SAMHSA

Substance Abuse and Mental Health Services Administration

37TH MEETING
OF THE
SAMHSA NATIONAL ADVISORY COUNCIL

Monday
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110 West C Street, Suite 1209
San Diego, CA 92101
(619) 236-9325

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COUNCIL MEMBERS PRESENT

1
Charles H. Curie, M.A., A.C.S.W.
2 Chairperson

3 James R. ("Duke") Aiona, Jr.
Co-Chair
4
Daryl Kade, M.A.
5 Executive Director

6 Toian Vaughn, M.S.W.
Executive Secretary
7
Columba Bush
8 Member

9 Gwynneth A. E. Dieter
Member
10
Diane Holder (Telephonically)
11 Member

12 Barbara Huff
Member
13
Thomas A. Kirk, Jr., Ph.D.
14 Member

15 Thomas Lewis
Member
16
Theresa Racicot (Telephonically)
17 Member

18 Kenneth D. Stark
Member
19
Kathleen Sullivan
20 Member

21 Beverly Watts Davis

22 Westley Clark

23 Kathryn Power

24

25

1 SAN DIEGO, CALIFORNIA - MONDAY, JUNE 27, 2005 - 9:15 A.M.
2 --oOo--
3 CHAIRPERSON CURIE: Good morning everybody and
4 welcome to the 37th meeting of the SAMHSA National Advisory
5 Council. I want to begin to get underway because we have a
6 lot to discuss today. And as you all know, we also have a
7 full afternoon today.
8 In response to a request from the members of the
9 Council at our last meeting, we have arranged to visit the
10 California Screening Brief Intervention Referral and
11 Treatment Program here in San Diego. I know that Council
12 members have been wanting to see programs first-hand. So
13 this is our first opportunity.
14 I might mention that our good friends and
15 colleagues, Theresa Racicot and Diane Holder, are joining us
16 telephonically this morning. I think they're adjusting the
17 connection right now to help take care of some of the
18 interference.
19 Can you hear us, Theresa? Hello?
20 (No response.)
21 CHAIRPERSON CURIE: Well, maybe we took care of
22 the interference, but we lost our Council members. I'm sure
23 they'll try to regain them in a moment.
24 I, again, am pleased to see everyone here today.
25 Again, as you can see, our Council members that are here

with us today, first of all, I'd like to recognize Lieutenant Governor Aiona, who was not able to join us in December, but it's wonderful to see Duke here today. I'm also pleased to announce -- as you all know, Pablo Hernandez left the Council, and I've asked Duke if he would be willing to serve as co-chair of the Council, and he graciously agreed.

(Applause.)

CHAIRPERSON CURIE: Again, as you can see, we have Columba Bush with us today, we have Ken Stark, and Gwynneth Dieter, and Kathleen Sullivan. Also, I'd like to highlight that we have -- and I did mention Barbara --

MS. HUFF: That's all right.

CHAIRPERSON CURIE: You're worth mentioning twice, Barbara. And then I'd like to introduce a new member of the Council today, and that's Tom Kirk, who is the director of mental health, as well as substance abuse is under his purview, in the State of Connecticut. I've known Tom for over a decade. He's been a colleague. Connecticut's one of those cutting edge states in terms of operationalizing recovery in a very real way, and as representing really the state mental health program directors, as Ken represents the state drug and alcohol directors, it's just wonderful having you aboard, Tom. I just welcome you here today.

MR. KIRK: It's an honor to be here. Thanks.

CHAIRPERSON CURIE: I want to make an announcement about one of our Council members. Gwynneth, we met you last night. I'm pleased to hear -- I was a little concerned -- I was happy for you -- you might want to share the good news about your husband's appointment. The good news is Gwynneth is going to continue to serve on the Council and continue to attend our meetings. We'd like to share this wonderful news with the Council.

MS. DIETER: My husband has been confirmed as of ten days ago as Ambassador to Belize.

(Applause.)

MS. DIETER: It's a huge honor. We're really excited. And we will move down there. But one of the first things I said is, can I be on SAMHSA still? And so we called, and they said, yes, you can still serve on the Advisory Council. So I'm very happy that I'll be able to do that.

CHAIRPERSON CURIE: Well, that's good news for us and for substance abuse and mental health. So congratulations, Gwynneth. I'm also pleased to hear you'll be able to actively participate and still be attending the meetings. That's great.

As you know, absent from today's meeting is Thomas Lewis. Do we have an update on Thomas, Toian?

MS. VAUGHN: He's still very, very ill.

CHAIRPERSON CURIE: Very ill. So he's unable to attend.

And as you know, Dr. Jane Maxwell, who's just been a phenomenal Council member through the years, her term expired, and we're in the process of preparing a nomination package for the current vacancy.

I also would like to recognize some individuals today who are here as guests. One individual that I would like to recognize is Kathryn Jett. Kathryn is the State Drug and Alcohol Director for California, and just does a phenomenal job out here. Again, we're blessed with some very strong people in our field, in substance abuse and in mental health around the country. I'd just like to ask Kathryn if you'd like to say a few words.

MS. JETT: Well, thank you very much, Mr. Curie, and thank you all for selecting California for your meeting today. I hope some of you got to enjoy the fireworks last night. I got to my room just at the precise time where -- about ten o'clock -- when the fireworks started. So if you're staying this evening, and you didn't have a chance to see the fireworks last night, enjoy it this time.

We're pleased that you're here. You picked one of our gem cities to meet in. So I hope you'll enjoy San Diego while you're here. On behalf of Dr. Naberg, Director of our state mental health organization -- thank you -- he's

the Director of our State Mental Health Department -- and he's running around the state. We each inherited a proposition. I inherited Proposition 36, and interestingly enough, he inherited Proposition 36 (sic), and so they just inverted the numbers -- 63 -- sorry -- 63 and 36. So he is running around the state dealing with the many complications to come about when you get this type of an initiative. But it's, I think, a welcome addition to the mental health area for the state, as was 36 to the drug area. We're in the process of debating the reauthorization. Proposition 36 actually expires next year. But one of the key components of that proposition was that the funding is the only part that expires. The proposition stays on the books. So if we -- actually, if we fail to fund it -- guess what -- we would've probably legalized drugs in California, wouldn't we? So this is a very interesting debate that we're moving towards this year.

Other areas that I think are important in California that we're focusing on that may be of interest to you is, again, Dr. Naberg and I are very much engaged in addressing co-occurring disorders from the vantage point of having two separate departments in this state provide leadership. We find that both of our hands are very full. So we sort of take each other's back, as I am trying to do for him today in greeting you.

The other areas that we're focusing on are methamphetamine. We'll be talking with both -- certainly Dr. Clark and Beverly about, because it's certainly -- it's -- California, unfortunately, has a lot of data in this area. With Proposition 36, over 50 percent of the people that come in are meth addicts. Of those, the highest proportion of meth-addicted people are women, and they're women of child-bearing age. So this is something that's of great concern to us. We're also seeing a spike in seeing that Asian Pacific Islanders are becoming -- females -- are the largest user group in California of methamphetamine, and Hispanics are also growing. It's something that we're working with public health very closely with trying to get at the potential epidemics that surround that particular drug use.

Then lastly is what I mentioned, the reauthorization of Proposition 36, where we have about four different laws running through the legislature this year. The signals are very good that we will be able to amend the law. I think we're going to base the amendments of the law on research. This will probably be challenged in the courts. But I think with having the kind of data that we have behind us, I am optimistic and hopeful that we will see Proposition 36 look more like drug courts that have more accountability. I think that, plus what we need for the funding, will put

us in good stead in California, and hopefully we'll be able to share that with the nation.

Thank you.

CHAIRPERSON CURIE: Thank you so much. Thank you, Kathryn.

I'd also like to recognize two individuals from sister federal agencies, Dr. Craig Vanderwagon, who's the Medical Director for Indian Health Services. We are doing our meeting jointly with the Indian Health Service in conjunction with our behavioral health conference here in San Diego. We've worked very closely with Craig in a variety of settings. I just appreciate Dr. Vanderwagon's partnership. Thank you for being here today.

I'd also like to recognize Beth Bowers, who's here representing the National Institute for Mental Health on behalf of Dr. Richard Nakamora and Dr. Tom Ensel. We also have -- I'm pleased -- the three senator directors for SAMHSA here today. I'd like to now turn it over to the co-chair, Duke Aiona, for a few words and an opportunity for people to introduce themselves.

MR. AIONA: Thank you. I did graciously accept this position a couple days ago.

(Pause.)

Aloha to you. First of all, I'd just like to say thank you for this opportunity. I did miss the meeting in

1 December. But a lot has been done in the State of Hawaii
2 also. Before we go around, maybe we just can share -- when
3 we go around, if we can just share something that we've done
4 in our states, or as Dr. Hernandez said, ambassadors of
5 SAMHSA.
6 So for me, the biggest -- I wouldn't say the
7 biggest, but one of the big things that we did was the
8 teach-ins -- Reach Out -- Reach Out Now. I did that a
9 couple years ago when they first came out. We did one
10 school, and then last year I did about three or four schools
11 on my own. This year what I did was I said, I want to make
12 it a little bigger, and let's try to see if we can kind of
13 put it on the scale of Read Across America. I don't know if
14 you know about that program, Read Across America. They get
15 as many people as they can and try to cover every school in
16 the state. At least in Hawaii that's what they do. They
17 try to cover every school in the state with somebody reading
18 to the second, third, fourth graders.
19 I wanted to do that with the teach-ins. We did
20 pretty good. We got over 30 celebrities who were like
21 coaches. We only have one big university in the State of
22 Hawaii. It's the University of Hawaii. So I got all of the
23 coaches from football, basketball, volleyball, and got all
24 of them involved, got some of the local media personalities
25 involved, newscasters, radio personalities. Got this one

big local comedian, who's really big with the kids, and got him to do it also. It was real successful.

What I did was I put together a PowerPoint presentation, and kind of -- if you want to -- let them use if they wanted to. But they were so good at it, they didn't use it. They did it on their own. I just gave 'em the material, and I said, Here's the curriculum. You can look at it. Make sure you hit a couple of points, and you do whatever you want in the classrooms. But just make sure you engage the students in what you're trying to get across. And they did, and it was very successful.

The other thing that we did was we got together three of our local celebrities, who did very well nationally. You might've heard of 'em -- Brian Clay, who won -- who was the silver medalist for the decathlon, Jasmine Trias, who was on American Idol last year and was a third runner up, and a surfer who lost her arm to a shark, Bethany Hamilton. We had three of them do anti-drug, anti-alcohol ads for us, and we put it all together, and I'm putting a tape together now so I can go back and show it to the fifth graders, who are now going to be in the sixth grade, and see what kind of impact we had on that.

So next year I think we can cover almost every school in the state, which would be about 270 schools. We're going to try to make that really a big thing. So I'm

kind of proud of that. I'm proud that we're mobilizing right now. We have underage drinking as our big target right now. Hopefully we made some great strides, and we'll continue to do that.

So why don't we just go around the room right now, and I'll start to my right, and we'll go with Columba first.

MS. BUSH: Thank you. Good morning.

I've been working in drug prevention for many years now. When my husband became governor, then he thought to have an office for drug control. We've been very blessed to have Jim McDonough as a director. He's been very, very successful because of -- he takes care of the office, and he has put all the organizations together. We have two summits a year. Every year we have more and more and more participation.

What I do is travel through the state and to other states, visit schools, go to conferences. I think we have a lot of wonderful support. Whenever we put action into our words, I think that is what has worked for us, and also to have a director, because he is focused in that. And so my husband and I, we just participate. We just try to do our best, and I'm just very, very proud to serve for SAMHSA.

So thank you.

MR. AIONA: Thank you, Columba.

Ken.

1 CHAIRPERSON CURIE: We're going to introduce --
2 just go around the table, and you can introduce yourself.
3 Kathryn Power, our wonderful, competent Director of the
4 Center for Mental Health Services, who's leading our mental
5 health transformation.
6 MS. POWER: Thank you very much. Good morning
7 everyone. It's wonderful to be here. It's a great
8 opportunity for us to actually do two things, because the
9 Indian Health Services is meeting over across the way, so we
10 were able to say hello and good morning to all the substance
11 abuse treatment specialists from Native American and Alaskan
12 Natives this morning. So Beverly and Westley and I were
13 there. So I'm going to have an opportunity to speak with
14 you and talk with you a little bit on a presentation at 11
15 o'clock. So I welcome that opportunity, and thank you all
16 for being here.
17 MR. STARK: Ken Stark, State of Washington, single
18 state agency director for alcohol/drugs. One of the things
19 that's fascinating for me is we've done a lot of research in
20 Washington State, and that over the years, we've worked
21 really, really hard to try to reduce stigma and to try to
22 increase services in both prevention and treatment. It has
23 been a long, hard struggle. But we've been fortunate enough
24 this last year to get the legislature to give us a 50
25 percent increase in our state funds. It represents a 30

1 percent increase in our overall budget. That's about $67
2 million new money for the biennium. But with that comes a
3 great deal of expectations to continue to prove cost
4 offsets.
5 One of the things I want to thank SAMHSA for is
6 having the SBIRT grant, the ATR grant, as well as SPF SIG.
7 Those three federal grants will go a long way in helping us
8 provide a full continuum of services to folks in Washington
9 State. So we thank you for that.
10 CHAIRPERSON CURIE: Thank you, Ken.
11 MS. DIETER: I'm Gwynneth Dieter from Boulder,
12 Colorado. I've just continued being involved in the Boulder
13 Effort, which is a parent engagement network, and then
14 Compass House, and haven't done as much the last few months,
15 but -- because I was busy doing other -- but they have made
16 tremendous strides, actually. I'm just so proud of all the
17 people who have worked harder than I have, because we've met
18 with the school district. Finally it's accepted as a
19 force -- Back to School Week -- Back to School will include
20 in high schools now talks, information for parents on
21 substance abuse and mental health. There are going to be
22 workshops all during the year. This network -- people get
23 information on the network. So if a parent just even has a
24 concern what's happening -- I just found something in my
25 child's backpack -- they can just call one of these people

and start talking to them.

Then we have -- and the Compass House, which is organized by a psychologist who had been a counselor -- there are 50 -- or -- I'm not exactly sure of the exact number -- psychiatrists and psychologists who have volunteered their time. They assess the students and families who come in, and then they see them in various capacities at a reduced rate. And now they're giving classes, and now they're considering having a residential program, because at the same time, we've been getting funding and support from businesses and people within the town, which -- so, finally, after years, it's like this huge sort of community effort coming together, and a recognition that -- you know, what the problem is, and mostly trying to also, you know, educate parents as to the dangers and what to look for and so forth. So I'm very proud of their work in particular.

Thank you.

MR. CLARK: I want to thank Charlie for having this meeting here in California. Although this is my fourth time here in California in the past month. I visited Tom Kirk and Ken Stark here in the past month. We've been actively addressing the issue of ATR and SBIRT. We're going to be visiting -- this Council is going to be visiting one of our SBIRT grantees, Kathy Jett, this afternoon.

I've been actively outreaching the faith community as a part of our ATR efforts involving a wide range of groups, such as Teens Challenge, making sure that it's clear that the faith community is a part of our recovery management services and feels welcome to participate in the access to recovery initiative.

We're getting ready for our September Recovery Month. I want to encourage the Council members to keep that in mind, because September is Recovery Month.

Thank you.

MS. SULLIVAN: My name is Kathleen Sullivan. I have been on the -- as well as Barbara Huff -- have been on the Planning Committee for the upcoming IHS SAMHSA Behavioral Conference. Both of us have made sure, as everyone has on this Behavioral Conference, that the needs of the American Indian community in addressing the high rates of suicide, as we have addressed within this advisory board, are reflected in the agenda of the upcoming conference within its plenary sessions and also some of its work groups. We hope that some of the agenda items that we have had here in this Advisory Council will be reflected in the upcoming conference.

Also, over the past couple months I've been working with Mark Weber and other people, other consultants, in the upcoming Voice Awards, which will be held in a month,

which will award -- and it's going to be held in Los Angeles at the Skirball Center, which is somewhat put on with SAMHSA -- correct? -- yes -- which will award the Hollywood community, producers, stars, people who have portrayed -- given a favorable view of those who have done well -- or how should I say it? -- have given a favorable light to those who have overcome mental illness, a favorable light in conquering stigma. We hope that this will -- it's the first -- first time this has been done in Los Angeles. I think Charlie will probably talk more about this. Mark Weber is very, very happy with the way this is coming together. It should be a very, very successful event. We'll tell you more about it in December.

MS. WATTS DAVIS: Well, good morning. It's a pleasure to be here.

