

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

43rd Meeting of the
SAMHSA National Advisory Council

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

2 ***Welcome; Opening Remarks***

3 DR. CLINE: Take your seats; I know it's a
4 great time to have some of those sidebar conversations,
5 which are pretty tempting. I would like to welcome you to
6 the SAMHSA National Advisory Council. It's a great pleasure
7 to have all of you here this morning, and we look forward
8 to a very lively presentation and great interaction from
9 our Advisory Council this morning.

10 I would like to recognize Laura Gerhard, the
11 Director of the Office of Policy and Planning Development
12 with the US Department on Aging -- if you would just stand
13 up and let us acknowledge you, please. Thank you for being
14 here.

15 I would also like to point out that we have a new
16 staff member, Pete Delaney, who is the Director of the
17 Office of Applied Studies. Pete, thank you for joining us
18 as well.

19 What I'd like to do now is ask everyone to
20 briefly introduce yourselves so that our visitors will be
21 aware of who you are and what your role is, and learn just
22 a little bit about you. If you could keep that to one or
23 two minutes, that would be greatly appreciated, and Toian,
24 let's actually start with you and we'll work our way
25 around.

1 MS. VAUGHN: Good morning, I am Toian Vaughn,
2 and I'm the designated federal official for this SAMHSA
3 National Advisory Council. I'm also the Committee
4 Management Officer for the Agency.

5 LT. GOV. AIONA: Good morning, I am James
6 Aiona, Lieutenant Governor for the State of Hawaii, co-
7 chairing also this meeting, and I'm happy to be back again.

8 DR. HUMPHREYS: Good morning. My name is Keith
9 Humphreys, I am a professor of psychiatry at Stanford
10 University, and I am just beginning a term on the Council.

11 DR. GARY: Good morning, I am Faye Gary, I hold an
12 endowed chair in nursing at Case Western Reserve University
13 in Cleveland, Ohio.

14 MR. BRAUNSTEIN: Good morning. I am George
15 Braunstein. I am the executive director of Chesterfield
16 Community Services Board in Virginia, and I'm just starting
17 my role on this council.

18 DR. MARSH: I'm Anna Marsh, Acting Director of
19 the Center for Substance Abuse Prevention.

20 MS. CUSHING: Good morning. My name is Judy
21 Cushing, and I'm president of the Oregon Partnership in
22 Portland, Oregon.

23 DR. KIRK: Good morning, I'm Tom Kirk, the
24 Commissioner of the Connecticut Department of Mental Health
25 and Addiction services.

1 DR. LEHMANN: Good morning. I'm Larry Lehmann
2 with the Department of Veterans' Affairs Office of Mental
3 Health Services.

4 MR. CROSS: I'm Terry Cross, Executive Director of
5 the National Indian Child Welfare Association, and member
6 of the Seneca Nation of Indians.

7 DR. CLARK: Hi. I'm Westley Clark, I'm the
8 director of the Center for Substance Abuse Treatment.

9 DR. WANG: Ed Wang, Director of Office and
10 Multicultural Affairs, Massachusetts Department of Mental
11 Health, and good morning.

12 MR. ALEXANDER: Good morning. I'm Marvin
13 Alexander. I'm a clinician at Mid-South Health Systems in
14 Jonesboro, Arkansas, and Vice-Chairman of Youth Move
15 National.

16 MS. WAINSCOTT: I'm Cynthia Wainscott, from a
17 little town north of Atlanta, Georgia, and I think the
18 thing I'm proudest of is that I am the daughter, mother and
19 grandmother of people who live successfully with mental
20 illnesses.

21 MS. FIEDELHOLTZ: Good morning, I'm Jennifer
22 Fiedelholz, I'm the director of the Planning and
23 Performance Measurement Unit in the Office of Policy
24 Planning and Budget, and I'm here today for Daryl Kade, who
25 is the director of that office.

1 DR. CLINE: And we also, I believe, have Ken Stark
2 on the telephone? Ken, would you please introduce yourself
3 to the group?

4 DR. STARK: Yes. I'm Ken Stark, I'm the Director
5 of the Mental Health Transformation Project in the
6 Governor's Office in Washington State.

7 DR. CLINE: Thank you, Ken. And Jennifer has a
8 couple of updates for us. Let's move to those updates.

9 MS. FIEDELHOLTZ: Just a few technical updates
10 for those of you who were present at the orientation
11 yesterday. We decided to postpone or time-delay the other
12 administrative duty session. So we will handle that today,
13 after taking a 15-minute break as you have your lunch. That
14 will cover things like travel procedures, how do you get
15 paid, and et cetera.

16 And the second announcement is that typically, in
17 an Advisory Council meeting, we approve the minutes from
18 the previous meeting. For the September meeting minutes, we
19 will be forwarding those to you electronically within the
20 next two weeks for your review and comment. Per federal
21 regulation, you, along with the chair, will approve and
22 certify those minutes, and we'll be planning to handle that
23 electronically in the future. Thank you.

24 DR. CLINE: I also would like to express
25 appreciation to our visitors. I know that we have

1 representatives from the Food and Drug Administration, from
2 the National Institute of Mental Health, as well as Indian
3 Health Services and HHS's Office of Women's Health. I know
4 people will come and go throughout the day. But thank you
5 very much for your participation in here and supporting the
6 work of the Council and supporting the work of SAMHSA.

7 I would like to turn now to the co-chair, Lt.
8 Gov. Aiona, and to ask for his comments.

9 LT. GOV. AIONA: Thank you, Dr. Cline.

10 Very briefly, again, welcome members -- I think
11 we only have three of us who I think have been on the
12 Council for a while, and that's Dr. Kirk and Dr. Gary, and
13 myself, and of course Ken, who is on the line right now. I
14 just want to say I hope you had a good session yesterday
15 and that you got a little understanding now of what the
16 Council is all about.

17 Probably the best feature of our bi-annual
18 meetings is the discussion, the round-table discussion,
19 that we get at the end of the day. And so at the end of the
20 day, we get to really let it all hang out, if that's what
21 you want to call it. And so I'd ask that you formulate in
22 your mind right now, because of what you've learned over
23 the past couple of days, any topics of discussion, any
24 suggestions and recommendations that you might have, et
25 cetera, because you will have that opportunity at the end

1 of the day to discuss that and make the suggestions or
2 recommendations to Dr. Cline, and we can take that up as a
3 group.

4 So enjoy the day. We're going to learn a lot
5 today. It's always been fruitful for me to listen to
6 everyone's presentation, and then of course, at the end of
7 the day, also, if you want to share your experiences in
8 your state or in your community or in your works throughout
9 the country, that's the time to do it.

10 So without any further ado, we'll get this
11 meeting going. Thank you, Dr. Cline.

12 ***Administrator's Report***

13 DR. CLINE: Thank you very much for those
14 comments.

15 This is time now for me to move to the
16 Administrator's Report, and I will fly through that report.
17 What I would like to do is provide you with a little bit of
18 an overview. I would like to talk with you briefly about
19 some initiatives that we are engaged in. You will be
20 hearing from the center directors later this morning about
21 some legislative and budget priorities and issues. So some
22 of this may tie together with that. I don't think it will
23 be redundant; it will complement what you will hear later
24 in the day.

1 But as Lt. Gov. Aiona stated, there is a lot of
2 information, I think it will be valuable for you, and again
3 we look forward to your comments in response to that
4 information.

5 As you have heard from me say in the past, SAMHSA
6 is engaged in really moving SAMHSA and the country toward a
7 public health approach, and really embracing a public
8 health approach, and looking at the broader continuum of
9 services, all the way from prevention to more acute
10 services, and recovery and sustaining recovery for
11 individuals across our country, and not neglecting any one
12 piece of that. In the past, I think anyone who has worked
13 in these systems knows that we are sometimes in the habit
14 of robbing Peter to pay Paul, and will do one piece of the
15 continuum without doing the other, and without really
16 engaging in a comprehensive approach that recognized the
17 contribution and the significance of that entire continuum.

18 So we are moving and really disciplining
19 ourselves to make sure that we are attending to that entire
20 continuum. Part of that will involve a focus on
21 integration, with primary health care, with primary health
22 care systems and other practitioners; integration of our
23 work into the work of others, whether that's at the federal
24 level or the state level or the local level; discussion
25 really about not necessarily trying to convince others to

1 join us in our agenda, but really recognizing how we can
2 impact the agenda and the priorities in other agencies and
3 other organizations across the country. Part of that is
4 recognizing that many, many stakeholders across the country
5 have a significant role to play in addressing the needs of
6 people who are at risk for or people who are experiencing
7 mental illness or substance abuse in their lives or the
8 lives of family members.

9 So there's a role for each of those, and again, I
10 think we've all been party to asking people to partner with
11 us, and usually when we say that, we mean "can you give us
12 something?" Can you give us some money? Can you give us
13 some time? Can you give us some resources? But really
14 helping to flip that is, then, what can we contribute to
15 you in terms of technical assistance, in terms of
16 expertise? How can we help you be more successful in the
17 fulfillment in your priorities and your agenda? Because we
18 believe that by addressing these issues constructively and
19 proactively, that we can significantly impact the agenda
20 that is out there for many other organizations.

21 Part of that, again, with this public health
22 approach is moving upstream, being proactive -- so many of
23 our systems are reactive, and we find ourselves picking up
24 the pieces of shattered lives or shattered systems, systems
25 that are overwhelmed, underresourced and then we find

1 ourselves wondering why we can never get ahead of the
2 curve. In terms of addressing if we only focus on that end,
3 the downstream piece of that, and we neglect the upstream
4 piece, my own personal belief is that we will never ever
5 get head of the curve. So we need to make sure that we move
6 upstream as well.

7 And again, this does not mean that we neglect
8 rescuing those drowning individuals, but that we do that
9 and at the same time move upstream to address those issues
10 as proactively as possible. When we don't do that, the
11 consequences, as everyone knows, are very, very high. And
12 I'll just run through some of those in encapsulated form;
13 and these numbers to me are absolutely staggering, and I
14 wonder why we don't hear more attention given to these
15 numbers across the country in terms of an outcry.

16 Of course, one of those numbers is that we have
17 32,000 people on average in our country, 32,000, every
18 single year, who intentionally kill themselves, who commit
19 suicide -- 32,000 people. I'm from a relatively small town
20 of about 25,000 people, so I try to imagine that that
21 entire town -- men, women, children, everyone -- being
22 wiped out, not just once, but every single year, and try to
23 imagine the attention that would be given to that by the
24 media and by others if that were to occur. I don't see that

1 response, but I certainly understand the magnitude of that
2 problem.

3 Homelessness, we have approximately 700,000
4 individuals on any given night who are homeless. About 20%
5 to 25% of those individuals would actually meet criteria
6 for a serious mental illness; about half of that group, a
7 subgroup, would have co-occurring disorders, with alcohol
8 and drug problems as well. In addition, about 38% of the
9 homeless population report problems with alcohol; about 26%
10 report problems with other drugs. Put all this together,
11 about 66% of the homeless population are reporting
12 significant problems with mental illness or with drugs and
13 alcohol.

14 We look at incarceration -- again, this is
15 spillover into over systems that are trying to pick up the
16 pieces, but obviously are struggling under the burden as
17 well. Depending on which study you look at and which
18 population, you're talking about in terms of jails or
19 prisons, about 16% to 50% of all incarcerated individuals
20 are individuals who have a mental illness; and up to 80% of
21 those individuals have a substance abuse problem. Eighty
22 percent of incarcerated individuals -- so again, if you
23 look at the costs associated with incarceration, and you
24 look at the cost for treatment as well as the outcomes in
25 terms of recidivism, we know that it makes good public

1 policy, it makes good sense, to move to the front and to
2 treat people up front for their addictions and for their
3 mental illness rather than having our prisons and jails
4 trying to pick up the pieces, again recognizing that over
5 half of those individuals would turn around and be re-
6 arrested in the near future once they're released from
7 prison.

8 Early mortality -- people with mental illness are
9 dying 25 years earlier than their counterparts without
10 mental illness. Huge health discrepancy; and individuals
11 dying of issues such as heart disease and complications
12 from diabetes, not talking about suicide but as a piece of
13 that.

14 Lost productivity in our country -- if we were to
15 look just at a couple of diagnostic categories, bipolar
16 disorder alone, the bill to employers across our country,
17 \$14.1 billion in terms of lost productivity. And then if
18 you look at major depressive disorder, that number is at
19 \$36.6 billion in terms of lost worker productivity. And
20 that is a bill that is picked up by employers; that is a
21 bill that is picked up in terms of costs being passed on to
22 products and consumers, not only in pick up but there are
23 actual costs associated with that.

24 When we look at our general health care system,
25 about a quarter of all community hospital stays are stays

1 that involve people with mental illness or with substance
2 abuse, with a diagnosis for either of those categories. So
3 a quarter of all hospital stays; that's 7.6 million
4 hospital stays out of about 32 million hospital stays. And,
5 I would say, the majority of individuals who are receiving
6 that care in the hospital stays are not receiving
7 specialized care, which again brings into question the
8 burden of cost to that health care system and also brings
9 into question the effectiveness of the intervention -- are
10 we doing the best job with those dollars that we can do? I
11 would say that we are not doing that.

12 We had an orientation yesterday. I talked about a
13 day in the life of adolescents, taking a look at addictive
14 behavior in adolescents, so I won't repeat that information
15 for you. But I'm going to give you a different slice. As
16 you know, we can slice the numbers in a lot of different
17 ways.

18 So you heard from me yesterday, in this
19 orientation, about what it would look like on any
20 particular day. Well, one of the things that we're
21 interested in when we're looking at prevention, when we're
22 looking at the possible burden over time, is the initiation
23 -- when are people first using drugs? So again if we look
24 at those 12 to 17 year olds, to get an idea of how many of
25 those adolescents and young people would be starting to use

1 drugs for the first time, it gives us another slice, which
2 I think is interesting. And it's, again, very alarming.

3 So if we look at 12 to 17 year olds on any given
4 day in our country, again, today, next week, November, it
5 doesn't matter what day it is -- we would expect to find
6 4,300 12 to 17 year olds who are using an illicit drug for
7 the very first time. Any given day. So think about what we
8 need to do in the tide that we're swimming against with
9 this. We have 4,000 12 to 17 year olds who are smoking
10 cigarettes for the very first time; 3,600 who are smoking
11 marijuana for the very first time. And, as we look at some
12 of the tides that we're swimming against, and some of the
13 trends that we're concerned about, 2,500 who are misusing a
14 prescription drug for the very first time. So today, if you
15 just took that on average, we would expect to see 2,500 12
16 to 17 year olds who are misusing a prescription drug for
17 the first time. And you could expect that tomorrow, and the
18 day after, and the day after. So it gives you a sense of
19 that tide that we're swimming against.

20 As many of you know, SAMHSA just released our
21 state by state data, which can give you a snapshot of
22 what's going on in particular states. That report does not
23 draw conclusions from that; it simply presents the
24 information and allows individuals who are interested in
25 going in that particular state to draw their conclusions to

1 use that information, see red flags, to get an idea about
2 what needs to be done in terms of prevention, what needs to
3 be done in terms of developing treatment systems and
4 response, what systems do you need to support people who
5 are struggling with certain kinds of issues, and bringing
6 that up to let you know of course we were interested in the
7 spread of that information across the country -- so we're
8 not simply preaching to the choir on these issues.

9 I heard this morning that when, for those
10 individuals that have AOL accounts, when you pull up your
11 AOL account, there is actually a link to the state by state
12 data. That is on the homepage for AOL that will allow you
13 to access that information. So every person across the
14 country who is using AOL, and I'm not pushing for one
15 product over another product this morning, just to be clear
16 about that. They are providing that information on that
17 homepage. And this is part of that dissemination of
18 information as we move forward.

19 And not to be a doomsayer entirely, I would like
20 to highlight some of the significant trends that we've seen
21 in substance use since 2001. We've seen a 24% reduction in
22 the overall rate of illicit drugs in our country. That's
23 significant. We've seen a 25% reduction in the rate of
24 marijuana use in our country since 2001, also significant.
25 In terms of alcohol and cigarette use, we've seen a 15% and

1 a 33% reduction respectively for those two issues, and
2 alcohol does include binge drinking as part of that
3 reduction as well. We're still concerned and we're having
4 more difficulty impacting underage drinking specifically,
5 but overall, we've seen significant rates of decline. Those
6 are important to acknowledge because it sends the important
7 message and reminds us that when we approach these issues
8 collectively, and we have a comprehensive approach, we can
9 definitely impact these rates across our country.

10 We are seeing a number of activities that are
11 ongoing; we are continuing our transformation efforts,
12 going full speed with those efforts in terms of the mental
13 health systems across the country. There is a federal
14 executive steering committee that is made up of
15 representatives of 9 cabinet-level agencies; you may hear a
16 little bit more about that later in the morning. But it is
17 bringing in, again together, representatives from all of
18 those agencies and departments with a focus specifically on
19 the behavioral health services in the country. It is a
20 historic first time that that has happened across the
21 federal government in that way.

22 Again, with this upstream approach, you will see
23 additional focus on children and families, as we hear a
24 little bit about some congressional support that has come
25 in the form of Project Launch, which is focused on really

1 our 0 to 8 population; so again a significant shift in
2 terms of mental health and substance abuse.

3 Looking at mental health promotion, and
4 prevention on the substance abuse side, there also is an
5 additional focus on veterans' issues. You will hear a
6 little more about that. We have had specialized
7 presentations on that, but that's an area that SAMHSA is
8 very concerned about and the good news is that we are
9 developing even stronger relationships with the DOD and the
10 Department of Veterans' Affairs.

11 The Mental Health Accord for the fiscal year
12 2009, you'll hear a little bit about that as well as a new
13 targeted capacity expansion, programs which really allow a
14 great deal of flexibility on the part of states and
15 communities to identify those needs, present those to
16 SAMHSA, and then have SAMHSA, through a competitive grant
17 process, provide some funding out to communities and out to
18 states, rather than SAMHSA saying here is the issue we want
19 you to focus on, letting those areas help identify that and
20 then feed that information back to us.

21 We also are seeing a great deal of momentum that
22 has grown around the strategic prevention framework. And
23 the strategic prevention framework really is providing that
24 conceptual framework to help states build the
25 infrastructure around their prevention efforts. This is

1 particularly exciting because many states and communities
2 have been engaged in this work, but it really has not been
3 brought together in a comprehensive fashion. But we have
4 had work that has been maybe outstanding work, but it's not
5 tied in with the larger picture. What that means is that
6 it's been difficult to collect data, information about the
7 effectiveness about our efforts and our programs; it's been
8 difficult to tie that in. Are we really making a difference
9 as a whole, even though we may have this outstanding work
10 that is taking place in individual pockets? So what can we
11 do to provide that framework as taking place within the
12 strategic prevention framework, which I think will actually
13 be, in terms of the public health approach in using that
14 model, will become a very important foundation that will
15 spill over, and I'm confident into other areas as well.

16 We have continued, just to let you know, that our
17 agreement with Ken Stark, as he was driving in for this,
18 that he would listen and not talk, and when he pulled into
19 the parking garage, he would actually disconnect from that
20 system. We were a little bit nervous yesterday when we got
21 the disconnect. I'm just letting you know that I believe
22 that he is fine, he's okay, and that he will rejoin us when
23 he's through all the other system that he has to get
24 through to be in his office.

1 We are continuing our efforts as well, on the
2 prevention of underage drinking; a significant rollout with
3 the surgeon general, who's been traveling around the
4 country, helping to spread the word in his call to action.
5 We also have an ongoing partnership with ONDCP, focusing on
6 the prevention of prescription drugs. Again, as you heard
7 earlier, it's an area that we're concerned about. A lot of
8 exciting work taking place with screening, brief
9 intervention, referral and treatment -- again, going where
10 people are to intervene, and trying to move upstream.

11 When people show up in an emergency room, and
12 they've been there three times because they've had
13 accidents in their house, there's a pretty good chance that
14 substance abuse may be involved in that. What's going on
15 there? We need to do screenings. And if we catch people
16 early enough in that process, we can make a significant
17 difference by intervening maybe just with education, maybe
18 through one or two or three brief interventions, instead of
19 having to wait until the person's in crisis and is either
20 rolling over into the criminal justice system or needing
21 more intensive services.

22 Of the people that we have screened, and we've
23 had over 545,000 people who have been screened through the
24 (?) program across the country, 22.9% of those individuals
25 actually required a brief intervention or referral to

1 treatment. Of those who received a brief intervention, 74%
2 reported significantly reduced alcohol or drug use, and 48%
3 reported no substances at all. So moving upstream, we can
4 make a significant difference -- a couple of saying that
5 are out there are "we're going fishing where the fish are".
6 We're not waiting for people to come to us, and somebody
7 had told me a nice little adage -- when someone asks a bank
8 robber why do you rob banks: I rob banks because that's
9 where the money is.

10 I mean, come on, it makes sense -- we need to go
11 where the people are. We need to not wait until people are
12 in crisis and come to us. We also, through the access to
13 recovery program, have surpassed our goals. We have served
14 over 199,000 individuals, which surpasses of our goal by
15 over 74,000 people. This is a voucher-based system that
16 really increases the scope of services provided as well as
17 broadening the base of providers involved in that system.
18 It's very, very exciting to see the uptake of that system
19 and the outcomes that we're seeing through the system as
20 well.

21 So again, we're focusing on this integration,
22 moving upstream, public health stream, forming those
23 strategic alliances with PERSA and with CDC, and with the
24 Institutes, with other federal partners, it's an exciting
25 time. Getting the word out there with NREPP, the National

1 Registry for Evidence-Based Programs and Practices; getting
2 those evidence-based practices to people who can use those,
3 who can pick and choose from those evidence-based
4 practices. This may be applicable to my community, for the
5 people that I serve, given the information I see there, so
6 I'm going to use that. Having a standard that has a little
7 bit more flexibility so that we can get more of those
8 community-based organizational level practices out into the
9 field; we're excited about that, as well as disseminating a
10 great deal of information through our health information
11 network; SAMHSA's health information network, which has
12 over 50,000 hits every single month -- moms and dads who
13 are calling for information; teachers, practitioners,
14 researchers who are calling to get additional information.
15 So we are continuing to push that out, as well as to our
16 ATTC which are helping move best practices, evidence-based
17 practices, into actual implementation in the field.

18 So it's a very exciting time. I had just wanted
19 to just give you that snapshot; you will hear a little bit
20 more about the direction SAMHSA is moving through some of
21 the budget and legislative issues later in the day. Just in
22 the interest of time, I just wanted to give you that brief
23 overview. I know I have kind of flown through that, and
24 we're going to move right into the other presentations. I

1 wanted you to have that 30,000 foot perspective as we move
2 forward.

3 So now we're going to move into presentations
4 from the three centers, and the focus will be on budget and
5 legislative issues. You've heard some information about
6 some of the programs, so I'm going to ask them to focus on
7 the congressional budget request and legislative issues as
8 they relate to those specific centers. You'll see some
9 areas that obviously cut across the centers as well.

10 And I think first up we have Dr. Clark, I
11 believe. And Dr. Clark is the Director for the Center for
12 Substance Abuse Treatment, and I see that he has his
13 presentation up, and so Dr. Clark, if you would please just
14 step forward and lead us through this. I think that we have
15 on cue, the presentations will be relatively brief.

16 Dr. Clark, I'm going to take the liberty of
17 saying that if someone has a question, because some of
18 these numbers are pretty complex and I wouldn't expect you
19 to be able to hold on to that information for too long --
20 if you have a question, I would encourage you just to raise
21 your hand and Dr. Clark or the other presenters will do
22 their best to address that. If we get off track, we may ask
23 people to just hold on to those questions. But let's try
24 that and see if it works, so it will be more interactive
25 and more responsive.

1

2 ***Overview of SAMHSA's Budget and Legislative Issues***

3 DR. CLARK: Thank you, Terry. And again, I agree
4 with you. That's the model that we will use here since,
5 again, these are a bunch of numbers.

6 I want to start off by noting that this is the
7 budget that we have at CSAT for 2007, through the budget
8 request and 2009. And as you can see, the budget for the
9 block grants was stable in 2007 and 2008, with a change to
10 the budget for 2009 if there's a proposed \$19.9 million
11 increase. For our programs of national and regional
12 significance, which is our discretionary portfolio, the
13 budget for 2007 and 2008 is about the same; there's a
14 slight increase in 2008. The proposed budget for 2009 is
15 \$48.5 million decrease. For our science and service, the
16 budget from 2007 to 2008 dropped a little, but for 2009 is
17 a \$14.5 million increase. So the total P on this line,
18 there's a budget decrease of \$63 million; if you add the
19 increase to the block grant, that is a \$43.1 million
20 decrease from FY2009.

21 The guiding principle for 2008-2009, based on the
22 HHS guidance is that we need a balanced budget by 2012.
23 There will obviously be no new taxes, and an emphasis on
24 direct services. Clearly some difficult choices were made
25 in order achieve a balanced budget and no new taxes;

1 difficult choices were made, and funding decisions involved
2 multiple factors.

3 The 2008 appropriation restored \$50 million to a
4 large number of discretionary programs proposed for
5 reduction; it maintained the block grant funding as
6 proposed. For specific programs, the 2008 appropriation
7 added \$3.5 million for tribes and tribal organizations;
8 maintained the minority HIV funding; reduced Drug Coop
9 funding from \$31.8 million, which was proposed, to \$10.1
10 million; reduced SPFP funding from the proposed \$56.1
11 million to \$29.6 million, and then added \$6.3 million for
12 approximately 25 earmarks.

13 In FY2008, we have some funding opportunities
14 listed there, SPFP, which is closed; we have proposed four
15 new ESBRT programs at \$10 million, all totaled. A medical
16 residency program, 10 grants, which closes on March 14, at
17 \$3.5 million; our target capacity in general for American
18 Indians, Alaska Natives and Asian-American/Pacific
19 Islanders, 14 new grants at \$3.5 million total, which
20 closes on April 18. And then recovery systems of care, \$3.5
21 million, 8 grants which closes on April 18. And then our
22 target capacity expansion, which closes on May 27, we
23 anticipate something like 52 grants in that portfolio.

24 Criminal justice for 2008, we've got a criminal
25 justice treatment grant; we anticipate about \$3.4 million

1 that the status of that is still open; it hasn't been
2 completed. The treatment drug corps has 18 new grants which
3 closes on April 10; pregnant and post-partum women has 16
4 new grants which close on March 18, and then we have a
5 small contribution to HBCU, which is \$500,000 which closes
6 on March 18.

7 And then treatment for homeless, which we're in
8 the process of resolving now; we anticipate that that will
9 close sometime toward the end of March, the first of April.
10 But we anticipate that there will be about 154 new grants
11 for a total of \$67.2 million.

12 The key FY2008 activities and initiatives --
13 we've implemented, we're implementing a cohort to the
14 access and recovery initiatives for 18 states, the District
15 of Columbia and 5 tribes; we're wanting to broaden the
16 availability of screening, briefing and intervention
17 programs through grants, the website and CMS codes. We want
18 to enhance treatment and services for American
19 Indian/Alaska Native tribes, including an ATP supplement in
20 Pacific Islander jurisdictions. We want to promote recovery
21 support services, recovery-oriented systems of care, and
22 then continue to address methamphetamine treatment needs
23 including through out ATI initiative.

24 Promote HIV rapid testing and discretionary
25 programs -- many of you are aware that the CDC has had some

1 changes in their approach to HIV testing. The focus is on
2 knowing your status, and we are promoting that theme.

3 We are currently conducting an OMB, participating
4 in an OMB part assessment of our drug court initiative,
5 along with the Department of Justice. We hope to finalize
6 and obtain outcome measures and assist states in developing
7 capacity to report block grant performance outcomes. We've
8 got an ongoing process of investigating methadone deaths,
9 promoting voluntary opioid treatment program reporting, and
10 communicating safe dispensing practices to physicians and
11 consumers. We're tying it to, of course, our ongoing
12 efforts to develop a substance abuse treatment workforce
13 and to adopt a public health approach to service delivery.

14 The 2009 President's Budget had a focus of
15 promoting market-based healthcare. Our response is to work
16 with the Office of Programming, Planning and Budget on
17 electronic health records. By expanding care for vulnerable
18 populations through our drug court treatment grants and our
19 screening and brief intervention, referral and treatment
20 process, we have always noted through our Office of Applied
21 Studies data that a large number of roughly 20 million
22 people who need care don't present to special delivery
23 systems. And so our efforts through SPFP is to go to, as
24 Dr. Cline says, based on Willie Sutton, he may not remember

1 Willie Sutton. I remember Willie Sutton -- why do you rob
2 banks, Willie Sutton? Because that's where the money is.

3 So we need to go to primary care settings,
4 emergency rooms and other settings to screen people for
5 substance use. And then, of course, another presidential
6 emphasis is supporting faith-based community programs and
7 we're doing that through our access to recovery initiative.

8 The President's budget, as he said, we continue
9 to support the President's initiatives in priority areas
10 through ATR and drug courts. We are maintaining funding for
11 the block grant with the proposed 2009 budget would add
12 about \$20 million for performance incentives to support
13 direct services of the infrastructure, to achieve savings
14 in lower-priority areas. The policy also eliminates funding
15 for congressional earmarks; and we don't anticipate any
16 reduction in SAMHSA staffing.

17 Now these are the 2009 programs that would be
18 increased or maintained: Access to Recovery, a 3% increase;
19 treatment drug courts, a proposed 280% increase; SPFP a
20 proposed 93% increase; Minority AIDS Initiative would be
21 maintained; the National Registry for Evidence-based
22 Practice would be increased by 157% to \$1.3 million, and
23 the Schering contract would be maintained.

24 These are programs that would be reduced under
25 the 2009 proposed budget: there would be a 32% reduction in

1 opioid treatment program funding; a 39% reduction in the
2 target capacity expansion in general; a 5% reduction in
3 treatment for homeless.

4 These are the factors that were considered in
5 making the 2009 program reductions and eliminations -- one
6 time expenditures that don't need to be replicated;
7 completed functions or commitments within grants. The
8 policy is to scrutinize automatic renewals; the notion is a
9 grant program should not exist in perpetuity. Programs with
10 purposes that are addressed elsewhere in other places;
11 underperforming programs, and programs without solid
12 performance measures, and then proposed reductions in the
13 past that were not enacted -- these are the issues and
14 factors that were considered in 2009.

