

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

38th Meeting

Tuesday,
December 6, 2005

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

IN ATTENDANCE:

Chairperson

Charles G. Curie, M.A., A.C.S.W.
Chair/Administrator, SAMHSA
1 Choke Cherry Road, Room 8-1065
Rockville, MD 20857

Executive Director

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

Executive Secretary

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

Members

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

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

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

IN ATTENDANCE:

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

Thomas Lewis
President and CEO
The Fishing School
7017 16th Street, N.W.
Washington, D.C. 20012

Theresa Racicot
Former First Lady of Montana
901 15th Street South #201
Arlington, VA 22202

Kenneth D. Stark
Director
Division of Alcohol and Substance Abuse
Department of Social and Health Services
P.O. Box 45330
Olympia, WA 98504-5330

Kathleen Sullivan
Journalist
Four Mission Court
Rancho Mirage, CA 92270

Ex Officio Members

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

C O N T E N T S

	PAGE
Welcome and Opening Remarks	
Charles G. Curie, M.A., A.C.S.W. Chair, SAMHSA National Advisory Council and Administrator, SAMHSA	6
Administrator's Report	
Charles G. Curie, M.A., A.C.S.W.	13
Discussion	34
FY 2006 Appropriations Update, HHS "Top 20" Priorities, and Hill Update	
Daryl W. Kade, M.A. Executive Director, SAMHSA National Advisory Council and Associate Administrator, Office of Policy, Planning, and Budget, SAMHSA	51
Discussion	58
Joseph D. Faha, M.Ed., M.P.A. Director of Legislation, SAMHSA	63
Discussion	69
New Mexico Strategic Prevention Framework State Incentive Grant	
Overview	
Beverly Watts Davis Senior Advisor on Substance Abuse Office of the Administrator	71
New Mexico Strategic Prevention Framework State Incentive Grant	
Don Maestas Project Director	76
Discussion	92
Public Comment	105

C O N T E N T S

	PAGE
SAMHSA's Response to Hurricanes Katrina and Rita Administrator's Update	
Charles G. Curie, M.A., A.C.S.W.	111
Key Elements of SAMHSA's Response to Hurricanes Katrina and Rita	
Daniel Dodgen, Ph.D. Emergency Coordinator, SAMHSA	119
What is SERC and What Did It Do?	
Brenda Bruun Program Analyst, Division of Prevention, Traumatic Stress, and Special Populations, CMHS, and SERC Coordinator for Hurricanes Katrina and Rita, SAMHSA	133
Discussion	155
Experiences of Deployed SAMHSA Staff	
Rachel Kaul, L.C.S.W., C.T.S. Public Health Advisor, Division of Prevention, Traumatic Stress, and Special Populations, CMHS	168
Kevin Chapman Project Officer, Drug-Free Communities, CSAP	180
Anne M. Herron, M.S., C.R.C., CASAC Director, Division of State and Community Assistance, CSAT	186
Discussion	191
Consideration of June 27, 2005 SAMHSA Council Meeting Minutes	212
Public Comment	212
Discussion on the SAMHSA Matrix	218

1 P R O C E E D I N G S (9:13 a.m.)

2 MR. CURIE: Good morning, everyone. One of the
3 biggest things that made an indelible impression on many of
4 us was the hurricane season this year. The hurricane
5 season brought people many things, including, most
6 importantly, hope. Many Americans lost their homes, their
7 livelihoods, their schools and communities, their places of
8 worship, their social supports and, of course, in many
9 situations people lost loved ones, witnessed death,
10 witnessed destruction and violence. It basically has been
11 a time that is somewhat incomprehensible when you consider
12 the extent and scope of the devastation that hit the Gulf
13 Coast. These storms brought challenges beyond comparison
14 to those who endured them.

15 It also brought several challenges to HHS and
16 SAMHSA, and brought (inaudible). I'm pleased to say that
17 as I take a look at SAMHSA and the members of the staff
18 throughout all of SAMHSA, that these challenges were met
19 with what I consider extraordinary skill. Virtually every
20 member of SAMHSA, every staff person, participated in some
21 way. In fact, we had over one-half of the individuals in
22 SAMHSA either deployed or served in our SAMHSA Emergency
23 Response Center. The other individuals filled in for the
24 individuals who responded, and it was just one time I can
25 clearly say with all confidence that 100 percent

1 participation was heard.

2 A new staff person that I spoke with knew they
3 were committed to serving not only as service to the
4 individuals in the Gulf Coast, but they saw it clearly as
5 service to the nation. So it was the epitome of why
6 they're in the civil service in the first place. So it was
7 a very inspiring situation for me, and also I think helped
8 a lot of us keep going to see how everybody was pitching
9 in.

10 Time has been set aside on the agenda this
11 afternoon to discuss SAMHSA's response to the hurricanes,
12 but I wanted to start today with these thoughts because I
13 wanted to also mark the important role substance abuse and
14 mental health services play and continue to play in the
15 overall public health response to this tragedy. When we
16 look over the course of the last five years, I think we see
17 clearly that mental health and substance abuse are viewed
18 as a critical, essential part of the response to the
19 disaster, as part of being prepared. 9/11 brought this to
20 the forefront, but I think Katrina and Rita in particular
21 was the first time we really were challenged since that
22 period of time, and again the attention we received from a
23 wide range of the public at large, from various
24 institutions, from the Hill, and again the unwavering
25 support of the Secretary and the White House to assure that

1 mental health and substance abuse consequences were at the
2 forefront, and also the clear understanding that we'll get
3 into this afternoon that in one sense we've only just begun
4 in terms of dealing with the consequences of Katrina when
5 it comes to mental health and substance abuse, and I think
6 we need to keep that in mind.

7 A lot of the (inaudible) response was finished
8 very quickly in the course of the first month or so. Our
9 process will continue on for a matter of not only months
10 but over the course of the next few years will still be
11 rather intensive as we begin to see consequences arise,
12 based on our experience. Again, we'll have more of a focus
13 a little later on, and this is just one indication that
14 we've made, I think, tremendous progress in our collective
15 efforts to assure that substance abuse and mental health
16 are viewed as part of public health.

17 I think part of our success is our
18 determination to stay true to what we refer to as the
19 redwoods on the matrix that spring from the presence of the
20 cross-cutting principles of each program. I have several
21 matrix updates for you today that I'll be sharing with you
22 in just a moment.

23 But I also want to recognize with all of you
24 here today that another contributor to our success is this
25 National Advisory Council. I've acknowledged and thanked

1 each of you for your dedication to SAMHSA's endeavors in
2 the past, but I want to thank you again. The Advisory
3 Council is made up of individuals from all walks of life
4 that relate to mental health and substance abuse. I think
5 you represent a collective viewpoint which, again, has been
6 extremely valuable.

7 Again, I think we're making tremendous
8 progress, and your support is cementing the changes that
9 will continue to move this agency forward in real valuable
10 and life-saving ways. I think we can keep in mind that
11 while our mission is a life in the community for everyone,
12 that also includes the fact that we are very much a
13 life-saving agency through the state authorities and
14 providers across the country.

15 Before I begin, I want to make sure that we
16 welcome everyone here today. In a more direct way, I want
17 to first welcome Thomas Lewis back to our meetings.

18 Thomas, it's wonderful to see you. You've been
19 in our thoughts, you've been in our prayers. It's just
20 great to have you back and have you with us again.

21 MR. LEWIS: Thank you very much.

22 MR. CURIE: I also want to extend a special
23 welcome to a newly appointed Council member, Dr. Faye
24 Annette Gary. Dr. Gary is a professor at Case Western
25 Reserve University at the School of Nursing in Cleveland,

1 Ohio.

2 We want to welcome you to your first meeting
3 with us, and we look forward to many positive contributions
4 that you'll be bringing to the work of the Council with
5 your background and your perspective. Thank you for your
6 participation in the field. Maybe you'd like to say a
7 couple of words.

8 DR. GARY: I would just like to say I think
9 it's a privilege and an honor to be on the Council and to
10 participate in discussions that are so essential for
11 improving the health of the nation's people. I look
12 forward to learning, and I look forward to sharing. Thank
13 you.

14 MR. CURIE: Thank you.

15 Other Council members in attendance this
16 morning, Gwynneth. This has to be a shock. This is
17 different from the climate you're growing accustomed to, I
18 would think.

19 MS. DIETER: That's right.

20 MR. CURIE: Thank you for being here. Gwynneth
21 Dieter is here with us today.

22 Of course, Barbara Huff. Thank you, Barbara,
23 for being back with us.

24 Tom Kirk, commissioner of mental health and
25 substance abuse in Connecticut.

1 Theresa Racicot. Thank you, Theresa, for all
2 your efforts here on the Council, and also your efforts
3 ongoing in addressing such important issues as underage
4 drinking, for your advocacy.

5 Theresa made sure I got connected with NAMI in
6 Montana in the last five to six weeks.

7 Again, Ken Stark, director of the Division of
8 Alcohol and Substance Abuse, Washington State. Ken, you're
9 in a new role here today. Ken has been in substance abuse,
10 and right now he's (inaudible). He has a mental health
11 side.

12 MR. STARK: I'll just touch on that a minute.
13 I'm the new director of the Mental Health Transformation
14 Grant, and we'll be looking over the next five years toward
15 making some changes in that.

16 MR. CURIE: And Kathleen.

17 (Laughter.)

18 MR. CURIE: I appreciate your participation,
19 and also your support of Kenneth.

20 (Laughter.)

21 MR. CURIE: Unfortunately, we were expecting
22 Diane Holder. I just received word that she became ill on
23 the way to the airport, so Diane is not going to be able to
24 join us today.

25 I also want to note that my co-chair,

1 Lieutenant Governor Duke Aiona, was unable to make it due
2 to a prior commitment, as well as First Lady Columba Bush
3 of Florida could not join us due to a prior commitment as
4 well.

5 I also would like to recognize this morning the
6 center directors that will be attending with us, attending
7 our meeting this morning. We have the CMHS director,
8 Kathryn Power, who will be joining us in a little bit, as
9 well as Wes Clark, who is here with us, the director of
10 CSAT. Also, I'd like to recognize Rich Kopanda, who is the
11 new acting director of the Center for Substance Abuse
12 Prevention. He's willing to roll up his sleeves and pitch
13 in in that capacity. Beverly Watts Davis has become my new
14 senior advisor for substance abuse, taking Stephenie
15 Colston's place. I also want to thank Wes Clark for the
16 sacrifice of Rich, who in his permanent capacity is deputy
17 director for CSAT but brings with him a depth of
18 experience.

19 I also want to recognize an ex officio member,
20 Larry Lehmann, from the Department of Veterans Affairs.

21 Larry, thank you for your ongoing support and
22 for being here today.

23 Larry also participates in things between these
24 meetings. He's very active in being an important liaison
25 for veterans, and especially in addressing the mental

1 health and substance abuse needs there.

2 Thank you, Larry.

3 Other distinguished guests include individuals
4 that we will recognize later. Thank you.

5 (Laughter.)

6 MR. CURIE: Before moving on, I have a few
7 agency updates to provide. At our last meeting I shared
8 with you that Andy Knapp began his position as acting
9 deputy administrator of SAMHSA after concluding his post as
10 deputy chief of staff for former Secretary Thompson. Andy
11 is with us actually in person this morning, and I'm glad to
12 have Andy here.

13 MR. KNAPP: I normally show up for work.

14 MR. CURIE: This is typical for Andy. Andy
15 does show up for work.

16 But we want to welcome you to your first SAMHSA
17 National Advisory Council meeting, Andy.

18 He's done a tremendous job as acting deputy
19 administrator, dealing with issues that are the
20 nitty-gritty of operations of many centers. Those of you
21 who have been in management leadership positions know how
22 much you appreciate your chief operating person, because
23 it's sometimes a thankless job. Andy does very well and
24 has put us on a very good track with our management in
25 general. In fact, SAMHSA received an exceptional rating

1 within the Department of Health and Human Services. Not
2 every operating division has gotten an exceptional for its
3 management and programmatic priorities.

4 (Applause.)

5 MR. CURIE: That goes to the whole leadership
6 team and to all of the SAMHSA staff who made that possible,
7 the focus on that arena in terms of the President's
8 management agenda, in terms of the priorities of the
9 Department. That's all reflected in our matrix, which is
10 something we really should celebrate, and it's something
11 that I'm very proud of with the staff and what we've been
12 able to accomplish.

13 Again, I'll announce that Beverly Watts Davis
14 has accepted the position of senior advisor. Stephenie
15 Colston, for those of you who don't know, was stolen by the
16 State of Florida. She's the new director of substance
17 abuse for the State of Florida, and we wish Stephenie the
18 best in that position. I wish the State of Florida the
19 best even though they stole her from me. Seriously, it's a
20 great opportunity for Stephenie, and based on her work here
21 at SAMHSA, I know that she will (inaudible) in many ways.
22 It's actually a win for us to be able to have her in that
23 position. She's really a trusted advisor and friend, and
24 I'll miss her very much.

25 Again, I introduced Rich earlier. I also want

1 to introduce to you Kana Enomoto to the Council. Kana is
2 now serving as my special assistant. She was previously
3 special assistant to Kathryn Power in the Center for Mental
4 Health Services, and is basically my key right-hand person
5 when it comes to keeping my engine on the right track and
6 keeping me on the right track. She's really filling in in
7 many of those areas that Gail Hutchings used to fill in.
8 So I'm very happy to have someone who knows the field.
9 She's a psychologist herself. She's well organized, and
10 she basically has the big picture in mind, as well as
11 follows up with the details. I don't want to say too many
12 good things about her because I don't want anybody to steal
13 her, but it's been great.

14 Welcome, Kana.

15 Cheri Nolan has joined us this morning. Cheri
16 is newly appointed to her position as senior policy advisor
17 for criminal and juvenile justice. I've known Cheri for
18 four years. She worked for the Department of Justice prior
19 to this. It's a real coop to have Cheri come aboard. I
20 have the highest regard for her in terms of the work she
21 has done, and she's going to be opening even new doors of
22 collaboration for us in substance abuse (inaudible). She's
23 also the new chair for the criminal juvenile justice matrix
24 work group. So I encourage you to get to know Cheri. I
25 view her as our new major connect with that field or arena.

1 Is Javaid here this morning? Dr. Javaid Kaiser
2 has joined us this morning. He's our newly appointed
3 director of the Office of Applied Studies. Also, we've
4 expanded that position to really be focused on the overall
5 SAMHSA data strategy and to be looking at all information
6 and data gathering throughout the system. The OAS is the
7 home of the Household Survey, it's the home of the DAWN
8 Survey, it's the home of TEDS, the Treatment Episode Data
9 Set, and it does very important work throughout the year in
10 terms of informing the substance abuse and now mental
11 health with the mental health aspects to those instruments
12 being added. But again, Javaid brings with him great
13 experience, and I've really appreciated his perspective on
14 how we truly begin to use leveraged data in decisionmaking.

15 Thank you, Javaid, for being here this morning.

16 Other members of the staff who have joined us
17 this morning or who will be joining us as the agenda moves
18 on, as you can see following my report, Daryl Kade and Joe
19 Faha will provide an appropriations update, and an overview
20 also of the top 20 priorities, and an update of legislative
21 actions.

22 Again, honoring your past requests for more
23 reports from grantees, we have a presentation scheduled
24 later this morning on the New Mexico Strategic Prevention
25 Framework State Incentive Grant, and then following lunch

1 we'll discuss SAMHSA's hurricane response efforts.
2 Tomorrow's agenda includes a critical topic of preventing
3 underage drinking, along with an overview of the National
4 Child Traumatic Stress Initiative. We'll also hear about
5 recent activities of all of you as Council members, as I
6 know all of you do a lot of work between these meetings as
7 well.

8 Again, together I think we've accomplished a
9 lot. We've established our most pressing priorities and
10 management principles, and to aggressively implement them
11 we gave those priorities some cross-cutting principles and
12 identity, the matrix, and again it's helped us, I think,
13 align our focus and our resources, and it will help us
14 operationalize recovery. That theme is a theme that I've
15 worked on often, because I think really what we're doing,
16 what SAMHSA is doing, whether we're talking to the Advisory
17 Council or at the global policy level, making policy
18 decisions, finance decisions, funding decisions, creating
19 new grant programs, working to enhance current grant
20 programs, it's all operationalized in recovery in ways that
21 we have never operationalized them before from a public
22 finance and a public policy standpoint.

23 We did say on the matrix that expanding
24 substance abuse treatment capacity was a priority. We said
25 we had to find new and innovative ways to grow the

1 substance abuse treatment system into one that was driven
2 by the client, driven by the family, and offering more and
3 more (inaudible), and allowing for choice of the
4 individual. We've been able to gain ground on that through
5 Access to Recovery. The Access to Recovery program is up
6 and running. Two people around this table can attest to
7 that from Washington and Connecticut, who are two
8 individuals that are in charge of Access to Recovery in
9 those two states. Also, I know Wes Clark can attest to it,
10 too, with his staff working very diligently to implement
11 this.

12 So far, approximately 38,000 individuals have
13 used vouchers to purchase treatment recovery support
14 services that were among the choices for them. Actually,
15 being more specific about that figure, it's closer to
16 31,000 people received vouchers. Some may not have
17 received vouchers but may have been supported by the Access
18 to Recovery program.

19 We also said improving services for those
20 individuals with co-occurring disorders is a priority. I
21 was glad to see my good friend, Rob Primrose, here from
22 Pennsylvania. He was very much involved when I was in
23 Pennsylvania, was really a part of the heart and soul of
24 getting the co-occurring efforts rolling a decade ago in
25 that state. Again, he's able to share with us how well

1 things are going in Pennsylvania with co-occurring
2 disorders, and really (inaudible) to where I think we're
3 understanding how co-occurring disorders are part of the
4 issues we address in the (inaudible) in our service
5 delivery systems.

6 We're continuing to advance the Blueprint for
7 Change. The Blueprint for Change in SAMHSA's report to
8 Congress still serves as the critical guide on co-occurring
9 disorders, and also we've outlined in the report the
10 development of the National Co-Occurring Center for
11 Excellence, a co-occurring Treatment Improvement Protocol,
12 or TIP, and we (inaudible) national co-occurring policy
13 academies. In fact, I would say the TIP on co-occurring
14 disorders is one of the most talked about TIP. I know I
15 travel the country and (inaudible). I see it a lot, not
16 only on a lot of shelves but a lot of desks, opened up on a
17 lot of desks around the country, so I know it's being used.

18 We also said we'd find new ways to help our
19 state partners to begin to interface substance abuse
20 screening, referral and treatment services, the same
21 services in mental health and primary health care, to begin
22 to help create the Co-Occurring Disorders State Incentive
23 Grants. We implemented those grants in 15 states, and
24 again, what we're seeing is more and more people are
25 receiving the appropriate assessment, screening and

1 treatment as they present with co-occurring disorders.

2 We've also raised mental health transformation
3 to a priority level, and the transformation process is
4 underway. As you know, the action agenda was released in
5 July. The action agenda, again, is the federal
6 government's response to the Mental Health Commission
7 report. It's a roadmap. It's a document that reflects the
8 responsibility of the federal government in making changes,
9 and it's a promise to be kept; and also the action steps
10 will help us lay the strong groundwork across this country
11 to transform the system of care that crosses over and runs
12 through individual delivery systems and runs through the
13 states.

14 We said we needed to find new ways to assist
15 our state partners with developing and implementing
16 comprehensive mental health plans, plans that are necessary
17 to develop a strong, sustained effort. Again, we have used
18 the state incentive grant method for more transformation,
19 and we awarded \$92.5 million to seven states, which was
20 (inaudible) in Washington to focus on that. With the
21 release of the action agenda, the release of the mental
22 health (inaudible) and the tremendous amount of energy and
23 support around the field, mental health transformation is
24 truly rolling out. Again, I'll probably do more talking
25 about the elements of transformation. Connecticut is

1 another state that we (inaudible) that is very much in the
2 throes of the transformation process.

3 The ability of consumers and families to
4 participate fully in their communities can no longer be
5 derailed by outdated science, outmoded financing and
6 (inaudible) discrimination. That's our goal, to address
7 those three things. They really are the three major
8 barriers to people receiving treatment.

9 While we've made significant changes in the
10 substance abuse and mental health systems, at the same time
11 we've been paying close attention to the issue of
12 prevention. We said that prevention is a priority. We
13 carved out a logical, common-sense approach to align
14 prevention resources with more individuals and communities
15 to really harness the power of prevention, the benefits and
16 the strengths. We said we needed to step back and begin
17 building a framework. We needed to stop just (inaudible)
18 prevention programs. While each program we funded had its
19 own evaluation criteria, it was still not a strategic
20 approach to prevention throughout the states. We needed to
21 embark upon a process to truly have a strategic prevention
22 framework, which is exactly what we created.

23 The SPF is a model for what we know works in
24 prevention. It's about setting the step by step process
25 that empowers communities to identify their unique risk and

1 protective factors for substance abuse, and then implement
2 the programs that are best suited for meeting those
3 particular needs. In other words, when you take a risk and
4 protective factor approach to prevention, you identify what
5 the risk factors are, and then you identify which
6 preventive factors can address those risk factors, what
7 programs reflect those protective factors and really begin
8 making decisions to leverage your prevention dollars toward
9 doing the right thing that's individualized for that
10 community.

11 We have also reinvigorated the Drug-Free
12 Communities Program and continue to build toward the
13 promise of making that stronger. If you take the portfolio
14 in substance abuse prevention, we really have brought
15 together coalition building, brought together strategic
16 prevention frameworks, brought together a risk and
17 protective factor approach. We have our National Registry
18 of Effective Programs for bringing together the evidence
19 base, and our goal is to work with our state partners to
20 assure every community has access to that information and
21 has the resources available to be able to put it in place,
22 programs within their own strategic prevention framework.

23 We also then have a baseline for each community
24 of where they're beginning so we can measure are they truly
25 making progress in individual communities in reducing

1 illicit drugs, as well as reducing underage drinking. The
2 other thing I want to stress is we'll be hearing more about
3 underage drinking. There was a tremendous national
4 conference. Theresa was able to participate in that
5 conference, as well as Columba was able to come from
6 Florida, and with our strategic prevention framework, from
7 the very beginning we explicitly stated that each of those
8 plans need to address underage drinking, because as we put
9 it before, alcohol is the most abused substance of youth in
10 every community. If there is a community where it's not,
11 we want to visit that community and find out what they're
12 doing right to implement what they're doing. So again,
13 there's a focus on underage alcohol use along with illicit
14 drug use.

15 Again, to measure and report on our progress in
16 all of these areas, we're also looking to regional
17 approaches and service agencies to make sure we fulfill our
18 mission as we were created and mandated by Congress. So we
19 need to measure and report on our progress in these areas.

20 So we're implementing the new National Outcome Measures in
21 close partnership with the State Substance Abuse and Mental
22 Health Authorities. Data for reporting on these measures
23 is coming in from states through the new State Outcome
24 Measurement System, called SOMS, and we anticipate full
25 state reporting on all National Outcome Measures by the end

1 of 2007 fiscal year.

2 This list of accomplishments I think is a list
3 we can all feel very good about, that we actually can point
4 to concrete projects, products and progress that we've
5 made. It's still (inaudible) to do the (inaudible) on any
6 of these things, especially if you take a look at the lay
7 of the land and the many things you have to address in
8 order to move an agenda forward. Many of the priorities
9 and cross-cutting principles identified in the matrix,
10 again, are well underway, are providing a solid foundation,
11 and I think we have the support in place to continue that
12 progress.

13 The thing about celebrations, though, when I
14 say we need to celebrate things, I think celebrations
15 should last for about a minute. Then we need to move on
16 and make sure that we don't rest for too long. We need to
17 rest to regain a second breath, but pausing is something
18 that's very dangerous to do, especially in the fields we're
19 in and what we're up against and dealing with bureaucracies
20 at all levels.

21 So it's important that we look ahead and focus
22 with determination on what can and should be done in the
23 time that remains, especially with this administration.
24 Three years will be going by very quickly, and we need to
25 make sure that we build on the gains that we've made, that

1 we solidify our gains.

2 As you all have heard many times, I've
3 mentioned the matrix several times. I view the matrix as a
4 dynamic tool. I believe it should evolve as the needs of
5 the people we deal with change. Once again, it's time for
6 our annual review to take a look at how to reload the
7 matrix. I refer to it as the matrix reloaded after the
8 movie title, and I'm seeking your input before we discuss.

9 I would like to share some of my thoughts about the
10 matrix, kind of lay out some thoughts that I want to
11 encourage you all to challenge, to give your input and
12 feedback on. But I think it's important for us to begin
13 thinking about making sure that the matrix is relevant to
14 the state of affairs currently in the field and what we're
15 facing.

16 For example, disaster readiness and response is
17 a priority that's been strengthened. It's been supported
18 to become, I think, part of the (inaudible) of SAMHSA. We
19 have it down to much more of a science the way we
20 implemented the SAMHSA Emergency Response Center. We've
21 come a long way since 9/11/01 when we really began to put a
22 major focus on disaster readiness and response and make it
23 a priority.

24 It may be a priority that we view as more of a
25 cross-cutting principle as we go along, that we need to be

1 ready and prepared in all that we do, all of our
2 priorities. I'll give you an example. Our disaster
3 response has to not only take into account the
4 post-traumatic stress issues and the issues that people
5 that are victims of a disaster face -- that's a major part
6 of our response -- but we also need to be thinking about
7 continuity of care of people that have serious mental
8 illness and need ongoing treatment, people who are
9 receiving treatment for addictions, people in methadone
10 centers, for example, people who are in therapeutic
11 communities who may get displaced. How do we make sure
12 that individuals and children with serious emotional
13 disturbances are receiving treatment and intervention?

14 All these programs, their operations, are
15 unoperational in a hurricane like Katrina in the impacted
16 areas. So part of our mission also has to be very much not
17 only addressing overall the victims' needs, but also the
18 specific people that we are responsible for all the time.
19 So it really is a cross-cutting issue in that sense, our
20 HIV/AIDS response, substance abuse treatment capacity,
21 mental health treatment capacity, children and families,
22 all those other priority areas (inaudible) response
23 readiness.

24 But I think we need to evaluate can we move
25 that from an individual priority, understanding it's

1 something that (inaudible), and also it opens up a space
2 for other priorities that we need to address. This is the
3 (inaudible) process.

4 Workforce development has been a cross-cutting
5 principle that we need to address in everything that we do.

6 However, there are many tasks that have been hanging
7 around for years, and it seems that we keep studying the
8 issue, we get more clarity on the issue, we keep looking at
9 the issue and thinking a-ha, we need to make this
10 correction. I think we've done a fairly good job of
11 analyzing the issue and have an idea about what needs to be
12 done. But it seems now we need to get even more serious
13 about making progress. So I believe that one way you make
14 progress is to begin saying something is a programmatic
15 priority for a period of time. So do we need to begin
16 thinking about moving workforce development into a stated
17 programmatic priority that we begin to address? Something
18 to consider.

19 Again, these are not fait accompli. You guys
20 can give feedback. This is your chance to change the
21 matrix if you want to leave your imprint on the matrix in
22 terms of making sure we're making that a priority.

23 I also believe we need to do more around
24 suicide prevention. As you know, the federal government
25 has a national plan to address 30,000 suicides committed

1 per year in this country. I always make the comparison
2 that that compares to 18,000 homicides. There's a lot
3 governments do at all levels to bring the murder rate down.
4 We should bring the murder rate down, or bring the
5 homicide rate down, but I think we also need to really
6 focus on those 30,000 individuals, which we know is a low
7 count because that basically goes by reported suicides, and
8 we know that many times suicides are reported as accidental
9 deaths. We need to play an active role in rolling out that
10 plan. Is it time to specifically state suicide prevention
11 as a priority? That's a consideration.

12 Again, 90 percent of the people who commit
13 suicide, the research shows us, have depression or another
14 diagnosed mental illness or substance abuse. So what we do
15 is very much connected to that tragedy that hits year after
16 year.

17 At the same time, when we can talk about
18 suicide prevention, I think it's important for us to be
19 considering the fact that a major role is to get suicide
20 prevention into the mainstream specialties, because it's
21 something that people don't talk about unless they've been
22 in (inaudible). I had the honor of participating in the
23 first national conference that brought together survivors,
24 but also those who(inaudible), and it was a profound
25 experience to bring individuals together. Again, I think

1 we have a strong foundation upon which to build the agenda.

2 We also need to push the seclusion and
3 restraint agenda to a new level. When we have firmly
4 established that seclusion and restraint practices are the
5 norm in all settings, adult psychiatric settings,
6 (inaudible) settings, (inaudible) settings, seclusion and
7 restraint could become a priority that shifts to a
8 cross-cutting principle as well. But again, for now, I
9 think we need to talk about it. We've made great progress
10 on it, and we need to continue to state that as a priority.

11 We need to continue to bring that home. We need to hear
12 from you and examine that. Again, it's an issue near and
13 dear to me personally, something that has to be addressed.

14 We also need to impact underage drinking in
15 this country. As a nation we're not doing enough to
16 prevent it. As an agency working with our good friends at
17 NIAAA, who have done a tremendous job of bringing the
18 research forward and providing leadership, with also
19 obviously the First Spouses Program, we need to ratchet our
20 efforts up in terms of building a culture of prevention
21 which does more to address this issue, to take a hard look
22 at underage drinking. We have the support of the
23 Secretary. The Surgeon General is going to be doing a Call
24 to Action. We need to pay attention to this and we need to
25 talk about how do we reflect that, reflected more directly

1 in the matrix as well?

2 There is dedicated time in tomorrow's agenda
3 for talking about the matrix. So I'm planting the seeds
4 today so that you can contemplate. I encourage you all to
5 do your own examination and your own evaluation of the
6 matrix and bring your input and thoughts and your
7 perspectives so that we can have a consensus approach in
8 terms of where we need to be with the matrix.

9 We also have the opportunity to focus on
10 consumer- and family-driven care, self-directed accounts,
11 consumer choice in voucher programs, the use of electronic
12 health records to improve health information, technology
13 for improving information in a family-driven system. An
14 immediate SAMHSA objective is to intensify our efforts
15 where the CMS, the Centers for Medicare and Medicaid
16 Services, is making self-directed accounts a reality for
17 persons with mental and/or substance abuse disorders.
18 Consumer- and family-driven care also means actively
19 engaging in involving parents in their role as the key
20 decisionmakers in the assessment and treatment of their
21 children. The Screening, Brief Intervention, Referral and
22 Treatment grant program, known as SBIRT, is a strong
23 program that we should consider bringing to scale. I think
24 all of you saw firsthand in San Diego how an SBIRT program
25 works. There was a tremendous example of early

1 intervention dealing with people who are beginning to abuse
2 substances, how these brief interventions can be extremely
3 effective if identified in a primary health care setting,
4 or needs to be done also with regard to the criminal and
5 juvenile justice matrix priority. Again, I know Cheri will
6 be a tremendous asset in bringing shape to that agenda and
7 other initiatives, from concept to reality.

