

SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

41st Meeting

Thursday,
March 8, 2007

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

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1 P R O C E E D I N G S (9:07 a.m.)

2 DR. CLINE: Well, good morning, everyone. I'd
3 like to call the meeting to order and welcome you back this
4 morning and thank you for being here. Hopefully, you had a
5 pleasant evening.

6 I would like also to welcome Ms. Sullivan, who
7 is on the line. Good morning, Ms. Sullivan.

8 MS. SULLIVAN: Good morning.

9 DR. CLINE: It is quite early where you are.

10 MS. SULLIVAN: I remember when Duke was on the
11 line on the last meeting. Aloha, Duke.

12 MR. AIONA: Aloha.

13 DR. CLINE: Thank you for being here again and
14 taking that effort to be on the line.

15 We have one visitor who I'd like to
16 acknowledge, Bob Shelborn, who is the Director of the
17 Division of TANF Policy with the Administration for
18 Children and Families. If you'd, please, just stand up.
19 Thank you for being here this morning.

20 As part of my opening comments, my opening
21 remarks, I'm going to talk about just some of the themes
22 that I heard yesterday. There were many more items that we
23 have detailed, but these are just some of the overarching
24 themes that I heard.

25 A lot of concern around the budgeting process;

1 the importance of partnerships on issues, as well as
2 partnerships for resources; attention to the needs of
3 people in the armed services and people who are returning
4 from service; also the need to discuss populations at risk
5 and vulnerable populations; the importance of the economic
6 impact on our issues and then making certain that that
7 information gets shared with others, such as the National
8 Council on State Leadership; also attention to the science
9 to service approach, as well as making sure that we have
10 that focus, not just science to service but also the
11 service to science piece of that, whether that's field
12 testing or other types of kind of promising practices that
13 are coming from our communities, and paying attention to
14 informing the research and science piece of that, and then
15 making sure that that's available and attending to those
16 opportunities to spread those practices wherever possible.

17 And then the last question, which will tie in with some
18 later discussion, is really this kind of urging from the
19 council about how you can be most helpful to me as the
20 Administrator and also to SAMHSA. So I appreciate that.

21 Any other kind of general themes? Again, there
22 were a lot of specifics and we have all the specifics. We
23 have several follow-up items, as well, that we have marked.

24 But was there some kind of all-pervasive theme that was
25 not captured by those comments that any of you would like

1 to highlight right now?

2 (No response.)

3 DR. CLINE: Okay. Well, we're all set.

4 We will then move into our presentation, and
5 this was an issue that was highlighted several times
6 yesterday in terms of an interest of the council and also a
7 pressing need for our nation as we look forward. So we're
8 very fortunate this morning to have Kathryn Power, the
9 Director of the Center for Mental Health Services, who will
10 be providing us with a presentation on behavioral health
11 workforce development.

12 And, Ken, you can see it's going to take us a
13 while, but your comment is still registered with us.

14 Good morning, Kathryn.

15 MS. POWER: Good morning, Terry. Thank you
16 very much. Good morning, everyone.

17 I'm very honored to be with you to discuss this
18 very important topic, and I think it's important to say
19 that SAMHSA comes to this very important issue at, I think,
20 an important time, an important developmental time, in
21 terms of SAMHSA, in terms of the fields, and in terms of
22 the overall pressing nature of the societal demographics.
23 We've heard for a number of years, woe is me, the sky is
24 falling. We're really worried. The workforce is changing.
25 The workforce is aging, et cetera.

1 So I think the fact that we have taken this on
2 as an issue I think is a credit to our leadership and it's
3 also, I think, emblematic of how important we think that
4 people are to our business. People are the core of our
5 business, and it is the people-to-people connection, it is
6 the people-to-people work, it is the personal engagement
7 with the individuals we serve that really marks the quality
8 of recovery-focused systems. So we count on people more
9 than any other and probably people take anywhere from close
10 to 90 percent of the resources in any system, particularly
11 in one that is intensive in terms of mental health and
12 addictions and substance abuse disorders.

13 So I think it's a propitious time and I really
14 am very honored to be named as the co-lead of the matrix
15 area, along with Beverly Watts Davis, who is my senior
16 partner and senior co-lead for this matrix area.

17 I want to just contextually place some thoughts
18 in your head as we talk about this important topic this
19 morning. The first is that there's been an acknowledged
20 shortage of health care workers in mental health and in
21 substance use, both prevention and treatment.

22 It's also been acknowledged that there is
23 really a geographic maldistribution of workers, that there
24 are areas of the country that do not have the number and
25 kind of individuals that are necessary in order to deliver

1 these important services.

2 The third area that's been acknowledged is that
3 there is a tremendous lack of ethnic diversity and cultural
4 expertise across the workforce, and as our population in
5 America becomes more diverse, that lack of diversity and
6 cultural experience really needs to be reflected -- I mean,
7 we need to pay attention to it in terms of focusing in on
8 developing the workforce. And that ethnic diversity and
9 cultural expertise really comes out in areas where there
10 are vast health care discrepancies, where there is a
11 distinction around primary care and behavioral health care
12 integration.

13 The whole issue of older Americans and the
14 aging issues of older Americans is a tremendous, tremendous
15 difficulty across the health care spectrum and, frankly,
16 one in four individuals who are older have some form of
17 psychiatric or emotional disturbance.

18 And then there are children in our communities
19 who are extraordinarily diverse and the lack of having
20 children expertise, particularly child psychiatry, is noted
21 among the workforce almost everywhere and, I might add,
22 particularly in the military as part of the DOD task force.

23 They're having the same difficulties in the military that
24 we broadly are having within the major society.

25 Another acknowledgement is there is a

1 recognition that much of our education, much of our
2 training that occurs in our universities and academia is,
3 frankly, outdated and not necessarily reflective in
4 accurate and updated training content, in accurate and
5 updated training methods in terms of the needs of our
6 systems, and it is not consistent, frankly, with what we
7 know works in terms of evidence-based practice.

8 We can all look back on our own training
9 experiences and say, was I trained for what I do now? And
10 I think that the workforce is asking themselves that
11 question. Any of us who have been working in systems or
12 have run systems know that there is a huge gap between
13 those that are trained and they come out of schools or they
14 might be going through specific training and the actual
15 things we ask people to do, the tasks we ask people to do.

16 I often remember when I ran the system in Rhode
17 Island that some of my best case managers were music
18 therapists and art therapists who then came out of liberal
19 arts education and then were trained to be good case
20 managers by having an inoculation of a special recovery
21 orientation or a special training that was put on by the
22 state or the community mental health centers.

23 So we need to think about that and how are we
24 going to accommodate the workforce of the future, but we
25 certainly need to be looking at the more formal educational

1 processes and the credentialing processes.

2 Finally, we know that there are a wide variety
3 of state-to-state variations in the scope and practice that
4 exist and in the level of quality and in the level of
5 competence. Tremendous variations across the country,
6 across the world, across the states, and even across
7 regions and even across local areas. There is tremendous
8 variation.

9 So those are really the important aspects of
10 this workforce issue that I want you to keep in mind as we
11 go through the matrix report.

12 I also thought it would be helpful just to stop
13 and think about your own personal experience. Workforce
14 issues really come down to thinking about ourselves as part
15 of a workforce, being identified with a group of people.
16 And our experience of being identified with a group of
17 people comes from our training and education and the
18 process and experience that we have.

19 I want you to kind of put yourself in the
20 position of thinking through systematically how you would
21 advise us, how you would advise the Administrator, how you
22 would advise the council, how you would advise the matrix
23 area to start to grapple with some of these issues because
24 they're very broad and yet they're very narrow. They're
25 very wide and they're very deep. I think if you put

1 yourself in the position of saying, let me think about my
2 own experience -- and I don't want to bore you with the
3 details of my life, but I think it's important that you
4 know that in thinking about workforce, we have to think
5 about it from our own personal professional perspective and
6 then broaden out from there.

7 So when I think of myself, I think of myself as
8 a teacher. I taught elementary school. I taught high
9 school. When I was a teacher, I cared very much about
10 mental health promotion. So I was a mental health
11 promotionist, and I wanted to care deeply about the
12 emotional life of the children that were in my classroom.

13 Then I became a counselor and I had my own
14 counseling practice with another woman. And it grew out of
15 working in the rape crisis and domestic violence areas. So
16 I became a crisis counselor. Then I became a feminist
17 counselor who believed in empowering women around their
18 issues about crisis and about trauma, and that's where I
19 learned my whole set of beliefs about trauma. So I became
20 a trauma counselor.

21 Then it moved into working on the state level
22 and working in communities, and I became the head of a
23 substance abuse business-backed prevention coalition. Then
24 I became a preventionist. And the business community
25 funded an effort so that we could take a statewide

1 community prevention effort like you heard yesterday from
2 Kentucky and move out with the business community saying we
3 care deeply about this issue and we want to prevent
4 substance abuse.

5 And then I became the drug czar at the state
6 level. So I had to take all of the substance abuse
7 programs that were in education, that were in criminal
8 justice, and that were in mental health and substance abuse
9 on the state level and combine them under an office of
10 substance abuse.

11 And then I was a parent, so I cared deeply --
12 deeply -- about the emotional life of my children and their
13 life in the community and their life in terms of their
14 development and their future.

15 So all of us have those different roles. We
16 all come at this from a different place. We all have
17 different experiences. So I'm pointing that out not to
18 bore you with my life, but to show you that there are very
19 narrow times when I would think of myself only as a mental
20 health counselor or only as a substance abuse preventionist
21 or only as a grief counselor or a trauma counselor. And
22 then I would step away and think of myself as a policy
23 person and as a practitioner and as an advisor and as a
24 guide in terms of systems development.

25 So we have come to the point where, in looking

1 at this issue, we have now developed very firmly in SAMHSA
2 a formal process, and that formal process is the beginning
3 of a matrix group. I've never been at the birth of a
4 matrix group, and I have been witness to the birth of a
5 matrix group in the past year.

6 When we were appointed, Beverly and I had a
7 conversation about how do we take the richness of this
8 discussion and bring it to bear in terms of the disciplines
9 that are important, the fields that are important, and how
10 do we start organizing ourselves to think about ways in
11 which we should approach this for SAMHSA and for the
12 fields.

13 As you all know, this was a new matrix priority
14 area that was designated in 2006. There had been much work
15 done in workforce development issues across the three
16 centers prior to this time. That is, it had been a cross-
17 cutting principle that we cared about workforce issues
18 since 2003, and there had been some work across all three
19 centers and particularly in the fields of mental health
20 services, substance abuse prevention, and substance abuse
21 treatment. So we had been doing some work that had, in
22 some cases, been isolated within that field or we had just
23 had informal conversations across SAMHSA.

24 In terms of what I want to just touch on today,
25 we're just going to start with the fact that the matrix

1 area has been formulated. You all know that one of the
2 first things that we did in the matrix process was that we
3 held a workforce development conference last July. I'm
4 going to talk a little bit about what happened at that
5 conference and the proceeds from that conference.

6 We've also now begun to identify what we
7 consider to be some proposed, far-reaching goals that we
8 really would like you to offer some ideas about, whether or
9 not these goals are consistent with your experience and
10 consistent with your notions about the way in which we
11 should address workforce. And we're also going to talk a
12 little bit about our contract that we have on workforce
13 development, and then we'll move to some open discussion.