15 These are the programs that are proposed for
16 elimination in the 2009 budget: eliminate the Co-occurring
17 state incentive grant, at \$4.3 million; eliminate the
18 treatment for pregnant and post-partum women; eliminating
19 STAR (Strengthening Treatment Access and Retention);
20 eliminating the recovery community services program;
21 eliminating treatment for children in families, and that's
22 a \$24.3 million elimination. The Minority Fellowship
23 Contribution would be eliminated; our Knowledge Application
24 Program would be eliminated; the Progress for Recovery

1 program would be eliminated, and our Recovery Month
2 activity would be eliminated.

3 These are the grant programs that would be
4 terminated early in the 2009 budget: the Co-occurring state
5 incentive grants, we would have terminate 4 grants; we'd
6 have to terminate 7 TCE general grants early. We would
7 terminate 16 pregnant and post-partum women in treatment
8 grants, 15 recovery and community services program grants,
9 the 1 Historically Black College and University grant; 17
10 family therapy model grants; 10 criminal justice treatment
11 program grants, and 4 Minority Fellowship grants.

12 Nevertheless, despite that news, we still will
13 have funding opportunities for 2009. We will anticipate the
14 number of SPFP grants at 29; the number of treatment drug
15 court grants at 82 new grants, and the treatment for
16 homeless, we would have 6 new grants, for 117 new grants,
17 for a total of \$53.8 million of new funding opportunities
18 for 2009.

19 We encourage people to look at our website at
20 www.SAMHSA.gov; our helpline and our treatment facility
21 locator. And our ATTC line can be seen at
22 www.attcnetwork.org.

23 Any questions? Dr. Humphreys?

24 DR. HUMPHREYS: Thanks, Dr. Clark.

1 I saw in the budget proposal statement that the
2 end of the Co-occurring state incentive grants would
3 perhaps be compensated for by increased emphasis on
4 screening and SAMHSA funded programs for disorders. Could
5 you elaborate on that or maybe Dr. Power is the person to
6 elaborate on that?

7 DR. CLARK: Well, the emphasis will be on
8 screening and brief intervention for people in primary care
9 settings, basically. One of the things that we've talked
10 about internally is making sure that we try to include some
11 questions about mental health and the expert portfolio. Dr.
12 Power, when she does her presentation, has some comments on
13 that, if possible.

14 MS. FIEDELHOLTZ: The other thing I would like
15 to note is that many of our service grant announcements
16 require a screen for co-occurring disorder just as a
17 routine course, which is something new this year.

18 DR. CLARK: That's a good point. We are
19 requiring that of jurisdictions. We are modeling our outfit
20 after Tom Kirk's outfit in Connecticut. Dr. Kirk is also an
21 ATR recipient, and so is the state of Washington. The state
22 of Connecticut is addressing this issue in a very robust
23 fashion and integrating it into the overall delivery
24 system.

1 MS. WAINSCOTT: Not so much a question as a
2 comment -- one of the really upstream programs that could
3 have made a huge difference that's now going to be
4 terminated early is the pregnant and post-partum women.
5 That's too bad; you have to make hard choices, I know.

6 DR. CLARK: Okay, thank you.

7 DR. CLINE: Thank you, Dr. Clark.

8 We are going to reconnect Ken Stark right now,
9 and that is going to add just a little disruption as Anna
10 makes her way to the podium.

11 Anna Marsh, Dr. Marsh, is the Acting Director for
12 the Center for Substance Abuse and Prevention. And we'll
13 pull that up and we'll move right ahead.

14 DR. MARSH: Good morning. I'm pleased to be
15 with you this morning.

16 I'm going to focus pretty much exclusively on the
17 FY2009 budget, and feel free to stop me if you have
18 question as we're going through.

19 So our total budget for fiscal 2009 is \$158
20 million, which is a decrease of \$36.1 million from the 2008
21 level. We have a new program that has been proposed for
22 targeted capacity expansion at \$7 million, and some
23 programs maintained at the 2008 level -- that includes the
24 fetal alcohol spectrum disorders program at \$9.8 million,
25 and the HIV/AIDS program. This is a grant program to

1 prevent substance abuse, HIV and hepatitis, particularly
2 among minority populations, so that's maintained at \$39.4
3 million.

4 We have a number of programs proposed for
5 decreases from the 2008 level. Terry mentioned the
6 Strategic Prevention Framework Program. This encourages
7 states and communities to use 5 main principles in their
8 prevention programs. The first is to assess the community
9 needs, assess needs; build capacity; develop strategic
10 plans; implement evidence-based prevention programs; and
11 then evaluate them. So it's those five principles, and we
12 give grants to states, state incentive grants for the
13 strategic prevention framework. So the decrease proposed is
14 \$9.3 million.

15 The next item is our data analytic coordination
16 and consolidation center; this is the main vehicle through
17 which we collect data to assess the performance of our
18 grant programs. That's slated for a \$5.2 million reduction.

19 The STOP Act is a new program in fiscal 2008. I'm
20 not sure if you've heard of it or not. STOP stands for
21 Sober Truth on Prevention. It's a program focused on
22 underage drinking. The eligible applicants for the grant
23 program are current and former Drug-Free Communities
24 grantees, and they're eligible to apply for a \$50,000 grant
25 each. And it's to extend the efforts that they've already

1 put forward for their Drug-Free Communities programs that
2 specifically focused on underage drinking to support the
3 Surgeon General's call to action on underage drinking. So
4 the entire program in fiscal 2008 is \$5.4 million and it's
5 slated for elimination in 2009.

6 The next item is our Centers for the Advancement
7 of Prevention Technologies, those are our main technical
8 assistance vehicles to support our grantees, and that's
9 slated for an \$8.5 million reduction. That would zero out
10 the amount of money that they are currently getting through
11 our PRNS, or Programs of Regional and National Significance
12 line item. It's hard to read some of the writing there, but
13 there would still be a \$4.4 million expenditure on block
14 grant set-aside funds. But the proposal would zero out the
15 PRNS money from that.

16 This is a summary table that shows you the new
17 activities, those maintained at the 2008 level, those
18 maintained at a reduced level, and then those eliminated.
19 So under new activities, we have, as I mentioned, the
20 prevention, targeted capacity expansion program for a total
21 of \$7 million in 2009. The programs maintained at the 2008
22 level include the fetal alcohol spectrum disorders, for a
23 total of \$9.8 million; the HIV/AIDS grants, no change at
24 \$39.4 million; our contributions to the National Registry
25 of Evidence-based Programs and Practices or NREPP, which is

1 a cross-center initiative -- there will be no change there;
2 and our contributions to the SAMHSA Health Information
3 Network, our clearing house, a cross-center initiative --
4 there would be no change there.

5 Maintained at reduced levels include our
6 Strategic Prevention Framework state incentive grants, so
7 they would be maintained at \$95.4 million, a reduction of
8 \$9.3 million. Our lab certification program -- this is part
9 of our Drug-Free Workplace program. We have a statutory
10 mandate to certify laboratories that conduct drug testing
11 for federal agencies and for federally regulated
12 industries. That's slated for a \$1.7 million decrease. So
13 we'll be facing some challenges in maintaining a statutory
14 requirement. Our data coordination consolidation center, as
15 I said, is our vehicle for collecting data on performance
16 measures, and that's slated for a \$5.19 million decrease,
17 leaving it at \$0.83 million.

18 Programs that would be eliminated would be the
19 Workplace Youth grants, the methamphetamine grants, the
20 STOP Act that I mentioned before, the Centers for
21 Application of Prevention Technologies, the zeroing out in
22 the PRNS line -- although, as you see, as I said before,
23 they'll still have some block grants set aside funds. And
24 then other programs, including underage alcohol programs

1 and our Native American Resource Center, would be zeroed
2 out.

3 The next couple of slides give a historical
4 trend, just for historical interest of the President's
5 proposed budget and then the enacted by Congress and signed
6 by the President at the end of the process. So you can see
7 there's been a pattern there. Likewise, this is broken down
8 for the programs of regional and national significance, so
9 the blue shows the President's proposed budget and the
10 purple shows the enacted.

11 This summarizes the new or increased initiatives.
12 As Westley mentioned, there is a proposed \$20 million for
13 the block grant for supplemental performance awards for the
14 top 20% of grantees who show superior performance. And even
15 though there have been overall reduction in our SPFSIG, as
16 we call the Strategic Prevention Frameworks State
17 Initiative grants, a number of them are coming to an end,
18 so we would have \$38 million for new SPFSIG grants, and
19 then the \$7 million for a new target capacity expansion
20 program, which would be to states and local communities for
21 emerging issues and to fill gaps and services.

22 This is also of historical interest. The figures
23 show not only the dollar amounts that come through SAMHSA's
24 appropriation, but also the green bars there show the Drug-
25 Free Communities program. This is a program that we

1 administer for the Office of National Drug Control Policy.
2 So the red bars are the total amounts of money CSAP
3 manages, including the Drug-Free Communities, and then you
4 see broken out the yellow is the programs of regional and
5 national significance, blue is the block grant, the
6 prevention part of the block grant, and as I said green is
7 Drug-Free Communities, and read is the total managed by
8 CSAP.

9 So, in summary, the President's budget would
10 provide 94% of CSAP's current funding for 2008, combining
11 both the PRNS and the substance abuse prevention and
12 treatment block grant funds. There would be reductions
13 achieved through program efficiencies, elimination of some
14 activities, and we could sustain major CSAP program
15 initiatives and have some new increased initiatives as
16 well.

17 Any questions or comments?

18 MR. ALEXANDER: How did the Center determine which
19 programs would be eliminated?

20 DR. MARSH: Well, it's a collaborative
21 enterprise; the Center puts forward proposals and SAMHSA
22 comments on them, and they go to the department, and more
23 comments, and Office of Management and Budget, and then it
24 comes out in a final package. So I think overall there's an
25 attempt to weigh the different options. We're in a time of

1 tight budgets, obviously, looking at issues such as
2 duplication and how programs have been performing in the
3 past, and then an overall consensus. That's the best case
4 under the current scenario, given the constraints that
5 government is facing overall.

6 MS. CUSHING: Dr. Marsh, thank you for your
7 presentation.

8 Regarding the reduction in SPFSIGs of \$7.9
9 million, would that have normally been the allocation for
10 states who have not yet received a SPFSIG?

11 DR. MARSH: Peggy Thompson correct me if I'm
12 wrong; but I think the reduction would come out of new
13 awards. That is, I don't think we'd be planning to cut
14 continuations.

15 DR. CLINE: There is enough funding to
16 continue those existing grants, and we believe the goal for
17 the SPFSIG is to make sure that every state and territory
18 actually has SPFSIG in place. The amount of money that is
19 allocated would get us to cover all the states and, I
20 believe, 5 out of the 6 territories. It's very, very close
21 to that mark.

22 DR. MARSH: Thank you.

23 MS. CUSHING: My question really related to the
24 states that do not have SPFSIG. And secondly, the STOP Act
25 funding -- that funding, those grants are on the street

1 right now for this year. So that means that those grantees
2 would have funding for one year and one year only, is that
3 correct?

4 DR. MARSH: That's true.

5 MS. CUSHING: Thank you.

6 MS. WAINSCOTT: Another question I should probably
7 know the answer to, but I don't -- on the second slide it
8 says that there's been a decrease of \$36.1 million out of
9 \$158 million, that's about a quarter. On the last slide, it
10 says 94% of CSAP funding from fiscal year 2008. What's?

11 DR. CLINE: Part of that would be that there
12 would be some reductions -- so you have your overall
13 reductions, and then you have those areas where there is
14 proposed increase.

15 DR. MARSH: Thank you.

16 DR. CLINE: Okay, thank you, Dr. Marsh.

17 And Kathryn Power -- Kathryn is the Director for
18 the Center for Mental Health Services, and we'll turn the
19 podium over to you.

20 DR. POWER: Good morning, everyone. It's
21 delightful to see you again today, and you'll notice that
22 Anna and I follow the same pattern in terms of our
23 PowerPoint slides -- and I have even fewer than she has.

24 So let me just start off by saying that yesterday
25 I shared with you the portfolio that the Center for Mental

1 Services has in our program profiles, and that's really the
2 picture for 2008. So we are going to concentrate here for
3 just a few minutes on the 2009 budget and on some
4 legislative and policy issues that we were actually asked
5 to speak about as well. So I'm going to touch very quickly
6 on the budget and then I'm going to go to some of the
7 legislative and policy issues that I think are important
8 and that we're paying attention to at the Center for Mental
9 Health Services.

10 You've heard from my other fellow directors; the
11 situation for us is that the total 2009 budget, all the
12 drivers are the same here in terms of the priority setting
13 and the deliberations and the fiscal realities. We have a
14 budget set for \$784 million, which is a decrease of \$126
15 million from our 2008 level. And that is a combination of
16 both increases and decreases. So the overall reduction, for
17 example, in PRNS was \$144 million, but it was on the plus
18 side by virtue of some of the changes.

19 So we've just tried to highlight some of the
20 changes for you. The programs that were increased were the
21 Children's Mental Health Services Program. That is plussed
22 up by \$12 million; and that is a program that is the second
23 largest program in the Center for Mental Health Services,
24 after the block grant. So that started well over 10 years

1 ago, it's over \$100 million now, and it's a plus up of \$12
2 million in the Children's Mental Health Program.

3 The second program that has been given an
4 increase is the projects for assistance and transition from
5 homelessness, known as the PATH program. That is a formula
6 grant program. It is also a matching grant program. And
7 it's considered very successful because the states match
8 more than they have to -- there's a 25% match requirement
9 on this formula grant program, and states traditionally
10 give much more money than that. And so, it's a very, very
11 successful program, and that has been plussed up by \$6.3
12 million.

13 The one program that's been maintained at the
14 fiscal 2005 level that is of note is our block grant
15 program. So the \$20 million incentive program you see on
16 the subsidy side does not pertain to the community mental
17 health block grant program; it is maintained at the same
18 2008 level.

19 And the significant programs that are decreased
20 from the 2008 level are protection and advocacy for
21 individuals for mental illnesses at minus \$880,000, so it
22 will be maintained at \$34 million level. And the whole PRNS
23 grouping -- remember that lovely list I gave you yesterday?
24 All of those 35 programs that were in that handout
25 yesterday; that's been reduced by \$144 million.

1 Now, we have the same layout here, so if you take
2 a look at this chart, you will see most of the major
3 information relative to the balance of new activities, and
4 those new activities have not been defined yet. These are
5 simply new categories of funding that, in some cases, were
6 a surprise when we got the budget. So mental health-
7 targeted capacity expansion of \$7.2 million, and mental
8 health drug courts of \$2.2 million. So those will be new
9 initiatives in 2009 under our framework.

10 And then we have the list of those that will be
11 maintained, and be either maintained at the current 2008
12 level or will be increased. Notably, the (?) suicide
13 prevention campus program will be increased by a small
14 amount, and the AIAN, which is American Indian/Alaska
15 Native suicide prevention initiative, will be plussed up by
16 some amount. Minority AIDS Program, there's no change;
17 HIV/AIDS education, no change, and NREPP and SAMHSA with
18 slight increases so that our portion, as it were, of what
19 we pay for SAMHSA and what we pay to SAMHSA for
20 participating in this programs, this is a proportional
21 breakout by center.

22 Those that are going to be maintained, but will
23 be reduced are the third column: Westley talked about the
24 Co-occurring state incentive grants, youth violence
25 programs, trauma informed services, the state and tribal

1 suicide prevention; these are reductions and you can see
2 the amounts of what sits in the budget and then the amount
3 that it was reduced. Homelessness prevention,
4 criminal/juvenile justice, etc.

5 And then those that come to either a natural end
6 or are going to be eliminated in 2009 are listed here:
7 alternatives in seclusion and restraint; some of the
8 children and family programs; mental health transformation
9 activities, and those include things like the Voice Awards
10 and the Anti-Stigma Campaign and our track system. The
11 Mental Health Transformation State Incentive grants which
12 go to the nine states; behavioral and physical mental
13 health services, which is a project launch, which is the
14 one I talked about yesterday, which is started in 2008, but
15 is not included in 2009. Older adult programs, other
16 congressional projects, et cetera.

17 That is really the snapshot for all of our major
18 programs in terms of what will be new, what will be
19 maintained and increased, what will be maintained at a
20 reduced level, and then what will come to a natural end or
21 eliminated. And I also included a slide that just talked
22 about the funding trends, just take a look at the
23 President's budget and the final appropriation and we move
24 traditionally and historically in that direction.

1 Now what I want to talk about for just a few
2 minutes are some of these legislative policy issues that I
3 think are very important. The first issue is, as Joe
4 mentioned yesterday -- and those of you that weren't here
5 yesterday, we talked a little bit about re-authorization.
6 Re-authorization continues to be an important policy and
7 legislative issue for all of us. And in particular, both
8 substance abuse, prevention treatment and mental health
9 services had a very robust conversation with all of the
10 folks here at SAMHSA. We're going to continue to pay
11 attention to that, and as Joe indicated yesterday, it's
12 going to come up, we hope, next year. So re-authorization
13 is a major policy issue.

14 The other, some of the other policy and
15 legislative issues that we're working on are that we are
16 currently having conversation and are awaiting a ruling
17 from the Federal Communications Commission, the FCC, on the
18 ownership and operation of the hotline that feeds into our
19 Hopeline and Lifeline. As you know, we get funding from
20 Congress to support 1-800-273-TALK. We have also petitioned
21 to the FCC to be able to cognizance over 1-800-SUICIDE; and
22 because of a history that is very complicated and very
23 complex; I will just tell you that we are awaiting the
24 final, we hope, final FCC ruling which will be coming,
25 hopefully, April 22. We are anticipating that that ruling

1 will have some significant policy impact on the overall
2 schema in terms of our responsibility to support a 1-800-
3 SUICIDE series of lines as well as the Crisis Center
4 Network that Congress funds us for. So we're very
5 interested in that, and I think that's a major policy
6 issue.

7 The other areas, legislatively, that we're paying
8 attention to are, of course, mental health parity -- you've
9 followed, I'm sure, the Congressional deliberations. We now
10 have the House passing the Paul Wellstone Mental Health and
11 Addiction Equity Act. That's an interesting transition to
12 now looking at a piece of legislation; and that piece of
13 legislation now basically expands the Mental Health Parity
14 Act of 1996, and basically prohibits group health plans
15 from imposing treatment or financial limitations on mental
16 health benefits that are different from those applied to
17 medical and surgical services.

18 In addition, we are also paying attention to the
19 Mentally Ill Offender Treatment and Crime Reduction Act,
20 which is HR3992, and that is going to look at improving
21 mental health services for inmates and boosting training
22 for law enforcement officers. So we have an interest in
23 working with our partners at the Department of Justice and
24 making sure that we understand what that act does.

1 And then of course, the Community Mental Health
2 Services Improvement Act, Senate Bill 2182, has been
3 offered by Senator Jack Reed and Senator Gordon Smith, and
4 also introduced in the house. And so that improvement act
5 really calls for two major provisions -- and it takes a
6 look at co-locating primary care services and community
7 mental health settings and also to support innovative
8 programs for mental health workforce recruitment and
9 retention.

10 And then finally the other policy and legislative
11 issue that we're tracking is that the Senate, in February,
12 approved the Indian Health Care Improvement Act Re-
13 authorization bill, which was Senate 1200, which contains
14 an amendment that places a moratorium on the centers for
15 Medicare and Medicaid services' rules on the case
16 management and the targeted case management services. So
17 we're really interested in how that is going to progress
18 over time in terms of the policy issues and in our
19 negotiations and deliberations with our partner at CMS.

20 So those are some of the legislative and policy
21 issues we're looking at; those are the budget issues for
22 the Center for Mental Health Services for 2009, and I'd be
23 happy to take your questions.

24 Judy?

25

1 ***Council Discussion***

2 MS. CUSHING: I have a question about the 1-800-
3 SUICIDE number because that's so critical. It's the number
4 that people remember. You're trying to educate them about
5 the other number. I'm just wondering what would happen if
6 the FCC does not rule in SAMHSA's favor?

7 DR. POWER: We're about ready to have a series of
8 deliberations and discussions, both with the network and
9 internally within SAMHSA about what are the potential
10 options for what that means. I think part of what that
11 means is that certainly we're hopeful that that will not
12 happen. Secondly, we will obviously need to have a
13 strong communications strategy, and a strong working plan
14 with the crisis centers to begin to take a look at what are
15 the ramifications for that. And I think that there are some
16 very strong sets of ideas about how we're going to deal
17 with that, and so we're in the midst, literally, of putting
18 that together right now.

19 MS. CUSHING: Thank you.

20 DR. KIRK. An observation and then a question, and
21 I don't know if it's for Kathryn or for you, Terry --
22 things like the mental health transformation grant; these
23 are true, true system change right down to the core. I'll
24 state my basis, and I'm sure others will agree or disagree.
25 Those things do not occur overnight, and trying to sustain

1 momentum for these extraordinarily important and very, very
2 informed system changes takes an effort. How can we help
3 you in our neck of the woods, communicate that when one is
4 talking about outcomes and I don't know all the hoops that
5 you need to jump through -- how do we help to communicate
6 to people who will get informed in your decisions are
7 short-sighted sometimes and say "well, we don't see any
8 results from this"?

9 It's moving from what I call a Band-aid approach
10 or sort of allays the project of the moment to true types
11 of change. Because Terry, when you talk about the public
12 health model -- I would imagine that you are very, very
13 effective at communicating that, but that again is so
14 systemic that in all the programs you have, I would imagine
15 that it's a major challenge just to get people to
16 understand at other levels that you're cutting a core
17 particular component or you're being premature in your
18 judgments about the efficacy of a particular program.

19 As a body, what is it that we can do, or do you
20 have any suggestions as to how we can help to inform that
21 agenda? Otherwise, I think the project really doesn't get
22 there.

23 And just one other really quick comment -- in the
24 presentation of Dr. Marsh, I remember a slide that somebody
25 had that clearly showed major investments in prevention,

1 dollar-wise and then there was a slide, that was an
2 overlay, that clearly showed the results of those
3 investments. Again, you don't see those in one year; you
4 see a trend. And I think that the more we can thing in
5 terms of trend analysis of true system change, then the
6 upstream type of approach that you're talking about, that
7 will make a difference.

8 But if we continue to get caught up in
9 nickel/dime type of stuff, it's hard to get there.

10 DR. POWER: Do you want me to start?

11 DR. CLINE: How about I jump in for part of
12 it, and then turn it over to you, and maybe you can talk
13 about some of the transformation efforts as they moved
14 forward outside of the grant program?

15 DR. POWER: All right.

16 DR. CLINE: You are absolutely right. There is
17 a constant challenge to be able to demonstrate the
18 effectiveness of the programs. And we have seen that, as
19 you know, in Oklahoma, the state that I'm from, is one of
20 the 9 transformation states, so I know these issues up
21 close.

22 It's been very, very difficult, within that short
23 period of time, to have the data to demonstrate the
24 effectiveness of those dollars. And you're right. It's a
25 long term investment. And what we find ourselves, the

1 environment that we're in today, is focused very much on
2 balancing that budget by 2012 -- and that's one of the
3 factors in combination with the absence, as this program is
4 being developed, and as the entire initiative is being
5 developed, in the absence of that concrete data, it has
6 made this particular program vulnerable to that. So what we
7 have needed to do, and again with that accountability and
8 focus on performance, that vulnerability exists for the
9 transformation of grants themselves.

10 So the charge for us is figuring out what we can
11 do to continue that emphasis because we believe that's
12 critical. Absolutely critical. So what can we do, as an
13 agency, in collaboration with others, or on our own, to
14 further that agenda?

15 In terms of your specific question about what can
16 the council do or as members -- I think we continue to
17 drive home that point about the ripple effect of these
18 services. And you'd be hard pressed to find a presentation
19 where I didn't talk about the impact on the health care
20 system or the impact on the criminal justice system or
21 those others.

22 And I think we need to continue that mantra in
23 terms of making clear that it's not a matter of not paying
24 for those services now, or investing there, because we are
25 investing, across our country, billions of dollars -- the

1 question is are we doing it effectively? Are we doing it in
2 a way that has positive outcomes? And the bottom line is
3 that as a policy, we're not, which is why we see that
4 ripple effect over into all those other systems.

5 I think we have to continue that mantra. And
6 there are several initiatives that Kathryn will talk about,
7 where you will see that we're continuing that push.

8 So let Kathryn do that piece, and then we can
9 move to other questions. That is a great, great question.

10 DR. POWER: First of all, the way you framed
11 your question is very important in that you do have a role.
12 You do have a role as a person who sits on this council, or
13 you do have a role in terms of your credibility as a
14 commissioner in mental health, and to talk about the kinds
15 of things, and to talk about the kind of time that systems
16 changes takes, and I think that that's an important
17 process. If you look at any kind of change, just talking
18 with the public in general about the fact that these things
19 take time is very important, and certainly something on the
20 scale of transformation takes time.

21 I think, overall, in this environment, the
22 overall DHHS budget was reduced by \$2 billion. We fit into
23 that; we fit into that overall reduction of \$2 billion that
24 in fact is the focus of trying to drive towards a budget
25 balanced in 2012.

1 You'll notice that the programs that were
2 increased -- both the children's mental health program and
3 the PATH program, were programs that had rated very well
4 under the PART process.

5 DR. CLINE: Do you want to just say a word
6 about what the PART process is?

7 DR. POWER: That's the Program Analysis
8 Reassessment Tool. It's the performance process. I can't
9 tell you that that's really a hard thing for us to explain
10 to people, about how difficult and complex that process is,
11 but it's very significant, and it very significantly plays
12 a role in terms of budget deliberations. And so it is
13 important for people to know that because of those
14 programs, the children's program and the PATH program were
15 rated so well in the performance analysis, they were given
16 the plus-ups.

17 In this environment, Tom, one of the things that
18 we try to do was balance this issue about do we fund
19 infrastructure or do we fund services? And we have
20 constantly said that we need to do a balanced portfolio.
21 Now sometimes the political winds shift back and forth
22 between those, but we believe that we have to have a
23 balanced portfolio of both infrastructure and services.

24 This transformation program is 2.5 years out, and
25 we need to demonstrate its performance and it's coming at a

1 time when it's hard to capture those performance measures
2 2.5 years into the grant program.

3 I am, however, and I know that the administrator
4 is very concerned about sustaining, particularly in this
5 transitional time, sustaining, the transformation agenda.
6 And we are going to do that through a variety of targeted
7 focus of our programs and making sure that we continue to
8 support specific both infrastructure and service change. So
9 our investments in the Leadership in Psychiatry program,
10 our investments in the Transformation Transfer Initiative.
11 These are smaller programs, but they will give us an
12 opportunity to continue to move, recovery-focused systems,
13 evidence-based care, putting consumers at the center of
14 care, et cetera. And trying to seed those pieces, even in
15 the absence of other transformation dollars.

16 DR KIRK: I think one of the things that grantees
17 could possibly help you with is that -- this is just the
18 approach that I use -- we never go after grants just to get
19 more money. My approach is we have spent a lot of money,
20 HHS runs a big agency. My directions to my troops are I
21 want you to show how the dollars that we're getting from
22 grant are serving to redefine in the allocations of our
23 base dollars. So it's not add-on. and I think that the more
24 we may be capable of feeding that to you, that as a result
25 of such and such project, we actually converted, we have a

1 better outcome for X number of millions of dollars that was
2 actually part of our stated core budget.

3 So our legislator, I'm sure, is like others --
4 he'll presume that federal grants are simply going to be
5 rolled into state dollars. They will not do that.

6 But I think, going back to your point, Terry, as
7 well as Kathryn's -- the more we can show conversion of
8 services to be better on an incremental basis, then we can
9 be able to show you that you gave us X number of millions
10 of dollars for such and such project. That had a return on
11 investment because we're spending smart. That to me is our
12 responsibility as recipients of some of these grants and I
13 think the more that you could have a way at that, we could
14 help you with that, so much the better. That's what a true
15 system change is.

16 I think in many ways, my read is that when you
17 get to mental health and addictions, we need to be part of
18 every agenda. Whether it's education, whether it's criminal
19 justice; the more we can communicate to the powers that be,
20 the better off we're going to be.

21 DR. CLINE: We have Ms. Wainscott, and then
22 Mr. Braunstein, and then Dr. Gary.

23 DR. POWER: These are all for Terry, right?
24 Not for me?

1 MS. WAINSCOTT: All I want to do, and I'll go
2 ahead and say it, is Kathryn, thank you for your sustained,
3 patient, focused leadership on 1-800-SUICIDE.

4 DR. POWER: Thank you. George?

5 MR. BRAUNSTEIN: I just wanted to follow up on
6 Dr. Kirk's comments. Are there grant recipients aware of
7 the measurement system that you have just alluded to, that
8 the federal government is using to determine, or you are
9 using to determine? And so is there some communication that
10 gets at how well they're doing? Because I think that that
11 will be key to part of getting at communicating the
12 effectiveness -- if we're measuring something different
13 than what you are.

14 DR. POWER: Well certainly grantees are aware
15 of the fact that all of the programs collect GPRA data,
16 which is Government Performance Results Accountability
17 data, and grantees, actually by virtue of receiving a
18 grant, agree to collect GPRA data, which also informs our
19 NOMs (the National Outcome Measures), and we are also at
20 the Center for Mental Health Services, capturing data
21 through the Trak system, which just came online in May of
22 2007, in which we're capturing the impact of data from
23 technical assistance, et cetera.

24 The difficulty we have, George, is defining what
25 is a performance measure when you're trying to transform a

1 system, and to metricize, as it were, that data? In
2 Connecticut, it may be very difficult than Hawaii, which
3 may look very different than Oklahoma, which may -- in
4 other words, what are those calculating? What are the
5 arithmetic pieces that you can create that then show
6 performance? And frankly, we're in a performance management
7 environment where oftentimes it is the numerator is the
8 amount of money, the denominator is the number of people
9 served, and that becomes a measure of how effective a
10 service is -- much more difficult to capture when it comes
11 to infrastructure change; much more difficult to capture
12 when you're trying to embed a philosophy into a system when
13 you're trying to put evidence-based practices into hands;
14 very difficult.

15 Now it's interesting to watch how the SPF creates
16 that, in terms of community improvement, community
17 penetration, et cetera. And there may be some learnings
18 there across those kinds of measures -- but we have to
19 establish new measures for each new grant program. And
20 therein lies the difficulties.

