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DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

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ADMINISTRATION (SAMHSA)

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JOINT MEETING OF THE SAMHSA NATIONAL ADVISORY COUNCIL

8

(NAC), CENTER FOR MENTAL HEALTH SERVICES NAC, CENTER

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FOR SUBSTANCE ABUSE PREVENTION NAC, CENTER FOR

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SUBSTANCE ABUSE TREATMENT NAC, ADVISORY COMMITTEE FOR

11

WOMEN'S SERVICES (ACWS), AND SAMHSA'S TRIBAL TECHNICAL

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ADVISORY (STTAC) COMMITTEE

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14

Tuesday, August 16, 2011

15

8:30 a.m.

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1 Choke Cherry Road

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Rockville, Maryland 20857

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

2 MS. GRAHAM: This meeting of the SAMHSA National
3 Advisory Councils is hereby called to order.
4 Administrator Pamela Hyde is the Chair.

5 Ms. Hyde, please?

6 MS. HYDE: Good morning. How is everyone?

7 [Chorus of replies.]

8 MS. HYDE: Good. Well, it's great to see all of
9 you here. I want to welcome you to SAMHSA and to the
10 joint meeting of the SAMHSA Advisory Councils.

11 Let me just tell you that we have you back there
12 just a little bit because last time, we tried to get
13 you all up here, and it was a problem for the cameras.
14 So the cameras are letting lots of folks around the
15 country participate in this meeting and conversation
16 with us. So that's why we have a little space up
17 here, for the cameras to be able to do what they need
18 to do.

19 So welcome to everybody. It's really great to
20 see you. I hope everybody had good travels and a good
21 opportunity to participate in the -- those of you who
22 participated yesterday in both our Tribal Advisory

1 Committee and also the Women's Services Committee. So
2 it was good. I spent time with each of them, and
3 there was lots of good conversation and ideas and
4 thoughts going on. So thank you for being here.

5 This is a joint meeting of six of SAMHSA's seven
6 Advisory Committees. They are the SAMHSA National
7 Advisory Council.

8 And everybody who's on that one wave your hand.
9 Okay.

10 The Center for Mental Health Services National
11 Advisory Council, wave your hand. Just so you guys
12 get a little flavor of that.

13 The Center for Substance Abuse Prevention
14 National Advisory Council, and the Center for
15 Substance Abuse Treatment. All right. Great. And
16 the Women's Services Group? Terrific. And the Tribal
17 Group? All right.

18 So we've got lots of great perspectives and lots
19 of great advisors in the room. And again, thank you
20 for everything that you provide to us: your insights
21 and guidance. And we are increasingly trying to
22 engage some of you on a more individual or small group

1 basis around particular issues. So for those of you
2 who are participating in some of that work, we
3 appreciate it as well. We've done some calls around
4 workforce, and we may engage a few of you around the
5 quality issues and other things. So thank you for
6 doing that.

7 We want to spend just a quick minute doing
8 introductions, just so you, kind of, have a flavor of
9 who's in the room and what you all represent. So, if
10 you would, I want to go around the room and have
11 everybody just -- we'll have to do this fast, or we
12 won't be able to stay on time. And that's really
13 important, for many reasons, which I'll talk about in
14 a minute.

15 But if you would say your name and which council
16 you're on and then, just one statement about either
17 the state or something that you're from that matters
18 to you, just so we have a flavor of where you're from.

19 So, Ben, you want to start?

20 MR. SPRINGGATE: I'm Ben Springgate.

21 MS. HYDE: And we are going to have to -- we are
22 streaming to a lot of people, so we're going to have

1 to use microphones.

2 MR. SPRINGGATE: Ben Springgate with the National
3 Advisory Council and from New Orleans and have done a
4 lot of work in the post-disaster era there. Thank
5 you.

6 MS. WINDOFF: Sue Ann Windoff, [inaudible] Alaska
7 with the Tribal Advisory.

8 MR. ALAWNEH: Good morning. Abe Alawneh. I am
9 with the American and Eastern Resource Center in
10 Dearborn [inaudible]. And I am with the CSAT. Our
11 organization and mission is building the bridges for
12 recovery and well-being. And we are a member of the
13 MC3 coalition, which is sponsored also [inaudible.]

14 DR. CAMPBELL: Good morning. Jean Campbell. And
15 I hail from Missouri, where I am at the University of
16 Missouri in St. Louis at the Missouri Institute of
17 Mental Health. And I direct the program in consumer
18 studies and training there. And I'm on two
19 committees, the Committee for Women's Services and the
20 Subcommittee for Consumer Survivor Issues.

21 MR. DANIELS: Hi. Allen Daniels. I'm on the
22 CMHS Advisory. And I'm from Cincinnati, Ohio.

1 MS. ROTH: I'm Dee Roth. I'm a new member of the
2 SAMHSA National Advisory Committee. And I was
3 formerly Chief of Evaluation and Research for the Ohio
4 Department of Mental Health.

5 MR. BOTTICELLI: I'm Michael Botticelli. I'm the
6 Director of Substance Abuse Services for
7 Massachusetts. And I'm on the CSAT National Advisory
8 Council.

9 DR. McBRIDE MURRY: I'm Velma McBride Murry,
10 Professor at Vanderbilt University. And I do research
11 on rural African-American families, do longitudinal
12 perspective research and also preventive intervention,
13 HIV AIDS risk reduction, alcohol and substance abuse.

14 MR. BORDEAUX: [Foreign language greeting.] Good
15 morning. My name is Rodney Bordeaux. I'm president
16 of [inaudible] of the Great Plains Region.

17 MR. McFARLANE: I'm Bill McFarlane from Maine
18 Medical Center. I'm currently doing work on
19 prevention of psychotic disorders. And I'm on the
20 CMHS Advisory Council.

21 MS. STEIN: I'm Flo Stein from North Carolina
22 from the Division of Mental Health, Developmental

1 Disabilities and Substance Abuse Services. And I'm on
2 the National Advisory Council.

3 MR. SAGE: [Foreign language greeting.] Allison
4 Sage, Northern Arapaho Tribe, [inaudible] Indian
5 Reservation, Wyoming. I'm on the CSAT Advisory
6 Council.

7 MS. WONG: Good morning. Marleen Wong, Assistant
8 Dean, USC School of Social Work and formerly the
9 Director of Mental Health at L.A. Unified School
10 District.

11 MR. GARCIA: [Foreign language greeting.] Good
12 morning. I'm Joe Garcia, Joe MistyLake, otherwise
13 known. And I come from Okay Wingay, New Mexico. I'm
14 Head Councilman there, former NCI President. And I'm
15 on the Tribal Technical Advisory Committee. Good to
16 be here.

17 MS. CONNELLY: Good morning. I'm Eugenia
18 Connelly. I'm the Director of Statewide Projects with
19 the Maryland Alcohol and Drug Abuse Administration. I
20 have served as the MPN for many years. And I am on
21 the CSAT Advisory Council.

22 MR. CAPOCCIA: Good morning. I'm Victor

1 Capoccia. I'm on the CSAT Advisory Council. I work
2 with the University of Wisconsin on quality
3 improvement system change work, primarily in the area
4 of health reform implementation.

5 MS. INTERPRETAVALA: Good morning. My name is
6 Martha Interpretavala. I'm a member of the San Carlos
7 Apache Tribal Council representing the District of
8 Bilas. And I'm also a member of the SAMHSA's Tribal
9 Technical Advisory Committee. Thank you.

10 MR. RISSER: I'm Pat Risser. I'm a consumer
11 survivor, advocate representing the voice of the
12 people who use services, from Ohio.

13 MS. FORMAN: Good morning. I'm Harriet Forman,
14 currently living in Portland, Oregon. I am a former
15 preschool special education consultant from the state
16 of New Mexico. But I'm currently living in Portland,
17 Oregon.

18 MR. GLOVER: Good morning. I'm John Glover,
19 former Deputy Director of the Alcoholism council of
20 New York, the new equality state.

21 MR. WILSON: Good morning. My name's Arthur
22 Wilson, member of the [inaudible] Nation representing

1 the Tucson area on the Tribal Technical Advisory
2 Committee.

3 DR. HOWELL: Good morning. I'm Beth Howell. I'm
4 a psychiatrist on addition, medicine specialist,
5 addiction psychiatrist. I'm at the University of Utah
6 Neuro-Psychiatric Institute in Salt Lake City. And I
7 run the Center for Substance Abuse Treatment,
8 obviously, CSAT Advisory Council.

9 DR. GONZALES: Good morning. Buenos dias. My
10 name is Arturo Gonzales. I'm the Executive Director
11 of [inaudible] Crystal Community Health Partnership.
12 I'm a member of the National Advisory Committee from
13 Santa Fe, New Mexico and have done a lot of work
14 through the SBIRT program in integrating behavioral
15 health and primary care services.

16 MS. MRAZEK: Good morning. I'm Pat Mrazek. I'm
17 from Rochester, Minnesota. And I'm with the CSAP
18 Council.

19 MR. HAYES: Good morning. My name is Emmitt
20 Hayes, Austin, Texas. I serve as the Director of
21 Probation Services, Travis County Juvenile Probation
22 Department. Good morning, again.

1 MS. BENAVENTE: [Foreign language greeting.] I'm
2 Barbara Benavente. I'm with the Guam Department of
3 Mental Health and Substance Abuse, a member of the
4 Pacific Behavioral Health Collaborating Council and
5 serve on the Committee for Women's Services.

6 MR. JACOME: Good morning. Marco Jacome, CEO,
7 Health Care Systems, the state of Illinois, working
8 primarily with the Hispanic, Latino population in
9 Chicago. I'm on the CSAT National Advisory Council.

10 MS. WHITEFOOT: [Foreign language greeting.]
11 Good morning. My name is Patricia Whitefoot. I'm a
12 member of the Yakima Nation. I'm the [inaudible]
13 Director on the Yakima Indian Reservation and
14 currently the President of the Washington State Indian
15 Education Association and immediate past President for
16 the National Indian Education Association. Good
17 morning.

18 MR. FRIEDMAN: Good morning. My name is Bob
19 Friedman, recently retired from the University of
20 South Florida in Tampa. I'm on the CMHS Advisory
21 Council. And my recent work is on strategies for
22 making system change and for expanding systems of care

1 throughout states.

2 DR. FELITTI: Good morning. Vincent Felitti.
3 I'm on the Advisory Committee for Women's Services and
4 am a physician at Kaiser Permanente in Southern
5 California.

6 DR. LEIGHTON HUEY: Good morning. I'm Leighton
7 Huey. I'm with the CSAT Advisory Committee. I'm
8 Professor of Psychiatry and one of the Associate Deans
9 at the School of Medicine at the University of
10 Connecticut. I'm also on the Board of Directors of
11 the Annapolis Coalition on Workforce.

12 MS. NARASAKI: Good morning. I'm Diane Narasaki,
13 Executive Director of Asian Counseling and Referral
14 Service in Seattle. And I'm on the Center for Mental
15 Health Services.

16 MR. KUTI: I am Michael Kuti. And I'm on the
17 CSAP Advisory Council and Juvenile Court Administrator
18 for the 19th Judicial Circuit in Missouri.

19 MS. GARDUQUE: Good morning. My name is Laurie
20 Garduque. I'm with the MacArthur Foundation in
21 Chicago, where I direct grant making and juvenile
22 justice.

1 MS. FRAZOLE: Good morning. I don't know if I'm
2 allowed, because I'm just a grunt. But I'm Linda
3 Frazole. I work for the 43 tribes in the Northwest
4 part of the country for the Northwest Portland Area
5 Indian Health Board.

6 FEMALE SPEAKER: [Foreign language greeting.]
7 American Samoa, first lady of American Samoa. And I
8 belong to CSAP, with a P, National Advisory Council.
9 Hello, up there. Made it. Thank you.

10 MR. SUDBECK: Gil Sudbeck, CSAP National Advisory
11 Council from South Dakota, Head of Behavioral Health
12 Services in the Prevention Area in the state.

13 DR. McGRATH: Hello. I'm Jane McGrath. I'm a
14 pediatrician from New Mexico and on the CSAP Advisory
15 Council.

16 MR. CROSS: [Foreign language greeting.] I'm
17 Terry Cross, member of the Seneca Nation of Indians,
18 Director of the National Indian Child Welfare
19 Association. And I serve on the National Advisory
20 Council.

21 MS. GURLEY: Good morning. My name's Tricia
22 Gurley. I am a member of CMHS. And I am the

1 Statewide Youth Motivating Others Through Voices of
2 Experience Coordinator for the state of Maryland.

3 DR. ROSEN: Good morning. I'm Don Rosen. I'm on
4 the SAMHSA National Advisory Council. And after 12
5 years of living in Portland, Oregon, I recently became
6 the CEO and Medical Director of the Austin Riggs
7 Center in Western Massachusetts.

8 MS. DAVIS WHEELER: [Foreign language greeting],
9 everyone. Good morning. My name is Julia Davis
10 Wheeler. And I'm on the Nez Perce Tribal Council in
11 the state of Idaho. Presently, I serve as Chair of
12 the SAMHSA Tribal Technical Advisory Committee. But
13 before that, I served with the state of Idaho on the
14 Commission of Alcohol and Substance Abuse.

15 MS. HYDE: All terrific. We have a lot of wisdom
16 in this room. So we expect to extract it all from you
17 in the next 24 hours. Even while you're asleep and
18 everything else, we're going to just keeping good
19 advice from you. So thank you, again, all of you, for
20 coming.

21 We have a few people on the phone who are on our
22 councils. I want to make sure, if they are there,

1 they get an opportunity to introduce themselves.

2 Chris, are you online? Chris Wendel, who is with
3 CSAT Advisory Council is expected to join.

4 And, Jim McNulty, are you on, Jim?

5 Okay, he'll be around shortly.

6 Johanna Bergen, are you on the line?

7 MS. BERGEN: Hello?

8 MS. HYDE: Do you want to introduce yourself?

9 MS. BERGEN: Hi. This is Johanna Bergen. And I
10 serve on the Women's Committee for Women's Council.
11 And I [inaudible] national.

12 MS. HYDE: Great. Thank you.

13 And, Larry, are you on the phone?

14 MR. LEHMANN: Yeah, hi. This is Larry Lehmann
15 from the Department of Veterans Affairs. And I'm on
16 the SAMHSA National Advisory Council.

17 MS. HYDE: Great. Thank you. Thank you for
18 joining us.

19 And there may be other council members that join
20 us.

21 We have at the moment -- actually, this was as of
22 a few moments ago, and people are calling in rapidly.

1 So we have about 50 or so people on the phone or
2 through the Web participating. We had several hundred
3 sign up ahead of time that were interested. So
4 throughout the day, there may be several people
5 joining us.

6 We also have people in the audience in the back,
7 both SAMHSA staff and stakeholders and others who are
8 interested. So our meetings generate a fair amount of
9 interest. And people may come in and out, based on
10 the topic that we're dealing with at the time.

11 I'm going to introduce a few people up here in a
12 minute. But before I do, I want to say a couple of
13 things about the day. I'm going to try to facilitate
14 and manage our time pretty closely. And there will be
15 times during the day when that's a little bit of a
16 challenge.

17 If you look at the agenda, you can see that we
18 have a couple of panels this time that are pretty big.

19 And part of the reason for that is you all helped us,
20 from last time, pick the topics that you wanted to
21 focus on. And also, you wanted to ask us to focus a
22 little bit on our collaborative relationships with

1 other operating divisions within HHS. So we've got
2 guests from HRSA and a guest from CMS with us in a
3 couple of the topics. And we also have panelists. In
4 some cases, you all are reacting, and in other cases,
5 we have experts who are going to help us react to
6 certain topics.

7 What that means is -- because our desire is that
8 we spend most of the time interacting with you. And I
9 know this room and setup is not always as conducive to
10 that as possible. But we have managed to do it. But
11 we've also managed to have an agenda that was a little
12 less packed in the past.

13 So if you're new to this, know that we don't
14 always intend to talk at you quite so much. On the
15 other hand, today really is a reflection of what you
16 asked to know a little bit more about and get some
17 more information about and some big issues like
18 recovery issues and quality issues and workforce
19 issues that we want your advice about. But in order
20 for you to advise us, you need to know a little bit
21 about what we're working on.

22 So I want to encourage you that if you don't get

1 a chance to talk today or say what you want to say, or
2 if you have thoughts, as you get on the plane and go
3 back, or whatever, or as you go into your other
4 advisory council meetings tomorrow, I encourage each
5 of the advisory councils to spend just a little bit of
6 time, sort of, reflecting what you heard today and
7 doing any kind of feedback. And then, if you have
8 other comments, please feel free to send them in.

9 I think the person that you need to send them to
10 is Cynthia Graham. You may notice that she is the --
11 a different person than Toianne, who was with us
12 before. Toianne has since retired. And I don't know.
13 Given the age I am, I'm starting to get very curious
14 about all these people who say they've retired or that
15 there really is life after government. So we wish
16 Toianne well.

17 She served for many years, and we really
18 appreciate her. And we appreciate Cynthia taking over
19 this role for us in the meantime until we can fill
20 that position permanently. So please get to know
21 Cynthia. Cynthia Graham, spelled pretty much like it
22 sounds. So if you want to send in a comment later,

1 please feel free to do that. Or you can send it to
2 any one of the leadership in SAMHSA, if you feel like
3 that. And we will certainly make sure everybody else
4 knows about it and hears about it.

5 So I am going to try to keep us on time.
6 Sometimes that will mean I'll be using a whip a little
7 bit. And other times, we'll let the conversation go
8 on. But it's important that people who are joining us
9 by phone or Web can, sort of, expect when to start the
10 next topic. And it also is important for you all to
11 get breaks and such, and those of us up here to do so
12 as well. So that's how we will manage today.

13 I also just want to say, as a general matter -- I
14 always like to say this at the beginning of any
15 advisory committee meetings, that I actually get quite
16 excited about these meetings and the topics and what
17 we can talk about and, kind of, interaction and input
18 that we get from you is very stimulating for us. And
19 to the extent that we have to struggle with and make
20 tough decisions sometimes, that kind of information
21 from you is really helpful.

22 So I think of advice as a product. And so,

1 today, you are producing a product that we need and
2 want and are really looking forward to having and
3 incorporating into our thinking. So please don't
4 think it goes into thin air. It does -- what you tell
5 us matters. We often think about it and listen about
6 it and talk about it later after you have gotten back
7 on your planes and have gone. So please continue to
8 do that.

9 And don't just think that it only has to be these
10 meetings. We look forward to your comments and
11 thoughts and interactions throughout the year. So I
12 appreciate that. And I know that each of the leaders
13 of the centers who work with the individual councils
14 and also Kana with the Women's Council and Sheila with
15 the Tribal Council -- we all want to hear from you.
16 So please do that.

17 All right. Let me take an opportunity to do some
18 introductions here, which I am also both sad about and
19 excited about. So the first thing I want to do is
20 acknowledge what I think many of you may know. And
21 that is Dr. Rick Broderick, who's been with the
22 federal government for 38 years and with SAMHSA six or

1 so, five and-a-half, six or so now, is retiring.

2 And his last day in the office will be Friday.

3 So we are -- we've had lots of times to give him our
4 best and our thanks. And I want to do that one more
5 time publicly to thank him for, not only his service,
6 but his personal help to me in the last 20 or so
7 months in getting acclimated and supporting and
8 helping us move an agenda.

9 And, Rick, there couldn't have been anybody
10 better to be a great partner. So thank you. And
11 we're going to miss you. And --

12 [Applause.]

13 MS. HYDE: I have surprised Rick on many
14 occasions by giving him an opportunity to say a few
15 words. This time, I asked him if he'd like to do so.

16 And he said yes. So I'm going to turn it over to
17 Rick.

18 DR. BRODERICK: Thank you, Pam. Thank you for
19 those kind words.

20 Thank all of you for what you've taught me over
21 the last six years. I've worked with some of you very
22 closely for a long, long time. And some of you I

1 don't know as well. But I've learned a lot in the
2 time that I've spent here. I know everybody at this
3 table very, very well, including this young lady,
4 who'll get introduced in a minute.

5 And I know I leave here with SAMHSA in good
6 hands. And I want to thank you, as I said, for the
7 opportunity to work with each of you. The advice that
8 you've given me and this agency over the course of
9 those five or six years -- I guess I'd make -- do I
10 have some time?

11 MS. HYDE: Uh-huh.

12 DR. BRODERICK: -- make a couple of observations.
13 I believe that this country cannot get better
14 collectively until we as a society confront the issues
15 of mental illness and substance abuse collectively and
16 acknowledge that it affects every day, affects every
17 family in this nation in some way. And the nation
18 doesn't do that now. And you know it, and I know it.

19 And we all need to continue to work to that day,
20 to when that is just, sort of, accepted as a course of
21 fact and people do what they need to do to help people
22 get better. And the statistics, I don't think, will

1 get much better until we have done that and we have
2 succeeded at that work.

3 A couple of things I've observed here over the
4 last six years are really encouraging for me. The
5 interest and the adoption of the public health model
6 is something that will help get us to where, I think,
7 we need to go, relative to, sort of, national
8 acknowledgement and acceptance. Integration of care,
9 quite frankly, is fundamental to that.

10 Until our colleagues in the rest of the medical
11 system look for, screen for, and think about making
12 sure people get treated that they see, who haven't
13 come to them necessarily for a mental health or a
14 substance abuse issue -- until they do that and very
15 actively, it's going to be difficult for the rest of
16 providers to make an impact. So a lot of work has
17 been done. It's very cool to see it happening. And
18 it needs to continue.

19 I guess I'd leave you with one challenge, or two,
20 maybe. One is that you'll see a topic on the agenda
21 later in the day that talks about quality, quality of
22 care, essentially. Great work has been done around

1 the evidence base and evidence-based practices
2 promoting them. I would urge you to do whatever you
3 can do to push for the day when there is a standard of
4 care, a clear standard of care, such that people who
5 seek treatment know what that treatment should be and
6 will know whether they got the standard of care met.

7 It's a fairly fundamental principle in medical
8 practice in general. It should be in these two fields
9 as well. And there is a ways to go, and there is much
10 been done. So, please, please, please continue to
11 work on that.

12 And lastly, I would say that there is oftentimes
13 tension between substance abuse and mental health,
14 probably more so in this town than there is in places
15 in America where good care is hard to get. But
16 wherever you see that, to the extent that you can,
17 sort of, avoid that distraction and learn to, sort of,
18 look past your particular need in terms of your
19 program or your funding and think about what people
20 need, I think that would be great. Thank you very
21 much.

22 [Applause.]

1 MS. HYDE: Thanks, Rick.

2 Always the consummate professional. Rick has
3 done what I think is just an amazing job of succession
4 planning. He has managed to work very hard over the
5 last few months, since he told me he was going to
6 retire, to help make sure that people were in place to
7 carry on.

8 So with that, I am very pleased to announce that
9 Kana Enomoto, sitting to my left, will become
10 Principle Deputy Administrator as of Monday, or as of
11 whatever day. And we're very pleased to have her.
12 She has come through many things in SAMHSA and has a
13 lot of experience and history and has already become
14 very much a right hand to me.

15 So, Kana, is there anything you want to say about
16 that?

17 MS. ENOMOTO: I actually just want to say thank
18 you to Rick. He's been a fantastic boss and mentor.
19 And many of you from the outside can't see, but he has
20 such a deft hand at leadership and management. And
21 it's been such a pleasure to work with him for the
22 last five and-a-half years.

1 So thank you, Rick. I'm going to miss you a lot.

2 MS. HYDE: Okay. I'm also very pleased to
3 introduce to all of you, including to some of our
4 staff who haven't actually had a chance to meet her
5 yet. Mirtha Beadle, to Rick's right, will be joining
6 us -- the dates get kind of fuzzy here. Also next
7 week, but, kind of, in and out finishing up her job as
8 the Assistant -- or the Deputy in the Office of
9 Minority Health in the Assistant Secretary for Health.

10 So, Mirtha, welcome, for Deputy for Operations.
11 We're really looking forward to you coming onboard and
12 being ready to rock and roll. So I'm going to give
13 you an opportunity to say hello.

14 MS. BEADLE: Well, thank you so much, Pamela. We
15 did appreciate the opportunity to serve. I think it's
16 just so exciting to be here with you and your
17 executive leadership team and all of the council
18 members. I love this kind of opportunity. And I'm
19 here to serve.

20 I do want to say thank you to Rick as well. He's
21 been, I think, just a phenomenal human being for a lot
22 of us. I especially like the fact that he called me

1 young. I'll remember that for a while. But he's
2 been, I think, a leader and a champion in many, many
3 ways, sometimes unrecognized. And so, I also want to
4 say thank you very much, publicly. But I'm here to
5 learn and here to learn from you. So I look forward,
6 and I'm honored to be here and a part of SAMHSA.
7 Thank you.

8 [Applause.]

9 MS. HYDE: Great. Thank you.

10 Now, I think -- I don't know if it's on your
11 agenda or not, but just so we can get this right from
12 the beginning, Mirtha's name is spelled with an I
13 rather than an A. So it's not Martha. It's Mirtha.
14 And her last name is Beadle.

15 You didn't want to say a word or two about your
16 background? Why don't you do that?

17 MS. BEADLE: Sure. I'm not the talkative type,
18 but I will say that I actually -- as Pam mentioned, I
19 come from the Office of Minority Health, which is the
20 federal lead for health disparities. In fact, I know
21 some of you from my health disparities work. Prior to
22 the Office of Minority Health, I actually worked in

1 the immediate Office of the Secretary, really working
2 with many, many parts of HHS and making sure that the
3 Secretary's work on a number of issues, including
4 SAMHSA's issues, were actually managed in a very
5 neutral and in a very community-centered way. So I
6 did that.

7 I've also worked with the Ryan White program over
8 the years, Special Projects of National Significance.
9 I hail from Michigan, so those of you who are from
10 Michigan, I'd love to talk with you. Hello. But
11 long, long history also with state government and love
12 being a civil servant and love joining all of you. So
13 thank you.

14 MS. HYDE: Great. Thank you. So take an
15 opportunity to get to know Mirtha at the breaks or
16 lunch. She's going to be with us all day. And we
17 thought this was a great opportunity for her to get
18 introduced to many of our issues and many of you. So
19 thanks a lot. We're looking forward to her joining
20 us.

21 A couple of other people I want to introduce.
22 Mike Ensinger.

1 Are you out there, Mike?

2 Maybe he'll be around. I saw him earlier today.

3 Mike is relatively new, a few weeks now, Deputy in our
4 Center for Substance Abuse Prevention, working for
5 Fran Harding and with all the people there. So we
6 want to welcome Mike. If you get a chance and he's
7 around later, get to know him.

8 Also, I'm going to introduce him again later, but
9 let me just say it since we're introducing people
10 today. We also have a new Legislative Director, since
11 you all have been with us. That is Brian Altman. He
12 comes from both public policy and legislative advocacy
13 background, most recently, doing work around suicide
14 issues and some other issues for a number of agencies.

15 So when he's down here, maybe right before lunch,
16 we'll have an opportunity to have him wave at you so
17 you'll know who that is. And to the extent that any
18 of you are looking for information or interacting
19 around legislative issues, Brian is your guy. So
20 we'll introduce him again later.

21 All right. Is there anybody else I'm supposed to
22 introduce today? Everybody else? Well, why don't we

1 introduce ourselves up here?

2 Kathryn, you want to start?

3 MS. POWER: Good morning. Kathryn Power,
4 Director of the Center for Mental Health Services.

5 DR. CLARK: Westley Clark, Director of the Center
6 for Substance Abuse Treatment.

7 MS. HARDING: And good morning. Fran Harding,
8 Director for the Center of Substance Abuse Prevention.

9 MS. HYDE: Okay. I guess I didn't introduce
10 myself. I'm Pam Hyde. I'm the Administrator of
11 SAMHSA. For those people who have a disembodied voice
12 to listen to, that's who this is.

13 All right. So we're excited to get started here.
14 We want to first -- I think I'm going to first turn
15 this over to Kana for just a second to talk about
16 where we are with the strategic initiatives.

17 MS. ENOMOTO: Until I become Principle Deputy,
18 I'm the Director for the Office of Policy, Planning,
19 and Innovation, which I will continue doing for an
20 interim period. And in that role, our office has
21 taken the lead in helping push the strategic
22 initiative paper forward and think through. Now that

1 we've, sort of, mapped out what our work is, we have
2 to come up with a reasonable plan for getting it done.
3 It's a four-year plan. It's the, you know, leading
4 change 2011 to 2014.

5 In it, there are 400 goals, action steps, and
6 objectives. So, as you might imagine, we have set out
7 a pretty big footprint for ourselves, which is very
8 ambitious. With 500 people, we can't each, sort of,
9 assign everybody an action step and say run with it.
10 We're going to need to prioritize and, sort of, put
11 first things first.

12 So following the Pareto principle, where 80
13 percent of your effect comes from 20 percent of your
14 action, the OPI Office, the Office of the
15 Administrator, and the strategic initiative leads with
16 the centers and other offices are coming together to,
17 sort of, sort through of the 400 items that we have
18 said we're going to do, which are the ones that we
19 really need to focus on in the next 18 months.

20 And so, in that process, I think we hope to come
21 up with a vital few where we can really focus our
22 attention and energies and make sure that the efforts

1 of the Office of the Administrator are used to the
2 best effect to make sure that we're pushing the
3 envelope and we're getting the, kind of, policy
4 changes and supports and we're getting the budget
5 directed where we need to get it so that after the
6 next 18 months -- or I think we said, what do you
7 envision having completed by December 2013.

8 We can say, you know, this is -- we've made a big
9 dent in what we've set out to do. So just that
10 process is underway. And we hope to be able to get
11 back out to folks with where we are prioritizing our
12 efforts for the next few months.

13 MS. HYDE: Thanks, Kana.

14 And actually, a couple things that Kana said
15 reminded me of things I forgot to say about the
16 strategic initiatives. It is amazing, as we've gone
17 through this process and all of the strategic
18 initiative leads sitting up here and a couple of
19 others who are not with us today, are how much we've
20 already been able to do.

21 And a lot of that has to do with our stakeholder
22 support and with people working with us out in the

1 states and the communities and through our grants and
2 other things. So we've done a lot of work already,
3 but trying to be clear about where we focus for the
4 next few months is going to be important.

5 We'll try to figure out ways to communicate that
6 to you. So the main thing I want you to hear is, as
7 we do this, this is really a prioritization for a
8 point in time. It is not to say the things we aren't
9 going to make a priority doesn't mean they're not
10 important. It just may mean they're going to come
11 later.

12 So those are the kind of discussions,
13 unfortunately, we're having to have these days because
14 of budget and other kinds of things and just simply
15 workload. So we'll talk a little bit more about that
16 later.

17 But Kana mentioned something that I forgot to
18 say, or mentioned something that made me think about
19 something I forgot to say. Is the other position that
20 we are trying to fill in our leadership team is Chief
21 Medical Officer.

22 This is something that I've been very interested

1 in getting onboard for a long time. We've had
2 clinical leadership within the centers for particular
3 things. But we haven't had that kind of clinical,
4 medical, whatever word is comfortable to you,
5 leadership at the agency level. So we are in that
6 process.

7 We have done some preliminary interviewing of
8 folks. And we're actually down to some folks that we
9 think may be a good group to pick from. So hopefully,
10 that will also come soon. And we'll let you know when
11 that position gets filled as well.

12 All right. Let me go next to just remind you
13 that -- I think Jim McNulty has joined us and
14 Stephanie Le Melle.

15 Jim and Stephanie, do you want to introduce
16 yourself? Jim, do you want to start.

17 MR. McNULTY: Hi. Yeah, sure. This is -- can
18 you hear me?

19 MS. HYDE: Yes.

20 MR. McNULTY: Yeah, hi. Jim McNulty, member of
21 the CMHS National Advisory Council and from the state
22 of Rhode Island.

1 MS. HYDE: Great.

2 Stephanie?

3 Uh-oh, Stephanie just disconnected. It's the
4 wonders of technology. We'll get her back in a
5 minute.

6 Yes, Yolanda. You weren't here when we did
7 introductions. Do you want to introduce yourself?
8 Remember to use the microphone.

9 MS. BRISCOE: Hello, everybody. Yolanda Briscoe
10 from the Women Advisory Committee.

11 MS. HYDE: Okay.

12 And, Hortensia, I think I saw you walk in.

13 DR. AMARO: Yes. Hi. Hortensia Amaro from the
14 National Advisory Council, from Northeastern
15 University. Thank you.

16 MS. HYDE: Great. Thank you.

17 And all of you are being really good. But let me
18 just say it out loud. We really do have to use
19 microphones, not only for each other to hear, but for
20 the people on the phone, and stuff, to hear. It's
21 important that you push the button, make it red when
22 you want to talk. When you aren't talking, it's

1 important to turn it off so it doesn't get buzz and
2 feedback. So everybody can help each other remember
3 that as we go.

4 All right. So let's jump on into some other
5 topics. I wanted to talk just a little bit about
6 block grant. The reason I want to talk about that is
7 because it has been on our minds and it's been a
8 center to a lot of our work for the last few months.

9 You're going to see, a little bit later when we
10 talk about budget, what a huge portion of SAMHSA's
11 budget the block grants are. And, as a consequence,
12 how we work with states around those dollars is very
13 important. And with 2014 coming, it has been
14 important to us to rethink and readjust and redirect
15 how we are working with the states on those two major
16 pieces of funding streams.

17 So the uniform block grant application, as you
18 probably know, has been out for public comment. It is
19 finally complete. It went through a jillion processes
20 that government requires happen. We got lots of
21 input. We made lots of shifts. Lots of people had
22 their hands on it, from policy people to lawyers to

1 editors. And we now have a complete application and
2 process that was out on the streets end of July, I
3 believe.

4 Unfortunately, because of the long process it
5 took us to get through all that, the block grant
6 application or S -- there's one or two that states can
7 decide to do, either a combined one or two different
8 ones -- are due September 1st. So we're getting very
9 close. States are actively engaged in that work. And
10 we have -- because of the time scrunch and because
11 there's changes in the application process this year,
12 we have offered the states the opportunity to tell us
13 in their plan what it is they are planning to do.

14 So in some cases, they'll be done with their
15 planning. In other cases, because it came a little
16 bit late, they will have an opportunity to say, this
17 is still the work that we're working on in terms of
18 getting relationships with tribes established or
19 getting particular data in or whatever. So this is,
20 kind of, a dynamic process.

21 And this particular block grant application we
22 are also doing for a longer period of time than usual,

1 not just a year, but more than a year, but less than
2 two years, because we're trying to get on a timeframe
3 where we will actually get in front of the planning so
4 the planning is actually done before the year starts
5 that the money is flowing. And we're trying to get
6 this one done so that it covers the states and the
7 states know what they're doing up through the
8 beginning of 2014.

9 Now, interestingly enough -- and those of you who
10 deal with block grants will just about fall on the
11 floor with what I'm about to say -- is as we've
12 thought about what this means, we are literally only a
13 few months away from having to put out the application
14 process for the next two-year process. So that means
15 that we have not fallen asleep on the job.

16 We're already thinking about what went -- what
17 did we manage to do in this process, we're already
18 reaching out to NASHBET and NAZAD, who are two key
19 partners around the state relationships around how to
20 go forward next. So just know that that will be
21 coming soon.

22 In this particular block grant change, what we've

1 tried to do is direct the block grant toward four
2 major purposes, which is treatment and supports for
3 individuals who are without insurance or who are
4 between coverage in some way, with the focus on 2014
5 when many more people will have access to payer
6 sources that they don't have access to today and to
7 fund those priority treatment support services that
8 are not covered by Medicaid, Medicare, commercial
9 insurance, so people who are losing coverage or don't
10 have coverage still and services that are not covered
11 by Medicaid and Medicare.

12 And at the same time, we're trying to do all of
13 that in a way that is consistent with what we call our
14 good and modern service approach, which is trying to
15 work with CMS, particularly Medicaid, to define a
16 service delivery -- or service package that should be
17 available, even though it may be different funding
18 streams that fund different parts of it. And in that
19 process, we're also trying to -- believe it or not,
20 this is a pretty profound construct for some folks,
21 which is to have a common service definition.

22 So can you imagine if we had one definition of

1 counseling throughout the country or one definition of
2 ACT teams or one definition of recovery support or
3 whatever it is that -- one definition of family
4 support, or whatever we decide those service
5 definitions are? So there's a lot of work going on
6 about that.

7 John O'Brian is our lead on that. But he is not
8 with us this week. So if you have any questions about
9 that, feel free to get in touch with him and take a
10 look on the Web site as well, because that work
11 continues.

12 So the third major area within the block grant is
13 to fund universal, selective, and targeted prevention
14 activities and services. We have, in fact, proposed a
15 different way of doing prevention. But until that
16 happens, we will continue, at least on the substance
17 abuse side, to have a major focus there. And to the
18 extent that we are allowed on the mental health side,
19 to do that as well, since prevention's our number one
20 priority.

21 The four major area is to collect performance and
22 outcome data to determine the ongoing effectiveness of

1 behavioral health prevention treatment and recovery
2 support services and to try to plan for the
3 implementation of new services on a nationwide basis,
4 as the evidence suggests that that needs to happen.
5 There are a number of things that we got feedback
6 about during the process. Substantively, I think the
7 couple of areas that we got the most input about was
8 kids, a lot of input about adolescents, substance
9 abuse in adolescents. So we have tried to focus on
10 that group, or asked states to do that.

11 And then, we've also gotten quite a bit of input
12 on the mental health side about services and systems
13 of care for kids. And since we have programs that
14 we've been working on for 20 years that we know work
15 around systems of care for high-need, high-risk kids,
16 we're trying our best to see if we can get -- help
17 states to know how to implement that state-wide.

18 We've also put out two separate grant programs
19 with one-time dollars. One, a set of grants to states
20 to, in fact -- states and territories to -- if they
21 choose to take systems of care to scale. So that's
22 one year planning money to do that.

1 And then, we've also put out dollars on the
2 substance abuse prevention side for states to take the
3 SPIFF approach to scale and to really get ready for
4 state-wide preventions -- state prevention grants in
5 the substance abuse area. So there are some ways in
6 which our grants are lining up with our block grants
7 and trying to move the country's programs forward.

8 We've really taken the position at SAMHSA that
9 our job is not just to fund grants, but rather to use
10 our grant-making authority, whether it's in grants or
11 our discretionary grants, to try to move the nation's
12 behavioral health systems forward. So we're trying to
13 think much more about what we call our theory of
14 change and trying to understand how our investments
15 can help the country move forward in better behavioral
16 health care.

17 I think some of you know this, but let me just
18 say it -- is that the thing that is new about this
19 block grant application, the uniform block grant
20 application, aside from all the content areas that are
21 different, is that we have given states much more
22 flexibility in how they do these applications. They

1 can either do one application or two, in other words,
2 a substance abuse one and a separate mental health
3 one. Or they can put them together and do a common
4 one addressing each of those issues.

5 And they are doing one over two years rather than
6 four. So we're really trying to reduce the burden on
7 states in terms of that planning. We don't think,
8 frankly, the needs change that much from one year to
9 the next. It takes a little bit longer for those
10 needs to change. So that's one thing that we're
11 doing.

12 We're trying to focus right now on planning for
13 populations that won't be covered and services that
14 won't be covered after 2014 and, as I said, trying to
15 really focus on consumer, peer support issues,
16 recovery issues, trying to focus on things, for those
17 states where it is an issue, tribal consultation and
18 also trying to encourage states to use those dollars
19 to really get prepared for 2014.

20 All right. There's a lot more I could say about
21 the block grant, but I really just wanted to give you
22 that heads up. And I'm not actually going to spend

1 too much time here on taking input about this, because
2 we have done that publicly, sort of, to death. So I
3 just wanted to make sure you were aware. If you have
4 any questions about that, at the break, please let me
5 know or Rick know or Kana know. And we'll try to
6 answer your questions in any way that we can.

7 On the agenda is that I should also announce or
8 talk a little bit about health reform. I'm not even
9 sure what else to say about that, other than what
10 we're already saying, which is health reform
11 continues. We thoroughly anticipate that it will
12 continue to be the law of the land. And in various
13 and sundry aspects, the stuff that matters to
14 behavioral health continues.

15 We are working very hard with CMS, both in the
16 Medicaid and Medicare side. We had a great meeting
17 with Don Berwick a couple of weeks ago with a whole
18 host of issues ranging from parity issues to service
19 definition and service issues to quality and outcome
20 issues, which you're going to hear about some today,
21 to our integration of primary and behavioral health
22 care. And then, later we were joined by the two co-

1 chairs of the National Action Alliance for Suicide
2 Prevention talking about how we could do better about
3 follow-up out of emergency room care and service
4 delivery in primary care for identifying those
5 individuals who might be at risk of suicide.

6 So we had great conversations. Don has great
7 ideas and is a great partner about that. He and his
8 staff have been terrific at helping us think about
9 behavioral health and at trying to help us include
10 mental health and substance abuse issues in everything
11 from screening to actual service delivery to payment
12 mechanisms to innovations, et cetera.

13 John continues to do a lot of work on health
14 homes and accountable care organizations. So I guess
15 the main thing I would just leave you with about that
16 is we continue to try to be, and I think are doing a
17 pretty good job, of being at every table. Now,
18 whether or not the conversation completely ends up the
19 way that we want it to be is a bigger issue. But it
20 certainly is not for want of trying on either our side
21 or on the side of those people who are primarily
22 responsible for health reform.

1 I think people have gotten that behavioral health
2 is an issue, that it is an issue for people being
3 served. And it's also an issue for America. What we
4 haven't yet gotten is what Rick referred to -- is we
5 haven't yet completely gotten how that is a public
6 health issue for America and that we need to do
7 something about that.

8 The National Council, actually, on tomorrow will
9 be talking a little bit about that issue a bit
10 further. So stay tuned.

11 All right. I think those are the content things
12 I wanted to tell you about. I did want to tell you
13 just one other thing that we're doing from a personnel
14 point of view here in SAMHSA. We are on our third --
15 we're about to start our third executive exchange.

16 And for any of you who don't know what that is,
17 it is basically taking two people in -- or in one
18 case, three people -- in particular jobs and shifting
19 them around to share or to trade jobs for a period of
20 four to six months in order to expose people to
21 different parts of the organization that really need
22 to work together better. We've done that three times

1 -- or two times. We're about to start the third one.

2 This time, we are doing an executive exchange
3 between Bill Tretsker and Bill Reed, one of whom does
4 the hardware part of I.T., and the other one of whom
5 does the communications and use of that hardware to
6 get at electronic communication issues. So those two
7 individuals are going to change jobs for a while. And
8 then, that starts August 29th.

9 And on that same day, Crystal Saunders and Diane
10 Abate, who one of whom is in CMHS doing work around
11 grants, and the other one who is a grants review
12 person. So those two people are going to change so
13 that we learn -- they learn a little bit about how
14 we're currently doing grants review and what it means
15 to develop a grant proposal or an RFA to get out on
16 the streets.

17 So we continue to do that work. And we will
18 continue to do these executive exchanges and continue
19 to let you know. We have done the last couple of
20 executive exchanges at a different level than the
21 folks sitting up here on the -- in the tables this
22 morning. But we will eventually go back at this level

1 as well, because we all want to understand the whole
2 organization as well.

3 We also have now Chris Wendel on the phone.

4 Chris, do you want to introduce yourself?

5 MS. WENDEL: Good morning, Pam.

6 Good morning, everybody. This is Chris Wendel.

7 I am on the CSAT -- that's the T -- Advisory Board. I
8 am the Chair of the Behavioral Health Planning Council
9 of New Mexico. And I am a consumer in long-term
10 recovery since 1985.

11 I'm sorry I couldn't be with you all today, but
12 it's nice to see your smiling faces. And I'm actually
13 going to hang up and just watch it on the Web, live
14 Web thing. So good morning, everybody.

15 And thank you, Pam.

16 MS. HYDE: All right. Good morning, Chris.

17 We have several of our council members on the
18 phone joining us today.

19 All right, so we have a really full agenda.

20 We're going to focus today, as I said, on

21 collaborations, because you've asked us to do that.