14 Last July, we sponsored a conference called
15 "Building a Behavioral Health Care Workforce for the 21st
16 Century," and this was a dialogue with 200 of our closest
17 friends. Those friends really came from many of the
18 professional guild areas, many of the advocacy
19 organizations, many of the national players in terms of
20 mental health promotion, mental illness prevention,
21 substance abuse treatment, and substance abuse prevention.

22 So it was a host of interested parties, many of whom had
23 participated in some of the individual work that had gone
24 on across the three centers.

25 At that time, we delivered basically to the

1 group two important documents. The first one was
2 "Strengthening Professional Identity," which is the report
3 about challenges of the addictions treatment workforce
4 which was a report that was provided as a result of a
5 congressional inquiry or congressional appropriations
6 language that requested it. And that report was out. And
7 we had also commissioned a report with the Annapolis
8 Coalition, which is this thousand voices, "The National
9 Action Plan on Behavioral Health Workforce Development."

10 These two substantive reports, which were
11 basically commissioned by us, became the vehicles really in
12 which we asked folks at the July meeting to look at them
13 and to think about them and to react to them, mainly
14 focused on the Annapolis Coalition report and, in addition,
15 some additional conversation on strengthening competencies.

16 We had a variety of broken-out discussions
17 relative to what they thought SAMHSA should do in the
18 future and what they could do in the future. And that was
19 really what we wanted to do, was to get these reports into
20 the hands of those individuals who had been saying that
21 workforce was an issue, but we really weren't quite sure
22 where to go and what to do.

23 So these reports now are on the SAMHSA Web. We
24 also have the trimmer version of the Annapolis Coalition,
25 which is the executive summary. Those three documents now

1 sit on the SAMHSA Web and are out there for the public, for
2 all of our stakeholders to use because they're chock-full
3 of ideas, just chock-full of strategies and goals and
4 recruitment strategies and retention strategies.

5 So go forth and do good things was the idea
6 that SAMHSA had about making these resource documents
7 available to the field and moving forward. Frankly, we've
8 heard from many, many constituency groups, particularly
9 some of our ATR states or our seclusion and restraint SIG
10 states or our mental health SIG states, that they're using
11 them. And that's really important and I think really
12 essential.

13 Then the Administrator, Dr. Cline, sent a
14 follow-up letter to these conference participants in
15 February, which included a summary of the conference about
16 the long-term and short-term actions by the participants
17 and some of the key findings. And we so noted that we
18 would consider all of the recommendations, and that's part
19 of the pool of information that the matrix work group is
20 working with.

21 These seven goals I want to go over very
22 quickly. These are the goals that were derivative from the
23 Annapolis Coalition report that we asked participants at
24 the meeting to mull about, to think about, and to give us
25 some direction. I'm just going to briefly touch on them.

1 These are very broad workforce goals that are informing our
2 contemplative deliberations within SAMHSA for the matrix
3 area.

4 Goal number 1 probably is the most significant.

5 It says to expand the role of individuals in recovery, and
6 families when appropriate, in participating in and
7 ultimately directing or accepting responsibility for their
8 own care, providing care and supports to others, and in
9 educating the workforce. This gets to the heart of
10 empowerment. It gets to the heart of our systems in terms
11 of recovery-focused, consumer-centered systems of care.

12 In fact, we had much to learn from each of the
13 fields, much to learn in terms of prevention's view of
14 this, much to learn in terms of the addictions field in
15 this area, and much to learn from the evolving world of
16 mental health recovery. And this really captured the
17 spirit of peer support services, consumer-directed
18 services, et cetera.

19 The second goal was to expand the role and
20 capacity of communities to effectively identify their needs
21 and promote behavioral health and wellness.

22 The third goal is to implement systematic
23 recruitment and retention strategies at the federal, state,
24 and local level. So I specifically want to emphasize if
25 the goal is for us to do something at the federal level,

1 your input for us would be very helpful because we're
2 clearly looking at CDC and HRSA and other agencies that
3 have been looking at workforce issues over time and looking
4 at some of their work in the past and saying is that an
5 effective strategy for us to apply and to think about.

6 Goal 4 is to increase the relevance,
7 effectiveness, and accessibility of training and education.

8 Goal 5, to actively foster leadership
9 development among all segments of the workforce, which
10 really gets to, Faye and Tom, your comments yesterday.

11 Goal 6, enhance the infrastructure available to
12 support and coordinate workforce development efforts.

13 And goal 7, to implement a national research
14 and evaluation agenda on workforce development issues.

15 So those are from the Annapolis Coalition and
16 those are the goals that they derived. I'm not going to go
17 through the process of the Annapolis Coalition. I can do
18 that in Q and A, if you need to know that process.

19 The other informed document I mentioned is
20 "Strengthening Professional Identity: Challenges of the
21 Addictions Treatment Workforce," also an information
22 resource for us. There were 20 recommendations across
23 those areas, and you can see listed here the areas that
24 they focused on in terms of a set of recommendations. Very
25 important that again from the addictions field perspective,

1 these were the areas, and we have provided you a list,
2 which was on the table with the handouts, of the
3 commonalities across these two reports and the areas where
4 they differed. The commonalities, of course, outweigh the
5 differences. There were just differences in terms of scale
6 and scope on the numbers of individuals who were
7 interviewed, scale and scope of the process that was used
8 to create the report, et cetera. But it's a most
9 fascinating crosswalk to take a look at how similar the
10 issues are and the issues were, and that, frankly, is of
11 benefit to our work at SAMHSA.

12 I might also add just for purposes of
13 discussion two additional documents that we're using. The
14 first is -- and I'm sure you all have your own copy of this
15 -- the IOM report. This is the IOM report on the quality
16 of health care for mental and substance use conditions. If
17 you don't have this, I have copies of it. There is a
18 tremendous section in here on increasing workforce capacity
19 for quality improvement. So the IOM, when they took on
20 mental and substance use conditions report, spent time
21 looking at how to improve the workforce, and they spent an
22 awful lot of time detailing some of their goals and
23 objectives.

24 Then, in addition, yesterday I just received
25 "Mental Health and Rural America: 1994 to 2005," and

1 workforce development is one of their prime areas in rural
2 America and mental health. So, again, two more documents
3 that we will use to help inform our process and help inform
4 our deliberations in addition to the two that I'm citing
5 here today.

6 So we're looking at, from a SAMHSA perspective,
7 what are some of the derivative goals from what we have
8 already read, from what we have already described, and from
9 what we have already conversed with folks about, and these
10 are the three that come to bear. Strengthening the
11 workforce through implementation of systematic recruitment
12 and retention strategies. Enhancing the infrastructure
13 available to support and coordinate workforce development
14 efforts. And broadening the concept of workforce through
15 expanding the role of individuals in recovery, and families
16 when appropriate. So these consensus goals kind of came to
17 bear when we reviewed those documents, and those are
18 absolutely, positively open for your review and for
19 discussion and for your deliberation and for your comment.

20 The next area is that I was asked just to talk
21 a little bit about the fact that we do have a current
22 contract, and this contract that we are utilizing for our
23 workforce development efforts began, of course, last year.
24 We have already done some tasks under this contract.
25 We've conducted an inventory of center workforce

1 development-related activities and how those activities
2 relate to the three goal areas that we are emphasizing.
3 And we're also asking the contract to work with us to
4 inventory and identify other future activities that might
5 be appropriate to offer the Administrator as part of our
6 workforce development matrix area.

7 Let me just give you some examples of some of
8 the things that are going on.

9 CSAT for many, many years has developed and
10 instituted and performed a leadership institute. They have
11 an addiction technology transfer center system in which
12 they do an enormous amount of training, and they have the
13 knowledge application program.

14 From CMHS, we are using our Mental Health
15 Transformation State Incentive Grants to encourage
16 workforce development strategies in our SIG states,
17 Co-Occurring State Incentive Grants, and the National TA
18 Center for Children's Mental Health.

19 Let me just add here not only are the
20 Co-Occurring State Incentive Grants an opportunity to do
21 something specifically, but it is also reflective of the
22 larger sort of workforce approach that SAMHSA takes. Dr.
23 Clark and I co-chair that matrix area, and it was decided
24 in terms of enhancing the capability and competence of the
25 workforce, that we would do both a tool kit on co-occurring

1 disorders from the CMHS perspective and a TIP on
2 co-occurring disorders from the substance abuse
3 perspective. So that's an interesting way to try to
4 influence the workforce, which is another thing for you all
5 to think about. Are there ways we can influence the
6 workforce, as well as help with direct recruitment and
7 retention in the workforce?

8 And then for CSAP, they of course have their
9 Prevention Fellows Program, which is a very successful
10 effort for professional development in the prevention
11 community. They have Centers for the Application of
12 Prevention Technology, and the Coalition Institute, which
13 are grants that CADCA administers on behalf of CSAP.

14 That gives us sort of an overview of some of
15 the activity to date and some of the things that we are
16 deliberating about, and these are our next steps.

17 We are going to develop a final workforce
18 matrix plan, a matrix workforce plan. We are going to be
19 drafting that. Actually, we're drafting it now in terms of
20 the matrix area. We are in the midst of working on that
21 and we hope, since the Administrator told Congress that we
22 would be looking at this in April, we decided April would
23 be a good time for us to complete this. So we are moving
24 toward that goal and we know we will be able to deliver
25 that to the Administrator at that time.

1 But the important thing is that this is a
2 process, and the process is ongoing and we don't have all
3 the answers. We need input specifically from this council,
4 in your personal roles and in your professional roles, to
5 help guide us in those things that you think are
6 priorities.

7 Then we're having some internal discussion --
8 as well, I'd like to hear your ideas about this -- about
9 some possible, potential workforce development activities.

10 Those would include things like possibly -- which were
11 suggestions, by the way, in all of these reports -- that we
12 need to review effective recruitment and retention
13 strategies and give people some models to look at and some
14 experiences that are practical.

15 We need to look at career path models and what
16 would be an appropriate career path for our field.

17 We need to identify existing behavioral health
18 care competencies and curriculums developed and being used
19 by professional guilds, stakeholder agencies, and consumer
20 and other organizations.

21 It's been suggested that we might think about
22 developing a behavioral health website or portal to provide
23 an expansive repository of searchable information.

24 Also it's been suggested that we might
25 disseminate information on innovative practices to support

1 the fields in promoting and implementing their own
2 workforce initiatives.

3 And then there has also been put on the table
4 the idea of perhaps exploring some specific authorization
5 for SAMHSA to do a training grant program, which harkens
6 and pulls back to some of the ideas that worked very
7 effectively in the late '80s and early '90s about fostering
8 the development of specific leadership in the health care
9 agenda.

10 Before me move, Terry, to the discussion, I
11 really want to add that, again, thinking broadly and yet
12 thinking narrowly and then thinking broadly and then
13 thinking narrowly is an important dynamic here in terms of
14 the workforce. We not only have to get other disciplines
15 knowledgeable about mental and substance use conditions --
16 that's our first challenge. I think that was mentioned
17 here yesterday. We have to persuade and we have to
18 influence as many other disciplines as possible to become
19 knowledgeable about mental and substance use conditions,
20 and at the same time, we have to build and strengthen the
21 professionals in this particular aspect of health care. I
22 think that that's our challenge in terms of the discussion
23 around where we proceed.

24 All of these reports say tremendous things
25 about what the federal government should do or what SAMHSA

1 should do. We now have to distill from those things what
2 we think is practical, reasonable and, in fact, doable for
3 our behavioral health care workforce development.

