARLENE LEWIS: I’m Charlene Lewis, and I am privileged to be spending the
19 next 4 months in the prevention center learning more about prevention. And I want to thank you
20 all for having me here today and letting me hear what you have to say coming in from the field.

21 MS. DONNA BUSH: Hi. My name is Donna Bush, and I’m with Office of the CSAP
22 Director, and I’m here to listen and learn and hear what you all have to say.

23 MS. BEVERLY JACKSON: My name is Beverly Jackson. I’m the conference manager

1 and the logistics person for this meeting, so if you need any help or have any questions about the
2 hotel or anything else, let me know.

3 MS. HARDING: Okay. We knew this was going to take a little chunk of time with so
4 many of us who are new at the table. Thank you to our guests for introducing yourselves. It's
5 always nice to know who's listening and who has your back in this particular case and the way
6 this room is set up.

7 I hope it was as pleasant news to you as it was to me, all the different areas we have
8 represented on the Advisory Council now. We have state alcohol and drug experts, juvenile
9 court, the First Lady of American Samoa, which brings such a richness to the table as well.
10 Someone from higher education, a mental health and substance abuse professional working with
11 our tribal communities across the country. A retired gentleman, and you needed to say no more
12 than that, to give us a perspective that all of us probably envy at the moment at one point of our
13 lives. But also it comes with us with a richness of HIV/AIDS teachings. Higher education has
14 become such a focal point for our country to really look at when we're talking about substance
15 abuse/mental health disorder prevention programming. I couldn't be happier, and those of you
16 who have worked with me know that this is a passion of mine and always will be in the area of
17 substance abuse and, more recently, mental health disorder prevention.

18 Our pediatrician. I don't want to say token pediatrician, but our pediatrician just the
19 same— When we first started meeting in the National Advisory Council, one of the areas that I
20 most sought after was a pediatrician, with all that the work that we do with our young people.
21 We know that we talked about this last time. Our goal is to begin to show the country how we
22 integrate with general health, especially seeing that SAMHSA primarily focuses, at least under
23 Pam Hyde's leadership, youth. So it's so fitting to have someone with your variety of talents and

1 skill sets, but the fact that you know so much about the growth of children and, I will suspect,
2 parents as well, working with young people. So we thank you, Jane, for being among us.

3 A professor of psychiatry and, if you listened closely, preventive medicine. I love that,
4 Michael. What he didn't tell you is that he also is an accomplished publicist of several books
5 around the subject of substance abuse and mental health disorder, and I suspect schizophrenia,
6 but I haven't read anything specific to that. It looks like I'll have more reading to do. So when
7 we're talking about prevention, especially now, and it's an especially fitting time that we are
8 here in Washington, because over the next three days health reform is really going to be
9 discussed.

10 So you're here adequate time for a couple of reasons. One, because health reform is being
11 discussed at the Supreme Court. That's very important. We are in the anniversary week of
12 passing the affordable health care legislation, and we are also here at SAMHSA celebrating our
13 20th anniversary of existence.

14 I'm not going to preempt our administrator. I know she's going to be doing a lot of
15 discussion about that, but later on, I'll tell you a little bit about some of the fun things that
16 SAMHSA is planning over the next year. We are using the 20th anniversary as a way for us to
17 get our message out. People will read something if they see that something is being celebrated
18 for the 20th time. So we are using that to our advantage. We'll talk about that a little bit and how
19 you as ambassadors to SAMHSA in your new role here at the National Advisory Council, how
20 you can help us with that and hopefully advise us on how we can do that better. We are in the
21 beginning stages of that.

22 One of the items, if it's okay with everyone, we have a few minutes to get into— We
23 wanted to make sure that all of you, dinosaurs, veterans, or newbies, had a chance to actually ask

1 any questions you might have of your role here, sitting around this table, and the role of which
2 you'll hear tomorrow from Administrator Hyde. It's not on your agenda, I don't think. Around
3 2:30, somewhere between 2:15 and 3 o'clock, Administrator Hyde is going to come and visit
4 with us and touch base, which I think is a very nice ability. We've not done this in the past
5 because we've not been able to schedule these meetings in a fashion where we are usually having
6 our national advisory councils when Administrator Hyde—who, as all of you who know her,
7 likes to be called Pam, so I'll be referring to her as Pam from this point on— Pam usually has the
8 SAMHSA National Advisory Council at the same time we had our center advisory NACs. This
9 year we finally got it right. So all of the center NACs are happening prior to both the Joint
10 National Advisory Council and the SAMHSA National Advisory Council.

11 So this supports Pam the opportunity to go visit. Hopefully we're not the last group that
12 she's visiting with, because she might not be here on time. If we are the first, we'll be able to set
13 the pace for my colleagues.

14 In your packet there is a Fundamentals of Advisory Council one-pager. It looks like this.
15 Do you all have that? They have that correct?

16 MS. HAYNES: They should.

17 MS. HARDING: If you don't, you can have mine.

18 It gives you a little bit of an idea of why the NACs were formed and what are some of the
19 roles that we see you playing on the National Advisory Council. I talk a lot about this second-to-
20 the-last one, which is the ambassadors. This has just been described for the first time last time we
21 met, I believe. This was something that Pam had coined the phrase, as being ambassadors. And
22 it's worked out quite well. I know a couple of you already have used your role as Council
23 members to talk about the topics that we've been talking about, to help spread some of the

1 messaging.

2 We are in the middle of a lot of controversial topics, especially with prevention. Last year
3 the President's budget had a new proposal for prevention funding that rocked the world a little
4 bit in the substance abuse field, meaning that the President's budget suggested that the 20% set-
5 aside of the Substance Abuse Prevention and Treatment Block Grant be literally set aside and
6 combined with CSAP's discretionary portfolio dollars. And that we would make a Substance
7 Abuse State Prevention Grant. We touched on that a little bit the last time we spoke.

8 If you remember, Michael Botticelli had some very strong opinions about that. However,
9 I also know that Michael was then quoted in a conference after we had the National Advisory
10 Council, and he did very well in explaining to the people in the conference, the participants, what
11 SAMHSA's position was, and why the President and why we were embracing outside of the
12 obvious reasons why we were embracing, but why we were embracing programmatically,
13 bringing together for the first time, a Substance Abuse State Prevention Grant. The President's
14 budget also proposed a Mental Health State Prevention Grant, which was using dollars a little
15 differently. It was taking the Project LAUNCH, which is the early childhood 0–8 prevention
16 program and expanding it for all of the states to utilize. And then the Tribal Behavioral Health
17 Substance Abuse and Mental Health Services grant for tribes.

18 Well, 2012 came. We are in 2012. There are no grants of this nature, but in 2013, if
19 you're up on your reading of the budgets, they are all back in. So we may or may not talk about
20 that in some respect. That will have to do with what your desires are.

21 But that's a lengthy explanation of what some of the role of ambassador is. It doesn't
22 have to be that dramatic. Just been helping us sell to the country that SAMHSA has been in
23 existence for 20 years and some of our main principles going forward is also an exciting venture.

1 So, if you take 3 seconds to look over what we think your role is here, and if you have
2 any questions, now would be the good time, with my experts here at the table, to answer, if you
3 were wondering as you were writing, traveling, flying, and however you got here, thinking
4 about, “Okay, now what did I get myself into?”

5 DR. McGRATH: Fran, just a quick question, having been a little bit in this role with the
6 American Academy of Pediatrics, in serving as an ambassador I think we also need to be careful
7 about how we represent SAMHSA, so it might be useful to get some guidance about if you were
8 approached by someone to give some kind of quasi-official statement, what should one do, who
9 does one go to? That kind of thing.

10 MS. HARDING: That’s very good. I think what we could do, as we go through the topic
11 areas for discussion, we could then feed back to you by the time you get back to your home base,
12 as suggested couple of sentence or a paragraph if you’re not feeling like you have the answers—
13 and even if you think you do have a handle of SAMHSA’s view while we’re here, we most
14 certainly can get that into your hands. And actually, because this week is unique, before you
15 leave tomorrow, we can actually get those paragraphs or sentences to you, so you can look them
16 over and, if you have any questions, see any one of the SAMHSA/CSAP representatives here.
17 That’s a very good thing.

18 We do that all the time. We have Q&As that basically help with some of the tough issues.
19 We certainly have plenty around the state grants opportunities. But there are several others.

20 Jane, that’s very good.

21 Okay, we have about 4 minutes left before you go on a break. Hearing no other questions
22 about your role, if I were sitting in your chair and this was the first time I was a member, I think
23 that I would be sitting back—and I might actually ask you this question at the end of the day—is

1 there anything that you have thought of since we have been working back and forth?

2 If Matthew will remind me at the end of the day to squeeze that in before or after our
3 public comment period, that would be great.

4 I would like to indulge you in one area. In February SAMHSA had its sixth Prevention
5 Day, which is a day that SAMHSA has exclusively—the first day of the CADCA Coalition
6 Conference—here in Washington. American Samoa was one of the recipients of our VOICES
7 Award—Faces and Voices, them, too, let’s steal from our friends in recovery—the VOICES of
8 Prevention Award. We are very proud to honor, and we happen to have the awardee who
9 accepted for your jurisdiction. I don’t know if you want to stand up and tell a little bit about your
10 program. Miriam, maybe you would like to?

11 Notice how they’re jumping? They’re leaping at the opportunity!

12 We awarded five awards. We try to do this every year around substance abuse and mental
13 health disorders. We actually gave this year an award to one of our tribes, as well as several of
14 our school-based mental health programs, which was around suicide. I should have brought it
15 with me instead of relying on my memory.

16 But I will not forget the incredible delegation from American Samoa. You looked great.
17 It was a unity. We have pictures, and if we have time during the break, I’ll go get them in case
18 you haven’t seen them. It was a very nice, touching showing.

19 If you want to tell a tiny bit about what your program was that you got recognized for?

20 REPRESENTATIVE FROM AMERICAN SAMOA: Thank you very much, Fran. I think
21 you’re mistaking me for Luisa, but I was the project director when the SPF-SIG grant was
22 funded. I’d like to thank Mr. Alan Ward. He was our initial project officer when we first got
23 funded 6 years ago.

1 MS. HARDING: Did he ask you to say that?

2 [Laughter.]

3 REPRESENTATIVE FROM AMERICAN SAMOA: No, he didn't!

4 But for the last 3 years I have been on special detail to the Governor's Office, working on
5 staff with the First Lady. But we have been keeping abreast of the SPF-SIG project. That
6 particular project was recognized because they utilized the SPF-SIG framework to the T. They
7 used all the five steps.

8 When we got funded for SPF-SIG, American Samoa did not have any community
9 coalitions in existence at all, so we really started from the ground up and worked throughout the
10 community establishing grassroots coalitions, following the SPF process. Set up twelve of them.
11 Have spent a lot of SPF-SIG resources investing in building local capacity and really engaging
12 our religious leaders and traditional leaders in the prevention framework. It really has set up a
13 unique infrastructure that our whole island community can benefit from in moving forward.
14 Thank you.

15 MS. HARDING: Thank you. I did mix you up. I'm sorry.

16 I'm just so thrilled with the underage drinking effort that you reported on. You're such
17 leaders in the field, and with the programming that you're doing with the Strategic Prevention
18 Framework—that's what the SPF is—you'll hear a lot about that acronym while you're here. I
19 did want people to see that it really doesn't matter your location. Your voice is heard throughout,
20 and I just wanted to take the few extra seconds we had to acknowledge you and to thank you in
21 public.

22 So if you're okay with it, we'll take a 10-minute break. It's the morning. You were
23 traveling. We got you here. So take 10 minutes.

1 The facilities, for those of you who may not be familiar with the building, if you go out
2 the door, take a right, go all the way down pretty far, and they're on the left. We'll see you back
3 here at 11 o'clock sharp.

4 [Break.]

5 MS. HARDING: Okay, I know you would probably prefer to have half an hour to just
6 catch up, which we hopefully will provide you with an hour lunch. I don't think we're bothering
7 you during lunchtime. You can have a relaxing hour and a half. Whoa! We're being very
8 generous!

9 STRATEGIC INITIATIVE #1: PREVENTION UPDATE

10 This is the section of the meeting where you're going to get a lot of information about
11 what CSAP is doing, for future discussion. The first thing that I promised you last time that we
12 would do is keep you informed on how the strategic initiative for SAMHSA that is the number
13 one initiative, on Prevention of Substance Abuse and Mental Illness, how it's progressing and
14 what are we doing. Hopefully, this will help you see where programs within SAMHSA are
15 fitting within the initiative and maybe begin to make more working sense of where both
16 SAMHSA is going and how we are perceiving moving the agenda along of SAMHSA's strategic
17 plan overall, which are those eight initiatives.

18 As a review, the Strategic Initiative #1 is the Prevention of Substance Abuse and Mental
19 Illness. We have four goals, as you might remember. One goal is focusing around emotional
20 health. Another goal is focusing around underage drinking. The third goal is focused on suicide
21 prevention. And the fourth and final goal is focused on prescription drug abuse and misuse. If
22 you noticed, they're pretty much into the forefront. All four of those initiatives are goals and
23 they're working. So it's been rather—I hate to say “easy”—for me to be able to fit a lot of the

1 activities that we're doing here in SAMHSA underneath these goals.

2 But to make it a little bit more complicated for the outside viewer—that's a joke—we
3 have separated it even further. Remember, these are in 18-month chunks, that what we're going
4 to focus on in the first 18 months—and we're still in that 18-month period—so we've now
5 chopped this up even further into what we call our “vital few” topics, our “critical task” topics,
6 and our ongoing activities.

7 What you have in front of you is a list of where what falls into what, and hopefully that's
8 a little bit of a guide for where we're going. I don't want to go through this, and I'm sure you
9 don't either want me to go through every single goal and initiative on the updates. I'll skim over.
10 I want to make sure you have the visual in front of you, because this is a lot to look at.

11 It will also hopefully help you see what we fit into the different goals. Our first vital few
12 is the prevention of substance abuse and improved well-being in states, territories, tribes, and
13 communities across the nation. We've been able to highlight quite a few of our activities that are
14 ongoing here in CSAP. Our Partnership Achievement Grants, which Richard Moore told you,
15 falls within his leadership and guidance as far as the state programs.

16 Our Project LAUNCH—remember, this is a substance abuse and mental health disorder
17 prevention initiative. Two meetings ago this was another one of those eye-catching, earth-
18 shattering changes that we put prevention under one umbrella, the prevention of substance abuse
19 and mental illness services for the first time. We still have the two centers, the Center for
20 Substance Abuse Prevention and the Center for Mental Health Services. We haven't physically
21 moved anybody, but the management, which Pam talks about a lot, is horizontal management.
22 Even though substance abuse prevention and mental health disorder prevention are sitting in
23 different centers, the overall program leadership and management of those fall within this

1 strategic initiative.

2 Does that make sense? Okay.

3 Project LAUNCH falls within the portfolio of mental health services and falls within the
4 Strategic Initiative #1. So we've shown you where we're going with Project LAUNCH.

5 Safe Schools/Healthy Students, another historically tagged with mental health disorder
6 prevention programming, and this, too, falls under this vital few in the strategic initiative for
7 prevention of substance abuse and mental illness.

8 Our stopbullying.gov—exciting, exciting project as we're going forward, and we've
9 linked up with Facebook. There is now a number where, if you know a friend that is
10 contemplating, talking about, or even just giving hints of suicide, you can get on Facebook and
11 call up or email a number in a particular location, where they can be linked up immediately to
12 the hotline for suicide prevention. It's proven already in a very short amount of time to be a great
13 entry and a really good use of some of our new media.

14 Also a launch on March 15, Lady Gaga— If you can picture this, if any of you has
15 physically seen or met our Secretary, Secretary Sebelius— How would I describe her? A very
16 elegant lady of tremendous skill and talent, next to Lady Gaga. Even if Lady Gaga tries to dress
17 conservatively, just picture her and our Secretary together. I was not present, unfortunately,
18 because I would loved to have been there to see this, but I have been told by those who were
19 lucky enough to be there that it was a fabulous coming together, as I would suspect.