22 You wanted to see a little bit -- we talk a lot about

1 what we do with our other operating divisions. So
2 we're going to highlight some of that today. We've
3 got major topics that we want to focus on.

4 The first one is about efforts around women and
5 girls. That issue has come up in a number of ways,
6 both in this meeting, and then, we had -- I was able
7 to spend a little bit of time yesterday with that
8 group. And actually, before we do that, though, we're
9 going to talk about budget. So I will come back to
10 budget first.

11 And then, we're going to spend a little bit of
12 time on what we're doing around recovery. We're
13 trying to define recovery and principles of recovery
14 in a way that will allow us at a system level to
15 understand what we're doing about this and track it.

16 One of the things that I find that sometimes
17 impedes us as fields is that we have very different
18 language for the same constructs. And people hold
19 onto that language sometimes because they feel that
20 there are really fundamental differences. And we're
21 trying to get to what are the similarities about these
22 things. So we'll talk about that.

1 After lunch, we will talk about workforce
2 development. This is an issue that we initially had
3 said was a strategic initiative. Then as we finalized
4 our paper, we realized that there was no way that,
5 with our authority and funding, that we could really
6 be the primary lead on this. And yet, we do a whole
7 lot that touches the behavioral health workforce.

8 We have engaged our partner, HRSA, who -- the
9 deputy for HRSA will be here. And we have lots of
10 people to talk about what we are doing about that
11 along a lot of the initiatives.

12 And then, finally for the day, we're going to
13 talk about the national behavioral health quality
14 framework, which is a major effort that we have just
15 embarked on. And I think you'll find it fascinating
16 about all the work that we're doing.

17 I want to take an opportunity to introduce
18 Richard Frank. I think I saw him come in.

19 Richard, are you there?

20 Yes, way back in the back. Lots of folks know
21 Richard. He will be part of that national behavioral
22 health quality framework discussion. Even though he

1 went back to Harvard, we have snagged him and agreed
2 with Harvard to use a fair amount of his time to work
3 with us on a number of things, one of which is the
4 quality efforts. So he will be participating in that.

5 We will do public comment at the end of the day.

6 But it's not a lot of time. So those of you who are
7 from the public, either online or sitting in the back
8 of the room, if you want to make a comment, we will
9 give you a minute to do that. But it's going to have
10 to be really short. Anybody who wants to provide
11 written comment, we will definitely take that and
12 absorb it and take it in.

13 If there is time, although in this particular
14 agenda, I sort of doubt this -- but if there is time,
15 we have in other meetings stopped at the end of each
16 topic and let the public make a comment or two. I
17 don't know if we'll have time to do that today just
18 because the agenda is so packed. But if we do, we'll
19 get to that as well.

20 All right.

21 So does anybody up here have anything to add to
22 what we've said so far or what's going on for the day?

1 Joining us on my right is -- do you want to
2 introduce yourself, Daryl?

3 MS. KADE: Yes. My name is Daryl Kade. I am the
4 Director of the Office of Financial Resources, the
5 CFO. And I'm here to help Pam talk about the budget.

6 MS. HYDE: Okay. Let me just stop and ask if
7 anybody has any questions about what we have said so
8 far, any of our council members. And then, if not,
9 we'll move right on into the budget discussion. But
10 anybody got questions, anything you heard and you want
11 clarification? All right.

12 So I want to let you know where we are a little
13 bit with budget. And I'm going to talk, sort of,
14 about the budget and what it looks like and, sort of,
15 some of the issues we're dealing with. And then,
16 Daryl's going to give you some more detail about
17 anything I didn't say and particularly about maybe,
18 sort of, 12 and 13. And then, Rick, I think, has got
19 some things to add about how we're dealing with the
20 finalizing the fiscal year '11 grants and contracts
21 process.

22 And, Kana, we may want to come back. If you want

1 to make a comment about the 12 process, you can do
2 that as well.

3 All right. There are overheads up here. What I
4 want to do is just -- some of you have seen this data,
5 but it's -- and I think it's in your book as well. Is
6 that right? So you have it hard copy. I just want to
7 give people a frame about SAMHSA's budget, because
8 sometimes we talk about this and people have their
9 heads wrapped around one program or one center or one
10 stream of funding and don't, sort of, always see the
11 whole. So I wanted to let you see that.

12 Before I do, I assume it goes without saying that
13 we are in very difficult budget times. And those
14 words come out of our mouth very easily, but they are
15 very deep difficulties that we struggle with. We did
16 take some reductions in 2011, as you all know, because
17 of the continuing resolution debates. And we really
18 didn't have a final budget until half-way through the
19 year almost.

20 For fiscal year '12, we are being given pretty
21 clear direction that there will be continuing
22 resolution of some sort. In other words, we will not

1 have a budget for '12 on October 1st, which means we
2 will still be dealing with an uncertain future.

3 You all read the newspapers as well as we do, so
4 you know what the issues are with the Super Committee
5 and other things that Congress is going to deal with
6 in terms of what '12 and going forward looks like. So
7 not only will we not know what '12 is going to look
8 like when we go into fiscal year '12, we also don't
9 know really what the range of issue is going to be.

10 What we are pretty certain about, pretty much
11 take to the bank, no pun intended, is that there will
12 be less money rather than more. So fiscal year '11
13 has a little less money than '10. Fiscal year '12 is
14 likely to have a little less money than '11. How much
15 less is not clear.

16 And if you, again, read the papers and see how
17 this plays out, how the deficit reduction discussions
18 play out, the real drops in funding don't come until,
19 like, '14 and beyond. So even though '12 and '13 are
20 going to be tough, the likelihood of '14 and beyond
21 getting even worse is high.

22 So we're in a different kind of budgeting

1 environment. We're in an environment where we think
2 about where our dollars are spent in the largest sense
3 of the word. We're having to think about what the
4 priorities are, truly what the priorities are, not
5 what all the good things are that we do or could do,
6 but truly what -- if you only got \$100, where are you
7 going to spend it when you wish you had \$500?

8 So those are the kind of discussions we're having
9 to have. And if you had \$120 yesterday and you've
10 only got \$100 today, you know, what \$20 worth of stuff
11 are you not going to do?

12 So those are not fun conversations, but we want
13 to engage you as advisors in that conversation with
14 us. We had one meeting with stakeholders and got some
15 very fascinating feedback about what we should think
16 of as priorities. And we're trying to absorb that.

17 And this affects '12 as we think about how we go
18 forward in '12. But it also affects '13, because the
19 '13 budget is being developed now, even though we
20 don't have a '12 budget. And I think Daryl and Rick
21 will talk, maybe, a little bit more about that.

22 In fiscal year '12, the president's budget that

1 is proposed has really not had a conversation because
2 of all the debt ceiling and deficit reduction
3 discussions that have gone on. And yet, the president
4 continues to say that while the '12 budget that he
5 proposed last January is not the dollars that he might
6 propose if it were today, it is still the direction
7 and the priorities that he remains committed to. So I
8 think you can think about how we restructured our
9 budget, how we prioritized certain things for '12 in
10 the president's budget and know that at least at this
11 moment, that continues to be, sort of, our general
12 priorities and directions.

13 We are very unclear at this point in the year in
14 ways that we probably have really never been before
15 exactly what kind of direction we may get before this
16 process is done. We are at the point in time where we
17 would normally be putting in 2013 budgets, final
18 budgets that would go to OMB, and then, more
19 conversation throughout the fall with OMB.

20 We are totally on hold about all of that. And
21 yet, it could break loose in a day. And we would have
22 not much turnaround time. So we've been trying to

1 think about all of that.

2 So we're dealing with finishing up '11, which I'm
3 going to show you some data about. We're wondering
4 what the heck's going to happen about '12 and thinking
5 about how we're going to manage in '12, which starts
6 in just a couple of months. And then, we're also
7 preparing for fiscal year 2013, kind of, in the dark.
8 So welcome to our budget world.

9 All right. Some of you have seen these slides.
10 This is for 2011. Well, it's from 2007 to 2012. And
11 you may or may not be able to see the stuff at the
12 bottom down here. So you may want to look on your
13 pieces of paper.

14 To the far left is the actual size of our budget
15 in '07. And if you go all the way to the one in the
16 middle that says at the bottom, fiscal year '10
17 actual, as you can see there, we had pretty steady and
18 significant growth in SAMHSA's budget.

19 And then, if you look at the fiscal year '11
20 president's budget, which is this one right here, the
21 president's budget was very favorable for SAMHSA,
22 given a lousy budget year. We got a proposed

1 increase. The next one -- so it's this one right
2 here, the second from the right -- is the 2011
3 enacted. And you can see it is the blue line. And
4 I'll come back to that. It's slightly less than '10.

5 And then, for 2012, the president's budget, even
6 in a tight budget time that we understood at that
7 point, literally a year ago, was also favorable for
8 SAMHSA. The two tallest bars on this graph are, sort
9 of, irrelevant at this point in the sense of they're
10 not real about what we are going to get or have. They
11 are relevant in the budget in the president's support
12 of behavioral health. So that has been very critical.

13 The blue line is important, because it is what we
14 call budget authority. It is basically the
15 appropriated dollars. The PHS or the reddish or rust-
16 colored parts of the bar are a tap that happens across
17 HHS that is used and then goes back into the
18 department or the operating divisions for data and
19 evaluation and other kinds of things.

20 Those dollars, as you can, sort of, see, we've
21 had for quite some time. They were pretty common and
22 consistent at about \$132 million up through the

1 president's -- up through the enacted fiscal year '11.
2 And then, for '12, the president's budget gave us more
3 of those dollars. And Congress has indicated they're
4 a little concerned about that tap growing.

5 So we actually get tapped for that money, but
6 then we get a fair amount back. So it is an
7 interesting way that those dollars happened. But the
8 point of this graph is that those are not really
9 dollars that we can assume will grow in that way.

10 And sometimes we even wonder if they will decline
11 some, because if you're tapping something that's lower
12 at 1 percent, then 1 percent of less money is less
13 money. So those are always the things that we have to
14 worry about.

15 The little green level that started in 2010
16 actual is actually the Affordable Care Act prevention
17 dollars. That's important, because it was new money.
18 And starting in fiscal year '10, we got some of that
19 new money to the tune of about \$20 million.

20 However, as you can see in the enacted 2011
21 dollars, we got more of those monies, which is a good
22 thing. But what that means is that some of the budget

1 authority, or the blue dollars, are being, sort of, in
2 some ways, replaced, not the activities, but the
3 dollars, in a total sense, are being replaced by some
4 of the prevention fund dollars. And that is true also
5 in the president's 2012 dollars. Now, the blue line
6 stays about the same between 2011 enacted and 2012
7 president's budget.

8 So point here is that we fared as well as could
9 be expected in the 2011 reductions. But the kind of
10 money that we have that we're being proposed by the
11 president and, certainly, that Congress will be
12 looking at, are not dollars that we can thoroughly
13 count on. Those prevention fund dollars have been
14 talked about in three ways.

15 One is there's a group of congresspeople who
16 would like to get rid of it entirely. There's a group
17 of congresspeople -- and, in fact, in 2011, Congress,
18 sort of, did replace a fair amount of CDC money with
19 prevention fund dollars. And then, thirdly, even
20 though those dollars are increasing by law, there is a
21 discussion in the deficit reduction discussions about
22 the possibility of capping those dollars rather than

1 letting them continue to grow.

2 All three of those things have an impact on
3 SAMHSA. If we're going to be relying more heavily on
4 those dollars than any one of those scenarios is not
5 good for us.

6 All right. So that is, sort of, the basics of
7 the last few years. The next few slides -- I'm just
8 going to tell you, kind of, what's here.

9 MR. GARCIA: [Off-mike.]

10 MS. HYDE: Yes, Joe?

11 MR. GARCIA: Yeah. Just a simple question. It's
12 probably a complex answer. But I am; kind of,
13 concerned that in the budget protocols, if we're
14 talking about new initiatives, strategic initiatives,
15 you know, I know about operations in that many times,
16 you up-front dollars to improve operations and improve
17 services and all that. So it takes away from the
18 budget, if you will.

19 And in this case, if the departments are mandated
20 to use those dollars only for services and not so much
21 operations, we may be killed in our initiative
22 efforts, strategic initiatives, if we can't use those

1 dollars for improved operations, improved services,
2 and the strategies that have been, kind of, laid out.
3 And so, I hope that there's not such a mandate from
4 congressional legislation.

5 MS. HYDE: That's a great question, Joe, or
6 comment, observation. We have tried in the last two
7 budget cycles to think about our strategic initiatives
8 as the priorities that we are trying to put all of our
9 dollars around, whether it's dollars for our
10 operations or whether it's dollars out there in the
11 field to either do grants or to improve services.

12 So either way that we look at that, we're trying
13 to focus our efforts around the strategic initiatives.
14 So, for example, the behavioral health tribal
15 prevention grant is, in fact, part of our prevention
16 strategic initiatives. So it's a new proposal that
17 comes out of those green dollars that I showed you in
18 that last slide. So that proposal comes out of that
19 green -- the green part of the bar.

20 We've tried to think about that in both
21 implementing 2011, in proposing 2012, and then, also
22 in proposing '13. So I think I'm pretty comfortable

1 that we're pushing the strategic initiatives forward.
2 I think the question is just how much money is there
3 to do these things. That's the big issue, I think.

4 All right. So this pie chart that's up on the
5 board now is just to show you -- these are all 2011
6 dollars, because they're enacted. We know what they
7 are. So these 2011 dollars -- you can see the
8 difference between block grant and non-block grant.
9 So our block grants represent about 61 percent of our
10 dollars; non-block grant, 36 percent; and the
11 prevention funds, about 3. You can look at what is in
12 the non-block grant part of our money.

13 If you look at the next slide, here are two pie
14 charts that show you the difference between substance
15 abuse programs and mental health programs. So in our
16 mental health programs, about -- I'm sorry. I'm
17 trying to get the colors right. The colors change on
18 each one of them, so they get me a little bit here.

19 On the mental health side, just about 42.5
20 percent is block grant. And 57.5 is non-block grant
21 services or grants and programs. On the substance
22 abuse side, in SAMHSA, the block grant represents

1 about 73.6, 73.5 percent; and the non-block grant,
2 about 26.5 percent. So you can see there's a
3 difference in the substance abuse side. The block
4 grant is a bigger portion of the dollars that we have
5 to give out, or put out, than on the mental health
6 side.

7 That has an implication when people talk to us
8 about, well, don't cut the block grant. That has a
9 different implication in different sides. Or don't
10 cut this program. You know, how big in portion it is
11 -- if we're asked to take a 3 percent reduction or a
12 10 percent reduction or whatever it is, there are ways
13 in which these dollars sit.

14 And we don't have a lot of options but to hit
15 some of the bigger programs. Or we don't have an
16 option but to completely eliminate some of the smaller
17 programs, if we want to try to preserve some of the
18 big programs. So those are some of our dilemmas.

19 The next set of slides, or the next slide, is
20 getting a little bit more detail for you, looking at
21 the program as a whole. The substance abuse -- this
22 is the substance abuse side. The substance abuse

1 block grant and the amount is there and how much other
2 mental health block grant, proportionately. You can
3 see the mental health block grant is significantly
4 smaller than the substance abuse block grant. That
5 also has implications for -- if we get asked to take
6 cuts. And then, you can see where PR&S -- by the way,
7 is essentially discretionary parts of both our mental
8 health and our substance abuse programs.

9 The other is important here, because it starts to
10 introduce some of the things that many of you may care
11 about, the PATH grants, the formula grants, the PMA
12 grants, or what we call Pammie, the health
13 surveillance and support, so some of our surveillance
14 work, et cetera. Then this is a little bit more
15 detail.

16 And this one, I think is particularly telling.
17 Again, if you have to take big reductions -- and
18 Rick's always good at talking about this, so maybe he
19 will -- that at some point, depending on how big the
20 reduction is you have to take, we'd have to get rid of
21 every one of the little, small programs in order to
22 maintain the big areas of spending, or vice versa.

1 In fact, in some cases, I don't think there's
2 even enough to do that. So there's just no way to do
3 that. And then, in other cases, we would have to
4 reduce the big portions fairly significantly. And we
5 can't protect them if we have to come up with the kind
6 of reductions that are there.

7 There's a fair amount of detail there. I'm not
8 going to go over them. I'm just going to let you see
9 and know that it's there. It gives you a bigger sense
10 of the whole.

11 We really have been asking our stakeholders to
12 think with us about the whole of SAMHSA budget, not
13 one particular program or one particular slice.
14 Because, unfortunately, we're at the point where when
15 people say, please don't cut this program, that is
16 actually not even helpful, because it's, like, okay,
17 then what else would you take \$5 million out of or \$10
18 million out of or \$20 million out of in order to not
19 cut that program? Those are the kinds of tough, tough
20 decisions that we're having to take a look at.

21 So that is the context, probably more than you
22 want to know about the -- but maybe what you need to

1 know to be able to help us as well.

2 I want to turn this over to Rick, let him talk a
3 little bit.

4 And then, Daryl, if you want to talk a little bit
5 about the deficit stuff and what that means for '13 --
6 '12 and '13.

7 DR. BRODERICK: Thanks, Pam.

8 So that, sort of, frames it pretty well. And
9 what I often remind our colleagues of when we're
10 talking about these scenarios -- we do a lot of
11 scenario planning and what if it was this and what if
12 it was that. If our total budget is \$3.5 billion and
13 someone says, well, what would you do if we cut your
14 budget 120 percent, \$350 million.

15 And so, you don't raise that with a bake sale.
16 You don't raise that by cutting everybody a few
17 dollars and trying to keep things the same. You face
18 fundamental issues about what do we preserve, what's
19 really important. And some programs that are a
20 million or \$2 million, it's very difficult, very
21 difficult choices. So we're talking about large
22 amounts of money.

1 We're not talking about, you know, a few dollars
2 here and a few dollars there and just cut a little bit
3 from everything. And we go through that. We try
4 that, in spite of having done it many times. It's
5 very tempting to say, well, we could, kind of, just
6 shift some things around. And we can come up with 10,
7 20, \$30 million that way.

8 And we're still left with another \$300 million to
9 raise. And so, it makes it very difficult to
10 conceptualize and understand what those options are,
11 given those very large numbers. So that's a
12 particular challenge.

13 As we face this exercise -- and I'm going to talk
14 a little bit about 2011 and, sort of, what we've done
15 to align.

16 And it goes to your question, Joe, about
17 alignment of resources around priorities and how we
18 went about that. We have a grant portfolio that's
19 been pretty constant in terms of the content over the
20 course of time. And we have about -- and that
21 represents -- if our block grants in total are about
22 \$3 billion and the rest of it is more or less a half a

1 billion dollars in discretionary grants and about \$300
2 million in contracts. That's just in round numbers
3 the way it works out.

4 We have -- and you can see in this graph, that
5 one right there, where all the grants are, the
6 discretionary, non-block grant stuff. And so, we,
7 typically, in the past, have had a process whereby we
8 reviewed all the grants that were going to be renewed
9 and made some decisions about what those grants would
10 look like. And they typically looked similar from one
11 year to the next.

12 And in the past, we've had a contracting process
13 where there was a review of the contracts and many of
14 those contracts had stayed the same over the course of
15 time. As Pam laid out, addition for SAMHSA and
16 established the initiatives, in 2011, we reviewed
17 every RFA. I mean, I'm not talking about a project
18 officer reviewed them. We reviewed them.

19 We read them. We read every statement of work in
20 a contract. And there are a lot of those. There are
21 a couple of hundred contracts. And I think this year
22 there were probably 30 or so RFAs and changed them

1 dramatically, changed them to make sure that they were
2 consistent with the statements of work. That doesn't
3 sound like a big deal. I will tell you it was pretty
4 chaotic, because there were a lot of ideas about how
5 to realign them with the strategic initiatives.

6 If you look at our contracts or grants, if you're
7 in a position where you do that, you will see that
8 there were some fairly significant changes in a number
9 of our grant programs. We tried to align them. We
10 tried to braid them across centers. We tried to braid
11 them across agencies. And we did that.

12 And so, the outcome is we have a grant portfolio
13 now that is very well-aligned with the strategic
14 initiatives. And we have contracts that are about to
15 be awarded now that have changed fairly significantly.
16 We eliminated some. I can't remember the numbers
17 right off-hand. I think probably 40 or so contracts
18 just don't exist anymore out of that couple hundred.

19 And we aligned them so that centers were asked
20 to, as they had similar contracts, if there were three
21 contracts that did technical assistance for AIDS
22 grantees, there's now one, that kind of thing, to try

1 to find opportunities for economies of scale and
2 alignment and alignment with the strategic
3 initiatives. So it's been a fairly difficult year,
4 just technically in terms of making all these changes.

5 And I want to acknowledge the work that the
6 executive people did to make that happen. But our
7 staff here really, really, really worked hard to make
8 this happen. And trying to get, sort of, clear
9 understanding from every floor on this building in
10 terms of what needed to be done and what changes
11 needed to be made took a lot of, a lot of work.

12 And I guess one reflection of that is that we
13 were -- the Congress is about to shut the government
14 down. And I think it was in March. And we faced a
15 deadline to get grants out if people were going to
16 have a reasonable amount of time to write them.

17 And there were 30 or 40 or 50 people in this
18 building 'til probably one o'clock in the morning that
19 evening, that Friday night. And we got the word at
20 11:20. I mean, every TV in this building was on, that
21 had a person in it -- 11:20 that evening that the
22 Congress had made a deal. And people stayed here,

1 nonetheless, until one and pushing those buttons,
2 sending those grants out. They could have come back
3 Monday, but they all said, let's stay and do this.

4 And so, it's a reflection of the commitment of
5 SAMHSA staff to get the work done. And they all are
6 unsung heroes. People will never know what they did
7 to get that work done. So it was a great effort.
8 There will be more to come next year.

9 But we're in a really good position to make that
10 happen. So that alignment will continue. And we'll
11 continue to focus on putting our resources --
12 essentially putting our money where our mouth is,
13 putting the money out to do the things that we think
14 are most important.

15 MS. HYDE: Thanks, Rick.

16 Daryl, do you want to talk about where we are
17 with budget planning?

18 MS. KADE: Yes.

19 I think that Pam described the situation with
20 regard to 2012 and beyond rather well. I wanted to
21 just provide some -- a little bit more specifics in
22 terms the two drivers that everyone's looking at and

1 how it might impact SAMHSA.

2 The deal really is that we start with a base in
3 2012. The government starts with a base in 2012
4 that's .7 percent below 2011. And that's rather
5 important. And then, there are ceilings that are
6 developed for discretionary, non-discretionary
7 spending starting from that 2012 base that actually
8 allows for about 2 percent growth up through 2021, a
9 little bit less, a little bit more. But it averages
10 out to about 2 percent growth.

11 Now, that is to initially accomplish the
12 reduction of \$900 billion. Those are caps. Those are
13 not targets.

14 In addition to that -- and this is the second
15 driver -- 1.2 to \$1.5 trillion needs to be cut over a
16 nine-year period between 2013 to 2021. Of that 1.2,
17 \$1.5 trillion, about \$500 trillion is focused on
18 discretionary spending. How that's being taken --
19 that is to say how much you get below the cap for any
20 particular year is really what the Super Committee is
21 about to do their business upon.

22 So what does that mean? Certainly, it means for

1 my shop we're not working on 2012 yet. But, as Pam
2 said, we're on call any day now. Ordinarily, we'd be
3 wrapping up the budget and submitting to OMB in the
4 first week in September.

5 But OMB now is looking at those budget caps --
6 not targets, but caps -- and then, what needs to be
7 done between 2013 and 2021. And it's trying to
8 develop targets for the various agencies, both on the
9 discretionary side and the non-discretionary side.

10 Just to give you a sense of what that might mean
11 if a .7 percent cut were applied to SAMHSA, which is
12 not necessarily the case, because it's a cap, and we
13 don't know how this is going to be applied across
14 departments and within departments, within bureaus,
15 and operating divisions. But if you look at our
16 budget, a .7 percent cut, with or without ACA funds or
17 PHS evaluation funds, is at least \$25 million,
18 relative to 2011. So not only would we not be
19 growing, but we'd be shrinking by at least \$25
20 billion.

21 Now, what does that mean? We don't know. It may
22 be we may have more of a cut. We may have less of a

1 cut. This is the nature of the deliberations now that
2 the department and OMB needs to work on. Ordinarily,
3 they'd just be working on 2013. Now, they have to
4 work on 2012 and 2013 at the same time, which is why
5 we're waiting for our 2013 pass-back.

6 Now, in terms of implementation, I am expecting
7 at least a three-month C.R. We have been going
8 through exercises, responding to the department and
9 OMB about what would happen if you had a one-month
10 C.R., a two-month, a three-month.

11 I think you all know, based on newspapers, that
12 we're not going to get anything from the Super
13 Committee until before Thanksgiving. And we won't
14 have an up or down vote before December. So there's
15 no -- in my mind, I think three months would be
16 optimistic.

17 But what happens under a C.R.? Usually,
18 traditionally, a C.R. --

19 MS. HYDE: I'm sorry, Daryl. Can you just tell
20 people what a C.R. is?

21 MS. KADE: A continuing resolution. So when you
22 don't reach closure on a budget, an enacted budget,

1 there is a continuing resolution that's passed that
2 stipulates what you can or can't do and usually limits
3 your expenditures to a five-year average of
4 expenditures over the past five years and requires
5 that the -- generically requires that that level of
6 spending be the lesser of, either the Senate mark, the
7 House mark, or what you got the previous year.

8 Well, I doubt whether we're going to have a House
9 mark or a Senate mark. And the question would be --
10 and the assumption will be, certainly, based on a .7
11 percent reduction below 2011 as the starting base with
12 a cap in 2012, that, unlike previous years, our C.R.
13 is probably going to be lower than our 2011 base.

14 So not only would we expect to have less money
15 than what we had this year, but usually under a C.R.,
16 you are prohibited -- you, the departments, are
17 prohibited from starting any new programs. So we can
18 continue operations. We can continue ongoing
19 activities. We probably can continue or even start
20 new contracts, but for continuing activities, not for
21 new activities, under a C.R. And that really was part
22 of the challenge of 2011.

1 Not only did we try to realign the grants and
2 contracts through the strategic initiatives, but a lot
3 of that activity that Dr. Broderick was talking about
4 happened during a C.R. So we had to explain how these
5 were not new programs, but innovative approaches to
6 existing programs so that we'd stay within the
7 confines of the C.R. So I expect we'll be facing
8 similar challenges for 2012 as well, because we don't
9 want to wait until the spring to lay out our
10 portfolio. So it will be a very interesting
11 challenge. And I can't wait to hear more about the
12 2012 planning process.

13 MS. HYDE: Cool. Thank you, Daryl.

14 So hopefully, you're getting a flavor for what
15 we're struggling with here. I just want to say one
16 other thing about the 2012 process. I don't know that
17 Kana wants to get into that yet, because we're not
18 finished with it. But we are trying to put together
19 what the process is for 2012.

20 As chaotic as it was, as Rick described, we're
21 -- I'm glad that we did in '11, because it got us
22 through some of the really tough stuff that I think is

1 going to get even tougher. And so, I think we're
2 positioned well. The question for us internally is
3 just what's the process that we use to make some of
4 these tough decisions going forward.

5 I think I want to go back a minute to just wrap
6 this up.

7 Unless, Kana, do you want to say anything at all?

8 [No response.]

9 The thing I want to do -- and I think we're going
10 to -- at this point, we've used this budget slide
11 quite a bit. But I think now we're going to try to
12 take out some of these things that don't mean as much
13 any more. It was just an attempt to show you, kind
14 of, where things had been going.

15 But if you look at this -- and I need to continue
16 to have a mike while I do this. If you look at this,
17 this one is really irrelevant now, so we'll take that
18 one out. This is what's enacted. So where we're
19 starting from here -- this one is, kind of,
20 irrelevant, in terms of numbers now.

21 The direction is still important, the president's
22 budget. But the numbers aren't. So if you redo this

1 slide from here to here, you'll, sort of, see where
2 we're going, or have gone. And then, the other thing
3 that's important is this bottom line is \$2.9 billion.
4 So it's not 0. It is \$2.9 billion.

5 However, if you think about scenarios, and you
6 read the newspapers, and you look at what they say
7 about this much cut or that much cut, we are having to
8 develop scenarios. We're trying to prepare for
9 anything from a minor reduction to a major reduction.

10 So we could be looking at reductions to down at
11 this level or down at this level or even down at this
12 level. And so, what you see here in the trajectories
13 are minor compared to the kinds of reductions that we
14 could be asked to look at and scenarios we could be
15 asked to put together.

16 So that's where we are with budget. It is a
17 tough thing to try to figure out what to do, not only
18 because the stuff that's being discussed is huge, but
19 because it's so uncertain at this point. So that's
20 what we're trying to deal with.

21 We have time for a question or two. And then, we
22 will get on with the next thing. So I'll start over

1 here and just go around.

2 Mike?

3 MR. BOTTICELLI: So I often start this kind of
4 conversation with I hope I don't sound whiny. You
5 know? And I hope this goes without saying that,
6 particularly at the state level, it's been
7 unbelievably challenging in terms of the confluence,
8 not only of state appropriation reductions over the
9 past few years, but now, quite honestly, not just in
10 terms of SAMHSA reductions. And, quite honestly, I
11 feel grateful in terms of what some of my colleagues
12 in the public health department are going through in
13 terms of substantial federal -- other federal
14 reductions.

15 And just a couple suggestions -- and I know, even
16 at a state level, sometimes you're asked to provide
17 this information at lightening speed, and you can't do
18 the thoughtful analysis that you would like to. But
19 one of the things that we try to do as a health
20 department is look at what are the confluence of all
21 of the reductions across our various funding agencies
22 have on a community level and, quite honestly, on a

1 population level.

2 So, for instance, CDC just really restructured
3 how they're doing prevention funding. And, quite
4 honestly, Massachusetts is looking at huge reductions
5 of, quite honestly, for good prevention work,
6 unfortunately, in terms of -- and all of that has a
7 confluence at the community-based level. And so, I
8 know we're talking about workforce later, but I'm
9 really concerned about the fragility of our community-
10 based infrastructure, particularly our agencies of
11 color, who have never been stable.

12 Many of them have never been stable to begin
13 with. So if there is any sort of across-HHS analysis
14 that can look at what's the combined impact of some of
15 these reductions at the, either state level or
16 community level, it would be really appreciated.

17 The second piece -- and I just wanted to -- I
18 know the uncertainty. But it's been really
19 challenging to do any sort of fiscal and programmatic
20 planning at the state level. It's an exercise in
21 imagination.

22 And so, even unofficially, if there can be some

1 conversation with states about what we -- what
2 scenario planning we should be doing at the state
3 level would be really helpful, just because, you know,
4 state budgets -- we're often asked to turn around, you
5 know, kind of, major contractual reductions in warp
6 speed. And so, any, sort of, advanced planning that
7 we could have in terms of what we're looking at in
8 terms of changes.

9 And then, just the last thing I'll say is to the
10 extent possible with looking at what are any sort of
11 cost implications for any programmatic changes that
12 we're doing, I think, has to be taken into
13 consideration as it relates to the block grant,
14 because, again, you know, there is just no more
15 dollars at the table. So, whether it's enhanced data
16 infrastructure or serving new populations, I think
17 there's got to be a cost analysis in terms of saying
18 do those programmatic changes have a cost at the state
19 level. Thank you.

20 MS. HYDE: Thanks a lot. I was going to make a
21 comment about that, but I'll come back to it. Let's
22 have just more comments.

1 I think, Pat, you had your hand up.

2 MS. WHITEFOOT: Yes, I did. Thank you. It's
3 along the same line that was just asked. But my
4 question is more specifically to communities that are
5 in rural and remote areas and talking about the
6 fragile nature of our communities. I'm really
7 concerned about the high rate of suicide amongst
8 Native populations.

9 And so, I appreciate all the work that the staff
10 did, you know, at the eleventh hour doing the work and
11 pulling together to make certain that internally that
12 there's alignment going on. But I'm also concerned
13 about the other federal agencies. And I guess I'd
14 like to take a look at the other federal agencies.

15 I'm not saying it needs to be done here, but the
16 question is how do we ask those questions, or how do
17 we get together to take a look at that braiding that's
18 going on, for instance, with Indian Health Service or
19 the Department of Education, these other agencies,
20 too, when we, you know, have this major concern about
21 the lives of our young people in our tribal
22 communities. Thank you.

1 MS. HYDE: Yeah, thanks.

2 Let's get another comment or two, and then we'll
3 wrap up.

4 Way in the back there.

5 MS. NARASAKI: Hi. This is Diane Narasaki. And
6 a couple of meetings ago, when we were discussing the
7 strategic initiatives, we talked about how important
8 it was to include efforts to close health care
9 disparities throughout those initiatives. And
10 subsequently, there was discussion about inclusion of
11 language within the block grants to ensure that, as
12 you put it so well, that the priorities of the
13 strategic initiatives were being played out in SAMHSA
14 investments.

15 And so, we were asking the question of could
16 language be included in block grants that had to do
17 with closing those health care disparities. I
18 appreciate the comments made before about the
19 confluence of impacts from many different levels. And
20 I appreciate the fact that we have a new addition from
21 OMH who can speak to health care disparities.

22 But in this climate where these fragile

1 populations are receiving impacts from many different
2 places, I feel even more strongly that it's important
3 that that be looked at as a priority as SAMHSA goes
4 forward in determining where to invest its dollars.
5 And I'm wondering whether that language was included
6 in the block grant and how closing those gaps will be
7 addressed in the budget planning process.

8 MS. HYDE: Okay.

9 Victor, I think, you had your hand up, and then,
10 Pat, and then, Marleen.

11 MR. CAPOCCIA: I guess the comment that I'd make
12 is to start with an agreement in terms of the impact
13 analysis that's already been referenced, also to
14 support what you described for Kana as doing in terms
15 of developing scenarios. But I'm wondering if for
16 both of those kinds of activities there aren't sets of
17 principles that should be being debated and
18 prioritized.

19 So principles that include things like funding
20 gaps in insurance in people and services as a
21 principle. Or a second principle would be
22 surveillance and the function of surveillance. A

1 third principle would be how does SAMHSA develop
2 performance standards for the fields of mental health
3 and addiction prevention and treatment and push those
4 out and demonstrate them. A fourth principle would be
5 how we develop capacity. A fifth would be the
6 spreading of innovation.

7 So I would wonder about taking a set of
8 principles like that and saying, okay, how do we rank
9 them, what's the discussion, what are the
10 implications. And then, that becomes some of the
11 guidance for the impact analysis. It becomes the
12 guidance for the scenario development in terms of
13 budgeting.

14 MS. HYDE: Thanks, Victor. And I assume you'll
15 send those principles to us; right?

16 [No audible response.]

17 That was helpful. But I didn't get them all.

18 Pat?

19 MR. RISSER: Yeah, Pat Risser with CMHS Council.

20 I'm hoping you can briefly address what our role
21 might be in prioritizing, as you're looking at, you
22 know, potential cuts or moving program -- you know,

1 shifting dollars around.

2 MS. HYDE: I'll make remarks about all of these,
3 but I want to get all the comments out. So I hear
4 that it's questions.

5 So, Marleen?

6 MS. WONG: Yeah, there has been some important
7 information that's come out from the Census Bureau.
8 And I'm wondering to what extent SAMHSA has considered
9 the shifts in population, particularly of minority
10 populations, to various states. And, specifically, I
11 believe the highest growth rates were in California
12 and Florida and also to suburban areas.

13 MS. HYDE: Thanks.

14 Wana, you're on the phone. I think you want to
15 make a comment.

16 MS. MAHU DIXON: Am I okay?

17 MS. HYDE: You want to introduce yourself, too?
18 Because I think you weren't on when we did that.

19 MS. MAHU DIXON: No, I wasn't. I [inaudible].
20 This is Wana Mahu Dixon. I'm a traditional appointed
21 councilwoman for the [inaudible] band of [inaudible]
22 Indians. And I also serve as the first [inaudible].

1 But primarily, I am the Pacific Rep. for SAMHSA with
2 California and Hawaii.

3 I have been listening. It's quite amazing. And
4 had it not been for the earlier conversations, Pam,
5 with your jump drive with your voice and dialogue on
6 the budgets, it would have been, kind of, crazy to
7 follow this morning.

8 But I looked at -- what I would proposed at this
9 point, from our perspective as to our needs in Indian
10 Country for substance abuse and mental health, we can
11 pilot -- not necessarily pilot, but [inaudible], as
12 you say, special programs or those programs that are
13 chosen to be funded if we could also put with that a
14 P.R. plan of how we achieve any of the eight strategic
15 goals with the limited funding that we have and
16 knowing that it's going to go out for a year or three
17 years until '14, even, that if we could build inside
18 of that this -- some kind of an achievement process,
19 acknowledgement of that achievement.

20 And one of the things we're learning how to do
21 and we've learned to do really well in Indian Country
22 is passing it on. What works and pass it on, and how

1 tribes who have limited budgets can make that work
2 with those modalities that work that not necessarily
3 can be funded by SAMHSA. But if there's a way to have
4 a track that [inaudible] and those things to achieve
5 as a practice, even though -- and then begin to at
6 least set aside some kind of idea of money to gather
7 that data of those things that [inaudible] without the
8 dollars, but were met by just need.

9 You know, we've got to look at that in as a tough
10 thing to do. And it isn't going to fix everything.
11 But it's an idea.

12 Then the last question I have -- and if you could
13 just, kind of -- and I agree -- I think Pat was the
14 one who just mentioned this -- that those things that
15 we can do as tribal leaders to address each thing as
16 level funding as we can with Congress -- give us our
17 bullet sheets of our cards to walk in to do that.

18 MS. HYDE: Okay. Thanks, Wana.

19 I've got Bill.

20 And then -- Johanna's on the phone?

21 And Don. So we'll take those three comments.

22 Then we're going to have to make one quick response,

1 and then, get you into your break.

2 So, Don.

3 Or, Bill is next. Where's Bill?

4 MR. McFARLANE: Yeah, I just wanted to recommend,
5 as strongly as I could, that we not follow historical
6 patterns in doing budget reductions. Up until
7 recently -- I've been through several of these, as I'm
8 sure most of you have. The usual pattern is to cut
9 prevention services in budgets in the face of general
10 operational -- maintenance of the general operations.
11 Michael just said it's happening in Massachusetts.

12 I really wanted to say that that might have made
13 sense before when we didn't have a lot of evidence as
14 to whether prevention worked. But it doesn't make any
15 sense now. And it really -- I think that shift is
16 really reflected in the strategic initiatives. And I
17 think the temptation, of course, will be to have those
18 kinds of things go first. That's just the way history
19 has played itself out in this country.

20 And I don't know whether this is an opportunity
21 to do it differently, but I think that probably is one
22 of the most profound issues that you'll face in this

1 process. And I don't know how we could help you,
2 maybe, make that outcome look a little different. But
3 it was really a whole public health priorities over
4 service provision. That's a tough one. I mean,
5 that's where it really comes down to.

6 MS. HYDE: Thank you.

7 Johanna? You on the phone?

8 Okay, Don, we'll go to you.

9 DR. ROSEN: Thank you. This has been a very
10 thought-provoking discussion. And Michael and Victor
11 and Bill's comments, amongst others, have really
12 spurred a lot of thought for me. And there's some
13 information that would help me think more fully about
14 this.

15 And that is -- in what programs that we currently
16 are providing that are most effective at, say,
17 reducing incarceration, reducing job loss, decreasing
18 --

19 MS. ENOMOTO: Can you speak closer to your mike,
20 please?

21 DR. ROSEN: What programs are we currently doing
22 that have the greatest impact on reducing

1 incarceration, reducing job loss, and keeping people
2 in school and productive, and lowering disability? So
3 I am trying to think through the very complicated
4 question of how do we approach the issue of where we
5 pare back and try to build the synergies and economy
6 of scale. Thank you.

7 MS. HYDE: Okay, thanks.

8 These are great comments and input. I'm pleased
9 to say that some of what you're suggesting we're doing
10 -- we should do, we are doing. There are other things
11 that you suggested that were really helpful.

12 The way that you all can provide input is today
13 and throughout the process. Anything that we have
14 that's public, please comment. You have ways to get
15 into to do that with us.

16 We are limited, as you know, on some of the
17 things that we are allowed to say publicly while the
18 internal conversations are going on. So we push as
19 far up to that edge as we're allowed. But some things
20 we just can't do with other than federal people. So
21 we will try our best.

22 There is an effort going on across HHS to do

1 cross-cutting budget scenarios. I tell you, this is
2 hard. It's been hard in SAMHSA to do it, cross-
3 cutting. To try to do it across HHS is hard. But
4 know that we are trying to do that with our
5 colleagues. And we're picking off little pieces as we
6 can.

7 The issue that you raised, Michael, the states --
8 we now know that the states have lost somewhere in the
9 neighborhood of \$3.2 billion on the mental health
10 side. That's not counting our money. That's state
11 money.

12 I don't yet have the total number on the
13 substance abuse side. We're waiting for NAASADAD to
14 give us that total. But we know it's big, equally.
15 So we're probably looking at least 5 billion, if not
16 more.

17 We also know that they do tend to cut prevention
18 first. And, frankly, part of the reason we tried to
19 restructure our prevention budget and pull it away
20 from the block grant was so we could protect it. But
21 we've also had people who thought that we were trying
22 to do something bad about it.

1 So our commitment to major have prevention be a
2 number one and a protected priority. But we're going
3 to have to almost be able to pull it away from the
4 substance abuse block grant in order to protect it,
5 because those dollars, whether they're cut 1 percent
6 or 2 percent or 10 percent, are going to get right
7 along with any other cut that goes out there. So
8 we're trying to do that with prevention, but haven't
9 completely gotten there just yet.

10 We are -- without going into details, just know
11 that we are working tremendously with other
12 departments and agencies trying to either make up for
13 cuts that they took, or ask them to make up for cuts
14 we had to take. So there's a lot of collaboration
15 with Education, HRSA, and other places about that.

16 We also -- I like the idea of principles for
17 scenarios, some of which, I think, we're doing,
18 Victor. But I don't know we did it as explicitly as
19 you said. So it really would help to have that back.

20 The population shifts -- we are trying to look at
21 some of that in our surveillance stuff, Marleen. But,
22 again, I think more input from you all would be

1 useful.

2 And then, the [inaudible] -- on the P.R. issue
3 about strategic initiatives, we are trying to look at
4 each of our strategic initiatives and what is the
5 public awareness approach to them that we need to
6 take. So we're doing a little bit of what you all
7 suggested, but you gave us lots of other ideas. So
8 thank you for that.

9 And I'm going to let Kana wrap this up, and then,
10 we'll move on.

11 MS. ENOMOTO: I think, just to go back to where
12 we were in coming up with our 2012 scenario, whether
13 or not that comes to pass -- but I guess it's not
14 going to come to pass. But I think the principles and
15 the priorities are the same.

16 And we did, in thinking about also, in our '13
17 planning, we did have a set of principles. You know,
18 one of the challenges that when the numbers start to
19 get very big, you know, and you have set of
20 principles, everything's important, and the numbers
21 become an impediment to following them. But, you
22 know, I think some of the key principles we did have

1 were preserving the safety net and trying to look at
2 what would the impact be if we made these cuts,
3 because we're really looking to bridge to 2014. And,
4 you know, it's no good to have Medicaid expansion and
5 a whole bunch of our people getting cover if there's
6 no one there to serve them or do prevention services
7 or provide mental health services.

8 So I think that was one of our key principles. I
9 think you have no greater proponent for preserving
10 prevention in hard times than Pam Hyde. You know,
11 she's been very clear about that. She's been clear
12 about that with the department, with our partners in
13 the White House and on the Hill.

14 And so, I think that's been very clearly front
15 and center for us in how we've looked at '12 and '13
16 and beyond. Leveraging partnerships -- one of the
17 things that didn't get mentioned -- and we are looking
18 very closely at where can align and braid and take
19 advantage of where other people are.