4 So with that, Terry, I'll end and move to
5 discussion.

6 DR. CLINE: Kathryn, I'm going to ask if you
7 would facilitate that discussion.

8 MS. POWER: Oh, certainly.

9 DR. CLINE: If you don't mind.

10 MS. POWER: Certainly.

11 Ken?

12 MR. STARK: One of the challenges that I see,
13 Kathryn, and probably more so on the mental health side
14 than on the alcohol/drug side --

15 DR. CLINE: Ken, just to interrupt you for a
16 second. Actually, Kathryn, if you turn that off, then it
17 allows us to record that a little more easily. Thanks.

18 MR. STARK: In the public sector on the mental
19 health side, my experience in my meager year and a half in
20 this new job as the transformation project chair and, of
21 course, my historical experience on the alcohol/drug side
22 working with mental health centers, is that in the public
23 sector mental health system, it really is not a mental
24 health system. It's a mental illness system, most of the
25 services being tied to the most severe and persistent.

1 As a result of that, many of the clinicians in
2 the mental health centers aren't really doing counseling
3 per se. Many of them really are doing case management. In
4 some cases, given the caseloads, I wouldn't even call it
5 that. I would call it case monitoring with then the
6 relationships with psychiatrists and medical professionals
7 with medication management, and then, of course, a major
8 emphasis on acute and crisis care. Whereas, in the public
9 sector, as you know from being a private therapist, private
10 therapists really are doing a lot more of the counseling
11 work with the private pay clients and less severe.

12 I really think that that presents an incredible
13 challenge in looking at the workforce in that in the public
14 sector, what do we really want to be as a field? Are we
15 really moving to, as we hope to, a health
16 promotion/wellness model, a recovery model where we
17 actually can serve people along the range, all the way from
18 prevention or early intervention to crisis and acute? If
19 that's really where we want to go on the public sector
20 side, we all know that's going to be a challenge with
21 resources and a number of those issues.

22 But that truly then enhances the whole issue
23 around workforce development and who does what and what
24 kind of training do you need. Things like case management
25 can be very generically trained. A case manager in

1 alcohol/drugs and a case manager in mental health really
2 require the same kinds of skills. But when you get into
3 the actual clinical work, as you know, there are
4 differences in the treatment approaches and the etiology.
5 So that requires specialized training.

6 If we make the mistake of thinking that
7 everybody can be cross-trained in mental illness, mental
8 health, alcohol/drugs, then we have even a bigger workforce
9 development problem because we've got some people that are
10 over-trained for what they're doing. Lots of challenges.

11 I really think we need to kind of segment it
12 out, and I think we need to take a look at the kinds of
13 duties and functions that we need if we're going to have a
14 certain continuum of care, and then identify, as you
15 mentioned earlier when you kind of described your
16 historical life experiences, you don't necessarily need a
17 bachelor's degree or a master's degree even for some of
18 these case managers. But you do need certain competencies
19 and you do need certain personalities, and you do want
20 certain amounts of enthusiasm and passion.

21 So I think as we look at workforce development,
22 we've really got to kind of look at those different
23 positions and the different duties in a well-rounded
24 program and train to that or recruit to that.

25 MS. POWER: A very rich conversation, Ken, and

1 I hope we captured all of that because I think that's very
2 informative for all of the other matrix members to hear.
3 But specifically your notion that we need to envision the
4 system, what is the publicly funded mental health system
5 going to look like? What is the substance abuse treatment
6 system going to look like? What is substance abuse
7 prevention going to look like? What is primary care and
8 mental and substance use conditions, if they merge, going
9 to look like? So this whole notion of trying to envision
10 and then plan for what that future may be is really where
11 we are, and I think you captured that very nicely.

12 We've got four states basically represented
13 here -- and I'm including Oklahoma, Terry -- that have
14 tried to look at, from a transformation standpoint or from
15 a systems change standpoint, all of those things. And
16 every state will look at it differently. So that has
17 impact then for how Hawaii may want to think about their
18 approach to workforce. Oklahoma's transformation approach
19 is that they have an initiative to put consumers in the
20 workforce. That was the initiative that they had started.

21 What does that mean and what are the implications for the
22 future relative to who is going to do what and at what
23 level is it going to occur? So very rich conversation.

24 And, Ken, we may come back to you if you all
25 don't mind. We may come back and reach back to some of you

1 and say, can you give us a little more idea about this
2 segmenting issue? That might be very helpful.

3 Barbara?

4 MS. HUFF: Thank you. Thanks for your
5 presentation, for your interest in taking the lead on this,
6 amongst a million other things that you take the lead on.
7 I said to Gwynneth, I think it was, or somebody yesterday,
8 she's like the Energizer bunny. You know, you just don't
9 stop.

10 A million things run through my mind on this,
11 and I want to kind of segment it out into maybe three
12 areas.

13 I live in Kansas. It's a very rural state, and
14 we don't have what we need there in terms of a professional
15 workforce. Never have, probably never exactly will. So we
16 have a fabulous waiver, as you well know. Home and
17 community-based services. We're able to keep kids out of
18 home placements. Only half the mental health centers
19 utilize that waiver. I think if you looked real carefully,
20 you would find that the mental health centers are scared to
21 open the door for fear they can't provide the services in
22 the waiver. They don't have the man/person/woman power to
23 do it. So nobody is thinking through that with them. I
24 think they're scared to even kind of broach why this is
25 happening. Those that are utilizing it are doing a

1 fabulous job. And it is rural western Kansas that is not.

2 So that tells us something. And that's a general
3 statement about rural western Kansas.

4 So now I want to go to Nebraska for a second.
5 Being the kind of rural person that I am --

6 MR. STARK: Where are we going to now?

7 MS. HUFF: Nebraska.

8 My oldest daughter -- and many of you have
9 heard me talk about her -- is the one that has struggled
10 with breast cancer. She was living in North Platte,
11 Nebraska and she was running a program. The reason she was
12 is because the state offered up the mental health centers
13 in Nebraska a grant to do business differently, kind of to
14 promote wrap-around kind of concepts and processes for
15 doing business. So it was kind of a pot of money of about
16 \$100,000 or so for each of their regions. So they had six
17 in Nebraska.

18 So region 2 out in rural western Nebraska
19 decided to turn that down. They didn't want the money
20 because they couldn't provide the services, didn't want to
21 provide the services.

22 So Corrie, my daughter, was hired by Omni
23 Behavioral Health to go in and do that work that the mental
24 health center didn't want to do. She had an assistant and
25 she put \$50,000 in a checking account and then her salary

1 on top of that, but she basically had \$50,000 a year
2 flexible money. And she went in and provided at one time
3 23 families, who had kids that were at risk of going out of
4 Nebraska for services, the support and services in a 17-
5 county area surrounding North Platte. She provided those
6 services and supports.

7 In the end, when they evaluated this project,
8 program, whatever, they found out -- they asked the
9 families that had been served over a five-year period of
10 time because finally the mental health center got their
11 money back and they decided to just provide those 50-minute
12 mental health center visits with it. And she came back to
13 Kansas. But, nevertheless, they asked a question. And the
14 services that the families most wanted and utilized were
15 attendant care and tutoring for their children.

16 Now, Corrie trained up behavioral aides to work
17 in the schools and the schools paid for the behavioral
18 aides. She got managed care to pay for some services, and
19 she utilized Catholic Social Services and Lutheran Social
20 Services, places like that that were already providing
21 mental health services.

22 So for \$50,000 a year, it's just kind of
23 something to think about. These were all paraprofessional-
24 level people. A lot of college students provided attendant
25 care, which also acted as respite care, which also acted as

1 mentoring. You understand there's a broad kind of
2 definition for whatever attendant care can be.

3 So the bottom line for me in all of this in
4 watching that for five years roll out -- and it was the
5 kind of \$50,000 in a checkbook that you could write a check
6 for any service she wanted. She paid Lutheran Social
7 Services when she got mental health services for a child
8 and family. It's the kind of alternative that we don't
9 look at for rural communities very often, but I watched
10 this and it was most incredible. For \$50,000 a year, 17
11 counties on \$50,000 a year plus her salary, and she had one
12 support person kind of on the ground.

13 She has a master's degree in public
14 administration, but she has a sister with anorexia and drug
15 and alcohol problems and everything that Kristi has dealt
16 with over the years. So she lived with it and she knows it
17 and she loves working in it.

18 But the reason I say this is because I think
19 that we've got to look at some alternatives not just for
20 Systems of Care, Terry, which are never going to be in
21 every community in my lifetime probably. I'd love it if
22 they were. But what are some alternatives that we could
23 utilize in communities like in rural Nebraska or rural
24 Kansas if they don't have a system of care? What are some
25 other ways that we can look at this? And I'm also telling

1 you because I think there is a huge purpose for
2 paraprofessional-level trained-up and supported kind of
3 people.

4 Now, the last thing I want to say -- and I know
5 I am a terrible broken record about this with these
6 statewide family organizations. But again, I'm an interior
7 designer. I didn't know how to run the Federation of
8 Families for Children's Mental Health. I didn't know how
9 to run Keys for Networking. I had a lot of supportive
10 people around me that helped me do that. We cannot throw
11 the baby out with the bath water. If you need from us
12 certain kinds of data -- we are the paraprofessional
13 workforce running these family and consumer organizations.
14 We're, most of us, not trained up for this.

15 So I say to you we need the support just like
16 other people out there that are doing paraprofessional work
17 need. I feel like anytime you have this kind of rich
18 workforce, I think you need to bring them together and you
19 need to talk about what it is they need from the federal
20 government. And if you're not getting what you need or
21 what you think the field needs from them, then we need to
22 have some conversation about that, not just acts in the
23 budget.

24 So I make that one last point on that because I
25 think all paraprofessional support in the field needs a

1 certain level of oversight and support and training and
2 ongoing everything. Nevertheless, it has to be planned and
3 utilized carefully, but it works. I swear it works. And
4 we are never going to be at a place that we have got
5 psychiatrists wherever we need them and that we've got the
6 kind of workforce we really need out there to serve every
7 need.

8 Thanks.

9 MS. POWER: Thank you, Barbara. I think you've
10 really triggered a couple of things for us in terms of the
11 matrix discussion.

12 The first is that this whole notion about
13 paraprofessionals are alive and well and are the backbone
14 of the system, we really need to capture that and capture
15 that in a way that we can then speak to it and get data
16 about it. So I think that's a really important trigger.

17 And the other thing is in all of these reports
18 -- and particularly, I haven't read the rural one yet -- we
19 need to give models and examples, just like you talked
20 about in Nebraska, and describe that. So we come back to
21 you and say, give us your description, or I'll pull it from
22 the minutes and say, here's a model of a working program
23 that built on the strengths of the indigenous community.
24 And I think that's really an important principle.

25 MS. HUFF: You know, Bill Reay, who runs Omni

1 Behavioral Health in Nebraska in Omaha, and Corrie put
2 together a really wonderful presentation about that, and
3 I'm sure anytime would be happy to either send you their
4 overheads or present it to you.

5 MS. POWER: Thank you very much.

6 Please, Gwynneth. We'll go right down the line
7 here.

8 MS. DIETER: Yes. When you first began, of
9 course, the first question that came to my mind is why is
10 there a workforce shortage. It's come up over some of our
11 meetings several times, rural locations, isolation,
12 qualifications for work, maybe low pay. But in listening
13 to what Barbara is talking about, is part of it that very
14 fact that they're looking for people who are trained at a
15 certain level with certain qualifications? That person
16 isn't going to be paid enough there and isn't willing to go
17 there, but maybe we don't need to look for that person. I
18 mean, is that why there is a workforce shortage in part?