20 If you ever do get an invitation to meet our Secretary, I'm her number one fan. She has
21 proven herself to be a real champion for our cause. She and Pam have a very good working
22 relationship. I think it's a tad unusual, that's how strong it is. And she is just so elegant and able
23 to speak to all people at all levels, whether it's her first job right out of the box. She was on the

1 job for maybe a week when she was talking about the flu and going on nationally. She has
2 proven herself time and time over—not that she had anything to prove.

3 Most of you know that I was in a leadership exchange with Kathryn Power last year. It
4 seems like it was just yesterday, but it was a whole year ago. I loved it. Kathryn and I had this
5 secret thing going on that we promised each other that we would go back to our original jobs,
6 which we did. But I have to tell you, the prevention programming and the richness it brings to
7 help mental health disorder prevention, to help them see the breadth of what they could be and
8 the breadth of where we can bring them—that’s one of the areas we’ll want to hear more from
9 you about. How can we even make this better in bringing some of the prevention in mental
10 health?

11 The possibilities are endless. The only thing that holds us back is ourselves, because as
12 professionals in the rubric of SAMHSA, we are so ingrained on being labeled in one center or
13 the other, the only thing that prevents the vision and achieving greatness, in my opinion—

14 Doesn’t it sound like we’re in the middle of a snowstorm? We’re not. I apologize for that
15 noise. I was wondering whether I’m the only one who heard it.

16 What we’ll be tapping into is, how do we bring these two fields closer together? Many of
17 you talked about working in both fields, on both sides. As we have been talking, we are trying to
18 get to general health. Better to go to general health hand in hand with our mental health partners
19 than to remain totally separate.

20 National Prevention Week, going back to substance abuse. We’re very excited about this!
21 I just did some tapings for our nation to get people excited about National Prevention Week. It’s
22 the first week that we’ve had here at SAMHSA, and it’s May 20–26.

23 I have experts for almost all of these sitting in the room, so we’ll be tapping in if you

1 have questions.

2 The Policy Academy, the first ever, I think, with the Center for Mental Health Services
3 and the Center for Substance Abuse Prevention coming together again, trying to transfer the
4 lessons learned and the knowledge and the progression of substance abuse prevention to our
5 mental health partners, so that we can become stronger and unified, and at the same time learn
6 more about mental health and how mental health and substance abuse really come together. It's a
7 vision that we all have now in CSAP and in CMHS to move forward.

8 I'm not going to try to paint a pretty picture any prettier than it is. We may not be in
9 vibrant colors right now, but we are certainly out of the muted-color stage, and we are beginning
10 to work together much better than we have had in the past. So I don't want to give you an
11 impression that this is easy and that it lacks challenge, because we certainly have a lot of
12 challenge in front of us.

13 Again, I go back to my original description. It's because we are so ingrained as federal
14 workers working in a certain block, and what we're trying to do is to melt those blocks and try to
15 help the field of prevention come together universally, so that when we begin to show how we fit
16 into healthcare and show how we fit into general medicine, so when our country focuses on
17 diabetes and heart disease and obesity and cancer, they see automatically how substance abuse
18 and mental health fit within that total connection.

19 So that's our main overview goal of what this strategic initiative is all about.

20 Those are our vital few. There are some major descriptions.

21 I can't read and talk at the same time. Sorry.

22 We have given you a document that we should have stamped on here in several places
23 "do not share." One of your roles on the National Advisory Council is that you see things that the

1 outside world does not. If you notice people around you, if they're not SAMHSA employees,
2 they don't get a copy of the materials that you have. Be mindful of that. We can't get advice and
3 guidance from you if you're not on the same page of where we're at. So much of what you see
4 here, particularly the grants, like Project LAUNCH and the suicide prevention and the
5 Partnership Achievement Grants, taking it to the next level in the 2013 budget, which you'll get a
6 review after lunch. Actually for 2012 we do have money, \$31 million, and it will be easy for you
7 on this first one. We've changed this so much since this was written, even if you were to talk to
8 someone, it would be wrong. So I'm very comfortable with that one.

9 The essence of what the rest of it is is where we're going. Steven, you'll notice that we
10 are talking about tribes in every single area. You'll see that tomorrow when we go through all the
11 strategic initiatives as well as a lot of disparities. HIV/AIDS is one of them. A big highlight—as
12 a matter of fact, next week we're having a 2-day meeting on following the President's guidance
13 of our LGBTQ2-S population, as well as many other areas of disparity, which you'll hear a lot
14 more about tomorrow, so I don't have to get into it.

15 So, what we would like to do is to have a conversation about the strategic initiatives. I
16 can go into any one of these areas that you may have some interest in. If something's missing
17 and you think that we should be focusing on this, and you have a question why it isn't here, we'll
18 take that. Tell us how you feel about some of the projected areas that we're looking at.

19 The one I will tell you that is probably the one that's under most construction is the Safe
20 Schools/Healthy Students, and the reason for that is because Education this year does not have
21 money to sustain their portion of Safe Schools/Healthy Students. That is a program that has been
22 very successful for SAMHSA, working in partnership with the Department of Education.

23 I'm going to stop talking and allow any questions, guidance, suggestions. "I love this."

1 "I'm not quite sure why that's there." "Did you think about doing this this way?" Anything.

2 MR. COUTY: Fran, I like what I see in all these areas, because these are areas that I face
3 on a daily basis. There's one, though. I know SINAR set-aside, we're seeing an increase within
4 our area, and I have gotten our locals to actually pass an ordinance that when we catch a kid
5 smoking the first time, it's a \$135 fine. The second time it's \$350, and then it goes up to the max
6 of \$500 on the third and continuous time after that. Then they pay the fine plus community
7 service.

8 MS. HARDING: Good question. Richard, can you give us an update of where we're at
9 with SINAR and possibly address Michael's observance in Missouri that it's going up a little?

10 MR. MOORE: Sure, I'll be happy to.

11 In terms of SINAR, still intact, still part of the existing Substance Abuse Prevention and
12 Treatment Block Grant. Even with the President's budget proposal for the implementation of the
13 Substance Abuse State Prevention Grants, SINAR will still remain part of the block grant, and
14 the requirements associated with the block grant will still be intact.

15 Actually the program has had tremendous success in terms of working with states to
16 prevent youth access to tobacco through vendors. For Missouri you've actually caught me here,
17 because I know you're under the 20% RVR rate, but in terms of our efforts we are still working
18 with states very closely in terms of implementing the state SINAR program.

19 We actually have about 34 states that are under 10%, which I think is excellent. I just
20 don't know what Missouri's rate is right now.

21 MR. COUTY: I wasn't looking at the statewide, because you have localities. You're high
22 in one area, low in an area. When you balance it out, you may be underneath that 20% or 15% or
23 whatever it was the previous year.

1 MR. MOORE: You're absolutely right.

2 MR. COUTY: In the locale that I'm in, we're seeing that pop up again, and as a result,
3 we're throwing some things from a local perspective, not a state perspective, in order to address
4 it financially. It doesn't hit the kid's pocket. It's the parents' pocket, so when it hits the parents'
5 pocket, ears pop up at that point.

6 MR. MOORE: Absolutely. And when we go to the states to work with them, we're
7 looking at putting a statewide infrastructure together, but we do focus on the individual localities
8 based on the information that we receive from state officials. We are continuing to encourage
9 particularly our SPF-SIG and our Partnership for Success and our SPE grantees who receive
10 funding through the state, but the intention is to filter that money down through the local
11 communities to help support their efforts.

12 MS. HARDING: Richard, do you know if the Health and Human Services tobacco
13 strategic plan, is that out yet or is that still surfacing? Do you know, because I don't?

14 MR. MOORE: It has been issued. Right now the plan is that the Surgeon General's report
15 is scheduled to come out very soon.

16 MS. HARDING: Yes, that's what I was talking about.

17 MR. MOORE: As a matter of fact, next month. It's not out yet. But there is a renewed
18 focus on tobacco use, youth access to tobacco. A report is coming out by the Surgeon General
19 very soon. As part of the National Prevention Strategy, issues around tobacco is one of the seven
20 priorities that will be part of the focus. There's a lot to come in terms of tobacco use.

21 MS. HARDING: And I bring that up, Michael, because I think that that's what we're
22 seeing, this underlying current that perhaps it's time to have what I call in prevention terms a
23 booster session for the country around the dangers of tobacco use, especially around our youth,

1 although both the Surgeon General's report and the Secretary's overall prevention report have a
2 focus on not just youth, but there certainly are sections, especially in the Surgeon General's
3 report. And I know that they're not coming out as quickly as we would like.

4 Nothing comes out as quickly as we would like. We're impatient people in the prevention
5 world. A lot of that has to do with the year that it is and making sure that everything is checked.
6 If you can imagine, when we get out these Call to Action reports and strategies, it takes a while.
7 But it will be out and we'll make sure that all of you have the link to that when it does come out.

8 DR. McGRATH: I have a question, Fran, and you'll probably correct me and say that this
9 really is not a role that SAMHSA can take on. But I'm just struck that the prevention of underage
10 drinking initiative has a national media campaign that cannot begin to hope to counteract the
11 enormous amount of media that is directly aimed especially at young males in our society.
12 Having two sons myself, I find it really distressing that this isn't something that we can come to
13 some kind of consensus around.

14 MS. HARDING: It is something that SAMHSA takes on. At the level you're talking
15 about, that will forever be our struggle. Let's make sure we're all on the same page. Our strategy
16 here is to work one community at a time so that we can make a difference at the local level, tie it
17 with the state level, which, by the way, if we run out of things to talk about, that's the area I've
18 come with a hidden agenda to talk to you about that strategy, and then make the inroads where
19 we can at the level where we can make them.

20 And then the issue, of course, is, we never seem to have enough time, effort, and ability
21 to be able to take all of those smaller efforts across the country and tie them all together and have
22 enough money to be able to have all of our communities doing the same thing—meaning the
23 same target, obviously using different strategies, depending upon their population and their

1 community itself.

2 But we actually have two people. Ginger can speak directly to what our initiative is—and
3 don't forget New York City, even though I told them about that last time. Not everyone was
4 here. She can tell you where we're going and how we're doing that, especially with our town hall
5 meetings and those kind of things.

6 And John, I'm just guessing that having higher education as part of your area of
7 control—using that word wisely—that you might have something particularly that Jane brings up
8 is that focus around young males as far as are we getting anywhere with that? Then of course, we
9 have Charlene in the back, who's our data person coming straight from working with NSDUH,
10 who may be able to help out with some of the data and show you some of the trends there. So we
11 have a lot to talk about this.

12 Yes, Ginger.

13 MS. MACKAY: I'll let Charlene bat clean-up and I'll start us off. I want to start with the
14 national media campaign. We're very lucky that the STOP Act does have explicitly within it the
15 national media campaign here.

16 You're right. When you look at the million dollars we get for this versus the hundreds of
17 millions of dollars that the industry spends on it, it seems like we have a little bit of an uphill
18 battle here.

19 What we have decided to do with this campaign is not to play on their playing field. This
20 campaign is aimed at the parents. This one in particular, the parents of 9 to 15 year olds. What
21 we are doing is noting where the real levers are in prevention of underage drinking and, again,
22 pulling from the data and our experience in the field. We know the parents are one of the
23 strongest influences—even stronger than the industry spending hundreds of millions of dollars.

1 So what we are trying to do is to leverage their role by, first of all, getting their attention.
2 And I will tell you that actually that turns out to be an issue. The attention of parents of 9 to 15
3 year olds right now is not on underage drinking. It's on bullying. It's on texting while driving.
4 And a lot of the other issues that are newly coming into focus for them, feeling that they didn't
5 watch their own parents deal with that, so they need to spend more of their energies to get behind
6 it. Alcohol feels like something they know about and have always been around.

7 So, first of all, getting their attention; secondly, putting tools readily accessible at their
8 use to go ahead and exert their own influence.

9 The plan here is that by not going head to head with the industry, but by going through
10 the prevention channels and building on prevention science, that we will stand a chance in this
11 ongoing challenge.

12 When Fran said "New York City," that meant the Times Square ad, the big Jumbotron in
13 Times Square. As she mentioned at the last NAC meeting, through a really funny coincidence of
14 events, it became available that we were able to have an ad up there, 15 seconds every hour, 18
15 hours a day from April through December, with hundreds of millions of impressions, again
16 focusing on parents with the message that "Your children actually do listen to you. Please keep
17 talking to them. And here's where you can go to get some help."

18 I could go on and on about underage drinking, but in terms of the issue we're making
19 about we're the David, they're the Goliath, we're trying to identify those slingshots.

20 DR. CLAPP: Looking a little bit older on the developmental cycle, and then I'll come
21 back for a minute to the age group that Ginger mentioned, a couple of interesting things. When
22 you start looking at college students, the drinking patterns between males and females converge,
23 and there is a number of studies right now. I've been doing this for 20 years, and it used to be a

1 nice slope like this, where females were down here and males were up here. And over these 20
2 years, they're converging. There's actually now a number of studies with field data that show in
3 certain contexts women out drink men. Often those are very dangerous, sexually charged
4 contexts. So we've lost ground in that respect.

5 Among the younger cohorts, I think some of the data is encouraging on underage
6 drinking. We've actually made some progress.

7 Unfortunately marijuana is starting to fill in that gap. We're working on a study right now
8 with some data out of Boston where marijuana use has actually become more normative than
9 alcohol use among middle school and high school kids, including normative for driving, which is
10 very scary.

11 When you ask these kids, "Is it okay to drink and drive?", they almost all tell you "no."
12 "Is it okay to smoke marijuana and drive?" A bunch of them do it and don't see any problem
13 with it, etc. So there's always going to be a new challenge, unfortunately. I'll leave it there for
14 now.

15 MS. HARDING: And I'll tag on with that ONDCP, Office of National Drug Control
16 Policy, has an effort underway around drugged driving. When they began this almost a year ago,
17 people kind of looked at them, "Why are you bothering? The real problem is underage drinking
18 and texting." But they have found similarly that it is a growing concern around the areas of
19 drugged driving. We always seem to have another hazard thrown at us as we're trying to make
20 some ground here.

21 I have a follow-up question for Jane. Charlene, do you have anything to add to this as far
22 as the data, what you're hearing? I think some of what John was talking about I know you must
23 have data on, especially the marijuana use, which takes us a little bit off, but not quite.

1 MS. LEWIS: I made some notes while you were talking. Your point about the media. I
2 don't know how many people know that SAMHSA does have a relationship with the
3 Entertainment Industry Council and also with a group out of UCLA that pitches story lines to
4 script writers. So you might see a story on marijuana abuse or alcohol abuse in ER or Bones—I
5 don't have a television, so I'm not up on programs—or NCIS that's actually been pitched
6 through SAMHSA's Office of Communication to the group at UCLA to script writers. It's
7 something that we could bring again to folks in Communications.

8 The effectiveness of prevention messaging is really, really clear. The last time I did an
9 analysis of the effects of prevention messages versus youth use of alcohol, tobacco, and
10 marijuana, I found something very interesting. We've had more than a decade's focus on tobacco
11 prevention for kids. You've done a marvelous job. Kids between the ages of 12 and 17 believe
12 it's far more risky to smoke cigarettes than it is to use marijuana. The efforts that were put into
13 that type of prevention messaging can be, I believe, replicated and expanded to both alcohol and
14 marijuana. All of these are dangerous for kids. But the effectiveness of that focus is very, very
15 clear in the trend data since 2004. So that's a wonderful thing.