20 There's also going to be places where other
21 people are leading and we need to get out. You know,
22 I mean, I think we can't be everywhere and do

1 everything for everybody. And we have to find
2 efficiencies. And we have to say, you know what, if
3 someone else is doing more of this, we're just not
4 going to do it, because we've got to give up
5 something.

6 I think we did talk about rewarding and fostering
7 performance, so where we can keep supporting programs
8 that are performing well and make sure that we do our
9 best at helping others demonstrate how they're
10 performing. I think we try to pay a lot of attention
11 to vulnerable populations, not only in communities of
12 color, women, kids, as well as people in recovery and
13 those populations that are at highest risk.

14 And then, the other challenging way of
15 approaching it -- well, and we made it harder on
16 ourselves -- was that Pam was really clear that we
17 needed to make strategic rather than convenient
18 reductions. So it's not -- I mean, as she mentioned,
19 it's not the haircut.

20 The other thing is that it's very easy -- people
21 say, well, don't cut any grants. Don't reduce any
22 grants. Just take the grants that are recycling or,

1 you know, the grants that come to their natural end,
2 you know, they end in 2012. So in 2013, you use all
3 that money, and you give that up as grants. Well,
4 that -- I mean, that's just an artifact of time, where
5 a grant happened to start and end. That doesn't mean
6 that that thing isn't a priority.

7 And so, we went the hard way where we would be
8 doing some new grants and programs, and we would be
9 taking some reductions in other programs, which means,
10 you know, a little bit more heartache for some folks
11 and work for our staff. But I think there is a
12 commitment to making sure that where we take
13 reductions reflects a strategy or a thoughtful
14 approach at minimizing the hardship that we place on
15 communities that we really care about and that we take
16 advantage of what is happening elsewhere.

17 And then, I think everyone has to remember that
18 we're doing all of this amidst some very strong
19 feelings, both in the administration and in our
20 partners in Congress, about what SAMHSA does. So, you
21 know, it's very easy to say we should pay attention to
22 this, we should pay attention to that. We don't have

1 a lot of walking-around money in our budget.

2 We have a lot of SLOWA lines. And I don't know
3 what SLOWA stands for, but our budget's broken out in
4 lines that everybody pays attention to. And we can't
5 move money easily across one line to another line.
6 And there is -- for every single one of our programs,
7 there is a champion. Right? So there's nothing that
8 we could do away with it and no one's going to notice.
9 Someone will raise a stink about every single one of
10 those lines, you know, down to the \$120,000 contract.

11 You know, we've got people writing to their
12 congresspeople about any of those changes. So it's an
13 easy, intellectual exercise. But, as those of you
14 that are out there know, it's very hard in practice.
15 And then, just the complexity of our particular budget
16 and the levels in which Congress and others pay
17 attention to what we do is just that contextual
18 challenge that I hope you all can take into
19 consideration when you see the final outcomes.

20 MS. HYDE: All right. Well, that was a joyful
21 way to start the day.

22 [Laughter.]

1 MS. HYDE: So we are a little bit behind. So I'm
2 going to ask you to be quick. I'm going to ask you to
3 be back and ready to go at 10:30. And for those folks
4 who are on the phone -- we have about 170 or so people
5 -- we will start up again at 10:30. And we'll take up
6 the issue of women and girls.

7 [Break.]

8 MS. ENOMOTO: Thank you very much. I appreciate
9 the opportunity to have this panel today on women and
10 girls and how they are represented across our
11 strategic initiatives and to get thoughts from our
12 many council members here on ways in which SAMHSA can
13 continue to pay attention to -- I mean, it's an
14 important population. It's half the population --
15 within our strategic initiatives and in our portfolio,
16 even taking into consideration the constrained fiscal
17 times we're entering.

18 You know, why pay attention to women and girls?
19 It's not in lieu of paying attention to men, but that
20 we need to be vigilant about the unique risk and
21 resilience factors that affect women and girls, about
22 the patterns of use, their prevalence, their different

1 vulnerabilities, their pathways to recovery, as well
2 as the barriers they experience. And we know that
3 women have different physiological, sociological,
4 biological factors that affect their interaction with
5 symptoms, with treatments, with drugs and alcohol
6 differently, and their roles as mothers. They're
7 also, obviously, going to affect them very much.

8 And so, within -- one of the things that we're
9 very pleased about is statutorily SAMHSA's been
10 required to look at -- to set aside funding within the
11 substance abuse prevention and treatment block grant
12 for women's services, for women who are pregnant,
13 post-partum. And in the uniform block grant, for the
14 first time, while we're not requiring -- we don't have
15 a similar set-aside on the mental health side, we are,
16 for the first time, asking for the mental health side
17 to tell us about the services that they are providing
18 to pregnant women, which is, if nothing else, going to
19 give us very good information to what's happening out
20 there. And I know that there are some states and
21 territories that are looking with fresh eyes at women
22 on the other side of the house.

1 So with that, I would like to introduce this
2 panel. We have Sharon Amatetti will be leading us off
3 with a 10-minute overview on some of SAMHSA's women
4 and girls-specific activities within the strategic
5 initiatives. Sharon is newly been announced as our
6 Women's Issues Coordinator for SAMHSA. She works in
7 the Center for Substance Abuse Treatment.

8 She has had a long history of leadership for
9 women's treatment issues, fostering -- or nurturing
10 the SAMHSA Women Recovery Conference and really
11 shepherding a Women Addiction Services Leadership
12 Institute, which has taken a behavioral health flair
13 in the last year. And so, she's responsible for
14 bringing up a new generation of leaders in behavioral
15 health of women leaders.

16 And she's so well-respected in the field. And
17 she's agreed to take on this role across SAMHSA
18 working with me as the Associate Administrator for
19 Women's Services. So Sharon will lead us off with a
20 10-minute presentation.

21 And then, we have two respondents today. And
22 we're pleased to have Mary Worstell, who's a new

1 member of the Office of Women's Health staff. She's a
2 senior advisor there. She comes from CMS, the Office
3 of External Affairs. And Mary had just a brief
4 conversation -- has a long history as a public health
5 advocate.

6 Recently had a long tenure with the Asthma and
7 Allergy Foundation of America, but has worked as
8 Executive Director of a number of public health
9 organizations and clearly has a very strategic way of
10 thinking about how to provide messages to the public
11 about key issues affecting the health of Americans.
12 And so, we're looking forward to her responses on what
13 we're doing in the area of women's health and any
14 suggestions she might have.

15 And we are fortunate to have our member of the
16 NAC, Flo Stein, who is pinch-hitting, actually, for
17 one of her staffers, Starleen Scott-Robbins is a
18 member of our Advisory Committee for Women's Services.
19 She was scheduled to present today, but she had to
20 attend to an injured back. And we wish Starleen well
21 with that.

22 But Flo is the Director of Substance Abuse

1 Treatment in North Carolina. And she's been a
2 wonderful advocate for women's issues and a supporter
3 of the Evidence-Based Practice Network in North
4 Carolina and a great member of our NAC.

5 So thank you, to the two of you, for providing
6 your responses.

7 So with that, we will go ahead and start. And
8 then, we'll hopefully have about 20 minutes for joint
9 -- I came up with a new acronym. It's the SNAC, the
10 J-SNAC, the Joint SAMHSA National Advisory Council,
11 the J-SNAC. We'll have 20 minutes for J-SNAC
12 comments.

13 [Laughter.]

14 MS. AMATETTI: Okay. Good morning, everybody. I
15 want to thank Pam and Kana for giving me this
16 opportunity to present this morning. And I know that
17 Pam has her whip, she told us, so expediency is
18 valued. And I'm going to try and go over a fairly
19 significant amount of information in the short time.
20 So I apologize for that, but we really wanted to leave
21 time at the end for you to be able to respond to us
22 about what you've heard and what we've been talking

1 about.

2 I also want to thank the Advisory Committee on
3 Women's Services. Pam said this morning that what you
4 say to us matters. And that's absolutely right.

5 And this committee really pushed us to be
6 articulate about how women's services fit within the
7 strategic initiatives. They were listening closely to
8 strategic initiative descriptions and how it's shaping
9 our work here at SAMHSA. And they wanted a clear
10 vision about how women and girls really fit within the
11 strategic initiatives. So this really prompted us to
12 spend some time looking at that.

13 You all are very familiar with the strategic
14 initiatives by now. And so, in order for us to get a
15 handle on what activities we have that relate to women
16 and girls in our portfolio in the strategic
17 initiatives, we really had to look at all the things
18 that SAMHSA does, whether it was block grant funding,
19 discretionary grants, the things that we do through
20 policy making, our T.A. and training portfolios, our
21 contracts and grants, our data collection efforts and
22 also, what we have been doing through public affairs

1 and awareness, and look at those things, those things
2 that we do, and then, line them up, really, against
3 the strategic initiatives. And then, we could see,
4 you know, where are we doing well, where are some
5 things that we need to strengthen.

6 So much of the work on women and girls has really
7 begun before the establishment of the strategic
8 initiatives. But by organizing the SAMHSA priorities
9 by the strategic initiatives, it helps us identify
10 those gaps wherein women's issues may not be as fully
11 represented as we had hoped.

12 You know, I think that what's apparent is that
13 there is a lot of overlap when you do this kind of
14 analysis. Whether it be for looking at what you're
15 doing around women and girls or what you're doing
16 around adolescents, maybe HIV AIDS, you're going to
17 see that there's overlap, because the strategic
18 initiatives overlap sometimes. And then, the work
19 that we do doesn't always necessarily fit neatly into
20 just one or the other strategic initiatives.

21 By way of example, for instance, CSAT has
22 discretionary grants, our targeted capacity expansion

1 grants, our grants that are offered to communities to
2 identify what they think are some of the pressing
3 needs in their communities and to get funding for
4 that. Some communities say that they want to work on
5 women and girl issues as part of their grants. And
6 perhaps it's a grant that's looking at a trauma issue
7 for women and girls or recovery support.

8 So it's that intersect area that there might be
9 quite a lot of people served and quite a lot of money
10 expended for that population. And it falls across
11 different strategic initiatives.

12 So the exercise was really to try and look at
13 each strategic initiative and then look at some of the
14 things that we are doing that are significant and that
15 would fall into that strategic initiative. So our
16 first strategic initiative around prevention of
17 substance abuse and mental illness -- we discovered
18 that a lot of the work that's being done around women
19 and girls is really work that's being funded through
20 our block grant, programs such as training on gender
21 or programs for mothers and daughters or maybe
22 college-age women, that sort of thing, or programs

1 that were being funded through the block grant.

2 In our Center for Substance Abuse Prevention, we
3 have also been funding for many years our Fetal
4 Alcohol Spectrum Disorder Center for Excellence, which
5 is working on issues of pregnancy and alcohol use.
6 And then, we also have partnership grants for success,
7 which are doing a lot of work around binge drinking
8 for both girls and boys.

9 In our trauma and justice initiative, our
10 partnerships are very important. And we have really
11 developed some partnerships that are very specific to
12 issues for women. We've co-sponsored with HHS' Office
13 of Women Health a seminar series on the impact of
14 trauma on women and girls across a life span. We also
15 have our National Center on Substance Abuse and Child
16 Welfare, as well as our National Center on Trauma-
17 Informed Care, which grew out of our Women and Co-
18 Occurring Disorders and Violence study.

19 And it's very focused on gender issues, as well
20 as publications that are very, you know, pertinent for
21 women's specific concerns, like our substance abuse
22 treatment for women offenders, as well as issue brief

1 on trauma-informed criminal justice system for women,
2 and other publications as well.

3 Military families -- we have a lot of work that's
4 going on around the military families strategic
5 initiative, importantly the work looking at the
6 certification and participation of behavioral health
7 care providers through TRICARE, which is the military
8 health insurance program, and also, some things that
9 are very gender-specific for women, such as Webinars
10 that we're planning on military sexual trauma, and
11 also, again with the HHS Office of Women Health, a
12 Webinar on trauma, women in the military. Other
13 partnerships in T.A. is planned as well, including
14 policy academies and work with the Department of
15 Defense and working with the National Military Family
16 Association.

17 For recovery supports, we think a lot about the
18 work that we're doing through our discretionary
19 portfolios. Many of you are familiar with our
20 pregnant and post-partum women grants. But our other
21 grants, as well, our other discretionary portfolios
22 serve a far greater number of women, actually, than

1 the pregnant, post-partum women grant program can and
2 aren't necessarily thought of as women's programs.

3 But, like I said in the beginning, oftentimes
4 they are women's programs, and they have special T.A.
5 on women and gender issues. Again, like in
6 prevention, our block grant funded programs serve
7 women and girls very significantly. And this
8 September, we're going to be funding a new T.A.
9 center, bringing recovery supports to scale, which
10 will be looking at issues -- a broad ranges of issues,
11 including ones such as trauma and recovery and women's
12 issues.

13 Health care reform -- we talked about that some
14 this morning. And we talked about the block grant and
15 that the women's set-aside in the block grant is being
16 retained and that in the mental health block grant,
17 while there isn't going to be a set-aside for women,
18 for the first time, we're asking states if they would
19 be willing to comment on the extent to which services
20 for pregnant women and parenting women are being
21 provided. So we hope to get more information about
22 that through the mental health block grant.

1 Through health care reform, there has also been a
2 very large expenditure of a new program, the Home
3 Visiting Program that HRSA is managing. And this past
4 year, it's -- this year, in 2011, it's \$250 million
5 for that program. And we're happy to report that we
6 were consulted on this program. And we saw to it that
7 the single-state authority for alcohol and drug abuse
8 was to be consulted as part of the requirement of the
9 grant and then, to be involved in the development of
10 that program. So we're happy that that occurred and
11 that we will continue to work with HRSA on that
12 program.

13 And also, very recently, some of you may have
14 seen this in the news that HHS had asked the Institute
15 of Medicine to make recommendations about women's
16 health prevention services that should be included in
17 the provisions of services that would not require a
18 co-pay. And so, those services have been announced
19 very recently. And one of the recommendations is that
20 services for screening for interpersonal and domestic
21 violence would be part of the package and that that
22 would become more of a broadly-provided service.

1 Also, you know, the Affordable Care Act asked
2 that HHS offices raise the visibility of the issue of
3 minority health. And many of our HHS agencies have
4 been asked to describe how they were going to do that
5 and to create an Office of Minority Health.

6 And I think, to our Administrator's credit, she
7 has created the Office of Behavioral Health Equity
8 here at SAMHSA and has identified women and girls as
9 one of the priority populations to be served through
10 that office as well as racial and ethnic minorities,
11 LGBT populations, and other special populations. But
12 women and girls is something that you don't see in all
13 of the other Offices of Minority Health that the other
14 HHS agencies have created.

15 So thank you, Pam, for that.

16 In health information technology, a lot of work
17 going on there as well working with the Office of
18 National Coordination for Health Information
19 Technology and other SAMHSA strategic initiative work
20 groups. We have a contract that's open behavioral
21 health information technology architecture initiative,
22 which is really looking at SBIRT and also working with

1 electronic health record applications.

2 There is a company, i-Triage, which is pretty
3 exciting that we're going to be able to now have a
4 phone app. that we can access the SAMHSA treatment
5 locator through. And then, there are also electronic
6 health record supports for alcohol, drug, tobacco, and
7 depression screening. We think that depression
8 screening is particularly important for women.

9 Data outcomes and quality -- I think most of the
10 people in this room are pretty well-aware about the
11 national surveys that SAMHSA manages, five large
12 national surveys. I hope that you know that all those
13 data can be analyzed by gender, and not just by us.
14 But actually, they're publicly available. And the
15 public can go on and use our data that we've collected
16 for their own interests and analyze by gender.

17 Similarly, we have discretionary grant data
18 collection through our GPRA data. And gender analysis
19 is available through that system as well. And our
20 grantees can do gender analysis.

21 We have a lot of special reports on women and
22 girls. And our offices continue to look for important

1 and interesting findings that we can share with the
2 public, which leads to public awareness and support.
3 As I said, that we have a lot of press releases on
4 women and girls' topics. I think there are 40 reports
5 right now, and we're continually issuing press
6 releases, you know, every couple of months on topics
7 that relate to women.

8 We have a lot of T.A. materials on women and
9 girls. At the Advisory Council meeting yesterday, I
10 brought a huge stack of materials. I mean, it's just
11 a lot of material.

12 As Kana mentioned, we manage a national
13 conference on women. And we do that every other year.
14 We are now developing a cadre of women leaders through
15 are Women's Addiction Leadership Institutes, that we
16 hope to broaden to be more inclusive of professionals
17 working in mental health and also prevention.

18 And then, we also support NSSATS Women's Services
19 Network, which has been another really important
20 vehicle for us to strengthen the capacity of women's
21 services coordinators throughout the country to work
22 together and learn from one another. And I think that

1 they've found that extremely valuable.

2 So in closing, as, I think, a couple people
3 mentioned this morning, you know, this is a difficult
4 time fiscally federally and in the state level. So
5 we're not talking now about large, new initiatives.

6 But we are very interested in your input about
7 how to build on existing initiatives that we have and
8 that you have and to develop more strategic
9 partnerships around advancing the needs of women and
10 girls. I think you can provide really good feedback
11 to us about the policy and practice considerations in
12 the field and help us to prioritize what things are
13 most important, because we know that's a process that
14 we're all going through right now.

15 So with that, I would like to turn it over to our
16 invited guests to perhaps share some of their thoughts
17 on what I've said and also what they've just been
18 thinking about in terms of their work in their
19 respective fields. Thank you.

20 MS. ENOMOTO: Great. Thank you, Sharon.

21 [Applause.]

22 MS. ENOMOTO: First, I'd like to hand it over to

1 Mary Worstell. And something I want to point out --
2 that each of our panels today we have an invited guest
3 from one of our HHS partner agencies as well as one of
4 our National Advisory Council members.

5 So, Mary?

6 MS. WORSTELL: Great. Thank you very much.

7 And I'd like to say that I am here on behalf of
8 Nancy Lee, who is the new Director of the Office of
9 Women's Health. So my comments really include her
10 comments, and then, a nod to the Centers for Medicare
11 and Medicaid Services.

12 And we've been asked to talk about what SAMHSA
13 could do to expand what they're doing most
14 strategically within this fiscal climate and the
15 opportunities for SAMHSA, as we might see them, from
16 the perspective of the Office of Women's Health. So
17 I'm going to focus on two key words, one being
18 leverage, and the other one being gap analysis. And
19 I'm going to link these to some of the strategic
20 issues, strategic initiatives of SAMHSA.

21 And I used to manage an advisory council. And I
22 always felt that the council members would leave these

1 meetings feeling like they had taken a drink out of a
2 firehose, with all the information that you're given.
3 So I'm going to try and simplify this, limit to a few
4 key points, and then, other issues may come up in the
5 discussion.

6 Foremost, I want to say that the Office of
7 Women's Health sponsors a Coordinating Committee on
8 Women's Health. It has done this for many years now.
9 There are about 20 plus federal agencies or offices
10 within agencies that participate on this panel. The
11 purposes are to share information, to leverage the
12 resources, primarily to avoid duplication within the
13 federal sector.

14 We are always looking to identify program models
15 that have successful, demonstrated outcomes and to
16 promote innovation in what we are doing. We meet
17 monthly. And we look at the issues about women and
18 girls across the life span. And SAMHSA has been a
19 regular and very proactive partner in this
20 Coordinating Committee.

21 And, as Sharon alluded to, we already, out of
22 this work that we've begun, we coordinate on Webinars

1 that both -- in the strategic initiative of trauma and
2 justice as well as working with military families. We
3 will only continue and expand those kinds of
4 collaborative opportunities. And, as Sharon also
5 alluded to, we are very pleased right now. A lot of
6 what we do in this Coordinating Council is focus on
7 health care reform as well as the Secretary's
8 strategic priorities.

9 And, of course, within that, one of them that we
10 have promoted, even prior to the recent action of IOM
11 and then, the Secretary, was domestic violence. And
12 so, we're very pleased to coordinate with SAMHSA on
13 that.

14 I'd also like to say that the Office of Minority
15 Health is a member of the Coordinating Committee on
16 Women Health. And I think there are tremendous
17 opportunities, both for leveraging what we are doing,
18 as well as addressing some gap analysis in this.

19 What I am doing in my detail from CMS to the
20 Office of Women's Health is focusing on older women's
21 health issues as we have looked at the work of the
22 Office of Women's Health across the federal sector,

1 we've seen that a lot of the emphasis has been on
2 maternal and child health, and we haven't really
3 balanced that with older women's health issues. And
4 we now have the baby boomers moving into Medicare.
5 There are between 7 and 10,000 new enrollees to
6 Medicare every day. And we will continue at that pace
7 for another 19 years.

8 The fastest-growing population in this country is
9 women over the age of 85. And one of the other things
10 that -- so we need to be addressing this and finding
11 some balance. It, kind of, surprises everyone.

12 The other thing that I think -- and when we look
13 at minority health, right now, 80 percent of Medicare
14 beneficiaries is, sort of, like, me, white, non-
15 Hispanic. But within 20 years, that percentage will
16 drop to 59 percent. So we will have a much more
17 diverse older population in this country. And we need
18 to begin now proactively building the infrastructure
19 to address that population.

20 So I really believe that we've done an
21 environmental scan of the federal sector. SAMHSA has
22 been a very active participant in that. And we are

1 looking right now at what is happening in the federal
2 sector addressing people 50 and older, whether for
3 women or for women and men. And we will be able to
4 sit down together as a sector and look at those areas
5 where we can leverage each other's initiatives in this
6 fiscal climate, and as well as identify gaps that need
7 to be addressed to ramp up for what lies ahead.

8 A third area -- and I want to talk about the
9 prevention services. Obviously, one there, the
10 electronic health records is very important in the
11 work with ONC and the work with CMS on those kinds of
12 issues, and depression screening. In this prevention
13 services for women, as we are looking at interpersonal
14 and domestic violence, this is, as I said, was a
15 consensus focus of the Coordinating Committee on
16 Women's Health.

17 The challenge, however, within this is -- so if
18 we say yes, we will reimburse for screening for
19 interpersonal and domestic violence, when we look at
20 it from a provider's perspective, many of whom are not
21 trained in this and how to screen on this, how do we
22 help the providers do it? Because it's wonderful that

1 we can do it. But how are we going to help the
2 providers to actually bring this to pass?

3 The checklist exists. But if a provider will
4 say, you know, if I start screening for this and I get
5 a yes response, what am I going to do with that
6 information. So we also need to -- so a thought is to
7 wrap this with well women visits to physicians. But
8 then, there's an issue about can we get the
9 reimbursement rate -- can we reimburse and extend the
10 patient's visit to the physician long enough to
11 include this kind of screening and reimburse for that.

12 So one of the things that the Office of Women's
13 Health has, since 2009, is a project called Project
14 Concern. It's a national initiative. It is a
15 partnership to change clinical practice and policy.

16 It has focused, since 2009, on the state public
17 health. And it involves the Domestic Violence
18 Coalitions and other stakeholders. And it produces
19 training and support materials for providers and
20 health systems in how to screen for interpersonal and
21 domestic violence.

22 It provides patient education materials. It is

1 piloted now in eight states and two Native health
2 clinics. It is promoting data collection as well as
3 policy changes to support and sustain this kind of
4 screening. It's goal is trauma-informed care for all
5 patients. And the next stage beginning next year will
6 -- they are monitoring the outcomes of this pilot with
7 the public health systems.

8 Next year, it will now begin to be piloted with
9 private providers. And we can certainly provide more
10 information to anyone who is interested in that. But
11 I think that there are unlimited opportunities for
12 SAMHSA in working with Futures Against Violence Group
13 and with the Office of Women's Health and other
14 stakeholders in this issue. And I think that it's an
15 issue that, I think, we can bring forward with the
16 Coordinating Committee on Women's Health to work
17 across the federal sector.

18 Finally, I just want to say, in the latest
19 edition of ARC, there's an article about screening
20 young girls or women with unintended pregnancies,
21 because there is -- it's known that unplanned
22 pregnancies are a risk factor for depression during

1 and after pregnancy. I think there's some
2 opportunities for that for all of the women's health.

3 And then, in closing, I just want to bring
4 attention on yesterday. CMS has now put out a request
5 for comments. It's a short comment period. Comments
6 are due by Friday, but on two different areas. One is
7 they are proposing to add alcohol screening and
8 behavioral counseling for payment and that would cover
9 -- I'm sorry. Let me read this.

10 "Recently proposed to add alcohol screening and
11 behavioral counseling and screening for depression to
12 the comprehensive package of preventive services now
13 covered by Medicare." And the proposal, one, would
14 cover annual alcohol misuse screening by a
15 beneficiary's primary care provider. And it would
16 include four behavioral counseling sessions per year
17 if a beneficiary screens positive for alcohol
18 misabuse.

19 And the second proposal for comment is an annual
20 screening for depression in primary care settings that
21 offer staff-assisted depression care. And so, if any
22 of you are interested, those are -- we're in a public

1 comment period. So please submit your comments. And
2 there's information online. Comments are due by the
3 19th of August.

4 MS. ENOMOTO: Thank you.

5 [Applause.]

6 MS. STEIN: I'm just going to take this
7 opportunity to say a little bit about what one state
8 has done with women's services and how the things that
9 we've developed try to build on SAMHSA initiatives.

10 I'm very honored to speak for Starleen Scott-
11 Robbins. I hired her in 1994 to be our Women's
12 Services Coordinator. And since our multiple
13 reorganizations, my office coordinates all the mental
14 health, intellectual and developmental disability and
15 substance abuse services in the community in North
16 Carolina. You'll see that we've been able to leverage
17 and use lots of different approaches to this
18 population.

19 So Starleen is also a member of the Women's
20 Services Committee. And it'd be wonderful if some of
21 you could get up here and do this part. And she's
22 also the Chair of the Women's Services Network of

1 NAASADAD. So she's a busy lady these days. And
2 that's probably why she wrenched her back and had to
3 go home last night. So I have this lovely Hilton
4 Garden Inn stationary where she told me what I should
5 say today.

6 [Laughter.]

7 MS. STEIN: So, first of all, thanks very much to
8 SAMHSA, and especially the guidance from Sharon over
9 the years in the development of women's services,
10 particularly in our state, but across the nation. The
11 set-aside in the block grant, which we have been able
12 to add to with state dollars and other dollars, gave
13 us the opportunity to create a Women's Services
14 Network, which probably wouldn't have existed
15 otherwise.

16 So sometimes the federal initiatives give impetus
17 to things that could happen in the states. And we
18 appreciate that. And our legislature has particularly
19 liked this initiative.

20 For those of you who try to advocate for
21 addictive disorders, you know sometimes it's hard.
22 But this particular program, because of the babies

1 that are involved and the very young children, people
2 have really focused on it. They like it. We have a
3 number of physicians in our legislature, and they have
4 always supported this program strongly.

5 We work with -- I'm going to tell you a little
6 bit about our partners, because I think that's really
7 important, both programmatically and financially.
8 These are our partners. The Administration for
9 Children and Families here in D.C. funds some of our
10 special pilot demonstrations. We have programs in
11 FQHCs that are some of our oldest programs rather than
12 newest.

13 We've been doing women's services through FQHCs
14 for almost 20 years. The Division of Social Services
15 -- when Temporary Assistance for Needy Families came
16 along, we immediately partnered with them. The
17 Division of Medical Assistance of Medicaid is the
18 other largest payer for the support of these services;
19 the Department of Correction, because our TANF statute
20 allows for women with H&I felonies to be part of
21 treatment. And if they participate successfully in
22 treatment, they are allowed to maintain their

1 benefits. So that also involves our Administrative
2 Office of the Court.

3 Our very newest two initiatives are we are now
4 part of the High-Risk Pregnancy Health Home initiative
5 in North Carolina, where our network is part of that
6 plan. If you are fans of extreme makeover, you know
7 that we just opened a homeless shelter or a homeless
8 residence for homeless women veterans in Fayetteville,
9 North Carolina, where Fort Bragg is located.

10 And we have, I think, over 200 homeless women
11 veterans in that community alone. And so, that new
12 facility is really an important partnership between
13 the state and the Department of Defense and the
14 community around Fort Bragg.

15 I'm just going to give you really quickly a
16 couple of the kinds of things that we've done over the
17 years that build on these initiatives. And just
18 because Fran is sitting right here looking at me,
19 there's an old CSAP initiative, which we have loved in
20 North Carolina. And even though it goes away, we
21 still do it. And it's called Girl Power.

22 And it's another one of those ideas that people

1 and communities really, really like. It allows girls
2 to be all that they can be in their own families,
3 their communities, their schools. And it works toward
4 empowerment of young girls, so really important.

5 All of our peri-natal and women's programs,
6 except very young mothers -- and there are very young
7 mothers. We originally got started in this initiative
8 because North Carolina, a thing we're not proud of,
9 has extremely high infant mortality. And some of the
10 mortality was due to limited prenatal care and lots of
11 alcohol use.

12 And the resulting outcome was a number of very
13 low birth-weight babies. So our original peri-natal
14 programs really focused on that issue. And I am happy
15 to say that we have had hundreds, probably thousands,
16 of very healthy babies born as part of these programs.
17 Every once in a while, we do a big celebration with
18 either flowers or balloons that represent all these
19 mothers and their children. And it is an amazing
20 sight to see.

21 So we do a lot of all kinds of programs that
22 include recovery supports. There are a variety of

1 outpatient and residential programs. I just want to
2 mention that we have an initiative that's probably
3 about 10, 12 years now that we joined in with Robert
4 Wood Johnson and the Center for Addictions and
5 Substance Abuse at Columbia University, which tried to
6 look at the concurrent treatment of people -- women
7 who were pregnant and women who needed to work and try
8 to do all that at the same time to say that work is
9 treatment and treatment is work. And if families are
10 going to become self-sufficient, they have to do both
11 those things at the same time.

12 And so, we have a network of supported housing
13 and treatment that still exists across the state. And
14 those are regional and accept referrals from
15 everywhere. We also use mental health block grant
16 dollars in that program to support the developmental
17 supports for the children.

18 Children born in these families need lots of
19 special attention for both atypical development and
20 developmental delays, especially sometimes the
21 previous children that are in the family prior to the
22 birth of the baby, that have been in treatment --

1 those babies tend to be fine. But there are often
2 other older children in the families. And we accept
3 families, including their children up to age 12, in
4 all these programs.

5 We have one special program called the Horizons
6 Program, which is at the Medical School at the
7 University of North Carolina at Chapel Hill. It takes
8 very, very, very high-risk pregnancies. And women can
9 stay there prior to delivery for up to three months to
10 make sure they're babies are born as healthy as
11 possible. And then, they can step down into a
12 supportive housing and treatment program. That's
13 called Horizons. And we want everybody who wants to
14 to come and visit it.

15 And we have also used our Oxford House Program to
16 support women and families. And we have 34 Oxford
17 Houses that are dedicated to women with 246 beds.

18 Thanks from Starleen.

19 [Laughter.]

20 [Applause.]

21 MS. ENOMOTO: Thank you. Thank you, Flo.

22 And to Starleen, in absentia.

1 I also want to acknowledge Elizabeth Neptune from
2 our SAMHSA Tribal Technical Advisory Council, who
3 wasn't able to be here for the meeting this week. But
4 we had also hoped to have her.

5 So with that, I'd like to open up to the council
6 members for comment.

7 Dr. Gonzales?

8 DR. GONZALES: Thank you, Kana. I'd like to ask
9 a question, probably, to you, Kana, but also to Mary
10 on the Office of Minority Health. I guess I'm curious
11 as to how does the -- in a time when we're talking
12 about lack of budget opportunities and even getting
13 worse in the future and we're using the words of
14 leveraging between organizations, between HRSA, SAMHSA
15 and collaboration, how that is really, really
16 occurring. And let me give you an example as to why
17 I'm asking that question.

18 You mentioned that the Office of Minority Health
19 is now looking at screening for domestic violence for
20 trauma, you know, for depression, et cetera and trying
21 to ensure that this happens. Just recently, SAMHSA
22 came out with an RFA for expanding SBIRT programs,

1 Screening Brief Intervention, Referral and Treatment,
2 to include trauma and depression. And then, the RFA
3 was rescinded because of lack of funding.

4 So I guess I'm wondering -- SAMHSA has a track
5 record with evidence-based practices of doing this
6 screening and this intervention, particularly the
7 screening. And does the Office of Minority Health
8 take that into consideration?

9 You know, the overview that took place earlier of
10 all the women's programs and what's there, what has
11 been done -- is there such a process that takes place
12 with regard to who's doing screening; intervention,
13 and those kinds of things by the other offices?
14 Because it seems to me that is a very significant
15 contribution that SAMHSA could make to the Office of
16 Minority Women's Health.

17 MS. ENOMOTO: I think what Mary was referring to
18 was an initiative within the Office of Women's Health.

19 DR. GONZALES: Well, either office or whatever
20 office it is, it's still an issue.

21 MS. WORSTELL: No, and I was mentioning -- I
22 think there's opportunities within the Office of

1 Minority Health. I'm speaking on behalf of the Office
2 of Women's Health and just saying that because of the
3 acceptance of the Secretary now with the
4 recommendations for IOM and in that regard, the
5 interpersonal and domestic violence, the fact that
6 screening is now -- she's accepted that that would be,
7 in fact, reimbursable.

8 I'm saying that the Office of Women's Health has
9 a program called Project Connect that, in fact, is --
10 the issue is once -- it's okay to say, yes, we're
11 going to screen, and we're going to pay for it. The
12 question is how do we implement it so it's meaningful
13 for the community. And so, I was just raising the
14 fact that there's a Project Connect that, in fact,
15 trains physicians in how to do that.

16 So we would be working -- now that this is out
17 there, that we would be working in collaboration with
18 SAMHSA and other groups in that. And I cannot speak
19 -- perhaps someone else can speak, at the table, if
20 SAMHSA has been involved in that project.

21 DR. GONZALES: Well --

22 MS. WORSTELL: I know that the Office of Women's

1 Health has partnered with a number of agencies in that
2 project.

3 DR. GONZALES: If I could just follow-up briefly.
4 You know, to me, the issue of not looking at what
5 SAMHSA has done or SAMHSA not say what it's done in
6 screening in brief intervention is problematic to me,
7 because I think there is something valuable to offer
8 that can be done. Excuse me.

9 The last point is even if the Secretary says that
10 they're trying to find out how to pay for those
11 screenings, whether it's through SAMHSA -- you know,
12 whether SAMHSA does it or the Office of Women's Health
13 does it, I'm wondering if there's any leverage from
14 the departments, HHS and SAMHSA, et cetera, through
15 the block grants or something to the states that'll
16 force the states to implement the dollars under
17 Medicaid to pay for these services. Because just
18 because CMS comes up with the codes and says they're
19 acceptable, the states aren't going to do it unless
20 there's some pressure to do it. So it doesn't do any
21 good just to have the codes.

22 MS. ENOMOTO: I think the first step about

1 partnering around the trauma screening and some kind
2 of response or intervention to work with providers --
3 as Mary was talking, I was writing down Project
4 Connect. We need to set up a meeting with Nancy and
5 Mary and go over and figure that out.

6 We have been working on -- as you know, we had
7 this SBIRT trauma module RFA that was on the streets.

8 We weren't able to fund that this year. But we
9 continue to look at opportunities for advancing the
10 field on the primary care base screening and brief
11 intervention opportunity for trauma.

12 So I want to go to -- Patricia, I think, had a
13 question, and then, Joe, and then, Harriet.

14 MS. WHITEFOOT: The question has to do with -- I
15 appreciate the comments that were made by Sharon.

16 You identified, Sharon, the need to also address
17 gaps that exist in providing services for women and
18 our young girls. I do have a concern, though, about
19 statements that are made that our fastest-growing
20 population are those over the age of 85. And I would
21 wonder how many people of color are in that.

22 So I just have a concern with those kinds of

1 statements are made, because if I were to take a look
2 at the data on our -- in our communities, our -- the
3 majority of our women are in the age 24. And so, 85
4 would be, you know, somewhat unrealistic. So just a
5 concern about that, again, in identifying gaps.

6 But another gap that I think that needs to be
7 addressed and I haven't heard it, I think, to the
8 depth that I think it needs to be addressed is that of
9 historical trauma in Native communities, particularly
10 for the Native women and the young girls that carry
11 that trauma. It just has an array of support systems
12 that need to be in place.

13 We are currently, in our coalition in the Yakima
14 Reservation, conducting a young Native women's study.
15 We're conducting focus groups with a variety of women,
16 of our Native women that include older women, but also
17 young women. And we're finding that it's the younger
18 women that are sharing more about the impact of
19 historical trauma on their families. And it's the
20 older women who have a difficult time even addressing
21 that. Currently, we're in the preliminary stages of
22 the study that we're doing in our coalition, and we

1 look forward to sharing more of that.

2 I also just wanted to say about the T.A. centers.
3 I wanted to make certain that we are also, again,
4 bringing, you know, that necessary support to scale in
5 awarding these to address some of these issues that I
6 have brought up and will continue to bring up. And
7 finally, I just want to state that the depth and
8 breadth of historical trauma in Native women as a
9 whole really takes a specialized approach, because
10 we're talking about trauma that has been -- that has
11 impacted our communities in such a way that it has,
12 over time, included marginalization of Native
13 communities.

14 And that covers the whole spectrum of support
15 systems that should exist in our communities, but does
16 not necessarily exist. We're talking about here,
17 health, but across a spectrum, I'm also talking about
18 education, social services, environmental justice
19 issues. So it's broad, in a way.

20 And it has a huge depth to it because of the
21 history that has gone unresolved. And I think that's
22 important to always address when addressing the depth

1 in Native communities and Alaskan villages as well.
2 And because I work with Hawaiian natives, the same
3 thing exists as well. So I want to thank the panel
4 for the conversation, the dialogue that you had with
5 us.

6 MS. ENOMOTO: Thank you. I would love to see
7 more of what you have around historical trauma in
8 Indian Country and Alaska Native populations, because
9 it's something that we have had some activity with the
10 National Child Traumatic Stress Network as well as
11 through the Women's Committee. So thank you for that.

12 Joe?

13 MR. GARCIA: Yeah, thank you for the time. And
14 thank you for the presentation. My question is
15 somewhat related to Patricia's and has to do with -- I
16 don't know if it's specific to the program in North
17 Carolina, but if there's a partnership between the
18 tribes in North Carolina and the programs from the
19 state level. And that would include the Eastern Band
20 Cherokee, Haliwa-Saponi, and the Lumbee tribes. And I
21 wonder if those are included within the services
22 provided.

1 But related to that, in a general form, is how
2 are programs like this inclusive in Indian Country and
3 Alaska Native villages. And then, the follow-up
4 question would be is there a partnership with the
5 Indian Child Welfare Programs that are available for
6 tribes and what not? Thank you.

7 MS. STEIN: Well, I'll start. And it won't be
8 the perfect answer, but I'll tell you what we do. Our
9 very first women's treatment residential program in
10 North Carolina was part of Robinson Health Care, which
11 is Robinson County, the home of the Lumbee. And that
12 is an all-Native-run program. Jenny Lowry is the
13 Director of that FQHS. And that is why we partnered
14 with them early on.

15 We have had about a 25-year contract with the
16 Commission on Indian Affairs in North Carolina, which
17 represent the 11 non-federally recognized tribes,
18 including the Lumbee and the Haliwa-Saponi. And we
19 have had programs with the Eastern Band of the
20 Cherokee. And recently, we completed a needs
21 assessment for them, because they are feeling a lot of
22 pressure to add some residential services for male

1 members of the tribe.

2 We decided to do a comprehensive assessment for
3 them to look at all the possibilities of things that
4 they could be doing and also consider the kinds of
5 funding that are available, because for straight out
6 residential, it's very hard to get dollars any more
7 from Medicaid or even the block grants. So we look at
8 ways to combine all those sources with some of their
9 resources to do the residential program that they are
10 interested.

11 So we are very involved with them. It's probably
12 not enough. And we want to do more. And we're getting
13 ready to take a team to the veterans tribal
14 consultation in Salt Lake City. And we're taking
15 Lumbee and Cherokee members. And I have to say, I
16 have a Lumbee tribal member on my staff who's worked
17 for us for about 25 years. And she makes sure we
18 never forget.

19 [Laughter.]

20 MS. AMATETTI: Yeah. And I just wanted to
21 quickly mention that we have a National Center on
22 Substance Abuse in Child Welfare. And one of the

1 partner organizations with us is NICWA, the National
2 Indian Child Welfare Association. Terry Cross is here
3 today. And just in the back. So, you know, that's
4 been a partnership that's been going on for nine years
5 working very closely with them to provide the
6 technical systems and T.A. to tribes for us. So you
7 can talk to Terry, too.

8 MS. ENOMOTO: So although we started 15 minutes
9 late, I don't want to go too far into the next panel's
10 time.

11 So let Harriet make the last comment, and then,
12 we will wrap up.

13 MS. FORMAN: Thanks very much.

14 I appreciate your presentation.

15 And, Mary, I particularly appreciate your talking
16 about focus on older women's health issues, rapidly
17 becoming an older woman myself, thankfully. And I
18 would like to ask you to consider --

19 MS. MAHU DIXON: This is Wana. You know, I can't
20 hear everybody. You keep going in and out there the
21 whole series of time. Do I need to call back in?

22 MS. FORMAN: Okay, I'd like to ask you to

1 consider, as you develop this, the special needs of
2 lesbian women as we age, who are more likely to have
3 no birth family to be a part of their lives and, as
4 they age and become more dependent on others for help,
5 tend to go back into the closet. We know there are
6 health implications about hiding who we are. And so,
7 if this could be something that you do keep in mind as
8 you go forward with this. I thank you very much.

9 MS. WORSTELL: That is certainly a part of the
10 agenda on this. Thank you.

11 DR. AMARO: Hi, Kana. I wanted to add a comment,
12 if you don't mind. This is Hortensia.

13 So I'm really -- I mentioned this yesterday when
14 I was asked to make some comments in the Women's
15 Committee. But as somebody who has worked, both in
16 gender issues and in race and ethnic and health
17 disparities issues, one of my struggles for 30 or more
18 years has been how these two groups have not come
19 together. And as a result, you have both at the
20 scientific literature level and at the practice level,
21 sort of, people who take a gender focus or people who
22 take a health disparities focus.

1 And women of color get lost in the middle of
2 that. And so, I would encourage SAMHSA to really
3 think about how to manage that as, you know, we
4 develop this broader initiative on gender across all
5 of the SAMHSA units. And I think it's related to some
6 of the previous comments that were mentioned regarding
7 Native communities.

8 MS. ENOMOTO: Great. Thank you.

9 Thank you to our council members.

10 And thank you to our panelists.

11 MS. HYDE: Thank you very much, Kana and Sharon
12 and Flo and Mary.

13 Let's give them a hand. I appreciate the
14 conversation.

15 [Applause.]

16 MS. HYDE: As we're doing the transition here --
17 so these folks are going to go wherever it is that you
18 are sitting. And Kathryn's going to come up. Let me
19 just make one comment about a couple things that were
20 stated.

21 And actually, Harriet, I have upstairs a thing
22 that the Aging Office did on gay and lesbian seniors,

1 if you'd like me to share it with you. It's really
2 terrific. I'll show it to you at the break.

3 But that's a segue into part of what I wanted to
4 say -- is one of the things that we're having to
5 struggle with at SAMHSA, in part because of the
6 budget, but in part, because just no matter how much
7 money we have, we have limitations. And that is how
8 do we relate to other agencies. That's part of what
9 you've asked us to talk about is these collaborations.

10 So sometimes we find that we're actually more
11 effective in helping the Administration on Aging do
12 something or helping the Office of Women's Health do
13 something or helping the Office of Minority Health do
14 something or helping CMS get something into the
15 Medicare program. It's going to have a more profound
16 impact on seniors or on whatever group we're looking
17 at than something we might be able to do because we
18 don't have the resources to do it.