I just wanted to just share with you, one of the things of being at this conference has been a very, very nicely and much needed conference. I am pleased to report to you all, we will be having a meeting between both the tribal leaders and the state and the national prevention and the state prevention directors to figure out how we can do a much better job of integrating many of the tribal issues within the whole state planning system. So I'm looking forward to that meeting. I am really pleased to report that we actually have our first Native American program that has

1 actually been an in-rep., and they're represented here
2 today -- Mr. McClellan Hall -- I've known him for 15 years.
3 His program with the National Indian Youth Indian
4 Leadership Project is in our in-rep., and we are now
5 supporting the second program called Walking in Beauty.
6 That's very important, because the tribal customs and
7 practices, the way that they -- they have a different way of
8 measuring things. So we're going to be working with them to
9 come up with measurements -- culture-competent measurements
10 to be able to really look at how they're affected in their
11 community. So I'm really pleased and excited about that.
12 And that will just expand upon what we're all about.
13 MR. KIRK: I'm Tom Kirk. I'm the Commissioner of
14 Mental Health and Addictions for the State of Connecticut.
15 I am honored to be at this first meeting, at least for me,
16 for the Council.
17 A couple of things that we're particularly proud
18 of -- when I began my term about May 2000, whenever it was,
19 I made a very -- some very significant decisions, at least
20 in my part, I think. One was that the agency that I oversee
21 we describe as a health care agency. Why would we do that?
22 Chances are everybody in this room has a card in the back
23 of their pocket, purse, whatever, that's their health care
24 card. What that health care card implies, at least to me
25 anyway, is that when I go to my health care provider, I

1 should get better -- not necessarily be cured of whatever my
2 illness is, but I'm going to get better. Furthermore, the
3 person who holds that card has the choice of health care
4 providers.
5 So consistent with the emphasis on the health care
6 agency, we then moved on and said recovery would be the
7 driving force behind our whole service system. In
8 Connecticut, we treat about 60 to 80,000 people a year for
9 mental health and substance abuse issues, and on the
10 prevention side, a much larger group of people.
11 The idea for me behind recovery is really two
12 things. One of them is that anybody who comes into our
13 system for care should expect that, as a result of that
14 interaction, they will learn the tools to help them manage
15 their illness or their symptoms. And secondly, as Charlie
16 Curie has continually pointed out, what is equally, if not
17 more important, is that once managing their illness, they
18 will go on to have the highest qualify of life that they
19 could possibly achieve.
20 As a psychologist, I will say I feel guilty about
21 the fact that for too many years within our system, coming
22 into an agency such as mine was viewed as a lifetime
23 journey; that once you come into the mental health or
24 substance abuse agency, you would be in there for the rest
25 of your life. Treatment, to me, is a point in time.

1 Recovery is a lifetime journey.
2 A couple months ago in Connecticut we had one of
3 the breast cancer walks, and I participated in it. The
4 persons who were survivors of breast cancer, they wore
5 certain things on their head. It was a different color.
6 When you think about that, people who are recovering from
7 mental illness, people who are recovering from substance
8 abuse issues, would it not be something to see that we would
9 have a walk similar to that, and people would proudly run
10 and walk such as that, and not be ashamed of who and what
11 they are in their illness.
12 And so one final piece that ties back to this.
13 Where I grew up, it was very, very common that if someone in
14 the neighborhood was ill, you'd send 'em over a casserole --
15 or if they were in a hospital. When was the last time you
16 have heard anybody in any neighborhood where a person went
17 to a substance abuse treatment center or a mental health
18 treatment center, and someone sent over a casserole to that
19 particular family? That's the kind of stigma that we're
20 trying to overcome.
21 So what I'm particularly pleased at, the Access to
22 Recovery Award, the Strategic Prevention Framework, all of
23 these are based upon what I call a wellness or a health
24 approach. So as long as I've been in this field -- and I
25 mentioned it to Charlie last night -- I think this is the

most exciting period of change. But sometimes it's scary. It's quite a challenge. So I hope that forums such as this will help us to continue to push the agenda, because thousands of people's lives depend upon what we do, and what you do at SAMHSA.

Thank you much.

CHAIRPERSON CURIE: Duke, I might mentioned that Theresa and Diane just joined us again.

Can you hear us, Diane and Theresa?

MS. RACICOT (Telephonically): Yes.

CHAIRPERSON CURIE: We want to make it clear, they did not leave us, we left them. I think the technical difficulties have been overcome at this point. So welcome back. Duke is now chairing the meeting. We're going around --

MR. AIONA: We've been going around the room. So we'll go to Barbara, and then we can go to the phones.

MS. HUFF: Hi, Theresa and Diane. We miss you here.

MS. RACICOT (Telephonically): Well, we miss you, too. I bet you're having a wonderful visit.

MS. HUFF: It is really nice. Yes. Thanks.

I'm Barbara Huff. I'm formerly the Director of the Federation of Families for Children's Mental Health in the Washington, DC area. I'm a parent, and I say that

because I really believe that I represent families on this Council. I just want to say how proud I am to sit next to you, Tom, who just said all that about breast cancer, because I have a daughter with breast cancer. I've said for a long time that we need to figure out how we got to the place where breast cancer can be talked about at anyone's dinner table.

Anyway, I loved it that you said it, because it now means that I can kind of lean back and not have to say it all the time. So -- and I have other people that are fan clubs of those kinds of messages.

I just want to say that -- as most of you know, I kind of semi-retired and moved out to Kansas in October. So I'm working part-time with Vanguard Communications and systems of care, and working with families and service providers on how to create a message in their community about systems of care and about children's mental health in the broader perspective, as well. Then, of course, when I came back to Kansas, I couldn't help but get totally immersed in everything that's happening in Kansas. I didn't mean to, but I did. I do love Kansas. I have to say it's been really neat.

Jane Adams, who is Commissioner on the New Freedom Commission, runs our statewide family organization. Immediately she said, Barbara, would you want to run some

1 focus groups for us across the State of Kansas on some of
2 the goals of the New Freedom Commission? And the one we
3 picked first was family and consumer-driven services. So I
4 ran focus groups with consumers and family members and
5 children, younger kids and older kids, transition age
6 youngsters, young people, and older people, to see if we
7 could take the definition that the federation was asked to
8 come up with, to define what that really meant, what
9 "family-driven" meant. The Center for Mental Health
10 Service, Carrie Blough, and the Child Adolescent Family
11 Branch asked the federation to define it. And we did. We
12 had a lot of focus groups, and that was going on when I was
13 still there. So we took the definition, and went around in
14 Kansas, and got total buy-in in Kansas from NOMI (ph), from
15 the older adults organization, from -- and like I said, from
16 families who had three to five-year-olds, and families who'd
17 been dealing with substance abuse problems. So we got total
18 buy-in about what that meant with that definition. We were
19 really proud of that.
20 What we didn't do as well as we should've is to
21 have gotten the professionals in the service provider
22 community and the mental health center directors -- we
23 didn't get the same buy-in. So we're still working on that.
24 So anyway, I -- so that's kind of what I've been
25 doing. But I also got back from Hartford -- and loved

1 Connecticut, and that was a neat experience. So I've been
2 going to some of the regional meeting on system of care. So
3 that's been really fun, too. So I'm semi-retired, kind of.
4 That's all I can say. I'm not really.
5 MR. AIONA: Thank you, Barbara.
6 Diane, why don't we go to you first. We're just
7 kind of introducing ourselves and just giving a little
8 bit -- just a little about what's been happening.
9 MS. HOLDER (Telephonically): My name is Diane
10 Holder. I am the President of the University of Pittsburgh
11 Medical Center's Insurance Services Division. Essentially
12 what that is is it's a group of insurance health management
13 companies that manage benefits for people who are either
14 covered by commercial insurance, Medicaid or Medicare. As
15 part of that umbrella of insurance companies, we also have a
16 company called Community Care Behavioral Health, which
17 manages benefits for approximately, at this point, over
18 600,000 individuals. But many of those individuals are part
19 of the Medicaid program. And so many of them have
20 persistent severe mental illness, as well as other physical
21 health needs.
22 My background prior to managing and running the
23 insurance companies was I spent about 20 years fairly
24 exclusively in the field of behavioral health, where I was
25 the head of Western Psychiatric Institute and Clinic, which

is a large academic medical center teaching hospitals for psychiatric residents, and had a large clinical service. And so that I have always had a great deal of interest in helping develop clinical service programs for folks with psychiatric or substance abuse problems.

Then the newest part of my life is really transitioning into, how do you help finance services and programs so that people can recover and get the kind of services they need for a price that the people who are buying those services can afford to pay? So that's a little bit about me.

MR. AIONA: Thank you.

Theresa, good morning.

MS. RACICOT (Telephonically): Hi, Duke. How are you?

MR. AIONA: I'm doing good.

MS. RACICOT (Telephonically): I'm sorry not to be in California with you again.

MR. AIONA: That's all right.

MS. RACICOT (Telephonically): I'm Theresa Racicot, and I'm actually a displaced Montanan to Washington, DC. I tell people I'm retired, but I don't know if that's really true, because I don't seem to be idle. I'm a volunteer, basically. I spend a lot of my time working on the Leadership to Keep Children Alcohol-Free, the Spouses'

Initiative, addressing childhood drinking in America. We recently formed our own foundation, and I'm actually the President right now, I think because I reside in DC. I'm very interested in mental health, have been for years. I worked on it a lot when I was in Montana, and Charlie was kind enough to invite me to join the Council. So I'm delighted to be a part of it and to be working on getting rid of stigma and making life better for people who suffer with mental illness.

MR. AIONA: Thank you, Theresa.

MS. KADE: I'm Daryl Kade. I'm the Director of Policy, Planning and Budget. I've been busy working on the '05, '06 and '07 budgets. Mr. Curie will be talking about that later on.

MS. VAUGHN: I think everyone knows me. I'm Toian Vaughn, and I'm your Executive Secretary.

MR. AIONA: And she's also indispensable.

One more item before we go back to Charlie. We have the minutes of the December 7th and 8th, 2004 meeting. We need to approve these minutes. I guess I need --

MR. STARK: Correction. If we could go to page 11, page 11 under the Council round table discussion, if we could delete the second paragraph, Medicaid no longer provides monetary backup for programs, that needs to be deleted. Then if we go down to the last sentence in that

paragraph, the next to the last line where it says, "Reduction in opioid drugs being disbursed or dispensed at treatment," cross out the word "treatment." It should say "hospital emergency rooms."

MR. AIONA: Where was this at again? I'm sorry, what paragraph?

MR. STARK: The next to the last line in the first paragraph, where it says, "Reduction in the opioid."

MR. AIONA: And the change again?

MR. STARK: The change again is the next to the last line in that first paragraph, where it says, "Reduction in the opioid drugs being dispensed at" -- and then it says "treatment." Cross out "treatment" and replace it with "hospital emergency room" -- or "rooms" -- and that's it.

MR. AIONA: Any further comment on -- or how about comment on just these changes, anybody object to it?

(No responses.)

MR. AIONA: No objection. Any other comments?

(No responses.)

MR. AIONA: Can I get a motion to approve these minutes?

MR. STARK: So moved.

MR. AIONA: Second?

MS. DIETER: (Raises hand.)

MR. AIONA: All in favor.

(Hands raised.)

MR. AIONA: Thank you. All opposed.

(No responses.)

MR. AIONA: There being none, it'll be accepted.

CHAIRPERSON CURIE: Before I begin my report and then move to the budget discussion, I also want to recognize some other individuals that are with us today -- John DeMirand (ph) is with us today from the National Association of Alcohol, Drugs and Disabilities. Welcome. Donna Demetrich (ph), who is -- I knew from my Pennsylvania days. She's now with the Johnson Institute, works with Johnny Allen with the Johnson Institute. Welcome, and thank you for being here today.

I'd like to invite anyone else in the audience that we have not recognized who might want to -- okay -- if we've covered -- Steve Sawmelle is here from SAMHSA working with -- he is our tribal liaison, and obviously has worked with this conference that we're participating in. I also want to recognize Mark Weber, our Director of Communications. And I'm still speaking to Gail Hutchings, even though I have to let you know today that she's going to be leaving SAMHSA. She is quite ably and just in the most competent way has served as the Chief of Staff at SAMHSA. Although I will miss her, and her contributions have been extremely valuable as you take a look at everything from the

conference in New York City after the 9/11 attacks, the substance abuse and mental health planning conference bringing states together within a matter of -- that was, what, three days? -- I think you pulled it toge- -- oh, three weeks -- that -- what a lot of folks said it takes nine months to plan a national conference, and it was planned and wonderfully executed -- to all the work on the Mental Health Commission and everything she's contributed in terms of that action agenda -- and also I take -- just being engaged with all three centers and the work of SAMHSA, I think people have always found her to be an extremely competent advisor in helping us guide the agenda in a very, very effective way. Substance abuse and mental health is further along because of her efforts. We'll miss you, Gail, but thank you.

(Applause.)

CHAIRPERSON CURIE: To talk a little bit about the conference, we're preparing for and tending to the last-minute details for this large national conference, which begins here in San Diego -- actually tomorrow officially begins. San Diego was chosen as the location because it, again, coincides with this conference -- over 500 federal, state and tribal government leaders, along with medical and mental health providers and substance abuse prevention and treatment providers will participate in this three-day

1 conference. Also, this has an international aspect to it.
2 We have international guests from New Zealand, Mexico,
3 Canada and Australia. So again, I know some of you are
4 planning on attending. I think if you're able to, I think
5 you'll find it very worthwhile, and I encourage everyone's
6 participation in this conference.
7 I also understand that Kathryn Jett, of course,
8 will be a participant and participating, so it's great.
9 Again, in addition to the conference tomorrow,
10 we've also been reaching out -- as I mentioned, the
11 international scene -- continuing our efforts working with
12 many international partners, just to update you in some of
13 our efforts there, including the Iraqi Ministry of Health.
14 As an emerging democracy, Iraq has begun making decisions
15 related to public health. We've been working with --
16 SAMHSA's been working through HHS with the Iraqi Health
17 Ministry in the development of their new mental health and
18 substance abuse plans.
19 One piece of progress I want to mention is
20 substance abuse is now clearly in the planning process.
21 Initially they reached out on mental health. Initially they
22 weren't necessarily identifying that they had any substance
23 abuse problem. Now they are saying, yes, we do. And the
24 great news is it's a very good public health approach.
25 Since we met last, SAMHSA organized and sponsored

1 an action planning conference for Iraq -- mental health --
2 that was held in Amman, Jordan in March. The conference
3 brought together Iraqis, along with more than 20 American
4 and British experts who served as information resources.
5 Since then, we also attended -- in fact, Gail accompanied me
6 to London -- and the West Kent Trust in London hosted the
7 Iraqi professionals for a period of several weeks for
8 training in community-based services. We were able to work
9 with them in the conference there.
10 Also through the International Initiative for
11 Mental Health Leadership and other organized activities,
12 SAMHSA's gaining strong international partnerships, which
13 bring opportunities for learning and sharing information I
14 think we otherwise wouldn't have. What's I think
15 exciting -- and Kathryn's been participating very actively
16 in helping us lead in the International Initiative for
17 Mental Health Leadership -- is the fact that recovery --
18 and, Tom, I appreciate so much your remarks earlier --
19 recovery has developed to an international focus in terms of
20 people understanding that we're looking to manage illnesses
21 and manage life and looking at those outcomes. Clearly we
22 must remain committed, I think, to nurturing these
23 partnerships, and in doing so, demonstrate that we are a
24 compassion nation that's continuing to reach out.
25 I also want to thank all of the Advisory Council

1 members, our ex-officio members, our state and federal
2 partners present today, as well as the representatives of
3 the constituent groups for the tremendous work you do. Just
4 listening to you share at this table today -- and I've
5 noticed going out and meeting with constituents when I speak
6 with Kathryn, Wes, or Beverly, as they are doing their work
7 across the nation -- when you hear people articulating more
8 common themes -- and recovery is one, resilience is another
9 that people are talking about, and people are focused on the
10 same outcomes -- you're hearing the outcomes discussion
11 occurring to where -- I think at one time when you had a
12 discussion of outcomes five years ago, ten years ago, there
13 was a lot of disparity in that discussion -- what we should
14 be measuring. We're seeing, I think, a consensus emerge, if
15 you will, which I think is going to move us forward.
16 Then listening to all of your activities today,
17 the difference that could be made at the local level as
18 these efforts are translated, really I think we have a lot
19 of true partners in helping realize that vision of a life in
20 the community and building resilience and facilitating
21 recovery. I'm pleased to say, individually and
22 collectively, each member of our Council I believe brings a
23 valuable resource to SAMHSA. Again, we'll have an
24 opportunity to talk more about our efforts.
25 When we met in December, we had a chance to review