21 But yes, grantees will know that they are
22 responsible for capturing data that feeds the NOMs that
23 comes through the GPRA process.

1 DR. GARY: Thank you very much for your
2 presentation. I'm looking at a -- my question is related
3 to, again, a council perspective, and long term.

4 Several questions: number one, could you share
5 with how programs would be communicated with that their
6 initiatives will not be supported or have been terminated?
7 I would think that that would be a very, very important
8 process for several reasons. I know it's very difficult to
9 cut programs, because any program, even with inadequate
10 measures, does some good.

11 The other problem is that the measures that are
12 collected may not reflect the changes that are happening.
13 So there are some tensions there.

14 The other is -- is there a mechanism in place
15 that would help those individuals whose programs will be
16 closed to have sense of support, intellectual support,
17 material support, emotional support, et cetera to maintain
18 at least the part of a program that has been inculcated in
19 a community with a group of people so that there can be
20 some sustaining ripple effect?

21 DR. POWER: Before you ask me another
22 question, can I just answer these right now, or do you have
23 another question tied to that?

24 DR. GARY: I think it's tied to that -- if it
25 doesn't happen, when monies become available and programs

1 have to start up again, to address the same issues, money
2 is lost, lives are lost, well-being is compromised, and
3 there are a lot of frustrations in communities and people
4 don't believe that the mental health system is going to
5 really help them because they give and at the same time
6 they take?

7 And I'm just wondering if we've looked at some of
8 those infrastructure, philosophical, methodological kinds
9 of approaches as we look at different communities
10 throughout the United States so that we can maintain some
11 momentum, maintain the relationship that SAMHSA was worked
12 very hard to develop with grass-roots people in the
13 community.

14 I'm concerned that that's never lost -- because
15 if it is, it just takes too long to build that;
16 transformation just doesn't happen.

17 DR. POWER: Let me start with your first
18 question.

19 We do get out and we do talk to the constituency
20 groups and to our grantees about what the budget says, and
21 so we have started that process. The administrator
22 communicates associations and provider groups; we do
23 presentations to the states, to the grantees about what the
24 2008 and 2009 budget contain. And yes, we try to explain it

1 as soon as we have that information starting in February
2 and it goes forward from here.

3 We also answer questions about what the
4 implications are for some of those budget decisions and it
5 starts with that very issue in your second question -- and
6 that is the issue of though a grant program may not
7 continue, there is a natural end or there is a termination
8 or an elimination, that the issues of sustainability and
9 the issue of building learning communities has really been
10 a part of the work that we have done, particularly at CMHS
11 around those grantees who go through certain cohorts, in
12 other words, certain periods of time. We try to connect
13 them to either other grantees that may be continuing or we
14 try to connect them to grantees who have been terminated
15 but are trying to continue to create materials, substantive
16 communication opportunities, and that kind of individual,
17 personal and professional connection. We have modeled that
18 through the National Child Traumatic Street Network; that's
19 a group of grantees that we have continue to create a
20 learning community about.

21 My sense is that will happen also with
22 transformation -- that there will be some, and we're
23 building learning communities around transformation, either
24 directly under the grant programs or by connecting
25 recipients across different programs. So Seclusion and

1 Restraint that I talked about yesterday, making sure that
2 that's connected with the Transformation folks; making sure
3 that that's connected with the Systems of Care in
4 children's mental health, and hopefully, yes, using some of
5 our resources and some of our time and talent to be able to
6 support those individuals so that this doesn't get lost,
7 because I heartily agree with you that we have to sustain
8 and encourage and nurture and to continue to facilitate
9 those individuals who have an investment and leadership in
10 wanting to change the systems.

11 Are there any other questions for me?

12 Yes?

13 DR. WANG: This is Ed Wang.

14 I think, certainly, all the Council members have
15 raised concern of, really, the impact because of what's
16 being cut, what's being maintained, and also in terms of
17 new programs.

18 As a new member, I really have to follow
19 Commissioner Kirk's comments in that I think it's important
20 within the role of the Council members to have a little bit
21 more detailed discussion in terms of what can be helpful,
22 and I would love to see that as an agenda item later on
23 this afternoon, just following the schedule.

24 DR. POWER: Thank you, Ed.

1 MR. CROSS: I want to second that and to
2 follow up with it.

3 It seems to me that the federal government has a
4 couple of major ways that it influences public policy with
5 regard to things that states are primarily responsible for,
6 and one is a regulatory function where the powers of the
7 purse strings are strong enough to influence states to set
8 certain policies to get the money.

9 What we're talking about here isn't in that
10 category. SAMHSA, it seems, has gained most of its
11 influence over public policy at the state level through
12 leveraging; through being the demonstrator, the convenor,
13 the educator, the publisher, the communicator, about
14 effective ideas. And I think that when you're looking at a
15 budget and you're trying to be strategic about how you can
16 approach systems change and transformation, that
17 sacrificing programs of regional and national significance,
18 which really are those leverage points, that you sacrifice
19 your long term effectiveness. So this is, I just want to
20 re-emphasize that, and I think that's an important
21 discussion that we need to have.

22 I also think that the Children's Mental Health
23 Program has good scores in part -- the legislation requires
24 that 10% is sent for evaluation. It's got great data; it's
25 a great program. It should be effective, given what we know

1 about it. I don't think the programs of national and
2 regional significance can stand up against that kind of
3 data, and so I wonder if we even have a level playing field
4 to make good decisions at that level.

5 DR. POWER: I think that that's a very fair
6 observation. And the reality is that as you look at the
7 portfolio yesterday, of the 35 programs that sit under the
8 PRNS portfolio, how do you find a set of measures that
9 apply across 35 programs that are consistent?

10 Now if you're going to pull out a program from
11 that portfolio and put it under the PART score, you'd have
12 a much better chance of having some evaluative data. But
13 it's very difficult, given our Seclusion and Restraint
14 program, our Suicide Prevention program, et cetera to find
15 a set of measures that are going to measure up, as it were,
16 to what is in the Children's Mental Health Program. I think
17 that's a very fair observation.

18 Any other questions, observations for me?

19 Thank you all.

20 DR. CLINE: Thank you, Kathryn.

21 We are right on schedule. Before we start the
22 break, just to remind you that in your packet, you have the
23 list of recommendations and subsequent actions from the
24 last Council meeting, so at some point I would encourage
25 you, if you have not already read those, just to help

1 inform part of our discussion at the end of the day, the
2 roundtable. And for some reason if that's not in your
3 packet, let me know that or let Toian know that; we'll make
4 sure that you have a copy of that.

5 So we'll take a 15 minute break, and we will
6 reconvene at 10:45. Thank you.

7 (Break)

8 ***Member Recognition Award***

9 DR. CLINE: Thank you all for rejoining us,
10 and we have a slight modification to the schedule. You know
11 how some people say the federal government is rigid and all
12 those kinds of things? Well, just to demonstrate our
13 flexibility to you, I just want to talk briefly about our
14 schedule -- I have actually just been called to a meeting
15 downtown, which is one of those meetings that you don't say
16 "no" to, so I am going to say "yes". I will need to excuse
17 myself at 12:30, which means I will miss the roundtable
18 discussion.

19 I am going to ask -- she does not know this yet -
20 - Dr. Broderick if he will be able to facilitate that; the
21 co-chair will facilitate the movement of the meeting, so
22 we'll continue with that.

23 The one piece that I did not want to miss; I am
24 moving up into the schedule, knowing I couldn't do the full
25 roundtable, so please bear with me for just a couple of

1 minutes, and that is to recognize one of our retiring
2 Council members, Lt. Gov. Aiona. So we are going to do that
3 right now, and allow him to say a few words to the Council.
4 I'm going to ask him to move with me to the podium.

5 So the lieutenant governor has served for four
6 years on the Council; we have a letter that's going to him
7 as well as an actual award. But basically the letter says
8 that at SAMHSA and the US Department of Health and Human
9 Services, we're very appreciative of your strong leadership
10 on issues of drug abuse, of underage drinking in
11 particular; that you've made a contribution as a former
12 drug court judge, and now as a leader in your state -- an
13 incredible contribution here.

14 I had the good fortune of spending a day and a
15 half, two days, in Hawaii, which I thought was going to be
16 this great vacation for me. But it turns out it wasn't
17 because the lieutenant governor had some influence over my
18 schedule, and our very first press conference was either at
19 6:00 or 6:30 in the morning. We were on the morning talk
20 shows, talking about these issues, and it just continued
21 throughout the entire day and evening.

22 So he's someone who has an incredible passion
23 about these issues; someone who's in great demand at home,
24 but has taken the time to come here and participate very,
25 very actively as the co-chair and as a member of the

1 Council. He has had a wonderful track record in terms of
2 the level of participation, which is a great burden given
3 the distance to travel, and the time changes, and all those
4 things. And so I personally would like to thank you and on
5 behalf of Secretary Leavitt, I'd like to thank you and
6 present you with this letter, and present you with this
7 award and ask you to say a few words as well.

8 LT. GOV. AIONA: Thank you so much.

9 Well, I want to thank Dr. Cline for those nice
10 words, those kind words, thank you very much.

11 I want to thank the Council. It's been, like I
12 said yesterday, I have learned so much by being on this
13 Council and looking around now at the new members that we
14 have; I just told Dr. Cline that I think you've got a
15 great, great mix here. You've got the young, you've got the
16 community members here; you have the academic side of it
17 all -- you are going to be a great Council. And I will miss
18 this dearly.

19 If there's anything that I would recommend it's
20 for you to be as active as you can and you are all so very
21 active right now. Make this a part of your agenda; make it
22 a part of your passion, and I know that's the reason you
23 are all here. But you can have great influence on national
24 policy as well as where you are locally. And that's
25 basically what I've taken from this.

1 This is an area that we deal in -- every day you
2 hear about tragedy; every day you hear about lives being
3 lost. And, you know, it's an area, though where we can make
4 a great difference if we use just a little bit of common
5 sense, because that's really what it comes down to.

6 Again, I just want to thank, first of all, Dr.
7 Cline, and of course his predecessor, Charlie Curie, who
8 have given me the opportunity to be a part of this great
9 council, and I'm going to miss it. And as we say in Hawaii,
10 a hui hou, which means "until we meet again" and, mahalo,
11 "thank you very much". God bless you all.

12 DR. CLINE: And we will squeeze the lunch time
13 a little bit off of each of the afternoon sessions to make
14 sure that we have the full amount of time for your
15 presentation. So thank you very much.

16 And with that, I will turn it over to Larke
17 Huang. Dr. Huang is the Senior Advisor to the Administrator
18 on issues related to children and families.

19 Larke, the podium is yours.

20 ***Eliminating Health Disparities***

21 DR. HUANG: Okay, Dr. Cline.

22 As Dr. Cline mentioned, I'm the Senior Advisor on
23 Children, Youth, and Families to the Administrator. I also
24 am the agency lead for cultural competence and eliminating
25 disparities.

1 What we were invited to talk with you about today
2 to the Council members is some of our work on cultural
3 competence and disparities. So that's the focus that I'm
4 going to talk with you about.

5 We have a number of -- I have a number of co-
6 presenters that I will introduce to you, and I have also
7 wanted to call your attention a little bit to the materials
8 in your packet. Prior to doing that, I want to bring out
9 the SAMHSA matrix of priorities, which I think you have in
10 your packets, and you are probably familiar with. If you'll
11 note that cultural competence and eliminating disparities
12 is on the top of the matrix as a cross-cutting principle
13 and a cross-cutting concept.

14 We don't always have workgroups around those
15 particular cross-cuts; some we do. With Dr. Cline's
16 support, we do have a SAMHSA-wide matrix group on Cultural
17 Competence/Eliminating Disparities, or what we call CCED,
18 and that is composed of about 20 different SAMHSA staff
19 across the three centers, and the offices as well. And that
20 is a working group, and we have developed a plan for the
21 agency around cultural competence.

22 In your packet, you have the plan that looks like
23 this, and it's on legal size paper, which means it's a
24 legal plan and it was too big to fit on letter paper. So
25 you have that there. And accompanying that, you have -- a

1 plan is only as good as the work that goes behind it. So we
2 also have a work plan that's also on legal-sized paper, and
3 it has the specifics of the plan as well as our benchmarks
4 in terms of both short- and mid- and long-term outcomes.
5 I'm not going to refer to that in detail; you have that in
6 your packet.

7 So you have your roadmap and the workplan, and
8 basically our workplan focuses on internal capacity-
9 building issues around cultural competence and eliminating
10 disparities as well as some external projects. So some of
11 our internal work is focused on our in-services and
12 professional development and putting things into our
13 executive leadership performance plans, because we find
14 that what fits into performance plans are often the things
15 that get done cascade down through each of our plans
16 throughout the agency.

17 We've done some work looking at language and
18 RFAs, around cultural issues, ensuring that our cultural
19 competence is a piece of what needs to go into our RFAs,
20 and that the RFA language does not make our resources less
21 accessible to our culturally diverse communities.

22 So, for example, we did some changes around the
23 RFA recommended language around evidence-based practices
24 that if, in fact, an evidence-based practice is not
25 particularly relevant to the community you're serving,

1 there are options to that in terms of looking at other
2 cultural adaptations or practices that have some kind of
3 evidence relevant to the community. So that we're not
4 building things into our grant language that makes it
5 difficult for our culturally diverse communities to access
6 our resources.

7 Then we also do some data gathering in terms of
8 what are our current data gathering efforts and how do we
9 ensure that attention to this issue is also part of our
10 measurement issues.

11 Then we have a number of external projects, and
12 we'll be speaking to you about one of those in a little bit
13 more detail -- the National Network to Eliminate
14 Disparities in Behavioral Health, which is a very exciting
15 national level project we have going on, and I have invited
16 some of my partners on that project across the country to
17 also present to you today.

18 One of the issues in terms of our internal, in
19 terms of our seed work group that Dr. Cline proposed this
20 question to us -- as we think about the changing population
21 demographics, rapidly changing in our country, how does
22 SAMHSA, how is SAMHSA poised to meet the current and
23 emerging needs of those particular populations?

24 So we posed this as a question for you as a
25 council to help us think about, and wanted to just give you

1 a quick, quick overview about what we're trying to do
2 around gathering the appropriate information to help us
3 address that question, and even refining the question. So
4 maybe you can also, in your deliberations, think about what
5 are really the questions we should be asking.

6 One of the things, we did some census population
7 projections -- we looked in 2000, 2007 and now to 2012. And
8 I'm just showing you the Hispanic population changes.
9 You'll have this in your materials if you can't see the
10 details very much. We took this off of population census
11 data. This is what -- and we're focusing here on the
12 Hispanic population, which is, we're kind of looking at the
13 pink sections and how that changes over time. So you can
14 see that the change is moving towards the Northeast,
15 towards the South, towards the middle of the country, more
16 density even in terms of the West and Northwest regions and
17 that's in 2012.

18 So, if you think about that, we wanted to look at
19 if we overlay our programs, if we look at our prevention,
20 treatment and mental health programs, just at a quick
21 glance, where are we serving? Where is the density of our
22 programs in terms of different population growth? And we
23 started to do this with our different subgroups of
24 populations and tease apart even further -- are state
25 grants hitting down and trickling down into populations of

1 color? How does it look in terms of when you give out our
2 resources directly to communities? Will that reach
3 communities in a different way than perhaps our state
4 grants?

5 We're playing around with this question, and
6 would like any input that you can help give us. This has
7 tremendous issues for our allocation of resources, and
8 certainly for our workforce population and our workforce
9 trading efforts, as we see really major demographic
10 changes.

11 Also along with that, we are looking at some of
12 our programs to see how well we are accessing, this is
13 access to programs, it's not necessarily those getting
14 treatment. So if I just pulled out a couple of our CSAT
15 programs to look at what are the percentages of the
16 different populations that we're serving in some of our
17 programs? I'm not going to spend time on this, but you can
18 see that we get variable responses in our different
19 programs in terms of the degree of access to our programs
20 by these culturally different groups. We looked at when
21 adolescents start screening before intervention, referral
22 or treatment.

23 What I now want to speak to you about is one of
24 our external projects. In other words, we're doing things
25 to try to build our own capacity, or own awareness, our own

1 sensitivity to are we improving access to resources
2 internally. And we have a number of internal activities,
3 and you can see that on our workplan and road map.

4 One of our more externally-focused activities is
5 the development of a national network to eliminate
6 disparities in behavioral health, the NNED, and I want to,
7 at this point, introduce my co-presenters, who are
8 representing an entity of the NNED: Ken Martinez, who is to
9 the left of that table there, is a board member from the
10 National Latino Behavioral Health Association, and also a
11 mental health specialist in one of our TA, contracts in the
12 Technical Assistance Partnership in Mental Health. Next to
13 him is David Mineta, who is the Deputy Director for Asian
14 American recovery services in the San Jose area in
15 California, and he represents one of our community entities
16 on this network. And then to his left, is Dr. Mareesa
17 Isaacs, who is the Executive Director of NAMBHA, the
18 National Alliance of Multi-ethnic Behavioral Health
19 Associations. They are also going to be giving you brief
20 presentations around the NNED.

21 So this is a network structure that consists of
22 community and ethnic-based organizations and networks. This
23 is, as opposed to a state- or a national-driven network,
24 this is a community-focused, community-driven network.

1 A second entity, or what we are calling our
2 knowledge discovery centers. Those are centers who may work
3 with the community-based organizations around different
4 priority areas around workplace development, around
5 developing the research around the practices, developing
6 the evidence around the practices in these community-based
7 organizations; and then the National Facilitation Center --
8 which is really the coordination and the glue that holds
9 all the components of this NNED together.

10 Briefly, when we look at health disparities, in
11 particular behavioral health disparities, we really look at
12 it in terms of what the public policy literature has talked
13 about as wicked problems; pernicious, intractable, cross-
14 cutting problems that, in fact, they say are the kinds of
15 the problems that can't be remedied or resolved by a single
16 thrust -- a single center or a single program, but it
17 really takes crossing silos at agency work, crossing silos
18 at different sector work. We know that the disparities that
19 occur in mental health often lead to the disparities of
20 overrepresentation in criminal justice or justice, which in
21 many cases becomes a de facto behavioral health care
22 association for many people with mental health or substance
23 abuse issues, and that traditional ways of working really
24 defy, they don't help us to move further along in terms of
25 how disparities work.

1 So we've come up with this new structure, which
2 also links to some of the other work going on in the center
3 for mental health services, which has a very strong, under
4 Kathryn Power's leadership, a strong Eliminating Mental
5 Health Disparities initiative; under CSAD, under Dr.
6 Westley Clark, the affinity groups for the particular
7 cultural groups and a lot of the work they are doing. So
8 we're not trying to create a silo effort here; we're
9 linking that as a cross-agency effort as well.

10 Basically, what we get from this is that we
11 really need to work in new ways to really begin to address
12 these wicked problems, and network structure is one that
13 we're finding in different areas of these wicked problems
14 that seems to be pulling some of the best work together.
15 Without the different network structures, a CDC network on
16 Reach 2010, a health communities network structure; we
17 looked at a HERSA network structure where there are
18 disparities, collaborated, worked with them; and we looked
19 one of our own network structures here, the National Child
20 Traumatic Stress Network, and tried to take some of the
21 best learnings from those structures.

22 We have a vision for this NNED, this network
23 structure, which speaks to our diverse populations really
24 being able to live thriving lives, not just recovering
25 lives, but really thriving, contributing lives, in

1 supportive communities. We have a mission around this in
2 terms of really building this natural network across
3 different stakeholder groups, across different sectors, and
4 different culturally diverse groups.

5 We have key assumptions that we know that around
6 the country, there are what we call these pockets of
7 excellence that are doing very good work in terms of
8 reducing disparities in access to care, of quality of care,
9 for our diverse populations. We have David Mineta's site as
10 one of those that are doing tremendous work in recovery
11 services for his diverse population in the Bay Area in
12 California.

13 We know that there's a lot of good practices out
14 there; we know that people are taking the evidence-based
15 practices and doing cultural adaptations. They are all
16 occurring in different pockets in silos. So the idea of
17 this network is to really begin to link this together.

18 So again, here is our structure, with the three
19 types of entities. Some of the building that we've done to
20 date on this infrastructure, we have a governance
21 structure, with a steward group with a membership of 20. We
22 have an operations center through NAMBHA; we have community
23 strategies where we have built an internet virtual webspace
24 and work space for the network members. We are building a
25 website with a geomapping and a GIS component. We have a

1 monthly newsletter, our NNED Note, which talks about
2 funding opportunities, trainings, and other NNED activities
3 and updates, and then we have our membership invitation and
4 recruitment.

5 These are some of our current activities in the
6 NNED; Ken Martinez is going to speak to you in a little bit
7 more detail about one of these, that's our community-
8 defined evidence models to measure practice, effectiveness.
9 We also have a mental health education and anti-stigma
10 campaign for diverse communities that we're doing in
11 working with the Ad Council and a core part of our network;
12 and we also have one on prevention on underage drinking
13 campaigns -- again targeted to our diverse communities,
14 working with the Ad Council and our office of
15 communications here at SAMHSA.

16 We have several learning clusters, so our network
17 consists of learning collaboratives, or clusters. We have
18 several underway in Phase I of the NNED; one of those is
19 focused on parental depression in ethnic communities, a
20 highly prevalent multi-generation issue. It's particularly
21 prevalent in low-income neighborhoods and communities. We
22 have an integrated behavioral health and primary care
23 initiative; again, linking with some of the CMHS where it's
24 going on this. And we have a community engagement in

1 behavioral health, which is being led by Morehouse College,
2 their Community Voices Project.

3 This is a quick picture of our websites; these
4 are static shots of it. This is what we look like now
5 around the country in terms of we try to graphically
6 represent with the small dots a community-based ethnic
7 organization involved in this. Our knowledge discovery
8 centers, which will be the leads around these hubs of
9 learning collaboratives -- I might be totally confusing you
10 because I'm speaking so fast, but we actually have a very
11 cool structure here, which I'm trying to give you a visual
12 sense of what it looks like.

13 What we do with the geomapping piece is that you
14 can click on any of these centers that are part of it. I
15 pulled David's center up here, and see what the center is
16 doing, particularly they are doing some model interventions
17 around MET/CBT and also doing an Asian adaptation of an
18 evidence-based prevention brief strategic family therapy
19 for substance use. Our idea is that as we put this up here,
20 we will also have a searchable database of interventions
21 that are being developed in these community-based
22 organizations, the cultural adaptations being developed by
23 these organizations in their learning collaborations in
24 conjunction with our knowledge discovery centers.

1 This is what our steward group looks like, where
2 they're located and how they represent different
3 communities and knowledge discovery centers. This is our
4 learning collaborative around parental depression. This is
5 Phase I, so we have a group of very innovative, some are
6 community health centers, some are Caribbean Women's Health
7 Center, for example, Haitian Health Center, Boston, who are
8 all focused on this particular issue in their communities
9 and we are, through the NNED, bringing them together to
10 share their best practices and then also to disseminate
11 through the network.

12 This is our learning collaborative around doing
13 the public education and information campaigns; you can see
14 it's broken out by the different ethnic groups as well.

15 This is a picture of our shared virtual website,
16 where we do a lot of our work and exchange; and this
17 accessed internal to SAMHSA as well as our external
18 partners in it.

19 And these are some of our benchmarks -- and these
20 are in your handouts. But we wanted to not be words in
21 rhetoric and not be pictures on glass, but really have real
22 clear-cut benchmarks for each of our areas here. and these
23 are some of our benchmarks. And I won't go into details
24 over those.

1 Products, geomapping, growing our network; and
2 then I'm going to come back to questions and ask David to
3 come up now and speak from the perspective of one our
4 community-based organizations involved in the NNED.

5 ***Presentations by Consumers and Council Discussion***

6 MR. MINETA: Thank you very much, Larke.

7 Good morning. I think it still is morning. I'm
8 not sure what time I'm on right now. But I just want to say
9 thank you to Dr. Cline, Lt. Gov. Aiona, Council members,
10 SAMHSA staff, and the public who are here today -- thank
11 you all for, one, having us, and also Larke for having us
12 here.

13 I'd like to actually also begin by just thanking
14 SAMHSA and through Larke's efforts of having taken such
15 great leadership in the area of eliminating health
16 disparities. The existing of our agency, the Asian American
17 Recovery Services, is living testament, not just our
18 agency, but many ethnically-based organizations, to the
19 existence of the health disparity. We were created in 1985
20 because of a barbiturate epidemic in San Francisco that
21 Asian-Americans, and largely these were acculturated Asian-
22 Americans, second and third generation Japanese- and
23 Chinese-Americans in San Francisco, which had such a large
24 population of Asian-Americans, could not receive treatment,

1 or were not receiving treatment in the main treatment
2 system.

3 So as a result, ours was created, and has found
4 that it's trying to fulfill that same role in other
5 countries. In fact, I actually think we could probably, or
6 similar organizations could be throughout all 58 counties
7 in California now. The existence, again, of AARS speaks to
8 the health disparity around engagement, outreach,
9 successful treatment outcomes, retention and particularly
10 in this one very diverse community.

11 It turns out, now, and again in Santa Clara
12 county, in San Mateo county, some of the richest counties,
13 actually not only in California but actually in the entire
14 country, that we have these devastating health disparities.
15 So as a result AARS was created and now it turns out that
16 we service half our clients are non-API. And many are
17 Latino, so our staff, because of our cross-cultural
18 competency that we practice within the API community, now
19 we have the larger communities as well the same assistance.

20 One thing I wanted to talk to you today a little
21 bit about is about the experience that we had in the field
22 is our local contracts, our state work, and our federal
23 work, is moving all to evidence-based models. And for us,
24 we look at SAMHSA's NREPP list as our place to go and look
25 for validated, reliable means of providing high-quality

1 services and seeing if we might be able to modify that for
2 our Asian-American and/or Pacific Islander communities.

3 The golden chalice, or the Holy Grail in the
4 field, I think is being on that list, or using programs on
5 that list. However, one of the things that we're finding is
6 getting on this list, and getting your program on that list
7 is a very, very difficult process. So I'd like to point out
8 this one particular piece on the NREPP list as it stands
9 right now, according to the website. This is off the
10 website, and this is not Asian-American, these are not
11 Asian-American programs.

12 The AIAN, this is American Indian/Alaska Native,
13 so of the 88 programs that are currently on NREPP, 31 of
14 the 88 say that or they designate that they also are
15 responsive to American Indians or Alaska Natives.

16 Now, just so you know, there are 7 ethnic
17 categories on that list. And of that, 28 of 31 of those
18 that are designated AIAN serve at least three other ethnic
19 groups -- three or more. So 28 of the 31 do multi-ethnic
20 group, it's proven, it's been effective multi-ethnic group.
21 Two of the 31 served AIAN and two other ethnicities. So
22 only two of them served specifically three ethnic groups.
23 What I was interested in was the one that actually only
24 served one or had another ethnic group, because I know that
25 that one was actually normed out in that community. It

1 came, it was practiced in that community. And not to say
2 that that other ones won't have effect; clearly they do.
3 But the genesis of that program probably came either a
4 tribe or a reservation or one of the communities.

5 So I looked at that one more -- that one
6 particular one, the contact is actually a professor from
7 Stanford. Now for most ethnic-based organizations, it may
8 or may not be difficult to get a professor from Stanford to
9 actually take up your cause, and to be the primary contact
10 on the program.

11 Two weeks ago, I feel very appreciative of
12 SAMHSA, the Public Health Advisor, Love Foster, actually
13 had convened the targeted capacity expansion cohort, the
14 first targeted capacity expansion cohort, for American
15 Indians, Alaska Natives, and AAPI, and in Portland, to try
16 to get the current cohort's programs onto that NREPP list.
17 So she had this great training -- I think it was actually
18 one of the best trainings I'd ever been to in 17 years of
19 this work. And much credit to SAMHSA for doing this.

20 But my question on that was: we're trying to get
21 on that list programs that are coming from the communities,
22 and we just want to keep saying that it's really difficult
23 for us to peer review to get in there on reliable and
24 validated instruments, a whole host of issues. So part of
25 our -- and this is a very well-heeled group in SAMHSA's

1 first cohort; there are Native American groups that are on
2 the clinical trials network, and I'm telling you that my
3 sense is in the room, that if any one of us can get on that
4 list, then all of us should meet again and have a party
5 because that will be a great day. For community-based
6 organizations that may or may not be connected to a
7 research institution could make it on that list, then it is
8 a great day for communities everywhere; people where the
9 program is coming up with an effective evidence-based
10 model.

11 Partly, I just again want to thank SAMHSA for
12 one, both this opportunity to come here and talk about the
13 NNED, which we're all very excited about; and also
14 opportunities for talking about NREPP. And we're hoping in
15 that some ways -- my hope is that we can help get agencies
16 such as mine or even smaller agencies, much smaller, can
17 get them through and stamp its approval on their way,
18 maybe, to NREPP. But it's through the NNED process and this
19 support.

20 So I just wanted to share that short story and
21 again, thank Larke and the SAMHSA staff for having us here.

22 I guess at that point, I was so nervous trying to
23 put this together that -- literally I haven't slept in the
24 last two days, just trying to get this thing out and over
25 to Naveen, and then it was late, but anyway.

1 I guess with that, I guess we'll take questions
2 in a minute. With that, I guess I'd like to turn it over to
3 Dr. Martinez. I'm actually short. I came in really kind of
4 early.

5 Thank you all very much.

6 DR. MARTINEZ: Well, as David said, thank you all
7 very much for inviting us, especially Dr. Cline and the
8 Council and thank you for your time.

9 Today, I want to build on what David just said in
10 terms of a body of evidence that I think we need to expand
11 upon what else we might think of as credible evidence,
12 especially in cultural communities that describe best
13 practices, and I'm going to describe a method that we're
14 looking at through the NNED that will help us get there.

15 There's no way to sugarcoat this, and I try to be
16 straight-faced when I present, but this has a problem. And
17 the problem is the disparities in mental health care are
18 widening between whites and people of color; and
19 ethnically, racially and diverse populations experience a
20 greater disability burden from those emotional and
21 behavioral disorders than to white populations.

22 So how do we address it? Well, evidence-based
23 practices have been one method to address it; and they have
24 been developed to address quality and accountability. And
25 in some cases, fortunately or unfortunately, they are

1 becoming legislated in some places, either by state law or
2 by policy regulation of some sort.