19 Now, what that means for you as advisors, because
20 it's confounding for us as well, is it is less obvious
21 what we do sometimes. It's not a SLOWA line or a
22 grant program. And yet, we are able to do a whole lot

1 more by being, as I often say, at those tables. So I
2 also just encourage you to keep saying to us what
3 tables we should be at, not just what should we fund,
4 because unfortunately, that conversation's going to
5 get slimmer and slimmer.

6 And then, also, I don't know if Arturo's still
7 here. But the conversation and the question about can
8 we force the states to do SBIRT codes -- the answer is
9 no. As a political scientist -- or at least that was
10 my undergrad degree, I learned this concept of
11 federalism as I have gone through from city, county,
12 state and now federal levels, I have learned that when
13 you're at the state, you think the feds are awful and
14 they're making you do everything. When you're at the
15 federal level, we can't make you do anything.

16 [Laughter.]

17 MS. HYDE: So there is always this balance
18 between the states' rights to make decisions in their
19 own world. But what we are able to do with SBIRT and
20 other things is make it clear why it's important,
21 making sure that the screening is required, or at
22 least allowed. And so, we are trying to do those

1 kinds of things as well. And, you know, as somebody
2 who's for -- balance has never been one of my strong
3 suits, this is something I'm learning in my old age
4 and how to balance these things.

5 So anyway, hopefully, that's helpful. There's
6 lots of work going on.

7 So with that, I'm going to -- I want to turn this
8 to Kathryn. This is one of our things today that is
9 not a panel. Because we have a lot going on here
10 about the recovery issue, we know that there is a fair
11 amount of controversy, opinion, and concern about it.
12 And so, we want to make sure we have plenty of time
13 for conversation.

14 Kathryn's going to tell you a little bit about
15 what we're doing and why we are trying to create some
16 commonality about the recovery construct. That
17 doesn't mean there aren't differences for different
18 people or different addiction and mental health and
19 other things. But we're trying to focus on the
20 commonality. And we'd like your input about that.

21 So with that, I'm going to turn it over to
22 Kathryn Power, who's our Center for Mental Health

1 Services Director, and the lead on both our military
2 families initiative and our recovery supports.

3 So, Kathryn?

4 I could have done that.

5 [Laughter.]

6 MS. POWER: Good afternoon, everyone. Can you
7 all hear me?

8 [No audible response.]

9 Okay, great.

10 First of all, thank you, Pam.

11 And I appreciate the opportunity to talk with all
12 of you again. I think the last time I was in front of
13 you, I talked about the recovery support initiative
14 and went through some detail about that. So I want to
15 just say thank you all again for being here, and I'm
16 looking forward to your comments about this.

17 The good news is that SAMHSA continues to be the
18 agency that takes a leadership role in the discussion
19 of recovery. We continue to take that role on. I
20 think that's one of the most important parts of our
21 mission, is that we are the spokesperson about
22 recovery. And we want to talk about recovery. And we

1 want to convince people that recovery is important. I
2 think that's a huge issue.

3 The second piece of good news is that the
4 Administrator, since she's come here, has asked
5 everyone she's met to comment on recovery. And so, in
6 encouraging that kind of comment, we have a very rich
7 field of discussion and a very rich set of dialogue
8 that has been going on for quite some time.

9 What has been happening as a part of the recovery
10 support strategic initiative is that that work group
11 has been charged, over this last year, to take a look
12 at the developing definitions of recovery that have
13 existed at SAMHSA over many, many, many years.
14 Recovery has been talked about for at least the past
15 40 years, 30 years, 20 years, 10 years. And it has
16 evolved over time.

17 And so, one of the things this gives us a chance
18 to do is to stop and take a look at that issue of
19 language that the Administrator wants us to be aware
20 of, but also take a look at how we're talking about
21 recovery in the context of health care reform and in
22 the context of the evolving and emerging health care

1 environment. So as a part of our work over the last
2 year, we've had an opportunity to talk with many,
3 many, many people in the field about the definitions
4 of recovery that we hope begins to capture what are
5 the essential and common experiences of those
6 individuals recovering from mental and substance abuse
7 disorders and, in fact, the 10 guiding principles that
8 inform that.

9 Now, originally, we were going to just talk about
10 the 10 guiding principles, but I think the most
11 important issue is that the guiding principles are
12 probably intuitively appropriate and intuitively
13 understandable by an audience like you. You work with
14 these principles. You work with those issues. And
15 so, I'm going to touch on those very, very briefly.

16 What we want to do today is try to drive this
17 issue about why it's important to establish some
18 definitional parameters around recovery, because we
19 have to project what, in fact, we want the insurers
20 and payers to do when it comes to looking at the issue
21 of recovery. One of the key events that led to this
22 current working definition of recovery that we have

1 was the 2010 meeting of behavioral health leaders and
2 mental health consumers, people in recovery, people in
3 addiction recovery, a number of providers. And
4 working on that draft definition was really the task
5 of members of the recovery support initiative,
6 particularly Paula del Vecchio and Cathy Nugent, who
7 have really been the leaders as a part of our group in
8 pulling that discussion together.

9 So in recent months, SAMHSA has been looking at
10 working drafts of the recovery definition. And we
11 continue to hear back from stakeholders. And we
12 continue to hear back from where we might improve the
13 working definition.

14 Now, what we are doing today is we're starting
15 with the fact that we start always with the definition
16 in the dictionary. What does it say about recovery?
17 And this is under tab six in your notebook. What does
18 it say about recovery? And what are we trying to
19 capture in terms of talking about recovery?

20 And I think it's important for us to set in our
21 heads the fact that recovery generally encompasses
22 five major elements. It generally talks about the

1 regaining of something lost or taken away, a
2 restoration or return to health from sickness,
3 restoration or return to a former or better state or
4 condition, restoration of function, and regaining of
5 one's strengths, composure, and balance. Oftentimes,
6 when you look at the root word in Latin, we get caught
7 up in the context of applying it to health care. And
8 in health care, it really often refers to heal or cure
9 or overcoming some disability or to rehabilitate.

10 We've often used the term recovery in terms of
11 setting it as a framework or setting it as a
12 construct. We've also often referred to it as a
13 process and a goal. And for many people, it is both a
14 process and a goal. And we have had some interesting
15 conversations about that.

16 Now, I'm going to take you for a moment into the
17 health and insurance systems and ask you to think
18 about what the health and insurance systems challenge
19 us to think about. The reality is that we have to
20 understand what those systems do and how they operate.
21 And in general, the health care system functions a
22 posteriori, to treat disease and systems in a very

1 pre-defined context of covered definitions and
2 procedural technologies in a very pre-determined
3 reimbursement structure. That is how our health care
4 system works.

5 Now, in that, an insurance plan will, of course,
6 be the contract between an insurance provider -- and
7 the only difference might be who the sponsor is of
8 that insurance plan -- between an insurance provider
9 and an individual. The type and amount of health care
10 costs that will be covered are specified in writing.
11 In a member contract, an evidence of coverage booklet
12 for private insurance or in government-stipulated
13 plans, it's very important for people to understand
14 what kind of insurance is covering them or what kind
15 of government insured program is covering them. And
16 now, we're trying to take this concept and construct
17 of recovery and say is it really something that should
18 be separated over here, or can we fit recovery into
19 these structures. So how do we take recovery as it
20 has been defined and understood and begin to
21 understand that it has to work in a health care system
22 that functions a posteriori and, in fact, is

1 reflective of the use of insurance plans?

2 Now, is behavioral health itself, that is, mental
3 illnesses and substance abuse disorders, trying to fit
4 in this picture now? And my answer is yes, we are
5 trying to fit into this picture. And we've actually
6 had decades of operating outside of it, which is why
7 we had separately funded, distinct mental health and
8 substance abuse systems across 50 states and
9 territories. We've operated outside of that.

10 Now we've only had up to this point very marginal
11 participation, that is, with certain psychotherapies
12 and certain evaluation and certain management
13 techniques. But the use of recovery as a practice is
14 going to be the true test of whether or not we can, in
15 fact, move into the big picture.

16 Now, what happens in our health care and
17 insurance systems? They utilize order and structure
18 to organize their treatment and manage their resource
19 allocation. Being part of that system is dependent on
20 cooperation, inclusion, and adherence to the confines
21 of the structures that those systems use.

22 And basically, there are three kinds of coding

1 methodologies that are used in those systems: the ICD
2 coding system, the International Classification of
3 Disorders, which, of course, is what the DSM, of
4 course, will in 2014 be under the cognizance of the
5 ICD under the Affordable Care Act. We use Current
6 Procedural Technologies, or CPT codes. And we also
7 use Health Care Common Procedural Coding Systems, or
8 HCPCS.

9 Now, these are just the coding methodologies that
10 are used. What is also used in terms of looking at an
11 alignment around the health care system is the
12 disability adjusted life year. And the sum of what
13 the disability adjusted life years mean across the
14 population or a burden of disease is often thought of
15 as a measurement between the gap between current
16 health status and an ideal health status.

17 This listing are just prime examples of the
18 formalized rules of health care and insurance systems.
19 They apply to all treatment modalities. And they are
20 in place to set up a structure for treatment and for
21 expectation of outcomes. These are the rules of the
22 game. And they are intended to codify and to

1 standardize a very highly variable system.

2 Now, we move into the system and say, can we
3 claim that recovery is equal to or not equal to what
4 is medically necessary. Let's take a look at SAMHSA's
5 current working definition. This is our current
6 working definition on recovery. "Recovery is a
7 process of change whereby individuals work to improve
8 their own health and wellness and to live a meaningful
9 life in the community of their choice while striving
10 to achieve their full potential." That is our current
11 working definition.

12 Let's take a look at the Center for Medicaid and
13 Medicare Services definition of medically necessary.
14 "The patient must have a significant health problem.
15 And the services rendered must have a direct
16 therapeutic relationship to the patient's condition
17 and provide reasonable expectation of recovery or
18 improvement of function." This is an important place
19 for us to start the conversation.

20 Is there a disparity between the two statements?
21 Are we talking about apples and oranges comparison?
22 Or is this a fair comparison? We think that they are

1 contrasting styles of characterizing recovery, because
2 one establishes a recovery belief and an
3 encouragement, while the other sets a threshold for
4 appropriate services. And yet, they are not
5 dissimilar. Hold that thought.

6 Now, the core of our recovery definition falls on
7 these 10 principles. These 10 principles have many,
8 many, many, many words behind each of them. And I'm
9 not going to do a dramatic reading of all 10
10 principles.

11 Those 10 principles I'm going to ask you to go
12 onto the SAMHSA blog. And we just started a SAMHSA
13 blog as of yesterday. You will go onto the SAMHSA
14 blog and read how these principles are described,
15 because each one of these 10 components is an
16 important launching pad for us to understand where we
17 may go in our final definition of recovery and should
18 build on that definition of recovery.

19 But in particular, I'm going to highlight just a
20 couple. When you think of person-driven, we're
21 thinking about individuals optimizing their autonomy
22 and their independence to the greatest extent possible

1 by leading, controlling, and exercising choice. We
2 think many pathways. There are lots of ways for
3 people to move into recovery and beyond the journey of
4 recovery, because people have different needs and
5 strengths and preferences.

6 When we say it's holistic, we're talking about
7 the fact that it should include self-care practices,
8 it should include family issues, housing, employment,
9 education, et cetera. When we talk about the fact
10 that recovery should be supported by peers and allies,
11 mutual support and mutual aid groups, including the
12 sharing of experiential knowledge and skills, play an
13 invaluable role in individuals' recovery.

14 We move through, then, the fact that we need to
15 have supportive relationships and social networks, the
16 fact that we have emphasized across our other
17 strategic initiatives, but, clearly, in terms of our
18 experiences in learning about trauma, that we
19 absolutely have to address trauma if we are going to
20 support a recovery dimension. And, in fact, we have
21 to make sure that we are focusing on community systems
22 and social acceptance, appreciation for people

1 affected by mental health and substance abuse problems
2 and, in fact, including the fact that we need to
3 continue to protect the rights of individuals with
4 mental illnesses and substance abuse disorders and
5 continue to eliminate discrimination, which gets to
6 the respect issue.

7 And finally and most importantly, the issue of
8 hope has always emerged as the fundamental core value
9 of recovery. That, in fact, recovery emerges from
10 hope, that the belief that recovery is real and
11 resilient, is vital provides the essential motivating
12 message of a much better future, so that, in fact,
13 people can and do and will overcome both the internal
14 and external challenges that they may face in terms of
15 confronting their disorder. I will ask you to
16 seriously go back and take a look at the verbiage that
17 is used to describe these 10 principles and give us
18 some feedback about that.

19 Now, let's move to recovery as treatment.
20 Recovery as a treatment outcome can be defined as the
21 state, based, remember, on those dictionary
22 definitions of recovery, pulling us into the real

1 world about what people are expected in terms of
2 outcomes, the symptoms of the illness are no longer
3 manifested. The symptoms of the illness no longer
4 negatively impact the ability of the individual to
5 successfully live and integrate in society. The
6 individual is able to adapt in a manner that his or
7 her symptoms no longer create impairment. And/or the
8 individual can successfully learn to have a healthy
9 and successful life, despite his or her impairments or
10 symptoms.

11 So this is an issue about saying these are the
12 expected outcomes as we help people move toward
13 recovery and, in fact, does that make sense. And does
14 that fit into that overarching sense about how
15 recovery, as a medically necessary goal, can, in fact,
16 be supported by the health care systems?

17 Now, medical insurance is designed to address
18 recovery from medical health problems. Recovery of
19 health is supported when other life goals also are
20 addressed. And guess what? Those four -- health,
21 home, purpose, and community -- are the four
22 dimensions under the recovery support strategic

1 initiative. Instability in any of those goals puts
2 recovery from health problems at very serious risk.
3 Recovery-focused systems increase the likelihood of
4 improvements in outcomes.

5 So what I want to do now is take a look at - here
6 we have Maslow's hierarchy of needs. And we remember
7 that from our basic self-actualization studies. And
8 we're going to overlay on Maslow's hierarchy of needs
9 the way in which we begin to look at who covers what.
10 If you take a look at the lower level needs in terms
11 of the pyramid, we have a health and insurance system
12 that, in fact, is responsible and can be responsible.
13 And we're going to match this to the recovery
14 definition.

15 So we're going to overlay Maslow's hierarchy of
16 needs, matched to the recovery definition, which
17 basically reveals to us that the health and insurance
18 system provides for basic and foundational support in
19 recovery. This is a very important point to
20 recognize. As the individual recovery journey is
21 supported by systems to a particular point, individual
22 responsibility and personal commitment are recovery

1 drivers in lieu of system supports. There is a clear
2 delineation of ownership in recovery treatment from
3 the system to the individual. And take a look at what
4 is perceived to be, then, what the health and
5 insurance system may pay for or care about and what,
6 in fact, is a personal responsibility.

7 So there's the transfer point. Now, if you take
8 a look at recovery outcomes being described as either
9 internal or external, that means internal to the
10 individual in recovery and external as the treatment
11 system outcomes, currently structured, there are
12 limited, if any, treatment services that are available
13 and reimbursable to increase internal outcomes. These
14 internal outcomes are absolutely critical to the
15 recovery journey. But they have limited value to the
16 health and insurance system. What has value to the
17 insurance system is what is approved for payment.

18 Consequently, we need to continue to proceed
19 developmentally with caution. Through the working
20 definition of recovery, we have concisely and
21 accurately to this point described the how, that is
22 the esoteric and conceptual context of recovery, at a

1 very high level. And we think that that definition
2 really does, in fact, reflect the emerging science
3 about what works with our priorities and our
4 principles and what SAMHSA believes and what the field
5 believes we should reflect in terms of social justice,
6 in terms of entitlement, and in terms of advocacy,
7 and, most importantly, in terms of social inclusion.

8 We think we're almost there at the conceptual
9 level. Now what we have to do is align this
10 understanding with how of the how with the definition
11 of what that is used for all the other parts of health
12 as well as in general usage. We think by doing that,
13 by moving from the esoteric to the practical, we're
14 going to ground recovery in outcomes rather than just
15 process and set equal footing for inclusion in the
16 health and insurance systems. And we think that
17 that's the most important thing to do.

18 Some of the efforts and accomplishments that
19 we've been working on over these many years as we look
20 at recovery is that, obviously, the recovery support
21 strategic initiative is part of that. The recovery to
22 practice initiative -- most of these are familiar to

1 you. If they're not, I'm sure we can -- you can find
2 out information about them, or I can answer them. But
3 there are lots of different approaches that we've
4 taken, different programs, different approaches,
5 different strategies, different training, different
6 ways in which we have tried to take a look at moving
7 this recovery construct and moving this recovery
8 practice embedded in our systems.

9 And most recently, as you all know, we have --
10 for the first time this year, we are doing an
11 integrated recovery month in September, so that we're
12 talking about recovery for mental illnesses and
13 addiction and substance abuse disorders for the first
14 time in many years that SAMHSA has ever done that.
15 And this September is significant in that way.

16 We all do focused leadership about recovery. The
17 APA just came to us last week and said they're very
18 concerned about the under 40 psychiatrists coming into
19 training. They think they're ripe for recovery to
20 practice training. We're going to help them, so that
21 we know that there's an interest in wanting to figure
22 out how to get this embedded in practice, that we have

1 to make the connection, though, between those esoteric
2 conceptual principles and the practical reality of who
3 pays in the system.

4 Our future work is going to reside in these
5 particular areas. We're going to be taking a look at
6 making sure that we develop highly-reliable
7 instruments to measure recovery outcomes. We're going
8 to keep on informing clinical practice by
9 demonstrating which practices are most effective in
10 achieving recovery. We're going to improve individual
11 outcomes with the best level of service to a specific
12 stage of recovery.

13 We're going to measure recovery across phases of
14 illness and episodes of care across the life span,
15 continue to work on establishing recovery clinical
16 protocols and pathways, which actually can describe
17 the time, the intensity of effort, the skill, and the
18 risk to the patient associated with recovery services.
19 And, in fact, we're going to do all of this work with
20 partners. With you as our partners, we're going to
21 identify and continue to measure best practices.

22 And we're going to continue to explore the best

1 possible ways to continue to exploit the use of peers
2 and peer supports. We know, in fact, that this future
3 work is part of the work that we do through our
4 portfolio. It's also part of the work that you all
5 are doing every day.

6 Now where do we go from here? What we're doing
7 is a number of things. The first is the Administrator
8 mentioned a good and modern system this morning. We
9 have a set of definitions in the good and modern
10 system paper that talk about recovery and recovery
11 support services. Those services are defined in the
12 paper. And we're hoping, again, that that paper will
13 influence the states and the communities as they move
14 forward to shape their recovery-focused systems under
15 the Affordable Care Act.

16 So some of those services under the good and
17 modern paper include peer support coaching, patient
18 navigator services, peer-run recovery support
19 services, and self-directed care. In addition, we
20 want to try to influence other bodies who are involved
21 in looking at the range of services and make sure that
22 we are informing them about the kinds of services that

1 might be included in a recovery system of care and in
2 a recovery orientation.

3 We clearly want to continue to try to influence
4 insurers and payers. We are, in fact, trying to move
5 forward with a parity communications plan, because we
6 think that parity continues to be the law of the land
7 and the bedrock of the Affordable Care Act and the
8 actual realization for people to be able to get
9 recovery support services in their journey. And, in
10 fact, we want to influence many, many, many more
11 people looking at defining and messaging about parity
12 and, in turn, influencing other payers and
13 communicating across different groups about parity.

14 And, in fact, we want to be sure that we continue
15 -- and you'll hear, as part of the behavioral health
16 quality framework -- building recovery focus into that
17 quality framework. And so, our -- you know, we
18 continue to be chanting the appropriate way in which
19 recovery needs to be framed so that, in fact, in the
20 future health care system, it will be supportive and
21 defended and paid for.

22 As of yesterday, the social media blog page is

1 open for business. We did a soft launch on Friday.
2 Starting yesterday, this blog is now available for
3 people to go in and look at the working definition,
4 look at the 10 dimensions and 10 principles of
5 recovery. And you've got two weeks. So starting from
6 yesterday through the close of next Friday, the 26th,
7 you have an opportunity to tell us what you think
8 about the words, about the framing, about the way in
9 which we have to move forward.

10 We're hoping to build a responsive recovery-
11 focused system of care in every community in every
12 state. And as we build it, we want the insurers to
13 come. We want the payers to come. We want them to
14 pay attention to what is essential for people to
15 achieve recovery.

16 And I hope that you will join us along the way in
17 doing that. And I'll look forward to reading each and
18 every one of your comments as they come into the blog.
19 Thank you very much.

20 [Applause.]

21 MS. HYDE: Thank you, Kathryn.

22 I have to say that I saw these overheads, or the

1 PowerPoint, ahead of time, and I wondered how this was
2 going to come out. Because you did an incredible job,
3 Kathryn, of laying that out.

4 MS. POWER: Thank you.

5 MS. HYDE: Thank you very much.

6 MS. POWER: Thank you. Thank you.

7 MS. HYDE: It is both an incredibly simplistic
8 concept, and yet, an incredibly difficult one. So
9 with that, the floor is open. And Kathryn or anyone
10 can respond.

11 So let's start with Jean.

12 DR. CAMPBELL: Well, I certainly embrace the
13 effort to continue to fund recovery services and take
14 a leadership role by SAMHSA. And I think that, in
15 many ways, represents over two to three decades of
16 collaboration within the consumer movement --

17 MS. POWER: Right.

18 DR. CAMPBELL: -- and people within SAMHSA. So I
19 think this is one more step. I do have some
20 reservations because of the research that I've done
21 and the research in positive psychology. The studies
22 show that there's a real difference between the

1 treatment of illness and the promotion of wellness and
2 that the absence of wellness factors is not the same
3 thing as illness. And therefore, the approach in
4 terms of the remediation of illness and building these
5 advantages in one's life are two different processes.

6 MS. POWER: Right.

7 DR. CAMPBELL: And how we conceptualized it in my
8 research in peer support services was a collaboration
9 that the traditional mental health services treat
10 illness, which is important, and peer services promote
11 wellness. And those two discrete types of services
12 together enable us to support recovery processes.

13 And so, that's been the theory, based on the
14 research and what we found in our studies. So the
15 idea of recovery as a treatment in illness in order to
16 answer -- I mean, I understand that who pays, because,
17 I mean, our peer specialists need to be paid.

18 MS. POWER: Right. Right.

19 DR. CAMPBELL: And establishing medical necessity
20 is one way.

21 MS. POWER: Right.

22 DR. CAMPBELL: But I hope we don't give ourselves

1 into haste in doing this, because I think we need a
2 lot of collaboration with research in the process. We
3 need to go carefully in that that we don't do damage
4 to the concept of recovery and what are the profound
5 meanings of a recovery by going in this direction. So
6 I thought it was important that you identified, what I
7 would call the promotion of wellness factors, in your
8 presentation in talking about home purpose and
9 community.

10 MS. POWER: No, I --

11 DR. CAMPBELL: And so, I think there's a way that
12 that could be worked out. But I think it's really
13 important that we also include the social scientists
14 and services researchers as we proceed in this
15 direction in addition to, I think, the important work
16 in the consensus building around attitudes and
17 theories of recovery, which is where, in many cases,
18 where SAMHSA's at right now in getting this
19 definition.

20 MS. POWER: Right.

21 DR. CAMPBELL: And some people may even confuse
22 the definition with what we scientifically know as

1 opposed to our principles or what we think we know,
2 our opinions or perceptions. And I'll stop there.

3 MS. POWER: Jean, thank you very much. I think
4 we've had some similar conversations amongst the field
5 and amongst players here, because we're trying to
6 create that balance between the focus on prevention
7 under the number strategic initiative in terms of
8 prevention and wellness and wanting to move that, at
9 the same time, trying to balance it against, sort of,
10 this medical world and health care, you know, system
11 world in terms of getting them to acknowledge what are
12 the appropriate interventions that will help people
13 move towards recovery, you know, that are
14 interventions, but that we don't want to lose either
15 of those concepts. And trying to reconcile it, as
16 you've indicated, I think, will be some work.

17 MS. HYDE: Thanks, Jean. That is an important
18 construct, because wellness can be before disease or
19 as a process of recovery after disease. And those are
20 things we have to take into account.

21 I saw a lot of hands back there. Let's get the
22 list of hands, and then --

1 DR. CAMPBELL: It could also be a resiliency
2 factor in maintaining people within the community.

3 MS. POWER: Right. Right.

4 DR. CAMPBELL: And studies have shown that. And
5 one thing I would suggest also would be a review, a
6 systematic review of the literature looking at
7 whatever our definition is and showing what science
8 says in terms of that definition.

9 MS. POWER: That's a great idea.

10 DR. CAMPBELL: So we have both of those.

11 MS. POWER: Okay. Thanks.

12 MS. HYDE: Okay, I've got Emmitt and Terry and
13 Allison and Ben. And we've got about 15, 20 minutes
14 here.

15 So, Emmitt?

16 MR. HAYES: I really think this was an excellent
17 presentation. And I really appreciate the concept of
18 moving into defining recovery. One of the things that
19 I was attempting to do as you were providing the
20 information is thinking about in terms of adolescent
21 recovery, if you will. And I know that may be yet a
22 tricky area.

1 One of the things that I do want to acknowledge
2 and really demonstrate appreciation for is using a
3 Maslow hierarchy of need, because very often, what we
4 find is that, with children and adolescents, that part
5 of the scale, many times, may not be addressed. We
6 move very quickly to self-actualization and esteem and
7 all of those sorts of things. And in reality, the
8 family has a significant role in that very first step
9 in terms of physiological needs that children need to
10 address.

11 One of the things that I think will be important
12 going forward is ensuring that we do not blur the
13 lines of adolescents and adults and keep adolescents
14 in mind when we look at recovery, especially beginning
15 at the first rung of the hierarchy of need.

16 MS. POWER: Thank you very much. We've already
17 heard from some of the people on the blog about that
18 very issue, about the developmental needs of children.
19 Recovery's not a word that works for children. You
20 know, we need to be focusing on the developmental
21 needs and truly, try to figure out how to craft that
22 in a way that resonates with those who are looking at

1 the children and the family construct and why that's
2 so important in terms of the overarching approach
3 towards health mental health and the mitigating of
4 mental illnesses developing in younger children. So
5 thank you for that.

6 MS. HYDE: This just shows the complexity. We've
7 had some conversation in here about resiliency being a
8 construct that's just as important at age 60 as it is
9 at age six. And yet, at the same time, it is clearly
10 different for children. We've also got adolescents
11 who are clearly dealing with recovery from substance
12 abuse and mental health issues. So it's like trying
13 to figure out this distinction is something we're
14 going to continue to struggle with a little bit. So
15 thanks.

16 All right. I've got Terry, Allison, Ben, Jane,
17 and Bill.

18 So, Terry, you're next.

19 MR. CROSS: Yeah. Thank you.

20 And, Kathryn, I'd like to commend you on your
21 work. Your systems thinking is right on, as usual. I
22 appreciate that.

1 One of the things that I wonder if you've done is
2 to think about the parallel between the chronic --
3 treatment of chronic health problems as a parallel to
4 recovery, because it seems to me, you know, as a
5 recovering person, I know that if I drink, I'm going
6 to die. And same as with a diabetic eats sugar. So
7 there are some parallels in that thinking that the
8 medical profession may be able to buy into from a
9 treatment point of view.

10 The second thing I want to comment on is the
11 Maslow's hierarchy of needs and the different cultural
12 conceptualizations of that. Native culture would draw
13 that more as a circle with the spirituality and the
14 self-actualization in the center. And we now know
15 from good data that it is often that core element in
16 being intact that allows the rest to occur. So I want
17 to make sure that anything we do in terms of
18 supporting recovery has embedded in it the richness of
19 the influence of culture and spirituality to human
20 health.

21 MS. POWER: Thank you, Terry. And you'll see
22 some of that language when you look at the description

1 about both culture and holistic. You'll see that as
2 the descriptive language around those two dimensions,
3 both culture and holistic.

4 And your other comment struck with me, because
5 there is a multiple chronic conditions approach that
6 HHS has been taking in looking at healing or dealing
7 with multiple chronic conditions. And you just
8 triggered for me we should do some crosswalk with that
9 and the work that HHS is doing on that, because that
10 would be a nice segue for folks that are working with
11 multiple chronic conditions to accept what we're doing
12 on recovery and vice versa. So thank you for that.

13 MS. HYDE: Thanks.

14 Allison, you're next.

15 MR. SAGE: Thank you, Kathryn. One of the things
16 that I had was on the -- you talked about the health
17 insurance payers. Is there a movement, or do you have
18 a consideration in there for Native cultural practices
19 that are not evidence based certified or, you know --
20 because we have our traditional healing modalities,
21 treatment modalities that we use and we've been using?

22 MS. POWER: Right. Right.

1 MR. SAGE: But we have -- when it comes to the
2 payer for these services, our traditional healers
3 aren't certified through the state or through the
4 federal government. So do you have a process of how
5 you can help us proceed that?

6 MS. POWER: Well, there's a couple things that
7 are happening. First is that in the good and modern
8 service paper, there are descriptions of service
9 definitions that do include alternative services and
10 do include some faith-based and other tribal-based
11 healing services. So we describe that as a potential
12 services. And it doesn't have to necessarily meet the
13 standard of an evidence-based practice.

14 But I think we also encourage those practices
15 that are unique to cultures or that are alternative
16 approaches to work with the National Registry of
17 Evidence-Based Practices and look at trying to get
18 exposure for those practices so that they can be
19 tested out in other populations. So I think those are
20 two things that I would definitely do, is check out
21 the good and modern services definition and check out
22 NREP.

1 MS. HYDE: Okay, great. Thank you.

2 Ben?

3 MR. SPRINGGATE: Thank you. I appreciated your
4 framework. And it's very enlightening.

5 I'm wondering if what you see as the more
6 effective venues or means to partner with the insurers
7 and payers, both private and public, as you try to
8 advance this recovery framework, and how will SAMHSA
9 be able to or think about encouraging adoption of this
10 framework when the federal government and states take
11 on an even more substantial coverage role in 2014 with
12 many of the most vulnerable affected populations?

13 MS. POWER: Well, I'll start the answer. And I'm
14 sure that the Administrator and/or Kana probably have
15 some thoughts about this.

16 We're trying to influence that, basically,
17 through the leadership of the health care reform
18 initiative and John O'Brian's work with the states and
19 with the communities. And we've been having --
20 convening regional meetings and state meetings to help
21 them shape what their networking exchanges might look
22 like and how they're going to create the pool of

1 individuals who will receive services under the
2 adoption of health care reform come 2014. So we're
3 trying to provide information, technical assistance,
4 et cetera, to help frame that. And we do that through
5 promoting what we're calling, of course, recovery-
6 oriented systems of care.

7 And so, in terms of buying into a recovery
8 philosophy, educating people about the elements of
9 recovery, that's all a part of those discussions
10 relative to helping the states think about the framing
11 of their community-based service systems or their
12 networking exchanges or who will be insured and who
13 will fall out from that insurance and how they need to
14 prepare for that, and also, trying to convince them
15 that the work that the health care reform group has
16 been doing is to influence the other payers, is to
17 influence Medicare and Medicaid and other payers to
18 make sure that they are acknowledging that recovery-
19 focused and recovery-supported interventions are worth
20 it in terms of achieving the outcomes that they want.
21 So we're doing a variety of influence strategies with
22 the states.

1 I don't know, Pam --

2 MS. HYDE: I think the question you asked, Ben,
3 is a really profound one. And maybe tomorrow at the
4 National Council, we could have a little bit more
5 conversation in the context of the national dialogue.
6 But in the meantime, one of the good things about a
7 lousy economic environment is that people really are
8 paying attention to the costs. And so, the payers,
9 whether it's states looking at their Medicaid programs
10 or whether it's Medicare as a national program or
11 commercial insurers or the executive exchanges that
12 are getting put up, they're actually starting to look
13 much more at what is driving costs.

14 And, you know, there's been discussion about
15 what's driving costs forever. The thing that never
16 gets up there that's starting to break through is that
17 the way people's behavioral health needs are addressed
18 or not has an impact on cost. Now, that might not be
19 the exact way we would as a group of behavioral health
20 professionals choose to start our values discussion.

21 But the fact is the money's going to drive some
22 of this. And I think that's why the way Kathryn

1 framed this was really excellent, is we are trying
2 everything we can to help them see that it costs more
3 to treat someone with diabetes if their alcohol or
4 their depression is not dealt with at the same time.
5 It costs a lot more to deal with dually-eligible
6 people in Medicaid and Medicare if they don't pay
7 attention to how much of that is psychiatric or
8 substance abuse in nature.

9 So we're actually starting to break through that
10 just a little bit. And people are, kind of, going,
11 oh. Now, going from there to what do you do about it
12 is another thing. But I think one of the things we at
13 SAMHSA have been trying to do is just break through
14 that cloud. And I think we're making some headway at
15 that. But it's going to be a long-term conversation,
16 I think.

17 I don't know if you want to add anything to that.

18 MS. ENOMOTO: I think, also, I mean, we've been
19 very active in conversations with CMS about health
20 homes and then, thinking about some possibilities
21 around innovations and CMMI. So, you know, I think
22 they're definitely paying attention. And I think,

1 even having the conversation about -- what is it, two
2 services in one day?

3 MS. HYDE: Yeah, same-day billing.

4 MS. ENOMOTO: Same-day billing.

5 MS. HYDE: Okay, great.

6 So I've got Jane, Bill, Allen, Abe. And then, on
7 the phone, we have Stephanie and Chris.

8 Jane?

9 MS. McGRATH: I just want to say a couple of
10 things as they relate to your analysis with the
11 parallel between the definition of recovery and the
12 way the health care system, kind of, organizes and
13 categorizes things. First, I'd like to say I love the
14 title of a good and modern system. In this world of
15 hyperbole, it's really nice not to be shooting for
16 excellence and outstanding whatever, but just going
17 for something that's going to be good and solid.

18 Thank you, Pam.

19 MS. HYDE: It's John O'Brian. I have to give him
20 credit for that.

21 MS. McGRATH: I just find that very reassuring.

22 The other thing, I wanted to say, I think one of

1 the struggles of bringing mental health, substance
2 abuse services into the primary care setting is the
3 positivity of good measures for which reimbursement is
4 structured. So typically, that would be what is
5 called the hedis data set. So that's for those of you
6 -- are probably all familiar with it. But it's the
7 health effectiveness data and information set, which
8 is how health plans are -- it's how they're evaluated
9 on their care of patients.

10 And so, those measures typically are very big
11 drivers in the health care setting. And if you look
12 at what they are -- and I did just do that quick
13 lookup to see what they are for mental health and
14 substance abuse. And they're pretty vague, and
15 they're not very good. And you probably already know
16 that.

17 MS. POWER: Right.

18 MS. McGRATH: But in terms of recovery, it
19 strikes me that it's going to be very hard to find a
20 single hedis measure that's really salient for
21 recovery. But I'm wondering if you've thought about
22 looking at other instances in which, kind of, more

1 diffuse packages of services have been bundled. And
2 the one that comes to mind -- and, please, I don't
3 mean this as a depressing thought, but simply as a
4 program that had a more diffuse approach, which was
5 hospice.

6 So hospice had, you know, patients with diffuse
7 needs, kind of, chronic relapsing and, kind of, a
8 fluctuating course, often. And those services were
9 bundled. And I think once a bundled rate was
10 established for hospice, the program was really able
11 to gain some footing. And I'm not saying that you
12 necessarily -- I mean, there's downsides to bundling
13 services, obviously, especially as budgets get cut.
14 You know, the rate for your bundle tends to not go
15 anywhere.

16 But it is a thought to think about how you might
17 structure reimbursement for activities that promote
18 recovery that could also be measured in a primary care
19 setting so that they could be quantified and people
20 could get credit for them. And it might, sort of,
21 push the more alternative kind of services into that
22 structured, more straight-line medical system.

1 MS. POWER: Thank you. Thank you. And there has
2 been some discussion, actually, over the years about
3 trying to influence the hedis system. I mean,
4 certainly, in taking a look at the measures and trying
5 to get them more concrete, more practical, and more
6 outcome-focused. And there is some work that has gone
7 on in that, particularly when we originally talked
8 about the transformation of behavioral health
9 services. And so, that's one route.

10 Bundling -- I think we want to make sure before
11 we do that that there is an acceptance about bundling
12 within the payer world at the point of doing that kind
13 of work. Though I think it has some attraction to it
14 in terms of thinking about it in that way. Similarly,
15 to Terry's comment about multiple chronic conditions
16 and are there a set of services that might have to
17 become available, given the fact that there are
18 usually multiple conditions. And how do you bundle
19 those in that way? Thank you.

20 MS. HYDE: So, Jane, your comment about hedis
21 measures -- kind of a silver bullet of quality is
22 going to be useful in the next conversation that we

1 do, or later in the afternoon about quality. So hold
2 that thought, and bring it back.

3 Okay, I got Bill, Allen, Abe, Stephanie, and
4 Chris. And we want to try to get through that so we
5 can get to lunch.

6 So, Bill?

7 MR. McFARLANE: Well, I'd just like to echo your
8 courage as well as your work on taking this on. I
9 think it's --

10 MS. POWER: I didn't volunteer.

11 MR. McFARLANE: Yeah, I bet.

12 [Laughter.]

13 MR. McFARLANE: I'm a strong believer in
14 recovery, but I wouldn't have touched this with a 10-
15 foot pole. So really, terrific work.

16 I'd like to add that I think this is a really
17 opportune moment to pursue this particular piece of
18 work for the following reason: One is I read an
19 editorial by a group that published in this month -- I
20 think it's this month or last month -- the American
21 Journal of Psychiatry. So I think everybody here
22 knows that about 15 years ago, at least American

1 psychiatry would have said the road to recovery is
2 anti-psychotic drugs. They will work their way all
3 the way up Maslow's hierarchy and pretty much take
4 care of the problem.

5 The editorial says, well, now we've done some
6 federally-funded research, and the findings are
7 anywhere -- nowhere close to that for, particularly
8 anti-psychotics and also anti-depressants, to some
9 degree. Meanwhile, SAMHSA has been supporting and
10 promoting something called the five evidence-based
11 practices that are -- as the developer of one of them
12 -- one of them is family psycho-education. There's a
13 review coming out shortly that will show that 40
14 control trials, none of them supported by any
15 commercial interests, have effect sizes for that
16 intervention, somewhere between .5 and .8. That's
17 just an incredible level of efficacy.

18 And so, in a sense, SAMHSA bet on the right
19 horse, very strongly. And your friends down the
20 street, I don't know. Not so sure. So what I would
21 like to suggest is to solve the abiding problem with
22 those practices, which is that they're not reimbursed

1 by CMS nationally. So 10 percent of the country who
2 [inaudible] gets psycho-education, probably less that
3 for supported employment, et cetera, et cetera, et
4 cetera.

5 So right in that middle range where we're trying
6 to -- the providers have an enormous opportunity to
7 promote, at least the foundations of recovery.
8 Provider systems can't do it, because, certainly, in
9 the private sector, but also on the public insurance
10 side, you can't get this stuff paid for. And yet,
11 it's highly effective. And the drugs can only amplify
12 those effects a little bit, if they don't get in the
13 way through side effects.

14 MS. POWER: Right.

15 MR. McFARLANE: So I think this is a great
16 opportunity for CMS to go back to CMHS, or SAMHSA as a
17 whole go back to CMS and say, we've got to deal with
18 this, because it's the only way forward for that
19 range, this middle range of your nice pyramid there.
20 As one of the developers, I've never claimed to
21 promote all the rest of the upper levels of that. But
22 I think we can provide a foundation that's incredibly

1 solid, very reliable, and, frankly, much more humane
2 than a single reliance on psychopharmacology. That's
3 not to throw the pharmacology out. I'm not doing
4 that. It's just a wonderful opportunity.

5 MS. POWER: Thanks, Bill.

6 MS. HYDE: I think you're absolutely right. And
7 it underscores why, when we think about bringing
8 things to scale, we don't just think about what SAMHSA
9 does or just think about what a state does or just
10 think about CMS. We're trying to think about all of
11 it, all the payers, and how you put it together.

12 We may or may not get CMS to pay for family
13 psycho ed., but there are some managed care companies
14 who are starting to do it, because they've figured out
15 that it makes a difference for their bottom line. And
16 there are ways in which we may want to take our block
17 grant and other programs and fund those things that
18 other payers can't. So that's part of why we're
19 trying to sort this out. So that's very good, very
20 good input.

21 All right, I've got Allen, Abe, Stephanie, and
22 Chris. And then, we're going to break.

1 So, Allen, you're next.

2 MR. DANIELS: Thanks.

3 Kathryn, I think this is really very timely,
4 because we now have Accountable Care Act, which
5 provides coverage for people. We've got parity, which
6 provides a benefit. And what I think you've done is
7 very elegantly lay out a logic model for this concept
8 of recovery that's been hanging out without a clear
9 definition of where it fits within health care. And
10 you've done it very nicely around payment versus
11 patient responsibility, where it fits, I think, in
12 mental health and substance abuse and prevention, as
13 well as really chronic illness and the outcomes of
14 care that need to be assessed with that.

15 I think the challenge -- and it sounds like
16 you're doing that through the blog -- is to really
17 define -- to refine the definition of what recovery is
18 and where that really fits as a health construct
19 within the system. And so, I commend you on doing
20 that, because I think it really brings together all of
21 what SAMHSA's trying to do and fits within the health
22 systems changes that are going on now.

1 MS. POWER: Thanks, Allen.

2 MS. HYDE: Thank you very much.

3 Abe?

4 MR. ALAWNEH: -- we have what is direct
5 relationship between permission and treatment. From
6 Arabic culture perspective, I can see recovery also is
7 a prevention. We've conducted focus group with
8 divorced women, divorced men and also victims of
9 domestic violence. We have noticed that the highest
10 percentage of women who are divorced, they are
11 receiving mental health services.

12 Also, the highest percentage from divorced men,
13 also, they receive, like, mental health services, or
14 they have substance abuse problem. So I can see that
15 this can be really prevention to prevent divorce and
16 also to prevent domestic violence. So recovery also
17 can be prevention. Thank you.

18 MS. POWER: Okay, thank you.

19 MS. HYDE: Great. Terrific.

20 Okay, Stephanie Le Melle, are you on the phone?

21 DR. LE MELLE: I'm here, but I'm, kind of, fading
22 in and out.

1 MS. HYDE: We can hear you. You're on.

2 DR. LE MELLE: Great. So, yeah, so the comment I
3 want to make is that, you know, we often think of
4 recovery as something that's consumer-driven and
5 driven by the individual person. We don't think about
6 recovery as a term that we've necessarily -- that's
7 associated with clinicians. And I think it's
8 something that we need to address. And I think maybe
9 this afternoon when we talk about workforce
10 development, it may come up again.

11 But I think clinicians are trained in a medical
12 model. They're not trained in a recovery model. And
13 the responsibility onus of care is, sort of, the way
14 we teach clinicians, that they are responsible for
15 providing care and services, which really doesn't
16 incorporate recovery principles. So I think that it
17 would be helpful to keep in mind, as we talk about
18 recovery principles, that it has to apply both to
19 clinicians and providers of care and to the individual
20 clients who are recovering, who are in the process of
21 recovering, because -- and even when we're talking
22 about funding sources, you know, our funding streams

1 are really based on services.

2 And services are provided by service
3 providers/clinicians and not by the people who are
4 actually recovering. So it's, kind of, this
5 directional piece that I think -- and I think the
6 first person who commented about cooperative care, not
7 only with clients and with peers, but also with the
8 clinicians. And it really has to happen that way.

9 And I think the funding streams have to, sort of,
10 think that way, that affecting clinicians as how they
11 operate. It's not just the individuals who are
12 recovering. And I know this is a little disjointed,
13 but maybe we could think more about how to really get
14 the terms to apply to clinicians as well as to the
15 consumers.

16 MS. HYDE: Thanks, Stephanie. We heard that.
17 And I think that you are hitting the heart of the
18 matter -- is that recovery is a construct that is not
19 an either/or. It is a both. And that's really
20 exactly what we have to have some conversation about.
21 There's more to say about what we're doing around
22 workforce about that, but we'll hold that until the

1 afternoon.