16 It just so happens that last week I was looking at teenagers, 16 to 18 year olds, and
17 whether or not they report driving drunk, and I was appalled at what I found. One in ten
18 teenagers reports having driven drunk at least once in the last year. One out of every ten kids that
19 you see behind the wheel has the potential to be an impaired driver.

20 I'm sorry I don't have anything more off the top of my head.

21 MS. HARDING: No, that's good. Thank you. I had wanted to try to put some contextual
22 overlay on our discussion.

23 My question to Jane and others around the table is, much of our programming is guided

1 by the amount of dollars that we have. It's a problem, which comes first, the chicken or the egg?
2 Depending on how good our messages are and how much our country people actually focus on
3 the problem, and they get the messages to the power brokers, which are our legislators at the
4 state level, our congresspeople at the federal level. It all circles around. We're finding that when
5 we tap into the medical profession, around helping people see where we fit into general health,
6 that seems to be an effective way to help people from the outside world that don't work with this
7 the way we do start to listen a little better.

8 Have you any kind of anecdotal success you can report out that this is something that we
9 should continue? Do you see a contributing factor?

10 Our theory is, the more we can get parents listening to their doctors, and particularly their
11 pediatricians again, and other physicians—you deliver an authority that I can't deliver, and many
12 of us around this table with all of our pedigrees can't deliver, because of the way our society
13 looks at physicians and the medical community.

14 Do you have any insight on that? Or, off the top of the head, you don't want the burden
15 shifted to you. All of the above.

16 DR. McGRATH: I think there's a lot of stigma about mental health and certainly, for
17 parents of younger children, the thought that your child might have a mental health issue is very
18 frightening.

19 There is a movement in medicine towards collocation of behavioral health with primary
20 care, and I think that in my experience, that's a great model. Two things. First of all, if you train
21 the primary care providers to do a better job of screening for mental health problems—
22 emotional, behavioral, whatever term you want to use—the primary care provider can normalize
23 mental health treatment for parents, especially parents of kids, in a way that is helpful. And I

1 don't know anything about the research, but collocation of primary care and mental health I think
2 is a very powerful model for two reasons. One is I think you increase the understanding and
3 willingness of primary care providers to do a better job of screening, because if you think about
4 it—

5 I'm an adolescent medicine physician, and many of the physicians I work with, their
6 approach is, "So you're doing okay, right? Life sounds like it's just fine!" And in their limited
7 amount of time, they're terrified of opening Pandora's box and then trying to shove everything
8 back in it again. And they have limited resources for referral.

9 And we do know that when you refer a kid out— So you see a kid in your office, and
10 they have a significant issue that you think needs mental health follow-up, there's really no
11 guarantee that people make that connection. I'd say somewhere around a third of people just
12 never quite get there.

13 So when you have collocation of services, even if you don't have an appointment
14 immediately available, one of the things that I really like to do is make sure that my patient and
15 the parent meet the mental health provider, so even though you may not be able to completely
16 close the gap and have them see them right away, you at least have them coming back to a
17 familiar place, and they've already met the person that they're going to see. It goes a long way
18 towards destigmatizing.

19 I think also making that partnership between primary care and mental health is also really
20 good in the other direction, which is that mental health providers have an opportunity to say,
21 "Gee, when was the last time you had a complete physical? And do you have anything that's
22 bothering you?" and making sure that those kids get back into primary care as well.

23 I'm a huge fan of that model of collocating services, and I think it works really well. And

1 it's the model that we use in school-based health centers, which is why I think, again, that's a
2 pretty powerful way to go.

3 MS. HARDING: Thank you. How about anyone else? It doesn't have to be underage
4 drinking. You can take off on the primary care connection.

5 Yes?

6 MR. GREEN: I was so pleased to see the Tribal Law and Order Act mentioned here. My
7 task, and the task for all of us in Indian Country, is to put together behavioral health systems of
8 care that support the Tribal Law and Order Act. We're looking at two areas. Clearly, the
9 attorneys are going to look at competency examinations, and I've got Michael Compton over
10 there to help me with the schizophrenics.

11 But we're really looking at increased services in domestic violence and substance abuse
12 prevention, Fran. So I noticed your second bullet under the tribal action plan was that there was
13 going to be an inventory of four proven approaches recommended by tribes that are evidence-
14 based practices. We would certainly welcome those recommendations. Do you have a target date
15 when those might be introduced?

16 MS. HARDING: Actually, I am going to punt this one also to Ginger. Ginger is
17 overseeing the new Office of Indian Substance Abuse Services for SAMHSA and to guide the
18 Tribal Law and Order Act, and she is very much involved in the guidance of what we're doing in
19 that act.

20 Can you touch a little bit on the direction of where we're going?

21 If you've noticed, the staff look a little tired. It's because everything we talk about here—
22 I keep punting because we're involved in so many different things that are all under the same
23 rubric, and we're all moving in the same direction, which is primary care and general health. But

1 in doing that, there are a lot of balls in the air at the same time.

2 Ginger?

3 MS. MACKAY-SMITH: And one of the most interesting balls in the air is the Tribal
4 Law and Order Act, which includes a provision that SAMHSA have a special role, and it created
5 an office called the Office of Indian Alcohol and Substance Abuse. This office is the one that
6 Pam Hyde put under Fran's direction, and it's in my division now.

7 One of the interesting parts about the Tribal Law and Order Act from my perspective is,
8 it's really telling the federal government to do our job better. There is no money involved. There
9 are no new programs involved. They say, you're already doing a lot of work. What you need to
10 do is do it in a more coordinated, coherent way so that it turns out to be better help and support to
11 the tribes, who are, after all, the ones in charge of directing their own services and approaches to
12 their people.

13 The inventory that you pointed to is one of the first efforts in that direction to identify
14 exactly what it is that the various departments and agencies are working on. And when I say
15 *various*, I mean not only the Indian Health Service, Bureau of Indian Affairs, Bureau of Indian
16 Education, several offices in the Department of Justice, but we've also been joined by a few
17 other departments that were not named in the legislation. The Department of Education has been
18 participating. Department of Labor has been participating. Within our own department,
19 Administration on Children and Families has been participating as well.

20 So to identify the resources and programs that are already there, give a quick description
21 of what they are, and a point of contact, so that tribes that are trying to develop programs,
22 approaches, etc., that suit their communities, their needs, will have a one-stop shopping. That's
23 idea behind it.

1 I don't speak Spanish, but my sister who does says, "It's a hard language to learn because
2 you learn the first part very quickly, but then in order to really be completely fluent, the last 20%
3 takes a tremendous amount to get to." We're finding the same thing with the inventory. We're
4 able to quite quickly identify a broad range of services, but in order to complete the inventory to
5 the extent it is most useful to the tribes—what the nuances are about the resources and how to go
6 about getting them—that part is a tougher nut to crack. But we're working hard on it.

7 Again, I could go on through lunch, but I'll let you direct the questioning a little more.

8 MR. GREEN: Thank you for the feedback and the information.

9 MS. HARDING: I will do a little infomercial. Within the next couple of weeks, and
10 certainly by the end of April at the extreme latest, we will have on the street a position
11 announcement to fill the director for this new Office of Indian Substance Abuse Services, so
12 watch out for that.

13 MR. GREEN: I will.

14 MS. HARDING: You might be able to forward that. We would appreciate any help any
15 of you can help us with in trying to locate the strongest candidates possible that are very familiar
16 with tribal concerns, either from a tribe themselves or at least have working knowledge to try to
17 garner the respect of the tribes across the country.

18 We have a fabulous working relationship because of the Tribal Law and Order Act and
19 putting that together, and Dennis Romero sat in the acting position of the director while we were
20 putting this together. Ginger came on the end of that and helped us actually push it through. So I
21 know we have a very good relationship

1 We are going into working with tribal communities and the Alaska natives. It just takes
2 time, and you obviously can teach me a lot about, which I am learning very quickly. So thank
3 you.

4 Okay.

5 MS. CONOLLY: I just have a quick question.

6 MS. HARDING: That's why we have those people up there, to tell me.

7 MS. CONOLLY: I really like the announcement regarding the National Prevention
8 Week, and I heard about it not too long ago. I guess my concern is that it is may, and while I
9 think it's a great idea, I think that the information going out happened just recently, and I was
10 just wondering -- you don't have to say why, I realize you guys have a lot on your plate, but
11 will there be a toolkit or some type of supportive documents that will assist states, communities,
12 and groups so that they have an understanding of their role and how best to go ahead and address
13 that?

14 And I'm just saying that because we just went through the town hall meetings in March,
15 and then now we'll have this in May. I think that we have done such a great job in terms of
16 Recovery Month and how we go about getting back to out. I've just recently seen the tool for the
17 observance this year already. I was just wondering if you can update in terms of how things are
18 proceeding with that.

19 MS. HARDING: This actually is an easy answer. If you look down at your agenda at 2
20 o'clock this afternoon, we have a whole session wrapped around an update on Prevention Week
21 and all the tools and products that are coming out associated with that by David Wilson. So if
22 you can hold on till 2 o'clock, we'll give you all the information.

23 DR. CLAPP: Just looking at the national strategy update, a couple of questions were

1 triggered by this comment here. An interesting note, growing interest in place of last drink data,
2 which is an area of particular interest of mine. I know in California these data are used quite a bit
3 in all the prevention planning.

4 Related to that I was just curious as to whether there would be any guidance coming out
5 for states, communities, grantees about how best to do that, and whether there might be any
6 interest in the future and looking at some of the model prevention strategies that CSAP has,
7 which now are still models. But there's been quite a bit of new science in the last 5 to 10 years
8 that could probably inform those models and help integrate them better.

9 MS. HARDING: Do you have any suggestions on either the target that we should be
10 trying to reach, or is there a form that is getting data information in these types of reports out to
11 you that would be most useful to you and to others? We are in the process of putting all of this
12 together to go out, and Ginger certainly can offline tell you about that. But is there something
13 that we should possibly be paying attention to?

14 DR. CLAPP: I just know from working with a lot of communities in Southern California,
15 it's one of those things that they find very useful but they struggle to do. So there is really very
16 few resources out there that tell them how to collect these data and how to best use them. It's
17 done in a lot of different ways, school surveys, police departments collect, drunk driving
18 programs collected sometimes. It just depends.

19 But I think there is a place for some sort of guidance for folks to better know how to use
20 and collect those data.

21 MS. HARDING: I think one of the things that SAMHSA has as a huge hurdle is, we
22 collect a lot of data, and we get a lot of data from our communities. Not as much as we would
23 like, but we collect a lot of statewide data. We borrow data from our other federal partners. And

1 we're having some struggles now, and Charlene can best tell you offline what some of those
2 struggles are. But we are trying to wrap our arms around what do people most need and how
3 much do they need? And is there special packaging?

4 Some wanted virtual. Some wanted pieces of paper. I have to tell you, pieces of paper are
5 going. I envision us sitting around the table with all iPads soon, because we soon are getting to
6 the point where paper is going to be obsolete.

7 Maybe that's a follow-up, one of the things will discuss at the end of today's meeting in
8 follow-up questions. How can we get information out to you that we discussed today, and how
9 can we get information from you that you may want to elaborate on? Since we have these three
10 NACs, especially the two that that all of you are involved with, it does not afford us the
11 opportunity to keep you for 2 days anymore. And that's truly when you get an opportunity to
12 present, discuss, and then for us to send back to you. We are missing that second day. It's not a
13 complaint, just a fact.

14 So I'm trying to figure out with staff how do we meet your needs better and that we get
15 the richness. So, thank you. Charlene can talk to you and Ginger can talk to you offline or at
16 lunch or something.

17 We are having that problem. We have books like this, and I'm not joking, and trying to
18 sift through what do we need. And we are getting that question from Pam and other leadership,
19 not to mention Congress. So when you have multiple consumers out there, we're trying to
20 package things up so that they'll best use them. We know that one-pagers are great, but even
21 one-pagers are difficult in trying to figure out what to put on. So we'll be sending you out some
22 information to help you guide us on that, too. We have the data. We have even analyzed the data.
23 But how do we get it out so people will actually use it?

1 So we are almost down to the second before we keep you on track so you can have your
2 full, relaxing hour and a half for lunch.

3 Is there any last thing on here that maybe you don't understand, that we wanted to
4 become a part of, that we should spend more time talking about after lunch? We certainly have
5 the flexibility to do that as well. Would you like the lunch to think about it, and we can regroup
6 right before? Give you some time to think.

7 Hearing none, I suggest that I will ask that before we start next time.

8 Now eat lunch, get your energy back up, because I think it's going to be an exciting part
9 of the agenda. One, you'll learn about the projected proposed grant announcements that are
10 coming out this year, and they are coming out this year. You'll hear much more about our
11 National Prevention Week.

12 Eugenia, I don't think you'll get much pushback. May's not the best time, after the town
13 hall, but you'll see how the town hall meetings and the activities of Prevention Week go hand in
14 hand, which I hope will ease that direction.

15 You'll learn about the budget, which may bring up some questions.

16 Last, but certainly not least, a conversation about what you may want to consider your
17 positioning for tomorrow in the joint session meeting. For those of you who have been in the
18 joint meeting in the past, you know that right off the bat as ambassadors to SAMHSA/CSAP in
19 helping to get some of the prevention messages to your colleagues across the country and my
20 colleagues and our colleagues from SAMHSA to hear the directives that we must get on the
21 agenda and front and center. So if you think we have competing interests outside of SAMHSA,
22 wait until you hear for the first time competing interests inside SAMHSA.

23 You can tell, I'm pretty competitive. I'd love a second day after the joint council to sit

1 and talk about where do we go from here. So we can talk about opportunities for that at the end
2 of today as well.

3 So we have a packed afternoon. We are seconds away from being right on time. I thank
4 you for that.

5 I think we have guidance on your sandwiches for those of you who ordered. And we'll
6 see you back here if you leave at 1:30 promptly. Thank you.

7 [Break.]

8 BUDGET OVERVIEW AND DISCUSSION

9 MS. HARDING: I'm going to turn this over to Suzanne Fialkoff, who is Director of the
10 Office of Program Analysis and Coordination at CSAP, shortened by saying Policy and Budget.
11 She's going to give us an overview of both the 2012 and 2013 budget, and then we'll take
12 questions.

13 I'm going to move away from the screen so I won't blind myself and also I will not be in
14 your way. And then we'll have a discussion afterwards.

15 Will you take questions as they come, or would you prefer to get through?

16 DR. FIALKOFF. It really doesn't matter. The presentation is not that long.

17 The last time we were together, we did not have a fiscal 2012 budget yet, which is pretty
18 much the way it goes. Budgets are very seldom, if ever, passed on time.

19 What you've got here is a comparison of what our fiscal 2012 budget request was versus
20 what was actually enacted. This is a "good news" story, because the bottom line—you see total
21 at the bottom—we actually got more than we did request. It worked out well.

22 Some things might seem a little funny about this table, the Programs of Regional and
23 National Significance, that, is our whole discretionary portfolio. All of our grants and contracts

1 are in there, basically everything that CSAP does except for the 20% set-aside of the block grant
2 is in what we call our PRNS.

3 You can see the total under Programs of Regional and National Significance, and then
4 underneath them, as non-adds—these are the components of them.

5 What looks a little funny there is, as Fran mentioned earlier, in the 2012 budget we did
6 request the Substance Abuse State Prevention Grants, which would have incorporated the 20%
7 set-aside of the block grant plus our Strategic Prevention Framework portfolio of programs. And
8 that did not pass in 2012, so the budget is back to the structure that we had before. We have the
9 20% set-aside. We have our Programs of Regional and National Significance. We have our
10 Strategic Prevention Framework budget line, and those grants are continuing. So you can see all
11 of the different programs there that are included in that.

12 Are there any questions on this, the 2012, what we requested versus what we got?

13 Let me say one more thing about 2012. One thing that we did get in 2012 was that our
14 appropriation was divided into four separate appropriations. Usually we get one appropriation for
15 SAMHSA, and now there are four: one for prevention, one for treatment, one for mental health,
16 and one for health surveillance and program support, which supports our Center for Behavioral
17 Health Statistics and Quality and a number of other SAMHSA-wide activities.