3 But the problem is that many evidence-based
4 practices are developed linearly. I don't have a slide to
5 describe that one, but if you take out all the concentric
6 circles away from the Child and Family and then look at the
7 Child and Family and then go right to Methodology and then
8 go right to Best Practices, that's the linear model that
9 many evidence-based practices take in developing. Now what
10 we're saying is that it's much more complex than that in
11 cultural communities in particular. It's too simplistic,
12 and it's not culturally appropriate or accurate.

13 So this is another model that we might look at --
14 especially in communities of color, we are looking at a
15 very complex problem as well as a solution that needed to
16 be a little bit more complex as well. And that is all those
17 concentric circles outside of the child and family have to
18 be taken into consideration as we go through that evidence-
19 based practice development, including the historical
20 values, contextual and transactional.

21 These are listed for you, and I'm not going into
22 any detail, but I highlighted some of them in yellow, just
23 to point out how important some of them are. And in terms
24 of historical variables, racism and ethnocentrism, the
25 world we live in, it's not perfect and we live in,

1 unfortunately, a society that still espouses some of these
2 beliefs and practices. Our values, cultural beliefs and
3 world view have to be taken into consideration. If world
4 view is not part of the development of an evidence-based
5 practice, I think we're missing the boat completely because
6 we can't just apply an academic model to a behavior or a
7 symptom in a manualized approach and think that we're going
8 to come out on the other end having addressed all of the
9 more complex issues that children and families walk into
10 our settings with.

11 Contextual variables -- these days in particular,
12 immigration status is a gigantic contextual variable that
13 many times we don't consider when we're developing
14 evidence-based practices. What generation in the United
15 States these families are, whether they be Asian families
16 or Latino families, and there are acculturation levels
17 which is extremely important.

18 Transactional variables such as engagement -- we
19 have to find very creative ways of engaging cultural
20 communities in our work. We missed the boat early on
21 because we were trying to impose an evidence-based practice
22 on a group that we can't even get engaged. And why? Because
23 maybe our engagement strategies aren't very effective; they
24 don't take the world view of our cultural communities into
25 consideration.

1 And engaging not only in treatment, but engaging
2 in research -- our cultural communities need to be a part
3 of the development of everything that we do in our research
4 methodologies. And the methodological issues themselves
5 have to be addressed; we work from an empirical model, and
6 that's sort of been a tradition in our Western world, and
7 we need to look at non-empirical models, and I'll be
8 addressing that in just a moment.

9 So what are the facts? The bottom line is that
10 ethnic and racial groups are largely missing from efficacy
11 studies that make up the evidence based. There is some,
12 albeit limited research, that some empirically supported
13 treatments are appropriate for some ethnic groups. There
14 was a study done as part of the Surgeon General's report in
15 2001 that spoke about this, and out of 10,000 participants
16 in 4 areas that looked at the ethnic/racial background of
17 the participants in those studies to develop those
18 practices for bipolar disorder, depression, ADHD and
19 schizophrenia, there was a minimal amount -- there were
20 about maybe, I don't have the exact number but probably
21 under 200 ethnic or racial participants out of a population
22 pool of 10,000.

23 Now is that representative? Does that tell us
24 much about whether these practices are appropriate for
25 these groups?

1 So we have an alternative. Our research base
2 really has to expand to include communities, especially
3 those of color, and it needs to grow from the community up
4 and not just from the top down. Our usual empirical
5 approach, which is a top-down approach, which is an
6 academic approach using the empirical model, where we have
7 a problem, we have a symptom, we have a set of behaviors
8 that we want to change, so we put our best knowledge to
9 think about how might that change? We do it through
10 randomized control trials, and then we put it out.

11 Well, many times our randomized control trials
12 don't even include those groups that we want to apply it
13 to, and therefore it may render some of those invalid, at
14 least maybe not necessarily culturally appropriate.

15 So community-defined evidence is a set of
16 practices that communities have used and determined to
17 yield positive results as determined by the community
18 consensus -- and that's a very important part: community
19 consensus over time, which may or many not have been
20 measured empirically, but have reached a level of
21 acceptance by the community. That's our definition of
22 community-defined evidence. So it includes world view,
23 historical and value based contexts, and it's a
24 supplemental approach. We're not advocating that this

1 replace evidence-based practices, but be a supplemental
2 approach.

3 So what is community-defined evidence intended to
4 do? It's intended to identify and describe, or what we call
5 discover, measurable community- and/or culturally-based
6 practices. Our contention is that these effective practices
7 already exist in communities and don't have to be developed
8 in the laboratory. A lot of our cultural communities know
9 what works. They're never going to reach the NREPP status
10 necessarily. Hopefully we can help them get there, but if
11 they don't, that isn't necessarily a bad thing because
12 sometimes our practices will not measure by that goal
13 standard. We need to find another measurement stick as I
14 call it to help them reach that level of acceptance in the
15 general public, and by policymakers and funders and make
16 them credible and that's what this project is intended to
17 do.

18 We want to promote the use of culturally-informed
19 methodologies and measurement practices through research
20 methods that involve a community. This is a participatory
21 action research methodology that we want to use in order to
22 get at what those essential criteria are that make
23 practices effective in cultural communities, and identify
24 the common characteristics among the identified practices
25 and define those essential elements and the practices that

1 work. We know that there are many practices out there and
2 they all have some common elements to them. We all need to
3 find out what those elements are, and develop some criteria
4 that we might use in addition to the criteria used in the
5 empirical model as evidence to say these are the ones that
6 work.

7 And my time is up already and I'm not even done.
8 Can I borrow a little bit of David's time? The community
9 defined evidence is a partnership and a part of the NNED
10 with the National Latino Behavioral Health Association, the
11 NNED, and the collaboration with the Department of Child
12 and Family Studies at the University of South Florida's
13 Florida Mental Health Institute.

14 The CDEV approach is informed and will be used by
15 other ethnic groups. So we're starting off with the Latino
16 community; we hope that these learnings will apply to other
17 ethnic and racial groups as well to diffuse the knowledge
18 through the NNED and to develop an inventory of those
19 community-defined practices throughout the country.

20 We want to share our knowledge briefs; we want to
21 influence legislative and policy efforts to prioritize
22 funding for culturally-based research on racial and ethnic
23 and behavioral health disparities, and advocate for
24 effectiveness measures that are culturally- and community-

1 appropriate and based, and provide technical assistance to
2 those communities that need it as we go through our study.

3 In summary, we want to develop an evidence-based
4 that might be described as the platinum standard. We have
5 the gold standard; let's look at what the platinum standard
6 is for cultural communities, which comes from the community
7 and we hope that that will influence the research agenda,
8 academically and also the evaluation agenda and the agenda
9 of policymakers and funders to look at alternatives to the
10 traditional empirical evidence-based model that we have so
11 that we look at practices that are effective that the
12 communities tell us that are effective, and that we're
13 going to find a way to measure so that they are considered
14 in that list of acceptable practices.

15 Thank you very much.

16 DR. ISAACS: Good morning, everyone.

17 I also would like to thank Dr. Cline and the
18 Committee for having us present. I'm going to talk about
19 the National Facilitation Center, which is right now one of
20 the more developed parts of the NNED.

21 The National Facilitation Center is under the
22 auspices of NAMBHA which is the National Alliance of Multi-
23 ethnic Behavioral Health Associations. And there's a reason
24 why we started with NAMBHA, and I'll talk a little bit
25 about it.

1 NAMBHA is an umbrella organization that has four
2 ethnic-specific associations under it; those are listed --
3 the National Latino Behavioral Health Association; the
4 National Asian-American/Pacific Islander Mental Health
5 Association; the National Leadership Council on African-
6 American Behavioral Health; and the First Nations
7 Behavioral Health Association. And I would just like to
8 acknowledge that the mission of NAMBHA is really to bring
9 together all of the voices of these groups so that we don't
10 keep having different groups speak, but we come together
11 around the collective needs of our communities.

12 All of our communities, in many ways, experience
13 disparities. They may not be the same types of disparities,
14 but certainly we all have in common that we experience
15 disparities when trying to access the mental health system.
16 So NAMBHA is supposed to be that voice that brings together
17 that collective voice in order to seek change.

18 I would just like to say that most of these
19 organizations, in fact, all of them, really came about
20 because of SAMHSA support. Through a series of conferences
21 that SAMHSA held over three or four years, especially the
22 Center for Mental Health Services, they seeded and helped
23 develop each of those associations. And so we feel a real
24 partnership with SAMHSA and hope to continue that.

1 So I'm going to talk a little bit about the
2 networks and why NAMBHA was chosen. When we looked at the
3 network literature, and networks don't start things from
4 scratch -- they bring together the groups that have
5 expertise, like making a movie. Movies are often made by
6 networks. You bring in your cameramen, you bring in your
7 directors: one agency doesn't try to do everything; it
8 doesn't try to be expert in every area. Instead you
9 collaborate and you bring together people that then get you
10 a movie.

11 So that's the idea that we had for NNED. We
12 believe that there are many, many people who are out there
13 doing good work, so we don't need to reinvent the wheel;
14 what we really need to do is to bring those groups together
15 to make the whole larger than the sum of its parts. And so
16 NAMBHA was chosen to be the National Facilitation Center,
17 at least initially, because we already had an umbrella
18 organization; we already had leadership from the four major
19 ethnic groups in the country; we already represented
20 professionals, community providers, families, consumers,
21 people in recovery, youth; we already had a focus on both
22 mental health and substance abuse; and we were already
23 trying to create a collective voice. And so why not bring
24 that together and add to it rather than to start from

1 scratch? And so that's how we became the National
2 Facilitation Center.

3 As the National Facilitation Center, we had many
4 roles, but the most important one is to really build the
5 network, starting with the community and ethnic-specific
6 organizations. In other words, to change that triangle so
7 that at the top of the triangle are the community-based and
8 build out from the community up rather than from something
9 else outside of the communities down.

10 And so we developed and maintained an
11 infrastructure; we identify and link entities like David,
12 like the NLBA work that's going on; we convene meetings and
13 gatherings; we share information -- this is the most
14 important thing, we share information and disseminate
15 knowledge because many of our communities do not have
16 access to grants, to issues around funding; they don't know
17 and so what we try to do is to bring that knowledge so that
18 they will be able to participate.

19 We coordinate, track and monitor the NNED
20 projects; we provide training, vehicles; we have already
21 designed the website, we will maintain it; and we support
22 the learning collaboratives. And we, finally, act as a
23 fiscal agent for the network and eventually we will develop
24 and hopefully implement a funding plan to keep it going.

1 And here are, I've just looked at some of the
2 NNED priority areas that came out of some of the work that
3 we've been doing in the communities. Community engagement,
4 community capacity-building -- our communities are very
5 concerned about the integration of health and behavioral
6 health because there's such stigma just focusing on mental
7 health issues or substance abuse.

8 A focus on early intervention, wellness and
9 prevention, is really important because so many times we
10 don't get into systems until it's really at the very acute
11 stages. As Ken said, we will identify and disseminate
12 culturally appropriate practice models, and we are also
13 looking at innovative approaches to education and training
14 in those workforce issues.

15 This just gives you an idea of some of the recent
16 activities of the NNED. I'll reflect a little bit about
17 most of them; I'll just say that most recently, we put
18 together a track at the 25th Annual Meeting at the
19 University of South Florida. We had a track on disparities,
20 which the NNED shared with the Matilda Garcia Group at the
21 Florida Mental Health Institute, and it was very hard work.
22 But it worked very well, and people were very excited about
23 having a focus on disparities at that meeting.

24 I think I'll stop here and turn it back over to
25 Larke.

1 Thank you.

2 DR. HUANG: So, very quickly in our time,
3 we've tried to paint a real quick picture and actually give
4 it to you more in these handouts of what we're trying to do
5 at SAMHSA, and what we're trying to do with this particular
6 project on the NNED, this network structure.

7 I'd like to go back to our questions here, that
8 we posed for the Council; I'd also like to recognize Ken
9 Stark on the phone and certainly have him weigh in. He
10 probably didn't see all the presentations, so you'll have
11 to use your best imagination on what we said. But we have
12 some questions that we wanted to just pose to you, and you
13 have those in your handouts.

14 I guess the first one really goes back to the
15 first part of my presentation in terms of how can we ensure
16 that SAMHSA's programs, resources, tools -- and I find that
17 we can't keep creating demand for increasing shrinking, or
18 at times, just holding on the resources, but we actually
19 have a tremendous number of tools that we create, whether
20 it's our online tools and our treatment locators, some of
21 our collaboration tools, or a lot of tremendous products.
22 But how do we ensure that the resources, programs, tools
23 initiatives are really reaching our much less underserved,
24 under-reached, difficult to reach populations? And how can
25 we actually begin to measure that?

1 In terms of questions regarding specifically the
2 NNED, the structure we just presented to you -- we had one
3 of our members say "Well how do we really reach? We're
4 trying to link up and through this information
5 infrastructure and get to organization that are really
6 doing well but struggling to serve their communities. How
7 do we get to some of those really isolated communities, or
8 isolated tribes serving their communities? What are the
9 outreach strategies you need? What are some of the
10 strategies you need to obtain ongoing funding for the NNED?
11 We have seeded it, some of it here, not as a dedicated line
12 item anywhere, but from program reserve money that we've
13 leveraged with Foundation money."

14 We actually have some interest on this from some
15 of our other federal partners in this. So that's something
16 that we throw out to you -- how do we develop a strategy
17 around that?

18 What would you, and again, maybe this is a
19 premature question because we have kind of thrown a lot of
20 information to you on what this structure is. But what
21 would you consider a NNED success, and how would you begin
22 to measure that? And what would you like to see coming from
23 your own perspectives and venues? What would you like to
24 see as priority areas for the NNED to address?

1 Those are some of the questions that we posed to
2 you for discussion. And certainly, if you have any
3 questions about any piece of what we said, both in terms of
4 our SAMHSA strategy for cultural competence, disparities
5 and our NNED. We are open to that.

6 DR. CLINE: And just to say, we have about 15
7 minutes for this discussion, so I would encourage you to
8 just jump right in there.

9 Thank you Lark, and thank you as well to our
10 three presenters. Thank you.

11 MR. ALEXANDER: I really enjoyed your
12 presentations, all of them. And I think that this
13 presentation, it draws me back to the presentation before
14 about the cuts and where SAMHSA made those cuts. And one of
15 those areas was the Minority Fellowship. So we asked the
16 first question on the other screen was what could SAMHSA
17 do?

18 And I think that one of the things was revisit
19 those cuts -- we obviously know that there is a lack, if we
20 look around the table, there is a lack of -- we do a better
21 job around the table, but there's a lack of people from
22 multi-ethnic backgrounds that's in the field. And not only
23 in the field, but also in positions of leadership that's
24 able to make things happen, if you will.

1 And I think that's one of the things that SAMHSA
2 should do is really look at, you know, really there wasn't
3 a lot of money in the Minority Fellowship Program, anyway.
4 And yet, that was one of the things that got cut. I think
5 that's something we definitely could do to revisit it, is
6 revisit it.

7 MR. CROSS: I want to congratulate the group
8 on some really fine work. This is, it gives, I think some
9 real frame work to work that's needed to be done for quite
10 a while, and I think in particular beginning to deal with
11 some of the issues around evidence-based practice and the
12 need to bring some reason to the conversation to the
13 dilemmas that evidence-based practice presents,
14 particularly to communities of color, and to rural
15 communities, and to community-based programs where family
16 involvement is really strong.

17 It's a dilemma that's shared between ethnic
18 communities and some of our family and youth programs as
19 well.

20 So, just fine work and congratulations, and
21 looking forward to seeing more of this.

22 DR. CLINE: Dr. Gary?

23 DR. GARY: I wish to thank the group for the
24 presentation; I think it's very, very insightful and very,
25 very cutting edge.

1 I had several comments to make and I pick on Mr.
2 Cross's comments -- and that is, when I talk with people
3 about evidence-based practice to people of color, they say
4 "whose evidence"? I haven't been asked, I don't get any
5 services, so whose evidence are you talking about?

6 I think this particular approach helps to address
7 that basic fundamental question that people who practice
8 evidence-based practice never get to this level and ask.
9 Because they may have excellent measures, they have good
10 statistical power, they have good effect, but actually it
11 means very little to the communities who have the
12 disparities. So I think you for the conceptual way of
13 looking at this.

14 The other piece is that when the cultural
15 diversity and the different populations are so very
16 complex, I am going to say, specifically from an African-
17 American perspective. African-Americans are not recent
18 immigrants, and so when you look at people who have been
19 here and have a history of no health -- if you look at the
20 Freedman's Bureau that was promised, you know no health
21 ever happened, and so how do you build a system that never
22 existed in the minds of the people that you're trying to
23 serve?

24 And if you are then poor, disenfranchised for
25 three, four, five generations, two centuries -- I think the

1 approaches have to be very, very different from recent
2 immigrants that have been here for one or two years. I
3 think the training will have to be different. I am back to
4 Marvin's issue -- unless we do something about workforce;
5 we'll have excellent data, we'll have excellent outcome on
6 paper, and we will ensure that the mortality and morbidity
7 rates of people of color continue to soar.

8 So I think we really need to have some in-depth
9 drill-down dialogue about what we are talking about, and I
10 think that your presentation brings that to the fore. I
11 think we have to look at new models; we have to look at new
12 theories; we have to look at new interventions.

13 The other piece is that in poor communities,
14 there is no way that people receive education except
15 through formal agencies. They don't have a social worker
16 who lives next to them; they don't have a person at SAMHSA
17 who lives next to them. They are totally disenfranchised
18 and isolated, culturally, socially, intellectually, and
19 emotionally.

20 And I think our models have to address that; and
21 many of them have given up that there is any hope. If you
22 look at the suicide rates among American Indian children on
23 the reservation, you know that. If you look at suicide
24 rates among African-American in urban cities, you know
25 that. So I think we're talking about a good subordinate

1 kind of structure that has its own unique, particular
2 features that address certain populations of people.

3 And when I look at the research, not only are
4 there no people of color as subjects, but there are even
5 fewer people of color who are PIs, and who engineer and
6 design the research. And people on peer committees who
7 approve the research are not people of color.

8 We act as if we are talking about gospel, when we
9 are really are not talking about gospel. What we are doing
10 is we are continuing to supplement and provide resources
11 for a system that has been in place for years and years and
12 years that produces one product that does interdigitate
13 with the products with the people who need the services.

14 Thank you.

15 DR. CLINE: Mr. Braunstein?

16 MR. BRAUNSTEIN: I also want to congratulate
17 you on the work you're doing. This is my first awareness of
18 this work, and I'm pleased; I plan to share it because we
19 are trying to expand access to different culture in
20 Virginia.

21 I'd to suggest a couple of ideas to get very
22 concrete, if you will, to your questions. For one, is, as
23 in my experience in the private sector, when I worked as a
24 behavioral health director in an integrated health system,
25 we put a nurse practitioner in an Asian-American section of

1 the city Milwaukee where in, essentially, a community
2 center, and she was placed there as a nurse, not as a
3 mental health provider. She was a psychiatric nurse
4 practitioner; we found that to be the most effective way to
5 reaching out to cultures who are not accepting of the
6 traditional system.

7 But I think more important to my point is not
8 only is it important to continue to work on the integration
9 of behavioral health to not just primary care services but
10 into community centers, but also to work with the
11 integrated health systems and the managed care providers
12 and push them very hard to make them some type of
13 contribution in their various communities.

14 I know that it's not always easy, but I think
15 that has to be a point of leverage because there is no way
16 that you can build capacity, and even move towards any
17 evidence base without their participation and cooperation
18 and contribution.

19 DR. CLINE: Yes. Dr. Wang.

20 DR. WANG: I just want to say that first of all,
21 this is something that I do at the state level, picking up
22 Dr. Cline in terms of state and federal partnership; I
23 think this is good, it could be a very good example to do
24 that. And specifically, there are individuals or offices

1 across all states that have dedicated focus in the area of
2 elimination of disparities.

3 The question is how do we link that up with NNED;
4 how do we link that up with SAMHSA? And I think that (?)
5 could play a very significant role to do that.

6 I just want to actually make three points. First
7 of all, I'm going to steal, plagiarize, the term being used
8 "project du jour" from Dr. Kirk, and this is another
9 example that this is not a project du jour. This is a
10 cross-cutting principle in the matrix.

11 The whole structure is being developed in a very
12 short time, in terms of the network and the interlocking
13 activities of the network. It takes a lot of time to build
14 that, and that's a great example in saying that when you
15 want to transform services for the cultural and linguistic
16 population, it takes time. And it takes effort to be
17 continued, and resources to continue to do that.

18 The other comment is that in terms of what I'm
19 hearing is that the fact that we are no longer talking
20 about wide disparities, the diminution of disparities, wide
21 cultural and linguistic competence -- I'm seeing, through
22 the presentations, and I know that they can tell me much
23 more, is that they are actually solutions. They are
24 solution in terms of the elimination of mental health and
25 health disparities.

1 And the question, then is that how do we, again,
2 focus on these solutions?

3 Then it goes to the third point, which will be in
4 terms of how to we prioritize? I'm trying to answer up all
5 your questions in kind of one scoop.

6 There is a reality, in terms of what the budget
7 situation is, and I think that in many ways we need to take
8 very concrete, realistic, small steps towards continuing
9 what we can commit ourselves into the elimination of
10 disparities.

11 And I think one of the things that I'm also
12 hearing, which is rather than -- the question was what do
13 we think? I think that one of the exciting pieces of this
14 is that they are able to energize the communities to be
15 involved. I would say that I would throw it back to you and
16 to say work with the communities that you all represented
17 and to see what they want in terms of prioritizing.

18 If I give you my ideal prioritization, it's
19 purely an opinion. That's where the network is important.
20 It is a collective opinion of what needs to be done for the
21 next step.

22 DR. CLINE: Mr. Cross?

23 MR. CROSS: I have a question back to the
24 group -- David you did a nice job of laying out some of the
25 dilemmas in the NREPP database, and the concern that I have

1 about the programs that are represented in the database as
2 applying to Native populations when, if you drill down into
3 the details into the database, you'll find that only 3% of
4 the evaluation sample was Native American.

5 Do you have any suggestions for improvements in
6 how that information is portrayed in the database to make
7 it more realistic? It feels like a mis-representation at
8 this point, so suggestions that you might have?

9 MR. MINETA: Thank you, Mr. Cross. And I know
10 that Mareasa and Dr. Martinez and Dr. Huang will probably
11 have additional, greater information than I have.

12 One of the things that I've done because we have
13 to look at those lists to look at our programs, is that
14 we'll check to see and drill down on that list to see what
15 the sample size was, all of that. And you really have to do
16 a lot of investigation on there to find out, which I think
17 makes it difficult for a lot of communities to do and to
18 kind of get a grasp of that information on there.

19 It would be helpful, I think, that if something
20 actually on the initial page on the website, if it said,
21 right there, because you wouldn't have to drill down so
22 far, or get into actually printing out the full evaluation
23 report. I think once you get down in there, then people
24 start just moving away from it.

1 The other thing is that I have a feeling that as
2 we were saying earlier, the existence of the by-and-large,
3 the ethnic community-based organizations and the networks
4 across the countries are, I think the answers lie there
5 right now, and honestly, the local, the state, and probably
6 the federal networks are going to rely on the existence of
7 these ethnic-based organizations to solve the health
8 disparity. We're getting that feedback from our local
9 offices, and I think we're part of the NNED because of that
10 partnership.

11 I'll just say right now, though: we are in very
12 difficult times on the ethnic-based organizations. I think
13 there's a lot of -- funding is getting much tighter, and as
14 a results, a lot of larger, better (in terms of business
15 models) agencies are able to do it, and they can service a
16 lot of people. The problem is it's in those smaller based
17 ethnic organizations where a lot of the answers lie. And my
18 worry is that a lot of them are going to go under now, just
19 because of the funding problems.

20 And our answers are going to go under as well --
21 because they were the evidence, how to do outreach, how to
22 keep somebody, keep their chair warm, make sure that their
23 grandparents are okay: suicide rates among Asian-American
24 women are through the roof, Chinese women, how do you get
25 them? And the stability of those agencies I think is

1 definitely in question right now. We're seeing that, and
2 we're trying to work on that, to try to help agencies in
3 our local area stay afloat, and it's really, really
4 difficult.

5 So it's a bunch of things.

6 DR. CLINE: Thank you David. I think we're
7 going to have the lieutenant governor have the last
8 question, and Larke is there a mechanism that people can
9 use if they have additional questions? Should those be
10 directed to you or how would you like us to do that?
11 Because I know that we're limited in the amount of time we
12 have here and people's thinking has been stimulated by
13 this.

14 DR. HUANG: Yes, please direct them to me. I
15 have a response -- I'm kind of sitting on my voice here --
16 I have a response to each of these questions, and Dr.
17 Gary's questions, and I have a whole paragraph I could give
18 you on it.

19 And just echoing what David said, I was in the
20 Bay Area when we were first starting his agency in the
21 early 80s, and a lot of the agencies -- some are there, but
22 a lot of them are gone. Mareasa and I did a survey then.
23 And I think what we're trying to do is help build capacity
24 with very limited resources. When the managed care movement
25 came in, a lot of our community-based agencies just went

1 under. They couldn't re-form, they couldn't remake
2 themselves in the managed care technologies.

3 We're not just looking at evidence-based
4 practices here; that is an issue, but we're concerned that
5 if funding is attached to the evidence-based practices and
6 they're not being able to have that uptake, that training,
7 the remake and these community-based organizations, they're
8 not going to get that community-based funding stream
9 either. And many of them are, as David said, they're really
10 struggling.

11 And these are the agencies that are serving the
12 communities that aren't being served by our mainstream
13 organizations. And these are the populations that are
14 growing. We're seeing, as David said, high rates of
15 suicide, high rates of suicide attempts; 1 in 5 Latino
16 teenage girls. The largest cohort of kids going into foster
17 care, under 5 years of age now, Latino and African-American
18 babies -- we need to get on this track with our work.

19 We're trying to take this novel approach to
20 really bring the communities together that are doing great
21 work and try to help them build their own evaluation, work
22 with our partnering, to develop the research capacity to
23 say these are practices that are working, that have
24 empirical support for that, or this is how you do outreach.

1 Dr. Gary, I'd love to talk to you about our
2 parental depression network; primarily in black
3 communities, built by black women who suffered through
4 multiple generations of depression, substance abuse and
5 domestic violence. These are fragile organizations that
6 want to be part of this network. Do you think how can they
7 can get tools and get resources?

8 And we get so much excitement around this when
9 you talk about it in communities, because they're isolated
10 and we're trying to bring them together as a collective
11 effort.

12 DR. CLINE: Could you provide us with your
13 email address so we can email you and also a telephone
14 number?

15 DR. HUANG: Sure. Should I give that to Toian?
16 Absolutely, thank you very much.

17 LT. GOV. AIONA: Real briefly, and I guess
18 this goes back to what Marvin said and what Dr. Kirk said
19 with regards to the programs and the cutting of programs,
20 and I wish I could answer your questions.

21 But I feel that these infrastructure grants are
22 something that can really be beneficial in helping you all
23 out. We just started a couple of ours; we got the
24 prevention infrastructure grant as well as the
25 transformation grant.

1 As you know, Hawaii, I hope we can be the model
2 for you all. I think that we lead the country with regards
3 to diversity. I believe that's a key, and again, we just
4 saw the presentations on the budgets and what's happening
5 with these infrastructure grants, and of course the
6 difficulty in measuring it. But that's what they're all
7 about. Infrastructure grants are to build these coalitions
8 and to build capacity and everything else that you need out
9 there, and who you serve, et cetera.

10 That's where the plug can go in, maybe we can go
11 in; if you've got some synergy and some coalitions going;
12 that's where the emphasis can be put. I just wanted to
13 mention that.

14 DR. CLINE: Thank you. Thank you again for the
15 wonderful presentations. I appreciate that very much.

16 I am now going to excuse myself from
17 participation and would like to thank all of you and wish
18 you safe travels back home. I'm turning over the mike to
19 Toian, who will talk with you about the logistics of
20 associated with lunch as well as some of the administrative
21 logistics. So thank you again for your service, and I look
22 forward to seeing you all soon.

23 Thank you.

24 MS. VAUGHN: Okay, we've had a busy morning.
25 And I'm sure that you want to take a necessary break, i.e.,

1 your food orders are on their way. They've picked them up
2 and they should be here shortly. The restaurant from where
3 we'll be getting the food is next to the place where you
4 ate yesterday. It took about 10 minutes or so for the
5 person to return.

6 So maybe you'll want to stretch a bit, get a cup
7 of coffee and some water, and then hopefully when you
8 return the food will be here. And then as you're dining,
9 I'll give my presentation on administrative
10 responsibilities.

11 Okay? Thank you.

12 ***SAMHSA's Data Strategy***

13 LT. GOV. AIONA: Welcome back to myself. The
14 second half of the agenda for today's meeting will begin
15 with Dr. Broderick, who is the Deputy Administrator for
16 SAMHSA, who was at one point the Acting Director for about
17 a year? Six months. He's done a great job.

18 So, Dr. Broderick, if you don't mind, you can
19 discuss with us the data strategies, and you will our co-
20 moderator with me, co-chair, I'm sorry.

21 DR. BRODERICK: Thank you, Duke.

22 Greetings, I know many of you from your service
23 on the Council; some of you I don't know. My name is Rick
24 Broderick, as Duke has said, and I'm the administrator

1 here. I will be with you this afternoon to talk about a
2 variety of things.

3 First on the agenda is our data strategy. Let me
4 start by saying first, the process that led us to this, I
5 believe you all have a copy of it. it looks like this. It's
6 very recently published. I'm very happy that it was
7 published.

8 The process that we used to do this strategic
9 plan around data was one that lengthy but suffice it to say
10 that I am not a data person and never characterized myself
11 as such, but was asked by Dr. Cline to facilitate the
12 completion of the data strategy.

13 I'd like to acknowledge, before I start a
14 discussion of what's in there, the folks who were
15 instrumental in putting the document together. Each of the
16 centers were represented; Jeff Buck who is here with us;
17 Kevin Malvey who is no longer with SAMSHA and Endrick
18 Hoffstein(?) who is also no longer with SAMHSA, were the
19 three center representatives. In addition, Anna Marsh,
20 Daryl Kade and Larke Huang also participated. And the
21 person who probably needs the most credit is probably
22 standing to my back left. Lisa Park staffed the group, and
23 although Lisa quite young, she has endured much in the
24 completion of this process and I am surprised that she

1 doesn't dye her hair, because it did require the patience
2 of Job through this process.