2 Kathryn, anything else you want to say about that
3 one?

4 MS. POWER: Pardon me? What?

5 MS. HYDE: Oh, we'll take that as a no, just in
6 terms of time.

7 MS. POWER: No. No, I thought you were going to
8 summarize there.

9 MS. HYDE: Okay, I'm going to take one more
10 comment from Chris, and then, we're going to -- I'm
11 going to do one introduction. And then, we'll break
12 for lunch.

13 So, Chris, your last comment?

14 MS. WENDEL: Okay, thanks, Pam.

15 Kathryn, I just want to echo what everybody else
16 said. What a great job, really interesting way to
17 look at recovery relative to the hierarchy.

18 MS. POWER: Thanks.

19 MS. WENDEL: My perspective is one of someone in
20 recovery from substance abuse issues. And I just want
21 to throw in a couple things.

22 One, when you were talking about the hierarchy,

1 I'm not sure I'm positive that I didn't hear it. But
2 I really want to keep stressing that whole notion of
3 the critical, integral part of service. As someone
4 recovering from, especially in my perspective, from
5 substance abuse issues, that notion of, "to keep it,
6 you have to give it away." And so, I want to make
7 sure that service somehow fits into that hierarchy.

8 And then, the second thing I want to say is -- I
9 think I heard you correctly when you were talking
10 about outcomes. One of the first ones, I think, was
11 something along the lines that victims no longer
12 present themselves or exist. I want to take a
13 slightly different take on that and just maybe a word
14 of caution. I've been sober for a long time. And I
15 still drink alcoholically. I just don't drink
16 alcohol.

17 And I think there's a distinction there. That
18 whole notion of progress, not perfection or firm
19 reduction or whatever the verbiage is, that we make
20 that fit in. So I just wanted to throw that in.

21 MS. POWER: Thank you. Okay. Appreciate that.

22 MS. WENDEL: Thank you.

1 MS. POWER: Okay.

2 MS. HYDE: Terrific.

3 Any final comments, Kathryn?

4 MS. POWER: No.

5 Thank you very much. And I look forward to
6 reading your blogs. Please take advantage over the
7 next two weeks. And thanks again for your attention.
8 It was really great.

9 [Applause.]

10 MS. HYDE: This was a very -- thank you.

11 Thanks, Kathryn. That was really excellent. It
12 was a rich discussion. And hopefully, it generated
13 some things you can talk about at lunch.

14 Before we go to lunch, I want to introduce to you
15 Brian Altman. I told you about him earlier.

16 Brian, just wave your hand so people can see you.

17 And hopefully, he'll stay around for a few
18 minutes, if anybody wants to just say hello. He's our
19 new Legislative Director. He's been on for a couple
20 months and already kicking you know what.

21 [Laughter.]

22 MS. HYDE: So we appreciate that. Thanks, Brian.

1 And then, also we want to turn this over to
2 Cynthia, who's going to give you a little lunch
3 logistics. Before she does that, even though we're a
4 minute or two behind, we are going to start right on
5 time at 1:15 and see if we can stay on time this
6 afternoon. Thank you.

7 MS. GRAHAM: Your lunches, those of you that
8 chose to partake in the catered lunches, are in the
9 back of the room. There are tables that are set up
10 back there, if you want to sit around and talk with
11 your colleagues. There are tables in the break room
12 where you went to get your coffee earlier. You're
13 welcome to go there. So however way you choose, but
14 your lunches are in the back of the room. And they
15 are labeled with your names on them. Staff will be
16 back there to assist you, should you have any
17 problems.

18 For our new members, Ben Springgate, Dee Roth,
19 and Marleen Wong, we're going to take you to another
20 room where your lunches are awaiting you, for
21 orientation. These are our new members.

22 MS. HYDE: Okay, enjoy lunch. We'll see you at

1 1:15 promptly. Thanks.

2 [Lunch Break.]

3 MS. HYDE: Let's get into our chairs so that
4 folks on the Web and online know that we are ready to
5 rock and roll. I'm going to just introduce this panel
6 and then turn it over to Wes.

7 We have been doing lots of work around workforce
8 and particularly with our colleagues at HRSA. And
9 they are represented here. And Wes can do the
10 introductions.

11 But workforce issues go through every one of our
12 strategic initiatives. You all asked last time lots
13 of questions about that and what we were doing. So
14 we're trying to give you some flavor of what the
15 issues are and what we're doing about them.

16 So turn it over to Wes Clark. He is leading for
17 us on our health information technology. But he's
18 also working with Larke around some workforce issues
19 around all of our efforts.

20 So, Wes, turn it over to you.

21 DR. CLARK: Thank you, Pam. And I do want to
22 thank you for the opportunity to discuss workforce

1 development issues through this panel discussion.

2 SAMHSA has also hosted two teleconferences on the
3 subject in the past month. Participants in these
4 calls were Dr. Jane McGrath, Dr. Elizabeth Howell, Dr.
5 Stephanie Le Melle, Dr. Donald Rosen, and Dr. Leighton
6 Huey. I want to thank all of them for taking the time
7 out of their demanding schedules to share their
8 thoughts and insights with us.

9 A number of common issues and concerns arose from
10 the two teleconferences that I'd like to briefly
11 mention before we begin the panel discussion. One
12 strong theme throughout the calls was the need to
13 promote more interdisciplinary training in substance
14 abuse and mental health treatment and behavioral
15 health prevention for both pre-professionals and those
16 in the field. The feeling is that psychiatrists, for
17 instance, don't have a clear understanding of
18 recovery, primarily because recovery is not included
19 in their training. This is true across disciplines,
20 such as psychology, social work, marriage and family
21 therapist counselors, and others.

22 Another involved program certification and the

1 need to develop state licensure requirements for
2 substance abuse treatment. There were also concerns
3 raised about the need to improve the initial screening
4 process used in primary care. The challenges
5 surrounding attracting new candidates, particularly
6 minorities, to the primary care field was also
7 discussed. This impacts behavioral health because of
8 the increased emphasis on integrated care.

9 Opportunities to incentivize new students and
10 provide more valuable educational experiences,
11 including more field work, were discussed. Today's
12 panel continues that discussion and builds on those
13 issues.

14 We're going to start with an overview of SAMHSA's
15 workforce development activities by Linda Kaplan.

16 DR. KAPLAN: Is it on now? Yes?

17 Thank you very much. I want to thank Pam very
18 much and Dr. Clark for this opportunity.

19 Just so you know, I have a lot of slides and 10
20 minutes. So I'm going to do two things. I'm not
21 going to go over all of those slides. And I'm going
22 to talk in my New York-ese, which means that I'm going

1 to go very quickly. And what I'm doing is providing
2 you with a very quick overview of some of the issues
3 in the field and then hitting very briefly on some of
4 the things that SAMHSA is doing so that we have plenty
5 of time for discussion.

6 As you can see from this slide, only a portion of
7 the people who need treatment, whether it's mental
8 health or substance abuse services, gets it. And as
9 we know, the need for treatment is actually growing
10 substantially, both in terms of the need of veterans
11 and their families and also in terms of the fact that
12 health care reform will increase the number of people
13 who have access to treatment. Workforce is critically
14 important, obviously, because it's the people who are
15 working in the field who will be providing the
16 services. So this is very, very important for us.

17 Here are some of the challenges. Number one, we
18 have worker shortages. We have a mal-distribution of
19 the workforce. We have rural counties that have
20 absolutely no behavioral health workforce at all. We
21 have inadequate compensation. We have an aging
22 workforce. And I can attest to that. Only my

1 hairdresser knows the truth.

2 We have a growing demand for workers, but
3 difficulty recruiting people into the field,
4 especially minorities. And you'll see some of the
5 data about that. We need to start really integrating
6 peer specialists and people in recovery into the
7 workforce. And, obviously, we have some real
8 challenge in terms of meeting the needs of the
9 Affordable Care Act in terms of enough people to work
10 in the field and provide services and also the need to
11 integrate primary and behavioral health care.

12 The other thing we have is a sparcity of data.
13 And no where is that more apparent than in the
14 prevention field, where we really have very little
15 data or very little data I could access. And I do
16 know that we have about 2,700 certified
17 preventionists. But that was the only data I found
18 readily available. And in some cases, we have a
19 poorly-articulated career pathway.

20 As you can see from this slide, the demographics
21 of the field do not match up with the demographics in
22 the country. And we do know that minorities tend to

1 stay in their communities or are more likely to stay
2 in the communities and provide services. So it is
3 really critical that we begin to recruit more
4 minorities into the community and diversify our
5 workforce.

6 Here is the average median age, not the average
7 age. This is BLS data, Bureau of Labor Statistics.
8 And one thing I want to point out, aside from the fact
9 that psychiatrists -- 65 percent of them -- 46 percent
10 of them are over 65 -- is that it is a very, very
11 female-dominated field, as you can see. You know,
12 social workers are over 80 percent female. And this
13 is the reverse of the -- at least on the substance
14 abuse side.

15 But I think also we'll see that as we have more
16 people coming in with the ACA with health reform,
17 you're going to have more younger men, young males,
18 coming into the system who now do not -- are not
19 covered by Medicaid. So there is a real discrepancy
20 here.

21 The other thing is the median wages. This is,
22 again, from BLS data. But I wanted to point out that,

1 in fact, wages in the field are low. And this study
2 here, which was done by the National Council, really
3 demonstrates this very graphically. As you can see, a
4 direct care worker makes less than an assistant
5 manager at Burger King. This is not to say anything
6 detrimental about Burger King, but it does point out
7 that it shows where the society values people who are
8 working in this field.

9 The other thing is many people in the field have
10 said over many years that there is stigma, not only
11 attached -- the stigma attached to these diseases also
12 is reflected on those people who work in the field.
13 As I said, I hope I'm not talking too quickly.

14 But in 2007, two reports were issued. One was
15 The Action Plan on Behavioral Health Workforce
16 Development, which was driven a lot by the Annapolis
17 Coalition. And the other was Strengthening
18 Professional Identity Challenges of the Addiction
19 Treatment Workforce. Both of these came up with very
20 similar issues. And, again, this was 2007. Actually,
21 the work was done before that.

22 You will see same issues are still confronting

1 us: recruitment and retention of personnel, sort of,
2 the inadequate, in many cases, pre and in-service
3 training, adoption of evidence-based practices, which
4 is something we really need to start training folks in
5 evidence-based thinking. They need -- you know, you
6 don't learn an evidence-based practice and then do
7 that for the rest of your life. You have to keep
8 learning new skills. And for that, we are going to
9 need, as you'll see later, more clinical supervision,
10 because that's what helps people adopt it and also
11 stay, you know, true to the basic practice.

12 Preparation of the next generation of managers
13 and leaders -- if you have an aging workforce, a lot
14 of the people who are currently managing and leaders
15 are going to be aging out and leaving. We need to
16 really do that. SAMHSA has, in its wisdom, starting
17 doing some of that work. We need to have a
18 recruitment of qualified staff in rural and frontier
19 areas and increasing the diversity of the workforce
20 and integration of peers and family members into the
21 workforce.

22 And again, this has been a lament since I've been

1 in the field. And that's about 25 years. Ongoing
2 collection of data is critical. We really don't
3 usually have adequate data.

4 There is a changing landscape, as you can see.
5 And a lot of that is driven by health care reform,
6 which is also going to increase the integration of
7 care. But we also need -- and I think you heard a
8 very eloquent presentation this morning from Kathryn
9 Power. And we really need to start making sure that
10 all of the professions understand, and all of those
11 people working in the field, what recovery is,
12 recovery-oriented systems of care, and how to work in
13 that system.

14 CMS is also expecting that care will be patient-
15 centered and patient-directed. So this is not just
16 for behavioral health. It really extends throughout
17 health care -- and again, use of evidence-based
18 practice.

19 I just wanted to show you this is very
20 interesting, because in most -- for most of the
21 professions in behavioral health field is an
22 expectation that there's going to be a much higher

1 than average growth rate. And this data predates the
2 passage of the Affordable Care Act. So we know that
3 there's going to be an even greater demand as more
4 people come into the field. And we really have to
5 start looking at how we start recruiting more people
6 into the field.

7 So, as I said, the impact of health care reform
8 -- you all know this -- is going to be an influx of
9 many new patients into the behavioral health care
10 system. We need to implement health I.T., and not
11 just health I.T., but tele-health.

12 I was just at a meeting at ONDCP. And this woman
13 gave a marvelous presentation. She's from upstate New
14 York. Makes me feel good. But she really did talk
15 about how she has integrated health, sort of, tele-
16 health into the delivery, particularly, of behavioral
17 health services. And it was really astonishing. And
18 I think it's something we really need to look at. And
19 she's running an FQHC.

20 Again, evidence-based practices, increased
21 credentials in education for behavioral health
22 workforce is another issue. And, as you all know, I

1 know you all have heard, I'm sure, about SBIRT. And
2 we really need to start looking at both prevention --
3 and we need to really look at building resilience and
4 early intervention and all of those important things
5 that help provide recovery support for those people
6 who already have the disease, but also for people who
7 need to get into treatment.

8 So again, this is -- I'm not going to go into
9 this in any great detail. I do want to emphasize that
10 cross-training is going to be needed, and
11 bidirectional training is needed, both for the primary
12 health care field as well as the behavioral health
13 care field. And in behavioral health, we also need to
14 look at making sure that we can treat adequately
15 people with co-occurring disorders.

16 I just wanted to point out quickly training and
17 education needs. The National Association of
18 Community Health Care did an assessment. And it found
19 that there were many areas of primary care
20 practitioners said they needed more training in
21 behavioral health care. We know for folks in our
22 field, they're going to need to learn how to work as

1 part of teams. The work environment is very different
2 in the primary care system than it is for our system.

3 We also know and have to include peers and people
4 in recovery in the workforce. They're an integral
5 part of the workforce. They'll also be a way for us
6 to begin to address some of the shortages. And they
7 will be able to help people maintain their recovery.
8 Again, we are taking much more of a chronic care
9 approach. And so, this is going to become more
10 important. And I've defined some of the activities
11 here, so I won't go into that.

12 As Pam said, the strategic initiatives all have
13 workforce activities embedded in them. And, as you
14 can see, under prevention, we have SBIRT and training
15 around suicide prevention and prescription drug abuse.
16 Under trauma, there's a T.A. center. And we're
17 working to really make sure that services become
18 trauma and trauma informed.

19 Military families, the distribution of training
20 and development of training curricula -- recovery
21 support services -- obviously, we're looking at trying
22 to do recovery to practice so that we can really make

1 sure that, not only is the current professional -- not
2 only are the current professionals in the field
3 prepared to work in a recovery-oriented system, but
4 that we really do have peers well-integrated into the
5 system.

6 Okay? I'm done here. The ongoing workforce
7 development programs that we have -- we can address
8 that, SBIRT. And the big thing, which I'm hoping that
9 Marsha talks about -- Marsha Brand talks about, from
10 HRSA, is our Center of Integrated Health Solutions.
11 And I just thank you very much.

12 [Applause.]

13 DR. CLARK: Thank you, Linda, for that quick
14 overview. I know you wanted to talk about addiction
15 technology, transfer centers, the minority fellowship
16 program, and the National Center for Trauma-Informed
17 Care. But we'll wait until the discussion.

18 Our next speaker will be Dr. Marsha Brand, the
19 Deputy Administrator of the Health Resources and
20 Services Administration. Clearly, HRSA is a major
21 partner of ours.

22 DR. BRAND: Well, thank you. And thank you for

1 this opportunity to visit with you this afternoon.

2 I applaud SAMHSA, Pam, and her crew for the
3 approach that you've taken to pull all of you
4 together. I understand there are six advisory teams
5 here. It's a great strategy. There is very little
6 work that any of us do that does not have a workforce
7 component. So it's terrific to get you all here
8 talking about these issues and concerns.

9 HRSA does this, too. We have three advisory
10 committees that are directly related to workforce
11 issues and concerns. I am always a bit daunted by the
12 brain trusts that we convene when we have three of
13 them together. I'm not quite sure how it feels to
14 have six of them together. So hopefully, this will be
15 a very robust and interesting discussion for you.

16 I also want to thank Dr. Kaplan for her excellent
17 presentation. She's done a really good job, I think,
18 of highlighting the issues and concerns and the
19 challenges in workforce around behavioral health.

20 I had a chance, Linda, to read the entire thing
21 to the very end. And I found it very, very helpful.

22 By way of background, there are a couple of

1 remarks I'd like to make before I start talking about
2 what HRSA has been doing, particularly in partnership
3 with SAMHSA. One of the hallmarks of this
4 administration has been the expectation and,
5 hopefully, the lasting legacy, that there will be
6 cross-agency collaboration.

7 And so, perhaps our efforts to address behavioral
8 health challenges affords us the most striking -- one
9 of the most striking opportunities for collaboration,
10 because HRSA, SAMHSA, CMS, AOA, ARC, NIH, you know,
11 all the parts of HHS, as well as other federal
12 departments such as Labor and Justice, are looking at
13 access issues around behavioral health. And so,
14 that's something that I hope continues as a legacy.

15 I think it's also important to note that when Dr.
16 Mary Wakefield, who extends her regrets, was unable to
17 be here today, arrived at HRSA, she helped our agency
18 go through a fairly extensive agency-wide strategic
19 planning process. And one of the key goals that the
20 agency set was to improve access to quality care and
21 services and specifically, by expanding behavioral
22 health services and integrating mental health and

1 behavioral into primary care. So this has been a goal
2 for our agency from the beginning of this
3 administration.

4 And so, we've been trying to work to create a
5 high-quality system of care in which behavioral health
6 professionals are on every primary care team and
7 behavioral health and needs are addressed in every
8 treatment plan. So that's been a goal for the agency.

9 One of the primary goals that we share with every
10 one in this audience today and every professional
11 involved in behavioral health care or substance abuse
12 treatment is to make sure that when someone seeks
13 treatment, he or she is able to find a well-trained
14 team of health professionals capable of providing
15 integrated care. And so, achievement of that goal, as
16 we all know, is contingent upon having an adequate
17 number of highly-trained behavioral health providers
18 who are well-distributed and culturally appropriate
19 linked up with an adequate number of well-trained
20 primary care providers who share all those same
21 attributes.

22 And so, I think, finally, one of the other things

1 that's important to know about what HRSA brings to
2 this arena of work is that while it is so important to
3 have programs that specifically address behavioral
4 health and behavioral health workforce issues, it's
5 also very important to have agencies like HRSA, which
6 is a \$7 billion agency, looking across all of our
7 programs, across all o four policies and looking for
8 all opportunities to engage around behavioral health.

9 So our goal is to encourage all of our programs to
10 engage around behavioral health activities.

11 Linda spoke about the ACA, the Affordable Care
12 Act, and some of the impacts that it will have on
13 access. Certainly, we hope to contain costs, support
14 systems change. And there are specific aspects of the
15 ACA that support workforce development.

16 There is a National Health Workforce Commission,
17 which has yet to receive funding, but would, if stood
18 up, look at behavioral health workforce as well as
19 other workforce challenges. There is a
20 reauthorization, and there are some new flexibilities
21 for the National Health Service Corps. And that
22 provides opportunities to develop the behavioral

1 health workforce as well. And many of HRSA's programs
2 which have a behavioral health component were
3 reauthorized by the ACA.

4 And so, while we all have great sympathy for CMS,
5 because they have had to implement a large part of the
6 ACA, HRSA had 51 provisions that were directly
7 assigned to it. And a lot of those are around
8 workforce. And so, we've been engaged actively with
9 our good partners in the department to implement those
10 programs.

11 We all know that as the implementation continues
12 and we see another additional 33 million folks added
13 to the rolls of the insured, we are going to have to
14 stand up every opportunity that we can to expand the
15 workforce. And so, in 2014, we're ready to provide
16 care for those folks who will be seeking it. And so,
17 as Dr. Kaplan discussed, we're going to need more
18 providers.

19 And then, we'll also need to engage a number of
20 different, sort of, non-traditional providers. And
21 these are groups with which HRSA has some considerable
22 experience such as patient navigators and lay

1 community health workers. And so, we're hopeful to
2 partner with others in reaching out to engaging
3 different and somewhat non-traditional providers
4 around behavioral health. I'm trying to stay within
5 my time limits, because I know Dr. Clark's got that
6 thing that makes a noise.

7 [Laughter.]

8 Dr. Clark and I share a unique bond. We both
9 provided testimony at a congressional hearing where
10 there were 25 bills that were to be discussed. And
11 so, for all of us, it was a bit of a near-death
12 experience. And we bonded. So where was I going?

13 Oh, yes, specifically, what HRSA's doing around
14 behavioral health and workforce activities, I think
15 most folks that know HRSA, know the Health Center
16 program. And the Health Center program certainly
17 provides care through 8,100 sites to a very large
18 number of folks in this country. And we employ, I
19 think, a significant number of mental health care
20 providers -- alone, 360 psychiatrists, you know, 394
21 -- excuse me, psychologists, 394 psychiatrists. And
22 so, we support a very large part of the health system.

1 And I think one of the things that that does is
2 provide us an opportunity to model the kind of
3 integration that you're speaking of.

4 And so, we've been actively engaged in the
5 development of patient-centered behavioral health
6 consultations and, in particular, helping to develop
7 medical homes. And so, we've been trying to encourage
8 what we call the patient-centered medical health home
9 initiative. And there are a number of sites that are
10 looking for third-party recognition, NCQA and joint
11 commission. And we've got a couple hundred sites that
12 -- well, 153 sites that have already enrolled in this
13 activity. But 700 more want to. And so, you know, as
14 we create medical homes, I think we can certainly
15 foster coordinated care.

16 We're also working with CMS around advanced
17 primary care practice demonstrations. And so, the
18 creation and support of medical homes will, I think,
19 go a long way to improving the integration of
20 behavioral health and primary care. We support
21 training for folks in behavioral health through our
22 HIV and AIDS programs, through our rural health

1 programs. Specifically, we've been doing a lot of
2 work in Appalachia, where -- that's where I'm from.
3 I'm from West Virginia. I start my day in West
4 Virginia. I wouldn't want to start anywhere else. It
5 does take a long time to get here, but I'm still glad
6 to go home at the end of the day.

7 And in Appalachia, we have an enormous substance
8 abuse problem. And in many, many of our communities,
9 our jails have become the waiting rooms for mental
10 health services and behavioral health services. And
11 so, we have been actively engaged at HRSA through our
12 rural health activities in looking at, particularly,
13 methamphetamine and prescription drug abuse and trying
14 to figure out ways to engage community leaders,
15 because these lay community health workers are the
16 folks that we're going to need to collaborate with
17 going forward, particularly in rural communities.

18 Another important part of our health professions
19 portfolio is the National Service Corps. I think most
20 folks know what the National Service Corps does. It
21 provides loan repayment for folks who go to serve in
22 the hardest to serve areas. We have a field strength

1 now of about 2,500 mental health and substance abuse
2 providers. And the National Health Service Corps
3 continues to grow. And so, we are looking forward to
4 encourage folks to go to these places that are hardest
5 to serve.

6 And remarkably, the retention rate -- and I'm
7 sorry I don't have the statistic for mental health and
8 substance abuse treatment providers. But the
9 retention rate is really pretty good. Folks go to
10 these communities, discover what an important
11 contribution they can make, and then, they stay.

12 I want to close by just saying a few words about
13 our health professions programs that specifically
14 address training. And most folks, I think, are
15 familiar with the Area Health Education Centers, or
16 AHECs. And an important statistic is that 75,000
17 health professionals received some training at or on
18 mental health, behavioral health, and substance abuse
19 through the AHECs last year, or for the most recent
20 year for which we have data, which is a pretty
21 substantial number of folks. And of that number,
22 29,000 were mental health professionals.

1 We have residency programs and other programs
2 that provide specific training opportunities for
3 health care providers. And we'd be happy to talk with
4 you about those in detail. But fearing the clock, I
5 just want to quickly go to a couple things we're doing
6 specifically with SAMHSA.

7 And SAMHSA as been a terrific partner around
8 workforce. Dr. Wakefield and Dr. Hyde have, I think,
9 a shared vision for what we can do together. And it's
10 been a terrific catalyst for, then, other staff to
11 engage. And Linda's referenced the Center for
12 Integrated Health Solutions. And what we're doing
13 there is targeting the integration of primary and
14 behavioral health care and related workforce
15 activities. And I think her slide does a good job of
16 capturing all of the activities. So I would encourage
17 you to look at it specifically.

18 But one example of how powerful that
19 collaboration is and that center is that we provided a
20 Webinar on SBIRT training. And there were over a
21 thousand people signed up. People are looking for
22 this information about how to successfully integrate

1 primary care and behavioral health. And so, I think
2 you'll get to see -- hear more from us about that
3 collaboration.

4 One other thought, in closing, and for those of
5 you who have been around while we've been working on
6 health reform, one of the greatest challenges around
7 the workforce was figuring out how many health care
8 providers there actually are. And, you know, we
9 started trying to figure out how many primary care
10 providers there were. And after we got to some
11 consensus on what primary care providers were, you
12 know, then we still had a challenge counting them.

13 And similarly, I think we had the same challenge
14 here with behavioral health. Who do we included in
15 that cohort? How many are there? Where are they
16 located? And to what extent are they credentialed?
17 And then, as we move to other kinds of providers, how
18 do we enumerate those?

19 And so, this is a very important collaboration
20 that we're doing through HRSA's Center on Workforce
21 Analysis with SAMHSA and a contractor that they have.
22 So hopefully, in the not too distant future, we'll be

1 able to tell you what the numbers are, I think, with
2 more precision than we are.

3 So I'll just close by saying that we at HRSA want
4 to be a good partner with you, with SAMHSA, with our
5 other sister agencies, and all the stakeholders around
6 these issues. And I thank you for the opportunity to
7 visit with you. Appreciate it.

8 [Applause.]

9 DR. CLARK: Thank you, Dr. Brand.

10 And I'd also like to point out that SAMHSA has an
11 SBIRT residency program that follows our SBIRT
12 program. And that SBIRT residency program has trained
13 almost 2,900 residents. And it also has trained 2,300
14 non-residents, including psychologists, social
15 workers, physician assistants, and others so that they
16 can address the issue of the integration of health
17 care and its substance abuse. But obviously, we want
18 to move beyond substance abuse to an integrated
19 paradigm.

20 Our next speaker Dr. Jean Campbell, the Research
21 Association Professor, Missouri Institute of Mental
22 health.

1 DR. CAMPBELL: Aren't those tech. people really
2 good? They caught that mistake right away.

3 [Laughter.]

4 DR. CAMPBELL: You know, I hesitated to be part
5 of this panel, because my major focus in my work isn't
6 on the workforce. But, you know, in reflection, I
7 decided that, actually, I've lived the experience as
8 being part of the workforce in being both a woman and
9 a person with mental illness. And interestingly
10 enough, in retrospect, I saw that this brought both
11 advantage and disadvantage. And I don't think
12 sometimes we think about it in that way.

13 I'm a now full professor in mental health.

14 [Applause.]

15 DR. CAMPBELL: Thank you -- which is part of that
16 story -- at the Missouri Institute of Mental Health
17 for the University of Missouri in St. Louis. And I've
18 been there -- in November, it'll be 18 years. But
19 when I came there, I was the second woman to be hired.
20 And the first woman to be hired and I faced a lot of,
21 I would say, soft discrimination that it's just
22 interesting being told -- the men would regale about

1 how easy it was to get policies adopted and to move
2 forward when there hadn't been women bringing up all
3 these other issues -- and also that our time at the
4 Missouri Institute of Mental Health would be better if
5 we went easier on the men and weren't so hard in our
6 opinions.

7 And so, when I was hired there, I thought the
8 main issue would be that I was a mental health
9 consumer. And what I found out -- that being a woman
10 was actually a starker reality for me than being a
11 consumer. And several years later, I was invited by
12 Rosalynn Carter for the Rosalynn Carter Symposium on
13 Workforce Issues to talk about my experiences. And I
14 chose to talk about this one instance in which we had
15 a visiting professor come to MIMH to look at our
16 archival hospital data.

17 And she was leaving to go back to Scotland, where
18 she was a professor. And she gave a presentation on
19 Scottish mental health institutions, particularly in
20 the 1700s. And she showed photographs and drawings of
21 people with mental illness. And that was part of the
22 diagnostic protocol, to diagnose somebody, was to

1 actually look at their physical features. And as she
2 was showing these to my colleagues, she started making
3 jokes about their appearance. And my colleagues
4 started laughing at those people that she was showing
5 on her slides.

6 And as that went on, I mean, I was more of a
7 firebrand when I was early in my career. I debated
8 about whether to say something, but I didn't, because
9 she was a guest, and she was leaving after that
10 presentation. But what I didn't expect was the amount
11 of alienation and separateness that I felt from my
12 colleagues after that, because we had such a different
13 experience. I mean, I saw those people as human
14 beings to be respected. And I felt that the
15 disrespect that was shown to them was also a
16 disrespect shown to me and to my work.

17 Now, here we are 18 years later, and I just made
18 full professor. And they said in my letter from the
19 chancellor that it was my work in research and my
20 strong advocacy and scholarship that led to the
21 decision to give me the full professorship. So, I
22 mean, there were -- that promotion, though, wouldn't

1 have happened without also advantages, because I
2 receive lots of advantages from being a mental health
3 consumer in my professional work working with SAMHSA.

4 And I think around the issue of inclusion, going
5 back almost 20 years, to be invited into the
6 discussions, to be funded to go to conferences, to be
7 invited to present at conferences, to be in the room
8 and then be at the table and to be presenting, this
9 was a process. But it was an important process. And
10 there are many of you out there that worked with
11 myself and other people over the years where we were
12 supported.

13 And that made a tremendous difference, I think,
14 to the field and where we're at right now in talking
15 about recovery and where SAMHSA is going. I think
16 that's been a very fruitful partnership. So I think
17 that where there's inclusion and where there is
18 support -- and even though there can be problems in
19 terms of the adjustment in terms of our minority
20 statuses, because we have many of those, that you can
21 have positive outcomes.

22 I wanted, overall, to make three points in the

1 rest of my presentation. One is the importance of
2 lived experience and behavioral health equity in
3 meeting the needs of our diverse minority consumer
4 populations. I think that that is a really good
5 starting point. And by diversity, of course, I mean
6 age and gender, race and ethnicity, amongst other
7 demographic populations and then, the convergence of
8 those, like myself, a woman with mental illness, and I
9 could have been black or Native American, you know,
10 having those different statuses.

11 And also, I think that diversity includes
12 stakeholders and their preferences such as service
13 recipients, family members, providers, professional
14 associations, administrators, and policy makers. So
15 there's a diversity there as well.

16 Second, I wanted to emphasize the importance of
17 providing support and recognition of minority health
18 issues. I think one thing we don't pay attention to
19 is how important that recognition is to address health
20 disparities and also to reduce the inequities within
21 the behavioral health workforce related to inclusion
22 and decision making, power, choice, priority setting,

1 and issues of access. And those are process points
2 that I'm making. But those are also really, really
3 important.

4 I thought, in the slides, there really showed
5 some advances and still some gaps that needed to be
6 resolved. I wanted to give a shout-out to SAMHSA and
7 to the people who worked on this presentation for
8 really focusing on, or highlighting, the integration
9 of peer specialists, people in recovery, and family
10 into the workforce. And that has been a long road.
11 And I think that that is a significant step forward.

12 And wanted to mention that lots of studies have
13 shown that people who don't go to traditional mental
14 health services, seek out traditional mental health
15 services, often go to those services provided by peers
16 and people in recovery. So you meet a population that
17 doesn't receive services by expanding the workforce to
18 include peers. And also, that these are really the
19 heart of our recovery and support workers as well.

20 And also, I wanted to recognize the increased
21 emphasis on the integration of primary and behavioral
22 health care. And I know one reason is because people

1 with mental illness are dying 20 years sooner than
2 others in the general population, which my colleague,
3 Pat Risser, brings up every time we have one of these
4 meetings.

5 I haven't heard that at this meeting, Pat. But I
6 thought I would do that for you.

7 But also, that requires exchanging cultures and
8 beginning to understand the peer culture and also
9 minority health issues and behavioral health between
10 our behavioral health service providers and our
11 primary care providers. On the other hand, I did see
12 in the slides, some gender inequities in the
13 behavioral health occupations.

14 While primarily the field is dominated by women,
15 70 percent of the psychiatrists are men. And the
16 psychiatrists are paid three times as much as the
17 salary of psychologists and four times that of social
18 workers and counselors. So I thought we still have a
19 way to go in that area.

20 And then, the final point is that I believe that
21 we need to continue to move forward to define the core
22 competencies of evidence-based, gender, cultural, age-

1 specific practices. I think that that is really
2 important. And to even go forward, that in
3 collaboration with stakeholders, in order to build a
4 diverse and competent behavioral health workforce,
5 that we also have to carry this emphasis of minority
6 health care into our training and other forms of
7 professional development, certification, supervision,
8 and continuous quality improvement. So thank you.

9 [Applause.]

10 DR. CLARK: Thank you, Dr. Campbell.

11 Our next speaker is Ruth Satterfield, who is the
12 Chief of Prevention Services, Ohio Department of
13 Alcohol and Drug Addiction Services, a Co-Chair of the
14 National Prevention Network Workforce Development
15 Committee.

16 MS. SATTERFIELD: How about now? There we go.

17 Okay, thank you. Again, my name is Ruth
18 Satterfield. And I am the National Prevention Network
19 representative for Ohio. The National Prevention
20 Network is an affiliate of the National Association of
21 State Alcohol and Drug Abuse Directors. And it's
22 comprised of prevention directors representing the

1 states, jurisdictions, territories, and the tribes.

2 As the representative of the NPN, National
3 Prevention Network, so I don't have to say that 500
4 times, Workforce Development Committee, I can say that
5 we share concerns that have been discussed here at the
6 table and feel very pleased to be a part of this
7 discussion. We are working collaboratively with
8 SAMHSA on several initiatives and are working to
9 complement and enhance the efforts that they are
10 currently working on. I would like to focus on the
11 infusion of prevention and health promotion more
12 prominently within the discussion.

13 The NPN Workforce Development Committee is
14 charged with exploring how to prepare our workforce
15 for the challenges already identified as well as
16 addressing overall low emphasis on prevention and
17 promotion or to maintain health and influence
18 behavior. It would be a disservice to our citizens to
19 wait until illness is an indicated threat before we
20 offer support for their health. A robust prevention
21 workforce is needed to provide communities the
22 strategies to maintain health and influence behavior.

1 As mentioned, the 2007 document, An Action Plan
2 for Behavioral Health Workforce Development: A
3 Framework for Discussion, that was prepared for SAMHSA
4 and contributed to by the NPN Workforce Development
5 Committee, does a good job of stating the breadth of
6 background of prevention specialists. The list
7 contains professional disciplines such as social work,
8 education, psychology, criminal justice, health care,
9 counseling, clergy.

10 And it also lists individuals from multiple
11 community sectors such as parents, teachers, youth
12 leaders, law enforcement, fraternal organizations,
13 civic and volunteer groups, and health care. This
14 workforce is identified as falling into basically
15 three segments requiring a diverse set of knowledge,
16 skills, and abilities.

17 The first would tribal, state, territory, or sub-
18 state managers of prevention funds and systems. That
19 would include NPN representatives. The second would
20 be direct implementers of prevention programs and
21 activities; and third, community or coalition members
22 that are engaged in promoting the behavioral health

1 and wellness of communities. I expect that a part of
2 our workforce was represented in the data that was
3 presented by Linda. But it is likely that many were
4 missed as prevention specialists have not been
5 specifically studied.

6 A Society for Prevention Research spring 2011
7 newsletter article notes, "The limited availability of
8 formal education opportunities with a focus on
9 prevention sides that can be easily identified." In
10 an eight-hour search, they found no bachelor's level
11 programs, only six master's level programs, and four
12 doctoral level programs with an emphasis on prevention
13 science, across the nation. This leaves the
14 development of our prevention workforce to other
15 systems, which may differ by state and expectations.

16 With this in mind, the Workforce Development
17 Committee brings the state voices together. And its
18 activities include analyzing certification
19 requirements across states, territories, and tribes,
20 basically gathering information to assess the various
21 levels and expectations, promoting certification at
22 the national level through working with the

1 International Certification and Reciprocity Consortium
2 as partners, sharing information and supporting
3 efforts to strengthen the prevention certification
4 process, and move forward with evolving needs of the
5 field.

6 There are currently 40 states, 3 Indian Health
7 Services, Puerto Rico, the U.S. Army, and the U.S.
8 Navy with IC&RC prevention certification that is
9 available. There are a total of 2,700 individuals who
10 are certified. But that also includes Canada, Greece,
11 Iceland, Cyprus, Malta, and Bermuda. Clearly, they
12 are not nearly enough to meet the need.

13 We are also exploring existing higher education
14 prevention science offerings in ways to encourage
15 development of curriculum and focus areas. The
16 Workforce Development Committee members are serving on
17 the SAMHSA core competencies work group, which is
18 working to identify the standardized set of knowledge
19 and skills following the strategic planning framework
20 to assist states, territories, and tribes as they
21 building training and workforce development efforts.

22 And we are beginning a medical engagement work

1 group to focus on how to build relationships and
2 enmesh prevention science and strategies within the
3 medical community. We need to better understand each
4 other and utilize the strengths of all of our systems.

5 We're providing current research and practice
6 findings through the annual NPN Research Conference --
7 commercial here. It's September 20th to the 23rd in
8 Atlanta, Georgia. If you haven't signed up, make
9 those arrangements, and come on down to Atlanta. And
10 we're working with SAMHSA to provide leadership
11 training and information sessions to support the state
12 leadership.

13 The committee is identifying ways to prepare our
14 workforce to participate in and to effectively operate
15 within the evolving health care landscape. What will
16 our roles be? And are we ready as a knowledgeable
17 workforce? And it's encouraging emphasis on
18 environmental strategies to achieve population-level
19 change and support the need for continued focus on the
20 universal target audience as well as those at high
21 risk.

22 We are exploring ways to partner within

1 behavioral health professions to better support
2 workforce development and cross training. We're
3 beginning a relationship with NASHBID to share
4 leadership, lessons learned, and support moving
5 forward together. And we're also partnering with the
6 Center for Application of Prevention Technologies to
7 provide input regarding training curriculum
8 development.

9 In the end, what we hope is clear is this: that
10 if we truly are committed to the health of our nation,
11 we must promote it and prevent illness whenever
12 possible. Those efforts must focus on substance use
13 prevention and mental health promotion. If we are
14 truly committed to cutting federal, state, and local
15 budgets, we must promote health and prevent the need
16 for treatment whenever possible. Those efforts must
17 focus on substance use prevention and mental health
18 promotion. To do these things, we must attend to the
19 rapidly evolving prevention field and workforce needs.

20 The NPN and Workforce Development Committee are
21 committed and look forward to our continued
22 collaboration with SAMHSA to build the prevention

1 workforce and boldly place prevention in the
2 forefront. Thank you for the opportunity to be here.

3 [Applause.]

4 DR. CLARK: Thank you.

5 And our next presenter would be Shirley Beckett
6 Mikell, Director of Certification and Education from
7 NAADAC.

8 MS. BECKETT MIKELL: Good afternoon. It is
9 really a pleasure to be here. After listening to my
10 colleagues speaking, I'm not certain that I have much
11 more to say.

12 The slides are there. You know; you always need
13 your prompts and your protection. But today, it
14 appears that, and for the group that is here, our
15 thoughts are almost -- are so similar. I shouldn't
16 say almost. They're so similar and so supportive one
17 of the other that to think of the term integrated
18 care, I think we're integrated community. So thank
19 you very much for allowing me to be a part of this
20 event this afternoon.

21 I work with the National Association for
22 Addictions Professionals, NAADAC. I'm the Director of

1 Certification and Education. So what I'd like to do
2 really is to show the correlation of the specialty of
3 substance use disorder counselors and what we're
4 looking at in terms of integrated care and the place
5 for those counselors in the integration of care.

6 Linda began her presentation with looking at a
7 lot of aspects. So I'm trying to examine what she
8 presented and then using some of her titles as well.
9 She talked about the need and demand for behavioral
10 care services. And when we're looking at the
11 integration of substance use disorder practitioners as
12 a specialty profession in the integrated care issue,
13 it is essential that we examine that specialty itself.

14 The recognition of substance use disorder
15 professionals has supported medical, mental health,
16 and other behavioral health professionals and is
17 paramount to the continuation of integration of care.

18 And the acceptance also of substance use disorder
19 professionals needs to be there, because we have
20 emerged, over the last 36 years, as a full-fledged
21 profession.

22 I know that, sitting in our audience, there are

1 those of us who go back 36 years to when there were
2 alcohol counselors, drug counselors -- never the twain
3 shall meet, when, in fact, there was not recognition
4 of the profession, except through those persons who
5 were in self-help or self-support groups. And reality
6 now, as you'll see further along in the presentation,
7 our profession has grown to where persons who
8 understand very clearly the need for professional and
9 competent care have gone beyond the self-help
10 conundrum and are now engaged in educational pursuits
11 beyond that of master's degrees.

12 We are a specialty profession. We have specific
13 training and education that's required of us. We do
14 have a special skill set and skill sets for every
15 level of competency. And we do have core competencies
16 and knowledge that's required by the credentialing
17 systems that are nationally based. We do have to have
18 practice experience in order for us to continue as
19 those persons who are interns coming into the field
20 now must be interns generally for 18 months before
21 they can become certified. So, therefore, you can see
22 where the field actually has changed.

1 The profession itself, with its core
2 competencies, scopes of practice -- and, thanks to
3 SAMHSA, that was something that we are now pushing,
4 hopefully, to have all states accept the scopes that
5 SAMHSA has put forward as of last year and through
6 this year, the career ladders established. And, of
7 course, as has been since 1983 -- there's been a
8 standard of ethics.

9 The scopes of practice include clinical
10 evaluations, treatment planning, referral, service
11 coordination, counseling, client, family, and
12 community education, documentation, professional and
13 ethical responsibilities. And these were taken
14 through the tab 21. They have been revised, revamped,
15 reviewed, exorcised, so to speak, to the point that
16 they are workable and working well for our profession.

17 The scopes of practice -- there are now four
18 categories. And I'm hoping that all of you had the
19 opportunity -- I know that Linda sent them out to all
20 of the major organizations that are in the substance
21 use disorder arena. We've encouraged, through NAADAC,
22 the association for Addictions Professionals -- I know

1 that IC&RC also has -- and the American Academy has --
2 those are the three major addictions credentialing
3 systems in the United States. They all encourage the
4 state cert. boards to review those scopes and to talk
5 with their SSAs and to talk with their facilities
6 managers to make sure that they understand and can
7 incorporate those scopes within the states.

8 So they are -- the four categories are there for
9 your review. Clinical supervision is the first, of
10 course, number four, but number one, if you want to go
11 the reverse, clinical disorder counselor. And that
12 would -- the first would be with the Master Ph.D.
13 level. The second with a bachelor level with at least
14 five years of experience; the third, the substance use
15 disorder counselor, category two would be a person
16 with a bachelor, possibly a two-year certificate
17 program with less than three years of experience. And
18 the category one, the associate, would be a person
19 with one to two years of experience and/or those
20 persons still working in an internship capacity.

21 The treatment disorder workforce does have the
22 same implications of care, the same persons working as

1 do other professions. So when we look at substance
2 use disorder treatment workers and its workforce, we
3 do have clinical supervisors who are there for social
4 workers MFTs, for substance use disorder counselors.
5 I'm just going to point out a few. The prevention
6 specialist -- we do also have now peer recovery
7 coaches who are coming in because we're looking at the
8 inclusion of all persons working in every aspect of
9 care.

10 I'd just like to -- I looked at Linda's stats,
11 and then, I thought about what we have had -- we've
12 been gathering stats from the national perspective.
13 And because a couple of years ago the national boards
14 began to work together on collaborative efforts, so
15 there was some stats gathered, statistics gathered.
16 And what I'd like to share with you are the statistics
17 from three of those national boards in terms of the
18 race and other essential issues around addictions
19 counselors. So when you see the term certificant,
20 we're talking about persons who are certified within
21 the major national boards across the United States.