8 We'll also continue to strengthen our
9 partnerships and non-traditional partnerships with criminal
10 justice. Already Cheri has connected us with the National
11 District Attorneys Association, that group from Chicago,
12 just within the last month. Also, we've been reaching out
13 to groups such as the United States Conference of Mayors.
14 Again, I think some of the partners that we've not really
15 had as partners before I think SAMHSA needs to engage to
16 move our issues forward.

17 Integrating substance abuse treatment with
18 mental health care, with primary care, is also essential to
19 public health. Again, this is a priority for mental health
20 transformation. SAMHSA's leadership can keep it in the
21 spotlight. Again, I think we need to be aware that we're
22 the only federal agency that has a focus on mental health
23 services, that has a focus on substance abuse treatment
24 services, that has a focus on substance abuse prevention
25 services. NIH are critical partners in research. We're

1 responsible for program and making it happen, and we need
2 to remember that that's an awesome responsibility for lives
3 and how we shape that.

4 Also, as we transform the mental health system
5 here in the U.S., as we also make tremendous strides in
6 substance abuse treatment capacity and prevention, we
7 should continue our efforts with the international
8 community as well, building and in some cases rebuilding
9 their systems. This is especially critical in
10 post-conflict countries, countries which include
11 Afghanistan and Iraq. Our work with these countries is a
12 responsibility we share with all the Department of Health
13 and Human Services to improve the human condition
14 throughout the world.

15 One report that was just implemented or just
16 released within the last six weeks was a report out of the
17 Institute of Medicine's report which really took a hard
18 look at the mental health service system and directions
19 that we need to address. The good news out of this IOM
20 report is we can begin to gain traction and effect change
21 if we build the right partnerships. A lot of the IOM
22 report talks about those partnerships, and I think that
23 report will be released on the heels of the action agenda
24 being released, which puts us in a position to be able to
25 help influence systems in ways that we haven't been in a

1 position to influence before.

2 Licensing boards and accrediting bodies, for
3 example, can become valuable allies and can be among our
4 strongest partners in improving and expanding workforce.
5 For instance, again we've struggled for over a decade to
6 develop and institute core competencies for all conditions
7 in providing mental health and substance abuse treatment.
8 It's even more difficult to establish the core competencies
9 and move them into education programs where they can be
10 incorporated into licensing and certification requirements.

11 It's challenging, but I think it can be done. Again,
12 we've talked many times about when individuals enter the
13 field out of graduate schools, the graduate schools really
14 aren't focused on the state of the science or really what
15 the providers are looking for in terms of folks who are
16 dealing with these needs, as well as a focus on social
17 competency and other kinds of issues.

18 So again, this issue basically is going to
19 require fruitful cooperation and partnership to resolve.
20 Again, as I said earlier, workforce development is no
21 longer just a good idea. It will play a large role in the
22 transformation of our nation's mental health delivery.

23 Also from workforce development to suicide
24 prevention, if you look at that pendulum of responsibility,
25 I'm confident we can (inaudible) solid ground with these

1 priorities and with others. We actually started laying the
2 ground rules for many of these changes four years ago. Now
3 we need to focus intently on our priorities, generate
4 ongoing energy, excitement and urgency to the field, at the
5 same time that we need to permeate the (inaudible) and to
6 secure our budget request that Daryl and Joe will discuss
7 in a few moments.

8 Again, the other challenge before us that I've
9 not spoken about but that we'll be hearing more about is
10 the fact that in reading the papers and paying attention to
11 what's occurring here in Washington, there's a real focus
12 on the need to curtail spending, the need to make cuts, and
13 I think it also demonstrates the great importance on us to
14 prioritize more than ever before what is truly important
15 that we want to see move ahead and move forward to be able
16 to make that case, because the environment is now one
17 (inaudible) a major focus.

18 So again, I'd like to now open up my comments
19 for discussion, to give you an opportunity to discuss
20 further any of the priorities on the agenda for tomorrow.
21 Again, I want to thank you for your intense listening at
22 this point, your ongoing leadership, and open it up for any
23 comments you might have. Thanks.

24 Ken?

25 MR. STARK: Would it be possible to get copies

1 of your printed materials?

2 MR. CURIE: Sure.

3 MR. STARK: That would really be helpful to me,
4 because I'm taking notes.

5 MR. CURIE: You got it.

6 MR. STARK: Thanks.

7 The other thing that would really help me in my
8 current transformation (inaudible) the transformation grant
9 is to get my hands on the action document you referred to.
10 That would be very helpful.

11 MR. CURIE: You got it.

12 MS. POWER: You want the action agenda, Ken?
13 Okay. I was also going to suggest that if people want a
14 copy of the IOM report, we can probably get that for them
15 as well today. So those who would like the action agenda
16 and the IOM report, we'll make that happen.

17 MR. STARK: Both would be nice. Thank you.

18 MS. POWER: But it would mean I'll have to
19 leave the room.

20 MR. STARK: The final comment I want to make,
21 Charlie, is you covered a tremendous amount of stuff in
22 that talk, and I certainly didn't disagree with anything
23 you said. I think a challenge for us on the issue is going
24 to be privatization. I struggled myself looking at what
25 are the things that we can focus on, truly focus on from a

1 national level and SAMHSA can be a major driver working
2 with (inaudible), versus what are those things that from a
3 national perspective you probably need to set aside and
4 (inaudible) a little more of a policy push, because the
5 rubber hitting the road is going to be local, and it's
6 certainly the locals that (inaudible) the effort in here,
7 with your encouragement, pushing the leadership, and I know
8 that's going to be a struggle for you and the SAMHSA staff
9 to try to prioritize, and for us in the states.

10 For instance, workforce development as an
11 example. Workforce development is an issue that I think
12 everybody is dealing with in both alcohol, drugs and in
13 mental health, and the question is what role, other than
14 the leadership and the pushing and prodding of SAMHSA,
15 versus how much of the real workload on that has to happen
16 within the states and across the counties or whatever
17 geographies they have?

18 MR. CURIE: Other thoughts or comments? Faye?

19 DR. GARY: I thank you for your presentation.
20 It was quite comprehensive and (inaudible). I also want to
21 make specific reference to the matrix that I find to be
22 exceptionally useful, very clear in giving direction to
23 people who are service providers or people who (inaudible),
24 et cetera.

25 In your deliberations about the matrix and the

1 possibility of change, in your presentation you did not
2 mention stigma. At least I did not hear stigma of mental
3 illness and stigma as related to substance abuse. That
4 begins at a very early age among children, families, some
5 communities, but also among professionals, mental health
6 professionals as well as other people in primary health
7 care. I think the literature is very clear that
8 individuals who have mental health problems and heart
9 problems get a lesser quality of care, et cetera. You can
10 imagine how that would happen with thought disorders given
11 the sense and attitude and behaviors toward individuals
12 with mental illness.

13 So I'd like to ask that we spend some time on
14 stigma and how that could, in fact, be a cross-cutting
15 piece of the matrix and other kinds of programmatic issues.
16 That was the one issue.

17 I also like the idea of collaborating in
18 partnerships, and for example, with regard to stigma,
19 keeping that theme alive and collaborating on developing
20 partnerships with the Mental Health Association, for
21 example, as well as other federal agencies, state agencies,
22 et cetera, so that we can keep that alive, keep that in the
23 forefront of what we also need to address, and also with
24 accrediting bodies and academic institutions where they
25 look at stigma and how it is expressed among providers, and

1 also among individuals and family members, because I think
2 when you put stigma juxtaposed with a real killer, such as
3 suicide, we find that stigma is one of the barriers that
4 keep people from getting health care.

5 The other issue is regarding suicide, which I
6 highly embrace. I look at those populations where suicide
7 is increasing yearly, and that's among African American
8 males, and American Indians where it has also been a
9 problem for years, and Hispanic youth, especially among
10 adolescents and young adults. So I would ask that we give
11 that some special deliberation so that we can see what the
12 barriers are and what the protective factors are and what
13 kinds of programmatic issues would be useful for that
14 population.

15 MR. CURIE: Thank you, Faye. I appreciate your
16 support for examining the suicide arena, and also your work
17 on stigma. That is probably one of the biggest, in one
18 sense, invisible barriers. It becomes visible through
19 discrimination and through things that are unspoken, and I
20 think examining its role in the matrix is critical.
21 Currently it is listed along with recovery as a
22 cross-cutting principle, but the idea is is there a way of
23 prioritizing it further or highlighting it and (inaudible)
24 the discrimination that occurs with it.

25 Thank you, Faye, very much.

1 Tom?

2 MR. KIRK: Let me reinforce Ken's comment to
3 see a copy of your remarks, because one of the things that
4 strikes me about what you're doing and our support of that
5 is that Access to Recovery, transformation, state incentive
6 grants, the strategic prevention framework, I don't see
7 these in projects. These are major system change issues.
8 What I find challenging within my own state that I think is
9 an important piece for us to focus on is that we have these
10 different grants. So Connecticut has each of those three,
11 and it's a marathon. It's not a sprint. Trying to have
12 stakeholders understand that we're truly talking about
13 changing the system of care, access to care, health and
14 addictions, cross-linkages, and our focus is on prevention
15 from a wellness point of view, that our providers as well
16 as state agency folks are not used to grants. These are
17 projects, and the funds are going to run out.

18 So I'd be interested sometime during the next
19 day and a half to think about how do we take these
20 particular change levers in terms of funding, these funding
21 figures begin to jump out. Here in the platform it says
22 building on those things, they become the core of the
23 service system. I think that's an extremely important
24 point to communicate.

25 Two other points, one I cannot emphasize

1 enough. When one looks at the danger at least that I've
2 seen at one of the recent mental health commissioner
3 meetings, I may be wrong in the specifics of this, but the
4 lifespan of persons with serious psychiatric disabilities
5 is somewhere in the range of 10 to 15 years less than the
6 larger population. As part of Medicare Part D, we've
7 looked at the medications that (inaudible) in Connecticut.

8 It averages around five medications. Only two of them are
9 psych meds. The others are for diabetes, cardiac
10 conditions, cholesterol and those kinds of conditions. We
11 don't link primary care for these other disorders to our
12 recovery mission, which is part of the picture. I think
13 the more we can, with your support and your leadership, tie
14 the emphasis on health care to a larger span, so much the
15 better.

16 I want to request that sometime within the next
17 day and a half we have some comments about Medicare Part D,
18 what you see at the federal level. We were able to get our
19 legislature in Connecticut to put up dollars to cover
20 co-pays because we were so concerned about co-pays,
21 particularly dual eligibles. What might be going on at the
22 federal level through HHS as related to Medicare Part D?

23 MR. CURIE: Thank you, Tom.

24 Any other comments?

25 Barbara?

1 MS. HUFF: Well, I could comment on everything,
2 but I'm going to try to keep it to a minimum, okay?

3 There is one thing that I'm also concerned
4 about funding coming up and how do we pay for what we're
5 doing. A couple of things. Maybe it's because I've
6 represented kids for so long that I just have to say this.
7 It feels like to me that if we could, when we fund
8 programs, when we fund systems change work, that the thing
9 that I liked so well about the transformation grants is
10 that they covered the lifespan, so you're getting a much
11 bigger bang for your buck. You're not having to do systems
12 change for kids, systems change for older people, systems
13 change for -- you understand what I'm saying.

14 It seems like related to seclusion and
15 restraint and some of these other high-priority issues that
16 we can do the same. It's not that we don't. It's just
17 that it feels to me like there is still -- it still feels
18 like the kids in seclusion and restraints are not getting
19 the same bang for the buck that adults are. I might be
20 wrong in that. You know it better than I, but in terms of
21 what you fund, in terms of technical assistance around
22 that, I'd like to see, I don't know, the GFAs or the RFPs
23 or whatever they're called right now deal more specifically
24 with kids' issues in some of those things. I'm not going
25 to recommend that you fund something related to kids on

1 seclusion and restraint. It seems like we could do
2 something much more overall around seclusion and restraint.

3 It should be a high priority. I'm doing some
4 volunteer work right now related to kids who are dying and
5 being hurt in unlicensed residential facilities, and I am
6 finding out things I never wanted to know. Seclusion and
7 restraint is just one piece of that, I mean just one piece.

8 So I want to make that statement that it seems
9 like we could more broadly look at the lifespan, things
10 that we do fund.

11 Secondly, around stigma, I'm going to say this.
12 Someday you're going to miss me on this council because I
13 say the same things every time, but around stigma, we need
14 to start over. In my opinion, we need to form a group that
15 begins to look at this differently. I totally agree with
16 some of the things you said. It has to start really early
17 with really young kids, but a lot of us on this panel had
18 things to say about the issue of stigma. I don't even like
19 the word "stigma," but I'd like to make a recommendation
20 that we look deeper and broader. I don't think we're doing
21 it right, but that is simply my opinion, okay? So there's
22 that.

23 Then in underage drinking we're going to
24 discuss. I don't have to say anything to you and this
25 council about suicide prevention because I always have at

1 least one meltdown every council meeting about this. So I
2 don't think I have to say very much about that.

3 I do want to say that in the last few years,
4 since Sybil Goldman has been with us, I think we're in far
5 better shape, and I want to thank you for that because we
6 had no shape before that. So I do want to say that I feel
7 like we have come much more into our own. We have a ways
8 to go yet. I don't think Sybil would disagree with me on
9 that. We have a ways to go, but I do want to say that I
10 think we're at least getting further along, and so I thank
11 you. I really think that these things that you mentioned
12 are exactly right where we need to be, and I do understand
13 the need for prioritizing, but I actually think we could
14 take a look at what we're doing and be more inclusive in
15 some of the things that we're doing.

16 MR. CURIE: I think that's very good, Barbara.
17 I think we absolutely need to be examining this. When it
18 comes to seclusion and restraint, we could demonstrate what
19 we've been doing in the children's area because --

20 MS. HUFF: I probably just don't know.

21 MR. CURIE: In fairness, we want to make sure
22 people are aware, because after we began to make great
23 progress -- this is about three years ago -- we began to
24 see that the adult state psychiatric institutions across
25 the country, with a very powerful partnership we had with

1 NASMHPD, we made real strides, and we made real strides in
2 general psychiatric settings, inpatient settings overall,
3 again a lot of the adult settings.

4 We did, with the Child Welfare League and other
5 associations, have begun processes over the last two to
6 three years to really put a press on children's settings.
7 I like your idea of the lifespan approach and making sure
8 that that's always embraced to move ahead.

9 I think what we have found, and it's of great
10 concern to me, is if you're talking about mental health
11 residential settings, you begin to make some progress. But
12 if you're talking about the other children's settings, and
13 I think those are the types of things you're uncovering, it
14 is frightening and we are needing to really press very much
15 forward. There are too many accounts we still read about
16 in the papers of deaths of children in various kinds of
17 residential settings, and they all are directly related to
18 improper restraint. A child being restrained so that their
19 windpipe gets cut off is typically what we find. Those are
20 the types of things we need to address, and we have been
21 actively reaching out and working with juvenile justice
22 facilities.

23 I think the interface with Cheri, along with
24 CMHS, can help us in that arena. If anyone is interested,
25 we can set that up to go over the portfolio and begin to

1 take a look at where we need to take it to that next level,
2 because I do believe we've only begun to scratch the
3 surface on that.

4 MS. HUFF: Can I just say one more thing?

5 MR. CURIE: Sure.

6 MS. HUFF: I would like to just kind of make a
7 plea for whatever does get funded and whatever comes to the
8 forefront related to priorities, I was stunned when we
9 talked about suicide prevention in this council meeting not
10 too long ago, and I said do we know that because we fund
11 these things that there are less suicides that take place,
12 and you said we didn't have a way of knowing that yet.

13 MR. CURIE: Yes, at this point.

14 MS. HUFF: At this point. I would rather have
15 you fund less and do it to where we've got some outcomes
16 and where we know what's been funded works. I'd rather
17 fund less and do it right. Do you understand what I'm
18 saying?

19 MR. CURIE: Absolutely.

20 MS. HUFF: Because otherwise the federal
21 government has no accountability related to what they've
22 funded. It doesn't work? Well, we don't know if it works
23 or not. Well, how can we say that we ought to put this
24 many millions of dollars into something we don't know?

25 It's like stigma. Somebody's got to tell me

1 that what's happening now is making a difference, and if
2 it's not, then we need to figure that out. You may be
3 doing more, but I do know in systems of care we can
4 actually say that kids are in school more, they're doing
5 better in school, there's less juvenile justice contacts.
6 I mean, we know those things, and that's how --

7 MR. CURIE: I think the other issue is bringing
8 to scale those things that demonstrate a measurable impact,
9 like systems of care. So I appreciate that. Thank you.

10 Other thoughts or comments? Gwynn?

11 MS. DIETER: Yes. I just want to say I think
12 the points you brought up to address are right on target of
13 things we discussed and need to move in that direction.
14 But I did want to in particular support the relationship
15 with criminal justice and juvenile justice because, as I've
16 said several times before on this council, I think it's
17 twofold. I mean, interacting with the criminal justice
18 system actually is a window of opportunity, and there
19 aren't going to be that many more windows of opportunity
20 for those people who are coming into that system, and there
21 isn't a relationship in many places at all. I think it's
22 so important and could have tremendous results if people
23 could be screened and assessed properly, and then judges
24 and so forth came to act as the people from Alabama were
25 doing down there, where it's a part of their whole

1 approach. I mean, it just sounds like they're making a
2 tremendous difference. I was just so impressed by their
3 program.

4 The other side of it is that families of
5 individuals who have either substance abuse, mental health
6 or a combination, where that individual is coming into the
7 juvenile or criminal justice system, those police or
8 whatever feel the problem deeply. Their hands are tied.
9 There is nothing they can do. They don't really want to
10 just throw them in jail.

11 So anyway, I'm passionate about that,
12 especially for young people, just because they have still
13 some hope there of making a change. I just think it's
14 critical. Every young person that comes into jail
15 practically has a substance abuse or mental health issue of
16 some type or other. Anyway, I just wanted to support that.

17 Also, we have been seeing some positive yet
18 unmeasurable results in our community in Colorado, where I
19 no longer am, in terms of underage drinking, and we're
20 really pushing through this Parent Corps to work to educate
21 and support and unify. So I just want to support those two
22 in particular.

23 MR. CURIE: Thank you, Gwynn. Thank you so
24 much. Very good comments on the interface, as you
25 described it, of the juvenile justice system, (inaudible)

1 some progress to bring it to a whole new level. I
2 appreciate your support.

3 I think we have time for one more comment. Is
4 there anyone else after Ken?

5 (No response.)

6 MR. CURIE: We'll give Ken the last comment on
7 this one.

8 MR. STARK: Going along with what Barbara said,
9 I too believe in repetition, and to me repetition is like
10 water on a stone, that over time you're hopeful it will
11 make an impression and somebody will hear it. In the last
12 meeting, our last National Advisory Council meeting, I
13 talked about an issue around language, and one of my pet
14 peeves is the whole issue of behavioral health and the fact
15 that that term, although it's a term that we in the
16 alcohol, drug, and the mental health field felt a necessity
17 to use in order to establish ourselves within the health
18 arena because you couldn't get primary care to recognize
19 us, in my opinion is having an unintended consequence --
20 actually, two potential unintended consequences. One is
21 that it feeds stigma. It negates the
22 physiologic/biologic/genetic basis of mental illness, as
23 well as drug addictions.

24 It also, I believe, now will create a
25 difficulty for us as we try to align more with primary

1 care, and many folks in primary care will continue to say,
2 oh, well, you're not really health. You're behavioral
3 health. You deal with behavioral problems rather than real
4 health issues. As much as it may seem like a petty issue,
5 a lot of stigma is about language. It's about impressions
6 that you create. I know SAMHSA doesn't have behavioral
7 health in its name, and I appreciate that very much, and I
8 would encourage anybody else out there in the community who
9 is using that term to really reevaluate how that term has
10 an unintended negative consequence.

11 MR. CURIE: Thank you, Ken. I think we do need
12 to take words seriously, and I think when we talk about
13 stigma -- and again, one word that I think we use a little
14 loosely at times is "discrimination," because that's the
15 evidence of stigma. But I think the words we use many
16 times unintentionally do undercut our mission, and I
17 personally don't believe behavioral health says anything.
18 It's a shorthand way of being able to talk about mental
19 health and substance abuse. Actually, my impression is it
20 started in the private sector more than the public sector.
21 But I think as we move ahead and continue to focus on
22 substance abuse, I think the one on co-occurring disorders,
23 some people felt behavioral health would address that, and
24 I think it only undercut that agenda as well, because we
25 are talking about different illnesses, different diseases,

1 but they co-occur sometimes in an interrelated way, and
2 sometimes folks are self-medicating because they have an
3 underlying undiagnosed mental illness.

4 But many times people truly have an addictive
5 disorder and can also have a mental health diagnosis, and
6 each needs to be treated in the appropriate way, just as
7 you would treat somebody with diabetes and high blood
8 pressure. You wouldn't treat one and not treat the other
9 because their primary diagnosis was diabetes and not blood
10 pressure, or hypertension.

11 So I think we've made some great strides, and
12 we're going to continue to keep (inaudible) on that.
13 Anyway, adding behavioral health in SAMHSA would ruin our
14 whole acronym.

15 (Laughter.)

16 MS. HUFF: Charlie, kids are telling us that
17 they take the language seriously, emotionally disturbed.

18 MR. CURIE: That term has been around long
19 enough that we need to examine it anew.

20 At this point, thank you for your discussion,
21 thank you for your input. I look forward to more
22 discussions around (inaudible). We'll make sure the
23 remarks that are in writing are available to all of you for
24 your perusal and consideration, and you can do your own
25 internal deliberations and perhaps deliberations between

1 each other.

2 I'd like to now turn it over to Daryl Kade, who
3 will be talking about the FY '06 appropriations update, and
4 also the top 20 priorities.

5 MS. DIETER: I don't think we have a copy of
6 the matrix in our notebooks at this time.

7 MS. VAUGHN: I'm getting them.

8 MS. DIETER: Oh, good.

9 MR. CURIE: We should make sure you get copies.
10 We could have brought those placemats today. They'll
11 thank you for that.

12 I'd like to turn it over to Daryl Kade and Joe
13 Faha. Daryl, as you know, is the executive director of the
14 Council, and also is director of policy and budget and
15 program planning for SAMHSA, a very valuable member of my
16 executive leadership team. Joe is director of legislation
17 and represents us on the Hill. The two together will give
18 you a fairly comprehensive update on the appropriations and
19 the top 20 priorities for HHS as we deal with the overall
20 HHS programmatic and managerial agenda.

21 Daryl?

22 MS. KADE: Good morning, everybody. The
23 appropriations update is going to be pretty easy. We don't
24 have a bill. We're on our second continuing resolution,
25 which should expire December 17. I hear from sources that

1 we should anticipate an omnibus bill, hopefully before the
2 CR expires, but at this point we're in a holding position.

3 The House mark or conference markup that we were working
4 with several weeks ago was based on the lower House mark
5 plus add-ons from the Senate, but it did not go anywhere.
6 We're anticipating, based on memos from the Department, a 1
7 to 2 percent recision at best. Joe will give you a little
8 bit more particulars about what's happening on the Hill in
9 that regard.

10 But we need to move forward. It is December.
11 We need to move forward on our contracts and our grants.
12 So what we've been doing is working with the centers to
13 assume a President's budget base, to assume a markup base,
14 and to proceed as expeditiously as possible, get a bill in
15 place, and then we'll make the necessary changes. But we
16 can't freeze up because there are deadlines that we have to
17 meet in the summer and in the fall.

18 We are working on the '07 budget. It's a
19 confidential document right now. I bring that up because
20 of what you said, Barbara, that data is absolutely key. It
21 doesn't matter what discussion we have with OMB, whether
22 it's our discretionary grants, whether it's our block
23 grants. To the extent we don't have data that clearly
24 portrays our effect not only on the systems but also on
25 individual client outcomes, we're at that much of a

1 disadvantage, which is why we are focusing on our data
2 strategy and focusing on investments in our data strategy
3 and, quite frankly, realigning other investments. This is
4 something that keeps on coming back to bite us, and there
5 are other issues that we need to talk about other than
6 data. So if we can cover that area, we're in a better
7 position to leverage other changes and other decisions. So
8 I wanted to make that point, that it's clearly an issue.

9 In your folder I believe you have the top 20.
10 What section is that in, Toian?

11 MS. VAUGHN: Under "Appropriations," Tab 2.

12 MS. KADE: I wanted to take a few minutes to go
13 over this with you because this is really the basis of our
14 communication with the Department, and the Department's
15 communication with OMB. It is not only crucial in terms of
16 our performance assessment but also the agency's and the
17 Department's.

18 It's called the Top 20. Last year it was the
19 10 by 10, the 10 program objectives and 10 management
20 objectives. But Secretary Leavitt has taken this
21 opportunity to integrate program and management, and it
22 alternates between program and management. I cannot stress
23 to you the importance of our reaching green and scoring
24 well on the management objective so that we can leverage
25 change in the program objectives. These are absolutely

1 key. So when I go over these, I will highlight not only
2 the program but the management, because they are of equal
3 priority.

4 We are currently working on Mr. Curie's
5 performance plan, and what we need to do is to link these
6 top 20 to his performance plan. That then trickles down or
7 cascades down to the management team's performance,
8 contracts, which then trickles down to or cascades down to
9 the division director and branch chief. So this is a very
10 critical document for us.

11 We haven't finalized the draft, but obviously,
12 number one, transform the health care system, is a key one
13 that we will be linking to, and in particular 1a, increase
14 access to high quality, effective health care that is
15 predictably safe. This touches on a lot of what you were
16 talking about, Ken, in terms of focusing on systems change
17 that will then increase access.

18 The next item, number 2, strategically manage
19 human capital, this is where we do have that cascading down
20 from the top 20 to our performance plans and our
21 performance contracts. It is where the deadlines for
22 appraisals become critical for us in order to position
23 ourselves well with the Department to negotiate and have a
24 common understanding and expectation of what our goals are
25 in the next year, and it takes place in these very

1 important documents.

2 The next one that directly affects us is also
3 in the management area, our competitive sourcing program.
4 We competitive source our review process, and we totally
5 support whatever the Department has in line for any other
6 activity.

7 The next area that is critical to us is number
8 6, which is improve financial performance. Here we refer
9 to OMB getting green. This is where we are judged on the
10 effectiveness of our budget and planning activities, and
11 also the timeliness of our budget and planning activities,
12 and a new item has been put into place, the A-123, which is
13 an emphasis on avoiding fraud and abuse. This is a very
14 high-priority item for the Department, and as an agency we
15 have to take a very hard look at our internal control
16 processes as well as our authorizations and make sure that
17 we are entirely in compliance with both financial laws as
18 well as our authorizations.

19 Number 7, secure the homeland; 7a, increase the
20 capacity of the health care system to respond to public
21 health threats and bioterrorism, as well as natural causes.

22 Obviously, we have a focus on this in our disaster program
23 priority area in the matrix, as we expanded that, and we
24 need to work with the Department in order to incorporate,
25 for lack of a better word, behavioral health care within

1 the plans that the Department develops for a federal plan,
2 as well as states, but also with our SERC, with our state
3 grants, with the state planning grants and emergency
4 grants. We do a lot of activity in this area and, quite
5 frankly, we're very well received by the Department in our
6 Katrina efforts. It worked very well in that.

7 The next area that is of particular concern to
8 me is number 10, improve budget and performance
9 integration. This is, again, an area that lines up, when
10 you look at OMB mandated green standards for success, this
11 refers back to the President's management agenda. But here
12 is where our strategic plan comes into play. Here is where
13 our data strategy comes into play. This is not just
14 budget. It's lining up our budget and our budget
15 priorities to the data we have, to how we all put it
16 together. This is absolutely critical for my operations in
17 my office, and then how we move to effect our program
18 priorities and achieve progress through objective measures,
19 milestones, activities, measures of success. If you don't
20 have those, when are we going to have those? You could
21 make a very strong case.

22 Another area, number 11, was not in the 10 by
23 10 last year, but it is in the top 20. It's improving the
24 human condition around the world. Here I would refer to
25 11b and health diplomacy. We've been doing a lot in the

1 world with regard to mental health and mental illness and
2 protecting against and preventing mental illness in Iraq,
3 in Afghanistan, in a lot of areas. We're getting more and
4 more involved in this area, and this is becoming a high
5 profile area with the Department as well, and at this point
6 we're trying to develop some sort of cohesive plan so that
7 we can put not only our activities but our funding in
8 perspective.

9 I would refer you next to a rather delicate
10 area, number 15. This is to promote quality, relevance and
11 performance of research and development activities. We're
12 not here yet. One of the sub-bullets that is not here is
13 really translating research into practice, a lot of the
14 activities that IOM has talked about. As you may know, we
15 released an update to our NREP process and have collected
16 public comments. One of the issues that we have with the
17 Department is why isn't there a sub-bullet here that talks
18 about getting this research out, not just biomedical
19 research but the research on the effective practices out to
20 the field? More on that later.

21 Number 17, emphasize faith-based and community
22 solutions; number b, expand faith-based and community
23 partnerships in providing effective health care services.
24 Last year this was a specific reference to ATR. This year
25 it's a more generic reference, a cross-cutting area in our

1 matrix, and obviously ATR specifically focuses on
2 collecting data on the number of faith-based providers. It
3 appears that that's a metric that the entire Department
4 wants to work on as well.

5 Finally, if you look at number 19, emphasize
6 healthy living and prevention of disease, illness and
7 disability; sub-bullet c, reduce the incidence and
8 consequences of injuries, violence, substance abuse, mental
9 health problems, et cetera, this is our hope for mental
10 health and substance abuse. How it relates to number 1,
11 transforming the health care system, is what we have to
12 work on. Obviously, number 1 and number 19 are intimately
13 related. This is where we housed our redwoods mental
14 health systems transformation, the Strategic Prevention
15 Framework, ATR, and the co-occurring set. This is where we
16 want to identify what our milestones, our achievements, our
17 progress is, and negotiate reasonable objectives with the
18 Department so that we're in a good position of assessing
19 our success next year.

20 So I wanted to share those with you, and if you
21 have any questions about the top 20, I'll be happy to
22 either answer them or relate them back to Mr. Curie and the
23 Department.

24 MS. SULLIVAN: Daryl, are the OMB mandated
25 green --

1 MS. KADE: Yes, the presidential management
2 agenda --

3 MS. SULLIVAN: -- for success, are those
4 criteria listed on a website?

5 MS. KADE: Yes, they are, and I can get them
6 for you. They're generic. We also have a translation of
7 those.

8 MS. SULLIVAN: In abbreviated form?

9 MS. KADE: Yes, I can.

10 MS. SULLIVAN: Could we see those?

11 MS. KADE: Absolutely. We also have specific
12 metrics that were given by the Department every quarter.
13 We're actually scored every quarter on them. Let me see
14 what's publicly available.