19 MS. POWER: Well, I think that the
20 acknowledgement about the shortage really comes with sort
21 of the demographics of the baby boomers coming into a
22 retirement mode. So that's what I meant about hearing
23 about the sky is falling. Demographically there is a
24 shift.

25 At the same time, there is a shift in the

1 demands for the kind and quality of services and what
2 people want, which is very different than in the
3 institutional-based system that might have been around or
4 very different from long-term inpatient care or long-term
5 residential care. We've moved into, over the last many
6 years, a much more consumer-focused, community-based world,
7 and that I think also speaks to the shortage, Gwynneth, in
8 terms of the field saying, we're not necessarily getting
9 the numbers of people or the right kind of people in terms
10 of their --

11 MS. DIETER: No, that's kind of what I was
12 thinking. It's not just numbers. It's looking at what
13 kind of people the workplace wants.

14 DR. GARY: Thank you for your continuing
15 support about issues regarding workforce.

16 When Ken was talking, it reminds me that in our
17 workforce, we have basically two levels, as I see it. I
18 think we have some universal issues, and then we have some
19 particular issues. Another way of saying that is we need
20 to have generalists and we need to have specialists.
21 Specialists will always be fewer in number than
22 generalists.

23 But if we track what happens to people, we know
24 that people in the public sector, poor people, don't get
25 specialty care until they get severely ill. It just

1 doesn't happen. So the question then becomes where do
2 individuals get care. They get care at public health
3 departments, community mental health centers, private
4 practice, nurse practitioners, primary health care, or they
5 get none at all until they get very, very severely ill.

6 We have to also look at the context. If we
7 look at the average length of stay in a hospital, for most
8 hospitals in the United States, it's between three to five
9 days. When I started as a psychiatric nurse, inpatient
10 unit, it was three to six months, sometimes a year.

11 So we have had a phenomenal paradigmatic shift
12 in terms of how we treat people, and I think every
13 inpatient unit in my mind is a crisis stabilization center
14 because as soon as we stabilize them because of the
15 psychopharmacologic agents now, they are out. I never
16 dreamed that I would be discharging people to the Salvation
17 Army or to Taco Bell, but that's what happens sometimes
18 because of the lack of resources.

19 Now, we do have psychopharmacologic agents that
20 can help people sustain themselves, but what's missing is
21 the human element for helping them with activities of daily
22 living, monitoring, and also the co-occurring issues such
23 as substance abuse. So I'm saying this to give some
24 context about how complex the workforce issue is and what
25 we need to do.

1 But despite that complexity, I have recognized
2 that when the federal government changes its priorities,
3 changes its agenda, and sets the standards for funding,
4 everybody else falls in line. Everybody falls in line. So
5 if you send out an RFA and you say these are the
6 requirements and there are \$3 million or \$4 million
7 attached, people change their curriculum, they change their
8 hours of service for students. Everything falls into
9 place. And so I think a lot of the power is driven by
10 money and resources which is set by the federal government.

11 So I think we need to remember that particular kind of
12 caveat.

13 We also need to do some critical thinking about
14 reimbursement in the real world. For an example,
15 psychiatrists. I'm sure Dr. Lehmann could address this.
16 Psychiatrists do medication checks now. One of the reasons
17 they do medication checks -- and all of the other kinds of
18 services are done by nurses, social workers, psychologists
19 and other paraprofessionals. One of the major reasons that
20 that happens is the reimbursement process. If you see
21 patients in group therapy/individual therapy, then you get
22 \$50. If you have a med check and ask, how are you doing,
23 Joe, and whatever, then the reimbursement is much more. So
24 psychiatrists feel that they need to make more money, and
25 that's how they have structured their practices all over

1 the United States. So I think we have to look at
2 reimbursement and rewards and incentives for the provider.

3 The other piece. Ken made the point about
4 public and private mental health. As I see public and
5 private mental health, what I have tracked over time is
6 that unless the person is the worried well, that individual
7 is going to eventually end up in the public sector. No one
8 can provide services for a family member in the private
9 sector for any sustained period of time. No one. It's
10 just too expensive.

11 So my effort would be to look at the public
12 mental health sector where the majority of people receive
13 their mental health care because once we set the bar high
14 there, I think the private sector has to at least meet that
15 kind of bar.

16 Plus, I think the private sector -- there's so
17 few now because a lot of the private hospitals, as you
18 know, over the last 20 years, have closed because they're
19 too expensive to operate.

20 I also would like to propose that we give some
21 serious thought to public health models, to get back to
22 what Ken said about prevention. I think we have to address
23 both. We have to address prevention, but we also have to
24 recognize that we have people (inaudible) some kind of
25 care, various gradations of care by specialists, by

1 generalists, by paraprofessionals or whatever. But they
2 will need care. So I highly recommend that we look at the
3 public health model.

4 I also would ask that you and the committee --
5 and I'd be happy to help -- look at the early blueprint for
6 community mental health that was designed a long time ago
7 when I was a student. I did my thesis about it. It had
8 something like 12 required services: consultation, school
9 consultation, school services, the chronically mentally
10 ill, hotline services, crisis intervention. And over a
11 period of years, all of that got chipped away. I'd like to
12 state that I think that works, and it was in communities.

13 The other piece I'd like to add here is that we
14 give some serious thought to self-help groups, which we've
15 never really invested a lot of time and energy in doing.
16 That empowers individuals. That helps them to be
17 accountable and responsible for their own illnesses.
18 There, again, is a lot of good work done at the University
19 of Vermont on self-help groups.

20 But one thing we have not done is we've not
21 embraced them. We've not made them a part of our culture,
22 and I think it's time for us to do that because mental
23 illness is, indeed, a chronic kind of condition that can be
24 controlled with the psychopharmacologic agents, but
25 individuals do not do well unless they have all of the

1 other support systems that the rest of us who call
2 ourselves normal and well have every day.

3 I truly embrace and endorse the
4 paraprofessionals. I think that education needs to take
5 place in academic communities. I agree with Ken that it
6 has to be competency-driven and perhaps even a licensure
7 associated with it. So that's our one way to assure levels
8 of competency and basic levels of performance.

9 In conclusion, I do not think that we can plan
10 any program without looking at issues regarding diversity
11 of the workforce, diversity of the populations of
12 individuals who get sick. And I think we also have to look
13 at the social determinants that set people up for mental
14 illnesses and co-occurring disorders and maintain them
15 there.

16 Another way of looking at this is how do people
17 get homeless and what do we do that helps them to stay
18 homeless because I think that we really do know that people
19 need more than housing. They need education. They need
20 jobs. They need work. They need incentives. They need
21 the same thing that we do. So I think we have to look at
22 our comprehensive programs. That brings me to the notion
23 of looking with what the Department of Labor can provide,
24 what FEMA can provide, what NIMH can provide, the Cancer
25 Institute, whatever.

1 Again, I think the trump card is at the federal
2 government because that's where colleges, universities,
3 institutions, and service agencies get their money. So I
4 think if we structure our agenda, people will have no
5 choice but to look at this new paradigmatic shift that is
6 going on.

7 Thank you.

8 MS. POWER: Thank you, Faye. Tremendously rich
9 commentary.

10 I was actually going to try to respond to each
11 one, and I can't because I was ticking off in my brain,
12 well, let me tell Faye about what we're doing in peer
13 support services, et cetera, but I won't do that. Thank
14 you so much for all of that rich commentary.

15 Tom?

16 DR. KIRK: I don't want to repeat what other
17 people have mentioned.

18 What I would suggest is I think the workforce
19 development piece can serve as a core, if you will, center
20 of any number of other issues. Let me try to tie them
21 together.

22 At least in Connecticut, there's a lot of
23 attention to health care plans. Universal health care
24 plans or something in accord with that. I think that this
25 particular focus that you're working on, as well as on the

1 state level, is an opportunity to tie to those health care
2 plans. Let me give you a couple examples.

3 I think the distinction between the
4 public/private sector is increasingly small. We all can
5 have the best wish that a parity plan is going to pay for
6 what it is we want to pay for, but I can't wait for that
7 for the people that need services. So we will have people
8 who are in the private sector with family members with
9 substance abuse or mental health issues, and they're
10 willing to pay big-time dollars to buy their services from
11 the state system.

12 In the report you did where you went into the
13 business community and they were willing to buy from state
14 systems, that to me says the distinction between public and
15 private is fast decreasing. So I think as we look at this,
16 an important premise would say that that is decreasing and,
17 therefore, it should affect how we go about our business.

18 Going back to the health care component -- I
19 think I mentioned this yesterday -- the data reveal that
20 persons with serious psychiatric disabilities have life
21 spans as many 15 years less than other persons of generally
22 healthy conditions. I was talking to one of my substance
23 abuse providers last week, and he was saying he has a lot
24 of recovery people in his service system. And guess what.
25 His health care plan costs are extraordinarily high

1 because of their history.

2 So tying it to the fact that people with
3 psychiatric disorders, people with substance abuse
4 disorders have serious health care conditions associated
5 with that, tie it back to the health care plan. If you
6 want to make an investment in managing health care costs,
7 pay attention to these particular issues, and that would
8 then tie it to the wellness piece.

9 Two other comments. We had a brief
10 conversation yesterday. It ties back to your point about
11 case management. Somebody once told me, Commissioner, you
12 don't have a treatment system in mental health. You have a
13 case management system. I don't necessarily think that's
14 bad as much as it needs to be tweaked. "Tweak" is probably
15 an understatement.

16 And when we've talked with those case managers
17 about a recovery-oriented model where the person and the
18 family member have more to say about what occurs, as one of
19 them said, you know, I've been working with these patients,
20 clients, consumers, whatever you're comfortable with, for
21 the last 10 years. It's to the point where if they were
22 going to commit suicide or make a suicide attempt, I will
23 tell you where they would go, I would know what their
24 method was to do it, and you want me to sit with them and
25 negotiate what it is care should be? Their view is that

1 I've managed those cases. I know them well, and this thing
2 of empowering the consumer to be more a part is going to be
3 a challenge.

4 In a similar way, when you talk about the
5 workforce piece, again, it was mentioned yesterday the
6 largest amount of face time with the people we serve is not
7 people like me or executive directors. They are the line
8 staff, and they represent the largest proportion of the
9 workforce. I'll speak for myself. I don't think that I
10 pay anywhere near the attention to direct line staff and
11 empowering them and training them as we should. They're
12 the ones that are the true change agents in a service
13 system. So I think that when we look at these workforce
14 development pieces, I think some attention should be paid
15 to who are the true change agents in terms of care.
16 They're not the executive director types. They are the
17 people who were at the line level.

18 The last point I would like to make is that if
19 you think of tying us to a health care focus and health
20 care plans and uncompensated care as the major component,
21 if you think of the fact that the distinction between
22 private and public is no longer as strong as it was before,
23 if you think of the fact that a large majority of the
24 people that we try to provide care for have continuing care
25 disorders -- I won't use the word "chronic" -- and just

1 like the rest of us, they need what I call recovery
2 checkups -- you know, you come back and then go on -- that
3 the structure of our service system and the role and vision
4 of SAMHSA as to what its responsibility is is very, very
5 different. I'll use this one example.