1 our progress and to begin to examine what still needs to be
2 done. We also began to map out our future plans during our
3 President's second term and the direction of the new
4 Secretary. One other development since we last met, we do
5 have a new Secretary of Health and Human Services, Michael
6 Leavitt. Secretary Leavitt has issued his 500-day plan,
7 which, if you haven't seen a copy of that, we want to make
8 sure you all have that available to you. I think you all
9 should've received a copy of that.
10 What I find very exciting about the plan, and in
11 my discussions with the Secretary and his Chief of Staff,
12 Rich McKeown, is the alignment we have. When you hear
13 Kathryn talk later about mental health transformation, the
14 alignment between that transformation agenda and how it's
15 aligned with overall health care transformation, which is a
16 major priority for the Secretary, health information
17 technology is a major priority, Medicare -- implementation
18 of the Medicare Act and transformation of Medicare, top
19 priority -- Medicaid, top priority -- as well as pandemic
20 flu. In most of those priority areas, we very much have a
21 lot of activity foundation laid from the first term that
22 we're going to continue to build upon the second term, and
23 have alignment. So it's very exciting to see that.
24 Again, when Tom said we are probably at the most
25 exciting time perhaps ever in the behavioral health field in

1 terms of the federal, state, local partnerships, and public
2 and private partnerships that can occur, seeing this
3 alignment with Secretary Leavitt's leadership is extremely
4 exciting and gratifying.
5 One other change I might mention, too, at SAMHSA
6 that I didn't note earlier, we do have a new Acting Deputy
7 Administrator since we last met, Andy Knapp. Many of you
8 knew Andy. He was Deputy Chief of Staff for Secretary
9 Thompson, and actually handled the portfolio which SAMHSA
10 was included for Secretary Thompson. So he's been a strong
11 advocate for SAMHSA, and a very able manager. He's holding
12 the fort back in Rockville today. So I wanted to make that
13 announcement.
14 Going back to our meeting in December, I shared
15 with you that our plans, both immediate and long-term, would
16 need to incorporate a focus on increasing efficiencies,
17 taking a look at outcomes, pushing science, and pushing
18 science into service in a more efficient way, containing
19 health care costs while increasing access to services, and
20 operationalizing -- again -- recovery from a public policy
21 and public finance perspective. Again, just as I share
22 those things, you can tell they're daunting and challenging
23 tasks.
24 But much has taken shape since our last meeting.
25 The six core goals of the Secretary's plan that I mentioned

1 earlier, one, transform the health care system and modernize
2 Medicare and Medicaid, advance medical research, secure the
3 homeland, protect life, family and human dignity, and
4 improve the human condition around the world. I think when
5 you think of those points, everything that we've been
6 mentioning in terms of different activities in which we're
7 focused on relate to each one of those areas, and we have a
8 role in each.
9 In particular, we'll need to be prepared to ensure
10 a smooth transition for people with serious mental illness
11 and addictive disorders when the Medicare Modernization Act
12 is implemented on January 1. This is something that we are
13 keenly focused on. We are working with CMS, the Centers for
14 Medicare and Medicaid, and also through the states. The
15 partnership with the states will be critical during this
16 period of time to help consumers understand how and when to
17 pick a prescription drug plan that can best suit their
18 needs.
19 As of January 1st, persons who have both Medicaid
20 and Medicare, or that are called dual-eligibles, will pay
21 for medications through the new Medicare benefit under the
22 Medicare Modernization Act. In the United States, there are
23 approximately seven million people who are in that category
24 of dual eligible. Just under half of these people have some
25 form of cognitive impairment or issues around mental illness

1 or mental disability. In Part -- Medicare Part D, the
2 prescription drug benefit, CMS has put into place several
3 regulatory provisions that are designed to assure each
4 Medicare beneficiary will have access to the medications
5 they need. We know this is particularly true for people
6 with mental illnesses. We will continue to work closely
7 with CMS to manage the changes the act sets forth, and will
8 continue to work with our partners to make the transition as
9 smooth as possible. We want to make sure this is done
10 right. CMHS is engaged very directly with this. Anita
11 Everett is the point person out at the Office of the
12 Administrator who's working with CMS and leading our
13 efforts. The Secretary has engaged every operating division
14 in making it very clear that each of us are expected to have
15 a role in this, and recognizing each of us have our own
16 constituency groups that are impacted by this.
17 We've also sent a letter out to the state mental
18 health and drug and alcohol directors asking each authority
19 to appoint a point person in the state that we can continue
20 to work with and help states roll out plans for reach-out.
21 Because the states are going to be a critical partner in
22 this process.
23 We've accomplished many needed changes over the
24 past few years, and have dug deep, I think, to building a
25 new foundation that -- again, a goal I think we all have --

1 because I talk a lot about myself being a temporary steward.
2 Clearly, I think Council members are in the same boat.
3 You're term-limited. So we are temporary stewards in this
4 position.
5 I think the good news is the progress we're making
6 will bring about changes, and are bringing about changes
7 that will outlast us. The key is when we leave that we have
8 confidence that recovery is secured in terms of influencing
9 public policy, that resilience is understood, that outcomes
10 are going to be clear, and that we have more confidence
11 we're going to measure them and paint a picture -- the type
12 of picture Ken paints in Washington State we can paint for
13 the whole nation. I think it would be just incredible.
14 I think one of the tools we've used that's helped
15 us is the SAMHSA matrix. The matrix, along with our vision
16 and mission, will continue to be our guide. The matrix is
17 aligned, again, with Secretary Leavitt's priorities. So the
18 great news is we have no need to start from scratch. All
19 the work and investment that we've put into the progress so
20 far can continue. But I think there's going to need --
21 there's a great need to have -- keep a close eye on what we
22 define as priorities and to make changes in the matrix as
23 the needs change and as the data tells us.
24 Again, you've heard me talk about redwoods.
25 That's what we're about doing is planting some solid

1 redwoods that are going to stay and be around. If we grow
2 the redwoods, they'll continue to make solid, lasting
3 improvements.
4 If we focus on our core set of priorities and
5 accomplish them right away, then I think we'll see what we
6 need to be doing in terms of fulfilling our
7 responsibilities. For example, what we're doing in
8 substance abuse prevention and treatment is a cornerstone of
9 what is being done to stop the spread of HIV/AIDS. We're
10 pleased to say that we have over 213,000 rapid testing kits
11 that are across this country. We've never had that capacity
12 before, and we've been working in partnership with state
13 public health authorities, substance abuse authorities, to
14 get those kits in the hands of providers where people will
15 appear who could be at risk of HIV/AIDS so that they can
16 find out.
17 CDC -- and this points out an important partner-
18 ship, that we at SAMHSA always need to be partnering with
19 CDC, with our other agencies, operating divisions, fellow
20 operating divisions within HHS. CDC came out saying that
21 they believe there's up to one million people in this
22 country that are HIV-positive and don't know it. We know
23 that the population we serve is in the highest risk
24 categories when it comes to substance abuse, when it comes
25 to mental illness. So we need to step forward, assume

1 responsibility, and see what we can do to try and bring that
2 number down, and so people will know whether they are or
3 not, and then can take the appropriate action. And also
4 it's a prevention effort, as well, that we need to be
5 focused on.
6 What we're doing in mental health system trans-
7 formation is what needs to be done to better serve those
8 that are homeless or that are in the criminal justice
9 system, and that all of our efforts combined better serve
10 children and families. That's a major focus of the matrix,
11 and we need to be thinking about how all these efforts are
12 continuing to press that forward.
13 This approach is a strategic approach. We have a
14 President with a strong management agenda with expectations.
15 We have efforts that must be aligned with our department
16 and must be in step with performance measurement and
17 management requirements. And that's an ongoing goal that we
18 have.
19 SAMHSA's now operating more than ever before in a
20 performance-based, outcomes-based environment. We have
21 to -- and I think all of us can agree want to -- provide
22 services which bring about real outcomes for real people,
23 outcomes that measure recovery and resilience. The matrix,
24 along with our data strategy, is doing just that. We've
25 made considerable progress in the development and

1 implementation of a SAMHSA data strategy. Our goal is to
2 achieve a performance environment with true accountability.
3 We've looked at the data that we're collecting.
4 We've asked, why are we collecting it? And we've asked, how
5 are we using it to manage and measure our performance? If
6 we found we're not using it, we choose to lose it, and
7 really put our efforts in what really is measuring what we
8 intend to see in terms of outcomes. So our emphasis is on a
9 limited number of national outcomes related to these outcome
10 measures. They're built on a history of extensive dialogue
11 with our colleagues in the state mental health and substance
12 abuse authorities, and most importantly, from feedback from
13 people in recovery, from consumers, from families, from
14 parents.
15 The domains we've identified, again, embody
16 meaningful, real-life outcomes for people who are striving
17 to attain and sustain recovery, build resilience, to work,
18 learn, live and participate fully in their communities.
19 Again, those domains -- I think you've received a listing of
20 those. They include abstinence. They include when we talk
21 about a job, a home, and connectedness to others. We are
22 going to be measuring those types of things in these
23 domains. We're going to be measuring whether people have
24 access to what they need as they attain recovery, whether
25 they are sticking to their recovery plan, and is the

1 recovery plan working for them? Also, are they involved in
2 the criminal justice system, or have less involvement in the
3 criminal justice system?
4 I want to give a lot of credit to both NASHBUD
5 (ph) and NASIDAT (ph), because, again, they've been the
6 critical partners for over a decade trying to come to some
7 sort of clarity on what type of national outcome measures we
8 need. And we've attained that with both of those
9 organizations due to the leadership of those organizations,
10 sitting down and taking a look and, I think, listening on
11 the part of all parties in terms of also what's doable, what
12 are developmental measures. You know, we haven't fully
13 arrived yet on those measures, but we have to have an open
14 dialogue and process to move it ahead. I'm pleased to say I
15 think we've made more progress probably in the last six
16 months than we did in the previous nine years in terms of
17 reaching that level. I know Ken and Tom have some thoughts
18 on that, as well, so when there's a chance to share about
19 this -- but it's profound -- when we pull this off -- and we
20 will, and we are -- it'll be profound in terms of putting us
21 in a position to be able to describe to all Americans,
22 members of Congress, people in OMB, how our dollars are
23 helping people achieve those meaningful outcomes, and people
24 understand that outside of our fields -- and that's the
25 other thing that's a critical part of what we need to be

1 doing.

2 The other thing that I want to mention that we're
3 working hard to do at the national outcomes is again
4 assuring that those are the domains that we're measuring in
5 everything that we do -- our block grants, the discretionary
6 grant portfolios in all three of our centers -- and that
7 will help give us a comprehensive picture.

8 While we're aligning ourselves around national
9 outcomes, it's also important for us to think about those
10 things that -- and we have a long-term view -- those things
11 that may emerge in an urgent or crisis-oriented way. SAMHSA
12 needs to remain nimble and responsive to the needs of
13 particular consumer groups to emerging trends, and also to
14 unpredictable or catastrophic events. As examples, we'll
15 continue our efforts to make older adults aware of the
16 dangers involved with inappropriate use of prescription
17 medications. We'll continue our suicide prevention efforts
18 focused on our nation's youth. And we'll continue to fund
19 our targeted capacity expansion grant programs to address
20 emerging needs in states and communities across the country,
21 emerging drug use needs as we might be identifying them in
22 different parts of the country.

23 We will provide assistance when tragedy strikes,
24 like the Florida hurricanes, for example, this past year,
25 which I know one of our Council members is all too familiar

1 with the devastation that occurred last year with that.
2 In fact, later this morning after we discuss the
3 budget status and resume from our break, as I mentioned
4 earlier, Kathryn Power, Director of our Center for Mental
5 Health Services, will provide greater detail on SAMHSA's
6 response to the recent tragedy at Red Lake. Again, our
7 partnership with IHS has been critical in that process. We
8 were all shocked and saddened by the recent onset of
9 violence among the Red Lake Band of Chippewa Indians in
10 Minnesota. We responded and was able to make available
11 $73,000 in emergency response grant to continue mental
12 health and substance abuse services to help combat the
13 widespread psychological consequences for those who live,
14 who go to school, and who work on the Red Lake Reservation.
15 Again, building resilience and facilitating recovery is a
16 common thread among each of these activities.
17 As I mentioned earlier, those priorities are
18 mentioned in our matrix, and I just want to highlight a few
19 others as part of my report -- aspects of the matrix.
20 Access to Recovery -- increasing substance abuse treatment
21 capacity -- and we're doing that through Access to Recovery.
22 It was designed to expand treatment capacity by increasing
23 the number and types of providers, including faith-based
24 providers, who deliver clinical services as well as recovery
25 support services. Again, the ATR program is based on

1 consumer choice, using a voucher. It allows consumers in
2 need of treatment to use their voucher to find and purchase
3 the best services for them. In this way, recovery can be
4 pursued in that very personal, individualized way, which
5 recovery is all about. As we talk about operationalizing
6 recovery, it clearly -- Access to Recovery is one way we're
7 striving to do that in a very concrete manner.
8 We have funded 15 grantees, 14 states, and one
9 tribal organization. There's a solid chance this coming
10 fiscal year, if we continue to rally, we still may get an
11 additional $50 million. I think all of us here, I assume,
12 are disappointed to see the House mark kept Access to
13 Recovery at really a level funding. What's good to hear, at
14 least from states like Washington and Connecticut, who have
15 Access to Recovery, that you're going to continue your
16 funding. But it was disappointing to see we can't expand
17 that to other states because of the interest, of course,
18 with 66 -- also California's an ATR -- gosh, we have three
19 ATR states represented, and with the First Lady of Florida,
20 we have a lot of ATR states represented here. But again, we
21 need to do what we can to see that we're able to expand
22 treatment capacity, because we know the gap -- the treatment
23 gap is great in this country. Hopefully we'll fare better
24 in the Senate mark. The good news is we're not finished
25 yet. So hopefully there can continue to be support for the

1 President's budget.
2 Along with dealing with both the issues around
3 recovery, stigma's been mentioned this morning by several
4 individuals. I think it's critical for us to be thinking in
5 terms of how to address this, because it is a barrier on
6 both the substance abuse and mental health side. In
7 particular, when we look at mental health systems
8 transformation, finding help for people with mental illness
9 is equally as important. Not knowing where to go for
10 treatment is the first roadblock for many people seeking
11 help. We have to do more to take the mystery out of where
12 to go for help.
13 The objective has to be getting in the groundwater
14 of our society. The notion of -- and I like Tom's visual
15 depiction of the day that perhaps we overcame stigma with
16 diseases such as breast cancer and cancer in general, and
17 people speak with pride about being survivors now -- that
18 we're able to bring mental illness and we're able to bring
19 addictive disease out in the open, and people can talk about
20 where they're at in their own recovery. We're trying to
21 take a fresh approach to combating stigma. The anti-stigma
22 messages that we've been sending out for decades, while have
23 made some progress, I think we would all agree we have a
24 long way to go to make a definitive impact on American
25 society.

We need to craft a message that's effective, the message that mental illness is an illness like any other, and help is available, and that treatment works, and that recovery is real, that addictive diseases, as well, is an illness like any others that can be treated. We're looking to find new audiences and different audiences to hear from us and learn from us. One such opportunity just occurred. I participated in the United States Conference of Mayors. I had a chance to talk to mayors about issues around mental illness, their desire to open up opportunities for people to find treatment in their communities, being able to work with their criminal justice systems and address it as a public health as well as a public safety issue, and do it in a non-stigmatizing way.

I had a very good discussion with Mayor Daly about the issue of recovery in Chicago, with the conference being held in Chicago. I think there's some partnerships we can develop. I know Kathryn's been working with the National Governors Association, as well, reaching out there and talking with the upcoming issues around mental health transformation.

We've conceptualized recovery. We now need to articulate it in ways that more local governments and the public can understand it. There are 19.6 million people with mental illness in this country, 22 million people with

a serious substance abuse problem. First and foremost, we need to -- and again, keep in mind that they're people with lives to get on with. Thankfully, today we know more than ever before. So again, a lot of the work we need to be doing is doing what we know -- doing what we know and implementing what we know. I think that's the awesome responsibility of SAMHSA as a services administration.

I'm pleased to say that this week we're going through some final briefings within the Department, and I'm very hopeful that the action agenda, which, again, has been Kathryn's primary -- one of her primary -- definitely her top priority as she's come aboard to help shape -- with 20 federal agencies. It includes other departments besides HHS, as well as pretty much all the operating divisions within HHS, to have an aligned agenda. I'll be meeting with the Secretary this week. We'll be briefing him on the action agenda.