3 What I'd like to do is run through the data
4 strategy, and I don't want to necessarily read it; you can
5 do that. I'd like to give you some insights as to how we've
6 developed it and why we made some of the decisions we did
7 and how it's laid out, and then have an opportunity to get
8 feedback from you about your advice and guidance on its
9 implementation and how we foresee it from here.

10 I'm sure you've all seen many strategic plans.
11 Jennifer Fiederholtz is a planner, and she participates in
12 the development of many as well. There are three models
13 that I would characterize very simply: there is a one-page
14 plan; there's a 20-page plan; and there's a 200-page plan.
15 Ours is the 20-page variety. You will note, as many have,
16 that it doesn't have a lot of implementation information
17 and we're going to use our approach with regard to two-year
18 action plans develop that implementation approach over the
19 course of the five years.

20 What you'll see is a vision that I will go over
21 with you. The vision is to provide timely, comprehensive,
22 relevant and accurate data, that can guide and improve
23 policy making, program development and performance
24 monitoring in support of SAMHSA's vision, a life in the
25 community for everyone.

1 So with that as the overarching thing that we are
2 striving to, we approached this in such a way that we have
3 established three broad goals and I'll characterize them in
4 a very few words: one deals with epidemiology, if you will
5 -- prevalence and incidence of mental health and substance
6 abuse issue as well as financing issues and information
7 about the workforce.

8 The second goal, the second broad goal deals with
9 performance and the way we measure performance of our
10 various programs with block grants and discretionary
11 grants.

12 The third deals with integration and the issues
13 with sharing that behavioral health, mental health and
14 substance abuse issues that are included in an overarching
15 effort to create an electronic health record and implement
16 that.

17 So those are the three broad goals that we set.
18 Each of the goals had three or four, had an objective, and
19 then each objective was broken down into three or four sub-
20 objectives, and then the milestones were actually where we
21 saw either current activities that need to be continued or
22 where we knew there were gaps. And we tried to identify how
23 we would know if we were making progress over time on the
24 strategy by establishing these milestones for us.

1 And then what would come, what we are currently
2 working on, is taking these milestones and then conducting
3 a gap analysis to see what we're already working on, what
4 we know we need to work on to try to address those
5 milestones that represent areas that need attention.

6 With regard to goal 1, as I said, that is the
7 goal that sort of deals with national information around
8 incidence and prevalence of substance abuse and mental
9 health disorders, and information about the providers' pool
10 and financing. You'll see that there are, I believe, with
11 regard to that one, there are 7 milestones.

12 And so as you look at these milestones, they are
13 in the PowerPoint on slides 6 through 8 -- you can kind of
14 pick out where we feel that we need more in terms of our
15 ability to have data.

16 The first milestone has to do with assessing the
17 national data needs of SAMHSA; the second needs, focuses on
18 the need for a prevention locator system. We spent a lot of
19 time talking about the data that were available and some of
20 the disparities that exist between data that support the
21 mental health system versus those that support the
22 substance abuse system -- and there are differences, quite
23 frankly.

24 We spent and used the expertise from the folks
25 from the centers to help focus our discussions on how and

1 why we might explain why it's that way. But secondly,
2 trying to address how we rectify that particular set of
3 circumstances. For instance, our national household survey,
4 our national survey of drug use and health is the basis of
5 it, largely is a substance abuse survey. Of late, we've
6 begun to develop components of that survey that focus on
7 mental health, and we know that there are existing needs to
8 learn more and to know more about the prevalence and
9 incidence of mental health in this country.

10 So you'll see, as we focus on these milestones,
11 that developing these milestones, we've sort of laid out a
12 picture, if you will, of the things that we need to
13 continue to focus on that we already are focusing on as
14 well as those that serve as areas of challenge for us.

15 The third milestone on the first goal has to do
16 with mental illness and substance use disorders of inmates.
17 It identifies a group of folks in this instance that SAMHSA
18 does not have the capacity to go out and get data on at
19 this point, and will probably not have the capacity to do
20 it. It tells us that there are folks who do that, and do
21 survey those populations, and it speaks to our need to
22 partner with those entities, in this case the Department of
23 Justice, to collaborate to establish their capacity, quite
24 frankly, with partnership from us, to develop the questions

1 on their surveys that will help address that data need. And
2 those conversations are underway.

3 With regard to the additional ones on the
4 milestones for data strategy one, the three on slide 8 talk
5 about the need to publish nationally representative data on
6 adults with serious mental illness. Again, it speaks to the
7 need to have additional mental health data and also the
8 need to have data obtained on persons who use opioid
9 treatment programs.

10 The second goal, as I said deals with performance
11 issues around the block grant and the discretionary grant
12 program. We recognize that having epidemiologic data, or
13 data on the provider network, or data on financing sort of
14 misses the performance requirements that we currently
15 operate with regard to our program effectiveness and our
16 performance-based budgeting.

17 So we felt that this is a fairly critical
18 component to include in the data strategy; much work has
19 been done around developing national outcome measures, and
20 there are also three systems in place, one in each of the
21 centers, that deals with the performance of the
22 discretionary grants. And so we developed, as I said, some
23 sub-objectives around those performance-based data and
24 developed a set of milestones, six milestones in this case
25 to deal with NOMs and the need to be able to demonstrate to

1 those who are interested internally, as well as to those
2 within the administration and to our userbase and
3 constituents that in fact our programs do perform, and that
4 if they are in need of improvement, we recognize that and
5 have the capacity to measure that performance improvement
6 as it occurs.

7 With regard to the third goal, that deals with
8 interoperable electronic health records, and health
9 information technology. Principally, the sub-objectives and
10 the milestones focus on a number of things -- first of all,
11 to encourage the development of standards that relate to
12 substance abuse; secondly the inclusion of mental health
13 and substance abuse standards into the overarching
14 development of an electronic health record for the medical
15 system at large; and third, the encouragement of the states
16 to adopt that capacity for use among its substance abuse
17 and mental health providers, and to increase the number of
18 states that have interoperable systems in play.

19 So those are the, just a very brief description
20 of how the report is structured, and what the goals and
21 milestones are.

22 What I would like to do is talk about, and get
23 some feedback from you on your thoughts about it. We shared
24 it in draft form, I believe with you; we appreciate the
25 comments that you have provided. We shared it with other of

1 our constituents and tried where possible to incorporate
2 their comments as well. Now we're at the point where being
3 in the process of developing our first two-year action plan
4 that will work toward implementation and there are some
5 questions -- I think, Lisa, it's the last slide -- that we
6 would like to discuss with you and get your feedback on it.

7 I'd like to get some sense, from where you sit,
8 in terms of what the gaps are. You can kind of tell where
9 we think the gaps are, but if they're not where you think
10 the gaps are, then we need to go back and rethink that. We
11 need to talk about how we could then address those and talk
12 about implementation of all three goals, including the
13 electronic health record. I know that the electronic health
14 record has been of interest to our colleagues at NASADAD(?)
15 and NASBID(?); I've talked to a number of folks from a
16 variety of organizations that are encouraging us to pursue
17 with some enthusiasm that particular venture. And as you
18 perhaps know, Sara Wattenberg, who joined the data strategy
19 development team about two months before we concluded, is
20 now in a position to provide some oversight around our
21 efforts around electronic health record standards
22 development and implementation as well.

23 With that, what I'd like to do is to just throw
24 it open for discussion.

25 ***Council Discussion***

1 MS. WAINSCOTT: Well, from the place that I said,
2 in Atlanta, Georgia, the biggest barrier to finding out
3 what is happening to people served in our public mental
4 health systems is lack of communication with other agencies
5 that are serving them.

6 For example, we recently had two things happen at
7 once -- Medicaid instituted managed care for the children's
8 population that we're talking about particularly, and our
9 public health system instituted a fee for service. This
10 happened within about a 9-month period. We have yet to
11 learn, a year later, what happened to somewhere between
12 13,000 and 33,000 kids, we don't even know how many it is,
13 who are not accounted for in the public mental health
14 system. The public mental health system believes that that
15 they are served by Medicaid; we don't know that. We know
16 there's been an increase in the number of kids in the
17 justice system.

18 So that total disconnect between government
19 systems profoundly affects our ability to know what was
20 happening.

21 Just for another example, in November, our Mental
22 Health Planning and Advisory Council was told that we had
23 \$27 million in our reserve fund for free for service that
24 had not been spent. We've learned that there are operators
25 that have been providing for 20, 30, 40 years that are

1 crashing, burning and dying because they're not getting
2 reimbursed. And we're not able to find out -- literally not
3 able to find out; we're probably going to have to do a
4 Freedom of Information Act request -- about how much is in
5 that reserve fund now.

6 These are lofty and wonderful goals, but on the
7 ground, where I advocate, it sounds like it's so far from
8 where we need. We need basic information. Basic information
9 -- where are the kids that aren't served in the mental
10 health system anymore? How much money is in that reserve
11 fund? Just simple, simple things.

12 That's not to pull us away from what you're
13 saying, but to just describe a reality that is just so far
14 from that, that it almost hurts my head to listen to where
15 we should be. I'm grateful that you're trying to go there,
16 but.

17 DR. BRODERICK: Thank you. Judy?

18 MS. CUSHING: I wanted to follow up on what
19 Cynthia was saying about populations that we don't have
20 data on. For instance, homeless youth -- I know this is a
21 problem in our neck of the woods; on any given day there
22 are 1000 homeless youths on the street in Portland. And
23 that's just one city. I understand that Portland is a bit
24 of a mecca for the young people in terms of the climate, et
25 cetera in terms of not being terribly cold in the winter.

1 But is there a way that we, can you, as a federal agency,
2 can look to gather data from untapped populations? Both
3 ethnically, ethnic populations that are, we don't have
4 enough data on because of various barriers and issues like
5 kids who are not in schools, not in treatment or on the
6 streets?

7 DR. BRODERICK: Thank you. Let me sort of go to
8 Cynthia's question, er, statement, first.

9 MS. WAINSCOTT: It's really not a question.

10 DR. BRODERICK: ... and then to your question.

11 I guess I would ask you how we could help you
12 with that. What barriers are you encountering in getting
13 that what seems like fairly fundamental information that
14 ought to be available locally? Or at the state level
15 anyway, and how might we help you with that particular
16 problems?

17 It's not really a strategic kind of issue, but
18 it's a very practical, on the ground, here and now,
19 tactical issue.

20 MS. WAINSCOTT: Yes. And I assure you that there's
21 a group of us working hard at that. But it seems to me that
22 the issue that SAMHSA has sort of the dog in the fight
23 about is the availability of information to the public. And
24 the federal mental health block grant is not a lot of
25 money. It doesn't drive the system, but if it were to be

1 withheld, it would be very significant, particularly in
2 these tight budget times.

3 A question that you could ask before that money
4 was released was "Give me your data" -- and if it's not
5 there, it's a gate that you get to to get to those dollars.
6 So that's one thing.

7 And the other thing is leadership at the national
8 level to get common data sets that make sense between
9 Medicaid agencies and mental health agencies -- and let's
10 dream, criminal justice agencies. But we can't do that from
11 where we sit in the states; those things are prescribed,
12 what they have to keep. And there's no requirement that
13 they communicate. In the best of all worlds they do, but in
14 reality most of the time they don't. And the result of that
15 is a) poor planning; b) poor accountability and c) lack of
16 fiscal incentives that make sense for wellness.

17 So it seems that there's two push points.

18 DR. BRODERICK: It kind of transcends several of
19 the goals that we've talked about, and it segues nicely
20 into Judy's comment. We will never collect all of the data
21 that every will ever want. Maybe it's collected by multiple
22 people, as you've implied, and part of our, I see part of
23 our role as reaching out to those others who may have the
24 opportunity and already are collecting information. And if

1 it were only just done a little bit differently, it might
2 be more helpful.

3 MS. WAINSCOTT: In our state, we're working hard
4 to try to get some kind of common data sets, between
5 particularly Medicaid and mental health because that's just
6 a terrible stumbling blocks for us now. but I know that in
7 other states, because I talk to other people who have the
8 same kind of difficulty -- we're not talking about
9 collaboration, we're not talking about sharing money; we're
10 talking about numbers that make sense when you put them
11 together.

12 DR. BRODERICK: With regard to the block grant and
13 using access to block grant funds as an incentive to change
14 behavior, I guess -- clearly there's been much effort
15 underway with regard to national outcome measures. They're
16 there to help measure outcomes, if you will, in the block
17 grant. The kind of things that you're talking about are
18 really national outcome measures; that's information that's
19 available to have a look-see as to what's actually
20 happening in the block grant.

21 MS. WAINSCOTT: It's accountability. And, of
22 course, our council met yesterday while I was gone, and
23 they were going to have some discussions about what
24 authority they have.

1 But to the degree that you can just be aware of
2 those difficulties; that's not to say this is not
3 important. But it's underneath it.

4 DR. BRODERICK: I understand. Kathryn?

5 DR. POWER: I just wanted to mention that we do
6 have a small pilot project with a couple of states that's
7 really looking directly at that issue, Cynthia. Oklahoma is
8 one of them, and I can't remember off the top of my head
9 what the other states are. But there's a handful of states
10 that have really approached us, and we're trying to work
11 with them to try to figure out are there common platforms?
12 Are there ways that they can do some cross-sharing of
13 information? And we're just facilitating that conversation
14 in some ways, and also helping the Medicaid and mental
15 health folks explore and exploit that.

16 I'm hoping that from that discussion about common
17 platform and looking at consumer and client data in those
18 system will derivatively be able to give some guidance to
19 the rest of the states in terms of what works and what
20 didn't work.

21 DR. BRODERICK: One other thing that's sort of
22 emerging here is as we had our conversation about what's
23 known about financing of mental health services and
24 substance abuse services -- that there are folks here who
25 work very hard on it. Oftentimes, though, our work is a bit

1 reactive; CMS will propose something and we'll scramble
2 around trying to figure out what the implications are for
3 our communities of interest.

4 We're in the process now of developing a contract
5 on financing to make that information more available in a
6 prospective way, so that we try to anticipate what the
7 needs are about financing and create the capacity to have
8 it ahead of time as opposed to what typically happens now
9 is we get a rate for clearance and we say Oh my goodness!
10 And our staffers are chasing it after the fact, and trying
11 to figure out what it all means to us.

12 Suffice it to say that I think that when you see
13 the references to financing in here, it's because we know
14 that we don't know enough, and we'll focus on trying to
15 increase our ability, anyway to provide that.

16 With regard to Judy's question, the strategy is
17 structured in a way that it, again, realizes that we will
18 never be in a position to collect information about every
19 group of individuals that has every particular type of
20 problem. And there's a need to know that kind of
21 information. And so partnerships and collaboration are a
22 fundamental part of the strategy.

23 I met last week, along with Pete Delaney, who is
24 our Director for the Office of Applied Studies, with the
25 Acting Assistant Attorney General for the Office of Justice

1 Programs to talk about the two surveys that they do on the
2 criminal justice population and the victims population. And
3 work has been underway; we had a meeting with his
4 predecessor a year ago, and work has already been done,
5 quite frankly, to provide them technical assistance around
6 developing mental health question for the CJ population
7 survey. They haven't done as much with the victims survey
8 as yet, but I think the opportunity is there as well.

9 That's just one example of the need that exists
10 to identify, first of all, where all those data sets
11 reside, who collects them and what their process is for
12 modification of the surveys and how might we best partner
13 with them to make sure that opportunities that exist are
14 capitalized to include questions that will generate data in
15 those surveys to learn about those different populations of
16 interest.

17 And I'm sure we don't know all of them at this
18 point; we'll be meeting with Dr. Gerberding at CDC, the
19 executive staff here with her executive staff in mid-April,
20 and that's one of the conversations -- data and what they
21 collect and what we collect. We currently have a
22 collaborative project with them around the BRPS(?) data,
23 that Kathryn might want to speak to, but there are many,
24 many places where you can go to try to influence that

1 knowledge base, and suffice it to say that we're committed
2 to doing that.

3 Yes, sir?

4 MR. BRAUNSTEIN: First of all, I do want to
5 applaud you for the overall strategy, and also for the NOMs
6 that you're working on. I'd like to -- I have two comments:
7 one is to suggest that at some point, that you look at
8 working with, if not with full states, with some localities
9 or regions in states to do the whole CQI process with some
10 of the NOMs so that there can be opportunities to learn
11 from the data and improve performance versus seeing it as
12 either a "if you don't hand it in, there's a penalty".
13 Because I think that states as a whole, especially as
14 states are trying to move towards a more transformational
15 recovery approach, need to start moving in directions where
16 they're measuring different things, and get away from the
17 traditional medical measures of decreased hospitalization
18 and those kinds of things.

19 The second suggestion is, or the second comment
20 is as the head of a relatively large agency that is moving
21 towards purchasing our own software, which will put us, by
22 the end of 2009, with a fully implemented electronic
23 medical record. We're one of many local agencies who
24 struggle, who have struggled for years with a legacy
25 system. we can't live with it anymore. It's creating

1 problems with getting billing out; it's creating problems
2 with tracking and getting good, clean data.

3 So we've given up on not only at the federal
4 level guidance, but at the state level guidance and I'm
5 just saying as comment, not as criticism, it's just the
6 process of determining criteria has been too slow for the
7 business that we're in. And so what we're doing -- we're
8 hoping that we're going to purchase a system which we hope
9 will be able to relate to other systems, and I don't think
10 I'm alone -- I know we're not alone; I know there's at
11 least 20 other decent-sized local systems in Virginia, so
12 we're talking about hundreds throughout the country, who
13 are probably out there either purchasing or in the process
14 of. That's my comment on the electronic record and other.

15 DR. BRODERICK: You know, it's kind of the classic
16 dilemma in terms of where we are relative to the power
17 curve. There are individuals who are, sad to say for them,
18 invested heavily in 8-track tapes, and the standard changed
19 on them. And the same with technology of any kind; the
20 standard development process often does not occur quick
21 enough for the proprietary demand that's created and
22 someone will fill that need and try to sell it.

23 Ultimately, there is a format or standard that
24 emerges as the victor in that process; unfortunately, it's
25 sometimes very difficult for those of us who have to endure

1 that struggle to see who emerges. And if you choose
2 incorrectly there's a price to be paid for it.

3 We understand that very clearly, and I think the
4 role that HHS is engaged in at this point and time, rather,
5 is to try to not necessarily become part of that
6 proprietary system of developing the software, but engage
7 in the standards development process. Because the need is
8 great, those are who are in the business of selling
9 software try to guess right, and I'm very appreciative of
10 the dilemma that you have, and we're trying to make sure
11 that as the standards are developed, it's being driven by a
12 bigger engine, as you can imagine, to know that substance
13 abuse and mental health standards are being developed along
14 with it and we're part of the bigger set of standards.

15 I don't know the answer to your comment -- it's
16 something that we need to be mindful of, and continue to
17 engage in, and hopefully the chaos that may go along with
18 it is manageable. I don't know how to try to influence in a
19 major way.

20 DR. POWER: I think one of the things that
21 we're observing is exactly, George, what we talked about,
22 that certainly the population of providers, the 1300 to
23 1400 provider agencies that belong to NCCBH are certainly,
24 I think, the cutting edge of the economic picture. I mean,
25 the economic realities of the fact that they are caught in

1 a time and place when they need to have the kind of
2 supportive systems where you can do your job better, and
3 you can do your mission and you can help people.

4 I think one of the things that has driven us at
5 the federal level is that we have for too long observed
6 that behavioral health is not on the table in the
7 discussion about the electronic medical record. And so all
8 we can do, and I think somebody mentioned it this morning,
9 is that one of our roles is to leverage the power that we
10 have and to learn from the tip of the spear, because you're
11 all at the tip of the spear trying to modify systems and
12 shift from legacy systems, and then hopefully retrofit
13 whatever those standards and functionality are that we can
14 come to some agreement about.

15 But behavioral health has to be at the table, and
16 unfortunately, I think in all of the systems development,
17 it's been a catch-up game. So kudos to those folks who are
18 out there on the tip of the spear, and I'm hoping that that
19 match between the functionality and the standards for what
20 we create will, in fact, then have the force of the
21 government behind it to say this is an acceptable way to go
22 and we don't want to see behavioral health records divorced
23 from health records, or medical records. We want to see
24 them fully incorporated; that's going to be the driver for
25 primary care and behavioral health integration.

1 So hopefully there are larger goals, even if we
2 can't meet the most immediate in terms of the providers
3 stepping out and making those decisions.

4 DR. BRODERICK: We are making compatibility with
5 any known software, including non-VABRAL(?) software, one
6 of the criteria that we're expecting.

7 DR. KIRK: First of all I want to thank you for
8 this for a couple of different reasons. Within our state,
9 it's interesting -- we have about six state agencies,
10 commissioner types, who sat down at the table two months
11 ago specifically focusing on interoperability. And the
12 players are Medicaid agency, Labor, Public Health,
13 Developmental Services, and I'm forgetting one or two
14 others.

15 Part of the advantage of this document, I'm not
16 going to go back, copy this document and in our public
17 meetings, show what you folks are pulling together. But the
18 key advantage for us at this point in time relates to --
19 where are the opportunities from a behavioral health point
20 of view to show agendas are related? For example, we looked
21 at, we took our data in my agency, overlaid it with
22 Medicaid dollars being spent for physical health care, and
23 identified outliers, and we're talking millions of dollars
24 of physical health care expenses.

1 So as we talk about aligning different components
2 together and understanding mental health is essentially
3 physical health, rate of commission, so on and so on --
4 these are opportunities that people such as me in a
5 Medicaid agency can talk about as to how a greater degree
6 of integration, case management, whatever you want to call
7 it, can result in much better care being provided to
8 people. And some of the dollars that Terry talked about
9 this morning that aren't particularly well-spent can be
10 more informed.

11 In a similar way, employment. From my point of
12 view, employment is essential in terms of recovery-oriented
13 service systems. When we sat down with the Labor
14 Commissioner, this is about a year ago, her position was
15 "what do I have to do with mental health? I don't have to
16 do anything with that?" However, she has become, if you
17 will, part of the choir, because she can see, when we ask
18 her, if these people are treated for mental and substance
19 abuse issues: can we look a year later and look at your
20 employment data to see what the pre- and post- is in terms
21 of increased income?

22 Technologically, I'm an idiot about this kind of
23 stuff, but the point is that the kind of information and
24 the most critical business questions, business questions,
25 not rhetorical questions -- the more we can begin to get

1 some of that data out and use it, I cannot emphasize to you
2 enough how powerful that is with legislators and other
3 policymakers who say "what do you have to do with housing?
4 What do you have to do with employment? What do you have to
5 do with the way we're spending our health care dollars?"

6 I was astounded. I just couldn't believe the
7 numbers of people that were telling me that we looked at
8 our Medicaid physical health care data and looked at
9 persons that were in and out of the mental health services
10 system. And I'm talking about millions of dollars within a
11 year -- millions of dollars of physical health care costs.
12 And as part of our care of people, we're not aware of that.
13 So how do we mix that a different way to truly change the
14 system?

15 Based on Eric's brief, this is going to be a
16 journey. This is a journey, and I think that going back to
17 the points that were raised and what our technical people
18 tell us is that "help us, the technical people". What are
19 the four or five business questions you really want to be
20 able to answer? Because as a commissioner, when I sit down,
21 we get involved with data creep -- we get everything under
22 the sun. What are the four or five key business question
23 that we would want asked? And then play off of those.

24 As you say, whoever helped you to do this
25 probably had the patience of Job, but I cannot emphasize

1 enough how strategic and how important this is for state
2 agencies -- keeping in mind that the private non-profit
3 system, they are struggling for basic information types of
4 things. That's sort of the next stage; but this is
5 extraordinarily important and I thank you for that.

6 DR. BRODERICK: Thank you. I think Terry, and then
7 Faye.

8 MR. CROSS: I have a question about outcome
9 measures, and particularly going back to our question and
10 the conversation this morning about the budget and the
11 transformation and programs of national and regional
12 significance and how hard it is to come up with the
13 measures, comparable measures across programs.

14 My question is what is your current state of the
15 art? Is there a process of developing or using theories of
16 change or logic models? Are you isolating those outcomes at
17 different stages, whether immediate or long-term? How does
18 that work going forward?

19 DR. BRODERICK: Thank you. That particular
20 question, I guess I'll cast it a bit more broadly is how
21 are we approaching the need to evaluate performance of our
22 discretionary grants.

23 The techniques that you described are sort of a
24 ways down the road from where we are today. We've got three
25 systems in place and we can describe them real briefly if

1 you'd be interested. The Trak(?) system is the system that
2 is available in CMHS; the one that's probably most advanced
3 is the one that's in CSAP; and then CSAMS is available in
4 CSAP to incorporate data into those data sets that allow
5 that to happen.

6 Why don't I ask Rich and Kathryn and Anna if
7 they'd like to comment about the state of development of
8 those three systems, and sort of how they're headed toward
9 where you're suggesting we should be but we're not now.

10 MR. KOPANDA: Well, also to get to Tom's point
11 about how are we going to move the system forward? It's not
12 that many years ago when agencies like SAMHSA basically
13 just made grant awards and then walked away. We might have
14 gotten a report at the end of the year, but that was about
15 it. Over the course of time, we developed our SAIS system
16 and started monitoring primarily the outputs, not so much
17 the outcomes of our discretionary grants.

18 And we've been managing them ever since; now that
19 we have the NOMs of course, we're focusing on performance
20 of the NOMs, but in large part it's still numbers of
21 clients served rather than, for example, outcomes of
22 treatment.

23 But the next step in this process has been really
24 moving toward the incentives. In our discretionary grants,
25 we're kind of taking action when our grantees are not up to

1 performance. We've put into three of our programs -- Drug
2 Courts, AATR, and now a proposed for 2009, positive
3 performance incentives; that if grantees have a certain
4 level of, achieve a certain follow-up rate, increase the
5 number of clients, once again, still focusing on outputs
6 but not outcomes, we're going to probably be forced to
7 continue in that direction, hopefully in the positive sense
8 in the positive rather than the negative. But I can foresee
9 that happening in many of our programs, and working in that
10 way to move the system.

11 In employment, I tend to agree with you,
12 employment is a key NOM in outcome measure. That's where we
13 see our outcome going and we can of course have much more
14 control over the discretionary grants rather than the block
15 grants. Right now in the block grants, we're focusing on
16 getting the system established where people are able to
17 just report. But that's where I see it going.

18 DR. KIRK: I can assure you that based upon
19 feedback that I get from my grant people, you've got their
20 attention.

21 DR. POWER: Well, I started to talk a little
22 bit about this this morning, when we were sort of talking
23 through the how do we get good performance data for the
24 programs. So I have probably a pretty simplistic and naïve
25 approach to this question, and I apologize for that.

1 But let me start with the issue that when I came
2 to SAMHSA, it was clear to me that many, many of the
3 investments related to data, and to data development and to
4 data strategy have been substance-abuse focused and not
5 mental health focused. And so what we've tried to do over
6 the last couple of years is to begin to exploit and explore
7 how do we get better data relative to mental health. This
8 is not talking about the kind of data that you call collect
9 at states that feeds the URS through the mental health
10 block grant. We're really talking about much more solid
11 national prevalence and incidence data. We really need to
12 do more work in that; we really need to understand what
13 kind of systems are available, which really gets to the
14 issue that Rick was talking about, how we are going to have
15 further conversations about who's collecting prevalence and
16 incidence data on mental health.

17 And, believe it or not, there's a number of
18 agencies that do it, and it's not us. So we need to just be
19 understanding what HERSA collects, what CDC collects, what
20 level of the survey is different or distinct or complements
21 what we already do. We need to explore adding some
22 questions to the National Household Survey, which was a
23 substance abuse initiative. Those questions may be
24 derivatively helpful in terms of helping us capture data,

1 but it's also a small subset. I mean, the National
2 Household Survey is about 92,000 interviews.

3 If you go to CDC and look at the BERTHA(?)
4 system; this is a behavioral health survey system that
5 looks at large regional areas; it's very real and very
6 timely, and it connects the public health system to the
7 mental health system, which we thought was really quite
8 transformative. So we tried to just grow a little bit of
9 the BERTHA(?) system in combination with CDC. And the
10 BERTHA system actually recounts what mentally unhealthy
11 days look like at a local and regional level. Boy, there's
12 an interesting question. What does that tell you about your
13 community?

14 So we're trying to match what they're discovering
15 or what is available with building a higher level portfolio
16 about our own knowledge relative to incidence and
17 prevalence of mental illnesses, incidence and prevalence of
18 psychological distress or other mental health disorders;
19 and then we have a better platform on which, then, to
20 measure the practicality of the performance of our programs
21 in affecting those outcomes.

22 My understanding about NOMs is that NOMs, over
23 time, will develop. We will develop more recovery-focused
24 measures that will be more reflective of the outcomes that
25 clients themselves want. And for us, we liked the SAIS

1 system in CSAP, but each center did not have at the same
2 time the capability to create those systems at the same
3 time within their center. So we have created what I
4 affectionately refer to as the Son of SAIS, which we call
5 Trak. And within that system, which I mentioned this
6 morning, just came online starting in May of 2007, we're
7 going to start to pull some of that impact data about the
8 programs that we hope will be coupled with good prevalence
9 and surveillance data and good program assessment data and
10 then good impact data.

11 In my mind, that's the direction I think we're
12 going in.

13 DR. BRODERICK: Anna, do you want to add anything?

14 DR. MARSH: Well, I was going to tell you
15 about our system. I am a data person, so I could get really
16 detailed about it but I'm not sure it would be that useful.
17 But I'll start and you stop me when it's too much.

18 You've got one system of national outcome
19 measures that we use for the SPFSIG, the Strategic
20 Prevention Framework State Incentive Grants, and I was
21 mentioning yesterday what we're using for those were the
22 state population estimates from the National Survey on Drug
23 Use and Health -- state population estimates for past month
24 use and for perceived risk of the substances.

1 I pointed out yesterday that's good because the
2 data are available; it's risky because obviously if you
3 have a relatively small amount of money going into
4 particular communities for prevention programs or even
5 several communities in the state, holding that grant
6 accountable for moving the population level estimates for
7 the whole states, that's not fair. If they're going in the
8 right direction, great; if they're not, it's pretty risky.