22 And so, the certificant certified across the

1 United States by race right now -- the majority are
2 Caucasian. The mean age of those persons is 61, 27
3 percent.

4 We talked about, Linda, the aging profession.
5 We're aging everywhere. Your hairdresser knows, and
6 mine might want to know.

7 The certificants by license and credential -- as
8 you can see here, alcohol and other drug counselors,
9 of course, hold the lion's share. But when you look
10 below that and you look at the LPCs and the social
11 workers, you can see that those persons are also
12 seeking through identification an ability to validate
13 the skills in substance use disorder practitioners.
14 They, too, have joined our profession. We have
15 psychiatrists and psychologists also becoming
16 certified as addictions professionals and being
17 licensed within their states.

18 The workplace setting that's there for most of
19 our addictions professionals still is the private
20 sector. I'm sorry. Why the private sector? More of
21 them are going into private work because of the pay.
22 One of the things we've talked about is the lack of

1 pay. Addictions professionals can make more in a
2 private practice, because they're billing on their
3 own, than they can working for public sector programs.
4 So we're losing a lot of our public sector-equipped
5 individuals to the private sector work at this point.

6 The challenges we face -- still, inadequate
7 college, university-specific courses. Yes, we do have
8 national standards now that we are offering for
9 addiction-specific courses from the certificate level
10 to the Ph.D. level. Many of the colleges, because of
11 the cost, have not been able to incorporate those
12 changes.

13 When you think about having to change a program
14 within a college that has to go through all of the
15 rigors of review and approval and then accreditation,
16 they do have a difficult time accepting those courses
17 that are being offered. The syllabi and curricula
18 that are being given to them for free is there. But
19 the reality is the cost is on them to implement them
20 within their colleges.

21 The lack of ability for student loan forgiveness
22 and student loans, period -- inadequate supervision.

1 I've been working in this field longer than -- anyway,
2 since I was two years old.

3 [Laughter.]

4 MS. BECKETT MIKELL: An the issue has been
5 inadequate supervision since I started. I can recall
6 the day that I was supervising at five different
7 facilities in Charleston, South Carolina. And to have
8 run one half a day here, half a day there in order to
9 make sure that persons were being supervised. Do you
10 know that's still happening? And it's not just in
11 rural America. So we still have that as an issue.

12 The licensing, credentialing requirements that
13 vary from state to state -- because of state
14 regulations now and particularly because of state
15 licensing for addictions professionals becoming
16 imminent and the desire and drive for that across the
17 nation, every state has its own requirements. So that
18 from state to state, you're going to see a difference.

19 And we're fighting that battle for similarity and
20 uniformity. Is it going to happen? Probably not,
21 because every state has its own ability to make those
22 decisions. Still, again, the inadequate salaries.

1 The other challenges that we're looking at is
2 that there's inability on the state level right now to
3 tie the career ladder to the scopes of practice.
4 Funding, more than likely, and the fact also that many
5 facilities would have to determine how it is that they
6 would, with persons graduating to a higher rung on the
7 career ladder, how they're going to pay them. So
8 those are things that they're looking at there.

9 Still a challenge after 37 years is the stigma
10 attached to patients and those professionals who serve
11 those patients. Opiate addicts are still seen as the
12 dregs of society. The name junkie is still out there.
13 So there's some things in our profession, though it
14 may not be used by the professionals, within the
15 community is still there for those persons we serve.

16 It is difficult to recruit minorities for our
17 profession, particularly because the reality for them
18 is they can't afford to pay loans back sometimes after
19 the first year of work with us. So they leave the
20 profession after sometimes 24 months in order for them
21 to begin to pay for a mortgage, for loans, for
22 children, daycare, those things.

1 Excuse me. We still have -- and, thankfully, we
2 are being included in the Service Health Corps. So
3 that's one thing that is really not as much of a
4 challenge as has been before. We do need to have
5 promotion recognition at the agency and state level to
6 enhance recruitment, if there were even recognition of
7 addictions counselors day within a state. It may be
8 that people -- everybody wants a pat on the back. It
9 may be that that's some way, at least, to recognize
10 the profession that would help to encourage and maybe
11 to retain.

12 I've got one minute. And I'll skip over that
13 slide.

14 Preparing for the landscape -- I think Linda has
15 brought that out clearly and quite well. The only
16 thing that I'd like to include there is the
17 understanding the role of the certificants play right
18 now and peer recovery and peer coaching, because a
19 level one counselor who has two years of experience or
20 two years of education more than likely is doing that
21 type of work already. And I don't think that our
22 profession is quite aware that that is something that

1 they can easily move into.

2 For the future, I think we all need to continue
3 looking at integration of all services. The Technical
4 Assistance Center that has been referenced, I think,
5 needs to begin now in order for everyone to be
6 prepared immediately for changes that are coming.

7 For all professions, also clear paths of career
8 -- and so, that they would know what's out there in
9 the landscape for them. I don't think anybody really
10 understands how to move ahead in the future. For
11 mental health professionals, for substance abuse
12 professionals, we really don't know how to -- where
13 did he go, how did he get there. So we need to have
14 that path clear for them and to build collaboratively
15 and collegiately so that our workforce becomes
16 stronger and is better prepared for what is to come.
17 Thank you.

18 [Applause.]

19 DR. CLARK: Thank you.

20 And our last panelist would be Dr. Leighton Huey,
21 the Birnbaum/Blum Professor of Psychiatry, University
22 of Connecticut.

1 DR. HUEY: You know, as I was sitting here and
2 thinking about how I was going to organize my remarks
3 today, I was thinking, well, what is my role in the
4 workforce debate. And what I came up with is that I
5 consider myself to be a semi-professional heckler.

6 [Laughter.]

7 DR. HUEY: Now, my comments are going to touch on
8 both illness and health. And I want to read you a
9 couple of things for your consideration. And I'm not
10 -- this is an executive summary, a paragraph, from the
11 American Association of Medical Colleges. And I don't
12 represent the AAMC. But I thought you would find this
13 interesting.

14 2010 -- "Academic medical centers deliver more
15 than one-fifth of U.S. health care, train most
16 physicians and many other health professionals,
17 provide half of continuing medical education, and
18 carry out the majority of federally-funded medical and
19 health services research. They can and must lead the
20 way in improving quality, lowering cost growth, and
21 enhancing care for patients and communities while
22 incorporating changes into the training curricula for

1 the next generation of health care professionals. If
2 health professionals are trained in an environment of
3 constant innovation, they will be more likely to be
4 change agents in their decades of clinical practice."

5 "In addition, changes in delivery systems must be
6 supported by the strong research infrastructure in
7 these institutions to provide real-time evaluation and
8 course correction. In short, medical schools and
9 teaching hospitals contain the building blocks to
10 improve health and health care for the nation." So
11 that's one piece.

12 The other piece is an excerpt from something I
13 wrote called, The Forgotten Planet: Behavioral Health
14 Care. "Behavioral health care is like a lost planet,
15 often orbiting by itself with limited gravitational
16 pull from other more sizeable heavenly bodies. Maybe
17 it's not even a planet. Maybe it's just an asteroid
18 or a collection of space dust for some. Whatever it
19 is, it has not been integrated into mainstream health
20 care in the way needed."

21 "The involved disciplines are not developing
22 systems or training individuals to substantively

1 improve health and, therefore, reduce morbidity for
2 individuals, populations and communities. Care in
3 behavioral health, its shaky relationship to the rest
4 of health care, the perversity of how it is funded,
5 and the challenges bordering on irrelevance at times
6 in how its practitioners are trained makes it not only
7 a forgotten planet, but probably a lost one as well."

8 "By virtue of its complexity, the work in
9 behavioral health care must address biological,
10 psychological, and social perspectives. Otherwise, it
11 is a fallow effort. Additionally, no one discipline
12 is capable of doing everything necessary to ensure
13 proper, competent, comprehensive assessment, and care.
14 Disciplines remain trained separately, i.e.,
15 psychiatrists, psychologists, social workers, nurses,
16 occupational therapists, alcohol and drug counselors,
17 peer specialists, primary care physicians, and other
18 relevant specialists all being trained mostly apart
19 from one another."

20 "Guild competition and outright animosity among
21 them contribute to the impasse. The pedagogical
22 offerings remain focused primarily on piecemeal in a

1 particular discipline and not on an integrated
2 approach to assessment and care with an eye to
3 improving the public's health. This dearth of
4 substance and experience in coordinated
5 interdisciplinary training to improve the behavioral
6 health of individuals with physical health problems is
7 lamentable, given the considerable and often untreated
8 behavioral health co-morbidity of those individuals
9 having common physical disorders."

10 "Conversely, the physical health morbidities
11 associated with many individuals treated in the
12 behavioral health care system are legion. For
13 example, metabolic syndrome, from over-prescribing
14 atypical anti-psychotics resulting in early mortality
15 for many individuals who are, quote, unquote,
16 'carried,' within the behavioral health care system
17 with poor or non-existent attention from physical
18 health care."

19 "If things are so bad, and if we had known about
20 these various disconnects for such a long time, why
21 have the training institutions not kept pace and not
22 developed innovative paradigms to correct the

1 problems? Some have caustically joked that the
2 present generation of health care providers must die
3 off before proper reform can occur in this area.
4 Federal agencies, cognizant of this issue, are making
5 efforts to integrate behavioral health into existing
6 primary care systems. But proper and enduring reform
7 will not emerge until training institutions recognize
8 the problems and develop new models for training in
9 integrated, interdisciplinary fashion.

10 While there are discipline-specific knowledge and
11 processes that are sacrosanct, there are other
12 relevant and timely training approaches to be
13 developed if the historic trend on both sides of the
14 physical and behavioral health care fence is to be
15 reversed. Health care reform represents a particular
16 opportunity to galvanize changes in our training
17 systems so there can be a different workforce of the
18 future more relevant to societal needs."

19 "Patient-centered medical homes and accountable
20 care organizations afford a platform on which to
21 change training systems. With reform efforts placing
22 greater emphasis on public health, early

1 identification of people at risk, prevention
2 strategies, outcomes tracking, evidence-based
3 assessment and treatment, and the integration of
4 improvement efforts, these represent opportunities to
5 create a super team system that can do many things
6 well and do them cost-effectively. If super teams are
7 to be created, then people need to be trained in their
8 function. And that training needs to start at the
9 pre-professional level."

10 "Academic systems should convene cross-
11 disciplinary planning groups to construct a blueprint
12 for how training in a super team paradigm should
13 occur. Federal funding to support demonstration
14 projects on pre-professional super team development
15 should be regionally based to cover urban and rural
16 areas. Determining which disciplines should be folded
17 into a super team and the division of labor among
18 those disciplines would be an outcome."

19 "Behavioral health care, incompletely understood
20 in the professional and general public, must be
21 integrated into mainstream health care. Reform
22 demands it. Addressing this problem through the

1 introduction of a new system of collaborative pre-
2 professional training can profoundly impact the health
3 of a population and improve the quality of life of an
4 individual. The key is training early so needed
5 reform can occur and be sustained. Being a lost or
6 forgotten planet is no longer acceptable."

7 Now, my remarks, my talk -- I agree with the
8 concept of integration. Who could disagree with that?

9 But it's functionality that is the key. How does the
10 system function?

11 We've known about the problems outlined by Linda
12 in her slides for a long time. Where is the
13 innovation? Why are we still in this fix? Why do
14 bright neuro-science majors in college end up being
15 plastic surgeons?

16 Many people have written about the fragmentation
17 of the general health care system. But probably no --
18 the most fragmented is in behavioral health care. And
19 this is not an era of let a thousand flowers grow.
20 This is an era of focusing on what we need to focus on
21 where the evidence supports what we need to be doing.
22 And for all the great ideas that are out there, we

1 can't afford that.

2 I'd like to ask you, how many of you consider
3 yourselves to be experts. Only about six? Okay. I
4 thought everybody would raise their hands. You're
5 just very modest.

6 I would say, yeah, you are experts. You're an
7 expert in diagnosis, or you're an expert in
8 psychopharmacology. Or you're an expert in
9 psychotherapy or economics or addition. But that's a
10 good part of the problem, that no one has the ability
11 to be an expert in everything that's required. So the
12 only way to function is to function on a team system
13 that is focused. Again, we don't have a thousand
14 flowers. We can't let a thousand flowers grow any
15 longer.

16 Tom Ensall, on a recent talk -- and this gets to
17 the illness issue. He was basically making the case
18 that mental illnesses are developmental disorders.
19 Okay? And because of our technology at this point in
20 time, we can't detect them until they manifest
21 themselves symptomatically. We can't detect them.
22 There's no blood test yet that will tell which child

1 is going to become schizophrenic or bipolar, and so
2 forth. He says, "It's time to fundamentally rethink
3 mental illness. Mental illnesses are disorders of
4 brain circuits caused by developmental processes
5 shaped through a complex interplay of genetics and
6 experience."

7 He says, "This model will upend the existing
8 conceptual model, which is diagnosis is made by
9 observation of manifest symptoms, detection of illness
10 is late, prediction of illness is poor, ideology is
11 largely unknown, treatment is trial and error."
12 That's the state of what we have. So when we go to
13 ask for more money from physical health care or
14 providers, eyes glaze over, because that's our
15 heritage.

16 Now, far-sided universities, some, are beginning
17 to consider the challenge. And the challenge doesn't
18 just begin and end with reorganizing the current
19 workforce. It really has to begin at the
20 undergraduate level. It's not just the medical
21 school. It's undergraduate. It's graduate. And it's
22 post-graduate. All have to be integrated in some

1 fashion in order to pull off what we're talking about,
2 in my opinion.

3 It's an atmosphere that the IOM calls team
4 learning. And team learning begins at -- should begin
5 at the undergraduate level. Our professional
6 development needs to change. That paradigm needs to
7 change.

8 We were talking at lunch about the fidelity of
9 our diagnostic system. And it's not really good.
10 It's not very good. Compared to the diagnostic slop
11 that existed before DSM-4, I think DSM has been
12 helpful. But it's also been problematic, because
13 people think that the beginning and end of behavioral
14 health begins with DSM. And there's a lot more that
15 goes into making a diagnosis than looking at a
16 checklist.

17 And are we training our people to think in those
18 terms? I don't think so, regardless of what
19 discipline you're from. So there are many, many
20 different issues that we should be considering.

21 DR. CLARK: Okay, Dr. Huey, thank you for setting
22 the stage for the next group of questions from the

1 audience, because there are many different issues that
2 we should be considering.

3 And with that, I want to thank everyone on the
4 panel.

5 And we'd like to open it up for general
6 discussion.

7 MR. JACOME: Dr. Clark, Marco Jacome. Actually,
8 I really thank all the panelists for their great
9 presentation and great comments and issues that help
10 bring awarenesses to the field. I think one of the
11 issues that I have as a minority is one -- the lack of
12 minority in workforce development, not only in
13 institutions like non-for-profits, but in government.
14 The other comment will be in the paraprofessionals
15 mentioned about the role that we're going to be
16 playing, how it's going to be dealing with
17 reimbursement.

18 As you know, managed care has implemented
19 reimbursement issues with the credit people. And we
20 have some concerns in terms if that is going to be
21 recognized in terms of reimbursement in the future.
22 And that's my comments.

1 DR. CLARK: All right, any of the panelists want
2 to respond to the issue of reimbursement and the
3 involvement of a diverse group of paraprofessionals
4 and professionals?

5 DR. KAPLAN: Yeah, I just -- I do know that CMS
6 does, in some states, provide reimbursement for
7 certified peer specialists. And, you know, they have
8 categorized that. But they have to be number one
9 certified. Number two, they have to be supervised by
10 usually a master's level professional. And they have
11 to be recertified every two years. So, you know, it's
12 not a static one-time only certification.

13 The rates, from what I remember, there is --
14 actually, in the [inaudible], there is a reference you
15 can look at which shows you the rates for, like, 15-
16 minute sessions, which range from something like \$3
17 for the patient to about \$15. And don't quote me on
18 the higher end, because I don't exactly remember. But
19 it was something like that. So that is slowly being
20 established.

21 I also know that some private insurance -- I know
22 -- oh, god. I know Aetna was one, and I can't

1 remember. It may have been value Options -- are also
2 paying for some peer recovery support services. I
3 know one program in Texas that's doing that. And
4 there may be several others. So slowly but surely,
5 that's happening. What exactly the rate is, I mean,
6 we can try and get you more information, if you'd
7 like. But that's what, you know, I'm aware of right
8 now.

9 DR. CLARK: All right.

10 Benjamin?

11 MR. SPRINGGATE: Thank you. This is a really
12 terrific set of presentations. And I've appreciated
13 the insights from each of you.

14 I guess, I would initially follow-up on the
15 question, the prior question, which I thought was a
16 very appropriate question in that, you know, as an
17 example, I've personally participated and led training
18 programs for everyone from community health workers to
19 psychiatrists in collaborative care for depression --
20 as an example, teen-based care. And, you know, one of
21 the most significant challenges, then, because this is
22 an evidence-based, you know, very well-thought of

1 intervention to actual implementation after the fact,
2 is that there is no way to reimburse it. Whether it's
3 care management -- unless you're in a capitated
4 system, there's not a way to pay for care management,
5 which is perhaps the most critical component.

6 We have actually recognized the costs associated
7 with this. We have a community health worker training
8 institution now, training to train community health
9 workers to serve in this role instead of social
10 workers or nurses, who are too expensive in, you know,
11 many settings to provide that -- some of those
12 services.

13 So I would say that, you know, as we give some
14 consideration to these workforce challenges and all of
15 the opportunities and the history that you all have
16 presented, it really does have to be -- consideration
17 does have to be given concurrently to what's the
18 reimbursement that's going to permit the
19 implementation of these teams and more effective
20 dissemination of these types of well-trained personnel
21 into the settings in which they're needed.

22 And then, lastly, very briefly, I would just like

1 to follow-up on Dr. Campbell, who noted -- your talk
2 was very compelling. And you noted appropriately the
3 inequity in the proportions of psychiatrists versus
4 other types of workforce. And I would simply note
5 that at least between 2007 and 2010, 55 percent of
6 trainees in psychiatry are women. So there is a
7 reversal. It's coming. And was also noted, many of
8 the men are getting older. Thank you.

9 [Laughter.]

10 DR. CLARK: Go ahead. Then we'll go to Michael,
11 Lynn, Paul and --

12 DR. KAPLAN: I just wanted -- my understanding in
13 terms of reimbursement -- and I want to go back to the
14 good and modern paper. I know that part of what's
15 happening is we're working, as, I think, Pam has
16 mentioned many times, with CMS very closely on
17 defining services that can hopefully be reimbursed
18 through Medicaid. So, you know, exactly where we are
19 on that, Pam is probably better suited to respond than
20 I am. But I do know that that's part of the thing.

21 And generally, I think that more and more of
22 people going into medicine are actually women. And

1 so, it's not just psychiatrists, but it will be a
2 great change.

3 DR. CLARK: Dr. Campbell?

4 DR. CAMPBELL: Yeah, I just wanted to add one
5 thing on reimbursement -- that in our state, where
6 we're working to be able to pay our peer specialists,
7 that the problem isn't so much the reimbursement.
8 It's getting the agencies to make the match on the
9 reimbursement. And that tends to be -- it's our
10 suspicion that it's really the lack of -- still the
11 lack of really valuing the work of the peer
12 specialists. So even with the Medicaid reimbursement,
13 the small amount of money for the match -- they do not
14 prioritize those roles. So in any budget cuts, for
15 example, those are the first to go.

16 DR. CLARK: All right, Michael?

17 MR. BOTTICELLI: A couple thoughts and a
18 question. One is -- and I really appreciate people's
19 time and efforts around this. But, you know, having
20 done this a while, I think everybody, kind of, comes
21 to the conclusion that, you know, you see a problem
22 program, and you see a problem agency. And so, I

1 don't think our workforce efforts can just be focused
2 solely at the individual practitioner level, that we
3 really have to look at the overall health of our
4 organizations to provide the clinical supervision, to
5 provide -- you know, it's like implementing an
6 evidence-based program. You have to do it at multiple
7 levels in the organization. And so, I think there's
8 an opportunity to do that.

9 I also think, too, that part of what, I think,
10 we're seeing in Massachusetts and we're likely to see
11 as health care reform rolls out nationally is what is
12 the construction of our agencies. And, you know, I
13 think we're likely to continue to see mergers, larger
14 and larger agencies. I'm concerned that some of our
15 smaller agencies that are agencies of color or small
16 agencies that are providing niche services are not
17 going to be able to play in this world, and so, how we
18 think about supporting them and involving them in
19 that.

20 And then, the last piece is -- one of the things
21 I didn't hear is the extent to which, quite honestly,
22 both state and federal laws prohibit the involvement

1 of peers in our work. And I'm thinking particularly
2 around criminal involvement and what they -- so one of
3 the areas that we see in Massachusetts is the extent
4 to which, you know, peers who have some level of
5 criminal involvement or really, you know, precluded
6 from joining the workforce. And I think it's an issue
7 that we have to really examine, both on a state and a
8 federal level. And I didn't know if there were
9 efforts underway to look at that.

10 DR. CLARK: You're talking about histories of
11 criminal involvement as opposed to active criminal
12 involvement.

13 MR. BOTTICELLI: Yeah, yeah.

14 DR. CLARK: Right. So I just wanted to clarify
15 that.

16 [Laughter.]

17 MR. BOTTICELLI: From a personal perspective,
18 yes, I can see history.

19 [Laughter.]

20 DR. CLARK: We are looking at -- there are number
21 of laws which are labeled barrier laws, and Legal
22 Action Center has done a nice survey of a few

1 jurisdictions. And that is an issue. And we do have
2 to think in terms of rehabilitation. If it means
3 rehabilitation, but it stops with your history, then
4 that's a problem with regard to both mental health and
5 substance abuse disorders.

6 Flo?

7 MS. STEIN: I just [off-mike] reinforce the
8 discussion of teams and team-based care and how
9 important the work is at better preparing them in the
10 universities. We do a lot of team-based care. And it
11 results in many, many, many audit issues, because the
12 team, even though we construct the team, they're not
13 sure how to work together, how to document, who does
14 what, when. So that's a great suggestion.

15 DR. CLARK: And I think that fits into Dr. Huey's
16 contention that we need to prepare our evolving
17 workforce on the notion of working in teams and
18 collaboratively so that, indeed, they can be more
19 effective.

20 Yeah, the gentleman in the back, and then --

21 DR. ROSEN: I'd like to thank the panel for a
22 really nice, broad discussion. And it set the stage

1 beautifully, I think, for the discussion that we're
2 having now. And a number of issues struck me. And I
3 just wanted to mention a few of them as we move
4 forward.

5 And I wanted to thank Dr. Springgate for his
6 comment. There's really been a seismic shift in the
7 demographics of people who are going into psychiatry.
8 I've directed a training program for 10 years. And
9 the majority of the trainees that I trained and many
10 of my colleagues trained were women. But there are
11 challenges in academic medical centers, financial
12 motivation in the way that they're structured for
13 training primary care physicians versus specialty
14 physicians. And I think until we develop a reasonable
15 alignment in how academic medical centers are
16 reimbursed for the services that ultimately go to
17 training future physicians or graduate -- in graduate
18 medical education, especially, we're going to struggle
19 with training enough primary care physicians. And it
20 strikes me, too, that not only is there no
21 reimbursement for the interdisciplinary care or
22 conferences. There's really no support for the

1 training along interdisciplinary lines. So one of the
2 reasons training is fragmented along different
3 specialties is because there's no economic motivation
4 for them to integrate them.

5 And, you know, we have faced a particular
6 challenge in the field of internal medicine where 90
7 percent of the people who go into internal medicine go
8 on to sub-specialize in other specialties. And then,
9 of the remaining 10 percent, half of them practice in
10 a hospital as hospitalists. And the other -- only 5
11 percent of them are actually doing primary care work.

12 And, you know, the last point I wanted to make --
13 Dr. Huey, you noted challenges in the fidelity of
14 diagnostic accuracy. And one of the things that we
15 have faced in the settings I have worked at is the
16 evidence-based literature itself is very much focused
17 on single diagnosis and single treatment
18 interventions. But most of the patients that we treat
19 have multiple diagnoses and have multiple treatment
20 interventions. And it makes it hard to reconcile the
21 clinical reality with the evidence-based practices
22 that are supposed to inform it. Thank you.

1 DR. CLARK: Thank you.

2 Patricia?

3 MS. MRAZEK: Thank you. This was fascinating
4 today. And I'm not a psychiatrist, but I'm married to
5 one, so I'm going to tell you one of the things I
6 learned this summer.

7 [Laughter.]

8 MS. MRAZEK: And that is that fellowships in
9 addictions have, to this point, been pretty much
10 exclusive to the field of psychiatry. And this
11 summer, for the first time, a different addictions
12 qualifications board has set up a new fellowship in
13 addictions that is across all of medicine: primary
14 care, internal medicine, pediatrics. People from
15 these programs can now do specialized addictions
16 training.

17 Those programs, as far as I know, this is a new
18 thing that's just starting. Those programs have
19 filled across the country. The American Board of
20 Psychiatry and Neurology has not been happy about
21 this. That's to be expected. But the encouraging
22 thing is that it just takes a few people sometimes

1 with a zeal and an idea and go for it. And I think
2 they're going to fill the workforce need in this one
3 little, tiny area. But I think it does give us some
4 hope.

5 DR. CLARK: Allison?

6 MR. SAGE: I want to thank the panel -- good job.
7 I just wanted -- I have a couple thoughts. One of the
8 things that I didn't hear was -- well, actually, two.
9 But one of the things that I didn't hear was in all
10 of our workforce, which is majority women, no
11 childcare support. And, you know, when we train them
12 to work, we automatically think they can learn, that
13 they know how to read. And a lot of times, they don't
14 know how to read.

15 When they go to your office and you say, "Here,
16 fill this paper out," they say -- they look at it, and
17 then, they -- oh, you can bring it back. Take it
18 home, and bring it back. They take it home, and their
19 family -- somebody fills it out for them. Then they
20 bring it back. So they need that help. But maybe we
21 should think about child youth leadership, youth
22 medical, youth health training.

1 Another thing is how we get so far with the cycle
2 of living situation that we're in is we've got no
3 family planning. There's no intervention to stop and
4 say, "Wait. Hold on." I mean, you know, we're
5 talking about careers, but no one's talking about
6 sitting them down -- but I'm glad you got the case
7 manager -- I forgot what you call them, you know, the
8 peer counselors.

9 That's really good, because in -- we have -- in
10 our diabetes program, we have navigators who do the
11 same thing as a peer -- and that's really an important
12 aspect for our people to learn how to live. And they
13 just keep tabs on them. And so, they take them by the
14 hand, and they lead them.

15 But we need to -- you know, we talk about this
16 spinning wheel that we're in. There's no
17 intervention, no family planning, no career planning.
18 And so, I think -- I hope I'm not saying too much.
19 But thank you.

20 DR. CLARK: Thank you.

21 Allen Daniels, and then, we'll have --

22 MR. DANIELS: I thought I'd speak to the issue of

1 the peer support workforce. There's an initiative --
2 and there are two reports from the first two pillars
3 of peer support summits that have been held in
4 conjunction with the Carter Center. They're available
5 on pillarsofpeersupport.org. The first one addresses
6 states who were billing Medicaid in 2009. 2010
7 focused on states that were not billing Medicaid. And
8 2011 will focus on whole health peer support.

9 But in the 2009 report, there is data on what
10 states pay for peer support. And also, Optum Health
11 Care has done a comprehensive study of peer support
12 and family support work credential across the
13 different states. And I'm sure they'd be glad to make
14 that available.

15 DR. CLARK: Elizabeth Howell?

16 DR. HOWELL: Okay. I thought Gib was first, but
17 two things. One is to talk about what Patricia was
18 talking about, the American Board of Addiction
19 Medicine is what you're talking about with the
20 fellowships. There are 10 that were accredited. And
21 I just got accredited for an addiction psychiatry
22 fellowship. And what's really interesting is that

1 even though those have been around for a long time,
2 they don't usually fill.

3 And I'm trying to recruit for next year already.
4 And I've got a fellow for this year, but I have a
5 resident I thought was really interested. And he
6 said, "Well, there are all these jobs out there. And,
7 you know, they're going to promise me all this, you
8 know, money. And I don't really see why I should do a
9 fellowship." And I'm thinking, "Well, dude, you don't
10 really know what you don't know," is part of the
11 problem. But he thinks he knows everything because
12 he's a fourth year resident.

13 And so, anyway, and so, I think part of it is
14 that we need to, I think, convince folks in
15 psychiatry, at least, that they need to learn about
16 addiction, because the problem is that if they don't
17 do it now, they won't likely come back and do it later
18 on. And more than actually for their own training,
19 they need to be able to train people that are working
20 with them. So it's not so much that, you know, you
21 just need to have all this training for yourself. You
22 have to -- I think you need to have it for you and

1 other people.

2 The other thing is that when I see that in
3 medical education, when medical students are in their
4 first couple of years or in their undergraduate years
5 before they go to medical school, they really think
6 psychiatry is a joke and that we're, sort of, a --
7 mental health is, you know, it's like fluff and it's
8 really not very serious. And then, it's only when
9 they hit their clinical rotations and they start to
10 see people who are psychotic or severely depressed or
11 whatever's going on, they see people with mental
12 illness that's really active, that they realize how
13 serious and severe this is.

14 And they begin to see how medical it is, too,
15 that, not just the mental illness itself, but that
16 people have medical illnesses that we're taking care
17 of while we're taking care of people with their mental
18 illness and trying to stabilize them. And they, then,
19 also see how often their mental illnesses and
20 addiction are playing into the illnesses that they
21 deal with on other services that they begin to take it
22 more seriously. So I think the earlier that they can

1 be exposed to that, whether it's undergraduate or in
2 their first couple of years of school, the better it
3 would be for everybody, at least in medical school,
4 maybe other disciplines, too.

5 DR. CLARK: Great.

6 Gib, and then, Robert Friedman?

7 MR. SUDBECK: Thank you. Just an observation.

8 As we was talking about the different licensure and
9 certification, I really didn't hear anything about the
10 whole issue of co-occurring. And I know that's been a
11 big initiative of SAMHSA for, what, five, six years
12 now, to take a look at getting to a point where
13 everybody's co-occurring-capable of providing
14 services.

15 And hopefully, at some point in time, there will
16 be some detail as to what types of standards that
17 takes for people to become co-occurring-capable. Just
18 something to think about. You know, I don't know if
19 we're still moving in that direction, or something
20 else is happening. Thank you.

21 MS. BECKETT MIKELL: There are right now four
22 states who have requirements within their licensure

1 and credentialing processes that they're the evidence
2 of 36 to 48 hours of co-occurring training and
3 education. And for IC&RC, I know that they already --
4 they do offer a co-occurring credential. The National
5 Board of Certified Counselors, through their NCC,
6 their general counselor track, also offers specialties
7 for co-occurring.

8 And the certification system through NAADAC is
9 working with an endorsement. Persons who already have
10 a license or credential need to show evidence of
11 proficiency, not necessarily another credential. So
12 we will have that completed by the end of this year.
13 But, yes, the focus is still there. And, as I said,
14 already there are four states who are stating to their
15 certificates and licensees that they have to show 36
16 to 48 hours of training education in order to keep
17 their licenses within those states.

18 MR. SUDBECK: Just a follow-up comment. To
19 really initiate capable co-occurring-capable
20 programming, you have to have everybody within the
21 center or within the agency that provides it having
22 some type of training in basic skills that they impart

1 to people that walk in the door. So as you unveil
2 these standards and take a look at the training event
3 or training curriculum, I think you also have to look
4 at the overall agency and what type of training the
5 janitor needs, the receptionist needs, the board of
6 directors needs. Otherwise, you're really not going
7 to have an integrated system. You'll just have
8 another piecemeal system.

9 MS. BECKETT MIKELL: I totally agree.

10 DR. CLARK: Indeed, SAMHSA has supported NIATECS
11 as a construct. And what you're saying in terms of
12 totally integrated system is relevant to that, because
13 at any point, an individual presenting for treatment
14 may be discouraged from that treatment by anybody with
15 whom they have contact.

16 We'll take Robert Friedman. And then, Stephanie
17 Le Melle's on the phone. And anybody else on the
18 phone needs to let us know. And then, we will have
19 Ms. Wong.

20 MR. FRIEDMAN: An observation and a comment. We
21 really started off today, I think, talking about
22 SAMHSA's efforts to align its actions with its

1 priorities and its strategic initiatives. And we
2 identified prevention as perhaps a top priority
3 amongst the strategic initiatives. We know that, for
4 individuals with mental disorders, for 50 percent, the
5 age of onset has been 14 or younger. For 75 percent,
6 it's been 24 or younger. We know the key to substance
7 abuse prevention is in children and adolescents.

8 We know -- for the strategic initiative on
9 trauma, we know the long-term impact of trauma on
10 children and youth. And yet, we've had excellent
11 discussions, all important things. But I haven't
12 heard a lot of attention to some of the issues of
13 reaching out to the workforce that affects children.
14 We haven't talked about schools, really, for example.

15 The president's new Freedom Commission had a very
16 strong recommendation about the importance of schools
17 as a point of identifying children in need of services
18 and as a delivery point. The partnership with the
19 schools seems to be key. And, you know, Dr. Campbell
20 talked about age-related competencies. And I think
21 that's very important, both in clinical competencies,
22 but also the outreach to the proper professions to

1 help identify and provide the services for kids. So
2 I'd be interested in any thoughts that the panelists
3 have or actions that are going on that are more
4 targeted towards where we might have a greater impact
5 from a preventive standpoint.

6 DR. CLARK: Anyone want to comment on children
7 and adolescents? Obviously, a very, very important
8 group.

9 FEMALE SPEAKER: In the area of prevention with
10 substance abuse, we are partnering with as many
11 entities as possible. Through State Voices, we talk
12 frequently about working with our partners, which
13 would be Departments of Education, which would be
14 Criminal Justice, all of the different areas. And we
15 do speak quite a bit about focus on looking at the
16 early onset issues and trying to get before that level
17 of concern so that we are actually doing that
18 predominant primary prevention concept and building
19 those relationships.

20 Because for us, we realize very clearly it's a
21 community effort, that it has to include all the
22 sectors of the community. And we do a lot of work

1 with coalitions. And we encourage them to bring into
2 that coalition education members, working with their
3 school districts and their superintendents and all of
4 the folks who are involved in those networks. So from
5 the coalition perspective, it is a community
6 responsibility in bringing everybody in to work on
7 that.

8 So there is a lot of partnering in development,
9 because we recognize they are a part of our workforce,
10 that that community as a whole becomes our workforce
11 for prevention. And that's why it's so important to
12 be doing universal efforts to make sure that it's
13 recognized by everyone. We use the example of
14 dentistry.

15 We all know that it's important to brush our
16 teeth. It isn't just a certain sector that recognizes
17 that. Everybody knows it. And so, we have to make
18 ourselves as prominent in all communities so that they
19 understand that it's a part of what we do in every-day
20 life. It's the way you live your life for a life span
21 starting pre-birth.

22 DR. CLARK: Stephanie?

1 DR. LE MELLE: A comment more about the aspect of
2 training. And I think that -- you know, I think, as I
3 had mentioned at one of the meetings previously, you
4 know, taking a systems-based practice approach to
5 training mental health care providers, I think, is
6 really essentially. Number one, it's ACCMA-required,
7 that, as a competency, that all residents are trained
8 in specific practices. But I think, in particular
9 psychiatrists are well-suited towards this type of
10 training.

11 And it really encompasses, sort of, four whole
12 major roles. And one is as the patient care advocate.

13 And that's really the one-on-one, sort of,
14 interaction that psychiatrists have with clients
15 beyond just medication management, but really
16 advocating for their needs and, you, with a recovery-
17 oriented model.

18 Another role is as a team member, a boundary
19 spanner and the team not just being, you know, as a
20 multi-disciplinary medical team. But team members can
21 be -- for young adults and for children going into the
22 school system, it can be team members as family

1 members. It can be the primary care medical
2 providers. It can be with housing providers, benefit
3 providers. You know, it's multiple team members.

4 Information integration is another role as, sort
5 of, taking information from all of these different
6 systems and really trying to analyze the information
7 and make it into a useful format.

8 And the last role is the resource manager and
9 understanding both the resources of the individual
10 person that we're trying to serve and of the various
11 systems that we're working. It either can be in the
12 clinical setting of the provider's clinic setting, or
13 it could be in a macro resource setting of what
14 Medicaid will reimburse or what Medicare can
15 reimburse. But, sort of, training people with this
16 model, I think, really prepares mental health
17 providers, and particularly psychiatrists, to meet the
18 needs of the folks that we're trying to treat and the
19 various needs, including criminal justice, trauma, and
20 all of the other basic needs that people have in their
21 different systems of care that they have to navigate.

22 I think that part of the problem now is that we

1 train -- at least in psychiatry, we train
2 psychiatrists really using a private practice model,
3 which doesn't apply any more. The majority of
4 psychiatrists in the United States aren't actually
5 full-time in private practice. They may have a small
6 private practice on the side, but they're usually
7 organizationally based. And so, we really need to
8 change the way we're training people. And I think the
9 systems-based approach really fits well with, sort of,
10 trying to meet the needs of the systems and of the
11 people that we're trying to provide care for.

12 DR. CLARK: Thank you.

13 Dr. Huey has a comment.

14 DR. HUEY: Well, I fully agree with your
15 comments. And they stimulated a thought about who's
16 the point person when somebody enters the health care
17 system. What can that individual do to address the
18 several things that you've addressed? It seems to me
19 that that person should be a pretty high-level person
20 to help support and facilitate the process of
21 receiving health care in a complex health care system.
22 That would be very important. And I don't know

1 whether that's really been addressed or not.

2 DR. CLARK: All right.

3 Marleen Wong?

4 DR. WONG: I want to thank the panel for their
5 presentations. It was really thought-provoking. And
6 it, sort of, gave me some hope that, at least at the
7 agency level and maybe some of our universities, are
8 really looking at integrated training, which is so
9 important. But I wonder if the discussion would be
10 different when you think about guild issues and
11 organization, professional identity organizations,
12 that there may be barriers there that, you know,
13 prevent us from moving forward as quickly as we could.

14 Also, I just wanted to make a comment about the
15 school mental health issues. HRSA did fund a National
16 School Mental Health Center, which is located at the
17 University of Maryland. And their annual conference
18 -- national conference is at the end of September in
19 Charleston, South Carolina. So it's a great
20 organization that brings together a lot of people
21 under the umbrella of school mental health.

22 DR. CLARK: And HRSA also funded school health

1 centers. And, obviously, in the integrated dialogue,
2 we want to make sure that, in our partnership with
3 HRSA, that they address behavioral health issues. And
4 I'm sure that's on Mary Wakefield's mind as they're
5 facilitating the discussion on integrated care. So
6 both of those efforts should facilitate dealing with
7 the needs of children and adolescents as well as
8 setting the stage for prevention and facilitating
9 recovery.

10 William McFarlane?

11 MR. McFARLANE: Just a brief comment to amplify
12 Dr. Huey's comments about teams. And that is to
13 remind people of a SAMHSA study of supported
14 employment. And it was a large enough study with
15 enough sites and enough variation across sites'
16 methodology to test whether the integration of various
17 disciplines made any difference. And the answer was a
18 definitive yes. That is the closer the psychiatrist
19 or social worker worked with an employment specialist,
20 the higher the employment rate of the recipients of
21 care.

22 And I think there are other evidence base, I

1 think, for this notion of team. I think we need to
2 pay attention to those, because it'll be a tough sled
3 to convince the workforce that it's better to hold
4 humility alongside your colleagues who, as you said so
5 clearly, you can't know everything. And the best
6 outcomes can be by putting expertise beside other
7 expertise that's complimentary and then, doing that
8 on, kind of, a squared basis as you get more
9 expertise.

10 But that's part of the SAMHSA -- not just the
11 toolkit, but it's actually part of SAMHSA's, sort of,
12 set of feathers in their caps that it was really
13 proven that that makes a difference. It makes it,
14 actually, not a small difference. It was a really big
15 difference.

16 DR. KAPLAN: I just want to reinforce the whole
17 idea of working in teams. And this was an article in
18 the New Yorker a number of years ago that studied,
19 sort of, the adoption of -- it's actually heart
20 surgery, open-heart surgery by two physicians who were
21 both extremely well-known and very competent in the
22 field. And one team went, as they were learning this,

1 had a number of fatalities, unfortunately. The other
2 team didn't. And it was actually because the team
3 that was more successful from the get-go did, sort of,
4 they rehearsed all the time beforehand. The doctor
5 used the same team. They debriefed after every
6 surgery. And so, there was a real emphasis on team.
7 And it has a major impact.

8 And the only other thing I want to say is in
9 terms of the restoration of rights and the barrier
10 crime laws, this is also where peers and people in
11 recovery can be very helpful, because I know, in many
12 cases, and in many programs that I've worked with,
13 they actually will help people go back and restore
14 their civil rights. And that's another role that
15 peers can help play in many ways.

16 DR. CLARK: Anybody else on the phone?

17 Okay.

18 Next speaker?

19 MR. RISSER: Hi, I'm Pat Risser with CMHS
20 Advisory Council. I believe that health care begins,
21 actually, at the lowest level. Most people I know in
22 the real world ask a friend or family, do you think I

1 should go to the doctor, do you think I'm sick enough
2 I should go see somebody. And where I come from --
3 I'm not going to tell you my age, but back in the '60s
4 and '70s, I started out volunteering at a free clinic
5 and talking an awful lot of people down from a bad
6 trip.

7 I found those skills of having heart and soul and
8 compassion have held me in good stead as I've trained
9 people to be peer providers and, you know, right where
10 the rubber meets the road, the people on the streets,
11 the people, you know, who are out there at the grass
12 roots level, the people who are too scared to go see a
13 doctor. And, honestly, sometimes, you know, an M.D.
14 and a Ph.D. doesn't mean you've got heart and soul and
15 compassion.

16 And I really hope that in our discussions about
17 developing the workforce that we look at why is it
18 that people don't want to go to the doctor, how can we
19 impart some of that heart and soul and compassion to
20 help our population get healthier and take better care
21 of themselves. You know? I don't think it's rocket
22 science. I think we just need to have a little more

1 heart and soul and compassion.

2 DR. CLARK: I think that's a good -- one more?

3 MS. DAVIS WHEELER: Yes, thank you. My name is
4 Julia Davis Wheeler. And I'm with the Nez Perce Tribe
5 in the state of Idaho. I really appreciated the
6 comments on the workforce development that has been
7 going on. And it sounds like you all have a pretty
8 good handle on what needs to be done and how you're
9 going to go about doing it.

10 Ruth Satterfield from Ohio made a comment that
11 really came to my mind. She works with the states,
12 territories, and tribes. And one of the things that
13 she made a comment on is if we are truly committed, we
14 must attend to the workforce needs. I truly agree.

15 I'm President of the Youth Treatment Center up in
16 Spokane, Washington. And that's a consortium of
17 tribes that have a youth treatment center, ages 12 to
18 18. And one of the things that we're developing
19 within our staff is to, how do you say, encourage
20 those that are not up, you know, on the certified
21 level to go back to school, to get that training so
22 that they can work.

1 And what we have found is that the youth listen
2 to the youth. And so, the comment that was made
3 earlier about having a peer counselor -- it really
4 does work. And I just really appreciate the work that
5 you have done and the reports that you have brought
6 forward. Thank you.

7 DR. CLARK: Thank you, Julia.

8 As we wind up this panel, I want to make it clear
9 that there's a wide range of issues that have been
10 discussed. But I also want to link workforce back to
11 Kathryn's discussion of recovery, because it does
12 involve peers. It involves family. It involves the
13 individual who is struggling with either mental
14 illness or addiction issues.