15 MS. SULLIVAN: So we can see what we're up
16 against. Thank you.

17 MS. KADE: Sure.

18 Barbara?

19 MS. HUFF: Under 13b, increase the percentage
20 of adults and children who have access to quality health
21 care services through private health insurance, does that
22 happen to include mental health as well as health?

23 MS. KADE: I don't know, and that's something
24 that we can look into. That was certainly an objective
25 that was developed with CMS in mind, but that doesn't mean

1 that we can't partner with them.

2 MS. HUFF: It just seems like that should
3 include mental health for kids, as well as health care, the
4 CHIP program and those kinds of things. But sometimes it
5 has to be spelled out. But I was just curious that there
6 was some assumption that that included mental health.

7 MS. KADE: When we first got this top 20 list,
8 it was several pages long, and they truncated it, and I
9 don't know whether or not they eliminated a bullet that
10 might have affected children. Also, it's unclear how we
11 would work with the other OPDIVs on some shared issues, but
12 another OPDIV has a lead and I can convey that message.

13 MS. HUFF: Thank you. Thank you very much.

14 MS. KADE: Any other questions? Yes?

15 MR. STARK: A couple. On 19a, when I think of
16 behavioral health, even though I hate that term, I think of
17 diabetes, obesity, asthma, heart disease, stroke, cancer.
18 You can throw alcohol, drugs and mental health in there
19 too, but it's a very broad definition of behavioral health.
20 Most people, however, when they think of behavioral
21 health, they only throw out alcohol, drugs and mental
22 health.

23 The second one is related to 18. I'm wondering
24 whether or not, since consolidation is sort of the new
25 (inaudible) of government, I'm wondering whether or not 18

1 will result in a centralization of more functions within
2 HHS, and would that mean a loss of certain specific
3 functions within SAMHSA that will be again centralized in
4 the broader HHS.

5 MS. KADE: Yes, it does.

6 MS. SULLIVAN: Can you repeat that, Ken, go
7 through what you said? Instead of being covert.

8 MR. STARK: Yes, okay. Instead of being
9 covert, say it like it is. Bottom-line it. So are you
10 going to get whacked within SAMHSA, and are some of your
11 staff or functions going to be out of your control in the
12 future through a centralization process?

13 MS. KADE: I wouldn't put it that way, getting
14 whacked.

15 (Laughter.)

16 MS. KADE: I think the Department realizes that
17 there are certain benefits, certain economies of scale, as
18 well as common data needs. I think the CIO is one function
19 that clearly is being centralized. They're trying to be
20 sensitive to the needs of the smaller OPDIVs, as well as
21 the larger OPDIVs. Every now and again there is some other
22 conversation with regard to grants management, contracts
23 management. We'll see where we go and how we'll feel about
24 it.

25 MR. STARK: That was a good answer, very good,

1 very political, a very diplomatic answer. Let's hope that
2 in the end, it really is something that will create
3 efficiencies rather than simply assuming it creates
4 efficiencies and, as a result, the centralization actually
5 results in inefficiencies.

6 MS. KADE: One of the issues that has been
7 presented at the Department's management forum, Anna Marsh
8 and myself, is the issue of performance with regard to the
9 STAFF/DIVs, not just the OPDIVs but the STAFF/DIVs, one of
10 these centralized functions and how it is important to make
11 sure that those contract plans are reflective of the
12 consumers of those centralized functions which can be
13 improved in that regard. So I think we'll have an
14 opportunity to start inputting into those STAFF/DIV
15 contract plans, and hopefully that would give us the
16 opportunity to identify how we define success and how we
17 define failure for those services.

18 MR. KIRK: I think I asked this last time, but
19 I don't remember. As a new member of this group, from a
20 protocol point of view, what is it that would be
21 appropriate for us to do to advocate on behalf of SAMHSA,
22 legislation (inaudible) as individual members?

23 MS. KADE: I'm going to ask Toian to give you
24 our standard advice on this matter.

25 MS. VAUGHN: When you're here at a Council

1 meeting and you're representing the agency and advocating
2 on a particular issue that you have in mind (inaudible) as
3 a Council member, unless you've been in violation of the
4 ethics rules. When you wear a different hat at home
5 attending meetings, then you can share with your fellow
6 individual organizations that you're involved in issues
7 that have been raised here. But while you're on the
8 government payroll, advocate for SAMHSA's issues.

9 MR. KIRK: I guess what I was talking about,
10 the Connecticut legislative delegation, can I have
11 conversations with the Connecticut legislative delegation
12 in support of things that I hear here?

13 MS. VAUGHN: Yes, you can, but not as a Council
14 member, as a representative of the state agency.

15 MS. KADE: Thank you.

16 Joe Faha is our director of legislation. He'll
17 give us an update on what's happening on the Hill.

18 MR. FAHA: Thank you.

19 Tom, did that make sense to you? Okay. As
20 long as you're not going up and talking to members and
21 saying I'm talking as a member of the SAMHSA Council.

22 Daryl brought up the appropriations. This has
23 been a fun year with our appropriations. The House moved
24 expeditiously in passing a Labor HHS appropriations bill
25 and had it done before the August recess. That's the first

1 time that's been done in a very long period of time. The
2 Senate took a little longer, but they too also passed their
3 own bill for appropriations in Labor HHS. There was a
4 conference. That conference ended about the 16th of
5 November. They reported a conference report at the end of
6 the evening on November 17th, rushed it to the Rules
7 Committee so it could be brought up for a vote on the floor
8 the next day, and to everyone's surprise, particularly the
9 Republicans' leadership surprise, it went down in a rather
10 monumental way, by 20 votes, and it was largely because I
11 think 22 or 24 Republicans voted against it. So it fell.
12 All the Democrats and the one independent voted against it,
13 and then 20 Republicans voted against it. So it went down.

14 That meant that we were on a continuing
15 resolution, as we are through the 17th. There is an
16 assortment of things that Congress now has in its pocket
17 that it could do. It could go back and it could
18 reconference. They have no intentions of doing that. I
19 can assure you that none of the staff either on Senate or
20 House, Republicans or Dems, are working on new numbers at
21 all. So we are left with what we've got with going to a
22 conference report. Then if you followed this scenario,
23 there would be renegotiations and reconsiderations over the
24 conference report on the floor. That's not going to
25 happen.

1 Congressman Lewis, who is the chairman of the
2 appropriations on the House side, has indicated that he
3 would like to see a continuing resolution for the entire
4 year, which would continue funding at a lower rate, the
5 lowest rate, comparing what we got in '05 to what the House
6 mark was, to what the Senate mark was, to what the
7 conference report is. So if indeed that were the chosen
8 path, then we'd have to sit around and find out what the
9 rules of the CR are before we would get a sense of what our
10 appropriations are.

11 The more common expectation is that our
12 conference report, as voted down by the House, would be
13 attached to the Defense appropriations, which is the only
14 other appropriations bill that has not been passed and
15 signed into law. The Defense appropriations is also going
16 to be -- around this season they call them Christmas trees,
17 because you keep putting ornaments on it. So you get a
18 bill, and then you start attaching other bills to it so
19 that it will carry through. One of those attachments will
20 be the conference report that has already been rejected and
21 put on the Defense bill on the assumption that people could
22 not vote against it lest they vote against defense.

23 Also expected to go on that is the reallocation
24 of \$17 billion in already appropriated funds for Katrina,
25 and an additional \$2.3 billion added to that, making for a

1 total funding somewhere in the vicinity of \$19.5 billion,
2 and there will likely also be funding for Avian flu and flu
3 vaccines to prepare.

4 Coupled with that, everyone, as Daryl
5 mentioned, would be a 1 to 2 percent across-the-board cut
6 on all appropriations bills except for Defense, at least
7 right now. Just so you have a sense of what that means to
8 us, it potentially means a reduction of \$33 to \$67 million
9 from our budget, depending upon whether it's 1 or 2
10 percent. So that's basically our status.

11 In the meantime, as Daryl indicates, we're on a
12 continuing resolution until the 17th. We fully expect that
13 this is going to be taken care of. Members do not like to
14 be here the week of Christmas. Hell, they don't even like
15 being here in December. So they likely will want to get
16 out.

17 Before I move on, are there any questions about
18 that?

19 (No response.)

20 MR. FAHA: With regard to reauthorization,
21 we've discussed this at the last Council. Reauthorization
22 technically means that you change a couple of dates in the
23 statute. Pick any program that we have, be it the
24 children's mental health service program, there's a section
25 that says "Be it authorized to be appropriated for the

1 purpose of carrying out this section for fiscal year 2001,
2 \$100 million." I'm making that all up. "And for 2002 and
3 2003, such sums as may be needed." That's typical language
4 of what you see. Reauthorization means changing that to
5 read, "For the purpose of carrying out this section, be it
6 authorized and appropriated \$100 million for fiscal year
7 2006, 2007 and 2008." Effectively, that program is now
8 considered to be reauthorized.

9 Reauthorization, however, has a bigger meaning.
10 Even though that may be what technically it is about, it
11 offers an opportunity for SAMHSA and the Department to sit
12 in front of Congress and have a policy discussion and to
13 talk about the directions of the agency and where we want
14 to go, especially if in order for us to go where we want to
15 go we need some legislative change. There is authority
16 that we need to be able to move in the direction that we
17 want to move in, or we'd like to get rid of some of the
18 restrictions that currently exist. So it becomes a
19 wonderful opportunity to have that dialogue on mental
20 health and substance abuse issues.

21 The Senate has indicated that upon completion
22 of the Ryan White reauthorization, which they had thought
23 they would be able to take care of in January but have
24 found out yesterday will not happen until the beginning of
25 March, they then intend to start picking up SAMHSA

1 reauthorization. Briefings, et cetera, will be starting on
2 that sometime in January, and we will be going up to the
3 Hill quite often to share with them what we have been doing
4 and what we need with regard to mental health and substance
5 abuse treatment and prevention services.

6 In our reauthorization, just so that you know,
7 it immediately goes to bills that are currently out there
8 for consideration that may be brought up in the context of
9 SAMHSA reauthorization, and some of those bills, just so
10 you know issues that are likely to come up, underage
11 drinking, mental health transformation, methamphetamine in
12 a big way. Accountability is going to be a big issue with
13 Mr. Enzi, who is dedicated to performance measurement and
14 accountability. Workforce development, mental health
15 services for homeless individuals, services for the
16 elderly, and some concerns from Senator Collins with regard
17 to why do parents have to give up custody of their kids in
18 order to get mental health services. So those issues will
19 come up in the middle of reauthorization.

20 One bill that did pass outside of
21 reauthorization that should be noted is NASPER, which would
22 give the Secretary of Health and Human Services the
23 authority to run a block grant program that would provide
24 funding to states for the purposes of setting up
25 prescription monitoring systems. Unfortunately, two

1 things. One, there's no money appropriated for it; and
2 secondly, there is an existing competing program in the
3 Department of Justice meant to do exactly the same thing.

4 Having said that, are there any questions?

5 MS. SULLIVAN: What do we have to do with that?

6 I mean, why wouldn't that be under our reauthorization?

7 MR. FAHA: It wouldn't. This bill has already
8 passed separately. It's not a part of --

9 MS. SULLIVAN: Oh, you're not talking about the
10 issue with -- you're going back.

11 MR. FAHA: (Inaudible.)

12 MS. SULLIVAN: Joe, when you just went through
13 that laundry list of what's important for reauthorization,
14 can you get us a copy of that laundry list and maybe we can
15 see --

16 MR. FAHA: Sure. This is not a comprehensive
17 list, but I can make it more comprehensive if that would be
18 helpful. That was just based on bills that I know have
19 already been introduced by, for example, Senator Kennedy,
20 Senator Dodd, Senator DeWine. So they would be brought up.

21 MS. SULLIVAN: I know I'd like to know what
22 specific interests those key senators have specifically.
23 Thank you.

24 MR. FAHA: Be glad to, and Toian will bother me
25 until I get it in.

1 MS. KADE: Yes, she will.

2 MR. FAHA: Any other questions? Additions?
3 Deletions? Subtractions?

4 (No response.)

5 MR. FAHA: Thank you very much.

6 MS. KADE: We're running a little late. I have
7 been advised that a 10-minute break would be a good thing
8 to do now. So my watch says 10 minutes to 11:00. So if we
9 can meet at 11:00, reconvene, that would be terrific.

10 (Recess.)

11 MR. CURIE: Again, I'd like to welcome everyone
12 back after the break. Our next item on the agenda is very
13 exciting. It's an opportunity to see firsthand the work
14 that's being done with the Strategic Prevention Framework.

15 Don, thank you for coming all the way from New
16 Mexico. We appreciate Don's leadership for quite some
17 time, and appreciate you sharing.

18 First, I mentioned earlier that Beverly Watts
19 Davis is now my senior advisor on substance abuse in the
20 Office of the Administrator and already has just gotten off
21 to a tremendous start there. Beverly did a tremendous job
22 as director of CSAP up to this point in time. In fact, the
23 Strategic Prevention Framework became a reality under her
24 leadership, again in the form of the state incentive
25 grants, and also putting meat on the bones of the idea of

1 the concept of the framework. Today it's a pleasure for me
2 to introduce her to share with you and for you to see
3 what's happening really on the front lines of New Mexico in
4 operationalizing the Strategic Prevention Framework.

5 So, Beverly, take it away.

6 MS. DAVIS: Thank you all. I am just so
7 pleased and honored, and I just have to say this because I
8 start off (inaudible). She said, Beverly, is this a good
9 thing? I have to tell you all that working for Charles
10 Curie is a phenomenal thing. It is one of the few jobs
11 I've ever had in my life, seriously, where you're excited
12 to get up and come to work. The reason I say this to you
13 all is the vision. The vision is there. We have worked so
14 hard to connect our systems, and we know that in
15 communities it's the fragmentation. As Mr. Curie would
16 say, you've got lots of flowers out there, but do we have
17 the stakes in the ground, the redwoods, that are going to
18 actually help create the infrastructure we need to really
19 make change from the state level to the community level and
20 help them solve local problems?

21 That vision was realized through the Strategic
22 Prevention Framework. I was so excited when I came in to
23 interview with Mr. Curie and I saw his vision, and he
24 talked about the framework, and I knew he got it. He
25 understood that what we need to be able to do is to create

1 flexibility within the states, but accountability.
2 Barbara, you talked about that earlier. How do we make
3 people accountable? All pulled in together with this is
4 the whole idea of how do we make states be able to actually
5 implement data-driven decisions? Because as I shared with
6 you all earlier my story, we can be doing lots of things,
7 but do we really hit the target?

8 We know we have to address risk and protective
9 factors of children. We've got to know the nature, the
10 extent, and the scope of where our problem is, and that's
11 where we've got to get those resources to if we're ever
12 going to change this frame.

13 What the Strategic Prevention Framework did is
14 exactly when you see that spinning wheel behind you, it
15 really looked at the most effective prevention planning
16 process we have. It focused in on how do we make sure that
17 assessment is done well, that people really do understand
18 all the convening and converging factors that between
19 consumption patterns and consequences in communities really
20 impact, that are impacted by substance abuse, and then how
21 do we make sure the capacity, that we build the capacity in
22 states to actually do what needs to be done.

23 Once we mobilize our resources, then we've got
24 to help our states really come up with a plan that is
25 driven by the data so we know that we're actually hitting

1 the target. We're making sure that the resources are put
2 where they need to be and that we're actually addressing
3 the risk and protective factors of our young people. The
4 whole idea, once we build the capacity and we've got our
5 plan, then we really need to implement. We say that, and
6 we know that that's what that means, but we've got to make
7 sure that people aren't sitting on the dollars and sitting
8 on the dollars and sitting on the dollars. It's about
9 getting it out there so the communities will in fact do
10 what they need to do so we can move that and reduce
11 substance abuse ultimately.

12 And last, this is where the accountability
13 comes into play. Through Mr. Curie, the whole data
14 strategy, what we're going to be reporting on, common
15 measures within prevention and treatment and mental health,
16 we're going to be able to truly know and be able to see the
17 result of the work and constantly have evaluation, not as
18 an afterthought of what we've done after we've had our
19 grant for a year or a year and a half, we now do the
20 evaluation part. It's the evaluation that is occurring
21 that is totally involved in everything that we implement so
22 that we know early on if we're implementing a strategy that
23 isn't effective. We don't wait until 12 months later to
24 find that out. It's that whole thing that we talked about,
25 about having those evaluators accountable, a part of what

1 we do. It's changing the way we do business.

2 I've given you all a map in the (inaudible) of
3 really realigning CSAP's resources. We were really able to
4 move from going to implement this in only 10 states. So
5 I'm very proud to report that in our first cohort we were
6 able to put this in 19 states. In addition to that, when
7 we went back and looked at our resources and figured out --
8 again, Mr. Curie was fully supportive of us saying does
9 this work? Is it needed? If it doesn't match that, why
10 are we doing it? And supported us being able to realign
11 our resources so that we were actually able to roll this
12 out in 24 total states and 2 territories.

13 Our goal is to have the Strategic Prevention
14 Framework state incentive grant in every single state. No
15 doubt, with Mr. Curie's leadership and God's help, we can
16 make that happen ultimately. So I wanted to share with you
17 all a map. This morning we had the meeting with the five
18 new states. Those are the ones that are in red on your
19 map.

20 This morning I think they all excited you all.
21 They were just talking about all the things they were
22 going to do, and I walked in the room they were saying we
23 got our Framework grant, we're going to do this. I mean,
24 they were just so excited. It was just great to be here
25 this morning with them. And again, what was really

1 important was that in many of these states, as we look at
2 other epidemics across our country, whether it be meth, X,
3 et cetera, the flexibility that the Framework has is it
4 does allow states to not just focus on a specific drug but
5 focus on the very multi-complex nature of substance abuse,
6 because it's oftentimes many drugs, whether it's underage
7 drinking and meth, or underage drinking and marijuana, or
8 underage drinking and other risk factors that are going on.

9 This grant allows a state to be able to implement that.

10 I'm so pleased to introduce you all to a state
11 that has done a phenomenal job with their SPF SIG grant,
12 and I say that because the other key thing about the SPF
13 SIG grant is it is about helping states bring others to the
14 table who are doing similar work. Within the federal
15 government, we have 27 sources that actually fund substance
16 abuse prevention, and when they get into the states they go
17 into not the substance abuse and mental health service
18 agency. They may go into education, but their goals are
19 the same. The SPF SIG, one of its key components is having
20 that state advisory council that literally brings all those
21 people together so that we're leveraging funds.

22 I'm so looking forward to the brilliant work
23 that Kathryn Power has done with mental health
24 transformation because it really dovetails into this. It
25 is about looking at all your resources to address the

1 complex nature of mental health and substance abuse. One
2 person who has done this so incredibly well is someone who
3 I've known for many years, Mr. Don Maestas. He has a
4 Master's in social work, and he is a licensed social worker
5 who I believe, quite frankly, are God's angels to the
6 earth, as they have been truly working in communities to
7 really make that difference from client to family to
8 community. He is the project director of our SPF SIG
9 grant, and he has been the national prevention networker
10 for New Mexico since 1995. He truly helped us in the very
11 first round of state incentive grants to actually roll in
12 the whole idea of evidence-based work, of really getting
13 people not to have to start all over, reinvent the wheel
14 every time a new program was out, but to begin to see
15 what's working around the country, and then to share that.

16 He has worked with many state and national
17 prevention leaders, and I have known him for many years.
18 He has actually built one of the strongest prevention
19 systems in the country, and I want to emphasize prevention
20 systems, where you're truly connecting all the programs
21 that you are funding in a state with other sources so that
22 you're actually able to help states help communities to
23 solve local problems.

24 So with that, I'd like to introduce you to my
25 friend and colleague, Mr. Don Maestas.

1 (Applause.)

2 MR. MAESTAS: Thank you very much.

3 Administrator Curie, members of the National
4 Advisory Committee, thank you for having me this morning.
5 I'm grateful for the opportunity to come and present New
6 Mexico's prevention system to this body.

7 What I'm going to share with you is one of the
8 best prevention systems in the country, and as we go
9 through it I just wanted to -- can you go to the slide
10 show, please? -- call your attention to the handout that
11 was provided to you. I think it's on your tables. I'll
12 just start with that.

13 So what I'm going to talk about is New Mexico's
14 prevention service system, which is really a national
15 prevention service system, and you'll see why. Who is in
16 the system? Of course, we have many partners and
17 collaborators in this, and those include the Department of
18 Health, Children and Families, Education, a long list of
19 state partners, and then of course the Center for Substance
20 Abuse Prevention, SAMHSA -- they've been our partner for
21 many, many years and helped us to create the prevention
22 system you now see in the State of New Mexico. We also
23 have a lot of support from PIRE, as well as the CAPT
24 center, the Southwest Center for the Application of
25 Prevention Technology, and the Border Center for the

1 Application of Prevention Technology. Certainly, the NPN,
2 where we helped out.

3 I was remiss in not mentioning CADCA.
4 Certainly they've been a strong partner with us for many
5 years as well.

6 What I want to start off with is to talk to you
7 about the system in real life. I want to give you examples
8 of the programs, what kids we work with, what they
9 experience, and what happens to them afterwards.

10 Rocky Mountain Youth Corps is an evidence-based
11 prevention program in Taos, New Mexico, and this young man
12 is part of that program. He was experimenting with drugs,
13 and his best friend committed suicide. He found meaning in
14 participating in community service, learning with youth.
15 He stopped using drugs. He serves in a crew leadership
16 position, directing others, and wants to contribute to the
17 community. He plans on attending college next semester at
18 New Mexico State University.

19 This young lady was struggling with peer
20 pressure and had legal problems, had no plans except
21 getting a GED. She developed trust with instructors and
22 attended her first year of school at UNM Taos. She's
23 currently working with area children teaching substance
24 abuse prevention, as well as tutoring and mentoring.

25 This young man is from the National Indian

1 Leadership Project, which is a national model program
2 through SAMHSA. This young man, Chance, is 11 years old.
3 He's on his way to becoming a great National Indian Youth
4 Leadership Prevention Service staff youth leader. Most
5 importantly, he wants to experience his life to the
6 fullest.

7 We've worked with (inaudible) in New Mexico in
8 terms of substance abuse prevention and evidence-based
9 prevention programs. I just wanted to give you a couple of
10 examples of the different kinds of prevention programs for
11 zero to 6-year-olds and older kids. We have a State
12 Incentive Enhancement Grant in New Mexico. (Inaudible)
13 that we're seeing, for instance, the evidence-based Parents
14 as Teachers program. What we're seeing is children are
15 more advanced in language, problem-solving and other
16 intellectual activities by three years of age; also more
17 advanced in social development. Eighty percent of the
18 children in the program are ahead of their peers by the
19 time they reach kindergarten.

20 Excel Educational Enterprises, Inc. Programs.
21 This is a program located in Albuquerque. It's an
22 Effective Black Parenting Program, which is also a
23 nationally recognized program, and this is a quote from
24 Mary Juzang, the project director. "Any culture can use
25 parenting skills, but we have problems different from

1 others in this country." She characterized African
2 American discipline as harsh and punitive, resulting from
3 the days of slavery and necessary to ensure instant
4 obedience to protect children from white harm.

5 What she does in her program is encourage
6 African American parents to help their children learn
7 internal control instead of relying on external control,
8 and she's having a lot of positive outcomes.

9 Gila Regional Medical Center. While there's a
10 demonstrated significant (inaudible) very positive impacts
11 on positive family interactions related to bonding with a
12 child.

13 The reason I brought those programs to your
14 attention (inaudible) with individuals and families in New
15 Mexico. With the state incentive grant, the emphasis is on
16 changing community-level indicators. So when this grant
17 and the opportunity to apply for it came to New Mexico, we
18 really felt this was the step we needed to take to have the
19 impacts we need to have on our populations that are
20 experiencing problems. Governor Richardson is a grantee.
21 It's \$2.3 million per year for five years. It includes a
22 statewide needs assessment, helps build capacity, and
23 includes a comprehensive strategic plan for prevention that
24 guides local planning implementation of prevention
25 activities in New Mexico. It puts forth evidence-based

1 prevention programming directed at reducing risk and
2 promoting resiliency to reduce underage drinking and other
3 substance use, and to promote youth abstinence. It
4 requires rigorous local, statewide and national evaluation.

5 Certainly, the primary purpose of this grant is to look at
6 changing community-level indicators and building stronger
7 communities.

8 (Inaudible) to really emphasize what the
9 framework is about. The first portion, it's been a little
10 over a year now. We received the grant in September of
11 2004, and we began with a statewide needs assessment where
12 we profiled the population needs, resources and readiness
13 to address needs and gaps. We then moved on to capacity,
14 where we helped build capacity of community-based
15 prevention providers in terms of the use of the framework,
16 in terms of using data to identify where the problems were,
17 and using data to really focus on the interventions that
18 were going to help change some of the problems that exist
19 in the State of New Mexico.

20 We moved on to planning and developed a
21 comprehensive strategic plan, and we're currently
22 implementing the evidence-based programs and activities.
23 Of course, as part of all this is monitoring, evaluating,
24 sustaining, improving and replacing those that fail. It's
25 very important to New Mexico, as it is in the other six

1 states, that sustainability and cultural competence are
2 part of the entire framework. So I'm just going to walk
3 you through where New Mexico is at in implementing the
4 framework.

5 From the assessment, we did develop a SEW
6 workgroup. That's the State Epidemiological Workgroup, and
7 that's been in place since early '04. Actually, we've had
8 a long-term relationship with our division of epidemiology.
9 We've been working with them for a number of years. So as
10 we walk through one of the documents in your handout,
11 you'll see that there's quite an extensive array of work
12 that's been performed by that workgroup to this point. Of
13 course, the purpose was to create in a systematic way a
14 prioritized set of state-level data indicators that will
15 drive the identification of state and local level
16 intervening or causal factors; support the selection of a
17 range of effective, evidence-based strategies to
18 comprehensively impact the prioritized indicators; assess
19 substance abuse-related problems, risk and protection
20 assets and resources, gaps in services and capacity,
21 readiness to act; specify baseline data and identify
22 priorities. The SEW will function throughout the five-year
23 period to refine data, its analysis, and its priorities.

24 They have a lot of work to do. Certainly,
25 they've done a lot of work to date. They helped identify

1 measurable indicators of community-level change. They
2 helped to identify effective strategies that may be
3 implemented by community groups to address indicators.
4 Here's a list of folks that make up the workgroup. It
5 includes the New Mexico Department of Health Epidemiology
6 Division, New Mexico Voices for Children, Children Into
7 Families Department of Underage Drinking Coordinator,
8 Southwest CAPT, Behavioral Services Division Prevention
9 staff, the Strategic Prevention Framework evaluator, and of
10 course the SEW coordinator and others.

11 In terms of the assessment, what we found in
12 New Mexico in the past decade is it's rated first or second
13 in chronic alcohol mortality and drug-related mortality.
14 Some of the substance abuse patterns included in the
15 assessment include chronic drinking, binge drinking,
16 drinking and driving, marijuana use, other illicit drug
17 use, and tobacco use.

18 This is analyzed by gender, ethnicity, age,
19 geographic location, and we certainly utilized a logic
20 model, including consequences of consumption, intervening
21 variables and strategies.

22 What we have here is the New Mexico Community
23 Logic Model, which starts off in the upper left-hand corner
24 with substance abuse-related consequences, moves on to
25 substance use, causal factors, and strategies. Under the

1 substance-related consequences are included the high rate
2 of alcohol-related crash mortality among 15- to
3 24-year-olds. If you look at the youths, underage and
4 young adult drinking and driving, as well as underage young
5 adult binge drinking. Then the causal factors include easy
6 retail access to alcohol for youth, low enforcement of
7 alcohol laws, easy social access to alcohol, low perceived
8 risk of alcohol use, social norms accepting and/or
9 encouraging youth drinking, promotion of alcohol use,
10 including advertising and movies and billboards, et cetera,
11 lower discount pricing of alcohol.

12 Some of the strategies we're going to be using
13 to combat these problems include enforcing underage retail
14 sales laws, social event monitoring and enforcement, media
15 advocacy to increase community concern about underage
16 drinking, restrictions on alcohol advertising to youth
17 markets, bans on alcohol price promotion and happy hours,
18 and others.

19 Some of the criteria that we used according to
20 the indicators include the severity, including the state
21 ranking within the nation; the severity rate per 100,000;
22 the burden, number of persons and size of the problem; the
23 economic impact and social impact; as well as trend
24 characteristics, including increasing or stable compared to
25 the national trend.

1 What I want to draw your attention to now, and
2 it's in your booklet, is the statewide epi profile. This
3 is what it looks like. It's currently marked draft and
4 it's in your packets. What this was was one of the key
5 products developed by the SEW workgroup. You can see that
6 it is a very comprehensive profile that identifies really
7 the problems or the extent of the problems or the extent of
8 the problems in New Mexico related to alcohol- and
9 smoking-related death, drug-related death, as well as
10 suicide. What you see here as you go through this -- of
11 course, we won't have time to go through the entire
12 document, but what you really see is, by county, where the
13 problems are in the State of New Mexico. So this is the
14 kind of information, the kind of data that we're using in
15 New Mexico to help target resources to really address the
16 problem. By utilizing this type of data, and of course
17 using this as benchmarks, we'll see in the next several
18 years the outcomes of our efforts.

19 The next thing I wanted to call your attention
20 to is that this is what we use, this tool that's currently
21 on the screen, and it's in your packets, of course. It's a
22 tool that we use to prioritize the data indicators. So we
23 convene focus groups throughout the State of New Mexico, we
24 share with them the data profile, we walk through the
25 profile and show them how to use the document. We then use

1 this tool to identify the priorities for the state
2 incentive grant for the State of New Mexico.

3 So really what we came up with as we went
4 through this process is the two that we chose in New Mexico
5 to focus on are alcohol-related chronic disease death and
6 alcohol-related morbidity, as well as alcohol-related
7 mortality, the chronic disease death.

8 Go on to the next slide, please.

9 So that would indicate the focus, and this is
10 part 2 of that form. There's part 1 and part 2. We
11 couldn't get it on one form. This is the tool used to
12 identify, and once again using the data and focus groups,
13 this is what determined our focus for what we would be
14 funding for prevention programs in the State of New Mexico
15 as related to this project.

16 In terms of capacity, we felt it's really
17 important to build capacity throughout the State of New
18 Mexico to be able to implement this framework. So we've
19 developed and implemented problem-focused training 1 and 2
20 provided throughout the state in multiple locations.
21 Problem-focused training 3 will be provided to successful
22 bidders in the first 30 days of the award. This SPF SIG
23 framework is being incorporated into overall workforce
24 development programs, as well as our assessment training,
25 capacity training, and planning training.