18 Let me go on to 2013. In our fiscal 2013 request, which was released in February, we're
19 again putting forward the request for the Substance Abuse State Prevention Grants and
20 continuing to support that idea. So again, that's why you'll see, under Programs of Regional and
21 National Significance, it looks like it's gone down. But where you see those funds will be under
22 Substance Abuse State Prevention Grants at the bottom. So we're continuing to work with
23 Congress and with our other partners on those grants.

1 The appropriations bill this year also had a provision that had not been in there before,
2 which prohibits us from spending money on activities that are—I have the exact language at my
3 place here—that are designed to restrict the sale of any legal product. That raises some questions
4 about what this means for our grantees on the ground who are doing environmental strategies
5 and working for things like keg laws and other kinds of legislative and environmental activities
6 that will help prevent substance abuse.

7 We're working with our general counsel on getting some guidance on what this means,
8 so you'll be hearing more about that. It's not quite finalized yet. The language is finalized; what
9 it means for our grantees is not quite finalized yet.

10 In another few weeks, we'll be starting to work on our 2014 budget request. We're
11 always in the middle of three fiscal years here at SAMHSA.

12 It's very likely that, this being an election year, that we will have a continuing resolution
13 again come this October 1, and it's possible that we will have a full-year continuing resolution. A
14 lot remains to be seen as to where our budget will go.

15 I'll take questions on any of this.

16 Okay, thank you.

17 MS. HARDING: Okay. I'll get questions out of you!

18 [Laughter.]

19 MS. HARDING: You just don't know the right things to ask! So let's try to leave the
20 board up just in case. Actually you have it in front of you. It's in your packet. It just looks
21 prettier in here than it does up there.

22 Do you understand the different in the types of programming? We're going to go through
23 the grants that are being planned for 2012. But the shifting of the appropriations, you'll probably,

1 though I haven't seen a final agenda for tomorrow, but you'll probably be going through that in a
2 little bit more detail than what Sue just told us.

3 It has caused some difficulty because it's very difficult to figure out where our money
4 really is, because we've never worked with four separate appropriations. So Pam will say
5 something like, "It's not that we're trying to hide anything. We're just trying to find still where
6 some of the money is, because there's not a straight line any longer, where all the substance
7 abuse prevention dollars go over here, and the programming for our HIV/AIDS goes over here."

8 To complicate that, some of you know that Pam has been asking us to consolidate several
9 of our programs. For instance, HIV/AIDS. HIV/AIDS programming is now under one contract,
10 so we have taken— This was before we knew we were going to have four separate
11 appropriations. So if you can think of this administrative nightmare, before we found out that our
12 funding was going to come to us in a different way, Pam has the three centers fold, because
13 CBHSQ, our fourth center, doesn't have money in this area, I don't think—

14 Sue's shaking her head "no." Thank you.

15 —that the three centers' all of our contracts and grants had to come together under one
16 umbrella. And then, once we got that all taken care of, we find out now we're all separate again.
17 So we are programmatically under one umbrella, meaning that the programs are all mixed in, but
18 our money is separate.

19 I guess maybe we are learning what we ask some states to do at times, which is to
20 combine programming but keep the budget books separate. That's only Fran Harding's
21 interpretation, not SAMHSA's. Let's keep that clear.

22 The way we are looking, and like I said before, the biggest controversy out there among
23 the states, territories, not so much tribes, is the fact that 2012 the President's budget outlined the

1 State Prevention Grants. In 2013 the President's budget is outlining State Prevention Grants. Not
2 popular by Congress's standards or states' standards for the most part. So we're struggling a little
3 bit in how we put grant opportunities out there.

4 And the other issue is if you look at the budget for 2013, we don't have any new
5 prevention dollar in our discretionary portfolio.

6 Is that correct? Because if I say anything incorrect, correct me.

7 So that limits our ability to plan, and it constrains the 2012 grant opportunity that you're
8 going to hear about in a bit, because we only have 1-year funding. In the world of prevention, 1-
9 year prevention is difficult. You can put your own word in there. It's a continuous struggle with
10 a juggling act. And if we have a CR for a year, we could have more than 1-year funding—but
11 you can't plan for that. So it's difficult to try to decide to put a prevention agenda out there
12 where our states could have an opportunity to really bring the Strategic Prevention Framework
13 logic model into play to identify the areas of high need, to identify the substance or problem that
14 puts young people at the highest of risk, but only have a year to do it in and that we're requiring
15 these outcomes to show Congress and others that we're making a difference.

16 So are you getting the feel of why this has been a difficult year and will continue to be?

17 However, what we've done is, we're getting pretty good at bobbing and weaving, and
18 how to set a grant opportunity up that could be continued—because sustainability is always our
19 issue. I think we discussed that a tiny bit last time—trying to put grant opportunities out there
20 that could be, and ask states and territories and communities, our whole issue is something's
21 doable.

22 What's doable? What's doable is this gap between the state and the community. So every
23 grant opportunity we're trying to put out there is meeting all those other requirements but also

1 helping states and communities learn to work together better, and to the point where you're
2 going to hear from someone who will be talking about how important it is for states to learn that
3 success at the community level—where you will see success—then eventually over time will
4 bubble up and feed into the success of a state.

5 Right now that's really where we feel we have our biggest strength, in helping Congress
6 and local legislators and county leaders and anyone else that's looking at us to show them that,
7 stop looking and judging us at the success of moving the needle of use at the state level, when
8 you give us a year or 3 years to make a difference. Let us show you how the success at a local
9 level on indicators and changing those indicators, changing keg registration law, reducing the
10 number of young people that go to the local emergency room with an alcohol- or drug-related
11 incident, changing the percentage of young people being bullied in a school over a year's time
12 because of a program that was implemented—those kinds of measures—and helping both our—

13 See, now, the problem is we're teaching everybody at the same time—states seeing the
14 richness of those indicators, helping Congress and others see that the benefit of doing this, and
15 then also helping them understand, "This is not the end product. These are just small successes
16 that we're trying to gather together to make the large impact over a couple of years' time." So
17 that's what we're doing in the budget that isn't seen with the numbers.

18 And when we talk to you about our grant opportunities, I ask you to think about that and
19 see if you're hearing that kind of a match-up with putting as few unfunded mandates as possible
20 on our grant opportunities. We're hoping that this process will increase sustainability, because
21 you'll be leveraging funds from other grants that are coming out there.

22 The dollars for prevention are out there. It's just not out there labeled "substance abuse
23 prevention," "mental health disorder prevention." It's out there in different ways. CDC has

1 money out there. HRSA has money out there. Indian Health Service has money out there. Our
2 project officers that are managed by that back row, back there, and the talents they have helping
3 their staff help the states and the communities connect the dots.

4 So that's actually what we're all trying to do. So our jobs have changed a little bit. And
5 what we could benefit from a future phone call meeting is to hear from you, once you get a
6 review of also a paper that we're presenting to you today, looking at the grants, looking at the
7 paper, listening to the philosophy, and then we'll have a call to put it all together and see if you
8 feel we're going in the right direction. Or if you have a better idea. "You missed this
9 opportunity." "Have you thought of that opportunity?" And those kinds of things.

10 That's the master plan for programming.

11 Knowing that, are there any questions on the budget? You'll get the budget again
12 tomorrow, I imagine, pretty extensively.

13 We narrowed it down just to CSAP's budget. The piece that you don't have here are the
14 dollars for mental health. That was purposeful, because we didn't want to confuse you, because
15 the mental health prevention dollars are not pulled out as easily here. It's not really our budget
16 for this NAC to be looking at—although the programming can make some sense of that. But we
17 can certainly at another time send you the CMHS budget as well.

18 Is there a problem? No.

19 DR. FIALKOFF: I just wanted to add one thing. The administrator did give a webinar on
20 the budget a month or so ago. I believe that is still posted on the SAMHSA website under Budget
21 on the whole SAMHSA budget.

22 MS. HARDING: Yes?

23 UNIDENTIFIED: Can you comment briefly on interest groups?

1 MS. HARDING: Remember, you're all part of SAMHSA sitting in these roles. You
2 signed your forms.

3 Interest groups. Interest groups, there's a combination of them.

4 The field of substance abuse prevention, not so much mental health, because mental
5 health, although they have issues—we'll do the mental health, it's easier— The mental health
6 side of the house, this is all rather new to them. Their block grant didn't prevent you from doing
7 a preventive program, but it also didn't encourage you. And it most certainly didn't have a set-
8 aside in the block grant itself. So adding a component to the mental health block grant isn't as
9 difficult.

10 At that level the stakeholders are more concerned about: What are we talking about?
11 What kind of prevention programming are you talking about? Are you talking about screening
12 and brief interventions? Are you speaking about, there is no prevention for schizophrenia, which
13 we now know that's not necessarily true? But the science is not as known yet, and that's new. So
14 it's a different kind of a conversation. So not getting a lot of pushback. It's just a lot of new. "Do
15 we really want to take Project LAUNCH? Was that the right thing to do and expand it for more
16 states to be able to use?" Project LAUNCH is that program for 0–8 around emotional health and
17 substance abuse.

18 On the substance abuse side, the controversy is around the 20% set-aside. It's breaking
19 the block grant. That's really what this is about. The Substance Abuse Prevention and Treatment
20 Block Grant has been around—I don't know how long. Michael, do you know?

21 MR. COUTY: I want to say 1981.

22 MS. HARDING: So it's been around for a long time. States see it as a stable source of
23 income. It very rarely gets touched, although it did get reduced in kind of a complicated way.

1 The 20% ensures in every state that there will be a prevention component within programming.
2 The pushback is that there are nonbelievers. The belief of SAMHSA is that if you take the
3 discretionary portfolio of SAMHSA, and you combine it with the 20% block grant set-aside, you
4 will then establish a place for people to enhance and to grow prevention programming.

5 Every dollar you put into the block grant, 80% goes to treatment, 20% goes to prevention,
6 so if you do that math, if you have a separate funding stream just for prevention, if you put in a
7 dollar you get a dollar, that you don't have to share the dollar, that will grow.

8 And the block grant really hasn't grown significantly. It's grown, by bits and pieces, but
9 not significant growth.

10 We all share that we do not have— The country is not investing the type of dollar in
11 substance abuse and mental health disorder prevention that it should or could it to make the kind
12 of impact we're being asked to make. We are being held accountable to higher standards and we
13 have less money. The President's budget supported a way for us to grow.

14 So it's fear based on history, that the block grant is more stable. At this to one more piece
15 where the Department of Education had their discretionary portfolio taken away from them two
16 years ago. And it has taken this long for it to be realized with the programming, but that was cut
17 off because Congress did not feel— This was Safe and Drug Free Schools, the formula grant for
18 Safe and Drug Free Schools. So they are seeing what happened to Education. This could happen
19 to substance abuse and mental health. So that's the pushback.

20 People around the table have been dealing with this on the other side, and I didn't know
21 whether you would like to add anything. Did I leave anything out?

22 MR. COUTY: Since I have no allegiance in that area anymore, since I'm at the county
23 level and not the state, from the state's perspective, when you first hear that, the 20%, they view

1 that as something taken away, not that you're sharing it, because it was in one camp. Now you're
2 going to spread it across three camps, and two camps are not putting anything in there. Only one
3 is putting it in there. If you look at it from that perspective, one loses and two gain. But then the
4 state, in totality, gains when you look at spreading the wealth.

5 MS. HARDING: And the only additive to that is, that is true and a little tiny bit of a myth
6 as well, that we can't seem to correct, which is, we are not taking from substance abuse and
7 giving it to mental health and tribal. It's not where the money is coming from. It's coming from
8 another portion of funding. There is the big problem from where controversy comes. SAMHSA
9 has not been able to identify where that money is coming from, and there is a reduction in the
10 substance abuse prevention budget. So until we figure out what happened—but it's not a dollar-
11 for-dollar match, but it still will be helpful once we are able to figure that out.

12 But Michael is absolutely correct.

13 Another positive is, right now states are held accountable to a minimum of 20%. Some
14 states put in more than 20%. So they are concerned about, well, what do I do with that?

15 Now in the law itself, or proposal, it does allow states to continue to put more than 20%
16 in it. It has to have a minimum of 20% being brought in, but that's clumsy, if you think about a
17 state budget: How would I do that, if this is now deemed for treatment and over here it's deemed
18 for prevention?

19 Yes, Eugenia.

20 MS. CONNELLY: Just for some of the new members, the 20% set-aside has been really
21 the sole pot of dollars in the block grant for just about every state. It has provided the foundation
22 for substance abuse prevention programs and activities. As Fran has stated, the concern was that
23 there has been no growth in those dollar amounts and what could possibly be done as a means to

1 grow the amount of resources, fiscal and nonfiscal, that could be provided to prevention and
2 particularly to support that 20% set-aside.

3 DR. McGRATH: I may be wandering right into a major sacred cow here, so if I am, my
4 apologies.

5 It would seem to me, with the move towards mental health parity and some of the
6 changes towards health reform, that the whole concept of block grant that provides funding for
7 treatment would begin to be somewhat of an anachronism potentially, which would then also put
8 at risk the 20% set-aside, because if you are taking away the treatment dollars, you don't have
9 20% of anything. Is that doomsday scenario where we are heading?

10 MS. HARDING: No, I think that it could be in some minds, but I think this is a difficult
11 time to create and propose this type of change. I've grown to accept that it's not that it's a bad
12 idea, and I see the strengths. But it's a difficult time during when money is going away for
13 everyone, not just substance abuse and mental health. In the prevention field, we are not real
14 comfortable that people have really accepted what we're doing and that what we're doing works.

15 Eugenia points out something that is so very important. In many of our states the only
16 dollars they get for prevention these days are the 20% set-aside and, if they're lucky, a grant.

17 Once we got the President's budget, we are trying to eliminate this need for being reliant
18 on having to do grant making and having to apply for grants. We want long-term, sustainable
19 funds that go to the states, so you don't have to apply. You would have to apply for the dollar,
20 but you would not have to compete for the dollar. So every year the dollar would grow or would
21 not grow together, and that would be your pot. So we would be like the block grant.

22 Yes, Michael?

23 MR. COUTY: Just so I can wrap my arms around this, then. If the 2013 budget is

1 approved for a state prevention grant, does that mean, then, that the dollars I had allocated for
2 2012 I would need to at least bring back in? I would not maintain that funding, what I had for
3 2012? Because if that 20% is going to be pulled in, and that's what I'm using my dollars in the
4 state is out of that 20% set-aside, and it's going to be then for State B, you had \$10 million out
5 there in 2012, but then we're saying for 2013 we're going to use that \$10 million now for
6 prevention mental health and treatment prevention at \$10 million that I had for State B. Am I
7 thinking about that in the same way?

8 MS. HARDING: That's one way of thinking about it.

9 MR. COUTY: So for 2012 I can keep that same \$10 million out there, plus another \$10
10 million.

11 MS. HARDING: Right. Let me answer it a different way. Let me say this, that every state
12 would receive the same amount of money in 2013 that they would normally receive with the
13 20% set-aside. So that doesn't mean an equal amount that you're getting in 2012, because in
14 2013, if we get another reduction, whatever reduction we would have received, you as the state
15 —\$10 million may now go down to \$9 million—it would go down to \$9 million whether it was a
16 20% set-aside or whether it's in the state grant. You start from that base.

17 Where we got hung up is, I think, we said you'd have the same amount of money in 2013
18 that you have in 2012, which is not really the accurate statement, because we don't know—
19 unless any of you do, please share it—we don't have a crystal ball. So we don't know what's
20 going to happen.

21 Whatever you would have normally had as a state or territory in 2013, as a block grant
22 the way it originally is, with the minimum of 20%, you will have that. That will be your base in
23 2013.