15 When we talk about workforce, the idea is
16 essentially similar to what Patrick had said. Do I
17 need to go to a doctor? Do I need help? And we want
18 to create an environment where that question can be
19 answered. But we also need to make sure that whoever
20 that person goes to is able to answer that question,
21 either using mental health first aid or directing them
22 to a professional.

1 The next question is, if I go get help, will it
2 help. And that's an integral part of the recovery
3 paradigm. And we're going to hear, after the break,
4 I'm assuming, from Pete Delany, who's going to talk
5 about our behavioral health quality framework, because
6 implicit in that discussion is making sure that we are
7 able to answer the question that the person has, if I
8 go get help, will I get help. That is an essential
9 part of insurance.

10 They want some kind of outcome that can be
11 monitored, measured. And they want some kind of
12 assurance that whoever's providing the service,
13 whether it's a peer or a professional, that they do no
14 harm. And so, the team approach helps with that. And
15 I'm glad to hear that talked about, because, indeed,
16 you're bringing to bear multiple levels of training
17 and focusing on a wide range of issues. Because not
18 every individual who presents has the issue for which
19 the clinician has special training.

20 We've talked about a wide range of ages. We've
21 talked about the elderly. We've talked about the
22 young. We've talked about ethnic groups. We also

1 need to make sure that people who are addressing the
2 needs of the LGBT communities are knowledgeable about
3 that, because not only is it formal training in terms
4 of degrees or in terms of programs, it's also training
5 into the unique issues with which the people present.

6 And so, the people have to feel welcome.

7 We haven't talked much about culturally-sensitive
8 training in terms of what goes on in a reservation or
9 Alaska Native, Hawaiian, or training of those on the
10 islands, like in Guam, whether there is specific needs
11 and cultural issues which present substance abuse
12 issues and mental health issues in a different
13 context. I think that's something we can't forget,
14 because recovery, as Kathryn pointed out, does involve
15 these issues.

16 So I want to stress that our focus has been on
17 the workforce. And that includes prevention, as Fran
18 Harding would remind us about, so that, indeed, we
19 have a wide range of individuals who are skilled in
20 assisting our largest society. And it does take the
21 whole community to address these issues.

22 So with that, I'm going to turn this back over to

1 my boss.

2 MS. HYDE: Thanks, Wes. That was a great
3 summary. Thank you.

4 And thanks to the whole panel.

5 [Applause.]

6 MS. HYDE: You all did a lot of stimulation.

7 I just want to acknowledge that even though
8 Marsha had to leave from HRSA, Alex Ross, who is from
9 HRSA and who works with us a lot on these issues and
10 others, has been here through the whole conversation.

11 So I really appreciate, Alex, you being here.
12 Thank you for doing that. HRSA's been a terrific
13 partner.

14 As we move to the break, I want to just tell you
15 that, in all of these conversations, I always take
16 notes about the high points. And there's usually four
17 or five under each topic that, kind of, stick out for
18 me. I've got to tell you, here's what I think you
19 told us we need to work on.

20 The numbers -- we don't have enough:
21 recruitment, retention, the demographics, they're
22 aging out, the inequities, disparities, including

1 women, tribal issues, and LGBT. We have training
2 issues, specialties, initial training, ongoing
3 training, specialties around prevention, justice,
4 children and youth. Peers -- we need to do a lot more
5 with peers and family support workers and navigators.

6 We got competency issues we've got to deal with.

7 We've got to figure out orientation. It's got to be
8 recovery-oriented, not otherwise. We need to do
9 something about the data. We've got to look at
10 geographic distribution, because we have huge rule
11 issues. We have bi-directional integration issues
12 going on. And we have fragmentation of expertise.

13 We've got issues about super team and cross-
14 disciplinary treatment and training. We've got
15 inadequacies of our organizational structures. We
16 have supervision issues. And we have reimbursement
17 policies. And, oh, by the way, we have major social
18 issues about what we value.

19 So those are just a few things, I think, that we
20 heard from you that we need to take on.

21 [Applause.]

22 MS. HYDE: All right. With that swimming in our

1 heads, let's take a break. We're going to start right
2 at 3:30. And we have a really interesting
3 conversation about quality and measures coming up. So
4 come on back.

5 Okay. If you want anything else to drink or
6 coffee or whatever, the Uncommon Café is open for
7 another few minutes.

8 [Break.]

9 MS. HYDE: All right, we're going to get started
10 again. If you could join us and get to your seats. I
11 hope all the chatter is some good conversation going
12 on about the incredible discussion we had earlier, and
13 also, maybe just a gravitation toward the cookies. So
14 good conversation and sugar are the two things that we
15 offer this afternoon.

16 All right. We have one final presentation this
17 afternoon. And hopefully, again, we will get through
18 it in a way that will offer lots of opportunity for
19 comment. I think it will stimulate your thinking.
20 We, as you may recall, offered you last time a little
21 highlight of how we were starting to think about the
22 national quality behavioral health framework, or the

1 national behavioral health quality framework. Sorry.

2 I always get that backwards.

3 I just want to set up just a little bit here that
4 SAMHSA has really taken on, in a way that, I have to
5 admit, I didn't start out wanting to do. Pete
6 probably would say the same thing. But it was because
7 of some advice from folks like yourselves and others
8 who really said, you know, everybody's touching
9 measures, everybody's touching quality, there's
10 quality in figuring out what's the best thing to do
11 everywhere. And yet, there's no real consistent way
12 of thinking about it or no real consistent way to have
13 a framework to hang our thinking on.

14 So we actually have taken that on in many ways.
15 And what we're here to do today is tell you about the
16 next iteration of the framework. You've got some
17 flavor of that last time. We rolled it out on June
18 15th, if you had an opportunity to participate in that
19 Webcasted public input process. And we have been
20 telling everyone that, before we finalize it, we
21 wanted our national advisers, namely, all of you, to
22 react to it. And we can tell you, then, where we are

1 in the process and what's coming next.

2 So I'm going to turn this over -- the
3 presentation -- over to Pete Delany, who is head of
4 our Center for Behavioral Health Statistics and
5 Quality and who also leads our strategic initiative on
6 data outcomes and quality.

7 And with him -- well, you can introduce them,
8 Pete. I'll let you do that.

9 MR. DELANY: Okay.

10 Hi. Good afternoon.

11 [A chorus of greetings.]

12 MR. DELANY: Thank you for coming. We ordered
13 the weather just for you. When you leave, it's going
14 to be bad again, so good time to go.

15 [Laughter.]

16 MR. DELANY: I want to acknowledge my colleagues
17 on the panel: Dr. Richard Frank, who is working with
18 us and has been collaborating on this for a while with
19 us; and also, Ms. Cheryl Powel from the Center for
20 Mental Health -- Center for Medicare and Medicaid
21 Services. I remember it as HICFA. It was so much
22 easier.

1 [Laughter.]

2 MR. DELANY: So, yeah, where's that extra M?
3 They lost it. It's, kind of, like, it maybe have gone
4 to Yugoslavia, for all I know.

5 Anyway, and I also want to thank Dr. Kevin
6 Hennessey, who has really been the point person for us
7 in pulling a lot of this information together.

8 And I guess I can thank Pam for making this an
9 interesting challenge. But, you know, some days she's
10 happy with me. Some days, you know -- and it has been
11 very -- it's been a challenge, and a good challenge.
12 It's been trying to think these things through and
13 where we're going to go and trying to make sure --
14 because, as she says, it keeps bumping against
15 everything here.

16 It's bumping up against health care reform. It's
17 bumping up against the health I.T. It's bumping up
18 against our data strategies. So it's, kind of,
19 bumping up against everything. But the thing that it
20 always begins with is really the measurement issue.
21 So this is the presentation.

22 I, kind of, want to lay out for you -- again,

1 going back to the 2001 IOM report that highlighted a
2 need for some real changes in the structure of health
3 care systems, to address the quality, costs, and the
4 application of health information technology. So
5 there is a -- which had a lot to do and, kind of,
6 supports the national quality strategy, which has
7 three overall aims, which is the better care, so to
8 improve the overall quality by making it more patient-
9 centered, reliable, accessible, and safe; focusing on
10 healthy peoples, healthy communities, so an improved
11 population health through proven interventions;
12 address behavioral, social, and environmental
13 determinants of health in addition to delivering
14 higher quality care; and then, affordable care, reduce
15 the costs of quality health care for individuals,
16 families, employers, and the government, so three,
17 kind of broad-reaching aims.

18 And then, six priorities within that, which
19 include safer care, includes person and family-
20 centered care that are fully engaged as partners in
21 the system, effective communication in the
22 coordination of care, effective prevention and

1 treatment practices that really reduce mortality,
2 starting with cardiovascular disease. That's just a,
3 kind of, a priority from the Secretary's level.
4 Working with communities to promote wise use of best
5 practices to enable healthy living; and then, making
6 quality care more affordable, developing and spreading
7 new care models.

8 Okay, all of this, as you see, there's a
9 tremendous shift in the quality strategy of moving
10 more toward a preventive approach, more of a
11 population prevention approach rather than focusing on
12 the disease, kind of, model and disease approach. So
13 in doing this, in a lot of discussions internally and
14 also with some of the players in the system, we really
15 feel that, to be able to be significant and have some
16 chance to push this issue of behavioral health into
17 the larger health care discussion, we've really
18 aligned ourselves with the national quality strategy in
19 terms of the three big aims. But we have a little bit
20 different structure in terms of our priorities.

21 First of all, we think that we need to reorder
22 the priorities according to where we need to go. So

1 part of this is to promote the most effective
2 prevention and treatment and recovery practice for
3 behavioral health disorders, assure that behavioral
4 health care is consumer and family-centered, encourage
5 effective coordination with behavioral health care
6 systems and between behavioral health care systems and
7 the primary care and social service systems, assist
8 communities in utilization of best practices to
9 support health living, and then, make behavioral
10 health care safer by reducing the harm cause, and
11 finally, foster affordable quality behavioral health
12 care for individuals, families, employers.

13 So there's a lot of repetition in what you're
14 seeing. But we've reordered some of the priorities
15 according to where we think SAMHSA needs to go. So
16 that's one of the questions today. Do we got the
17 right order? If we do, great. If we don't, send us
18 an e-mail. We'll work on that later. So these are
19 our steps.

20 And again, we're doing this very specifically,
21 because we're going to have to operate within the
22 broader quality strategy. We need to really align

1 ourselves as we do this. And part of the process is
2 setting out there where SAMHSA thinks the country
3 needs to go in terms of behavioral health care so that
4 this becomes part and parcel of overall health care,
5 not, oh, and by the way, there's behavioral health
6 care, that behavioral health care is part of health
7 care, is part of quality health, quality living.

8 So let me, kind of, move on and just give you a,
9 kind of, a framework for how we're thinking about
10 right now. We've, kind of, gotten this drafted.
11 We've gotten a lot of feedback, a lot of it very
12 positive, about the, kind of, general overall
13 strategy. But what we're going to do now is just
14 present a little bit about the goals, some of the
15 illustrative measures.

16 I want to be really clear. These are
17 illustrative. They're not the measures. They're just
18 here for putting a little fruit on the tree. The next
19 steps are going to be -- and I'll talk about this a
20 little bit more at the end. The next step is going to
21 be getting some -- starting to hang a few more
22 measures and doing some environmental scans -- see

1 what's out there.

2 We don't want to repeat what everybody else has
3 done. We want to get an environmental scan, pull the
4 measures, start hanging them on the coat hooks,
5 whatever. We're trying to come up with a good
6 metaphor. I like the coat hook measure. So we can
7 hang the right measures on, make sure that those are
8 the ones we want to start with, because what we start
9 with now and use, maybe, for the next three years are
10 not going to be where we're going to be in 5 or 10
11 years. But at least it's a start.

12 So if you think about this -- I'm just going to,
13 kind of, quickly run through. So thinking about three
14 different levels, what we actually impact, what are
15 SAMHSA-determined measures in terms of our grants and
16 our contracts. And then, kind of, at a structural
17 level, thinking about where the practitioner, where
18 the program is, and where the system is, not
19 necessarily that we directly influence, but things
20 that we have some indirect influence, but we start to
21 push out.

22 Say, okay, we're pushing that here. But it

1 should be also things that programs and systems should
2 be looking at as well as practitioners. And then, at
3 the population level -- and this is, clearly, where a
4 lot more work is being done at the HHS level where
5 they're trying to identify what are the key population
6 measures that they're going to set targets from.

7 So we have effective prevention treatment and
8 recovery practices. So we think of, for example, for
9 SAMHSA, percentage of clients in a grant or a contract
10 who are receiving services who report improved
11 functioning or improved living conditions, improved
12 social supports, maybe the number of programs
13 demonstrating sustainable models for improving quality
14 of service; at the system, use of recovery measures in
15 community report cards on outcomes; at the population
16 level, for example, percentage of youth 12 to 20
17 reporting use of alcohol in the past 30 days. That
18 one's directly related to our first strategic
19 initiative around prevention.

20 And the second one, assuring behavioral health
21 care, is consumer-friendly, consumer and family-
22 centered -- so structuring services in ways that meet

1 individual and family needs and make patients
2 centrally involved in the decision making about their
3 care. And what we're really trying to do is really
4 bring in that idea that this is a collaboration. I
5 just saw some faces. Okay, we'll work on that later.

6 But we're trying to make sure that what we have
7 at the end of the day is that we start measuring that
8 they're doing care differently, that consumers and
9 their families are really part of the whole structure
10 and that they're part of developing their own care
11 management plans and that we're following it. This,
12 to me, is, kind of, hearkening back to my days when I
13 started as a social worker with strengths-based
14 management.

15 So looking at, again, at the SAMHSA -- number of
16 states developing -- adopting shared decision making
17 models all the way up to population level of
18 percentage of individuals reporting that they received
19 information that helps them make informed decisions
20 about treatment options. So we're trying to be
21 consistent. There's going to be some hanging on in
22 different ways. So I'm going to run through these.

1 So I'm not really going to -- I don't really want to
2 run through all these, because then we get hung up in
3 measures.

4 But so there's a similar structure through each
5 of these where we're looking at -- and I don't even
6 know if we have the right structural model. So we're
7 still playing with that. So if you have some
8 feedback, we'll ask for that, too. But let me get
9 down to where I think I need to go.

10 So we're looking at, as we move through this,
11 there's a lot of stakeholders in this process.
12 There's clinicians and health care professionals.
13 There's provider organizations. There's government
14 organizations. There's employers. But at the center
15 of this whole thing are the individuals and the
16 families and the communities that they're the ones
17 that are going to make the changes down the line. So
18 they're at the center of that, now, in that process.

19 But thinking about this, so how are we doing
20 this? Well, we're working on next steps. And we're
21 going to be bringing in consumers. We're going to be
22 bringing in professionals. We're going to be bringing

1 in providers. But again, this whole thing starts with
2 measures. It ends with measures. So when you look at
3 it, we have a whole lot of stakeholders.

4 One of the things I want to talk about is we have
5 a lot of people that are playing nice together in ways
6 that I've never seen us play nice together before. So
7 if anything ACA has done, it's, kind of, created an
8 environment that makes it okay to share and to give
9 feedback.

10 So we have ONC, the Office of National
11 Coordinator, which is on health I.T. issues. We have
12 CMS. We have a partner here today. We have HRSA here
13 today. I don't know if anybody from ARC is here
14 today. We have, certainly, ASPE. And they've been
15 very big partners. And then, obviously, SAMHSA is
16 there, and so, kind of, the government partners.

17 But we also have other partnerships that are a
18 really important part of this. For example, the
19 National Quality Framework. That should be NQF.
20 Don't type late at night, people -- and then, the
21 NCQA, the National Center for Quality Assurance.
22 Again, these are organizations that are helping to

1 develop, helping to define, helping to set up
2 measures, structures for use in EHRs and for use in
3 other areas. So that's part of the big stakeholders.

4 But one of the things that -- again, that it's
5 important for you to be aware of is how hard this
6 agency and staff here are working with our colleagues
7 in these different agencies so we're not duplicating,
8 that we're trying to leverage each other's work, and
9 that -- so that, at the end of the day, hopefully,
10 what we have as behavioral health measures is what the
11 other agencies have as behavioral health measures so
12 that it also reduces the burdens on the state.

13 So similar to the National Quality strategy, the
14 national behavioral health care framework, the
15 priorities, goals, and illustrative measures really
16 are designed to begin a dialogue with the
17 stakeholders, which began in June. And at the end
18 point, we're going to create some specific
19 quantifiable goals and measures, that, with our
20 partners at HHS, we're going to promote some effective
21 measurement and minimize the burden of data
22 collection. We're going to align measures across our

1 programs, certainly, internally with our other
2 colleagues and other agencies. We're going to focus
3 on coordinating measurement with the private sector so
4 that, again, we're not repeating everybody else's
5 wheel, and then, develop plans over time to integrate
6 reporting on these quality measures with requirements
7 that go into meaningful use measures for electronic
8 health records.

9 I'm just going to, kind of, highlight a couple of
10 initial things. And I'm going to ask Dr. Frank to
11 maybe build on this a little bit. But some initial
12 thoughts that I'm going to -- I stole this directly
13 from him. But I'm going to let him play with it.

14 But to think about this -- again, it begins with
15 measurement. It ends with measurement. So where can
16 we use these tools? For example, where do we use it
17 in the measurement process? How do we think about
18 quality measures, process and outcome measures in the
19 technical assistance programs? How do we think about
20 it when we write contract specifications or the terms
21 and provisions of grants?

22 How do we think about it as an agency in terms of

1 assessment and dissemination of best practices? And
2 then, where do we fit with health homes or different
3 parts of the Affordable Care Act? How do we think
4 about building relationships with our partner
5 organizations around payment systems or incentive
6 systems?

7 I've been reading a lot about freakonomics
8 lately. And it's all about incentives. But I wonder
9 -- I think we have the incentives all wrong sometimes,
10 because we just keep thinking if we put money into it,
11 people will change. And I'm finding that out. I
12 should have learned that as a behavioral health
13 practitioner, that, especially with my nine-year-old,
14 money doesn't always work. Actually, a lot of things
15 don't work with a nine-year-old. Just be aware. So
16 anybody has any ideas about nine-year-olds, I'd like
17 to know.

18 [Laughter.]

19 MR. DELANY: So that's a very quick and rough --
20 and I apologize for running through it at speed, but I
21 want to make sure that my colleagues get a chance to
22 talk.

1 So some next steps, not only today, but for the
2 next couple of weeks. We'd ask if there are other
3 comments that are going to come in beyond today's
4 discussion, because I know a lot of our best comments
5 are, you know, at midnight. So feel free to send them
6 to the SAMHSA info and put quality in the e-mail. And
7 that sorts it out for us so we can take new comments.

8 And I think that -- if there's any real quick
9 clarification questions, let me do that. If not, I'm
10 going to turn it over to Dr. Frank. Any quick
11 clarifying questions?

12 Yes. There you go.

13 Any clarifying questions? Okay. I know I wasn't
14 that good. But I'm going to turn it over to Dr. Frank
15 now.

16 [Applause.]

17 DR. FRANK: Good afternoon. And I'm going to --
18 in addition to, sort of, talking a little bit about
19 the strategy that we're using to, sort of, pursue some
20 of the quality agenda, I'm going to use this for a
21 personal matter. Many of my friends here on the
22 council and at SAMHSA believe I'm incapable of

1 speaking publicly without PowerPoint.

2 [Laughter.]

3 DR. FRANK: So today I'm going to try to do that.

4 And so, we'll see how well that goes.

5 As Pam and Kana, sort of, noted early in the day,
6 they laid out an enormous number of tasks for you.

7 And, if nothing else, they made you acutely aware that
8 the resources for a growing agenda are not growing.

9 In fact, they're going the other direction, if
10 anything. And so, when those kind of things collide,
11 which is a growing, ambitious, aggressive agenda to do
12 important work and fewer resources to do it, it means
13 that you really have to think strategically. And you
14 really have to, sort of, focus your efforts.

15 And somebody today -- I think it was Leighton --
16 talked about not being able to afford a thousand
17 flowers blooming any more. And I think that's what
18 we're seeing here.

19 And so, what I'm really going to try to spend my
20 time with you on is talking about how we think
21 strategically, not only about measures, but about the
22 things that we do other than measures to promote

1 quality in behavioral health. As Pete's remarks
2 emphasized, the effort starts with measurement. And
3 he said it ends with measurement, too. Hopefully, it
4 ends with really good quality and measurement.

5 But the reality of the Affordable Care Act and
6 many of the other trends that are going on in the
7 health care system today is that we are developing,
8 not only a proliferation of measures in health care
9 broadly, but also a proliferation of new
10 responsibilities that we're putting on providers. And
11 Pam and a number of other folks from SAMHSA and HRSA
12 recently met with Don Berwick. And he impressed upon
13 us the amount of noise that he's hearing from the
14 field about the burden that's being placed on
15 providers for both measurement, accountability
16 reporting, and likewise.

17 And so, I think the practicality of the matter is
18 that we have to focus our efforts, not only in the way
19 we apply different strategies broadly to promote
20 quality, but we also have to be real smart and real
21 focused in how we choose our measures. And so, the
22 consequence of that is that in our efforts to vet

1 existing measures and put them into practice and in
2 our investments that we're going to be making in
3 developing new measures, we're going to have to be
4 very carefully to align the policy priorities of the
5 department, of SAMHSA, of the stakeholders with what
6 we choose to measure and what we choose to report on
7 and what we ask the provider community to put their
8 effort and resources into.

9 So let me give you some examples of how that
10 might start to work. So if you think about some of
11 the things you've heard about this morning, talking
12 about, sort of, what's at the top of the list of
13 SAMHSA's to-do list. You have integration of
14 behavioral health and general medical care. You have
15 prevention. You have coordination of care. And you
16 have implementation of very specific areas of the
17 Affordable Care Act like coverage expansion, like
18 exchanges.

19 So what you'd like to do is you'd like to focus
20 on the measures that will allow you to track progress
21 in those priority areas where you're making new
22 investments, say, like integration. And you'd also

1 like to use your measurement strategy to complement
2 what you're doing, for example, in the implementation
3 of the Affordable Care Act. So if you're going to put
4 a new benefit system into place and you're going to
5 put a new insurance market into place, you want to --
6 for example, if you're worried that perhaps behavioral
7 health might be shortchanged for some reason or that
8 certain types of markets may not work as well for
9 behavioral health as they work in other parts of
10 health care, then you'd want your quality measures to
11 be able to pick that up and to give you an early
12 warning system.

13 And so, it's those types of things that, I think,
14 we're starting to think through as we hang things on
15 the coat rack, put things on the Christmas tree,
16 things like that. Right, Hanukkah bush, yes.

17 So that's, sort of, the strategic part about
18 measurement selection. And it fits exactly with what
19 Pete was talking about. But measures are only one of
20 the tools in the toolkit.

21 And what I'd like to do is spend a few minutes
22 talking about what else is in the SAMHSA/HHS toolkit.

1 And it starts as an observation that Pete made in the
2 midst of his remarks, which is that SAMHSA has
3 enormous influence over behavioral health policy in
4 this country. Some of it is direct through its grant
5 programs, through its technical assistance, through
6 its contracting. But a lot of it is indirect in that
7 they serve as a partner with CMS on the development of
8 key policies like health homes.

9 They work with partners at HRSA in figuring out
10 how integration is going to work with federally-
11 qualified health centers. And so, they have multiple
12 opportunities, to, sort of, help steer the ship.

13 And so, how this influences exercise and the
14 strategy that underlies it is critically important.
15 So let me just start by giving you my, sort of, top 10
16 list -- or it's probably more like top six list -- of
17 the key areas where SAMHSA has important policy tools
18 and then make a few comments about each.

19 But before I do that, let me emphasize that what
20 this means and what you probably already gathered, is
21 that SAMHSA has to continue down this path that Pam
22 has, sort of, set out so nicely, which means reaching

1 out and energetically engaging just large parts, not
2 only of the government, but of the behavioral health
3 and health sectors generally. And that includes
4 communities. That includes states. That includes
5 other federal agencies like CMS and HRSA. But it also
6 includes quasi-governmental bodies like National
7 Quality Forum and NCQA and consumer organizations.
8 And so, all of that is a part of this. So let me give
9 you my list.

10 Pete mentioned the first one, which is contract
11 specifications, how we write contracts. And this is,
12 sort of, what Rick was alluding to a little bit this
13 morning, is really important to, sort of, making
14 policy, that how you write contracts, how you think
15 about them, what you decide to contract for, and how
16 you decide to do it can be very important.

17 Second is the terms and provisions contained in
18 grants, block grants being one, but discretionary
19 grants being a second group -- can also steer the ship
20 and set expectation for what we look for in quality.
21 Organizational design -- I mentioned that SAMHSA is
22 serving as a key partner with CMS in the design of

1 health homes. And so, that's a place where that kind
2 of influence can be exercised.

3 Payment systems -- for example, there are new
4 payment systems being proposed in connection to
5 bundled goods, which were mentioned earlier, health
6 homes, accountable care organizations. All of them
7 have important payment systems. All of them will,
8 either directly or indirectly, affect behavioral
9 health. And there are opportunities there, because
10 SAMHSA is at the table, as Pam said this morning, in
11 every one of those conversations.

12 Two others are the design and the execution of
13 technical assistance programs, and finally, the
14 assessment and the dissemination of best practices.
15 First, identifying what the best practices are, how
16 they're evolving, and then, helping people figure out
17 where to go to find them, how to get the expertise to
18 implement them.

19 Okay, let me say a few things about each of the
20 ones that I just mentioned. Now, grants and contracts
21 -- SAMHSA distributes a large number of them. And
22 Rick, sort of, alluded to them this morning. And the

1 way the performance indicators that you asked for, the
2 incentives that you create for service delivery
3 organizations can be powerful tools in influencing
4 quality and service delivery in this country. It's
5 very much in the spirit of the Obama administration to
6 use contracts, to use performance incentives to start
7 to move the productivity of government. And I think
8 that that's one thing that, sort of, flows directly
9 from that type of policy into this area.

10 Organizational design -- as I said, health homes
11 are an example. Accountable care organizations are a
12 second kind of thing. New integration efforts are
13 all, sort of, opportunities where we can take evidence
14 about what works, what we've learned about structure
15 in the behavioral health area, and make contributions
16 to, sort of, creation of structural measures.

17 Payment systems -- there are just a lot of
18 opportunities: gain-sharing systems, pay-for-
19 performance, bundled payment systems. All of these
20 are powerful tools for changing the behavior of the
21 provider system. And each of them has the potential
22 to be very influential in how behavioral health care

1 is delivered.

2 Technical assistance -- you've heard about a few
3 of them today. I think the importance here is it's
4 another opportunity to bring evidence, to bring best
5 practices to the field, and to actually look at the
6 way we do it in an evidence-based way. And so, I
7 think if we're strategic in terms of aligning our
8 measures, our incentives, and our best practice
9 support systems, this can be a very powerful tool.

10 And then, finally, just identification of best
11 practices -- you know, SAMHSA has made a new
12 commitment to evaluation. It has a draft guidance
13 that's being developed. And I think, again, it's
14 aligned well with the Obama administration's efforts
15 to bring evidence-based budgeting to the fore. And
16 again, this is a place where this can all be aligned.

17 Best practices can be identified, evaluated, and
18 promoted through each of these mechanisms.

19 So I will stop there and let my colleague from
20 CMS take over.

21 [Applause.]

22 MS. POWEL: Oh, sorry about that. Hi. I'm

1 Cheryl Powel. I'm the Deputy Director of a new office
2 that's called the Medicare and Medicaid Coordination
3 Office within CMS. And I'm going to talk a little bit
4 about our office and some of the work that we're
5 doing, because I think it echoes a lot of the
6 priorities that we've heard through the first two
7 speakers in this particular panel and also illustrates
8 how closely we're working with SAMHSA and the work
9 that we're doing with them.

10 So I do want to highlight that CMS is also
11 undertaking an effort to streamline, I think, or think
12 about parsimony when it comes to quality, think about
13 being very strategic. There's always the temptation
14 to measure, to measure because we can measure
15 something. But thinking about how to measure across
16 programs, across initiatives, within the context of
17 Medicare and Medicaid and various other CMS programs,
18 because you are talking about the same providers, the
19 same individuals and working across other agencies
20 like SAMHSA and ARC and others to make sure that we
21 are doing it very thoughtfully and strategically as we
22 move forward.

1 So our office, as I said, it's the
2 Medicare/Medicaid Coordination Office, otherwise known
3 as the duals office. And we focus specifically on --
4 we have the luxury and the responsibility of focusing
5 specifically on people who are dual-eligibles, those
6 individuals of both Medicare and Medicaid. There are
7 about 9.2 million dual-eligibles. And they are much
8 more likely to have mental health, mental illness,
9 behavioral health issues, multiple chronic conditions,
10 and limitations of daily -- in activities of daily
11 living.

12 And few are currently served in coordinated care
13 models. And few are in integrated care models. And
14 this population is disproportionately -- accounts for
15 disproportionate amounts of spending in both Medicare
16 and Medicaid.

17 In 2006, for Medicare, it's about 21 percent of
18 the population that accounted for about 36 percent of
19 expenditures. And in Medicaid in 2007, it was about -
20 - the dual-eligible population made up about 15
21 percent of the population with 39 percent of the
22 spending. So it's very much -- the dual-eligible

1 population that are in the Medicare and Medicaid
2 enrollees are disproportionately more expensive and
3 also continue -- use many services, have many multiple
4 chronic conditions, and a much higher level of
5 behavioral health and mental health issues.

6 So our office was created by the Affordable Care
7 Act. It's the Federal Coordinated Health Care Office.

8 It's not the easiest title. So we refer to ourselves
9 as the Medicare/Medicaid Coordination Office.

10 And the purpose of our office -- it's in the
11 statute, but it's also what we live and breathe every
12 day. When we come in, this is what we hope to
13 accomplish and what we really strive for. This is
14 really in our hearts.

15 We are here to improve quality, reduce the costs,
16 and improve the beneficiary experience for those dual-
17 eligibles. And doing that -- it's to ensure that
18 individuals have the full access to the services which
19 they're entitled to across Medicare and Medicaid, to
20 improve the coordination between the federal
21 government and the states, to develop innovative care,
22 coordination, and integration models, and eliminate

1 the coverage and financial misalignments that may lead
2 to poor quality and cost-shifting.

3 But essentially, we're here to focus on the
4 beneficiary and on the person and on the person-
5 centered delivery system, to improve dual-eligible
6 satisfaction with program awareness, health,
7 functional status, and well-being, and assure that the
8 dual-eligibles are receiving high-quality, person-
9 centered acute behavioral long-term services care and
10 supports. So we're very much focused, very much in
11 line with many of the priorities at SAMHSA and the
12 quality strategy.

13 So I want to highlight a couple of the, sort of,
14 beyond the measures piece, because we are embarking on
15 developing a quality strategy related to dual-
16 eligibles, focused on the dual-eligible population,
17 but also to highlight a few of the other things that
18 we're doing. All of these working in concert together
19 to improve quality for dual-eligibles, to improve
20 their experience so that when somebody is accessing
21 care, they don't have to think about am I accessing a
22 Medicare benefit, am I accessing Medicaid, how do the

1 rules work together across those two. But I have care
2 needs, and I can receive those needs in a way that is
3 easy to navigate.

4 One of the areas we worked on is program
5 alignment across Medicare and Medicaid, literally,
6 cataloguing all of the areas within the two programs
7 that bump up against each other. They were created
8 separately. They work very, very well separately.
9 When you talk about the 9 million individuals who have
10 to access both, there are areas where they don't
11 dovetail nicely at all times.

12 So we have catalogued all of those. So you can
13 find on our Web site a list of them. We would love
14 your input. We had a federal register notice
15 requesting input on those. We will then -- so not
16 just creating a list, but taking that list and going
17 forward with prioritizing how we should move through.

18 We'd love to do them all immediately. We have to
19 prioritize a little bit. We have 20 people in our
20 office. We're very mighty, but we do need to think
21 about prioritizing that.

22 And so, I recommend, if you'd like, to please --

1 it's on the CMS Web site. It's under dual-eligible --
2 to look at that. And let us know. Look at the issues
3 related to mental health services, behavioral health
4 services. What can we do? What should we tackle?

5 And don't be bound -- don't limit yourselves to
6 just regulatory and sub-regulatory guidance. But,
7 please -- we will report annually to Congress with
8 suggestions for changes in the statute to make it --
9 that these programs work better for dual-eligibles.
10 So that's one area we're working on.

11 Another area is in our data and analytics. We
12 have, for the first time, integrated Medicare and
13 Medicaid data at CMS for dual-eligibles. It's
14 happened this year. And where we have an actual area
15 in the database where you can look at the Medicare and
16 Medicaid individual across.

17 So you can see the whole person. And looking,
18 again, at the person-centered -- what are the needs of
19 that individual. How do we provide better care for
20 that individual?

21 We've also made available to states timely data
22 for Medicare A, B, and D so that states now, for their

1 dual-eligibles, it goes to the state Medicaid agency
2 for care coordination purposes so that the states can
3 really look at what are the needs, what are, maybe,
4 the unmet needs that -- because before, I couldn't see
5 what was going on on the Medicare side. Now I can
6 see.

7 I see somebody is taking a medication. I didn't
8 know they were taking that medication. How can I
9 better meet the needs of that individual? How does
10 that fit in potentially with other chronic conditions
11 that they have and better manage their care? So this
12 year, we announced the availability of the timely data
13 for those.

14 And we're working on the analytics as well. We
15 know there's -- because previously a lot of the
16 analytics done related are on duals and what we know
17 about dual-eligibles is based on data from one
18 program, not data that's integrated across the both
19 programs at a person level. And we're very excited
20 about finding out more about dual-eligibles.

21 When you integrate that data, how do you look at
22 it? How do we measure quality? What are things that

1 we can do across Medicare and Medicaid to more
2 meaningfully measure quality for the dual-eligibles?
3 And to look at areas to help inform policy there as
4 well. So we're very excited about that.

5 And then, we're also working in partnership with
6 the Innovation Center to test new delivery system
7 models. We have several ways that we're doing this.
8 We have 15 states that we're working with that
9 received design contracts or a competitive process to
10 develop and test new models of care that integrate
11 across behavioral health, mental health, the acute,
12 primary acute, the more Medicare-focused side,
13 Medicaid side. So we have 15 states that are
14 designing those across the spectrum into long-term
15 services and supports and into additional community-
16 based services.

17 And how do we then think about measuring that?
18 We believe we know that coordinated care, integrated
19 care is important, that it provides better outcomes
20 for people, and that it will improve the lives of
21 dual-eligible individuals, but thinking about what are
22 the right measures, what are the right measures for

1 this to indicate the quality and to assure quality for
2 individuals in those.

3 We also have a financial alignment initiative,
4 which is an opportunity for states to better align
5 across both Medicare and Medicaid the coverage,
6 financing, and the incentives across the two programs
7 for dual-eligibles. These will be -- will focus on
8 quality. We want to assure that these, not only --
9 that they primarily improve quality, but also reduce
10 costs, if you can integrate them across both Medicare
11 and Medicaid for dual-eligibles.

12 So those are some of the initiatives that we
13 have. There are other things that we have underway.
14 But we're also working collaboratively on focusing --
15 I'm going to go back to the statutory charge that we
16 had to focus on quality and quality improvement for
17 dual-eligibles.

18 And we've begun -- we've embarked upon creating a
19 framework. And the first step in that was to realize
20 we've undertaken a bit of an inventory on what exists
21 specific to dual-eligible individuals. There is very
22 little that exists currently. And then, we thought

1 about how do we move forward with, then, measuring and
2 demonstrating that there is quality improvement for
3 dual-eligibles. But the programs that they're in in
4 Medicare and Medicaid, that the integrated programs,
5 these coordinated care programs, are improving quality
6 for dual-eligibles.

7 And so, we began an inventory of all measures
8 that are out there. There are a lot of measures that
9 impact this population -- and trying to think
10 strategically about how -- what are we trying to
11 measure and how does everything fit within the -- how
12 do we integrate and make sure that what we're doing
13 fits within the overall framework of CMS's work on
14 Medicare, Medicaid, other initiatives there, as well
15 as work that other agencies are doing and the
16 framework within SAMHSA and other agencies.

17 So we are also -- we are working with NQF and
18 with NCQA as we think about how do we best measure for
19 dual-eligibles. What are their specific needs?

20 We've had tremendous support, and we've been
21 working very collaboratively with SAMHSA on this,
22 because one of the areas, going back to one of the key

1 areas of the impact of behavioral health and mental
2 health on dual-eligible individuals and assuring
3 within particular sub-groups of individuals with
4 severe mental illness, that we're able to focus, not
5 only on those sub-groups, but also those with other
6 chronic conditions and that may have chronic
7 conditions in conjunction with mental or behavioral
8 health issues, but also those who have behavioral
9 health concerns.

10 So we're trying to focus on those and assure that
11 our quality measures are sub-set and created
12 strategically to fit within the larger framework. And
13 that's been a charge, as well as to fit within the
14 framework of the other CMS efforts and other HHS
15 efforts underway.

16 So we are supportive, tremendously supportive, of
17 the framework, the quality framework within SAMHSA,
18 working to assure that we are incorporating a lot of
19 these elements into the new models that we're
20 creating, as well as thinking about the quality
21 framework that we have moving forward and to assure
22 that they integrate and dovetail well. And now, I

1 think we're at questions.

2 [Applause.]

3 MS. HYDE: Thank you, Cheryl, Richard, and Pete.

4 Before we open it up for comment, let me just say
5 two or three things. One is what's up here is not
6 correct. Sorry about that. There should be no WWW
7 before it. So forget the WWW. And everything else is
8 right. If you want to send us comments about the
9 framework by September 1st, it's
10 samhsainfo@samhsa.hhs.gov. So please ignore the WWW.
11 We're not talking about World Wide Web today.

12 The second thing I wanted to say is just a
13 reminder that part of what we want from you today is
14 do we have the framework. And, you know, to make it
15 the most simplistic, we have six priorities:
16 effective care, consumer and family-centered care,
17 coordinated and integrated care. And that's -- you
18 know, we've been talking about coordinated and
19 integrated care between primary and behavioral health,
20 behavioral health and primary. But now we've also
21 introduced the concept of Medicaid and Medicare
22 integration. So is that one of them? Community

1 health or community healthy living is a priority.
2 Safe care and affordable care -- I mean, those are six
3 priorities that we have picked to frame, you know,
4 sort of, the way we're thinking about quality.

5 Then, if you'll recall -- I want to just show it
6 to you again -- this example of how we're thinking
7 about measures. Because, I think, part of what you
8 heard in all of these presentations was the issue of
9 how we measure quality is a big deal. And everybody
10 and their brother is trying to do it.

11 What SAMHSA is trying to do is not recreate that
12 wheel. We don't want to create a measure where there
13 already is one. On the other hand, if there is a cell
14 where there's not a measure, we do want to help create
15 the right one. We want to work with our colleagues at
16 CMS and others to make sure, for example -- it's just
17 an example.

18 If we're going to measure readmission rates after
19 hospital discharge for Medicaid and Medicare
20 populations, then that same measure should give --
21 should be appropriate for other people with behavioral
22 health needs who are leaving hospitals and are hitting

1 readmission rates. So just things like that. Can we
2 get the measures the same?

3 And then, thirdly, there is the issue, which is
4 where our partners come in, of an endorsed measure
5 versus those measures that aren't endorsed. And
6 that's where NQF comes in. So we're working a lot
7 with them.

8 And then, obviously, we put up here the idea of a
9 SAMHSA measure, because we have things in our programs
10 that we have to measure, either because Congress
11 suggested it, or because it's the nature of the
12 program. But so does CMS, and so does HRSA, and so do
13 other payers have specific measures that they need.

14 And more and more, we'd like the quality measures
15 that are, sort of, general quality measures to line up
16 with what we're asking for in the programs that the
17 federal government pays for, which is why Richard's
18 comments were so important, which is what are the
19 tools that SAMHSA has to start getting a little bit
20 more consistency and a little bit more focused in our
21 drive toward what is what we think of as quality
22 systems.

1 And we, obviously, have understood, as we've gone
2 through this process, that sometimes it's at a
3 practitioner level. What does the psychiatrist, the
4 social worker, the counselor do, the peer person do?
5 What does the program do? And what does the system
6 do?

7 So those are different, sort of, levels, we're
8 trying to think about. And then, in the end, I think
9 what we all want is the population showing less of the
10 things we don't like, like suicide or suicide behavior
11 or binge drinking or mental health disorders in
12 children or whatever it is that we're trying to
13 prevent and reduce.

14 So hopefully, just to, sort of, lay that out. We
15 want your input about all of these. Do we have the
16 goals right? Do we have the collaborations right? Do
17 we have the tools right? Are there some other things
18 you would suggest to us as we think about the Hanukkah
19 coat rack, I guess, is where we're going with this;
20 right?

21 [Laughter.]

22 MS. HYDE: All right. So with that, let me open

1 up. We do have -- continue to have about 175 people
2 on the phone or Web listening in. So it's great.
3 There continues to be a lot of interest in your
4 discussions.

5 So who's interested in making a comment?

6 I see Michael.

7 And then, Bill.

8 MR. BOTTICELLI: So this, for me, is, kind of,
9 the link to, kind of, everything of which everything,
10 kind of, hangs together. I look at this, and I say to
11 myself, "Okay, so who's going to measure it"? Right?

12 So who is the entity that's responsible for all of
13 this? And I can tell you, you know, my pie in the sky
14 dream is that I have this integrated multi-payer,
15 multi-system database that I can track those kinds of
16 outcomes. So it's not necessarily the framework, but
17 who is responsible.

18 So part of what, you know, we've been trying to
19 work with is how do we get Medicaid to share data with
20 the state agency on a client-centered basis, because
21 right now, neither one of us can see what services
22 people are accessing. So if we want to look at the

1 decrease in emergency department as a result of a
2 client's episode of care, sometimes Medicaid doesn't
3 even know that.

4 So the framework -- so it's a little bit, kind
5 of, afield in terms of the questions that you were
6 asking, Pam.

7 But part of this is what are the opportunities
8 with our federal partners to create these state-level
9 databases to allow us -- and particularly on the
10 private side, because we get no information from the
11 private side in terms of this information now. So
12 what are the opportunities to create these, kind of,
13 client-centered, all-payer databases at the state
14 level to allow us -- because we're only seeing one
15 piece of the pie.

16 So it's a little bit afield from what you're
17 asking, Pam. But it's just important to me.

18 MS. HYDE: It's a great question, although I was
19 about to twitch. I thought you were about to say a
20 single-payer system.

21 [Laughter.]

22 MS. HYDE: Any of you have any --

1 MR. BOTTICELLI: Another time.

2 MS. HYDE: Another time.

3 Anybody have any -- on the panel, any comments
4 about how we move toward a single set of measures
5 across all payers?

6 MR. DELANY: Well, I think there's a different --
7 he's asking a different question. Maybe let me do --
8 single measure is a different issue than a single
9 system, because you're talking about a single system
10 where it's across the state and it connects the --
11 love to work with you on a work group.

12 [Laughter.]

13 MR. DELANY: But, I mean, there's a difference
14 between setting a measure, which I think we're all
15 trying to get to a handful of measures that we all
16 like and that really help us move the field forward.
17 And I think that's part of the key is the measures
18 have to really be moving the field forward, not just
19 what we're already doing, but where we need to be.

20 But what you're asking about, I think, is not an
21 abstract. It's a real practical. How do we, kind of,
22 start pulling these things together? Off the top of

1 my head, you know, I think this is just something we
2 have to be thinking through. And part of it is,
3 though, it's coming together, I think. With my
4 colleague, Wes, we're working a lot with ONC and
5 thinking about how do we get the measures there.

6 And so, as everybody starts to line up, I think
7 that creates the possibility of that. That's the
8 reality. It's the possibility exists if we can all
9 get together on the same set of measures and we're
10 measuring the same thing and then, these other
11 systems.

12 The private group's always an interesting thing,
13 because they're willing to share for a bit of money
14 and maybe not the information you really need. But I
15 think we're moving towards that, Michael. I really
16 do.