The great news is we haven't waited for the release of the agenda before we've started our work. Again, the transformation -- state incentive grants that are out there to help states have the resources they need to have an alignment -- an aligned agenda at the state level have been approved, and we're implementing those. We're well underway with suicide prevention efforts. What the action agenda will do for us, it'll show the whole picture of what a

1 transformed system can begin to look like. And it's really
2 the federal action plan in terms of the first federal steps
3 for the federal government to demonstrate leadership and
4 commitment to mental health transformation. Again, we'll be
5 hearing more from Kathryn about the transformation efforts.
6 Strategic prevention framework. And again, what
7 I'm really pleased with with the three center directors
8 here, each one of these three directors have awesome
9 responsibilities and are very much key leaders in moving the
10 agenda ahead for SAMHSA. For Beverly and CSAP, the
11 strategic prevention framework -- which, again, the other
12 thing I might note, all three centers are working on all
13 three of these initiatives together, as well. While one
14 center may be the lead center, the collaboration that's
15 occurring is at a level, I think, unparalleled before within
16 SAMHSA.
17 But our strategic prevention framework, I
18 explained at the last meeting the concept of the framework.
19 Fortunately, word about what works in prevention I think is
20 getting out more and more, the notion that each community
21 will have a plan within those states to get an SPF, a plan
22 in which they will understand what prevention dollars they
23 have available to them, that they will be able to identify
24 the risk factors in their community, the protective factors,
25 and then invest their money in programs that we know that

1 work to address those risk factors.

2 Of course, one thing I'd like to highlight when it
3 comes to strategic prevention framework is the whole issue
4 that we must address underage drinking in that process.
5 While we made progress in teen youths and other areas, and
6 we're at 17 percent decreased illicit drug use among teens,
7 compared to over three years ago 600,000 fewer teens are
8 using illicit drugs than they were in 2001, we are seeing
9 underage drinking rates remain stubbornly the same, and
10 binge and heavy drinking in some areas actually going up.
11 Again, we have our work cut out for us.

12 The original legislation for SPF highlighted that
13 we expect underage drinking to be addressed in each of those
14 grants. I've always said, show me a community that doesn't
15 have an issue with underage drinking. I want to visit it,
16 find out what they're doing, because we can learn from that,
17 because it's really the most pervasive substance being
18 abused.

19 We also need to be pressing and working toward an
20 overall strategy. And I'm pleased to say that the
21 Interagency Council, which SAMHSA chairs for the Department,
22 is going to be submitting its final report to Congress by
23 the end of this summer. For the first time, we will have a
24 federal strategy, again with alignment of federal agencies
25 to address underage drinking and to bring this to the

1 forefront. And it's a multi-faceted effort. We must
2 address this at many levels. And again, Theresa mentioned
3 the First Spouses Initiative. They're a very critical group
4 in pressing this agenda. The Reach Out Now efforts that
5 Duke mentioned -- and I know that many of you participated
6 in in your own areas -- are all a part of, how do we begin
7 to get parents to talk to children about the issue?
8 We also are working with the Ad Council, and we're
9 hopeful now that we've been able to find the funding. The
10 good news is we had funding for one PSA. Between SAMHSA and
11 the National Highway Safety Transportation Administration,
12 we've been able to come up with dollars to fund another one.
13 There was a little bit of a shortfall in the Congressional
14 Act. I heard it was an honest mistake that was made. But
15 we were able to find dollars for this and be able to have
16 two PSAs. A lot of it is trying to get to the day that
17 underage drinking is really viewed as something that has to
18 be stopped, and that it isn't just kind of viewed with a
19 wink and a nod, unfortunately, in our society. And again,
20 we know more than ever before, and I think we'll be held
21 accountable for that.
22 Again, in our Reach Out Now efforts, we're excited
23 that next year -- it expands every year -- and I know with
24 efforts being put forth by the first ladies -- and I know --
25 well, Duke, you participated directly; Columba, you

1 participated directly; and I know Theresa did -- it just
2 makes an impact. Kids bring the piece of paper home with
3 them to take to their parents to say, Talk to me about this.
4 That's really critical and important.
5 I just want to conclude by saying that SAMHSA will
6 continue to do our part to build upon the matrix priority,
7 to develop and be guided by our strategic plan, which you
8 know was circulated for public comment, and it's also been
9 posted on our website, and it's now to be revised, cleared
10 and published before the end of the fiscal year. And most
11 importantly, we'll continue to put consumers and families at
12 the center of care for them to drive care and move ahead.
13 So thank you. And now I'd like to open it up for
14 any discussion, comments, thoughts from Council members.
15 Ken.
16 MR. STARK: You know, it's always been fascinating
17 to me, as we talked about stigma, thinking back on the
18 history of the field of addictions, as well as mental
19 illness, that in our zeal to separate ourselves and create a
20 distinction, we created these terms like "behavioral
21 health," and that that became a very common term. I believe
22 that in our zeal to create that distinction, we've actually
23 done a disservice to our consumers, that the term in and of
24 itself, "behavioral health," does differentiate us from
25 health. People then don't see us as a health problem, they

1 see us as a behavior problem. That in and of itself negates
2 the physiologic, biologic and genetic basis for mental
3 illness, as well as addictions, and focuses simply on the
4 behavior.
5 I think that we need to get away from that. I
6 think if we're truly going to be a health field and remove
7 stigma, we need to get away from the term "behavioral
8 health." That's a mantra that I've been singing for a long
9 time, and I'm going to keep singing it, that our stigma will
10 not go away as long as people think these are nothing but
11 behavior problems.
12 CHAIRPERSON CURIE: Thank you, Ken.
13 MR. KIRK: Medicare Part D, when are the vendors
14 selected, the ones who would operate the plans?
15 CHAIRPERSON CURIE: When are they selected?
16 MR. KIRK: Yeah.
17 CHAIRPERSON CURIE: We can get that information of
18 any time frame. I think they're in the process right now.
19 MR. MARK WEBER (Speaking from Audience): So much
20 of it's coming together right now. We're actually working
21 with CMS to get information out on the specific vendors to
22 the states, to the people who will be making the choices.
23 CHAIRPERSON CURIE: So we'll get -- and that's
24 information that we're going to have to every point person
25 in the state in terms of the timing of that.

1 Barbara.
2 MS. HUFF: Do other countries have the same
3 problems with underage drinking? I mean, is this worldwide
4 an issue?
5 CHAIRPERSON CURIE: I think it varies from nation
6 to nation. But I think it is something that is more
7 pervasive internationally. It depends really on the society
8 and the tolerance for alcohol and its use.
9 MS. HUFF: Okay.
10 MR. AIONA: We brought this up at the leadership
11 conference meeting last month about in Europe, I believe,
12 they have a lower drinking age of 18 in some countries.
13 They were supposed to be the model of alcohol and how it
14 affected our young people. It's been devastating. I think
15 the data will show that it's really a big problem in the
16 European countries in what it's led to. A lot of people
17 don't believe that it's a gateway to other drug use and
18 problems in the community. So I know there's a lot of data
19 out there. I don't know exactly where we can get that, but
20 I know there's a lot of data. We had a big discussion on
21 that.
22 If I can just kind of move -- you know, it was
23 after the last meeting in June -- last June meeting that we
24 had -- and there was a packet on terminology that was sent
25 out to the members. I guess I got one. What's the status

of that at this point?

CHAIRPERSON CURIE: Mark?

MR. WEBER: We started out with the treatment packet, and as we went around and people -- it became more where we need something similar for prevention, as well as mental illness, and there was actually a series -- I saw it last week -- a series that three guys were putting together -- that we're going to be using that. So it's getting close.

MR. AIONA: So it's being finalized?

MR. WEBER: Uh-huh. Absolutely. It's created -- it's another one of those things that's created a lot of internal conversation, too, about which word to use, and how to use it, and -- and so --

CHAIRPERSON CURIE: Be careful what we say about "behavioral health," Mark.

MR. WEBER: And the word "screening" doesn't exist. But anyway, so it's created quite a discussion, but it's still moving along.

MR. STARK: I would hope it comes back here as a draft before it goes out as a --

CHAIRPERSON CURIE: Absolutely. One comment I want to make about the behavioral health observation -- and I think Ken makes a very good point. I know it's pressed at time what you name a state authority. I think substance

1 abuse and mental health services administration, I think
2 that gives clarity in terms of what we're about. I know
3 that I've been personally resistant to any public entity
4 begin to be named "behavioral health" because the term
5 hasn't been well-defined at times.
6 MR. AIONA: I'm just saying that the terminology
7 discussion kind of plays onto what Ken just stated. I found
8 that to be very interesting. And I circulated it amongst
9 our providers. It did create a lot of discussion. So ...
10 CHAIRPERSON CURIE: Any other comments from
11 Council members?
12 (No responses.)
13 CHAIRPERSON CURIE: I also might mention, in the
14 report to Congress on underage drinking, you're going to --
15 that's going to be a multi-faceted approach, comprehensive,
16 the role the other federal agencies are playing, an
17 inventory of what's being done coordinating it, plus the
18 role of a national summit that we're looking to have in the
19 fall, and participation by the Secretary and the Surgeon
20 General, as well as there's serious consideration being
21 given of how the Surgeon General could have a call to action
22 with addressing underage drinking specifically. So I think
23 there's going to be a lot of opportunity to bring this
24 awareness to the forefront.
25 Diane, Theresa, is there anything you'd like to

share? Since you're not here, if you raise your hand, we can't see you.

UNIDENTIFIABLE FEMALE VOICE (Telephonically): You're not calling on us today?

CHAIRPERSON CURIE: We're asking you -- yeah, we're assuming maybe you raised your hand, so we want to ask you, is there anything you'd like to add?

(No responses.)

CHAIRPERSON CURIE: Okay. Let's now move into a discussion -- our next item is discussion on SAMHSA budget priorities. Do you recall -- this is something that has been discussed here at the Council. I know several members have indicated that they want to make sure that they have an opportunity for input. We want to elicit your input around our budget, as we're in the development, as we're looking at '07. And '06, now, of course you know, is being considered before Congress.

I think some things to think about -- I'm going to be turning this over to Daryl to facilitate it, since she is my key ELT lead on budgetary matters and developing the budget -- in examining what we are -- I guess I can put -- what -- what we're up against is a time in which there's a real contraction as we take a look at trying to move ahead, if you look at the '06 budget compared to '05, it's a rather pervasive perception right now, both within the Executive

Branch and the Legislative Branch, both are struggling with finding the dollars to fund all the needs that need to be funded and addressed. So much of what we're trying to do is prioritize -- how to leverage dollars better, where do we want to put dollars for priorities? And again, I would say the matrix has come in even handier during the more austere budget times than when the budget times were a little better.

That said, I think as we take a look at resources, we have an opportunity to reallocate resources as we examine what we have around priorities, leverage resources, and I don't think we should hesitate during budget development to also think about, if we are able to garner new dollars, where would we want to put our efforts to think about asking for new dollars in this type of environment?

So those are the types of, I think, elements we need to keep in mind as we think about input to the budget process. And I'd like to now turn it over to Daryl.

MS. KADE: Thank you. What I am going to do is briefly go over the President's budget, some of the principles that we used for '06, and then briefly review the House mark, and then hand it back to Charlie to go through a discussion in terms of future budget directions and some funding scenarios.

My material is in Section F. Toian, is this the

same section in their briefing books, Section F?

MS. VAUGHN: Yes.

MS. KADE: Great. And what I wanted to point out in Subsection 1 is the standard -- what we call the APT table, which is the all-purpose table. What you have here is a lining out of '05 enacted, the '06 President's budget, which has been on the Hill since February. We now have the House mark. The deltas, the changes that we look at, are changes relative to the President's budget, and also relative to our current enacted level.

I then wanted to take you to Subsection 2, which are budget accomplishments and a synopsis of the '06 President's budget, not organized by our APT table, which is by budget line, but organized by our matrix areas. In presenting the budget on the Hill, we have presented it in both ways, in the traditional budget line way, as well as the matrix way. Then I wanted to point out that we even have a table that we publish in our budget that presents the funding by matrix area.

I wanted to point out some of the principles we used for the '06 President's budget. I can answer questions about it, but it's been on the Hill for so long, I wanted to at least share the principles, because these are principles that we take with us as we go into an analysis of the House mark and the Senate mark, and then as we bring forward our

1 recommendations to the Secretary and OMB as we go forward
2 into '07.
3 Clearly what Charlie said is our guiding
4 principle, which is everything is referenced back to the
5 matrix. In addition, within the matrix, we grow our four
6 redwoods as much as possible -- major big redwoods. You can
7 see the focus in our '05 enacted level, and our '06
8 President's budget in terms of the increases overall in
9 terms of our overall level of funding, as well as
10 reallocations to ATR within CSAT and SBF within CSAP, the
11 mental health transformation grants within mental health,
12 and co-occurring, which is jointly funded by CSAT and CMHS.
13 We have a balancing act between the discretionary
14 grant programs, as well as the block grant programs. We
15 have consistently supported the block grant programs as
16 we've been growing the larger redwoods with new funds, as
17 well as reallocated funds. Then as you go through our
18 budget, within the discretionary grant portfolio, we have
19 two sets of programs. We have capacity expansion programs,
20 which focus on infrastructure development and services, and
21 we have best practices programs, which focus on the
22 identification and scaling up of best practices and service-
23 to-science, science-to-service activity.
24 You can see in the President's budget, especially
25 with a restricted amount of money, you can see the

maintenance of the block grant programs and a shifting between best practices and capacity expansion. Primarily the cuts that we see are in best practices, primarily the investments, either additional resources or reallocations or in-services. And we're constantly trying to balance that act. These are principles that we deal with all the time.

Another principle that we dealt with in the President's budget, regardless of the fiscal climate, we try to avoid cutting any continuations. To the extent that we need to stop programs, we wait for the natural expiration of the program to avoid problems in the field. That is our first priority, and we try and do everything we can to avoid those contingencies. We have to make very hard choices between grant programs and contract programs in order to make sure that our grant programs are not terminated before they are completed.

So these are the principles that we take with us as we not only develop a budget recommendation, but as we see it through as it goes through various phases on the Hill, as we develop impact statements, and as we prepare for the '07 budget.

I now wanted to take you to Subsection 3. Here is really the latest and greatest information that we have. It is on the House mark. Here I'm going to talk in a little bit more detail to give you the latest update. We obviously

1 don't have the Senate mark, but they will be working on it
2 when they get back from recess.
3 I'll point out the table above, which is a summary
4 of our House action. Although we have an overall cut of
5 37 million below the '05 enacted level, we have an increase
6 of 16 million above the President's budget. But the story
7 is very mixed as we go through all of our centers -- CMHS,
8 43 million above the President's budget; CSAP, 10 million
9 above the President's budget; CSAT, 37 million below the
10 President's budget.
11 What I wanted to do is go over the highlights of
12 each of the centers. For CMHS, again, it's 43 million above
13 the President's budget. As you can see through the
14 highlights, we have significant activity in the PRNS line.
15 The SIG grants have been funded as requested at $26 million.
16 School violence, a best practices program, has been
17 restored. The National Child Traumatic Stress Initiative
18 has come in as requested. The big question in CMHS, as
19 funds are restored, counting up those funds, and making sure
20 that we have enough funds to allocate among the various
21 directives, and seeing what else is left and the extent to
22 which we have flexibility.
23 And you'll look at the other line. CMHS has the
24 most budget lines. Everything else, the Mental Health Block
25 Grant, the Children's Mental Health Program, homeless and

1 PNA are basically straight-lined.
2 As we move to CSAT, again, 12.9 million below what
3 we currently have, and 37 million below what was requested.
4 Obviously, the big item here is Access to Recovery funded
5 at the same amount as last year, which means, again, as Mr.
6 Curie had mentioned, we're still working on an additional
7 $50 million with the Senate. We'll see what happens there.
8 Screening, Brief Intervention, Referral and
9 Treatment, we got what we had requested.
10 In the PRNS portfolio for CSAT, I think the big
11 question is, as we go through internally our analysis of the
12 House mark is, what sort of flexibility do we have to grow
13 the ATR budget with the amount of funds and the direction we
14 have from the House? And I think a lot of it will depend
15 upon what we get from the Senate in terms of dollars, as
16 well as direction, direction to do things, and directions
17 not to do things.
18 Finally, CSAP has a decrease below the '05 level,
19 but significantly, a $10 million increase above the '06
20 level. Here you have sort of the opposite situation of
21 CSAT. Here, with the increase for $10 million, the question
22 is, how will those funds be used? -- since, unlike the CMHS
23 situation, you don't have a description or particular
24 directives, how to best use those funds consistent with the
25 administration, consistent with the support on the Hill, and

consistent with our own priorities within the matrix. Here, especially in CSAP, you have that interesting balance between best practices and capacity expansion. How do we develop the correct balance for us?

The reason why I'm going through this is not only to give you a highlight of the House action, but the very same logic model that we would use to do the internal analysis of the House action and to look at the Senate action would be the very same framework that we would use as we approach the '07 budget, and how to apply those principles in various funding scenarios.