6 We're rebidding our service system, and one of
7 the points we were trying to make was how do we have more
8 access types of approaches in the front end and how do we
9 have more continuing care approaches in the back end.
10 Someone came up with the idea of we should not continue to
11 fund solely mental health treatment centers, substance
12 abuse treatment centers. We should go ahead and put in
13 place something we call continuing care centers. A person
14 would move from the intensive treatment component to some
15 variation thereof, and they come back for continuing care
16 support, very, very community-focused, sort of playing off
17 the SPF/SIG. But that's very different from our service
18 system. I think it also would serve to diffuse, if you
19 will, some of the stigma that's associated with the field.

20 My last comment is that if you think of things
21 from this point of view -- and I may not be very clear in
22 these things -- it seems to me that this has extraordinary
23 implications for who and what SAMHSA is. I think my mental
24 health folks will tell me, you know, Commissioner, you've
25 got to pay attention to the fact that these persons with

1 serious, persistent mental illness will always be
2 shortchanged in our larger health care system. And that's
3 why we need to continue to focus just on them. The mental
4 health transformation piece, in my judgment, says that has
5 to change, but it's not to shortchange those persons with
6 serious, persistent mental illness as much as it is to have
7 a more responsive service system at every tier, so whether
8 it's disparities or others.

9 And for all those reasons I think there's a
10 confluence of context factors that says the vision and role
11 of SAMHSA -- I think, Dr. Cline, what you're saying in
12 terms of the vision and mission, I think that they're right
13 on the mark. But what the infrastructure is that supports
14 that is different. So as we continue with what you might
15 call a visioning process, or whatever it is -- just a side
16 comment.

17 When you look at the data, at least in my
18 state, for why people are dying at such a premature age,
19 it's not the suicide. It's not drug overdose. It's
20 related to diabetes, respiratory problems, the things that
21 you and I are likely to die from. I grieve, if you will,
22 when critical incidents come across my desk, as they do, at
23 a 50-year-old person in our service system has died from a
24 heart attack. As a psychiatrist in a forum that I was at
25 recently said, it's gotten to the point where he frankly

1 can say to a person, I can tell you you're not going to die
2 from your psychiatric disorder. You're going to die from a
3 diabetic condition, and I don't know how to treat diabetic
4 conditions. It's a whole different framework.

5 And I think that as you look at SAMHSA for the
6 next X number of years -- and I don't understand things
7 like reauthorization and what that means, but it seems to
8 me the role of SAMHSA in accord with the mission that you
9 have or the vision that you have -- there's an opportunity
10 for redefinition and not simply continuing to do what we've
11 been doing for all this time. And I think the workforce
12 piece is a great, great vehicle to run the course, so to
13 speak, run the agenda.

14 So I applaud the fact you're taking it on.
15 There's no doubt that if you look at it just from a
16 workforce development point of view, it's there. My point
17 is I think it's an opportunity to tie things to health
18 care, to the other kinds of components, to broaden the
19 focus, and I think we can get the choir to be broader
20 because someone may say, I could care less about mental
21 health addiction issues. Do you care about health care?
22 Yes, I do. Then fine. Tie it to that.

23 So that's my comment.

24 MS. POWER: Thank you very much, Tom.

25 Ken?

1 MR. STARK: Keying off that, when I think about
2 the tremendous sort of community process we went through
3 the first year of the transformation grant, many, many
4 public meetings and 6,000 pages of transcription from those
5 community meetings, which was totally overwhelming, the
6 message that truly came out from family members and
7 consumers was that we really do need whether you want to
8 call it an addition to or a transformation of the existing
9 system. The consumers and families wanted to see some
10 significant availability of like recovery support centers
11 and programs that were run by families and by consumers who
12 had specific training and experience and that it didn't
13 have to be a real expensive, big, professionalized trained
14 program with psychiatrists and doctors, although as part of
15 the system, they needed to be there.

16 But many of the consumers felt for the
17 stability of their recovery -- without having that system
18 in place, some of them got through with family and with the
19 faith community and other friends that helped them when
20 they had a crisis. But others ended up having to go to the
21 professional system who has a standard operating protocol
22 of interventions, which they didn't feel was helpful to
23 them at that time.

24 So that kind of ties in yesterday with the
25 comment I made about, if nothing else, looking at the

1 Access to Recovery Grants on the alcohol/drug side, the ATR
2 grants, and seeing about their usefulness in the mental
3 health community.

4 When I then kind of look at Washington State
5 and see our system, I recall during that process we had
6 interviews with physicians and health plans. There's this
7 group of health plans we have in Washington State called
8 Healthy Options. Those are managed care, physical health
9 plans that are available mostly to TANF families. It does
10 have a small mental health benefit in it, up to 12 visits,
11 but most of it's really tied to medical.

12 When you talk to the physicians in those health
13 plans, their feeling was that they as physicians were more
14 than adequately confident that they could basically deal
15 with sort of the walking wounded, if you will. I hate that
16 term, but I think most of us know what it means in terms of
17 not the severe, persistent mental illness diagnosis, but
18 people who are having challenges with daily life and
19 whatnot that may, in fact, get worse if somebody doesn't
20 intervene. But those physicians felt that they could
21 handle those cases. But they clearly didn't feel that they
22 handle the more severe diagnoses, and they would then send
23 them off to the other system, the mental health system.

24 I keep thinking to myself that we've got to
25 figure out and agree. Are we going to part of a health

1 system, going back to what you said, Tom, and my harping,
2 if you will, on this terminology of behavioral health --
3 are we or are we not going to be part of the health system?

4 If we are, we've got to vision that. We've got to change
5 our language and support that so that we really are seen as
6 part of the health and wellness system.

7 Then we've got to figure out how we sort of
8 integrate some of that primary care stuff on both the
9 prevention and intervention side, along with the
10 alcohol/drug stuff, along with the mental health stuff.
11 And that doesn't mean merge all these systems. What it
12 means is integrate the care when and where appropriate.
13 And I'll give a simple example of something that's fairly
14 low cost to do.

15 If you're running a mental health center, for
16 instance, and given the research that Tom speaks of, of the
17 fact that many people with severe and persistent mental
18 illness die 15 years younger than folks without severe and
19 persistent mental illness and die at an average age of 54
20 -- and they do die from things like diabetes and stroke and
21 heart disease, and if you look at the risk factors of those
22 individuals, the risk factors are around smoking and
23 substance abuse and obesity, lack of exercise, that sort of
24 thing.

25 What that tells me is that, okay, fine, as a

1 strategy within our mental health centers, shouldn't we be
2 looking at, in addition to the traditional mental health
3 services, some pretty strong sort of health and wellness
4 programs within those centers that talk about simple things
5 like --

6 MS. POWER: Nutrition.

7 MR. STARK: Yes. Training and teaching people
8 about how to cook nutritious meals, how to buy low-cost,
9 but nutritious meals. They come to the center, and as part
10 of coming to the center, maybe you can have some low-impact
11 aerobics stuff going on on a regular basis and maybe you
12 can do walkabouts in the neighborhood kind of a thing.

13 But those are simple, low-cost things that are
14 preventive, and they are health and wellness, and they are
15 ways of sort of integrating services without breaking the
16 bank and then, at the same time, having these recovery
17 support sessions, whether you want to call them tune-ups or
18 whatever you want to call them for individuals. But they
19 don't always have to be tied to mental health centers
20 either. They can be tied to community, family, and
21 consumer organizations.

22 So it is going to take a transformation. I
23 think we all need to talk about that. We all have our
24 biases. When I talked to those physicians, by the way, and
25 we talked about, well, where would you refer, many of the

1 physicians aren't comfortable with paraprofessionals. They
2 won't even refer to psychologists, some of them. They want
3 a psychiatrist, only a psychiatrist. So we've got to kind
4 of get past those biases too, as we move forward.

5 MS. POWER: Thank you very much, Ken.

6 Larry?

7 DR. LEHMANN: Yes, just a few things. I'm
8 extremely lucky to work in a system like VA where mental
9 health and other health care are kind of together a lot
10 more than in a lot of other public and certainly private
11 systems.

12 But we still have our work cut out for us, and
13 one of the things that we're doing is actually putting some
14 money into models of collocated and collaborative care
15 where mental health clinicians of a variety of stripes --
16 there are some psychiatrists, mostly social workers,
17 nurses, and psychologists -- are actually going to be
18 working with the primary care folks. It will decompress
19 them tremendously. Wherever you see these programs
20 popping, they're really appreciated by the primary care
21 folks. So it's part of the idea if you fund it, people
22 will use it. That's much more difficult to do, I think,
23 outside a system like ours.

24 But the other thing is for ourselves within the
25 mental health provider community, we really have to educate

1 up our folks into the value and the power of the recovery-
2 oriented activities. And we have some very, very, very
3 good examples of that, certainly within VA where we have in
4 our network -- three in New York -- they had like 100
5 people who were like long-term stay people in their
6 facilities, and they whittled them down to about 13 using a
7 pure recovery-based system where these folks were helping
8 to run each other's programs.

9 Now, sure, in VA, the patients have all been in
10 the military. They hark back to those kinds of things.
11 But you can develop comparable approaches to this.
12 Certainly that's what AA has been doing for years.

13 So we've got to train up our people. This gets
14 back to the issue of the curriculums. We've really got to
15 train up our people in high school, in university, in the
16 medical and nursing schools about the value of these
17 approaches so that people who go into primary care will be
18 able to accept it and people who go into the mental health
19 professions will be able to accept it, kind of a second
20 nature. So this whole business of having to focus on
21 workforce development is really something we can capitalize
22 on. It's come at a marvelous time.

23 The other thing is the fact that second-
24 generation antipsychotics have these problems of a
25 metabolic syndrome of increasing cholesterol and

1 triglycerides is kind of a blessing in disguise because
2 it's been a tremendous kick in the pants to the mental
3 health professionals who are saying, oh, my gosh, I've got
4 to look at diabetes. I've got to look at health promotion
5 because otherwise these folks who really may need this
6 medication are going to start dying from something else,
7 which is what I don't want.

8 So it's a two-way street and just a lot of
9 opportunities for presenting the range of models that may
10 work in different areas and teaching that to people as
11 they're coming up in their education, but then also using
12 -- and I hark back to the presentation yesterday about the
13 train the trainer models. If you can start working with
14 people who are actively engaged in care now, that's a very,
15 very, very good model. We've been using this since the
16 1970s in prevention and management of disturbed behavior,
17 for example. And you've got a cadre of folks who are
18 master trainers and people who are trained up in our
19 facilities for doing that. It builds generations of people
20 who understand how to use a particular model. So in a
21 sense, what I would suggest is use train the trainer for
22 the people who are in the professions now and then teach
23 the ones who are coming up these concepts so that they'll
24 be able to pick that up and use it in the future.

25 MS. POWER: Thank you very, very much. I know

1 we are running out of time.

2 MS. SULLIVAN: Kathryn?

3 MS. POWER: Yes, I was going to ask Kathleen if
4 you wanted to say something about the workforce strategy.

5 MS. SULLIVAN: Thank you. Two things. One on
6 early retirees and the second on continuing education, one,
7 a personal note.

8 And Barbara, you know, I love your
9 personal notes.

10 But one of my former producers, believe it or
11 not, at CBS and then she was also at NBC, is now living in
12 Montecito of all places. She got her master's in social
13 work after she left CBS, and now she works with substance
14 abuse and the mentally ill in Santa Barbara. For her, it's
15 her secondary career.