1 Correct, Richard and Sue?

2 MR. MOORE: Correct.

3 MS. HARDING: So that's where you start. And then the discretionary dollar is what is
4 going to be the changeable number. Remember, that's our SPF line, the line that was shown in
5 the budget. If you see it in 2013, you follow that down, you'll see that's where the \$404 million
6 comes from. That's where that's created from. That would be, as of today, we don't know about
7 a reduction, that would constitute the amount we would have for both the 20% set-aside and
8 what we're calling our discretionary portfolio.

9 Is there another way to call it? No. Discretionary.

10 Is that helpful?

11 DR. McGRATH: We're glad you understand it.

12 [Laughter.]

13 MS. HARDING: Well, we've been living with it. We've been trying. It's laden with a lot
14 of questions, and it's not just the states' burden. It's also all of our stakeholders, mostly because
15 it's confusing to understand. Why are we making so many changes when the budget's being
16 reduced? How is this going to affect me? In other words, if you're a community-driven
17 organization, how is it going to affect those community programs that we currently have, if
18 you're going to combine all these dollars down to one?

19 So it's really fear. And one of the other fears is trying to help people understand that Pam
20 truly is looking at prevention. As Michael has stated a number of times, it's back to the strategic
21 initiative. It's the substance abuse and mental health disorder prevention portfolio. In our statute
22 we have to keep our substance abuse dollars separate from our mental health dollars separate
23 from our tribal dollars. So we are in the process of linking that up. And that's a lot of layers, and

1 it's very confusing.

2 Yes, Michael? Last question and then we need to go on to David.

3 MR. COUTY: Perhaps you can help me here. If we're talking about the block grant for
4 2013 is going to be \$404, but then the SPF-SIG is roughly \$109, it's almost like you're bringing
5 in all the rest of the prevention funding to add to that across the board. A state would have to—

6 MS. HARDING: Are you looking at both of these budgets? Because in 2012 you have
7 the Substance Abuse Treatment Block Grant is \$344. Okay?

8 MR. COUTY: Yes.

9 MS. HARDING: Okay. Is this just the 20%?

10 DR. FIALKOFF: Yes.

11 MS. HARDING: Okay. So that's the 20%. You add to that the money that's in the
12 substance abuse prevention discretionary fund, which is in the SPF line. See how the \$4 million,
13 \$41 million, \$7 million. That all adds into the \$404.

14 So what was the question that I misunderstood?

15 DR. FIALKOFF: \$404 and \$530?

16 MS. HARDING: No, \$530 is 2012. We're looking at 2013 only. Did I miss the question?

17 DR. FIALKOFF: The total includes all of the other discretionary activities. The
18 Substance Abuse State Prevention Grants would include the 20% set-aside plus just what used to
19 be the SPF line, the Strategic Prevention Framework line.

20 MR. COUTY: Right, that's what I thought.

21 DR. FIALKOFF: It would not fold in all our discretionary activity.

22 MR. COUTY: Right, because every state may not have all of the discretionary funding,
23 either.

1 MS. HARDING: Oh, wait a minute. You might be asking a different question. Not every
2 state is going to— The only thing that every state is guaranteed, is that what you're getting at?

3 MR. COUTY: Is the 20% and that they have a SPF-SIG?

4 MS. HARDING: If they have a SPF-SIG while the life of the SPF-SIG is alive.

5 MR. COUTY: Right.

6 MS. HARDING: Yes, that's true.

7 MR. COUTY: Okay. Then I'm on base with you.

8 [Laughter.]

9 MS. HARDING: I like it when people are on the same page.

10 We can spend more time afterward, because I think the grants conversation may go a
11 little smoother. But we can spend more time on this after you think about it a little bit and you
12 hear about the grant opportunities. Write your questions down, if you're like me and I forget, and
13 I'll be happy to spend much more time on this, because it's confusing.

14 We're talking about being ambassadors. This is what you will be hit with the most.
15 That's why I'm very happy you asked the question and started this conversation. This is what
16 concerns the field the most about SAMHSA. What are we doing with the prevention dollar? Like
17 I said, primarily it's being guided by the states because they feel that they're the biggest winners
18 and losers, depending on which state you're sitting in. It also, though, encompasses, because it's
19 the entire portfolio of the Strategic Prevention Framework dollar, it encompasses all community
20 programming as well.

21 However, Sue said something I should have said, and I didn't think about it, so I thank
22 you. It's not the entire prevention portfolio for substance abuse that will go into the state grant,
23 but it's certainly the overwhelming majority of it. And that's purposeful so we can grow it and

1 that each state would have a maximum number of dollars so that they could plan and guarantee,
2 as much as one can guarantee, our money with the percentage cuts that we would take. But we
3 will grow together and we will shrink together. And everybody will be in the same boat.

4 That will not happen, by the way, until 2016. 2016 will be the first year where, if this
5 were to be enacted in 2013, it won't be until 2016 where all the current Strategic Prevention
6 Framework dollars are invested. They will have all recycled out and into the state grant.

7 So as our SPF line programs recycle out—meaning when they end—then that money, if,
8 if, we have a state grant, that money will automatically go into the state grant and be delivered as
9 part of the formula to the states.

10 So we are eliminating grant making for the majority of our dollar. That is a big shift in
11 the way we do business for substance abuse and mental health disorder prevention.

12 Different shift for mental health because they've never had to do it. So the big shift for
13 mental health is, are we really ready and prepared to take on a prevention portfolio in general,
14 which means a lot of training, a lot of technical assistance, and a lot of sharing. That's why we
15 have the proposed academies coming up, where substance abuse and mental health are coming
16 together in the prevention world to learn from each other, so we can try to prepare the field for
17 2013.

18 Okay, can we move on, and then reserve the right to come back if you think about—oh, I
19 should have asked this? Or maybe something in our discussions coming up will trigger
20 something.

21 Okay.

22 NATIONAL PREVENTION WEEK: OVERVIEW

23 MS. HARDING: Let me introduce to you David Wilson. David is going to give us a lot

1 more detail in 15 short minutes or less on the National Prevention Week.

2 And David, I just want you to know ahead of time that Eugenia over here in the corner to
3 my left has brought up a question, which she'll probably ask you again if you don't answer her
4 question. Just be prepared that you'll have at least one question.

5 Do you want to go through the whole week quickly and then take questions?

6 MR. DAVID WILSON: Yes, if I could.

7 MS. HARDING: Okay, then I turn you over to David Wilson. If you could tell people
8 what you do, so that they have a little context.

9 MR. WILSON: Got you.

10 Good afternoon, everyone. My name is David Wilson. I am a member of CSAP's
11 materials development team. I work in the Division of Systems Development under my leader
12 over here, Virginia MacKay-Smith. I'm also the project officer of our health communications
13 and marketing support contract. And as part of the team, we've been working very, very hard on
14 the promotion and coordination of National Prevention Week.

15 I want to say, first, I'm very excited to give you an overview today. I'm also joined with
16 another member of my team, Tracy Farmer. Tracy Farmer actually, I have to give her some
17 kudos. She was really the initial brain, creative mind behind National Prevention Week. I'm just
18 the current spokesman right now. She's going to help me in taking questions at the end of my
19 PowerPoint presentation.

20 My slides are in the folder on the left-hand side. I'm going to dive right on in, because I
21 know I have only 15 minutes.

22 What is National Prevention Week? I like to tell people as I'm giving my spiel that
23 National Prevention Week is a brand-new, week-long, public health observance sponsored by

1 SAMHSA, which at its core is going to celebrate the work that individuals, community
2 organizations do around substance abuse prevention and mental and behavioral and emotional
3 well-being.

4 Why May 20–26? We thought that this time, at the end of May, was a perfect time,
5 because it’s usually looked at as the kickoff to the summer season. It’s also looked as the kickoff
6 to activities and recreational events that are often times linked to substance abuse and misuse, so
7 we were hoping, with Prevention Week being this week, that it would be a counterbalance to all
8 those things that happen during this time of year, like graduations and proms and weddings and
9 the like. Also, we chose this time because we wanted to allow schools to be able to be involved
10 in some of the prevention-themed events before the end of the school year.

11 So we have five things that are going to be taking place during that week. As you can see
12 in front of you, on Monday we’re focusing on the prevention of underage drinking. Tuesday
13 we’re focusing on prevention of illicit drug use and prescription drug misuse and abuse.
14 Wednesday we’re going to focus on the prevention of adult alcohol abuse. Thursday is a
15 spotlight on the prevention of suicide, and on Friday is the promotion of mental, emotional, and
16 behavioral well-being.

17 The overall theme of National Prevention Week is “We are the ones: How are you taking
18 action?” I like to think of this theme not only as the theme for the week, but as a call to action to
19 individuals and communities to ask them to reflect on what they can do to prevent substance
20 abuse and to promote mental, emotional, and behavioral health.

21 This theme was kicked off in the middle of 2011 as a part of SAMHSA’s video PSA
22 contest, and I also wanted to show you the winner of the PSA contest to break up my spiel on
23 National Prevention Week—and hopefully it plays. The winner was selected from many

1 organizations from across the country of young people. This winner comes from Richmond,
2 California, and they won primarily because their 30-second PSA really speaks to the theme of
3 National Prevention Week.

4 So here it is.

5 [PSA screened.]

6 I think that really does get to the heart of the theme, and we were so very proud of that
7 PSA. It's also being shown as part of our exhibit and our collaboration with the Drug
8 Enforcement Administration as a part of their Target America exhibit, which is currently in
9 Tampa.

10 The goals of National Prevention Week. First and foremost, what we want to do with the
11 week is provide an opportunity not only for community members, but for individuals to learn
12 more about behavioral health issues and to get them involved in prevention efforts. It's also
13 important for us to not only to celebrate, to honor, to lift up the work of community
14 organizations to do the work, but as with all good public health observances, we want them to be
15 able to raise awareness. And for this, we're asking that they raise awareness about SAMHSA's
16 prevention efforts through local events and through national participation.

17 Of course, the foundation of National Prevention Week rests with our strategic initiatives
18 and also our national priorities. Even though the main thrust of National Prevention Week
19 focuses on Strategic Initiative #1 and Strategic Initiative #8, as you can tell from the previous
20 slide from the five themes that I listed for each day of the week, it also touches on all of
21 SAMHSA's strategic initiatives, either directly or indirectly. Then, of course, we couldn't be
22 doing National Prevention Week unless it aligned tightly to the National Prevention Strategy.

23 Another mark of a good public health observance is promotion. One of the ways that we

1 knew that we needed to promote this week, which is brand new, is that we wanted to have
2 promotion on the ground. So we've decided to select 60 organizations from across the country to
3 conduct prevention activities in their communities. The 60 organizations are representative of 47
4 states, and that also includes the Pacific jurisdiction and the District of Columbia.

5 The organizations that make up these 60 organizations are community-based
6 organizations and coalitions, faith-based organizations, youth-serving, educational, and military
7 organizations. We got the selections of the 60 organizations primarily from our NPNs, but
8 because National Prevention Week just isn't a CSAP-sponsored observance, we also reached out
9 across all our sister centers to get recommendations for organizations that would be worthy of
10 getting the pilot sites.

11 We're giving them a small \$575 stipend to conduct their events, and with giving them the
12 \$575, we are planting a seed for this year. Of course, in planting a seed, you want to make sure
13 you have the best possible seed, and then when you're planting the seed, you also want to make
14 sure that you're nourishing and watering that seed properly.

15 One of the ways that we're planning to do that is with our National Prevention Week
16 Toolkit, which is available online. I want to talk about two of the bullets under the toolkit that I
17 think are very important for the communities that are doing their events.

18 The fact sheets are a very useful component for them, because the fact sheets are focusing
19 on the five featured topics. And also, the second thing that I wanted to draw out from this slide is
20 the toolkit really offers them good guidance on identifying and connecting with potential
21 partners, which could in itself be another goal of Prevention Week. We practice and we preach
22 collaboration. One of the things that we hope that these communities will take away from doing
23 these events in their communities is building those connections with other organizations within

1 their community, because that's what's going to make this activity last just beyond the week.

2 Oh! My boss says that toolkits are also available to community-based organizations that
3 don't get the \$575. And that's true.

4 This slide highlights the goals of the events. Of course, we want them to increase the
5 visibility of the topics that are highlighted for each and every day. We're hoping that the events
6 provide a forum for their community. And, of course, I can't say this enough, we hope that these
7 events create opportunities for further networking and community collaborations.

8 This is a map that shows where the 60 organizations are. As I said before, the 60
9 organizations represent 47 states and the Pacific jurisdiction and the District of Columbia. We
10 also, in selecting these 60 organizations, we wanted to make sure that each of these organizations
11 not only covered the United States but that they were representative of the five themes and that
12 they were representative of the eight strategic initiatives.

13 Of course, with awarding the pilot sites for our on-the-ground promotion, there's also an
14 online component to the promotion for National Prevention Week. I was going to click just to
15 show you the face page of National Prevention Week. As you can see it announces the week. It
16 tells communities, even those who don't get a stipend, how they can be involved, how they can
17 host an event, the themes of the event, and to take the Prevention Pledge, which I want to talk
18 about next.

19 The Prevention Pledge is another one of the key components of the toolkit. It's one of
20 those things that we thought would allow individuals to commit to the promotion of emotional,
21 mental, and behavioral well-being in addition to the prevention of substance abuse. It also is
22 another way for us to track the activity that is going on online with all of the communities that
23 are doing something around National Prevention Week. It's going to be one of my pledges to

1 you guys, I hope that as ambassadors of CSAP and SAMHSA that you guys go to our website
2 and that you also take the Prevention Pledge and that you eventually spread the word.

3 Lastly, there's a huge digital component to National Prevention Week. I'm going to
4 quickly go through this. We have three rounds of the outreach to bloggers. We have already
5 completed the first round of outreach to our bloggers, and we're only targeting information about
6 National Prevention Week to the prevention and mental health bloggers. We have three rounds
7 of custom outreach to our federal partners, health agencies, listservs, and the Recovery Month
8 planning partners.

9 I want to say that I've been very pleased with the cooperation that we've gotten so far
10 from some of our federal partners. We have already started some cross-promotion with CDC. We
11 have started cross promotion DEA, with ONDCP, with CADCA.

12 One of our other big partners right now is APHA. I'm sure that many of you know that
13 APHA has their own public health observance, which happens April 2–9. They have been an
14 outstanding partner to us so far. It just so happens that the theme of their public health service
15 week really focuses a lot on prevention and well-being. While they have offered to give us
16 access, not only to their 15,000+ membership, which expands our reach of course, but also they
17 have a communications mechanism that rivals CDC that will also extend the outreach of our
18 week as well.

19 We are also doing heavy promotion with our SAMHSA Facebook and/or Twitter
20 accounts and because of the collaborations that we have so far with our federal partners, we are
21 going to be doing a lot of guest blogs on both our Facebook and/or Twitter accounts. Dr.
22 Benjamin from APHA has already committed to a guest blog. Michele Leonhart, who is the
23 administrator of DEA, has already committed to a guest blog, and I am hopeful that Mary

1 Wakefield from HRSA and some other federal partners will also be doing guest blogs as we lead
2 up to the launch of National Prevention Week.

3 Lastly for promotion, one of the things that I'm really excited about is our Google ad
4 campaign. We met with Google because, of course, we know that success is going to be on how
5 big our reach is of this week. So we have been aggressively seeking their help. Our Google ad
6 campaign launched just today, so I'm very excited about that.

7 I just wanted to show you two of the seven display ads that we have up on Google now.
8 This is the display banner for the prevention of underage drinking. And this is the community
9 involvement banner ad.

10 Lastly, in closing, I hope to be able to present to you guys the next time we meet the
11 success of National Prevention Week, and we're going to be able to measure the success of
12 National Prevention Week in metrics of five categories: the Prevention Pledge, social media
13 exposure, blogger engagement, the website and the toolkit, and the success of the individual
14 community events.