9 On the other discretionary grant programs for HIV
10 and methamphetamine programs, we have specific measures on
11 the number of people who were not using when they entered
12 the program; were they still not using at exit? And that's
13 looking pretty good -- it's around 95% of people that are
14 sustaining non-use through the program, and these are high-
15 risk populations. And then, if people were use at
16 discharge, did their past month use decrease by exit, and
17 that's looking at about 45% to 50% range. We're looking
18 forward to pulling together some of these outcomes and
19 publishing them.

20 We have a lot of discussions going on about how
21 we might improve the NOMs for the block grant and the
22 SPFSIG program. We have to, in prevention, take into
23 account the target population for the particular prevention
24 program, if it's aimed at the entire population like in a
25 media campaign, or if it's aimed at the community or if

1 it's aimed at particular individuals. In addition, we're
2 currently having to re-examine our cost-effectiveness
3 measure, which is one of our NOMs; that is, we had been
4 using information about whether the program was within the
5 cost band per person, and OMB is now telling us that's not
6 good enough -- they want something more like cost per
7 person. We'd like to not just have cost per person, which
8 if we have to keep reducing, reducing the cost per person,
9 that could put us in a pretty bad situation; we prefer to
10 actually have a cost-effectiveness measure where we're
11 looking at perhaps costs per successful outcome, either at
12 the individual or community level. So that's where we are.

13 DR. BRODERICK: Thank you, Anna. Dr. Gary?

14 DR. GARY: Thank you very much for the data and
15 for your explanation.

16 I was looking at goal three, and I don't know if
17 I've misinterpreted goal three, but just let me tell you
18 what I think it means to me, anyway. It tells me that, and
19 goal three you're also going to be looking at health
20 information, which translates for me as health literacy for
21 individuals. I don't think that's right.

22 For the purpose of improving quality and safety
23 of care, and to encourage consumer and family
24 participation, so I'm not so sure how families and
25 consumers can use the technology to help improve their

1 health literacy so they can have a higher quality of care -
2 - so I guess my question is: in the electronic data, will
3 there be a system whereby patients and consumers can access
4 basic information about themselves? Primary health care
5 information, information that would be necessary for their
6 own self-care, through the medical records system as well?

7 DR. BRODERICK: I'm trying to recollect that,
8 Faye, as we talked about goal three -- and I don't
9 recollect a lot of discussion about goal three; Anna can
10 help me if I'm not recollecting exactly.

11 But to go to your point, in a transformed system,
12 obviously, that is consumer-driven, people would have
13 access to information about their own care in order to be
14 in a position to direct their care or to have a part in
15 directing their care, obviously they have to have
16 information about it.

17 Other than to agree with the premise under which
18 you're operating under, I don't know if I can sort of
19 answer under the how part of it, in terms of how that will
20 work.

21 Anna?

22 DR. MARSH: This is a big emphasis on the part
23 of the Secretary of Health and Human Services, which you
24 may be aware of, I don't know, but if not, then you'd might
25 like to be aware of it. That is, Secretary Leavitt has a

1 couple of initiatives in health information technology, one
2 of which is these personalized health care records -- I
3 don't know if there's anyone here who knows more about it
4 than I do. But we are participating with the department in
5 moving that along.

6 As I understand it, there are at least two parts
7 to the Secretary's vision. He's had a very substantial
8 initiative on this. One part is these interoperable systems
9 that are also easy access; that is, the concept being like
10 we use our ATM cards now and ATM machines, you can get off
11 the plane in Paris, and put your card in and get money from
12 a cash machine, and the idea is moving toward an electronic
13 health records system that would be that universal, that
14 easy to use. Your record would be accessible through a
15 variety of mechanisms in a very large network.

16 The other aspect to it is a personal health
17 record where you would have personal access to it and that
18 would be incorporated into your health care -- I think
19 there are a number of private health care providers and
20 organizations that are moving along pretty rapidly in that
21 direction. So SAMHSA's definitely at the table, I would
22 say, and participating in these conversations.

23 I wouldn't say that we had a separate,
24 independent activity right now in the personalized health
25 care though, health care records.

1 DR. GARY: Then I think my question is embedded in
2 the data strategy -- will these particular features be
3 evident and manifest for providers, for patients, and for
4 systems? That would be my question.

5 DR. MARSH: I think it should be as part of
6 goal three, which you're looking at. That is, part of our
7 objective is to continue to participate in the general
8 health care initiative in that direction, which the
9 department's undertaking right now. It might not be as
10 explicitly spelled out as it could have been, but I think
11 it is in tandem.

12 DR. BRODERICK: Verné?

13 MS. BOERNER: My name is Verné Boerner, I'm with
14 the Northwest Portland Area Indian Health Board, and I only
15 just wanted to add a quick comment to the discussion.

16 Data has long been a discussion of tribes
17 overall. It's an issue that the Office of Minority Health,
18 HHS Office of Minority Health has also started looking at
19 as well. They just funded a small exploratory/research
20 project called Data Into Action, where they're looking at,
21 we administer this grant. It's just a pilot project at this
22 point, but we're looking at what are the data sources out
23 there? How are they being accessed? What are the barriers?
24 How are they being utilized?

1 It's taking a broader scope and just being here,
2 just hearing the discussion here, it prompts my own
3 thinking as to what are some of the things, the questions
4 that we're not looking at -- because before today, I was
5 just really thinking what are the health data that are out
6 there as opposed to where else can you access this kind of
7 information? So it sort of piggybacks on some of the
8 comments of the cross-agency collaborative efforts as well,
9 because it's not just an interest of SAMHSA, but an
10 interest in HHS overall, beyond DOJ and such as well.

11 I just wanted to throw that in.

12 DR. BRODERICK: Thank you Verné. This is a sort of
13 a good segue. We're running a bit behind, I guess.

14 If you'd like to expand this discussion during
15 the roundtable the follows the next segment, I think we've
16 got the capacity to do that.

17 But Verné's comments are a good segue into the
18 next item on the agenda, which is a discussion about the
19 SAMHSA's tribal agenda.

20 Before I begin, let me introduce her: Verné is
21 the administrative officer for the Northwest Portland Area
22 Indian Health Board. The reason we invited her here today,
23 and Verné, thank you so much for taking time from your
24 schedule, coming all the way from Portland to be with us.
25 Verné worked with SAMHSA as part of a group of tribal

1 representatives to help us in revising the SAMHSA tribal
2 consultation policy, and she will spend some time
3 describing that process to you.

4 ***Overview of SAMHSA's Tribal Agenda***

5 What I would like to do, before she does that, is
6 to give you a sense of what our tribal agenda is all about,
7 and provide, then, the opportunity after Verné gives you an
8 overview of the consultation policy itself, an opportunity
9 to have some conversation about that as well.

10 Prior to 2005, there were habitual questions
11 about whether tribes were or weren't eligible for SAMHSA
12 discretionary grants. If the grant announcement came out
13 and it said "States and local communities" does that mean
14 tribes or does that not mean tribes? Is the local community
15 a tribe? And there was this confusion that existed prior to
16 that in time.

17 That point was resolved by our former
18 administrator Charlie Curie when he made the policy
19 decision that tribes and tribal organizations were eligible
20 for all SAMHSA discretionary grants, and if a SAMHSA
21 component was proposing that they not be eligible, then
22 that needed to be approved by the administrator prior to
23 the RFA going out. In the two years I've been here, I've
24 never seen a request like that come forward, and I think I
25 can say with some confidence that tribes and tribal

1 organizations are eligible for all our discretionary grants
2 at this point in time.

3 In 2006, we developed a tribal agenda that
4 included a number of action items. The first was revision
5 our tribal consultation policy. There has been a series of
6 executive orders over time; the most recent being executive
7 order 13175 that required each executive department to have
8 a tribal consultation policy. The executive order said that
9 if an agency is going to take action that is significantly
10 going to affect one or more Indian tribes, they need to
11 consult with them before they take that action. It goes on
12 to talk about the ins and outs of that, but that, I think,
13 summarizes fairly succinctly, an executive order that is 5
14 or 6 or 7 pages long.

15 SAMHSA had a tribal consultation policy prior to
16 the revision that was done, but it was developed prior to
17 the point in time that the HHS consultation policy was
18 signed by Secretary Thompson in January 2006. And so we
19 undertook a process that Verné will describe to revise that
20 policy. Suffice it to say that that was successful, and Dr.
21 Cline signed SAMHSA's tribal consultation policy, about a
22 year ago, the first of March in 2007.

23 One of the things that consultation policy calls
24 for is the establishment of a tribal technical advisory
25 committee to provide advice and guidance to the

1 administrator on matters of substance abuse and mental
2 health as they affect Indian country.

3 I'm very happy to report that that group, that is
4 made up of elected tribal officials from 12 regions of the
5 country, as well as representatives from the National
6 Indian Health Board, and the National Congress of American
7 Indians, met for the first time earlier, I guess it was
8 last month, mid-month last month, in an inaugural meeting,
9 to take up that business. And we were very happy to have
10 that opportunity to have that expertise.

11 It's a little bit different than this council,
12 and the other councils that are representative of the
13 centers in that, as I said, they're elected officials. A
14 few of them also have expertise as providers of mental
15 health and substance abuse services, but the relationship
16 that we have with them is on a government to government
17 basis as opposed to a group of technical experts, like you
18 represent, or a group of consumers, or others that might be
19 on a council. So we are looking for opportunities for that
20 group to interact with you, to interact with other native
21 people who are available to SAMHSA in a technical capacity
22 to have that combined capacity to address both the service
23 provision and policy needs as well as the perspective of an
24 elected official for a particular sovereign government.

1 That represents, for us, a process that took
2 about 18 months to develop the infrastructure, identify the
3 members, and go through the process of vetting them and
4 signing them up and getting them here to SAMHSA. So it was,
5 as I said, a very good day for us.

6 Some other things that tribes have pointed out to
7 us that we've tried to address in this tribal agenda is the
8 very nature of the granting process creates difficulties
9 for tribes. As I'm sure you're aware, they're not eligible,
10 with one exception, for our block grants, and that causes
11 that causes some concern. The reason is that some states
12 deal quite openly with tribes and the resources that come
13 to them from the states from those block grants are shared
14 and in other states that does not occur. The tribes, I
15 think, if they had their wish, would prefer that there be
16 some kind of set-aside where the funds could go directly to
17 them. We don't have the authority to have that at this
18 point, and what we're trying to do is look for
19 opportunities to foster collaboration and conversation
20 among the states and the tribes around block grant
21 resources.

22 Rich and I were in Montana about a month ago, and
23 met with a number of tribal representatives there and the
24 governor of Montana to talk about that very topic -- how
25 can the state of Montana, SAMHSA, and the seven tribes in

1 Montana have a conversation about that and open that
2 dialogue where up to this point in time I don't think it's
3 been open? That has occurred in other states over the
4 course of time, and we stand prepared and willing to join
5 that conversation over those block grant resources.

6 With regard to the discretionary grants -- they
7 are eligible, as I said, for all of our discretionary
8 grants, and there's a variety or a spectrum of capacity
9 that exists in tribal communities from very, very capable
10 to competing on a level playing field with states; in fact,
11 some of the grants that we awarded last year, the highest
12 scores were attained by tribes in full competition with
13 states. Other tribes that are smaller have significantly
14 less capacity to compete to write to and to administer our
15 grants.

16 So one of the things that we've done is engage
17 them in a conversation about, or a technical assistance
18 forum, if you will, where they have provided us technical
19 assistance on the structure of our grants; Jennifer and
20 several of her colleagues sat with four or five tribal
21 officials, grant writers for a wheel and they went through
22 nine of our RFAs line by line. And they provided us
23 feedback on how we could improve the structure of those and
24 the content of those RFAs and we're in the process this

1 year, and we'll continue that process of incorporations
2 that the tribes have provided with regard to those RFAs.

3 We believe that there are sort of 2 prongs to
4 that approach to increasing the ability of tribes to
5 compete for our grants. One is to make our grants easier to
6 compete for in general; that sort of floats all boats
7 higher if you will. But also to provide technical
8 assistance to them such that we improve their capacity to
9 write to and to administer grants in general.

10 Toward that end, we partnered with probably six
11 or seven federal agencies now to provide technical
12 assistance in sort of a one-stop shop mode over the course
13 of the last couple of years. The partnership began as one
14 between the Department of Justice and SAMHSA, the Office of
15 Justice Programs and SAMHSA; it started off as a technical
16 assistance venue around grants that we were currently
17 putting out on the street -- to provide workshops, to
18 explain and provide technical assistance, to compete for
19 those grants. That partnership has grown now to include the
20 Indian Health Service, the Department of the Interior
21 Bureau of Indian Affairs, several other entities at
22 Justice, the COPS program, the office of Victims of Crime
23 at HUD, the Indian Program at HUD, and at the Small
24 Business Administration.

1 So we have additional partners that have joined
2 that initiative to now not only provide an opportunity for
3 technical assistance around federal grants that are made by
4 those programs, but also to provide a policy forum or a
5 consultation forum for tribal leaders to express their
6 issues and concerns regarding issues that intersect public
7 health and public safety.

8 And so, we see ourselves clearly in that venue,
9 and just included the latest of the three sessions this
10 year, the second session that was just convened last week,
11 here in DC. The next one, I think will probably be in the
12 summer, probably August, and we look to that opportunity to
13 increasing that capacity of the tribes.

14 We also participate in regional consultation
15 sessions that are sponsored by the Department of Health and
16 Human Services, as well as an annual budget consultation at
17 the forum that the Secretary's office convenes here in DC.
18 In fact, the reason that Daryl is not here and Jennifer is,
19 is that Daryl is providing information to the tribes and
20 consulting with them around SAMHSA's 2009 budget request
21 right now.

22 Suffice it to say that we are an active
23 participant in that process as well, and believe that to
24 the extent that we can create opportunities to dialog with
25 tribes, to learn from them, to consult with them around a

1 host of issues that they face in their particular
2 communities will make SAMHSA more capable of addressing
3 those issues on the one hand, and on the other hand, create
4 a better understanding among tribes about SAMHSA because
5 they're very, very familiar with the Bureau of Indian
6 Affairs, and they're very familiar with the Indian Health
7 Service. They're a lot less familiar with SAMHSA and a
8 number of the other granting organizations that up to very
9 recently, they've had limited success or spotty success in
10 securing resources from.

11 At this point, Verné, could I turn it to you and
12 you could talk about the revision of our consultation
13 policy, and how the tribes participated in that?

14 ***Presentation by Consumers and Council Discussion***

15 MS. BOERNER: Yes, I'd be happy to.

16 Thank you very much. Dr. Broderick had done a
17 great job talking about some of the issues that some of the
18 tribes had brought forth in this process, the overall
19 arching issues.

20 So my focus is really just kind of go through the
21 process that we took and basically our role, and I can
22 speak from the tribal perspective, moreso than anything
23 else, in the technical team workgroup for the revision of
24 the tribal consultation policy.

1 Before I do that, I have been excusing myself all
2 day, because I am a bit sleep-deprived and I tend to lose
3 my thoughts mid-sentence. I do have my comments here; I
4 have them written out, so I may be doing some reading. I
5 may expound upon that just a bit, but I will try not to
6 because I will lose myself in that process.

7 And before I get started, too, I want to ask your
8 indulgence so that I can provide just a little background
9 that may not seem to get down to business right away, but
10 from my own perspective, have to do to honor my own family
11 and my people. I am Iñupiaq Eskimo; I was named after my
12 grandmother -- her Iñupiaq name was Qaanaaq, and she was a
13 tribal health aid for over 27 years in Kiana, Alaska. To be
14 named after someone, it a very -- it is a namesake, it
15 means that person's spirit leaves within you. And so the
16 activities that I do, I really try to make sure that I
17 honor her. She passed away in 2005, and since then I have
18 wanted to recognize her work as a community health aide,
19 her contributions to overall health issues, and really just
20 honor where I come from as part of my own identity.

21 Again, my name is Verné Boerner, I'm the
22 administrative officer for the Northwest Portland Area
23 Indian Health Board. The Board is what is called a 638
24 Tribal Organization. We have a membership of the 43
25 federally recognized tribes in Washington, Idaho, and

1 Oregon, and the work that we do is directed and driven by
2 our tribes, grounding all of our activities in tribal
3 sovereignty. And the basis of that, just going back to just
4 even the US Constitution -- the US Constitution names three
5 sovereigns: the federal government, the state government,
6 and tribal.

7 And so, from that, going on through the numerous
8 treaties that have been entered into as well as the
9 executive orders, these are the basis to which the tribes
10 have really fought for to maintain their tribal sovereignty
11 status through the years.

12 I also want to start on the drivers that have
13 been presented to me by tribal leaders over the years on
14 the government to government relationships. That is,
15 without a doubt, the top priority in all of our
16 interactions, especially with federal, state, and even
17 local governments.

18 Even before that big-picture issue of the tribal
19 sovereignty, whenever I am with the tribal leaders, it
20 always boils down to their personal stories; the anecdotal
21 information per se. While we are working hard to develop
22 mechanisms to improve data and best practices for measures,
23 that is not the heart of the commitment of the tribes; it's
24 a product, or a desired product, because in many cases, it
25 doesn't exist just yet.

1 I was appreciative of Dr. Cline's comments this
2 morning on how he reflected on how suicide and mental
3 health and substance abuse could be considered or brought
4 into the picture by bringing in his own personal experience
5 in talking about his community and where he is from. The
6 motivators that work for many tribal communities are not
7 experience-led; they were personally driven by experience
8 with one's own family and loved ones near and dear to them.

9 I grew up in a region in Alaska that had, at the
10 time, when I was growing up, the highest rate of suicide
11 per capita in the nation. I used to think that if I made it
12 past my teenage years, then I was good, without killing
13 myself. That was a thought process, going through my head
14 as a child: if I make it through my teenage years without
15 killing myself, then I'm safe. I've made it through. It
16 boggles my mind to think about it today, to reflect upon
17 that, that that was a child's thought process, and
18 realizing how it shaped my own childhood, but not just
19 mine, the friends that I have had, and the impact that it
20 has had on their lives throughout the years.

21 I first engaged on federal tribal relations back
22 in 1995, but it was an HHS consultation conference that I
23 heard one of the most enlightening statements to ever
24 impact me. A tribal leader was speaking on the importance

1 of addressing, alcohol treatment. He had said "Alcoholism,
2 left untreated, is a terminal illness."

3 It was a complete shift in how I had viewed
4 alcoholism and substance abuse. Before I could have
5 sympathy and forgiveness, but it was still a sort of issue
6 of thought choice; I had even heard that alcoholism is a
7 disease, but I hadn't made the stretch or the paradigm
8 shift in my own thinking at that point. But to hear him say
9 that really was a light being switched on for myself.

10 In 2005, I had witnessed it very personally, as
11 my sister who had been fighting the disease for years,
12 simply stopped fighting. Her body required alcohol; if she
13 didn't have it, she could have seizures, the cold sweats,
14 the heart racing. She constantly lived in fear of having a
15 heart attack and just absolutely would not even think of
16 going to detox unless she knew that there was a medical
17 monitoring system for her heart. She passed away 3 days
18 before her 29th birthday -- not from an overdose, not from
19 poisoning, but from complications of chronic alcoholism.

20 And I share her story with you because he is a
21 driver for me, and I have an obligation and a
22 responsibility to honor her and her story, which, sadly, is
23 a common story. Like I said before, there is not one person
24 in Indian country that I know that has not had some
25 personal experience in this area.

1 When I was offered the opportunity to participate
2 in the technical team workgroup to revise SAMHSA's tribal
3 consultation policy, I was very thankful. Thankful, as I
4 had learned from my work from the Northwest Portland Area
5 Indian Health Board that our actions today don't just
6 affect us, but it affects our grandchildren's
7 grandchildren. And my participation would be a way to honor
8 my sister and the children that she left behind, and then
9 thinking ahead to my sister's grandchildren's grandchildren
10 as well, hoping to help create a better way to address the
11 issues and build an understanding.

12 And to be here with you today, and to be
13 presenting along with Dr. Broderick, I am very much honored
14 to so. The important of this work was felt by all members
15 of the technical team workgroup. So this is not sort of a
16 unique driver for me. It was very impassioned; the
17 involvement from the technical workgroup on both sides: the
18 fed side and the tribal members' side was really -- the
19 understanding of the importance of this was there from the
20 start. And that's one of the key issues, I think that
21 contributed to the success of it overall.

22 On that first day Dr. Broderick met with us, he
23 put forth his priorities and the goals for getting the
24 consultation out. He shared his personal commitment to
25 implement the new tribal agenda at SAMHSA that would

1 improve to improve the coordination of SAMHSA services to
2 tribal communities and presented an ambitious schedule to
3 complete the revisions for existing tribal consultation
4 policies by early 2007. For us, at that time, we were
5 hopeful, but I have to admit, not many were too optimistic.
6 But we were very, very glad to hear it.

7 But the schedule and the activities truly went
8 like clockwork, and as Dr. Broderick had proposed, the new
9 tribal consultation policy was signed as was hoped. And to
10 me, that really is an amazing thing.

11 So, as you had already heard, HHS had revised
12 their tribal consultation policy in March 2005, and the
13 impetus, or one of the drivers for SAMHSA was the fact that
14 it needed to come into compliance with that. But there were
15 outside drivers and motivations that exceeded that, and I
16 just know -- it really is an awesome feeling for me to know
17 that these are things that are going to have impact and
18 they are tangible for tribal communities overall.

19 Also, one of the facilitators of being able to
20 attack such an ambitious schedule was that the wheel was
21 already invented. Other models had already been developed
22 in response to the HHS tribal consultation policy, and had
23 already been vetted through one or another of the HHS
24 operating divisions. Prior to convening in that workgroup
25 in 2006, SAMHSA had used the HHS document as the basis to

1 create a draft of SAMHSA's policy to be shared with tribes
2 at each of the HHS regional tribal consultation sessions.
3 So the initial work was already being done prior to the
4 convening of the technical workgroup.

5 This document was shared with tribes, and tribes
6 were asked to provide initial review and comments which
7 were then incorporated into a draft. It was during that
8 process as well that Dr. Broderick and other senior SAMHSA
9 staff members asked for volunteers interested in serving on
10 what would become a technical team workgroup.

11 By the end of June 2006 that team was formed, and
12 members serving on the workgroup included Lyle(?) One
13 Horse, Navajo Nation Division of Health; Trudy Anderson,
14 formerly of the Alaska Native Health Board; Tom John of the
15 Chickasaw Nation of Oklahoma; and Dee Sabatis(?) of the
16 United South and Eastern Tribes; and myself.

17 The federal staff serving on the workgroup
18 included Gena Tyner-Dawson, formerly of the HHS Office of
19 Minority Health before she moved over to the Department of
20 Justice; Beverly Watts Davis, SAMHSA's senior advisor for
21 policy, and Valerie Jordan of the Office of Planning,
22 Policy and Planning and Budget.

23 The first meeting of the workgroup took place in
24 mid-July of that year. At this meeting, SAMHSA provided a
25 document that provided the HHS consultation policy, and as

1 I had stated, as the wheel had already been invented, the
2 IHS consultation policy was sort of melded together and
3 then put on a side-by-side comparison with SAMHSA's
4 existing tribal consultation policy. It was from that
5 document and a whirlwind of the first meeting that was just
6 straight pounding out section by section, line by line, the
7 initial draft -- there was so much momentum going and so
8 much volume that we were able to get a lot done in a short
9 period of time.

10 After that meeting, we had produced the second
11 draft of the SAMHSA tribal consultation policy. The tribal
12 representatives were clear that these activities, and this
13 was another key issue for us at that time, that those
14 activities from the workgroup were not to be considered
15 tribal consultation. And this immediately understood and
16 agreed upon by the SAMHSA representatives as well.

17 But before the new draft was open to tribal
18 comment and review, it first had to go through an internal
19 review and comment period by SAMHSA's executive leadership
20 team. This is a bit of a black box for me, as that's on the
21 other side of the gamut. But, again, it goes to the --
22 there is many trust as far as faith issues that go between
23 tribes and agencies that just go way back, and we just
24 weren't sure how things would go.

1 But it went through the internal system very
2 quickly. Tribes have had many experiences where their
3 issues just sort of disappear into black holes for various
4 federal agencies, and thankfully, and to the credit of
5 SAMHSA's leadership, this did not occur, and the internal
6 review of the policy was completed in September and was
7 ready for the first review and first tribal council
8 activity of the new product developed by the technical team
9 workgroup.

10 One October 1, 2006, SAMHSA's draft tribal
11 consultation policy was mailed, along with a "Dear Tribal
12 Leader" letter to over 560 federally recognized tribes, as
13 well to national and regional tribal organizations, among
14 others, for review and comment. In keeping with the
15 timeline, tribes were initially asked to submit comments
16 within a 90-day period, or by December 31, 2006. However,
17 SAMHSA took into the consideration the holidays that occur
18 during the months of November and December, and extended
19 the deadline of accepting tribal comments through the first
20 two weeks of January 2007.

21 SAMHSA received two sets of comments from the
22 tribal review: one from the Cherokee nation, and the United
23 South and Eastern Tribes. At the end of January, the
24 technical team workgroup met by conference call for one
25 last time to make the workgroup's final edits to the draft,

1 based on those two sets of tribal comments that were
2 received. Edits were agreed upon the workgroup, and were
3 made to the draft, which was then submitted to HHS general
4 counsel for review. This was, again, returned to the black
5 box, and we never did encounter a black hole -- the
6 internal workings of SAMHSA, which switched into gear.

7 What I do know is that this is a credit to Dr.
8 Broderick and the work of the dedicated staff members and
9 that Dr. Cline approved the revisions and signed the policy
10 document on March 2, 2007.

11 In closing, I want to also express the Northwest
12 Portland Indian Health Board's appreciation for the
13 groundwork set forth by Charles Curie. It is my
14 understanding that when he first came to this position, he
15 didn't necessarily have much experience working with
16 American Indians and Alaska Natives. But he took time and
17 acted with humility to learn of the issues and the
18 disparities affecting American Indians and Alaska Natives;
19 not just speaking with, but partaking in deeply spiritual
20 and culturally relevant activities, including sweats,
21 smudges, and canoe pulls, just to name a few. We are also
22 very thankful for him in bringing Dr. Broderick to SAMHSA.

23 I also wish to express gratitude to Dr.
24 Broderick, as his commitment and foresight is not just
25 evident in his words and behavior, but it is evident in the

1 products and the outcomes. The dedication of the tribal
2 representative for their specific knowledge and skills were
3 also key to the success in the completion of the tribal
4 consultation policy in the time schedule.

5 And finally, I wish to thank the federal
6 participants in the work group as well. The quality of
7 their work, commitment, and skills and aptitude facilitated
8 this good work.

9 My thanks to the National Advisory Council and to
10 Dr. Cline and Lt. Gov. Aiona for having me here today.
11 Thank you.

12 DR. BRODERICK: Would anybody care to load a
13 question or two? Keith?

14 DR. HUMPHREYS: Congratulations on getting this
15 done. Congratulations to SAMHSA and to Charlie Curie, also
16 for this work on this.

17 You've got the good policy; that's good. So the
18 next question would be how will we make sure that the
19 policy is followed? And second, how will we make sure that
20 people feel that it's been followed, which isn't always the
21 same thing?

22 DR. BRODERICK: I guess I would answer that to
23 say: one person at a time.

24 There's a clear history between this country and
25 Indian tribes and oftentimes the government is viewed with

1 distrust and let me answer that question with a statement:
2 this year in Dr. Cline's performance contract for his SES
3 managers, there's a requirement that we collectively will
4 go to 20 Indian communities, boots on the ground, not a
5 conference, boots on the ground in those communities, and
6 interact with people where they live.

7 Rich and I were in Rocky Boy, Montana a month
8 ago, and Kathryn was in Montana about three weeks before
9 that. So each of us, Anna, me, Rich, Kathryn, and our
10 colleagues at the seniormost levels of this organization
11 will go to where the Indian people are. And I don't know a
12 better way, quite frankly, of coming to appreciate and
13 understand the challenges that exist there.

14 Once that occurs, the policy is easy, it takes
15 care of itself once that understanding occurs.

16 MR. CROSS: I'd like to comment, first of all
17 to thank SAMHSA, to thank you Dr. Broderick for your
18 leadership in this area and Terry Cline and others.

19 It has been, I think, a difficult journey for
20 tribes to have recognized his government to government
21 relationship and often people think of Indians as another
22 minority group, when in fact, as Verné pointed out, the
23 Constitution recognizes the sovereignty of tribes and the
24 importance of agencies like SAMHSA recognizing that
25 governmental authority; and SAMHSA, frankly, is in the

1 leadership of that across the federal government. It's a
2 great example of what can be done; I want to thank you.

3 And that's so important, because in most parts of
4 the country today, tribes are the only provider of
5 services. There aren't other options for children and
6 families for people with mental illness. There's been quite
7 a transformation in Indian country and we use this
8 transformation notion in mental health. But it's taken 40
9 years; prior to 1968, nearly every aspect of life on an
10 Indian reservation was controlled by the federal
11 government, and primarily by the Bureau of Indian Affairs.
12 There wasn't access to other services or other branches of
13 the government.

14 And really, in the last 20 years, we've seen a
15 transformation in tribes taking on the responsibility for
16 their own services for making a substantial change. My
17 career spans 35 of those 40 years, and from the days that I
18 first started working in my own community in child welfare
19 issues. The conditions are night and day; we've got a long
20 way to go and so the help that is rendered here is vital to
21 that.

22 But it is additionally important at a time when
23 we are making significant progress to have important and
24 informed partners to help our communities to do that.
25 Earlier today, you heard one of the presenters talk about

1 the concept of community-defined evidence. Some of the work
2 that I've been able to be part of is asking our
3 communities, asking our elders, what success looks like in
4 their communities, do to this community-defined evidence.

5 In a focus group that I was in a little more than
6 a year ago, one of our elders said "Our youth may come out
7 with good science and math scores, but if they don't know
8 how to honor their elders or to honor their ancestors, or
9 to follow the protocol of how we act with one another in a
10 respectful way, then what good are they to us in our
11 communities?" And Verné, you did it, thank you.

12 DR. BRODERICK: Other questions or comments? Rich?

13 MR. KOPANDA: I would just note that in our
14 treatment programs, we are seeing tribes more successfully
15 compete for our discretionary grants, not only when we
16 reserve a pot of money eligible for only tribes. For
17 example, in the Access to Recovery program, in our first
18 cohort, we had one tribe out of fifteen grantees; in our
19 second, we had five tribes out of twenty-four grantees, a
20 substantially increased number. And part of that may be due
21 to the increased willingness to partner in some way or
22 another -- either as a consortium, or a couple of tribes
23 getting together, or as we're requesting this year, to
24 partner with our ATTC program in terms of applying for some
25 of our grants.