16 I see this as a great opportunity now for those
17 people who have left one career. They have early
18 retirement and they want a secondary career. As you said,
19 many people come from other arts or from music and want to
20 once again contribute to the society. And how do you make
21 that aware to people?

22 I was thinking I live in an area of actually
23 now early retirees where we're seeing people retiring here
24 at 50. And, Ken, you're up in Washington with a great
25 amount of affluence in the Seattle area. And there are

1 pockets now of people who want to recontribute to society,
2 and we see the turnover of occupations where in the
3 continuing education realm, with continuing education
4 classes being offered all over the country now through
5 universities -- I don't know, Kathryn, do you have an arm
6 that has reached into the Department of Education or how
7 that works actually. If continuing education classes can
8 be created -- and, Faye, you would know much of this. How
9 it could be stimulated where people could get this training at
10 least through continuing education courses at the community
11 colleges so that the retiree group, the fifties, people who
12 are 50 years old can see this as an opportunity. I'm not
13 looking at the 20s and the 30s, but the 50-year-olds who
14 see it as a secondary career.

15 MS. POWER: Yes, I think it's absolutely
16 something that we need to look at and consider. I just saw
17 a monograph yesterday about how we should take on and look
18 at that cohort in terms of training for second and third
19 careers relative to giving back to society and kind of
20 looking at it from not only the paraprofessional approach.
21 So, yes, we'll look at that and take it under
22 consideration.

23 Actually, there are some model programs in some
24 communities that have been cited in the Annapolis Coalition
25 report where they did do a particular recruitment strategy

1 towards that. So we can cite some of those.

2 I know, Faye, you want to make a comment and
3 then, Governor, if you wanted to make any comment about
4 workforce before we end, and then we'll move to the end of
5 this discussion. Thank you.

6 DR. GARY: This is very, very quick. I just
7 wanted to add to what Tom and Ken were talking about, and
8 also when I heard Kathleen, I thought that one of the other
9 pieces that we haven't mentioned here today regarding
10 workforce -- and as we look at workforce as a major, major
11 catalyst to transformation, I would ask that we also
12 integrate into any plan a specific agenda to do more
13 teaching with the patients and with their families. I
14 encounter patients who have had schizophrenia for 20 years
15 and they don't know anything about the illness or the
16 families who feel so disenfranchised because they say the
17 professionals won't talk with them about the illness. I
18 know there are issues of confidentiality, et cetera. But
19 beyond that, I think we have to engage families.

20 If you look at some of the earlier work done by
21 a man named Lamb -- he was at UCLA. I don't know now --
22 where he used to literally invite the families of the
23 patients into the auditorium at the university and they
24 would have these one-on-one lectures. And I've done the
25 same kind of thing with families, and they really love it

1 and appreciate it, feel empowered, much more cooperative
2 with their families, and perhaps it even decreased the need
3 for hospitalization.

4 The other and final comment is that as we look
5 at models that would integrate primary health care, the
6 mind and the body as one, and we look at public health
7 models, I think we need to examine what the World Health
8 Organization has done in many of the other countries
9 throughout the world. There are some excellent, excellent
10 models that involve communities, families, self-help
11 groups, community health workers, et cetera.

12 Thank you.

13 MS. POWER: Thank you, Faye.

14 Governor?

15 MR. AIONA: Very briefly. We had a great
16 discussion. A lot of merit to what everybody has said.
17 I'm just here maybe just to summarize what I envision and
18 what I see.

19 I would just say that SAMHSA can't drop the
20 ball on this. We've heard this term being used the last
21 couple of days. I really believe that there's urgency to
22 workforce development. I just hope SAMHSA doesn't, one,
23 first of all, define workforce development in its
24 traditional sense, which is we need to train up more
25 psychologists or psychiatrists or substance abuse

1 counselors and these are the skills and the knowledge that
2 they need because it's much more than that, as we've seen
3 through this discussion, about what workforce development
4 is all about.

5 When I listened to everything and I tried to
6 sum it up, I came away with this. I keep thinking this,
7 that it seems like everyone in this room is a part of this
8 workforce. We're all a part of it, and we all, to some
9 extent, have degree of knowledge and skill in regards to
10 what is needed to help people who have -- and we'll use our
11 traditional terms here -- substance abuse problems and
12 mental health problems.

13 So you have an opportunity. Or I should say
14 SAMHSA -- not an opportunity, but SAMHSA needs to take the
15 lead in making sure that when we talk about workforce
16 development and where we're going to go, we're going to
17 change this paradigm and we're going to make it now such
18 that it's broad enough for the simple lay person to be a
19 part of this, and they need to be a part of it.

20 And that's basically all I have to say.
21 Everything else was just a great discussion.

22 MS. POWER: Thank you very much. Terry, I
23 appreciate the opportunity to come before the council. I
24 want to thank all of the council members for your
25 tremendous engagement in this discussion, and I look

1 forward to following up with you.

2 DR. CLINE: Thank you, Kathryn. Thank you,
3 members of the council. That was very rich. And thank you
4 for the summary as well, which I think hit the nail right
5 on the head.

6 At this time, we don't have a scheduled break,
7 but I would like to check with the council to see if you
8 would like to take a 10-minute break and reconvene or
9 whether you would prefer to charge ahead. What's the will
10 of the council?

11 Time for a break? Okay, let's go with the two
12 people who spoke first. We'll take a 10-minute break and
13 reconvene in 10 minutes. Thank you.

14 (Recess.)

15 DR. CLINE: We're going to jump right back into
16 it here. Thank you for coming back to the table.

17 We have about 35 minutes remaining before we
18 need to adjourn. I know some people have flights and other
19 commitments.

20 The good news on this is the precursor to our
21 work started during our last conversation. So this is like
22 priming the pump, to use an Oklahoma expression. I don't
23 know how often it gets used here, but I think the pump is
24 primed.

25 The other good news is we have another good

1 facilitator, much as we had with Kathryn, now and we are in
2 the hands of Governor Aiona. So I will turn it over to you
3 at this point.

4 MR. AIONA: Thank you, and let's not waste a
5 minute of the 35 minutes that we have.

6 We actually started this yesterday. When we
7 opened up, I had asked that we all think about issues or
8 topics that we wanted discuss at our subsequent meetings.

9 Then yesterday we started talking about how as
10 an advisory group we could help you, Dr. Cline, and SAMHSA
11 in its role and in accomplishing its mission and its
12 vision. So I'd like to open up discussion on those two
13 topics, and I guess if we could summarize it and put it
14 under one heading, I guess the line of discussion would be
15 how can we, as the advisory group, develop and assist and
16 advise or create a vision for SAMHSA in the subsequent
17 meetings that we have from today.

18 As an example, yesterday we had great
19 discussion on the budget. Everyone was very much in tune
20 with it. We understand, I think, as a body how the budget
21 will drive the mission and the vision of SAMHSA, and I
22 think we all want to be a part of it. For me -- now I'm
23 speaking on behalf of myself -- if it's at all possible, I
24 would like to be a part of developing that budget in a more
25 relevant setting and time constraints. I mean, in other

1 words, I know it's a little too late for this new -- is it
2 a biennium budget that SAMHSA has?

3 DR. CLINE: Yearly.

4 MR. AIONA: A yearly budget? Well, being a
5 part of it before it happens when discussion is happening
6 so we can kind of shape it that way, I'd like to be a part
7 of that. I understand the policy constraints that the
8 agency has, but nonetheless, I think we can add because of
9 our diversity here in not only what we do, but where we
10 come from. I think we could add a lot to how the budget is
11 shaped.

12 So I throw that out for discussion, and
13 anything else that would come to mind to our members here.

14 So I open it up to anyone, or we can go down the line. It
15 doesn't matter, however we want to do it.

16 Ken?

17 MR. STARK: I would agree, Duke. The issue for
18 me yesterday was just as you described it a minute ago, and
19 that is, that it really would be nice to feel like, talking
20 for myself, that I had an opportunity to have input into
21 and possibly influence the future agenda. And I, too,
22 understand all the constraints. I'm not interested in
23 trying to be a decision-maker around individual budget
24 items. I mean, that's not appropriate for an advisory
25 group.

1 But clearly, in looking at your future budgets,
2 are there ways that I and the other members can actually
3 take a look at some of the program areas, some of the focus
4 areas that you might be looking at relative to priorities
5 for the 2009 budget or the 2010 budget?

6 I've already sort of mentioned some of the
7 things both this morning and yesterday that I clearly want
8 to recommend, and that's looking at things like ATR and
9 SBIRT for both mental health and alcohol/drugs and looking
10 at the prevention arena across SAMHSA so that it's looking
11 at prevention and early intervention for mental health and
12 alcohol/drugs.

13 And then there are other things that I'd be
14 very interested in understanding, the kinds of criteria
15 that was applied to different programs as you talk about
16 elimination of those programs. Again, just feeling like
17 I'm making a difference, and knowing that having an
18 opportunity to give input and getting my way are two
19 different things, I clearly understand that.

20 DR. CLINE: Governor, if I could just make a
21 quick comment.

22 MR. AIONA: Sure.

23 DR. CLINE: Ken, as you mentioned all those
24 program areas or areas of focus, what would be helpful, in
25 addition to identifying those, is going that one step

1 further. What would you want those to look like in five
2 years or ten years? And then as we get input from multiple
3 stakeholders and others, then we can try to put that
4 together and try to operationalize some of those ideas so
5 that they're consistent with the vision and mission for
6 SAMHSA.

7 Because you outlined those so clearly, could
8 you take a couple of those and just say briefly what you
9 would hope those would look like in the future?

10 MR. STARK: Just quickly, and not just focusing
11 on SBIRT or ATR, for instance, or necessarily just
12 prevention specifically. And this is sometimes heresy as a
13 state person to say this to a federal agency, but I go back
14 to the alcohol/drug system and one of the things that
15 SAMHSA did in order to promote prevention was, in fact, to
16 push the issue via a requirement. And I hate set-asides,
17 but at the same time, I also know as a manager, when you're
18 trying to influence systems that already feel buried with
19 where they're at and already have their own stakeholder
20 pressures and politics, that sometimes those with the money
21 need to use the money to influence and shape future policy.

22 So from a strategy perspective, if I'm looking
23 at, say, prevention and if we truly believe that mental
24 health and alcohol/drugs both need to have a continuum from
25 prevention, early intervention to crisis and acute, it

1 seems to me that somehow getting that written into SAMHSA's
2 vision and then that vision gets translated into the block
3 grant that gets translated into discretionary funds that
4 are available -- I mean, I look at the transformation
5 grant. One of the ways that SAMHSA is trying to transform
6 states' mental health systems is through a grant program.
7 If we want to look at things like ATR and SBIRT on the
8 mental health side, then similar to what you did on the
9 alcohol/drug side, you used the resources as an incentive
10 and made it a competitive process.

11 And I think that those are the ways that a
12 federal agency as a funder, as a payor is going to cause
13 systems change. As sad as it is to say that it's done
14 through money, it is done through money. I mean, that's
15 the way states do it with their locals. That's the way
16 substate regions do it with their providers or community
17 organizations. One of the ways to influence policy change
18 is by the incentive called "resources."

19 So I think that that's something that I would
20 encourage even though it may be somewhat heresy coming from
21 a person from the state to tell a federal agency to require
22 that of us or push us in that direction.