1 In planning, we held our 11th annual state
2 prevention planning meeting on May 11th in 2005. I put
3 this on the screen just to illustrate to you that New
4 Mexico has been in a process of building one of the
5 strongest prevention systems for a number of years, and we
6 were one of the recipients of the initial state incentive
7 grants, and you'll see some of the outcomes at the end of
8 the presentation from that grant. Certainly, we have
9 really strived to promote evidence-based prevention
10 programs in the State of New Mexico, and that's really our
11 standard at this stage. Really, we had to overcome some
12 concerns about that from local providers, but most of the
13 providers are (inaudible) 100 percent as they've seen the
14 outcomes of the efforts, and certainly that's done through
15 strong, rigorous evaluation.

16 So we developed the strategic plan. The
17 strategic plan was presented to our advisory committee in
18 May, and it was approved by CSAP. Of course, it's been
19 incorporated also into the strategic plan for the New
20 Mexico Behavioral Health Plan for the State of New Mexico.

21 A continuum of prevention services, development
22 of RFP for distribution of services, the resources to be
23 distributed based on statewide needs assessment,
24 evidence-based prevention programming directed at reducing
25 risks and promoting resiliency to reduce DWI and underage

1 drinking and other substance abuse, and to promote youth
2 abstinence. We've gone through that process, and we
3 selected eight implementation communities, as well as five
4 capacity communities. We're currently still in the process
5 of our procurement process, so I'm not able to share those
6 communities with you today. Hopefully in the next several
7 weeks, as soon as all the contracts are signed and sealed
8 and delivered, it will become public information.

9 But certainly we just wanted to emphasize in
10 terms of these implementation communities, what they will
11 be doing in the month of December is we're bringing them
12 together and providing an all-day training to them, as well
13 as going over all the expectations. These communities were
14 selected because we felt they're ready to implement the
15 framework. We just want to make sure we're all on the same
16 page and pushing forward together in order to have the
17 maximum input with this program.

18 January we'll be focusing on capacity with
19 these implementation communities, and February we'll be
20 really focusing on planning. By the end of February,
21 beginning of March, we'll be asking our communities to
22 submit strategic plans to us for approval so they can move
23 forward with implementation.

24 Really what we want to see in those strategic
25 plans is how they'll use the epi data, how they build

1 capacity within their communities, how they develop a
2 strategic plan, and how they begin to move forward with the
3 implementation of the program. So we're really excited
4 about these communities and the opportunities they have to
5 create change in the communities in New Mexico.

6 We recently selected five capacity communities.
7 (Inaudible) proposals that were submitted, but certainly
8 communities with high need and low capacity. We're going
9 to work intensively with these communities for the next
10 seven months to help build capacity, with the hopes of
11 making them full implementation grantees beginning July 1
12 of '06. So we're going to be moving a little slow with
13 them, going through that same process in terms of getting
14 them up to speed on the assessment and use of data, on
15 building capacity in communities, and on putting together a
16 strategic plan for the implementation.

17 In terms of evaluation, we have a contract with
18 behavioral assessment, and we've worked with them for about
19 seven years now. They're our primary evaluator for the
20 state incentive grant, the original state incentive grant
21 for New Mexico, and they've been working with us to develop
22 problem statements, as well as really working well with us
23 on the actual prevention framework.

24 The evaluation system is to be enhanced to
25 measure community-level indicators. This is something that

1 many states are really challenged with. We can and have
2 measured successful individuals and families. It's
3 difficult to measure change in community-level indicators,
4 and certainly this is the task we feel that we're up for,
5 we're ready to take on, and certainly with our partners we
6 feel we'll be successful in doing this.

7 We're in the process also of developing tools
8 to measure the effectiveness of environmental strategies,
9 and of course we need to be able to consistently count the
10 number of individuals being impacted by environmental
11 strategies. Certainly, as I'm called to the legislature to
12 talk to them about what we're doing and who we're doing it
13 with, an intelligent thing to do, once we get (inaudible)
14 focus on individuals and families, we are going on when we
15 talk about communities, who we're impacting and how we're
16 impacting them.

17 (Inaudible) the presentation and just talk to
18 you about some of the successes in the system (inaudible).

19 Certainly we've seen reductions in substance use and abuse
20 in New Mexico. We're working on our third five-year
21 prevention plan. We funded evidence-based prevention
22 programming in over 40 New Mexico communities. We have a
23 strong grants management system, a comprehensive workforce
24 development system, and we've been doing outcome
25 evaluations since 1996.

1 Some of the outcomes, just to give you an idea
2 of the outcomes we have achieved, if you look at this graph
3 what you see is in the pink is the comparison group. The
4 darker color is our intervention group. On the pre-test,
5 you see the intervention group is about 24.6 percent, and
6 our comparison group is a little over 23 percent. We saw
7 increases in our implementation group, as well as increases
8 in the comparison group. So this shows the efficacy of
9 prevention programming in the State of New Mexico, and this
10 is the percent of past 30-day alcohol use.

11 This is very similar. This is in terms of the
12 past 30-day marijuana use, and we see a similar occurrence
13 here, where we see reduction in use for the implementation
14 group and an increase in the comparison group.

15 The next slide is percent of past 30-day
16 tobacco use, very similar as well.

17 What these slides show us is that
18 evidence-based prevention is effective, it can be measured,
19 it has been measured, and certainly I think we would all
20 like to see greater increases in use regarding those
21 programs. Certainly, there are more factors that we need
22 to look at as we (inaudible) our prevention programs on an
23 annual basis. The pre-test, for instance, just to give you
24 an example of the high-risk individuals who we're working
25 with, the pre-test shows you that 23 percent or greater

1 were already using, and we saw the increases in use at our
2 post-test.

3 One of the things (inaudible) are we using the
4 right programs for the right individuals? There are a lot
5 of evidence-based programs out there, but (inaudible) on an
6 annual basis take a look at those programs, how effective
7 they were and whether or not they were the right programs
8 for the right populations. That's certainly something
9 we're doing in New Mexico.

10 One of the other things I'll just mention since
11 I've got the microphone is that the evidence-based programs
12 that we're doing, certainly we support them, but certainly
13 in New Mexico we adapted most of those programs while
14 working with the creators of the (inaudible) program. So
15 that's really key to make them culturally competent, make
16 them fit our populations. So I don't think we have a
17 single evidence-based program that's a canned program, just
18 so the group is aware of that as well, because I think
19 that's real important and that's one of the knocks against
20 evidence-based prevention programs that I hear over and
21 over again.

22 That's it for my presentation. Once again,
23 thank you for the opportunity to come here to Washington
24 and to talk to you about the New Mexico prevention service
25 system.

1 (Applause.)

2 MR. CURIE: Ken?

3 MR. STARK: A question for you, Don. It sounds
4 like you all have done some really, really good work there
5 in doing the documentation. Are you looking at taking it
6 to the next level to look at, for those individuals who
7 have participated in these programs, are you seeing any
8 changes relative to some of the other risk factors, looking
9 at archival data sets? For the kids, have you seen any
10 improvements in school participation, in grades, reduction
11 of school dropout, reduction of school attendance problems
12 or reductions in criminal justice? I'm not looking at that
13 from a self-report standpoint but using existing archival
14 data sets to truly do that analysis and match up these
15 participants with those databases to be able to then sell
16 it to legislatures as cost-effective programs?

17 MR. MAESTAS: Yes. Thank you for the question.
18 We have, in fact. When we received the state incentive
19 enhancement grant, that was one of the things we were going
20 to do with it, or we are doing with it. So certainly the
21 data from that will be made available shortly. Really what
22 we did is we took -- because that's always a concern and a
23 question. You have an impact over a 30-day use. What
24 about the long-term impacts? So certainly we're in the
25 process of gathering that information, and we should be

1 able to report on it probably in the next six months or so.

2 MR. STARK: Yes, it sounds like you're well
3 positioned to be able to do that.

4 MR. CURIE: Barb?

5 MS. HUFF: Two or three comments. First of
6 all, thank you for coming and sharing that with us today.
7 It's really exciting.

8 One of the things I just wanted to kind of
9 point to, on one of your slides here on page 7, you talked
10 about assess the substance abuse-related problems, risk and
11 protection assets, resources for services and capacity, and
12 readiness to act. I just want to thank you for mentioning
13 readiness to act.

14 I've been around this town for a long time.
15 I'm 60 years old now, so I've been doing this for a long
16 time, and I just want you to know that I have seen so many
17 communities get money who were not ready to act. I came
18 from Wichita, Kansas 20 years ago. They gave back their
19 local CASSP grant because they just could not -- they just
20 said don't send us any money because they couldn't act.

21 So you can do a lot of things, but I love it
22 that you put down here readiness to act. It's so
23 important.

24 Then the next thing I want to mention is the
25 whole issue around evidence-based practices and how they

1 translate to stigma in New Mexico, which has such a diverse
2 population of people, and what we as families, parents with
3 kids with mental health and substance abuse problems, have
4 been saying for a long time that we're nervous about that.

5 We're nervous about whether or not evidence-based practice
6 really does translate into all communities. Will what
7 works as an evidence-based practice in inner-city New York
8 go to New Mexico?

9 So I'm glad you're recognizing that, and I know
10 you want to say something, but I like to hear that.

11 MR. MAESTAS: Well, in terms of the first, in
12 terms of the readiness to act, certainly that was a big
13 part of the Request for Proposal that went out. Certainly
14 the communities were selected for high capacity or high
15 readiness to act and high need. Certainly that was the
16 focus.

17 MS. HUFF: But sometimes people have great
18 grant writers that can produce a readiness to act that
19 really aren't ready to act. I'm sorry, but people pay a
20 lot of money for grant writers.

21 MR. MAESTAS: And actually that's one of the
22 things that we're going to determine in the first three
23 months of the grant as well, because we're going to make
24 sure -- that's what's different about this grant as well.
25 Prior to even allowing them to implement it, which all of

1 us, CSAP and SAMHSA, did with the states, they will be
2 ready to act before they act. That's one of the things we
3 really just shared.

4 Your second question was regarding adaptation
5 of programs. Certainly that's something that initially,
6 going back seven years, eight years ago, there were a lot
7 of programs in communities that had some real concerns
8 about this, and (inaudible) evidence-based programs.

9 One of the things that we've been doing is
10 working very, very hard with those communities to adapt
11 them. But also we've been working with our communities to
12 bring in what we call the homegrown programs and helping
13 them to get to model programs. So we have about five of
14 those in New Mexico that obtained that status over the past
15 several years. So we're really proud of that because here
16 we have programs that have evaluation tied to them, and we
17 worked with them to achieve the model program status.

18 I got an interesting thank-you letter from one
19 of our programs, one that I highlighted before, one of the
20 first model programs in New Mexico. The first model
21 program was a home-visiting program, and initially when
22 they received the grant, they were doing good work. We saw
23 that; we funded them. But they were real hesitant and
24 really concerned about putting 10 to 20 percent of their
25 grant money into evaluation. Well, I got a thank-you

1 letter last week thanking me for emphasizing the need for
2 them to do that, and they appeared in last week's Social
3 Work Journal in terms of model programs. So a great
4 success for the families and program that are working in
5 Silver City, New Mexico.

6 MS. HUFF: Can I just ask one more?

7 MR. MAESTAS: Please.

8 MS. HUFF: How are you interfacing -- I'm real
9 familiar with the language of (inaudible). How does this
10 interface with mental health, children's mental health, and
11 the fact that you have kids with mental health problems
12 (inaudible)?

13 MR. MAESTAS: Thank you for asking that
14 question. As I was going down that list, I knew I was
15 going to be remiss in not mentioning people. Certainly I
16 work within the same division that does the children's
17 mental health, and then also we have in New Mexico the
18 Behavioral Health Collaborative, which is really 17 state
19 agencies working together to purchase behavioral health
20 services in the state. Also, we're working very closely
21 with my colleagues who are administering the ATR grant, the
22 SBIRT grant, the co-occurring SIG grant in the State of New
23 Mexico. In fact, the project director is in the office
24 next door to mine.

25 MS. HUFF: Ken Martinez used to be there. He

1 was a good friend of mine.

2 MR. CURIE: Other questions? Yes, Faye?

3 DR. GARY: Thank you for your presentation. I
4 think it's very insightful and also very encouraging.

5 I also want to comment that I'd make the
6 epidemiological data -- it's a very excellent set of data
7 on which to build a program. So I wanted to just comment
8 that this is the kind of data that we need that provides
9 evidence so that people know what the issues are in states
10 of what should be addressed, and also to have it by county,
11 because as I looked at this and look at your very excellent
12 program, it seems to me that if you wanted to get specific
13 and really do evidence-based practice that improves the
14 lives of people, that the interventions might change county
15 by county based on the epidemiological data. So I think
16 that's a real strength of what you present and you bring
17 here. So I just wanted to commend you for that kind of
18 insight and that kind of thoroughness in your thinking and
19 in your program.

20 The other is I was wondering about health
21 literacy with regard to individuals that you work with.
22 Even though you did not address it directly, I think it's
23 underneath. I think it's under-girded here, because when
24 we talk about prevention, especially with adolescents and
25 young adults, but also with any human being, to address

1 head-on their health literacy, their understanding of the
2 responsibilities of the self-care behaviors that they can
3 implement based on informed information from health care
4 providers goes a long way in helping to sustain the kinds
5 of behaviors, the kinds of thinking and the transformation
6 that we're really looking at with regard to the behaviors
7 that we wish to change.

8 The other question I have is with regard to
9 marijuana use, alcohol use, give us data about the 30 days
10 post. Do you have data beyond the 30 days? And the second
11 question is do you have involved in your program boosters
12 to sustain this kind of transformation that you have gotten
13 in your program?

14 A final question is to what extent would you
15 address the involvement of other community-based
16 organizations, tribal chiefs, et cetera, in the community
17 to help sustain the kinds of gains that you have seen?

18 MR. MAESTAS: Thank you for your questions. In
19 terms of the answer to your first question, I think I
20 addressed it earlier and emphasized that it's part of the
21 state incentive enhancement grant. We do have resources to
22 follow up on some of the individuals who benefitted in our
23 30-day use grants. So we'll be seeing that data probably
24 in the next several months.

25 DR. GARY: For what period of time will you

1 follow up to see the sustainability?

2 MR. MAESTAS: What we're seeing is I think
3 there's three data points we'll look at six months after
4 and a year after.

5 In terms of boosters, throughout this process
6 we really worked -- and I didn't emphasize it enough, and I
7 should have, really the community empowerment, the
8 community partnership that occurred throughout this
9 process. Certainly we look to our communities to show us
10 what they feel the needs are, and certainly this data helps
11 that. But when we start looking at booster assessments,
12 for instance, we do have some in many communities. In
13 fact, there are some communities that are doing it, the
14 middle schools in Santa Fe, for instance. They do Botvin's
15 life skills through 6th, 7th and 8th grades throughout, so
16 we can start looking at the progression and the booster
17 assessments that they're adding to that program. Other
18 programs vary, so not all of them have booster sessions.
19 But certainly we're hoping the Strategic Prevention
20 Framework state incentive grant becomes our booster,
21 because what it's really doing is looking at changing and
22 creating norms towards alcohol use, et cetera. So we're
23 hoping we can continue to work with individuals, including
24 the zero to 6-year-old population, parents and families,
25 our middle school kids, as well as 17-year-old kids, as

1 well as adults as individuals and families.

2 But certainly this SPF SIG grant really gives
3 us the opportunity to help provide boosters to the entire
4 community and really provide that insulating factor for
5 those individuals and families.

6 In terms of the work within farm communities,
7 thank you for asking that question. We're proud of the
8 work we've done over the past several years, and we worked
9 really hard to build partnerships with them. We worked
10 with a consultant named Nadine Fafolia for the past seven
11 years, and what we did is we recognized in the State of New
12 Mexico, and this occurred several years ago, is what we'll
13 call an (inaudible) in terms of funding the services, et
14 cetera, in Native American communities.

15 What I mean by that is every year we go out and
16 do site visits in these tribal communities, and because of
17 a lot of factors, including tribal leadership changes, and
18 many of them change governors on a yearly basis, some every
19 other year, what we saw is the lack of continuity in
20 service programming. What would happen when we would do
21 the site visits is we would take money away from them every
22 year because they weren't performing to the level they
23 needed to perform.

24 So what we did in prevention is we convened a
25 group of tribal leaders that had been successful in

1 maneuvering the federal and state prevention systems, and
2 we asked them for assistance, and they've been working on
3 this now for probably the past six years to help build
4 capacity in Native communities.

5 In fact, this past year, we held our fifth
6 annual Native American summit in Albuquerque, New Mexico,
7 and really the purpose of the summit is bringing together
8 tribal leaders to help build capacity, let them know what's
9 going on, get their input into what needs to happen in the
10 State of New Mexico, and we have some really strong Native
11 American programs as a result of that.

12 MR. CURIE: Yes, Tom?

13 MR. KIRK: I thank you very, very much. Very,
14 very impressive program. Congratulations.

15 I want to make a comment and see whether other
16 members will resonate to this one. What you mentioned
17 before about system change, many of the things that you
18 have built into this are geared toward what are called
19 asset development, promoting health. I think New Mexico is
20 one of those mental health transformation states; is it
21 not? That kind of collaboration you have built into that
22 actually represents a great stepping stone so that in the
23 mental health transformation initiative, health
24 promotion/prevention types of activities like you talk
25 about can be part of the infrastructure built in.

1 Part of the reason why I say that's so
2 critical, and we're struggling with that, struggling in the
3 sense of identifying it as a challenge that we need to
4 build upon, people with serious prolonged mental illness,
5 as we work to get them stable in terms of illness, building
6 off the recovery approach, many of the things that are
7 built into health promotion activities such as you're
8 talking about can precisely do that, sustain their health
9 in the community.

10 When we looked at our Access to Recovery
11 initiative under the guise or the umbrella of what we call
12 recovery support services, health promotion, i.e.
13 prevention activities, would fit in there also. I think we
14 can connect the dots on these types of things to produce a
15 system change that we're all interested in. So I think
16 what's striking about your presentation is that it flags
17 those pieces. It is assets based. It's health promotion.
18 It is a collaborative type of piece, and not just based
19 upon the members of who is in the system, but your question
20 before about the outcome measures, the next stage may be
21 what's the next level of outcome measures that are more
22 system based and that are, if you will, targeted to what I
23 call the covered lives approach.

24 I don't know how many people are in New Mexico,
25 but one of the things that I use in my "stump speech" is

1 that Connecticut has got 3.5 million people, and I see
2 myself as the director of a health care plan. So the
3 penetration rate in that health care plan, quality of life
4 for people in Connecticut is tied to this thing. I think
5 the more we can tie some of those things together, so much
6 the better.

7 But kudos to you in New Mexico for the type of
8 initiative that you put into place, because it goes back to
9 somebody's question before, I guess it was Barbara's
10 question. A lot of people say they're going to do, but
11 clearly it's far easier to say you're going to do than
12 actually do, and you're going about doing it. So
13 congratulations.

14 MR. MAESTAS: Thank you.

15 MR. CURIE: Other questions or discussion?
16 Larry?

17 DR. LEHMANN: (Inaudible.)

18 MR. MAESTAS: Yes, absolutely. We have sites
19 that we selected that include both rural and urban. Then
20 also, as you know, we have 1.8 million people in the State
21 of New Mexico, and of course we have a very diverse ethnic
22 rate as well. Certainly that's also apparent in terms of
23 the sites that were selected. Once again, once we complete
24 the procurement, I'll make sure that Beverly has that
25 information and they can share it with this advisory

1 council as well.

2 MR. CURIE: Other comments, questions,
3 discussion from the Council members?

4 (No response.)

5 MR. CURIE: Don, I just want to say thank you
6 so much for taking the time and effort to come and share
7 with us your program, the results. I think you've answered
8 the comments made by the Council members that clearly
9 you've demonstrated that you can implement a strategy
10 that's based on outcomes. You show prevention works.
11 That's one of the toughest messages to convey, one of the
12 biggest challenges when we're appearing before Congress
13 when we're trying to make the case with the budgeters.
14 Proving that you prevented something from happening is a
15 tough thing to do, but you've been able to demonstrate a
16 real impact on the lives of young people, and we thank you
17 for offering the model, and we think there are a lot of
18 lessons here that we can bring to scale. So thank you for
19 your invaluable work.

20 MR. MAESTAS: Thank you for having me.

21 (Applause.)

22 MS. KADE: Thank you very much.

23 Now is our time for public comment. I think we
24 have a Cheryl Reese. Please, come up.

25 MS. REESE: Good morning. My name is Cheryl

1 Reese. I'm a licensed professional counselor in the
2 D.C./Maryland area. I have a background in addictions and
3 served with the Marine Corps for 23 years. So I'm a
4 retired Master Sergeant, and I've worked with behavioral
5 health, and I'm on the national board of Lesbian and Gay
6 Addiction Professionals. I want to thank SAMHSA first of
7 all, and CSAP in particular, for their support of LGBT
8 issues in the past, especially production of the 2001 "A
9 Provider's Introduction to Substance Abuse Treatment for
10 Lesbian, Gay, Bisexual, and Transgender Individuals."

11 Since 2001, CSAP promised a subsequent training
12 manual to accompany the Provider's Introduction document.
13 We know that a draft exists, but emails and letters have
14 not produced any additional progress on that matter. Last
15 spring our vice president, Phil McKay, and members of the
16 LGBT community national health coalition met with Wesley
17 Clark and others from your agency, and we were assured that
18 LGBT issues, including the training manual, were still
19 going to be addressed.

20 Now, what I'm going to talk about in the next
21 few minutes are specifically pointed to the comments made
22 by Council members earlier regarding inclusion, stigma, and
23 suicide associated with alcohol and drug use and behavioral
24 health. That struck home with me because in the LGBT
25 community, stigma, inclusion and suicide are issues that

1 affect our community and contribute to the increase in
2 abusive drinking and drug use, and certainly impact the
3 nature of our health. We're talking about health care for
4 those that are underserved or underinsured.

5 Statistics clearly show an emerging increase of
6 youth suicide in the LGBT community. We're asking SAMHSA
7 to simply join us in a viable partnership that recognizes
8 the value of our advocacy and our resources to the
9 community. NALGAP wants a seat at the table not as an
10 afterthought but as a primary team player. We'd like you
11 to respond to our letters and emails and publish the
12 training manual. If you're sincere about acknowledging the
13 issue of stigma and inclusion, begin with us. Thank you.

14 MS. KADE: Thank you very much.

15 Are there any other public commenters in the
16 audience? Yes, please.

17 MR. CURIE: This is Susan Rogers from the
18 Southeastern Pennsylvania Mental Health Association.

19 MS. ROGERS: Hi. Thank you very much.

20 I have two comments. I wanted to, first of
21 all, talk about the seclusion and restraint comments that
22 Mr. Curie made earlier. I'm from Pennsylvania and, as you
23 know, Mr. Curie was responsible for our very effective
24 initiative to move toward zero use of seclusion and
25 restraint in Pennsylvania, and I wanted to alert people to

1 the fact that there's a wonderful section in the September
2 issue of the Psychiatric Services magazine that includes
3 actually an article by Mr. Curie. It's about seclusion and
4 restraint, and it's a variety of articles that are all --
5 it's not a very balanced section. It's all very much
6 talking about why seclusion and restraint is a bad thing
7 and why we need to get rid of it, and the evidence that
8 getting rid of it is effective.

9 Mr. Curie has said in the past that seclusion
10 and restraint is not treatment. It's a treatment failure,
11 and the section is all about that, and it includes the
12 voices of people who have experienced seclusion and
13 restraint. So I think that's important for people to know
14 about. I hope they can get the September issue, and if
15 they can't, I can send one. I have a copy of it, and I can
16 send people a copy of it.

17 The second thing I wanted to talk about was
18 following up on something Ken Stark said about language.
19 He was talking about the use of the phrase "behavioral
20 health services," and I actually agree with him about that.

21 But I also wanted to mention the use of language when it
22 comes to the word "stigma," because the word "stigma," as
23 some people here have actually said, they don't like that
24 word, for good reason. I'd like to urge that people, as
25 the Center for Mental Health Services habitually does, I'd

1 like to urge that people use the word "discrimination" when
2 they say the word "stigma," refer to both stigma and
3 discrimination, because it's really the discrimination that
4 is the killer. It doesn't matter what you think about me,
5 but just do not discriminate against me.

6 In fact, Pennsylvania's anti-stigma campaign
7 doesn't even use the word "stigma." It's called Open
8 Minds, Open Doors. It calls itself merely an
9 anti-discrimination campaign, and I'd like to recommend
10 people look at our website, which is
11 www.openmindsopendoors.com, not .org, it's .com. It's a
12 really good website with wonderful anti-discrimination
13 messages, and it also has extremely useful information for
14 employers. It's very much focused on the issue of
15 employment because, as we know, employment is extremely
16 important in helping people with their recovery.

17 So those are the two comments I wanted to
18 mention. Thank you.

19 MS. KADE: Thank you very much.

20 Anyone else?

21 (No response.)

22 MS. KADE: Okay. So we're at the point where
23 we're going to break for lunch, and I think Toian -- yes,
24 please.

25 DR. GARY: May I? I just wanted to link the

1 whole issue of seclusion and restraint to workforce issues.

2 Hopefully we can talk about that sometime, because when
3 you talk about seclusion and restraint, we're back to
4 assessment and how do we treat, how do we respond. That is
5 directly linked to the sophistication, the knowledge and
6 the training of the workforce. So I think you can't get
7 away from that. So could we please talk about those?

8 MR. CURIE: Absolutely.

9 DR. GARY: Thank you.

10 MS. KADE: Sure.

11 Lunch.

12 (Whereupon, at 12:05 p.m., the meeting was
13 recessed for lunch, to reconvene at 1:30 p.m.)

14

15

16

17

18

19

20

21

22

23

24

25

1

2

3

4

AFTERNOON SESSION

(1:50 p.m.)

5

6

7

8

9

10

MR. CURIE: I'd like to welcome everybody back, and I'd like to delay the consideration of our hurricane response and an opportunity for you to meet some of the key individuals that SAMHSA was instrumental in providing the leadership and management of SAMHSA's response to Hurricane Katrina.

11

12

13

14

15

Before I introduce our presenters, I've already shared briefly with you my own observations and thoughts on our response to Hurricanes Katrina and Rita, but I'd like to go a little bit more in-depth just for a few moments in terms of my own observations.

16

17

18

19

20

21

22

23

24

I had the privilege of accompanying Secretary Leavitt to the Gulf Coast, accompanied him on at least two occasions. Once I made a trip on my own to the Gulf Coast, and the fourth time I accompanied Secretary of Education, Margaret Spellings, each trip having somewhat of a different focus but really homing in on the public health response, what was needed, and of course more specifically the mental health and substance abuse response that we had with SAMHSA.

25

It allowed me really several opportunities to

1 meet one on one with mental health and substance abuse
2 officials, state officials in the affected states in
3 particular, as well as local officials. I also was able to
4 visit several shelters in the process, shelters located in
5 the impacted states as well as those states that were
6 taking evacuees and victims of Katrina who needed to move
7 out of the state for a time because they were, in essence,
8 having no home. It was clear to me during each trip that
9 the providers, the officials consistently were having a
10 sense of (inaudible) the magnitude of the disaster.

11 That said, it was remarkable the tremendous
12 work these individuals did in the process in terms of
13 addressing needs as they were manifesting themselves.
14 First responders, the emergency medical teams,
15 firefighters, law enforcement, physicians, nurses, all were
16 very much engaged in the process. What was an additional
17 challenge above and beyond many disasters we've seen,
18 especially when compared to 9/11, while that was a disaster
19 of horrendous magnitude, the locations of those disasters
20 lent themselves to a lot of resources already being readily
21 available, New York City and Washington, D.C., for example.

22 The nature of Katrina and Rita was such that they were
23 devastating communities that were already somewhat remote
24 from resources once their own resources were destroyed.
25 That in and of itself I think presented a challenge which

1 was very different from what we had seen before.

2 The one thing that struck me as we looked at
3 the devastation and we looked at how overwhelmed folks were
4 was the level of resiliency demonstrating the pressing
5 needs, and I think that's a major message that we can't
6 forget in this process. The word "unprecedented" was used
7 in an unprecedented way, legitimately so around Hurricanes
8 Katrina and Rita. The level of resiliency and the strength
9 that individuals demonstrated through this process was
10 remarkable.

11 One thing that we did at SAMHSA in the
12 immediate aftermath of the hurricane is we immediately
13 activated the SAMHSA Emergency Response Center supporting
14 those grantees that were impacted by the storms, and
15 additional support was provided immediately for a national
16 suicide prevention lifeline, which experienced a spike in
17 calls. In fact, I think the average number of calls we
18 received on the lifeline a day is somewhere in the vicinity
19 of anywhere from 100 to 120 calls per day. The average
20 spike in call volume in the period of time after the
21 hurricane hit was an over 60 percent increase. In fact,
22 one day the volume hit 900. It leveled off, the data is
23 showing us, somewhere from 180 to 230 calls per day. But
24 as you can see, that's still a higher level than what was
25 experienced pre-Katrina.

1 We also held weekly conference calls with
2 SAMHSA constituents to keep them apprised of our efforts
3 and answered questions that they may have had and addressed
4 any concerns that they had, and these calls were
5 coordinated with CMS, the Centers for Medicare and Medicaid
6 Services, made the coordination with emergency response
7 services to the same consumers, if you will, as transparent
8 as possible.

9 We also launched an expansion of our website to
10 provide quick access for the victims and to provide some
11 topics about where to get help, to publications and
12 assessment tools, training guidelines, other technical
13 assistance materials, and also other links to other key
14 resources and organizations.

15 Within the first week of Katrina striking, we
16 began the process of making available SAMHSA Emergency
17 Response Grant dollars. SAMHSA has the capacity and the
18 authority under its authorization and statute to be able to
19 make available up to I think it's about 2.5 percent of
20 appropriated dollars for emergency response services. It's
21 discretionary dollars.

22 One thing to keep in mind is this occurred at
23 the end of the fiscal year. So taking a look at dollars
24 that were available, it was more limited than it would have
25 been if it had occurred at the beginning of the fiscal

1 year. Of course, we don't coordinate (inaudible) schedules
2 in terms of the amount of dollars being available. But the
3 good news is we were able to find \$600,000, albeit the
4 scope of the disaster seemed like a small amount. It was a
5 lot of money we found immediately that we were able to
6 allocate to the four major impacted states, Louisiana,
7 Mississippi, Alabama and Texas, and I think they actually
8 had the dollars within 14 days after landfall of Katrina.

9 These funds were specifically given to fill
10 gaps that would be left by the FEMA dollars. FEMA doesn't
11 (inaudible) resources available for crisis counseling.
12 SAMHSA is responsible for the application process for the
13 crisis counseling dollars that FEMA makes available in the
14 aftermath of a disaster.