1 DR. BRODERICK: I guess I will just close with
2 sort of an observation.

3 SAMHSA is here to serve the American people, and
4 it's all the American people. And to the extent that
5 communities that are disproportionately affected with
6 conditions that are of interest and a responsibility of
7 SAMHSA, we are obligated to try to address those needs,
8 whatever those communities might be, Indian communities
9 among those.

10 Historically, as Terry so eloquently put, the
11 tribes were sort of left with, pushed toward, I don't know
12 how you want to describe it, but the Indian Health Service
13 and the Bureau of Indian Affairs was the only act in town
14 that they could participate in. That's changing, and we
15 don't see ourselves as replacing anybody. We're here, as I
16 said, to serve the American public around and to provide
17 leadership around mental health and substance abuse in this
18 country. And so to the extent that we can do that Indian
19 country and in other communities, we will do that.

20 I guess to add to what Rich said, and I guess
21 it's an outcome measure to your question, Keith, two years
22 ago, SAMHSA resources that went to tribes were about \$45
23 million. Last year, it was \$60 million. So it's not a lot
24 of money relative to what the national expenditure is, but
25 we believe that we're making some progress, and we'll

1 continue to partner with tribes and tribal organization in
2 that endeavor, as we will with other organizations that
3 also are representative of need. It's an area that the data
4 points us there, plus it's the right thing to do.

5 LT. GOV. AIONA: We're going to go into our
6 final stretch; we're going to take a break here. But before
7 we break, just a couple of things.

8 First of all, if there's anyone who wants to make
9 a public comment, we do have a policy, if you don't sign up
10 at the registration table, you're not going to be able to
11 make a public comment. So if you want to make a public
12 comment, please sign up at the registration table, and you
13 can make your public comment, after we have our roundtable
14 discussion in about 10 minutes, 15 minutes, and we will
15 take up our action items at that time so we can start
16 formulating in our minds how we want to do that. Okay?

17 ***Council Roundtable Discussion***

18 DR. BRODERICK: We'll start with the roundtable
19 discussion. I'll plug this particular thing right here. It
20 says work is underway to develop the next decade of
21 national health promotion objectives. Stay informed and
22 involved by going to www.healthypeople.gov, and there's a
23 series of six regional meetings scheduled throughout the
24 course of this spring to talk about, I assume, Healthy
25 People 2020.

1 MS. FIEDELHOLTZ: These are a set of regional
2 meetings to get input on the next of objectives of -- the
3 next generation of Healthy People 2010 will be Healthy
4 People 2020. So we just wanted to make sure that folks were
5 aware of that; if you would like to go, obviously you would
6 be going in your capacity in your private world. But we
7 wanted to make sure that people had that opportunity; I
8 think somebody asked yesterday what opportunities do we
9 have to influence the objectives, and this certainly is one
10 of them.

11 LT. GOV. AIONA: Okay, we can start. We have a
12 couple of things that we can do, but maybe we can take care
13 of our action items first.

14 The action items are -- when I gave some brief
15 statements this morning, I said we can talk about
16 recommendations and suggestions, and that's what the action
17 items are. There was a handout given this morning regarding
18 our last meeting, and it was on the recommendations that we
19 made at the last meeting.

20 You can see how we did it the last time. We took
21 it by subject index, basically, and we had some
22 recommendations, most of those recommendations in regards
23 to the various items that we took, we had on our last
24 meeting. So we had suicide; we did some work on suicide. We

1 did some work on workforce development, so we, accordingly,
2 developed recommendations in that regard.

3 Today, I know we had some recommendations, or
4 what I would call action items in regards to some of the
5 topics we had, and in particular the budgets, when we first
6 started the afternoon, I'm sorry it was the morning
7 session.

8 So we have Lisa who is going to help us out.
9 She's going to be drafting the recommendation, so I hope we
10 have a wordsmith here in the group? Dr. Kirk? So whoever
11 wants to open it up, and we can start developing our
12 recommendations.

13 Dr. Gary had a bunch.

14 DR. GARY: I think we can probably start with
15 Marvin's recommendation about issues regarding workforce.
16 Marvin had brought the issue up, so I could ask Marvin if
17 you could speak to the issue that you brought up about the
18 need for workforce that cross-cuts everything that we've
19 been talking about today.

20 MR. ALEXANDER: The Minority Fellowships, and I
21 know -- I really don't understand, this is my first
22 meeting, so if you all can help me understand. I know what
23 the program is; I don't see how it fit into a category that
24 would cause it to be eliminated, so maybe that can be
25 explained -- or even how that process works. How do we

1 determine, or how does SAMHSA determine, well we saw how
2 they determined, that was explained earlier, but where does
3 that fit in? Is there a way to, I guess, find out -- can we
4 make that program exist still even with the budget cuts?

5 LT. GOV. AIONA: Maybe before, maybe if I can
6 frame it, because -- you were here, you know what the
7 discussion was this morning. Go ahead.

8 MS. FIEDELHOLTZ: Well, I think that the
9 technical question of "Can the Advisory Council make the
10 program work, or can even SAMHSA make the program work"
11 that will ultimately hinge on the appropriation that we
12 receive.

13 That's kind of a reality but I think, that
14 certainly the Advisory Council's recommendations as to the
15 workforce development activities we should be doing, where
16 our priorities should be should funding become available --
17 those kind of things are helpful.

18 Does that help, Marvin? No.

19 MR. ALEXANDER: What happens when SAMHSA gets
20 money? Do they determine, I guess -- who determines, I'm
21 assuming there is some sense of flexibility. Every center
22 produces their own, from the president's budget, they
23 produce their own analysis, if you will? They said which
24 programs would come to a natural end, and which would be
25 eliminated in fiscal year 2009 -- is that already

1 determined outside of SAMHSA or does SAMHSA determine which
2 programs they would come to a natural end or be eliminated?

3 MS. FIEDELHOLTZ: There are a couple of
4 questions in there. The fiscal year 2009 President's budget
5 is published and final; however that's not the end of what
6 we get in terms of money to spend in fiscal 2009. That will
7 depend on the funding that Congress appropriates. You may
8 recall that I think Anna and Kathryn showed two lines over
9 time, the funding requested in the President's budget and
10 the funding appropriated by the Congress, ultimately.

11 So ultimately the question will be when the
12 Congress appropriates funding to SAMHSA for fiscal year
13 2009, do they say anything about Minority Fellowships
14 Program? They usually start with the President's budget as
15 a base, and sometimes there's flexibility, but often they
16 have identified the priorities of the programs or at line
17 levels.

18 Kathryn, you look like you might want to -- did I
19 misread the look on your face?

20 DR. POWER: I'm not sure -- I'm mulling over
21 here right now what would be the appropriate response to
22 Marvin.

23 When I walked out of the room a little while ago,
24 I was handed this letter. This is a copy of a draft letter,
25 that is currently being circulated by interested parties

1 who are communicating the Congress about their support for
2 the Minority Fellowship Program.

3 So I think the best thing I can do is pass this
4 to Marvin, and let Marvin see that there is some activity
5 going on relative to certain interested parties who really
6 believe and desire to see the Minority Fellowship Program
7 activated in the budget. I think that that will give you
8 some sense of some of the activities that some people may
9 be doing in terms of talking about this program.

10 So that's an example.

11 MR. ALEXANDER: Thank you very much for the
12 letter. Does SAMHSA have a role in determining where money
13 is spent?

14 Let me just say this -- my recommendation would
15 be that SAMHSA, if they have control that we look at this
16 Minority Fellowship Program as being a substantial program,
17 especially in terms of the workforce development, and in
18 terms of being able to eliminate disparities. I think with
19 those two, it ties in.

20 DR. POWER: And we have included the Minority
21 Fellowship Program as an example of the kind of workforce
22 development that needs to continue in our workforce
23 development strategy. Whether or not it gets funded in this
24 2009, whether it's identified in the 2009 budget, Marvin,

1 we still have it as a strategy and an approach in a larger
2 context of workforce development.

3 So we will not lose that thrust; it's kind of
4 like saying if we don't have a bona fide -- if the program
5 isn't sitting in the budget, we still think there's merit.
6 And therefore there is merit to the approach, and in fact,
7 we will then look at perhaps other funds that may be
8 reprogrammable, and the administrator will make that
9 decision about where some of those funds may be used that
10 are available that come out of the 2008 continuation.

11 So there are other strategies, internally, that
12 we try to address and make those decisions, but the role
13 for SAMHSA is to support the 2009 President's budget. And
14 that is our role. So what happens now is that that budget
15 is in play. It is a placeholder budget; it is in play. And
16 our role is to support it. The rest of the world is now in
17 play in terms of trying to influence that budget.

18 MS. WAINSCOTT: I was just going to say
19 essentially the same thing. SAMHSA cannot at this point
20 advocate against the President's budget. We, as Advisory
21 Council members, acting in the capacity of Advisory Council
22 members, cannot do that. Acting as individual citizens, we
23 can advocate to anything we want to.

1 DR. HUMPHREYS: I just want to understand this
2 program better. Does HERSA also fund this, or is all out of
3 SAMHSA's budget, the Minority Fellowship Program?

4 DR. POWER: This is a distinct SAMHSA program.
5 HERSA has another series of health professional development
6 programs as well, that are focused on some of the public
7 health professions and some of the folks that work in
8 community health. What's unique about this program is that
9 it's been around for 33 years, and that it targeted what
10 were the traditional mental health professions of nursing,
11 psychology, psychiatry and social work. In particular, it's
12 unique because it used to be sort of a stipend program and
13 a payback program; now it's a training stipend that goes to
14 those professions who are identified by the professional
15 associations, who are in the minority community and who
16 then later work in, generally, publicly funded mental
17 health and substance abuse agencies. So it is unique in
18 that perspective.

19 DR. HUMPHREYS: Thank you.

20 DR. KIRK: I'm not sure what we can and cannot
21 say, so let me just say it. I think that over the last 8
22 years or so, looking at SAMHSA, that the initiatives that
23 you have all moved to the table, Access to Recovery, mental
24 health transformation, restraint and seclusion, cultural
25 initiative based upon length of time that I've in the field

1 are most progressive that I've seen in my professional
2 tenure. And I think it would be, I would recommend that
3 this body has an Advisory Council had a statement of
4 support of how progressive and trendsetting the policy
5 direction of SAMHSA has been. You can get into all sorts of
6 individual programs, but overarching.

7 Secondly, and I'm talking for myself -- I would
8 recommend that SAMHSA reinforce or communicate to those
9 receiving funds for these major efforts, reflect how those
10 dollars are being used to leverage and refine the larger
11 base of dollars that are in a state that are being used for
12 these kinds of purposes. Part of the reason why I say that
13 is that Terry's comments this morning and well as Charlie
14 Curie before him that these kinds of initiatives are doing
15 things like decreasing repeated admissions into emergency
16 room presentations; decreasing people going into repetitive
17 psychiatric admission; a decrease in all sorts of things.
18 And those dollars are, if you will, the leveraged dollars.

19 And I think the more SAMHSA can ask us to do that
20 as funding sources of their dollars, and then I think on a
21 state level, people such as myself or other states can be
22 in a better position to reinforce the agenda that is set.

23 One of the things that we did this past session
24 legislatively -- we presented our budget to the
25 legislature; we called it a health care business plan. And

1 the idea behind it was when we're going into expansion
2 options, most staffers were saying "you've said these
3 things before, why are you making us do this again?"

4 So what we did is we said "Let's come up with an
5 estimate of how much money is being spent in corrections,
6 in other kinds of parts in the service system, and repeat
7 admissions, or just admissions into psychiatric inpatient
8 care that are, frankly, not well spent, and if we spent the
9 dollars more smartly, you'd have a better business plan."

10 I think that if we can think in terms of SAMHSA
11 as like a national health care plan: it puts money into
12 block grants and other kinds of pieces. And your commitment
13 is to assure that those dollars are well-spent -- probably
14 if anybody is more important that they represent an offset
15 of dollars that are spent to these other systems that are
16 simply not well spent.

17 So my point is one, reinforcing or having a
18 statement from this body that reflects how progressive,
19 informed social policy/health care policy, the initiatives
20 SAMHSA has put there. And they are so systemic, so system-
21 changing that they surely will test your ability to come up
22 with the most refined outcome or system outcome measures to
23 truly see the changes. And that's a journey.

24 The second piece is again suggesting that SAMHSA,
25 in their funding of the discretionary dollars, to direct

1 states or to show groups that are funded to show how this
2 will change the way that they spend their existing dollars.
3 So it's sort of like a matching dollar kind of approach. I
4 think the benefit of that will reinforce how important
5 substance abuse and mental health is to the education
6 system, to the child welfare system, to corrections, public
7 health system, et cetera.

8 LT. GOV. AIONA: I agree with that you're
9 saying; it doesn't address a single program, but it is a
10 statement of affirmation or, I guess, a statement of
11 position on the Council's part. The second part of it would
12 be more of a -- I don't want to say a directive, but it's
13 almost like a directive in regard to where we stand as a
14 council.

15 Does everybody understand what Dr. Kirk is
16 saying? Does anybody kind of disagree with that or agree or
17 do you think that we can do that as a council? Can we do
18 that as a council?

19 We have to articulate it.

20 MS. VAUGHN: During the September meetings,
21 there were a set of recommendations that were provided. If
22 you have a list of ideas, and you need now to conceptualize
23 them into a central thought. The first one is ensuring that
24 SAMHSA's programs and resources are reaching culturally

1 diverse and underserved, difficult to reach population and
2 what can be done to ensure this?

3 The first three bullets, based upon your
4 discussion -- the eliminating disparities discussion, that
5 now the council would like to look at, revisit that
6 discussion and decide whether or not you feel as though
7 there is a desire to make a recommendation. What I'm
8 hearing is there is some sense from the council that you
9 want to formulate something, and now we're looking for a
10 recommendation.

11 I'm trying not to put words in your mouths. What
12 I'm looking for is from you a sense as a council of what
13 you would like to do with regard to the eliminating health
14 disparities discussion -- is there a recommendation, is
15 there a desire to support the agency, or nothing?

16 LT. GOV. AIONA: If we were to categorize, if
17 we were to put this recommendation -- we'll call it a
18 recommendation for now -- on a topic that we discussed
19 today, I guess maybe that's the first thing that we should
20 decide. Do we put that under "Eliminating Health
21 Disparities" or "Overview of SAMHSA" -- I guess we could do
22 that also: the budget and legislative issues? I don't think
23 it would be Data Strategy. So it would be under Eliminating
24 Health Disparities.

25 Go ahead, Dr. Gary.

1 DR. GARY: If I'm following correctly, if were to
2 take the concept Eliminating Health Disparities, I would
3 think that we could then think about how we would go about
4 that. And what I've heard today, I think our major issues,
5 some major issues regarding eliminating health disparities
6 is a culturally diverse workforce. So that would be under
7 health disparities. The other would be, I like the
8 discussion about community-based evidence regarding
9 interventions and health programs in the community.

10 So I would ask, if you're going to use this
11 model, that the community-based evidence be highlighted so
12 that we can begin to track what those outcomes look like,
13 what that process is that develops these community
14 evidence-based programs, et cetera. And, again, that we
15 examine the workforce issue specifically by looking at the
16 contribution from the Minority Fellowship Program and
17 putting that juxtaposed with how many ethnic minority
18 people have degrees and credentials that would qualify them
19 to work in substance abuse and mental health.

20 LT. GOV. AIONA: Okay. Now we have to phrase
21 that.

22 DR. HUMPHREYS: I'm not solving that problem, but
23 I'm trying respond to the thing that Faye just said about
24 community-based evidence. This is a place where I think we
25 would want to think about leveraging, because SAMHSA is not

1 a research agency. So one suggestion might be that SAMHSA
2 enter into some kind of dialogue with the Institutes -- the
3 NIH, the NIDA and the NIAAA -- on increasing representation
4 of people of color in treatment research samples, where
5 they are grossly underrepresented, as we heard today, so
6 that we don't end up with the kind of things Terry has
7 pointed out, a study with 3% Native Americans intended on
8 how to be the guide to do intervention.

9 I think it has to be in partnership with NIH
10 because they've got the dollars to do this, and SAMHSA is a
11 services agency.

12 MS. WAINSCOTT: I want to make sure that I think I
13 understand that we're going to make recommendations on what
14 we heard today.

15 LT. GOV. AIONA: We can make it generic.

16 MS. WAINSCOTT: I think the one Dr. Kirk just
17 described to us fits very nicely under the report of the
18 administrator. "Council supports the recent progressive
19 initiatives of SAMHSA which add to the capacity to make
20 sustained change."

21 Transformation, recovery, you said something
22 else? ATR, and just list them.

23 But I think it could be way broader than
24 disparities. In other words, if that impacts every person
25 who walks through the door, those three things, and there

1 was a fourth one -- exclusion, restraint, recovery,
2 transformation.

3 MR. CROSS: And the cultural --

4 MS. WAINSCOTT: So you come back to the cultural
5 issues.

6 But that workforce may end up in the, along with
7 the Minority Fellowships, under the last thing.

8 MR. CROSS: I think that what Dr. Kirk was
9 talking back was really the broader endorsement of the
10 progressive nature of endorsing the work that's gone
11 forward. I think that adding the language as to something
12 about the budget priorities within the available resources
13 that are appropriated that SAMHSA hold to that agenda.
14 That's what I was hearing.

15 And that might be a broader question than the
16 health care disparities, which is, I think, an important
17 area for us to talk about.

18 I have a couple of other recommendations that I
19 can come back to after we settle this one, or what?

20 LT. GOV. AIONA: If you look at the board
21 right now, you can see we've got some bullets up there. I
22 don't know if we can wordsmith that in any way and try to
23 put it some form of a statement or recommendation.

24 Why don't you go ahead and share your
25 recommendations?

1 MR. CROSS: This is a recommendation about the
2 NREPP database. I'd like to see a recommendation that the
3 database receive a critical review for the scientific
4 validity of the listed programs for the populations listed,
5 and an appropriate qualifying language be added to the
6 website with regard to their applicability.

7 As I said yesterday, I really believe in science
8 to practice, but the listing in a national database that a
9 program is appropriate for a population that only has 3%
10 represented in the sample is not good science. So I just
11 want that to be very clear-cut with regard to what SAMHSA
12 is recommending to service providers or governments that
13 are requiring evidence-based practice.

14 LT. GOV. AIONA: One minute. Could you please
15 repeat that for Lisa?

16 MR. CROSS: The NREPP database receive critical
17 review for the scientific validity of listed programs for
18 the populations listed, and that appropriate qualifying
19 language be added to the website.

20 I had one more thing about the NREPP database --
21 that the database be inclusive, rather than exclusive,
22 listing a range of evidence typology. As we heard about
23 community-based evidence, there are also groups working on
24 practice-based evidence; there's a group in Oregon working
25 on culturally-based evidence. So all of this needs to be

1 somehow incorporated into the website. This is going to be
2 an ongoing big chunk of work, but it needs to be part of
3 the work done.

4 LT. GOV. AIONA: Very good. Edward?

5 DR. WANG: I think this is just an extension of
6 the developed statement of support for SAMHSA's progressive
7 programs. This is not specifically related to the FY2009
8 budget, but I think that based on yesterday's
9 presentations, I found that two significant practices are
10 happening at SAMHSA's level right now. One is in terms of
11 SPRT(?), and I would actually recommend that the same model
12 of SPRT be used for mental health treatment in terms of
13 quick-screening and brief intervention, and as well as
14 referral. I think that is a very well-demonstrated program
15 for substance abuse and I think that has applicability,
16 definitely, in terms of mental health.

17 The other one is also a demonstrated program
18 specifically related to, and I think in some sense, relates
19 to what Terry is talking about, it's the Access to Recovery
20 program. The specific aspect I wanted to highlight is the
21 use of treatment modalities that beyond this so-called
22 evidence-based practice.

23 By having the ability, I guess, to contract with
24 those modalities, I guess I am referring to community-based
25 type of approaches, linguistic as well as culturally

1 competent approach; what they need, though, is to
2 demonstrate in terms of evidence of success. I think that
3 is a different approach than looking in terms of evidence-
4 based practice because then you are looking at in terms of
5 outcome -- and output and outcome, as a measure of those
6 specific community, cultural and linguistic programming.

7 LT. GOV. AIONA: Dr. Gary? Your microphone is
8 off.

9 DR. GARY: I want to follow up on what Edward was
10 saying, and also add here that when we talk about
11 collaborating with NIH to make sure that the sample is more
12 culturally diverse or more racially/ethnically diverse. I
13 just think that's one part of it. I'd like to extend that
14 thinking to say that the research investigating team also
15 has to be more culturally diverse, because if it's not,
16 then you'll have outcomes that might look okay and you
17 don't even know that they're wrong. So I think it has to be
18 at every level.

19 Also, evidence that the community has been
20 involved in shaping the conceptual framework methodology,
21 design, et cetera -- this research that gives us our
22 evidence-based practice and our outcomes that we utilize as
23 platinum-standard.

24 LT. GOV. AIONA: You wanted the population to
25 be also --

1 Judy?

2 Anna, did you have?

3 Cynthia?

4 MS. WAINSCOTT: I think that all that I've heard
5 in these last two days, the thing that is most
6 revolutionary, and least likely to happen without our
7 endorsement and pushing, is moving that -- Kathryn
8 described it as a box, and Dr. Cline described it as moving
9 upstream -- we're pushing the box pretty well out of the
10 treatment box, which is now focused on people who are
11 really sick, pretty well for the aftercare and recovery;
12 we're not doing much except lip service for the promotion,
13 prevention and early invention.

14 And that is not going to happen by itself. So I
15 would really like to see us take a strong stand to support
16 that, and would be glad to try some language.

17 MR. ALEXANDER: I just want to add to that.

18 You know, promotion and prevention -- we found
19 that, in the youth world, young people as far as prevention
20 and promotion of mental health, young people in terms of
21 helping other young people are sometimes more beneficial;
22 because young people are around other young people all the
23 time. And the more they know about mental health and the
24 more they are able to share with their peers about mental
25 health, or their family members. A lot of times, young

1 people can't advocate for themselves, so their family
2 members have to do it for them. It's very significant in
3 being able to prevent and promote overall mental health.

4 I want to make a recommendation that -- in a lot
5 of those programs, Youth Move National and difference
6 consumer groups, the consumer organizations, it looks like
7 it will be cut out of the budget or there would be support
8 from SAMHSA in fiscal year 2009 or very limited support
9 from SAMHSA.

10 I think that as part of that treatment continuum
11 that Cynthia was talking about, we probably need to look at
12 those groups as well. Not just the treatment aspect, but
13 also the other how are we going to sustain the work that
14 has already been done that SAMHSA has supported time and
15 time again? How will we continue to sustain that work?

16 MS. CUSHING: I just wanted to ask Marvin a
17 question -- are you comfortable also including alcohol and
18 drugs in that? The same is true on the prevention side for
19 alcohol and drugs. There are few youth support groups, and
20 early education and skill building among young people.

21 I think we need to think about wrap-around and
22 continuum of services because so many of those kids end up
23 with mental health problems who started using early.

24 LT. GOV. AIONA: We can start with our easy
25 one, and that's the recommendations regarding NREPP.

1 Anybody got any amendments to it or we can put that as a
2 separate recommendation.

3 MR. BRAUNSTEIN: Mr. Chairman, may I -- are we
4 finished making recommendations?

5 LT. GOV. AIONA: No, we're not. I'd just like
6 to see where we -- we don't have much time left, so we
7 should start formulating the recommendations that we've got
8 up here.

9 MR. BRAUNSTEIN: Can I ask for one clarification?

10 LT. GOV. AIONA: Sure.

11 MR. BRAUNSTEIN: Dr. Kirk, a while ago, made two
12 points, and I think the first one is up there; I'm not sure
13 if the second one is.

14 And the second one more fits with what I was
15 thinking of, but I think he articulated it better than I
16 could -- could you repeat your second point that you were
17 looking for?

18 DR. KIRK: The one up there that says ask
19 discretionary grantees how they are using their grant
20 dollars to leverage existing dollars. That doesn't really
21 say what I was -- the word leverage is the one I'm having -
22 - it's not a matter of if I can get matching dollars or how
23 you're going to sustain it. What I was talking about is if
24 I was to ask the discretionary grantors how they're using
25 their grant dollars, the results of the discretionary

1 grant, to modify or change they are spending existing
2 dollars in their service system.

3 How they're using their grant dollars -- the
4 results from their -- how they're using the results from
5 their grant dollars to change the way they are allocating
6 their existing state dollars or resources in general.

7 MR. BRAUNSTEIN: Essentially, if I could put it
8 into some simple words -- you're saying how are you using
9 grant dollars to do business differently than you have
10 been?

11 DR. KIRK: You got it.

12 MS. FIEDELHOLTZ: Can I ask for just a quick
13 point of clarification? When we say discretionary grantees
14 there, are we talking about states or tribes that have
15 responsibility for a system, or are you including
16 community-level discretionary grantees as well.

17 DR. KIRK: Both.

18 MS. FIEDELHOLTZ: The thing that threw me off
19 was the folks on the state level.

20 LT. GOV. AIONA: George, would you like to put
21 that in a bullet, what you just said? Or are you satisfied
22 with what's up there right now?

23 MR. BRAUNSTEIN: I need to work on it. Let me
24 see if I can get something on paper first, and then try to
25 chime in in a minute.

1 LT. GOV. AIONA: So right now, when I look at
2 these -- we can go bullet by bullet; but based on what
3 everyone has said, I have come up with three
4 recommendations.

5 The first one would be, like I said, we can
6 discuss the NREPP recommendation first.

7 DR. HUMPHREYS: Terry and I have just drafted some
8 language the does the NREPP and also the NIH point as one
9 just being typed in, so people can see if they like it or
10 not.

11 LT. GOV. AIONA: It's being typed in right now?

12 DR. HUMPHREYS: Yes.

13 MR. CROSS: While we are waiting, I have one more
14 recommendation --

15 LT. GOV. AIONA: Well, she's --

16 MR. CROSS: I just want to throw it out for
17 discussion whether it's appropriate or not.

18 It has to do with our discussion earlier this
19 morning about the budget. My recommendation is that SAMHSA
20 develop a theory of change applicable to transformation and
21 systems change, which identifies outcome indicators
22 associated with desired long-range impacts.

23 I think that's going to take some kind of
24 workgroup, but I think it would be very beneficial to be
25 able to identify those intermediate items. I heard about

1 it's possible to measure the outputs and the number of
2 people served or trained, and a desire to measure,
3 eventually, what's the reduction rate in the community of
4 usage.

5 But in between those two things, there are some
6 outcomes that represent conditions that you would theorize
7 would be associated with getting from point A to point B.
8 It would be things like mission statements, policies that
9 are adopted, goals that are established, infrastructure
10 that's built, policy-level decisions that are made,
11 memorandums of agreement that are entered into,
12 relationships that are forged, constituents that are
13 engaged, partnerships that are developed, money that's
14 spent or leveraged from other sources, leadership -- and
15 I'm just listing off some possibilities of the conditions
16 that you'd want to see in place for transformation to be
17 possible.

18 Does that make sense?

19 DR. STARK: Duke?

20 LT. GOV. AIONA: Yes?

21 DR. STARK: This is Ken.

22 LT. GOV. AIONA: Go ahead, Ken.

23 DR. STARK: I have got something that came up,
24 but I got a couple of quickies -- and all of them have been
25 touched on by somebody else.

1 One, I absolutely believe that SPRT is something
2 that SAMHSA can look at relative to the mental health side.

3 Two, I clearly think that as SAMHSA does on the
4 alcohol/drugs side, on the mental health side, we need to
5 look at mental health promotion and mental illness
6 prevention, as strategies.

7 And then the third one is, the last gentlemen who
8 spoke -- one of the reasons that transformation and other
9 projects are on the cut is on the cut block isn't because
10 philosophically people disagree with them; it's because we
11 haven't done a good job of clearly defining, collecting,
12 and reporting out the impacts or the outcomes. So with
13 mental health transformation, we need to do that, we need
14 to do that quickly, and we also need to do that with any
15 new programs as they come along. And those outcome measures
16 need to be defined before the grants are given out to
17 whoever the grantees are, or they need to be developed
18 within the first six months of the projects.

19 So that's kind of where I'm at; but I got called
20 out; I've got to run. So sorry, everybody. I'm glad to be
21 on the phone, wish I was there in person; it would have
22 been a lot more fun for me, and I hope you all have a good
23 rest of the day.

24 LT. GOV. AIONA: Okay, thanks Ken. We'll miss
25 you. Bye.

1 DR. STARK: Bye.

2 MR. BRAUNSTEIN: I was just working on the
3 language of one, whichever one that I said I would work on,
4 and it might speak also to what Ken just said, at least to
5 some extent.

6 Require discretionary grantees to exhibit how
7 they are using this grant money to impact their process of
8 providing services that reflects a change in how they serve
9 their customers.

10 MS. FIEDELHOLTZ: Could you repeat that real
11 quick?

12 MR. BRAUNSTEIN: Require discretionary grantees
13 to exhibit how they are using this grant money to impact
14 their process of providing services that reflects a change
15 in how they serve their customers.

16 Did I speak too fast?

17 MS. FIEDELHOLTZ: One more time, after "process".

18 MR. BRAUNSTEIN: After "process" -- of providing
19 services that reflects a change in how they serve their
20 customers.

21 That would be instead of "ask discretionary
22 grantees". But it might -- I don't know if it totally
23 reflects the second recommendation that Ken just made too.

24 LT. GOV. AIONA: We are running out of time, so
25 this is what we've got to do. Jennifer, any ideas?

1 MS. FIEDELHOLTZ: We can do it either way.

2 I think the key point is that we need to settle,
3 we at SAMHSA need to understand which recommendations the
4 committee wants to put forward as the consensus of the
5 committee. I'm hearing there was an initial recommendation
6 on support for the progressive programming. I think worked
7 out a bullet on that one.

8 The one that George just read requiring grantees
9 to exhibit how they're suing their grant money to impact
10 this process; the one that Terry crafted on NREPP -- I'm
11 sorry, I didn't catch Ken's.