23 MR. AIONA: Anyone? Go head, Faye.

24 DR. GARY: In the future, I think it would be
25 also helpful for us if we would be able to get more

1 information about our programs that SAMHSA funds, supports
2 so that we can see what the outcomes are and probably spend
3 time discussing those outcomes, what makes that work, and
4 why things did not work. In other words, I think we would
5 be getting at the crux of core issues in substance abuse
6 and mental health if we were to be more involved in that
7 and to use those kinds of data, again, to shape future
8 strategic plans, policy, content for RFAs, et cetera.

9 And for some specific kinds of areas on our
10 matrix, I think that we should know what specific
11 activities relate to our matrix and what is the profile of
12 those particular activities, whether you're talking about
13 homelessness, if you're talking about restraints, seclusion
14 and restraint, or we're talking about child mental health
15 issues, so we can have some general view of what we do
16 have. And then we can talk from a more informed posture
17 about what it is that we need.

18 MR. AIONA: Thank you.

19 Yes, Barbara?

20 MS. HUFF: I, too, think it would be a great
21 idea if we did have some input into the development of the
22 budget. It's not really the development but some response
23 to what you're funding, as they said, based on what you
24 think the outcome is and things are or are not.

25 I'm probably not going to be on the advisory

1 council long enough to maybe get totally engrossed in that
2 or invested in it, if you do it. If I could envision what
3 it might look like, for me I think it would be a marvelous
4 idea to bring four family leaders in to sit in front of
5 this council and talk about -- I think SAMHSA is lacking
6 huge in family involvement in mental health. There is no
7 family involvement across substance abuse treatment and
8 prevention.

9 I sat in the room before Sandra took my
10 position at the federation and had some discussion with the
11 leaders, but the leadership has changed in some areas too.

12 But to just kind of sit down and have some conversation,
13 listen to what it is they say they do and need and what
14 kind of support they need from you -- but also if you read
15 -- do you remember reading "Blamed and Ashamed" at all when
16 we had the Tulsa conference? And there was a huge, big
17 focus on co-occurring with kids. SAMHSA funded "Blamed and
18 Ashamed," and it was around co-occurring mental
19 health/substance abuse issues with kids and with
20 adolescents.

21 I think it would be a great idea to hear how
22 families think they'd like to be involved at the local or
23 state level, community level, and at this level around both
24 substance abuse treatment, prevention, and mental health.
25 I also think they could provide some conversation with you

1 at some point in time. I think that we need to sit back.

2 I think Systems of Care is wonderful and it's
3 moving along and it continues to be funded. Evaluation
4 still tells us it's worth doing. But like I said, I think
5 there may be a place and time that we want to bring forward
6 some other ideas and options for service delivery for kids
7 in different kinds of communities, whether it be urban or
8 rural or whatever. I think it would be a good idea to hear
9 from families, where they think this is at right now.

10 You're new and I think it would just be
11 phenomenal to bring in -- and I'll even tell you that New
12 York, Georgia, Mississippi, and Kansas will give you a huge
13 diversity of people to listen to and very strong family
14 leaders who have been around for a while. I think it would
15 be well worthwhile to bring a few people together and have
16 some conversation with you about the value of families
17 across SAMHSA.

18 Thanks.

19 MR. AIONA: Thank you, Barbara.

20 Gwynn?

21 MS. DIETER: Yes, I agree with what Duke said
22 and several other people that we would all like to feel
23 that we're making a contribution and helping SAMHSA in
24 whatever way possible.

25 The vision or your plan really drives the

1 budget. At this point in time, there is a transformation
2 agenda going on. So there are items in the budget, of
3 course, that are from an earlier time and place.

4 I think what I was struggling with yesterday --
5 and just thinking about the budget, I also do not want to
6 look at any line items and say, this program -- I have no
7 idea. But I would like to get a sense of how the vision, a
8 newer vision for SAMHSA, follows into that budget. I would
9 like to see that happening and would like to be, hopefully,
10 involved in that way.

11 We're talking about a shift in the paradigm of
12 the workforce also in relation to transformation of mental
13 health, substance abuse, treatment, or an overall health
14 model more than a crisis intervention/treatment model. I
15 think that's why the budget was an item that got some
16 discussion before because we're all wondering how does this
17 reflect what we're trying to do here. And a lot of times,
18 just as in a household, okay, now my daughter is going to
19 college, there's going to be shift in my budget. We're no
20 longer going to go on vacation because we're going to put
21 this money to her. Things happen and I'm interested in
22 seeing how we can help in assisting in this somewhat of a
23 shift in strategy and vision and how that's then reflected
24 through into the budget.

25 MR. AIONA: Ken?

1 MR. STARK: Kind of the way I see that
2 potentially happening, in terms of a process standpoint, is
3 -- I mean, we have to get the timing right, given obviously
4 all of time lines that SAMHSA has to meet in developing
5 their plans. But it sure seems to me that we could have an
6 annual work session. I won't call it a retreat because
7 that makes it sound like we're partying on the beach, but
8 an annual work session where we're, as a group, able to
9 take a look at some future time, whether that's looking at
10 2010 or 2011 or however far out we have to go, where the
11 decisions haven't been made yet. And you can kind of use
12 us as a body to help give you some feedback on some of the
13 priority areas that we might see that maybe you can take a
14 look at.

15 At the same time, depending upon how that's set
16 up, if you've already done with your staff and whatever
17 mechanisms you've had and gotten some input on that and
18 have some ideas of direction you're already wanting to go,
19 that could be brought to us. You can give us that input,
20 and then you can get some feedback from us. Then from
21 there, you go forward with whatever else you need to do.
22 And then the rest of that year for us could be dealing with
23 issues more in the current day of getting to know what's
24 happening now, this year, including some of the stuff that
25 Barbara talked about and getting us more educated on some

1 of those program areas of national significance. There's a
2 whole lot of different stuff.

3 The more we -- and when I say "we," I'm even
4 talking about future advisory council members as we go off.

5 The more we as council members understand about the
6 programs that are out there and how those programs tie into
7 the ultimate vision and mission and how well they're
8 working, the more we're going to be effective at giving you
9 input into the future budgets in terms of program areas and
10 whatnot, again, from our perspective. So that's just an
11 idea.

12 MR. AIONA: Yes, sir? Tom.

13 DR. KIRK: The impression I have from the last
14 day and a half is that the issues related to mental health
15 and addictions, whether you want to call it transformation,
16 system change, whatever, that there are some very, very
17 significant differences. I think, at least what I've
18 picked up, the definition of what a service is is different
19 than what it used to be. Access to Recovery got us into
20 housing, transportation, other kinds of things, and we
21 concluded -- and the evidence is there -- those are
22 significant components to improve the quality of life,
23 stability, recovery, and so on.

24 Mental health transformation. We're looking at
25 things in mental health transformation that in a

1 traditional sense would never be considered services.

2 The structure of the service system. We go
3 back to the health care and a side conversation. What's
4 the structure of the service system that goes beyond just
5 the mental health clinic and the substance abuse treatment
6 agency or the regional prevention component? So what's the
7 definition of a service in this new system? What's the
8 structure of the way we deliver services, how we deliver
9 them, and who is the target population? Is it an
10 individual? Is it a family? Is it a community?

11 My point is that when you look at all those
12 different dimensions, the traditional system that most of
13 us were either trained on or grew up on over all these
14 years, it's not the same.

15 And when I look at this piece here, I thought
16 one of the striking -- and apparently you all were thinking
17 about this, whoever put this together -- coordinating the
18 content. We've got COSIG grants. We've got homeless
19 initiatives and all these kinds. How does it tie together?

20 What I would hope or propose is that -- and I'm
21 not disagreeing with my colleagues' comments relative to
22 the budget thing. I'd be interested in having a budget
23 discussion not in terms of the budget itself as much as how
24 the things, the allocations, if you will, overall are
25 promoting this new system as compared to individual things.

1 I'll just use a concrete example. I don't know
2 what your discretionary grant portfolio is, but it's a big
3 piece of change. One of the things that we're experiencing
4 is that -- let's use mental health transformation as an
5 example or Access to Recovery or anything else.

6 Instead of the approach that says, well, you've
7 got a five-year grant, and you get to a certain point, then
8 the dollars end, and so on, suppose SAMHSA took the
9 position that we want to build into our grant discretionary
10 portfolio linkage points or connect the dots together. So
11 a provider, whoever gets the funds -- it's not so much of
12 talking sustainability as to where they're going to get the
13 new funds to support it as much as maybe they're required
14 in the last year of their grant to submit -- one of the
15 deliverables has got to be the strategic plan as to how
16 it's going to be carried out after that, not just the
17 dollars. How do you take what it is that you've been doing
18 for the last three years that you folks supported and have
19 a strategic plan in place that sees how this stuff is tied
20 together? Otherwise, it comes across as a project.

21 So whether it's a family component system of
22 care or whatever the descriptor is, it has a life. It has
23 legs, if you will, post that. And the good Lord willing
24 and we all hit the lottery, then maybe you think about, as
25 part of that, what you might call transitional grants or

1 linkage grants that are not just tied to COSIG and they're
2 not just tied to homelessness, but something that ties it
3 together which essentially says that if I'm an applicant, I
4 have mandated a partner with different people than I used
5 to partner with because you're looking at a person-centered
6 system in a larger sense than just the narrow thing that
7 you have on the table. I think that that type of paradigm
8 modeling, if you will, at your level could help to inform
9 the powers that be in Congress and the people that you have
10 to report to.

11 I remember Mike Hogan coming to Connecticut and
12 he did a presentation to our legislators and a bunch of
13 other folks relative to mental health transformation.
14 Almost one of the first things out of his mouth was that
15 many of the things that are important to people with
16 psychiatric disabilities are not in the state mental health
17 authority. We don't have any control over them. If you
18 want to reframe the system, transform, whatever it is,
19 you've got to pay attention to those other things.

20 Last week I was up before my appropriations
21 committee. They think in a very narrow sense, in part, the
22 way they do their business. They don't see how these
23 things tie together. So I think the more that you folks at
24 the national level can help to reframe or redefine what a
25 service system is that is person-centered and that it's

1 reflected on the basis that these things coordinate the
2 content in such a way that you truly do give people life in
3 the community, but it's not like I did when I practiced my
4 psychology or practiced whatever it is I did. It's a very
5 different system.

6 So if I was to leave a bumper sticker, I'd love
7 to have a session that you all have at one of our
8 subsequent meetings. Maybe it is a day-long session. You
9 may want to call it a strategic planning or a strategic
10 discussion session. Given the content that you have, the
11 paradigm or system change, building off the things that you
12 have been funding and your own vision, what does that mean
13 then in terms of fiscal considerations as well as what we
14 as a body could help to provide some counsel to you for?
15 We could get overwhelmed by program presentations. And you
16 know, you've seen one. You've got 999 that you didn't see.

17 I would hope that SAMHSA -- and to me, you're
18 doing it through these things, you're doing it through any
19 number of things. You are truly laying a different
20 groundwork for the issues related to mental health and
21 substance abuse. But I've been doing this for a long
22 period of time, and I frankly believe that what we have on
23 the table now from a health care point of view and so many
24 other points of view is the most exciting and opportunistic
25 framework that I've seen in my field to this date in time.