15 However, you aren't able to use those dollars
16 for such things as ongoing treatment of people with serious
17 mental illness or ongoing pharmaceuticals or ongoing
18 interventions or, as I mentioned earlier, methadone, for
19 individuals receiving methadone treatment. Those FEMA
20 dollars are not eligible to be used toward those needs.
21 The initial dollars we provided were able to be used for
22 that.

23 So we allowed states the opportunity to assess
24 where they had these needs with a specific focus on how to
25 do the care issues with individuals that were displaced who

1 were seriously mentally ill, children who had serious
2 mental disturbances, as well as individuals with addiction
3 that needed treatment.

4 We also, as I mentioned earlier, working with
5 FEMA, awarded 29 full and 2 partial grants to states for
6 immediate services. Those grants total \$20.5 million.
7 Then on top of that we coordinated the mobilization through
8 our SAMHSA Emergency Response Center of over 300 people to
9 work in the field on mental health and substance abuse
10 issues. In fact, in one two-week deployment in Louisiana
11 and Mississippi, volunteer providers counseled 1,889
12 evacuees and made 2,020 referrals. Of these, 17 percent
13 were in mental health services, 3 percent to substance
14 abuse services, and 80 percent to other services such as
15 the Red Cross.

16 Additionally at this point in time, 30 states
17 are now eligible to apply for regular services program
18 grants. We're in the process of reviewing applications for
19 these grants which will provide funds for up to nine months
20 following the disaster declarations. We're going to
21 continue to work with states to ensure that mental health
22 assessment and crisis counseling are readily available to
23 residents and evacuees of the impacted areas; also to
24 establish a longer-term plan to assure that post-traumatic
25 stress disorders are addressed. We're especially going to

1 have a focus on first responders (inaudible) and vulnerable
2 populations.

3 We're going to continue to work with our
4 federal partners (inaudible) chronic disorders. We know
5 from past experience and we also know from research that
6 the psychological impacts of the recent hurricanes can be
7 very extensive. We're able to estimate in those areas
8 impacted directly by the hurricane that 25 to 30 percent of
9 those individuals will experience clinically significant
10 mental health needs. An additional 10 to 20 percent may
11 experience sub-clinical but not trivial needs that need
12 some form of support. With those figures in mind, that
13 could mean close to half a million people from the impacted
14 areas may need some sorts of supports and interventions.

15 Again, we don't want to forget the fact of
16 resilience. Most individuals will come through this, and
17 most individuals will be able to come through this in a
18 healthy way. But again, we also recognize that there are
19 those individuals, especially those who are right in the
20 target areas, so to speak, and experienced the most
21 devastating impacts, those individuals who (inaudible) are
22 the ones we are concerned about.

23 What's critical right now in the recovery
24 operations phase is assisting those who need help. We need
25 to continue to make sure that we're making connections to

1 the services. Looking back at those initial days and weeks
2 after the hurricane, again I'm proud of the job SAMHSA
3 staff did. We're talking a commitment that people made,
4 many working 12- to 16-hour days with virtually no break
5 during the week, no weekends. Again, that couldn't go on
6 forever. People worked hard to also make sure people were
7 taking care of themselves (inaudible). But again, as I
8 mentioned earlier, nearly half the people on the SAMHSA
9 roster either were out in the field or in SAMHSA's
10 Emergency Response Center, and the other half were filling
11 in and helping out to make sure the work could continue.

12 This afternoon we have the opportunity to hear
13 directly also not only from those that led and managed our
14 process but the people who were on the front lines
15 providing services. Two individuals I want to highlight at
16 this point, one you're going to hear from immediately after
17 me, Dan Dodgen. Dan is the SAMHSA emergency coordinator.
18 During those first few days on site, he also was an
19 individual who not only helped us get things started here
20 -- and also I want you to know that the planning that has
21 been done for disaster, Dan was very active in that, along
22 with a division of CMHS that has focused on emergency
23 response services, and also (inaudible) for the
24 three-center process, CSAT and CSAP (inaudible) involved
25 along the way as well.

1 But from tabletop exercises to thinking through
2 what an emergency response needs to look like, all that
3 work that they'd done prior to Katrina paid off in terms of
4 us being in a much better position to be able to activate
5 an emergency response and activate the Emergency Response
6 Center. On top of that, Dan was our representative
7 downtown at the Secretary's operation center and command
8 center that the Secretary (inaudible) was linked into and
9 is part of the Secretary's operations. So Dan was our eyes
10 and ears and conduit down there, and he did just a
11 tremendous job.

12 We're also going to hear from Brenda Bruun, who
13 I can't say enough good things about Brenda Bruun and the
14 leadership she brought as incident commander of SAMHSA's
15 emergency response team and center. She was extremely
16 reliable, organized, had a deft knowledge and sensitivity
17 about who would fit best in what type of deployment, and
18 just led our efforts in a magnificent way.

19 So I'm really pleased that you're going to hear
20 from these two individuals today, and it's my privilege to
21 turn it over to Dan Dodgen.

22 DR. DODGEN: I'll speak into the mike more so
23 that you can hear me say flattering things about everybody,
24 because they're well deserved.

25 Let me just start by saying that I'm going to

1 try to keep what I say fairly brief because you want to
2 hear from the people who have been out on the field, as
3 well as Brenda got all of her wonderful work here at the
4 SAMHSA Emergency Response Center.

5 What I'm going to do is just really give you
6 kind of a bird's eye view from a national and from a
7 Department perspective on what's happening and how it is
8 that SAMHSA fits in to all of those things. I think all of
9 you at this point have heard of the National Response Plan.
10 That's the national plan that was approved about a year
11 ago, just right about this week in December of '04, that is
12 the plan that governs what all of us in the federal
13 government, as well as the American Red Cross, do in an
14 emergency. In theory, when an emergency affects a state
15 such that two or more federal departments have to be
16 involved in helping that state respond, that's kind of a
17 minimum threshold. But as you can imagine, it's really up
18 to the prerogative of the President and others at the
19 Cabinet level should they choose to invoke it in another
20 circumstance. But that's the basic threshold.

21 Clearly, that was a criteria that was met very,
22 very quickly. One could argue that before Katrina, we knew
23 before it hit, just after it hit Florida and before it
24 passed through the Gulf, we knew that we were going to use
25 more than two departments or agencies. So what is in there

1 particularly that's relevant to us? This IIMG -- and I
2 apologize. I can never remember what the second I stands
3 for. I think it might be Incident. I think it might be
4 Intergovernmental Incident Management Group.

5 But the IIMG is basically the group that sets
6 the policy for the disaster response in terms of how that's
7 going to work.

8 The reason that it's a key for us to talk about
9 here today is this is the group that has a representative
10 from each department. Most departments only have one
11 representative at the table. Actually, for the first time
12 ever during this response, the Department of Health and
13 Human Services and said mental health issues are so
14 critical that we would actually like to have a second seat,
15 and we want it to be occupied by a SAMHSA person. That had
16 never happened before. I don't know how our colleagues at
17 other HHS agencies felt about that, but I think it reflects
18 how important the Department viewed this.

19 Now, because of space limitations, we ended up
20 making that essentially a virtual seat in that we had
21 people here at SAMHSA that were on call to respond to the
22 needs of the IIMG because we couldn't actually put more
23 people in that room. It's a small space with some very,
24 very senior people in it. But I think the fact that we
25 were notionally there, the fact that the Department invited

1 us to have names that would be on call to represent that
2 second HHS representative is indicative of how important
3 the mental health and substance abuse issues became very,
4 very early on in this response.

5 Another aspect of the national response that I
6 think you may have heard about is incident and command,
7 ICS. I think Brenda is going to talk a little bit more
8 about that, so I won't say too much other than just to say
9 that's really the model that governs how we set up an
10 incident response so we make sure everybody knows what
11 they're supposed to do. Of course, the NRP also
12 (inaudible) the roles and responsibilities of various
13 federal departments, and I'll talk a little bit more in a
14 second about what the HHS ones are.

15 One of the key aspects of the National Response
16 Plan is the emergency support functions. There are 15
17 emergency support functions. The ones that are most
18 critical to us, of course, are Emergency Support Function
19 6, EFS6, which is (inaudible). As you see, the lead agency
20 for that is the American Red Cross. But as you can
21 imagine, mass care human services clearly includes a mental
22 health component. So one of the things that we do is
23 provide support to the Red Cross in their ESF6 function.

24 In addition the ESF8 function, HHS is the lead
25 agency for that, and that's really where the bulk of the

1 activities that we've been engaged in have happened, under
2 this ESF8. Two others that you might want to be aware of
3 are ESF14, the long-term community recovery and mitigation.

4 In many ways that's the phase that we're in now, although
5 certainly there are still some acute things happening on
6 the ground. This is actually an emergency support function
7 that historically has not paid very much attention to human
8 service and mental health, and frankly even public health
9 and substance abuse issues as well. That's changing now.
10 I think for the first time people are realizing that it
11 isn't just about applying for small business loans and
12 rebuilding houses and bulldozing damaged property, et
13 cetera. So I think that we're going to see this ESF
14 changing a great deal over the next year. I think one of
15 the things that's going to happen is we're going to see our
16 issues included more than they have been in the past.

17 ESF15 is external affairs and public affairs,
18 and that includes public education and information, which
19 we also provide a consultative role on.

20 So where do we fit in in terms of other pieces
21 of it? I know everybody has heard all the horror stories
22 about FEMA, the Federal Emergency Management Agency. I do
23 want to say also that the folks on the ground at FEMA
24 continue to do very good work, and we've been able to work
25 with them in a number of different ways. One of those is

1 through a mission assignment process, which is the process
2 by which -- I do have some acronyms up there so you all can
3 get used to it. When you do disaster work, it's alphabet
4 soup. There's acronyms for everything. ARFs are action
5 request forms. MAs are mission assignments. ESFs are
6 emergency support functions. We'll have a quiz at the end
7 of the day today for those of you who aren't paying
8 attention.

9 But anyhow, these are three acronyms that
10 you'll hear quite a bit about in this particular area.
11 Basically, a state completes an ARF, an action request
12 form. If it's approved there's a mission assignment to the
13 ESF lead agency to decide what they want to do with it. I
14 think Brenda is going to talk a little bit more about this
15 process, so I won't say too much more other than there is a
16 process that's in place, and it's a process that SAMHSA has
17 not historically taken advantage of. I'm going to talk
18 about one very strong program that we do with FEMA, but we
19 haven't historically taken advantage of the mission
20 assignment process. This is the first time that we have,
21 and I think it was also astounding what we've been able to
22 do. Brenda is going to talk more about what those
23 accomplishments are.

24 I do just want to say again that the crisis
25 counseling -- yes, go ahead.

1 MR. STARK: Can you, in this context, define
2 "deconflicting"?

3 DR. DODGEN: You know, I love the word
4 "deconflicting." I use it all the time, much to the
5 chagrin of some of my colleagues, I think. But in this
6 context, when people use the word "deconflicting," what
7 they're talking about is when you have information that's
8 inconsistent and you need to get to the bottom of what's
9 really going on. As you can imagine, in a disaster that's
10 an extremely common experience where one person says we
11 need 1,000 psychiatrists on the field, and the next person
12 says, well, we need 1,000 people who can address mental
13 health issues, but that doesn't mean we need 1,000
14 psychiatrists. So what do we really need, and how do we
15 get to the bottom of the confusing information that we're
16 getting so we can actually make sense of it and respond to
17 it?

18 MR. STARK: So it really gets back to basically
19 sharing information across systems so that you all
20 understand what you're saying when you say it.

21 DR. DODGEN: Right, and making sure that the
22 information that you have is brought to the table, because
23 as you can imagine, 99 percent of the problems that we
24 experience, whether it's internal to the organization or
25 anywhere in these kinds of events, it's usually because

1 everyone is acting to their best of their ability according
2 to the information they have, but often people don't have
3 the same information. So people end up butting heads
4 because they don't share information. So that's what you
5 do when you deconflict.

6 As I was saying earlier, the importance of our
7 crisis counseling program, the last bullet there, cannot be
8 overstated. That's really been the bedrock of our disaster
9 response work for 30 years, more than 30 years now, through
10 the relationship we have with FEMA, and it's really the
11 incredible work that folks at CMHS and the Emergency Mental
12 Health and Traumatic Stress Services Branch has done under
13 Seth Hasset, and before that lots of other people who have
14 also done great work, that really has in many ways
15 established the credibility of SAMHSA to now be able to
16 move well beyond that and do the issue assignments and have
17 the credibility so that people know when we say we're going
18 to do something or we weigh in on something, we're weighing
19 in on the basis of our own experience and expertise as a
20 result of the work that the agency has done in the past.
21 So it's an important bedrock of the work that we do.

22 Just very quickly, in terms of where SAMHSA
23 fits within the Department, obviously it's very important
24 to make sure that we communicate with all of our ESF8
25 partners, which includes the Department of Defense,

1 Veterans Administration and other agencies, some of whom
2 have mental health and substance abuse workers. Some
3 don't, but they may have other things such as the ability
4 to transport workers, which is a key factor. So there are
5 all kinds of things that are involved in the discussions
6 that take place with ESF8 and FEMA's involvement, and the
7 Emergency Response Center that brings (inaudible) that Mr.
8 Curie referred to earlier. It was also (inaudible) as
9 well, daily, maybe twice a day, to allow us to really
10 (inaudible) what people are doing.

11 The Secretary's operations center Mr. Curie has
12 already talked about. That's the hub in town where all of
13 the ESF8 partners, as well as all the agencies within HHS
14 -- the CDC, HRSA, FDA, the Administration on Children and
15 Families, the Public Health Service Corps -- everybody has
16 a presence at the operations center, and the idea is if you
17 can bring everyone together, you can deconflict problems
18 and you can make sure to provide the very best response to
19 the states.

20 In addition, of course, we talked about our own
21 Emergency Response Center. We also have the Secretary's
22 emergency response teams. These are the units on the
23 field, the eyes and the ears of the Secretary, (inaudible)
24 people for the response. So SAMHSA made sure we would
25 always have people on those teams in the field, and we have

1 people in Louisiana and Mississippi and in Texas during the
2 time when the teams were stood up there. Those folks on
3 the ground were really, really critical. The people in
4 most of the states rotated, so it wasn't always the same
5 person. I won't give you the whole list, but that was
6 really critical to have someone there on the site who could
7 work the states as well as who could provide leadership
8 within the Secretary's team on the ground.

9 Then, of course, there was a policy group that
10 was developed that also met downtown that SAMHSA was
11 represented on.

12 So where else do we fit in? I hope it doesn't
13 feel overwhelming yet, but I want you to get a sense of the
14 scope of SAMHSA's involvement in all the different things
15 that we were doing. In addition to the ESF8 calls, which I
16 mention there again just because they are such a critical
17 point of communication, we also, of course, maintain
18 communications in ways that Mr. Curie has described with
19 other agencies and with non-governmental organizations, and
20 we actually have a great success story with the Red Cross.

21 Brenda is going to say more about that.

22 Unfortunately, I can't say a lot, but I want
23 you to get a sense of the way that SAMHSA did incredible
24 things, but part of why we were able to do such incredible
25 things was because we were really able to take the

1 relationships that we already had with significant partners
2 and build on them and advance them and use those
3 relationships to really address concerns that were
4 happening at the local level with the states.

5 For example, a situation where we couldn't get
6 the right people into Red Cross shelters because
7 (inaudible) and some things we were able to do to
8 deconflict that situation.

9 Another thing that I wanted to mention is I'm
10 sure most of you are familiar with OSHA, the Occupational
11 Safety and Health Administration, which is really
12 responsible for worker safety in the United States. It's
13 part of the Department of Labor, and OSHA has the
14 responsibility for making sure that people working in the
15 field are properly taken care of and receive what they need
16 to receive in order to be able to do their work, as well as
17 when they return if they have any physical, or mental or
18 (inaudible) issues, that those are addressed. The
19 Department actually appointed SAMHSA as the agency to work
20 with OSHA on developing strategies for how we're going to
21 support people.

22 As you can imagine, coming back from these
23 deployments, particularly people who very early on were in
24 Camp Swampy, didn't even have water or toilet facilities,
25 much less other things, as well as just (inaudible) like

1 having to do with human remains and having to deal with a
2 number of other things. There were some very traumatic
3 things that people who were working in the field were
4 exposed to, not to mention just being around people who had
5 lost everything. So OSHA is working on this, and SAMHSA
6 has developed materials that OSHA is going to be using, and
7 we have a whole program developed for how we're going to
8 provide support to these workers. I think again it speaks
9 to how much people are appreciating the importance of
10 behavioral health issues, as well as what a good job SAMHSA
11 has been doing, that the Department asked us to take the
12 lead on doing that.

13 We kind of talked about the cost, so let's move
14 on to the next slide.

15 I just wanted to say I love this slide.
16 Douglas Fairbanks riding in on a white horse. That's not
17 SAMHSA's job, actually, but there's a little bit of that
18 component because we do so much want to be able to help.
19 But really our role is to assist local communities in being
20 able to respond, and as part of that, of course, our job is
21 to coordinate the resources, assets and activities to
22 provide subject-matter experts, to provide grants for
23 planning, for response, and to facilitate getting services
24 on the ground through the (inaudible) process.

25 So how does all of that translate into action?

1 MR. STARK: Just a quick question. If you had
2 an example, and I'm not sure if Katrina or Rita provided
3 that, but if the role is as you described it, and I would
4 agree that it would be, what about those circumstances
5 where maybe the state, who usually would be who you would
6 coordinate with to help get those grants and those
7 resources out to their locals, what would happen if their
8 state infrastructure had been decimated and so they really
9 couldn't do it? I would imagine some of that happened. So
10 is that kind of part of your crisis plan, disaster plan?

11 DR. DODGEN: We'll foreshadow a little bit,
12 because I think there are two answers to your question.
13 The first answer is you're going to hear more about what we
14 did. But I think the more complete answer is I think that
15 all the planning that we did was incredibly helpful in
16 being able to activate the SERC, in being able to have our
17 own plans in place, in being able to establish the
18 relationships that we needed to have.

19 But the truth is I don't think any of us could
20 have anticipated the scale of the disaster that befell us
21 and the impact that it had because of the number of people
22 that were impacted and the geographic spread. I mean,
23 we're really talking about the entire Gulf Coast,
24 essentially from Houston/Galveston to Pensacola that was
25 impacted by Katrina and Rita. Then, of course, you've got

1 Wilma, which extended the impact down pretty much through
2 most of the bottom half of Florida. So I think all of the
3 planning was incredibly helpful, but I think we faced a
4 situation that was bigger than any of us really
5 anticipated, and I think that's where some of the things
6 that Brenda is going to talk about -- you'll hear about how
7 we expanded our mission and how we really saw ways to do
8 things that we hadn't done before in order to address the
9 very question you're asking, which is what do you do when
10 the needs are so extreme that the local and state agencies
11 that you would expect to be able to play a significant part
12 in responding may not, at least in that very initial phase,
13 have been able to do as much as they would normally do.

14 That's not to say they weren't doing a lot,
15 because they were, even with the under-resources. The
16 states and locals were performing above and beyond in
17 incredible ways. But nevertheless, it was really beyond
18 what any of us expected. As a consequence, they weren't
19 able to do as much as they normally would be able to do.
20 So I think SAMHSA was able, in some very creative ways, to
21 try to help meet that need and facilitate the states
22 getting back on their feet and getting their infrastructure
23 back together, and that really gets to my last slide, my
24 hero.

25 This is James Bond, who always knows what to do

1 in any circumstance. Of course, what we really need to
2 think about, he was a man of action. So how did we, in
3 fact, turn all of these things I'm talking about into
4 action? I think when you hear Brenda Bruun's comments, and
5 then when you hear the comments of the panel that's going
6 to follow us, I think you'll get a much better sense of how
7 we really turned all of these -- our defined mission and
8 our defined goals and all these calls and networks and
9 phone calls, how did all that really make a difference, and
10 what did it really mean in terms of what we were really
11 doing on a daily basis to assist the impacted states and
12 the evacuees. I think that you'll know the answer to that
13 question by the time you've heard Brenda and the next
14 panel.

15 So if there aren't any further questions, I'll
16 turn it over to Brenda, and then I think we'll be available
17 for questions later on.

18 DR. GARY: I don't know if it's appropriate to
19 ask these questions and make one or two comments. So if
20 it's the wrong time, just tell me and I'll wait.

21 MR. CURIE: Well, I think we're going to have
22 questions for everyone after Brenda presents.

23 DR. GARY: I'm willing to wait.

24 MS. BRUUN: I think as we go through these
25 presentations, you're going to see that we're starting off

1 with the macro perspective of disaster response across the
2 nation. My job is to bring you what the agency did, and
3 then the folks behind us will talk about their individual
4 (inaudible) on behalf of SAMHSA to provide consultation to
5 health services directly.

6 I'm going to start our presentation with some
7 slides that were taken from some of our staff that were
8 deployed to the field so you can get a sense of what we
9 experienced as we started to prepare for this disaster. So
10 if you could just run through the slides.

11 When this disaster happened, Mr. Curie
12 activated the SAMHSA Emergency Response Center right away,
13 which mobilizes all of the resources in a very streamlined
14 management structure. This is something that, while we've
15 done pieces of it before, this disaster actually required
16 the mobilization of everyone in SAMHSA. So we had to
17 implement the structure that was similar to that being used
18 by the Department, by the Department of Homeland Security,
19 and this in fact started to be replicated at the state
20 level, not only with their emergency management agencies
21 but also the departments of mental health and substance
22 abuse.

23 The Incident Command System is really a
24 standardized structure for organizing and controlling the
25 response. It helps eliminate duplication of effort. It is

1 the coordinated way of communicating messages, especially
2 when the communications systems may be disrupted. It
3 clarifies lines of authority and command so that there's no
4 ambiguity in terms of who is in control and who is making
5 decisions, but it also (inaudible). So in that case it's
6 also very effective at being able to identify who is
7 responsible and to get to that person quickly.

8 This is actually how SAMHSA's emergency
9 response system fits in with the Department's response.
10 You have the Administrator, who reports directly to the
11 Secretary. We have Dan, who reports to the Secretary's
12 operations center and represents SAMHSA at that table so
13 that our efforts within the agency are coordinated with all
14 of the other agencies within HHS. The incident commander,
15 which in this case was me, reports directly to the
16 Administrator and coordinates very closely with the
17 emergency coordinator to make sure that what I'm doing is
18 consistent with the policies and guidelines and doesn't
19 start to encroach on other agencies' missions. Then his
20 job is to help them not encroach on ours.

21 Within the Incident Command System you have
22 seven functions. These functional areas are basically
23 streamlined parts of the agency that help us mobilize all
24 of SAMHSA's resources very quickly. We have a personnel
25 function, a logistics function, a planning function, a

1 finance function, public information, a recording function,
2 and we included phones in there because phones ended up
3 being such a large job. Each of these functions is staffed
4 by people who have background in this, who are trained in
5 this, and are fully prepared to make decisions on behalf of
6 the agency, and those functions all report to the incident
7 commander.

8 In addition, we coordinate with CDC Emergency
9 Response Center, other partners and agencies like the Red
10 Cross. We coordinate directly with the emergency
11 management agencies, with national organizations who have
12 an interest (inaudible) like the National Association of
13 Mental Health Program Directors, the National Association
14 of Directors and (inaudible), and a lot of the major
15 (inaudible) like the American Psychiatric Association, the
16 American Psychological Association, and many, many others.

17 All of them have resources to offer in an emergency, and
18 our role is not just to provide services. In many cases,
19 we actually don't do that. This was an incident that
20 required that on our part, but we actually just coordinate
21 the delivery of behavioral health care services after a
22 disaster to support state and local efforts.

23 Next slide, please.

24 This is just a brief description of each of the
25 incident command functions, and I see that it's too dark to

1 read, but I'll basically tell you kind of what they do.
2 The incident commander and the deputy incident commander
3 are responsible for all operational decisions within the
4 Emergency Response Center. We triage and assign tasks,
5 coordinate with the emergency coordinator and other
6 departments responding to all kinds of requests from the
7 public and from other agencies for resources. We have a
8 planning function whose job it is to prepare an overview of
9 the impact of the disaster. I think that this is one of
10 our most difficult functions but one of the most critical
11 in organizing our response effectively because you really
12 have to know what it is you truly (inaudible) and how
13 (inaudible) where resources are going to be (inaudible),
14 what resources we have versus the resources we will have to
15 get from (inaudible).

16 We have a logistics function that does
17 everything from creating the emergency operations center
18 (inaudible), additional phone lines, fax machines, copiers,
19 printers, laptop computers, videoconferencing to preparing
20 all of the travel arrangements for staff that need to be
21 deployed, giving them the equipment and supplies they need,
22 (inaudible) in the field, being a resource in the field
23 (inaudible), shipping materials to places that need
24 (inaudible). They also have a very (inaudible) job,
25 (inaudible) a difficult job considering the lack of

1 housing, how difficult it was to get transportation into
2 the impacted areas, having to find supplies we don't
3 normally buy in this agency, like sunscreen to put in
4 (inaudible) because people were spending so much time in
5 the field under (inaudible) intense heat, and that's to
6 protect our staff to the best of our ability from the
7 dangers that can occur while they're working in such a
8 disaster area.

9 The finance function tracks all of our spending
10 related to the disaster activities, including overtime and
11 travel for the staff, supplies and equipment, funds to
12 cover printing materials, contracts that are awarded,
13 grants that are awarded. Anything that we do related to
14 this incident they can track, and they also oversee the
15 internal controls to be able to respond to audit requests
16 and information about our expenditures related to this
17 disaster.

18 The public information office has a tremendous
19 role in providing accurate information about the mental
20 health needs and the mental health response capabilities in
21 providing information that can actually help people
22 through, a psychoeducational approach to promoting
23 resources that we have, such as using public service
24 announcements to promote the National Suicide Prevention
25 Lifeline as a resource for people to call for help if

1 they're in a crisis after the disaster, to preparing fact
2 sheets, answering media requests, legislative requests, and
3 I think rumor control is a huge one that needs to be
4 mentioned. Sometimes their job is tracking down
5 misinformation and then getting the correct information
6 back out there. Rumors can be incredibly damaging to
7 response efforts.

8 The personnel function identifies staff within
9 the agency and others to deploy to the field. They match
10 the people's skills with the functions they're going to be
11 deploying to the field. They're also responsible for
12 briefing and preparing folks before they go out about what
13 to expect, what their role will be, who they're going to
14 report to in the field. They're responsible for checking
15 in on them, the (inaudible) check system where you can call
16 folks in the field every single day to find out how they're
17 doing, what they're working on. This allows us to be able
18 to make sure that they're staying within the scope of our
19 mission, help them problem solve things that they might be
20 running up against in the field, and also assess where
21 they're at health-wise. Are they taking care of
22 themselves? Are they feeling supported in the field? This
23 is a very big and time-consuming role, but we're finding it
24 not only incredibly valuable to the agency's efforts at
25 maintaining and supporting our staff and those of the

1 people we deploy from outside of SAMHSA, but also it's a
2 really gratifying role to be able to talk with the folks
3 who are doing it face to face with those who have been
4 impacted on the ground.

5 A reporter and recorder maintain and prepare
6 all reports, data, track SERC activities, prepare reports
7 for the Administrator, reports that are sent down daily to
8 the Secretary's operations center, and do planning
9 research. They also have started to prepare a lesson
10 document, helping with that. There are many things that we
11 can continue to learn from and adapt to as we get better at
12 this.

13 I think it's important that there's no
14 correlation between the incident command structure and the
15 organizational or administrative structure of the agency
16 necessarily. I think some functions seem relatively clear
17 that we have these capabilities within, but they don't
18 necessarily have that (inaudible) within the agency. Each
19 of these functions can be subdivided as needed, although we
20 didn't. We're a very small agency. We were able to
21 operate within those broad functions. If you came into the
22 Emergency Operations Center for the first few weeks, you
23 would have found at least 25 people in a very small room, a
24 lot of noise, a lot of activity, everybody working
25 incredible hours in tight quarters and doing some really

1 incredible things. When you see some of the things we were
2 able to accomplish in about eight weeks, we're truly
3 impressed with what we were able to pull off. It's a very
4 small agency within HHS working on such a large disaster
5 and a large need.

6 I think the key to an incident command
7 structure being successful is not only having a well
8 trained staff who can serve in these functions, being able
9 to identify an incident commander who is given the
10 authority to make those decisions, but it has to be very
11 streamlined. Most people might look and say, well, why
12 isn't the Administrator the incident commander? Because
13 clearly he's the head of the agency. Well, he has a very
14 important role to fill after a disaster, and much of it is
15 outside of the agency and he can't be here to follow up on
16 all of the millions of details that come up in a disaster
17 response. So he has to put in place people he trusts to
18 carry out his vision of how this agency is going to
19 respond, and we thank him for putting that trust in his
20 SAMHSA team, because I think everybody stepped forward in a
21 deliberate (inaudible), and we appreciate the work that he
22 did on the agency's behalf but also on the impacted areas
23 to meet the mental health and substance abuse needs of the
24 victims of Hurricanes Katrina, Rita, Wilma, and all the
25 others.

1 Next slide, please.

2 Our role is really to just mobilize and manage
3 resources, provide a coordinated response, a coordinated
4 message, and to provide a consistent operational structure
5 that made it easier for Dan to deal with a consistent
6 person when he was trying to get information to take back
7 to the table. It became something that you really relied
8 on not only coordinating with Dan and the Secretary's
9 operations center, but I think the folks in the field also
10 really came to rely on the structure in place, I'm not out
11 here by myself. There's an entire agency and department
12 behind this effort, so there are places to go when you need
13 help, and you know exactly where to go to get that help.
14 There was no ambiguity about that.

15 Next slide.

16 Part of this was doing briefings. I think that
17 it's very easy to get myopic in a disaster response, to get
18 so bogged down in your own niche or your own specialty that
19 it's hard to see the big picture. So we instituted
20 twice-daily briefings for everyone. Anybody at the agency
21 was welcome to attend those as well, but certainly it was
22 open to anybody working in the response center so that you
23 would have an idea of what's going on, what the other
24 agencies are doing. The information is being shared from
25 the field, and everybody hears it. That way they know how

1 their function and their role fits into the larger picture.

2 Since August 29, we have deployed or worked in
3 the (inaudible) 257 of SAMHSA's staff, which is just about
4 50 percent of the agency's staff, as Mr. Curie noted
5 earlier. The other 50 percent were back behind these folks
6 so that the agency's regular business could continue,
7 because we do actually have dual roles in a disaster, an
8 agency this small. You can feel it when a disaster hits of
9 this size and requires so much of the agency's resources to
10 be redirected.