15 Thank you.

16 I know I have one question, from Eugenia.

17 MS. HARDING: You actually answered her question.

18 Any other questions about the week for David or how to get the materials online right
19 now and take the pledge?

20 MR. WILSON: www.SAMHSA.gov/preventionweek. I think my information is in the
21 packet, so if you have any further questions please feel free to call or e-mail me. I also put in
22 your packet a very basic Q&A sheet that I think will be very helpful for anything that I might not
23 covered.

1 MS. HARDING: Yes, Ginger?

2 MS. MACKAY-SMITH: I hope people around this table have picked up on some of what
3 David was saying about at so many different stages along the way in building Prevention Week,
4 it has been integrated with other kinds of prevention resources that are available and activities
5 going on. The metrics that you saw on his slide are all process measures, but to the extent that we
6 can as we move forward, we are also going to look forward to links to the more comprehensive
7 approach to see what, if anything, National Prevention Week is contributing on a comprehensive
8 level. I just wanted to add that part.

9 MS. TULAFONO: David, you folks have already identified the 60 pilot sites, the
10 organizations?

11 MS. HARDING: Yes.

12 MS. TULAFONO: I don't see anything for the territories. Is that already closed off? Is
13 there the possibility that you could still apply, or is that closed?

14 MR. WILSON: It's technically closed, but I'm—

15 MS. TULAFONO: Okay, I just wanted to know where you were going. Thank you.

16 MS. HARDING: Thank you.

17 Thank you, David. I know how difficult it is to try to put an hour's presentation into 15
18 minutes. We appreciate it. We all would like to talk more about the programs we've put a lot of
19 effort into. So David will be around at the end of the day and tomorrow, we can take up that
20 issue offline. Thank you.

21 Okay, so where at the 2:30 half hour, the time Pam is scheduled to come visit. She is not
22 here, obviously, unless she's hiding, which, if you know Pam, that's not possible. She always
23 makes sure that you know she's in the room, because she has a lot to impart to us.

1 So we're going to continue with the agenda, and when Pam comes, we'll stop what we're
2 doing and allow her to say what she came here to say, which I believe is a welcome. I don't
3 believe it's anything secret that is going to be life shattering. So if we could move on.

4 *GOOD AND MODERN PAPER: PREVENTION ADDENDUM*

5 Here's an opportunity that was presented to us. As most of you know SAMHSA put out a
6 document a year ago. We started working on a document called the "Good and Modern
7 Addictions and Mental Health Services." The document is being used not quite as a locator, but
8 something similar to, here are the important things that are in both of mental health and
9 substance abuse treatment and prevention system, to take a look at, that would be funded under a
10 new healthcare system as described. Except for one minor problem: as we got developing this,
11 and we started seeing the drafts, it became quite obvious to me and others that substance abuse
12 prevention was not anywhere noticeable in this document. So when inquiries started to come to
13 John O'Brien at the time, we realized that this was a document whose sole purpose was to put
14 out their suggestions to states and to our stakeholders. Here are the activities and services that
15 Medicaid would eventually pick up and that CMS was looking at. It was never meant to be a
16 program guide to everything that SAMHSA does that's important.

17 The problem is that when it went out into the field, that's exactly what it became. People
18 starting to look at it as a program guide to make sure that these are the important issues that
19 SAMHSA believes should be in the substance abuse and mental health services system. Big
20 problems for us and several others in the field, because it lacked a tremendous amount of
21 prevention.

22 Long story short, we were asked under the direction of the strategic initiative for
23 substance abuse and mental health disorder prevention to help work together with CMHS and

1 CSAT and come up with an addendum that could accompany this document that was service-
2 delivery driven, but also have a component for substance abuse and mental health disorder
3 prevention programs that may never be funded with Medicaid dollars or insurance dollars. But
4 you never know. But for the most part, an environmental prevention initiative will probably
5 never be funded and shouldn't be funded under a healthcare system. However, important under
6 public health, that we have these services out there and people are going to read into this
7 document the way they have read into the document.

8 So what you have in your packet, and Ginger is going to walk you through what you
9 have, not because we expect some reaction from you right now. We'll set up a meeting by
10 telephone in an appropriate period of time, so that we can have a discussion on this document, so
11 that we can finalize it and put it through the normal federal approval process, which will take a
12 while.

13 This is one of those things that you are the only ones who've received this. The people
14 around the audience have not, because this is a document that may not be shared because it has
15 not been approved for public viewing. This is part of your role that you have accepted to help us
16 when we write something of such significance. It's not perfect and, as a matter of fact, you don't
17 even have the final draft. Over the weekend I received four more edits from our colleagues
18 within SAMHSA who have been asked to take a look at this and give us some feedback. So we
19 will quickly incorporate those and send that out to you, but we still wanted to keep this in mind
20 so that you can see what our thinking is. We'll need your heavy critique as possible, because this
21 will become a document that will guide us for the next few years as we go through health reform.

22 So, Ginger, so I don't give away your entire 10 minutes, would you like to walk them
23 through what this is, a little history, and then we'll take questions and, hopefully, Pam will be

1 here.

2 MS. MACKAY: Yes, thanks, Fran. One other thing that I want to just draw your
3 attention to about that Good and Modern paper is that it was designed, as it says right there in his
4 introduction, to “foster discussion among the federal agencies that were working at
5 implementing the Affordable Care Act and health reform, to focus discussion in a productive and
6 proactive way about what that Good and Modern system was supposed to look like.”

7 So in this addendum we are trying to do the same thing. We are trying to structure it in a
8 way that will help the agencies involved discuss, but then also clearly the field has to be involved
9 in that discussion as well. So when we do get you together on the phone to talk about it, what
10 we’ll be talking about is not only what you think about it, but also what you think about the ways
11 we are trying to promote discussion.

12 When I walk you through it today, I’m going to try to point out how we set it up, what we
13 were thinking in terms of getting that conversation ball rolling, and if you have any immediate
14 thoughts about how effective this aspect or that angle is, please do feel free to toss it in right
15 now. As Fran said, she got four more sets of comments over the weekend, so it’s very much a
16 work in progress.

17 Okay, so the Good and Modern paper actually ended with a short section on the
18 challenges awaiting. There were six altogether, but two in particular relate to what we are doing
19 here. One said that policy makers and payers have limited knowledge and, to some degree,
20 continued skepticism regarding the efficacy of available prevention strategies, treatments, and
21 approaches. Another challenge was that there are still significant boundary issues within and
22 among mental health, addiction, primary care, and other social service systems, and it ended up
23 saying more permeable boundaries will need to be created.

1 So we're really taking off on those two challenges, that even in this advanced day and
2 age, there is still a lingering lack of information out there about what works as prevention, and
3 there are still some pretty solid walls separating us from our colleagues.

4 With that in mind, here's how we structured the paper. I believe most of you anyway
5 have a copy of the paper. It says "draft" right across middle of it.

6 Let me tell you how we set it up. Overall structure is, to start up we establishing the scope
7 of the problem and the role that prevention has in health reform and in building a good and
8 modern system. The second thing we do is we take explicit note of prevention science and
9 national policy, again remembering this is supposed to promote discussion among the federal
10 agencies. Then we move on to what we know about the approaches that have been shown to be
11 effective and we finally end up with "let's move forward in this direction" kind of section.

12 To begin with, you'll see that introduction page. What we wanted to do was ground the
13 discussion in the national policy of health reform and in the priority and direction that the field
14 and SAMHSA's own agency and mission are taking.

15 We start off with identifying what SAMHSA's mission is. You'll see right there a third of
16 the way down, the first paragraph, we point out that SAMHSA's mission is a unique
17 responsibility to focus the nation's healthcare and social policy agendas on these preventable
18 issues. So we are staking our claim there and then tying it in with the role that we have in
19 Affordable Care through the rest of that paragraph.

20 Then we take a step up to the national level. In the paragraph that follows that, we link
21 the role of prevention back into the ACA, the Affordable Care Act, and the National Prevention
22 Strategy that last June was put out. The paragraph after that identifies the specific strategic
23 initiative within SAMHSA's plan of *Leading Change* that relates to it. So at that point we have

1 set up that the world is moving in the direction of integrating prevention into the larger health
2 world and that SAMHSA has a particular role to play.

3 Right after that we put our cards on the table and say, “And what is our role?”

4 And, here is someone who knows more our role than anyone else. So maybe I will pause
5 right here.

6 MS. HARDING: We’re prepared.

7 ADMINISTRATOR HYDE: Hi, there. Sorry to just walk in and interrupt. I apologize for
8 being late. It was a last-minute call about the Supreme Court arguments. I’m trying to keep us up
9 to speed on what’s going down there. It’s an amazing and historical time.

10 I would love to know who’s here.

11 MS. HARDING: If we can just go around again, re-introduce yourself. If you already
12 know Pam, remind her where you’re from. And if you want to let her know you’re new, she’d
13 like to know who the new people are. Thank you.

14 MS. CONNELLY: Hello, Pam. I’m Eugenia Connely. I’m the Director of Statewide
15 Projects with the Maryland Alcohol and Drug Abuse Administration, and I am a veteran.

16 MR. COUTY: Michael Couty from Missouri. I’m a juvenile court administrator.

17 MS. TULAFONO: Good afternoon, Pam. Mary Tulafono, First Lady of American
18 Samoa. Good to see you.

19 MR. GREEN: Hello, Pam. It’s good to see you. Steven Green from Gila River Indian
20 Community, Sacaton, Arizona.

21 DR. CLAPP: Hello, John Clapp from San Diego State University and the US Department
22 of Education’s Higher Education Center for Alcohol, Drug, and Violence Prevention.

23 MR. MONTGOMERY: Hi, Pam. I’m Michael Montgomery. Retired.

1 MS. HYDE: Aaaah, he's not retired. We can suck you right back in.

2 [Laughter.]

3 DR. McGRATH: Hey, Pam. Jane McGrath from New Mexico.

4 DR. COMPTON: Hi. I'm Michael Compton, from George Washington University
5 downtown. I am a psychiatrist and a preventionist.

6 MS. HYDE: Great. That's an unusual combination.

7 DR. COMPTON: It is, but a fun one.

8 [Laughter.]

9 MS. HYDE: You were probably going to take a break.

10 MS. HARDING: We are after you!

11 [Laughter.]

12 MS. HYDE: I was hoping to hear your conversation about the paper a little bit.

13 MS. HARDING: That's what you walked into.

14 MS. HYDE: Yes, do you want to just keep going with that for a bit?

15 MS. HARDING: Ginger was finishing up on what's in the paper, and they have not had
16 time to review the paper, so that's why Ginger was showing them the highlights that were in
17 there and that we were going to have whatever comments we had after.

18 But the idea is that we are going to have a telephone call, which you may want to be on
19 once they have some time to look at it, and we send them the next draft, because I got four more
20 comments papers over the weekend. So we don't have that in there, and I want to have full
21 comments.

22 MS. HYDE: I haven't seen this version of it either, so I'd be very interested in your
23 feedback, whether I can participate in the call or not. I am curious about your thoughts about it.

1 We want to get this out for public comment. I'm sure Fran told you that. It's been a long time in
2 coming, so we are anxious to get it out.

3 I don't know if you want to continue.

4 MS. MACKAY-SMITH: Sure.

5 We just talked about how we were establishing that SAMHSA had a role in this
6 conversation about the appropriate role of prevention in the good and modern system.

7 We do take some time next in the paper to talk about the Strategic Prevention
8 Framework, because that is SAMHSA's approach to prevention, and we want to make sure that
9 as we frame the conversation we are building on that.

10 At that point, again thinking about fostering discussion, we take a step back and talk
11 about the scope of the problem. On page 2 you'll see there are several paragraphs there that look
12 at the role both in terms of the individual and the societal cost of substance abuse and mental
13 health. This is one area that we would appreciate your contributions on. We say some of the
14 things that we all know, for instance, 14 to 20% of youth have a mental health issue. Over half
15 the adult mental health issues started in youth. And then we move to the more concrete stuff like
16 that nice number at the end of the top paragraph, \$247 billion in cost to the country.

17 We are trying to spark conversation, finding effective ways to make the issue meaningful
18 to the people who will be doing the discussion. It's an important issue for us.

19 After that there are some paragraphs that go into some specific issues—suicide, alcohol,
20 tobacco, illicit drugs. That carries you pretty much through the end of page 3, where again we
21 wind up the next to last paragraph there talking about how these issues are a major burden on
22 society and need to be addressed. We do make a point of coming back to the dollar issue because,
23 of course, traditional conversations about the health don't admit prevention into it because it's

1 not a patient-billed kind of activity. So to make the case about the financial role that prevention
2 place in a healthcare system is something that we have to establish.

3 Then we have our little segue paragraph saying, given that prevention has a role in
4 healthcare and health reform, SAMHSA has a role in directing this conversation, and here is the
5 situation we are trying to prevent. Then we say, and you know what, we know what to do about
6 it.

7 That leads into the section on epidemiology and research. Interestingly, you can see in
8 that subhead, epidemiology and research to understand the role and, of course, as we know, to
9 build on it as well.

10 You'll see about two thirds of the way down, that first paragraph under the subhead there,
11 this is our call to arms for prevention. It bears a dramatic reading, so I'll read it to you:

12 Effective prevention has to be comprehensive, data driven, integrated, multifaceted,
13 strategically planned, and evaluated. These are the hallmarks of not only the Strategic
14 Prevention Framework, but effective prevention as documented in the literature.

15 Again, we wanted to focus this discussion on, we are building on a science base. Not only
16 that, we are building on a practice base as well.

17 The next few paragraphs there, again, to spark discussion, go into a little more detail for
18 some the comprehensive nature of this approach, then on the data-driven nature of the approach,
19 and making the point that this prevention, the science-based and practice-verified prevention, is
20 in fact results oriented.

21 MS. HARDING: Ginger, with Pam's time, can we just go through the major portions,
22 like next comes public health, looking at that compared to the IOM, that kind of high-level, just
23 so that we can get to the end and Pam can have a better view of things.

1 MS. MACKAY: The next section, Prevention in Public Health, in order to have a
2 discussion, we need to have the terminology. The next section you will see—oh, Michael, this
3 will be very familiar to you—not only addresses the traditional prevention approaches of
4 primary, secondary, and tertiary, but makes the connection to that translates from a disease-based
5 framework to an audience-based framework on the IOM approach. Again, if we’re going to have
6 people talking about it, we need them to know what universal, selected, indicated means, and
7 that it’s not just sort of the new terms for primary, secondary, and tertiary.

8 I will skip ahead to page 8, where building on all of this, we also make, two thirds of the
9 way down the page, the case for “effective prevention means environmental strategies.” We tie it
10 in to the risk and protective factors, and the contributing conditions.

11 On the following page there is a brief discussion about a funding mechanism. If we are
12 going to be dealing with prevention as a normal and established part of the health system,
13 funding becomes an issue. This is just one example, but again, we need to discuss how to use it.

14 And then we have the final section, direction setting, moving forward. There are three
15 broad categories listed there having to do with reliability, of accessible data, with policies that
16 support a healthy environment, and with services that support effective prevention efforts.

17 How’s that for editing down?

18 MS. HARDING: That was very good. Thank you.

19 ADMINISTRATOR PAM HYDE: REMARKS

20 MS. HYDE: Let me just say a word. I’ve been bouncing from committee to committee
21 today, and let me just tell you a couple of things that I said to the other folks as a way to get into
22 what we need from you about this.

23 I really am very much aware that when we ask you to come here, we may pay for your

1 way, but we don't pay for your time, and you are giving us an incredible gift of your time and
2 your thoughts. So we're going to pay you back by giving you homework. So hopefully what that
3 does is give you also access to some of our thinking so you can help inform it.