12 LT. GOV. AIONA: Ken was more or less in support
13 of things that had already been said.

14 MS. FIEDELHOLTZ: And was there a fourth on NIH-
15 funded research?

16 LT. GOV. AIONA: Yes. And then Terry came up with
17 another recommendation.

18 MR. CROSS: -- having to do with intermediate
19 outcomes, identifying intermediate outcomes. And Ken was --

20 LT. GOV. AIONA: -- which is basically what Ken
21 was saying.

22 MS. WAINSCOTT: And Ken was supporting promotion
23 for specifically setting mental health. The way that we've
24 written up there for you to look at, it's up high now; it
25 does not specifically mention mental health, and maybe we

1 want to do that. It says "Council supports SAMHSA's focus
2 on prevention, promotion and early intervention activities
3 through work with agencies like the Department of Education
4 and National Business Group on Health." It doesn't mention
5 mental health. It says SAMHSA. And that's what, certainly,
6 Dr. Cline talked about was a cross-sample as well.

7 MS. CUSHING: I would put a plug in for alcohol
8 and drug prevention as well. There's really nothing up here
9 that speaks to the budgetary issues that we heard about
10 this morning: huge cuts in prevention, and I would like to
11 see us make a recommendation to examine the issue of
12 underage drinking and SAMHSA's investment in that issue,
13 and example one-year grant programs and what can be done to
14 avoid that, if possible, but I don't have that in language.

15 But that could be just deadly for people. While
16 we want and urge people to work on the underage drinking
17 issue, I realize that SAMHSA's hands are tied because of
18 some legislation that isn't in the President's budget this
19 year, that doesn't mean that as a council, that doesn't
20 mean that we shouldn't perhaps make a recommendation to.

21 LT. GOV. AIONA: Well, my understanding on
22 underage drinking is that you've increased the budget on
23 underage drinking, right?

24 DR. MARSH: I think she's talking about the STOP.

25 LT. GOV. AIONA: The STOP Act, to be cut, right?

1 DR. MARSH: It's in the 2008 budget but not in
2 the President's amount.

3 MS. FIEDELHOLTZ: But we did do for the programs
4 this year, because recognized this challenge of one-year
5 grants and what does it mean? Obviously we know what's in
6 the President's budget and what's not in the President's
7 budget and we do have to support the President's budget.
8 However, we did allow in most of those programs, multi-year
9 projects to be proposed, which gives us some flexibility.

10 MS. CUSHING: I'm sorry that doesn't do it
11 because it's a \$50,000 grant program for a huge problem,
12 the number 1 problem for kids. So don't tell us that it's a
13 2-year grant program so you can spend \$25,000.

14 MS. FIEDELHOLTZ: No, no, no, that's not what I'm
15 saying. What I meant is that if you were applying for a
16 STOP Act grant, you can propose a grant application of
17 \$50,000 a year for however many years. Obviously, as with
18 all of our grants, future funding depends on an
19 appropriation. But should the Congress restore that
20 funding, you would not have to reapply.

21 MS. CUSHING: Oh, I see. What you're saying.

22 MS. WAINSCOTT: Judy, would you be comfortable if
23 we just didn't make that prevention/promotion thing
24 specific to mental health, but had it SAMHSA-wide, which
25 what I think is what we all want to do?

1 MS. CUSHING: I would be comfortable, but at
2 some point, I hope this council, with Duke's leaving,
3 really understands that we had a huge problem with underage
4 drinking, and I haven't seen anything much in the previous
5 meeting about that issue. And it impacts mental health and
6 other things, too, so. I just wanted to make that
7 statement.

8 LT. GOV. AIONA: What we should do, and what we
9 can do -- Jennifer, you want to finish this off? Either
10 way.

11 We got the recommendations up there; what we can
12 do since we're running out time is we just have to agree,
13 as a council, as a body, what recommendations we want to
14 have go forward. And then we can work on these in the
15 interim. The individuals that made the recommendations and
16 all of these as a body could work on it, and then we can do
17 it electronically, and then vote accordingly on the final
18 language of these recommendations.

19 But first we have to decide what recommendations
20 we want. So if we could --

21 DR. HUMPHREYS: I just want to add one thing; it's
22 my opinion based on Duke's and my experience on the Drug-
23 Free Advisory Commission. One wants to add everything in
24 recommendations, but actually a few oak trees have more
25 impact than a million flowers. So some of us may have to

1 give up some of our smaller ideas to get things we all feel
2 are really high-impact.

3 LT. GOV. AIONA: So, Jennifer, I think you
4 summarized it best -- the first recommendation? Instead of
5 all these bullets, because these are more or less things of
6 substance that could go into the recommendations. So if we
7 go line by line we're going to be here all day. So why
8 don't we just go by --

9 The first recommendation was?

10 MS. FIEDELHOLTZ: The first one I think we have is
11 the recommended statement of support for the recent
12 progressive programming that has the potential to lead for
13 assistance change; Cynthia, I think you gave me the actual
14 text that got pulled in later. We listed several programs.
15 So that was the first recommendation that I got.

16 LT. GOV. AIONA: And that was all based on Dr.
17 Kirk and his statement.

18 We are in agreement for that recommendation?
19 Okay. Now we have to wordsmith that.

20 MS. FIEDELHOLTZ: How much words -- do you want
21 to?

22 LT. GOV. AIONA: We'll let Lisa do that?

23 MS. FIEDELHOLTZ: We need to scroll down so that
24 we can see how that --

1 LT. GOV. AIONA: The bullet's up there -- which
2 one encompasses that?

3 MS. FIEDELHOLTZ: Here's what I have written down
4 from what Cynthia gave me: The National Advisory Council
5 supports the recent progressive initiatives of SAMHSA that
6 have the capacity to make systemic change. These programs
7 include mental health transformation state incentive
8 grants, the Access to Recovery program, seclusion and
9 restraint state incentive grants, the Minority Fellowship
10 Program and other cultural competence programming.

11 Dr. Wang then added the screening, briefing,
12 intervention, referral to treatment program, with a
13 recommendation that model be expanded to mental health.
14 And, also, we have to figure out how to wordsmith this, but
15 Dr. Wang then added was interested in highlighting the
16 emphasis within ATR that goes beyond evidence-based
17 practices as the requirement and focuses on evidence of
18 success among grantees, and that that particularly
19 important with regard to culturally diverse communities.

20 LT. GOV. AIONA: If we could add into that the
21 underage drinking.

22 MS. FIEDELHOLTZ: Underage drinking.

23 LT. GOV. AIONA: STOP program.

24 MS. FIEDELHOLTZ: That is what I had with the
25 first.

1 LT. GOV. AIONA: Is that what we wanted?

2 DR. WANG: Yes.

3 Can I also, I suggest we add NAPP(?) because we
4 had a very good presentation that provided a structure in
5 terms of what we do?

6 LT. GOV. AIONA: I think that encompasses, does
7 it? Pretty much, that's what you wanted, Dr. Kirk?

8 There was a second portion to it, which is up
9 there right now. If you could scroll down.

10 MS. FIEDELHOLTZ: Right, on leveraging funding.

11 LT. GOV. AIONA: That would be a part of the first
12 recommendation.

13 MS. FIEDELHOLTZ: So it's a part of the
14 recommendation; they go together?

15 LT. GOV. AIONA: Right. So what you read and that
16 would be our first recommendation. Everybody agree on that?

17 MR. BRAUNSTEIN: Just clarifying -- that second
18 part requires action that is fairly specific; the others
19 are more of a philosophical statement of support. Putting
20 them together, will the second part get lost as part of a
21 statement of support and not get followed up on? That's my
22 only objection to combining.

23 MS. FIEDELHOLTZ: I agree. That last sentence is
24 a stand-alone recommendation. I think that's pretty major.

25 LT. GOV. AIONA: Anybody disagree?

1 Okay, can we make that number 2. We'll make that
2 number. 2.

3 Your next recommendation was?

4 MS. FIEDELHOLTZ: I think the third one I had was
5 the NREPP recommendation that also got typed up.

6 LT. GOV. AIONA: Is that it right there?

7 So if you could read that and see if you have any
8 objections to that?

9 MS. FIEDELHOLTZ: The fourth recommendation that
10 I had --

11 LT. GOV. AIONA: Let's get that out -- so the
12 third one, any objections? Dr. Kirk?

13 DR. KIRK: Does the -- the way this statement
14 reads awfully ugly: "underrepresents people of color". Is
15 that broad enough to communicate what we're saying?

16 DR. HUMPHREYS: Certainly you can say that it
17 underrepresents rural populations --

18 MS. WAINSCOTT: But it doesn't capture what Faye
19 said about the investigators being people of color.

20 DR. HUMPHREYS: That, I think, goes together with
21 the Minority Fellowship Program about building a workplace.

22 LT. GOV. AIONA: I understand what Dr. Kirk is
23 saying in that it isn't broad enough, because it's just
24 people of color. Is that gender also? Age?

1 MR. CROSS: It could say just "underrepresented
2 populations".

3 LT. GOV. AIONA: Diverse? Is that better?
4 Add on to it? "And diverse and underrepresented"
5 -- is that going to be clear enough?

6 DR. HUMPHREYS: Then we have underrepresented
7 twice in a row. Underrepresents, underrepresented.

8 MR. CROSS: Just "diverse" is fine. We don't need
9 "underrepresented" twice.

10 LT. GOV. AIONA: Is that going to cover it if we
11 say diverse.

12 MR. CROSS: Yes. It will do it.

13 LT. GOV. AIONA: Is diverse good enough for all
14 of us?

15 You've got to go on the record, Marvin.

16 MR. ALEXANDER: I agree, Faye, that maybe that we
17 can replace "often underrepresent" with "typically do not
18 include" diverse population. I think that language is
19 stronger.

20 LT. GOV. AIONA: So what's the recommendation?

21 MR. ALEXANDER: We can take "often" out. The
22 recommendation was to replace "often underrepresent" with
23 "typically do not include" diverse populations.

24 LT. GOV. AIONA: Comments?

1 MR. CROSS: The word "treatment research" maybe
2 should be broader. We could just eliminate the word
3 "treatment" because we want to be inclusive of services and
4 prevention. So maybe if you just take out "treatment" it
5 gets broader.

6 LT. GOV. AIONA: In the last line also, you have
7 "treatment". In the second to the last line, take
8 "treatment" out.

9 MS. WAINSCOTT: Could it say "treatment and
10 services"? Or "interventions".

11 LT. GOV. AIONA: Or it could just put "services".
12 Just services.

13 MR. CROSS: You could even say "entries" because
14 it refers to the entries in the database.

15 A further recommendation was down below and it
16 has broader implications about the NREPP database be more
17 inclusive, and I don't know if you want to incorporate it
18 up there. It's a longer range goal; the other one is pretty
19 specific.

20 LT. GOV. AIONA: Why don't we wait on that and go
21 on with the next?

22 MS. FIEDELHOLTZ: Well, I did have in addition
23 to what was up there in the increasing representation, NIH
24 funded research, a recommendation to increase the cultural
25 diversity of research investigating teams, and to ensure

1 that communities are involved in shaping the research
2 design.

3 I don't know if that's a separate recommendation,
4 but I heard somebody say that there's a separate
5 recommendation.

6 LT. GOV. AIONA: Maybe we could read that as a
7 fourth recommendation.

8 MS. FIEDELHOLTZ: A recommendation that SAMHSA
9 enter into dialogues with NIH on increasing the cultural
10 diversity of research investigating teams.

11 LT. GOV. AIONA: She's got it written up
12 there.

13 MS. FIEDELHOLTZ: Oh, you've got it.

14 LT. GOV. AIONA: So that would be number 4, Lisa.
15 That's number 4. That would be the fourth recommendation.

16 MS. WAINSCOTT: Jennifer, your second statement
17 about communities, that's critical.

18 MS. FIEDELHOLTZ: So the second part of it was:
19 And ensuring that communities are involved in shaping the
20 research design.

21 DR. HUMPHREYS: The first second of number 4 seems
22 to be the same as number 3.

23 [sound disturbance]

1 The American mental health system needs a
2 culturally diverse workforce in both the clinical area and
3 in the research area.

4 This is really a workforce thing. I would put
5 that with the recommendation about the Minority Fellowship
6 Program and the culturally diverse workforce for services.
7 Because, as a practical matter, a lot of times the people
8 who do these research studies are also clinicians; they
9 start their careers as clinicians, not that there are many
10 of them, but people who went that route.

11 So I'll try this off the top of my head: Council
12 believes that a culturally diverse service and research
13 workforce is essential for promoting mental health for all
14 Americans, and for the elimination of all disparities.

15 And I'd like to announce my candidacy -- no, just
16 kidding.

17 MR. ALEXANDER: I'd like to add to that
18 "culturally and ethnically diverse".

19 MS. CUSHING: Keith, would that not also be true
20 for treatment and prevention?

21 He said specifically promoting mental health.

22 DR. HUMPHREYS: Okay, promoting mental health,
23 reducing substance abuse, and eliminating health
24 disparities. Thank you.

1 We therefore recommend that SAMHSA use its own
2 authorities and collaborate with the NIH.

3 LT. GOV. AIONA: That could be lead?

4 DR. HUMPHREYS: Yes, yes, you could put that up
5 there.

6 LT. GOV. AIONA: Number 4.

7 MS. FIEDELHOLTZ: So we need to add number 3 to
8 number 4 now?

9 I thought that was what Keith was saying -- the
10 intro to 3 and 4 were the same, and therefore we needed to
11 change it.

12 DR. HUMPHREYS: I am also suggestion that just
13 below that we have the culturally diverse workforce. That
14 has now moved up there as well. So we asked for the
15 collaboration with NIH, and think we should say something
16 about the Minority Fellowship Program or efforts like that
17 -- Marvin, do you want to add language that you want to
18 propose? Do you like the way it is?

19 LT. GOV. AIONA: Okay, you had one more
20 recommendation?

21 MS. FIEDELHOLTZ: I had another one on promoting
22 peer support for young people?

23 MR. ALEXANDER: I have some words.

24 MS. FIEDELHOLTZ: Marvin's got words. I have the
25 idea, but no words.

1 MR. ALEXANDER: I don't like those words.

2 LT. GOV. AIONA: What do have, go ahead?

3 MR. ALEXANDER: The Council continues to recognize
4 the important role of consumers, youth, and families in
5 assisting SAMHSA fulfill its vision of "a life in the
6 community for everyone". We recommend that SAMHSA continues
7 to invest in the voice and choice of these constituencies
8 and continue support of venues --

9 And this is where I need help. I want to say "to
10 make this voice possible", but I'm sure ...

11 DR. HUMPHREYS: "... that these voices will be
12 heard."

13 MR. ALEXANDER: Well, I want to talk about those
14 consumer groups that really support each other -- those
15 family organizations, community organizations that support
16 each other. So not just support the venues where they will
17 be heard, but also the venue where they're created.

18 LT. GOV. AIONA: That's good. Anybody have any
19 recommendation to this fifth recommendation?

20 MS. FIEDELHOLTZ: And then the last one with
21 the focus on promotion, prevention and early intervention;
22 again, I didn't capture all the words.

23 LT. GOV. AIONA: That was the last one on
24 underage drinking. I think we got that. Yes? No?

1 MS. CUSHING: Cynthia, wasn't that in the first
2 bullet with Dr. Kirk's statement, you were standing on
3 that?

4 MS. WAINSCOTT: On prevention? I don't think it
5 got in there. Maybe you could add some language up there?

6 MS. CUSHING: A bullet by itself.

7 MS. FIEDELHOLTZ: I think everything else is good
8 to go.

9 LT. GOV. AIONA: Everything else is actually taken
10 care of.

11 Well, look at number six. I don't know where that
12 came from, but let's look at 6.

13 MS. FIEDELHOLTZ: I'm having a hard time reading
14 this; I'm so sorry. I don't have my right glasses on.

15 LT. GOV. AIONA: It might not have what I think we
16 wanted, but it says "Council supports a focus on promotion,
17 prevention, and early intervention activities with
18 collaboration from agencies like the Department of
19 Education and National Business Group on Health."

20 MS. WAINSCOTT: We may just want activities
21 period.

22 MS. CUSHING: Or through investment or
23 significant investment and collaboration -- and that can be
24 investment in many ways, not just money. Investment, it's
25 almost like "the will".

1 "Early intervention activities through
2 significant investment and collaboration with agencies and
3 organizations" -- so that's the public and private sector.

4 DR. GARY: With agencies and what?

5 MS. CUSHING: The public and private sector for
6 the well-being of children, what would you say?

7 DR. GARY: I would say "throughout the lifespan".

8 MS. CUSHING: Throughout the lifespan.

9 DR. GARY: Because elders, and everybody.

10 MS. CUSHING: In the public and private sector.

11 DR. GARY: For populations throughout their
12 lifespan.

13 MS. CUSHING: For populations throughout their
14 lifespan.

15 MS. FIEDELHOLTZ: Get rid of the rest?

16 LT. GOV. AIONA: Terry, you had one more?

17 DR. KIRK: I'll just be the devil's advocate and I
18 would say well, SAMHSA already does prevention, early
19 intervention, so whoopedoo. What I would suggest is just a
20 couple of words. "Council supports an intense and sustained
21 focus", and I would change to health promotion: Council
22 supports and intense and sustained focus on health
23 promotion, prevention, and early intervention. Otherwise,
24 it's too watered down.

1 MS. CUSHING: I totally agree; I would suggest
2 changing the word "activities" to either "strategies" or
3 "programs".

4 MS. WAINSCOTT: We need to say what we're
5 preventing -- can we use the language "mental and substance
6 abuse conditions". Prevention of mental and substance abuse
7 conditions and early intervention strategies.

8 LT. GOV. AIONA: You have one more?

9 MR. CROSS: Yes, it's just the issue of the
10 inclusiveness of the database. So if you go back up to
11 three, I think, at the end: Undergo critical review to
12 ensure that services are not being prematurely rated
13 effective for demographics not represented in the evidence-
14 based and examined in inclusion of a broader range of
15 evidence.

16 DR. GARY: I looked at those databases and I had
17 the same concern that you did. I'm wondering if it's more
18 than prematurely determining that they're excellent. I'm
19 wondering if we need to take a look at the criteria that
20 are used to determine excellence. I think that might be the
21 critical problem.

22 MR. CROSS: I think it's beyond the language of
23 this recommendation, but this is one that we're going to
24 revisit over and over I think. This gets us started.

25 LT. GOV. AIONA: Any objections?

1 Okay, so we've got 6 recommendations. Dr. Gary?

2 DR. GARY: We also had talked about oral health,
3 and the impact that oral health has on the health and
4 wellbeing of individuals with mental and substance abuse
5 conditions in a public health model. And we said that we
6 wanted to put that on the table so that that issue could be
7 addressed as well.

8 Even though it's not a mandate from SAMHSA, we
9 wanted to recognize that in a public health model, we have
10 to be holistic and we have to look at the oral health of
11 individuals with substance abuse and mental health
12 conditions.

13 DR. POWER: And yesterday, Terry commented
14 that we have a deputy administrator who is deeply committed
15 to oral health, and Westley and I both talked about the
16 connection between appropriate public health interventions
17 from a wellness approach and from a total integrated health
18 care approach, which really gets at this health promotion
19 issue, and we said that our deputy leads us in the right
20 direction on that score.

21 LT. GOV. AIONA: Okay, well thank you for -- I
22 have got one more thing; I'm going to let Toian do this by
23 way of email, probably. And we've got to select the next
24 meeting and the next meeting schedule for September. This
25 we can do real quick right now. It's the first or second

1 week of September, and the dates are -- September 1 is a
2 Monday, and that's Labor Day. You can do it on Wednesday
3 and Thursday of that week or the following week. So that
4 would be the 3rd and 4th of September or the following week
5 or the 9-10 or 10-11. So you have Tuesday/Wednesday of the
6 first week or Wednesday/Thursday of that following week of
7 September.

8 MR. BRAUNSTEIN: Could you send out some dates,
9 because it's real hard to start --

10 LT. GOV. AIONA: You guys want to do it that way?
11 Send out dates and you choose? Is that okay?

12 DR. POWER: It would help to do it quick so we can
13 get it marked down on our calendars.

14 LT. GOV. AIONA: Okay, so Toian, we'll do it that
15 way. And she might as well send you the dates for March,
16 also. Yes, Dr. Gary?

17 DR. GARY: Yes, I just wanted to also ask the
18 Council to please think about meeting at a site where we
19 can see some of the outcomes of the SAMHSA funding. And if
20 you agree with that, I would ask that we ask the staff to
21 convene the next meeting at an Indian reservation.

22 LT. GOV. AIONA: That's a recommendation.

23 DR. HUMPHREYS: I was hoping for Hawaii.

24 LT. GOV. AIONA: You are all welcome, anytime.
25 Let me know. You guys are all welcome.

1 MS. CUSHING: I have a question of Toian. It
2 appears that the Council has set a hefty agenda, or hefty
3 action items for its robust agenda, and I was wondering
4 that if this Council has ever met more than two times a
5 year.

6 MS. VAUGHN: Last year -- either last year or the
7 year before last -- we met three times, but that was
8 because the Council wanted to deal with a particular issue,
9 and that was the Medicare prescription drug benefit, and it
10 was a two-hour meeting in which CMS was on the screen.

11 For the past six or seven years, if not longer,
12 they have met only twice a year. The Law states that the
13 Council will meet at least twice year.

14 To answer your question, yes. Years ago, the
15 Council would meet three times a year, and at one time this
16 Council -- I'll just leave it at that. Yes, but it's been
17 several years now.

18 MS. WAINSCOTT: I'm very supportive of the idea of
19 investigating meeting somewhere where we would see
20 programs, where it's happening on the street is different
21 than Washington. I don't know how much of a problem it
22 would be to do that, but I think it's certainly worth
23 examining.

24 MS. VAUGHN: The Council has gone off-site in
25 years past. But what I've heard is that 1) you're

1 interested in going offsite and 2) the first site that
2 you'd like to meet is on an Indian reservation. Is that
3 what I'm hearing?

4 LT. GOV. AIONA: Okay.

5 MS. VAUGHN: Do you have any recommendations for
6 locality or specific programs?

7 DR. GARY: I think we can, I don't specifically,
8 but I can be driven by data that we have. We know that some
9 reservations, the Pima reservation has the largest
10 percentage of diabetics in the United States. We could go
11 to places where substance abuse is a main problem or where
12 child abuse -- I think we need to be quite targeted and be
13 data-driven in our decision.

14 DR. BRODERICK: Thank you for that recommendation.
15 Perhaps that I could suggest that you consider
16 collaborating with our other Council, our Tribal Council;
17 perhaps they could provide some recommendations on
18 locations that would meet whatever need you identified and
19 things that you wanted to see. It's a group of 14 elected
20 tribal officials with a fairly good handle on Indian
21 country.

22 LT. GOV. AIONA: Well, I hate to be the Grinch,
23 but we have --

24 DR. WANG: Just a very quick comment about this --
25 in a very short time we came up with six wonderful

1 recommendations, but I hope that if we have another
2 additional meeting, those are the six areas that we need to
3 focus on. I agree with the site and so forth, but I think
4 the primary thing for me is how we're going to focus on
5 those six recommendations and flush it out even further in
6 terms of action.

7 LT. GOV. AIONA: That's a good recommendation.

8 MR. BRAUNSTEIN: As a follow-up to both Judy and
9 Ed's allusions -- I'd like to recommend that if not this
10 year, then in future years, that the Council do two work
11 sessions here, where we do what we usually do, but that a
12 third one and maybe it's just a single day be at a site
13 like a tribe.

14 My guess would be that we won't get a lot of this
15 policy work done when we go to the tribe because it would
16 be very hard to take tours, to hear from the various people
17 that we want to talk to and want to talk to us and at the
18 same deal with some of the presentations that we saw.

19 So it's just a suggestion to kind of tie those
20 ideas together.

21 MS. VAUGHN: We'll take your recommendations back
22 to Dr. Cline, and just for your information -- when we do
23 offsite meetings, it's generally a two-day meeting. The
24 first day will be a business meeting and the other day

1 would be the site visit. But we'll take your
2 recommendations.

3 **Public Comment**

4 LT. GOV. AIONA: Thank you, Council. And now we
5 have some public testimony. Is that correct?

6 The first public comment is from Sandra Spencer.
7 If you could take mike and state your name and your
8 organization, for the record. Thank you.

9 MS. SPENCER: Good afternoon, again. My name is
10 Sandra Spencer, and I am the Executive Director of the
11 National Federation of Families for Children's Mental
12 Health. We have been around for around 18 years, and we do
13 a lot of work with SAMHSA, specifically with the Center for
14 Mental Health Services.

15 Our organization is national -- we have about 130
16 chapters, and what we're made up of is parents and other
17 caregivers of children with mental health issues. So we do
18 a lot of work around that.

19 What I wanted to speak just a little bit about,
20 and I was very glad to see some of Marvin's recommendations
21 up on your board -- one of the programs that's slated to be
22 cut in the 2009 budget is the Statewide Family Network
23 grant. And these are grants that fund family-run
24 organizations and they're very small amounts of money, and
25 they also have a piece of that that does youth

1 organizations as well. And we understand that we have to
2 support the President's budget and the cuts. But what I'm
3 hoping is that we can talk about is how to be a little bit
4 more creative to keep some of these organizations alive
5 because some of them, this is the only money they function
6 with and they do a lot.

7 But one of the biggest areas that they have
8 impact is they impact the grant in CMHS that really was
9 sustained is community-based systems of care that we saw
10 that did not get cut; actually it was one of the programs
11 that got money added to it. One of the biggest elements
12 that made those systems of care as successful as they are
13 is the fact that they really do have a lot of family and
14 youth environment. And these family and youth forces, they
15 help plan, implement, and evaluate these system of care
16 programs. So we know that that has put those programs on
17 the map; that has made them really, really successful.

18 And I just hope that you all really do focus and
19 flush out that recommendation to make sure that that youth,
20 that family and young adult bourse is sustained and that
21 it's helped. Even within the budget cuts, if we could just
22 look at how we are funding these community-based systems of
23 care to make sure that these family organizations, youth
24 organizations don't go away.

25 So thank you, very much, for listening to me.

1 LT. GOV. AIONA: Thank you, Sandra, for your
2 patience and comments. The next public comment is from Paul
3 Pizzano. Thank you for your patience also.

4 MR. PIZZANO: Thank you for your leadership for
5 sitting in this room all day and talking about a lot of
6 important issues.

7 My name is Paul Pizzano. I'm with the National
8 Beer Wholesalers Association. We're with the alcohol
9 industry, but I'm here to talk about something that was
10 just discussed, actually -- the STOP Act. That's something
11 that's a \$17 million program in a \$2 billion budget; why
12 are we talking about this.

13 I think we're talking about this -- our
14 organization, we represent beer distributors across the
15 country; they're the ones with the beer trucks that you see
16 on the street. We're regulated at the state level and the
17 federal level.

18 Industry and public health community got together
19 on this bill because of several items that we were at
20 loggerhead over for a long time, but I think there's a
21 shared common interest in fighting underage drinking. But
22 there's also the interest in what is the proper role of
23 both the state and the federal government in this ongoing
24 debate?

1 So one of the items in the bill, besides the
2 funding stream, is some language recognizing the importance
3 of the states and the 21st Amendment, and as you go back to
4 your states, these debates are happening in your state
5 legislatures. There's a voice in there.

6 And secondly, I just wanted to make the Committee
7 aware of this, and something that we fought for very hard,
8 and is to make sure that SAMHSA is in the driver's seat and
9 the chairman of the ICPUD. ICPUD is the interconnected, all
10 of the federal agencies, the group to talk about underage
11 drinking.

12 We wanted SAMHSA to be in charge of that because
13 of the public health concern, to have that prism, to have
14 that focus on these issues, because too often -- and
15 there's a trend, especially very prevalent in Europe, and
16 it's moving into America, they treat alcohol just as any
17 other ordinary commodity, treated as milk or soda. And this
18 country's had this debate before; it's the 75th anniversary
19 of the repeal of Prohibition.

20 And it's something that has different laws for
21 different reasons, and something that the public health
22 community, there's a lot of litigation, a lot of state
23 legislative hype -- I'm not sure the public health
24 community understands the impacts of some of these

1 arguments. They may look like industrial skirmishes, but
2 they will affect communities across the country.

3 I just wanted to plant the seed that these issues
4 are out there as you head back to your states. And again,
5 thank you for your leadership. Last year, we were helpful,
6 we worked very hard to get some money in a very tight
7 budget year into the STOP Act. We were happy that there is
8 at least some money to get some of the programs started. I
9 know there's nothing in this budget, and there's nothing
10 you can really say about that, but we will be working to
11 try to get more money into the STOP Act in this upcoming
12 legislative year.

13 Thank you again, and thank you for your service
14 and thanks for hearing me out.

15 LT. GOV. AIONA: Thank you, Paul.

16 Well, is there anyone else? Thank you very much.

17 ***Closing Remarks***

18 Well, I want to again thank the Council for such
19 a great job that you all did. You came up with six great
20 recommendations in a record time, I think. So a good start
21 for this Council.

22 Before I leave, I do want to thank, and I think
23 we should all give a big round of applause to the staff,
24 especially Nevine Gahed, and Carol Watkins, and of course,

1 Toian. And our wordsmith, Lisa. Let's give her a big hand
2 also.

3 We want to thank Dr. Broderick for stepping in
4 for Dr. Cline, and I will turn it over to you.

5 DR. BRODERICK: Well, let me close with something
6 that those of you who are new to the Council have heard
7 many times over the last couple of days -- welcome, and
8 thank you for agreeing to join us in this quest that we're
9 on. We look forward to seeing you frequently over the next
10 several years. Those of you who have been with us for a
11 while, it's always good to see you again, and Lt. Gov.
12 Aiona, thank you so much.

13 I have many highlights of my time here at SAMHSA,
14 but getting to know you and witnessing your leadership here
15 on this council has been among the nicest. So thank you
16 very much for the role that you have played and the support
17 that you have provided.

18 On behalf of Dr. Cline, we look forward to these
19 continuing opportunities to solicit and seek your guidance
20 and advice, and I, too, like Duke, am really amazed at the
21 short period of time that it took to generate six wonderful
22 recommendations that synthesize what you have sort of come
23 to grapple with over the last couple of days.

1 Thank you very much again, and please travel
2 safely on your way home, and we look forward to seeing you
3 soon.

4 (Whereupon, the meeting adjourned.)

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