17 DR. FRANK: Just a couple reactions. First is,
18 under the stimulus package, CMS is experimenting with
19 an all-payer data set. And so, I think we're starting
20 to learn about that. So that's one piece.

21 The second thing goes to, I think, something that
22 was implicit in your question, which is that as the

1 Affordable Care Act rolls out, some of the boundaries
2 that you're pointing to are going to start to blur.
3 Right? And so, the exchanges have to work with the
4 Medicaid extension populations, which have to work
5 with the Medicaid state plan things, which have to,
6 sort of, tie into the Office of the Dual -- et cetera.

7 And so, that's going to force a lot of
8 integration of data, and, therefore, measurement. And
9 then, I think Pete was exactly right that, sort of,
10 the, sort of, third prong of that pressure is coming
11 from the meaningful use rules around HIT.

12 MS. POWEL: I would just like to echo -- I think
13 the opportunity is there now. But, sort of, it's
14 building. It's bubbling up. There are areas where
15 that data sharing is beginning through the MAPCP
16 program where there is all-payer within certain
17 states, where they come together. And there's data
18 sharing there.

19 The ACOs require data sharing. Our work in
20 getting the Medicare data for duals to states so that
21 states can integrate that -- these are all pieces, I
22 think, moving forward. And opportunities are there.

1 And I think it does involve the coming together and
2 thinking about how to do this and moving forward. But
3 I do think, especially with all of the things that
4 Richard was talking about: the Affordable Care Act,
5 the coming of 2014, the ACOs, the need for the
6 exchange of data and the integration of data to
7 provide better care and care coordination is beginning
8 to rise, that feeling for that. So I think there's a
9 tremendous opportunity, and it's figuring out how we
10 come together and do that.

11 MS. HYDE: Just one final comment about that,
12 having come from a state where we tried to have
13 multiple agencies put our money into one entity. And
14 that one entity held the data set. So we came closer
15 to having a single data set for all funding streams:
16 Medicaid, Children, Youth, and Families, Child
17 Welfare, behavioral health, block grant. All of those
18 data were in the same contractor's data set.

19 There's a lot of other challenges to that. But I
20 think one of the things and the reasons that that
21 experience was critical is because, as the Affordable
22 Care Act moves us more toward Medicaid and Medicare

1 being an exchanges and those things together, we got
2 this danger of fairly important set of dollars being
3 left out of that data set. So, actually, John and
4 folks at CMS -- I think, it's a different part of CMS
5 -- have been talking about the possibility of a state
6 Medicaid director letter or something about talking
7 about moving -- thinking about data sharing or data
8 issues at the state level. So another way in which
9 we're trying to connect some dots.

10 Okay. I've got Bill, and then, Terry, and then,
11 Bob Friedman.

12 MR. McFARLANE: Hi. It's wonderful to see this
13 new center unfolding in this way. I hesitate to say
14 this, because I said it the last time we met. I'm
15 being a nudge. But there's no place in this country
16 where you can go and find out the incidents rate of
17 the key disorders -- schizophrenia, bipolar disorder,
18 et cetera, that we work with. It'd be a little like
19 the National Cancer Institute not knowing what the
20 rate of prostate cancer was.

21 And I think we've got an opportunity here to
22 correct that. And you simply cannot really embark on

1 prevention initiatives of a major scope without
2 knowing what the incidents rate was and then what it
3 is now. HRQ keeps track of hospitalization for all
4 but, I think, two states. And I have actually had the
5 experience of trying to get that data and then turn it
6 into incident rates. And it's really a piece of work
7 that, I think, this organization could do.

8 I raised it last time because of its theoretical
9 importance. I mean, we ought to know what our
10 incidence rates are. However, in Maine, that rate has
11 gone up by two and-a-half times for a rather broad
12 definition of psychosis in the last -- from about 1998
13 to 2007.

14 And this month, in the Archives of General
15 Psychiatry, is a report on incidence rates for the
16 country and reports a near 80 percent increase in
17 psychiatric hospitalization for youth and adolescents,
18 children and adolescents. While comparably, the
19 hospitalization rate for the elderly has been going
20 down quite substantially. And the level for adults is
21 level.

22 So it's conceivable, looking at this data -- and

1 there's some comparable data from Europe -- that
2 there's a, kind of, epidemic going on of these core
3 disorders amongst children and adolescents which we
4 may not be aware of. And I think that would be a real
5 problem if it were happening. It's particularly a
6 problem in the context we're embarking on more
7 ambitious attempts to do prevention.

8 So it's a suggestion. I'm going to keep making
9 it until somebody does it. I think it's actually
10 relatively easy to do, given working with AHRQ for
11 this, because they have that -- they have a
12 hospitalization database.

13 MR. DELANY: You know what? I'd like to have a
14 longer conversation with you bout this. And I really
15 understand a little bit better where you're talking
16 about and maybe discuss the idea. I mean, we're
17 building the analytic capacity within the agency now.

18 And we might be able to address some of this.

19 But I need to understand a little bit better
20 where you're going, because it's not a question of
21 just collecting more data, because there's just some
22 limitations, literally, to collecting certain kinds of

1 data. But if we can maybe talk about this and
2 collaborate a little bit?

3 MR. McFARLANE: Sure. Be glad to. By the way,
4 I'm not an epidemiologist or a statistician. I'm
5 trying to use this data myself in our own research to
6 try and document changes in incidences within areas in
7 which we are actually intervening to alter these
8 rates. And so, we've had a little bit of experience
9 in, sort of, gathering the data.

10 And it's really a state-by-state -- you know, now
11 you've seen Illinois. You've seen Illinois. It
12 doesn't help at all when you go to Washington, et
13 cetera. You know that story.

14 It's just that AHRQ collects all this state data
15 for hospitalizations generally. And from that data,
16 it may be possible -- I know it is, in some states --
17 to derive incidents rates, because, you know,
18 obviously, hospitalization is prevalent. But
19 incidences -- you've got to figure out when's the
20 first time somebody actually had a hospitalization.

21 MR. DELANY: I think it's worth a longer
22 discussion.

1 MS. HYDE: Okay, thanks, Bill.

2 There may be data that we also have or that the
3 federal government has that we haven't also made
4 available yet, either. So that's worth conversation
5 as well.

6 Terry is next. I have Terry, Bob, Flo, and Dee.

7 MR. CROSS: Yeah, I just wanted to comment on a
8 couple things. The timing of this work is just really
9 critical, I think, with regard to SAMHSA's influence
10 as health care reform unfolds. And I'm reminded of
11 the -- an adage that I learned early in my career that
12 measure what you value, and people will value what you
13 measure and that whole notion about measuring some of
14 these things that we want people to value in terms of
15 what's important in the behavioral health field.

16 And I would point to some existing measures that
17 SAMHSA already has, particularly -- the one I know
18 most about is the evaluation of the children's mental
19 health initiative, the systems of care measures. And
20 there are really well-proven measures there for
21 cultural competence, for systemness, for consumer
22 involvement. And so, it would be important to look at

1 what's already producing really good information
2 that's proven and, you know out of 10 years of usage.

3 The other part that I would encourage you to
4 think about is that there are known social conditions
5 that contribute to either negative or positive
6 outcomes, whether it is -- for example, the ACEs, the
7 Adverse Childhood Experiences and its relationship to
8 negative outcomes in adult or the Search Institute's
9 40 Assets Model of the positive things that are
10 associated with positive outcomes.

11 That those kinds of -- what you're trying to do
12 in the situation where you're using those as measures
13 is you're looking for proximal outcomes rather than
14 distal outcomes. And it's much easier to see and show
15 that you are creating the conditions that are
16 associated with positive outcomes, because, frankly, I
17 don't think you've got enough time to prove that
18 you've created the final outcome.

19 MS. HYDE: Thanks. Well, in the theory of
20 creating something for seven generations from now,
21 hopefully, whatever we're creating today will
22 eventually be able to get us there, Terry, so we can

1 see over time whether we're making a difference. I
2 think that's the goal, a lofty one, no doubt. But
3 more about that would be good.

4 So, Bob, you're next. Bob, Flo, Dee, and Pat.

5 MR. FRIEDMAN: I think that this is an
6 outstanding beginning to the framework. And I think
7 that the priorities -- you know, one could quibble a
8 little bit here or there. But I think the priorities
9 are very sound, though there was one small thing.

10 I was wondering about -- and then, a larger point
11 I wanted to make. One is states aren't really
12 referred to -- they may be a part of government, but I
13 don't know, as a part of the theory of change behind
14 it, whether it's to work through states. Sometimes
15 SAMHSA has worked through states. Sometimes SAMHSA
16 has bypassed states. And I think that's just
17 something to clarify.

18 I also liked very much, Richard, your policy
19 tools. And I know we talked a little bit earlier
20 about the evolution of a theory of change for SAMHSA.

21 And I see that being a strong foundation for a theory
22 of change.

1 I think one of the roles that SAMHSA plays --
2 it's a very important role, and I really appreciate it
3 -- is the role in knowledge development. It seems
4 apparent and when it comes to complex systems and
5 policy issues, the knowledge is going to have to be
6 developed by SAMHSA. That's not NIMH's strength or
7 interest or any of the NIH entities. And we're not
8 going to get the help there. So I really like and
9 value SAMHSA's role in knowledge development.

10 And, in fact, I think there's so much for us to
11 learn about innovative efforts from the field that
12 that knowledge development has to -- you know, your
13 last one, which I might move to number one. And I
14 don't know whether, Richard, you presented them in any
15 particular order -- which was really to identify -- to
16 assess what's going on out there and identify best
17 practices so they could be disseminated.

18 It just seems to me that as we move ahead in all
19 these problem areas and all these priority areas, one
20 of the critical first steps is really to do exactly
21 what that policy tool says. Let's take a look at
22 what's going on that we could learn from and benefit

1 from. And whether it's ready for dissemination or
2 whether we have to strengthen it in some way or follow
3 it for a little longer before it's ready for
4 dissemination, because I think that's a critical one.

5 I also think that SAMHSA has provided, through
6 the years, incredibly helpful technical assistance.
7 But I would like to see us learn more about how to do
8 it as effectively as possible. I really think we need
9 to study, again, as I've said this before, how to do
10 these tools effectively. Technical assistance comes
11 in all shapes and forms. It's person to person. It's
12 written products. It's Webinars. It's conferences.

13 For what purpose does particular technical
14 assistance work -- what kind of technical assistance
15 work best? So I really would encourage further
16 development of the thinking around the policy tools
17 and the knowledge development and knowledge
18 dissemination roles that I think SAMHSA has already
19 done a good job, but could do even a stronger job at.

20 MS. HYDE: Thanks. That's good input. Thank
21 you, Bob.

22 Flo?

1 MS. STEIN: I just wanted to comment on an
2 opportunity that we're benefiting from, but we didn't
3 think it up, over in our division. But in the
4 Medicaid side of North Carolina, in the primary care
5 managed care system, we have a health informatics
6 system that CMS has helped fund. And all these funds
7 that have been coming through have been helping build
8 it. And in that informatic center, we just signed
9 data-sharing agreements with all our community mental
10 health centers and our hospitals. And we transferred
11 our first data just two weeks ago.

12 We were having a little trouble sending our data
13 over. We had a lot of attorneys' opinions about all
14 of it. But it all went over. And so, you can go in a
15 portal, a provider portal or a manager's portal, like,
16 for us, and you can see everything that has happened
17 on the Medicaid side with people: their
18 hospitalizations, their labs, their medications, their
19 primary care services, their behavioral health care
20 services.

21 And when you get all that together, you change
22 what you're going to measure, when you can see it all

1 at once. Some things are already answered by the data
2 in there that would have taken us years to figure out
3 how to measure. And other things, you really find out
4 you need to know.

5 So we're at the very beginning. But we're
6 really, really grateful. And we are benefiting
7 greatly from the work of our colleagues.

8 MS. HYDE: Great. Thank you.

9 Dee?

10 MS. ROTH: The microphone monster over here. Not
11 to make things more complicated or anything, but I was
12 interested in Bill's comment about dramatic increase
13 in hospitalization for youth. There is -- data
14 collection is very important. But there's data
15 collection, and then, there's data interpretation.
16 And as you move from the individual to the program,
17 particularly to the system level, that data
18 interpretation becomes much more critical.

19 You know, I would tend to ask, as a sociologist,
20 does that have to do with kids and what's happening
21 with them, or does it have to do with hospitals and
22 what's happening to them. So it's just something else

1 that we have to think of in terms of getting all this
2 data. Then, how are we really going to thoughtfully
3 try to interpret it and what it says?

4 MS. HYDE: I think you're highlighting the
5 difference between having data to manage by and the
6 issue of a measure that will tell you whether or not
7 something is a quality indicator or not. And I think
8 Bill was clear when he was raising the incidence
9 issue, that it's not the same thing. But you need the
10 incidence to know whether you're making a difference
11 at a population level. So that's a good point.

12 All right.

13 I have Pat next, and then, Jane. Wait a minute.
14 I've got another hand back there. And then, Julia.

15 All right, so, Pat? Yes, you. Sorry. There's
16 too many Pats. There's a couple of Pats in the room.

17 Sorry about that.

18 MS. WHITEFOOT: Okay, thank you. Yes, I can't --
19 could you go back to number one, please, on the
20 overhead? Thank you. Oh, you had it right there.

21 I was just looking at the illustrative measures
22 with regard to population level, percentage of youth

1 12 to 30 reporting use of alcohol in the past 30 days.

2 And then, another one, further on this document, you

3 know, addresses binge drinking. And just based on

4 some of the work that we've been doing with our SPIFF,

5 you know, we're looking at the protective factors and

6 the risk factors.

7 And I would like to just echo also at the

8 community that interpretation is going to be very,

9 very critical. And so, I am wondering what we are

10 doing in taking a look at -- because the SPIFFs are

11 using, you know, the protective factors and the risk

12 factors.

13 And so, I'm not sure how these are correlating

14 with that and the numbers of youth that we're talking

15 about regarding binge drinking in the past 30 days,

16 because, just in my experience, that's -- and where

17 I'm located -- and if we're talking about, you know,

18 communities of color, that isn't coming through clear

19 for me with regard to binge drinking. And so, what

20 we're finding is more, you know, family-oriented

21 approaches are going to be critical in the kind of

22 dialogue that we're having.

1 I'm just thinking about our county in the state
2 of Washington. I live in a county where we are at the
3 top of all, you know, poor health indicators, with the
4 exception of air quality. And I worry about, you
5 know, the fact that in our state, we're at the top of
6 every poor health indicator, meaning we really have to
7 take a look at this very holistically and very
8 broadly, and then, also, allow for community dialogue,
9 too, in interpreting what these factors are stating.

10 And so, I guess I'm wanting to see, as someone
11 said earlier, you know, a more dialogue with schools.

12 And so, when we start talking about youth, where are
13 we talking with schools? And I haven't seen that in
14 any of these documents with K-12 systems. I mean, we
15 see teenagers having young children in those ages.
16 And so, then we get into early childhood education as
17 well. It's very global.

18 MS. HYDE: So, Patricia, let me just make sure
19 that I'm getting your point. I think you were
20 raising, sort of, two points. One is, kind of,
21 building on what Dee said about the need to interpret
22 or think about how to interpret the data. But I also

1 was getting that whatever data we do for measures
2 needs to be parsed out by tribal members or Native
3 Americans versus some other sub-sets that may -- we
4 might be doing a really good job overall in binge
5 drinking in the nation, but not among tribal youth,
6 for example.

7 MS. WHITEFOOT: Yes. And I don't know that,
8 because I don't know, you know, what information is
9 used and what data is being used until we take a look
10 at the total picture.

11 MS. HYDE: Yeah.

12 MS. WHITEFOOT: You know, other than just my
13 community. And then, I'm just using my community.
14 We're predominantly Hispanic and Native.

15 MS. HYDE: Yeah.

16 MS. WHITEFOOT: And so, what does that say?

17 MS. HYDE: Yeah.

18 MS. WHITEFOOT: And then, we're having to
19 interpret in the community in saying, well, what ratio
20 are we talking about. What students are we talking
21 about? So currently, we're in the process of
22 disaggregating data, but also looking at the research

1 at the same time.

2 MS. HYDE: Great. Thank you.

3 Jane?

4 DR. McGRATH: Well, I just want to say I really
5 like the framework. And I think, you know, I'm sure
6 will need some more work. But essentially, it looks
7 like it's going to mesh really well with -- and it's
8 just great to see the level of integration between the
9 different systems as this gets constructed.

10 I'm going to throw a thought out there -- which,
11 you know, I work in quality improvement myself. And
12 I, sort of, understand it and appreciate it and like
13 it and think it's great. We do have a tendency, in
14 government and in life in general, to adopt whole-hog
15 the latest and greatest. And, you know, I think
16 quality is the latest and greatest, to a great extent.

17 But we had a conversation at lunch that I thought
18 was really interesting. Several of us around the
19 table were saying, you know, it was really interesting
20 today that one of the things we all shared a concern
21 about was the condition of young males in our society.

22 And if you look at some of the data that are out

1 there that aren't necessarily directly under the
2 purview of SAMHSA -- but just to throw out some
3 examples, obesity rates, rates of people graduating
4 from high school, rates of people going on to college,
5 those would all be higher for girls and young women
6 than for boys: obesity, higher for young men than for
7 young women; incarceration rates, higher for young men
8 than young women; sort of, alarming rates of autism,
9 higher for young men than young women. So a lot of --
10 you know, by a lot of measures, I think, some reasons
11 for us to start to be concerned about what's happening
12 with young men in our population.

13 And I just would want to point out that although
14 the quality framework informs us in a lot of ways,
15 it's a little bit -- it's sort of retrospective, in a
16 sense. It's these are the people that are already in
17 the system because of certain conditions. And it
18 doesn't inform us much about what's coming down the
19 road at us.

20 And so, I would just throw that out there as a
21 way to, kind of, think about are there also other
22 tools that we need to be able to assess the broader

1 environment beyond just the immediate quality
2 indicators for services that are being provided
3 through SAMHSA that inform us about how things are
4 evolving within the society that we live in.

5 MS. HYDE: Yeah, that's a good point, too, Jane.

6 I'm trying to think right now about the difference
7 between our prevention initiatives and what we're
8 trying to understand is going on in communities that
9 we need to have an impact on versus what, I think, we
10 started out here, which is how do we know that a
11 service delivery system is producing high-quality
12 results. So those are a little bit different. And
13 maybe we've confounded that a tad by throwing in the
14 population-based data elements. But so, this is
15 worthy of some comment.

16 Do any of you guys have any reaction to that
17 issue? Because I think we are beginning to mix apples
18 and oranges just a tad.

19 Yeah?

20 DR. FRANK: I just have to -- I mean, one is a,
21 sort of, I guess, a plea for understanding, which is
22 there's a law called the Affordable Care Act that

1 requires us to focus on quality. And so, you know, a
2 lot of this is dictated by the fact that we're, sort
3 of, executing what Congress asked us for. And it's
4 not a frivolous exercise. It's a really important
5 one.

6 The other thing is is that this administration
7 and Pam here at SAMHSA have pushed some really
8 important new policies: focus on integration, new
9 focus on prevention, coverage expansion. You know, if
10 we're going to serve the taxpayers and tell them that
11 we've done a good job or not, we need to, sort of,
12 figure out what's going on.

13 And to some extent, you know, I think we're
14 trying to be forward-looking, you know, even though
15 you can only cover -- you can only collect data on
16 what you've already done. You want to be forward-
17 looking, because you're trying to map a trajectory
18 that your policy is trying to take you on and to see
19 if you're on that right path so that you can tweak it
20 if you're, sort of, not where you think you ought to
21 be.

22 MS. HYDE: So, yeah, one more comment up here.

1 This is an interesting dialogue, because it does raise
2 an issue for how we're, sort of, framing this.

3 Yeah?

4 MR. DELANY: Well, I also want to think about
5 that this framework provides a framework, that at a
6 community level, there are different things happening
7 that aren't going to be measured necessarily at the
8 SAMHSA level or at the -- definitely not at the
9 population level, but at the community level. So it
10 provides a framework that actually can move you
11 forward, locally.

12 You know, for example, you brought up the idea
13 of, you know, young males who seem to be, in a lot of
14 areas -- I'm taking it you're taking it from your
15 experience where you are -- who seem to be pretty high
16 on all these little indicators. Well, I think what we
17 do is you take, and you say, okay, now, where are we
18 locally, because we don't have the resources to go
19 delving all the way down all the time. But locally,
20 how does this connect up with some of these big key
21 quality issues?

22 And I think that that's -- it's a tool for you to

1 be thinking about, oh, in contrast to what are all
2 these quality issues that we're trying to move the
3 whole country forward. So locally, there may be some
4 gaps that we're not going to cover. And that gives
5 you some thinking -- ways to think about your local
6 gaps. And it gives you some ways to think about,
7 okay, these are big things for the country, but for
8 us, here's where we're going to go.

9 I think, again, the term framework was very, very
10 specifically used, that it is a thing to start
11 hanging. But it doesn't also end with that framework.

12 There are different applications that you should be
13 thinking about from, kind of, a local perspective to
14 be thinking about where are some of the gaps, where
15 are some of the ways we want to fill, and, quite
16 frankly, where are the things that we just want to,
17 kind of, say that's really important for us, too.

18 So I think between the fact that we have programs
19 that we're pushing, but also that you have local
20 issues that you're, kind of, doing is to, kind of, put
21 the whole thing into your own framework as well.

22 DR. McGRATH: Can I respond to that, just

1 quickly?

2 MS. HYDE: Sure.

3 DR. McGRATH: I really understand and appreciate
4 the importance of quality improvement and the
5 importance of having a framework that works across
6 systems from both the level of the human being to the
7 population level. I don't think the things I was
8 talking about are local issues. They're national
9 issues.

10 If you look at educational attainment for young
11 men, for example, you know -- so these kinds of issues
12 that have a broader impact or a broad national -- or
13 are issues of national significance, but fall outside
14 of a quality framework for health services -- and I'm
15 just saying that I think we need to keep our minds
16 open to the fact that having a quality framework to
17 address the quality and safety and efficacy and all
18 those efficiencies of our health system are very
19 important.

20 And I appreciate that, and I think it's great. I
21 also think that we need to have another way of looking
22 at what's happening in population health across the

1 populations that we're discussing.

2 MS. HYDE: Yeah, I think you're making a good
3 point, Jane. And I hadn't really thought about it
4 that way. So thank you for that. And we'll, again,
5 take that under advisement. We may come back at you
6 to get you to give us some input about a different way
7 of thinking about this. So thank you.

8 Emmitt, you're next. And we've got Julia, Ben,
9 Rodney, and Arturo. And we're going to be pretty much
10 out of time at that point, unless somebody's burning,
11 because we do have to take a few minutes and do public
12 input. The public input is for you as well as for us.
13 It is for you to hear from the public. I don't know
14 if there's folks out there. And we didn't spend too
15 much time this time. But I do want to have a few
16 minutes for that.

17 So, Emmitt, Julia, Ben, Rodney, and Arturo.

18 MR. HAYES: Just quickly. One of the things that
19 I would love to hear more about is -- the integration,
20 of course, I think, is a great, great idea. But the
21 Secretary of Education and the discussions I've heard
22 so far about schools have pushed this into the

1 community level -- and I do wonder where interactions
2 might be with the Department of Education at the
3 Secretary level. So that's one aspect. And I really
4 would like to see representation here at some point in
5 time where we can have a broader discussion, because
6 that's where our children are.

7 And to the extent that -- I look at this first
8 slide and just hearing some of the other comments as
9 well, as I look across it and heard -- I think Pete
10 mentioned the Secretary wanted cardiopulmonary
11 disease, perhaps, listed in the priorities. And,
12 then, of course, I think that's probably related to
13 heart disease being the number one killer across the
14 country.

15 But the number one killer, I think, of teenage
16 and youth are driving. And there's about a third of
17 those, I think, that are also those accidents
18 resulting in the drinking and driving. And I'm just
19 wondering, within the framework as we look at it now -
20 - and I do see the under-age drinking, problem
21 drinking, binge drinking, perhaps drinking and driving
22 -- I'm not real sure and don't want to spread the bets

1 too far over the table. But I think that may be an
2 honorable or an important mention to have in this
3 conversation.

4 MS. HYDE: That's a good point. And it may go to
5 whether or not we're doing the right kind of screening
6 or early intervention for young people and their
7 drinking. So thanks. That's a good point.

8 Julia?

9 MS. DAVIS WHEELER: Yes, thank you, Pam.
10 Yesterday, when we were having our meeting, the SAMHSA
11 Tribal Technical Advisory Committee, we did look at
12 this paper. This one is marked up quite a bit, as you
13 can see. We did give our comments to Pam to let her
14 look those over.

15 But one of the things that I really need to say
16 is, you know, I do appreciate the work of the SAMHSA
17 with the national behavioral health quality framework.

18 But looking at the wording in here, it does state
19 that since different communities have different assets
20 and different needs, they will likely take different
21 paths to achieve the six priorities.

22 One of the concerns I have, Pam, is -- and I know

1 this document will probably change after September 1
2 when you receive all of your comments. But I would
3 recommend that there be a seven for the development of
4 strategy to determine the community assets. And that
5 goes back to the comments made earlier.

6 I heard a comment about the young men's data, but
7 also as a tribal leader, we have -- I have seen a lot
8 of young women having some startling data regarding
9 violence and things going on in their lives. And the
10 data that I looked at, the girls were having more of a
11 problem than the boys were. And that goes back to
12 bullying, et cetera, et cetera.

13 But I just -- I really appreciate this paperwork
14 that has been brought forward. And we do have our
15 comments that we will be submitting before September
16 1. Thank you.

17 MS. HYDE: Thanks a lot, Julia. And thanks to
18 the tribal group yesterday for taking a look at it.

19 So I've got Ben, Rodney, and Arturo.

20 MR. SPRINGGATE: I would note that, you know, in
21 addition to the framework, which I think is a great
22 start, SAMHSA and its --

1 MS. HYDE: Ben, can you talk right into the
2 microphone for us?

3 MR. SPRINGGATE: Yes. Sorry about that.

4 MS. HYDE: Thank you.

5 MR. SPRINGGATE: I would note that, in addition
6 to the framework, which I think is a great start,
7 SAMHSA and its partners will soon be concerned with
8 the implementation of the framework. And already,
9 we're seeing, sort of, building the airplane and
10 flying it over and -- over at CMS, for example,
11 concurrently. And we'll have to give some
12 consideration beyond, you know, the considerable
13 consideration that's already been given to the
14 information, the infrastructure, and the incentives
15 that'll be necessary to implement this to support the
16 change.

17 Already, as was noted in the beginning of the
18 discussion around measurement, there's some potential
19 perception of burden on the providers, simply in the
20 area of measurement, not even considering how to
21 practically make this a reality.

22 And so, it may be useful sooner rather than later

1 because of the little bit of a headstart, perhaps,
2 that some of the other areas of implementation of the
3 -- very little headstart -- of the ACA already have to
4 try to provide or give some assessment, objective
5 assessment to what's been learned already in
6 development of the ACO regs, for instance, the
7 implementation of patient-centered medical homes by
8 NCQA, and the thousand-plus clinics that they've
9 worked with around the country, health information
10 technology incentives and adoption, multi-payer
11 databases and the few places that those exist in pilot
12 form and really try to learn now, you know, where the
13 -- you know, what has helped those things stay on
14 track or not stay on track and begin to allow that to
15 help guide the course.

16 MS. HYDE: Yeah, thanks, Ben. I really want to
17 underscore a couple of things you said, because the
18 concept of building plane while you're flying it is
19 one we use a lot, because there's stuff going on, and
20 we have to just keep moving while stuff's moving
21 forward.

22 There's no question the pressure on CMS and other

1 parts of the health care delivery system that's
2 implementing the ACA is having to put out rules and
3 regs yesterday and the day before and the next day.
4 And they have measures in them. And we're just having
5 to move as fast as we can. And we're trying to react.
6 And CMS is reacting. And we're all trying to do it
7 together as fast as we can.

8 Part of the reason that we chose to try to do a
9 framework is exactly that reason. It's because things
10 were -- and ONC is doing a meaningful use measures and
11 stage one. They're already looking at stage two and
12 stage three. We've already commented. We have
13 multiple agencies within HHS who have already come up
14 with what those should be. And then, these measures
15 are just like, you know, proliferating.

16 And we already know -- everybody said today
17 there's already good measures out of systems of care
18 grant. There's measures out of this. NQF's going
19 through endorsement processes. I mean, it's just,
20 like, overwhelming.

21 So part of the reason we took on this trying to
22 come up with a framework is if we don't have some way

1 of organizing this thought, then everybody who's got a
2 task to do is creating a measure for their task as
3 opposed to looking like what's the overall frame.

4 And, as Richard said, "Come on, we've got a law to
5 implement here." And there's some policy priorities.

6 And we need to focus on those as best we can.

7 Now, again, I had hoped that this thing we're
8 kicking off here provides a framework for discussion
9 as well as development for years to come. But getting
10 it all organized is exactly the flying the plane while
11 we're trying to build it. So thank you for that
12 analogy, because that is exactly how we feel. And I
13 think you're making the point very well.

14 All right, Rodney and Arturo. And then, we're
15 going to turn to the public.

16 MR. BORDEAUX: Yeah, as we improve our
17 opportunities for success, reducing suicides, under-
18 age and problem drinking, the Tribal Advisory
19 Committee yesterday -- we're trying to gather some
20 data on the effectiveness of the states. You know, a
21 lot of the block grants go to the states. And we're
22 trying to get some data as to how much the states are

1 helping out the tribes, and particularly, South
2 Dakota.

3 In 2006, [inaudible] tribe witnessed a lot of
4 suicides in a couple-year period. And during that
5 time, we were able to get a couple SAMHSA grants,
6 Garrett Lee and another one. But however, during that
7 time, I met with then-Governor Rounds in trying to, I
8 guess, get the state's assistance because we knew they
9 had some block grants. But we did not get any funding
10 from them.

11 Yet, the data shows that they did give some
12 funding out. Sheila was looking through some data
13 yesterday. So I was asking how -- where did they get
14 that information from, which tribes did they help
15 during that time. So we need more data, I guess, in
16 terms of how we can see the effectiveness of that.

17 And we're really appreciative of President Obama
18 in his \$50 million, hopefully, if it gets funded for
19 the prevention and wellness fund. And I think that's
20 a step in the right direction. You know, short of
21 getting block grants through tribes, you know, we have
22 treaties and all that. But we lead in every indicator

1 in regard to suicides, substance abuse, you know, per
2 capita, you know, nationwide. So just something to
3 think about, that we do need more data. Thank you.

4 MS. HYDE: Yeah, thanks a lot, Rodney. That's
5 very helpful. And we are trying to think about how we
6 know what's going on with each individual state,
7 because it's, kind of, all over the place. And
8 sometimes a state has it, and sometimes they don't.
9 Because we fund a community in that state, and they
10 may or may not have that information. So we're trying
11 to work with them on that.

12 Okay, one little comment from Arturo, quickly, if
13 we can. And then, we're going to go public comment.

14 Arturo?

15 DR. GONZALES: Thanks, Pam. I don't know if I
16 can be quickly, but I think the point made that how
17 are things evolving with the larger community and how
18 do we capture that data is not a local issue. I think
19 the point made was made very well.

20 MS. HYDE: Arturo, do you have your microphone
21 on? If not, can you? And if so, can you talk right
22 into it?

1 DR. GONZALES: Is it on now?

2 MS. HYDE: Yes.

3 DR. GONZALES: Okay. I was going to say, Pam,
4 that I think the point made that how are things
5 evolving in the larger community is not -- how we
6 gather data on that is not a local issue. I think
7 it's part of what health care reform was trying to
8 develop. And I think we have methods by which we can
9 do that, things like screening for obesity and
10 screening for depression and potential suicide, as
11 well as possible drinking and driving, can be done in
12 schools.

13 And, in fact, we have done that already through
14 the SBIRT national project. And I think that there is
15 data already there for that. And I think the
16 screening pools are there. And I would hope that
17 SAMHSA would see that as part of the continuum of data
18 that needs to be captured. And it's not really -- I
19 mean, there's things out there that can be supplied
20 that doesn't involve reinventing the screening tools
21 or the wheel with regard to universal screening. And
22 I think that's important.

1 MS. HYDE: Yeah, I think that's well-taken,
2 Arturo. Thank you.

3 All right. Unless anybody else on our council
4 has a burning issue to say, we're going to take -- we
5 have got two people who've asked for opportunities to
6 comment on this, or maybe something else.

7 The first one is Francis Purdy, who is with the
8 National Federation of Families.

9 Francis, will you come on up the mike? And we're
10 going to ask you to keep it to just a minute or two so
11 we can see if there are other people who want to
12 comment.

13 MS. PURDY: Sure, real quickly. I'm with the
14 National Federation of Families for Children's Mental
15 Health. Many of you have raised questions about
16 what's happening with parents, families, and children.

17 I just want to let you know that we actually certify
18 what is called parent support providers. There are
19 approximately about 5,000 in the workforce today.

20 We are also moving to certify youth-to-youth
21 support. These folks actually work. They bill
22 Medicaid. They bill Medicaid through traditional

1 mental health centers. They bill Medicaid either
2 directly, like Arizona. They bill Medicaid through
3 Medicaid waivers. And we have data about the
4 effectiveness. In other words, how much longer kids
5 stay in school when their parents get support, what
6 that support looks like, how it's measured.

7 And I just thought you'd like to know that the
8 certification is actually going on. The first
9 official certification goes out in November. And
10 then, we start recertification. We're proceeding
11 under ISO standards, not just whimsical certification.

12 So there is absolutely the job task analysis, core
13 competencies, and a sound test. Thank you.

14 MS. HYDE: Thank you very much. We've got both
15 peer specialists and family specialists being
16 certified, and, actually, billing. So it's a good
17 thing. Thank you.

18 Linda Frazole from the Northwest Portland Area
19 Indian Health Board?

20 MS. FRAZOLE: Thank you, Pam. I just want to
21 compliment you on taking a lot of the suggestions that
22 we submitted in regards to your strategic initiatives.

1 And I'll be honest with you. I haven't gotten clear
2 through the whole document yet, but I will by tomorrow
3 night.

4 But I do have a few comments I'd like to make in
5 regards to the final draft. And I'm looking at goal
6 2.1 under the action steps of objective 2.11. And I
7 would suggest a consideration to look at the HIS
8 epicenters. There's 12 around the country. That
9 would be a perfect opportunity for them to provide
10 some input and shouldn't be any cost to SAMHSA to do
11 that.

12 The next comment I'd like to make is in regards
13 to goal 2.13.1, objective 2.3.2 under the actions
14 steps number three. I would suggest that you consider
15 adding the Department of Commerce. Tele-medicine, to
16 not only Indian Country, but to rural America, is
17 extremely critical. Tele-psychiatry is very
18 successful. Beings they do the census and other
19 things, I think it's a nice marriage and maybe an
20 opportunity for a source for other data.

21 And then, the other comment I'd like to talk
22 about is on goal 2.4, objective 2.41 under the action

1 steps. Quite honestly, the action steps are a bit
2 weak in regards to tribal-specific. They talk about
3 having tribes involved in the planning efforts, but
4 that's where it drops off. On number four, it talks
5 about supporting training for state and local rehab
6 counselors. But it would be beneficial, because in the
7 Indian Health Care Improvement Act, there are specific
8 clauses for behavioral health counselors in that
9 regard.

10 And then, to fortify that, unfortunately the data
11 that I've reviewed that Native Americans, American
12 Indians, Alaskan Natives, whatever particular term,
13 really are disproportionately represented in our penal
14 system. And it's a sad situation. To go along with
15 that, the dollars spent, for the public's information
16 here, per capita for an American Indian, Alaskan
17 Native in the federal system is exactly one-half of
18 what this country spends on their federal prisoners
19 for health care.

20 And the last comment I'd like to make is two-
21 part. And in regard to the comment you made, Pam,
22 about the single pot of money, or so to speak,

1 Oregon's trying to do that, too. The Oregon tribes,
2 the seven tribes are not in favor of that, because it
3 forces the tribe to work with a subordinate of the
4 federal government, being a state. And that isn't
5 going to work very well for them.

6 And then, in regards to data -- and I mentioned
7 yesterday I kind of like data. Don't know why, but --
8 I would suggest that you all look at existing
9 databases and going outside the frame of health care.

10 And, of course, CMS can provide you the episodic
11 data, which has issues, if you only use that.

12 And SAMHSA really hurt us a couple years ago with
13 a statement that was made based on the TEDS data,
14 which is episodic data, a comment that the meth
15 problem in Indian Country was decreasing. In fact, it
16 is not. And so, there's issues with episodic data.

17 But the Department of Justice and Department of
18 Interior -- we get a lot of our law enforcement from
19 the Department of Interior. There is databases there
20 for violence and for what the arrests are and for
21 accidents and traffic and so on.

22 And the Department of Ed. and the Department --

1 or the CDC within HHS, the YRBS has scads of data, but
2 only in regards to school-age kids, and then, however
3 the states adjust that, per say. But every school
4 system in this country has to provide incident
5 reports, including the BIA tribal contracted schools.

6 So there is data sets there that are already
7 rigorous, and they would provide you a more
8 comprehensive view that isn't just based on episodic
9 data.

10 The cost to go out and do epidemiological studies
11 in the communities -- I mean, it's forbidding. But
12 behavioral health data, per say, is so subjective that
13 it's difficult. And the stigma that goes along with
14 people trying to access services or even wanting to
15 access services typically results in a gross under-
16 count of people who actually need.

17 So whenever you're doing your framework, it's
18 really important to figure out a comprehensive impact,
19 impact not being results -- and I direct a systems of
20 care project -- not being the results of where your
21 particular grant did the goals and objectives as to --
22 but what was the impact to the community. Was there a

1 project in the school that one student was involved
2 in? That one student has a parent, hopefully, or at
3 least a guardian. They have an extended family, maybe
4 a grandparent or whatever. It just reaches out like
5 tentacles into the community.

6 That's what the impact is. And that should be
7 what you would consider as what your data is going to
8 tell you, is what the impact is to the people, not
9 whether you've met your goals and objectives. Thank
10 you.

11 MS. HYDE: Thanks a lot. I appreciate that.

12 Is there anybody else in the public, either
13 online or in the audience, who want to speak?

14 Okay. Let me just tell you a couple things and
15 then, ask you one question. And then, we'll end for
16 the day.

17 We had online today with us, either through the
18 Webcast or on the phone, 273 people. I like to tell
19 you that and know throughout the day -- we, kind of,
20 like to know who's listening to what topics. And I
21 think it's important that you know that there are
22 close to 300 people in the country who are interested

1 in what you are having to say and what you are
2 hearing.

3 We also had here today, either here or online, 49
4 of our 64 NAC members. So that's really terrific. We
5 appreciate all of your being here and working with us
6 today.

7 We also had -- I don't know -- 40 to 50 people in
8 the audience. A lot of SAMHSA staff are listening, as
9 well as, from time to time, we've had members of the
10 public or stakeholders involved. So thank you for all
11 of that.

12 I just want to take the last couple of minutes to
13 ask you this last conversation really, kind of, went
14 from quality into what's the population, what's going
15 on in our communities and in our populations about
16 behavioral health. So it occurred to me -- but I'd
17 like your reaction -- that maybe that's something we
18 should -- you want to hear about, because the
19 databases that Linda talked about we deal with all the
20 time.

21 We work with them all the time. We get
22 information from all the time. It's another place

1 where we collaborate a lot. But this whole issue of
2 where are we focusing on populations that are either
3 doing not so well or doing better and how do we know
4 that -- that could be a topic that we spend time on.
5 It's another aspect of our data outcomes and quality
6 initiative, if you're interested.

7 And another couple of issues that I've heard
8 today -- one is, sort of, the consistent theme about
9 where is education in all this. We do a lot of work
10 with the Department of Education. Frankly, I don't
11 think we have for a while had a focus on kids. We
12 could have a focus on children and youth since we've
13 had a focus on tribal issues, we've had a focus now on
14 women and girls. But we could have a focus on
15 children and youth, if you thought that was of use to
16 you. And you could be helpful to us there.

17 And then, finally, we had a request to maybe look
18 at the issue of the impact that health reform was
19 going to have on disparities. And there's a whole
20 other set of issues going on on disparities.

21 Now, we had a presentation about that, I think,
22 last time. So I don't know if that's something that

1 you want to explicitly focus on or not. And I think
2 rather than having you -- well, you can take a couple
3 of minutes and tell me whether or not those topics are
4 things that make sense to you. Are there other topics
5 you would like to be engaged in with us?

6 We, obviously, will come back to you on the
7 things we feel like we need your advice about. And
8 that's exactly what we've done today.

9 So, yes, you've got a thought about that?

10 MR. JACOME: Yeah, I'm so glad that you talk
11 about that. You know, the issue of the Hispanic
12 population -- we're the largest minority in the state
13 of Illinois and the United States. And we're going to
14 be the largest minority. By 2050, it will be over 100
15 million people of Hispanic descent. And we're not
16 here much in the initiatives that we need to address.

17 One out of six people is going to be Hispanic
18 descent or connected to some Hispanic issue --
19 Hispanic ethnicity. And, I think, you know, there's a
20 concern. I think education is a concern. Primary
21 care is a concern. Behavioral health care is a
22 concern.

1 So definitely, I'm for it. And I really
2 appreciate that you brought up that issue, because I
3 think it's a passion for me. I think, you know, as a
4 minority and a Hispanic, we need to address these
5 issues that has not been addressed for many, many
6 years. And we are the largest minority in United
7 States and will be and we'll continue growing. Thank
8 you.

9 MS. HYDE: Great. Thank you.

10 Anybody else have any reaction?

11 Pat?

12 MS. WHITEFOOT: Yes. Just an emphasis on
13 children and youth, as you suggested. Just in terms
14 of working with schools, because much of the
15 prevention work that goes on is with schools. I mean,
16 we could talk about, you know, children's mental and
17 all of that, but I'm also concerned about early
18 childhood education as well on up to higher education,
19 because I think what we do is we do a disservice when
20 we don't talk about also the university-age students
21 as well. That's another issue, too. So the
22 continuing education.

1 MS. HYDE: Great. Thank you.

2 I think I saw Pat, and then, Jane. And then,
3 we're going to close.

4 MR. RISSER: Yeah, I get discouraged sometimes,
5 because I go back to the days when we used to measure
6 success by could we put ourselves out of business,
7 were people get well and healthy. And it would feel
8 encouraging to me if we had just a little bit of time
9 at these meetings to talk about where we are being
10 very successful and where we are helping people and
11 what it is that's working for folks.

12 Because it seems like we just continue to grow
13 bigger and bigger and try and find out more and more
14 ways to get more and more people into the system.
15 We're creating more entrance doors to the system. And
16 I'm not seeing us create as many exit doors out and
17 people getting well and healthy. It would really be
18 helpful.

19 MS. HYDE: Great. Thank you.

20 Jane, you have the last word.

21 DR. McGRATH: Just quickly, I would love to have
22 us do a -- see a presentation on school-based health

1 centers and what they're doing in schools and their
2 model of integrating health and mental health.

3 MS. HYDE: Great. Thank you.

4 This was really helpful. Again, the discussion
5 is just amazing. The stimulation that you give us and
6 the way we've been thinking -- and we think we have it
7 right one way and have you either validate that or
8 tell us, whoops, you're, kind of, going off direction,
9 it doesn't make sense to you all, is really helpful.
10 So thank you very much. I hope you all have plans
11 that are appropriate for you this evening.

12 [Laughter.]

13 MS. HYDE: And don't get any of us in trouble.
14 And we will see all of you in your individual center -
15 - oh, okay, the NAC, the SAMHSA NAC and -- who else?
16 The ACWS -- if you want to leave your books, we'll
17 pick them up for you or get them to where you need --
18 they need to be.

19 Thank you very much, everybody.

20 [Whereupon, at 5:16 p.m., the meeting was
21 adjourned.]

22