4 I worked with lots of advisory committees over the years in lots of ways, and I really
5 believe that advice—and you'll hear me say this fifty hundred times—is a product. So your
6 advice is something that we take as very real and something you are giving to us, and we take it
7 in and take it very seriously.

8 You may not always see the exact direct trajectory from what you said to us at the
9 meeting to what comes out on the other end, but believe me, we talk about it, we take it in, listen
10 to it, we think about it, we remind ourselves, etc. So thank you in advance for reading this paper
11 and for giving us your thoughts about it.

12 We have made prevention number one. We made it the first in priority initiatives.
13 Whether it's kids in schools or whether it's women in OB/GYN clinics or you-pick-a-place in a
14 group, and we really want to make sure that we are addressing prevention in a way that's going
15 to make the most sense, whether it's in our HIV/AIDS programs or whether it's in—

16 You'll be glad to know that Wes this morning was singing prevention's praises in the
17 treatment advisory committee, or whether it's mental health. And we also aren't really very
18 much now seeing the distinction in the women's committee. They were talking about young
19 girls, and every one of them who comes into treatment comes with depression and anxiety and
20 eating disorders and other things, in addition to the substance abuse that may be the presenting
21 factors. So we also are trying not to make these distinctions.

22 We know there are distinctions, clearly, in treatment and approaches, but you make a
23 distinction between meth addiction and alcohol addiction, you may approach those differently,

1 too, just like you approach schizophrenia and depression differently. But the fact is, it's all
2 manifested out of various and sundry issues, whether it's trauma or the brain, or any combination
3 thereof.

4 We really appreciate your time and your effort and your willingness to read these things
5 and give us time and thought about it, and all that you do. It is an incredibly historic time as well
6 as an incredibly pressured time, more desires and less money. So we keep trying to think about
7 how we can, as SAMHSA, do a better job of the parts of our authority and role that isn't giving
8 out grants, because we're going to have less and less of those to do, and also because those other
9 roles are equally important. So things like putting out a paper, even if it stirs controversy, is in
10 and of itself something that we can do for the field. Having you there to help us is really
11 important.

12 I know you haven't read it. I look forward to hearing what you have to say about it. I'd
13 just like a few minutes, and I know probably people want to get onto a break as well, but if there
14 are things that were on your mind, that you would like to either ask me about or put on the table
15 at this point, let's spend just a few minutes doing that as well, whether it's about the paper or
16 about something else.

17 I have not yet been to American Samoa, but we just got back from a trip to the other five
18 Pacific jurisdictions, which was incredibly profound. And I've said this a number of places, but
19 I'll say it here too: The Minister of Health for Palau, who is an incredible guy, a primary care
20 doctor, but who actually still sees patients two or three times a week while he runs the
21 department. Amazing that he can do this. Nevertheless, he said, "behavioral health is not
22 essential to health, its fundamental to health." The way he said it is, "heal the soul and the body
23 will follow." I am chewing on this, because it says to me that as bold as our vision has been, it

1 needs to be bolder yet. I learned at times from the Pacific jurisdictions and hope to get out to see
2 you all at some point soon.

3 Comments? Thoughts? We're going to talk about schools today, so Jane you're going to
4 be right there with us.

5 Gosh, this is a quiet group. What have you done, run them down?

6 [Laughter.]

7 MS. HARDING: We did have a conversation about, they're taking their role as
8 ambassadors seriously, and we spent probably the majority of our discussion time talking about
9 the conversation around the state grants. Who's bothered by it? What's the controversy? What's
10 our position?

11 MS. HYDE: We talked about that a little bit in the Women's Committee as well, because
12 there are differences of opinion, and we decided maybe we should stop thinking about states or
13 communities and go to the managed-care companies and ask them for new and creative
14 approaches, because they have flexibility that neither states nor the federal government have. For
15 example, in there we were talking about approaching them and saying, "Don't give us money for
16 a unit of service, give us money for a treated and recovered adolescents," to get a little more
17 flexibility.

18 We have to be more creative, I think, in these times.

19 Yes?

20 DR. McGRATH: We've been having a lot of conversations in New Mexico about
21 payment reform, really looking at how prevention services are built into any kind of
22 reimbursement model. It will be several eons before any of that actually probably gets
23 implemented, but it's been a very interesting discussion, and I think it's not entirely unreasonable

1 to think about how payers transform how they are going to do any of this kind of work.

2 MS. HYDE: I'm glad to hear that for two reasons. One is because the entire health care
3 debate gets focused on the things that are in this argument in the Supreme Court or the things
4 that people are disagreeing about. The things that nobody is disagreeing about, and tons of work
5 has been happening about, is the prevention focus, the National Prevention Strategy, which is
6 now out there, and substance abuse and mental health are in there. And also the approach to
7 quality and to measuring quality and paying for quality, and there's a ton of work going on about
8 that—not so quietly, actually. There's a National Quality Strategy, a report to Congress—the
9 first year report just went to Congress—and we were the only operating division that had in it a
10 reference to us taking on the quality issue ourselves. So we get a lot of credit for struggling with
11 that. We're not anywhere near done, but we were at least acknowledged for having dealt with
12 that. And I don't think you can do those two things without putting them together. The outcomes
13 you are seeking have got to be preventive in nature, got to be restorative in nature, if not
14 preventive in nature. And they're not the same thing. If nothing else, we need to change the
15 conversation. We've also been talking about it that way quite a bit lately.

16 DR. McGRATH: Can I just ask one other question? Is SAMHSA working at all at CMS's
17 Innovation Center? Could you address that?

18 MS. HYDE: Oh, yes. Absolutely. The Innovation Center, we live with these people.
19 We've got language in the RFAs that went out that specifically asked for behavioral health
20 innovation projects. It seems to me that something like a third of the applications that came in
21 have something to do with mental health and substance abuse in one form or another.

22 We have just been pounding, because part of the role of that is to look at payment
23 innovations, but also workforce innovations. And we've been pounding that diabetes with

1 untreated substance abuse and mental illness connected is five times more costly than diabetes
2 without those things. Or that behavioral health represents something like a third or 30%,
3 somewhere in that neighborhood, of the readmissions. It's one of the biggest things they want to
4 reduce for both quality and cost. So we are trying to keep telling them these things, and they're
5 really responding. They are doing a lot of effort to reach out to us, and in fact I think it's
6 sometime this week I have a meeting with them. Our lead on this, John O'Brien, just left and
7 went to CMS. So we were really sorry to lose him, but we think we've infiltrated actually.

8 [Laughter.]

9 He didn't go to the Innovation Center. He went to the heart of Medicaid that does
10 disability-related stuff. So mental health and nursing homes, substance abuse, and the DD and all
11 the disability-related areas. Nevertheless, they all know him and they know you'll be there, so I
12 think he'll be adding voice, also. There's lots of work going on about that.

13 Other comments or thoughts at this point?

14 Hey, Steve.

15 MR. GREEN: How are you doing? I had a discussion with Fran maybe an hour ago, and I
16 was telling her how delighted the tribes in Arizona were with the mandatory tribal consultation
17 around the SAPT dollars. It was very well received. Thank you.

18 MS. HYDE: Do they know about the tribal prevention grant? We need them to be out
19 there talking about it.

20 MR. GREEN: I've been informed, and we will apply.

21 MS. HYDE: Good. We need them to tell Congress that we need it. It has taken a while, as
22 you might imagine, with that many tribes around the country. We've been in front of them fifty
23 hundred times, reminding them about things that we need their help with. There are certain

1 things we can do and certain things their voice has to be out there in order for us to help them.

2 So how's Gila River doing?

3 MR. GREEN: Very well, thank you!

4 MS. HYDE: Good.

5 MR. GREEN: We continue to grow. We have a very strong focus on integrated
6 healthcare, and, in some instances, we actually have reverse integration in some of our programs
7 where our primary care service is delivered by master's-level counselors. We have a primary
8 care physician working in our substance use program now.

9 MS. HYDE: Great. Fantastic.

10 Other things? Michael, you've got juvenile justice under control?

11 MR. COUTY: Yes, we do. We have a good group.

12 [Laughter.]

13 MS. HARDING: One of the things, Pam, that I congratulated all of them about was the
14 eclectic nature of all of our talent and skill sets around the table, and how we feel that we finally
15 have a council that can really, truly be representative of our country, especially in this area of
16 behavioral health. So we're really happy about that. And they're ready to help us however they
17 can.

18 MS. HYDE: You've got a good group.

19 MS. HARDING: Yes, we do.

20 MR. COUTY: What do you hear from the Supreme Court?

21 [Laughter.]

22 MS. HYDE: Obviously, the Supreme Court is hearing arguments all week. This is
23 literally the biggest argument in 50 years. To be the solicitor general and getting to make this

1 argument—if you’re a lawyer, there’s nothing he can do bigger than this. But it also means tons
2 of pressure, so in our legal counsel—ours in the biggest sense—HHS’s is just spectacular about
3 this.

4 I think the headline is, there’s nothing that came out of today’s argument, which was
5 about whether or not they can actually decide the case, that changed anybody’s minds about what
6 they think the justices might decide. I think they all think that they’re seeking a way to get to the
7 merits, but they have to get through this legal hurdle about whether they have the ability to do
8 that or not.

9 It’s very complicated. It’s all wrapped up in different parts of the Code and how things
10 are viewed in different parts of the Code. It’s both a technical issue and a fairly simplistic one. Is
11 it ripe for decision or not? If they should decide that, even if though they’re going to hear the
12 whole thing this week, if they should decide it’s not ripe for decision, then basically everything’s
13 on hold—at least for that part of the argument. There are other arguments, like the Medicaid
14 argument, that I think can still go forward.

15 It was a recap on how they thought that went. You never know what the Supreme
16 Court— It’s nine people, nine individual people, so you need five votes. It all comes down to the
17 votes.

18 Tomorrow the argument may be about personal responsibility. That’s going to be a big
19 one as well. That’s the other name for the individual mandate, personal responsibility.

20 Those are interesting arguments, because the federal government makes all of us do
21 things all the time. The law seems pretty clear on that, but that doesn’t mean there won’t be an
22 argument about it.

23 What else? Anything else?

1 Great. I'll let you get to a break, and again I apologize for coming late. I want to try to
2 keep up on these things for you as well as for me. So thanks a lot. I'll see all of you tomorrow as
3 well.

4 MS. HARDING: Thank you.

5 And we are on a 10-minute break. We'll see you in 10 minutes. You can grab Pam on the
6 way out.

7 [Break.]

8 2012 GRANTS

9 MS. HARDING: All right, back to business.

10 We would like to give you a really quick review of the three grant opportunities that we
11 have out there. I have asked Capt. O'Neal Walker to give us a quick briefing. These grants fall
12 under his direction. They're all working with Drug Free Communities in one way or another,
13 which is the largest program in the Division of Community Programs, which Neal is leading.

14 Neal, if you wouldn't mind, let's walk us quickly through what they are, and then we can
15 take questions if anyone has some directly for you.

16 CAPT. O'NEAL WALKER: Thank you, Fran. What I want to do is to give you a quick
17 synopsis of the three programs. There are other programs within the division, the Minority AIDS
18 Initiative that we also manage.

19 You have in your packet, I think, three documents. If you would take a look at those
20 documents, you'll notice scripted at the top of the document is the particular annotation for that
21 particular grant. If you could follow with me, it says "Application for Drug Free Communities
22 Support Program." You should have that in your hand.

23 This actually closed last week, but these opportunities will continue for the next fiscal

1 year as it appears. If I'm correct, we should have a number of larger grants next year. We might
2 even have over a hundred and some grants, but we don't know for sure. We're hoping that's so.

3 For this particular iteration, if you turn to page 2 you will see that these grants are up to
4 30 grants that would be issued. As I said, applications closed last week. The Drug Free
5 Communities Support Program Grants is coming out of the Executive Office of the President
6 under ONDCP, Office of National Drug Control Policy. It started back in 1998, so it's about 13
7 years old. Initially it was housed at the Department of Justice, but in 2004 it was transferred to
8 SAMHSA. ONDCP has executive control for the program, but we work in partnership with them
9 in terms of staffing the program. So staffing comes out of SAMHSA and CSAP in the Division
10 of Community Programs.

11 As you can see on page 1, there are two bullets that give you exactly what the programs
12 do. I just want to read the first one. It says:

13 Establish and strengthen collaboration among communities, public and private nonprofit
14 agencies, and federal, state, local, and tribal governments to support the efforts of
15 community coalitions, working to prevent and reduce substance use among youth. For the
16 purposes of this RFA, youth is defined as individuals 18 years of age and younger.

17 Since the inception of the program, we have had about 2,000 of these grants given across
18 the country, just about every state. I don't think currently we have any in Delaware, so we are
19 hoping to fix that based on the competition as the years continue.

20 The second bullet says that: "Our emphasis is on youth in order to reduce substance
21 abuse among adults by addressing factors in the community and also to address the risk of
22 substance use and promoting the factors that minimize the risk of substance abuse."

23 Our aim and focus really is on youth. That's what we want to do. And we feel that based

1 on our strategic initiatives and our environmental strategies, we can address these in
2 communities.

3 Again, this just closed last week, so there is no opportunity for this particular grant this
4 particular year, but are looking forward to new grants. We have 30 awards that we hope to give
5 for this year. Currently these are being reviewed. Each award is up to \$125,000 for 5 years. Once
6 you get into your first iteration, then you become a continuation, and it's noncompetitive for the
7 next 4 years of that continuation award. That's in essence the DFC program with regard to the
8 support program.

9 Out of this program we have a mentoring program also, DFC Mentoring Program. The
10 mentoring program, as it says in the document, is intended to support those coalitions that are in
11 community, that would one day like to become a DFC grantee, but doesn't have the capacity to
12 do so. What we do provide is some funds for existing grants to support those individuals who are
13 fledglings so they can become up to speed, up to SPF, to apply for a grant. This year we are
14 going to have ten of these, for a total of \$750,000. Each of these grants is about \$75,000 up to 2
15 years.

16 This closes May 4, 2012, so there is still opportunity for the DFC Mentoring Program,
17 which also is coming out of the Office of National Drug Control Policy. But again, it is staffed
18 and populated here in SAMHSA. ONDCP does not have the staff capacity to run these programs.

19 One of the programs that is in alliance with this program is the STOP Program—Sober
20 Truth on Preventing Underage Drinking Act—which is a SAMHSA initiative. But it's a
21 supplemental program to the existing DFC Support Program. This closes March 29, so there's
22 still an opportunity to apply for this particular grant, as you can see on the top of your document.

23 What the STOP Act does is provide small funds— I laugh, and it's an inside laugh to

1 myself with regard to the challenge we had to get this grant out, but eventually we got it out. It's
2 a wonderful grant. The idea behind this grant is to provide supplemental funds to help those
3 existing programs out there to have some funds to work with on underage drinking. By underage
4 we're talking about young people who are 20 years and younger. We have 78 of these we will be
5 putting out, \$50,000 per year for up to 4 years.

6 So this is a SAMHSA grant. I think it's an excellent opportunity to supplement what's
7 existing in communities in order for us to continue to reduce underage drinking and ultimately to
8 save lives of our youth. That's the purpose of the grant. We do target or address those individuals
9 underage, and we hope to have information for their parents that can be useful as they work with
10 us to help to reduce these problems in the community.

11 So, Fran, anything else you want to add?

12 MS. HARDING: Thank you. That was quick. If anyone has any questions for Neal first
13 on some of the grants he went over?

14 I do have a question for you, hearing none. Do you, off the top of your head, either that or
15 your staff, give us a ballpark figure of how many STOP Act and DFC grants go to higher
16 education, so John could know what that is? Ballpark.

17 CAPT. WALKER: What we look at to see how many grants we are serving, there are
18 some grantees that work with communities but they also work with colleges and universities that
19 are located within their community. We actually have a spreadsheet that lists all of the grantees
20 that work directly with colleges and universities, and also the universities themselves. I could
21 give you that. I can't think of the number directly off my head, but I can give you a copy that has
22 all those listed if you prefer.