Yes?

MR. STARK: Daryl, what's the -- on the very bottom of that page in 3, on the very bottom of the chart up above, where it says, "Less public health service eval. funds," where does that money go?

MS. KADE: The PHS evaluation funds, the Department has the authority to tap various programs for PHS evaluation activities. Most of our budget is tapped but for the block grants -- all of the NIH budget, a lot of the optives. Then those funds are programmed. We receive a lot of the PHS evaluation funds as an offset to fund the set-aside portion of both block grants. Plus we get additional funds that are directed to our program management line. In the past, about two million was used to help finance a new

1 data activity for CMHS. But also in the past, and
2 continuing, is a certain amount of money used to offset the
3 household survey.
4 So the PHS evaluation funds is like a tap against
5 HHS. Once the funds are appropriated to the various
6 optives, they are then tapped and redirected. Most of them
7 are redirected by Congress. And so you can see that in our
8 report language.
9 MR. STARK: We call that a "whine list" in
10 Washington State -- a w-h-i-n-e --
11 MS. KADE: Yes, yes. That certainly plays into
12 the dynamics -- dynamics not only for the Hill, but also
13 especially when we're dealing with very restricted budget
14 scenarios, look in all sources of funding, and not just
15 direct approps, but reallocations and taps becomes an
16 interesting dynamic.
17 CHAIRPERSON CURIE: Do you have -- first of all,
18 any questions? Ken led off with some questions. Again, I
19 want to stress that what we try to do in looking at the '07
20 budget, and before we get explicit direction from the HHS
21 Budget Office, we try to think in terms of how we are going
22 to approach our budget if we're given direction that there's
23 going to be reduction of a certain amount. How are we going
24 to approach it if it's a level budget? And how do we
25 approach it if we get an opportunity to have a little bit of

an increase? We never think of a lot of increase, because we just -- we may try to make the case, but again, we try to go in with the best case possible to prioritize to show we've done our homework, to really be as responsible as possible, but yet still communicate clearly our commitment to the overall vision and overall priorities.

So keeping those three things in mind, as you take a look at some -- the -- the priority areas, as you take a look overall, and also just as Council members, as you bring to this table your thoughts about what's important, your thoughts as you look at this, and lay out some things you want to make sure we're considering in that budget process, I welcome that.

Also, I want to say that, while this discussion today is going to be rather short compared to the assignment of input, after today's meeting, we want to encourage you as Council members to bring forth your thoughts back. Today is primarily to have this initial discussion around budget.

I almost might mention, as guidance in terms of what Daryl's used, we have made -- tried to make very careful choices. And when we do look at reductions, or we're told that we need to reduce, as we look at this, we look at areas where grants are coming to a natural conclusion so that we're not cutting grants in midstream. And so those entities that know their grants are concluding

would not be depending on or expecting any other dollars. We try to mitigate it as much as we can as we move ahead.

At the same time, I think we need to be thinking of new and clearer ways to help grantees with sustainability if we begin to see that a grant's doing very well. That's where our partnerships with Medicaid can be real critical. Our partnerships with the states can be real critical -- criminal justice, other type of entities, as well. So we're always looking as to -- and we're really trying to encourage grantees from the first day they're awarded a grant to begin thinking about how they will sustain the effort -- if it's a successful effort, how they will sustain it after the three or five-year cycle ends.

So with some of those thoughts in mind, Barbara?

MS. HUFF: Of course, I immediately go first to children and families, and then I look at the rest.

CHAIRPERSON CURIE: I would expect nothing less from you.

MS. HUFF: Kathryn's going to do something here shortly for us around Red Lake, and yet I look at this School Violence Prevention reduction of 27.4 million, no new grants or contracts. I guess I struggle with that, because is it like are we thinking we don't have that problem anymore? I mean, do we just -- you know, we have a crisis, and we start funding things, and then, oh, we got a natural

end to Partnerships for Youth Transition, and it's not really my favorite program, so I'm not going to sit here -- I'm not going to probably advocate for that with you right now -- but, however -- it's not -- they don't do any family involvement at all -- but anyway, I think that, you know, it seems to me like I just would like to know how you make a decision like that and use balance.

CHAIRPERSON CURIE: I think it's an excellent question. I really would like to answer that. Because the disadvantage -- I mean, there's an advantage of listing these by matrix priorities. But the disadvantage is, when you have something like that, on the surface it looks like, are we backing away from our commitment to children and families?

MS. HUFF: Right.

CHAIRPERSON CURIE: That's primarily in the Safe Schools/Healthy Student area. It's not in kind of the traditional systems of care or other areas.

MS. HUFF: Right.

CHAIRPERSON CURIE: What we're looking at, a couple things go into that decision. One, as of yet, we don't have data that tells us how effective those dollars are going to be. So when you don't have the data in this environment, and you have the tough decisions to make, you begin to take a look at, what can we defend with data? And

1 those programs that have a strong parts score based on the
2 OMB evaluation process, or we have great outcome data that
3 tells us, here's what we're achieving, puts us in a stronger
4 position to advocate.
5 Safe Schools/Healthy Students, those dollars are
6 used in a variety of ways.
7 MS. HUFF: They are, yeah.
8 CHAIRPERSON CURIE: They're out there with school
9 systems. They're used in different ways. We're trying to
10 determine, what are the effective models that are bringing
11 about a true reduction in school violence? And we're going
12 to have, hopefully, our first round of data this fall. And
13 so as I shared with our subcommittee -- appropriations
14 committee -- is if we see that the data is pointing us to
15 programs that are really working, that puts us in a position
16 to take a look at '07 and future budgets for restoration or
17 for some further growth.
18 Also, as we look -- and we'll be talking more
19 about Red Lake -- we also need to sort out, where can the
20 dollars be best used? For example, when you look at the Red
21 Lake tragedy, how much of that is a general school violence
22 issue? How much of that is because of the challenges facing
23 Indian country? And there can be some differentiation with
24 that.
25 So, clearly, Barbara, you're right. We need to

keep this as a priority. We need to keep looking at it. But that's what's behind some of these decisions. It's not saying these aren't important areas. It's saying, in the context of this budget, what do we want to focus on?

One other point I'd make, too, is the danger with the matrix area and having a matrix out there is you want to see increases every year. And I'm pleased to say, the first term, we were seeing increases every year in our matrix areas overall. And again, the budgets were easier budgets during that period of time. We always should be keeping in mind that we're going to see increases some years in the matrix areas, and decreases in the matrix areas as we move along -- just the nature of the budget. But as long as we state it as a matrix area, we're keeping it out there as a priority so we don't forget it, and we keep accountability around all of us. Just as our discussion now is keeping the accountability around children and family. So I appreciate your efforts.

MS. HUFF: Thank you.

MS. POWER: Charlie, I'll just add that I know the concern has certainly prompted us to begin to take a look across the SPF initiative with substance abuse prevention and connecting the community efforts in substance abuse prevention with the educational departments and the school systems so that we can build the bridges. Even if some of

1 those grants don't continue, we will build those bridges
2 with some of the Safe Schools/Healthy Students initiatives
3 that can be tied into the SPF, and that we can tie into some
4 of the mental health transformation. So we're working very
5 hard to make sure that that goes on.
6 CHAIRPERSON CURIE: Wes.
7 MR. CLARK: Yeah. A good example of this
8 experience is I was just presenting on methamphetamine in
9 Tucson, Arizona. As part of my presentation, I was
10 reviewing SAMHSA's portfolio going into Arizona. I polled
11 the audience, and most of them didn't know that Arizona had
12 an SPF SIG, didn't know about the mental health grants,
13 didn't know about the community coalitions. They had about
14 four or five community coalitions.
15 So I realized that (speaking unintelligibly fast)
16 been getting together CSAP and CSAT among staff to have a
17 state grant round where everybody discusses what is going on
18 in the states from the block grant level to the specific
19 discretionary programs. And it's clear that at the SAMHSA
20 level, this kind of effort in terms of communicating with
21 project officers about what's going on in jurisdictions
22 helps the message get out to the states about what's going
23 on in jurisdictions getting multiple grants that are not
24 leveraged because things are fragmented. I think our effort
25 is to make sure that we coordinate things based on the

matrix will allow us to use both the block grant and the discretionary portfolio, involving the single state authorities both in the substance abuse (speaking unintelligibly fast) authorities so the money is well-spent.

CHAIRPERSON CURIE: These are moments that excite me greatly, because I'm hearing from two key leaders, from Kathryn and Wes, how their operationalizing matrix management and leveraging of resources and thinking in new ways. The SPF connect between CMHS and CSAP is, again, profound in terms of, how do we leverage the resources? I think it also points out the challenge of using our matrix, too. We've had discussions -- what -- what -- we're -- if you -- if you add up the matrix totals, it adds up to our budget. It's an unduplicated count. But in essence, there are things in the mental health transformation, for example, that really relate to children and families that aren't reflected in that line. SPF -- a lot of things we're doing in SPF, that's children and family and mental health-oriented, that's reflected in the SPF line, but not in the children and families line.

So we've talked about how we can really get a full reflection of that. So that's the other thing is leveraging is critical and important. Collaboration is critical and important. A systemic approach is critical and important. And yet the matrix would keep it an unduplicated count of

1 dollars, if you will, in terms of how it's reflected.
2 So --
3 MS. HUFF: Can I just say one more thing?
4 CHAIRPERSON CURIE: Yes, Barbara.
5 MS. HUFF: There's kind of more than one way to
6 skin a cat, so to speak. I'd be all right about eliminating
7 this, because I'm not -- or not new grants. I'm not always
8 thrilled with how people spend their money out in the field.
9 And I'm not sure that I like the idea of just spending it
10 on someplace that's spending that money on security. Okay?
11 But this is what I do know. We know a whole lot
12 now about bullying. The stuff you sent out in the mail,
13 Toian, about bullying, I gave that to my daughter, who runs
14 a preschool program, and she's started a curriculum with
15 three-year-olds on bullying. Okay. Now, we could do
16 something with that bullying stuff that you've got that I
17 think is really good stuff.
18 MS. POWER: It is. It's wonderful.
19 MS. HUFF: It relates right back to violence
20 prevention, in my opinion, --
21 MS. POWER: Right.
22 MS. HUFF: -- because of everything we know about
23 all these shootings and stuff around bullying. Now, so
24 maybe we could think differently about the use of some of
25 those dollars, but not give up on the notion -- I don't know

what that says about us if we're not interested in school violence prevention. But we know there's a lot of good stuff out there. I'm not sure it's getting all to the right people all the time and stuff. But I was wondering if we could just look at a different way of dealing with school violence prevention. I mean, if we could just say to ourselves, this is really important, you know, and --

MS. POWER: Barbara, it's key, and we do care about it. We're thinking about ways that we can take particularly the bullying program and replicate it even further, even beyond the life of it, and working with Mark's shop and making sure that we get those materials replicated, and think out a distribution and dissemination plan even beyond the life of that.

MS. HUFF: Yeah. Okay. Okay.

CHAIRPERSON CURIE: Kathleen.

MS. SULLIVAN: On the subject of bullying, if we're going to --

MS. HUFF: I'm sorry. I didn't mean to get us off --

MS. SULLIVAN: I'm sorry. I think I've made myself clear in the last agenda. I mean, I see this as a Department of Education problem, as something in the teaching area. But I don't understand how it links into mental health and substance abuse, et cetera. I mean, I see

this as something that is a local teaching -- something that's within school districts and school superintendents. I don't see the link here to mental health/substance abuse. It is a fabulous, it is an important issue -- no question. I don't see it within the realm of our purview.

Our resources are very thin. It's an important issue, but I can't see where -- if -- if we take our resources and go into this, I think we're getting out of our purview.

From the teachers that I've talked to, this is something -- this bullying issue is something that's very local. It's wonderful to have these pamphlets, et cetera, but maybe this is something that should be distributed by the Department of Education. When we have a chance, I want to continue on something.

MS. POWER: Well, and I think we do have a partnership with the Departments of Education. We think it is a local effort that has to happen. We've simply been able to provide, I think, appropriate materials, Kathleen, in terms of being able to give this program and replicate it and disseminate it out so that it's a tool. And I think it is appropriate, because we've found that the mental health status of children, and their readiness to learn, and their readiness to be in an educational environment is affected by their emotional state. And obviously their emotional state

is dramatically affected by the presence of bullying.

We actually got requests for information about, how do we address that? And that's how we developed the program. Once the program is developed, though, those resources get out to the local practitioners, to the schools, to the teachers, to the parents, and it just gives them the tools to take ownership of it themselves. So we believe that the ownership should be at that local level.

CHAIRPERSON CURIE: Beverly, go ahead.

MS. WATTS DAVIS: I'll make mine very quick.

One of the things that I wanted to emphasize about the Strategic Prevention Framework, that it happens at both the state and local level, Florida is the best example of when it works, and when it works right, how effective it can be. And then we don't have the discussion of, is school violence a mental health or not a ment- -- because what that does is it really is about looking at what's happening across your risk and protective factors in a community. And what you're going to find is there's going to be crossover. And when you begin to focus and target on addressing those risk and protective factors, you will address all of those issues.

What's very key about the framework is that it is about doing what Wes has talked about, where you've got the state looking at all of their funds, and instead of defining

1 themselves by their grant source, they begin to look at the
2 risk factors, and take all those fundings, and begin to fund
3 it toward their problems. That is the new way of doing
4 things, and we will find the leveraging that we need across
5 the board.
6 CHAIRPERSON CURIE: Tom.
7 MR. KIRK: New person on the block. Let me ask a
8 question. I don't know whether this is in accord with the
9 Council's activities or not. But when you go before
10 Congress, Charlie, what seems to resonate with them? What
11 is it they sort of focus upon? That, and secondly, this
12 group as a Council, how can we be supportive or more helpful
13 to you as you go -- the co-chair of the Appropriations
14 Committee in Connecticut, I mean, you get up before him, and
15 he says, can you tell me, Commissioner, is the situation the
16 same, better or worse? He doesn't want a five-hour
17 conversation about this piece. When you go before them,
18 what are the things that seem to stand out the most, so that
19 we in our role can somehow be supportive of moving the
20 agenda that we're talking about?
21 CHAIRPERSON CURIE: That's a great question. I
22 think one general answer I'll give to that is it's
23 interesting that if you take a look at the members of the
24 subcommittee, there's a level where each one has their own
25 issue, depending on their passion. For example, Congressman

1 Kennedy is passionate about mental health, mental illness,
2 co-occurring disorder, children and youth and older adults,
3 and hones in right on those matrix areas that he has a real
4 interest in. You can pretty well, each one of those
5 individuals, predict -- Congresswoman Ro (ph) Ballard is
6 very much focused on underage drinking, and is really a
7 leader in that area and arena. So one level is knowing what
8 each one's priorities are.
9 I think a general type of thing that works -- and
10 Chairman Regula (ph) is very much focused on outcome, and
11 Chairman Regula would ask not only is it good, better or the
12 same; he would say, how is it impacting my folks locally
13 back in my district? And that is kind of a common theme you
14 hear from all of them. I would say it goes back to -- one
15 common thread, again, would be the outcome focus. That's
16 why the real focus on being able to tell them in a succinct
17 sort of way, we're making progress in kids succeeding in
18 school, you know, who have serious emotional disturbance.
19 We're making progress in that there are less kids getting
20 involved in the juvenile justice system. More adults who
21 come out of prison, the recidivism rate's going down as more
22 people are entering substance abuse treatment -- and we
23 could show that link, and if we begin to paint that picture,
24 that will go a long way. So I would say helping educate and
25 support the notion of the outcome area would be real

critical.

Then any time they can understand how our dollars are being used locally -- what impact is it really making locally in their area? And that picture -- and each of you come from a Congressional district, and each of you have colleagues from different districts -- that's a powerful message for them to see.

One way you can help, as well -- I think it helped tremendously when some of us went to Ohio, where Chairman Regula and First Lady Hope Taft did a Reach Out Now right in his home district. We all did that. If the members of this Council would look at Reach Out Now and some other activities, and engage local members of Congress to heighten the awareness, and they can actually see the dollars in action, that would be extremely helpful.

So, now, clearly there's ethical issues in the sense that Council members cannot lobby Congress. But certainly in terms of heightening awareness of what's happening in the district, you can, you know, in terms of educating or in participating in a Reach Out Now program. And we can give guidance on that, as well.

I think each of you come with a different role. Again, working with your associations -- NASHBUD, NASIDAT, providers associations, the First Spouses Initiatives -- all of that, the groups you represent, can be extremely helpful.

MS. SULLIVAN: Toian, I'll make it quick. I think we're over. Just a couple things. Senator Grant, the special funding, does that come out of SAMHSA?