11 We awarded four emergency grants within 14
12 days, totaling \$600,000. We reviewed 29 crisis counseling
13 grants and made recommendations to FEMA, and they awarded
14 29 full and 2 partial awards to the states. These funds
15 could be used to do psychoeducation, outreach, crisis
16 counseling and intervention, assessment, referral, to help
17 ease the load on the health system. I think as you asked
18 earlier, what do you do when a state's infrastructure
19 itself has been destroyed or so severely impacted that they
20 can't mount a response on their own, part of that is this
21 program, although with this program there is a slight lag
22 time in getting it up and running because of the way the
23 funding structure works. In this case, in this disaster,
24 SAMHSA was actually able to fill that gap through the
25 (inaudible) process, which is as a lead agency for

1 behavioral health care. A state can come forward to FEMA
2 and say we don't have enough clinicians, we don't have
3 enough psychiatrists, psychologists, social workers,
4 addiction counselors, anything they need in the behavioral
5 health care realm, and say we need you to provide it for
6 us. FEMA goes then to the lead agency for that response or
7 for that function and says we want you to go do it, here's
8 the money to do it. That's what the mission (inaudible)
9 process really does. We mount that response. We
10 supplement the state's response capabilities using
11 resources.

12 In this case, the mission assignment funds have
13 been put into a contract where we then set up contracting
14 with guilds like the National Association of Social
15 Workers, both APAs, and I think five others across a
16 variety of disciplines -- pastoral counselors, addiction
17 counselors, addiction medicine. Then the state came to us
18 and said -- for instance, in Louisiana, I need five
19 psychiatrists in Baton Rouge to do X, and our job was to go
20 to (inaudible) and say give me a list of psychiatrist who
21 are willing to deploy and volunteer their time. They came
22 from across the country. They came from private practice.
23 They came from state hospitals in other states. We
24 deployed them to the impacted area for 14-day deployments,
25 which is the standard, and they provided the services that

1 weren't able to be provided by local providers.

2 In this instance, we had seen such a large
3 number of providers so directly impacted that they needed
4 time to take care of their own personal needs. Many of
5 them stayed on the job for weeks, sleeping in their
6 offices, attending to their clientele, their normal clients
7 on a daily basis, or 12, 14, 16 hours a day, seven days a
8 week, until we were able to step in and provide some relief
9 so they were able to attend to their own needs. That, I
10 think, I hope, answers your question about what do you do
11 when a state has been so overwhelmed by the impact.

12 We also served as an important gap filler to
13 the crisis counseling programs. Now that's up and running
14 in all the states. We shift our focus a little bit, not to
15 be doing any of the outreach and the crisis counseling
16 (inaudible), but again supplementing state resources that
17 have been lost to this disaster and providing clinical
18 services that can't be provided by the crisis counseling
19 programs. So it's constantly working with not only other
20 agencies and organizations that are providing these types
21 of services, but also working with other parts of this
22 agency to make sure that we are not (inaudible) so that we
23 can provide complete contingent care until the state is
24 ready to assume all of the responsibility for mental health
25 and substance abuse (inaudible).

1 We provided an awful lot of staff. It was a
2 continuous cycle. Three staff went to the Secretary's
3 operation center primarily then, but we had some down time
4 too. We have to look out for each other here, so we also
5 had to send some people down to substitute for him so he
6 could get a break. We sent staff to the Secretary's
7 emergency response teams in the field. Those were
8 typically a two-week deployment, although we had a few that
9 stayed much longer than that. Our Commissioned Corps staff
10 frequently were extended well beyond two weeks, from 14
11 days to 30 days, and in a few cases even longer.

12 We had staff who went and served (inaudible) in
13 Austin. We had staff who went out to serve as clinicians
14 and provided direct care services, and that is something
15 that we don't do often, but we were glad to be able to step
16 forward when there was such a crying need.

17 We sent out 4,000 emails, 4,000 faxes, and
18 4,000 snail mails for a survey, the Critical Infrastructure
19 Data System, which was designed to help us collect
20 information on facilities that were destroyed so we would
21 have a better understanding and picture at the national
22 level of what the capacity was prior to the disaster and
23 what it is now so that we would be able to better mobilize
24 and target our resources into those areas.

25 We worked onsite to utilize the data that's

1 already collected by SAMHSA around capacity and
2 utilization. We put it into a precise place on the Web
3 where states were comparing multiple grant applications in
4 order to access it quickly.

5 Planning function. I'm just going to highlight
6 a few things in each of these functions we were able to
7 accomplish. The planning function developed a couple of
8 important papers on assessing what the potential impact was
9 in the disaster area by utilizing various data sources plus
10 the research that we know about the likelihood of
11 post-traumatic stress disorder following a traumatic event.

12 This in no way, of course, covers everything that they
13 did. They did a lot of mapping of facilities to figure out
14 where our (inaudible) facilities were, how many of those
15 were functional, and operational, tracking those and
16 mapping them so that we can target resources and help the
17 state if the state was not necessarily able to gather all
18 of that data, with many responsibilities on their
19 shoulders. So this is information we could feed back to
20 them to help them prepare and utilize their resources.

21 Skip to the next one, please.

22 The logistics function. As I said earlier, it
23 created 72 government tribal orders. I don't know how many
24 they do in a week typically, but that was a significant
25 number.

1 Go bags. This picture here is actually of
2 packing go bags. The first six weeks of the disaster, the
3 physical environment our folks were working in was
4 incredibly harsh, so they were often in the field with a
5 backpack that had a first aid kit and other resources,
6 bottled water that they had to carry themselves because
7 they didn't have access to it. So this was something that
8 we weren't used to doing here, but they were very good at
9 getting all that material packed and ready to go as we were
10 shipping people out the door.

11 Go ahead and skip this one.

12 I mentioned earlier the finance function tracks
13 all of our finances. For fiscal year '05, this is the
14 amount of funds that we spent, \$916,000 in SERG grants and
15 money for the Department in mission (inaudible) funds. We
16 were actually awarded \$5 million in '05 to provide medical
17 services to the State of Louisiana around the state,
18 another \$1 million specifically to provide services on
19 cruise ships in New Orleans. This year we just accepted
20 another \$5 million for substance abuse services in
21 Louisiana, getting prepared to accept \$300,000 for the
22 cruise ship in Mississippi that is housing 1,200 evacuees,
23 and we're looking at probably another \$2 million to support
24 Alabama and Mississippi also for mental health services.
25 This is probably a little bit unusual at this stage in the

1 disaster in that it seems like the emergency basis is over,
2 except that the devastation to their critical
3 infrastructure was so severe that we're still at a point
4 where they're still needing assistance for direct clinical
5 support.

6 I mentioned earlier the public information
7 function. This was staffed by our Office of
8 Communications, some wonderful folks who just had
9 tremendous skills in taking information and collapsing it
10 into a very readable, very useable -- I think we did some
11 great documents that people just had to reprint and reprint
12 and reprint in this disaster. Also, our legislative
13 coordinator spent some time in there as well helping us
14 respond to questions from the Hill about what SAMHSA's role
15 and responsibilities were.

16 I'm going to skip forward.

17 The personnel function, as I mentioned, has
18 been one of the largest. In fact, probably between
19 personnel and logistics, it's the biggest function still
20 active. We operated the Emergency Response Center seven
21 days a week from 8:00 a.m. to 8:00 p.m. until October 21st.

22 After that point we scaled back services to those
23 functions that are still active, which is primarily the
24 incident commander, the logistics personnel, and the
25 finance for tracking. All the other functions have gone

1 back to their normal jobs. I do want to make it clear that
2 we are still very active in our response, and the incident
3 commander and the Emergency Response Center is basically
4 still operating. It's not (inaudible) in the Emergency
5 Operations Center, but it still gets responded to 12 hours
6 a day. It's actually closer to 24 between the folks
7 calling in from the field needing assistance to the phone
8 (inaudible). So we are sharing that burden across the
9 agency still.

10 I thought you would like to know that we
11 deployed nearly 500 people in 12 weeks, 92 of them federal
12 staff, 65 SAMHSA, and the others from HRSA, NIH, and the
13 VA, in addition to well over 160 private clinicians from
14 across the country.

15 MR. STARK: Quick question on the clinicians
16 that you were able to deploy through the KAP contract. Was
17 it in virtually all cases folks outside the disaster area,
18 or did some of that money actually go to pay for clinicians
19 in the area who might otherwise have lost their ability to
20 get a paycheck from their regular employer because their
21 building got destroyed and all kinds of other things, but
22 they still wanted to help and they just needed somebody to
23 cover their costs?

24 MS. BRUUN: Well, the system itself was
25 severely impacted. So many of those clinicians were

1 directly impacted. Either they lost their own homes or
2 they lost their jobs related to it. So in that case there
3 was a real need to bring in outside resources because they
4 just weren't there. Many of them evacuated and couldn't
5 get back to the area to provide services, so they weren't
6 there. Both the States of Louisiana and Mississippi have
7 asked us to prioritize hiring their local clinicians that
8 may have been displaced from the hurricane first, and we've
9 tried to accommodate that whenever possible. There has not
10 been a huge wave of folks coming forward and saying I'm
11 from Louisiana. I think we've done about 15 in Louisiana
12 and I think three in Mississippi that have come forward and
13 said I'm a displaced physician and I'd like to stay, can
14 you pick me up, and we've done that.

15 But I think we also have to be very careful
16 with some of these folks to make sure we really look out
17 for their well-being in the fact that they have been so
18 directly impacted. So we take extra care of them, but we
19 do think it's important to help them return to normal as
20 best as possible by getting them back to work in their home
21 area, if that's possible. So we do provide that support.

22 I want to update some of the data that we have
23 collected so far. All of our clinicians are required to
24 report on the kinds of services they provide. This is from
25 Louisiana only, but we provided well over 17,000 clinical

1 sessions; 91 percent of them were individual counseling
2 sessions, 26 percent get referred to local mental health
3 services. In a traditional disaster you might see that
4 being much higher, but right now those services are still
5 of such a limited capacity that you can't refer
6 (inaudible). That's why we are (inaudible) so high. Five
7 percent were referred to substance abuse services. I would
8 expect that number to actually start going up now at this
9 point in the disaster. Part of it is the timing. Part of
10 it is the fact that we now will be able to provide a lot
11 more substance abuse clinical services on the ground. Then
12 69 percent are referred to other kinds of disaster relief
13 services such as housing assistance, unemployment
14 insurance, things like that.

15 I mentioned earlier that our reporting function
16 prepared all of the situation reports from our activities,
17 which is forwarded to the Secretary's special (inaudible).

18 They prepared all kinds of special reports, so minutes
19 from conference calls and things like that.

20 I had to mention our (inaudible) database
21 function because it was staffed so well by many of our
22 interns. This is an intern opportunity I think that
23 doesn't come around very often, and we had some really
24 truly outstanding interns working in the operations center
25 that were an invaluable help to us. In fact, we actually

1 gave some of them an opportunity to go into the field with
2 more seasoned staff so they would have a direct
3 (inaudible). All of them have come back and said they had
4 no idea that they would get an opportunity like this and
5 how grateful they were to have been a part of this response
6 effort.

7 Fifty-one hundred emails have come in so far
8 and are still coming, although not quite as fast as they
9 were in the initial response, thankfully.

10 I wanted to close with two photos, because I
11 think that while I started the presentation with some
12 pictures of the level of destruction, I just recently came
13 back from a trip between -- I basically covered Ann
14 Mathews-Younes, who works on our personnel team and manages
15 the KAP contract, from Lake Charles, Louisiana to
16 Pascagoula, Mississippi, the entire coastline. In many of
17 those places, those pictures are exactly the same today as
18 they were taken weeks ago by people who were initially
19 deployed in the field, and that's a pretty devastating
20 environment to live in, and I think it helps give people an
21 idea of the kinds of emotional trauma that people might
22 still be carrying with them, just because they're still
23 surrounded by all this devastation.

24 But what I think is so important to recognize
25 is the incredible resilience of some of these folks. The

1 previous picture that said "We Shall Return," it's just
2 such a positive sign of strength, and that's one of the
3 things that our job here is to promote and support as well,
4 the strength of the community, the strength of the
5 individual, and the gratitude.

6 So I wanted to point out why I'm wearing this
7 orange shirt. Mr. Curie in his many visits to the field
8 recognized that there are a lot of relief organizations, a
9 lot of services being provided to the communities, and they
10 all have a shirt. So we thought we should have a shirt
11 because we wanted to make sure that not only was our
12 presence known and that people understood that the mental
13 health and substance abuse needs of the community were
14 being recognized, but they were also being responded to.
15 The orange color actually came out of a process of
16 elimination because all the other good colors were taken.
17 But it turns out this is the best color of all. It's
18 highly visible in the field, so you can spot it from blocks
19 away.

20 But when Ann and I were out in the field, we
21 had the experience -- and I can honestly say I'd never had
22 this before -- where people would walk up to me and say,
23 "You're one of the orange shirts. You're one of the good
24 guys." We were an agency that didn't walk in and promise
25 anything, but we also didn't take anything away. All we

1 offered was a supportive place to talk and pointing people
2 towards resources and connected them and empowered them,
3 and the gratitude for that was just incredibly
4 overwhelming. I don't think I've ever felt so proud to
5 work for an agency, to have people be that responsive and
6 know that they are -- in the cruise ship in Mississippi
7 they run commercials on their TV channel that just runs on
8 the ship. They run commercials that say, "You need to
9 talk? Find an orange shirt."

10 The same in the communities. There are signs
11 posted like that. There are articles in the local
12 newspapers or local newsletters that say if you need
13 somebody to talk to, find an orange shirt. So I think that
14 we really are having a direct impact and effect, and part
15 of it is the visibility which people can access us.

16 MR. CURIE: Thank you, Dan. Thank you, Brenda.
17 I appreciate you sharing the ins and outs of the
18 operations of the emergency response.

19 I'd like to begin with Faye, who has been very
20 patient. Please ask any questions or make any comments.
21 We'll open it up now.

22 DR. GARY: Thank you very much. I just had
23 (inaudible) reactions, but because you're talking about
24 such a phenomenally devastating kind of event that we've
25 all experienced in our lives (inaudible), thank you for

1 hearing that.

2 I just had several questions. Some may be
3 answered now, some may (inaudible), though I'm not sure.
4 But one of the questions was what kind of focus is being
5 given to health professionals who might also experience
6 some emotional and physical responses to working in such a
7 devastated environment (inaudible)? I was thinking
8 primarily about PTSD among professionals, not only mental
9 health professionals but social workers, firemen,
10 (inaudible) who might have had an overwhelming experience.

11 The other is you talked about other
12 stakeholders that you were partnering with and provided
13 assistance to other stakeholders. I would be interested in
14 knowing who the other stakeholders are, and that's very
15 much related to Ken's question about the extent to which
16 local people were used when possible vis-à-vis people from
17 outside of the area (inaudible) on the white horse.

18 The other question, I know that in times of
19 disaster, in times of distress, when you give literature to
20 people, sometimes it makes a lot of sense, and at other
21 times it doesn't. Let's say in Texas and New Orleans,
22 Louisiana and Alabama and Florida, the populations are in
23 some ways (inaudible), but in other ways they're very
24 diverse and very different. My thinking is that perhaps

1 when you're talking about looking at reading levels based
2 on what we know now, since we really developed some kind of
3 database about who is affected, what are the reading levels
4 of the individuals, and what are their cultural worldviews,
5 and how is it that the literature that we prepare for
6 people who are at risk would fit some kind of predetermined
7 criteria so that when they read it they understand and
8 would know what to do? Back to your concept of
9 deconflicting, that's a way that we could program ourselves
10 to minimize the possibility of having the conflict in
11 information and not having to deconflict.

12 Again, the issue about stigma, how is it that
13 people who (inaudible) services because of the stigma
14 issue, and what kinds of lessons learned that you could
15 share with us about stigma or reluctance to get help,
16 because it's related to mental disorders and substance
17 abuse.

18 The other is you said that there was a list of
19 grants awarded, and I'm asking if you could tell us or give
20 us a sense of who got those grants and what kinds of
21 requirements and restrictions are placed upon the grants,
22 especially as it relates to outcome data and some kind of
23 accountability, if you will.

24 I think (inaudible) mentioned this lessons
25 learned document. I think that is a critical document, and

1 if it can be shared with the Council, no one else is
2 interested, I certainly would be interested in knowing
3 about the lessons learned and the implications that it
4 would have for professional development and training across
5 the professions that SAMHSA works with, as well as when Mr.
6 Curie talked about educational training. What is it that
7 we can learn from the lessons you learned that should be
8 infiltrated into academic institutions so it would help us,
9 we'd be better prepared in the future for disasters,
10 hurricanes and other kinds of disasters, in our learning,
11 in our education, in our training? Again, what kinds of
12 literature could grow out of that?

13 The final issue is I like the concept of
14 resilience, because I think that's why we all keep coming
15 back every day, because we know the human experience is
16 willing to heal and move on. But there was no discussion
17 of poverty, and in my mind I think poverty is probably one
18 of the greatest devastating factors that mitigates against
19 mental health. I would like for us to have some discussion
20 about poverty and what position it is that we can take to
21 at least raise the conscious awareness about what poverty
22 does to people. It creates its own hurricane when there's
23 no wind, no rain, no storm. How can we integrate and fold
24 into mental health and substance abuse prevention and
25 treatment the issue of poverty, and what can be done with

1 our interventions and our thinking along those lines?

2 Thank you. I think it's very (inaudible) and
3 very (inaudible).

4 DR. DODGEN: Well, thank you. Fortunately, I
5 had a pad and a pen with me because I'm not sure I could
6 have gotten it all otherwise. But I'm going to do my best,
7 and I know Brenda will have comments to make as well. I
8 think some of your questions are really matters of
9 discussion for the Council that we may not be able to
10 respond to necessarily. But let me try and take your
11 questions in order.

12 You asked first off about the issue of worker
13 support. I think that there are a couple of things that
14 are important to say about that. First I think all you
15 have to do is listen to Brenda's remarks to know that one
16 of the hallmarks of the SAMHSA activities within the SERC
17 was with the support of our own workers. If we're going to
18 speak to OSHA and other people about that, we had darn well
19 better be modeling it, and I think we were, very much
20 thanks to Brenda's good work.

21 In fact, I don't know if Dr. Cynthia Hanson is
22 still in the audience. But anyhow, Cynthia is actually a
23 fellow working at SAMHSA this year with a great deal of
24 experience in this area and was part of the team that was
25 providing both orientations before deployment and

1 debriefings after deployment so that people who were in the
2 field could be better prepared, as well as have a chance
3 just to talk about that afterwards.

4 In addition, we have a brochure that Rachel
5 Kaul is going to be sharing with you during the next panel
6 that is specifically about stress and how people can manage
7 stress better while they're in the field. This is a
8 brochure that we have provided to every single person going
9 out into the field to have as part of that go pack that
10 Brenda has talked to you about that was really incredible.

11 I mean, she didn't tell you, but in addition to sunscreen
12 and first aid, they had granola bars and all kinds of other
13 things in there as well, gum, Altoids. We took care of our
14 people when they went into the field, and it's really
15 coming out in the course of the work we're now doing with
16 OSHA to provide a model that will be for all employee
17 workers, whether they are federal employees or employees
18 who are federalized just for the purpose of this
19 deployment, so people who volunteered through the Katrina
20 (inaudible). They all fall under the same mandate from
21 OSHA. So OSHA is actually under SAMHSA's guidance
22 developing brochures and sets of materials that will be not
23 only for workers but also for family members and for bosses
24 and supervisors to use when people return to help
25 facilitate their reentry into the workforce.

1 So I think that there are a number of things
2 that are very much groundbreaking that SAMHSA has been a
3 part of.

4 MS. BRUUN: I just have two things to add to
5 that real quickly. One is that the work that we did in
6 trying to take care of our own workers, we actually
7 required a contractor who was setting up (inaudible) on
8 behalf of the KAP contract. They did the same thing:
9 shirts, go bags, out-briefings, in-briefings, follow-ups to
10 make sure that (inaudible) very well once they returned
11 home.

12 But I think that your question also was a
13 general question about the workers that (inaudible), if
14 there were any special programs for them. I think the
15 struggle here is that they've been so directly impacted
16 that (inaudible) the population has been impacted. I would
17 say right now, other than the attention we're getting from
18 (inaudible) responders, especially those in New Orleans who
19 are on cruise ships, our efforts around supporting the
20 health care worker, the state mental health workers, the
21 (inaudible) workers, (inaudible) officials, has been to
22 provide mental health and substance abuse services to
23 either give them a break by (inaudible) them and letting
24 them go home for a few days or to be there to listen to
25 them and support them as they work, to help them work

1 shorter hours, because there does seem to be (inaudible).
2 Some felt that they couldn't take a break, but we allowed
3 them to (inaudible). I think we're still actually at that
4 phase.

5 DR. DODGEN: I'm aware that it's break time
6 just about, so let me try and respond to the rest of your
7 questions, and then perhaps if we want to talk about some
8 of this at the break, then we can.

9 But the issue that you also asked about
10 regarding stakeholders and who are our partners and who we
11 work with, it would be the folks that we talked about in
12 the slides. So all the ESF8 partners, as well as all of
13 SAMHSA's traditional partners. So the professional groups,
14 national organizations in the mental health and substance
15 abuse field, as well as some new partners such as the work
16 that Mr. Curie has been doing to collaborate more with the
17 Administration on Children and Families, the Department of
18 Education, et cetera. So in addition to all the
19 traditional partners, we really expanded into some new
20 arenas.

21 You asked also about the appropriateness of
22 materials, particularly vis-à-vis language and reading
23 level, and I think one of the things that our public
24 affairs office has really done is make an effort to develop

1 materials that are geared at a number of different
2 audiences. One the nice things about our long history with
3 the crisis counseling program is that many of our prior
4 crisis counseling program grantees have developed materials
5 related to disaster response in a number of different
6 languages, for parents and for children, as well as
7 teachers, different audiences. So we actually have a
8 pretty good library of materials that can be available in
9 that regard.

10 You asked if we worried about stigma, and I
11 think that there are so many layers to a question like that
12 because it's such a complicated issue, but I do think that
13 we have certainly broken some new ground in terms of the
14 recognition at the state and federal level of the
15 importance of behavioral health issues as integral to the
16 response.

17 As an example of that, I cite the fact that we
18 did have, for example, a seat at the IIMG, which is really
19 unprecedented, the fact that we did get the -- I think it's
20 \$11 million already in mission assignment. We've never had
21 even a penny in mission assignment dollars before to
22 SAMHSA. So I think that there are a number of things that
23 indicate that while of course stigma still exists, that the
24 walls are really breaking down. People are recognizing
25 that these issues are important in ways that they may not

1 have in the past.

2 You also asked about lessons learned, and I
3 think that it will be of interest to all the Council
4 members to know that we are going to be doing what's called
5 a "hot wash," another one of those disaster terms, here at
6 SAMHSA, just to go over our own internal lessons learned,
7 and we're actually going to be bringing someone in to write
8 up really an analytical look at our lessons learned so that
9 it isn't just the minutes of the meeting but to really do
10 an integrated look at that. We talked about how we can
11 prepare that, or at least an executive summary of that,
12 that might be useful for Council.

13 Then I think your last issue is one that I
14 would really prefer to direct to Council, because I think
15 what you're really asking is for a discussion of these
16 issues on the relationship between resilience and poverty
17 and other things. We could comment on that, but I think
18 that is perhaps something that merits a separate discussion
19 because it's such a large issue.

20 I didn't know if Brenda wanted to make any
21 other concluding remarks, and certainly I'll be happy to
22 respond.

23 MR. CURIE: Barbara?

24 MS. HUFF: I've known you, Daniel, since way
25 before SAMHSA, probably 15 years; and Brenda, I've known

1 you through your work with Ann Mathews-Younes as a stellar
2 project officer. So with that in mind, I'd like to just,
3 on behalf of the Council, say thank you to both of you for
4 your (inaudible) work with us.

5 (Applause.)

6 MS. HUFF: (inaudible) how you took care of
7 yourselves (inaudible). I can only imagine what this has
8 been like.

9 MS. BRUUN: I think the hardest thing to do in
10 this role has been to model self-care. So I'm just going
11 to be direct about that and honest about it up front. I
12 think that I've been serving as in-state commander since
13 September, and there are a couple of things I've done well
14 for self-care. One is I have probably 12 years so far in
15 disaster experience and (inaudible), so I kind of know how
16 to pace myself through the disaster, and I think that
17 helped.

18 The keys for me are eat healthy food, make sure
19 it's available, easy to get, drink a lot of water, try to
20 continue your exercise routine if you have one, and sleep
21 well. Those are definitely a challenge. I think for the
22 most part I was able to do almost all of them, but I also
23 think that what can keep you going for longer than you
24 think through a time like this is to have such wonderful
25 colleagues who support you and work with you. This is a

1 520-person team, and that's what makes anything seem
2 doable, to know that you're not doing it all yourself and
3 that you have a tremendous amount of support
4 professionally, and even offers from outside of our agency
5 were backing us up and supporting us. Even if we weren't
6 always able to utilize those resources, it at least meant a
7 lot to have people who were trying to look out for us as
8 well.

9 Then I would have to say my family and friends
10 really tried to step up and make sure that they cooked at
11 night or little things like figuring out how to get your
12 laundry done. That's a tremendous help and just one less
13 thing to worry about so that my downtime was spent resting
14 and not taking care of the little business of life.

15 MS. HUFF: Thanks.

16 DR. DODGEN: Thanks. Thanks for helping us
17 keep it real, Barbara. It's nice to talk about all these
18 things.

19 I really echo all the things that Brenda has
20 said. I think in terms of the self-care -- and I do want
21 to say, too, I think Rachel is going to talk a little bit
22 more about that, so I think you'll hear more about what an
23 important factor that is in the response. I think on a
24 personal level, I always talk about the three Fs --
25 friends, family, and faith -- as the things that help you

1 through.

2 But I think also I'm fortunate, like Brenda, to
3 have been in this field for a long time. My first major
4 national disaster response was the L.A. riots in '92. So
5 I've been doing this for a long time, and before that I
6 worked at a child abuse shelter doing interviews of the
7 kids when they were first brought in. I think I'm
8 fortunate to have a lot of colleagues in this area who know
9 mental health and know trauma. The other thing I do is I
10 debrief with people who have been in the field as long as I
11 have that get depressed. I think that for all of us in
12 this work, everybody in this room have very high-pressure
13 jobs that take a lot out of you, and we all know that
14 debriefing people who have been there is incredibly
15 helpful.

16 So I think we are ready for a break, but the
17 next panel is going to be wonderful, and I think Brenda and
18 I will be around during the break to take more of your
19 questions.

20 MR. CURIE: Thank you.

21 Let's take a 15-minute break.

22 (Recess.)

23 MR. CURIE: If we could reconvene, I think
24 you'll find the next (inaudible). Sharing with us today is
25 Ms. Rachel Kaul, Mr. Kevin Chapman, and Ms. Anne Herron.

1 Each individual, again, I think represents a perspective of
2 what it was like. We've seen the macro end of things.
3 We've seen the, if you will, 15,000- to 20,000-foot level
4 view of what happened and how SAMHSA's emergency response
5 occurred. This is going to give us more of the ground view
6 of what actually was occurring there.

7 So, Rachel, it looks like you're up first.

8 MS. KAUL: I'm up first. Thank you so much,
9 Mr. Curie, for letting me take some of your time to tell
10 you a little bit about my experiences. You have heard
11 quite a bit about the macro. I am going to try and give
12 you some detail and anecdotes to address some of the issues
13 that were raised not only during the presentations but by
14 the Council members themselves.

15 I am a project officer with the Emergency
16 Mental Health and Traumatic Stress Services Branch, which
17 is part of CMHS, and we do disasters all the time. That's
18 what we do. My job is that when a presidentially declared
19 disaster occurs, I immediately get in touch with the state
20 disaster mental health behavioral health coordinator and
21 start looking at their application process for the crisis
22 counseling program, which is funded by FEMA but monitored
23 in the long term by SAMHSA, and we also provide the
24 technical assistance and recommendation during the
25 application process. So as soon as the declaration occurs,

1 and often before, when I hear a hurricane is bearing down
2 on the Gulf Coast, I'm on the phone generally with one of
3 my colleagues and with the disaster folks in the targeted
4 states.

5 The thing I want you to know from a state level
6 is that the states have a very short timeline to apply for
7 the disaster emergency funding, the CCP funding.
8 Basically, the timeline is 14 days from the day of the
9 declaration. So I want you to think about Katrina for a
10 minute and the fact that when Katrina hit on August 29 and
11 devastated hundreds and hundreds of miles of coastline,
12 destroying service centers, homes, businesses, schools,
13 universities, transportation, communication,
14 infrastructures, the state still had 14 days to apply for a
15 crisis counseling program, each state.

16 So my colleagues and I were on the phone with
17 state people pretty quickly, but they weren't easy to find.
18 They were evacuating their families. They were trying to
19 find elderly relatives that were in nursing homes in harm's
20 way. They were trying to figure out how they were going to
21 staff emergency centers. We were preparing to start
22 emergency operations, and so were they, and it was very
23 stressful, as disasters always are. But this one, once it
24 hit, we realized that the level of devastation it created
25 was even more so. The scope and scale was beyond what we

1 normally deal with. However, it didn't change the
2 timelines. It just doesn't do that.

3 So our agency decided to deploy myself and two
4 of my colleagues down to the states to assist the state
5 personnel in assessing how they were going to amass
6 resources and apply the resources and start this process
7 rolling. Normally we would wait. We wouldn't go down
8 right away after a disaster. For one thing, often you're
9 in the way, right? The people working the disaster need to
10 be doing what they're doing, and they don't really need
11 their federal partners, whom they appreciate and truly
12 adore --

13 (Laughter.)

14 MS. KAUL: -- they don't need to have them
15 watching them do it. But in this case, they knew that they
16 needed a lot of help. This (inaudible) the fact that about
17 three nights in I was trying to reach the coordinator for
18 Mississippi. His name is Andrew Day. I called the office
19 number I had. I had been calling; there'd been no answer.
20 Finally, it's 9 o'clock, 9:30 at night, somebody answers
21 the phone. I said, great, I'm looking for Andrew Day, and
22 this very nice gentleman tells me that Andrew is somewhere
23 on the coast. Every staff person that could had gotten
24 into their cars to go down to the coast to find other staff
25 people, because there was no other way to reach people and

1 they didn't know where their people were. So they went
2 down to find people, and he didn't know when he'd be back.

3 Now Jackson, just so you know, is where the
4 mental health agency is, and the Department of Mental
5 Health and Mental Retardation. It's three and a half hours
6 from the coastline. So everybody was out, and I asked him,
7 well, does a cell phone work? Is there any way I can get
8 him a message? And he says, ma'am, I'm sitting in the
9 dark, we have one phone that works, there's no water here,
10 and I don't have anything to write with. And I said, I'm
11 really sorry; how are you doing?