1 So if we can build the infrastructure, if you
2 will, and redefine the agenda -- one of my previous
3 Governors said, those who control the policy define what
4 the agenda is going to be. And if we could help you within
5 your own vision to redefine what that agenda is, I think
6 that would be a major contribution. What I've heard in the
7 last day and a half is a redefinition of the agenda, all in
8 support of your vision and mission, but in a different sort
9 of way. All of us know the bureaucratic and all the kinds
10 of stuff that you all have to deal with.

11 As I said when we had our last session with
12 Charlie Curie, I thought that one of his major
13 accomplishments was that he served to move the agenda in a
14 different way. This is a legacy. We all build on the
15 shoulders of people who came before us. How do we move it
16 to the next level?

17 MR. AIONA: Kathleen?

18 MS. SULLIVAN: Duke, I missed the opening
19 question. Is it a bumper sticker?

20 MR. AIONA: The opening question you mean by
21 me?

22 MS. SULLIVAN: Yes, to the group.

23 MR. AIONA: We were just opening it up for
24 discussion amongst the members as to what we would like to
25 see in the future or what we would like to discuss in the

1 future, if anything, what issues we'd like to take up. We
2 opened it up yesterday asking the members to just think
3 about what future issues they'd like to bring up. And
4 yesterday we had some great discussion on different things.
5 One of them was the budget.

6 MS. SULLIVAN: Yes. That's what I was
7 guessing. When Kirk, or Captain Kirk, did the bumper
8 sticker, I was thinking of, Ken, something I would just
9 love to see -- I can't tell you guys how much I miss it. I
10 hear all your voices and I have so much fun looking at your
11 faces as you're talking. I'm sitting here, I just have to
12 tell you, looking at all your faces, just having a blast.
13 I see Ken. I see Tom, Barbara, Gwynneth. I see all of you
14 in the room, and it's very enjoyable -- and Kathryn -- to
15 see all of you and your reactions to things and to hear
16 you. It's just such an enjoyable conversation and I miss
17 you all.

18 I want Steve Mayberg at the next meeting. If
19 you had \$300 million out of the blue, what would you do
20 with it? I want to know what he's doing. Steve Mayberg of
21 California. Ken, Tom Kirk, don't you want to know?

22 DR. KIRK: I was asked in appropriations if I
23 hit the lottery, what I would do with the money. They
24 didn't like my answer.

25 MS. SULLIVAN: But don't you guys want to know?

1 I mean, I want to know what Steve Mayberg is doing with
2 \$300 million. In a perfect world, all of a sudden he's got
3 all this money and he can come up with anything he wants.
4 So he's, all of a sudden, looking at transformative care.
5 Is Kathryn in the room still?

6 DR. CLINE: Kathleen, this is Terry Cline. You
7 can't imagine my face because we haven't met yet, but I
8 look forward to meeting you in person.

9 Part of the visioning I think that we can do is
10 when we think about life in the community for everyone,
11 what does that really mean? And then our responsibility is
12 to figure out how to help individuals and families get
13 there. That's where I think we tap into all the various
14 levels of expertise that we have in terms of best thinking
15 around evidence-based practices, around systems that help
16 support people and families, and how would you construct
17 that.

18 MS. SULLIVAN: Wait. Dr. Cline, don't you want
19 to hear? If you were given \$300 million tomorrow out of
20 the blue and someone said, okay, here you go, go do
21 something with it, I mean, wouldn't that be just the most
22 wonderful thing in the world? And don't you want to hear
23 what Steve Mayberg is doing with it? I would just love at
24 the next meeting to hear Steve Mayberg, his vision, what
25 he's doing with it. California is the 13th largest country

1 in the world. I would love to hear what he's doing.
2 That's my thought. I think it would really help all of us.

3 MR. AIONA: Okay. Well, thanks, Kathy. We can
4 just envision your face right now.

5 (Laughter.)

6 MS. HUFF: I just want to say we both cannot
7 come off this council at the same time because you need one
8 or the other of us on here. I told Terry there's only one
9 person any more outrageous than I am on this council, and
10 it's Kathleen. So, Kathleen, I just appreciate that so
11 much. I just want you to know how much I miss you here
12 across the way.

13 MR. AIONA: And it's all meant in a good way.
14 I think we're running out of time right now.
15 Did you have something else, Faye?

16 DR. GARY: When Tom and Ken were talking, I
17 also thought about us giving some serious theoretical,
18 intellectual, practical thought to sustainability,
19 community sustainability, and capacity-building as related
20 to the programs that SAMHSA funds. In that, I would hope
21 that we would also discuss what -- when we get these
22 grants, we know all about the background and significance.
23 We know how terrible things are before the money comes.
24 But I think we should begin to think about asking people to
25 project about what will happen to individuals and families

1 when the grant goes. That part we don't ask, and we don't
2 really know. We get a summary statement and then that's
3 it.

4 But I'm back to Tom's issue about these
5 linkages. I think if we did that, we would begin to help
6 people to think about linking with other organizations,
7 with other community-based services, building family
8 capacity or whatever to address what these mental health
9 and these substance abuse issues are when the grant begins.

10 The other piece is that as grants or contracts
11 are constructed, I would like for us to have in the
12 guidelines that individuals who are writing the grants or
13 the contracts have to respond to something about the
14 evidence of communication with, support from, and
15 assistance from individuals who are the targeted
16 populations that will be serviced, that that has to be
17 written out what did happen rather than getting the money
18 and then going and saying, okay, now we have to do this and
19 we have to do that. I think that makes a collaborative
20 effort that moves the program. On a scale from 1 to 10, it
21 automatically moves it to 3 before it ever gets started.

22 Then the one thing that we've not discussed at
23 all much today is interdisciplinary learning in academic
24 institutions. I think we probably need to spend a good bit
25 of time because one of the phenomenon that one sees is that

1 physicians are trained over here, nurses are trained over
2 here, social workers are trained over here, psychologists
3 are trained over here. Then all of a sudden, we graduate
4 and then we're expected to work together in a team. If
5 you're in mental health and substance abuse, you must
6 develop the capacity to work in a team. But that's not a
7 requirement in the academic institution at all. Now, if it
8 happens serendipitously, that's fine.

9 Of course, that automatically forces people to
10 understand, respect the kinds of knowledge and skill sets
11 that different disciplines have. And it also forces some
12 sharing of power and authority, which many times is a real
13 issue in all of health care, as well as psychiatry. But if
14 we're going to have collaborative services and if these
15 systems are going to be transformed, mental
16 health/substance abuse professionals are going to have to
17 learn how to respect and talk with each other at a
18 different level. And I think we need to spend some time
19 talking about that.

20 MR. AIONA: Thank you.

21 Tom?

22 DR. KIRK: A comment and a question really. We
23 have in statute in Connecticut -- in my agency, there's a
24 whole bunch of statutes that apply to the agency in terms
25 of what the agency is supposed to do and so on and so on.

1 As we've continued to work on the things we're working on,
2 it is clear that the wording in those statutes is
3 increasingly antiquated.

4 (Laughter.)

5 DR. KIRK: So the population to be served -- I
6 got your attention, Kathleen.

7 MS. SULLIVAN: Tom, the reason why I think
8 Mayberg would really be great is maybe he could also show
9 all of us the importance of a public referendum and why it
10 communicated so well to the State of California. You know
11 what I mean as far as mental health and the transformation
12 and how -- when that was put on the ballot, that connected.
13 And I was shocked. I was shocked. I was amazed that
14 mental health screamed to the people of California on an
15 election, and they immediately funded it.

16 As we go into an election year on '08, I would
17 like to hear what he says and how the people responded. It
18 would be very interesting I believe, and that's why I'd
19 like to hear from you and Ken. It would be interesting for
20 you and also Dr. Cline to hear from the state perspective
21 is this really resonating and is this a new source of
22 revenue now.

23 DR. KIRK: Let me just finish one quick point,
24 partly to tie to what Kathleen is mentioning, but then
25 something else.

1 My point is that there are statutes, if you
2 will, which define what the responsibility of an agency is.

3 So that's the way it is in Connecticut. I don't
4 understand really what reauthorization is, but I would
5 imagine if my example for what describes what I'm
6 responsible for and the parameters, et cetera, if something
7 similar to that applies to you, then when we talk about
8 this new system, if you will, does that mean that we should
9 be thinking about a new discussion of what's in
10 reauthorization for SAMHSA?

11 I don't know what reauthorization really means,
12 but I presume it sort of defines what you're supposed to do
13 with the framework within which you work. And if we're
14 talking about a different kind of framework, is that an
15 opportunity then to frame the reauthorization of SAMHSA
16 that's more consistent with where it is you want to go?
17 Otherwise, you're going to keep hitting these barriers of
18 services.

19 What a service is in a traditional mental
20 health/addiction system in my judgment is not the
21 definition of services that we're talking about now. How
22 do you do that? Or does some legislator or Congressman
23 say, that's not a mental health/addiction service? You
24 can't fund that. Somebody else should do that.

25 We talked about yesterday that other agencies

1 are supposed to pick up some of these services. They
2 already have their mission. They identify what's important
3 to them. So chances are, support of something that we
4 think is appropriate for people with psychiatric or
5 substance abuse issues is on the bottom of their list.

6 MR. AIONA: Thank you. I think we've run out
7 of time. Sorry, Ken, but we're out of time.

8 Well, Doctor, you've heard the council members.
9 So now I'm going to turn it back to you and you can
10 summarize or tell us where you want to go from here.
11 Thanks.

12 DR. CLINE: Great. Thank you, Governor.
13 Thank you, members of the council. I appreciate your
14 candor, as well as your creative thinking on these issues.

15 You've given me a lot to think about. We will
16 have discussions internally about constructing the agenda
17 in the future to make that as useful, as beneficial as
18 possible for SAMHSA as we move forward.

19 I think you've identified several challenges,
20 which are not easy challenges. Some of the issues that
21 were discussed are things that will literally take years to
22 influence, and some things, as Barbara said yesterday, may
23 or may not happen in our lifetimes even.

24 But the next step we take is very important.
25 And is it a step in the right direction? Even though it

1 may not be at the end of the path, it is moving us in a
2 direction, and we want to make sure that that thread is
3 moving forward in a way that really helps us achieve that
4 mission. So every single step is important, whether it's a
5 program decision, whether it's a funding decision, whether
6 it's a strategic decision, or it's entering into the
7 conversation with our partners that we may not be able to
8 influence today, but we might be able to tomorrow,
9 depending on what we say in that next conversation.

10 So you've given me much to think about, and I
11 appreciate your guidance and your advice. This has been
12 very helpful for me. I know it has been for the other
13 staff. I hope that you as well take something back to your
14 respective roles and responsibilities, whatever those may
15 be.

16 And again, you are contributing a huge amount
17 in terms of your volunteer time. The folks that I do know
18 around the table I know are very busy individuals whose
19 time is precious. So the fact that you have traveled this
20 distance and are offering your time to us I think speaks to
21 your commitment and your dedication to literally save lives
22 across the country.

23 So with that, I will close. Again, thank you
24 for being here today. As council members, I want you to
25 know that I have an open door policy. I would love to hear

1 from you in the future. Please don't wait until the next
2 council meeting to engage in that dialogue with me.

3 So with that, I'll close the meeting. Thank
4 you very much.

5 DR. GARY: Dr. Cline, did we have any public
6 comment?

7 DR. CLINE: There were no public comments that
8 were registered.

9 (Whereupon, at 11:32 a.m., the meeting was
10 adjourned.)

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