CHAIRPERSON CURIE: Which one?

MS. SULLIVAN: Senator grant's funding, the suicide funding.

MS. POWER: Senator Smith.

MS. SULLIVAN: Oh, Senator Smith. I'm sorry. Senator Smith -- grant funding.

CHAIRPERSON CURIE: That's primarily in SAMHSA, yes.

MS. SULLIVAN: It is SAMHSA?

CHAIRPERSON CURIE: CMHS.

MS. SULLIVAN: And is that given a special designation?

MS. POWER: It's called the Garrett Lee Smith Act, Kathleen.

MS. SULLIVAN: And is that always funded -- I mean, do the senators and do the House people always know that that's kind of separate and designated as such?

MS. POWER: It is designated in the law. There are two sets of grants, one to the states, and one to colleges and universities. It has been appropriated in the law this year. So we will be enacting that. The grant solicitations went out --

MS. SULLIVAN: Is it always said that way, you know, so the senators and House members always know that it's designated that way within the budget?

MS. KADE: I think you're talking about report language.

MS. SULLIVAN: Yeah, report language. So they always know --

MS. POWER: It is.

MS. KADE: Yes.

MS. SULLIVAN: All right. So it's kind of -- all right.

MS. KADE: And then also in our budget we line it out in a table, and then we identify how much is --

MS. SULLIVAN: Right. Right, right. I was just -- you know, it says one million for the Rapid Testing Initiative. One million?

MS. WATTS DAVIS: That's in addition to what we've already been doing.

MR. CLARK: And that doesn't actually -- you're right, it doesn't include new money for that, so it has to come out of our existing --

MS. SULLIVAN: So what are we spending in total on the Rapid Testing Initiative?

MR. CLARK: What are we spending total on rapid testing?

MR. CLARK: We got 4.8 million before for the first year, and we're in the process of that. What this would do is require an allocation of one million.

CHAIRPERSON CURIE: Yeah. Go ahead.

MS. KADE: There are two sources of funding. We can use direct appropriation, which, this time, we're going to -- at least according to the House, we've been told to use some of our direct appropriation. But the initiative started through the emergency appropriation to DHHS, and we requested and received from them the funding and the authority to go ahead and start the program.

CHAIRPERSON CURIE: So it was departmental money not originally in our budget that was then transferred to SAMHSA to use for that.

Now, another point on HIV test- -- this is a good budget point -- is while we believe strongly in it, and we're putting up some of our own resources, and we've made a commitment, as early testing -- as rapid testing takes off -- and we're going to be following the data in terms of what we're discovering -- over time, this could easily become more of either a CDC overall department initiative --

MS. SULLIVAN: HERSA (ph).

CHAIRPERSON CURIE: -- and HERSA, as well.

MS. SULLIVAN: Don't they have money for this?

MR. CLARK: Well, we actually -- we're in the

1 process of pulling together the states. There's a set-side
2 requirement under the block grant for some 25 jurisdictions,
3 and they're supposed to do early identification and outreach
4 kind of activities. That amounts to about $58 million. So
5 we've been promoting to the states -- I introduced this
6 notion when I got to the NASIDAT meeting -- that we're
7 encouraging states to use some of their set-aside money for
8 the purchase of tests. Because basically what the CDC's
9 done is changed the whole paradigm for outreach. In the
10 past, outreach had a different kind of character because, of
11 course, there wasn't a whole lot you can do. You lost
12 roughly 30 percent of your people with the two-week testing
13 process. Now with the rapid testing, the states do have the
14 authority to spend some of that money, instead of investing
15 in traditional outreach activity where you lost 30 percent
16 of the people, you can use some of that money to purchase
17 tests, and you've got your people right then and there. I'm
18 fond of saying a cup of coffee and a donut and 30 minutes,
19 and I can tell you whether you're HIV-positive or not.
20 That, I think, is something we also have to think about.
21 But that needs partnering with the states, and we intend to
22 do that.
23 MS. SULLIVAN: I just find it shocking that this
24 is all in our corner, I mean, that this is not something
25 that CDC is embracing, but with us.

CHAIRPERSON CURIE: What I would say is we provided leadership in this area.

MS. SULLIVAN: Yeah.

CHAIRPERSON CURIE: We do have a high-risk population. It fit well with Secretary Thompson's overall initiative, which included all the operating divisions. This is what we contributed and opened up and --

MS. SULLIVAN: But as a budgetary item, the fact that SAMHSA's carrying this on its back -- and I don't see anything from the CDC --

MR. CLARK: No, no. CDC's got an active portfolio, and HERSA's got an active portfolio. We're working very closely with CDC on this. We're working with the Department on this.

MS. SULLIVAN: But any financial contributions on it?

MR. CLARK: Well, yeah. Everybody's spending --

CHAIRPERSON CURIE: Why don't we pull together a total of what all operating divisions are contributing --

MS. SULLIVAN: Right, for rapid testing. I'd like to see --

(Multiple simultaneous speakers; indiscernible.)

CHAIRPERSON CURIE: -- because everyone is very engaged in this process. Again, rapid HIV testing has been a newer aspect of this. I think clearly it's going to be

1 part of what all operating divisions are going to be doing.
2 MS. SULLIVAN: Yeah, because I'd like to see the
3 total money spent on rapid testing.
4 MR. CLARK: But again, I want to stress we're
5 spending -- we've got a set-aside on a block grant, and it's
6 $58 million, that's supposed to be spent on early
7 identification and outreach. So what we'll do is work with
8 the states so they can identify this. If we only spend ten
9 percent of that set-aside on this activity, which would
10 enhance their outreach activities and make it a lot more
11 performance-oriented, because, again, with the traditional
12 approach of the historical approach, you were not certain
13 what you were getting for your investment. But that was
14 what we had. Now we have tests, and now we can get
15 quantified results. So I think the states will see that
16 it's in their best interests also to use some of these
17 resources for that purpose.
18 CHAIRPERSON CURIE: I think we have time for one
19 or two more questions. Also, Theresa, Diane, do either of
20 you have any questions or comments?
21 UNIDENTIFIABLE FEMALE VOICE (Telephonically): Not
22 at this time, I don't, Charlie.
23 UNIDENTIFIABLE FEMALE VOICE (Telephonically): No.
24 It sounds straightforward. Thanks.
25 CHAIRPERSON CURIE: Okay. Any --

MS. SULLIVAN: Can I just ask one thing about Access to Recovery? Was the shortfall because they couldn't see an immediate outcome, and that's why the House didn't go for the increased funding is because there wasn't a -- you know, like you just said, that they couldn't have an outcome focus, and that's why they didn't go for the --

CHAIRPERSON CURIE: Well, of course, we made it clear that this is the first year operating ATR. So there was no -- they shouldn't have expected any outcome information. Though the reason you just gave has been an excuse used for that.

MS. DIETER: Why did they -- what was your sense of why they --

CHAIRPERSON CURIE: There's not enough money. There's all these needs, and --

MS. DIETER: So cut something, and because we --

CHAIRPERSON CURIE: -- and they had other priorities they wanted to fund in other areas of the budget. And so that's kind of how it goes in terms of the process. The key for us was we did -- we put a lot of effort into educating and impressing --

MS. SULLIVAN: When will you have a quantitative outcome?

CHAIRPERSON CURIE: Well, the Senate has to come up with their -- come out with their markup.

MS. SULLIVAN: No, I meant of ATR.

CHAIRPERSON CURIE: Oh, when we'll have the outcome measures. Wes, what are we looking for in terms of the initial outcome measures coming out of ATR? I think we're looking -- well, we're starting to get some already. But in terms of anything that would be reportable, I think we're looking toward the middle of the summer.

MS. SULLIVAN: So by 2007's budget.

CHAIRPERSON CURIE: Oh, yeah, we'll definitely have outcome information then. Yeah.

Tom, we have an answer to your question. Plans have submitted formularies already, and these are being analyzed. Once formularies are approved, plans submit cost bids, contracts signed by September 15th, plans begin outreach October 1st.

MR. KIRK: And then one of the critical questions in our state is what medications are going to be covered by the plans? Therefore, in these situations, if I'm on drug-X, medication-X, and X is not on the plan, what am I going to be moved to? Those are the critical pieces for us.

CHAIRPERSON CURIE: Understood.

Any other questions on the budget? One more. Again, I would encourage everybody on the Council, any further questions or thoughts, in light of this discussion, the information you've received, don't hesitate to get

feedback to us as we shape this budget.

Now I believe we're ready for a little bit of a break. Have we heard anything about picking up menus? Toian, housekeeping?

MS. VAUGHN: Okay. One small housekeeping matter. On your -- in front of you is a menu. I'd ask that you make your selections, put your name on it and your room number. We're going to collect them during the break. You'll be dining in the bar area. Once you go over there, you will place your order again. But this will give the catering people an opportunity to know what your selections are, in that the other meetings -- there are about 108 other people that will be converging on the cafeteria around the same time. So this will expedite the meal process. So if you have not completed your form, would you kindly do so, and then turn it in to me to Sandy Stevens or Geri Anderson.

CHAIRPERSON CURIE: So let's take a ten-minute break, and we'll reconvene with Kathryn leading off.

(Recess from 11:17 a.m., until 11:44 a.m.)

CHAIRPERSON CURIE: I'll introduce the Director for our Center for Mental Health Services, Kathryn Power, who will be talking about our response to the Red Lake shootings and suicide, and the efforts of CMHS and SAMHSA in that process.

Kathryn.

1 MS. POWER: Thank you very much, Charlie, and good
2 afternoon again to everyone. Or good morning still to
3 everyone.
4 I know Charlie's mentioned on several occasions
5 this morning that transformation is alive and well. I do
6 want to reiterate that I appreciate the support and the
7 attention that this Council has paid to transformation and
8 transformation issues. In many ways, I'm sorry that I'm not
9 going to just talk about transformation today. But I was
10 really heartened when Kathleen talked about the Voice
11 Awards. It's wonderful when I can hear my own agenda coming
12 from some of the Council members. We had a lot of great
13 staff work on the Voice Awards -- Paolo Delvechio from my
14 office and several people -- and we look forward to coming
15 back to California for those awards. But it's really
16 wonderful that -- and Tom, as well, speaking about
17 transformation, and many of you speaking about it.
18 So I feel like the agenda is yours, and I don't
19 need to spend a lot of time today talking about I think what
20 are the great successes of where we're heading in
21 transformation. But I was asked specifically to talk today
22 about SAMHSA's response to the issues of suicide in Indian
23 country. And so I'm going to take a few minutes to do that
24 today.
25 There's really two major issues I want to raise

1 with all of you and leave with you. The first and most
2 important is that SAMHSA is aware of the very great -- and I
3 repeat -- the very great need to improve mental health care
4 and substance abuse care for American Indians. I mean, we
5 are -- truly, truly, our awareness has been building over
6 time, and we are very emphatic about being clear about that
7 great need.
8 Last March, 16-year-old Jeff Weiss killed nine
9 people before taking his own life. His tragedy and the
10 tragedy of the Red Lake Chippewa community is a reflection
11 of the larger need to improve the mental health and well-
12 being of American Indians nationwide. Suicide is a tragic
13 indicator of the mental health crises among American
14 Indians. It is the second leading cause of death among
15 American Indian youth aged 15 through 24. The suicide rate
16 among this population is 250 times higher than the national
17 average. The problem is more acute in the Upper Midwest,
18 which is the location of the Red Lake and Standing Rock
19 Reservations, and home to the Chippewa and Lakota/Dakota
20 Tribes. American Indian teens in this particular area are
21 ten times more likely to commit suicide.
22 One of the greatest dangers to teens is cluster
23 suicide, or suicide contagion, in which the death of one
24 person leads others to take their own lives. According to
25 Senator Dorrigan of North Dakota, 288 Indian teenagers

1 living on the Standing Rock Reservation attempted suicide
2 last year. Ten teens died. Since the March 21st shooting
3 at Red Lake, two more teenagers at Standing Rock Reservation
4 have taken their lives, while several more have attempted
5 suicide.
6 Two young adults at the Fort Hall Reservation in
7 Portland, Oregon recently committed suicide.
8 SAMHSA immediately responded to the Red Lake
9 Reservation shootings to help prevent additional suicides
10 and to support a community in crisis. SAMHSA's response to
11 Red Lake was part of a multi-government show of support that
12 drew together federal and state and local agencies, as well
13 as the State of Minnesota and the Chippewa Tribe. SAMHSA
14 promptly provided staffing and resources to the Red Lake
15 Community. Within a week, our staff members were on-site at
16 the reservation, staff members from both CSAT and CMHS.
17 They stayed there for the next month.
18 Together with the Indian Health Service, as well
19 as other U.S. Department of Health and Human Service
20 agencies, we coordinated a federal response to this tragedy.
21 As other federal agencies arrived to lend aid, this core
22 group was prepared to guide their efforts to where the needs
23 were greatest. These agencies included the Public Health
24 Service Commission Corps, the Administration for Children
25 and Families, and its Administration for American Indians,

1 and the Office of Minority Health.
2 Initially, core federal group members referred to
3 their working quarters as the "crisis room." They later
4 changed the name to the "care room." This change is
5 symbolic of the help that we offered, and continue to offer
6 to the tribe. Our initial response addressed the intense
7 trauma and grief that immediately follows a crisis of this
8 dimension. Red Lake is a small and isolated community, so
9 everyone in the community was affected. Everyone was at
10 risk of mental health issues, including the Indian Health
11 Service hospital workers who cared for injured children.
12 Our subsequent efforts are designed now to help
13 the tribe facilitate the lengthy healing process, and help
14 to prevent long-term trauma among community members.
15 Before we arrived at the Red Lake Reservation, we
16 had identified SAMHSA grants for which the tribe could
17 apply. Once we were there, we provided technical assistance
18 to help the tribe access emergency funds. We advised the
19 tribal government on how to apply for a SAMHSA emergency
20 response grant, or a SERG. We facilitated efforts by the
21 state government to hire a specialized grant writer. We
22 quickly awarded the tribe, as Charlie mentioned, an
23 immediate SERG grant of $73,000. This particular grant is
24 funding three direct service providers and one support staff
25 member. Counseling and behavioral health outreach is

1 available to the community at large.
2 The tribe is incorporating traditional outreach
3 methods in their approach to draw upon the healing powers
4 and strengths of their cultural heritage. Our child trauma
5 program assisted in setting up the counseling services.
6 Also, as Charlie mentioned, we're now reviewing the tribe's
7 application for an intermediate SERG grant which can support
8 services for up to one year.
9 In addition, our Disaster Technical Assistance
10 Center is working with the Standing Rock community on its
11 own SERG application. In the three years that the SERG
12 program has existed, SAMHSA has given about one third of
13 those grants to American Indian communities.
14 The first point I made was that we are deeply,
15 deeply concerned, and we are tremendously aware of the
16 mental health needs of Indian country. The second point I
17 want to make and emphasize is that SAMHSA views its response
18 to the mental health needs of American Indians as very long-
19 term and as very broad-based. Jeff Weiss acted out of
20 hopelessness and desperation. He had lost both parents
21 within four years. His father committed suicide, and his
22 mother in a crippling car accident. His future prospects
23 were dismal.
24 Nearly 40 percent of Red Lake Reservation citizens
25 live below the poverty line. A third of its teenagers are

not in school, they are not working, and they are not looking for work. An internet quote attributed to Jeff exposes enormous mental anguish. In his own words, he said, "The kind of pain that makes you physically sick at times makes you so depressed you can't function, makes you so sad and overwhelmed with grief." According to a state survey of public school students, 43 percent of boys and 82 percent of girls at Red Lake have thought about killing themselves.

SAMHSA takes seriously the mental health challenges that confront American Indians. American Indian communities have extremely high levels of unemployment and multi-generational poverty. These environmental factors contribute to depression and to violence, and can lead to substance abuse. For American Indians, as well as Alaskan Natives, depression and substance abuse are the common risk factors for completed suicides.

Improving mental health services for American Indians presents several challenges. A major challenge is that we simply do not know enough about the differing cultures among tribes. Some tribal communities do not speak of death or suicide at all. We had two women from the Standing Rock Reservation come into CMHS the other day and speak to us, and said, you have to understand that in our culture, when we speak it, we believe that it will happen. Therefore, we can't speak it.