12 We talked, and I realized this was the deputy
13 commissioner for mental health I was on the phone with. He
14 was so kind and so patient, and he was sitting there trying
15 to man this one phone in case somebody called to say we
16 found one of our staff people. That's how intense the
17 disaster was. Days later, when I was talking to folks in
18 the states, they were living at their operation centers and
19 at their community mental health centers. They were living
20 there because gas was unavailable. So they couldn't drive
21 home because they might run out of gas. So it just made
22 more sense to just stay where you had to be, and these were
23 people with small children, with spouses, with elderly
24 parents, with neighbors, with damaged homes, and that's
25 what they were doing.

1 So from our perspective, normally we would
2 provide technical assistance, sending documents out,
3 reviewing grant applications. It's a pretty organized
4 system, and we're pretty good at this. But it was clear we
5 needed to do more, and we went down and I started in
6 Louisiana, landed in Baton Rouge at 10:30 at night, was in
7 a car and at the shelter at the airport outside of New
8 Orleans by midnight because the disaster coordinator needed
9 to go down to check on some of his people that he'd sent
10 out and wanted us with him, and we wanted to go.

11 I have had the benefit and the great privilege
12 of being involved in disaster response for over a decade
13 now, and I've seen a lot of disasters. I've been on the
14 ground early and I've had a lot of exposure to disaster
15 situations. But walking into that airport shelter was
16 unlike anything I've ever experienced before. There were
17 almost 5,000 people in that shelter when we got there.
18 There were people who had been plucked off of roofs and
19 interstates and walked there or however they could get
20 there, and it was almost silent because people didn't even
21 have the energy to talk, you know? They were just sitting
22 there.

23 I remember Linda Ligenza, my colleague and I,
24 it was hard to acclimate to this environment and figure out
25 who to talk to. But the amazing thing is you do acclimate

1 and start talking to people, and they tell you amazing
2 things, and they're grateful.

3 The one thing I remember most about that first
4 night was how many people said thank you for just being
5 there, for walking in and looking at people and asking them
6 how they'd come to be there and what they needed now and
7 what they were hoping for. We couldn't make any promises
8 because we didn't know what was going to happen next, but
9 we just wanted to hear it so we could communicate that back
10 and figure out how to prioritize this.

11 After that, Mr. Curie came down almost the next
12 day with Secretary Leavitt, and again what struck me was we
13 were in another shelter and how grateful people were to see
14 people from out of state, from the federal government that
15 weren't coming in to promise anything at that moment. They
16 were coming in to listen, and they were asking questions
17 and (inaudible). Then what happened was I went to
18 Mississippi thinking that that was as intense an
19 experience, and it left me with so many things that I could
20 work on and think about and plan for and do, and I went to
21 Mississippi and spent a day with my colleague, Cecilia
22 Casale, who had been deployed there, and the disaster folks
23 down there, and I'd never seen devastation to that degree.
24 It was as impactful to me. I'd never seen 60, 70, 80
25 miles from the coast of a hurricane telephone poles snapped

1 in two, cars spun around as if they'd been hit directly by
2 a tornado. This went on for miles. It was (inaudible)
3 along the coast, and that was shocking.

4 So what we are facing here is so huge and
5 complex, and then I look at my state colleagues and
6 compatriots and I say what do you need, and at that time
7 they were still very much in shock. They'd been working
8 for well over a week with very little sleep, away from
9 their families, away from their own concerns. But
10 everybody's primary concern was we want to do this right,
11 we want to take care of these people. And everybody was
12 saying, no matter what they faced, how much more concerned
13 they were about the people who had experienced more
14 devastation. It was truly remarkable.

15 What I am grateful for about that period is, as
16 project officers, we're going to be involved with these
17 states for a long time to come. We were able to work with
18 our agency and work with FEMA and change not the
19 regulations around the crisis counseling, around SERG
20 grants, but to creatively apply regulations and look at
21 where the gaps were and make resources, financial
22 resources, become mobilized very quickly, and then human
23 resources get mobilized very quickly. I'll give you
24 another example.

25 For these crisis counseling grants, we normally

1 don't have consultants go in and help people with these
2 grants. These people know how to write these grants.
3 They're trained to do it. But because of how much every
4 worker was being asked to do and what that meant to the
5 stress level, the energy level, the time level, what it did
6 to their cognitive abilities, we did mobilize people from
7 out of state to go in and support and help these people get
8 what they needed to get these grants written in such a way
9 that we could get them money and get these programs started
10 to get services on the ground.

11 So those are just some examples of what I was
12 really, really grateful for. What I know now, this many
13 weeks out, is that this was important to the state folks.
14 They were so grateful for our energy, for the fact that we
15 came in, we were able to help them problem solve. We
16 didn't tell them what they needed. We asked. We tried to
17 work with the resources that were available, that we're
18 familiar with, that we know how to use well and make them
19 fit in a neat way in the impacted areas. I know they're
20 doing better now because their sense of humor has returned.

21 The other day I called Mississippi, and I was
22 tight for time. I was late for a meeting, and I had a
23 piece of information I really needed, and I called the
24 crisis counseling program called Project Recovery. I
25 called Project Recovery, and the project director and

1 disaster coordinator were both on the phone with me, and
2 they said, yes, Rachel, what do you need? And I said,
3 well, I'm getting ready to go to a meeting and I need some
4 numbers. But first, Jenny, how was your weekend? And she
5 said, well, it was pretty good. It did some Christmas
6 shopping. And I said great, that's excellent. Andrew,
7 what about you? Did you get some time with your son? He
8 said yes, actually we played ball. And then he laughed and
9 said, Rachel, you're learning the southern way. I said,
10 yes, I am, I'm learning, this is how we do things. The
11 fact that there is now time to stop for a minute and find
12 out if somebody went Christmas shopping is a really good
13 thing, and it gives me a lot of hope.

14 So a couple of things I wanted to talk about
15 were the importance of the crisis counseling program in the
16 states is that it's going to provide services in these
17 areas for basically a year, give or take a few months. It
18 addresses some of the concerns you brought up already. The
19 crisis counseling program is designed to rely on people's
20 strengths, on a community's existing strengths, help a
21 community re-find its sources. Maybe it's lost, maybe it's
22 forgotten about. Help them create resources if they need
23 to.

24 The crisis counseling program hires folks
25 indigenous to the community. That's a key feature of it.

1 Paraprofessionals and professionals. We're hiring the
2 indigenous workers and we're training them to ask their
3 community members what they need and help them come up with
4 the problem solving, the resources that they need to help
5 their communities start what is going to be a long and
6 very, very difficult road to recovery. Yes, they're
7 (inaudible). The crisis counseling program is not going to
8 be (inaudible). But the other thing that has been very
9 gratifying about this experience is that the level of
10 involvement of the entire agency (inaudible), and the
11 cooperation and communication among every center and every
12 program has been very high.

13 What that means is that we can start to
14 identify aspects of other programs, other grants, other
15 resources that can work in conjunction with crisis
16 counseling to really help staffs and to help these
17 communities start building what they (inaudible) in terms
18 of capacity to recover. So that's part of it, and I'm very
19 grateful for that.

20 Another piece that I wanted to talk about was
21 something I'm left with that we're always working on. Our
22 branch has been concerned about emergency responders for a
23 long time, firefighters, police officers, medical
24 professionals, public health responders, disaster
25 responders. We asked for and had a guide created by the

1 (inaudible) called "A Guide to Managing Stress in Crisis
2 Response Personnel." The publication, this guide got
3 launched serendipitously right at the same time as Katrina.
4 So we were able to get this into the field and help states
5 also increase their focus on responders, because the other
6 piece of this that's important to remember is the
7 non-traditional responder.

8 It's the SAMHSA personnel or the NIH personnel
9 or the private therapist or the church volunteer that goes
10 out to a devastated area with unbelievable amounts of
11 trauma and just has never exposed themselves to this
12 before, and works and works their hearts out, and then come
13 back with the stories and the images that they've heard and
14 seen, and they grow from that experience but there's a cost
15 to it as well. I think we need to help all of these
16 agencies and our colleagues and our neighbors and our
17 friends recover from these experiences.

18 So I'm giving this to you so that you can see a
19 resource that we're very proud of, but also in case you
20 know someone, or maybe you yourself have been down there
21 and impacted, close to folks who have been responding. You
22 may find that there's really important information in here
23 for you. I hope you do. I know our state people are
24 grateful for it. So I'm going to start passing that around
25 for you.

1 MS. VAUGHN: Rachel, TaRaena will pass them
2 around.

3 MS. KAUL: Great. Whatever is extra can go to
4 anybody else.

5 Finally, just in closing, I do want to say that
6 that message of caring for ourselves, of caring for others,
7 we really did go down to the states to show them that we
8 were there to support them in any way that they needed. I
9 think it was our ability to walk in and to be a supportive
10 listening presence, but also to help them problem solve,
11 but without promising or even suggesting things that were
12 not already within that culture and community. It's really
13 about asking them what is it that's going to work for your
14 community and work here, and helping them think of
15 nontraditional things.

16 I was speaking with someone else about this
17 earlier, that we find that our consumers and the people
18 that we service in our community centers are frequently
19 somewhat almost some of the first people that want to come
20 forward to help respond, and they're some of the most
21 creative and effective at responding.

22 These are people that are used to reaching out
23 for resources, used to linking people with resources, and
24 they're certainly not separated from the community at
25 large. Those lines and barriers are broken down by the

1 disaster and that creates opportunity.

2 So these were people with mental illness,
3 people with substance abuse issues in prevention, who were
4 able to make a big impact in helping their community
5 members, their families, and their friends. So this is the
6 kind of thing that we can help the states focus on as a
7 resource to really rely on and start utilizing.

8 I'm going to stop there. We could all go on
9 for a long time about disorders we've heard, but I feel
10 really good about the response of this agency and that I'm
11 going to get to continue to interact with these states as
12 time goes on.

13 I'm happy to take questions at the end after my
14 colleagues have gone and to give you more information.
15 Thank you.

16 MR. CURIE: Thank you so much, Rachel.

17 I'd now like to ask Kevin Chapman if he would
18 share his experiences. Kevin is from our Center for
19 Substance Abuse Prevention.

20 Kevin?

21 MR. CHAPMAN: I had the opportunity to serve
22 SAMHSA in the hurricane relief effort in Houston, Texas.
23 Presently, at work at CSAP in the Division of State and
24 Community Assistance as a project officer. Historically, I
25 am a United Methodist minister specializing in pastoral

1 counseling with a Doctorate of Ministry in pastoral care.

2 We are a team of ten. We began our journey in
3 Houston. Our team initially made contact with the Harris
4 County Department of Mental Health and Mental Retardation
5 Authority. We consulted with the Executive Director and
6 the Director of Adult and Child Services to provide
7 professional mental health services for personnel who
8 responded to the crisis and delivered services to evacuees
9 and to help the county do long-term planning.

10 We began this process by touring two of the
11 largest shelters in Houston, the H.R. Brown Convention
12 Center and the Reliant Center at the Astrodome. To assist
13 in this process, we attended daily meetings with the Mayor
14 of Houston and the Harris County Executive, followed by the
15 Community Medical Working Groups. We also met with other
16 federal personnel who were deployed in Houston, attended
17 the Behavioral Health Provider Network meeting, and offered
18 assistance in any way that we could.

19 Many times we heard from the mental health
20 providers that their system was already at or beyond
21 capacity. We are trying to strategize and discover ways to
22 provide the extra services that will become necessary in
23 the weeks ahead.

24 Professionally, I had two assignments, one to
25 use my clinical and spiritual background in our consultive

1 and assessment process and to use my organizational skills
2 to assist the team leader and the group. In evaluating my
3 assignments, I believe my main missions have been
4 accomplished.

5 Initially we had contact with the Harris County
6 Department of Mental Health and Mental Retardation, but it
7 became noticeable to me that we were not talking with the
8 alcohol/drug counterpart. So I lifted up this concern and
9 our team leader gave me an assignment.

10 This became a very positive part of my journey.

11 I contacted Mr. Mel Taylor, President and CEO, and Mr.
12 Leonard Kincaid, Chief Operating Officer of the Council on
13 Alcohol and Drugs in Houston. I invited them to meet with
14 our team. We did meet with them, and we learned from them
15 that initially they had been there. They had been on the
16 front lines providing referrals and services for persons in
17 need of methadone treatment and other treatment services.

18 But after the initial crisis subsided, the
19 council was informed that their services were no longer
20 needed. According to the council, the American Red Cross
21 was the gatekeeper, and it would not recognize licensed
22 clinical dependency counselors to provide services to the
23 evacuees. It was also reported at that time that the
24 medical community did not see the need for substance abuse
25 services.

1 The council could also not access the shelters
2 to conduct 12-step meetings. Eventually, volunteers from
3 the community just went in on their own to the shelters and
4 formed 12-step meetings, even though they did not have the
5 privacy they desired.

6 Mr. Taylor and Mr. Kincaid kept in contact with
7 other agencies to provide their services. This is the
8 reason, from what I just said, why we did not see the
9 council in Houston.

10 Through this initial meeting with the council,
11 we were able to get in and reconnect to the Houston agency
12 group and the council willingly participated in the initial
13 steps. I also visited the council's office and with their
14 staff we learned about the appropriateness.

15 Secondly, I was able to assist in making
16 important connections back to the SAMHSA SERC, which leads
17 to my second accomplishment. I wanted to preface this
18 accomplishment by saying with my background as a minister
19 and a therapist, I tend to integrate the thoughts and
20 behaviors, so some of this experience is personal in
21 nature. I'm not bringing this up to you to call attention
22 to myself.

23 Our deployment was scheduled for 14 days. Our
24 team leader and two other members left after the first
25 week. Dynamically, this changed the group process, along

1 with Hurricane Rita threatening to hit Houston. More
2 members from our team came from Phoenix, from Value
3 Options, and provided direct services to the evacuees.

4 Three of the Phoenix team, and I will call them
5 the Phoenix 3, came to me on Monday of the second week and
6 asked me directly to work with SAMHSA to get us out of
7 Houston. We were watching in the evening the weather
8 forecast that Hurricane Rita was on its way and it was
9 going to hit the Houston area. One of the Phoenix 3 had
10 experiences living through hurricanes in Texas and she
11 said, "Kevin, you have to get us out of here." She knew
12 that if the hurricane did not hit Houston directly, the
13 power would certainly go off, and it would take us hours to
14 try to get out of the community.

15 This was a very difficult part of the journey,
16 and eventually became the reason I left the deployment. I
17 personally also felt unsafe and wanted to move deeper into
18 the state.

19 It was a very conflicting experience. On the
20 one hand, in Houston, we watched the remaining evacuees
21 being told that there was another hurricane coming. They
22 were offered to go to a military base in Arkansas by plane
23 or by bus, or they were given a one-way ticket to anywhere
24 in the continental United States.

25 We watched the evacuees lined up with their few

1 belongings in the sweltering heat in rows as they waited.
2 The next day, we, on the other hand, drove in an air
3 conditioned car to San Antonio. We made the drive in a few
4 hours. The next day motorists sat in hours and hours of
5 traffic.

6 By this time, I personally was having a
7 stressful reaction. I found myself reversing and
8 mispronouncing words. I kept thinking once we arrived in
9 San Antonio, I would feel safe.

10 On Wednesday evening, a couple of hours after
11 we arrived, we attended a meeting with other federal
12 personnel about the relief effort in San Antonio. During
13 this meeting, the convener, who was also a native of Texas,
14 talked about the hurricane. (Inaudible.)

15 That was the moment that I was stopped in my
16 tracks, literally. I thought we were safe, and now we were
17 going to be dodging another hurricane. We walked out of
18 the meeting, and a team member (inaudible). It was a very
19 eerie experience. Our team discussed how would we deal
20 with this situation? Basically, would we stay or leave?

21 By this time, I was physically exhausted,
22 mentally fatigued, and asking God, are you calling me? The
23 answer for me emerged immediately, but it took time to
24 accept it. I had taught persons for years that you have to
25 take care of yourself to be able to help others. I was now

1 faced with the question of how I was taking care of myself.

2 My wife and dog, especially my dog, depends on me.

3 (Laughter.)

4 MR. CHAPMAN: I asked to come home, which I did
5 on Thursday. After plane delays, I headed back to D.C.
6 late that Thursday. I felt guilty for being the only
7 remaining team member to leave, for not completing the 14
8 days, for being afraid.

9 On Friday, I came into SAMHSA and I was
10 relieved (inaudible) Houston team. That Friday, two of the
11 Phoenix 3 from San Antonio. They told me two things. "We
12 wish you were here, and Kevin, you made the right
13 decision."

14 MR. CURIE: Thank you, Kevin, very much for
15 sharing that.

16 Anne Herron, who is in our Center for Substance
17 Abuse Treatment, is here to share her experience and
18 thoughts.

19 MS. HERRON: My job in CSAT, the Center for
20 Substance Abuse Treatment, is as director of the Division
21 of State and Community Assistance. So I have the honor and
22 pleasure of working with the states. I'm also responsible
23 for issues of co-occurring disorders, homelessness, and
24 prisons that clearly come up because of these hurricane
25 experiences.

1 About two weeks after Hurricane Rita, we
2 assisted the Secretary of the Office of Mental Services in
3 the State of Louisiana. She was having some conversations
4 with some folks at SAMHSA. She actually said very
5 specifically that she would like some assistance.

6 Her needs were around, first, the command and
7 control system that is operation in the State of Louisiana
8 for disasters. At one point, they were separate state
9 responses that were operating. So there was some confusion
10 about the actions. So that was one thing that she would
11 like some assistance for.

12 The second thing she wanted some assistance
13 with, and this is two weeks after the hurricane hit, was
14 noticing that her executive team was really needing some
15 support because they were spending up to 14, 16 hours,
16 seven days a week, providing both direct care services and
17 providing support to her staff. So she wanted some support
18 for her.

19 She wanted to make sure that the work stayed in
20 the Office of Mental Health (inaudible) supporting first
21 responders was appropriate, it was long term
22 sustainability, and that it was the right thing to do.
23 That was the fourth issue.

24 The fifth issue was looking at the system of
25 care and what the needs where over the next three to five

1 years, and she said, "Can you give me some assistance,
2 give me some options, with a fresh pair of eyes?"

3 So I went down with another colleague, an
4 expert in the area, and he focused on that particular issue
5 and provided a number of options and recommendations to the
6 state agency about mental health services. Together we
7 looked at the organizational structure. We looked at the
8 important issues that the state had been dealing with and
9 what was going to come in the future.

10 In the State of Louisiana, the Office of Mental
11 Health, Office of Addictive Disorders, and Office of Mental
12 Disabilities are all together in the Office of Mental
13 Health. So there was an opportunity to do some significant
14 work around long-term planning, around media response, and
15 around the integrated options review and for staff
16 functions. So it was a great opportunity to at least be in
17 the discussion around some of these issues.

18 What we did find was that in our planning of
19 speaking with staff about their values and their tasks that
20 they needed to solve and that they needed address, we
21 figured maybe a half hour for it. It took easily, easily,
22 an hour and a half for each person because the first hour
23 was spent talking about their experiences. Eighty to 90
24 percent of the staff in central office in the State Office
25 of Mental Health were directly affected. They'd lost

1 houses, their family was displaced, and it was huge, huge.

2 So we were able to provide some
3 recommendations. We were able to talk to the Secretary of
4 the Department on the Assistant Secretary's behalf and they
5 began to implement the recommendations.

6 About two weeks later, SAMHSA received a
7 request from the Assistant Secretary of the Office of
8 Addictive Disorders. He said, "Some work that you have
9 done with the Office of Mental Health impacted us as well.
10 We'd like to have an assessment of our function, of our
11 planning over the next three to five years. Give us some
12 recommendations for how to streamline these processes and
13 reorganize our system in order to begin to respond to this
14 massive effort."

15 So we went and did a similar thing for the
16 State Office of Addictive Disorders. We looked at their
17 functions, values, projects, initiatives, and how they
18 needed to build relationships with some of the local
19 district staff. Again, very interesting for us, a
20 fascinating process of engaging with this macro systems
21 assessment and to have staff then say to us this makes
22 sense. They have since begun implementing some of those
23 recommendations and have asked for additional consultant
24 help.

25 So I feel that we have been quite successful in

1 a fairly short period of time, and letting them implement
2 at their pace, and not taking over responsibility
3 (inaudible) fix it.

4 A personal observation. One of the things that
5 was astounding to me, and I mentioned it to the Office of
6 Mental Health, was the number of staff in the agency who
7 were themselves very significantly impacted. This was
8 something that I had not seen. (Inaudible.)

9 As a result, the first time I went down, I
10 focused on crisis response. I focused on trying to help
11 people get a break, as Rachel and Kevin mentioned, from
12 their work they were doing really all the time. To try and
13 get them to back away and take care of themselves is very,
14 very difficult.

15 By the second time I went down, there was a
16 significant improvement in that process. It was then five
17 weeks after the hurricane, and they started reengaging in
18 the sense of routine, which was not present the first time.

19 Having that routine back, having achieved some
20 predictability to their jobs and to their lives, that was
21 so, so important.

22 Another thing that I mentioned that I think
23 really was a great accomplishment was providing some
24 administrative respite to the assistant secretaries and to
25 their executive secs. In crisis response, (inaudible) just

1 by a very, very short period of time, our being able to be
2 there and to begin to turn around the focus gave them
3 enough of a buffer to deal with that situation.

4 Those are some of my experiences.

5 MR. CURIE: Thank you, Anne.

6 Now I'd like to open it up to council for any
7 comments, questions, interactions.

8 MR. CURIE: Ken?

9 MR. STARK: Just a quickie. So in all of that
10 process, the 14-day rule survives. Is that true?

11 MS. KAUL: I'm sorry. Say that again.

12 MR. CURIE: The 14-day deployment?

13 MR. STARK: The 14-day process of the state
14 having to make the request. I keep thinking about, in
15 times of crisis or times of disaster, it is truly an
16 opportunity to reevaluate the bureaucracy we've created. I
17 mean that for me and everybody else.

18 MS. KAUL: Fourteen days is the crisis
19 counseling program. I really encourage you to go to our
20 website to look up everything about the crisis counseling
21 program at some point because it is a really, really
22 interesting program. I believe in it from many levels.

23 The 14 days is for the immediate grant. The
24 crisis counseling program is in two grants, an immediate
25 services grant and a regular services grant, and the idea

1 is you put in place something that's very quick. The
2 application is not as extensive as the longer one, but the
3 design of that first application and the first program is
4 to allow you to do more assessment, whether or not you need
5 a longer term.

6 What I will say is I have written these grants,
7 I have read these grants, I have worked these programs. As
8 much as I have heard people say we should change the
9 application or change the timeline, there is something
10 about it that just works, though. It's 14 days. They
11 knuckle down. They get it done in the middle of a crisis.
12 You always think they'd never get it done, that this would
13 never take priority over everything else. So you try to
14 make it easy, you try to give them help, and you try to be
15 on the phone at 11:00 at night when they're still working.

16 But yes, it is sort of something that seems
17 counterintuitive, but it kind of works in this aspect.
18 We're not asking for an application for the longer term.
19 We do give them more time for that and for other needs
20 assessment.

21 MR. CURIE: Faye?

22 DR. GARY: I wanted to thank each of you for
23 sharing your personal stories, especially Mr. Chapman, for
24 such a very personal and touching story. Thank all of you
25 for doing that.

1 My question relates to the crisis counseling,
2 which I truly believe in that concept, and I also believe
3 in the concept of the closer you have the services to the
4 people who need the services, the more likely you will get
5 the outcomes that are the outcomes that you were wishing
6 for.

7 So with that kind of background statement, have
8 you thought about how you can forge partnerships that might
9 be considered new and novel that you may not have had
10 before, or that you could strengthen with some people in
11 the community that have not been connected to SAMHSA? I
12 don't know who they are, but I would just suggest, for
13 example, and you can inform me, partnerships with, let's
14 say, beauticians in the community, storefront ministers, as
15 well as ministers with the Ph.D.s, or the historically
16 black institutions in Louisiana, especially in New Orleans,
17 Southern, Dillon, Xavier, et cetera, the sororities, the
18 fraternities, the Masonic Lodge people, all of whom have
19 great influence with the people that they are in constant
20 contact with.

21 The same with the Hispanic community. The same
22 with disenfranchised Caucasian communities. Many people
23 there are very poor, and they cross the ethnic minority
24 spectrum in our country.

25 So I was wondering if that's one of the lessons

1 that was learned, or could be learned about the new
2 partnerships that we could forge with people in the
3 community, and if you don't mind, I'd like to hear some
4 dialogue about that.

5 MS. KAUL: Just briefly, I'm really pleased you
6 brought that up, because the crisis counseling program is
7 often perceived of as people going out and talking to
8 people one on one and in small groups, but that's in the
9 very early stages. The real kind of push and what it
10 transitions to, and part of the actual model, is starting
11 to community build and to establish linkages across, and
12 partnerships.

13 It means that we encourage and that the
14 outreach programs are encouraged to be very creative in
15 this. Other groups beyond, and you mentioned a lot of
16 really good ones, postal workers. Something that's a
17 little counterintuitive, making sure that bartenders
18 receive information on problem drinking and substance abuse
19 as related to disaster response, and waitresses and
20 waiters, flight attendants.

21 I mean, there are all kinds of people, guilds,
22 groups, that yes, we encourage, through previous programs
23 and the lessons we've learned, we encourage our programs to
24 take a look at these groups, but then they are also much
25 more creative than we could ever be. Anybody outside, they

1 can tell you who in their state.

2 A huge partnership that is established very
3 quickly is always with whatever religious and faith-based
4 groups, volunteer organizations, the UMCOR's, the groups
5 that are doing rebuilding and outreach community case
6 management.

7 So these kinds of linkages are expected as part
8 of the application, and it has to be part of the program.
9 Then what I find is -- particularly as you're hiring people
10 that are indigenous to the community that are
11 paraprofessionals and don't have some sort of concept of
12 the way things should be, and they're just creating it
13 --they will do amazingly creative things.

14 So yes, that's part of it, and then we produce
15 reports and we bring people together whenever we can and
16 send things out via email and documents to share that
17 knowledge around the states.

18 So that is what we do. But I appreciate your
19 emphasis on that, and I need to write down some of those
20 groups you talked about because I hadn't thought about some
21 of them.

22 MR. CURIE: Kathleen?

23 MS. SULLIVAN: Rachel and Anne, could you tell
24 me while the fight was going on, were you watching
25 television at the same time? Because you had no

1 communications where you were, correct?

2 MS. HERRON: Right.

3 MS. SULLIVAN: So that played both sides. The
4 state providers and the people you were working with had no
5 idea of the foment and the screaming and yelling that was
6 going on on the television at the same time, correct?

7 MS. HERRON: Early on.

8 MS. SULLIVAN: Early on? So there was a nice,
9 agreeable relationship actually between the federal
10 partners and the state. So you were getting along at this
11 time, and everything was all fine, correct?

12 Were there some bumps in the road once, you
13 know, people found out about this hostility that had been
14 public between the Governor and the federal government?

15 MS. HERRON: I can speak from my experience
16 with the state agencies and going in and speaking with some
17 of the district staff as well. There was absolutely no
18 negative interaction at all with SAMHSA or any of the
19 SAMHSA staff. People would come up to us, and I think
20 Brenda talked about this earlier, when they found out who
21 we were and who we were representing and thank us for being
22 in the state. Not once did we see any kind of negative
23 interaction related to this.

24 MS. SULLIVAN: And even when you were working
25 around the state offices? You were never approached, no

1 one screamed at you, nothing?

2 MS. KAUL: No, and actually this is a point I
3 would make when I came home, because my family and my
4 friends, people would say, "Oh, was it hard? Were you a
5 target of any kind of hostility?"

6 One of the things, and I have always seen this
7 in disaster, if only when you're working in it. You're too
8 busy. What is going on in the media is frequently at that
9 political level, at that level. We're not at that level.
10 What we're seeing is the everyday work that people are
11 doing.

12 So could people talk philosophically about the
13 fact that they thought this agency or that agency could
14 have done a better job --

15 MS. SULLIVAN: This wasn't philosophical.

16 MS. KAUL: Right. No, no, no, but it's more
17 that what's happening on the ground level, everybody you
18 see is working so hard, and you're physically there, that
19 it just becomes an interaction that's really more personal
20 than that.

21 So it's like a background. I was aware of it
22 by reading the paper, but I wasn't aware of the intensity
23 of it.

24 MS. SULLIVAN: So in your dialogue with the
25 states, it was always let's get it done, let's work. You

1 were working around regulations, you were working in
2 partnership around regulations, and you weren't sending
3 nasty memos. Did nasty memos come to you? You didn't send
4 nasty memos to anyone, even though there are 100,00 nasty
5 memos that arrived on the Hill the other day?

6 MS. HERRON: Not one.

7 MS. KAUL: A lot of people said that, and I do
8 want to say of course I deal with a hugely bureaucratic
9 program. People were expressive of their frustration of
10 some of the bureaucracy, but more in terms of what can we
11 do about this?

12 I mean, normally we'd want to say we can change
13 this right now. Do we want to look at lessons learned and
14 address things? Absolutely, but I was hearing frustration,
15 but part of it is being there and being so accessible that
16 we were talking from that perspective of how can we get
17 this to the next level?

18 MS. SULLIVAN: Well, thank you so much for what
19 you both have done, and Anne, the story that you are now
20 creating is just a magnificent story, and one that I hope
21 Marcus Gray, once he gets everything all done -- I mean, I
22 hope that one my friends, Edie Magnus or Robin Roberts,
23 maybe at ABC, maybe back to Mississippi, she could go back
24 with you, because you have some wonderful post-Katrina
25 stories.

1 But completely revamping the system is just a
2 marvelous story and partnership between state and federal.
3 You all should be lauded for creating these wonderful,
4 wonderful relationships. Really, thank you so much.

5 MR. CURIE: Other questions? Tom?

6 MR. KIRK: One of the things that is striking
7 to me from an organizational point of view, one of the
8 reasons I had to call SAMHSA over the last couple of
9 months, and it was almost in some of the introductory
10 comments when you talk about maybe somebody I've known, it
11 was almost without exception. Everyone (inaudible).

12 My point is that I understand that part of this
13 comes with activities. It's part of some people's day
14 jobs, but for many people at SAMHSA, they already had day
15 jobs.

16 I'm interested in your point of view, and
17 Charlie, also you, in terms of lessons learned, what was
18 the organization of care that occurred that somehow helped
19 say yes, we have day jobs, but this is so extraordinary
20 that the charge of the agency, the charge of SAMHSA, bona
21 fide, so to speak, what did you experience in terms of
22 support for you that somehow made this less traumatic, if
23 you will?