23 MS. HARDING: Thank you. Rich and I were talking and we would have told you ahead

1 of time. It just didn't come to our thinking. But you all might be interested in knowing where
2 these grantees are. So we could actually get that list before tomorrow.

3 CAPT. WALKER: Sure.

4 MS. HARDING: Then we can circulate it so people can see where all these grants are,
5 the current ones.

6 CAPT. WALKER: We'll bring it in the morning with us and have it available for
7 everyone.

8 MS. HARDING: There were some controversial conversations and pushback around—
9 that's why Neal was laughing—the STOP Act grants. It was our first time in the STOP Act grant
10 history that we had some pushback in Congress. We had put some restrictions on the eligibility
11 of who could apply for a STOP Act grant. We did that purposely. We, SAMHSA, did that so that
12 we could target communities of the highest need.

13 Well, it's not that the idea was wrong, and it's hard to argue against communities of
14 highest need. It's that we were challenged that we didn't have the appropriate data to identify the
15 communities of highest need. That's one of the reasons why I'm telling you this. They were
16 right. The data we were using, it was state-based data, because that's the data the federal
17 government currently collects on substance abuse and mental health issues. We collect data from
18 the states. So we made a leap of faith that if you're a state of highest need, there's a good chance
19 that some of the communities in your state are of also highest need.

20 That was challenged by Congress, and we yielded. So now we have eligibility open to
21 everyone. That wasn't so pleasant. The positive outcome was, it has, which I'm very happy
22 about, brought the subject up that this country needs a community-based data collection system
23 that's universal for the country so we can start collecting some community-based data on

1 prevention and the needs for prevention across the country—including the Pacific jurisdictions,
2 including tribes, and including communities across the board.

3 Now, maybe not in my lifetime, but at least during the life of my job, let's put it that way.
4 But at least the conversation is now out there. It's out both in Congress. It's out with ourselves.
5 And we're talking about the very need that we have. That is holding us back on many things and
6 on many levels. So keep a watch out for that.

7 When Dr. Delany comes, maybe we can have him come to our next NAC meeting and
8 give us an update on how that's progressing, because SAMHSA is interested in working with our
9 federal partners to develop such a data collection system. I'm sorry that Charlene is gone, the one
10 piece that she could listen to. It will be a very difficult conversation, because once you open this
11 up, everyone wants you to collect data for their particular needs. So it will be most likely a future
12 agenda item.

13 So out of a difficult, challenging discussion that we had, and some tense moments, a
14 positive came out of it in, my opinion, which often happens in prevention with people not
15 realizing. We have the discussion now out there. No money this year. No money next year for
16 2013. You saw the budget. But it is something through our CBHSQ, Center for Behavioral
17 Health Statistics and Quality—that's what happens when you work in acronyms. You can never
18 remember the name. They are taking this very seriously. So we'll let you know.

19 Thank you, Neal, very much.

20 These are three grant opportunities that are continuous for us. People look for them.
21 We're trying to just tweak them enough so they fit into a broader spectrum in trying to fit
22 everything under a behavioral health rubric without spending substance abuse dollars on mental
23 health program and vice versa, which is of course what we can't do.

1 PUBLIC COMMENT

2 Okay. So we'll move into, barring any other questions, the public comment period. As I
3 look around, unless I'm wrong, officially is there anyone here who would like share a public
4 comment?

5 Hearing none, we'll go forward.

6 COUNCIL DISCUSSION:

7 As I promised you, we can open this up now for an open conversation of the Council
8 around roles and responsibilities. And now that you've heard a little bit about what we're doing,
9 do you have a question? Are you still wondering what your role is going to be? And then the last
10 conversation we'll have is next steps. And then we'll close. And we will be on time. I just
11 wanted to point that out to you.

12 Yes, Michael?

13 MR. MONTGOMERY: I just had a question about the Good and Modern paper. I look
14 forward to reviewing that, but can you clarify a little bit about exactly who the target audience is
15 for this, what it's being written for and who it's being written to?

16 MS. HARDING: That's a good question, and I'll let all of my colleagues chime in with
17 their opinions. I think one of the contributing factors of what's taking so long, I didn't tell you
18 that it took long. Pam did. She'd be right. It's been about a year. That's pretty long. Maybe 9
19 months, but too long. The reason why, I think the fact that we really didn't who our target
20 audience would be other than everyone, and that's a large everyone.

21 When we started writing this paper, we were asked to write a position paper on
22 prevention under the header of behavioral health. You can only imagine what a monster that was.

23 If someone had time, you could study it, and especially someone like yourself, might find

1 this to be fascinating. I found it to be incredibly frustrating. Remember I spoke earlier that it's
2 difficult for us to move forward with a behavioral health agenda because we're all boxed in our
3 individual centers and our individual thinking. So when Pam asked me to lead a project in
4 writing a prevention paper on bringing substance abuse and mental health prevention into one
5 white paper on what could guide the states, primarily.

6 So our first focus were the states, because this came right off the heels of the 2012 budget
7 proposal from the President that we were going to have a state grant. It wouldn't be a block grant
8 anymore of 20%; it would be a state grant. And there were a lot of issues.

9 We couldn't get the task done by ourselves, because all of the many of the professionals
10 who were helping within SAMHSA—understand, this is a within-SAMHSA project—could not
11 see past their own beliefs, their own teachings, their own science. Many were not open to the fact
12 that things might have to be tweaked and changed a little, and that, yes, the sciences could come
13 together. It was too much to ask under the time constraints.

14 So we went to an outside consultant and asked for help. Gave the consultant almost a box
15 full of revisions and thoughts and science and ideas and teachings for both the substance abuse
16 prevention world and the mental health prevention world.

17 Speed that up. Got it back. Did in hindsight maybe not the smartest thing we could have
18 done. Sent it back to the original committee that began this process. And what do you think they
19 did? Each side chopped it up and brought back everything that they had originally written—a
20 little differently, but it was the same principles.

21 Would you not agree? I'm looking at my staff. I don't know what to tell you.

22 In the meantime, again, positives come out of negatives. John O'Brien came down, and I
23 think it was Ginger and I were asked to go to his office. He had some thoughts about this paper,

1 because he was looking at this mess. He's the one who came and said, "Here, I've got an idea.
2 How about we focus on making an addendum to the "Good and Modern Systems of Care"?
3 Because every time we would have a meeting on Good and Modern, I'd always be raising my
4 hand and—on this side of the table, they know how persistent I can become—reminding them
5 that you can't have this paper go forward without acknowledging that there's a whole part of the
6 continuum of services that are not on there.

7 Putting everything together, that's how we came up with this. So to answer your
8 question, I'm not 100% sure we know who the audience is other than several individuals—the
9 state, for sure; our stakeholder system.

10 Help me out? Who else would you say? There are too many. You can already see, the
11 problem is there's too many. We're writing this for too many people. But the Good and Modern
12 was written for too many people, and that's being seen as the stable guidance policy for anyone
13 doing substance abuse and mental health programming.

14 MS. MACKAY-SMITH: And one of the things that we're trying to do with both papers
15 is to take advantage of where we are in history right now, implementing health reform. 2014 is
16 the day after tomorrow. As the states implement health reform, they have to do a lot of new
17 things, and what we are trying to do is make sure that in the thought process of developing all
18 those new aspects to their health system, they are now not only taking prevention into account,
19 but taking it into account according to what's been shown to be effective over the last several
20 decades of work.

21 One of the things that we run into inside the federal government, as well as what you all
22 face in the field, is a lot of people think they know how to do it, think they know what prevention
23 is. But they're not up to date on the science and the practice. So to the extent that we can help

1 move people who are inclined in the right direction, in the right direction, they then become the
2 audience. Anyone establishing a minimum benefits package or working with the small
3 businesses in their state or whatever becomes the audience for this paper.

4 MR. MOORE: You have to identify the original purpose, I do believe, in terms of to be
5 able to give guidance to the states as they grapple with their transitioning into the Affordable
6 Care Act. There were observations on the part of the states when we got feedback from them
7 during the public comment period that states really wanted to have some guidance on what was
8 considered to be a Good and Modern system, and what they should be aspiring to in terms of
9 setting up these systems. States have lots of flexibility, but we hadn't given them the type of
10 guidance that they felt they really needed to really zero in and focus on it.

11 Another thing that we wanted to make sure that we were able to do was to have a
12 standard, so to speak, so when we got plans back from states, that we would have a measurement
13 to ensure that the federal dollars that we were providing to states were actually purchasing an
14 effective model that would actually have results. As you heard us talk about looking at the
15 prevention science, looking at the science around behavioral health and to make sure that when
16 states put their plans together, and when communities are working, that they will base that on
17 good science and good evidence-based modeling. So that was another one of the reasons that we
18 wanted to develop these two policy papers.

19 MS. HARDING: Thank you.

20 It might also help you to know, once we get you a copy with all of the input from our
21 SAMHSA leadership, and you then give us some read from your perspective of where you're
22 coming from, this will go out for public comment. It has to. It will go out for public comment
23 within SAMHSA and then obviously outside SAMHSA for as much of a reach.

1 In the email that we'll send you with the final—sort of final—draft copy, we will explain
2 that further. We really could benefit from any groups, organizations, that you feel should be
3 looking at this for a critique, because we don't really want to do this over and over again. We'd
4 like to try to get a handle on this so we can start to use it, because as Ginger just mentioned, 2014
5 is right around the corner. And while we know here that most of the items we talk about in this
6 particular part of prevention, it's not preventive services. It's actually prevention programming.
7 Most likely we'll never see a dime of an insurance company or Medicaid. But then again, more
8 of it may, down the line, if we write this correctly.

9 My favorite example that I know a little bit about is that parents who have a child who's
10 diagnosed with juvenile diabetes, their education healthcare classes—the classes that they are
11 allowed to go to classes as parents of this child to learn all about this disease and how it will
12 affect their child and what their role is—that's all paid by insurance. So I have difficulty,
13 personal that it is, why we can't have a program covered by health insurance for parents who
14 have a child with a mental illness, for parents who have a child who has just been diagnosed with
15 an addiction, etc., etc. And it's covered. I don't happen to think, in my world, we're that far off
16 from getting there.

17 A couple of you know Pam far better than I do. I think the reason why Pam is allowing to
18 take so long, because it frustrates her, because if you know Pam, you know it's 48-hour
19 turnaround time. I like to believe it's because she knows that if we do this right, and we take our
20 time and collectively do this, that we will be setting the steps toward getting some of our services
21 that people wouldn't consider right now covered. Which is really what we're looking for.

22 So you're not the final word, but you will be an important voice for this.

23 The block grant that we've been talking about, the Substance Abuse Prevention and

1 Treatment Block Grant, and the Mental Health Block Grant, will also be informed by this paper.
2 It already has been by the draft, because we're preparing the block grant application for '14-'15,
3 and a lot of the theory base is in the block grant.

4 As you go through this paper, think about what we're trying to cover here, along with
5 everything else. One is the science. Pay particular attention to the science, the section that
6 describes what prevention science is all about. The section that tries to help people understand
7 that the IOM is not better than the public health model. The public health model is not better than
8 the IOM model. Preventive services is not more effective than environmental prevention
9 programming. Programming versus services. Preventive versus prevention. Intervention, where
10 does that fit?

11 All of that is in these few pages. We have to keep it small. We cannot keep it long, so
12 that's another challenge that we have.

13 It's outcome driven, what Richard has said, and we need to visually see the presence of
14 the teachings of the Institute of Medicine (the IOM) and the public health model, and how
15 prevention science of substance abuse can be the teachers of a lot of what we're seeing in mental
16 health. And there shouldn't be a winner and a loser in this.

17 So it's a lot to ask in a short 15-page document. But it's pivotal, because you know that
18 even may be stretching it. So I would answer the question, definitely states, stakeholders—but I
19 would also say primary care docs. I would say people who are working in both medicine and
20 schools, criminal justice as well as community leaders. So we're really writing this for a lay
21 person to understand as well as the seasoned professional in substance abuse.

22 Now that that's all been said, you read through this a couple of times and you say, "No,
23 no, no, no, no. They've missed it. This should be your audience, and then maybe the document

1 can be crafted in pieces.”

2 We are open to everything, as long as it doesn't delay it another year. Pam is being
3 patient, but she also has a job to do, and I'd like to keep mine.

4 [Laughter.]

5 Just teasing.

6 We really are working together, finally, as a group, and we struggled in the beginning
7 with our colleagues, and we're not struggling as much anymore, because we're starting to show
8 that a document like this does bond us together. But it's natural to have a little bit of competition.

9 So is there anything else through everything we've talked about? Are you pretty clear
10 what your roles, for those of you who are new?

11 Yes, Michael?

12 MR. COUTY: How soon will we get the redraft or update?

13 MS. HARDING: No more than a week.

14 MR. COUTY: Okay.

15 MS. HARDING: No more than a week because we have a deadline for comment period
16 within the group of individuals that we shared it with. I'm saying no more than a week only
17 because this is a week of NACs, and I'm in the same meetings you're in, so it's just the people
18 power to be able to put all the changes into one document and go forward. So I would say by
19 next week. It won't be waiting for you, but sometime next week. Before the end of the month.
20 Do I have another week in this month?

21 MR. LUCEY: No, this is it.

22 MS. HARDING: At the end of next week. April Fool's Day! Give us to the end of next
23 week. We'll have it in your hands. And then we will negotiate, as we always do, as far as timing

1 of when the next call will be, which will probably be about 2 months after, if 2 months is
2 approximately a good enough time for you to read it and comment. And if not, we can adjust
3 that. I will let Tia and Matthew juggle with that and the appropriate timing and let you all know.

4 We'll be emailing it. We're definitely a green society now. Emailing is good. I told you
5 my vision. We'll all have iPads. Notice I didn't say computers, because I've already seen the
6 iPad, so I know. Besides, I'm in love with mine. It's all about me!

7 Anything else?

8 CLOSING REMARKS

9 Before we adjourn, a few seconds early, I want to again empower you tomorrow to speak
10 up. Speak your mind. Speak prevention. Even if you feel it's not being heard, bring it up into the
11 conversation anyway.

12 It's not that people are not accepting of prevention or that they don't like prevention, it's
13 that it doesn't come to the forefront of their minds until someone like us brings it up. And then
14 you'll find, just as Pam was pointing out to me, Dr. Clark found a way to build it into treatment.
15 So I don't think it will be that much of an issue.

16 We will have a panel, but that's on schools. Help people to understand: Prevention in
17 schools is incredibly important. It's not the only place. The continuum of services, that's very,
18 vitally important. That there is no one program that's going to meet everybody's needs. That's
19 why we have a continuum. That's why we want to blend the public health model and IOM.

20 Just bring your excitement with you to the table, because the prevention of substance
21 abuse and mental health disorders is an exciting area of business that we have all decided to
22 become part of. I find that that's very infectious. We can definitely get people on board when
23 they see the excitement of changing lives, saving children, saving families and adults.

1 I thank you.

2 I would like us, if I could indulge you for one second more, to thank Matthew. This is his
3 first meeting. He's been working really hard. And to thank Tia for training Matthew for going
4 forward. I just publically wanted to say thank you, Matthew and Tia, for helping us through this
5 meeting.

6 Let me make sure I have done all my duties before we close.

7 ADJOURNMENT

8 If there are no further questions or business that we'd like to talk about, I need an official
9 adjournment, someone to move that we adjourn the meeting.

10 MR. COUTY: So moved.

11 MS. HARDING: Michael Couty, for the record.

12 Second?

13 MS. TULAFONO: Second.

14 MS. HARDING: The same two people who opened it are going to close it.

15 Thank you very much, and we'll see you all tomorrow. If you need any questions,
16 logistics or anything, see the two of them.

17 [Whereupon, the meeting adjourned at 4:00 p.m.]