1 We must design prevention and treatment programs
2 that respect cultural and spiritual beliefs and affirm the
3 unique strengths of individual tribes. This is how we can
4 make programs more effective, by making them more consumer-
5 focused on the cultures that need it.
6 Other challenges to improving mental health
7 services for American Indians include, of course, geographic
8 isolation, major transportation barriers, and a very few
9 service providers. Nationally there are only 150 American
10 Indian psychologists to serve a population for whom cultural
11 sensitivity and understanding are crucial to appropriate
12 care.
13 What are the consequences of being under-served?
14 More than one half of all American Indians who commit
15 suicide have never been seen by a mental health
16 professional. SAMHSA is proactively addressing these
17 challenges from multiple directions. Right now we're
18 working hard within the constructs of programs primarily
19 designed by and for non-native persons. But we are working
20 even harder to increase our understanding of native
21 cultures, and to increase our level of response consistent
22 with what we are learning.
23 SAMHSA has signed a contract with One Sky Center
24 to develop a database of culturally appropriate prevention
25 programs. In addition, we are part of a federal steering

1 committee led by the Indian Health Service, and with
2 leadership provided by the Surgeon General's Office. We sit
3 as a regular part of that steering committee. This
4 committee is developing a national suicide prevention
5 initiative for American Indians. Supporting this initiative
6 is a new database system that will provide more and better
7 information about suicide in native communities.
8 Prevention is especially, especially critical for
9 American Indian communities in which cluster suicides are
10 common. Two weeks ago, the Senate Subcommittee on Indian
11 Affairs held a special hearing about suicides among American
12 Indians. Twyla Rough Surface, a member of the Standing Rock
13 Sioux described a series of suicides triggered by the
14 accidental death of her young nephew. The day of the boy's
15 funeral, one of his friends who had acted as a pallbearer
16 committed suicide. The boy's best friend committed suicide
17 two months later. The boy's sister committed suicide. The
18 boy's mother attempted suicide. Following her attempt, the
19 mother confided that her pain was so great she thought that
20 only death could end it. No one involved ever spoke to a
21 mental health professional or had grief counseling.
22 To prevent tragedies similar to those at the Red
23 Lake and Standing Rock Reservations, SAMHSA is targeting new
24 and ongoing suicide prevention efforts to American Indians.
25 We've issued an emergency request for a proposal to provide

1 prevention technical assistance, planning, training and
2 services in some of the most at-risk American Indian
3 communities. We expect to award the contract to an American
4 Indian-owned company with significant experience in this
5 area.
6 In addition, when SAMHSA posted the request for
7 applications for funding under the Garrett Lee Smith
8 Memorial Act for Suicide Prevention Efforts, we actively
9 promoted applications from tribal organizations. We hosted
10 a conference call to provide an overview of the programs and
11 to answer questions that a tribe might have, and to offer
12 useful resources for developing an application. The Indian
13 Health Service was a very helpful collaborator in helping us
14 advertise this conference call. Just last week we hosted
15 free teleconference training in how to decrease the stigma
16 associated with mental illnesses among American Indian and
17 Alaska Native communities.
18 Suicide is preventable. We can do a great deal to
19 reduce suicide among American Indians if individuals at risk
20 receive treatment and intervention. As with any mental
21 illness, early identification and intervention is key.
22 In January, SAMHSA launched the National Suicide
23 Prevention Lifeline at 1-800-273-TALK. The lifeline is part
24 of the National Suicide Prevention Initiative. This
25 collaborative effort led by SAMHSA incorporates the best

1 practices and research findings in suicide prevention and
2 intervention. Along with the National Lifeline, a new
3 website is being launched at www.suicidepreventionlifeline.
4 org.
5 Part of our immediate response at Red Lake was to
6 ensure that members of the tribe and the larger community
7 would be aware of lifeline services. We made available for
8 distribution more than 2,000 magnets that promote the toll-
9 free number. I brought some of those today for you. In
10 addition, we provided more than 2,000 wallet cards that
11 describe the warning signs of suicide. Lifeline services
12 also offer guidance and support to friends and family
13 members who believe someone they know may be at risk.
14 We currently are working to improve lifeline
15 services for American Indian communities. We're exploring
16 ways to ensure adequate coverage across geographic regions,
17 such as linking local crisis centers to the national
18 lifeline. We've identified a American Indian communities as
19 one of three target groups for a public education campaign
20 about the lifeline. We will provide local organizations
21 with information resources to publicize our suicide
22 prevention services, as well as crisis intervention services
23 that they provide.
24 SAMHSA is providing the Indian Health Service with
25 an additional $200,000 to address suicide cluster response

1 and suicide prevention among Native American Indians and
2 Alaska Natives. This funding will support programming and
3 services contracts, technical assistance, and other related
4 services.
5 One example is the development of a community
6 suicide prevention tool kit. This tool kit will include
7 information on suicide prevention, on education, on
8 screening, on intervention, and on community mobilization.
9 The Administrator's policy at SAMHSA is to level
10 the playing field by ensuring that tribal entities are
11 eligible for all competitive grants for which states are
12 eligible, unless there is a compelling reason to the
13 contrary. In total, SAMHSA provides about $42 million to
14 American Indians and Alaska Natives annually.
15 In 1999, Congress responded to school shootings at
16 the Columbine High School in Colorado and in other states by
17 launching a Safe Schools/Healthy Students Initiative. The
18 Departments of Education, Health and Human Services and
19 Justice collaboratively administer this program with SAMHSA
20 as the lead within HHS. Two tribal sites were funded in the
21 initial cohort of 54 grantees out of nearly 500
22 applications.
23 Comprehensive community mental health services for
24 children and their families grant program, of course, also
25 provides funding for direct services to improve systems of

1 care for children and adolescents with serious emotional
2 disturbance and their families. Seven tribal organizations
3 are among the current total of 63 grantees.
4 And, of course, we have Circles of Care, in which
5 SAMHSA collaborates with the Indian Health Service and the
6 National Institute of Mental Health in this grant program.
7 The Circles of Care Program supports the implementation of
8 mental health service models designed by American Indian and
9 Alaska Native tribal and urban Indian communities. These
10 models use a systems of care community-based approach to
11 mental health and other supportive services for children
12 with serious emotional disturbances and their families.
13 The substance abuse treatment targeted capacity
14 expansion, or TCE grant program, continues to expand
15 treatment opportunities and capacity in local communities
16 that are experiencing serious emerging drug problems.
17 Tribes and tribal organizations have received more than
18 $31 million through direct and indirect grant awards during
19 the past three years.
20 In addition, SAMHSA is working very hard to create
21 a national strategic work force development plan. We're
22 also initiating a project to examine behavioral health care
23 education and to advance efforts to integrate mental health
24 and primary care for racial and ethnic minorities, with
25 particular attention to Native American communities.

1 Suicide is robbing American Indian communities of
2 their most valuable resource, their children and their
3 future. Suicide is the final hopeless act by individuals
4 whose mental health needs have been unidentified, untreated,
5 or inadequately addressed. To eliminate the high rate of
6 suicide among American Indian teens, we first must address
7 the comprehensive mental health and substance abuse needs of
8 the American Indian community at large. We are in for the
9 long haul. We are in for a broad-based approach.
10 The activities I've just described fit within our
11 ongoing efforts, of course, to make sure that everyone in
12 America has access to appropriate services, and, of course,
13 that includes access to recovery and mental health trans-
14 formation. SAMHSA currently is engaged in a national effort
15 to create a mental health system that is consumer-driven and
16 that is focused on recovery. We are moving toward that goal
17 in part by working to improve cultural competency in
18 programs and in providers, and to eliminate disparities in
19 mental health care. These disparities are striking hardest
20 at racial and ethnic minorities and those living in
21 geographically under-served areas.
22 All Americans deserve equal access to the services
23 and supports that can protect and promote sound mental
24 health. Ensuring this access is the only way SAMHSA and our
25 nation can fulfill the vision of a life in the community for

everyone.

I want to end with an unknown Inyut quote:

"I think over again my small adventures, my fears, those small ones that seemed so big for all the vital things I had to get and reach. And yet there is only one great thing, the only thing to live, to see the great day that dawns and the light that fills the world."

Thank you very much.

CHAIRPERSON CURIE: Thank you, Kathryn.

(Applause.)

CHAIRPERSON CURIE: I think it was difficult to listen to the account that Kathryn shared and not be moved by and overwhelmed by the tragedy at Red Lake, but I think more overwhelmingly, the daily plight that Kathryn described facing the American Indian and Alaska Native population in this country.

I'd like to open it up now for comments or questions from Council members. Ken.

MR. STARK: Do you know, Kathryn, is there any data that tries to get at how come the suicide rate in the Midwest is so much higher than in other tribes?

MS. POWER: I don't know, and I'm probably going to turn to my colleague from the Indian Health Service who's here with us today. My understanding is that the poverty level and the isolation are two major factors, Ken, in terms

1 of the fact that they're -- the isolation particularly. I
2 mean, just think about the geographic location. The weather
3 itself can be isolating.
4 MR. STARK: Right.
5 MS. POWER: The poverty levels, et cetera. So I
6 know that in the literature those are two factors that
7 certainly are contributory. I'm assuming that that is in
8 fact what lends to the data that shows that there is such a
9 higher rate in the Midwest, particularly because of the
10 northern isolated regions and the level of poverty, combined
11 with other factors. But those two seem to be the clearest
12 in terms of the Midwest. I don't know whether --
13 MR. STARK: Before you respond, though, one more
14 comment to that. I mean, that's what I was thinking,
15 Kathryn.
16 MS. POWER: Right, I would assume.
17 MR. STARK: And so I was thinking, well, is that
18 true, then, among other populations? Is the Midwest among
19 all racial ethnic groups got a higher suicide rate --
20 MS. POWER: I don't know. But, you know --
21 MR. STARK: -- or is it unique to Indian country?
22 MS. POWER: I was prompted when we started talking
23 about that in terms of Indian country to take a look at
24 that. And so I'm going to go and take a look at that and
25 see, you know, geographically. We obviously talk -- when we

1 talk at the state level about regional trends or regional
2 kinds of factors, and I think that is a very good question
3 and something we need to look at. So thank you.
4 Craig, if you wanted to add anything to that?
5 MR. CRAIG VANDERWAGON: George may want to
6 comment, as well. (Speaks in Native American language.)
7 For the health of the people. I think Kathryn's covered it
8 pretty well. I think the isolation, poverty and racism
9 plays more strongly in the Intermountain West generally than
10 they do on either coast. The other things that are
11 protective, I think, in one sense is that we terminated
12 tribes in many of the West Coast states -- California,
13 Oregon, Washington. For whatever reason, I think their
14 recapture of who they are as Indian people was useful to
15 them in terms of building internal dynamics that are
16 supportive and protective.
17 I think the most successful Indian communities are
18 those where the young people growing up know who they are as
19 Indian people, and have the skills to compete with the
20 dominant society. You see more of those successful kinds of
21 communities in those environments than you see in the Upper
22 Midwest, for whatever reason, I think. And that's something
23 that needs to be studied by the Indian people themselves.
24 It's of interest, because some of those tribes
25 have gaming money, and some don't. Twenty tribes in this

country generate 80 percent of the income from gaming. Those 20 tribes, obviously, have resources and are plowing those resources in. For most tribes, they do not make money on the gaming process. If they hire -- if they can put people to work, they've made major improvements in their community. But it's problematic.

The other thing is, I think, sovereignty as an issue has a different play on the coasts than it has in the Intermountain West. Remember, Indian Health Service, for instance, is not an entitlement program for individual Indians. It's built around a government-to-government relationship. The tribes on the coasts have been very aggressive about taking control of their own programs and exercising community policy in directing those programs. We see less of that in the Intermountain West and in the Upper Midwest than we see on the coasts. That's just an observation. I don't know that that necessarily contributes, but it's certainly suggestive.

The Administrator has been personally highly invested in this process. He's on a first-name basis with many of our tribal leaders, particularly up in your state. That's been critically important, because we're funded at about 50 percent per capita of what the Federal Employees Health Benefits package, for instance, provides in terms of per capita annual expenditures for care. Well, if you only

1 got 50 cents on the dollar, you really are working hard to
2 try and make the most of those dollars. To have partners
3 like Mr. Curie pitching in and supporting, and his
4 leadership team taking it, embracing it, it makes a
5 critically important difference. It also makes the move for
6 tribes -- as was suggested here, if they're dealt with as
7 states, then we're treating them like governments. That
8 sets an expectation for them, as well, in terms of, hey,
9 we've got to govern, and we've got to act like a responsible
10 government. I think that has real positive improvements, as
11 well.
12 I have some of my Indian colleagues here. George,
13 do you want to modify or alter anything I've said?
14 MR. GEORGE REAL BIRD: Again, my name is George
15 Real Bird. I am a member of the Crow Tribe in Montana.
16 Like I come from that Midwest -- from what he was saying,
17 you know, where suicide is higher. Crow Tribe, you know, we
18 don't have as much substance abuse of what's going on. But
19 in the Dakotas, where these incidents happened of suicides,
20 they're almost a hundred miles, 200 miles from any major
21 town or city. My tribe, we're next to the largest city in
22 Montana, and so we have venues there. I can use a SAMHSA
23 term, and it's "risk and protective factors." You know, we
24 have bowling alleys, theaters. You know, we have sports
25 venues to go to, whereas risk factors on those rural

1 reservations, it's -- the person you relate to within the
2 world, if they are struck by a car accident or, you know,
3 they die themselves, you know, the person you related to in
4 the world is gone, so what's your point in this world? It's
5 kind of a -- it's a tough thing to face, but that's one
6 thing that's there.
7 CHAIRPERSON CURIE: Thank you.
8 MS. POWER: Thank you.
9 CHAIRPERSON CURIE: Other comments? Kathleen?
10 MS. SULLIVAN: I noticed when I was looking on the
11 website that Indian tribes actually have to compete against
12 states, especially in the case of suicide prevention grants.
13 Is that true? I mean, shouldn't Native American tribes
14 actually have their own -- you know, shouldn't they actually
15 compete against each other for grants? Shouldn't they be
16 designated only to compete against each other instead of
17 competing against states?
18 CHAIRPERSON CURIE: I think you make a very
19 interesting observation. The step of tribes being able to
20 compete with states was to give them more opportunity, and
21 actually recognize them as an entity that could apply for
22 grants in those situations. Up until we instituted this
23 policy over the past year and a half or so, tribes didn't
24 even have an opportunity to compete. But what I'm hearing
25 you say, Kathleen, are there other options we should think

about in which there's dollars just for tribes to compete for in light of the high need that's been described? That's what I'm hearing you say, and that's something that we need to evaluate.

MS. POWER: My sense is that, particularly because there's been so many hearings lately, Kathleen, that the senators and congresspersons from these affected states have really become very public about their concern. I think that's always a precursor or an indicator that there will be some step in that direction. In the meantime, of course, we're trying very hard to collectively make sure that not only are tribes competitive in terms of information, but also being able to try to get specialized supports out through other mechanisms, not just through Connecticut grants.

My sense is that there's going to continue to build congressional interest. I think we'll see some outcomes from that continued congressional interest over -- I think in the short-term.

CHAIRPERSON CURIE: Thank you.

Beverly.

MS. WATTS DAVIS: This is real quick. I wanted you to know, and Charlie and Kathleen, you need to hear this, as well. I can't remember what month it was because we travel so much, but I went to the White Bison Conference.

One of the things that they had as a town hall meeting about what -- and the regulations -- people came and they talked about that. Charlie, you and Kathryn should know, the feedback, it was so touching, because what they said was the fact that they felt so served. They felt like we were in partnership with them, and we were willing to go the distance. They really -- they were very -- it was such a touching moment -- and when they talked about their brief and all those things.

Sometimes in our -- we're sometimes up here, and you never really know if you're touching people or if you make a difference. But I wanted you to know, I met with them afterwards, and they were just so very, very -- "complimentary" is not even the word -- they were just so -- they really felt like partners with us, and that from there we could move forward. Sometimes you don't hear that, but you needed to know that, that that was the feedback given.

MS. POWER: Thank you. Well, I think one of the real struggles for us -- I think for all of us -- is to figure out how to be respectful and helpful at the same time. And it's a very fine line that we have to fully understand and more completely learn about the way to be respectful and helpful at the same time. It's very different in Indian country than it is with other cultures.

CHAIRPERSON CURIE: I would also highlight, that's

where the partnership with Indian Health Service has, I think, served us very well, letting them lead us in terms of what's the appropriate way. Our tendency is to just dive in sometimes. That, we learned, is not the most effective way. So again, to Craig Vanderwagon and to Chuck Grimm and their leadership team and folks, it's been a very invaluable partnership.

Ken.

MR. STARK: One of the other things I would recommend is adding to the partnership, if you haven't already, CMS folks, because the other financial opportunity, if you will, for tribes is to create their own programs and to tap into the Medicaid funding, either as federally qualified health centers or using the encounter rate dollars. Clearly, given the sovereignty, and given the agreements from the federal government going way back, there is a federal responsibility for health care services. So as much as tribes can tap into, with help from SAMHSA, facilitating how they can tap into those other federal fund sources that they may or may not be tapping into now.