24 Because any number of things -- particularly
25 from the state agency point of view, different things

1 happen. You know, the mental health commissioner title,
2 we'll do mobile crisis. We'll crisis, but not for any
3 duration like you're talking about. Most of the time, I
4 can get my agency to respond in a very intensive way for
5 five days, seven days. This has gone on for months. What
6 is it that SAMHSA has done that it has learned from the
7 organizational care point of view that will help the rest
8 of us?

9 MS. HERRON: One of the things that I think is
10 very important is we limited amount of time that people are
11 going out on deployments. We talked about a 14-day period
12 of time to go out to the field. Some went for seven days.
13 Some went for 14 days. If you for some reason have a
14 particular kind of skills that were needed for more than a
15 single deployment, you couldn't go back out right away.
16 You had to be back for a period of time.

17 That was helpful in a couple of levels. It was
18 helpful from a personal level. It protected ourselves from
19 ourselves from doing too much. But from an organizational
20 perspective, what we told the rest of the staff is you only
21 have to take up some extra work for this amount of time.

22 That's the other component. I know this from
23 myself, but I know I can speak for the others. The staff
24 who were not deployed at the same time that somebody else
25 was absolutely without question, without looking twice or

1 complaining, picked up our work. Picked it up. It was
2 really amazing.

3 MR. CURIE: I would add, along with that, I
4 think from the very beginning it was clear that we needed
5 to have a real focus as to what was involved. How was
6 SAMHSA involved? What was our mission? How did this
7 change our day-to-day mission?

8 It came out clearly with a focus on providing
9 support to those who would be traumatized by the hurricane,
10 and then an equally important part of the mission, for
11 those people that day in and day out we worked for, people
12 with serious mental illness, people with serious emotional
13 disturbance (inaudible).

14 So I think being able from the very beginning
15 being able to pinpoint that this is very much in line with
16 our overall mission, the one thing that drives SAMHSA
17 employees, and I think what drew them into public service
18 in the first place, what drew them into mental health and
19 substance abuse, which are somewhat sacrificial fields in
20 one sense to go into, is being invested in something
21 outside of yourself and having a sense of serving the
22 country.

23 I think there have been two points in my tenure
24 here, 9/11 and Katrina, that really brought out that sense
25 of we are here to serve our country. That was an initial,

1 I think, unifying sense, and the fact also that we had
2 support from the Secretary of HHS in terms of SAMHSA being
3 prioritized in our issues from the very outset in terms of
4 substance abuse and mental health consequences being
5 recognized, and the fact that we were clearly a part of
6 that, playing a critical role, I think also played a major
7 role in helping people shift their focus and their mission
8 in making Katrina response their day jobs during that
9 period of time.

10 I also think people, we basically gained a lot
11 of support, energy, and maintenance from each other. I
12 know for myself, I was downtown a lot at meetings. That's
13 why the SERC structure and the center response with Brenda
14 as the commander was so critical, because I wasn't able to
15 be here onsite. I was in touch continually, but when I
16 come in and I'd be perhaps tired from a long day, the
17 energy in the SERC and watching people going would keep me
18 buoyed and I think we kept each other buoyed in that
19 process.

20 But also on a personal level, there was a lot
21 of interaction and talk about our people taking care of
22 yourselves. That was an element that we really tried to
23 bring from the beginning. I think the fact that we're a
24 bunch of mental health and substance abuse specialist folks
25 kind of makes it maybe a little more likely, that an

1 organization like SAMHSA would be tuned in to that area a
2 little more quickly.

3 But again, I appreciated the number of people
4 who would ask about me. I know that I saw people that I
5 worried about, and I asked about them. It was a natural
6 thing that occurred in terms of team effort.

7 So a lot of it is an attitude. A lot of it is
8 a culture that you try to establish. Brenda and Dan were
9 consistently preaching take care of yourself, and then as
10 Anne described, trying to build in automatic ways of also
11 taking time to celebrate. I think those daily briefings
12 and bringing people together twice a day, they were able to
13 celebrate accomplishments, see what progress they made, and
14 any good news and positive feedback from the field, from
15 the Secretary, from Homeland Security, we shared openly. I
16 think that was all very important as well.

17 Rachel?

18 MS. KAUL: The only thing I was going to add, I
19 think that that comes from an attitude and goes into how
20 you operationalize that attitude. Brenda and Cindy Hanson
21 and other folks in the SERC were really good about
22 recognizing what was working and operationalizing it.

23 That's the key. Often we think that we are
24 mental health or human service professionals, so we are
25 good at taking care of ourselves. But actually what tends

1 to be shown is we're not as good as other people, because
2 we're good at taking care of everybody else, and there can
3 be an element of shame to needing something.

4 So those of us who have done more crisis work
5 that know this know that you have to make it a protocol,
6 you have to make it procedure, and people have to talk to
7 you when they come back from a deployment. They have to
8 take a phone call from you. Then it becomes something that
9 becomes part of the culture and becomes much more natural.

10 But it was the fact that people in leadership
11 roles that, A, are kind of like this anyway, and B, were
12 able to understand this has to be operationalized or it's
13 not just going to happen magically every day. That was
14 really it.

15 MR. CURIE: Tom?

16 MR. KIRK: Just based upon this 9/11 experience
17 that Connecticut went through with people going down there
18 every day, do you have formal debriefing types of processes
19 in place? How did that work?

20 MS. HERRON: We did have formal debriefings.
21 Anybody who came back from the field went through a
22 debriefing process, and then was it was followed up to make
23 sure that even if everything was okay the second, third
24 day, fourth day after you get back, you were contacted.
25 It's a formal process, a routinized, formal procedure.

1 MS. KAUL: Just to add one more thing, as well
2 as formal check in procedures, the SERC had established a
3 procedure where people were checked in on on a regular
4 basis. So even if you're somebody that's not going to sit
5 down necessarily and say that much, or you're going to
6 pretty much say you're fine, the regular, everyday
7 telephone -- you know, it gave you multiple options for
8 checking in and being heard. It gave people more than just
9 one option.

10 MS. BRUUN: I'm sorry. I can't resist. I have
11 to jump into this particular discussion, because I think
12 anytime you get involved in a disaster response, the first
13 thing that you lose sight of is the people working around
14 you, because everybody is engaged, and they're your most
15 precious asset.

16 So I think that we organizationally worked very
17 hard to make sure that we took care of not only the staff,
18 but the people we were trying to support in the field. If
19 you put yourself in harm's way, you're no good to anyone
20 else.

21 So we did do a lot of operationalizing of
22 saying things that really took a tremendous amount of time
23 in managing that we could have sent people home earlier in
24 the day, except that we thought that this was one of the
25 most important things that we could do was make sure that

1 we called people at night in the field and checked in.

2 Debriefings per se, I don't believe in
3 mandatory debriefings, because I think that people have to
4 come them voluntarily or it's not an effective tool. We
5 have to acknowledge that people do have different strikes
6 and different resilience levels, and some people are more
7 tolerant of this kind of work assignment than others.

8 But I think that we have offered the kind of
9 support in a way that makes everybody actually want to use
10 it voluntarily, in the sense that you have to take some
11 mandatory rest time when you come home. You then come back
12 in and you check in with the SERC and you do your little
13 administrative things. You turn in your comp time forms,
14 and you check in your equipment, and then you get to talk
15 to somebody who just says what worked for you out in the
16 field? What kind of supports did you need? What more
17 training? And then out of that process, came a dialogue
18 that was incredibly rich for learning experiences for us,
19 and other things that we needed to be doing in support.

20 I think as an agency how that worked to
21 operationalize it and become an entire agency function to
22 support the staff is through the Incident Command System.
23 The leadership here had to take and give up a lot of
24 control to the decisionmaking of the SERC process and the
25 Incident Command Structure.

1 What I found was so helpful was the incredible
2 receptivity of the leadership when I brought issues forward
3 to say, hey, I think we need to be more flexible in how we
4 give people time, or I think we need to buy supplies we
5 don't normally buy. We don't normally buy Vicks Vaporub.
6 Being able to say this is why we need this, and oh, no
7 question, do it. Just take care of them.

8 I think having that leadership support, having
9 people feel an environment where it is safe to acknowledge
10 when they do need help, when they do need to come home
11 earlier than perhaps their deployment was supposed to end,
12 that's okay. It's creating an environment that feels safe.

13 One of the things that I think that we try to
14 tell everyone is there is no such thing as a perfect
15 disaster response. So if you make a mistake, you need to
16 tell us right away so we can work with you to fix it.
17 That's it. Then we are going to support you through that
18 process and do active problem solving.

19 So I just wanted to let you know that this is
20 something that we took very seriously as an entire
21 organization. I think that I'm still personally proud that
22 some of it worked and some of our folks that were deployed
23 out felt that it was supportive of them. I appreciate your
24 comments on that.

25 MS. KAUL: And can I just say one other thing,

1 Brenda, is that you guys work with best practices. We have
2 a lot of research and writing on what is best in terms of
3 bringing people in and out of the field and deployment.
4 They really work from a best practice model within the
5 National Center for PTSD and the VA and groups that are
6 used to doing this. I think that was important, too. They
7 weren't just identifying some system that didn't have
8 something behind it.

9 MR. KIRK: I think on that note, on the
10 debriefing piece, what we found, again based on 9/11, is
11 that you have to work with them.

12 The second observation is that, and I'm not
13 sure if it was you, Charlie, our experience with some of
14 this stuff, in just listening to what you say, is that
15 SAMHSA is never going to be the same organizational culture
16 and the ways that you do things. Life has changed in ways
17 that ways that may not have figured on and it's so
18 extraordinary. I would hazard a guess that between your
19 organizational care culture and your own professional
20 personal spirit says that SAMHSA is not going to be the
21 same much longer.

22 MR. CURIE: Thank you.

23 Theresa?

24 MS. RACICOT: Kevin, I want to thank you very
25 much for sharing your story and for helping us all remember

1 and teaching us that self-care is the first thing, and as
2 the oldest of eight children, the older girl of eight
3 children, and I'm Irish Catholic with a corner on guilt --

4 (Laughter.)

5 MS. RACICOT: And older than you, too. I think
6 it's a generation that that was not something that was
7 taught, and not something anyone cared about. You were
8 supposed to put up, shut up, and get to work.

9 So I thank you very much, because I think we're
10 learning this, and I think the younger generation is going
11 to bring this to the forefront, because they're not willing
12 to do what some of us old folks did.

13 (Laughter.)

14 MS. RACICOT: Which wasn't very healthy, I
15 don't think.

16 I'm surprised to hear you say that you think
17 that the mental health people are good about that, because
18 the worst patients in my experience are doctors and nurses.
19 If this group is doing that, my hat is off to you. But I
20 thank you very much.

21 MS. DIETER: Right. I really appreciate that,
22 too, Kevin, because I can also see the little bit of
23 anguish of even telling what your feelings were. I really
24 appreciate that. Thank you.

25 MR. CURIE: To clarify, Theresa, I do think

1 we're lousy at taking care of ourselves, but I do think
2 there is an overriding sensitivity that I was hearing from
3 the group, and I think it's because of the commitment to
4 best practices that Brenda was talking about, of people
5 checking on others. Yes, the point is well taken.

6 Larry?

7 DR. LEHMANN: I'd be remiss if I didn't make
8 just a brief comment in congratulating Dan and the rest of
9 the team here at SAMHSA. Not just for the work that you
10 all did in helping to keep in some of these calls different
11 organizations talking to each other. It is extremely
12 helpful and useful for all of us because some of the
13 prework that you have been doing as an organization,
14 particularly since that first meeting after 9/11 and a
15 number of the things that are ongoing now, as well as the
16 things you put together in helping us respond, it is a
17 really terrific interagency organizational job, and it's
18 very much appreciated.

19 MR. CURIE: Thank you, Larry.

20 Barbara, we'll make this the last comment.

21 MS. HUFF: I also thank you, all three of you,
22 especially Kevin with your own personal story.

23 I can't remember, and I think it was you,
24 Rachel, that mentioned this, but I really appreciate you
25 bringing it to the forefront because it's not an easy thing

1 to talk about. Being a family member myself and
2 representing families with kids who have serious mental
3 health needs on the council, one of the things that we
4 don't talk about very easily or very often, but it gets in
5 the way of our lives a lot is that whole issue about crisis
6 and how we deal with it and then how you not then deal with
7 it. After you deal with it and deal with it, and then when
8 there is not a crisis, how do you then come down after the
9 crisis?

10 I think it is really was helpful for me to hear
11 you acknowledge it, because I kind of talk about it in
12 corners, but we don't lay that out on the table, not about
13 ourselves, or about people we work with, or anybody else.

14 It is huge. It is huge in my business, having
15 been the director of the Federation of Families for
16 Children's Mental Health for 15 years in just the fact that
17 it is a huge obstacle in our work. For our staff and for
18 our family organizations across the country, we have not
19 acknowledged a couple of things, and one of them is our own
20 mental health issues, and how that plays out in our work,
21 and then the issue of not being able to get out of the
22 crisis, and how that is in the way of our work.

23 The fact that you acknowledge it today, I
24 really appreciate it, because I know it deep down, the
25 loss, and I have experience in watching people around me

1 all the time. It was really helpful for you to say that,
2 and I can't remember which one of you said it.

3 MS. KAUL: Anne.

4 MS. HUFF: It was you, Anne?

5 MS. HERRON: It's all the same.

6 MR. CURIE: Well, thank you, everyone.

7 Tom, getting back to your remarks, I think we
8 don't know yet totally how SAMHSA has been changed by this.

9 I agree with you, it has been changed. I think one thing
10 is people recognize the importance of the team. I think in
11 my whole professional career it is the best team effort I
12 have ever witnessed firsthand. Just the caliber of
13 commitment and professionalism that came forth was
14 something that made me extremely proud and privileged to be
15 a part.

16 So I want to thank all of you for sharing
17 today. Thanks to the panel. Thank you, Brenda and Dan,
18 for your tremendous ongoing leadership. Thank you to the
19 council for your interest.

20 Now we have a piece of business to take care of
21 real quick, and that is the approval of the minutes, the
22 June 27th minutes. Do I hear a motion of approval?

23 PARTICIPANT: So moved.

24 PARTICIPANT: Second.

25 MR. CURIE: All those in favor?

1 (Show of hands.)

2 MR. CURIE: The minutes are approved.

3 We would now like to take time to see if there
4 are any public comments. We have none pre-registered.
5 Yes? Please introduce yourself.

6 MS. SHINEHOLTS: I was hoping the emergency
7 people wouldn't leave. Can you stay?

8 My name is Marian Shineholts. I represent the
9 American Occupational Therapy Association. Occupational
10 therapists started their practice in mental health, but
11 somewhere along the way I guess we got mistaken.

12 But like the substance abuse treatment
13 professionals, we were also refused by the Red Cross when
14 our practitioners stepped forward to help in the disaster,
15 which is rather unfortunate. A number of our therapists in
16 the Gulf States continued to mobilize and assist in the
17 recovery effort. While occupational therapists may not be
18 first responders, we certainly are trained in mental health
19 to work with people with serious mental illnesses, we work
20 with older people with mental health problems, and people
21 with substance abuse problems.

22 In addition, the extended recovery effort is
23 probably where the community building, where we are most
24 likely to be helpful in terms of our real unique focus on
25 function and assessment of function.

1 So I just wanted to speak up and also say I
2 appreciated the discussion this afternoon. It was very
3 interesting about the response. Thank you.

4 MR. CURIE: Thank you.

5 Any others? Yes?

6 MS. KNIPMEYER: My name is Mary Knipmeyer. I'm
7 struck by the discussion about how SAMHSA will change. I
8 think we have to remember that there are going to be all
9 kinds of segments of society that are going to change.

10 For me personally, since one of the things I do
11 is grief counseling for people whose companion animals are
12 either in a hospice situation or have died, and in most
13 cases they have died, frequently in a traumatic situation,
14 that I think we were all struck by the initial response
15 when animals were torn out of children's arms. People
16 refused to leave their homes because their animals were
17 there.

18 I hope a positive thing that may come out of
19 this is a better awareness of the animal/human bond. As I
20 understand it, with Rita, there was some relaxation of the
21 shelter rules. I don't know if that's a 14-day issue or
22 not, but I'm really hopeful that the mental health aspect
23 of how we relate to our companions and where they fit in
24 terms of our own survival will be better understood as a
25 result of what has happened.

1 MR. CURIE: Thank you.

2 MS. KAUL: Mary, can I just tell you that my
3 mother was very concerned about the animal situation, and
4 the first thing I did when I was in the shelter, when I had
5 a minute, was most people were concerned about their dogs,
6 and it did relax.

7 MS. KNIPMEYER: It did relax.

8 MS. KAUL: The rule did relax, and she was very
9 happy to hear that, because we talked to people about
10 getting their animals out. It was a huge issue.

11 MS. KNIPMEYER: It was a huge issue. I really
12 think that photograph of that one child, of the guard, the
13 national guardsman, ripping, really, the dog out of his
14 arms, a four- or five-year-old child. That child is going
15 to need some sort of special assistance.

16 I don't know how many of you know this, but at
17 least 400 or 500 of the animals did come to Montgomery
18 County and are in foster care or are being placed. Some of
19 them are actually being held until January or February with
20 the hope that their original stewards will find them.

21 So I just had to make that comment.

22 MR. CURIE: Thank you. Thank you very much.

23 Susan?

24 MS. ROGERS: Hi. I'm sorry that Kevin left,
25 actually, because I wanted to say I think I was on the road

1 from Houston with him, because my agency, the Mental Health
2 Association of Southeastern Pennsylvania, had sent a team
3 down to Texas for the purpose of training people who might
4 help survivors of Katrina, and essentially especially
5 people who themselves are survivors of psychiatric trauma
6 and illness.

7 So we were down there in Texas, and then Rita
8 was coming. We were in Houston. I was supposed to speak
9 in Beaumont the next day, which was right where Rita was
10 going to hit, and so my boss told us to get out of town.
11 We were on the road from Houston going west Wednesday, the
12 same day that Kevin was, and I felt terrible and my
13 colleague felt terrible that we were leaving. But we had
14 gone to the Astrodome, and they said well, they've all
15 evacuated.

16 But the thing is, I'm glad you stayed, because
17 I'd like to ask you to expand on the subject of people who
18 themselves have mental illnesses, and what they can do, or
19 what they have done in a disaster response situation.

20 MR. CURIE: I would encourage for you and
21 Rachel and Susan have that discussion. If you want to make
22 a couple of brief comments for the record, I'd appreciate
23 it.

24 MS. KAUL: Yes, because I was going to say,
25 Susan and I can talk offline more, but I do think that

1 looking at people with mental illness who are in community
2 programs, in outpatient situations, as well as people
3 suffering, people experiencing substance abuse disorders,
4 et cetera, are often a really valuable resource to look to,
5 as opposed to an issue to take to handle. You know, oh,
6 this community we're serving is an issue we need to handle.

7 Once people are safe, there are really good
8 resources to use for reaching out and pulling them back
9 together. So we can talk more about it, but they are
10 really resilient. They already know how to access services
11 in a way that most of the community does not in a disaster.

12 MS. HUFF: They've had to.

13 MS. SULLIVAN: Isn't that a riot?

14 MR. CURIE: Thank you, Rachel, and I want to
15 thank everyone for their public comments.

16 I have just been informed that I'm going to be
17 unable to be here really all day tomorrow. I have been
18 called downtown for media interviews and I'm going to be
19 meeting the Secretary prior to the press conference as
20 well. So Daryl will be chairing the meeting. And that's
21 good stuff. It's a good thing.

22 MS. SULLIVAN: That's a good thing.

23 MR. CURIE: That's what it is. I think the
24 Secretary will be on CNN and I'll be on NBC.

25 MS. SULLIVAN: Really?

1 MR. CURIE: You seem awful happy about me not
2 being here. I don't want to read too much into that.

3 (Laughter.)

4 MR. CURIE: A couple other changes for the
5 agenda tomorrow. We have at 9:15 a.m. the Medicare
6 Modernization Act, based on Tom's request, to talk about
7 changes in Medicare, the update around our constituencies,
8 and what SAMHSA has been doing with CMS in the process. So
9 tomorrow morning, Anita Everett, who has been our point
10 person with that, will be here. We've added that.

11 Plus, Alvera Stern will be here instead of Mark
12 Weber to talk about the underage drinking prevention
13 advertising campaign. Mark will be with me.

14 We could take maybe, and again, this won't do
15 justice, but I'd like to at least hear a little bit of
16 feedback, five minutes, from folks to talk about the
17 matrix, thoughts you may have on the matrix, because
18 tomorrow you will have time to talk about that in a
19 roundtable discussion, but I won't be able to be here.
20 I'll definitely be paying attention to the record of the
21 meeting and looking for your input.

22 Kathleen?

23 MS. SULLIVAN: I talked to a couple of people
24 on the board about it. As far as taking what we now know
25 about the center, widening it a little bit, not just being

1 disaster response, but opening it to a crisis response
2 that's almost active in kind of a full mode that's more
3 toward a 24/7 feeling, and expanding it a little bit,
4 putting it into the matrix, as you said, and the cross-
5 cutting principles, Daryl, and opening it up to base
6 closings, military base closings, unemployment, Ford Motor
7 plant closings, 40,000 people unemployed here, 20,000
8 people unemployed when Ford closes a plant.

9 We're seeing also with cities now, being out
10 for employment for different companies, that city are just
11 losing immediately manufacturers and have huge unemployment
12 overnight affecting down the line different areas of mental
13 health. You know, the whole gamut for families'
14 interaction, complete crisis management.

15 So my thought is to, like you said, to put the
16 disaster response team into the matrix and expand it,
17 though not call it disaster, to make it crisis, and make
18 one of its goals also to take care of people who are in
19 crisis mode because of unemployment.

20 MR. CURIE: Thank you. I think we'll examine
21 that in light of how we have made a wide range of express
22 reactions, crisis reactions, a major focus of implementing
23 what we've learned from the research. I appreciate your
24 comments.

25 Other thoughts? Gwynn?

1 MS. DIETER: Suicide is not on our issues.

2 MR. CURIE: That's correct. It's not.

3 MS. DIETER: Wasn't it?

4 MR. CURIE: No, it never was.

5 MS. DIETER: But we did make it --

6 MR. CURIE: That's why I brought it up, though.

7 Maybe we should put it on.

8 MS. DIETER: That's exactly what we're sitting

9 here saying. Because we did make it --

10 MR. CURIE: We've never been explicit about it

11 on the matrix.

12 MS. DIETER: Right, but we did make it a

13 priority or initiative or action item about a year ago,

14 specifically, I thought. So I guess I haven't looked in my

15 matrix as closely, but we feel like it ought to be on

16 there.

17 MR. CURIE: No, I appreciate that. There are

18 certain things that we have to say that are included in

19 mental health transformation, but we haven't been explicit

20 about certain things. One purpose the matrix serves is

21 over time it gives us an opportunity to bring things to the

22 forefront, to really put a focus on for maybe a two- or

23 three-year period of time, even though it has been

24 represented in a more inexplicit way, if you will.

25 So what I'm hearing you say is it's time for

1 now to focus on it and to bring suicide prevention to a
2 more prominent place on the matrix. That's what I'm
3 hearing.

4 MS. DIETER: Yes.

5 MS. HUFF: Yes.

6 MS. DIETER: Now, does that involve removing
7 one of the other items?

8 MR. CURIE: Yes.

9 MS. DIETER: It does?

10 MR. CURIE: That's why, again, if we move to
11 disaster response as a cross-cutting principle, we'll lose
12 a slot.

13 MS. DIETER: Well, I could see a couple.

14 MR. CURIE: Well, if you want to remove
15 something, we can put that on the table, too,

16 MS. DIETER: Well, I mean, if we need to. I
17 would prefer having -- okay.

18 MR. CURIE: You'd prefer having it all on. I
19 hear you.

20 MS. DIETER: Yes. I'd prefer having all of
21 these on with the addition of suicide. I also think it's
22 foolish to make long, long, lengthy lists because then you
23 can't really attend to --

24 MR. CURIE: It doesn't prioritize.

25 MS. DIETER: No, it doesn't prioritize. So in

1 terms of priorities, and I hope I don't offend anyone by
2 giving my priority, I would prefer to have suicide rather
3 than homelessness.

4 MS. HUFF: No.

5 MR. CURIE: I appreciate that.

6 Faye?

7 DR. GARY: As you know, I have followed the
8 matrix very closely, and have found it very, very useful.

9 MR. CURIE: Thank you, Faye.

10 DR. GARY: Very, very useful. Easy to follow,
11 easy to use it to discuss with a variety of different
12 people who may or may not be the person about these issues.

13 I just had one kind of procedural question.
14 I'm just learning a bit more about the redwoods.

15 MR. CURIE: The redwoods, yes.

16 DR. GARY: The redwoods. I was wondering if
17 you've given any thought to how they could be identified in
18 the matrix.

19 MR. CURIE: Well, that's a very good question.

20 I mean, the actuality is, I know I reviewed all of those,
21 I think 11 priorities -- I believe there are 11 of them --
22 in the blue axis as, really, they are all redwoods. There
23 have been formed what I have called the big redwoods in
24 terms of prioritizing, and those would include Substance
25 Abuse Treatment Capacity Expansion, Co-occurring Disorders,

1 Mental Health Systems Transformation, and Strategic
2 Prevention Framework.

3 Those are viewed as definitely priorities that
4 are systemic in nature, and clearly, as I talk about, as an
5 issue's time comes, we try to move toward it to a tipping
6 point to really make a difference, and those are the four
7 big redwoods we've identified, and that helps us prioritize
8 further the budget process, because even among all these
9 redwoods, so to speak, we are not able to fund new money
10 each year into each one of these. So we've got to
11 prioritize which ones do we feel are the big redwoods, if
12 you will, that represent that systemic change. That is how
13 they have basically been sorted out so far, those being the
14 four big ones.

15 Now, I would also entertain from the council
16 thoughts you have if there are any thoughts of making any
17 sort of distinction of these priorities, and to bring any
18 others into the major, big redwood area.

19 Again, I think co-occurring is an example of
20 one that I'm hopeful that in a two- to three-year period
21 that we have solidified in our systems a predisposition
22 toward accounting for co-occurring disorders through
23 assessment, through treatment and treatment modalities, so
24 that perhaps it won't always have to be a big redwood, and
25 maybe someday not even be on the priority list because it's

1 the normal way we do business. That's how we hope some of
2 these things will drop off over time.

3 MS. HUFF: Maybe they should be in a different
4 matrix.

5 DR. GARY: I was thinking that I think you made
6 a very excellent point about the budget and if we were to
7 say what the redwoods are, how could we communicate that
8 visually to people who might be considering writing grants
9 focusing a program for states. I was thinking that
10 visually if there is a way to capture these redwoods, so
11 that people would know that, because it is going to drive
12 the bottom line, and it's going to drive what you're
13 funding. That would be helpful.

14 MR. CURIE: Yes.

15 MS. KADE: Actually, the first year that Mr.
16 Curie was here and introduced the matrix, what we did was
17 to translate the budget so that it is organized by various
18 matrix categories. One of the issues in this gets to be
19 lifespan continuum. One of the issues is that it had to be
20 a forced choice of more than one redwood or you'd be double
21 counting for the budget. As a result, some children's
22 programs were showing up in HIV/AIDS, et cetera.

23 One of the issues that we're facing in the last
24 couple of years as we put more and more money into those
25 four redwood categories, we're seeing that a lot of the

1 lifespan target populations that are on the matrix are
2 being addressed in the four redwoods, but you can't tell
3 from the budget, because it is a forced choice budget.

4 So one of the questions is how do you integrate
5 a lot of these priority areas into our redwoods because
6 they are being addressed by, for instance, ATR, and a lot
7 of the target populations for juvenile and critical
8 justice. It is showing in treatment capacity, but it is
9 also criminal justice, and it's also children.

10 DR. GARY: The other observation that I would
11 like to make is that I would like us to somehow integrate
12 stigma. We have it cross-cutting, but I think it is more
13 pervasive than being cross-cutting. I think it is one of
14 the major barriers that prevent people from seeking mental
15 health and from sustaining themselves in the program.

16 Of course, the other comment is that someplace,
17 perhaps in a letter, the idea of poverty, the alleviation
18 of poverty. I think it is, too, one of the major barriers
19 to well-being in this country or anyplace in the world. I
20 would want us to just be in front about it. People who are
21 impoverished just don't have good mental health, and are at
22 risk for everything. Heart disease, diabetes, mental
23 health, substance abuse, crime, you name it.

24 So I think we need to take the national lead
25 and say that and put that in some kind of language, so it

1 is communicated to everyone. So that would be another
2 recommendation that I would make.

3 MR. CURIE: Thank you, Faye. Thank you very
4 much.

5 DR. GARY: Thank you for listening.

6 MR. CURIE: Does anyone want to give one final
7 thought? I'm thinking Barbara would be the appropriate
8 person.

9 MS. HUFF: Well, unfortunately, we're having a
10 sideline conversation, and I don't like sideline
11 conversations, but we're trying to figure out the HIV/AIDS
12 and hepatitis on here, are we talking about mental health
13 needs for HIV and hepatitis? Explain that.

14 MR. CURIE: We're actually talking about the
15 fact that one of the biggest reasons HIV spreads in this
16 country, and also hepatitis C, is because of needles and
17 drug use. So that's a major part of it. It is also the
18 answer of yes, it has to do with the mental health needs of
19 those individuals.

20 MS. DIETER: No, but we have discussed that
21 once before, though, how it is addressed (inaudible).

22 MR. CURIE: If we're going to prevent HIV from
23 happening, it requires a public health response.

24 DR. GARY: I just wanted to add, too, that
25 especially with young adults and adolescents, one of the

1 issues that happens is the use of substances, alcohol and
2 substances, as a method of preparing themselves to
3 participate in unsafe sex. That's a problem with the party
4 life. You can't address HIV/AIDS unless you address
5 substance abuse and alcohol in adolescents and young
6 adults, and probably older ones, too.

7 MR. CURIE: So that's why it's there. Thank
8 you.

9 Is that it? Okay. I want to thank you all for
10 your thoughts and encourage you to continue the dialogue
11 tomorrow.

12 I also encourage you, even if you want to
13 express your thoughts to me informally, you have my phone
14 line, my email, and my door is always open. We're very
15 interested in your thoughts.

16 MR. STARK: Can we leave our stuff in the room?

17 MS. VAUGHN: Oh, yes.

18 MR. CURIE: Yes, you may leave the stuff in the
19 room.

20 MS. VAUGHN: We're going to lock the room, so
21 if you want to leave your items, they will be protected.

22 MR. CURIE: Very good. Have a nice evening
23 everyone, and I will see you at 2:00 tomorrow.

24 (Whereupon, at 5:12 p.m., the meeting was
25 recessed, to reconvene at 9:00 a.m. on Wednesday, December

1 7, 2005.)

2

3

4

5