CHAIRPERSON CURIE: That's very good.

MS. SULLIVAN: Aren't you chairing that plenary session? Isn't that the one that you're chairing?

MR. STARK: Well, it's called ugly money stuff.

MS. SULLIVAN: That's right.

1 CHAIRPERSON CURIE: Gwyn, did you have your hand
2 up?
3 MS. DIETER: (No response.)
4 CHAIRPERSON CURIE: Oh, I do know -- I believe
5 there's another individual who'd like to share. Please
6 introduce yourself.
7 MR. ED BROWN SHIELD: I certainly will. Dr.
8 Curie, and members of SAMHSA, my name is Ed Brown Shield.
9 My affiliation is the Spirit Lake Tribe of North Dakota.
10 I think everything that was discussed here this
11 morning is well-intended. But I think what we need to
12 understand is we need to go a little bit further. There
13 were 13 suicides at one time on Spirit Lake.
14 I'm going to give you an example, because it was
15 so moving for me. I was asked to do a presentation to the
16 elderly, which is a pretty strong organization on Spirit
17 Lake. As I was driving up there, I said, geez, you know, I
18 need to -- I want to talk about something that's going to be
19 respectful, but yet I want to get the point across. So I
20 started thinking about domestic stuff, domestic violence.
21 Preferably, I want to talk about the sexual abuse.
22 Immediately -- immediately -- a grandma came up to me and
23 she said, you know, my grandson, we don't talk about stuff
24 like that. And I said, you know, Grandma, no disrespect to
25 you as an elder, but I need to talk about it, because it's

here, it's now, it's real, and it's happening.

Of those 13 suicides on Spirit Lake a while back, 12 of those individuals came from one family. The other one was -- come from a family that that individual was pretty prominent in our community.

When we talk about ways of approaching this, really it needs to be at a level where -- not the Band-Aid effect, because I was sitting at a hotel when they had this delegation of people coming in, and they were talking about, well, you know, we're going to do this and do that with suicides. Well, they were there, and the next day they were gone.

I need to tell you, you know, I grew up on Spirit Lake. Tragedy upon tragedy in my family, but I was able to deal with it. So when we talk about -- certain funding is the big thing. I'm very grateful for SAMHSA, because I applied for -- probably one of the first Native Americans to get a SAMHSA grant. I'm very thankful, because I utilized that unobligated money to start a 15-bed facility. I'm really proud to say that that is self-sustaining today.

But as a leader, I think a key ingredient is visionary. You need to be visionary. We need to see beyond our noses. But the other thing, and this is key, we need to be able to implement. That's what's going to make the difference. I went home in 1998 -- didn't want to go

1 home -- but I'm from Spirit Lake. I always thought, you
2 know, my Native American people deserve the best. And I
3 said, I want to implement and establish a quality program
4 that's equivalent to anything in the State of North Dakota.
5 Better yet, I want it to be equivalent to anything in the
6 United States.
7 Overcoming local barriers, which we're going to
8 encounter if we're going to look at some of these issues,
9 that's why it's so critical to really look at, you know,
10 yeah, depression -- I know that -- all of this stuff. But
11 more important, people, they need to know that you're going
12 in there with some real concern, and they need to -- and
13 you're going to get 'em to be able to start trusting you.
14 Because when you have leaders in tribal council who I think
15 shouldn't be functioning in that capacity, our leaders, what
16 do you got to look up to? They weren't roll models for me.
17 I can openly tell 'em that, because education has done
18 something for me that is pretty important. That's something
19 nobody's every going to take away.
20 But I needed to tell you this because, during the
21 course of that presentation, I looked out in the audience,
22 and I told 'em -- I said, if I touch a soft spot with you
23 today, it's not intentional. It's probably something you
24 need to look at or address. In the course of my presenta-
25 tion, I heard somebody sniffling, and I just happened to

1 glance over, and it was a grandma. She was crying.
2 And so, you know, this is not something new. This
3 goes way back. So it's pretty not only devastating, it's
4 detrimental. In the course of my presentation, somebody
5 else started crying. I looked over, and it was another
6 grandma. You know, I was just waiting for that core group
7 to say, you know, get the hell out of here, we don't want to
8 listen to you. But you know what? They heard me out.
9 I built a quality program. I looked at -- they
10 had a tribal program, IHS-funded. I went back to my home
11 reservation in 1998 -- didn't want to go because I wanted to
12 utilize my skill. I know today in my heart that it doesn't
13 matter where I'm at, whether it's on a reservation,
14 Washington, DC, or Bismarck, North Dakota, I am going to be
15 an asset, because I got something to offer -- maybe a little
16 bit of education.
17 But more importantly, them people trusted me.
18 First thing, first comment came out, I was looking at state
19 licensure. We really have a good working relationship with
20 the mental health and substance abuse in the State of North
21 Dakota. You can call any one of 'em and ask 'em about Ed
22 Brown Shield. They'll tell you.
23 MS. POWER: That's great.
24 MR. BROWN SHIELD: So, you know, if we're going to
25 do this, if you're thinking about developing a task force,

there's things that you have to look at within yourself. How are you going to deal with this? How can we be most beneficial to people that are struggling, people that have been hurting for generations?

And I wanted to share that because I'm no longer there. I'm on to a -- I always tell people I turned another chapter in my life. I'm in a graduate program at the University of North Dakota getting into a little bit of research.

That's another thing, you know, organizing is the big thing. I'm certainly a believer in community organizing, because if you can organize intervention teams and utilize your grass roots people, along with professionals, you're going to get some work done. And I really appreciate you guys lending me an ear, because I grew up in that stuff, and it's very difficult to overcome.

CHAIRPERSON CURIE: Thank you, Ed. Thank you so much. We appreciate your remarks

(Applause.)

CHAIRPERSON CURIE: I think we have time for one or two more questions from Council members on this issue, or comments. Gwyn, I saw you pulling your microphone forward.

MS. DIETER: I'm just sort of thinking out loud, because it's obvious that Kathryn is concerned and you're concerned. But the conversation -- I mean, I really

1 appreciate that Tom made his comments, because we're hearing
2 about funding, we're hearing about money, we're hearing
3 about -- I live in Colorado. We've lived near some Indian
4 reservations which are not as isolated. How do you -- how
5 through all this funding do you get some professional people
6 who are committed to a long-term stay in these places to
7 gather and work with people on the ground, the grass roots
8 cooperation? I mean, to me, that's the issue.
9 It's terribly isolated if you've visited some of
10 those places. I mean -- and the poverty -- but you need
11 people who are willing. It's sort of like there are
12 people -- legal services people who used to go out and
13 commit to a three-year term on an Indian reservation down in
14 New Mexico and stuff. We knew some people that did that.
15 And only then with the people you build that trust, and then
16 you build -- and then people can look at thinking in a new
17 way if you can build that trust.
18 I mean, I just -- you can pour money -- there are
19 a lot of situations in the past -- this situation is really
20 not that new. Maybe it's just that we hear more about it.
21 I mean, my feeling is that that's what I've heard ever since
22 I've been in the West, and that's 34 years. It's terrible.
23 And I think you're totally onto it. But what I would ask
24 is that you focus on how to have this task force, have
25 individuals who would -- professionals who are willing to

1 make a long-term commitment to live in these locations, and
2 then gradually train and build support coalitions there.
3 CHAIRPERSON CURIE: I appreciate that. In fact, i
4 know work force development's a major focus in the efforts
5 right now, because you're exactly right, that we need to be
6 thinking in terms of who will be the local resource that
7 becomes part of the fabric of that tribe that can make the
8 difference.
9 MS. POWER: We're actually trying to look at
10 getting knowledgeable about how the Indian Health Service
11 and HERSA and other federal agents have been able to look
12 across some work force development programs, and then we
13 think about how there's applicability to that for the
14 behavioral health work force. But you really do have to
15 have leaders like those we've just heard from who are
16 willing --
17 CHAIRPERSON CURIE: Absolutely.
18 MS. POWER: -- to step into their communities and
19 bring it to bear and bring it as -- and be community
20 activists, and be the force within their own culture and
21 within their own group. We have to think about, how do we
22 help facilitate and support that in ways that I think would
23 be empowering for those tribes? -- that there would be some
24 investment longer term, and everybody didn't want to get out
25 and leave, you know, but that there would be an investment

in terms of people staying.

MS. DIETER: And the leaders may be there right now.

MS. POWER: Right. Absolutely right.

CHAIRPERSON CURIE: We need to foster that.

MS. DIETER: They may become that with some knowledge.

MS. POWER: That's right.

CHAIRPERSON CURIE: Thank you, Gwyn.

A quick check of the lay of the land in wrapping up, I see Ken, Tom. Do you want to make a comment? And I see Craig. Those three lightning round comments here, and then we'll move to public comment.

MR. STARK: I was going to be fairly quick. And, Ed, I really appreciate what you stated. It's very challenging for somebody from Indian country to go into a tribe and talk about the sexual abuse, or talk about the tribal chair who got three DUIs, and, you know, bring that issue up and not get run out of town, if you will. We all know that until those issues get resolved, it's going to be really, really difficult for kids and families to have change within their community.

So we really do need to identify leaders within each of the tribes and across the country who are willing to step up and step out. And we need to support them. I

really appreciate what you said.

CHAIRPERSON CURIE: Craig, and then I'll let Tom have the last word.

MR. VANDERWAGON: Just to reply to your comments, both of them, 75 percent of our employees at Indian Health Service now are Indian people. When I started 25 years ago, it was more like 25 percent. So we've made major improvements in developing capacity at the community level to do for themselves. That's really our public health mission. It's not so much about delivering medical care as it is about developing that capacity.

The reason we're just getting to it in some ways is because, first, we had to keep children from dying unnecessarily in infancy. And now our infant mortality is actually better than the U.S. general population in most places, the exception being that Upper Midwest.

So we've made improvements on that front. Now maybe we're getting to the core of where we got to go.

I think your comment, Ken, about the fact that we are developing positive leadership is critically important. That's where Charlie's first-name basis with Darrell Hill Air (ph), for instance, up at Wamee (ph) becomes important. You as a group, I think to the degree that you know some of these Indian leaders, they have common purpose with you.

Again, those that have gaming capability are

1 becoming more engaged in the outside world, and I think can
2 be a useful adjunct to this Advisory Committee in terms of
3 people that you can work with in an effective way to the
4 degree you're interested in Indian communities. Ultimately
5 it goes to Charlie's comment. When you started, Charlie, I
6 was really -- as Charlie knows, I spent six months in Iraq
7 as the Primary Care and Public Health Director there for the
8 Ministry of Health. The lessons that we're learning from
9 Indian country have so much applicability in moving forward
10 with the President's agenda around health diplomacy as a
11 tool in developing democracy. These issues -- depression is
12 the leading diagnosis on a worldwide basis, particularly
13 among women. So what we learned from our Indian experience
14 here and cross-cultural realities has real significance on a
15 broad scale, first, because we owe it to the Indian people
16 to give them the best we can. But secondly, because what we
17 all learn collectively allows us to do a better job
18 elsewhere, as well. That's my comment.
19 CHAIRPERSON CURIE: Thank you very much, Craig.
20 Tom.
21 MR. KIRK: I think the points that people made, I
22 don't want to repeat them. That's fine.
23 CHAIRPERSON CURIE: All right. Thank you.
24 Kathryn, thank you so much.
25 (Applause.)

CHAIRPERSON CURIE: We had no one sign up for public comment. The great news is we've had public comment throughout this report. I would -- is there anyone from the public who would like to make a comment before we move on? Yes?

UNIDENTIFIED MALE SPEAKER: I did send in a fax earlier saying I would like to speak.

CHAIRPERSON CURIE: Okay. Thank you.

UNIDENTIFIED MALE SPEAKER: I have some handouts here that I'd like to pass around.

I'm with the National Association on Alcohol, Drugs and Disability, and Faces and Voices of Recovery. I understand I'm the only thing standing between you and lunch, so I'll make this pretty quick.

Welcome to California. As an East-Coaster originally myself, I can attest to the value of having a West Coast perspective, which you'll all get over the next couple of days. I would encourage you to come to Northern California at some point in the future, though, because we have even better things up there to offer you.

MS. SULLIVAN: Boo.

UNIDENTIFIED MALE SPEAKER: In fact, during a research visit to Napa Valley for the Substance Abuse and Mental Health Services Advisory Council might be a good thing at some point.

1 I'm here on behalf of 51 million Americans with
2 disabilities, who have less access to services and more
3 alcohol and drug problems than the general population. I'm
4 here to mention that we are still waiting for SAMHSA, and
5 specifically the two substance abuse centers, to come up
6 with some designated and categorical projects and funding
7 and services for people with disabilities.
8 We've had many conversations with Dr. Farr (ph),
9 and some conversations with Mr. Curie. The people that you
10 in your materials talk about not being able to get into
11 treatment, or if they're able to get into treatment, not
12 able to be retained in treatment, many of them are people
13 with disabilities. If we could see some specific
14 categorical programs coming out of SAMHSA for people with
15 disabilities, we would certainly appreciate it,
16 specifically, the target capacity expansion program with a
17 disability spin.
18 I'm talking about physical, sensory, developmental
19 and cognitive disabilities. It's 15 years since the
20 Americans with Disabilities Act was passed. It's the 15th
21 anniversary. And still many alcohol and drug programs are
22 not accessible. We get calls almost every week from people
23 who are not able to be accepted into treatment because the
24 program doesn't have a ramp, or doesn't have a TDD, or
25 doesn't have training in disability.

1 So the ADA is very important to people with
2 disabilities who want to access substance abuse services.
3 But the second and last thing I'd like to say is that the
4 ADA is very important to people in recovery, as well, as we
5 know. There is no such thing as the Americans with
6 Addictions Act. It is the Americans with Disabilities Act
7 that does provide the protections against discrimination,
8 which is the flipside of stigma, for people in recovery.
9 Dr. Clark knows this really well.
10 We have been trying to alert the alcohol and drug
11 fields to a variety of court challenges that have eroded the
12 disability status of people in recovery, as well as people
13 with other disabilities. The last time I was here to talk
14 to you was two years ago. The case was Hernandez, and it
15 was in front of the Supreme Court, and one of the handouts
16 that you have is about that case. There are other cases
17 that are coming up right now. There's a case, a class
18 action, against UPS, there is a case against New York State
19 Corrections, where people in recovery from substance abuse
20 are treated differently because of their recovery status
21 than other people.
22 As the disability community fashions a legislative
23 response to this, often referred to as the ADA-II, it's
24 really important for the alcohol and drug field and the
25 mental health field to be connected to that initiative. And

1 that's really not happening. And that's the other handout
2 that you have in front of you about these erosions and the
3 need for the alcohol and drug field to become better
4 educated about the ADA, and how the ADA really does fight
5 stigma by fighting discrimination.
6 I'd really encourage SAMHSA and the centers -- and
7 Dr. Clark and I have had a number of conversations about
8 this, and I know he's very much on board with this. We have
9 got to be at that table. We were not at the table when the
10 ADA was originally crafted, and we've got to be at the
11 ADA-II table.
12 Thank you very much.
13 CHAIRPERSON CURIE: Thank you, John. Thank you.
14 My understanding is that the food is ready and on
15 the table. So would you explain -- do we just go over
16 across the hall?
17 MS. VAUGHN: Just go over to the bar area, and
18 that's where you're going to enjoy your lunch. And then
19 after that --
20 CHAIRPERSON CURIE: Please tell us about where
21 people are meeting and what are the logistics for that.
22 MS. VAUGHN: Okay. After your lunch, then you'll
23 meet in the lobby. There'll be a van to transport you to
24 Scripps Hospital for your site visit. You should be in the
25 lobby at 12:15 -- I mean, 1:15. The van will leave at 1:30.

CHAIRPERSON CURIE: All right.

UNIDENTIFIED MALE SPEAKER: Are we closing up this room, or can we leave our stuff in this room?

MS. VAUGHN: Okay. You can leave your materials in the room. We're going to adjourn the meeting. If you want us to transport your materials, to send them to you, you can either take the materials with you, or just leave them there, and we will mail the materials to you.

CHAIRPERSON CURIE: Is there someone who would move to adjourn?

MS. SULLIVAN: Move to adjourn.

CHAIRPERSON CURIE: Kathleen, and then --

MR. AIONA: Second.

CHAIRPERSON CURIE: -- Duke seconds it.

Meeting's adjourned. Thank you.

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(The meeting adjourned at 12:30 p.m.)

CERTIFICATE

I, Michael J. Williamson, certify, under penalty of perjury, that the foregoing is a verbatim transcription prepared from the electronic sound recording produced at the proceedings in the above-entitled matter, and is a true and accurate transcript of said proceedings to the best of my

ability and belief.

_____ _____
Transcriber Date